Sundhedsstyrelsen
National Board of Health

REPORT TO THE EMCDDA
by the Reitox National Focal Point

DENMARK
DRUG SITUATION 2003

Preface

This annual report on the drug situation in Denmark has been produced by the Danish ”Focal Point” under the National Board of Health. The report was prepared during the autumn of 2003 and is the eighth report submitted to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). The report is available in a Danish and an English version and has been prepared in accordance with the guidelines set out by the EMCDDA.

The report provides a description of the drug situation in Denmark. It is based on the most recent statistical and epidemiological data as well as current information on focus areas, projects, activities and strategies within drug prevention and treatment. In addition, the report contains descriptions of current legislation and policy within the drugs field.

Birgitte Bælum, Head of Section, is responsible for the epidemiology chapter in cooperation with Eva Hammerby, head of section, as well as the key issue chapters on drug and alcohol use, while Hans Henrik Philipsen, Head of Section, has prepared the part describing prevention, treatment and quality assurance. Mikkel Arendt, psychologist, and Lone Fjordback, MD, have written the feature sections on co-morbidity. Other sections of the report have been written in cooperation with the Danish Ministry of Justice, the Ministry of Social Affairs and the Ministry of the Interior and Health as well as the counties. The Danish member of the EMCDDA’s Scientific Committee, special consultant Anne-Marie Sindballe, and the Advisory Drugs Committee under the National Board of Health contributed comments and constructive criticism. Birgitte Neumann, the National Board of Health, was responsible for layout, design and proof reading.

Copenhagen, October 2003.

Ole Kopp Christensen
Head of Focal Point

The National Board of Health
National Centre for Health Promotion and Prevention

Sundhedsstyrelsen
National Board of Health

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Summary

In 2002-2003 the National Board of Health has been engaged in preparing estimates on the number of drug users. The estimate, which is described in Chapter 2, has been made on the basis of guidelines provided by the European Monitoring Center for Drugs and Drug Addiction (EMCDDA).

The estimate shows that in 2001, there were 25,500 drug users in Denmark. Calculations also show that out of this amount, more than 6,000 were cannabis users only. From 1996 to 2001, the number of drug users has gone up by 5,000, i.e. 24%. The estimate does not include experimental drug use, but only the number of persons who are persistent drug users and as a result suffer from physical, mental and/or social injuries. The actual drug dependent individuals have thus been included in the estimated figures as have the stabilised drug dependent (e.g. people receiving methadone treatment). The figures include cannabis users as well as users of CNS stimulants, opioids, etc. The estimate is based on data provided by the National Register of Drug Users receiving treatment and the National Patient Register.

Population studies, school studies, the treatment register, the regional hearings and information about drug-related psychiatric admissions report about increasing use of cannabis. Also, all the population studies indicate that cannabis remains the common most prevalent drug in Denmark.

The number of persons admitted to psychiatric hospitals with a primary diagnosis resulting from cannabis also appears to be on the increase. The trend is most clear in secondary diagnoses related to cannabis, with the number of persons increasing steadily from 431 in 1995 to 691 persons in 2002. During the entire period, persons with primary diagnoses in relation to polydrug use make up the largest group, and they have been increasing steadily in numbers up until 1999. Persons with cannabis-related primary diagnoses make up the second-largest group, in that 20% of those receiving psychiatric treatment were admitted with a drug-related primary diagnoses in 2002. At the same time, the proportion of

persons with opioid-related primary diagnoses have dropped steadily throughout the period.

As regards drugs other than cannabis, most indicators show an increasing experimental use – especially with cocaine and amphetamine. This applies to the same indicators as the ones in cannabis and to the information provided by the National Commissioner's Office, such information being based on drug seizures made by the police. All population studies point out that amphetamine is the common most tried drug after cannabis in the population in general. The CNS stimulants, however, appear very little as a primary drug among users receiving treatment.

Ecstasy is less prevalent than amphetamine in spite of massive media coverage. This is substantiated in population studies and in most of the regional hearings. Ecstasy also appears rarely among users receiving treatment.

Although the opioids are not prevalent among the general population, heroin and other opioids continue to play a major role in the drug user groups. The treatment register and the information received from regional hearings maintain that opioids, including heroin, are the most prevalent drugs among drug users. Also, heroin is the drug which appears most frequently in the random samples from police drug seizures and the cause of the majority of drug-related deaths. However, a declining share of heroin among random samples, information from regional hearings and a decreasing share of opioid users among newcomers receiving treatment suggests that a drug use problem involving CNS stimulants as the primary drug is evolving.

Typically, experimental users as well as drug users are overly represented by men. This appears in all population studies, in the treatment register, in data on drug-related psychiatric diagnoses and among the drug-related deaths.

Experimental use of illicit drugs continues to be seen primarily among the younger population, which is documented in the various population studies and the regional hearings. Experimental drug use takes place in age groups from 15-30 years, and reaches its peak among the 16-24-year-olds.

A study conducted by the Danish Prison and Probation Service in 2002 showed that experience with illicit drugs is far more prevalent among various types of prison clientele than the population in general. Among the clientele of the Prison and Probation Service, 75% have tried cannabis, 53% have tried CNS stimulants (cocaine or amphetamine) and 30% have tried opioids (heroin, morphine preparations, etc). More than half of the Prison and Probation clientele, i.e. 56% , are misusers, whereas 67% are drug users or problem drug users (use of alcohol included).

Police statistics on drug seizures and police records on drug-related deaths show an ever increasing geographical dispersion of illicit drug use during the

1990s. This means that all in all, there is no difference on the drugs appearing in the respective counties across Denmark according to the regional hearings.

The death rate statistics made by the National Commission of Police show a stable level at the beginning of the 1980s, a mildly declining tendency at the end of the 1980s and a significantly higher level in the 1990s. In 2002, 252 drug deaths were registered, which is the same level as in 2001 where 258 deaths were registered.

New drugs

Effective 23 August 2003, the drugs Amineptine, 2C-T-2, 2C-T-7, Salvia divinorum, Savinorin A and TMA-2 were included in list B of the ministerial order on euphoriant substances, according to which such drugs may only be used for medicinal or scientific purposes. Amineptine was included in the list following a resolution in the UN Drug Commission, whereas the remaining drugs were added to the list upon recommendation by the National Board of Health.

Recent developments within prevention and treatment

Prevention

In 2003, the National Board of Health finalised a 2 1/2 year development project on ecstasy prevention in two ”model counties”. The aim of the development project was for the ”model counties” to launch and develop enhanced and broad interventions to prevent against the use of ecstasy and similar drugs among young people as well as convey information about form, content, extent and methods to other counties focusing on the same goal. The development project focused on three areas: municipal drug policies, youth education and the party environment.

The development project revealed that the local drug user studies carried out by the counties were necessary for targeted intervention and have also established that rather than focusing narrowly on ecstasy, activities should address drug problems on a broader basis. The work with the municipal drug policies to strengthen prevention intervention should not be neglected, but the fact is that it requires a great deal of counselling from the county as well as clear political/managerial backing.

In connection with intervention aiming at the party environment and based on experience from a number of targeted courses, a ”no-tolerance guide” was published to the employees working in the commercial party environment . Experience shows that the success and establishment of such an initiative depend on how cooperation between prevention staff, police, the restaurant business and licensing authorities is organised.

Within the youth educational area (particularly in production schools), new methods have been developed, among others a manual providing suggestions for a drug policy in the educational institutions.

The establishment of municipal key personnel networks is a continuous procedure as is intervention in the party environment (particularly aiming at employees), which has spread to the major cities. Furthermore, several counties

have provided guidelines for municipalities in connection with their drug policies.

Treatment

On 1 January 2003, a new provision came into effect when Section 85 of the Danish Social Services Act was amended. This means that the county is obliged to initiate social treatment of drug use within 14 days after the drug user has contacted the county with a request to be admitted to treatment. The treatment guarantee means that the drug user has a right to choose between public and private treatment services of a nature similar to the one, to which the county has referred the individual in question. In 2003, the National Board of Health finalised the socalled “methadone circular”, in which rules are set out for the prescription of addictive medication. The circular defines, among others, what is meant by addictive medicine, and what needs to be considered when prescribing such medication. The treatment of methadone and buprenorphine users is described in detail as is pain therapy and treatment with benzodiazepines.

Within the past few years, additional resources have been granted to treatment services, including experimental schemes involving intensified psycho-social support to drug users receiving methadone treatment, increased outreach intervention aiming at the most deprived drug users and a pilot project in Copenhagen Municipality offering methadone in injected form. Intervention was further enhanced in 2002 when the government launched its action program “The common responsibility” aiming at supporting the weakest groups of society, including drug users and the mentally ill with double diagnoses. Most recently in October 2003, activities resulting from the Government’s action plan “The fight against drugs”, have been launched with a focus on drug users in prisons, young cannabis users, harm-reducing intervention and a strengthening of DANRIS documentation (the Danish Rehabilitation and Information System) of treatment programs and effect of various types of treatment, including an extension of registration to include treatment provided on an outpatient basis.

Several counties have in connection with their efforts to combat drugs – often in cooperation with the municipalities – established ”peer teams” focusing on early intervention vis-a-vis the young drug users in order to comply with increasing demand.

Several counties are also trying to strengthen outreach work by involving street teams.

The fight against drugs: a cross ministerial action plan

In October 2003, the Government announced its cross-ministerial action plan – ”The fight against drugs” – as a follow up on a number of recommendations submitted by, among others, the development project on ecstasy prevention and the expert group on intervention for the most deprived drug users.

The plan is part of a comprehensive operation ranging from intensified prevention intervention through involvement of local communities with a view to keeping – in particular the very young – away from drugs and to strengthen the social and medical treatment inside as well as outside the prison environment.

The plan also provides for taking steps to reduce even further the damage caused by drug use. The activities are meant to take place over the next three years.

Selected issue: Cannabis problems in a context: understanding increase in treatment demand

The chapter deals with the prevalence of cannabis use in Denmark, individuals receiving treatment for cannabis use, problems associated with cannabis use and the measures applied to combat problem cannabis use. 21% of all those receiving treatment in 2002 reported cannabis to be their primary drug, the percentage being 11% in 1999. Among all clients that have not previously been admitted to treatment, 39% reported cannabis as their primary drug. By comparison, the percentage in 1999 was 31%. Some of the factors behind the increase include the number of and the changes in treatment services, in that they are perceived as being more relevant to the cannabis users and therefore inspire an increasing number to accept treatment. The general increase in the use of cannabis among the population in general could also explain why an increasing number of people have developed a drug problem and therefore are being treated.

Selected issue: Co-morbidity (between cannabis use and mental problems)

Recent studies establish a correlation between the young people's perception of problems in everyday life and the use of cannabis, including a correlation between absence from school and average marks.

The very young drug users make up a group which has started to emerge in the social services provided to young people with social problems, e.g. the inpatient services provided by the counties. The general picture here is that the young drug users are often rejected from inpatient treatment because the staff do not feel sufficiently qualified to solve the task. Consequently, the counties have established peer teams which as part of their task must meet the requirements of the municipality of acting with young drug users. The chapter provides an example of such a peer team.

This chapter describes the situation and correlation between cannabis use and mental problems as well as mental disorders among cannabis users receiving treatment and misuse among psychiatric patients. Thus, 27.5% of the cannabis users and 27.9% of the users of other primary drugs had been treated in a psychiatric hospital during the period 1996-2000. The number of psychiatric patients using drugs is imprecise and characterised by under-reporting. However, the Psychiatric Central Research Register shows that during the period 1994-2002, there were several thousands of registered cannabis users within the psychiatric system, including a couple of hundred hospitalisations caused by cannabis-related psychoses annually.

In Denmark, the psychiatric system traditionally treats patients with psychiatric disorders, whereas drug users are treated elsewhere. Clear guidelines need to be formulated in terms of how treatment of those who belong to both systems at the same time should be handled. Thus, Denmark needs a system, under which it is possible to deal with drug use and mental problems within the same

treatment sphere. The chapter describes projects in Copenhagen and Aarhus, where attempts have been made to establish formal bridging between the two systems, such activities involving medicinal treatment and cognitive therapy according to environment therapeutical principles and supplementary training of psychiatric staff in treatment of double diagnosis. All those affected by the problem point out that the need for treatment of the most severely mentally ill with drug problems by far exceeds the number of treatment slots available.

Furthermore, it is described in the chapter that there is very little knowledge of optimum treatment planning and large differences in treatment services provided. Documentation of the effects of the treatments provided to double diagnosis patients is also scarce. The chapter concludes in a number of suggestions for future practice.

Chapter 1 Developments in Drug Policy and Responses

1.1. Political framework in the drug field

The Danish drugs policy is founded on a combination of the ban against non-medical use of drugs, persistent and targeted prevention intervention, multi-pronged co-ordinated treatment and effective control.

Some of the key elements applied within the drug area involve:

- striking a balance between prevention and treatment
- strengthening local prevention, including action targeted at vulnerable young people
- upgrading of treatment, including care, based on the principle of differentiated requirements and goals

In Denmark, drug use is perceived as a complex problem requiring co-operation across job demarcation lines and different sectors. Efforts to combat drug use are, therefore, the responsibility of both local and central authorities as regards prevention, treatment and control.

Drug prevention policy rests on the principle of prohibition of the ban against non-medical use of drugs, a high level of information as well as improvement of social conditions. In this connection, it is especially a deprived childhood, too little contact with adults and marginalisation in relation to education and training which inspire a small group of young people to start their experimental use of drugs, which subsequently, in many cases, leads to actual addiction.

The preventive efforts focus on national, governmental information as well as local direct support to individuals and minor groups included in more specific targeted initiatives.

The public sector is responsible for and shall undertake to carry out the social and medical treatment of drug users.

Public action is supplemented by voluntary organisations and independent, private organisations. This ensures that there are many potential kinds of initiatives, which enable clients to be offered several flexible, untraditional types of treatment and care.

The point of departure is an individual approach and demand-oriented treatment of and differentiated goals for each individual drug addict with a drug-free life not being the only goal, but an improvement of the individual's social situation and function being paramount realistic goals as well.

An even more crucial element in the treatment of drug users in Denmark has been the medical substitution treatment, particularly with methadone. At present

there are 5,500 drug users under the age of 50 years in long-term methadone treatment (for more than 5 months) (see also Chapter 2).

The control activities launched to combat drugs are administered by the police and customs authorities. Their operations are targeted at individuals and organisations supporting illicit drugs trafficking nationally and internationally, as well as trafficking on a street level. Another factor is the legislation on drugs used for illicit drugs production (precursors) based on EU regulations governing control with the manufacturing of and trafficking in certain goods used in illegal manufacturing of narcotic and psychotropic drugs.

Pilot project activities

On 1 January 2003, a new provision was enacted by the amendment of Section 85 of the Danish Social Services Act. This means that the counties must undertake to provide social treatment services to drug users within 14 days after the drug user has contacted the county with a request to be subjected to treatment. In this connection, the drug user is entitled to choose between public and private treatment services of a similar nature as the one to which the county has referred the individual. In pursuance of Section 110 of the Danish Social Services Act, rules will be stipulated on the contents, scope and provision of services within treatment of drug users. Furthermore, the Act will be comprised by legal surveillance in order to ensure that implementation of the scheme in the counties can be evaluated. In connection with the evaluation it will be considered whether the implications of the suggested scheme are compliant with the intentions of the law. Based on the evaluation, a report will be prepared and submitted to the Social Committee of the Danish Parliament after having been heard by the other authorities and organisations and when the law has been in action for three years. As an alternative to a heroin study, government funds were set aside on the 2000-2002 Budget for special pilot project activities aiming at addicts in methadone treatment and a project involving more intensive outreach work provided by social and health cares services to seriously deprived drug users in Copenhagen.

The objective of this three-year pilot project in three regions with addicts in methadone treatment, involving massive psycho-social activities as well as a qualitative and quantitative evaluation is to study to which extent results can be achieved corresponding to, for instance, the heroin project in Switzerland, in the form of better social, health-related and mental functioning, e.g. better housing, job and educational conditions, improvement of self-supporting basis, of the medical/mental status, reduction of drug use, infection risk and crime as well as an extension of network relations.

The City of Copenhagen is currently conducting a pilot project on injection of methadone.

The pilot projects will conclude in 2004/2005 and the resulting evaluations be submitted.

Government funds to raise quality within drug addiction area

Central government has set aside funds to help the social programmes offered to drug users and to add a quality lift to the area. For this special project, a special fund of Euro 1.4 million in 1999 and Euro 5.4 million was established for the subsequent three years, which, in addition to the projects mentioned, also included a follow-up of substitution treatment, funds will be awarded to new initiatives on treatment provided to special target groups. Post-treatment is one of the primary focus areas. The Research and Information Centre for Social Work gains experience from projects supported by these funds. At the end of 2003, pamphlets to be distributed to the counties and municipalities will be published.

With its action plan for the weakest groups from March 2002, also known as ”The Common Responsibility”, the Government has wished to strengthen the work with the weakest groups in society, including drug users and mentally disabled with double diagnoses. In the social financing agreement for 2002, an amount of EUR 68.1 million was set aside for the socially deprived for the period 2002-2005. In the social financing agreement for 2003, the amount was further raised by EUR 11.6 million for the period 2003-2006. One of the intentions of the social funds is to provide a basis for the establishment of temporary and permanent housing services, including necessary housing grants complying with the needs of the individual. Furthermore, the Government wishes to focus on re-integration flats and alternative nursing home places. The goal of this action plan for the weakest groups is to establish 300 new housing alternatives. The funds reserved for the socially deprived groups consist of an overall application fund and a reservation for the largest towns (Copenhagen, Frederiksberg, Odense, Aarhus, Aalborg and Esbjerg). Based on the actual application pool in February 2003 and the recommendations following negotiations with the cities, the number of new housing alternatives is estimated to amount to approximately 185 plus housing subsidies.

Relevant coordinating organisations, councils and committees

Denmark has 5.4 million inhabitants. Political decisions following elections are made at three levels: National, regional and local. The regional level includes 13 counties and one regional county; the local level includes 270 municipalities. Each county have an average of 330,000 inhabitants and each municipality has 20,000 inhabitants. The tasks of the municipalities are defined by law.

Governmental level

The responsibilities of the Government are to:

- develop policies
- prepare rules and regulations
- control the supply of drugs by controlling and financing the police, prisons, the courts of law and the customs authorities
- monitor drug use trends by retrieving, coordinating, evaluating and disseminating data
- support regional and local prevention
- promote research
- co-operate on an international level

Coordination of government services is managed by the Danish Ministry of the Interior and Health, which is also responsible for treatment services provided by the health care sector and for the prevention intervention. The Ministry of Social Affairs is responsible for the social treatment intervention, the Ministry of Justice is - on a local as well as a central level - responsible for control and law enforcement as well as for prison and probation services in relation to detained drug users. The Ministry of Tax is responsible for controlling the prevalence of precursors and handles customs control as well.

Being generally responsible for health prevention and health promotion, the Ministry of the Interior and Health has a dedicated responsibility, but other ministries also have tasks to fulfil within prevention, which are either determined or provided in the specific legislation administered by them. Thus, the Ministry of Social Affairs undertakes certain tasks and obligations laid down in the Social Services Act on prevention in the social area. The Ministry of Justice is responsible for law enforcement measures and for information as part of the crime-prevention activities of the police. The Ministry of Tax is responsible for border control including measures against smuggling. The Ministry of Tax is also the responsible national authority exerting control with precursors and actual chemicals pursuant to the EU Regulation and the EU Directive on this subject. The Ministry of Education is responsible for information in primary and secondary schools, and for general education and information concerning youth and adult education. The Danish Ministry of the Interior and Health as well as other ministries involved are assisted by an independent, expert National Council for Public Health.

On a central level, the Danish Ministry of Social Affairs is responsible for the social services provided to drug users and the treatment of them pursuant to the Social Services Act. The responsibility related to issues on medical treatment, including substitution treatment and the correlation between HIV/hepatitis and drug use as well as any issues relating to care lies with the Danish Ministry of the Interior and Health. The Danish Ministry of Justice is responsible for the treatment of criminal drug users.

Research is conducted at a number of universities, specialised research institutions and organisations operated by the counties. The Ministry of Social Affairs is responsible for the research conducted at the National Institute of Social Research. Since it was established on 1 January 1994, the Danish Centre for Alcohol and Drug Research at the Aarhus University has conducted a large number of studies, evaluations and analyses on drug use for the Ministry of Social Affairs and other institutions/public authorities. As part of the implementation of the social funds for 2001, the Centre has been established on a permanent basis. The coordinating task of the Danish Ministry of the Interior and Health is to collect statistics on drug use.

Police

The individual police districts are responsible for operative action against drugs. According to national law, policing is divided into two sections. The uniformed

branch is primarily responsible for the efforts to combat drug use and small-scale trafficking on a street level whereas the key activities of the C.I.D. are targeted at the manufacturing, smuggling and large-scale trafficking in drugs.

Each of the 54 police districts has a special drugs unit or they may have specially appointed contact persons who, in addition to their local tasks, act as liaison officers to other police districts and, in particular, to the central authority and the coordinating institutions in this area. In order to reinforce and render more efficient the combat against drug offences, department A under the National Commissioner of Police has set up a National Centre of Investigative Support (the NEC), which provides assistance to the operative investigations performed by the individual police districts. The NEC predominantly assists in the coordination and analyses of investigations. Furthermore, the NEC exchanges information with national and international contacts on general as well as specific projects.

The NEC also prepares national statistics and analyses as regards number of cases, seizures and mortality rates. The National Centre of Investigative Support, which has a special IT investigation register, also operates as a support and database for customs authorities in their activities in this field according to an agreement concluded between the police force and the customs authorities.

Customs

The customs authorities comprise the Central Customs and Tax Administration, 31 regional customs and tax administrations and a customs office in Padborg, a town on the border between Denmark and Germany. The Central Customs and Tax Administration is in charge of the general management of taxation and customs authorities. Monitoring activities are carried out by a control department, which is also responsible for the two-way communication of data with foreign authorities and with national police units. Operational control activities are the responsibility of the regional tax and customs administrations and the customs office in Padborg. Border control, inclusive of drugs control is organised by 13 regions which all have a customs control department. Control of factories and businesses is the responsibility of the regional control sections which are responsible for import and export control, control of VAT and special excise taxes, and for source-deducted and income taxes. Thus, these control departments know how the money moves about.

Counties and municipalities

Responsibility for the treatment of drug users, including methadone prescription, lies with the 13 counties as well as with the Copenhagen and Frederiksberg Municipalities. Cooperation between the counties and the organisation safeguarding the interests of the counties vis-à-vis the law and the state and municipalities is carried out by the Association of County Councils. The Association of County Councils enters into agreements with the Government and Parliament on behalf of the 13 counties on county budgets, including funds for prevention of drug use and prevention intervention, with the counties being obliged to provide treatment to drug users.

Given its direct contact with the citizens, the primary municipalities are responsible for preventive intervention as well as for early and regular services provided to addicts. Also, the municipality is responsible for the relevant services offered during treatment and after primary treatment, which may contribute to improving the personal function and development potential. The National Association of Local Authorities is an organisation safeguarding the interests of the primary municipalities, especially in relation to the law and to the state and counties.

The law provides that activities related to the treatment of drug users is carried out in close cooperation with the counties and that the distribution of tasks must be laid down in action plans. The law sets out that the county council may delegate referral competence to a municipality provided that the treatment activity is best administered by the municipality.

Council for the socially excluded

In connection with the adoption of the Budget for 2002, the Government decided to abolish the National Narcotics Council. Based on a desire to strengthen the services provided to the weakest group of people in society and create a framework for a coherent and overall strategy, the Government announced its action program for the weakest groups in March 2002 under the heading: *Our common responsibility*. The council has been appointed to fulfil the needs of the weakest groups, in particular the homeless, drug users, prostitutes, the mentally ill and alcohol users. The aim of the council is to represent a group of people who have difficulties in being heard. The responsibilities of the council include

- monitoring of the social services provided to the weakest in society
- submission of proposals for improved services provided to the weakest
- submission of proposals for how to involve the civil society more effectively in social work
- preparation of an annual report on the situation of the weakest groups.

The Council's first annual report will be published in September 2003.

GOVERNMENT

Ministry of Social Affairs	Ministry of the Interior and Health	Ministry of Justice
Treatment	Coordinating ministry Prevention Medical Treatment	Control

Council for the Socially exposed

National Board of Health	Danish Medicines Agency	Prison and Probation Services
Medical Treatment	Medicines control	The National Centre of Investigative Support (NEC) Danish Crime Prevention Council

COUNTY

13 counties, Copenhagen and Frederiksberg municipalities and the regional municipality of Bornholm	54 police districts

270 municipalities

- Schools
- Youth clubs
- Youth schools
- SSP-committees

PRIVATE ORGANISATIONS

National

- ”Ungdomsringen”
- YMCA’s social work (Denmark)
- YWCA’ social work (Denmark)
- Landsforeningen Kirkens Korshær

Local:

- Self-help groups
- Private treatment institutions (therapeutical communities, Minnesota-treatment institutions)
- Groups for relatives

1.2. Legal framework

Penalties in Danish law for possession of drugs are laid down in the Euphoriant Substances Act and in section 191 of the Criminal Code.

The Euphoriant Substances Act prohibits the importation, exportation, sale, purchase, delivery, receipt, production, processing and possession of certain substances unless they are for medical or scientific application. These substances are included in a special list of substances, which in the view of the health authorities pose a special risk due to their euphoriant effects. Violation of the Act is punishable by a fine, simple detention or imprisonment for a maximum of two years, cf. section 3 of the Act.

Section 191 of the Criminal Code supplements the above-mentioned Act and lays down that he who, contrary to the Act, transfers euphoriant substances to a large number of people or upon a considerable remuneration or under aggravating circumstances, is liable to the penalty of up to six years in prison. Should the transfer involve a considerable amount of a particularly dangerous or harmful substance, or if the transfer of such a substance has otherwise been particularly dangerous in nature, the penalty can be increased to ten years in prison. He who imports, exports, purchases, delivers, receives, produces, processes or possesses such substances with the intention of transferring them can be punished in the same manner.

For first offences, possession of substances for own use usually results in the police issuing a warning to the person in question. A warning can also be issued in the case of subsequent offences, but in more grave subsequent offences and in cases of repeated possession of substances other than cannabis, pursuant to the guidelines issued by the Director of Public Prosecutions concerning fine tariffs in police court cases, a fine should be imposed that varies from EUR 40 to EUR 400 depending on the type and quantity of the drug.

Recent legislation

Money laundering of gains from criminal activity is deemed an offence in Section 290 of the Danish Criminal Code on handling of stolen goods. This regulation was adopted by law no. 465 of 7 June 2001, when the former Section 284 on handling of stolen goods and Section 191a on handling of drugs were abolished. Section 290 of the Danish Criminal Code provides that he who unlawfully receives or procures for himself or others a profit gained via a punishable offence, and he who unlawfully handles stolen goods by hiding, storage and transportation, or in a similar manner subsequently acts to secure for another person a profit from a punishable offence shall be punished by a fine or imprisonment for any term not exceeding 1 year and 6 months. Where the handling of stolen goods is of a particularly aggravated nature, or the handling of stolen goods has been perpetrated for business purposes, the punishment may increase to a fine or imprisonment for any term not exceeding 6 years.

On 9 June 2001, Act no. 417 of 7 June 2001 on the prohibition against visitors in certain premises became effective.

The objective of the Act is to ensure more effective intervention in relation to the cannabis clubs and other types of organised crime being perpetrated in certain premises and causing inconvenience and insecurity with the neighbours.

The enactment of the law means the introduction of a scheme according to which the police, after advance warning, may issue a 3-month injunction against the person owning the premises to the effect that visitors are not allowed to arrive at or stay in such premises. The injunction, however, does apply to the people living their or their relatives.

The police notifies of the injunction via posters and in the local press together with separate notification to the person owning the premises. He who owns the premises may demand that a specific ruling pursuant to applicable law be submitted to the court by the authority having made the decision. Violation of any injunction shall be punishable by a fine. Where a repetitive offence is committed, punishment may increase to imprisonment for any term not exceeding 4 months.

Within the given legislative framework, police control efforts are aimed at persons and organisations supporting drug trafficking on a national as well as an international level and at street-level drug trafficking. In the area that concerns the police force – prevention and investigation of crime – it is natural to regard the drugs problem in an international perspective as very few drugs are produced in Denmark. In addition, an increasing number of police investigations show that drugs crime contains elements of organised crime. For this reason the Danish police continue to place increasing emphasis on international co-operation, which takes place in many fora and especially under the auspices of Europol and in the PTN co-operation between the police and customs authorities of the Nordic countries, where liaison officers posted abroad play a special role.

