



**2014 NATIONAL REPORT  
(2013 data) TO THE EMCDDA  
by the Reitox National Focal Point**

# **DENMARK**

**New Development, Trends**

## Introduction

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

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

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# Summary

## The current drug situation in Denmark

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

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

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

In spite of the documented drop in the experimental use of drugs, an increasing number of poisonings have been recorded in the emergency rooms in Denmark. The number of poisonings recorded as a result of illicit drugs peak in 2013 with 2194 recorded contacts, and it is assumed that this is a conservative estimate. The increase in the poisonings the past few years is especially seen in those aged 30 and above. Among the young people, poisonings are typically seen with cannabis and psychostimulants, whereas poisonings with opioids and compounds of several drugs most frequently appear among the older generation.

Also psychiatric admissions resulting from drug-related diagnoses appear more frequently in these years. However, the development in the number of such admissions in 2010 is more or less on the same level as in 2012. In 2013, 5,547 persons were reported admitted to psychiatric hospitals with a drug-related primary or secondary diagnosis. Polydrug use is a dominant factor in the psychiatric admissions with a drug-related secondary diagnosis. When the admission is caused by one single drug, cannabis is the main culprit. The number of persons admitted to psychiatric treatment with a drug-related secondary diagnosis and where cannabis use is involved was more than 2000 in 2013, and the number has more than tripled over the past 10 years. There are significantly fewer admissions where cocaine abuse appears as a secondary diagnosis (203 persons in 2013), however an increase is also seen here over the years, although the trend declines from 2008 and onwards. The increase in the recorded admissions with drug-related diagnoses may reflect both an actual increase as well as improved registration routines.

Among other health-related consequences of drug abuse, the increased mortality rates should also be mentioned. Drug abusers generally account for very high mortality rates

when considering the age distribution. The higher mortality rates are primarily due to poisonings in particular, but also a higher volume of somatic diseases, including HIV and hepatitis. According to statistics from the National Police on drug-related deaths, 213 drug-related deaths were recorded in 2013. This is the same level as in 2012. In 2012 and 2013, the level is significantly lower than in previous years. By comparison, 275 deaths were recorded annually in 2009 and 2010, whereas the number peaked in 2011 with 285 deaths.

The number of drug-related deaths in Denmark has thus dropped significantly from 2011. The considerable drop from 285 deaths in 2011 to 210 deaths in 2012 is particularly due to a drop in deaths in the Region of Southern Denmark. The drop is particularly noteworthy because this region accounted for very high mortality rates from 2009-2011. From 2012 to 2013 mortality rates continue to drop in the Region of Southern Denmark, whereas death rates in the Region of Central Jutland and the Capital Region of Denmark are higher in 2013 compared to 2012. In the other regions, the level is more or less the same in 2012 and 2013. Considering developments in drug related deaths from 2012 to 2013 in the major municipalities in Denmark, only Copenhagen and Aarhus account for higher death rates from 2012 to 2013. In Odense, Esbjerg and Aalborg, the number of deaths continue to fall throughout the period. These numbers have been retrieved from the municipality in which the drug abuser was domiciled at the time of death and not the place where death occurred.

The drug-related deaths are most often caused by poisoning, and those that are not occur as a result of violence, accidents, suicide and diseases. Annual analyses show that on average, between 3 and 4 different substances are found in the deceased's blood on each drug-related death, which documents prevalent polydrug use among those who die.

Finally, the consequences of drug abuse are also detected in the statistics on drug abusers admitted to treatment. The most recent figures from 2011 show that almost 16,200 individuals are being treated for drug abuse in Denmark. This is the highest figure recorded since registration started. Data from all the years show that the young generation in particular accounts for those receiving treatment, and their drug use problem is typically cannabis and/or psychostimulants. In 2011, almost 4 out of 5 (79.5%) of the young population between the age of 18 and 24 in treatment took cannabis as their primary drug, whereas 9% and 4% of the young people in treatment used amphetamine and cocaine, respectively, as their primary drug. In addition to the increasing use of the illicit drugs up through the 90s, it must be assumed that the increased treatment capacity, treatment guarantees and the improved and more targeted treatment programs have contributed to the documented increase in drug abuse treatment.

The number of drug abusers in Denmark is currently estimated to be 33,000, out of which figure 11,000 are estimated to be cannabis abusers. This estimate was made by the Danish Health and Medicines Authority in 2010. This is an increase in the number of drug abusers in Denmark compared to previous years. In 2006, the number of drug abusers was estimated to 27,000, out of which 7,000 were cannabis users only. The increase in the estimated number of drug abusers is thus characterized by an increase in the number of cannabis abusers from 7000 in 2006 to 11,000 in 2010. These figures do not include experimental drug use, but estimates the number of persons who are more permanent users of drugs leading to physical, mental and/or social injuries. Drug addicts are thus included in the estimate, including drug addicts receiving drug substitution therapy. At present, 13,000 drug abusers are estimated to inject the drugs. In-

jecting drug users are particularly at risk of developing severe injuries and diseases and eventually of dying.

### **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.

In 2013, the Danish Health and Medicines Authority drafted a preventive package on drugs similar to previous preventive packages on alcohol and tobacco. The purpose of the package on drugs is to support the municipalities in their efforts to prevent against young people's use of drugs and to track down and prevent against continued use of drugs among young people who risk developing regular drug use. The primary target group of this work is young people under the age of 25. The preventive package provides specific recommendations for prioritization of intervention programs in the municipalities.

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

The project "Udgående indsatser til unge med rusmiddelproblemer" (Outreach intervention targeted at young people with alcohol and drug problems) tests a cannabis group model for group programs offered to young people with drug and alcohol problems at the business and commercial schools in six selected municipalities. The National Board of Social Services administers the project which has been inspired by the Copenhagen Municipality's project under U-turn. The target group of this intervention is young people under the age of 25 years attending business colleges and production schools and having problems with the use of alcohol and drugs or abuse of primarily cannabis requiring no treatment. The aim of the project is to enhance their chances of completing an education.

The Danish Health and Medicines Authority's preventive work still includes focus on party settings as a risk arena. Examples of such projects include "Ansvarlig udskænkning" (Serving drinks responsibly) and media campaigns at selected risk arenas. In connection with the organisation Dansk Live, the Danish Health and Medicines Authority carries out campaigns at festivals and music halls, the so-called *Music Against Drugs* and *Less Alcohol – More Party* campaigns.

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

and in Aarhus since the autumn of 2013. As far as the latter is concerned, the experience acquired from Copenhagen has been outlined in Chapter 7 of this report.

#### New drugs and new legislation

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

Since the publication of last year’s National Report, the following drugs have been made subject to control as recommended by the Danish Health and Medicines Authority: As of October 2013, the drugs 5F-Apinaca and 5F-PB-22 shall only be used for medicinal and scientific purposes. As of 30 May 2014, the drugs 4,4’-DMAR, MDAI, 5-MeO-DALT, MPA, N-Methyl-2-AI, SDB-001 and STS-135 shall only be used for medicinal and scientific purposes.

As of 1 July 2012 it was decided that in Denmark the prohibition of individual drugs should be supplemented with groups of similar drugs (generic system) and consequently, a number of new drugs have emerged and are already comprised by the ban. On 28 October 2013, the so-called phenethylamine group was expanded to include drugs that hereinafter shall only be used for medicinal and scientific purposes.



# 1 Drug policy; legislation strategies and economic analysis

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

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

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

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

Within prevention, the Danish Health and Medicines Authority handles the overall monitoring and safeguarding of the identification and communication of new trends and drug problems. The municipalities are responsible for the specific preventive interventions, whereas the Danish Health and Medicines Authority is responsible for contributing to development of methods and make sure that counselling and guidance is provided locally.

Also, the Danish Health and Medicines Authority is responsible for the overall drug monitoring, for the preparation of surveys and analyses of drug use in the population and the drug market. The State Serum Institute is responsible for collecting data from the various drug records and together with the Danish Health and Medicines Authority, the institute will carry out ongoing qualification of the data collected. The Danish Health and Medicines Authority acts as the national focal point for the European Monitoring Center for Drugs and Drug Addiction (EMCDDA).

Finally, the Danish Health and Medicines Authority administers the rules on the legal use of psychoactive substances. The Authority issues authorisations to companies asking to handle psychoactive substances for scientific or medicinal purposes and performs control on these drugs through inspections. The Authority issues certificates for the transport of psychoactive substances across borders and is responsible for reporting to the International Narcotics Control Board (INCB) in accordance with the UN conventions of 1961 and 1971 on narcotic and psychotropic substances.

The Ministry of Children, Gender Equality, Integration and Social Affairs has the central responsibility for the tasks concerning the social drug abuse treatment and the remaining social support.

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

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

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

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

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

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

In 2014, the following laws have been passed:

- The Danish Road Traffic Act no. 457 of 14 May 2014 (as amended). This act provides rules on the re-acquisition of driver's license although the right to drive a vehicle has been suspended as a result of drug driving. The act sets out that the driver shall be entitled to re-acquire his/her driver's license on the condition that a course be completed on driving under the influence of psychoactive substances, etc. (a so-called ANT-course). The amendment of the Danish Road Traffic Act also included that as of 1 July 2014, the police shall be entitled to confiscate the vehicle in cases where the driver has been under the influence of psychoactive substances. Also, the act provides that the police shall be entitled to immediate license suspension in cases where the driver is suspected of drug driving and the risk of that same person doing it again shortly after.

In 2014, the following executive orders were amended:

- Amendment of Executive Order no 430 on quality standards for social treatment of drug abuse in accordance with Section 101 of the Act on Social Services. The amendment came into effect on 7 May 2014 and provides that quality standards must be prepared by the local council no later than 8 September 2014. As a result of the amendment, the local council shall be under an obligation to outline how follow-up is made on the citizen's treatment plan and the local council is also required to provide estimates for:

- The proportion of drug abusers who are clean after treatment and the proportion of drug abusers who have reduced drug abuse at the end of treatment.
- The proportion of treated drug abusers returning to drug abuse treatment within 12 months after end of treatment.

Since the completion of last year's National Report, the following narcotic drugs have been made subject to control:

- The executive order no. 1222 of 28 October 2013 on the amendment of executive order on psychoactive substances provided that the drugs 5F-Apinaca and 5F-PB-22 shall only be used for medicinal and scientific purposes and that the group of drugs under the phenethylamine group, which shall only be used for medicinal and scientific purposes, be expanded. The executive order became effective as of 28 October 2013.
- The executive order no. 538 of 27 May 2014 on the amendment of executive order on psychoactive substances provided that the drugs 4,4'-DMAR, MDAI, 5-MeO-DALT, MPA, N-Methyl-2-AI, SDB-001 and STS-135 shall only be used for medicinal and scientific purposes. The executive order became effective as of 30 May 2014.

## **1.2 Budget and funding schemes**

In continuation of the social reserve agreements according to which funds have previously been set aside for the strengthening of drug intervention, of the description in the 2013 National Report, the government and a broad majority of the Danish Parliament (the "Folketing") agreed in October 2013 that social reserve funds for 2014 should give high priority to drug treatment intervention by improving programs offered to individuals who wish to be admitted to treatment. The parties agreed that as of 2015, citizens should be entitled to a session with a doctor no later than three days after having contacted the local authorities with a wish of being admitted to treatment. Also it was agreed that citizens should be given the right to be subjected to medical drug abuse treatment no later than 14 days after their request and a right to free choice of treatment venue. Also the social reserve agreement of 2014 provided on the basis of experience gained from the pilot project "Projekt Anonym Stofmisbrugsbehandling" (Project Anonymous Drug Abuse Treatment) that funds should be set aside for the establishment of anonymous drug abuse treatment. It was agreed that the local social services will be obligated to offer anonymous treatment to individuals who require treatment for the drug abuse as their primary social problem. The target group includes drug abusers who, apart from being drug users, are not socially impaired and who have a relatively close affiliation to the labour market or the educational system.

Further information on the Budget over the years and the social reserve funds have been described in detail in the National Report of previous years.

From the Drug Reserve administered by the Ministry for Children, Gender Equality, Integration and Social Affairs DKK103million have been set aside from 2013-2018 to a drug abuse package containing 10 specific initiatives targeted at social treatment of drug abuse. The overall aim of the package is to contribute to enhance the quality of the social treatment of drug abuse via use of know-how and methods that have a documented effect on the citizens. The aim is also to ensure focus on comprehensive so-

cial efforts and follow-up on the individual citizen. The initiatives under this drug abuse package are outlined in section 5.4 of this report.

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

As for local government expenditure, the accounts and budgets show a heavy increase since 1995 in the funds reserved for social treatment of drug abusers. Thus the 2013 accounts showed an amount of DKK874million (2014 price and wage level), whereas the same figures for 1995 were DKK294million (2014 price and wage level). The trend from 2012 to 2013 shows a minor decrease of 2 per cent from DKK894million in 2012 (2014 price and wage level) to DKK874million in 2013 (2014 price and wage level).

As for treatment of drug abusers in the prisons, there has been a significant upward trend. Budgets for 2001 were thus DKK6.2million, whereas the same budget figures in 2013 were DKK101.3million.

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

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

### **2.1 Introduction**

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

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

In 2011, a follow-up was made on the international school survey project ESPAD<sup>1</sup> from previous years. It describes the development in the experimental use of drugs and alcohol - including the illicit drugs among the 15-16-year-olds. The results from the survey in 2011 show the same trend as that of the population survey among adults - a positive falling trend these years in the experimental use of illicit drugs.

In 2010, the first night club survey was made in Denmark (Järvinen 2010). The night club survey is part of a research project referred to as YODA<sup>2</sup>. The main results from the survey on drugs in the night life are described later in this chapter.

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

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

The results provided here are based on national population surveys of the self-reported use of illicit drugs from 1994, 2000, 2005, 2008, 2010, and 2013. All the surveys were

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<sup>1</sup> The European School Survey Project on Alcohol and other Drugs (ESPAD).

<sup>2</sup> YODA is the acronym for Youth, Drugs and Alcohol and is a survey of attitudes towards and experience with illicit drugs among the youth population and young adults in the population in general and in the nightclub environment in particular.

carried out by the State Institute for Public Health, the University of Southern Denmark. The analyses on the prevalence of drugs are based on a population aged between 16 and 44 years. In persons above the age of 44 years, use of illicit drugs is limited, and the over-44-year-olds are therefore not included.

### Prevalence of cannabis

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

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

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

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

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

### Prevalence of other illicit drugs

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

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

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

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

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

## Prevalence of illicit drugs among the young adults

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

**Table 2.2.4. The percentage of the 16-34-year-olds who used cannabis the previous month, last year, and ever in the year in question.**

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

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

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

	1994 (n=1.648)	2000 (n=4.019)	2005 (n=2.470)	2008 (n=1.710)	2010 (n=3.287)	2013 (n=3.011)
<b>Used one or several illicit drugs other than cannabis</b>						
Previous month	0,1	1,8	1,5	1,4	1,3	1,3
Last year (including previous month)	0,6	5,0	4,0	4,9	3,4	3,6
Ever	4,2	13,3	16,4	16,0	14,4	14,4

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

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

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

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

<b>Used cannabis</b>	1994 (n=735)	2000 (n=1.728)	2005 (n= 919)	2008 (n=862)	2010 (n=1.643)	2013 (n=1.652)
Previous month	3.7	7.8	8.2	8.1	7.1	8.5
Last year (including previous month)	12.9	20.1	20.5	21.3	18.9	23.9
Ever	34.7	41.5	44.2	41.1	38.0	41.5

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

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

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

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

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

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



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

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

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

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

	SUSY 2000 (n=1.684)			SUSY 2005 (n=894)			AiD 2008 (n=857)			SUSY 2010 (n=1.612)			SUSY 2013 (n=1.608)		
16-24yrs	men	wom- en	total	men	women	Total	men	wom- en	total	men	wom- en	total	men	wom- en	total
Ampheta- mine tried within the past year	9,0	3,1	5,9	6,5	2,4	4,1	9,8	2,1	5,4	4,9	1,2	2,8	2,4	0,9	1,6
Cocaine tried within the past year	4,6	1,3	2,8	5,4	1,9	3,3	9,8	2,4	5,6	5,3	1,1	2,9	3,6	1,3	2,3
Ecstasy tried within the past year	3,3	1,5	2,3	3,1	0,4	1,5	4,0	1,0	2,3	1,7	0,6	1,1	1,6	0,6	1,0

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

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

### Frequency in the use of illicit drugs

In the SUSY survey in 2013, those who are current users of cannabis or other illicit drugs within the previous month were asked how many times they had taken drugs.

There was a total of 8.5% among the 16-24 year-olds who had used cannabis during the previous month. A total of 82% of these used the drug 1-3 times. The remainder took drugs more frequently (9% used drugs 4-9 times and 9% more than 10 times during the previous month). When it comes to indications of how frequently drugs are used, the figures are very small, for which reason the accuracy of these results is uncertain.

### **Regional differences in the use of illicit drugs**

In SUSY 2013, regional benchmarking has been made on the prevalence of the illicit drugs. The results indicate that the use of cannabis is the highest in the Copenhagen region. Among the young people under the age of 25 years in the Copenhagen region, it turns out that 10 - 20 percentage points more of these young people have tried cannabis ever compared to those within the same age group in the other regions. As regards drugs other than cannabis, prevalence is geographically more even.

### **The age of first drug use**

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

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

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

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

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

**Table 2.3.1. The percentage of the 15-16-year olds who have tried illicit substances in 1995, 1999, 2002, 2003, 2007 og 2011**

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

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

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

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

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

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

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

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

### Experience with illicit drugs in nightclubs

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

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

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 this drug, which again confirms a riskier party culture among these young people than among the other young people.

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

### **Attitudes and risk assessments among the Danish youth**

Another focus point of "drugs and night life" was the young people's knowledge of drugs and their risk assessment of various types of drugs. The results are not based on the actual night life survey, but on focus group interviews among the pupils in business colleges and high schools, of which some have tried cannabis, whereas the majority of them have limited experience in drug use. This reflects the situation among young people in Denmark. Due to their lacking experience in drugs, they build their knowledge and perceptions of various drugs on the experience and perceptions of their friends. These perceptions - known as discourse - are interesting, as often they are crucial to the young people's willingness to experiment with a drug. The survey demonstrated that 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. On a closing remark, 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 as harmless, one of the reasons being that it is typically sniffed, and because it is associated with addiction. On the other hand, the drug is perceived as one without any impact on one's life as a whole and that it may even be "performance enhancing".

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

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

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

it drug other than cannabis. In summary: the so-called *drug and alcohol focused young people* have, to a large extent, experience in illicit drugs.

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

## 3 Prevention

### 3.1 Introduction

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

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

One of the focus points in the overall Danish health policy is to reduce inequality in health. In the spring of 2013, the Danish government launched a campaign under the title "Mere borger, mindre patient" (More citizen, less patient), the focus of which was to contribute to even out the inequalities in the health among the Danes.

In 2011, the National Health and Medicines Authority published the report "Ulighed i sundhed – årsager og indsatser" [Inequality in health – causes and interventions] (The National Health and Medicines Authority 2011a). The report describes the various conditions causing inequality such as use of alcohol, tobacco, and drugs. The report also emphasises the significance of sectors coordinating across political boundaries in order to reduce social inequality in health.

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

In 2013, the Danish Health and Medicines Authority and the National Board of Social Services published a pamphlet titled "Sundhedstilbud til socialt udsatte borgere" [Health programs provided to socially marginalised citizens] (The Danish Health and Medicines Authority 2013a). The aim of this material was to inform about tested methods for improving the health of socially marginalized citizens, including the prevention against drug abuse.

Furthermore, the Danish Health and Medicines Authority issued a drug prevention package to the municipalities in 2013 (the Danish Health and Medicines Authority 2013b). It was prepared in continuation of the previous prevention packages on alcohol (the Danish Health and Medicines Authority 2012a), mental health (the Danish Health

and Medicines Authority 2012b), and on tobacco (the Danish Health and Medicines Authority 2012c). The prevention packages include specific recommendations for the type of interventions to be prioritized by the municipalities within the various risk factors. Inequality in health is an overall theme in all the prevention packages. The recommended interventions are divided into basic preventive interventions which may strengthen quality of prevention programs in the short run and into interventions that may further develop prevention interventions in the municipalities in the long run. There are four types of prevention package interventions: framework interventions such as local policies and action plans (universal prevention), information and teaching (universal prevention), early detection, and finally various programs such as counselling, etc. (selective and indicated prevention). The recommended interventions are based on evidence from systematic research papers and from best practices currently in place.

The aim of the prevention package on drugs is to support the municipalities' work in preventing against the use of psychoactive substances, particularly among young people. The package focuses on preventing against early age of first drug use among all the young people (universal prevention) and to detect and prevent against continued use of drugs among young people at risk of developing regular drug use patterns (selective and indicated prevention). The primary target group of the package is young people under the age of 25 years. The secondary target group includes parents and professionals working with young people. Several of the recommendations included in the package also provides for prevention against drug use among citizens at the age of 25 and above.

Since prevention against drug use is closely correlated with prevention against the use of alcohol and tobacco and the improvement of health and well-being, the prevention package on drugs must be viewed in connection with the prevention packages on alcohol, tobacco, and mental health. The work with drug prevention in the municipalities is thus dependant on the municipalities working with the recommendations laid out in the three other prevention packages.

### **Distribution of tasks related to prevention intervention**

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

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

### **Benchmarking of local prevention interventions**

In order to uncover the municipalities' efforts, the Danish Health and Medicines Authority carried out benchmarking in 2013 on their preventive interventions within drug use (KORA 2013). 92% of the municipalities took part in the survey.

This benchmarking survey shows that 73% of the municipalities focus on drug prevention interventions as part of a policy/action plan, either as an isolated policy/action plan

or as part of the local community's children and youth policy or health policy. By far most of the municipalities focus their interventions on groups or arenas.

Furthermore, the benchmarking survey shows that drug prevention intervention in the municipalities often includes collaboration across sectors such as school, social administration and police (known as SSP). Furthermore, many municipalities cooperate with treatment institutions on prevention and approximately half of the municipalities work closely together with bars, restaurants and discotheques.

