Sundhedsstyrelsen

# REPORT TO THE EMCDDA

# BY the Reitox National Focal Point

# DENMARK

# DRUG SITUATION 2002

# REITOX

## Preface

This annual report on the drugs situation in Denmark has been produced by the Danish ”Focal Point” under the National Board of Health. The report was prepared during the late summer of 2002 and is the seventh 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 an overview of the drugs 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. This year’s report also includes three key issue chapters: Demand reduction expenditure on drugs in 1999”, “Drug and alcohol use among young people aged 12-18” and “Social exclusion and re-integration”.

Birgitte Bælum, head of section, has produced the epidemiological sections of the report in cooperation with Eva Hammerby, head of section, as well as the key issue chapter on drugs and alcohol use among young people under the age of 18. Hans Henrik Philipsen, head of section, has produced the sections on prevention, treatment and quality assurance. Martin Larsen, student assistant, has prepared the key issue chapter on demand reduction expenditure on drugs, and Dorrit Schmidt, head of section in the City of Copenhagen, has produced the key issue chapter on social exclusion and re-integration. 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. 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, chief secretary at the National Board of Health, has performed layout, design and proof reading.

Copenhagen, October 2002.

*Thomas Clement*
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## Summary

**The current drug situation in Denmark**

During recent years, there has been an increase in the use of illegal substances in Denmark. The increase is predominantly seen within use of cannabis, and within the central nervous system (CNS) stimulants such as amphetamine, cocaine and ecstasy. An additional portion of young people is now experimenting with these substances. Cannabis is by far the most prevalent drug followed by amphetamine.

The surveys reveal clear gender differences in drug use with an over-representation of men who use drugs both experimentally as well as on a more addictive basis. Also, the experimental use is most frequently seen among young people, primarily those aged 16-24 years. Often, this group of young people are the same ones to smoke tobacco and to drink alcohol in large quantities.

It is estimated that there are approximately 14,000 drug addicts in Denmark. Heroin is still the dominant primary drug in this group, with the secondary drug being cannabis in a large number of cases. Furthermore, during the past year there has been an increase among those seeking treatment for the first time with cannabis as a main problem. 33% of the “new” clients seeking treatment in 2001 reported cannabis as their primary drug. The same trend applies to the CNS stimulant which however still appears in low numbers as a primary drug used by persons under treatment. As regards the mental illnesses associated with drug addiction, there has been an increase since 1994 in the number of individuals admitted to psychiatric hospitals as a result of use of CNS stimulants and cannabis.

In 2001, the National Commissioner of Police recorded 258 drug-related deaths. In spite of a minor increase from 2000 to 2001, the number of drug-related deaths has stabilised since 1994.

**New illicit drugs**

In May, the drugs 2C-I and PMMA were added to list B of the ministerial order on euphoriant substances, according to which these drugs shall only be used in a medical or scientific context

**New legislation**

In 2002, an amendment was made to the Act governing the duties of the telecommunications companies to furnishing the police with relevant investigational information in connection with serious drugs crime (Act no. 378 of 6 June 2002). The amendment of the Act implies that 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.

**New development trends within prevention and care**

Based on national and regional (county) drug surveys, several counties have intensified the efforts within youth education, especially in the technical schools

and production schools. In extionsion of the activities launched in the youth schools and the generally positive outcome of establishing local key person network in the municipalities, an increasing number of counties have started to provide competence courses to key persons.

The development from the past year with enhanced drug prevention intervention directed towards the commercial party culture has continued in 2002. The initiatives have primarily been targeted at employees and licencees in party settings through services provided in the form of competence courses and development of guidelines.

During 2002, focus on the need for counselling and treatment provided to young addicts has increased. Several counties have thus established outpatient services directed at young addicts between 15 and 25 years. The primary substances used by this group of young addicts are cannabis and CNS stimulants.

**Key issue: Demand reduction expenditures on drugs in 1999**

This chapter focuses specifically on the demand reduction expenditures on drugs in 1999 and includes expenditure on treatment of drug addicts and prevention intervention targeted at drug use.

In 1999, there was no central budget for demand reduction activities. At the time, such activities were administered at a governmental, regional and local level, each with their own clearly defined responsibilities.

In 1999, financing of drug addiction treatment was shared between counties and municipalities. Total net expenditure incurred on drug addiction services provided by counties and municipalities amounted to DKK 494.5 million. The Budget for 1999 reserved DKK 6.2 million for prevention intervention administered at a central level. Added to this amount came the county and municipal expenditure on regional and local prevention which has not yet been computed in full.