The efforts to combat serious drugs crime were embodied in Act no. 378 of 6 June 2002 in which the rules governing telecommunications companies' rights to furnish the police with relevant investigatory data were amended.

According to this new Act, providers of telecommunications network and services are now obliged to record and store any telecommunications and internet communication data which may prove relevant to police investigations and assist them in legal action against punishable offences. The recorded data must be filed for one year. The fact that the police are now entitled (having obtained a warrant) to read non-publicly available data in, among others, personal computers have rendered it easier for the police to carry out this kind of work.

The same act renders it possible for the police, on the basis of a court warrant, through secret operations and without being present, by the means of computer programs or other equipment, to read non-publicly available data in an information system, ie stationary or portable computers or other kinds of data processing systems acting as personal computers.

As part of the intensified efforts to combat, among others, organised drug crime, an amendment to the Danish Criminal Code was passed by Act no. 436 of 20 June 2003, according to which seizure under Section 76 of the Criminal Code was extended. The provision now also includes the Act on Euphoriant Drugs, with the penalty ranging from a fine and up to imprisonment for a period not exceeding 2 years.

By the same amendment, the agent regulations under the Administration of Justice Act were amended so that civilians may introduce under cover agents into the criminal environment and in this connection, for instance, be able to order a sample of drugs. This Act also rendered it possible to withhold the identities of the anonymous informant and the policeman who had been operating as an under cover agent in a specific case.

1.3. Law enforcement

Law enforcement in relation to drugs is based on either Section 191 of the Criminal Code or on the Euphoriant Substances Act.

Prosecution practice in general

Section 191 of the Criminal Code provides for penalties between 6 and 10 years' prison. The maximum penalty of 10 years is used in particularly aggravating cases and only in cases involving hard drugs. In particularly aggravating cases, punishment may be raised by up to 50%. This implies that the offender may be sentenced to imprisonment for a period of up to 15 years. The highest sentence imposed up until today is imprisonment for 15 years.

Notwithstanding the above, the precondition for resorting to section 191 of the Criminal Code is that, be it for possession or importation purposes, the criminal offence involves the transfer or the intention to transfer at least 25 grammes of heroine/cocaine, approximately 50 grammes of amphetamine/ecstasy or 10 kg of cannabis or more.

Where the case involves lower quantities than the ones mentioned above, the offence is referred to the Euphoriant Substances Act, under which the penalty is a fine, simple detention or imprisonment for a maximum period of two years.

Where the case involves possession of drugs for own use, the punishment will only be a fine unless the offence is of a repeat nature. In the case of very small drug quantities, a first time offence will only trigger a warning.

As a rule, transfer of hard drugs will be punishable by a custodial sentence. Following an amendment of the Euphoriant Substances Act in 1996, cf section 1.2.a of this report on the developments in the Criminal Code, it will be considered a particularly aggravating offence when the transfer involves even very small quantities of particularly hard drugs.

Law enforcement performed by the police and the prosecution in connection with the transfer of drugs has high priority in general. However, the responsibility for planning of police operations to combat drug crime lies with the chief constables

of each police district (in Copenhagen, the Commissioner). Depending on the current situation, the activities carried out by the individual police districts are targeted against the organisations and people engaged in drugs trafficking on a national and an international level, as well as at street level.

Police activities have been particularly intensive in Copenhagen, where in a certain area near the Copenhagen Central Station street-level drugs trafficking has gained solid ground and therefore has been followed up by intensive police work.

As a result of the increasing ecstasy use taking place primarily in the discothèque environment, the police have also been involved in numerous targeted operations throughout the past few years, often in collaboration with other local authorities and restaurant owners.

As far as cannabis programs are concerned, it has been noted that the police and the prosecution are spending resources on following the trails of the group of more professional offenders. However, in areas where cannabis is traded on a street level, the police endeavour to take action against this type of crime as well. In this connection, the police have intensified their activities to combat cannabis trafficking in Christiania via targeted and far-reaching actions. Their activities have revealed numerous criminal structures and networks, some of them being in relation to the biker gang environment, and a large number of criminal cases have been closed and considerable seizures made.

Most recently, the efforts to combat cannabis have been intensified in connection with the implementation of the above act no. 471 of 7 June 2001 on the prohibition against visitors in certain premises, the aim of the act being to ensure more effective intervention vis-à-vis the so-called cannabis clubs.

The Act has had the desired effect. As an example it should be mentioned that the Copenhagen Police have closed down approximately 65 cannabis clubs since the law was adopted.

Law enforcement in relation to drug addicts

As regards drugs for own use, reference is made to the section above concerning drug users in possession of drugs for own use.

If a drug user deals in drugs himself/herself, this would normally have no bearing on the sentence. Sentenced persons, in turn, who display motivation will be offered to participate in detoxification treatment for drug use during their prison term, including re-integration into society through open institutions treating drug users. In the comments on the proposed amendment of the Euphoriant Substances Act from 1996 mentioned above, it is provided that the Ministry of Justice will render relevant treatment possible during prison service to those drug users who are sentenced to imprisonment of longer duration as a result of drug sales meant to finance the user's own drug use.

If a person who is charged with drugs sale has been released during the period preceding his trial, the court may pass a conditional sentence in certain instances. This happens if during the trial, the defence is able to produce substantiated evidence that the person in question is in the midst of a promising treatment program.

Expert group to identify focus areas for the heaviest drug users

On 18 April 2002, the Danish Parliament passed a resolution to abolish the revised provisions laid down in the Act on the retention of drug users in treatment. When the Act came into force on 1 July 1992, the counties as well as the Copenhagen and the Frederiksberg Municipalities were given access to retain drug users under treatment. Since then, the law has been revised several times, and it has now been decided to abolish the aforementioned revised provision.

During the 1st reading of bill B123 (a bill tabled on medically prescribed heroin to particularly heavy drug users) the Minister of Health (now the Minister of the Interior and Health) declared that he would appoint an expert group to identify the focus areas for the heaviest drug users. The expert group was appointed in September, 2001 with representatives from the health care and social sector as well as the sector of justice. The expert report was submitted in February 2002 and contains an updated overall technical description of the extent and nature of the problems facing the most severely deprived drug users, including the knowledge and results available and missing, as well as the type of barriers to appropriate health care and social measures. The report also provides a professional assessment of the advantages and disadvantages of various alternative solution models, including heroin prescription and the introduction of the so-called injection rooms.

New narcotic drugs under control

Effective 23 August 2003, the drugs Amineptine, 2C-T.-2, 2C-T-7, Salvia divinorum, Salvinorin A and TMA-2 were adopted on Annex B of the Act on Euphoriant Substances, following which such drugs may only be used for medicinal or scientific purposes. Amineptine was adopted on the list following a resolution taken in the UN Drugs Commission, whereas the other drugs were added to the list after professional recommendation by the National Board of Health.

Drug-related crime

Individuals who are addicted to heroin are very often involved in offences against property, e.g. in particular burglary into private homes, into companies and shoplifting. If such an individual has not previously been punished, the punitive reaction will often be a suspended sentence on terms of treatment for drug use.

However, if the crime is committed as a repeat offence, the court will normally not again pass a suspended sentence on the condition of treatment. An unconditional sentence would be the normal sanction. During imprisonment, the motivated drug user will, however, be granted the chance of treatment, cf above.

1.4. Developments in public attitudes and debates

Injection rooms, legalisation of cannabis and prescribed heroin are recurrent issues of the public debate. During the parliamentary year of 2002-2003, the members of the opposition tabled for the third time a proposal on the establishment of health rooms (injection rooms) for drug users, legalisation of cannabis and the release of cannabis for medical purposes. The proposal for the establishment of injection rooms was rejected in 2003 by a majority of the members of Parliament, and during the discussion of the proposal for legalisation of cannabis, there appeared to be a large majority against. The proposal for release of cannabis for medicinal purposes was adopted by the Parliament in May 2003 in amended form. As a result, the Government had to decide before 15 August 2003 whether or not patients suffering from sclerosis should be able to receive Marinol. If adopted, the act would become effective as of 15 August 2003.

1.5. Budgets and funding arrangements

The municipal and county accounts and budgets show a steep increase after 1995 in the funds reserved for the treatment of drug users. The municipal budgets for 2003 thus reserve EUR 86.4 million for this activity. In comparison, the figures in the 1995 budgets were EUR 30.2 million.

The county annual accounts include expenditure on methadone treatment. This figure, however, is included as a non-specified item of county expenditure on hospitals and social services, which is the reason why such treatment is not included in the figures mentioned above

The heaviest increase was seen from 1995-1997, with a doubling of funds reserved. However, the counties and the municipalities have also during the subsequent years reserved increasing funds to combat drug use.

From the governmental funds granted through the Fund to enhance social initiatives for drug users, an amount of EUR 2-2,7 million was granted annually from 1995 to 1998 to drug use intervention. As part of the governmental grants for 2003, an amount of EUR 10.6 million was reserved for financing of the treatment guarantee to drug users in each of the years 2003 and 2004 and EUR 9.2 million each year in future.

An amount of approximately EUR 0.8 million is estimated to be spent in 2003 on grants to the National Board of Health. The funds granted are being applied for information activities, development and analysis activities, teaching, etc. The funds are applied for activities carried out by the National Board of Health, as well as activities launched in cooperation with other authorities, organisations, groups and individuals, and activities financially backed by the Ministry of the Interior and Health and carried out by local authorities, associations, organisations, etc.

Furthermore, over a three-year period, the government has granted EUR 6.7 million to a pilot project involving intensified psycho-social support to drug users in methadone treatment and EUR 1.3 million a project involving enhanced

outreach social and health care activities in relation to the most severely deprived drug users in Copenhagen. This project was commenced on 1 October 2001.

Effective 1 January 2002, the provisions of the Danish Social Services Act on the funding of certain social services was amended. The amendment solely pertains to the structure of grants under the Social Services Act, including expenses for treating drug users. The amendment implies that grants to treatment of drug use, which have so far been shared between the municipality and the county, are now replaced by a scheme, under which the county fully pays the expenses for outpatient treatment, and in the case of in-patient treatment pays the expenses for the first 120 days, following which the municipality after 120 days - within the past 365 days - pays a base fee of EUR 13.875 annually (2002 prices), however no more than the actual expenses incurred.

In order to support the recommendations set out in the Government report: ”Activities launched for the most seriously deprived drug users”, the 2003-2006 Psychiatrics Agreement has set aside EUR 6 million over a 4-year period to strengthen the social work/social psychiatric work for individuals with double diagnoses.

The obligation to provide social services and the referral right of the counties are not affected by the amendment of the Act. Also, there are no changes in the citizen's possibilities of filing complaints against specific decisions.

Chapter 2 Prevalence, Patterns and Developments in Drug Use

This chapter provides the results of studies made on the prevalence of illegal drugs among the population and the young people. The chapter begins with a brief summary of the main trends and characteristics, following which drug use among the general population and among various groups are described individually. In addition, the newest trends are described, based on information from regional hearings and a qualitative study. In conclusion, the chapter presents the results of the recent estimate on the number of heavy drug users in Denmark.

2.1. Main developments and emerging trends

It is characteristic of the drug situation in Denmark in 2003 that cannabis is by far the most prevalent drug among the general population. Alternatively, cannabis is the drug most people have tried. While the experimental use of cannabis, stimulants and hallucinogens was increasing during the last half of the 1990s, the most recent figures suggest an increase in cannabis use alone.

Generally, there appears to be an increasing acceptance of drugs among young people, and the drugs have proliferated to many different youth environments and cultures across Denmark. Typically, men and predominantly young people aged between 16 and 24 years are the ones to use drugs.

The population studies point out that among the young people there is no connection between low social status of their parents and the use of drugs. Among the 31-44-year-olds, the proportion of users of cannabis and other drugs, however, is most prevalent among those who are excluded from the labour market: the unemployed and early pensioners.

There is a close connection between smoking, alcohol use and use of illicit drugs. It is thus frequently seen that the same young people are the ones who smoke, are heavy drinkers, use cannabis and take other experimental illicit drugs.

There are an estimated 25,500 drug users in Denmark. From 1996 to 2001, the number of drug users rose by 5,000, which equals an increase of 24%. The increase is lowest at the end of the period.

2.2. Drug use in the population

Drug use in the adult population is described in the two most recent national studies conducted on self-reported consumption from 1994 to 2000, ”Sundhed og sygelighed i Danmark 1994” (SUSY 1994) and ”Sundhed og sygelighed i Danmark 2000” (SUSY 2000), which were both produced by the National Institute

of Public Health (For a more elaborate description of the studies, please refer to the annex)[1].

2.2.1. General population

Cannabis

As it appears in table 2.2.1, a total of approximately 10% of the adult population up to 45 years in 2000 had smoked cannabis within the past year, whereas approximately 7% had tried it in 1994. There has been an increase in the use of cannabis from 1994 to 2000 in the age groups under 30 years. This applies to men as well as to women. Among individuals aged 30 and above, a constant prevalence is seen at a low level.

The proportion reporting having smoked cannabis within the past year falls gradually by age group, given that cannabis to a large extent is used by the youngest age groups from 16-24 years. This applies to men as well as to women although there are clear gender differences. More than double as many men (14%) as women (6%) are current cannabis users. (Kjøller & Rasmussen 2002).

[1] These studies make up a sufficiently uniform pattern to form the basis of a description of distinct development trends and the overall picture. Minor differences over time should, however, not be considered important, since a number of variances in study methodology prevent precise benchmarking. This applies in particular when comparing the prevalence of illicit drugs other than cannabis. In 2000, the study asks about the use of various illicit drugs, whereas the study in 1994, asks about the use of “hard” illicit drugs in the same category. Empirically, such a “consolidated category” might result in a lower level, since the respondents may more easily forget a few substances when answering. Furthermore, study methodology has changed from the interview form in 1994 to the use of a self-administering questionnaire in 2000, which means higher anonymisation in 2000. Finally, the sample population in 2000 was larger than in 1994 which – all other things being equal – should lead to more clear-cut results in 2000. The above reservations should be taken into considerationwhen presenting the developments over time.

Table 2.2.1. The percentage of women and men in the various age groups reporting having used cannabis within the past year in 1994 and 2000

		1994 n=2.521	2000 n=6.887	Denmark's population in the age groups in 2000
16-19-year-olds	Men	19	29	115,366
	Women	**10**	**20**	**111,110**
20-24-year-olds	Men	14	24	172,217
	Women	**9**	**12**	**167,570**
25-29- year-olds	Men	8	16	194,097
	Women	**5**	**6**	**189,304**
30-34- year-olds	Men	9	10	212,026
	Women	**2**	**3**	**202,174**
35-39- year-olds	Men	6	8	206,094
	Women	**2**	**2**	**197,150**
40-44- year-olds	Men	5	4	189,995
	Women	**2**	**2**	**183,597**
All 16-44 year-olds	Men	10	14	1,089,795
	Women	**5**	**6**	**1,050,905**
	All	7	10	2,140,700

Source: Kjøller & Rasmussen 2002 and Statistics Denmark

Among the 16-44-year-olds, 42% had tried to smoke cannabis ever in 2000. In 1994, the percentage was 37% (Unpublished data from SUSY 2000 and SUSY 1994)[2].

Within the age group of respondents aged 45 years and above, 0-2% are current users of cannabis, for which reason this age group is most often not included in the statistics on drug use in the population. (Unpublished data from SUSY 2000).

Socio-economic differences in cannabis consumption

As it appears in table 2.2.2, there is a clear tendency among the 16-30-year-olds that the proportion of cannabis users (defined as persons who have used cannabis within the past year) is higher among young people whose father or

[2] The category "used ever" is a more imprecise measure than "used past month/past year", since the longer a time span is used in the questionnaire, the more probable it is that the respondent has either forgotten or tried to repress the event in question.

mother[3] belong to the upper white-collar groups such as heads of department, high school teachers and consultant doctors (white-collar group I) or upper secondary school teachers, postmasters and nurses (white-collar group II)[4]. Also, it appears that young people who did not live together with their father or other provider when they were 14 years of age account for a large portion of those who smoked cannabis within the past year. (Unpublished figures from and analyses on SUSY 2000).

Table 2.2.2 The percentage of 16-30-year olds who have used cannabis within the past year illustrated in relation to the parents' socio-economic background

	Father's socio-economic background	Mother's socio-economic background
White-collar worker I	19.0	
White-collar worker II	17.9	22.5*
White-collar worker III	14.1	14.9
Skilled worker	13.1	7.8
Non-skilled worker	13.2	10.9
Self-employed/assisting	10.2	9.1
Not actively employed	14.1	14.0
Housewife	-	7.2
Not living with mother/father at the age of 14 years	19.0	16.8
Total	15.3	13.5

Source: Unpublished figures from "SUSY 2000"

*This figure includes white-collar group I and II in order to obtain a sufficiently large group.

The same pattern does not apply among the 30-44-year-olds illustrated on the basis of their own socio-economic background, given that this group includes a relatively high proportion of unemployed (table 2.2.3)[5]. This implies that the pattern involving a relatively high prevalence of cannabis used within the past year among young people is not consistent with that of the older generation, even within similar socio-economic groups.

[3] The 16-30-year-olds are typically in the midst of their educational development and have consequently not been placed in a socio-economic framework. This is the reason why the connection between socio-economic background and cannabis use within this age group is illustrated on the basis of their parents' (providers) occupational position when the respondent was 14 years old.

[4] The socio-economic classification applied here is the one previously applied by Statistics Denmark.

[5] Apparent differences among the other groups are not statistically significant.

Table 2.2.3. The percentage of 31- 44-year-olds who used cannabis within the past year compared with their socio-economic background (%)	
	Own socio-economic placement
White-collar worker I	3.3
White-collar worker II	4.8
White-collar worker III	3.3
Skilled worker	3.9
Non-skilled work	4.2
Self-employed, no employees	6.3
Self–employed, with employees	4.0
Unemployed	9.4
Students	4.0
Early retirement pensioners	6.1
Others	12.1
Total	4.6

Source: Unpublished figures from SUSY 2000

When comparing tables 2.2.2 and 2.2.3 it thus turns out that cannabis among the 16-30-year-olds is most frequently used in the upper social strata and among young people who did not live together with either their father or mother at the age of 14, where cannabis among the older age groups is most prevalent among the groups of unemployed people.

Other illicit drugs

Table 2.2.4 shows an increase in the use of illicit drugs other than cannabis from 1994 to 2000. In 1994, less than 1% of the 16-44-year-olds reported having tried substances other than cannabis within the past year, whereas an even lower percentage had tried within the past month. In comparison, more than 3% of the 16-44-year-olds in 2000 reported having tried one or several additional drugs within the past year (1.2% within the past month and 2.2% within the remainder of the year). Thus, the results from the study suggest that the number of people who have tried drugs other than cannabis has increased from 1994 to 2000 – both within the category of “past month” and “past year” [6][7].

[6] The study has not provided any significance test for the increase.

[7] As mentioned earlier in footnote 1, the methodology, under which comparisons are made on the development of use of drugs other than cannabis in the population from 1994 to 2000 is not quite correct. However, the National Board of Health finds that the increase in the prevalence of these drugs, as it is seen from 1994 to 2000, reflects the actual tendency.

Table 2.2.4. The percentage of 16-44-year-olds who used one or several drugs other than cannabis during the past month and the past year in 1994 and in 2000		
Used one or several illicit drugs other than cannabis	1994	2000
	(n=2.521)	(n=6.878)
Past month	0.2	1.2
Past year (past month included)	0.5	3.4

Source: Unpublished figures from the SUSY 1994 and SUSY 2000 studies

Table 2.2.5 of the annex illustrates the proportion of 16-44-year-olds who have tried the different drugs within the past year. In 2000, amphetamine and cocaine are the second most used drugs after cannabis, with 2.2% reporting having tried amphetamine the past year, and 1.4% tried cocaine.

As in the category of cannabis users, the proportion of men outnumbers that of women who have tried illicit drugs other than cannabis within the past year. This is also a phenomenon characteristic of the young people, given that the proportion drops concurrently with increasing age (Unpublished figures from SUSY 2000).

In 2000, more than 11% of the population aged between 16 and 44 years report having tried one or several illicit drugs other than cannabis ever. In comparison, this percentage was a mere 4% in 1994. Thus, the number of people among the adult population who have tried one or several illicit drugs other than cannabis has tripled during the period from 1994 to 2000[8].

Socio-economic differences in the use of illicit drugs other than cannabis

There are no differences in use of other drugs within the past year among the 16-30-year-olds in relation to their parents' socio-economic status. (Data not shown). However, the young people who have not lived together with their mother or father at the age of 14 years make up the largest proportion of drug users among young people. (Unpublished data from and analyses on SUSY 2000).

Among the group of actively employed aged 31-44 years, there are no differences in use of other drugs for the past year among various socio-economic groups. The unemployed and early retirement pensioners, however, make up the largest proportion of drug users within the past year (Unpublished data from and analyses on SUSY 2000).

2.2.2. Youth population

As demonstrated in table 2.2.1, the younger age groups clearly make up the largest proportion of those using cannabis as well as other drugs. Drug use among the youth population aged from 16 to 24 years is described on the basis of the SUSY 2000 study, whereas drug use among the group aged between 16

[8] See previous note on the questionable aspect in applying the category "used ever"

and 20 years is described on the basis of the MULD 2000, the MULD 2001 and the MULD 2002 studies. The use among the 15-17-year-olds is described on the basis of the ESPAD 1995 and 999 studies (see annex for an elaboration on the studies).

16-24-year-olds

Cannabis

Results from SUSY 2000 demonstrate that a total of 40.9% of the young people between the age of 16 and 24 years have tried to smoke cannabis (table 2.2.6). Drug use among men and women within this age group is not equally distributed, given that 46.5% of the men and 35.8% of the women have tried to smoke cannabis ever. More than 25% of the men and 15% of the women have smoked cannabis within the past year. Three times as many men (approximately 12%) as women (approximately 4%) used cannabis within the past month (Unpublished figures from the SUSY 2000 study).

Other drugs

As far as illicit drugs other than cannabis are concerned, 14% of the young people aged 16-24 years in 2000 reported having tried one of these substances ever. A total of approximately 8% had used additional drugs within the past year (table 2.2.6). There is a significant gender difference in the use of drugs other than cannabis. Three times as many men (12%) as women (4%) report having used one of the other illicit drugs within the past year, and five times as many men (5%) as women (1%) tried one of these drugs within the past month (Unpublished figures from the SUSY 2000 study).

Table 2.2.6. The percentage of 16-24-year-olds who report in 2000 having tried one of several different illicit drugs within the past month, past year and ever (n=1786)

	Past month	Past year (past month included)	Ever
Cannabis	7.7	19.7	40.9
Amphetamine	1.5	5.7	10.9
Cocaine	0.8	2.7	4.7
Psilocybin mushrooms	0.7	2.1	4.4
Ecstasy	0.7	2.3	4.1
LSD	0.3	0.6	1.6
Heroin	0.1	0.2	0.5
Other drugs*	0.6	1.0	2.1
” Drugs other than cannabis ” total	2.9	7.7	14.0

Source: Unpublished figures from the SUSY 2000 study.
*The category ”Other drugs”, includes GHB, various medicinal agents etc.

Table 2.2.6 demonstrates that amphetamine is the second most used illicit drug among the 16-24-year-olds. This applies to the use as it appears today as well

as to use before. Almost 11% had tried amphetamine ever, ie 15% men and 7% women. A similar pattern in terms of gender differences is seen in drug use for the past year and the past month (Unpublished figures from the SUSY 2000 study).

In spite of the massive media coverage, it turns out that ecstasy is much less prevalent than amphetamine. Ecstasy use remains at the same level as cocaine and psilocybin mushrooms. Almost 6% of the men and more than 2% of the women aged between 16 and 24 years had tried ecstasy ever (Unpublished figures from the SUSY 2000 study).

Table 2.2.7 provides the results from all three MULD studies.

Table 2.2.7. The percentages of the 16-20-year-olds who are experienced in illicit drugs in 2000, 2001 og 2002

	MULD 2000 (n=2046)			MULD 2001 (n=2090)			MULD 2002 (n=2041)		
	Men	Women	All	Men	Women	All	Men	Women	All
Cannabis tried ever	37	27	32	38	29	33	41	34	37
Cannabis last month	14	5	9	13	6	9	12	5	8
Amphetamine tried ever	11	6	8	11	7	9	9	5	6
Ecstasy tried ever	5	3	4	6	3	4	4	3	3
Psilocybin mushrooms tried ever	5	1	3	7	3	5	5	2	4
Cocaine tried ever	4	2	3	5	3	4	4	2	3
LSD tried ever	2	0	1	3	1	2	1	1	1
Heroin tried ever	1	0	0	0	0	0	0	0	0
Smokeable heroin tried ever	1	1	1	1	0	1	1	0	1
”Other” drugs	2	1	1	2	1	1	3	2	3

Source: The National Board of Health and the Danish Cancer Society 2002, the National Board of Health and the Danish Cancer Society 2003 and unpublished figures from MULD 2002.

*The category ”Other” drugs include GHB, various medicinal products, etc.

The 16-20-year-olds

There are no significant differences between the figures on drug use in 2000, 2001 and 2002 with the exception of a minor increase in the proportion of individuals having tried cannabis ever. This increase should, however, not be attached too much significance, since there has not been a similar increase in actual use.

One-third of the young people in this age group report having tried to smoke cannabis ever. The second most used drug after cannabis is amphetamine as stated in SUSY 2000, since 6-9% of the young have tried amphetamine ever. 3-4% have tried ecstasy ever and the use of ecstasy is thus almost half as prevalent as amphetamine and almost the same level as the use of psilocybin mushrooms and cocaine. Gender differences clearly appear among the group of

16-20-year-olds, the overall trend being that men are overly represented in the use of almost all kinds of drugs.

15-17-year-olds - 9th grade

In 1999, a follow-up on the ESPAD study from 1995 was conducted. The study describes the prevalence of illicit drugs among the 15-19-year-olds in the 9th grade. (Hibell et al. 1997, 2000).

In 1999, 24% of the 15-16-year-olds reported having tried cannabis ever. This was a significant increase from 1995 when it was 18%.

There are large differences in the prevalence of drugs among boys and girls In 1999, 31% of the boys and a little over 22% of the girls report having tried cannabis ever. The boys are the ones who represent the increase from 1995 to 1999. Also, almost twice as many boys as girls had used cannabis within the past month in 1999 (Sabroe & Fonager 2002)[9].

Table 2.2.8. The percentage among 15-16-year-olds experienced in illicit drugs in 1995 and 1999

	ESPAD 1995 (n=2234)	ESPAD 1999 (n=1548)
Cannabis tried ever	18,0	24,4
Cannabis last month	6,1	8,1
Amphetamine tried ever	1,6	4,0
Cocaine tried ever	0,3	1,1
Heroin (injection) tried ever	0,2	0,1
Smokeable heroin tried ever	1,5	1,3
Ecstasy tried ever	0,5	3,1
LSD tried ever	0,2	1,0
Psilocybin mushrooms tried ever	0,5	1,8
Sniffing tried	6,3	7,5

Sources: Hibell et al. 1997, 2000 and unpublished figures from ESPAD 2002

As regards drugs other than cannabis, 7.5% of the 9th grades participating in the study in 1999 had tried sniffing, whereas 4.0% and 3.1% had tried amphetamine and ecstasy. Parallel with the increase in the use of cannabis, there is an increase in the proportion of young people experimenting with other drugs from 1995 to 1999. Thus there are significant increases in the proportion of those who have tried amphetamine, ecstasy, psilocybin mushrooms and in the proportion of

[9] In the Danish reports on the ESPAD studies, Sabroe and Fonager use an extended study base in relation to the international study, in that they include all pupils in the 9th grade and not only the 15-16-year-old pupils.

boys who have tried crack and cocaine, and in the proportion of girls who have tried LSD (Sabroe & Fonager 2002).

Co-variation in the use of illicit drugs

Most of those who try cannabis, do not try other drugs. The MULD 2001 study points out that 60% of the boys and 71% of the girls who have tried cannabis have not tried other illicit drugs. On the other hand, cannabis is often the entry to other illicit drugs. The fact is that 98% of those who in the MULD 2001 study have tried illicit drugs other than cannabis have tried cannabis (the National Board of Health and The Danish Cancer Society). The ESPAD 1999 study reports a similar correlation: While none of those who have not tried to smoke cannabis have tried amphetamine, 32-36% of those who have smoked cannabis 20 times or more tried amphetamine at least once (Sabroe & Fonager 2002).