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

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

### **3.2 Structural issues**

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

### **3.3 Universal prevention**

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

#### **Primary school as an arena**

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

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

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



In its prevention package on drugs, the Danish Health and Medicines Authority recommends the following universal prevention interventions at a primary school level:

- Systematic knowledge and dialogue-based teaching in primary school on the use of drugs. The aim is to postpone the age of first drug use and prevent against and limit the use of drugs and alcohol through the development of personal and social competencies, well-being and attitudes. In this connection, it might be worthwhile to work with majority misunderstanding and social bearing.
- Preparation of drug and alcohol policies and action plans for primary school pupils with a focus on preventing against the use of drugs among children and young people as well as employees at the school, including action plans for handling of suspicious behaviour and knowledge on the use of drugs.
- Involvement of parents of children in primary school with a view to generating a dialogue on drugs and alcohol and to enter into agreements with parents in the classes.

As an inspiration for teaching about the use of drugs in primary school, the Health and Medicines Authority recommends the method known as "Tackling" (The Danish Health and Medicines Authority 2009a) which is originally developed in the US and subsequently adopted and tested in a Danish version. The Danish Health and Medicines Authority describes other methods involving pupils in its publication "Forebyggelse og sundhedsfremme i skolen" [Prevention and health promotion in school] (Sundhedsstyrelsen 2009b), viz. "Aktive vurderinger" [Active assessment], and "Du bestemmer" [You decide].

In the autumn of 2011, the Danish Health and Medicines Authority published two papers: "Dit barns festkultur" [Your child's party culture] aiming at parents (The Danish Health and Medicines Authority 2011f) and "Sæt rammer for alkohol, tobak og stoffer" [Determine limits for alcohol, tobacco and drugs] aiming at teachers and management in elementary schools (The Danish Health and Medicines Authority 2011c). Both publications contain facts about drugs and alcohol as well as their effect and silenced prevailing myths on young people, drugs, alcohol and smoking. The first paper also focuses on the drafting of a contract with parents in order to postpone the young person's age of starting to drink and avoiding drugs, whereas the second paper provides an outline on the most important elements contained in a drug and alcohol policy/action plan.

In 2013, the Danish Health and Medicines Authority revised and reprinted the drug facts pamphlet "Stoffer - hvordan virker de, og hvordan ser de ud" [Drugs - how they affect me, and how they look] (The Danish Health and Medicines Authority 2013c). The pamphlet provides general information on the most common psychoactive substances. It can also be used by personnel working with drug and alcohol prevention in youth education institutions and in local community institutions.

### **Youth education as an arena**

The benchmarking survey of local drug prevention intervention shows that 68% of the municipalities collaborate or have a dialogue with the youth education institutions on drug use prevention. This cooperation includes, among others, annual feature days, meetings with contact teachers, counselling and support to development of drug and alcohol policies in the schools as well as competence development and sparring with teachers and counsellors (eg methods for early detection, the difficult talk, etc). The benchmarking survey also shows that drug prevention intervention at the youth education institutions often has a wider focus on retention and well-being.

In the prevention package on drugs, the Danish Health and Medicines Authority recommends the following universal prevention interventions in youth education institutions:

- The municipality should enter into cooperation with the local youth education institutions and production schools in order to strengthen the institutions' drug prevention intervention on drugs and alcohol policies, action plans, well-being, etc. The municipality should facilitate dialogue and exchange of experience between the youth education institutions thereby ensuring common goals.
- The municipality should establish an outreach function of teaching and dialogue on the use of drugs and alcohol in youth education institutions, production schools, etc. The aim is to postpone the age of starting first use of alcohol and drugs, prevent and limit the use of drugs, improve well-being, personal and social competencies, attitudes and limit majority misunderstandings.

As a source of inspiration, the Danish Health and Medicines Authority published in the summer 2012 a catalogue titled "Sunde erhvervsskoler" [Health business colleges] to the leaders and teachers at business colleges on how to contribute to setting up a healthy framework in the schools and introduce health in the curricula, including use and abuse of drugs (Danish Health and Medicines Authority 2012d). The inspiration catalogue contains specific examples of how to convey knowledge about drugs to the young people and how to enter into dialogue with them.

Also, the Danish Health and Medicines Authority issued a publication titled "Til forældre på ungdomssuddannelsen: hjælp din teenager – med at skabe rammer for alkohol, tobak og stoffer [To the parents of children in youth educations: help your teenager – set out the framework for their use of alcohol, tobacco and drugs] (The Danish Health and Medicines Authority 2011d) and another publication titled "To the teachers and leaders of youth education institutions: Policy for drugs, alcohol and smoking" (The Danish Health and Medicines Authority 2011e)

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

The Danish Health and Medicines Authority administers the social reserve fund titled "Unge, alkohol og stoffer" which runs from 2011 to 2014. Six model municipalities have received a total of DKK 17million for projects focusing on prevention against alcohol and drugs in youth education institutions. The aim of the model municipality projects is to test whether enhanced and binding collaboration between the municipality and the youth education institutions can contribute to limiting the prevalence of drugs and alcohol among young people. The model municipalities' intervention is intended to strengthen prevention against alcohol and drugs and contribute to developing methods to promote a drug and alcohol prevention environment at the youth education institutions through the formulation of drug and alcohol policies. All projects are divided into two types of intervention: a universal and a selective one (described in section 3.4)

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

The mid-term evaluation made in 2013 shows that some projects have chosen to draft a joint policy, which applies to all the education institutions involved, whereas other projects have chosen for each institution to draft its own policy. The policies vary between

having a clear focus on drugs and alcohol, whereas others have a more broad focus on well-being and retention of the pupils, with drug and alcohol problems having high priority, but not the only subjects.

The final evaluation is planned to be made at the end of 2014.

### **Furthering mental health in young individuals at production schools and business colleges**

The Danish Health and Medicines Authority also administers a new social reserve fund for mental health in young individuals at the production schools and business colleges with a special focus on anxiety and depression. The project period runs from 2013 to 2016 and a final evaluation will be made at the end of 2016. The seven selected model municipalities will be testing a newly developed education programme, the aim of which is to further mental health in young individuals. Drug use will be subject to special focus.

## **3.4 Selective and indicated prevention**

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

The prevention package on drugs prepared by the Danish Health and Medicines Authority includes recommendations for a number of selective and indicated prevention interventions, especially under the focus areas "Programs" and "Early detection" (The Danish Health and Medicines Authority 2013b).

The selective part of the social reserve fund project "Unge, alkohol og stoffer" [Young people, alcohol, and drugs] (described in section 3.3) consists of early counselling and guidance to young people who appear to be en route to problem drug use. In this connection, all six model municipalities have received competence development in the form of training in talking to the young people about drugs in a recognizing and motivating fashion. Some of the model projects apply programs that focus directly on young people with abuse problems, whereas other projects are more broadly focused on well-being, with abuse problems constituting one out of numerous focus areas.

### **Internet-based information and counselling programs to young people**

The prevention package on drugs prepared by the Danish Health and Medicines Authority recommends that counselling to young people using drugs on an experimental basis be placed and offered to match the needs of the target group, including online counselling services (the Danish Health and Medicines Authority 2013b).

[www.netstof.dk](http://www.netstof.dk) is a nationally based service provided to young people seeking information and advice on alcohol, cannabis and other drugs. Netstof.dk has existed since 1998 and from being a small website for the 14-18-year-olds, netstof.dk has now expanded into a comprehensive and interactive youth portal with a problem page and young-young contact.

Netstof.dk has been evaluated and shows, among other things, that the portal reaches out to a group of young people experimenting with cannabis and other drugs, but who are traditionally difficult to reach, because they do not themselves recognize that they have a drug problem. The Ministry of Children, Gender Equality, Integration and Social

Affairs has granted social reserves to retain and further develop a national programme on internet-based counselling to young people visiting [netstof.dk](http://netstof.dk). The primary target groups is young people aged from 15 to 24 years at risk of developing abuse requiring treatment. The funds were granted for the period 2012 to 2015. Netstof.dk will continue to offer a debate forum, problem pages and information and will, also, add a chat function to the site.

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

### **Project "Outreach interventions to young people with substance problems"**

This project tests an adapted version of U-turn's cannabis group model with group programs offered to young people with alcohol and drug problems in business colleges and production schools in 6 selected municipalities. U-turn is a program offered by Copenhagen Municipality to young people under 25 years who smoke cannabis or use drugs. The aim of the project is to help vulnerable young people to finalise their education. The intervention includes short-term group sessions supplemented with individual sessions at the business college or the production school. The target group is young people attending business colleges or production schools, who have shown problem drug use or cannabis abuse requiring no treatment.

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

The project municipalities started the first group sessions in 2013. The model was finally determined at the beginning of 2014, following which it will be tested in the municipalities until mid-2016. The effect of the tested model will be documented.

### **Responsible serving of alcohol**

The prevention package on drugs prepared by the Danish Health and Medicines Authority recommends that the municipality establish prevention interventions in bars, restaurants and discotheques. In a cooperation forum of the stakeholders involved, contracts should be signed on responsible serving of alcohol (The Danish Health and Medicines Authority 2013b).

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

responsibly and in line with the other preventive interventions carried out by the municipalities on drugs and alcohol.

The benchmarking survey of the municipalities' work on drug abuse prevention shows that the municipalities use their experience from "Responsible Serving of Alcohol". Two out of three municipalities collaborate with relevant stakeholders and establish courses for door men and other staff working with drug and alcohol problems, first aid, conflict management, etc and the establishment of dialogue fora between municipalities, SSP license holders, police, educational institutions and other relevant stakeholders.

The contents of "Ansvarlig udskænkning" were based on experience from projects such as "Trygt natteliv" [Safe night life] and the model municipality project "Narkoen ud af byen" [Drugs out of town] as well as research results from the Swedish STAD-project dealing with "Responsible Serving of alcohol at inns"<sup>3</sup>.

### **3.5 National and local media campaigns**

Media campaigns in the form of mass media communication aiming at the entire population or the broad target group are not used in the drug 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 and in addition receives much attention in the media. Therefore, it is assessed that it is neither necessary nor appropriate to flash the problem further through widespread campaigning, which may lead to creating unintentional "advertising" for drugs and contribute to "majority misunderstandings" among the Danish population.

Drug prevention campaigns of an informative and attitudinal nature should, however, be limited to risk arenas where it is generally known that a large number of young people experiment in drugs. Therefore, since 2003, the Danish Health and Medicines Authority has worked closely together with Dansk Live, an interest group for festivals and music scenes. Since 2009, this cooperation was followed up by a campaign aiming at young people and their use of alcohol. In 2009, this collaboration was expanded to include a similar anti-drug campaign in these musical settings. The party settings have been selected as the central arena, as the studies show that it is in these venues that the risk of the young people experimenting with drugs is high. As an important part of the campaigns, the festivals and music venues have been the organizers of the campaigns. The idea is that as trendsetting players in the young people's party environment, the various organizers would like to have a good and positive message to send to the target group of young people.

#### **Dansk Live Against drugs and Roskilde Against drugs**

The Danish Health and Medicines Authority and Dansk Live's drug prevention campaign, "Music Against Drugs", was launched in 2013 at 14 festivals, including the Roskilde Festival which also supported the campaign with its own "Roskilde Against Drugs" campaign. The primary group is young people visiting the festival and particularly the 16-24-year-olds. The festivals have successfully used the material, which consists of printed and electronic elements. The festivals also have statements on their websites, in their programs, and in their festival newspapers. All the different elements contribute

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<sup>3</sup> [www.fhi.se](http://www.fhi.se)

to flashing a common attitude towards drugs. The campaign points out that the young people are free to choose for themselves, also when it comes to taking drugs. In effect this means that they should not do what their friends think they should do or what they think that everybody else does. The campaign slogan has varied throughout the past years. In 2013, the slogan was "DON'T LET OTHERS SPEAK YOUR MIND".

The evaluation of the 2013 campaign (the Danish Health and Medicines Authority 2013d) is based on festivalgoer surveys made at Roskilde Festival – which is by far the greatest of the 14 festivals – and at three small festivals selected at random among the other festivals. These festivals are: Vig, Tønder and Bork Havn Festivals. The four festivals address different target groups and therefore give a balanced picture of the campaigns reception across Denmark.

At the Roskilde Festival, the 2013 evaluation showed that 81% had seen the campaign, which is similar to last year's average rate, however with a slight increase compared to 2012. 25% had discussed the message of the campaign with others, which is a minor drop compared to 2012. 94% of the festivalgoers thought it was a good idea that the festival took action against drugs.

The 2012 evaluation from the three small festivals showed that approximately only half of the festivalgoers had seen the campaign, with the highest rate coming from the Vig Festival (58%). Here, 43% of the festivalgoers had discussed the campaign message, whereas this percentage was slightly lower at the Bork Havn and Tønder festivals (20% and 26%, respectively). Between 96 and 98% of the festivalgoers found that it was a good idea that the festivals displayed an attitude against drugs.

### **Dansk Live and Roskilde Festival – Young people and alcohol**

In 2012, 13 festivals and all the Grøn Koncert-events participated in the Danish Health and Medicines Authority's and Dansk Live's campaign Young People and Alcohol with the slogan "Less Alcohol – More Party". The focus of the campaign is teenage drinking, and it focuses on the age limits for serving and selling alcohol. The aim of the campaign is, among others, to urge to compliance with age limits for serving alcohol. The primary target group for the campaign is thus the young people's parents and employees at the festivals, but the campaign also addresses the young people under 16 years of age. The campaign elements are located at the tent sites and around the bars and primarily consists of printed media, but there is also a website. The contact to the parents is made via PR slogans, where useful advice is communicated to parents of teenagers.

Young People and Alcohol was – similarly to Against Drugs – evaluated both at the Roskilde Festival and at the three small festivals in Vig, Tønder, and Bork Havn (the Danish Health and Medicines Authority 2013e). At the Roskilde Festival, 34% of the employees had seen the campaign, which is a small increase compared to 2012. The result from 2013 also showed that 83% of the employees could answer the question of how old you should be to buy alcohol at a festival. As in previous years, the 2013 evaluation showed that 93% of the employees think it is a good idea to have such a campaign.

The 2013 evaluations from the Vig, Tønder, and Bork Havn festivals show that between 30 and 70% of the festivalgoers have seen the campaign, and that 36% of them have discussed the campaign with each other. Approximately 96% of the festivalgoers support the campaign. The quantitative employee survey in 2013 was not sufficiently completed to justify presentation of the results.

**Music against drugs**

In 2013, the campaign Music Against Drugs ran in 39 music halls during the period from September to November with the same slogan as the one used at the festivals ie: "DON'T LET OTHERS SPEAK YOUR MIND". The campaign addresses both the audience and the staff at the music halls. The primary target group within the audience is the young people between 16 and 24 years of age, whereas the staff target group is made up of all staff working in the music halls. In 2013, the campaign included printed as well as electronic elements, such as web banners, t-shirts for the staff, posters, stickers, badges, etc. Feedback from the audience and the staff again was positive towards the music halls voicing their attitude towards drugs. The feedback, however, also shows that it is more difficult to get the message through to the music halls than at the festivals, and that it is difficult to plan a campaign matching all music halls. The fact is that they all differ significantly in terms of target group and size.

## 4 Problem drug use

### 4.1 Introduction

The most recent estimate on the number of drug abusers in Denmark, which will be provided below, was made in 2010 and is based on figures from 2009. The chapter will describe the results from 2010 – which means the most recent estimate at this time.

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

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

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

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

### 4.2 Estimated number of drug abusers in Denmark

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

As in previous years, the estimate which was made in 2010, was made using the capture-recapture model<sup>4</sup>. The estimate is based on the National Patient Register (LPR) and the national register of drug abusers who are receiving or have received treatment (SIB). The approach has been to investigate how many persons are registered in the LPR with a drug-related diagnosis<sup>5</sup>. An analysis is then carried out of how many of these people are also listed in the SIB.

The estimate on the number of drug abusers from 1996 to 2009 appears in table 4.2.1. Since the calculations of the estimates throughout the years are based on the "live"

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<sup>4</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>5</sup> The codes F11.1, F11.2, F11.9, F12.1, F12.2, F12.9, F14.1, F14.2, F14.9, F15.1, F15.2, F15.9, F19.1, F19.2, F19.9 are used in this case.



registers, an adjustment in the estimates from previous years has also been made in connection with the preparation of the 2010 estimate.

The estimate includes the number of people who are more persistent drug abusers, as a result of which they suffer harmful physical, mental and/or social injuries. Drug abusers in substitution treatment have been included in the estimate.

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

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

Source: The Danish Health and Medicines Authority 2010b

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

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 chapter). There seems to be an actual, relative decrease in the number of drug users seeking treatment for opioids/heroin addiction, while there is an increasing number of users seeking treatment for addiction to cannabis and stimulants. The change is particularly seen among the "new" individuals in drug treatment and is assumed to reflect the similar changes in the population of drug abusers.

### 4.3 Scope of injecting drug use

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

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

As shown previously in this chapter, the Danish Health and Medicines Authority's overall estimate of the number of drug abusers is 33,000, of which 11,000 are cannabis abusers. As it is estimated that there are 13,000 injecting drug users in Denmark, it is

assumed that around 60% of the drug abusers (not including cannabis abusers) are injecting drug users (primarily users of opioids).

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

#### **Number of injecting drug users calculated by mortality rates**

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

#### **4.4 The number of homeless people with abuse problems**

The most recent homeless census made in 2013 shows that there are 5,820 homeless people in Denmark. The census shows that, apart from not having any fixed abode, the homeless often are up against complex social problems. Furthermore, the census shows that 65% of the homeless are abusers of alcohol, cannabis, narcotics other than cannabis and/or medicine. The number is highest among the homeless who sleep in the street and in shelters overnight, with 71% and 72%, respectively dealing with abuse problems. The percentage of abusers who stay overnight with family and friends is 60% and the percentage of abusers who stay overnight in shelters is 70%. Also among the young homeless at the age of 18-24 years there is a considerable proportion with abuse problems. According to the census, 58% of the young homeless have abuse problems within one or several of the categories mentioned above. The 2013 homeless census is a follow-up on similar homeless census surveys made in 2007, 2009, and 2011. The percentage of homeless with abuse problems has dropped slightly from 70% in 2009 to 67% in 2011. (Benjaminsen et al., 2013)

## 5 Drug treatment – demand and availability

### 5.1 Introduction

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

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

The number of drug users in treatment has increased steadily since 1996, when the Danish Health and Medicines Authority (then National Board of Health) started recording drug users admitted to treatment. From 1996 to 2006, the number of persons admitted to treatment almost tripled. The reason for this is primarily assumed to be the introduction of the treatment guarantee and improved treatment capacity. From 2006 to 2008, there was a drop in the number of drug abusers in treatment, which is most likely due to the changes in registration practice and the transition to the new SEI - the registration that changed the admission and discharge procedures. Another thing is that in these "transition years", registration was affected by the fact that the municipalities took over responsibility from the counties at the turn of the year 2006/2007. From 2008 to 2011, the number of people admitted to treatment started to go up again.

The most recent figures from 2011 show that there are almost 16,200 drug abusers registered in the register on drug abusers in treatment (SIB). More than 7,600 of these drug abusers receive substitution treatment – either with methadone or buprenorphine.

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

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

## **5.2 The treatment system – strategy, politics, and organisation**

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

The municipal council is responsible for the medical and social treatment of drug abuse, and for preparing a treatment plan for the following course of treatment. This treatment plan must be combined with the action plan under Section 141 of the Danish Consolidation Act on Social Services for citizens with considerably impaired physical or mental functions and citizens with serious social problems.

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

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

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

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

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

Typically, the social drug abuse treatment is provided by people with an educational background within social affairs or healthcare such as a social teacher, social worker or nurse, supplemented by supplementary training on abuse problems. Furthermore, there is a large group of professionals, including psychologists and doctors, ie psychiatrists specialising in drug abuse therapy.

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

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

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

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

### **Quality assurance of substitution treatment**

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

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

## **5.3 Drug users in treatment**

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

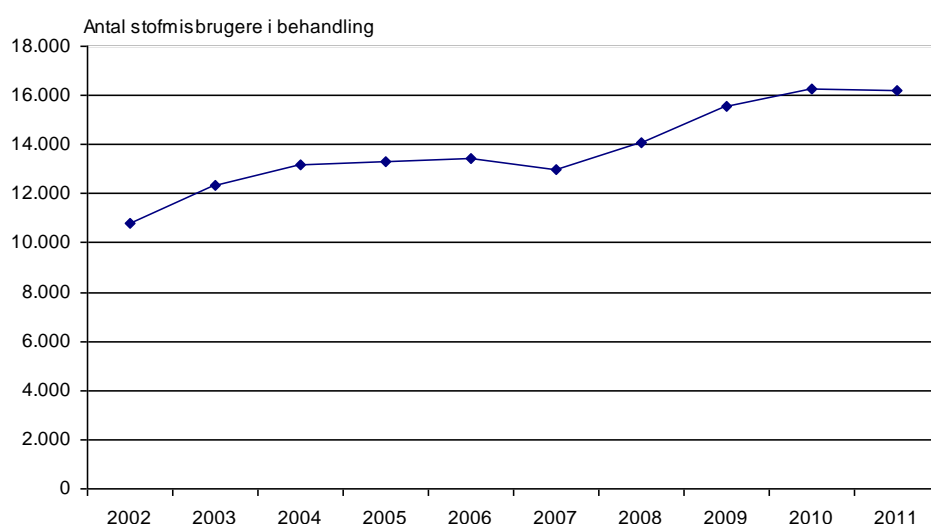
As of 1996, the Danish Health and Medicines Authority has registered all drug users admitted to treatment. Based on information collected from the "Register of drug abusers in treatment" (SIB) it is possible to obtain a description of those persons seeking help for their problem drug use. The register contains, for instance, information about treatment facilities, ie outpatient and inpatient treatment, as well as the type of treatment (methadone, drug-free, etc.) provided to the receiver. As mentioned above, the reporting for 2012 is not complete. The figures and statistics below are therefore based

on data from 2011 and are identical to the figures and statistics contained in last year's publication.