Due to lack of data, it has not been possible to estimate total expenditure incurred in Denmark on demand reduction activities to combat drug addiction. Registration of relevant information has improved considerably during the past few years and expenditure might be possible to compile within the years to come.

**Key issue: drug and alcohol consumption among young people under the age of 18**

This key issue chapter deals with drug use and drug use associated with alcohol among young people under the age of 18. Regional studies indicate that 8-12% of the age group of those less than 15 years have tried to smoke cannabis. Most of them, however, appear to have started at the age of 15. A national survey reveals that among the young people aged between 15 and 17 years, 24-29% have tried to smoke cannabis ever, while 8-10% have tried it within the past month. Studies also show that this age group makes up an increasing share of young people smoking cannabis.

Experiments with drugs other than cannabis is not particularly widespread for those under the age of 18 years. Young people under the age of 15 years have very rarely tried drugs other than cannabis, whereas 4-8% of the 15-17-years-olds have tried amphetamine. However, the trend within this group appears to be on the uprise.

Furthermore, there seems to be a strong link between alcohol consumption and the use of illicit drugs. In most cases, the ones who pass the maximum drink limits are the same ones to smoke cannabis and other illicit drugs.

**Key issue: Social exclusion and re-integration**

This key issue chapter deals with social exclusion and attempts to re-integrate drug addicts. Drug addicts are experiencing more social exclusion than other groups. They are often homeless, their education is shorter and they receive cash benefits and early pensions more frequently than the public in general.

Particularly endangered groups emerging as a result of drug addiction are children from families with addiction problems, violence and neglect and which have experienced early alcohol and cannabis addiction, young people from immigrant groups which are poorly integrated into the Danish society, refugees with traumatic experiences, mentally vulnerable people, the mentally ill and the homeless.

A number of projects have been launched with the aim of re-integrating addicts. Some of the initiatives have involved different kinds of dwelling communities and attempts to strengthen their access to the Danish labour market.

# Chapter 1 Developments in the 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 treatment, including care, based on the principle of differentiated requirements and goals

In Denmark drug addiction is perceived as a complex problem requiring co-operation across job demarcation lines and different sectors. Efforts to combat drug addiction 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 non-medical use of drugs, a high level of information as well as action to impact on 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 addicts.

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. This means that in cases where it appears difficult to guide the addict to a drug-free life, a more realistic goal would perhaps be to reduce the harm inflicted on the drug addict.

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

there are approximately 5.100 drug addicts undergoing long-term methadone treatment (5 months or more).

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 street level. Another factor is the legislation on 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**

As an alternative to conducting heroin studies, government funds were set aside on the Budget for 2000-2002 to 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 addicts 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.

**Pooled funds to raise quality within drug addiction area**

Central government set aside funds to boost the social programs offered to drug addicts and to add a quality lift to the area. For this special project, an application pool was established in the amount of Euro 1.4 million in 1999 and Euro 5.4 million for the subsequent three years, of which, in addition to the projects mentioned, which 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.

**Relevant coordinating organisations, councils and committees**

Denmark has a population of 5.4 million people. Democratic elections take place at three levels: national, regional and local. The regional level includes 14 counties and the local level covers 275 municipalities (As at 1 January 2003: 271 municipalities). The average population figure in the counties is 330,000, and in the municipalities 18,000. Municipal tasks are defined by laws passed by the Folketing (Danish Parliament).

**Government 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 addiction trends by retrieving, coordinating, evaluating and disseminating data
- promote research
- guide and counsel local and regional governments
- 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 addicts. The Ministry of Tax is responsible for keeping an eye on precursors.

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 has 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 Taxation is responsible for border control including measures against smuggling. The Ministry of Taxation 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. Finally, it should be mentioned that the Danish Ministry of Health has set up an independent, expert National Council for Public Health, pursuant to Act no. 141 of 5 March 2001 on the change of Act on the Danish Health Care's Central Government, etc and the Danish Hospitals Act, etc. The National Council for Public Health replaces the former Preventive Political Council, the Danish Council on Smoking and Health and the Contact Committee of Alcohol Policy, which have all been abolished.

On a central level, the Danish Ministry of Social Affairs is responsible for the social services provided to drug addicts 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 addiction as well as any issues relating to care lies with the Danish Ministry of Health. The Danish Ministry of Justice is responsible for the treatment of criminal drug addicts.