Co-variation in the use of illicit drugs

Several studies on the young people's use of drugs indicate that often it is the same young people who are heavy drinkers of alcohol, who smoke tobacco on a daily basis, who smoke cannabis and who have been experimenting with other illicit drugs. The MULD 2000 and MULD 2001 studies report on a clear connection between smoking cannabis and drinking alcohol. For instance, 65% of the boys, who in 2001 had tried to smoke cannabis within the past year had been drunk more than three times within the past month, whereas only 28% of those who had never tried to smoke cannabis had been drunk within the past month (the National Board of Health and the Danish Cancer Society 2003). In 2000, 44% of the 16-17-year-olds who had smoked cannabis within the past year had also exceeded the maximum standard drink limit of 14 and 21 drinks for girls and boys, respectively, per week. Among boys and girls who had not smoked cannabis within the past year, only 13% had exceeded the maximum standard drink limit. There is also a close connection between early alcohol debut and cannabis consumption (the National Board of Health and the Danish Cancer Society 2002).

Also, it turned out that 47-48% of those who had smoked cannabis within the past year were daily smokers, whereas 10-12% of those who had never smoked cannabis were daily smokers.

The ESPAD 1999 study also suggests that there is a correlation between the use of drugs and alcohol. Sabroe and Fonager find that the frequency of cannabis smoking, the frequency of alcohol consumption and the frequency of having been drunk are clearly interlinked. For instance, at least 73% of those who had tried to smoke cannabis had been drunk more than 10 times the past year. In comparison, only 25-30% of the young people who had never smoked cannabis had been drunk more than 10 times the past year (Sabroe & Fonager 2002).

As regards illicit drugs other than cannabis, Sabroe and Fonager find that among those who have been drinking alcohol at least 10 times within the past month, 9-11% of the boys and 6-7% of the girls had tried to take ecstasy or amphetamine. In comparison, 1-2% of those who had been drinking 0-5 drinks the past month had tried ecstasy or amphetamine (Sabroe & Fonager 2002).

”The sum of vices” is thus not constant as to a large extent, the same young persons are the ones who expose themselves to various health risks.

Perception of drugs and of the users

Several studies report on a wider acceptance of drugs among the young people. Regional hearings announce a more widespread acceptance of use – it is not a clandestine task, but taken/smoked openly. This concurs with a qualitative study which Advice Analyse conducted for the National Board of Health in 1999 on how many find it alright to smoke cannabis or try other drugs. Using drugs is not always stigmatizing – drug use is associated with heroin use and socially deviating behaviour (the National Board of Health 2000).

Well-being on a daily basis

The MULD 2001 study asks about the young people’s well-being in everyday life in the form of questions about their experience of having personal problems making it difficult for them to handle daily routines and their perception of loneliness on a day-to-day-basis. Among the group of young people with many problems, 60% of the boys and 42% of the girls had tried to smoke cannabis, whereas 33% of the boys and 23% of the girls without problems had tried to smoke cannabis. The perception of loneliness and the use of cannabis shows a similar pattern for boys, whereas there is no correlation for the girls (National Board of Health and the Danish Cancer Society 2003).

2.2.3. Regional hearings

Since 2000, the Medical Officers of Health have carried out regional hearings on a national scale at the initiative of the National Board of Health in order to obtain further knowledge about the problems related to consumption and drug use on a regional as well as a local basis.

The objective of the regional hearings is to collect data about the changes on the drugs scene as regards new addiction patterns, new groups of experimenting young people and possible new routes of administering the socalled ”well-known” drugs. The hearings were conducted from May to August this year. The summary of the results from the regional hearings in 2002 provides an overall impression of the drug situation in Denmark.

Most of the counties report that the situation remains unchanged compared to last year. Cannabis is still the most prevalent illicit drug. It is smoked in private, at school parties, outside and in connection with parties in youth clubs. The debut often takes place in 8^{th}-9^{th} grade. For several years, amphetamine has been the second most prevalent illicit drug after cannabis, but it is being increasingly reported that cocaine in numerous environments has taken over its place. In general, prevalence cocaine is reported to be on the uprise, one of the reasons being that it has become cheaper. Ecstasy appears to be less prevalent some places or the problems with the drug have stagnated. The age of debut for drugs other than cannabis is later than at the age of 18, and experiments reach a peak for young people in their mid-twenties. Amphetamine, ecstasy and cocaine are mostly used “downtown” at discothèques or at music events. However, there are

reports mentioning that these experiments “move home” to private parties when the discothèques become more restrictive as regards age limits and/or drug use.

The young people experiment to gain self-esteem and social acceptance as well as to strengthen their identity. The use of drugs has also become more widely accepted in many environments. Use is not taken to dark corners of the room, but is socially acceptable, also among non-experimenting individuals – It is alright to meet at a party where some drink, others take drugs/pills.

The geographic distribution of the drugs appears to be extensive, with the type of drugs used in the various counties being more or less the same. The fact is that most counties across Denmark experience experimental use of cannabis, cocaine, ecstasy and amphetamine. However, it appears that the geographic distribution of heroin, LSD, psilocybin mushrooms, sniffing of solvents and lighter gas, anabolic steroids, sedatives and tranquillisers is less extensive. Several counties report that drug experimenting has spread from the major cities to the young people living in the smaller cities and in the country.

The most common users of cannabis and/or other drugs are still the boys.

The reports, however, also describe drug use across social boundaries and among socially more diversified groups than before – also among well-functioning young people during weekends. Concurrently with the descriptions of this more widespread prevalence, it is also being reported that drugs typically are used by the socially most unadjusted and marginalised young people. These are young people who have not completed the first 9 years of school, who have not started an education, young people without work, young people living in institutions, young people from homes with drug problems and young people without a social network. Among the unadjusted young people, there are also young men with a background other than Danish, who according to reports use cannabis and experiment with anabolic steroids and cocaine.

As regards the known drug users, heroin in combination with alcohol, cannabis and benzodiazepines are still the most prevalent drugs. In addition, there is a secondary use of Rohypnol, mushrooms, cocaine, amphetamine and illegal methadone. Among heroin users, there appears to be increased use of smokeable heroin instead of white heroin.

2.2.5. Drug use in prison

In 2002, the Danish Prison and Probation Services conducted a study on drug problems among their clientele (Kramp et al. 2003). The study had a three-fold purpose: one was to investigate prevalence of drug user, the second was to analyse possible connections between drug use and crime, and the third was to analyse the needs of drug users and their motivation for treatment. The study included 1305 subjects who were representative of the group of prisoners,

individuals remanded in custody and clients under supervision[10].

The study showed that illicit drugs are far more prevalent among the prisoners than in the general population. Among the clientele under the Danish Prison and Probation Services, 75% had tried cannabis, 53% had tried central stimulating drugs (cocaine or amphetamine), and 30% had tried opioids (heroin, morphine preparations, etc).

More than half, ie 56% of the clientele under the Prison and Probation Service are drug users, whereas 67% are users[11] or problem drug users[12] (alcohol abuse included). From table 2.2.9 it appears how many of the 1305 interviewees had different kinds of drug use or problem drug use.

Table 2.2.9. Drug use and problem drug use in the institutions of the Danish Prison and Probation Services (read horizontally)

	Drug use		Problem drug use	
	n	%	n	%
Opioids	186	14	37	3
CNS stimulants	155	12	136	10
Cannabis	355	27	74	6
Benzodiazepines	82	6	43	3
Ecstasy	19	2	20	2
Hallucinogens	10	0,8	30	2
Solvents	1	0.1	3	0.2
Alcohol	383	29	137	11

Source: Kramp et al. 2003

An individual may be classified under several drug groups in the table – for instance, a person may be registered as an opioid user as well as a user of alcohol.

From the table it appears that 14% are opioid users, 12% are users of central

[10] Clients under supervision are clients who have been released or who have received a suspended sentence and are still under supervision by the Prison and Probation Services.

[11] Drug use is defined as the consumption of drugs twice weekly or more the last month prior to imprisonment/supervisory registration. Alcohol use is defined as the consumption of 11 standard drinks or more daily the past 6 months prior to imprisonment/supervisory registration, 10 situations of inebriation or the past month prior to imprisonment/supervisory registration and/or ongoing treatment for alcoholism.

[12] Problem drug use is defined as the consumption of drugs once a week or less the past month before imprisonment/supervisory registration. Problematic use of alcohol is defined as the consumption of 6-10 standard drinks daily the past six months prior to imprisonment/supervisory registration and/or 5-9 situations of inebriation the last month prior to imprisonment/supervised registration.

stimulants, 27% are cannabis users, and 29% are alcoholics. This is to a wide extent known as polydrug use. For instance, 67%, 39% and 20% of the persons using opioids are also users of cannabis, central stimulants and alcohol. This is why drug users are divided into sub-categories so that opioid users comprise all those who use opioids, no matter if they also are users of other substances. The group categorised as users of central stimulants comprise those who use this kind of drugs, but who do not use opioids. Finally, the cannabis user group comprises all those who use cannabis, but not opioids or central stimulants. After this grouping, 14% of the total clientele were placed in the opioid user group, 6% belonged to the group of central stimulant users and 14% belonged to the cannabis user group. Furthermore, 21% belong to the group of alcohol users, whereas 44% did not belong to any drug user group.

When considering the age distribution, the persons from the opioid user group are the oldest on average (38 years) and the ecstasy users the youngest among users with an average age of 27 years. There is no significant difference between the proportion of men and the proportion of women using opioids, but there are more men (13%) using central stimulants than women (7%). The same applies to cannabis drug use.

In 50% of the cases, the age of debut among the 780 persons who had tried cannabis was 15 years or younger, whereas the age of debut in 75% of the cases was 17 years or younger. For the 362 persons who had tried opioids ever, 50% had tried it when they were 19 years or younger whereas 75% had tried it when they were 25 years or younger [13].

The majority of persons belonging the group of opioid users has previously received treatment and continues to be motivated to receive such treatment. However, only half of them receive treatment. Also it seems that among the opioid users who have previously received treatment 86% are still opioid users, whereas only 67% of them who have not received treatment still are opioid users. Among those who use CNS stimulants only very few are motivated for receiving treatment and according to the study results, cannabis use is considered of less importance, to the users as well as to the therapists. There appears to be an expressed need for clear guidelines as far as treatment internally in the Prison and Probation Services is concerned and for increased cooperation with the counties. Furthermore, there is a need for increased treatment capacity.

The drug study is a cross sectional study and therefore gives no indication of how many users there are among the clientele of the Prison and Probation Services during one year. However, it has been calculated that almost 3200 drug users are sent to prison per year. Among the remand prisoners there are 3400 drug users per year and among the clients under supervision, there are approximately 2000 drug users per year.

[13] Traffic law violators have not been included in the analysis on age of debut.

2.3. Problem drug use

In 2003, the National Board of Health made an estimate on the number of drug users in Denmark. Such an estimate is associated with great uncertainty with the factors depending on the definition of a drug user and the methods and data material, on which estimates are based.

The recent estimates have been based on the capture-recapture model[14]. The method is applied within population studies to estimate unknown population sizes and is based on the method originally applied by biologists to estimate the number of wild animals in a region. A random number of animals was captured and marked, following which they returned to their areas. Subsequently , another group of animals were captured at random, and the number of marked animals in the first group of captured animals, and the number of marked animals in the group of re-captured animals is assumed to be the same as the relationship between the number of animals in the first group of captured animals and the total population.

The new estimate on the number of drug users has been made on the basis of the National Patient Register (LPR) and the national register on drug users receiving or having received treatment (SIB). The approach has been to examine how many people are registered in the LPR with a drug-related diagnosis[15]. It has then been examined how many within this group were registered in the SIB as well.

[14] The method is recommended by the European Monitoring Centre for Drugs and drug Addiction (EMCDDA) in order to make it possible to perform comparative analyses on a cross-national basis.

[15] Selection codes applied include 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.

The mathematical model appears as follows

		In LPR	
		Found	Not found
In SIB	Found	a	b
	Not found	c	d

d is calculated as b*c/a

The number of drug users is a+b+c+d.

The estimate on the number of drug users in 1996, 1998 and 2000 appears in table 2.3.1. Drug users in this context are defined as individuals using drugs on a consistent basis, leading to physical, mental and social damage. The estimate does thus not contain experimental use of drugs. Cannabis users as well as users of central stimulants, opioids, etc have been included in the estimate.

Table 2.3.1. Estimate on the number of drug users in 1996, 1998 and 2001

	1996	1998	2001
Number	20,500	24,500	25,500

Source: The National Board of Health 2003

As it appears in the table, the number of drug users increased by 5000 from 1996 to 2001. However, the estimate from 1996 is not directly comparable with the estimates from the two other years. The reason is that in 1996, it was still possible to be referred to one's own doctor for treatment, which meant that clients were being treated without being registered in the LPR. Consequently, it is likely to assume that part of the increase from 1996 to 1998 is founded in a technical change of calculation methods.

Based on the estimate on total number of drug users in Denmark in 2001, the National Board of Health has made a special calculation on cannabis users only[16]. The calculation shows that 6,000 out of the total number of 25,500 drug users in 2001 are cannabis users only. The number of cannabis users appears by subtracting estimated drug users of illicit drugs other than cannabis from the total estimated number of drug users. No comparative calculations from previous years have been made on drug users. However, it is assumed that the increase in number of drug users in general from 1996 until today also means an increase in the number of cannabis users during the same period.

Currently, the number of drug users is considered to be stagnating. A real increase took place during the first part of the 1990s, and the persons from this period are the ones recaptured in the treatment system and thus making up the basis for calculation of the estimates

[16] The National Board of Health, memo dated 27 October 2003. Health statistics. Estimated number of cannabis users.

2.3.2. Risk behaviour

The register of the National Board of Health on clients admitted to treatment contains information from the clients on sharing of needles/syringes. Of the clients admitted to treatment in 2002, 16% report having this type of risk behaviour ever. 4% had this risk behaviour within the past month. Among admitted clients who had not previously received treatment, 8% report that they have shared needles ever, whereas 3% report having done so within the past month. Among the new clients admitted to treatment, there is a drop in the share of heroin users over time with intravenous drug use. If this trend continues, this will be beneficial for the limitation of HIV, hepatitis, etc. among heroin users (See chapter 3).

Chapter 3 Health Consequences

This chapter provides a description of the various health consequences related to drug use. It includes information about drug users under treatment, mental illnesses in conjunction with drug use and drug-related deaths and infectious diseases.

3.1. Drug treatment demand

The data on drug users under treatment have been retrieved from the National Board of Health register on drug users admitted to treatment, which was established in 1996. The Register includes the individuals referred to treatment for their drug use by the county/local centres, whether or not treatment is provided on an out-patient basis, daily or in-patient treatment, methadone-supported treatment or drug-free treatment. Table 3.1.1. provides a status on number of clients admitted to treatment in 2002.

Table 3.1.1. Clients admitted to treatment for drug use in 2001

Number of clients admitted in 2001	**4310**
Not previously treated (%)	32
Men/women (%)	76/24
Average age men/women (%)	31/32
Opioids as primary drug (%)*	57
Cannabis as primary drug (%)*	21
Central stimulants as primary drug (%)*	8
Injecting drug users, previously treated (%)	41
Injecting drug users, not previously treated (%)	23
Paid salary %)	9
Daily benefits (%)	7
Cash benefits (%)	55
Early retirement pension (%)	12
Other income and undisclosed (%)	17
	100%
Clients with own dwelling (%)	50
Single men/women (%)	76/65
Number of children under the age of 18 living at home	456
Number of children under the age of 18 not living at home	516
Foreign citizens (%)	5.2

Source: The National Board of Health register on drug users admitted to treatment
*Percentage of those reporting a primary substance.

In 2002, 4310 were admitted to treatment on a national basis. This is a minor increase in comparison with the 4079 admitted in 2001. The total number of drug

users admitted to treatment during the year rose by 7% from 2001 to 11246 persons in 2002. (The total figure includes persons who have continued treatment from 2001 and further onto 2002).

32% of those admitted to treatment in 2002 had not previously been treated for drug use. A special list and description of these "newcomers" will be treated separately later in the chapter.

Nature of drug use

Heroin is the most frequently used drug among the clients receiving treatment, but cannabis, methadone and benzodiazepines are also being used by many. During the past few years, there has been a tendency towards fewer users taking opioids as their primary drug. The fact is that in 1998, 79% of the clients reported using opioids as their primary drug, whereas the percentage had dropped to 57% in 2002.

Cannabis as the primary drug appears on the other hand to be on the increase. Cannabis was the primary substance for 21% of those admitted to treatment and is also a very prevalent secondary drug. 31% of those admitted to treatment in 2002 report using cannabis as their secondary drug.

By far the most drug users seeking treatment, use several drugs. In 2002, 46% report having used more than one drug prior to admission, which is a mild decline compared to 55% the year before.

The CNS stimulants which are in focus in the young people's experimental use of drugs appear only to a moderate extent as the primary drug for users admitted to treatment. Only 4% report amphetamine, 3% report cocaine and 1% report ecstasy[17] as their primary drug[18], which is more or less the same as in 2001. These drugs are thus primarily being used as a supplement.

Age and gender distribution

In 2002, 76% men and 24% women were among drug users under treatment, which is by and large the same as in previous years. In 2002, the average age on admission was 31 years for men and 32 years for women.

Social background variables

The data on social background variables provides a picture of a marginalised group in terms of work, education, housing and social life.

A majority of the clients live on transfer income, only 16% are somehow registered on the labour market with almost half of them receiving daily benefits. 26% of them have an education higher than the 10th grade, and 17% of them have left school before the 9th grade. The low educational level is explained by the fact that most drug users have their debut at a relatively young age.

[17] Recorded as MDMA or similar drugs.

[18] Percentages are calculated on the basis of the share of the treatment population providing information about primary drug.

When considering their housing situation, the drug users also belong to a disfavoured group. Only 50% of them have their own home – 6% are actually homeless.

A large share of the male as well as female drug users are single, which is unusual given that the majority of the group includes young adults. In 2002, a total of 456 children lived together with a drug user receiving treatment, while 516 children under the age of 18 lived away from home.

Foreign citizens

A small proportion of drug users receiving treatment are foreign nationals, totalling close to 5%. The percentage of clients of foreign nationality corresponds more or less to the percentage of foreign nationalities among the general population.

3.1.1. Newcomers under treatment

The national registry of drug users in treatment contains information on whether or not the clients have been admitted to treatment. The data on newly admitted clients are particularly interesting as this group reflects recent developments on the types of drugs used in various environments, and the modes of intake among various age groups, etc. In other words, is it possible to follow new trends over time with regard to addiction and recruitment to drug use. Table 3.1.2 below provides a status on the number of newcomers.

Table 3.1.2. Clients admitted to treatment in 1999, 2000 and 2001 and 2002 and who have not previously received treatment for drug use

	1999	2000	2001	2002
Clients who have not previously received treatment	1026 out of 3,429 (30%)	1157 out of 3920 (27%)	1278 out of 4079 (31%)	1364 out of 4310 (32%)
M/W (%)	74/26	77/23	76/24	78/22
Average age M/W	28/28	28/28	28/27	28/29
Opioids as primary drug (%)*	52	54	38	35
Cannabis as primary drug (%)*	31	30	33	39
CNS stimulants as primary drug (%)*	Not compiled	14	11	15
Injecting heroin users (%)	40	35	25	23

Source: The National Board of Health register on drug users under treatment in 1999, 2000 and 2001 and 2002.

*Percentage of those reporting primary drug

As it appears in table 3.1.2, 32% of the clients admitted to treatment in 2002 had not previously been treated. As might have been expected, the average age among the newcomers was significantly lower than the average age among the treatment population in general. In 2002, the gender distribution among the newcomers and the old clients under treatment was more or less the same.

Primary drug and manner of intake

The proportion of newcomers reporting cannabis as their primary substance is significant larger than among those who have previously been under treatment.

The proportion of those reporting cannabis as their primary substance among newcomers is 39% in 2002. This is a mild increase compared to the previous years, with percentages being much lower (26%) in 1996 as well as in 1997.

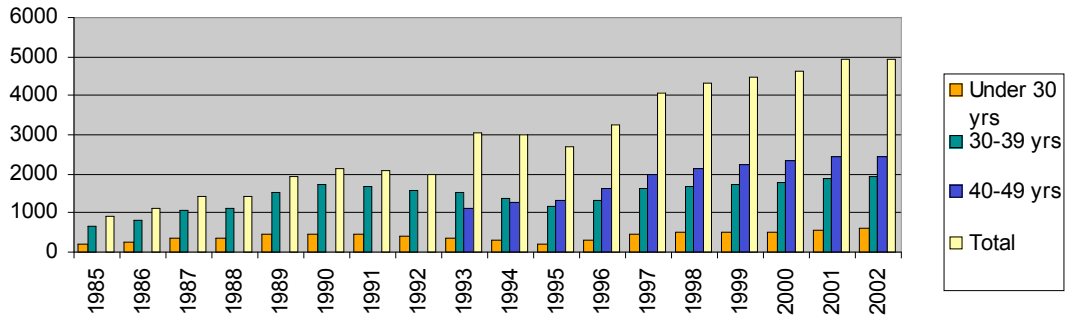
Among the 1339 newcomers with a reported primary substance use, only 35% report opioids as their primary drug, which is the same as in 2001 and much lower than in 2000, when 54% reported opioids as their primary substance. 15% report having used a CNS stimulant as their primary substance (in this case amphetamine, cocaine or ecstasy), which is a higher proportion than among the treatment population in general. This could imply that the CNS stimulants will become more prevalent drugs among the treatment population in the future, and the proportion of clients using opioids as their primary drug will be decreasing.

When considering the mode of heroin intake among the two "client groups" there are also variances, given that 23% of those who have not previously been treated report having injected heroin, whereas 41% of those who have previously been treated have injected the drug in 2001. Also, it appears that a smaller number of the newcomers in 2002 have injected drugs compared to the two previous years. The difference in the manner of intake between the two client groups is most likely due to a "shorter addiction career" and that smokeable heroin during the past few years has started to gain ground. The latter is evidenced by the drop in injecting drug users among the newcomers over time. See also the section of risk behaviour in 2.3.2.

3.1.2 Methadone treatment and prescription

Since 1985, the National Board of Health has recorded the number of clients in long-term methadone treatment, ie more than 5 months. Figure 3.1.1. illustrates the development in the number of drug users under the age of 50 years in substitution methadone therapy in December each year during the period 1985-2002[19]. The figure does not include clients in long-term methadone treatment under the Prison and Probation Services and clients without a civil registration

Figure 3.1.1 Individuals in long-term methadone treatment (more than 5 months) 1985-2002



[19] Prescription statistics also include prescription on indicators other than drug use (such as pain therapy). However, these prescriptions are estimated to be limited in numbers when it comes to long-term prescription (more than 5 months) for persons under the age of 50.

number under treatment[20].

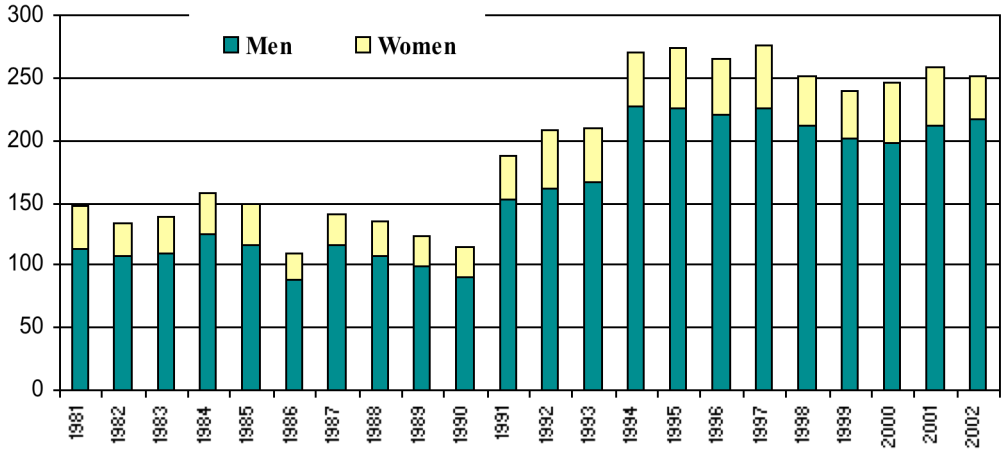
There continues to be an increase in the number of persons receiving long-term substitution therapy after the counties took over the responsibility for prescription, dispensing and control.

Until 1996, methadone registration was solely based on prescriptions. After the amendment of the act in 1996, statistics also included individuals who received methadone without a prescription from the county treatment centres. This contributed to the major increase from 1996 to 1997. The increase in the number of individuals subjected to long-term substitution treatment from 1996 also reflects changes in treatment services provided[21]. Apart from methadone, buprenorphine is used in drug substitution therapy. The number of persons receiving treatment with buprenorphine has not been registered.

3.2. Drug-related mortality

The National Commissioner of Police has registered drug-related deaths since 1970 (Police Drug Statistics 2002).

Figure 3.2.1 Drug-related deaths broken down by gender, 1981-2002



Source: National Commissioner's Drug Statistics 2002

National Commissioner's Register

The Register includes deaths which have been reported to the police for medico-legal autopsy. Such cases are, for instance, persons found dead. sudden unexpected death, accidents, homicide and suicide. Deaths caused by

[20] In 2001, 351 clients received long-term methadone therapy among the prisoners of the Danish prisons, and approximately received methadone on an alternative number (ie without having a civil registration number).

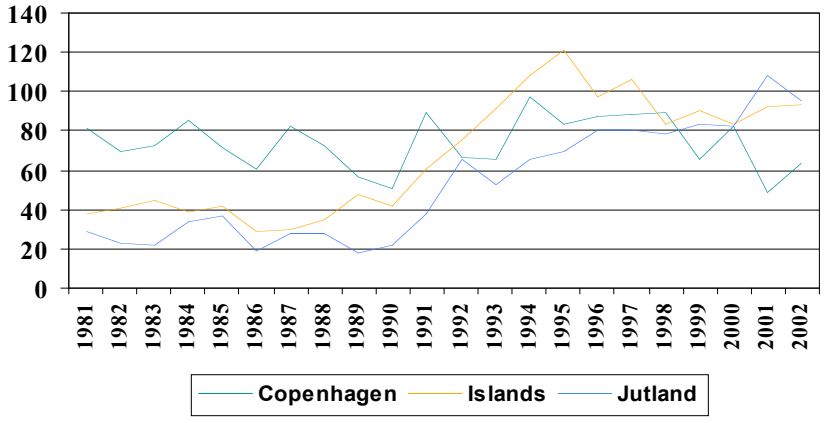
[21] Reference is made to the report produced by the Medical Officer of Health in Copenhagen, in which a description is provided on the positive and negative effects of handing over responsibility to the counties in January 1996 for prescription, dispensing and control of methadone as well as the social and medical treatment (Copenhagen and Frederiksberg municipalities 2001).

poisoning and deaths caused by accidents involving drugs will thus be reported to the police.

The National Commissioner's mortality statistics (figure 3.2.1) show a constant level at the beginning of the 1980s, a mildly declining tendency at the end of the 1980s and a distinctly higher level in the 1990s. In 2001, 252 drug-related deaths were recorded which is almost the same as in 2001 when 258 drug-related deaths were recorded.

Until the late 1980s, most of the deaths were among drug users living in Copenhagen. However, this tendency has taken a different turn when the number of deaths reported in the three regions of the county are very much the same. For the past two years, Jutland has had the highest number of drug-related deaths, followed by the islands, and Copenhagen accounts for a considerably lower number of drug-related deaths (figure 3.2.2).

Figur 3.2.2 Geographical breakdown of drug-related mortality rates (by the deceased's address registered at the National Registry), 1981-2002



The average age at death increased during the period from 1991 to 2002. In 1991, the average age at death was 31.5 years. In 2002 it was 38.0 years.

In terms of gender, the drug-related deaths primarily appear among the male population. The proportion of men has gone up during the period, from 72% in 1976 to almost 86% in 2002.