Since 2011, reporting to the SIB has been made via the new joint reporting portal, the database on drug abusers (SMDB) under the auspices of the National Board of Social Services. In connection with the establishment of a joint reporting portal, the existing data sources within the drug abuser field, including the VBGS<sup>6</sup> and the SIB were migrated and merged. Also, the merging variables that were previously reported to different registers were consolidated and updated. The transition to the joint reporting solution SMDB has caused data breakdown and the results from the report should therefore be interpreted with caution. The reports in this chapter are based on migrated SIB data (from 2007 and onwards) from the new drug abuser database and cannot be directly compared to the reports from the previous years.

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

**Figure 5.3.1. The number of drug users admitted to treatment, 2002-2011**



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

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

<sup>6</sup> VBGS: Waiting time for treatment guarantee to drug abusers.

Table 5.3.1 shows a few selected characteristics of the clients admitted to treatment in 2011.

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

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

\*Those who report a primary drug

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

### **Primary drug of abuse**

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

The psychostimulants that are particularly in focus of the young people's experimental use of drugs appear to a lesser degree as the primary drug for abusers admitted to treatment in 2011. 9% report amphetamine, 5% report cocaine, and 0.3% report ecstasy<sup>7</sup> as their primary drug<sup>8</sup>. These drugs are thus mainly used as a supplement. Cannabis was the primary drug for 63% of those admitted to treatment and is also used as a secondary drug among 14% of those admitted to treatment in 2011.

### **Age and gender distribution**

In 2011, 78% men and 22% women were receiving treatment for drug abuse. The share of women is thus the same as in previous years. The average age of admission

<sup>7</sup> Here recorded as MDMA or similar drug.

<sup>8</sup> The percentages are based on the treatment population having reported a primary drug.

in 2011 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 drug abusers receiving transfer income with only 10% being employed. Almost half of them either receive unemployment benefits or cash benefits. In all, 26% have completed an education beyond Primary school (primary and secondary school), and 8% left primary school before the 9th grade. The low level of education should be viewed in the light of the fact that most of the drug abusers start taking drugs at a very young age. The housing situation of drug abusers is also very bad. Only 53 % have their own home – as many as 3% are actually homeless. A majority of the male as well as the female drug abusers are singles.

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

### **Foreign citizens**

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

### **New recipients of treatment**

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



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

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

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

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

\*\*Those reporting primary drug.

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

### Primary drug and mode of intake

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

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

### Young people receiving drug treatment

Young drug abusers are accounting for an ever-increasing share of all drug abusers receiving treatment. Updated figures are given below, as part of an extension to the special survey carried out by the Danish Health and Medicines Authority in the spring 2005 based on data from the Danish Health and Medicines Authority's register on drug abusers receiving treatment, 2003.

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

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

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

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

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

### **Drug abusers receiving substitution treatment**

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

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

From 2008, the figures are based on the number of drug abusers in substitution treatment with either methadone or buprenorphine on data reported to the register on drug abusers in treatment (SIB). Since the compilation method<sup>9</sup> and the data basis<sup>10</sup> vary

<sup>9</sup> In previous statistical records, long-term substitution treatment was defined as receiving substitution treatment for 5 months. In this one, the number of persons receiving substitution treatment are calculated on the basis of the most recently started course of treatment with substitution medication for persons in treatment in 2011.

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

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

Buprenorphine and methadone are used in substitution treatment. The Danish Health and Medicines Authority's revised guidelines on the prescription of addictive medicines from 2008 (the Danish Health and Medicines Authority 2008a) emphasizes that buprenorphine should be used as a first-line preparation for opioid dependent drug users which 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 persons in substitution treatment with buprenorphine was approximately 1,400 persons in 2011, which is slightly lower than in 2010, which could be due to the transition to the new drug abuser reporting portal, SIB.

### **Treatment with heroin**

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

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

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

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

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

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<sup>10</sup> Former statistical recordings were based on figures provided by the prescription register, whereas this material is based on the register on drug users receiving treatment (SIB).

In the spring of 2013, the Danish Health and Medicines Authority evaluated the scheme on the basis of recorded data (the Danish Health and Medicines Authority 2013f). The evaluation shows that the scheme has been successful in terms of improving the drug abuser's social situation, limiting abuse of illicit drugs, reducing criminal activity, and reducing risky behaviour. Based on these results it was decided in the autumn of 2013 that the scheme should be extended to include administration of heroin as a tablet. Tablets can be used if injection is not possible due to the patient's damaged veins, if transfer of the patient to methadone treatment is insufficient, or if the patient does not wish to continue in heroin treatment, but wants to stop injection. The tablet may also be used for chronic heroin addicts who are not injecting drug users, but for instance smoke heroin instead. The first treatments with tablets started in October 2013.

The scheme will be evaluated again in 2015.

### Drug abusers admitted to inpatient treatment

Special data on inpatient treatment are collected from the Drug Abuse Database (SMDM/DanRIS-Døgn). All inpatient institutions treating individuals with drug abuse problems are committed to sending data to SMDB. There were 36 inpatient institutions registered in SMDB in 2013. Out of this number, 27 were actual inpatient institutions, and out of this number, four did not submit any data in 2013, one closed, and one which switched primary target group to young people under the age of 18 years. Furthermore, an institution with 24 admissions (25 in 2012) was reclassified from a treatment institution to halfway house, which is why it was not included in the statistics on admissions for 2013. The table below shows the developments in admissions every year from 2005-2013.

**Table 5.3.4 Drug abusers admitted to inpatient treatment in the year in question**

Time	N	Age	Women	Men
2005	1244	32,8	26 %	74 %
2006	1096	33,1	26 %	74 %
2007	1228	33,2	25 %	75 %
2008	1419	33,8	25 %	75 %
2009	1259	33,0	24 %	76 %
2010	1010	32,6	23 %	77 %
2011	773	32,0	22 %	78 %
2012	710	31,1	23 %	77 %
2013	704	32,6	23 %	77 %

Source: Center for Rusmiddelforskning (Center for Alcohol and Drug Research), Dansk Registrerings- og Informations-system, DanRIS 2013.

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

The average age for drug abusers admitted to inpatient treatment has not changed significantly over the years, and was 32.6 years in 2013. The proportion of women also appears to be relatively stable throughout the period, although there appears to a declining tendency in the proportion of women from 2008 and onwards. One person may be admitted several times per year, but at least 30 days will have to pass before a return to the institution is considered a new admission.

The 704 admissions that were recorded in 2013 are distributed on a total of 664 persons. None of the clients' average EuropASI composite scores (Addiction Severity Index/Severity Rate) has changed significantly compared to 2012. However, an almost significant drop is seen in crime severity rate (0,24 in 2012 to 0.20 in 2013 ( $p=0.06$ , Mann-Whitney U). As regards the other composite scores, the fluctuations are very small. Drug severity (0.40) and physical severity (0.39) are unchanged, whereas alcohol severity has gone up from 0.24 to 0.25. The score for conflicts with family, conflicts with groups other than family and physical severity has dropped (family: 0.33 to 0.31, network: 0.22 to 0.21 and mental: 0.40 to 0.48). The proportion of clients who are heroin users prior to start of treatment has dropped from 41% in 2008 to 25% in 2012 and 24% in 2013.

### **Completion and social severity factors**

The proportion of clients completing inpatient treatment as planned was 49% in 2013 and thus remains unchanged compared to the 50% who completed treatment in 2012. The average number of days admitted was 154 in 2013, which is an increase of 10 days compared to the 144 days in 2012. Median days admitted, however, remains unchanged, as in 2013 it was 92 days and in 2012 it was 93 days. This indicates that the increase in the average number of days admitted could be ascribed to the completion of a few very long courses of treatment in 2013.

In 2012 and 2013 the inpatient treatment institutions completed the EuropASI form for 65% and 67% of their clients admitted, respectively. Based on the ASI form, the social severity factors, including housing situation and being able to provide for themselves is calculated. Compared to 2012, this remains unchanged as far as housing and income are concerned. Both the proportion of those admitted without a home and the proportion of those with a regular income from criminal activities was 9% in 2012 and 10% in 2013.

The total of 704 admissions in 2013 come from 88 out of the 98 Danish municipalities, whereas the number was 86 municipalities in 2012.

In summary, the differences between 2012 and 2013 are relatively small.

## **5.4 Initiatives concerning drug abuse treatment**

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

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

The target group of the overall intervention is differentiated and ranges from citizens with a need for relatively short and focused help to citizens with complex problems, which may be in need of a number of interventions across local administrations and

sectors. The drug abuse package thus also includes initiatives focusing on drug abuse treatment in general and its framework, whereas other initiatives reach out to a more limited target group such as young drug abusers.

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

### **Method program for treatment of drug abuse**

The Drug Abuse Package includes a comprehensive list of methods aiming at the treatment of young people with abuse problems. The objective of the different methods is to strengthen the methodical and systematic work contained in the local drug abuse treatment schemes and thus further the use of treatment methods with a documented effect on young people and adolescents at the age of 15-25 years.

Evidence-based methods have been selected for the treatment of drug abuse. These methods are being tested in the municipalities participating in the program. The specific methods include Individual Cognitive Behavioural Therapy in combination with the Motivating Interview. Both methods are widely applied as treatment in Denmark and are being tested in strict adherence to the individual method and in a manual based version. Some of the young people participating in the project receive Individual Cognitive Behavioural Therapy and the Motivating Interview together with an element of Voucher based re-enforcement in order to be retained in treatment for as long as drug abuse treatment might work and thus ensure optimum treatment results. The program of methods also tests a model for follow-up treatment aiming at maintaining positive treatment results and preventing against recurring drug abuse. The follow-up treatment is considered a natural extension of the primary treatment, however with lower frequency and as a combination of personal interviews and telephone conversations.

Nine municipalities are participating in the method program and the project is expected to run until 2018.

### **National guidelines for the social treatment of drug abusers**

National guidelines are also being developed for the social treatment of drug abusers. The objective is to secure a joint platform for quality development of the social treatment of drug abusers, with such treatment being evidence-based and supportive from an overall perspective. The national guidelines on the social treatment of drug abusers will provide the municipalities with a tool to enhance quality within drug abuse treatment where abusers who require treatment are given treatment based on best practices and perceive drug abuse treatment as more accessible.

A working group was appointed with representatives from key stakeholders within drug abuse treatment. The preparation of the national guidelines is based on the European EQUUS project including the collection and quality assessment of national and international quality standards for drug demand reduction.

It is expected that the national guidelines will be publicized at the beginning of 2015.

### **Outreach and tolerant treatment of the most marginalised drug abusers**

The initiative of outreach and tolerant treatment of the most marginalised drug abusers involves development and testing of a model for the treatment of those who have drug abuse problems as well as social and health problems. The objective of this initiative is to develop a treatment model that may contribute to this group of citizens obtaining and maintaining stability, experiencing drug demand reduction or even discontinuation of

drug demand, and that their lives in general will be stabilized. The aim is for them to regain, develop or maintain their functional ability and reach a point where they gain control of and influence on their lives and daily functioning.

One of the pivotal elements in this kind of treatment is the flexibility combined with easier access to existing drug abuse treatment programs. The care providers become a familiar part of the target group's environment. Regular contact between the care providers and the target group generates relations building on confidence. The care providers give treatment that combines motivation and change through care. By their presence, it is possible for the care providers to be the motivating element and to be there when the citizen is ready for change, needs support to maintain treatment, and/or needs assistance in a certain problem. Presence in the treatment environment also means that the citizen may soon receive help if he/she interrupts treatment. Formal co-operation agreements with relevant local units ensure that the citizen is given relevant and comprehensive support focusing on his/her social and health problems.

Projects involving outreach and tolerant drug abuse treatment will be tested in Odense and Aarhus municipalities. The projects in the two municipalities started in November 2013 and will run up to and including December 2016. The initiative will be evaluated with a view to strengthening the knowledge base for future interventions of this nature to the target group.

#### **Survey of capacity in the social drug abuse treatment**

As part of the Drug Abuse Package, a survey was conducted by the SFI, the National Research Centre for Welfare, on social drug abuse treatment in Denmark.

The survey is a benchmarking study of the municipalities' capacity in drug abuse treatment on the basis of data from the Drug Abuse Database, questionnaires sent to all the municipalities in Denmark, and an in-depth qualitative survey on a number of case municipalities. The objective of the survey is to acquire new knowledge about the municipal arrangements, the use of resources and the effect of drug abuse treatment as well as to identify barriers and potentials for good drug abuse treatment.

#### **SMART Recovery self-empowering groups for citizens with drug abuse problems**

SMART recovery is a self-empowering concept based on a combination of methods designed to help and manage addiction problems. The method has been developed in the US and tested in both the US and the UK with good results.

The testing of SMART recovery includes the establishment of a number of anonymous self-empowering groups lead by voluntary, trained meeting facilitators. The aim is for citizens who have taken part in a drug abuse treatment program to meet and get support and to provide them with tools to maintain their treatment results. Another aim is to create a forum where the citizens can meet, exchange experience and form network groups, thereby avoiding stigmatisation and isolation.

The SMART recovery training program will be tested from 2013 to 2016 in collaboration with five voluntary organisations and ten municipalities: "Medmisbrug" and Faaborg-Midtfyn municipality, "Vælg Friheden" and Esbjerg municipality, "SMART Pilot" and Copenhagen and Frederiksberg Municipalities, "Frivillighuset" Varde and Varde Municipality, and "Frise" and Gladsaxe, Halsnæs, Tønder, Aarhus and Lyngby-Taarbæk municipalities. The National Board of Social Services will prepare an evaluation, which is to follow-up on the project's results.

Apart from the Drug Abuse Package, The Ministry of Children, Gender Equality, Integration and Social Affairs is working on a number of initiatives related to the social drug abuse treatment as described below.

### **Acute crisis centre for the socially marginalised with drug abuse problems**

Funds from the social reserve agreement running from 2012 and 2013 have been granted for an acute crisis centre for socially marginalised citizens who have drug abuse problems and find themselves in an acute and critical situation. A total of DKK 32 million has been set aside for this initiative. The purpose of the program is to give this group of citizens an acute offer for a protected stay in an institution where they are given support to find stability in a crisis situation and to maintain stability after their stay. During his/her stay, the citizen is provided social and medical help to stabilise the crisis situation, is supported in defining needs for relevant help after the stay, and an integration plan is prepared together with the his/her local social services and the centre.

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

The program is being evaluated in order to gain a stronger knowledge base for future interventions of this nature to the target group.

### **Group therapy for persons with abuse of cannabis and/or psychoactive substances**

Group therapy for persons abusing cannabis and/or psychoactive substances is an initiative particularly aiming at the new users arriving in the treatment system, and where cannabis, cocaine and other psychoactive substances are the primary drugs of these people's abuse. The target group of the treatment model is persons where abuse is their primary social problem, and where the users are still under education or working. Studies indicate that the least affected abusers experience the largest barriers in relation to seeking treatment<sup>11</sup>.

Copenhagen Municipality has developed a model for joint group therapy of persons abusing cannabis and/or psychoactive substances (the cannabis and cocaine project)<sup>12</sup>. The treatment model has been described in detail in a working catalogue and a concept for qualification of the group therapists has been developed. Based on the Copenhagen Municipality model a group therapy model is being developed and tested, which can be used and disseminated to other municipalities in Denmark. A total amount of DKK8 million has been set aside for the project for the years 2013-2016.

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<sup>11</sup> Københavns Kommune (2010b): *Rapport om gruppebehandling af hash- og kokainmisbrug*.

<sup>12</sup> Københavns Kommune (2010a): *Arbejdskatalog til anvendelse ved gruppebehandling af hash- og/eller kokainmisbrug*



### **Project Abuse treatment – treatment program for young people under the age of 18**

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

There are two Danish methods and 1 foreign method:

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

Preliminary results show that the young people's substance use is reduced, and several of them get a job in the short term. The young people primarily use cannabis. The interviewees speak favourably of the treatment courses and the therapists – although they may not have embarked on treatment voluntarily.

Publications and other types of informative material will be prepared in 2014, so that municipalities that are interested will be given the opportunity to replicate the models themselves in collaboration and agreement with the model owners. Other informative activities are expected to be held in the second quarter of 2015.

The project is part of a strategy referred to as Lige Muligheder [Equal Opportunities] from the social reserve fund agreement for 2008, and DKK60million have been set aside for the initiative. The final effect evaluation made by SFI is expected to be published in June 2015.

### **The pre-treatment program "Projekt Andre Valg" (PAV), Project Other Choices**

Based on the experiences from studies on the use of pre-treatment programs in Danish local prisons, young people with abuse problems staying in young offender institutions must be offered a pre-treatment program to prevent abuse. The pre-treatment program offered to the young people resembles the pre-treatment method known from "Project Over Muren" (POM) [Project Over the Wall], which runs in the Copenhagen Prisons. The purpose of the initiative is to motivate the young people to talk about their use of alcohol and drugs. The intention is to motivate young people with abuse problems to accept drug abuse treatment after their stay at the institution.

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

### **Development of model projects focusing on screening and examination of drug abusers with mental illnesses**

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

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

The five municipalities started by testing the models at the beginning of 2013. The staff receives on-going training in relation to implementation of the new screening practice and the adapted abuse treatment. DKK14million have been reserved, and the projects will be running up to and including February 2015.

### **Young mentally ill with abuse problems**

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

### **Integrated intervention for the mentally ill with abuse problems**

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

Under this intervention program, a treatment program is laid out for the citizen and treatment includes the whole range of problems, ie the mental illness, the abuse and the interaction between these two illnesses. The intervention program is performed by a team operating across the various sectors. A collaboration model is developed and tested using supportive tools. The collaboration model consists of five overall elements that are all pivotal parts of the establishment of a joint integrated intervention. The five

elements are (1) management, (2) physical framework, (3) interdisciplinary team, (4) outreach approach, and (5) joint processes and tools.

As regards the citizens, the aim of intervention is a) that the citizens acquire mental stability, b) that the citizens have reduced their abuse level, c) that the citizens experience improved quality of life, and d) that the citizens perceive the intervention as successful and relevant.

The program applies interdisciplinary principles, and intervention is provided on an outpatient basis. Testing of the collaboration model and its methods started in the spring of 2013 and will terminate at the end of 2014.

## 5.5 Research in the treatment of drug abusers

The focus areas related to research in the treatment of drug users is changed on an ongoing basis. The study *Randomiseret forskning i effekten af hashbehandling (CDOI)* at the Centre for Alcohol and Drug Research focused in 2013 on research in the efficacy of cannabis treatment. In this connection a randomised study was conducted on the efficacy of treatment of cannabis abuse<sup>[1]</sup>.

The study included 100 subjects admitted to treatment for cannabis abuse. The participants were distributed randomly in an experimental group receiving treatment under the Client-Directed Outcome-Informed (CDOI) method and a control group receiving standard treatment. The aim of the study was to examine whether the CDOI method is more useful in meeting the objectives mentioned above.

The study did not find any significant differences between the control group and the experimental group. The conclusions are broken down into three sections: *Retention*, *Termination/Reduction of use*, and *Reduction in other severity factors*:

**Retention:** The immediately largest challenge was retention (or dropout). Out of the 100 subjects who accepted to participate in the study, 18 never got round to an interview. 70 subjects were interviewed twice within a four-month period. 42 subjects were interviewed five times. 12 subjects took part in all the 8 interviews within a four-month period.

**Termination/Reduction in use:** At the first interview, everybody claimed having used cannabis during the month leading up to the interview. At the second interview, 78.4% and 85.4% had used cannabis during the month leading up to the interview, and finally at the third interview, between 65-79.3% had used cannabis during the past month. Between 21 and 35% had not used cannabis for at least a month at the six-month interview. The figures appear to be consistent with a previous Danish survey of Danish teenagers in drug abuse treatment, which showed that 26.9% had stopped using illicit drugs six months after being discharged

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[1] Pedersen, MU & Pedersen, MM (2013). Effekten af hashbehandling. En randomiseret undersøgelse af Client-Directed Outcome-Informed behandling af hashmisbrug. Aarhus Universitet, Center for Rusmiddelforskning.

[http://psy.au.dk/fileadmin/site\\_files/filer\\_rusmiddelforskning/dokumenter/rapporter/2013/2\\_Effekten\\_af\\_hashbehandling.pdf](http://psy.au.dk/fileadmin/site_files/filer_rusmiddelforskning/dokumenter/rapporter/2013/2_Effekten_af_hashbehandling.pdf)

Reduction of other severity factors: As a final observation, significant reductions were found in mental and financial severity factors. The proportion of those working thus increased from 27 to 40%. Despite the fact that crime was already low in this group, a reduction was found and close to being significant.

### **Young people's cannabis use**

SFI carries out ongoing research in drug abuse treatment. Most recently, SFI has conducted a major study on young people's cannabis use<sup>13</sup>. The study has included qualitative interviews with 30 young people admitted to drug abuse treatment and has had a focus on the young people's "cannabis careers", ie their path into comprehensive and problem cannabis use. The study shows that "cannabis careers" evolve from being a social phenomenon, where cannabis blends in different ways into youth life to becoming a more integral part of their everyday lives where higher priority is given to smoking cannabis than being together with friends. The study also shows that where the young people early in their "cannabis career" had very little problems with smoking cannabis, now start to feel that cannabis becomes a more problematic part of their life. The study recommends that abuse treatment provided to young people should include their network of friends.

In addition to this specific study, SFI has conducted a number of surveys on marginalised target groups where drug abuse is discussed in parts of the survey, such as: homeless persons' illnesses and their use of health services, preventive measures as an alternative to out-of-home placing of children and young people and young people's tendency towards self-injury and eating disorders<sup>14</sup>.

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<sup>13</sup> SFI: Järvinen/Ravn, 2014

<sup>14</sup> Benjaminsen, Lars; Birkelund, Jesper F. og Enemark, Morten H. 2013 *Hjemløse borgers sygdom og brug af sundhedsydelser*. SFI Rapport./ Lausten, Mette; Hansen, Helle og Myrup Jensen, Vibeke 2013 *God praksis i forebyggende arbejde*. SFI Rapport./ Vammen, Katrine S. og Christensen, Mogens N. 2013 *Unges selvskade og spiseforstyrrelse*. SFI Rapport./ Lausten, Mette; Andersen, Dines; Skov, Peter R. og Nielsen, Alva A. 2013 *Anbragte 15-åriges hverdagsliv og udfordringer*. SFI Rapport.