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 Center for Alcohol and Drug Research at the Aarhus University has conducted a large number of studies, evaluations and analyses on drug addiction for the Ministry of Social Affairs and other institutions/public authorities. As part of the implementation of the social funds for 2001, the Center 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 addiction.

**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 addiction and small-scale trafficking on a street level whereas the key activities of the C.I.D. are targeted at the manufacture, 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 on 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 authorities**

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 addicts, including methadone prescription, lies with the 14 counties as well as with the City of Copenhagen and Frederiksberg Municipality. 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 on county budgets, including funds for prevention of drug addiction and prevention intervention, with the government and the Folketing (the Danish Parliament) on behalf of the 14 counties, with these counties being obliged to provide treatment to drug addicted citizens.

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 addicts 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 addicts, prostitutes, the mentally ill and alcoholic addicts. 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.

## 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 Euro 40 (DKK 300) to Euro 404 (DK 3,000) depending on the type and amount of the euphoriant substance.

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.

As part of the efforts to intensify the fight against importation and distribution of drugs, the Danish government adopted two amendments to the law on the drugs area in December 1996.

The first amendment concerns Act no. 1052 of 11 December 1996 to amend the

Euphoriant Substances Act, pursuant to which repeated sale of a particularly dangerous or harmful substance is regarded as a significantly aggravating circumstance when sentence is passed for violation of the Euphoriant Substances Act or pursuant to rules laid down in accordance with the Act. The objective of the amendment was to implement a significant increase in the level of punishment in cases of repeated trade in small amounts of hard drugs, also at street level.

In addition, two new provisions were added to the Danish Aliens Act with Act no. 1052 of 11 December 1996. These provisions make the rules on deportation more severe making it easier to deport aliens who have been convicted of a committing a drug offence. As a point of departure, an alien shall be deported from Denmark if the person in question has received an unconditional custodial sentence or other punishment of a custodial nature for violation of drugs legislation, irrespective of whether the general deportation conditions have not been fulfilled. When a decision concerning deportation is being taken, the considerations that usually lead to deportation not being effected, including consideration of the alien's relationship to Denmark, will only be accorded decisive importance in exceptional cases. Deportation will not take place if this is contrary to Denmark's international commitments, including the European Human Rights Convention.

By means of a number of amendments to the law adopted on 28 May 1997, rules were introduced in Denmark for the reversed burden of proof in cases of seizure of drugs, and access was established for the so-called "secret search". The objective of the amendments was to enhance the possibility of the police force to investigate serious crime, especially within organised crime.

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.

**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 serious cases and only in cases involving hard drugs. In particularly grave 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.

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 addiction taking place primarily in the discothèque environment, the police have also been involved in numerous targeted operations throughout the past few years. At the request of the Danish Ministry of Justice, a working group under the Association of Chief Constables in Denmark publicised in 2002 a report on police initiatives launched within the pub-owner milieu, focusing in particular on the use of ecstasy. Hearings in police districts, meetings with central authorities and literature search have formed the basis of the report, which has provided an up-to-date overview of the current situation as regards control and prevention intervention in relation to ecstasy. The recommendations of the report are primarily based on which initiatives the police and public prosecution will be able to launch in the police districts.

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.

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 Copenhagen Police have closed down approximately 50 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 addicts in possession of drugs for own use.

**Drug trafficking**

If a drugs dealer may be addicted to 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 addiction during their prison term, including re-integration into society through open institutions treating drug addicts. 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 addicts who are sentenced to imprisonment of longer duration due to drug sales meant to finance the addict's own drug addiction.

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.

**Individuals' duty to notify authorities of pregnant drug addicts**

Effective 1 January 2001, the Minister for Social Affairs was entrusted with the necessary powers to stipulate regulations, under which persons in public service or office shall be obliged to notify the local authorities if during the exertion of their service or office, they become aware of a pregnant woman with addiction problems of such severity that there are grounds for assuming that she may need support.

In pursuance of this authority, consolidated act no. 1092 of 8 December 2000 was issued on the duty to notify local authorities.

**Expert group to identify focus areas for the heaviest drug addicts**

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

During the 1st reading of bill B123 (a bill tabled on medically prescribed heroin to particularly heavy drug addicts) 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 addicts. 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 addicts, 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 related to various alternative solution models, including heroin prescription and the introduction of the so-called users' rooms.