Cause of Death Register, the National Board of Health

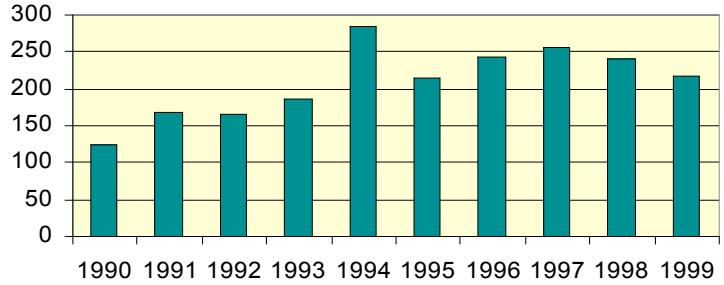
In addition to the National Commissioner's Register, the National Board of Health has a register on drug-related deaths in the so-called Cause of Death Register. This register includes deaths, which are defined as drug-related deaths based on common European criteria. Given the desire to perform comparative analyses on a cross-national scale, there are restrictions as regards diagnosis groups included in the retrieval procedure. Consequently, drug users who have died from AIDS will not be included in the register.

The Cause of Death Register at the National Board of Health includes deaths caused by harmful use of drugs, dependency and psychoses as well as deaths caused by poisoning (suicide as well as accidents)[22].

I 1999,[23] 217 deaths were registered, out of which men account for 72% (157). According to figure 3.2.3, which shows developments throughout the 1990s, the tendency appears at first to be mildly increasing and then appears to be falling at the end of the decennium. The major fluctuation in 1994 is artificially created and caused by a temporary adjustment of coding practices.

According to the Cause of Death Register (the National Board of Health), the average age of death for women was 49.3 years and for men 37.7 years in 1999, which equals a total average age of 40.9 years.

Figure 3.2.3 Drug-related deaths in 1990-1999



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

The differences between the figures in the two registers are explained by the differences in death populations and the differences in the definition of a drug-related death. For instance, the register of the National Commissioner's Office operates only with deaths requiring a medico-legal autopsy, whereas all deaths are registered in the National Board of Health's Cause of Death Register.

Furthermore, the European definition of drug-related deaths used for the figures in the Cause of Death Register does not include deaths caused by traffic accidents or other accidents occurring as a result of intoxification of the deceased. These deaths, however, have been included in the register of the National Commissioner of Police.

Investigation of drug-related deaths in Copenhagen, 1997-1999

The Medical Officer of Health for Copenhagen and Frederiksberg Municipalities, the Family and Labour Market Administration of Copenhagen Municipality and the Forensic Institute of Copenhagen University conducted a study together on drug-related deaths in Copenhagen from 1997 to 1999 (Embedlægeinstitutionen for København og Frederiksberg Kommuner et al. 2003). The primary objective of the study was to examine what drug users die from while receiving treatment.

[22] Up until 1994, ICD8 codes were used, following which ICD10 codes were used instead.
[23] Data from 2000 and 2001 are not available at present.

One of the main conclusions was that the number of drug users dying from illnesses is much higher than previously assumed.

Out of the 2956 persons who during the period 1997-1999 had contact with the treatment services in Copenhagen, 172 died during that same period. The total mortality rate was 2.5% per year for those drug users who had had contact with the treatment system. 37% died from poisoning, 44% died from illnesses, of which one-third was infectious diseases, and 18% died from other causes (violent death, including suicide, homicide and accident).

It was also concluded in the study that there is a correlation between mortality rates and a number of associated factors such as age, social marginalisation, morbidity and treatment. Social marginalisation in the form of homelessness and early retirement increased the risk of death, whereas education appeared to have a favourable impact on mortality rates. The prescription of anti-depressants and painkillers (other than methadone) appeared to increase the risk of death.

Research project on the mortality of drug users following release from prison

In 2002, Peer Brehm Christensen, specialist consultant, Ph.D Odense University Hospital and the National Board of Health conducted a research study on the mortality rates among drug users during the period after their release from prison. The objective of the study was to investigate whether drug users receiving treatment are subjected to over-mortality during the period following immediately after their release. The study was based on the National Board of Health's register on drug users under treatment which is coordinated with the Crime Registry of the National Commissioner.

The study is still running, but preliminary results suggest that during the first two weeks after being released, the drug users were more at risk of dying than other drug users. The reason for this could be that their drug tolerance is reduced while they are in prison. After their release, drug users will often take the same quantity of drugs as before they were imprisoned which results in an overdose.

3.3. Drug-related infectious diseases

Hiv/aids

Danish action against HIV is based on the principle of voluntariness, anonymity, openness, direct and honest information and security for individuals in their contact with the health authorities. HIV testing is voluntary, and persons who are HIV-infected are reported anonymously. The HIV reporting system comprises age, gender, information about any earlier HIV test and the presumed source of infection. Cases of AIDS are reported by name and personal data.

Table 3.3.1 shows the number of newly diagnosed HIV-positive intravenous-injecting drug users from 1992 to 2002[24]. The number of newly diagnosed HIV-positive has varied from one year to the other, as has the number of infected clients where the source of infection has been reported as being intravenous drug use.

[24] The figures from previous years have been adjusted and updated which explains why they may deviate somewhat from figures in the previous annual reports.

In 2002, 11% (31 persons) of the newly diagnosed HIV positive were intravenous drug users. This percentage has been rather constant around 10% the past 10 years.

The proportion of newly reported aids cases, where the source of infection is considered to be intravenous drug use has also been a steady approximate 10%. However in 1998, it dropped to 5% of all registered newly reported aids cases (4 out of a total of 74 persons), and peaked in 2001 to 15% (11out of a total of 72 persons).

Table 3.3.1 Number of newly diagnosed HIV positive and AIDS-diagnosed throughout the entire population and the proportion of intravenous injecting drug users among this group from 1992-2002

	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
Number of newly diagnosed HIV positive, total	380	331	298	304	268	273	212	285	260	319	282
Number of newly diagnosed HIV positive injecting drug users (% of all newly diagnosed)	52 (14%)	24 (7%)	28 (9%)	34 (11%)	25 (9%)	30 (11%)	13 (6%)	26 (9%)	20 (8%)	31 (10%)	31 (11%)
Number of newly diagnosed AIDS cases, total	209	239	237	213	159	109	74	76	57	72	39
Number of newly diagnosed AIDS cases with intravenous drug use (% of all newly diagnosed)	18 (9%)	21 (9%)	24 (10%)	28 (13%)	18 (11%)	11 (10%)	4 (5%)	7 (9%)	7 (12%)	11 (15%)	3 (8%)

Source: Unpublished data from Statens Serum Institut

Number of hepatitis B, total *	52	105	115	112	101	101	94	58	63	47	61
Number of hepatitis B cases with intravenous-injecting drug use (% of all diagnosed)	9 (17%)	36 (34%)	49 (43%)	39 (35%)	36 (36%)	30 (30%)	25 (27%)	13 (22%)	20 (32%)	11 (23%)	11 (18%)
Number of hepatitis C, total *	31	65	84	36	28	26	21	13	15	6	5
Number of hepatitis C cases with intravenous drug use (% of all diagnosed)	23 (74%)	49 (75%)	61 (73%)	27 (75%)	20 (71%)	20 (77%)	13 (62%)	11 (85%)	9 (60%)	3 (38%)	4 (80%)
	1992	**1993**	**1994**	**1995**	**1996**	**1997**	**1998**	**1999**	**2000**	**2001**	**2002**
Number of hepatitis A, total	172	227	145	103	107	115	86	88	81	63	83
Number of hepatitis A with intravenous-injecting drug use (% of all diagnosed)	1 (1%)	24 (11%)	6 (4%)	1 (1%)	0	0	0	0	0	0	1 (1%)

Hepatitis A, B and C

In spite of minor fluctuations, there seems to have been a drop during the past five years in the number of registered acute hepatitis cases throughout the population (table 3.3.2). During that same period, the proportion of acute hepatitis cases where the infected person was an intravenous drug user has been around 1% for hepatitis A, varied between 17% and 43% for hepatitis B and varied from 38% to 85% for hepatitis C. The number of registered cases is, however, so small that the percentages should be considered cautiously .

Source: Unpublished data from Statens Serum Institut
*The cases with acute hepatitis B and C include a certain overlap in that a total of 103 persons (92 IDUs) spread across the period were reported suffering from both Hepatitis B and C.

Studies conducted by the Funen and Copenhagen counties show that 60-80% of all drug users have been hepatitis B-infected, and that approximately 5% of them develop chronic hepatitis. (The Danish Ministry of the Interior and Health 2002).

As regards hepatitis C, studies have shown that 80-100% of the intravenous-injecting drug users are infected. In 75% of this group, the infection develops into a chronic one and approximately 25% of the infected individuals will develop cirrhosis of the liver, perhaps cancer of the liver within the next 20-30 years. (The Ministry of the Interior and Health 2002).

3.4. Other drug-related morbidity

3.4.1. Psychiatric co-morbidity

A total of 3352 persons were admitted to psychiatric hospitals with a drug-related primary or secondary diagnosis in 2002 compared to 2685 in 1996. During the period 1995-2002, an increase of more than 50% was seen in the number of individuals admitted to psychiatric hospitals with drug-related secondary diagnoses from 1150 to 1747 (table 3.4.2), whereas the number of persons admitted to hospital with drug-related primary diagnoses varied between 1500 and 1650 throughout the period (table 3.4.1.

The number of subjects admitted with a primary diagnosis related to the use of cannabis also appears to be increasing with, however, relatively large fluctuations. The trend becomes clearer in secondary diagnoses related to cannabis, where the number of subjects has gone up steadily from 431 individuals in 1995 to 691 in 2002.

During the entire period, individuals with primary diagnoses of polydrug use make up the largest group, and the number has been increasing steadily until 1999. The second most frequent primary diagnoses is related to individuals using cannabis, who in 2002 comprised almost 20% of the individuals in psychiatric treatment with a drug-related primary diagnosis. At the same time, the proportion of individuals with opioid-related primary diagnoses dropped evenly throughout the period.

Table 3.4.1. Individuals registered with drug-related primary diagnoses in psychiatric hospitals, 1995-2002

Diagnosis code	Mental illnesses or disturbances caused by using:	1995	1996	1997	1998	1999	2000	2001	2002
F11	Opioids	322	319	273	273	227	227	189	172
F12	Cannabis	312	304	279	314	317	270	327	364
F13	Sedatives / hypnotics	283	315	239	212	204	205	199	182
F14	Cocaine	7	12	15	21	23	23	31	36
F15	Central stimulants other than cocaine	85	94	82	82	71	76	75	109
F16	Hallucinogens	23	23	25	17	26	18	21	14
F18	Solvents	9	11	3	5	10	2	6	2
F19	Multiple or other psycho-active drugs	494	569	586	705	758	749	732	726
Persons with primary diagnoses, total		1535	1647	1502	1629	1636	1570	1580	1605

Source: Unpublished figures from the Psychiatric Central Register at the Department of Psychiatric Demography at the Institute of Psychiatric Basic Research, Psychiatric Hospital in Aarhus.

Table 3.4.1 shows the number individuals registered as receivers of psychiatric treatment (total of full-day, half-day and outpatient treatment) for use of opioids, cannabis, sedatives and hypnotics, central stimulants, hallucinogens and volatile solvents and poly-substance use during the period from 1994 to 2001. ICD-10 code classification was applied and the diagnoses F11.x to F16.x and F18.x to F19.x (primary diagnosis) were applied as retrieval criteria.

Table 3.4.2 Individuals registered with drug-related secondary diagnoses in psychiatric hospitals, 1995-2002

Diagnosis code	Mental illnesses or disturbances caused by the use of:	1995	1996	1997	1998	1999	2000	2001	2002
F11	Opioids	166	176	178	134	146	190	204	208
F12	Cannabis	431	427	477	524	566	584	637	691
F13	Sedatives / hypnotics	330	327	259	247	253	283	257	266
F14	Cocaine	8	8	17	13	15	17	19	34
F15	Central stimulants other than cocaine	46	67	56	53	58	52	58	56
F16	Hallucinogens	6	6	7	4	11	9	11	10
F18	Solvents	9	7	6	4	9	7	7	13
F19	Multiple or other psychoactive drugs	238	297	314	418	534	566	485	574
Persons with secondary diagnoses, total		1150	1225	1240	1335	1506	1630	1593	1747

Source: Unpublished figures from the Psychiatric Central Register at the Department of Psychiatric Demography at the Institute of Psychiatric Basic Research, Psychiatric Hospital in Aarhus.

Table 3.4.1 shows the number individuals registered as receivers of psychiatric treatment (total of full-day, half-day and outpatient treatment) for use of drugs and volatile solvents. ICD-10 code classification was applied and the diagnoses F11.x to F16.x and F18.x to F19.x (secondary diagnosis) were applied as retrieval criteria. Since a patient may have several drug-related secondary diagnoses, the “total” category is not a summation of the above individuals.

Chapter 4 Social and Legal Correlates and Consequences

This chapter provides a description of the problems following from drug use, including prevalence and development of drug offences in Denmark.

4.1. Social problems

Drug users experience to a higher extent social expulsion than other groups. They are more often homeless, they often have shorter education, and they are often provided for through cash benefits and pension than the public in general (See chapter 14 in the annual report from 2002).

Particularly threatened groups in relation to drug use are children from families with abuse, violence and desertion and who have an early debut with alcohol and cannabis, young immigrants who are poorly integrated, refugees with traumatic experiences, mentally frail individuals, mentally ill and homeless.

4.2. Drug offences and drug-related crime

Ongoing registration is made of filed reports, charges and decisions under the Euphoriant Substances Act, which primarily covers possession and sale of small quantities of drugs, and under sections 191 (1) (sale), 2 (smuggling) of the criminal Code, which deals with serious drug crime and Section 290 which deals with handling of stolen goods – including handling of stolen goods in connection with drug offences.

Charges for violation of drug legislation

The police presses charges, resulting in either imprisonment, other sanctions or acquittal. The National Commission registers the number of reports and charges filed annually.

In 2002, a total of 13,025 charges were registered. As it appears from table 4.2.1 below, the number of charges since 1999 has been relatively stable around the 13,000, which is a considerably lower level than at the beginning of 1990s. Since 1994, the number of charged persons has been around 9,500. Out of the 10,021 individuals charged in 2002, a total of 5,127 was charged for the first time.

Table 4.2.1. Drug crime 1992-2002. Charges and number of individuals charged

	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
Charges, total	17,282	18,604	15,155	14,654	14,371	13,454	14,251	12,928	13,178	13,143	13,025
Individuals charged	10,290	12,421	9,536	9,008	8,678	8,234	8,900	9,424	9,899	9,858	10,021

Source: Police Drug Statistics 2002

On 20 December 2002, there were 2440 individuals in prison. Out of this number, 493 (20.2%) were convicted of violation of Section 191 of the Danish Criminal Code or the Act on Euphoriant Substances.

Correlation between drug use and crime

As part of the drug study outlined in section 2.2.5, the correlation between drug use and type of crime was described. From table 4.2.2 of the annex it appears

which type of crime the various drug use groups have committed. Opioid drug users typically commit theft and other offences against property as well as robbery. Generally, serious crime is rarely involved since the group of opioid drug users together with the group of cannabis drug users are sentenced to shorter prison sentences than the other groups[25]. They are sentenced relatively often for violation of the Act on Euphoriant Substances and very rarely for violence, homicide or attempted murder.

CNS stimulant drug users are often convicted of/charged with serious drug crime and robbery. This applies to 15% and 21% of the group of central stimulant users, whereas it applies to 12 % and 14% of all clients. However, the group without drug use accounts for 57% of the persons charged with serious drug crime (Table 4.2.3). Cannabis users do not deviate significantly from the average, whereas the alcohol users frequently are convicted of violence.

Table 4.2.3 shows the distribution of drug users within each type of criminal offence (Table 4.2.3 is summarized horizontally and table 4.2.2 summarized vertically, for which reason the percentages are not the same)

Table 4.2.3. Criminal offences (primary) and drug user groups, not including traffic act violators

	Opioid user group		CNS stimulants user group		Cannabis user group		Alcohol user group		No drug use		Total	
Criminal offences	n	%	n	%	n	%	n	%	n	%	n	%
Homicide, etc	6	9	3	5	16	25	9	14	31	48	65	100
Violence	15	8	11	6	41	21	29	15	101	51	197	100
Arson	1	3	2	7	4	14	9	31	13	45	29	100
Rape	-	-	3	13	2	9	4	17	14	61	23	100
Other vice	-	-	-	-	-	-	3	10	28	90	31	100
Serious drug crime[1]	16	14	13	12	18	16	1	0,9	63	57	111	100
Act on Euphoriant Substances	7	26	4	15	5	19	1	4	10	37	27	100
Robbery	41	30	16	12	32	23	7	5	42	30	138	100
Theft	72	36	20	10	39	20	17	9	52	26	200	100
Other offences against property	19	19	2	2	9	9	6	6	62	63	98	100
Other offences under Criminal Code	1	5	1	5	2	10	5	24	12	57	21	100
Special acts	1	5	1	5	-	-	1	5	17	85	20	100
Total	179	19	76	8	168	18	92	10	445	46	960	100

Source: Kramp et al (2003).
To be read horizontally.
1) Applies in particular to violations of Section 191 of the Danish Criminal Code providing maximum penalty of 10 years' imprisonment.

It appears that among those being charged with serious drug crime as the primary offence, the vast majority (57%) was not drug users, whereas 14%, 12% and 16%, respectively, belonged to the opioid drug user group, the central

[25] In the list of the groups convicted of different types of crime, the individuals in violation of the traffic act are dealt with separately in other statistical material.

stimulants group and the cannabis user group. Among the clients convicted under the Act on Euphoriant Substances, 37% were not drug users, 26% belonged to the opioid user group, 15% belonged to the CNS stimulants user group and 19% belonged to the cannabis user group.

4.3. Social and economic costs of drug consumption

”NO INFORMATION AVAILABLE”

Chapter 5 Drug Markets

5.1. Availability and supply

In its report ”Report on organised crime in Denmark 2002”, the National Commissioner of Police points out that Morocco continues to be the primary producing country of cannabis in relation to the Danish market (The National Commission 2003). Spain and Holland continue to be the predominant distribution countries.

According to the National Commissioner, the vast majority of heroin is brought to Denmark from South West Asia, either via the traditional routes through Iran and Turkey or via newer routes through the former Soviet Republics.

Amphetamine and ecstasy seized in Denmark are assumed primarily to be produced in Holland and Belgium. Smuggling to Denmark is typically carried out via land through Germany.

5.2. Seizures

Police and customs authorities regularly register the quantities of illicit drugs seized as well as the number of drug seizures made at the borders, airports and harbours in connection with large-scale investigations and at a street level. The data on seizures are regularly reported to the National Investigative Support Centre (NEC), which prepares and publishes annual statistics on the subject (NEC 20002).

Statistics on the quantity of drugs seized and the number of seizures provides a very rough indicator of the quantity of drugs on the illegal market, and is also an indicator of the supply of drugs on the illegal market as well as an indicator of police operations. The publicized statistics do not distinguish between seizures of large quantities for reselling and quantities sold at a street level. Consequently, a parallel random sampling based registration of drugs traded on a street level has been carried out since 1995, cf the “Street Plan Project” described below.

Table 5.2.1 of the Annex demonstrates the development in quantities and number of seizures of heroin, cocaine, amphetamine and cannabis from 1990-2001. From 1995 and onwards, the figures also include quantities and number of seizures of ecstasy and LSD. The table shows major fluctuations in the quantities of drugs seized within most types of drugs in some years.

It appears from the table that the number of seizures of heroin dropped by almost 70% after 1996 when it reached its peak. The quantity of heroin seized reveals no clear tendency, but in 2002 it had reached a maximum of 62.5 kg. The number of seizures of cannabis dropped from 2001-2002, with quantities, however, rising from 1763 kg to 2635 kg.

The number amphetamine, cocaine and ecstasy seizures are relatively constant. The quantities of amphetamine and ecstasy seized in 2002 dropped to the

previous level from before the major seizures in 2001[26]. The quantity of cocaine seized has been declining mildly during the past few years.

Monitoring of illicit drug trafficking at a user level

Since 1995, illicit drug trafficking on a user level has been subjected to regular monitoring in the form of a “Street Plan Project”. The aim is to follow the development in terms of prices and drug purity as an indicator of the correlation between supply and demand on the illicit market, as well as to identify the prevalence of "dangerous substances" and consider the frequency and location of high purity drugs. Finally, the regular monitoring activities have aimed at following the introduction of new drugs in the illegal market.

Results from the analysis samples from the ”Street Plan project” in 2001

In 2002, the data material in the Street Plan Project consisted of small seizures based on random sampling from 5 police districts in Denmark (Copenhagen, Aarhus, Odense, Aalborg and Esbjerg) submitted for analysis at the institutes of forensic chemistry. During this analysis, the identity of the illicit drug is recorded, as are additives, if any. Furthermore the analysis determines purity and weight. Table 5.2.2 illustrates the distribution of drugs seized on a national level from 1996 to 2002.[27]

Out of the 198 samples analysed in 2002, 54% included CNS stimulants such as amphetamine and cocaine. This percentage has varied throughout the years and reached its peak in 2002. ”Ecstasy drugs”, ie the new designer drugs, were found in 2% of the 198 samples.

40% of all samples in 2002 contained heroin. Thus, heroin continues to be the frequently most prevalent drug. However, on a national scale there appears to be a drastic decrease in the number of heroin samples from 1996 to today, given that 57% of all samples in 1996 contained heroin. In Copenhagen, the predominant drug is cocaine (43% of all samples), whereas the most prevalent drug in Aalborg is amphetamine (46% of all samples) and Esbjerg (48% of all samples).

26 The drastic increase in amphetamine seized from 2000 to 2001 is explained by the four extraordinarily large seizures conducted in 2001. As far as ecstasy is concerned, the major increase in number of pills seized is explained by one single seizure in 2001 involving 105,753 pills..

27 The street plan project does not include cannabis or other cannabis products.

Table 5.2.2. Breakdown of drug types on user level 1996-2002							
Year	**1996***	**1997***	**1998***	**1999***	**2000**	**2001**	**2002**
Drug	n = 212	n = 217	n = 208	n = 216	n = 188	n = 152	n=198
Heroin	57%	60%	56%	45%	44%	45%	40%
Amphetamine	23%	26%	17%	23%	17%	22%	24%
Cocaine	14%	9%	23%	27%	24%	22%	30%
Ecstasy	3%	1%	<1%	3%	7%	9%	2%
Other euphoriant	1%	1%	1%	1%	5%	1%	3%
Non-euphoriant	2%	3%	1%	<1%	3%	1%	2%
Total	100%	100%	100%	100%	100%	100%	100%

Source: Kaa et al. 1997, Kaa et al. 1998, Kaa et al. 1999, Kaa et al. 2000, Kaa et al. 2001, Kaa et al. 2002, Kaa et al. 2003.

*In 1996, 1997, 1998 and 1999 figures from the Elsinore police district have been included.

Table 5.2.3 of the Annex shows the distribution between heroin base ("smokeable heroin") and heroin chloride (white heroin for injection) from 1996-2002. From 1996 the proportion of heroin base established among the heroin samples appears to increase steadily. In 2001, no heroin chloride was found among the samples from the police districts in Jutland, whereas only 19% of all heroin samples in Copenhagen consisted of heroin chloride (data not disclosed). As in previous years, Odense continues to distinguish itself significantly from the rest of Denmark, with 65% of the heroin samples containing heroin chloride.

5.3. Price/purity

Table 5.3.1 shows the purity of various drugs from 1996 to 2002 in samples collected under the Street Plan Project.

Table 5.3.1 Purity of illicit drugs on a user level, 1996-2002 (Median of active substance)[28, 29]							
	1996*	1997*	1998*	1999*	2000	2001	2002
Heroin chloride	64%	71%	70%	69%	59%	52%	50%
Heroin base	43%	32%	31%	30%	40%	48%	25%
Amphetamine sulphate	15%	16%	15%	9%	12%	9%	13%
Cocaine chloride	58%	57%	51%	54%	37%	43%	36%

Source: Kaa et al. 1997, Kaa et al. 1998, Kaa et al. 1999, Kaa et al. 2000, Kaa et al. 2001 og Kaa et al. 2002

*In 1996, 1997, 1998 and 1999 figures from the Elsinore police district have been included.

The purity median of white/beige heroin chloride from 1996 to 2002 has been between 50% and 71%. In 2002, purity was record low, but with an interval

[28] As of 1 January 2002, the forensic departments state purity (concentration) of illicit drugs as percentage active substance, which is why this table differs a little from that of previous annual reports.

[29] Since the purity of most drugs is distributed normally, this table applies the median value of purity instead of the average purity. This concurs with the practice employed at the institutes of forensic chemistry.

ranging from 18-78%. There were no significant differences in the figures from 2001 to 2002.

For heroin base, the median purity value was 25% in 2002. Compared to previous years, the purity of heroin base in 2002 was significantly lower. As was the case with heroin chloride, the purity variation interval for heroin base was large (3-62%).

For amphetamine, many samples contained low purity. Only five samples contained a purity above 40%. The median was 13% and the variation interval was wide (1-70%). Purity in 2002 was at the same level as in previous years, but lower than in the mid-1990s.

In 2000, cocaine purity dropped significantly as opposed to the previous years, but in 2001 and 2002, the drop came to a halt. The purity median rate was 36% in 2002, which was not significantly different from the two previous years. The variation interval in 2002 was large (10-86%).

There were no significant differences in purity of the individual illicit drugs seized in various parts of Denmark in 2002, as had been the case in previous years, but everywhere in the country the variation interval was large. All police districts were still finding drugs of high as well as low purity on the markets. For none of the drugs was it possible to identify periods of the year, during which purity was particularly high or low.

By comparing the samples collected from the Street Plan Project and the routine samples[30] examined at the institutes of forensic chemistry, the differences in the purity of heroin, amphetamine or cocaine are, as in previous years, undetectable. Therefore, there are no signs of the drugs being diluted before being sold at street level or being of more ”inferior” quality than drugs handled in large weight quantities. (Kaa et al.2002)

Monitoring of ecstasy pills on the market

In 2001, monitoring of drugs was enhanced when the National Board of Health, the National Commissioner of Police and the three institutes of forensic chemistry established an ecstasy database on chemical analyses of ecstasy pills seized in Denmark[31].

[30] The departments of forensic chemistry regularly analyze routine samples for the Ministry of Justice. Typically, the samples are submitted in connection with evidence produced in court hearings and are therefore not fully representative of geographical distribution, location, weight quantity, sampling date, etc. The samples often come from major seizures and therefore do not necessarily reflect the quality and distribution of drugs on a user level.

[31] Apart from the tablets containing MDMA (ecstasy), the database includes all seized tablets with a non-professional appearance based on their logo, colour and impression. Furthermore, the database includes tablets that have been proven to contain synthetic drugs or other euphoriant substances which are not natural ingredients of pharmaceutical products.

The ecstasy database systematically collects samples for analysis from all seizures of ecstasy in Denmark, which means large as well as small seizures. The pills are described in terms of drug concentration, drug mix and appearance. The database is a closed database, to which only the National Commissioner of Police, the National Board of Health and the institutes of forensic chemistry have access. The quarterly updating of analysis results as well as an extensive report is, however, available on the website: www.sst.dk/narkotika.

As part of the EU cooperation, photographs of ecstasy pills are sent to Europol with a view to determining whether ecstasy pills seized in various countries originally come from the same illegal production site.

In 2002, the institutes of forensic chemistry had examined a total of 22,701 tablets (Kaa 2003). Among this quantity, it is estimated that there are 116 different types of pills in terms of appearance and contents.

The pills are often white, beige or grey. However, 20% of the 116 different types of tablets also had other colours (red, blue, green or yellow). The pills are round, but can also be diamond-shaped or triangular. The samples taken in 2002 had 52 different logos, with Rolex and Mercedes being the most frequent ones, followed by Mitsubishi, which in 2001 was the most predominant logo. One third of the logos are only available in one variant, the others in several. For instance, in 2002, there were 13 different types of pills with a Mitsubishi logo and 10 variants of the Rolex logo. Pills with the same logo may vary in diameter, colour, weight, height, type and quantity of active substance.

Among the 52 logos found in 2002, 22 logos had not been seen before. These logos were: *B, Bacardi, Bulldog, Statue of Liberty, Harry Potter, Dog in Cherry, Love, Mercedes, Mortal Combat, MTV, Nike, Snoopy, Penis with Wings, Pikachu, Safe Sex- Durex, Casper the Ghost, Two Ticks, Wooden Shoes and Zorro*.