## 6 Health correlates and consequences

### 6.1 Introduction

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

The number of drug-related deaths are recorded in two registers - the register of the National Police and the Cause of Death Register under the State Serum Institute. The latter is used for benchmarking with countries in the EU and is based on a joint European definition. In 2013, the National Police recorded 213 drug-related deaths. This is the same level as in 2012, when 210 deaths were recorded. The levels in 2012 and 2013 are, however, significantly fewer than in 2011, when the number was 285. Analyses of these deaths throughout the years show that poisoning is the primary cause of death as a result of polydrug use.

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

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

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

### 6.2 Drug-related infectious diseases

#### HIV/AIDS

Action taken in Denmark against HIV is based on the principle of voluntarism, anonymity and openness, providing direct and honest information and security for individuals in their contact with the health authorities. The HIV reporting system includes the civil registration number (CPR no.), information about previous HIV test and risky behaviour and assumed manner of infection. AIDS is also reported with personal data. Table 6.2.1 shows the number of reported newly diagnosed HIV positive and out of them, the number of injecting drug users the past 10 years<sup>15</sup>. The number of persons newly diag-

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<sup>15</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. The State Serum Institute.

nosed 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 injecting drug use. In 2013, 6% (14 persons) of those newly diagnosed as HIV positive were registered as injecting drug users. This percentage has remained more or less the same between 4% and 11% the past 10 years.

The proportion of newly diagnosed AIDS cases with the source of infection being considered to result from injecting drug use has been relatively stable around 10%. In 2013, 13% of those diagnosed with AIDS were injecting drug users, which constituted five out of a total of 38 persons.

### **Hepatitis A, B og C**

Despite minor fluctuations, there seems to have been a decline in the number of registered acute hepatitis cases in the Danish population as a whole over recent years (Table 6.2.2 of the Annex). During this period, the share of acute hepatitis cases, where the infected person has been an injecting drug user, has been under or around 1% for hepatitis A, varied between 4 and 19% for acute hepatitis B, and between 0 to 86% for acute hepatitis C. However, the proportion of persons reported with chronic hepatitis C resulting from injecting drug use is relatively stable at 68-75%. The number of reported cases of acute hepatitis B and C is low in Denmark. Therefore, the major fluctuations in the proportion attributable to injecting drug use should be considered with caution. Since hepatitis C is often asymptomatic in the acute phase, the reported cases are most likely underestimated.

### **Studies on the prevalence of infectious diseases**

As part of the qualification, harmonisation and benchmarking of the prevalence of infectious diseases among drug abusers in the EU, the Danish Health and Medicines Authority supported a research project from 2004-2008, during which period the prevalence of infectious diseases among drug abusers (Christensen 2006) was investigated<sup>16</sup>. Studies have been made on the prevalence of HIV and hepatitis B and C among the drug-related deaths (approximately 250 a year), which were recorded in the National Police Register.

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

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<sup>16</sup> The initiative for the study was taken in the *national "key indicator group for infectious diseases"*.

**Table 6.2.1. Number of newly diagnosed HIV positive and AIDS diagnosed subjects of the whole population, including the share of injecting drug users in the year in question**

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
HIV positive subjects newly diagnosed	270	307	263	244	312	290	241	273	267	200	231
HIV positive subjects newly diagnosed with injecting drug use (% of all newly diagnosed cases)	24 (9%)	13 (4%)	17 (6%)	10 (4%)	21 (7%)	15 (5%)	14 (6%)	14 (5%)	10 (4%)	13 (7%)	14 (6%)
AIDS cases newly diagnose	41	61	45	54	50	40	41	47	60	43	38
AIDS positive subjects newly diagnosed with injecting drug use (% of all newly diagnosed cases)	11 (27%)	4 (7%)	4 (9%)	3 (6%)	4 (8%)	6 (15%)	4 (10%)	5 (11%)	5 (8%)	5 (12%)	5 (13%)

Source: Unpublished data from the State Serum Institute. For 2013 data, the figures are compiled on 13 May 2014. Number of newly diagnosed AIDS cases with injecting drug use (% of all newly diagnosed cases)

### 6.3 Other drug-related health problems

#### Non-fatal poisoning caused by illicit drugs

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

Table 6.3.1 of the annex shows the number and development of the recorded poisonings with the various illicit drugs from 2004 to 2013. From 2010, a data retrieval criterion different from previous ones has been applied. The compilation methods before and after 2010 are thus not identical. It is assumed that the poisonings are under-reported throughout the years, which means that these are minimum figures.

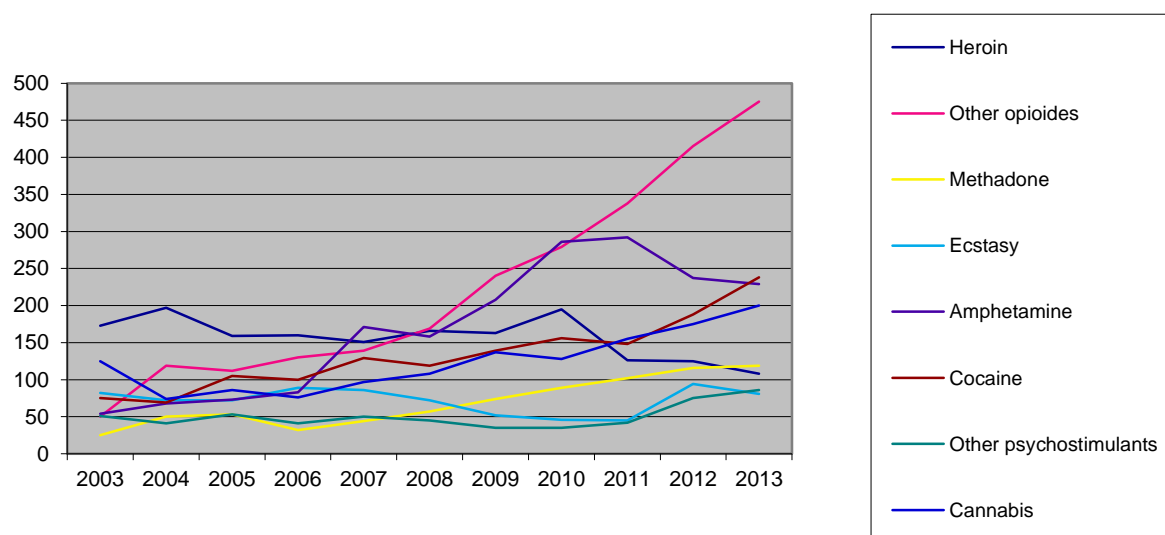
Each year, between 1163 and 2194 poisonings have been recorded with illicit drugs from 2004 to 2013. As of 2004, an increasing trend appears from 1163 poisonings in 2004 to 2194 poisonings in 2013, which equals an increase of 90% during the period. In spite of a general increase in the total number of poisonings from 2004 and until today, there is a drop in the number of poisonings caused by heroin from 2010 to 2013 (from 195 in 2010 to 108 in 2013).

The increase throughout the years is primary caused by poisoning with "other" opioids (not heroin) or psychostimulants – especially an increase in poisoning caused by cocaine. As mentioned, the figures are unconfirmed and should be considered with some caution due to diagnostic uncertainty and other sources of error.

A total of 16,000 cases of poisoning have been recorded during the past 10 study years. A vast majority of them, almost 94%, were treated in the somatic hospitals and the remaining almost 6% in psychiatric hospitals. As for distribution of gender, the men account for 2/3 (66%) and the women for 1/3 (34%).

The figure below shows the developments of poisonings caused by the various drugs from 2003 to 2013 (numbers shown in table 6.3.1 of the annex).

**Figure 6.3.1. Development in hospital contacts after intoxication and poisoning caused by illicit drugs 2003 - 2013**



Source: National Patient Register, Statens Serum Institut, data from June 2014

The poisonings in 2013 are shown in table 6.3.2 below. More than half of them (1212 out of 2194) of all poisonings in 2013 occurred in persons over the age of 30 years, whereas a little less than half of the poisonings (982 out of 2194) occurred in persons over the age of 30. Young people under the age of 25 accounted for 38% (748 out of 2194) of the cases.

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

**Table 6.3.2. Hospital contacts resulting from intoxication and poisoning due to the various illicit drugs in 2013 broken down by different age groups**

	< 20 yrs	20-24 yrs	25-29 yrs	≥ 30 yrs
Opioids	28	40	45	673
Psychostimulants	150	218	99	216
Mushrooms and hallucinogens	26	30	5	10
Cannabis	60	52	33	55
Polydrug use and unspecified	58	86	52	258
<b>Total</b>	<b>322</b>	<b>426</b>	<b>234</b>	<b>1212</b>

Source: National Patient Register, Statens Serum Institut, data from June 2014

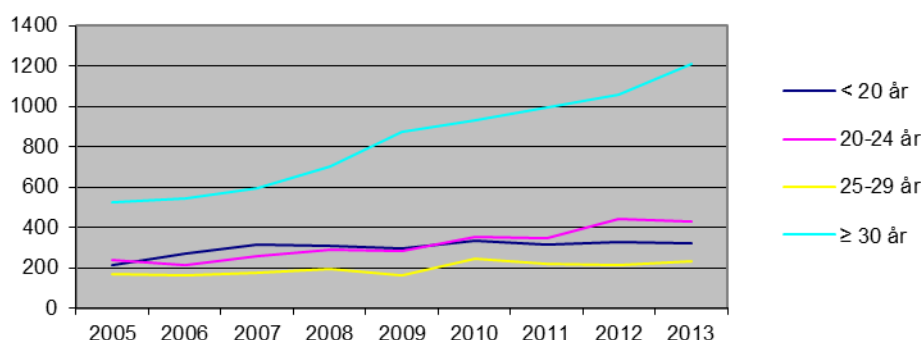
Among the psychostimulants, cocaine also appears, rather exceptionally, among the poisonings in the slightly older population. Persons at the age of 30 or older accounted



for 39% (94 out of a total of 238) of the poisonings caused by cocaine in 2013 (not shown).

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

**Figure 6.3.3. Hospital contacts resulting from intoxication and poisoning broken down by age groups 2005 - 2013**



Source: National Patient Register, Statens Serum Institut, data from June 2014

As previously mentioned the number of poisonings caused by illicit drugs has increased in recent years. This increase is seen in particular among persons at the age of 30 years and above. The increase from 2012 to 2013 is only represented by persons at the age group of 25 years and above – particularly among persons aged more than 30 (from 1057 to 1212).

### **Mental illness**

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

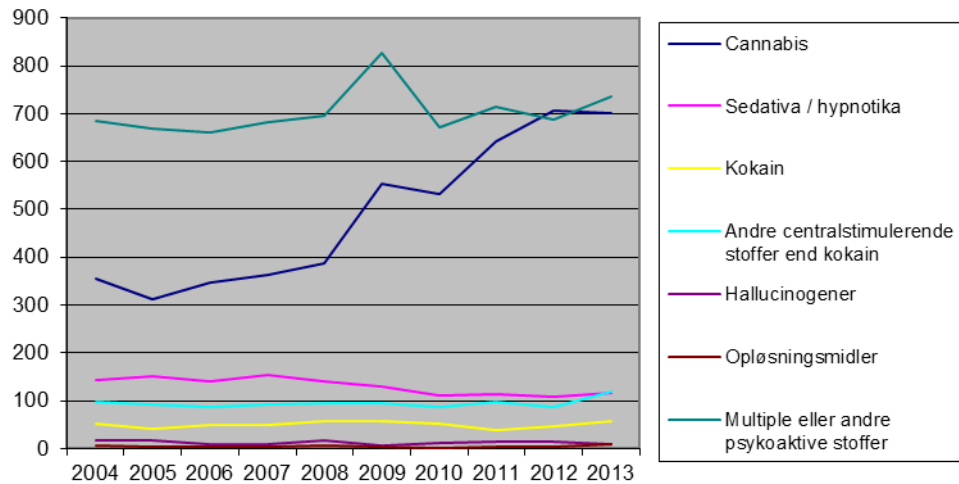
In 2013, a total of 5547 persons were admitted to psychiatric hospitals with a drug-related primary or secondary diagnosis (dual diagnosis). This is a slight drop compared to 2012 when the number was 5709. During recent years, a linear increase has been seen in the number of patients admitted to psychiatric hospitals with a drug-related diagnosis, however with annual fluctuations (see table 6.3.4 and 6.3.5 of the Annex).

In 2013, the number of persons with drug-related secondary diagnoses amounted to 3772 (3946 in 2012), and the number of persons with a drug-related primary diagnoses was 1775 (1763 in 2012). The number of persons and admissions caused by secondary or primary diagnoses is shown in tables in the Annex and illustrated in figures below.

Over the past 10 years, persons with primary diagnoses in relation to “polydrug use” (multiple or other psychoactive substances) have made up the most prominent group. However, during the period, a major increase has been seen in persons with a primary diagnosis related to cannabis. Persons with cannabis-related primary diagnoses ac-

counted for 40% of all persons admitted to psychiatric treatment with a drug-related diagnosis in 2013. Primary diagnoses related to psychostimulants such as amphetamine and cocaine are seen in approximately 10% of all admissions caused by a primary diagnosis in relation to drug use in 2013.

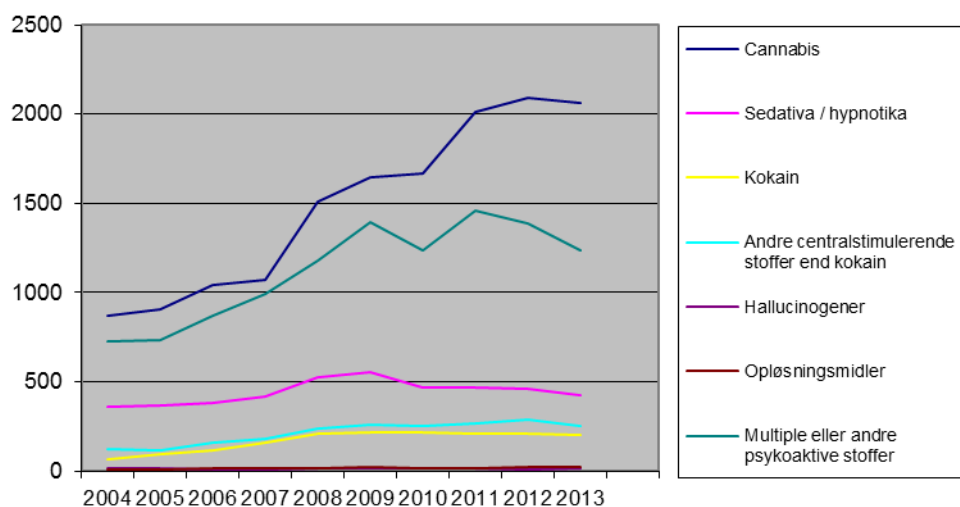
**Figure 6.3.4. Persons with drug-related primary diagnoses in psychiatric hospitals 2004-2013**



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

The number of persons with a cannabis-related *secondary diagnosis* has almost tripled during the past 10 years. The group included 873 persons in 2004 and 2061 persons in 2013. During the same period, there is also an increase in the number of persons admitted with secondary diagnoses related to cocaine and other psychostimulants, although the number of cocaine-related admissions from 2008 and up until today have stabilised. The number of admissions with cocaine and other psychostimulants, however, is significantly lower than admissions with cannabis secondary diagnoses.

**Figure 6.3.5. Persons with drug-related secondary diagnoses in psychiatric hospitals 2004-2013**



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

The number of admissions caused by "polydrug use" as a secondary diagnosis are considerable and account for more than one third of the total number of admissions with a secondary diagnoses related to drugs.

## 6.4 Drug-related deaths and mortality among drug abusers

The National Police has recorded all drug-related deaths since 1970. The register includes deaths involving reporting to the police for the purpose of post-mortem and where information of problem drug use is available. This could, for instance, be in the case of individuals found dead, sudden unexpected death, accidents – including poisoning, homicide and suicide. Deaths caused by poisoning or other type of accident where the individual in question had taken drugs will thus also be registered in the register of the National Police. The register also includes dead persons without a civil registration number (CPR number) which means that foreign nationals might be included.

In parallel with the National Police register, the Danish Health and Medicines Authority (which has now handed over the task to the State Serum Institute), has published a sequence of statistics on drug-related deaths since 1995. The statistics are based on data retrieved from the Cause of Death Register and comprises the deaths that are drug-related in accordance with the EU definition. The figures from the Cause of Death Register solely includes dead persons with a Danish civil registration number

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

The figures that are annually published by the EMCDDA on drug-related deaths in the EU are the so-called “national definition” of each country. As the collection from the State Serum Institute’s Cause of Death Register is the *Danish national definition* these are the figures which should be used for comparison with the other European countries. However, the various countries have different ways to calculate drug-related deaths. This means that comparisons of absolute figures between countries should be made with some caution, whereas tendencies are more reliable.

In a Danish context, the National Police register on drug-related deaths, however, is an important source for the analysis of developments over time and contains, among others, specific information about poisonings (so-called overdose deaths), which cannot be collected from the Cause of Death Register.

### **Statistics based on the Cause of Death Register**

In the figures from the Cause of Death register, the European definition is used on the drug-related deaths (EMCDDA, 2009)<sup>17</sup>. Compared to figures of previous years, extractions from 2014 have, however, been made with additional codes which now corresponds completely to the EMCDDA recommendations. The figures shown in figure 6.4.1 are updated from 2007. The new extraction criteria in 2014 therefore means that the figures cannot immediately be compared with corresponding figures in previous publications.

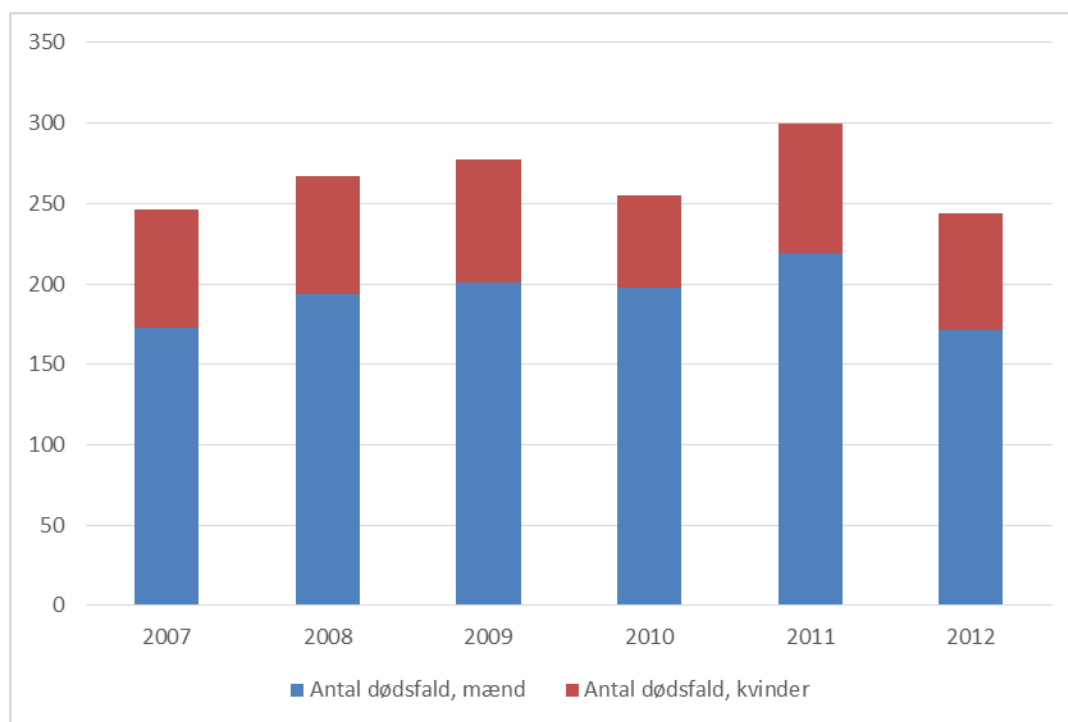
Figures, based on extractions from the Cause of Death Register from 2014, including the new codes, indicate an increase in the drug-related deaths. The Danish Health and Medicines Authority estimates that this is due to the fact that for some years deadly poly-drug abuse where a main source of poisoning cannot be found, have been increasing. These deaths have not been included in extractions from previous years based on the Cause of Death Register as they have been registered under a code which has not been included in the extraction. Thus it is not a question of new deaths in the period, but that more codes and thereby more deaths, as a consequence of the EMCDDA recommendations, have to be included as drug-related deaths. Even though the addition of these codes increases the level compared to previous figures it does not change the observed decreasing tendency.

The figures below include deaths coded as deaths as a consequence of harmful use of drugs or addiction and drug psychoses as well as deaths as a consequence of poisoning (intentional or non-intentional poisoning). Furthermore, this report includes deaths coded as poisoning accidents with several drugs (i.e. when several drugs have contributed to the poisoning accident). Deaths caused by traffic accidents or other unfortunate occurrence involving illegal drugs are not included in these figures, but in the National Police Register. Figure 6.4.1 shows the development of the drug-related deaths from the Cause of Death Register.

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<sup>17</sup> EMCDDA Drug-Related Deaths (DRD) Standard Protocol, version 3.2, 2009

**Figure 6.4.1 Developments in drug-related deaths recorded in the State Serum Institute's Cause of Death Register for the years 2007-2012.**



Source: State Serum Institute's Cause of Death Register, 2014

\* Data for the years 2007 to 2012 from the Cause of Death Register are not complete. As the actual number of deaths is known from the CPR register, the data for 2007 to 2012 have been increased by 1.7; 1.9; 2.1; 2.8; 1.8, and 1.4 per cent in order to benchmark with previous years.

In 2012, the number of recorded drug-related deaths was 244 and thus at the same level as in 2007. In 2012, men accounted for 70 % of all drug-related deaths. The average age of death among men was 45.7 years and among women 49.6 years.