**New narcotic drugs under control**

Effective 25 May 2002, the drugs 2C-I and PMMA were added to list B of the executive order on euphoriant drugs, according to which the drugs may only be used for medical or scientific purposes. The drugs were added to the list following the medical approval of the National Board of Health.

During the parliamentary year 2001-2001, members of the Danish Socialist People's Party tabled a bill for the third time on medically prescribed heroin for particularly heavy drug addicts. The bill was rejected by a majority of votes in the Danish Parliament in May 2002.

### 1.3. Laws implementation

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 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.

**Drug-related crime**

Individuals who are heroine addicts are very often involved in offences against property, including in particularly burglary into private homes, companies and shoplifting. In the case of offenders who have not previously been punished, the punitive reaction would often be for the court to pass an order requiring the offender to subject him/herself to detoxification.

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 addict will, however, be granted the chance of treatment, cf above.

**1.4. Developments in public attitudes and debates**

Medically prescribed heroin and users' rooms are recurrent issues in the public debate.

**1.5. Budgets and funding arrangements (2001)**

The municipal accounts and budgets show a heavy increase since 1995 in the funds reserved for the treatment of drug addicts. The municipal budgets for 2002 thus reserve Euro 81.1 million (DKK 602.3) for this activity. In comparison, the figures in the 1995 budgets were Euro 22.9 million (DKK 170.3 million).

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 addiction.

From the governmental funds granted through the Fund to enhance social initiatives for drug addicts, an amount of Euro 2-2.7 million (DKK 15-20 million) was granted annually from 1995 to 1998 to drug addiction activities. As part of the governmental grants compromise in 2002, an amount of Euro 90.2 million (DKK 670 million) was reserved for the next 4 years, during which programs to alleviate the problems of the weakest groups in society are to be launched.

In addition to the funds granted according to the Budget of 2002, an amount of approximately Euro 821,000 (DKK 6.1 million) was set aside for drug addiction prevention measures. 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, as well as 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 Euro 6.7 million (DKK 50 million) to a pilot project involving intensified psycho-social support to drug addicts in methadone treatment (Euro 5.7 million/DKK 40 million) and a project involving enhanced outreach social and health care activities in relation to the most severely deprived drug addicts in Copenhagen (Euro 1.3 million/DKK 10 million). This project was commenced on 1 October 2001.

Effective 1 January 2002, the provisions of the Danish Social Services on the funding of certain social services was amended. The change solely pertains to the structure of funding services under the Social Services Act, including expenses for treating drug addicts. Within the drug addiction services area, the amendment implies that funding of drug addiction treatment which has so far been shared between the municipality and the county is now replaced by a funding arrangement, 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 Euro 13,876.3 (DKK 103,100) annually (2002 prices), however no more than the actual expenses incurred.

The obligation to provide social services and the referral right of the counties is not affected by the change. 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 surveys 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, followed by a description of drug use among the general population and among various groups. In addition, the newest trends are described, based on information from regional hearings and a qualitative survey. In conclusion, the chapter presents the results of the recent estimate on the number of heavy drug addicts in Denmark.

## 2.1. Main developments and emerging trends

What is characteristic of the drugs situation in Denmark in 2002 is that cannabis is by far the most widespread drug among the general public. Second on the list is amphetamine, whereas ecstasy, in spite of the intensive mass media coverage, appears not to be more prevalent than cocaine, psilocybin mushrooms and other drugs. The trends suggest an increase in cannabis consumption and in the use of other illicit drugs.

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.

From a local perspective, the use of drugs is most frequently seen in young people with a weak social network and other problems, however the use among young people has also started to establish itself within all kinds of social environments. The population surveys have pointed out that among the young, there is no connection between their parents' low social status and the use of drugs. The unemployed and early retirement pensioners make up a large proportion of the 31-44-year-olds using cannabis and other drugs.

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.

It is estimated that there are approximately 14,000 heavy addicts in Denmark, out which most of them use heroin as their primary drug and cannabis and benzodiazepines as their secondary.

## 2.2. Drug use in the population

Drug use in the adult population is described in the two most recent national surveys 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 surveys, please refer to the annex)[1].

### 2.2.1. General population

#### Cannabis

As it appears in table 2.2.1, there has been an increase in the use of cannabis from 1994 to 2000 among the age groups under 30 years. This increase applies to men as well as women. Among the older age groups, there appears to be a tendency to continuous use at a very low level. In 2000, a total of approximately 10% of the adult population up to 45 years of age have smoked cannabis within the past year, whereas approximately 7% had tried it in 1994.