As regards ingredients, a large majority (92%) of the pills in 2002 contained MDMA alone. Approximately 5% of the pills contained MDMA and another stimulant (MED, MDA or metamphetamine), whereas 3% did not contain any MDMA but another active substance (MDS, 2C-I, 2C-B, 5-MeO-DIPT, amphetamine or metamphetamine). It was the first time that metamphetamine, 2C-I and 5MeO-DIPT was seen in Denmark. PMMA and PMA were not discovered in 2002.

The average quantity of MDMA per table was 66 mg in 2002, but the concentration of ingredients varied a great deal: The quantity of MDMA per table varied from 3-138 mg or from 1% to 62% of tablet weight.

Prices

In connection with the Street Plan Project, the forensic chemists received only scarce (7) information about drug prices, which made it difficult to say anything about prices.

In its report “Report on organised crime in Denmark 2002” the National Commissioner estimates that the street level prices for cannabis are approximately EUR 6.7 per gram (National Commissioner 2003). The average street level price per gram white heroin is estimated to be between EUR 161.5 and 188.4, whereas it is EUR 80 for smokeable heroin. Cocaine prices are estimated to be declining mildly with an average street level price of EUR 94 per gram. For amphetamine, the price per gram is estimated to be EUR 33.6, whereas the price for an ecstasy pill is estimated to be between EUR 6.7 and 16.8.

Chapter 6 Trends per Drug

This chapter deals with each main group of substances individually. Therefore, this chapter should be seen in conjunction with the previous chapters given that results from population studies, police seizures and treatment registers are included in order to provide an overall impression of the trends within the individual main groups of substances emerging on the illicit drug market in Denmark.

Cannabis

Cannabis has always been the most prevalent illegal substance in Denmark. Thus, approximately 10% of the Danish population aged between 16 and 44 years smoked cannabis within the past year, whereas approximately 3 % had tried other illicit drugs within the past year. Typical use is of an experimental/recreational nature during the years of youth. While the prevalence of cannabis for a number of years appeared to have stabilised, it appears from the most recent studies on self-reported use that there is an increase among young people under the age of 30 years. Although more men than women smoke cannabis, the increase is seen among both gender.

Among the 16-30-year-olds, the ones with a current cannabis use are young people of parents from the upper social strata. This pattern, however, does not replicate itself in the group of 31-44-year-olds where the majority of individuals with a current use are unemployed.

Data provided by the treatment sector indicate that cannabis addiction is the largest problem for a substantial portion of the group of younger drug users. The trend is that throughout the past few years, there has been an increase in the number of newcomers admitted to treatment and who report cannabis as their primary substance. Similarly, the figures available on receivers of psychiatric treatment suggest an increase in the number of individuals suffering from mental illnesses brought on by cannabis addiction – this development, however, is most significant in secondary diagnoses. The group of somewhat older drug users, however, rarely report cannabis as their primary drug, but more as a very important secondary drug (See chapter 15 on cannabis users).

Synthetic substances

Amphetamine

Studies conducted among the young people as well as in the population in general show that amphetamine is the second most widespread illegal drug in Denmark after cannabis. Its prevalence also appears to be on the increase up through the 1990s. The proportion of pupils in the 9th grade who report having tried amphetamine ever increased from 1.6% in 1995 to 4% in 1999. In the SUSY 2000 and MULD 2002 studies, 6-10% of the young people between 16 and 24 years of age report having tried amphetamine ever. Reports submitted from regional hearings also provide grounds for suspecting that amphetamine use is increasing.

Amphetamine, however, does not play a major role as a primary substance among drug users receiving treatment. In 2002, merely 4% of all drug users admitted to treatment reported that thy used amphetamine as their primary drug. However, amphetamine is frequently used as a secondary drug and may gain ground as a primary substance among new drug users receiving treatment.

Police statistics on amphetamine seized during the same period reveal major fluctuations year by year. Amphetamine is available all over the country in most police districts and counties.

Results from the Street Plan Project show a drop in amphetamine purity on a street level since the mid 1990s. The analyses of seized ecstasy pills also show that amphetamine is much less prevalent in the pills than previously. Less than 3% of all ecstasy pills analysed in 2001 contained amphetamine. In comparison 28% of all ecstasy pills contained amphetamine in 1998. It is not clear why the percentage of amphetamine in ecstasy pills has dropped so drastically.

Ecstasy

Ecstasy started to appear on the illegal drug market during the first half of the 1990s. The outcome of the population studies in 2000 and the MULD studies suggest that the prevalence of ecstasy does not exceed that of cannabis, amphetamine, cocaine or psilocybin mushrooms, since only around 4% of the young people had tried ecstasy ever. Regional hearings also substantiate the trend of decreasing or stagnating use of ecstasy.

Ecstasy still tends to be a minor problem among the drug users admitted to treatment. However, the number of individuals reporting ecstasy as their primary drug is increasing among new drug users receiving treatment.

LSD

LSD is far from a prevalent drug in Denmark. Previous studies among the population show that the prevalence of LSD is so limited that it has hardly been measurable. However, in the population study from 2000, almost 2% of the 16-24-year-olds reported having tried LSD ever.

Heroin and other opiates

The experimental use of (smokeable) heroin appears to be low and constant among the youth population. Around 1% of the 15-16-year-olds reported in 1995 as well as in 1999 that they had tried heroin, most of them having tried smokeable heroin (1.3% in 1999). Also the prevalence of heroin among young people between 16 and 24 years of age appears to be modest, given that very few (<1%) had tried this type of drug. The prevalence of heroin is thus so limited that it is difficult to measure in population studies.

Opioids are still the most used substance group among users receiving treatment. However, still a fewer number of people report opioids as their primary drug among those who have not previously been admitted to treatment, which might imply that the use of opioids in time will taper off among users under treatment.

Furthermore, a minor fall from 1996 up until today can be traced among injecting drug users admitted to treatment. One reason could be that an increasing number of addicts use smokeable heroin – perhaps due to the health risks associated with intravenous injecting drug use.

Heroin is also the most frequently appearing drug in the random samples collected for the street plan project. As mentioned earlier, percentages are, however, falling. At the same time smokeable heroin appears to account for an ever-increasing share of the heroin quantities seized.

Cocaine

Generally, it appears that cocaine is becoming more prevalent, and the police believe that this trend is continuing, one of the indications being an increasing number of seizures.

Similarly, regional hearings report about continued prevalence of cocaine among experimenting young people and as a secondary drug among addicts. From some places it is being reported that cocaine is becoming more prevalent than amphetamine. The assumptions on an increase in cocaine prevalence on the market are also substantiated by studies conducted on the experimental use among the 15-16-year-olds over the past 5 years. Results from population studies confirm that the presence of cocaine is increasing, with 4-5% of the young people aged under 25 years having tried cocaine.

Multiple use

The population studies reveal that often the young people who experiment with cannabis and other illicit drugs are the same ones who are heavy drinkers and daily smokers.

Around half of the clients admitted to treatment report being poly-drug users with cannabis, amphetamine, cocaine, alcohol, etc. being included as secondary drugs to a primary substance. However, this proportion dropped from 2001 to 2002. Also, the majority of patients admitted to drug-related psychiatric treatment are polydrug users.

Chapter 7 Discussion

This chapter will provide a summary of the main points and implications from the epidemiological section. This means a comparison of the various indicators applied in the previous chapter. Furthermore, the chapter will finally describe the current data basis and areas of priority as regards the development within drug monitoring in Denmark.

7.1. Consistency between indicators

Most of the indicators point towards an increasing use of cannabis. All reports from population studies, from the treatment register, from regional hearings and data on drug-related psychiatric admissions concur with this observation. Also, all population studies demonstrate that cannabis is the most prevalent drug.

Also, as regards drugs other than cannabis, most indicators point towards an increasing experimental use – especially with cocaine and amphetamine. This applies to the same indicators as the ones related to cannabis and for statistics from the National Commissioner of Police based on police seizures. All population studies suggest that amphetamine is the second most used drug after cannabis in the population in general. CNS stimulants, however, appear to a limited extent as a primary drug among drug users under treatment.

Ecstasy is less prevalent than amphetamine, in spite of the massive media coverage. This is documented in population studies as well as in most of the regional hearings. Ecstasy also appears rarely among users receiving treatment. However, this is inconsistent with the data on police seizures, which during the past few years have increased in numbers as well as in quantities. However, this could be explained by the fact that the police have focused a great deal on ecstasy.

The treatment register and data from the regional hearings state that opioids, including heroin, are the most frequent drugs taken by users. Heroin is also the drug appearing most frequently in random samples from police seizures and the cause of by far the most drug-related deaths. However, a decreasing share of heroin among random samples, data from the regional hearings and a falling number of opioid users among newcomers under treatment suggest that a drug problem involving CNS substances as the primary drug is evolving.

Police statistics on number of seizures as well as police records on drug-related deaths show an every increasing geographic dispersion of the illegal drug use during the 1990s. This means that to a large extent there is no difference in the type of drugs appearing in the various counties across the country according to the regional hearings.

Several indicators suggest that the use of drugs is about to become more widely accepted and that the attitude towards drugs is more liberal among the young people – also outside the traditional drug scene at techno parties and raves. This

is stated in the qualitative study from 1999 and in several of the regional hearings from 2002.

The most significant characteristic of experimental users and addicts is that the men outnumber the women. This is established in all population studies, in the treatment register, in data on drug-related psychiatric diagnoses and among the drug-related deaths.

Experimental use of illicit drugs is still a phenomenon primarily present during the young years, which is substantiated in the various population studies and the regional hearings. Drug use takes place in age groups from 15-30 years and reaches its peak among the 16-24-year-olds.

7.2. Methodological limitations and data quality

In 2002-2003, the National Board of Health has been working with new estimates on the number of drug users. These estimates which are outlined in Chapter 2 have been prepared on the basis of guidelines provided by the European Monitoring Center on Drugs and Drug Addiction. In future, the National Board of Health will prepare estimates regularly on the basis of the same guidelines in order to monitor trends and developments.

Chapter 8 Strategies in Demand Reduction at National Level

The overall Danish strategy to combat drug use is based on the report “Fighting drug use – elements and main problems” published in 1994 and prepared in cooperation with the Ministry of Health (today the Ministry for the Interior and Health), the Ministry of Justice and the Ministry of Social Affairs. Although the report dates back to 1994, it still forms the basis of the principles on which the combat against drugs is founded, the main line being a ban against any non-medical use of drugs combined with ongoing and balanced initiatives involving prevention, multi-pronged and coordinated treatment services provided to drug users and relentless control.

Action plan against drug use

In order to enhance common responsibility for, among others, drug users, the Government issued in October 2003 a consolidated cross-ministerial action plan – “The fight against drugs” -. The action plan was prepared by a committee of ministers and sets out the goals and means to achieve specific results within prevention, social treatment, medical treatment, law enforcement and treatment of criminal drug users as well as international cooperation.

The action plan provides for the launching of a number of specific activities (for further details, see Chapters 1, 9 and 11), which will be evaluated on an ongoing basis by the National Board of Health and form the basis of continuous adjustment of the Danish strategy with drugs and the initiatives launched.

Chapter 9 Prevention

National strategi

Three elements are traditionally included in drug prevention in Denmark:

- The drugs must be difficult to procure (prohibition)
- The information level must be high with a view to building principal barriers against drug use

The main objective of all prevention activities is to reduce the use of cannabis and other illicit drugs as much as possible - and to consider the problems, which potential users may encounter. The National Board of Health is the central authority responsible for the prevention of drug problems (informative material, knowledge-based data, advice, support to local prevention etc). On a local level, the counties and municipalities hold the overall responsibility. An intensified response to drug use has high priority in the government's 1994 policy platform on drugs. In addition to the broad and nationally oriented information campaign, the activities targeted at marginalized young people at risk must be supported and strengthened on a local level. Some of the ways to achieve this must be through development of methodology and strategies for:

- early identification and localisation of problem development and young people's risk behaviour
- contact and maintenance of sustainable relations to the young people and
- intensified cooperation between public, private and voluntary prevention aid organisations with young people as their target group and between professional groups, volunteers, parents and the young people themselves. .

Regarding expenditures on prevention, organisation and co-ordination within national structure please refer to chapter 1.

The fight against drugs

In its manifesto, the Government decided to enhance the common responsibility for, among others, drug users and issued in October 2003 a consolidated cross ministerial action plan "The fight against drugs". The action plan was prepared by a committee of ministers and sets out the goals and means to achieve specific results within prevention, social treatment, medical treatment, law enforcement and treatment of criminal drug users as well as international cooperation.

One of the main elements of the action plan is that the government will support and stimulate local prevention interventions by seeking and granting support to targeted cooperation with one municipality of each county. This cooperation must be carried out under the auspices of a three-year model municipal project "Drugs out of town". The overall objective of this project is to bring down the prevalence of drugs drastically in the local community through local and coordinated programmes. The more specific objectives of the project are to achieve significant reduction in the availability of drugs and in the number of young people who try and use drugs, as well as to reduce considerably the number of acute deleterious effects such as poisoning, drug-triggered psychoses and

violence and to ensure early intervention in relation to young people appearing to be on their way to drug use and to ensure special prevention intervention in relation to children living in families with drug use problems.

Experience from development project on ecstasy prevention in two model counties, North Jutland and Aarhus, 2002-2003.

The National Board of Health concluded the "Development project on ecstasy prevention in two "model counties" (2000-2003) by submission of its evaluation report at a national conference held in the spring 2003.

Project

The project was launched on the basis of increasing prevalence, increasing number of poisonings and more deaths caused by young people's use of ecstasy. The then minister of health, Ms Sonja Mikkelsen, took the initiative, and the counties of North Jutland and Aarhus were appointed model counties. The National Board of Health has been entrusted with a number of tasks during the project, heading a monitoring group represented by relevant ministries, the Danish Association of County Councils and the counties.

Objectiv

The model counties were to initiate and develop enhanced and broad-spectrum programmes to prevent against the use of ecstasy, etc among young people and to communicate experience gained on form, contents, extent and methods to the other counties in order for these counties to be able to step up their activities as well.

Focus

The development project had three main focus areas:
Municipal drug policies
Youth education
Party environment

Evaluation and communication

In order to comply with its obligation to communicate results, the project has been evaluated on an ongoing basis. Four news letters have been released (see for instance. http://www.sst.dk/faglige_omr/sundhed/Narkotika/nyhedsbrev/marts-02.pdf) See the evaluation on:
http://www.sst.dk/publ/publ2003/feststoffer_forebyggelse.pdf and
http://www.sst.dk/publ/publ2003/appendix_feststoffer_forebyggelse.pdf

Constructive experience

- Specialised knowledge has turned about to be necessary in order to target programmes effectively. Local drug studies determined the choice of focus areas. The studies also made it clear that drugs had to be dealt with on a broad basis, rather than on narrow issues such as ecstasy.

- Attention has been given to three new focus areas: drug policies in municipalities/institutions, youth education and party environments.

- The structure of a drugs policy as a framework for prevention intervention is important to enhance prevention on a municipal as well as an institutional level. However, it requires that the county provides counselling, and that the municipality/institution has the requisite managerial and political backing. Process guidelines have been issued to the municipalities.

- A “No-tolerance guide” against drugs in the nightlife has been published and accompanied by a website with background material. Also a course has been developed, aiming at the management and staff in restaurants. Experience has been gained in organising projects in cooperation with preventive consultants, police and the restaurant business.

- New methods have been developed in the work with drug prevention in youth education, particularly in production schools and technical schools where there is no tradition of working with drug prevention. A handbook has been published on how the educational institutions can formulate a drugs policy.

- County organisation of network for key personnel in local administration and contact personnel in youth educational institutions has been strengthened during the project period. These networks have proven to make up important knowledge sharing and qualification of these cooperation partners.

Some activities focusing specifically on ecstasy turned out to be futile. One example is the telephone helpline which was not used. Another is the emergency wards and treatment institutions that were supposed to cooperate on young people being admitted with ecstasy poisoning symptoms. This was not used because there were only very few cases of poisoning, and the person involved was not interested in receiving counselling.

The project has succeeded in establishing, in a positive as well as a negative manner, that cooperation and organisation are crucial to prevention intervention. This applies in particular because important focus areas on drug prevention are not guided by traditions, governed by law or controlled by resources for this type of operation (such as party environments and youth education). However, this also applies to the cooperation between county and municipality where this development project has demonstrated that fundamental organisation of prevention is necessary.

9.1. Programs in school

The school is perceived as the most important location for drugs information. This information is included as part of the subject “Health, sexual behaviour and family learning".

Training in health issues in the Danish primary and upper secondary schools aims at ensuring:

- that the pupils gain insight into the terms and values affecting health, sexuality and family life
- that the pupils gain an understanding of sexuality and the significance of family life to health as well as the correlation between health and environment
- that the pupils are strengthened in their personal development
- that the pupils develop a basis for being critical and taking a stance in order to further the health of themselves and others.

There are no fixed guidelines for the form, contents and scope of a drugs curriculum. Most often, educational drugs information is provided at the 7th-9th grade level. Typically, the teacher of the class will organise the sessions.

At many schools, the local SSP committee will provide drugs information at the schools and the role of the school in drug informative work is supported by the state and the counties. An SSP committee functions as formalised cooperation across sectors and consists of representatives from schools, social administration and police.

Drug prevention in primary school: A pilot study

In October 2002, the National Board of Health conducted a pilot study concerning the coverage of drug prevention in the primary and lower secondary school in Denmark. The pilot study was done in two selected counties (Northern Jutland and Frederiksborg). The table below covers 16 municipalities (76 schools) in the two counties (out of 270 municipalities). Consequently, the present study is not representative of the situation in Denmark. The questionnaire was distributed to key-persons, such as contact-persons at the schools or local representatives of the municipal SSP committee. This SSP consultant/coordinator is typically a school-teacher or a professional working with social administration or health promotion.

As mentioned, there are no systematic school-based programmes in Denmark, but it is possible to identify different approaches/methods or “types of interventions” as the 11 categories below in the table shows. The ”type of interventions” are being used by the teachers and SSP consultant themselves to describe the interventions. Regarding the intensity per year of drug/substance preventive interventions, the pilot-study shows that the average in 6th to 10th grade is 2-3 days with a variation ranging from 1-2 lessons (45-90 min,) to one week.

Feature day	12%
Feature days	7%
Prevention integrated in other subjects (biology, social subjects, etc.)	15%
Role play	4%
Project work	16%
Play in form of a dialogue	6%

Future workshops/Scenarios	1%
Peer Based	4%
Events for parents	18%
Events for parents and pupils	14%
Campaigns	3%

Government activities and school

At the governmental level, the National Board of Health is the executive body within drugs prevention. One of its tasks is to support and stimulate local preventive activities, ie school initiatives.

The National Board of Health works with two prevention strategies which are supposed to supplement each other: the broad, informative work aiming at the population and the narrow work focusing on high-risk groups.

Drugs information aiming at the population must ensure a high knowledge level among the young people, their parents and professional groups working with children and young people, thereby supporting a negative attitude towards drugs. It is being considered of importance that informative material on current drugs is available, that key persons and the press are constantly informed and, in particular, that every single new vintage of young people is well-informed via systematic information in school.

The intervention vis-a-vis high risk groups aims at those in need of a social framework and activities providing an alternative to drug use. In this connection, the National Board of Health focuses on the professionals who are in contact with the high risk groups.In this field in particular, the work of the National Board of Health is aimed at the professional groups who are in contact with the high-risk groups and is a supplement to the activities carried out in the social area.

The Board's drug intervention activities are developed in cooperation with the county alcohol and drug counsellors and the medical officers of health. This work includes model projects, development of informative and education material on drugs as well as meetings, courses and seminars for professionals (school teachers, pedagogues), volunteers and other key persons working with drug problems on a local basis.

Topical drugs information is published in the UNG magazine issued free of charge by the Committee for Health Information 4 times annually to pupils in Denmark in the 8th to 10th grade (14-17 years). As part of the information work about drugs in Denmark, the National Board of Health has established its own website with drug information containing facts on the effects and risks of drugs in the form of the drug pamphlets, educational material, articles and a "wheel of fortune", in which the young people can test their knowledge about drugs (www.sst.dk).

Regional level

According to the Danish Act on Public Social Service, the counties and local government are obliged to further local preventive and health promoting

activities. Initiatives involving drugs are especially launched by the alcohol and drug counsellors in the counties.

A number of counties have established their own prevention councils engaged in, among others, drug use. A number of major municipalities have also employed counsellors to handle their drug prevention services. The county alcohol and drugs consultants offer educational and informative sessions for the 6th-10th grades, their teachers and their parents. The services range from help and guidance on the organisation of each teacher's classes to large-scale campaigns of a local or regional nature. The county alcohol and drugs counsellors prepare – sometimes supported by the National Board of Health and others – materials and instructive activities for the purpose of creating a debate and inspiring school children to take a stance. Furthermore, it must be ensured that the county educational centres continue to have teaching material and films to support the teachers in their teaching about drugs in the schools. The teachers are invited to participate in informative meetings about the most recent material and the most recent knowledge within the field.

Example: www.netstof.dk

On a regional level, the counties and two municipalities in Denmark have entered into cooperation on the website www.netstof.dk which primarily addresses pupils in the 8th and 9th grades through interactive measures such as chats, conferences on selected issues and readers' letters answered by a team of 6 individuals (police officer, doctor, psychologist, former addict, drug counsellor and a supervisor).

During 2001/2002, www.netstof.dk was updated in a new version and extended with an intranet which is supposed to strengthen the cooperation and exchange of experience between the alcohol and drug counsellors by adding project descriptions and evaluations to the intranet. The National Board of Health granted financial support to the establishment of the intranet in which the Board will participate as part of enhancing mutual exchange of information.

Example: Education of peer drug counsellors

In 2002, the Copenhagen Municipality started the education of, to begin with, 16 young drug counsellors aged 21-27 years. The services of the drug counsellors will be offered to the young people in the upper grades of the secondary school and in youth educational institutions. Their job will be to inform about the effects and risks of using tobacco, alcohol and drugs. Furthermore, they are supposed to create a dialogue with and among the young people about their use of drugs, about norms, attitudes and myths associated with the use of drugs. They are also supposed to inform and know about the possibilities of treatment in the event that the young people contact them for help in case of over-dose or misuse.

Objective

- To convey relevant and worthwhile knowledge about the effects and risks of drugs to young people and parents of teenagers
- To start a dialogue with and among young people about their use of drugs
- To have children reflect on the need for starting to smoke in order to reduce the number of new smokers
- To have young people reflect on their own use of drugs in order to reduce the number of young people who either overdose or misuse drugs.

Target group

- Pupils in 7^{th}-9^{th} grade
- Pupils under youth education
- Members of youth clubs
- Parents
- Teenagers

Introduction and dialogue will typically run for two lessons (90 minutes), but depends on the needs of the target group.

Contents

The drug counsellors use the peer communication form to inform about the various effects and risks of drugs – and to start a dialogue with and among the young people about the use of drugs: Why? When? Where? How much? Why at all? Should one say yes or no?

A manual is prepared and is supposed to function as a management and aid tool to ensure that the counsellors touch on all relevant subjects, teach on the basis of advance knowledge about the target group and have the professional knowledge about drugs. The 16 young people are recruited and trained in teaching about drugs and in peer dialogue technique.

The work of the counsellors will be evaluated on an ongoing basis via feedback from the target group by use of evaluation sheets. Joint meetings will be held for the group at least once every three months with a view to collecting experience gained and discussing further education if necessary.

9.2. Youth programmes outside school

Danish social legislation provides that it is the responsibility of the city councils to ensure that older children and young people receive the requisite club and leisure services offered as a socio-educational measure. In cooperation with the older children and the young, these services must form the basis of activities and social settings promoting the versatile development and independence of the individual as well as the individual's ability to enter into a committing relationship. To the private club schemes offered to older children and young people, the municipality may grant a certain amount per child or youth. The city councils must ensure that objectives and framework are established for the service

activities as an integral part of the municipality's leisure, prevention and supportive intervention in relation to children and young people. This type of service is available in almost all municipalities.

Youth schools

Pursuant to the Act no. 679 of 1 August 1995 on youth schools in Denmark, all municipalities must provide services for children and young people aged from 14-18 years. The services of the youth schools are a supplement to the primary and lower secondary schools. Participation is voluntary and structured in such a manner that the young people themselves have an influence on activities. The preamble of the Youth School Act is based on young people's educational needs as well as the needs of society. Youth school services must comprise: General, courses preparing for examination, special courses and Danish language courses targeted at young immigrants. Approximately 50% of all young people in Denmark avail themselves of the services provided by the municipal youth schools.

The youth schools are particularly well prepared to enter into prevention intervention given that they are in contact with the broad group of young people as well as the marginalized groups.

Local projects among the young people

A large number of municipalities have launched projects and initiatives as well as special socio-educational clubs.

A number of the activities were established on the initiative of the SSP committees. In all these initiatives, the preventive aspect in terms of drugs is included either as a general and/or a specific aspect.

Outreach work

As part of their working method, many local SSP committees have chosen to hire a person engaged in outreach work – a so-called "street-worker", who is familiar with the local environment and who gets acquainted with the youth population and becomes their confidant/confidante. The street worker is perceived as a local resource person who must intercept signals and inspire young people to become integrated into the leisure activities available locally in the form of youth clubs, associations and other activities, and contribute to establishing alternatives to the current ones where the need may arise. Furthermore, the street worker will be able to provide guidance and refer young people to the right help when such needs arise. Especially, the street worker will be able to refer to municipal and county centres, which have the proper expertise to help young people with addiction symptoms.

9.3. Family and childhood

The prevention measures taken during pre-school age are of a general nature. This work includes preventing health-related, social and personal problems with the children, but does not at this stage specifically address the prevention of drug use. The prevention during pre-school age includes a number of activities based on legislation within the social area and the health care system. Using social legislation as the basis, all municipalities provide comprehensive educational day care services to pre-school children and special services on counselling and

support to socially deprived families. The municipalities are under a special obligation to intervene if children are living under socially threatening conditions. This safeguarding of social welfare is considered to have preventive effect (The Social Services Act).

The law on preventive health schemes for children and young people comprise all children and young people under the age of 18 years. The law provides free services to all children in Denmark under the age of 18, and the scheme is financed by the municipality, which also decides and determines resource consumption. The general practitioners are responsible for the preventive examinations of children before they start in school.

During the children's first 2 years of life, the family is offered home visits by a nurse approximately 4-8 times. Where justified by special needs, the family is paid additional visits by the nurse. During the nurse's visits the child's welfare and development, motor as well as emotional, are discussed, as is the contact between the mother and her child.

Having reached school age, all children are offered two medical examinations, an examination at school start, and one at school end and health sessions with the school nurse. The sessions are conducted in groups, individually or in class. The contents of the sessions are about lifestyle, sex, birth control, puberty, drugs, etc. The school nurse also has opening hours for the students, during which appointments can be made.

Several municipalities work together with counties on addressing the problems of children living in families with addiction problems. Through outreach work in the local institutions, schools and social administration, the authorities prioritise the preparation of guidelines for recommended activities in cooperation with institutions, etc in order to secure that the children receive the necessary support (see also the annual report of 2001).

Example: Families with drug user problems

In 2002/2003, Foldbjergcenteret in the county of North Jutland has carried out an analysis of experience gained from a 14-day course addressed to families with drug use problems. The analysis concludes that it has become easier to handle recurrent drug use because the family reacts more quickly and the user him/herself also becomes aware of an imminent problem. Children in this type of family have met others in the same situation and feel that "a load has been taken off their shoulders", because they are able to talk about their problems – with their parents as well as with other adults and friends. Furthermore, it was pointed out that it has become easier for the spouses to talk together about the drug use problem due to a higher understanding of each other's situation (see also http://www.fc.nja.dk/Foldbjergcentret/tilbud/privatpersoner/familietilbud.asp)

Prevention in recreational settings

Concurrently with the increasing prevalence of drugs and party drugs in night life settings, central as well as local authorities have reacted with a number of programmes targeted at limiting the availability of drugs in the party environment

Development of ecstasy prevention in two "model counties". Focus on the party environment

and reduce health-related injury caused by drugs. Thus during recent years, there has been an increasing interest among local authorities in having a closer cooperation established between actors within the field (local government, local police and restaurant owners). A few municipalities have formulated a local drugs policy, in which the local commercial party environment makes up a central focus area.