Among the 244 drug-related deaths, 211 were caused by poisoning, predominantly due to accidents (called OD or OverDose), but the number also includes cases where it is not known whether the cause of death is suicide or other accidents. The remaining 24 deaths were classified according to the information given i.e. drug addiction.

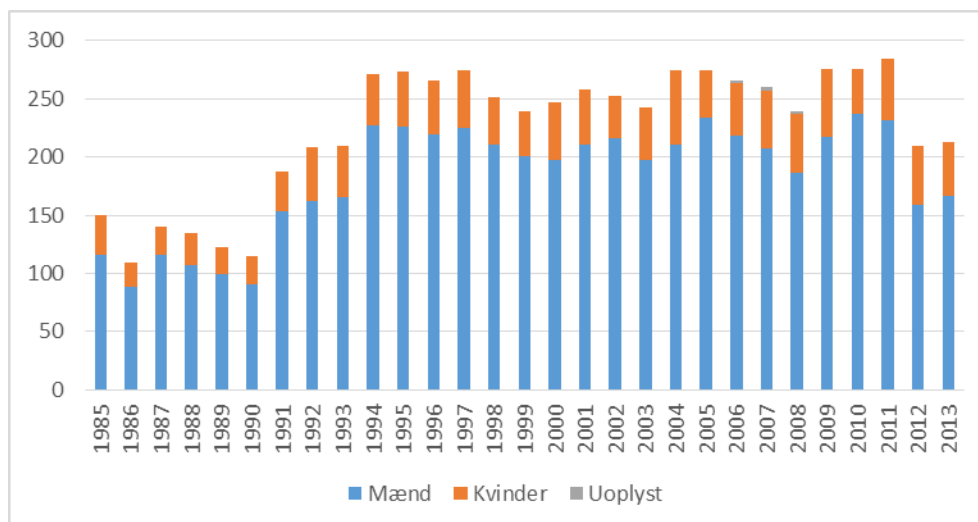
### **Statistics based on the National Police's Register**

From the middle of the 1990s (figure 6.4.2), the number of deaths recorded in The National Police's Register is more or less stable, however with annual fluctuations (see table 6.4.2 of the annex). In 2013, 213 drug-related deaths were recorded which is the level of last year with the lowest number of recorded deaths since 1994. The figures include persons without a civil registration number and thereby persons of foreign nationality. Out of the 213 deaths in 2013, 78% were men (167) and 22% were women (46).

The average age of death has been increasing for many years. In 1993, the average age of death was 33 years, whereas in 2013, it was 41.9 years, ie 41.3 years for men and 43.7 years for women.

The proportion of young people under the age of 30 was 16% of all drug-related deaths in 2013 (the proportion in 2012 was 13%).

Figure 6.4.2. Drug-related deaths 1985-2013, National Police's Register



Source: National Police, 2014

Out of the 213 deaths in 2013, 77% (164) were caused by poisonings with one or several drugs, whereas 23% (49) were caused by another type of drug-related death – for instance, injury other than poisoning, disease or unknown cause of death.

As table 6.4.3 shows, 23% of all poisonings (38 out of 164) are caused by heroin/morphine or heroin/morphine in combination with another substance, whereas 59% of the poisonings (97 out of 164) were caused by methadone or methadone in combination with another drug. 18% of the poisonings (29 out of 164) were caused by other drugs.

Table 6.4.3. Deaths caused by poisoning among drug abusers in the year in question grouped by the assumed most probable cause of death. Number in parenthesis is percentages

	1997	2005	2006	2007	2008	2009	2010	2011	2012	2013
Heroin/morphine	153(71)	77 (37)	83 (37)	69 (34)	70(36)	75(36)	67(33)	53(24)	40(24)	38(23)
Methadone	46 (21)	89 (43)	92 (42)	84 (41)	82(42)	96(47)	89(44)	114(52)	100(60)	97(59)
Other	17 (8)	40 (20)	46 (21)	52 (25)	43(22)	35(17)	48(24)	51(23)	28(17)	29(18)
<b>Poisonings, total</b>	<b>216 (100)</b>	<b>206 (100)</b>	<b>221 (100)</b>	<b>205 (100)</b>	<b>195 (100)</b>	<b>206 (100)</b>	<b>204 (100)</b>	<b>218 (100)</b>	<b>166 (100)</b>	<b>164 (100)</b>

Source: National Police, 2014

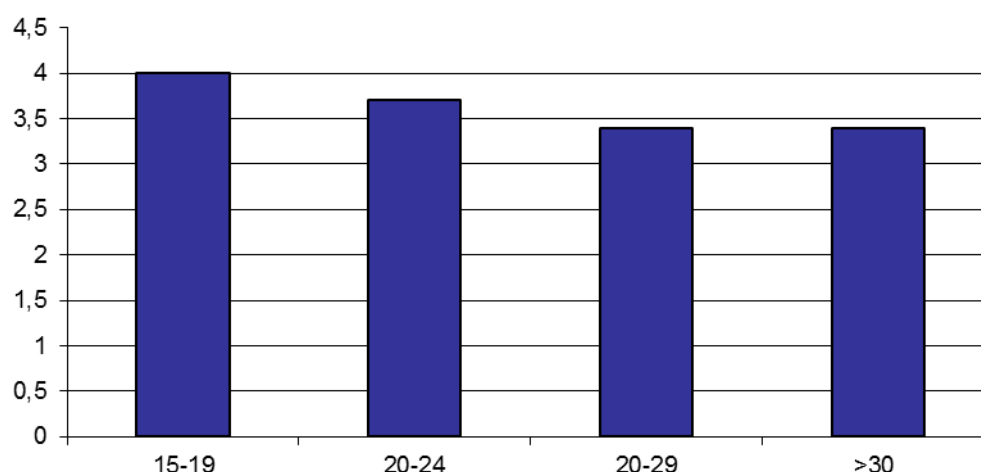
Table 6.4.3 shows the developments within the various deaths caused by poisoning in the years 2005 and until 2013. Furthermore, the year 1997 has been included. Overall, poisoning caused by opioids (heroin/morphine and methadone) accounts throughout the years for the majority of all deaths. The deaths caused by poisoning do not include accidental death or suicide.

However, from the 1990s and until today, there appears to be a drastic change in the pattern of poisonings. The fact is that within the group of poisonings caused by opioids, there is a decline in the number of deaths, where heroin/morphine poisoning is report-

ed as the primary cause. Conversely, there is a corresponding increase in the proportion of deaths, where methadone poisoning is reported as the primary cause. Finally, since 1997, there has been an increase in the proportion of deaths, where poisoning under the “other” category is stated as the primary cause. The rate, however, has been steady over recent years. The group of “other” contains drugs such as amphetamine and cocaine. In 2013, the “other” category included the following poisoning deaths: strong opioids (5) cocaine (3), amphetamine (2), ecstasy and ecstasy-resembling substances (1).

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

**Figure 6.4.3. The average number of drugs found in 2013 in different age groups, where poisoning was the cause of death**



Source: National Police, 2014

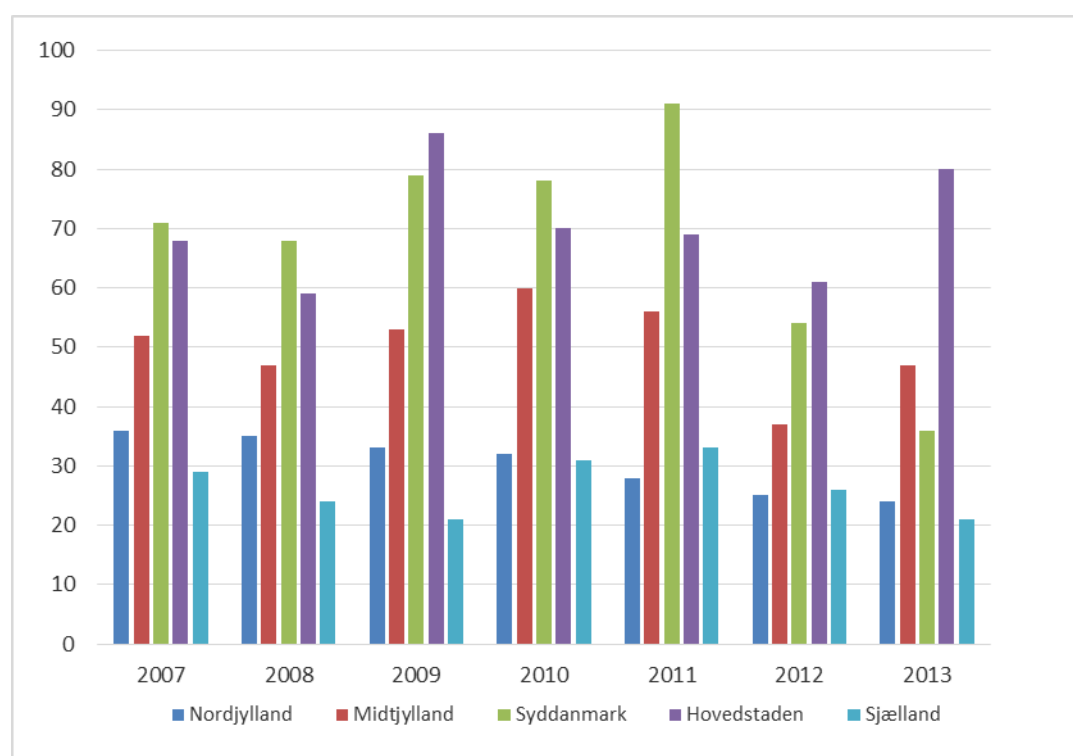
As the figure shows, an average of more than 3 different drugs were found among all deaths, which documents widespread poly-drug use among those who die from poisoning. This also applies to the very young. The most frequently found drug among all drug-related deaths is the group of “Other drugs” (73%) and methadone (67%) followed by benzodiazepines (56%) and cannabis (38%).

### **Geographical trends**

Out of the 213 drug-related deaths recorded in the National Police’s Register in 2013, a total of 109, 78, and 26 were examined and reported from the forensic departments/institutes in Copenhagen, Aarhus, and Odense, respectively. During recent years, a higher number of drug-related deaths have been seen in Jutland than on Zealand. In 2013, more drug-related deaths were seen on Zealand than in Jutland. Funen still accounts for the lowest number of drug-related deaths.

The development in the total number of drug-related deaths for the period 2007-2013 broken down by regions and the municipalities which account for the highest number of deaths appears in figure 6.4.4 and 6.4.5 below. The statistics are based on the figures from the municipality, in which the drug abuser was registered at the time of death, and not where death occurred. In those cases where a person has been registered with a substitute number, it would not be possible to indicate the municipality of domicile.

**Figure 6.4.4 Drug related deaths broken down by regions, 2008-2013.**



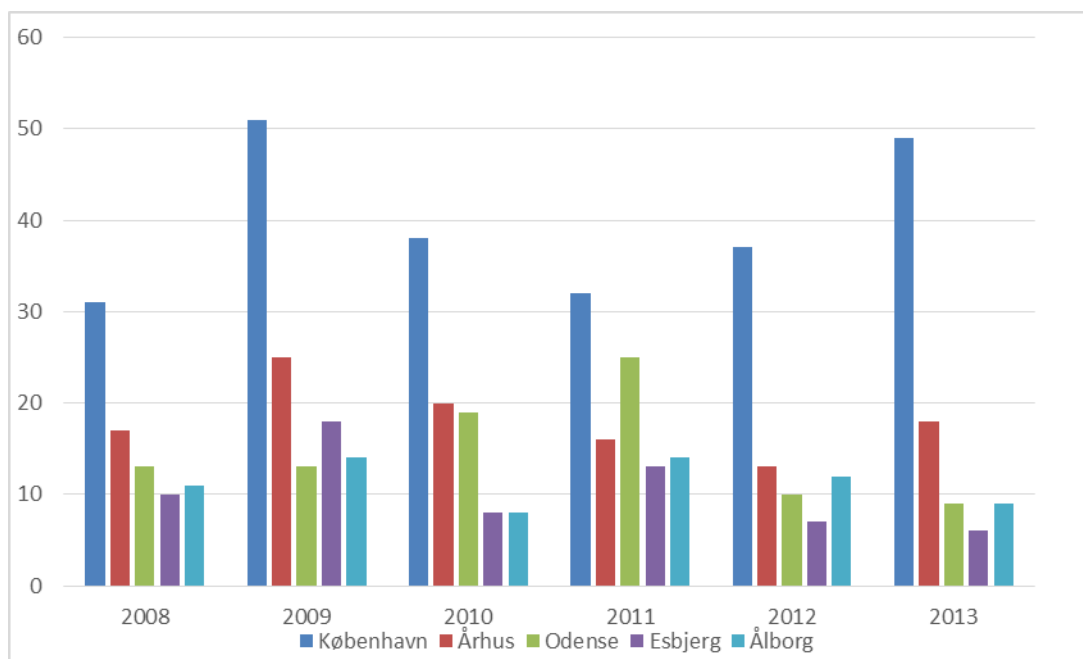
Source: National Police, 2014

Figure 6.4.4 shows that the number of drug-related deaths are distributed on all the regions with the highest number in the Capital Region of Denmark, and the lowest number in the Zealand Region. The development in the number of deaths from 2007 to 2013 varies within the five regions.

Copenhagen Municipality is the one accounting for the highest number of drug-related deaths (49) in 2013 followed by Aarhus (18), Aalborg (9), Odense (9), and Esbjerg (6), cf. figure 6.4.5. The figure also shows that while the number of drug-related deaths drops from 2012 to 2013 in Odense, Aalborg and Esbjerg, the number rises in Copenhagen and Aarhus during the same period.



Figure 6.4.5 Drug-related deaths broken down by selected municipalities, 2008-2013.



Source: National Police, 2014

## **7 Responses to health correlates and consequences**

### **7.1 Introduction**

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

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

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

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

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

### **7.2 Prevention of poisoning and drug-related deaths**

The number of drug-related deaths has been around 250 from 1994 to 2011, but from 2011 to 2012, this number fell significantly, particularly in the Region of Southern Denmark. Thus, in 2012, a total of 210 drug-related deaths were recorded. The lowest number since the beginning of the 1990s. Looking into 2020, the long-term aim is to reduce this number even further and maintain a level of 200 drug-related deaths.

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

prevent deaths among drug abusers in Denmark. The various initiatives are described below.

### **Guideline of the medical treatment of acute drug poisoning**

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

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

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

### **Drug consumption rooms**

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

At present, there are DCRs in Copenhagen and Odense, and in Aarhus.

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

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

Being in sync with its citizens and having knowledge of the local community are factors that need to be considered when the municipality plans social and health care intervention aiming at harm reduction from drug abuse in order to – after having decided to plan the interventions in a manner where DCRs can be included as a harm reduction activity under the municipality's overall drug abuse program – deal with issues such as access,

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

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

### **Experience with DCRs in Copenhagen Municipality**

On 6 August 2013, Copenhagen Municipality opened its permanent DCR known as *Skyen* at Mændenes Hjem in Vesterbro (western part of Copenhagen). The opening of *Skyen* has added to the number of DCRs in the area, ie: the interim DCR at Halmtorvet next to the *Sundhedsrummet* and at the mobile drug consumption room *Fixelancen*, which is presently parked next to *Sundhedsrummet*.

### **Capacity and usage**

With the opening of *Skyen*, Copenhagen Municipality now has a total of 20 injection locations and six smoking locations at the three DCRs. *Skyen* is the only location where drugs are smoked. The opening hours of the DCRs have been planned to ensure optimum utilisation of staff resources in relation to the number of users visiting the rooms. *Skyen*'s daily opening hours are from 7.45 am – 0.00 p.m, the daily opening hours of the interim DCR at Halmtorvet is from 11.30 am – 7.30 pm, and the "*Fixelancen*" is open from 1.30 pm to 5.30 pm.

Since October, *Fixelancen* has been placed at Halmtorvet next to – and as a supplement to – the interim DCR. Potentially, *Fixelancen* could also be placed in other parts of Copenhagen, for instance Sundholmen, where demand is high. The mobility of *Fixelancen* is, however, limited as it can only move to a new "stationary" location approved by the police and the ministry.

The DCRs are manned with nurses and social workers. There are always at least two nurses present in each DCR. All staff are trained in first aid. In addition, there is one doctor present to attend to medical services, counselling in specific cases and supervision of staff.

### **Number of drug intake acts and types of drugs**

Since the opening of *Skyen* in August 2013, an increase has been seen in the number of visitors using drugs in the three drug consumption rooms. Before *Skyen* opened, the average number of drug intake acts at a DCR was 1,967 per week or 281 visitors per day. After the opening of *Skyen*, the average number of drug intake acts is 2,830 per week or 404 per day. There has thus been an increase of 44% primarily ascribed to the number of smokers.

Some users appear many times a day, whereas others only turn up once. The smokers are recorded by number of visits, as opposed to the injectors, who are recorded by their number of injections. A smoker may smoke several times during a visit, and the

actual number of intake acts thus be much higher than the figures recorded. As the act of taking drugs varies among the smokers and the injectors, it is not possible to apply the same compilation method for the two groups. The smokers tend to spend longer time on taking their drugs and have an urge to start smoking again quickly after the first smoke.

### **Users of DCRs**

When comparing the type of drugs taken by the users, the rooms provide more or less the same distribution rates. The clearly most preferred drug is cocaine which accounts for between 61 and 70% of the injections. By comparison, injections with pure heroin account for merely 10-12%, methadone injections 7%, whereas injections with mixtures of opioids and cocaine account for another 12-17% (heroin/cocaine and methadone/cocaine). This is not surprising as cocaine's period of action is significantly shorter than for opioids.

The drug distribution rates provide another picture when it comes to smoking. In this case cocaine accounts for 55%, whereas opioids smoked (predominantly heroin) account for 31%. The smoker booths in *Skyen* have thus succeeded in attracting a relatively large share of the users taking their heroin as a smoke. A large part of the users of the smoker booths are men of ethnic origin other than Danish.

A majority of the users in the DCRs in total are between 24 and 53 years, however the age distribution varies within the range of programs. While the DCR at Halmtorvet attracts a significantly larger share of users between 34 and 43 years, *Skyen* attracts a great deal of young users and a slightly higher share of the elderly users from 54 years and above. The explanations to this varying pattern could be several, but *Skyen* probably attracts the young users preferring to smoke their drug instead of injecting. At the same time, the location of *Skyen* at *Mændenes Hjem* may contribute to the (elderly) drug users who already stay at *Mændenes Hjem* under the section 110 residential programme, and who prefer to use the room here.

Around 80% of the users are men, whereas 20% are women. *Skyen* attracts a relatively lower number of women than the DCR at Halmtorvet. A cautious explanation could be the same one as the one mentioned above, ie that the men predominantly use the other facilities at *Mændenes Hjem*. Also, as mentioned above there are more men of ethnic minorities who prefer smoking their drugs instead of injecting them.

Females account for 30% of the *Fixelancen* user group. The overall observation is that more women prefer this calm environment to the hectic DCRs.

45% of the users are based in Copenhagen and a total of 59% live in the Capital Region of Denmark. Only a few users live in Jutland, nobody comes from Jutland, but a few come from the municipalities around in Zealand.

22% of the recorded users have no Danish regional affiliation. It is uncertain from which country the users originate, but the general observation is that many of the users of DCRs come from our Nordic neighbouring countries. Copenhagen Municipality is aware that the DCRs per se attract foreign citizens to the open street environments of Vesterbro. However, as there is free movement and different social programs between the countries, marginalised foreigners are most likely still to be seen in the streets of Copenhagen and in the DCRs.

### **Treatment of overdoses**

In 2013, 109 cases of potential fatal drug poisoning were recorded, with staff having to intervene. The 109 cases are broken down by the following drugs/group of drugs: 68 (62%) with heroin or methadone, 28 (26%) with cocaine, and 13 (12%) with mild or unspecified drugs. No deaths caused by an overdose were recorded in the DCRs.

### **Teaming up with the treatment system and the social and health care system**

The staff at the DCRs have stepped up initiatives of teaming up with other public services. In particular, users are referred to various health care programs, for instance Sundhedsrummet, the nursing clinic at Mændenes Hjem and the emergency room/hospital. To an increasing extent, team-up activities have been made with social workers at "Sundhedsrummet" and to social workers at the contact facility at "Mændenes Hjem".

In conclusion it should be mentioned that team-up activities within drug abuse treatment has gone up significantly – mostly as a result of the projected intervention offered by Counselling Centre Copenhagen in the booths.

### **Problems in the local community**

Although outdoor drug abuse has not been eliminated, it appears that it has been reduced compared to before the DCRs opened. When drugs are taken outdoors this is more a question of acute need for drugs more than a conscious act of staying away from the DCRs. However, focus remains on outreach interventions towards the users who take drugs outdoors.

### **Prevention of deaths by using naloxone**

Countries outside Denmark as well as Copenhagen Municipality have seen good results with user-administered use of naloxone for the prevention of deaths caused by poisoning with opioids and harmful injury following such poisonings. Based on the positive outcome from a pilot project in Copenhagen Municipality, a project financed by the state has been initiated.

The purpose of this project is to reduce the number of deaths and other harmful injuries resulting from overdoses in patients with opioid abuse through user-administered naloxone combined with education.

This intervention is locally based in four municipalities (Copenhagen, Aarhus, Odense, and Glostrup) where drug abuse is heavy in the streets. Individuals with drug abuse problems, their relatives and people in the drug abuse environment are trained in CPR and the use of naloxone. Having the coordinating authority, Copenhagen Municipality is responsible for training the other municipalities' local trainers and to collect project data.

This evaluation will end with an evaluation report in the middle of 2015.

## **7.3 Prevention and treatment of drug-related infectious diseases**

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

Furthermore, all current and former drug abusers should be offered testing for hepatitis B, C, and HIV and be offered vaccination against hepatitis B if they have not been infected. Injecting drug users, cohabitants and family under the age of 18 related to hepatitis B infected and persons with hepatitis C are offered combination vaccine free of charge against both hepatitis A and B in order to reduce even further the exacerbation of the condition in the hepatitis C infected individual. Co-habiting relatives under the age of 18 years and steady going sex partners of individuals with chronic hepatitis B are only offered vaccination against hepatitis B free of charge.