The proportion of respondents having smoked cannabis within the past year declines gradually by age group, given that cannabis most frequently is used by the youngest age groups from 16-24 years. The figures apply to men as well as to women, although there are clear gender differences. Thus, there are twice as many men (14%) than women (6%) who regularly use cannabis (Kjøller & Rasmussen 2002).

[1] These surveys are similar enough 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 survey methodology prevent precise benchmarking. This applies in particular when comparing the proliferation of illicit drugs other than cannabis. In 2000, the survey asks about the use of various illicit drugs, whereas the survey in 1994, asks about the use of "hard" illicit drugs in the same category. Empirically, such a "consolidated category" may result in a lower level, since the respondents may more easily forget a few substances when answering. Furthermore, survey 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 conclusive results in 2000. Allowance should be made for the above reservations when 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 and Rasmussen 2002 and Danmarks Statistik

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, 0-2,3% 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 use**

As it appears in table 2.2.2, there is a tendency among the 16-30-year-olds that the proportion of cannabis users (defined as persons who have used cannabis

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

within the past year) is higher among young people whose father or 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 figures 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 Danmarks Statistik.

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

| Table 2.2.3. The proportion of 31-44-year-olds who have used cannabis within the past year in relation to their socio-economic background (%) . | |
|---|---|
| | Own socio-economic background |
| White-collar worker I | 3.3 |
| White-collar worker II | 4.8 |
| White-collar worker III | 3.3 |
| Skilled worker | 3.9 |
| Non-skilled worker | 4.2 |
| Self-employed without employees | 6.3 |
| Self-employed with employees | 4.0 |
| Unemployed | 9.4 |
| Under education | 4.0 |
| Early retirement pensions | 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.

**Drugs and marital status**

If the respondents are divided into groups of cohabitants, singles (who have been divorced), singles (who are unmarried), and married individuals, the unmarried group account for the largest group of those who have been smoking cannabis within the past year. When making adjustments for age and gender differences among the various groups, the married individuals account for a significantly lower proportion than the other groups who have been smoking cannabis for the past year (Unpublished figures from and analyses on SUSY 2000).

**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 survey 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” [67].

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

**Table 2.2.4. The percentage of 16-44-year-olds who have used one or several drugs other than cannabis during the past month and the past year in 1994 and in 2000.**

| Used on 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 surveys.

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. By contrast, 0.7% tried ecstasy within the past year.

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

....[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.

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

predominant proportion of drug users within the past year (Unpublished data from and analyses on SUSY 2000).

**Drugs and marital status**

As is the case in cannabis users, the unmarried singles make up the largest group of those who have tried other drugs within the past year. When making adjustment for gender and age differences, the married individuals as compared to unmarried singles, divorced singles and cohabitants make up the smallest group of those who have tried other drugs 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 survey, whereas drug use among the group aged between 16 and 20 years is described on the basis of the MULD 2000 and the MULD 2001 surveys (see annex for an elaboration on the surveys). An further description of drug use among young people under the age of 18 is provided in key issue chapter 15.

**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 survey).

**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). As in the case of cannabis use, 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 survey).

**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 survey.
*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 survey).

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 survey).

**The 16-20-year-olds**

Table 2.2.7 provides the results from both MULD surveys.

**Table 2.2.7. Experience gained in illicit substances among the 16-20-year olds in 2000 and 2001.**

| | MULD 2000 (n=2046) | | | MULD 2001 (n=2090) | | |
|---|---|---|---|---|---|---|
| | Men | Women | All | Men | Women | All |
| Cannabis tried ever (%) | 37 | 27 | 32 | 38 | 29 | 33 |
| Cannabis tried past month (%) | 14 | 5 | 9 | 13 | 6 | 9 |
| Amphetamine tried ever(%) | 11 | 6 | 8 | 11 | 7 | 9 |
| Ecstasy tried ever (%) | 5 | 3 | 4 | 6 | 3 | 4 |
| Psilocybin mushrooms tried ever (%) | 5 | 1 | 3 | 7 | 3 | 5 |
| Cocaine tried ever (%) | 4 | 2 | 3 | 5 | 3 | 4 |
| Lsd tried ever (%) | 2 | 0 | 1 | 3 | 1 | 2 |
| Heroin tried ever (%) | 1 | 0 | 0 | 0 | 0 | 0 |
| Smokeable heroin tried ever (%) | 1 | 1 | 1 | 1 | 0 | 1 |
| ”Other drugs” | 2 | 1 | 1 | 2 | 1 | 1 |

Source: Sundhedsstyrelsen & Kræftens Bekæmpelse 2002 and unpublished figures from MULD 2001 survey.
*The category ”Other drugs” covers GHB, various medicinal products, etc.