A sub-project "Focus on the party environment" under the "Development project on ecstasy prevention in two model counties" (see annual report 2002) was launched, including courses and a guide for restaurant owners and employees in the commercial party environment (see evaluation at: (http://www.sst.dk/publ/publ2003/feststoffer_forebyggelse.pdf)

The Association of Chiefs of Police in Denmark has written an "Ecstasy Report", including a number of recommended initiatives in party settings based on police work (see: http://www.jm.dk/image.asp?page=image&objno=63320).

Furthermore, a working group under the Danish Crime Prevention Council has drawn up a report describing a proposal for amendments of regulations for pub owners and formulating a number of ideas for "a safer framework for young people in nightlife settings" targets at local government, police, sports associations and organisers of "large private parties" (see: www.crimprev.dk/pdf/ungeibyen.pdf)

Local experience from work with party settings

Quarantine policy

In cooperation with the businesses within party settings, the policy in Randers and Aalborg have launched a quarantine policy, under which individuals may be imposed a 2-year quarantine period in cases involving serious violence and violation of drug legislation. In Aalborg, the ban has not been limited to the business itself, but applies to all the restaurants and pubs in Jomfru Anegade and the adjacent streets (the entire area, in which a large number of them are located).

The effects of a quarantine are more effective vis-a-vis the young people than the warnings and small-scale fines triggered as a result of drugs possession. The restaurant owners find the arrangement more advantageous, since it is the police, not the restaurants, who stop unwanted persons from gaining access. The public ban renders it easier for the restaurants to reject unwanted guests. In the event of a few restaurants experiencing drug problems, the police have demanded better lighting, supervision and remodelling of the toilets so that drugs cannot be used openly.

Persons under the age of 18 not allowed

In connection with the increasing ecstasy problems, Aalborg municipality adopted a rule in their restaurant plan, under which the restaurants are not allowed to let young people under the age of 18 gain access to the restaurants after 12 o'clock midnight. The restaurants are satisfied with the rule, because it

results in older guests and fewer problems.

If the above rule is violated, the restaurant owner will be imposed a fine of EUR 40.4 per minor present in the restaurant. On repeat violations, the night license may be suspended – often leading to major losses for the owner of the restaurant.

Police approval of doormen
Today, the police in Aalborg and Randers must approve of all doormen in Jomfru Anegade and Storegade. This implies that the doormen must not have a criminal record in cases involving violence, offences against property, handling of stolen goods and drugs. These approvals have meant fewer problems and well-functioning cooperation with the doormen. The close cooperation between the police and the doormen has meant that it is no longer difficult to find witnesses in cases of violence in Jomfru Anegade. After the doormen have been given a direct, open telephone number by the police, they are more inclined to filing reports about violence, which they have either witnessed themselves or have been involved in.

Restaurant owners are not exposed
The cooperation between the police and the restaurant owners has meant that the police has launched a press policy which abstains from "crucifying" individual restaurant owners unnecessarily. This applies in particular to the restaurant owners who are most cooperative with the police and therefore could attract some attention. If trouble arises in the nightlife of Aalborg (Jomfru Anegade), the restaurants are jointly and severally liable for their problems in relation to the press.

"No tolerance guide"

"No tolerance – a guide on drugs at night" is the result of the sub-project mentioned above "Focus on party settings" under the "Development project on ecstasy prevention in two model counties".

The purpose of the guide is to focus on the work in party settings through the preparation of a guide based on experience from a number of courses aiming at restaurant owners and employees in the commercial party industry in the two "model counties". The no-tolerance guide provides a number of specific guidelines as regards:

- appropriate structure of physical framework,
- proposal for preventive initiatives/guidelines adapted to the employees' various work functions,
- the image of the drug-free restaurant, and
- proposals for strengthening of cooperation
- first-aid aiming at drug-affected/poisoned guests
- drug facts about the most used drugs

The guide has been distributed to all the relevant restaurants in the counties of Aarhus and North Jutland. It is being planned to distribute the guide to all the countries in Denmark.
(See the guide on www.nultolerance.dk)

Roskilde Festival Against Drugs

In January 2003, the Roskilde Festival contacted the National Board of Health to seek advice as to how the organisers could launch a campaign aiming at attitudes towards drugs and prevention against drug use at the Festival.

Based on this, a large-scale campaign was launched at this year's Festival, including the use of mass media and informative material. The campaign was a supplement to established harm-reducing and controlled measures at the Festival. The campaign was based on best practice experience with the prevention of drug use among young people and experience from other international festivals.

Overall goal:

- To firmly establish Roskilde Festival's attitude towards drugs and emphasize that drugs do not necessarily walk hand in hand with drugs and socializing.
- To help the young people understand that they should not use drugs

Subgoals:

- To launch a wide-spectrum campaign focusing on attitudes and prevention against drug use through mass media effects and informative material. The mass media effects were supposed to stir attention and debate about drugs within the target group. By providing targeted fact information about drugs, it would be possible to add quality to the debate and furthermore help the young people understand that they should not take drugs.

The results:
The campaign and its messages about attitudes and prevention was obvious during the Festival for the more than 75,000 paying visitors and 20,000 volunteers at the Festival. Messages were flashed on outdoor media, in the festival programme, the festival website and on large screen spots on all the large stages immediately prior to each concert. Based on the number of distributed drug fact pamphlets, there appeared to be a large need for this type of information. Thus, during the festival 6000 post cards were taken and 4000 pamphlets handed out with factual information about drugs. The pamphlets and the post cards were available in the four information booths at the Festival (more information at: http://www.roskilde-festival.dk/object.php?obj=30f000c).This is what has been observed so far from the Roskilde Festival Against Drugs. This experience will be used in the ongoing prevention intervention carried out at other festivals and party settings. The project is described in the EDDRA database (http://www.reitox.emcdda.org:8008/eddra/).

Internet Example: www.mindblow.dk

The primary target group includes young people aged 15-25 years, which has determined the design and wording of the website. The secondary target group includes teachers and relatives of young (potential) users. The website is: www.mindblow.dk.

Chapter 10 Harm Reduction

In recognition of the fact that not all drug users are interested in treatment, that many relapse into drug use and that as a result of the Danish tradition of caring for all weak citizens irrespective of the causes for their social and health-related problems, various harm reduction activities are crucial, cf Part 33 of the Social Welfare Act.

Definition and goals

As a supplement to treatment services, projects have been implemented on the philosophy of reduction or drug-related harm or minimisation of drug-related harm for the group of drug users to which a drug-free life is an illusion in the short or long term. Reduction of drug-related harm means *minimising the damage that life as a drugs addict inflicts on the drug addict, close relatives and the society and to improve functional capacity and development potential.* Projects of a harm reducing nature could, for instance, be activities such as outreach street plan work, “drop-in centres” (low threshold services) syringe exchange programs and social support at home.

Current public/professional discussion

As mentioned in chapter 1, a group of experts represented by personnel from the health care and social sector as well as the justice system, was appointed in September 2001 with the aim of identifying focus areas for the most deprived drug users. The expert report was submitted in February 2002 and contained, among others, recommendations related to reduction of drug-related harm, such as free vaccination against hepatitis B and the preparation of an action plan to minimise the presence of hepatitis C, for which no vaccine is available, and an outreach health service aiming at the most deprived drug users. The expert group also found that clean needles have a significant harm-reducing effect in the form of reduced risk of infection.

- As regards injection rooms, one of the members of the expert group was unequivocally in favour of the establishment of such rooms. This strong support was based on the principle that a fundamental element of social policy is harm reduction, for which reason nothing that may contribute to improving the conditions of the very deprived groups should be untried. The other members of the group would neither directly reject, nor disapprove of the idea of establishing injection rooms, but were only more reserved and hesitant, as they were not equally as convinced that such rooms would significantly improve the health-related social condition of those using the rooms. The majority also found that the means granted for the establishment of injection rooms would be more appropriately used on various treatment forms such as intensified psycho-social programmes and other low threshold services. The expert group would not consider whether injection rooms were compatible with the international drug conventions. However, the Government has subsequently stated that the establishment of injection

rooms in Denmark will be in contravention of the UN drug conventions which solely allow the use of drugs for medicinal and scientific purposes. The International Narcotics Control Board (INCB) has acceded to this interpretation as well.

10.1. Description of interventions

In its cross ministerial action plan – "The fight against drugs" – the Government followed up on the recommendations made by the expert group, and one of the issues of the action plan is that the government, based on the evaluation of a project of targeted health services provided to the most deprived drug users, will consider the need for and possibilities of establishing such services as permanent programs in particularly affected city areas. In relation to a minor group of drug users suffering from or threatened by severe health complications, the government is also contemplating an upgrading of a methadone injection scheme which is presently being tested on a trial basis. Furthermore, the government will also give high priority to an arrangement with early and free vaccination against hepatitis A and hepatitis B as well as free vaccination of relatives of drug users against hepatitis B and launch initiatives to reduce infections caused by hepatitis C. Finally, the government will focus more on persons with double diagnoses, ie mental illness and drug use combined.

Specific projects: "The fight against drugs"

The Government, however, rejects motions including the possible legalisation of cannabis, establishment of injection rooms and heroin prescription given that these issues are too far-reaching and in contravention of the core element of the Danish drugs policy and, in the case of legalisation of cannabis and establishment of injection rooms, also in contravention of the international drug conventions.

Outreach work: Project in Copenhagen

From October 2001 to 2004, the City of Copenhagen will be working with a pilot project including more focused health care services provided to seriously deprived drug users.

The project includes activities such as tracing of and establishing contact to homeless and addicts who on a more or less temporary basis move about in the streets or who have been admitted to some kind of shelter for the homeless. It is expected that contact will be made to approximately 50 people, who will be regularly replaced by individuals from a target group of approximately 500 people (the Ministry of the Interior and Health).

The focus of this pilot project is the perception that the social efforts are crucial if health care goals are to be achieved. The activities must therefore motivate the individual user to change and to be responsible for his/her own life. The outreach work will thus involve contacting the case handler and a shelter. Furthermore, the outreach worker will seek to motivate the drug user and to establish contact to drug use treatment services as well as draw up individual social action plans.

The medical services of the project include diagnosis, treatment and follow-up on HIV, hepatitis, local infections, fungus and other skin infections, bladder infection,

urinary tract infections, etc as well as healing of ulcers and other injuries. The medical part of the project is set up in a treatment institution, where the health care and addiction counsellors are present. The project has hired 4 outreach social workers, 5 nurses, 1 doctor and 2 nursing aids.

”Nurses on wheels”

In 1999, a project using outreach nurses for the homeless and the socially excluded “Nurses on Wheels”. The project, which is a five-year pilot project, funded by Egmont Fonden employs two nurses as the permanent staff and 2-3 permanently associated volunteers (The Ministry of the Interior and Health).

In 2000, the project had approximately 20 daily contacts and long-term programs with approximately 25 people. The nurses have had permanent parking booths as well as a regular evening route.

In addition, there have been some more intensive programs with the most deprived users. They were followed very closely, one of the intentions being to show how often they become a plaything tossed about in the system and to assist in producing the necessary action plans. Furthermore, the project workers have accompanied the users to the emergency wards and visited the institutions for the homeless.

An external evaluation was made by the Centre for Nursing and Care Research under the University Hospitals in Denmark. This evaluation focused on the following formulated methods:

- doing something actively to solve problems – ie continuing until the problems in question were resolved best possible (for instance by referring treatment to other professionals)
- focusing on accompanying (”taking people by the hand”).
- having employees acting as role models for the users and as communicator/facilitator between users and other professionals.

Syringe programmes

Syringe programmes are a preventive measure addressed to injecting drug users with the aim of giving them clean needles in order for them to avoid HIV and other blood borne infections.

In 10 of the counties and in the Copenhagen and Frederiksberg Municipalities, exchange schemes had been established. In the 3 remaining counties and in the regional municipality of Bornholm, no schemes had been established. Most of the counties that had established exchange schemes had a pharmacy administer the scheme either through dispensing/sales at the pharmacy or by having the pharmacy stand for “operation” of one or several dispensing machines with clean needles in public sites or toilets. Only in a few places had the scheme been expanded with exchanging needles from users’ rooms, boarding houses or shelters. Almost all places with an exchange scheme had established some kind of collection of used needles/syringes.

Most of the places, no user payment was required on receiving syringes from pharmacies, one place had introduced restrictions (1 free syringe set per day), whereas several places charged payment when drawing syringes from dispensing machines (EUR 0.7-1.3 per syringe/needle set). In 8 of the counties and in the City of Copenhagen, measuring cups were dispensed together with syringes and needles – most places together with a cleaning serviette and cotton.

Copenhagen Municipality

In 2002, the Copenhagen Municipality dispensed 368,976 syringe tool sets, 592,018 needles and 25,395 syringes through pharmacies, shelters and from a so-called needle bus (the needle bus was closed in 2003 and syringes and needles were dispensed from the shelter known as “Mændenes Hjem”). The number of syringe tool sets dispensed dropped a little, whereas needles dispensed rose compared to 2001 and the number of syringes fell moderately. (Unpublished figures from the planning and Public Health Office, Copenhagen City Health Care Administration). Used syringes are collected from needle boxes placed around the town and volunteers from the Users Association (Brugerforeningen) do a great job in collecting used syringes and needles from the streets.

In the municipality of Copenhagen, approximately 3000 kg used syringes and needles are collected annually from the dispensing locations and from other containers established for this purpose.

Syringe programs in the prisons

There are no syringe programs in the Danish prisons. The Prison and Probation Service is of the opinion that access to clean syringes and needles may have an adverse effect on the number of addicts who have previously been injecting drug users, and who, during their time in prison, either fully or partially abstain from injecting drug use. Further, the Prison and Probation service believes that an additional number are likely to start intravenous drug use, that intravenous drug use could be perceived as being legal and that it could lead to larger prevalence of the drugs in prison if such programmes were introduced. Instead it has been decided that the prisoners should have free access to cleaning fluid (household alcohol containing 4.5% sodium hypochlorite). (The Ministry of the Interior and Health).

The Danish Prison and Probation Service provides no treatment programs or similar services aiming directly at the increased risk of overdoses/injuries associated with release from an open institution. However, as it is outlined in Chapter 12, a major effort is made to integrate drug users into relevant treatment programmes. Furthermore, the staff in the special prison departments for drug users are aware of informing the prisoners about the risk of suffering from an overdose after a longer drug-free period.

Vaccines

In March 1999, the Directorate under the Prison and Probation Service laid down that intravenous drug users in prison should be offered a test and, if necessary, a prophylactic vaccine against hepatitis B (the Ministry of the Interior and Health).

As part of the admission procedure of receiving treatment in Frederiksberg Municipality, all new clients are offered a blood test. If they are not diagnosed with hepatitis B, they are offered a vaccine. If they are diagnosed with hepatitis C, they are offered follow-up examination. During these visits, they are also informed about hygiene and spreading of infections.

Since 1 January 2002, the City of Copenhagen has offered blood testing and hepatitis B vaccination to all drug users free of charge. This vaccination is given at the counselling centres, treatment centres or at the general practitioner's. The drug users have received a very colourful brochure, which has also been distributed to the various institutions in contact with the drug users.

Users rooms / Safe injection rooms

During recent years, an increasing number of "drop-in centres" have been established around the country and today there are more than 70 drop-in centres in Denmark. Also a national association has been founded, the "National Association of Drop-in Centres for drug users and former drug users", the objective of which is to improve the conditions of the drop-in centres, of which many are user-controlled. Most of the drop-in centres and the various housing alternatives are subsidised. They are either established by public organisations, or by private organisations (NGOs) and receive public subsidies either fully or partially. There are a number of drop-in centres solely to be used by female prostitute drug users. The oldest one is "Reden" (the Nest) in Copenhagen which was set up by the local YWCA's social work (the place is partly government financed).

Chapter 11 Treatment

11.1. Treatment in general

Since 1996, the responsibility for the social as well as the medical drug treatment has been coordinated in the county addiction centres. These centres refer addicts to all kinds of drug use treatment, be it slow withdrawal, outpatient treatment, substitution treatment, in-patient treatment, or be it treatment in the county's own institutions or a private institution. From 1 January 2002 financing rules were changed, cf. Chapter 1. Only prolonged treatment in the private treatment institutions, which is financed by the addict and treatment during imprisonment (also publicly financed), do not fall within the county referral procedures.

Quality assessment of methadone treatment

As a crucial element in the Government's action plan – The fight against drugs – the Government plans to prioritise the launching and completion of a quality assessment of methadone treatment as a basis for future quality assurance and development in line with the services provided in the remaining parts of the health care system.

Detoxification, slow withdrawal and weaning

As part of the treatment, detoxification of the addict is made free of charge in private and public institutions and treatment centres through initiation of drug-free.

Slow withdrawal is made either as outpatient treatment or as in-patient treatment. The outpatient treatment is normally provided after contact to a county counselling centre, to which referral is made for the patient to talk with various treatment providers. This could, for instance, be a conversation once weekly and slow withdrawal and follow-up supportive sessions. These outpatient services could be followed up by in-patient treatment.

Slow withdrawal may also take place in connection with starting in-patient treatment services, where the goal is to become drug-free. These institutional stays may be private institutions, but the expenses are paid by the state if referral has been made though a county addiction centre.

The vast majority of inpatient services provided to drug users are intended to deal with drug use combined with social problems.

Double diagnoses

However, where treatment is offered to psychiatric patients who, apart from their psychiatric diagnosis, e.g. schizophrenia, also are diagnosed as drug users ("double diagnosis patients"), these patients are often treated in the psychiatric system, for instance in the psychiatric hospitals or in a social psychiatric in-patient program in the social system. The treatment of drug users outside the psychiatric system is provided in the social system.

Inpatient treatment is provided by the counties under Section 93(1), 2 of the Danish Social Services Act, and other care-related and supporting housing services fall under Sections 91 and 94 of the same Act.

Treatment services may be divided into a) in-patient treatment, which again can be divided into drug-free in-patient treatment and methadone stabilisation, b) the outpatient drug-free treatment, c) outpatient substitution treatment which predominantly consists of methadone treatment and treatment with buprenorphine, d) the outpatient psycho-social services and finally e) the more care-oriented and socially oriented services provided to an increasing extent in drop-in centres. The care-oriented services are especially targeted at the most deprived drug users who in most cases either are or have been opioid/heroin users.

In-patient treatment

Today, there are approximately 40 in-patient institutions. The reason for the inexact figures is that these institutions come and go. 6-8 of these institutions are publicly financed. The remaining in-patient institutions are mostly privately owned institutions or owned by a fund.

Out of the 35 institutions participating in a current study (DANRIS), 5 provide methadone stabilisation. Methadone stabilisation is an in-patient treatment services aiming at the clients in methadone treatment with the purpose of reducing their secondary drug use to a minimum and establishing an everyday life with social and employment activities which may help them form a structural living and develop social competencies.

The same 35 institutions have a capacity of 845 slots (June 2003). The general size is between 10 and 40 admitted drug users (some more, some less).

If capacity were fully utilised on a constant basis, the county expenditure on treatment at the 36 institutions would be approximately EUR 4.8 million per year. Utilization of capacity is currently being reviewed, but is estimated to be between 60-80%. The private institutions do not appear to be more expensive than the public ones. However, it is difficult to compare treatment expenditure in the two organisation types, which have completely different conditions and which to some extent are also aimed at different types of drug users.

Programmes and methods

The above 35 in-patient institutions provided the following program/methods: 11 Minnesota institutions (12-step treatment), 17 socio-educationally oriented institutions, 5 religiously founded institutions and 2 hierarchic therapeutic communities (Phoenix House) and 1 Italian inspired institution (in principle, a socio-educational institution).

Many of the above 35 institutions are closely located to integration dwellings/halfway-houses. Several of the Minnesota institutions practice a form of treatment, in which they combine elements and understanding from the Minnesota philosophy/12-step program with socio-educational principles. The

Minnesota institutions predominantly use former drug users as treating personnel. The same principle, however to a smaller extent, is applied at Phoenix House and the religious institutions. The socio-educational institutions mostly employ socio-educationally trained personnel who in many institutions are supplemented by a few former drug users.

Most of the institutions offer a detoxification and stabilisation program, whereas a number of institutions provide short-term relapse treatment services. Finally, two of the socio-educational institutions are particularly oriented towards family treatment.

How deprived are drug addicts in in-patient treatment

The 35 institutions have, so far, registered 2860 persons admitted to treatment within the past 2 years. Records on the first 1879 individuals who have been discharged from treatment show that half of them had completed treatment, and that those who complete treatment in particular are aged 30 and above. The high completion rate is somewhat attributable to the short admission period and poor data quality (those who drop out early during the program are not registered). The drugs addicts who, prior to their admission to an in-patient institution, are the most deprived (EruopASI = European Addiction severity Index) are women in prostitution and male drug users in methadone stabilisation treatment.

In the two Phoenix House institutions we find the youngest men who have a long criminal record and are heavy drug users without having been admitted to methadone treatment. In the religiously oriented institutions we find the oldest users with most physical and mental problems and who to a higher extent also are alcohol users. The two largest groups of institutions, the Minnesota and the socio-educational institutions, are slightly different with clients at the Minnesota institutions to a higher extent using heroin and receiving methadone treatment prior to admission. 9.5% of the 1980 users who have answered this question report that they have tried to commit suicide within the past 30 days prior to admission. 34.8% of the same group have had suicidal thoughts.

Outpatient drug-free treatment

In connection with obtaining information on the drug user's social history, the institution will draw up an action plan based on the individual drug user's situation. This means that the outpatient treatment is key in the treatment program, in which it may be possible to allow for in-patient treatment.

The treatment consists of planned counselling programs including individual or group therapy, social measures such as: activation, rehabilitation, housing services and health care services, care and support. As part of the treatment program, actual educational services may be provided, taking the form of daily school activities and thus in principle be similar to the programs offered to the unemployed, or the program may allow for "pre-rehabilitation", which is a service provided prior to an "ordinary" rehabilitation program.

Outpatient drug-free projects are categorised as follows: a) Outpatient drug-free projects which must be considered as drug-free post treatment for drug users

who have been subjected to long-term drug-free in-patient treatment, b) outpatient drug-free projects targeted at slightly younger and normally not yet considered a group of deprived addicts and c) outpatient drug-free treatment after short-term in-patient treatment, if necessary combined with a period in a halfway-house (combination treatment). The latter treatment (point c) is being included in projects to an increasing extent. Such a project is currently being evaluated.

Outpatient drug-free local treatment

Outpatient drug-free local treatment is a combination of pure outpatient drug-free treatment and a special local flat-sharing scheme offered to a minor group under the same drug-free treatment. 67 heroin users participated in a study of such a combinatory project. In the most significant areas, they were comparable with drug users subjected to inpatient treatment in general. However, there were fewer women and a larger number of users who had not been using heroin for the past 30 days up to the start of treatment. One year after completion of treatment, 25% were still drug-free and had been so for the entire period. The result is measurable with other inpatient treatment, however it was found that those who lived together and who had not used heroin for the past 30 days were the ones who had the most successful outcome. Those who did not succeed were the ones who prior to admission had received methadone treatment combined with heavy secondary use.

Effects from drug-free treatment

In a study conducted on 829 drug users in drug –free treatment 2000 it was discovered that 36% had completed treatment as planned. This group of 829 individuals included only drug users who had completed detoxification and had started actual drug-free treatment. The admission period for the 829 addicts was 211 days, median 166. Drug users who dropped out of treatment had been hospitalised for an average of 147 days, median 119. Drug users who completed the treatment were admitted on average for 297 days, median 260. (Pedersen, M.U. 1999 and 2000)

Recent results from the new in-patient treatment project (DANRIS) shows that approximately 15% do not complete the detoxification process. Also, the duration of admittance appears to have been reduced during the past few years (median, less than 100 days), which not surprisingly has led to a higher completion rate (more than 50%). Due to poor data quality, the number of days in treatment as well as the completion rate are, however, assumed to be even lower.

326 of the 829 addicts mentioned above were selected to the effect that they were representative of the 829 and have so far been followed for 1, 2, and 4 years after termination of treatment. 4 years of follow-up have come to a close, but will be published at the end of 2003.

Two years after completing treatment – either as a drop-out or completed process – 3% of the 326 had died. Out of the remaining 316, 19% were still drug-free. The 81% who had relapsed into drug use had, however, not been living with a constant drug use for the past 2 years. Many of the drug users who had

relapsed had been drug-free for periods. Thus, between 30 and 40% had been drug-free at any time, whereas between 20 and 40% of the 316 were constantly receiving methadone treatment. Those who had been heavy drug users had periods with massive drug use and periods with a more moderate use.

The effect of various programs/methods

When allowing for gender, age, and drug addict resources in the efficacy reports prepared prior to start of treatment, there was very little – and by no means significant – difference between the various treatment methods.

11.2. Substitution and maintenance programmes

In Denmark, substitution treatment primarily includes methadone and to a much lesser extent buprenorphine. Other substitution agents are used to a very limited extent. The outpatient psycho-social programs outlined in this report are the ones carried out in connection with the substitution treatment.

Substitution treatment and outpatient psycho-social program

The aim of the substitution treatment and the psycho-social program related to it is the same as the drug-free treatment: an improved functional level, improved quality of life and social integration. As in the case of general treatment, the substitution treatment also has a clear harm-reducing goal.

Effect of the psycho-social support

Preliminary results outlined in a Danish study show that methadone appears to reduce heroin use by 50% and significantly reduce the criminal behaviour and injection us. On the other hand, the use and misuse of benzodiazepines as well as use/misuse of cannabis appears to rise in drug users who received methadone treatment (Pedersen, M.U. , 2001).

Effect of psycho-social activities

During the winter 2000-2001, 212 methadone clients from 6 misuse centres and 149 former drug users (at least drug-free for 1 month) were interviewed. The 212 methadone clients were representative of methadone clients admitted to 6 centres as regards gender, age and time under methadone treatment. The table below provides an overview of which services these 361 clients had received the past 14 days prior to the interview in 8 areas.

The effect of the substitution treatment should probably be closely linked with the quantity and quality of the psycho-social support offered to drug users. In the Danish study, it has been established so far that the methadone clients who do not receive any kind of psycho-social support are significantly more prone to secondary drug use than the methadone clients receiving psycho-social support. This per se is not conclusive evidence of the importance of psycho-social support.

Table11.2.1. Proportion of methadone clients and drug-free former heroin users who have received various types of treatment within the past 14 days

	Methadone N=212	Drug-free * N=149
Number of drug users per therapist	25-40	
Professional counselling services**	54%	22%
Semi-professional counselling services***	12%	40%
Employment services****	18%	46%
Educational activities *****	5%	33%
Psychotherapy (within the past month)	6%	6%
Narcotic Anonymous	13%	66%
Drop-in centre services	32%	39%

*Former drug users who have been clean for at least 1 month (102 had been clean for more than 1 year). **Trained, publicly employed counsellor. ***Former addict. ****Salaried work, activation, voluntary work.***** Non-residential folk high school, Adult Education Centre (VUC), Labour Market Training Centre (AMU)

The methadone project and supplementary psycho-social support

With support from the Ministry of Social Affairs, a study is currently being conducted on the expanded psycho-social support provided to drug users under methadone treatment. The study is conducted in Aarhus Country, Aarhus Municipality, the county of western Zealand and the Copenhagen municipality. The methadone project includes investigating whether expanded psycho-social support in defined areas leads to better results than the kind of psycho-social support traditionally associated with methadone treatment today. 15 centres in all participate in the study, which is broken down into a randomised controlled study section and a quasi-experimental study section following natural groups of methadone clients. (Centre for Alcohol and Drug Research)

The expanded psycho-social support in the methadone project will mean more intensive services (for instance fewer drug users per counsellor and more services) and more systematic monitoring and clinical disclosure of client problems and resources.

New methadone circular

The National Board of Health circular no. 12 of 13 January 2003 sets out rules for doctor's prescription of addictive medication. The circular describes, among others, what is understood by addictive medication and which conditions should be considered when prescribing it. Rules have been provided for the treatment of own and other patients, prescription to the doctor him/herself and his/her relatives, reporting to the National Board of Health and more detailed about duration of treatment with addictive medication. Treatment of drug users with

methadone and buprenorphine has been described in detail as has pain therapy and treatment with benzodiazepines

Secondary drug use

In the Danish study mentioned above (Pedersen, M.U. 2001), the following self-reported secondary drug use was found in 165 methadone clients the past month leading up to the interview:

- 11% had had no secondary drug use at all the past month,
- 18% had only smoked cannabis,
- 7% had, in addition to their cannabis addiction, used opiates and cocaine once or twice the past month,
- 44% had, in addition to their cannabis addiction, used a mixture of illicit drugs 3-15 days the past month, and finally
- 20% had had massive secondary drug use, including heroin 15-30 days a month

Urine sampling control

Control of secondary drug use by means of urine sampling is used to a limited extent in most places. Urine samples are often taken, either because the drug users ask for one to be taken (to prove that they have no secondary drug use) or in connection with special cases such as family cases, in which children are involved. In some places, urine sampling is applied on a more routine basis, either as a mere control measure or as an educational tool in the treatment of drug users. The most predominant attitude is that urine sampling control has no practical significance to secondary drug use. By contrast, they may create an unfavourable relation between the therapist and the drug addict and at the same time contribute to keeping those drug users who are still capable of holding their own in the streets from seeking professional treatment. At present, there are no scientific studies or evaluation papers available.