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

### **Referral of patients with HIV**

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

### **Referral of patients with HBV or HCV**

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

### **Treatment of chronic hepatitis B**

Today, the treatments available cannot cure the patient completely, but may impede virus replication and inflammation and may permanently bring the patient to the inactive stage of the disease, so that the risk of developing cirrhosis of the liver and hepatic cell cancer is reduced.

### **Treatment of hepatitis C**

On acute treatment of hepatitis C everybody who are not spontaneously cured within 12 weeks are offered treatment which cures them more than 90%. Approximately 50-80% of patients with chronic hepatitis C who are treated can be cured with the currently available treatment programs. Patients with cirrhosis of the liver respond more poorly and have more side effects than patients without cirrhosis of the liver. Therefore, it is important to identify patients with chronic hepatitis C at risk of developing fibrosis and to complete treatment before the disease progresses to cirrhosis of the liver.

In 2007, the Danish Health and Medicines Authority made an action plan for the prevention of hepatitis C (The Danish Health and Medicines Authority 2007a), in which it is pointed out that the municipalities must ensure that the target group is systematically offered preventive measures, screening for hepatitis A, B, C, and HIV and also offered vaccination against hepatitis A and B when required. The target group includes all injecting drug users who are admitted to treatment and drug users who have only once injected themselves and therefore do not necessarily consider themselves as injecting drug users. The intended effect of the action plan is primary as well as secondary pre-

vention, given that screening and counselling must enlighten those infected as well as the non-infected of the risk of infection in general. Furthermore, treatment of infected drug abusers will eliminate the risk of these people transmitting the virus to non-infected persons.

In continuation of the action plan, the Danish Health and Medicines Authority established a reporting system on 1 January 2011, [www.stofbrugsdatabasen.dk](http://www.stofbrugsdatabasen.dk), as an instrument to monitor the municipalities' interventions and services.

### **Syringe dispense schemes**

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

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

In the summer 2009, as a result of a request from the Ministry of Health and Prevention, Local Government Denmark looked into the prevalence of syringe exchange schemes in the various municipalities in Denmark. In its report, Local Government Denmark concluded that the number of drug abusers who have access to clean syringes and needles is high. The reason is that all the large municipalities that have a relatively large number of drug abusers hand-out clean tools. The survey has not been broken down on a local level, but Local Government Denmark has found that it provides a useful picture of local practice. In 2014, new data have come up on the dissemination of the municipalities' dispensing of sterile injection equipment. The Ministry of Health and Prevention is currently looking into the matter.

## **7.4 Other interventions to reduce morbidity among drug users**

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

### **National family outpatient clinics**

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

The aim of the family outpatient clinics is partly to prevent against children being born with injuries as a result of the mother's use of alcohol, drugs and/or addictive medication and partly to treat congenital substance injuries and socially derived development problems/lack of care in children born of women with substance problems. This also applies to interventions targeted at children (up to school age) who have been exposed to drugs and alcohol during their mother's pregnancy, where the mother has not been



monitored by the Family Outpatient Clinic.

The clinics must ensure comprehensive intervention towards the pregnant woman, the coming child, a partner and siblings, if any, in cross sectoral collaboration with the relevant municipalities and regional stakeholders. In terms of establishing this sustainable collaboration, the Family Outpatient Clinics and the municipalities in the region must establish collaboration agreements on the intervention under the auspices of the Health Agreements.

Apart from the interventions targeted at women who have ongoing drug and alcohol problems or have had such problems within the past 2 years, the Family Outpatient Clinic offers counselling interviews with pregnant women (and their partners) who have taken alcohol and drugs or had episodes with high alcohol intake prior to pregnancy, but who have stopped. The aim of this is to inform of the damage inflicted by alcohol and drugs on the foetus and to provide support in the event of uncertainty about going through with the pregnancy or not and to resolve whether or not there is a need for more intervention.

In order for the pregnant woman to obtain easy access to as early intervention and counselling as possible, referral to the Family Outpatient Clinic is open.

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

The Center assumes the secretariat function for a cross-regional coordination group. This ensures common professional guidelines, common diagnosis lists, etc for the work in the five regional family outpatient clinics. The Center is also in charge of the implementation and continued development of the family outpatient clinics' joint clinical quality database, which was established on 1 February 2013. The Center is also working on a project involving requalification of health visitors for early detection and support to pregnant women with alcohol and drug use hazardous to the foetus, and to children who have been exposed to drugs and alcohol during their mothers' pregnancy.

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

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

### **Social nursing**

Project Social Nursing, "Socialsygepleje" started as a social reserve funded project in 2010. The project was based on KABS VIDEN, and four hospitals/centres were involved: Hvidovre Hospital, Bispebjerg Hospital, Psykiatrisk Center Glostrup, and Psykiatrisk Center Nordsjælland.

Social nursing intervention focuses on persons who have drug abuse problems/alcohol problems, are homeless, persons with dual diagnoses and prostitutes. The social nurse is the person who provides guidance, communicates information and acts as the link

between intervention counsellors and the socially most marginalised patients admitted to hospital. The aim of this is to enhance patient pathways and create qualitative coherence in treatment from admission and to the municipality takes over upon discharge.

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

As of 2010, the Project Social Nursing was followed and evaluated by COWI. Documentation from this evaluation paper points out that the goal of setting up a link between hospital treatment and social interventions has been fully reached in the somatic departments involved. The staff in the somatic departments have gained more knowledge of the target group's problems, and collaboration with the target group is perceived as being much better. In addition, the social nurse has a special expertise in how to medicate abusers, which, combined with the knowledge of institutions and programs, have added quality to both admissions and discharges.

Social nursing intervention has now been implemented at Bispebjerg and Hvidovre Hospital. The Capital Region of Denmark has, in addition, reserved funds for expanding and running the function at Glostrup, Herlev, Rigshospitalet [Copenhagen University Hospital], and Nordsjælland's Hospital, so that there are now 6 nurses working at the hospitals in the Region. Furthermore, a professional consultant has been hired to train and support the social nurses in their work. Social nursing has not been fully implemented in the psychiatric wards.

In 2013, KABS VIDEN published an anthology on the experience gained from Project Social Nursing under the title: 'Socialsygepleje i somatik og psykiatri'.

## 8 Social correlates and social integration

### 8.1 Introduction

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

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

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

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

#### **Children and young people in out-of-home placement**

The National Social Appeals Board is responsible for keeping statistics on the decisions made concerning children and young people that are placed out-of-home. These statistics are based on the municipalities' reporting of all decisions on placement of children and young people. Reporting is required to contain different types of basic information about the child/young person and the triggering cause of the placement such as abuse (drug and alcohol abuse) with the parents, or with the children/the young people (National Social Appeals Board 2013).

In 2011, *decisions were made on the placement* of 2,443 children and young people. 44% of these were aged between 15 and 17 years, 22% were aged between 12 and 14 years, whereas 12% were between 0 and 3 years. As mentioned above, the municipalities have reported the triggering causes of the placement, and often there are several reasons for an out-of-home placement. Statistics show that drug/alcohol problems at home/in parents in 2012 were a triggering cause for the out-of-home placement in 16% of the cases. When considering the triggering causes of out-home-placement in the child/the young person it is seen that the drug/alcohol problems in 2012 were the cause of 11% of the cases. These figures are not much different from the ones in 2011.

At the end of 2012, a total of 12,025 children and young people aged between 0-17 years *were placed* out-of-home.

## **8.2 Social integration**

Citizens with drug abuse problems are a diverse group with different needs of intervention and support. According to their treatment obligation, the municipalities must provide treatment services to all types of citizens with drug abuse problems through a sufficient range of programs and in consideration of a number of specific target groups. However, not all citizens with drug abuse problems receive such treatment. Therefore, there is an ongoing need for developing the services provided to citizens with drug abuse problems based on the knowledge available in order for the right programs to match each individual citizen's needs and special challenges.

The Ministry for Children, Gender Equality, Integration and Social Affairs has therefore launched a drug abuse package containing 10 specific initiatives, the purpose of which is to improve the quality of the social drug abuse treatment. One of the aims of the drug abuse package is to enhance treatment interventions and make sure they are founded on evidence-based methods with documented effect. Another focus is for the citizen to perceive a more systematic follow-up on the treatment and that problems other than their drug abuse are also being taken care of.

The initiatives of the drug abuse package are described in section 5.4.

There is a large variety of interventions that can be initiated to help the socially marginalised with drug abuse problems. Interventions focusing on an improvement of their housing situation, education, work, social relations and economy are important factors of social integration – both as a means and as an end in itself.

### **Stable housing situation**

As described in chapter 4, the most recent homeless census from SFI shows that in week 6 in 2013, the number of homeless in Denmark totalled 5,820. A considerable proportion of these citizens have major social problems and do not have a place to live. The census thus showed that 80% of the homeless men and 73% of the homeless women either suffer from mental illness and/or some type of substance abuse. 31% of the homeless suffer from mental illness as well as have abuse problems (Benjamin et al 2013).

In 2008, the parties supporting the social reserve funds agreement launched a large coherent project to reduce homelessness in Denmark. A total of approximately DKK500 million was set aside for the program during the period 2009-2013, where focus, among others, was to test methods to move people out of homelessness. 17 municipalities have participated in the Homeless Strategy. The Homeless Strategy is based on the Housing First principle<sup>18</sup>. The overall goal of the Homeless Strategy was to contribute to reducing the number of homeless people in Denmark.

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<sup>18</sup> In the Housing First strategy, early stabilisation of the homeless person's housing situation is applied in combination with individual social support as an important element in a recovery process. The individual support is sought achieved through a number of supportive measures, eg practical housing support, help to handle contact to the public authorities, stabilisation of finances, treatment programs, etc. In this connection, it is important that interventions have an overall approach and are coherently targeted at the individual's specific needs.

The key element of the Homeless Strategy is the work in implementing "Housing First" and three housing support methods with documented effect abroad into a Danish context. Evaluation of the Homeless Strategy (published in May 2013) indicates that homeless citizens have successfully been helped out of their homeless situation. As it turns out, 90-95% of the citizens who have been enrolled in the Housing First program manage to keep their new home for the entire project period.

As a result, the parties behind the social reserve funds have launched initiatives to roll out the experience gained from the Homeless Strategy in the municipalities that have participated in the work and to spread the good news to the municipalities that wish to strengthen interventions in this area. Added to this, the parties behind the social reserves under the social reserve fund agreement for 2014 set aside DKK 60.6million to enhance preventive, early and targeted intervention to young homeless persons and young individuals at risk of becoming homeless. Preventing young people from becoming homeless also has high priority in the agreement under the Finance Bill for 2014 and as a result, a Section 81 of the Act on active social policy was added as of 1 July 2014. This act gives the municipalities the opportunity to subsidize rent for young people under the age of 30 who receive cash benefits, educational grants or rehab payment and who are in a vulnerable housing situation.

### **Education and activation programs**

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

The focus of the cash benefit reform effective 1 January 2014 is that quick job or educational intervention should be provided to those who face complexity in their lives and who are recipients of cash benefits and education grants. Interventions must reflect the individual's need and take into account the citizen's social and/or health-related problems. The individual citizen with complex problems have a right to a coordinating case handler who must ensure that interventions are interdisciplinary and coordinated across the public authorities.

There is a group of citizens receiving cash benefits who are so vulnerable that they cannot avail themselves of job or education interventions. Instead they have the right and the obligation to accept a mentor who should help them in getting stability into their

lives to the extent that in time, they will be able to participate in any job or education intervention provided.

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

The programs are divided into 1) guidance and requalification 2) traineeship and 3) employment with wages being subsidized by the municipality, and 4) useful capacity. Guidance and requalification involve training and courses, as specially organised curricula that are supposed to develop or uncover the unemployed citizen's professional, social or language skills with a view to requalify the person to the labour market.

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

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

### **Employment**

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

Citizens who cannot get a job or stay in one on normal terms due to significantly impaired physical or mental capacity or special social problems, and citizens who cannot obtain or retain employment on normal terms on the labour market and who cannot avail themselves of the services under other legislation should be offered protected employment by the municipalities. Protected employment can be employment activities organised in protected workshops and employment can be organised in other organisational settings. It can be in other types of housing, temporary nursing homes, drop-in centres, shelters and social cafés. Protected employment can also be organised in private companies – on an individual level as well as for a group of citizens. Protected employment can be given to citizens receiving early retirement benefits or cash benefits, etc.

### **Stability in social relations**

A large part of the social work with drug users is carried out at drop-in centres. The drop-in centres are activity and social programs provided for in the Danish Consolidation Act on Social Services. More than 100 of the many drop-in centres in Denmark are organised in the Association of Drop-in Centres in Denmark. There are particularly 3

different types of drop-in centres targeting at drug abusers. There are drop-in centres aiming at a mixed group of active drug abusers, drug abusers in substitution treatment and previous drug abusers (approximately half of the drop-in centres). Then there are drop-in centres that solely address drug abusers in substitution treatment, and that primarily are established as a supplement to abuse centres. Finally, there are drop-in centres that only address former drug abusers.

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

### **Debt counselling**

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

### **Other social programs**

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

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

## **9 Drug-related crime, prevention of drug-related crime and prison.**

### **9.1 Introduction**

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

### **9.2 Drug crime**

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

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

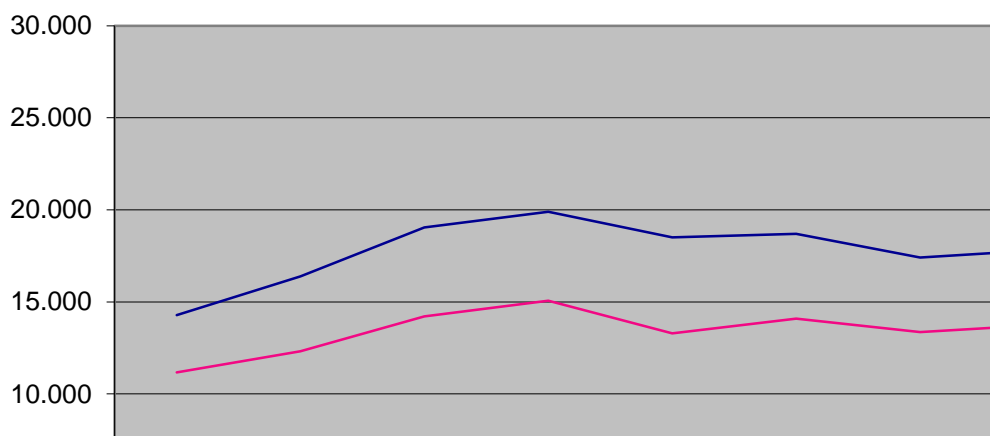
#### **Charges with violation of drug legislation**

In 2013, the National Police registered a total of 24,058 reports filed for the violation of the Drugs Act. In the same year, 17,865 persons were charged with the violation of the Drugs Act. Some persons were thus charged with several counts as regards violation of the Drugs Act.

The figure below shows the trends in the number of crimes reported on violations of the drugs act and the number of individuals who have been charged with violation of the Drugs Act during the period 2003-2013.



**Figure 9.2.1. Drug-related crime in the year in question. Crimes reported leading to charges and not charged**



Source: The National Police's Drug Statistics 2014, unpublished

### **Driving under the influence of psychoactive drugs**

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

On 1 July 2007, the Danish Road Traffic Act was amended, according to which a zero limit was introduced for driving under the influence of certain psychoactive substances which the driver had not taken in accordance with a legal prescription or which the driver had taken in accordance with, but not in compliance with a legal prescription. According to the new rules, Section 54 (ss1) of the Danish Road Traffic Act, the prosecution shall only prove that the person's blood – during or after driving – contained psychoactive substances, which under rules stipulated by the minister of justice are classified as being hazardous to traffic safety. In order to improve the possibilities for the police to identify drivers under the influence of drugs, the amendment furthermore gave the police the necessary powers to perform eye examinations as well as sweat and saliva testing.

This amendment led to a significant increase in the number of charges with violation of the Danish Traffic Act, Section 54 (ss1). Thus, the number of charges went up from 282 in 2007, to 1,101 in 2008, 1,502 in 2009 and 1,622 in 2010 2,477 in 2011, 3,269 in 2012, and 4,179 in 2013.

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

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

As of 1 July 2014, the rules for re-acquisition of a driver's license as a result of suspension due to drug driving was changed to the effect that re-acquisition in future is made conditional upon completion of a course on driving under the influence of psychoactive substances (a so-called ANT[Alcohol, Narcotics, Traffic] course).

Furthermore, the amendment of the Danish Road Traffic Act of 1 July 2014 resulted in the possibility of confiscating vehicles in cases where the driver was under the influence of psychoactive substances. Also, the amendment of the Act provided a legal basis for the police to suspend a person's driver's license on the spot (immediate suspension) in cases where the person in question was suspected of having driven under the influence of drugs and the risk of the person doing it again imminent.

### **9.3 Prison population and the Danish Probation Service strategy**

In Denmark, there are 13 prisons, 43 local prisons/lock-up units, 6 pensions (half-way houses) and 13 departments of the Prison and Probation Service in Freedom. In 2013, 14,423 people were incarcerated in prisons and local prisons. 1,156 were women and 13,267 were men.

A total of 9,967 unconditional prison sentences were reported to the Danish Prison and Probation Service in 2013. The sentences represented a total of 73,306 months of all sentences. 61% of the sentences were 4 months or lower and accounted for 13% of all sentences. 7% of the sentences were more than 2 years and accounted for 49% of all sentences.

By far the majority of the convicted persons do time in the open and the closed state prisons, whereas a minor share serves their sentence in a lock-up facility. Furthermore, imprisonment in special cases may be made either fully or partially in the Danish Prison and Probation Service pensions or institutions outside the Danish Prison and Probation Service. This may occur in pursuance of section 78 of the Danish Corrections Act if the convicted person is deemed to have a need for special treatment or care. In 2013, this happened in 143 cases.

In 2013, the Danish Prison and Probation Service had an average capacity of 4,126 places. On average, the occupancy rate was 97.1%, which equals 4,008 inmates per day. Out of this figure, 171 of the prisoners were women. The average daily occupancy of young people under the age of 18 was 12.1 inmates per day. The distribution of inmates was 858 in closed prisons, 1,365 in open prisons and 1,768 in lock-up facilities. The majority of all inmates in the local prisons and Copenhagen Prisons were remanded in custody.

On a specific date – 10 December 2013 - 65% of the convicted were between the age of 20 and 39 years. 11% were sentenced to 4 months and less. 40% were serving sentences of between 1 year and 5 years. 23% were convicted of drug crimes, 16% of violence, 11% of robbery and 1% of theft. 72% of the prisoners were Danish citizens.

### Strategy targeted at drug abusers

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

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

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

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

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

### The various treatment programs in the prisons

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

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

Similarly, there are programs for cocaine abuse treatment for inmates in open prisons and programs for **cannabis abusers** in all the prisons. The cocaine, cannabis and

substitution programs have been planned as day treatment (outpatient treatment), during which the inmates are referred to common departments where they participate in treatment for a short-term or long-term period as a supplement to or instead of training/other type of employment.

Finally, there are the *special so-called contract departments*, where no treatment is provided, but where inmates who do not wish to serve their sentence with drug abusers can be sure of serving their sentence in a completely drug-free environment. The Danish Prison and Probation Service also has 6 social re-integration pensions.

## 9.4 Drug abuse in the prisons

Table 9.4.1 below shows the use of intoxicants prior to imprisonment (The Danish Prison and Probation Service 2013). Almost 67% of the prisoners in prisons and lock-up facilities reported in 2013 having used intoxicants 30 days prior to their imprisonment. 36% reported that they had not taken any intoxicants, and 2% did not wish to inform about their drug use. In the open prisons, the proportion of prisoners who reported in 2013 having taken drugs 30 days prior to their imprisonment was 67% compared to 62% in the closed prisons.

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

Open prisons and pensions			Closed prisons		Local prisons		2011 13 Dec		2012 11 Dec		2013 10 Dec			
Did the inmate take any drugs prior to imprisonment?														
n		%	n		%	n		%	n		%	n		%
Yes	1,102	66.8	599	61.6	578	47.1	2,355	59.8	2,201	58.8	2,279	59.2	2,279	59.2
No	539	32.7	351	36.1	494	40.3	1,485	37.7	1,426	38.1	1,384	36.0	1,384	36.0
Not dis- closed	8	0.5	23	2.4	154	12.6	96	2.4	115	3.1	185	4.8	185	4.8
<b>Total</b>	<b>1,649</b>	<b>100</b>	<b>973</b>	<b>100</b>	<b>1,226</b>	<b>100</b>	<b>3,936</b>	<b>100</b>	<b>3,742</b>	<b>100</b>	<b>3,848</b>	<b>100</b>	<b>3,848</b>	<b>100</b>

Source: Prison and Probation Service 2013

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

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

	2010 18 December		2011 13 December		2012 11 December		2013 10 December	
Inmates have taken substances:	n	%	n	%	n	%	n	%
Opioids	572	23.4	468	19.2	417	18.9	442	19.4
Psychostimulants	1,533	62.8	1,525	62.5	1,306	59.3	1,292	56.7
Cannabis	1,681	68.9	1,685	69.0	1,579	71.7	1,632	71.6
Alcohol	862	35.3	742	30.4	716	32.5	751	33.0
Benzodiazepines	340	13.9	310	12.7	269	12.2	183	8.0
Hallucinogens	71	2.9	72	2.9	48	2.1	50	2.2
Other	159	6.5	153	6.3	136	6.2	148	6.5

Source: Danish Prison and Probation Service 2013

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

It appears from table 9.4.2 that almost every fifth of those who in 2013 confirmed having used drugs the past 30 days prior to imprisonment had used opioids, whereas it was every fourth a few years ago. As in previous years, the most preferred drug is still cannabis (almost 3 out of 4 cases) which in 2012 is even increasing compared to the year before, whereas psychostimulants are still at a high level, although a moderate drop was seen compared to 2012 to a little less than 57% in 2013.