Treatment-related consequences of secondary use

A few years ago, however, a drug user could risk being “administratively phased out” of drug treatment or lose the chance of being subjected to substitution treatment. This type of punitive policy is only rarely applied these days – at least no reports on such action have been publicised. The predominant attitude is that there is no point in forcing drug users into escalating drug use, which may be followed by criminal behaviour and risk of drug-related death.

11.3. After-care and re-integration

After having received inpatient treatment, the drug user is offered a number of possibilities for re-integration into society. In principle, there are four models:

1. Integration dwellings or halfway-houses in direct connection with the individual in-patient treatment service. When actual treatment has been stopped, the former drug user moves to another dwelling and joins either an educational or a job programme. This second dwelling is in direct connection with the in-patient treatment service or is owned by it so as to ensure daily contact. The aim is for everyday life to be as normal as possible and for the place to function as an intermediate station between own dwelling and the in-patient treatment service.

2. Integration dwellings or halfway-house in the local municipality. In a number of areas of the country, the county or the municipality has arranged for dwellings, in which the citizens of the municipality may stay once they have completed the in-patient treatment service and still receive support. These dwellings function as an intermediate station between the in-patient treatment service and the individual's own dwelling.

3. A specific agreement that, once having completed treatment, the drug user - either daily or weekly - continues to be in contact with a treatment service and still have his/her own home. The contact may either be in the form of support during a transition phase or more permanent contact.

4. A network of former drug users to approach after completed treatment. The largest organisation, NA (and AA) is associated with the 12-step model, but also other persons from other treatment forms join this network.

Self-help groups

During the past few years, the number of self-help groups has increased drastically in Denmark. These groups are composed in a variety of ways and thus comprise former and current drug users, parents, relatives and particularly interested individuals.

Most of the groups are established via municipal grant schemes such as associations with open café services, anonymous counselling shops/telephone lines and support groups for other parents and relatives.

Example: Narcotics Anonymous

In Denmark, there are a number of private treatment institutions and especially those with a treatment philosophy evolving around the Minnesota 12-step model have for a number of years involved the relatives in the treatment activities. Based on the work performed by these institutions, a number of NA groups (Narcotics Anonymous) have been established for parents and relatives all over the country.

There are approximately 100 NA groups in Denmark functioning as an independent network under the private Minnesota treatment institutions.

Drop-in centres

The drop-in centres make up part of the psycho-social activities and range from post treatment to low-threshold services provided to active users. In the late 1980s, there were only a few drop-in centres primarily established for drug users. Today, there are more than 70 drop-in centres, of which most where established during the second half of the 1990s.

A study was made on drop-in centres for drug users and former drug users in 2001 at 64 drop-in centres all over Denmark (Grytnes et al., 2001). The study was based on a) questionnaires completed by the heads of the 64 drop-in centres, and on b) focus group interviews with users and employees in 13 drop-in centres and on c) 961 questionnaires completed by the users of the participating drop-in centres.

Different types of drop-in centres

The drop-in centres were divided into a) Drop-in centres for former drug users (n=14). Here, 95% of the users are former drug users. b) Drop-in centres, primarily for methadone users (n=21). 85% are methadone clients, whereas 15% are active. c) Drop-in centres for a mixed user group (n=20). This group includes 40% alcohol users, 20% active drug users, 10% former drug users, 10% methadone receivers and 20% other. And finally d) drop-in centres for active drug users (n=9). This group includes 80% active drug users, 10% methadone receivers and 10% alcohol users. The drop-in centres distinguish themselves significantly in areas such as organisation, function, opening hours, services/facilities, user involvement, etc. A few results from the evaluation report are mentioned below.

The drop-in centres for former drug users have a considerably larger number of users and volunteers who are formally responsible for the drop-in centre on a daily basis, and the personnel at the centres is overly represented by former users. The users of the drop-in centres for methadone addicts characterise the centres to have firm regulations, sometimes a tense atmosphere, but they report being less stressed when coming to the drop-in centre. The mixed centres have the oldest drug users. There are many volunteer workers at the mixed drop-in centres, but the addicts have hardly any practical responsibilities at the centre. The drop-in centres for the active drug users focus very little on social needs, but more on basic needs such as heated premises and a hot meal. As the only group of the study, this one reports that the addicts learn nothing about responsibility for specific tasks or better relations to others.

Common traits

In addition to the above, there are a number of common traits characterising the different types of drop-in centres. What is unique about all the centres is that the users perceive the drop-in centre as a place different from what they normally meet in terms of institutions, social programs and “the system” in general. The drop-in centres are considered as a free haven, which, however, is not too free of regulations and norms. Many of the respondents maintain that the drop-in centre acts as a social venue –a kind of family with the inherent traditions – which they normally experience very little of.

Financing

Almost all the 64 drop-in centres are financed either fully or partially by public funds. Two drop-in centres report that they are not financed through public funds. The extent of public funds varies a great deal and ranges from 5-100%. 42% of the drop-in centres receive funds from various trusts and pooled funds. Drop-in centres referring to themselves as clerical organisations, associations or privately owned institutions are financed partially be the county and/or the municipality. In addition, financing is carried out via donations, speeches, recycling shops and a variety of services.

Chapter 12 Interventions in the Criminal Justice System

12.1. Assistance to drug users in prisons

The Prison and Probation Service in Denmark undertakes to impose society's sanctions as well as prison sentences. The Prison and Probation Service has 19 *departments and 9 local probation centres* around the country. These departments carry out supervision in relation to individuals with suspended sentences, prisoners on probation and mentally ill people who have been sentenced to psychiatric treatment.

Probation on conditions

Drug users often experience that in addition to conditions of a probation period and supervision by Prison and Probation officials, they must subject themselves to treatment if the supervisory authority deems it necessary. In these cases, treatment will always be made within the auspices of the social authorities or in close cooperation with the county drug use counselling centres. The social authorities are also responsible for financing such treatment.

Hostels

The Prison and Probation service runs *8 hostels* – social in-patient institutions that are primarily used in connection with re-integration after having served a sentence - but also to a certain extent receives clients with suspended sentences or sentences involving psychiatric treatment. The drug using prisoners will often receive outpatient treatment for their addiction, including substitution treatment in or via the county addiction centres under the social authorities.

Prisons

Prison sentences are normally served in one of the country's 13 major prisons or – in the case of shorter sentences – in one of the approximately 40 local prisons. According to the drug study carried out by the Prison and Probation service, approximately 50% of all prisoners have drug use problems. During the past ten years, focus has been turned towards the prisoners' special needs and on drug use as a criminogenous factor. This has led to the establishment of special prison units for drug users, new alternatives to prison sentences, etc. These initiatives are described further in section 10.1

Since 1995, there has been formalised cooperation – a contact group – between the Ministry of Social Affairs and the Directorate of the Prison and Probation Service. This has led to the publication of a joint "Instructive guidelines for cooperation between social authorities and institutions and departments of the prison and probation service" in April 1998.

These guidelines express the expectations of the central authorities for cooperation on, among others, drug users.

An evaluation report was published in January 2001 on the progress of this cooperation. The report points out that cooperation in relation to and with drug users appears to develop favourably.

During the period from May to 31 December 2002, an external evaluation was conducted through a questionnaire study in the municipalities, review of 331 cases and qualitative interviews in municipalities, prison and probation service and with citizens. The evaluation report from May 2003 shows that the Instructive Guidelines published in 1998 have not changed or improved cooperation across the public sectors, and that these guidelines in practice have not been implemented to such an extent that a general correlation between activities can be established.

As a result, the Minister for Social Affairs as well as the Minister of Justice agree that initiatives are required to boost such activities.

Therefore, as a joint initiative, a type of "coordinated action plan obligation" will be introduced for prisoners, whereby the Prison and Probation Service must draw up such plans in cooperation with the municipalities.

Strategy

In general, it has been much emphasized that it must be possible for the treatment initiatives launched by the Prison and Probation Service to be coordinated with the services provided by the social authorities, in order to achieve coherence in the overall public activities.

The national strategy is that treatment of criminal drug users must, to the widest extent possible, be handled by the social authorities. The treatment initiatives launched by the Prison and Probation Service must primarily be motivating to the users and be able to fulfil their needs. However, in cases where safety considerations prevent participation in external treatment, the Prison and Probation Service should be able to offer relevant treatment during imprisonment.

Medical interventions

Physically dependent drug users are offered medical detoxification by being placed in prisons or local prisons.

Detoxification and substitution treatments are administered by the medical staff at the prison (doctors and nurses).

Drug-free programmes

The Prison and Probation Service has contract prison departments and drug-free departments in several closed and open state prisons and a special contract hostel, which is used in connection with re-integration following detention in a drug-free prison department.

Special prison departments or forms

Furthermore, a motivation department and a treatment department have been established for female prisoners as well as motivation departments for men, partly staffed with external therapists. In addition motivation department and motivation courses have been established in cooperation with external treatment institutions – also known as the import model.

In addition, there are two departments in a closed state prison for men, and a department in an open prisonm for drug users who are offered treatment by external therapists. Finally, in 2003 yet another – semi-open treatment department has been established for men.

The contract prison departments are primarily intended for drug users who feel motivated to stop their drug use and who would like to be assisted in their decision. The prisoners must, prior to being received in the department, sign a contract, according to which they commit themselves to being drug-free during their stay and to give urine samples regularly. Furthermore, they must contribute positively to the everyday routines of the department. In turn, the department commits itself to create a positive atmosphere around the imprisonment. The department has a special activity program. It is considered of great importance that close contact is established between the prisoners and the staff, and that the departments have a supervisor with a psychiatric or a psychological background and participates in tripartite sessions with the prisoners and staff.

Basically, the staff of the treatment institution are in charge of the treatment which is also carried out in close cooperation with the prison staff. The staff of the Prison and Probation Service are responsible for security.

Re-integration following release from a contract prison department is sometimes done via a special contract hostel. This hostel acts as a development and treatment environment for former and present drug users who undertake a contractual obligation to be drug-free and stay out of crime.

Re-integration into society can also take place via transfer to in-patient institutional treatment supervised by the county, either under continued imprisonment pursuant to Section 78 of the Act on Enforcement of Punishment or in connection with (parole) release.

The drug-free departments are intended for non-drug users as well as for former drug users who wish to avoid being tempted to relapse into addiction. Detention in a drug-free department means that the inmate commits him/herself to being drug-free and to give a urine sample as proof.

Finally, it should be mentioned that in one of the major local prisons, an experiment has been made to subject persons in remanded custody to pre-treatment. This is a local cooperating initiative with the participation of police, courts, drug use centres, social administration, local probation centres and the staff of the local prison. The treatment is undertaken by employees from the local addiction centre, and the study is financially backed by the Ministry of Social Affairs.

Self-help groups

The Prison and Probation Service has learned that at some of the drug-free program departments, contact has been made to and cooperation launched with

local NA groups and similar groups, but the prison and probation service has no centrally collected information at present.

Substitution treatment

Drug users in long-term substitution treatment may continue such treatment whilst serving their prison sentence – according to agreement and in cooperation with the authority, which originally initiated the treatment.

Long-term substitution treatment may be initiated during imprisonment, but this is normally only done according to previous agreement with the – normally county – authority in charge of continuing prescription after release.

The possibility of receiving substitution treatment at the institutions under the Danish Prison and Probation Service (treatment with methadone or similar treatment) is being used increasingly. Thus, on 19 February 2002, the number of individuals subjected to substitution treatment amounted to 345 prisoners in prisons, local prisons and hostels.

Harm-reducing intervention

Drug users in prisons and local prisons have access to cleaning liquid. The purpose is to give the injecting drug users who share needles and syringes with other drug users, the chance to clean them in order to reduce the risk of transmitting diseases such as HIV and hepatitis B. Injecting drug users imprisoned in the institutions of the Prison and Probation Service, are offered to be tested for and, if necessary, receive vaccination against hepatitis B.

Cooperation with social authorities

As mentioned above, formalised collaboration has existed since 1995 – via a contact group – between the Ministry of Social Affairs and the Directorate of the Prison and Probation Service, one of the results being the publication of a joint "Instructive guidelines for cooperation between the social authorities and the institutions and departments of the prison and probation service", April 1998.

Based on the above guidelines, the institutions plan and launch treatment initiatives targeted at drug users with suspended sentences and for those who ready for re-integration into society after imprisonment. It is provided that the social authorities and the prison and probation service as early as possible formulate a joint action plan together with and for the benefit of the individual drug addict on the treatment program in a wide perspective. The plan must be made at the beginning of the supervision period/imprisonment and it must comprise a plan for re-integration and the period following the expiry of supervision/release from prison.

As mentioned earlier, the substitution treatment of prisoners will primarily be provided in agreement with the social authorities. Re-integration of people in retention could for instance be done via some kind of stay in the hostels of the prison and probation service, including medical and therapeutical treatment via the local addiction centre.

Cooperation with the social organisations outside the prison service is particularly used in connection with alternative prison sentences as described below.

§ 78 imprisonment – imprisonment in treatment institutions outside the prison or local prison

Drug users may – similarly to other prisoners with a treatment need – be granted permission to serve full time or part of their sentence in a treatment institution outside the domain of the prison and probation services, pursuant to Section 78 of the Act on Enforcement of Punishment. Until a few years ago, this option was offered to a little over 150 drug users per year, but recently this the figures took a downward trend.

The idea of serving a sentence in an alternative manner may be put forward by the convicted person him/herself, by the treatment institution/the social authorities or by the employees of the prison and probation service. The formal application is filed by one of the locations of the prison and probation service, following which the Directorate of the Prison and Probation Service will specifically consider whether permission can be granted. If the convicted person has less than 3 months left of his time, permission may, however, be granted by the prison or the local prison.

Alternative sentence programs are financed by the authority(ies) normally paying for such a stay in the treatment institution in question. Expenses incurred on drug users staying in treatment institutions are predominantly financed by the social authorities in counties and municipalities. When serving a sentence in one of the hostels under the prison and probation service, the operating costs are financed by the prison and probation service, whereas the social authorities finance the §78 prisoners' direct provision and outpatient treatment expenses, if any.

Re-integration after stays in treatment or contract departments in the prisons appears to be made via the § 78-scheme to an increasing extent.

Accessibility to alternative measures: principles, criteria for admission

The application of alternative to prison sentences depends on the capacity of the treatment institutions and on the budgets of the counties and municipalities. Since the middle of the 1990s, the trend has been positive in terms of capacity as well as grants to the effect that the drug users who are motivated for treatment, to a rather wide extent, are granted the possibility of serving their sentence in an alternative environment – or of being released on parole on the condition of treatment.

The criteria are primarily that the convicted person is motivated to enter into treatment; that it is possible to provide relevant treatment services; and that the specific case gives no immediate cause for concern from a safety as well as a legal perspective by granting imprisonment outside the walls of the prison or local prison.

Information strategies

The possibility of alternative imprisonment has existed for so long that the prisoners, the employees of the prison and probation service and the social collaboration partners are familiar with the rules.

The Prison and Probation Service provides instruction and teaching to new employees in the rules and holds internal courses on drug use. However, the prison and probation service does not otherwise have any information strategies.

12.3. Evaluation and training

No evaluations on the initiatives launched for drug users have yet been made, but such work will be initiated in this year.

§ 78 imprisonment

An evaluation made in January 2001 showed, among others, that more than 70% of the drug users complete the alternative imprisonment program. The evaluation also showed that this alternative is often applied late in the drug addict's criminal career, and that criminal recidivism is relatively low compared to the clientele's criminal record. The convicted persons participating in these alternative prison programs as well as addiction counsellors and other professional commented positively on the favourable aspects of this type of alternative imprisonment. However, they also mentioned certain problematic areas within cooperation between the involved public sectors, and in particular the re-integration services provided after an alternative prison sentence served in a treatment institution.

The most recent evaluations on cooperation between the prison and probation service and the social authorities and evaluations on the two treatment departments in the state prison of Vridsløse, however, suggest that the problems of re-integration are decreasing.

Statistics and research

Client study

A study conducted among all prisoners on 23 February 1999 showed that a majority of the imprisoned drug users were less addicted whilst serving their sentence than before they were sent to prison. They had either taken drugs more infrequently and/or in smaller doses, or they had replaced the type of drugs from more to less serious (typically from heroin/morphica to cannabis and heroin medicine addiction). A large part of the prisoners even succeeded in keeping their addiction at the same level during imprisonment, while a minor share took more serious and a larger quantity of drugs during their imprisonment.

Drug study

During the autumn of 2001, the Prison and Probation Service conducted an extensive study on the addiction patterns of prisoners as well as supervised clients. The outcome of the study were published in the spring of 2003 in the report "Drug study". The study includes alcohol as well as drugs. The prisoners and supervised clients were interviewed about their possible misuse up to one month prior to imprisonment. The study is representative of the entire clientele of the Danish Prison and Probation Service.

The study shows that 56% of all the clients of the Prison and Probation Service (prisoners and supervised clients) are drug users. They have a high degree of polydrug use and the drug users are often categorised in user groups:

- 14% belong to the opioid user group, using heroin, morphine or similar drugs. This group are also heavy users of other drugs.
- 6% are CNS stimulant users (amphetamine, cocaine), but do not use opioids.
- 14% are cannabis users, but do not use opioids and CNS stimulants. Many of the cannabis users also have an alcohol problem, and they use other drugs occasionally.
- The use of CNS stimulants is increasing.

Introduction of new statistics in the area

From November 2000, all the treatment initiatives either carried out or planned by the Danish Prison and Probation Service have been registered. They are now being processed and the result of the study will be available at the beginning of 2003. The study is expected to enhance our knowledge considerably about the drug use patterns of prisoners prior to and during imprisonment.
The first statistical results are expected to be available at the end of 2003.

This new registration renders it more feasible in future to gain access to the required data.

Study of treatment departments at the state prison in Vridsloselille

An evaluation has now been made on the two treatment departments as a follow-up on the previous evaluation and study on recidivism. Evaluator finds that the figures on recidivism are acceptable in relation to similar groups. The figures on recidivism are lower for those who finalise their stay at the department than for those who interrupt their stay.

Study on the development in cooperation with social authorities

As mentioned above, an interim evaluation of the “Instructive guidelines for the cooperation between the social authorities and the prison and probation service” has shown a positive trend in the cooperation around drug users. An external study has now been launched where the qualitative contents of this work will be reviewed closely in order to identify specific examples of good practice. The results of the study are expected to be publicised during the first six months of 2003.

Training

Teaching about drug use and treatment forms is included in the fundamental training of prison staff in Denmark. In addition, the staff may follow interdisciplinary supplementary courses on drug use.

In connection with the establishment of treatment units under the import model, prison and probation service staff receive extra thorough introduction in the principles and methods of the treatment model via the external institution, which

will be responsible for treatment in the prison department in the future.

Chapter 13 Quality Assurance

No formally drafted strategy or guidelines have been prepared on quality assurance.

Quality assurance procedure

Within the in-patient treatment sector, the Ministry of Social Affairs, the Association of County Councils in Denmark, and the Centre for Alcohol and Drug Research have launched a documentation and monitoring system within the drug use area (DANRIS). This is a pilot project with the overall purpose being to achieve registered and documented treatment programs as well as quality and effect of the various kinds of treated drug use. The system is being developed over a three-year-period in the counties of Copenhagen and Aarhus. From the government's action program for the most marginalized groups, it appears that the DANRIS system as a new initiative will be extended to include the entire country within the next few years.

So far, 35 in-patient institutions are participating in DANRIS. On 1 June 2003, approximately 2860 drug users had been entered into the DANRIS system. A website has been established at the address www.danris.dk, where it is possible to follow the project.

At present, DANRIS is about to be further developed as a more variable quality assurance tool to be used by referring authorities as well as by institutions. This can be done by designing an interactive website, into which the counties, municipalities and institutions may log, enter data and retrieve statistics at various levels. The system provides, among others, client-therapist ratio, occupancy rates, and whether the client admitted to treatment by the referring authorities have actually been registered and a great deal more. The aim is to ensure data quality and expand the practical usefulness of the system. The further development is carried out in collaboration with referring authorities/quality developers from counties and municipalities.

Evaluation of activities

Evaluation of prevention and treatment programs is a popular issue among politicians, administrators, practitions and citizens. Recent years' restructuring and resources channeled to the treatment sector has spawned the demand for evaluation in this area. The specific evaluation activities can be broken down into monitoring of clients (as a prerequisite for evaluation), administrative evaluations and evaluation research.

Monitoring within the treatment sector has been strengthened through the establishment of the national client statistics prepared by the National Board of Health. Also the DANRIS system will be able to contribute data on effects from treatment of drug users.

In connection with the restructuring of the treatment sector, a number of evaluation reports have been prepared on the basis of quantitative information

about number of openings, etc. The Ministry of Health follows-up on the restructuring of methadone prescriptions (through inquiries to all counties). Since 1994, the Centre for Alcohol and Drug Research carried out a number of studies and evaluations on drug use. In a number of reports ordered by the Ministry of Social Affairs, the Centre has thrown special light on the social services provided to drug users (see also chapter 12 in the 2001 National Report).

Research

As regards prevention, the counties regularly conduct evaluations of local programs. These evaluation reports typically describe experience gained and are included in the continuing work. The methodological quality of these studies covers a wide field. Actual scientific evaluations are rare, given that on a local level, there is a shortage of resources and competencies.

Chapter 14 Evaluation of Drugs – National Strategies

Please refer to chap. 8.

Chapter 15 Cannabis problems in a context: understanding increasing in treatment demand

This chapter deals with the prevalence of cannabis use in Denmark, individuals receiving treatment for cannabis use, problems associated with cannabis use and initiatives launched against problematic cannabis use.

15.1. Demand for treatment for cannabis use

Out of the 4310 individuals receiving treatment in 2002, 718 reported using cannabis as their primary drug (the National Board of Health register on drug users receiving or having received treatment). This means that 21% reported cannabis to be their primary drug upon registration. In comparison, the percentage in 1999 was 11%. Out of the 718 drug users, 64% had not previously received treatment. Among all the clients who had not previously received treatment, 39% reported cannabis to be their primary drug. In comparison, the percentage in 1999 was 31%.

Based on the above, there seems to be a trend that newcomers with cannabis use as their primary problem are increasing in numbers, also when compared with clients with other drugs as their primary one. This increase may be attributable to several factors. First of all, it could be caused by a change in the treatments provided, which are perceived as being more relevant for cannabis users and an increasing number therefore seek treatment.

The second factor is that there has been an increase in cannabis use in the population in general. As it is mentioned in section 2.2 of Chapter 2, there has been an increase in the use of cannabis from 1994 to 2000 within the age groups under 30 years. In 2000, approximately 10% of the adult population up to 45 years of age had smoked cannabis within the past year, whereas approximately 7% had done so in 1994 (Kjøller & Rasmussen 2002). Among the 15-16-year-olds, 18% had tried to smoke cannabis in 1995, whereas the percentage had gone up to 24% in 1999 (Hibell et al. 2000). This increase in the use of cannabis might be an explanation of the increase in persons developing drug problems and therefore being admitted to treatment.

15.1.1 Description of client profile receiving treatment for cannabis use

In 2002, 81% of the clients using cannabis as their primary drug were men. This means that the proportion of men among clients with cannabis as their primary drug exceeds to a minor degree the proportion of men among all clients in treatment (76%). When considering the age factor, the group using cannabis as their primary drug also distinguishes itself, since their average ages are 26 years and 28 years for men and women, respectively, whereas they are 31 years and 32 years, respectively, for all those registered in 2002.

As is the case of the other clients, the cannabis users are a marginalised group in relation to the labour market. 54% of the drug users receive cash benefits, and 10% receive daily benefits. Only 16% actually receive wages or salary, this figure, however, being somewhat higher than among all clients consolidated

(9%). This most likely mirrors the fact that cannabis use is less stigmatising and less obvious for which reason the clients are more likely to maintain or get a job. Also, the number of cannabis users receiving treatment as early retirers (5%) is lower than among all clients (12%), which may be explained by the shorter drug use career and the lower age.

The 718 clients with cannabis as their primary drug have a total of 91 children under the age of 18 years. Out of this total, 26 live away from home, ie 29% of all the children of cannabis users. In comparison, 53% (516 out of 972 children) of all the clients' children under the age of 18 live away from home.

15.2. Prevalence of problematic cannabis use and patterns of problems

In 2003, the National Board of Health made an estimate on the number of drug users in Denmark in 2001. The estimate was made by applying a capture-recapture model (see chapter 2.3). Drug users in this connection are individuals who are constant users of drugs and as a result suffering from physical, mental and social damage. As mentioned earlier in the report, the estimate does not include experimental drug use, but includes cannabis users as well as users of CNS stimulants, opioids, etc.

Based on the estimate on total number of drug users in Denmark in 2001, the National Board of Health has made a special calculation on cannabis users only[32]. The calculation shows that 6,000 out of the total number of 25,500 drug users in 2001 are cannabis users only. The number of cannabis users appears by subtracting estimated drug users of illicit drugs other than cannabis from the total estimated number of drug users. No comparative calculations from previous years have been made on drug users. However, it is assumed that the increase in number of drug users in general from 1996 until today also means an increase in the number of cannabis users during the same period

Problems related to cannabis use

In the ESPAD study in 1999, Sabroe og Fonager observed a correlation between smoking cannabis, absence from school and average marks. As for the girls, there is a significant correlation between experience with smoking cannabis and average marks below 8 as well as absence due to illness or playing truant (Sabroe & Fonager 2002). As for the boys, there is a correlation between smoking cannabis and playing truant. (Sabroe & Fonager 2002)

The MULD study in 2001 shows a clear correlation between the young people's perceptions of problems in everyday life and the use of cannabis. 60% of the boys and 42% of the girls with "personal problems that make it difficult to handle daily activities" had tried to smoke cannabis, whereas boys and girls without problems accounted for 33 and 23%, respectively (The National Board of Health and the Danish Cancer Society 2003).

[32] Note from the National Board of Health, Dep. of Health statistics, 30th October 2003.

For further information about cannabis use and psychiatric problems, see chapter 16 on psychiatric co-morbidity.

15.3. Specific interventions for problem cannabis use

The general picture is that treatment of drug use includes outpatient services, either in the form of individual talks, group treatment with sessions once or several times a week, or in the form of daily treatment requiring daily appearance. Inpatient treatment provided to drug users with cannabis as their primary drug is seen, but is far from typical. The establishment of services aiming at cannabis users has been developing over the past few years in the counties.

Quite a few of the municipalities have established street level services, etc to the young people using cannabis/with problematic cannabis use and tried to establish contact to the young people by adult contact and support, which in the case of the very young is one of the most pivotal points in the help they need. A number of municipalities have started to develop treatment oriented activities to young cannabis users who are offered social services as well as targeted intervention against their drug use. This could partly reflect the trend that the municipalities actually see the young people's cannabis use as only one of a number of social problems and considers the focus on the young person's set of problems to be a municipal task.

The very young cannabis users are a group who make up a large part of the social services provided to young people with social problems, e.g. the inpatient services provided at county level. The general picture here is that the young people with drug use problems are often rejected from inpatient services, because the personnel lack the professional insight to solve the task.

As a consequence of these conditions, several counties have established dedicated peer teams who as part of their work must fulfil the needs of the municipalities in dealing with young cannabis users.

Examples of treatment services

In Frederiksborg County such a peer team has been established at a drug user centre, the Misbrugscentret. This centre has developed a particular services for young people between the age of 15 and 25 years who are problematic users of one or several drugs. Treatment is provided by a special team: the Peer Team. The employees of this team are physically located at the drug use outpatient unit of the Misbrugscentret in Hillerod, Elsinore and Fredererikssund.

By providing this service, the Misbrugscentret wishes to comply with municipal needs for being able to deal with young people who are either problematic drug users or just drug users. The services include advice, guidance and counselling of municipal employees/and or relatives as well as (group) treatment programs to the young users.