## 9.5 Treatment and preventive interventions targeted at drug abusers

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

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

The treatment guarantee has been observed within the time limit in 87% of the recorded cases in 2013, which is an improvement of 5% compared to 2012. This improvement is probably due to enhanced focus on compliance with deadlines in the institutions.

All primary drug treatment programs under the Prison and Probation Service must follow an accreditation procedure, in which an expert panel assesses whether or not the treatment program complies with the standards for good treatment.

### **Inmates receiving drug treatment**

Overall from 1997 and until today, capacity has been expanded from 18 to approximately 290 places in actual treatment units. In addition, there are the contract department places and a varying number of inmates who receive day treatment.

Until recently, no consistent statistics have been made on the developments in the number of annual treatments. The Danish Prison and Probation Service points out that in 1998 and 1999 a total of 40 treatment programs were initiated, out of which 25 were completed as planned. The last 10 years' large extension of treatment programs have brought a massive increase in this number. Thus, treatment was initiated in 2578 cases in the prisons in 2013, which is an increase of 362 cases compared to 2012. Also, pre-treatment was initiated in 1829 cases in local prisons and lock-up units in the prisons, which is an increase of approximately 50% from 1208 in 2012. The figure in the local prison sector, however, does not reflect an actual increase, but is more attributed to higher validity of records in the sector.

The number of completed treatments in prison total 1947. Included in this figure is a completed treatment program defined as a program, under which the treatment was finalised prior to release from prison. This figure also includes 289 cases where treatment could not be finalised due to release or transfer to another prison.

In 955 cases treatment was discontinued, with approximately one third of the interruptions being caused by release and transfer.

As regards local prisons and lock-up units, the number of completed treatment programs was 1202. Pre-treatment programs were discontinued in 544 cases. The number of releases and transfers are significantly higher in these types of prisons than in the state prisons, as basically an offender is transferred to a state prison following conviction, and as the stays are therefore short in the local prisons, it is natural that the number of releases are higher during the treatment period. Thus the number of "genuine" interruptions, where the cause was not a release or a transfer to a prison, was a mere 111.

It should be noted that the statistics on initiated treatment programs are based on figures from 2013 solely, whereas the statistics on completed and interrupted programs for 2013 can be started either that same year or earlier.

The Danish Prison and Probation Service has not computed the distribution of the individual treatment types at the time of this report's going to the press. These figures will be provided in the Danish Prison and Probation Service's own annual report on abuse treatment which is estimated to be concluded in October 2014.

### **Prevention of diseases**

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

For the purpose of preventing infectious diseases, including in particular abscesses, sepsis, hepatitis, HIV and AIDS, the Danish Prison and Probation Service dispenses condoms, chlorine rinse fluid for cleaning of needles and syringes, vaccination against

hepatitis B and A and general physical exams, including information about the above diseases and general physicals on an equal footing with the rest of the population. Inmates, however, do not have access to free syringes and needles.

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

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

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

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

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

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

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

## 10 Drug markets

### 10.1 Introduction

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

Illicit drugs have no content declaration, and there are many different drugs hidden in the tablets and powders sold as, among others, "ecstasy". While the relatively new active substance, mCPP, which has stimulating and hallucinating effects, is dominant in the ecstasy tablets in recent years, the tide has turned, and MDMA is again the dominant active substance. To a large extent, MDMA is also found in powder samples, and a large part of the powder samples examined these years contain a combination of MDMA and ketamine.

Results from the forensic analyses of the drugs in recent years also show that there is a large variation in purity and in drug concentration of the illicit drugs on the market<sup>19</sup>, and the illicit drugs contain additives to a large extent. Cocaine is the type of drug, which is mixed with the highest amount of additives. Almost all cocaine samples examined by forensic experts in 2013 contain additives with the most frequently prevalent additive being levamisole which was found in 70% of the samples. Levamisole is a drug for the treatment of parasitic worm infections and it has immunomodulatory effects in humans. As the purity and concentration of the drugs are often unknown to the user, this implies a special risk on intake.

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

### 10.2 Availability and demand

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

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<sup>19</sup> Results from the special forensic analyses are based on random samples from the "Street Project" and from the project on monitoring of prevalence of ecstasy pills mentioned later in this chapter.

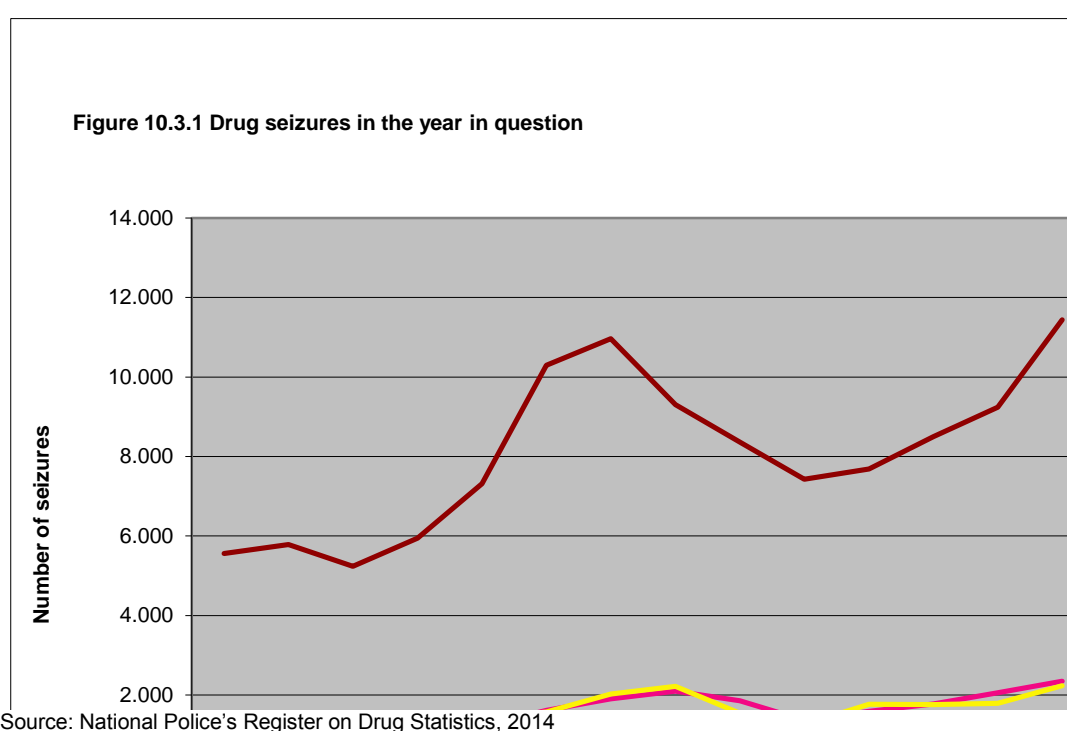


uted typically via Spain and the Netherlands. Large quantities of cocaine are also distributed to Europe via countries in West Africa and countries in the Baltic region.

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

### 10.3 Seizures

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



As for the quantity seized, major fluctuations are seen in most drug types from one year to the other. Particularly in 2013, there appears to be a dramatic increase in the quantity of cocaine seized which is primarily explained by a few major seizures. A total of 680 kilos of cocaine were seized in 2013, whereas 42 kilos were seized in 2012. The number of cocaine seizures has increased regularly throughout the past years and totalled 2,346 seizures in 2013. The quantity of amphetamine seized dropped from 2012 to 2013 by 301 kilos to 288 kilos in the years in question. The quantity of cannabis seized was 3,292 in 2013, which is significantly higher than the quantities of previous years. Also, significantly more cannabis seizures have been made compared to previous years. The quantity of ecstasy pills has dropped significantly from 72,654 pills in 2012 to 7,706 in 2013. In addition, almost 13 kilos of ecstasy have been seized (MDMA) in powder form in 2013.

The number of seizures and the quantity seized appears in table 10.3.1 of the annex.

## 10.4 Purity, drug concentration and prices

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

### Drugs trafficking in the streets

The data material of the Street Project consists of small random sampling based seizures from 5 police districts in Denmark (Copenhagen, Aarhus, Odense, Aalborg and Esbjerg), which are submitted for analysis with the forensic departments<sup>20</sup>. Table 10.4.1 of the Annex shows the distribution of types of drugs seized in Denmark from 2003 to 2013.

Out of the 206 samples analysed in 2012, 81% contained the psychostimulants cocaine and amphetamine, which is the same rate as in 2012. In recent years, the prevalence of the psychostimulants in the project – especially cocaine has, however, been increasing, whereas the prevalence of heroin has been declining. 10% of all samples in 2013 in Denmark were heroin. By comparison, 39% of the samples in 2003 were heroin. Furthermore, 6% of the samples in 2013 contained other psychoactive substances and drug compositions such as methamphetamine, MDMA and ketamine, and 3% contained non-psychoactive substances.

In Copenhagen, Aarhus and Aalborg, cocaine is the most prevalent drug in 2013 (85%, 48%, and 54%, respectively, of all samples, whereas amphetamine is the most prevalent drug in Esbjerg and in Odense (62% and 42% of all samples, respectively). Table 10.4.2 of the Annex shows the prevalence ratios of heroin base ("smokeable" heroin) and heroin chloride (white heroin for injection) throughout the years. In 2013, the heroin chloride and heroin base ratios were 38% and 62%, respectively.

In all the years, there has been a tendency toward Odense standing out from the other parts of Denmark by having the highest prevalence rate for white heroin. As in 2012, all heroin samples from Odense were white heroin for injection. By comparison all the heroin samples in Aarhus, Esbjerg, and Aalborg contained the brown heroin for smoking. In Copenhagen, the heroin chloride and heroin base ratio was 75% and 25%, respectively.

### Drug purity

Table 10.4.3 shows the contents of the various drugs from 2003 to 2013 in the samples analysed from the Street Project.

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<sup>20</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 Project does not include cannabis or other cannabis products. In addition, ecstasy was excluded from the Street Project. This is consistent with the fact that the project from 2003 and up until today is monitored on its own.

**Table 10.4.3. Purity of illicit drugs among users throughout the years (median of active substance)<sup>21</sup>**

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Heroin chloride	64%	63%	67%	53%	29%	52%	41%	46%	40%	32%	38%
Heroin base	25%	22%	28%	18%	21%	16%	14%	20%	11%	11%	18%
Amphetamine	9%	9%	10%	7%	6%	8%	6%	6%	5%	5%	5%
Cocaine	37%	24%	25%	18%	16%	19%	17%	21%	20%	23%	25%

Source: Lindholst et al 2014

The trend is that the concentration of the various drugs has dropped, however with annual fluctuations. For instance, the concentration of the white heroin chloride dropped from 67% in 2005 to 38% in 2013, whereas the concentration of the brown heroin during the same period dropped from 28% to 18%. Also, the concentration of cocaine has been decreasing. However, purity appears to have been relatively stable for the past three years, and in 2013, it was 25%. Purity of amphetamine is generally low and was 5% in 2012.

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

### Additives and fillers

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

**Table 10.4.4. The presence of additives in heroin base, heroin chloride, cocaine, and amphetamine in 2013 (the result as a percentage of the total number of samples of each drug type)**

Number	Heroin base (n=13)	Heroin chloride (n=8)	Cocaine (n=109)	Amphetamine (n=58)
Caffeine	100	88	24	93
Kreatine	0	25	31	72
Diltiazem	-	-	2	-
Hydroxyzine	-	-	3	-
Levamisole	-	-	70	2
Lidocaine	-	13	23	-
Paracetamol	100	50	-	10
Phenacetine	-	-	61	2
Procaine	-	-	2	-
Salicylic acid	-	-	-	2

Source: Lindholst et al 2014

<sup>21</sup> Since the purity of most of the drugs is not distributed by standards, the median value is applied here for purity rather than the average value. This is consistent with practice in the institute of forensic chemistry.

The fact is that almost all heroin base analysed in 2013 also contains caffeine and paracetamol (92% of all samples). In the cases involving heroin chloride in 2013, caffeine is found and paracetamol (in 50% of the samples) together with creatine (in 25% of the samples) and lidocaine (in 13% of the samples). Cocaine is the type of drug with the highest number of additives. All cocaine samples analysed in 2013 contain additives. Most frequently seen are the additives levamisole (in 70% of all samples in 2012), Phenacetine (in 61% of the samples) and creatine (in 31% of the samples). Levamisole is a drug for the treatment of parasitic worm infections and it affects the immune system in humans, whereas creatine is a substance that transports energy to the muscles.

### **Ingredients in tablets and powder**

Since 2001, the Danish Health and Medicines Authority, in collaboration with the National Police and the three institutes of forensic chemistry, have been monitoring the prevalence of ecstasy pills in Denmark. In 2011, this collaboration was expanded to include liquids and powder as well, and samples from SKAT [the Danish tax authorities] were included in the project. Samples analysed from seizures of tablets, liquids, and powder sent from the police districts to one of the three institutes of forensic chemistry are collected, examined and described in relation to drug concentration, drug composition and appearance<sup>22</sup>. Every six months, the results of these analyses and a major annual report is posted on the website of the Danish Health and Medicines Authority [www.sst.dk](http://www.sst.dk).

In 2013, a total of 483 samples of powder and fluid and 27 cases involving tablets were examined at the forensic institutes in order to determine ingredients and concentration. These cases were based on 424 seizures submitted by the police districts and SKAT to the forensic departments for analysis.

As regards the tablets in the ecstasy project, it can be summarized that in 2012 and 2013, there is a sudden increase in the proportion of tablets containing the active ingredient MDMA. This happens after a number of years when other drugs have been predominant on the market. A drug such as mCPP has been contained in a large number of the ecstasy tablets in recent years, but in 2013 the proportion of tablets containing mCPP only account for 8%. In 4% of the tablets in 2013, there were no active ingredients.

MDMA is not only found in tablets, it also appears in powder form. Out of all 397 powder samples examined in 201, 49% of these contained MDMA. A great deal of the cases also include MDMA in mixtures with ketamine. The list of ingredients in powders and liquids in 2013 appears in the Annual Report on Illicit Drugs in Denmark, 2013 (Aarhus University 2014).

### **New ingredients and their regulation**

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

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<sup>22</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.

enter the country. Chapter 1 of this National Report lists new drugs that have been banned as of 2013 and the first six months of 2014.

### **High and low drug concentration**

Concentration of the various active drugs in the tablets varies a great deal, which poses a major risk of poisoning on intake. For instance, since 2001, the quantity of MDMA varied in the drug samples from between 1 and 199 mg. The highest MDMA concentration, however, was found in a capsule and contained 226 mg of MDMA. Further information about drug concentration is provided in the Annual Report on illicit Drugs in Denmark, 2013 (Aarhus University 2014). Apart from a few exceptions with, for instance, methamphetamine, new psychoactive substances are being traded on the market, most often in a very pure form

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

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

### **Prices**

The National Police estimates that the price for cannabis in the streets amounts to around DKK50-120 per gram. The police districts state prices of between DKK50 and 120 for one gram of cannabis. The price per gram for heroin sold in the streets is estimated to amount to between DKK1,000 and 1,600 for the white heroin and between DKK500 and 1,000 for the brown heroin. The price for cocaine sold in the streets is estimated to be between DKK400 and DKK600 per gram. For amphetamine, the price in the streets is estimated to be between DKK100 and DKK200 per gram, whereas the price for an ecstasy pill is estimated to be between DKK30 and 80.

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

# Annex

## List of references

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

Ankestyrelsen. Anbringelsesstatistikken 2012. Ankestyrelsen 2013

Benjaminsen L., et al. Hjemløshed i Danmark 2013. SFI – Den Nationale Forskningscenter for Velfærd, august 2013.

Center for Rusmiddelforskning, Dansk Registrerings- og Informationssystem, DanRIS, Aarhus 2013.

Christensen P.B., Kringsholm B., Banner, J. et al. Surveillance of HIV and viral hepatitis by analysis of samples from drug related deaths (2006). Eur J Epidemiol 2006; 21(5):383-387.

Christensen, P.B., Grasaasen K, Sælan H. (2009, upubliceret). Skøn over antallet af injektionsmisbrugere i Danmark, 2009.

Due, P., Holstein, B.E. (2003). Skolebørnsundersøgelsen (2002). Health Behaviour in School-aged Children (HBSC).

EMCDDA (2005). DRD-Standard Protocol, version 3.1, 1. September 2005.

EMCDDA (2010). Trends in injecting drug use in Europe. Selected Issues 2010. The European Monitoring Centre for Drugs and Drug Addiction.

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

ESPAD (2000). The 1999 ESPAD report – Alcohol and Other Drug Use Among Students in 30 European Countries. CAN og Pompidou Group, Stockholm.

ESPAD (2004). The 2003 ESPAD report – Alcohol and Other Drug Use Among Students in 30 European Countries. CAN og Pompidou Group.

ESPAD (2009). The 2007 ESPAD report – Alcohol and Other Drug Use Among Students in 36 European Countries. CAN og Pompidou Group.

ESPAD (2012). The 2011 ESPAD report – Alcohol and Other Drug Use Among Students in 36 European Countries. CAN og Pompidou Group.

Järvinen M., Demant J., Østergaard J. (2010). Stoffer og natteliv. Hans Reitzels Forlag.

Järvinen M. Unges voksende hashmisbrug (2014). SFI 2014

Kaa, E., Nielsen, E., Rollmann, D., Breum Müller I., Findal Andreasen M., Johannsen M. (2003). Narkotika på gadeplan 2002. Rapport til Sundhedsstyrelsen.

Kaa, E., Nielsen, E., Rollmann, D., Breum Müller I., Findal Andreasen M., Johannsen

M. (2004). Narkotika på gadeplan 2003. Rapport til Sundhedsstyrelsen.

Kaa, E., Nielsen, E., Rollmann, D., Breum Müller I., Findal Andreasen M., Johannsen M. (2005). Narkotika på gadeplan 2004. Rapport til Sundhedsstyrelsen.

Kaa, E., Nielsen, E., Rollmann, D., Breum Müller I., Findal Andreasen M., Johannsen M. (2006). Narkotika på gadeplan 2005. Rapport til Sundhedsstyrelsen.

KABS VIDEN 2013. Socialsygepleje i somatik og psykiatri (2013).

Kriminalforsorgen 2013. Kriminalforsorgen – statistik 2013. Direktoratet for Kriminalforsorgen. København.

KORA (2013). Kortlægning af kommunernes forebyggelsesindsats over for stofmisbrug. KORA for Sundhedsstyrelsen, juni 2013.

Lindholst C., Nielsen, E., Rollmann D., Worm-Leonhard M., Breum Müller I., Findal Andreasen M., Johannsen M. (2007). Narkotika på gadeplan 2006. Rapport til Sundhedsstyrelsen.

Lindholst C., Nielsen, E., Rollmann D., Worm-Leonhard M., Breum Müller I., Findal Andreasen M., Johannsen M. (2008). Narkotika på gadeplan 2007. Rapport til Sundhedsstyrelsen.

Lindholst C, Breum Müller I, Rollmann D, Kastorp G, Johannsen M, Nielsen E. (2009). Narkotika på gadeplan 2008. Rapport til Sundhedsstyrelsen.

Lindholst C, Breum Müller I, Rollmann D, Kastorp G, Johannsen M, Nielsen E. (2010). Narkotika på gadeplan 2009. Rapport til Sundhedsstyrelsen.

Lindholst C, Johannsen M, Breum Müller I, Reitzel L, Rollmann D, Worm-Leonhard M, Lindal L, Kastorp G, Nielsen B (2011). Narkotika på gadeplan 2010. Rapport til Sundhedsstyrelsen, maj 2011.

Lindholst C, Johannsen M, Breum Müller I, Reitzel L, Rollmann D, Worm-Leonhard M, Nielsen B (2012). Narkotika på gadeplan 2011. Rapport til Sundhedsstyrelsen, maj 2012.

Lindholst C, Johannsen M, Breum Müller I, Reitzel L, Rollmann D, Worm-Leonhard M, Nielsen B (2013). Narkotika på gadeplan 2012. Rapport til Sundhedsstyrelsen, maj 2013.

MULD (2009). MULD-rapport nr. 7. Unges livsstil og dagligdag 2008. Kræftens Bekæmpelse og Sundhedsstyrelsen.

Pedersen, MU & Pedersen, MM (2013). Effekten af hashbehandling. En randomiseret undersøgelse af Client-Directed Outcome-Informed behandling af hashmisbrug. Aarhus Universitet, Center for Rusmiddelforskning.

Ramsbøl, H. (2003). Kriminalforsorgens og de sociale myndigheders samarbejde: Om udmøntningen af De Vejledende Retningslinier for samarbejdet mellem Kriminalforsorgens institutioner og afdelinger og de sociale myndigheder. Esbjerg, Formidlingscentret for socialt arbejde.

Rigspolitiet (2013). Narkotikastatistik 2012. Rigspolitiet, NEC (Nationalt Efterforskningscenter), København.

Rigspolitiet (2014). Narkotikastatistik 2013. Rigspolitiet, NEC (Nationalt Efterforskningscenter), København.

Socialministeriet (2006). Bekendtgørelse om kommunernes pligt til at koordinere *hand-leplaner med kriminalforsorgen for visse persongrupper*. Socialministeriets bekendtgørelse nr. 81 af 9. februar 2006.

Statens Serum Instituts Dødsårsagsregister, 2014. København.

Statens Serum Instituts Landspatientregister (udtræk juni 2014). København.

Statens Serum Instituts Register for stofmisbrugere i behandling (SIB) (Stofmisbrugs-databasen).

Sundhedsstyrelsen (2007a). National handlingsplan til forebyggelse af hepatitis C blandt stofmisbrugere. Sundhedsstyrelsen, august 2007.

Sundhedsstyrelsen (2008a). Vejledning nr. 42 af 1. juli 2008 om den lægelige behand-ling af stofmisbrugere i substitutionsbehandling. 2008.

Sundhedsstyrelsen (2008b). Narkotikasituationen i Danmark 2008. Side 33-34. Sundhedsstyrelsen 2008

Sundhedsstyrelsen (2009a). Tackling – Sundhed, selvværd, samvær. Sundhedsstyrelsen & Alinea.