As it turns out, the treatment requirements of the young drug users are rarely met in traditional treatment institutions which are established for older, heavily dependent heroin users. The young people have a completely different attitude

towards drugs. They use drugs primarily during weekends, and they do not take heroin, but alcohol, cannabis and the so-called party drugs such as amphetamine, ecstasy and cocaine. They rarely perceive their drug use as being problematic, as it is limited to weekend use and their friends often have the same use pattern.

The Peer Team tries to approach the young people in two manners: by taking the treatment programmes to, for instance, youth clubs, youth schools or drop-in centres, where the young people meet each other, and by using new methods which can contribute to dismantle the young people's prejudice against drug use and treatment of drug use.

However, it is also important for the Peer Team that local cooperation is created around the young individual/individuals – a partnership consisting of employees and resources at a municipal as well as a local level. This must be viewed on the background that the young people who are problem drug users often have other problems which need to be solved.

Chapter 16 Co-morbidity

Co-mobiditet between cannabis and mental illnesses

The correlation between cannabis use and mental illnesses has received much attention for many years. While the findings on the causal relationship are few, it has been established with great certainty that considerable drug use and mental illnesses are closely interlinked.

Figures from the National Board of Health show that the number of persons seeking treatment for cannabis dependence has grown significantly within the past year. The fact that many of these people have mental problems makes it more difficult to treat them. Another fact is that psychiatric patients using cannabis have a poor prognosis.

Traditionally, the psychiatric system will deal with patients with psychiatric illnesses, whereas drug use is carried out in a different treatment setting. It is difficult to gain an overview of the treatment provided to drug users and whether such treatment has any effect, given that registration is scarce. The psychiatric system also focuses very little on diagnosing and treatment planning. The problems revolving around co-morbidity between cannabis use and mental illnesses will be outlined below together with recommended procedures for future practice.

Mental illnesses among cannabis users being treated for drug use

Danish school studies have established that an increasing number of young people experiment with cannabis, and the same tendency has been observed in other EU countries throughout the 1990s (E.O.N.N. 2002; EMCDDA – The European Monitoring Centre for Drugs and Drug Addiction 2001; The National Board of Health 2002). Foreign studies provide a great deal of knowledge about the risk of developing dependency . An Australian report estimates that 23.3% of those who have smoked cannabis 5 times or more within the past year fulfil the criteria of one or several psychiatric diagnoses caused by cannabis use (Hall et al. 1998). Similar findings have been made in an American study, according to which 9.2% of those who have used cannabis in their life develop dependency (Anthony, Warner, & Kessler 1994). No similar studies have been made in Denmark. The newest report published by the National Board of Health, “Drug users receiving treatment 1996-20002”, states, however, that the number of drug users seeking treatment with cannabis as their primary drug has grown by 227 people. This equals an increase of 21% from 2001-2002 alone, and this group now accounts for 14% of all registrations in the drug use treatment system.

As stated in table 16.1 it has been found that a considerable number of Danish cannabis users have previously been treated in the psychiatric system (Arendt & Munk-Jørgensen 2003). These figures have emerged by consolidating “the psychiatric central research register” with the National Board of Health register on drugs users receiving treatment during the years 1996 to 2000. All in all,

27.5% of the cannabis users and 27.9% of the users taking other primary drugs had been treated in psychiatric hospitals.

Table 16.1 . Mental illnesses among cannabis users receiving treatment from 1996-2000

Psychiatric diagnosis according to ICD 8 or ICD 10	Cannabis users (n=1439)	Other primary drugs (n=9122)
Schizophrenia	54 (3.8%)	298 (3,3%)
Bipolar disorders	9 (0.6%)	62 (0,7%)
Other affective illnesses	52 (3.6%)	223 (2,4%)
Anxiety illnesses	93 (6.5%)	625 (6,9%)
Personality disturbances	157 (10.9%)	603 (6,6%)
Neuroses and personality disturbances	10 (0.7%)	113 (1,2%)
Psychoses other than schizophrenia and bipolar disorders	15 (1.0%)	200 (2,2%)

Source: Arendt & Munk-Jørgensen, 2003.

Although the cannabis users were only approximately 25 years on average when commencing their treatment for drug use, a very large share had shown early signs of severe mental problems. These figures reflect the more heavy part of the psychiatric spectrum in that treatment at general practitioner's, private practising psychologist's or psychiatrist's is not recorded in "the psychiatric central research register". Particularly high is the presence of schizophrenia, depression and anxiety disorders compared with how frequent these disorders are diagnosed in the population in general. The fact that the personality disturbances make up a large share is less surprising given the close correlation between drug use and diagnosis of certain personality disturbances. Foreign studies concur with these figures with a very high presence of psychiatric problems among drug users in the general population (Regier et al. 1990) as well as in the drug treatment system (Copeland, Swift, & Rees 2001).

Drug use among psychiatric patients

The number of psychiatric patients using drugs can only be made on a guesstimate basis. From "the central psychiatric research register" it appears that in 2001, there were 1580 persons in Denmark registered with drug-related primary diagnoses, and 1593 persons with drug-related secondary diagnoses. However, it is also known that drug use among psychiatric patients is not reported nor recorded in full. Hansen (2000) found in registers that co-morbid drug use accounted for 26.1 % of the psychiatric patients in Denmark. In a more extensive random sampling check it turned out, however, that the figures were approximately double as high, with 50.0% of the Danish psychiatric patients fulfilling the criteria of a drug use diagnosis. Of this figure, 37.3% had a co-morbid drug-related and non-drug related diagnosis, and this had only led to registration in 12.6% of the cases. Unfortunately, there are no accounts of how these figures were distributed on the different types of drugs in this study. The results concur with foreign studies reporting about higher prevalence of use of

hard drugs as well as cannabis among psychiatric patients compared with the public in general (Fowler et al. 1998; Lee & Meltzer 2001).

From the "psychiatric central research register" information can be retrieved on the number of cannabis-related admissions to Danish psychiatric hospitals during the period 1994 to 2002. As it is illustrated in table 16.2 there are, in spite of the poor reporting procedures mentioned above, several thousands of registrations of injurious use as well as dependency syndrome of cannabis within psychiatrics. As expected, these diagnoses are most often used as secondary diagnoses, which means that other psycho-pathology is considered to be primary. Approximately a few hundred admissions of cannabis-released psychoses are registered annually, and this diagnosis is generally applied as the primary diagnosis. As it appears, the psychiatric system must also frequently deal with cannabis use and dependency.

Table 16.2. Cannabis-related psychiatric admissions during the period 1994-2002

	Primary diagnosis	Secondary diagnosis
Acute poisoning	140	74
Injurious use of cannabis	562	2347
Dependency syndrome	893	2980
Psychotic condition caused by cannabis use	1265	231

*Please note that the table shows number of admissions. The same patient may therefore appear several times.

Problems with cannabis use in relation to treatment

In the US, marihuana is the main substance, for which most people seek treatment (French et al. 2002). As described, it appears that those who seek treatment to stop their drug use often have mental problems. Furthermore, the group of Danish cannabis-dependent users receiving treatment are equally as marginalised as the hard drug users. However, there is still some uncertainty as to what the mental problems among cannabis-dependent users mean to the possibilities of treating them. Nor have any studies been conducted to illustrate whether successful treatment requires that the mental problems are treated prior to cannabis-dependency. However, there is no doubt that drug users with mental illnesses are generally more difficult to treat. It has been established that more or less, their drug use remains the same over the years with the traditional treatments provided.

International research has established that cannabis use may trigger psychoses in vulnerable individuals; that cannabis use leads to increased relapse in patients who are already mentally ill; and that schizophrenic patients more easily become dependent on their drug (Hall & Degenhardt 2000; Johns 2001). Although the negative effect of cannabis use among mentally ill is limited according to several studies, there is thus no doubt that the use of cannabis among patients with severe mental disorders is problematic. Furthermore, persons who are mentally ill encounter certain problems from drug use. It is difficult to accept drug use, and for the mentally ill it is probably more difficult. Therefore, it can be difficult to motivate schizophrenic individuals to receive treatment for drug use.

Treatment of co-morbidity in Denmark

Given that only to a very limited extent is specialised treatment provided for patients with double diagnoses in Denmark, the following lines will focus on how the psychiatric system, or the drug use system, manages to tackle treatment of this group of people. There are no specific strategies for treatment of co-morbidity caused by cannabis use, for which reason focus will be made on double diagnosis treatment in general.

In Denmark, it is still the norm that the psychiatric system treats the patients' psychiatric disorders, whereas treatment of drug use is provided in a different system. No clear guidelines have been formulated as to how individuals belonging to both systems should be treated. None of the two treatment systems are geared to dealing with the double diagnosis group, and a patient with drug use as well as mental problems often ends up being thrown backwards and forwards between the two systems.

Psychiatric patients who are active drug users are easily rejected from treatment already at the emergency award of the psychiatric hospitals, because the attitude is that this is not a psychiatric target group, unless the patient is very psychotic or suicidal. If the patient is hospitalised, the problem is often that the staff remain unaware of the patient's drug problem and do not have sufficient training in the type of treatment this requires. After completed treatment, the patients are discharged and advised to stop their drug use where this has been observed, but no active follow-up is made on treatment. This in spite of the fact that everyone knows that psychiatric patients who are drug users have a poorer prognosis than patients who are not. They have more mental symptoms, more frequent relapses, higher risk of suicide, more financial and family-related difficulties, more frequent risk behaviour and are more prone to committing violent and criminal offences.

The same problems exist within the specialised treatment of drug use. Typically, the staff are not trained to diagnose or treat mental disorders and even if mental illness is suspected, it can be difficult to refer the patient to treatment. Staff working with drug use problems are not accustomed to using diagnoses and to evaluating the biological side of treatment which may be a central issue in many mental disorders. This is also contributory to rendering treatment of double diagnosis patients inefficient in this context. Staff in several treatment institutions have thus pleaded for more knowledge about mental disorders.

In summary, the Danish system shows poor integration between treating drug use and mental problems at the same time.

Who is responsible?

An expert group appointed by the Government recommends that the responsibility for the most deprived drug users with mental problems must be placed in the psychiatric system. It is recommended that a few persons or special units attain specialised knowledge, and that formalised cooperation is established between the special units and social drug use institutions. The special units must be able to provide acute, inpatient and outpatient treatment,

and cooperate with drop-in centres. Some units should carry out research in order for their work to be documented and knowledge-based (Ugeskrift for læger 51, 2002).

Peter Ege, medical consultant, and Søren Bredkjær, chairman of the Danish psychiatric society, concur with the recommendations that the responsibility should lie with the psychiatric system. Furthermore, they point out that these units must be provided with the necessary resources. However, these are only recommendations and there still is a long way to go before the plans are realised.

The fact remains that there is a need for treatment institutions capable of dealing with double diagnosis patients. In Copenhagen and Aarhus, it has been attempted to establish a formalised bridge between the two systems. Sct. Hans Hospital near Roskilde has a special unit for patients with double diagnoses and at Øresundshospitalet there is a special outpatient unit. In these institutions, medicinal treatment is combined with cognitive therapy in accordance with environment therapeutical principles. In Aarhus, a “drug use psychiatry team” has been established. This team deals with direct patient contact and with coordination and supervision of primary therapists as well as teaches and carries out research within the area. In the autumn of 2001, the team established the first supplementary training in double diagnosis treatment for employees of the psychiatric system. However, from this institution it is reported that the need for upgrading of staff to handle double diagnosis problems is far from met. From all institutions it is also stressed that the need for treatment of the most severely mentally ill who also have problems with drug use, by far exceeds the number of treatment slots available.

Cooperation also exists on other levels. In Aarhus, for instance, doctors who also act as alcohol counsellors in the local alcohol counselling service carry out referral of patients at the psychiatric emergency wards. However, at present there are no resources available for referral of cannabis or hard drug users. An increasing number of drug use institutions also have psychiatric expertise at their disposal, but the number of experts vary and cooperation is carried out on a counselling basis.

Contents and effects of treatment

In general, there is very little knowledge about the optimum planning of treating drug users as well as the group with co-morbid mental problems. There are major differences as to how these problems are tackled in Denmark, and no effect evaluations are performed so that treatment can be optimised.

Let us once again take the treatment of cannabis users as an example; there is no consensus, even within drug use treatment services, as to how treatment should be planned, neither as regards extent or content. A cannabis user will thus be offered different treatments, depending on in which area of Denmark the individual lives. In some places it will almost be impossible to be treated, in other places outpatient treatment will be provided, and again, in other places inpatient

treatment will be provided. This is not only a national problem in Denmark. The fact is that in general only very few international studies exist on the organisation and effect of cannabis weaning, and if there are, such studies are of a recent date.

The common denominator of the treatment services provided in Denmark is that their effect is only documented to a limited extent. The Ministry for Social Affairs states that in the county and municipal budgets for 2003, an amount of EUR 86.3 million has been set aside for the treatment of drug users, plus EUR 10.6 million from government funds to fulfilment of the treatment guarantee. These figures can be compared with those of 1995 when a total of EUR 27.5 million was reserved. Also, as it appears, major sums are spent, but it is not clear what the money is being spent for. The institutions providing treatment of drug users are not obliged to file accounts on what services they provide, and no statistics are made on whether the users actually become drug-free. In fact, there is no consensus on the success criteria applied for treatment. This is even more problematic given that the treatment institutions often are private enterprises that have a commercial interest in showing positive results. The lack of registration means that the accuracy and quality of results are impossible to document.

The fact is that it has not been proved that climbing trees or qualifying for a diver's certificate has any effect on drug use or psychiatric problems, and that being a former drug user does not automatically yield the qualifications for acting as a drug use therapist. Treating the double diagnosis group requires specialised training in drug use psychiatry. In certain institutions, medication in all forms is banned and the clients are urged to abstain from medicine, following which the condition of these individuals deteriorates. Other institutions use psychiatrists as consultants, but the individual institutions have a varied practice as to how much such expertise is applied. Finally, some treatment institutions advertise being particularly qualified for treating double diagnosis patients. However, no documentation is provided for such statements.

Given that this is the current status of treatment of drug use in general, there is still a long way before we are able to describe the specific success associated with treatment of co-morbid mental disorders.

A number of activities are upcoming. Since May 2000, the Centre for Alcohol and Drug Research at Aarhus University has been working with the implementation of a registration and monitoring system, known as DANRIS ("dansk rehabiliterings- og informationssystem") in 34 inpatient treatment institutions in Denmark. The objective is to provide a computer programme capable of self-evaluation and documentation of treatment practice. By means of the ASI ("Addiction Severity Index"), comparisons can be made with other countries and groups can be identified with special problems. The system covers 90% of the inpatient treatment of drug users and is about to be launched within the alcohol area as well. No registration is made of outpatient treatment.

Within psychiatrics in Denmark, very scarce knowledge exists on the problems characteristic of mentally ill patients who are also drug users. This in spite of the fact that international research has clearly established that this group of patients require special treatment and have a poorer prognosis than mentally ill patients without a drug use problem.

From an international perspective, some of these activities are being requested. In the US, there is, for instance ”The Drug Abuse Treatment Cost Analysis Programme”(www.DATCAP.com), where the price for various treatment programs is calculated thus rendering comparisons possible.

The estimated Cochrane institution has performed a review on international studies describing the effects of double diagnosis treatment. This report concludes that there is no proof of the effect of drug use treatment as a supplement to traditional psychiatric treatment, but at the same time it points out that there is much need for more controlled studies (Ley et al. 2002).

Another review of studies includes 10 studies showing that extensive integrated treatment, particularly if carried out over a period of 18 months or more, will result in significant reduction of drug use and in some cases mean a considerable degree of remission and reduction in the number of hospitalisations. However, this study also reaches the conclusion that more controlled studies are needed (Drake et al. 1998).

Suggestions for future practice

There is large diversity in the manner in which the counties and municipalities treat drug users internally and how the problems of co-morbidity are tackled. The key words are cooperation and integration of various activities in order to achieve optimum treatment effects.

There is a need for developing models to organise treatment. Within psychiatrics the scenario could be that the patients would be more motivated to stop drug use already during hospitalisation. One model could therefore be that external drug use therapists were involved as quickly as possible. This should not be so difficult to organise with the large-scale use of district psychiatry that has been introduced. It is also important that the staff at the psychiatric wards are better educated to identify and treat drug use.

Within the system of drug use treatment registration procedures should be improved in order to see if the drug users are receiving the right treatment. The individual treatment institutions should be comparable in terms of contents of treatment, price and effect. For instance, the institution could apply success criteria directly related to the drug use, e.g. drug abstinences, degree of reduced drug use or problems caused by drug use, or more “soft” criteria such as problems with the family, violence and crime. Furthermore, it is recommended that easier access is gained to psychiatric help within the drug use treatment system, and that uniform procedures are established. Finally, a minimum

knowledge of psychiatric problems should be compulsory for employees working with drug users.

The significance of Danish studies describing the most effective treatment is supported by foreign studies showing that those drug use clients who also suffer from psychiatric disorders are those who manage the poorest. There are no Danish studies examining whether intensive treatment of psychiatric patients is effective. There is also a need for investigating how drug users who have been treated for their mental disorder manage afterwards. The introduction of ASI or other standard tools will facilitate cooperation and contribute to create a joint framework of references across the individual treatment institutions.

Tables

Table 2.2.5. Percentage of the 16-44-year-olds who have tried one or several of the various illicit drug within the past month, past year and ever in 2000 (n=6878)

	Last month	Last year (last month included)	Ever
Amphetamine	0,6	2,2	8,4
Cocaine	0,4	1,4	3,8
Psilocybin mushrooms	0,2	0,8	3,7
Ecstasy	0,2	0,7	1,7
LSD	0,1	0,3	1,4
Heroin	0	0,1	0,6
Other drugs*	0,3	0,6	1,7
”hard” drugs total i alt**	1,2	3,4	11,3

Source: Undisclosed figures from SUSY 2000

*The category ”Other ”drugs, covers GHB, various medicinal products, etc.
** A consolidated category of ”used an illicit drug other than cannabis”.

Table 4.2.2. Drug user groups and crime (primary offence) excluding traffic law violators

	Opioid user group		CNS stimulants group		Cannabis user group		Alcohol user group		No drug use		Total	
Crime	n	%	n	%	n	%	n	%	n	%	n	%
Homicide, etc	6	3	3	4	16	10	9	10	31	7	65	7
Violence	15	8	11	15	41	24	29	32	101	23	197	21
Arson	1	0,6	2	3	4	2	9	10	13	3	29	3
Rape	-	-	3	4	2	1	4	4	14	3	23	2
Other vice	-	-	-	-	-	-	3	3	28	6	31	3
Severe drug crime	16	9	13	17	18	11	1	1	63	14	111	12
Act on Euphoriant substances	7	4	4	5	5	3	1	1	10	2	27	3
Robbery	41	23	16	21	32	19	7	8	42	9	138	14
Theft, etc	72	40	20	26	39	23	17	19	52	12	200	21
Other offences against property	19	11	2	3	9	5	6	7	62	14	98	10
Criminal code, other	1	0,6	1	1	2	1	5	5	12	3	21	2
Special legislation	1	0,6	1	1	-	-	1	1	17	4	20	2
Total	179	100	76	100	168	100	92	100	445	100	960	100

Source: Kramp et al. (2003).

Table 5.2.1. Drug seizures 1990-2002													
	1990	**1991**	**1992**	**1993**	**1994**	**1995**	**1996**	**1997**	**1998**	**1999**	**2000**	**2001**	**2002**
Heroin													
Kg	26.7	30.8	38.5	28.2	29.0	37.4	61.4	37.9	55.1	96.0	32.1	25.1	62.5
Number of seizures	1,501	1,735	2,405	2,941	2,666	2,973	3,161	2,509	2,199	1,230	1,499	1,304	966
Cocaine													
Kg	28.1	39.6	21.4	11.1	29.9	110.1	32.0	58.0	44.1	24.2	35,.9	25.6	14.2
Number of seizures	157	144	184	228	417	569	659	723	885	744	780	815	881
Amphetamine													
Kg	26.0	23.6	73.6	11.7	12.6	40.0	26.7	119.4	25.2	31.6	57.1	160.6	34.9
Number of seizures	1,556	1,345	1,323	1,111	747	1,167	1,386	1,324	1,609	1,250	1,152	954	1,134
Ecstasy													
Number of pills.						2,115	15,261	5,803	27,039	26,117	21,608	150,080	25,738
Number of seizures						9	84	110	143	197	444	331	340
LSD													
Doses						1,282	262	381	105	83	1.108	156	38
Number of seizures						6	16	15	24	15	18	29	8
Cannabis													
KG	1,250	1,703	2,152	1,273	10,665	2,414	1,772	467	1,572	14,021	2,914	1,763	2,635
Number of seizures	6,741	9,222	9,870	10,938	6,995	6,710	5,187	4,886	5,904	4,569	5,561	5,788	5,234

Source: Police Drug Statistics 2002

5.2.3. Distribution between heroin base and heroin chloride 1996 – 2002							
	1996* (n =120)	1997* (n =30)	1998* (n =118)	1999* (n =97)	2000 (n =82)	2001 (n =69)	2002 (n=80)
Heroin base	70%	68%	72%	71%	61%	77%	76%
Heroin chloride	30%	32%	28%	29%	39%	23%	24%

Source: Kaa et al 1997, Kaa et al 1998, Kaa et al 1999, Kaa et al 2000, Kaa et al 2001 og Kaa et al 2002.
*In 1996, 1997, 1998 and 1999 percentages include figures from Elsinore police district

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Sundhedsstyrelsen (2003). Nye tal fra Sundhedsstyrelsen: Stofmisbrugere i Danmark 1996, 1998, og 2001. Sundhedsstyrelsen, København.

Sundhedsstyrelsen & Kræftens Bekæmpelse (2002). Unges Livsstil og Dagligdag 2000 – forbrug af tobak, alkohol og stoffer (MULD rapport nr. 1). Sundhedsstyrelsens Publikationer, København.

Sundhedsstyrelsen & Kræftens Bekæmpelse (2003). Unges Livsstil og Dagligdag 2001 – geografiske forskelle og ligheder (MULD rapport nr. 2). Sundhedsstyrelsens Publikationer, København.

Søberg Hansen, S. (2000). Substance use disorders among hospitalized patients in Denmark. University of Aarhus, Århus.

Wittrup, I. (1997). Også ung i Århus - en etnografisk undersøgelse af unge flygtninges og indvandreres brug af rusmidler. Center for Rusmiddelforskning, Århus.

Aalborg kommunes Ungdomscenter (1997). Mod et stoffrit liv - en efterundersøgelse blandt x-narkomaner i Aalborg kommune. Aalborg Kommune, Ålborg.

Links and websites

Amtsrådsforeningen [The Association of Danish County Councils]: www.arf.dk

Center for Rusmiddelforskning [The Centre for Alcohol and Drug Research]: www.crf.au.dk

Danmarks Statistik [Statistics Denmark]: www.danmarksstatistik.dk

The European Monitoring Center for Drugs and Drug Addiction (EMCDDA): www.emcdda.org

EDDRA: http://eddra.emcdda.eu.int:8008/eddra/

Mindblow: www.mindblow.dk

Politiets Narkotikastatistik 2002 [Police Drug Statistics]: www.politi.dk

Statens Institut for Folkesundhed [The State Institute of People's Health]: www.si-folkesundhed.dk

Sundhedsstyrelsen [The National Board of Health]: www.sst.dk

Applied studies

An approximate brief English translation of the study headline is provided in brackets [ ]. The studies have not otherwise been translated into English apart from the abstract provided here.

"Sundhed og sygelighed i Danmark 1994 og udviklingen siden 1987" Dansk Institut for Klinisk Epidemiologi 1994 (now SIF) (Kjøller et al. 1995). [Health and morbidity in Denmark 1994 and since 1987]
A national study conducted in 1994 among a representative segment of the population aged 16 and above. The study included questions on a variety of health issues. A sample population of 6000 individuals was selected at random from the central personal registry. The question on use of euphoriant drugs was put to the age group of 16-44-year-olds, in which group a total of 2521 persons were included. The data collection was performed as personal interviews at home. A total response rate of 78% was achieved.

"Sundhed og Sygelighed i Danmark 2000 – og udviklingen siden 1987" Statens Institut for Folkesundhed (SIF), (Kjøller & Rasmussen 2002). [Health and morbidity in Denmark 2000 and since 1987]
A national study 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 study included as in 1994, questions on a variety of health issues. The sample population of a total of 22,486 persons was selected in three random sampling rounds. Data collection was performed as personal interviews in the homes of the respondents. In addition, the respondents were provided with a questionnaire, which they themselves were requested to fill in and submit. In the self-administered questionnaire, the questions on drugs were put to all age groups. Interviews were made with 16,690 persons – a total response rate of 74.1%. The self-administered questionnaire was completed by 63.4% of the selected respondents.

"Unges Livsstil og Dagligdag 2000 – forbrug af tobak, alkohol og stoffer" (MULD 2000), Sundhedsstyrelsen and Kræftens Bekæmpelse (Sundhedsstyrelsen & Kræftens Bekæmpelse 2002). [Monitoring the lifestyles and daily routines of young people – consumption of tobacco, alcohol and drugs]
In 2000, the National Board of Health and the Danish Cancer Society conducted a representative study on the lifestyles and daily routines of the 16-20-year-olds. The study included questions on the young people's use of drugs, including their experiences with illicit drugs. The sample population of 3048 young people between the age of 16 and 20 years was selected systematically. Data collection was made on the basis of questionnaires. The response rate was approximately 70%.

"Unges Livsstil og Dagligdag 2001 – geografiske forskelle og ligheder" (MULD 2001), Sundhedsstyrelsen and the Danish Cancer Society (Sundhedsstyrelsen & Kræftens Bekæmpelse 2002). [Monitoring the lifestyles and daily routines of young people – geographical differences and similarities]
Once again in 2001, the National Board of Health and the Danish Cancer Society conducted a representative study on the lifestyles and daily routines of the 16-20-year-olds. The sample population of 3048 young people between the age of 16 and 20 years was selected systematically. Data collection was made on the basis of questionnaires. The response rate was approximately 70%.

"Monitorering af unges livsstil og dagligdag 2002" (MULD 2001), Sundhedsstyrelsen and Kræftens Bekæmpelse, unpublished. [see above]
In 2001, the National Board of Health and the Danish Cancer Society once again conducted a representative study on the lifestyles and daily routines of young people aged 16-20 years. The sample population of ¤ young people between the age of 16 and 20 years was selected systematically. Data collection was made on the basis of questionnaires. The response rate was approximately ¤%.

"Unges brug af illegale rusmidler", Advice A/S for Sundhedsstyrelsen November 1999 (Sundhedsstyrelsen 2000). [Young people's use of illicit drugs]
In 1999, the consultancy firm Advice A/S conducted for the National Board of Health a qualitative study on the young people's drug culture. The study was based on personal interviews with young users and non-users as well as interviews with drug experts and informants from party and nightlife settings and the youth education environment.

"The 1995 ESPAD report – Alcohol and Other Drug Use Among Students in 26 European Countries" (ESPAD 1995), CAN and 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 study was conducted in 1995 on the young people and their relationship with drugs. The study was conducted among a representative segment of 15-16-year-olds in 9th grade at randomly selected "folkeskoler", private schools and continuation schools. Data collection was performed by handing out the questionnaires to the interviewees in the classrooms. A total of 2234 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" (ESPAD 1999), CAN and Pompidou Group (Hibell et al. 2000).
In 1999, the study 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 pupils participated in Denmark, which equals a response rate of approximately 90%.

"Unge og Rusmidler – En undersøgelse af 9. klasses elever" Institut for Epidemiologi og Socialmedicin, Aarhus Universitet (Sabroe & Fonager 1996). [Young people and drugs – a study on pupils in the 9th grade]
This reports was based on the Danish input to the ESPAD 1995 study (see above). This report, however had expanded its random sampling base in comparison to ESPAD 1995 and included pupils in 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. The number of participating pupils thus increased to 2545.

"Rusmiddelforbruget – i folkeskolens afgangsklasse og udviklingen fra 1995-1999" Institut for Epidemiologi og Socialmedicin, Aarhus Universitet (Sabroe & Fonager 2002). [Drug consumption in the 9th grade, and development from 1995-1999]
This reports is based on the ESPAD 1999 study(see above). This report, however had expanded its random sampling base in comparison to ESPAD 1999 and included pupils in 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. The number of participating pupils thus increased to 1750.