Sundhedsstyrelsen (2009b). Forebyggelse og sundhedsfremme i skolen. Sundhedsstyrelsen, september 2009.

Sundhedsstyrelsen (2009c). Ansvarlig udskænkning, 2009.

Sundhedsstyrelsen (2009d). Vejledning om etablering af regionale familieambulatorier. Vejledning nr. 49 af 30. juni 2009.

Sundhedsstyrelsen (2010a). Sundhed på tværs. Sundhedsstyrelsen 2010.

Sundhedsstyrelsen (2010b). Upubliceret opgørelse fra sundhedsstyrelsen over stof-misbrugere i Danmark.

Sundhedsstyrelsen (2011a). Ulighed i sundhed – årsager og indsatser. Sundhedsstyrelsen, maj 2011.

Sundhedsstyrelsen (2011b). Social ulighed i Sundhed - hvad kan kommunen gøre? Sundhedsstyrelsen, december 2011.

Sundhedsstyrelsen (2011c). Sæt rammer for alkohol, tobak og stoffer. Sundhedsstyrelsen, september 2011.

Sundhedsstyrelsen (2011d). Hjælp din teenager med at skabe rammer for alkohol, to-bak og stoffer. Sundhedsstyrelsen, september 2011.



Sundhedsstyrelsen (2011e). Politik for rusmidler og rygning. Sundhedsstyrelsen, september 2011.

Sundhedsstyrelsen (2011f). Dit barns festkultur. Sundhedsstyrelsen, september 2011.

Sundhedsstyrelsen (2012a). Forebyggelsespakke – alkohol. Sundhedsstyrelsen, juni 2012.

Sundhedsstyrelsen (2012b). Forebyggelsespakke – mental sundhed. Sundhedsstyrelsen, juli 2012.

Sundhedsstyrelsen (2012c). Forebyggelsespakke – tobak. Sundhedsstyrelsen, juni 2012.

Sundhedsstyrelsen (2012d). Sunde erhvervsskoler. Sundhedsstyrelsen 2012.

Sundhedsstyrelsen (2012e). Veiledning om behandling af akutte rusmiddelforgiftninger. Sundhedsstyrelsen 2012

Sundhedsstyrelsen (2012f). Veiledning om den lægelige behandling af misbrug af kokain og andre centralstimulerende stoffer. Sundhedsstyrelsen 2012

Sundhedsstyrelsen (2013a). Sundhedstilbud til socialt udsatte borgere, Sundhedsstyrelsen 2013

Sundhedsstyrelsen 2013b). Forebyggelsespakke – stoffer. Sundhedsstyrelsen, december 2013

Sundhedsstyrelsen (2013c). Stoffer – hvor dan virker de, og hvordan ser de ud, Sundhedsstyrelsen 2013.

Sundhedsstyrelsen (2013d). Roskilde Festival against drugs & mindre druk – mere fest. Evaluering af indsatserne 2013, december 2013

Sundhedsstyrelsen (2013e). Dansk Live against drugs & mindre druk – mere fest. Evaluering af indsatserne i 2013, december 2013.

Sundhedsstyrelsen (2013f). Evaluering af ordning med lægeordineret heroin til stofmisbrugere 2010-2012, Sundhedsstyrelsen 2013.

SUSY 1994 (1995). Sundhed og sygelighed i Danmark 1994 og udviklingen siden 1987. Dansk Institut for Klinisk Epidemiologi (nu SIF).

SUSY 2000 (2002). Sundhed og Sygelighed i Danmark 2000 – og udviklingen siden 1987. Statens Institut for Folkesundhed (SIF).

SUSY 2005 (2006). Sundhed og Sygelighed i Danmark 2005 – og udviklingen siden 1987. Statens Institut for Folkesundhed (SIF), notat af Niels Kr. Rasmussen og Ola Ekholm, september 2006.

SUSY 2010 (2010). Sundhed og Sygelighed i Danmark 2010. Statens Institut for Folkesundhed (SIF).

SUSY 2013 (2013, upubliceret). Sundhed og Sygelighed i Danmark 2010. Statens Institut for Folkesundhed (SIF).

Aarhus Universitet (2014). Illegale stoffer i Danmark. Årsrapport 2013. Udgivet 2014

## Web sites

Center for Digital Pædagogik og Slagelse Misbrugscenter  
(Center for Digital Education and Slagelse Drug Abuse Center): [www.netstof.dk](http://www.netstof.dk)

Kriminalforsorgen (Danish Prison and Probation Service): [www.kriminalforsorgen.dk](http://www.kriminalforsorgen.dk)

Socialstyrelsen (The National Board of Social Services): [www.stofmisbrugsdatabasen.dk](http://www.stofmisbrugsdatabasen.dk)

Sundhedsstyrelsen (The Danish Health and Medicines Authority): <http://stofinfo.sst.dk/>

Sundhedsstyrelsen (The Danish Health and Medicines Authority): [www.sst.dk](http://www.sst.dk)

Videncenter for Forebyggelse af Rusmiddelskader hos børn  
(Center for Prevention of Substance Effects on the Development of Children):  
[www.familieambulatoriet.dk](http://www.familieambulatoriet.dk)

## **The surveys applied**

### **"Sundhed- og sygelighedsundersøgelsen 2013, Statens Institut for Folkesundhed, Syddansk Universitet [Health and Morbidity in DK, 2013]**

The Health and Morbidity Survey 2013 (SUSY-2013) is based on random sampling of 25,000 Danes at the age of 16 years and above. All invited persons received an introduction letter and a questionnaire. It was also possible to provide answers in an identical web questionnaire. A total of 14,265 persons (57.1%) responded to the questionnaire. 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.

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

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

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

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

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

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

were also included, since they attend the 9th grade as well. Thereby, the number participating pupils went up to 1750.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Unge's erfaringer med rusmidler – i 2003 og udviklingen siden 1995. Institut for Epidemiologi og Socialmedicin, Aarhus Universitet (Sabroe & Fonager 2004)**  
**[Young people's experience with intoxicants]**

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 participating pupils went up to 2978.

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

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

**"Unge's 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.

**"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 (see Gundelach & Järvinen 2006) and their responses from 2008 thus make it possible to monitor them over time.

A focus group survey among typical Danish young people conducted during the spring and summer, 2008. The purpose of this survey was to analyse these young people's

attitudes towards and knowledge about drugs.

A nightclub survey conducted in the autumn and winter 2008-2009. The purpose of this survey was to analyse the prevalence of drugs in the night life and make contact with young people with broader drug experience than the typical Danish young people in the focus group survey mentioned above. The nightclub survey consists of a brief questionnaire survey conducted in the night clubs, an internet-based questionnaire survey, ethnographic observations from the night clubs and finally qualitative interviews (focus group interviews and individual interviews) with nightclub guests regularly using drugs. The YODA project has been financed by the Rockwool Foundation and the results are described in the book "Stoffer og natteliv" [Drugs and Nightlife) (Järvinen) 2010.



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**Table 2.2.2. The percentage of women and men in the various age groups who have used cannabis within the past year in 1994, 2000, 2005, 2008, 2010, and 2013**

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

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

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

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

Source: Unpublished figures from SUSY 2013

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

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

**Table 2.2.10. The percentage of the 16-24-year-olds with a current use of illicit drugs (tried one or several of the various illicit drugs within the last year) in 2000, 2005, 2008, 2010, and 2013**

	Last year 2000	Last year 2005	Last year 2008	Last year 2010	Last year 2013
Cannabis	20.1	20.5	21.3	18.9	23.9
Amphetamine	5.9	4.1	5.4	2.8	1.6
Cocaine	2.8	3.3	5.6	2.9	2.3
Psilocybin mushrooms	2.2	1.0	1.1	0.7	0.8
Ecstasy	2.3	1.5	2.3	1.1	1.0
LSD	0.6	0.6	0.2	0.4	0.3
Heroin	0.2	0.2	0.0	0.3	0.1
Ketamine**	-	-	-	-	0.5
GHB**	-	-	-	-	0.1
Other drugs*	1.1	0.7	2.3	1.1	1.5
"Illicit drug other than cannabis"	8.0	5.3	8.0	4.3	3.9

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

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

\*\* For the first time in 2013, questions have been asked about Ketamine and GBH "alone", as it has been done with amphetamine, cocaine, ecstasy, etc. In previous years, the answers on ketamine and GHB are included in the category "Other drugs"

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

	Previous month	Last year (incl previous month)	Ever
Amphetamine	0.6	1.6	5.7
Cocaine	0.8	2.3	5.7
Psilocybin mushrooms	0.1	0.8	2.4
Ecstasy	0.4	1.0	3.2
LSD	0.1	0.3	1.0
Heroin	0.1	0.1	0.4
Ketamine	0.2	0.5	1.6
GHB	0.0	0.1	0.9
Other drugs*	0.5	1.5	3.4

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

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

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

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Number of hepatitis A, total	71	241	48	42	28	44	45	47	13	53	103
Number of hepatitis A with injecting drug use (% of all diagnosed)	0	1 (0.4%)	1 (2%)	0	0	0	0	0	1 (8%)	0	0
Number of hepatitis B, total*	36	44	30	20	25	25	23	28	16	24	19
Number of hepatitis B with injecting drug use (% of all diagnosed)	7 (19%)	9 (21%)	3 (10%)	1 (5%)	2 (8%)	5 (19%)	3 (13%)	1 (4%)	1 (6%)	5 (21%)	2 (11%)
Number of hepatitis C, total*	7	8/378	2/371	7/398	11/408	6/318	4/292	6/315	7/285	12/239	10/224
Number of hepatitis C with injecting drug use (% of all diagnosed)	2 (29%)	3/285 (37%/75%)	0/253 (0%/68%)	6/279 (86%/70%)	5/292 (45%/72%)	1/216 (16%/68%)	0/211 (0%/72%)	3/230 (50%/73%)	2/195 (29%/68%)	5/169 (42%/71%)	4/156 (40%/70%)

Source: Unpublished data from the State Serum Institute. For 2013 data, the figures were compiled in May 2014

\*Among the cases with acute Hepatitis B and C a certain joint quantity is included.

Table 6.3.1 Trends in hospital contacts resulting from intoxication and poisoning due to various illicit drugs in the year in question											
	Code*	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013 <sup>23</sup>
Heroin	T40.1	197	159	160	151	166	163	195	126	125	108
Other opioids	T40.2 +T40.2A +T40.2B	119	112	130	139	169	240	279	338	415	475
Methadone	T40.3	50	53	32	44	57	74	89	102	116	119
Opioids	F11.0	49	65	48	60	72	63	73	92	77	84
<b>Opioids, total</b>		<b>415</b>	<b>389</b>	<b>370</b>	<b>394</b>	<b>464</b>	<b>540</b>	<b>636</b>	<b>658</b>	<b>733</b>	<b>786</b>
Designer drugs (excl. ecstasy)	T40.6A + T43.8A	15	3	6	10	40	37	61	64	60	49
Ecstasy	T40.6B +T43.6B	72	72	89	86	72	52	46	45	94	81
Amphetamine	T43.0A + T43.6A	68	73	83	171	158	208	286	292	237	229
Cocaine	T40.5 +F14.0	69	105	100	129	119	139	156	148	188	238
Other psychostimulants	F15.0	41	53	41	50	45	35	35	42	75	86
<b>Psychostimulants, total</b>		<b>265</b>	<b>306</b>	<b>319</b>	<b>446</b>	<b>434</b>	<b>471</b>	<b>584</b>	<b>591</b>	<b>654</b>	<b>683</b>
Psychoactive mushrooms	T40.6C +T40.9A	10	6	13	13	7	12	5	13	22	23
LSD	T40.8	2	7	11	16	27	7	8	14	7	32
Hallucinogens	F16.0	6	11	5	12	8	2	12	5	7	16
<b>Hallucinogens, total</b>		<b>18</b>	<b>24</b>	<b>29</b>	<b>41</b>	<b>42</b>	<b>21</b>	<b>25</b>	<b>32</b>	<b>36</b>	<b>71</b>
Cannabis	T40.7 +F12.0	74	86	76	97	108	137	128	155	175	200
Polydrug use and unspecified	T40.4 +T40.6 +T40.6V +40.6X +T40.9 +F19.0	391	400	449	367	449	447	497	446	439	454
<b>Intoxication and poisoning, total</b>		<b>1163</b>	<b>1205</b>	<b>1243</b>	<b>1345</b>	<b>1497</b>	<b>1616</b>	<b>1870</b>	<b>1882</b>	<b>2037</b>	<b>2194</b>

Source: The National Patient Register. Data for the year 2013 have been compiled in June 2014

\*New codes were introduced in 2004 and 2010. From 2004, a number of new sub codes of polydrug use and unspecified poisoning have been introduced. These are the following: T404A, T409A, T409B, T409C, T409D, T409X, T409Z

<sup>23</sup> The figures for 2013 are preliminary (data from the National Patient Register retrieved in June 2014). The final figures for 2013 may therefore change in subsequent statistics.



**Table 6.3.3. Hospital contacts resulting from intoxication and poisoning broken down by age groups in the year in question**

Age group	2005	2006	2007	2008	2009	2010	2011	2012	2013
< 20 yrs	221	279	317	309	296	336	317	328	322
20-24 yrs	251	223	259	292	284	356	349	442	426
25-29 yrs	175	172	177	193	162	248	220	210	234
≥ 30 yrs	558	569	592	703	874	930	996	1057	1212
<b>Total</b>	<b>1203</b>	<b>1243</b>	<b>1345</b>	<b>1497</b>	<b>1616</b>	<b>1870</b>	<b>1882</b>	<b>2037</b>	<b>2194</b>

Source: The National Patient Register under the Danish Health and Medicines Authority, data from June 2014

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

Diagnosis code	Mental disorders or disturbances caused by:	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
F11	Opioids	155	138	123	133	136	166	120	135	107	122
F12	Cannabis	354	312	347	364	388	553	533	643	706	702
F13	Sedatives/hypnotic agents	143	150	140	154	141	130	112	113	109	116
F14	Cocaine	53	42	49	49	56	57	51	39	47	57
F15	Psychostimulants other than cocaine	98	93	87	91	94	95	86	98	88	119
F16	Hallucinogens	17	16	10	10	18	6	11	14	15	9
F18	Solvents	5	3	3	4	7	3	1	4	4	8
F19	Multiple or other psychoactive substances	684	668	660	682	696	826	672	714	687	735
<b>Persons with primary diagnoses, total</b>		<b>1509</b>	<b>1422</b>	<b>1419</b>	<b>1487</b>	<b>1536</b>	<b>1746</b>	<b>1586</b>	<b>1760</b>	<b>1763</b>	<b>1775</b>

Source: Special data 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. Since a patient can have several drug-related secondary diagnoses, the "total" category is not a summation.

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

Diagnosis code	Mental disorders or disturbances caused by:	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
F11	Opioids	271	280	341	358	492	522	428	451	409	400
F12	Cannabis	873	908	1040	1072	1507	1646	1668	2011	2091	2061
F13	Sedatives/hypnotic agents	359	367	385	417	529	554	468	467	458	424
F14	Cocaine	66	97	118	163	210	217	214	209	207	203
F15	Psychostimulants other than cocaine	123	120	162	179	235	261	251	270	291	256
F16	Hallucinogens	13	14	8	8	13	14	14	16	10	16
F18	Solvents	11	8	18	13	13	24	17	18	26	20
F19	Multiple or other psychoactive substances	728	736	874	995	1176	1396	1239	1458	1386	1239
<b>Persons with secondary diagnosis, total</b>		<b>2074</b>	<b>2102</b>	<b>2430</b>	<b>2632</b>	<b>3418</b>	<b>3718</b>	<b>3445</b>	<b>3927</b>	<b>3946</b>	<b>3772</b>

Source: Special data 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. Since a patient can have several drug-related secondary diagnoses, the "total" category is not a summation.

**Table 6.4.1. Drug-related deaths in the year in question. Broken down by gender**

Year	Total	Men	Women
2007*	246	173	73
2008*	267	194	73
2009*	277	201	76
2010*	255	198	57
2011*	300	219	81
2012*	244	171	73

Source: Cause of Death Register, August, 2013

\*The figures for 2007 - 2012 have been raised by 1.7 pct., 1.9 pct., 2.1 pct., 2.8 pct., 1.8 pct. og 1.4 pct., respectively, in relation to the reported number of death certificates in order to be able to compare the figures of previous years.

**Table 6.4.2. Drug related deaths in the year in question. Based on the National Police's register on drug-related deaths. Broken down by gender**

Year	Total	Men	Women	Year	Total	Men	Women
1981	148	113	35	1997	275	225	50
1982	134	107	27	1998	250	210	40
1983	139	110	29	1999	239	201	38
1984	158	125	33	2000	247	197	50
1985	150	116	34	2001	258	211	47
1986	109	88	21	2002	252	216	36
1987	140	116	24	2003	245	197	48
1988	135	107	28	2004	275	211	63
1989	123	99	24	2005	275	234	41
1990	115	91	24	2006	266*	218	46
1991	188	153	35	2007	260**	207	50
1992	208	162	46	2008	239*	186	51
1993	210	166	44	2009	276	217	59
1994	271	227	44	2010***	276	237	39
1995	274	226	48	2011	285	232	53
1996	266	220	46	2012	210	159	51
				2013	213	167	46

Source: National Police, 2014

\*Undisclosed gender for 2 persons

\*\*Undisclosed gender for 3 persons

\*\*\*Adjusted for the total number of deaths

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

	2008	2009	2010	2011	2012	2013
Northern Jutland	35	33	32	28	25	24
Central Jutland	47	53	60	56	37	47
Southern Denmark	68	79	78	91	54	36
Capital Region	59	86	70	69	61	80
Zealand	24	21	31	33	26	21
Copenhagen Municipality*	31	51	38	32	37	49

Source: National Police 2014

\* The figures recorded under Copenhagen Municipality are also included in the figures for the Capital Region of Denmark.

**Table 6.4.5. Drug-related deaths broken down by selected municipalities, 2008-2013**

	2008	2009	2010	2011	2012	2013
Copenhagen	31	51	38	32	37	49
Aarhus	17	25	20	16	13	18
Odense	13	13	19	25	10	9
Esbjerg	10	18	8	13	7	6
Aalborg	11	14	8	14	12	9
Vejle	6	7	11	10	9	2
Kolding	6	11	4	8	5	5

Source: National Police 2014

**Table 9.2.1. Drug-related crime in the year in question. Reports leading to charges and number of persons charged**

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Reports leading to charges	14,272	16,390	19,037	19,900	18,506	18,692	17,403	17,825	21,211	21,498	24,058
Number of persons charged	11,160	12,313	14,204	15,060	13,294	14,093	13,354	13,749	16,065	16,401	17,865

Source: National Police's Drug Statistics 2014

**Table 10.3.1. Drug seizures in the year in question**

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
<b>Heroin</b>												
Kg	62.5	16.3	37.5	27.0	28.9	48.1	43.9	22.4	39.4	36.6	40.6	13.7
Number of seizures	966	894	1041	1064	927	1,016	906	648	699	488	430	497
<b>Cocaine</b>												
Kg	14.2	104.0	32.3	57.0	76.2	91.8	56.1	72.4	54.16	42.9	42.1	680.9
Number of seizures	881	1,095	1,207	1,615	1,901	2,098	1,858	1,365	1,589	1,777	2,056	2,346
<b>Amphetamine</b>												
Kg	34.9	65.9	63.0	195.0	79.4	70.4	119.8	103.8	193.9	240.3	301.5	287.8
Number of seizures	1,134	1,264	1,388	1,573	2,022	2,215	1,543	1,260	1,764	1,757	1,793	2,232
<b>Ecstasy</b>												
Pcs.	25,738	62,475	38,096	44,195	22,712	82,390	17,631	53,929	45,360	16,042	72,654	7,046*
Number of seizures	340	322	1388	461	540	452	251	200	200	209	523	592
<b>LSD</b>												
Doses	38	22	483	1201	521	47	482	468	159	1,003		1,238
Number of seizures	8	7	13	12	8	13	21	18	16	20	18	98
<b>Cannabis</b>												
Kg	2,635	3,829	1,758	1,406	1,035	877	2,914	1,220	2,318	2,326	1,334	3,292
Number of seizures	5,234	5,942	7,313	10,292	10,962	9,301	8,365	7,430	7,689	8,499	9,239	11,440

Source: National Police's Drug Statistics 2014

\* In addition 12.82 kg MDMA as powder (contained in 592 seizures)

**Table 10.4.1. Distribution between drug types among users in the year in question**

Year	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
	n=188	n=200	n=196	n=203	n=200	n=195	n=195	n=204	n=204	n=207	n=206
Heroin	39%	33%	34%	33%	30%	27%	28%	21%	21%	15%	10%
Amphetamine	20%	29%	23%	34%	30%	31%	29%	33%	27%	23%	28%
Cocaine	32%	34%	36%	30%	34%	35%	37%	37%	43%	48%	53%
Ecstasy**	-	-	-	-	-	-	-	-	-	-	-
Methamphetamine***	4%	1%	5%	1%	2%	3%	3%	1%	2%	3%	1%
Other psychoactive/drug compounds	4%	3%	1%	2%	2%	3%	3%	5%	5%	4%	1%
Non-psychoactive	1%	-	2%	1%	2%	2%	1%	3%	1%	4%	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. 2003 to 2005; Lindholm et al from 2005 to 2014

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

\*\*\*The prevalence of samples with pure methamphetamine became clear during the project from 2002 and is therefore listed in its own category in the table. Methamphetamine appears rarely and sporadically during the previous years and is contained in the category "other psychoactive/drug compounds" until 2003. The latter category for the entire period is also contained in the samples where methamphetamine appears in combination with other drugs.

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

	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>
	n=73	n=66	n=66	n=66	n=60	n=52	n=54	n=42	n=43		<b>n=21</b>
Heroin base	84%	77%	76%	65%	72%	77%	69%	64%	58%	42%	62%
Heroin chlo- ride	16%	23%	24%	35%	28%	23%	31%	36%	42%	58%	38%

Source: Lindholst et al 2014