There are no significant differences between the figures on drug use in 2000 and in 2002. In both these years, a little over 30% of the young people in this age group report having tried cannabis ever. According to the SUSY 2000 survey, amphetamine is the second most frequently used drug after cannabis, with 8-9% of the young people having tried amphetamine ever. 4% had tried ecstasy ever and ecstasy use is thus almost half as prevalent as amphetamine and more or less at the same level as use of psilocybin mushrooms and cocaine. Gender differences clearly emerge 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.

In 2000 as well as 2001, it appears that consumption increases by age from 16-20 years. Table 2.2.8 of the annex demonstrates the use of cannabis and amphetamines among the five age groups from 16-20 years. For instance, in 2001, 22% of the 16-year-olds against 43% of the 20-year-olds report having tried cannabis ever. In 2001, the figures in relation to amphetamine are 3% and 15% respectively[9].

**Co-variation in the use of euphoriant drugs**

The MULD 2000 survey suggests strong co-variation between the use of cannabis and other drugs[10]. Among those who have tried to smoke cannabis within the past month, 52% had tried other drugs, whereas 2% of those who had never tried to smoke cannabis had tried other drugs (Sundhedsstyrelsen & Kræftens Bekæmpelse 2002).

Also there appears to be a strong connection between smoking tobacco on a daily basis, heavy alcohol consumption[11] and cannabis use[12]. As an example it

[9] No signficance test has been made on the differences.

[10] There might be the same coherence in the 2001 material, however this material remains yet to be analyzed.

[11] Defined by exceeding maximum alcohol limits for adult of 14 and 21 drinks for men and women, respectively, per week.

should be mentioned that 44% of the boys who have been smoking cannabis within the past year have exceeded the drinks limit, whereas only 13% of the boys who had not tried cannabis within the past year had exceeded the drinks limit. “The total sum of vices” is thus not constant, since to a large extent the same young people are the ones to be exposed to the same health risks (Sundhedsstyrelsen & Kræftens Bekæmpelse 2002).

**Youth education and use of illicit drugs**

According to the MULD 2000 survey, the use of illicit drugs among young people in ”non-traditional youth education” is higher than among those in high schools and business/technical schools”[13]. For instance, 54% of the boys and 35% of the girls aged 16-18 years in traditional education tried drugs, whereas the figures recorded in high school education and business/technical schools are 35% and 38% for the boys and 23% and 27% for the girls aged 16-18 years (Sundhedsstyrelsen & Kræftens Bekæmpelse 2002).

### 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 addiction on a regional as well as a local basis.

The objective of the regional hearings is to collect ”soft” information 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 addiction situation in Denmark.

Reporting in general suggests that the young people carry out their experiments in many different social contexts in discotheques, cafés, large ballrooms, youth schools and, to an increasing extent, in private settings – either at parties or more informal functions. Cannabis is smoked at home, in cannabis clubs, or outside, whereas amphetamine, ecstasy and cocaine are consumed “in town”. The young people experiment to achieve a feeling of self-esteem and social acceptance, to experience something beyond the edge, to strengthen their identity, to suppress their insecurity and anxiety and “because it is part of being young”. The use of drugs has also become more widely accepted in many environments – it is no longer considered a clandestine activity.

Cannabis in combination with alcohol is still the most used and available drug, and it appears that the problems with cannabis use are increasing. In addition to the problematic cannabis use, an increasing number of people are experimenting with drugs – especially amphetamine and cocaine. Two Danish counties have

[12] Coherence between alcohol use and drug use is further outlined in chapter 15.

[13] Includes ”general work, sabbatical year, military service, free youth education and other education not comprised by traditional youth education, unemployed and long-term ill, etc”

reported that the use of lsd is becoming more common. Ecstasy, however, does not appear to pose an increasing problem. This could either be explained by the fact that ecstasy use has decreased or that the problems previously related to the drug have now stagnated. An exception to this is the county of southern Jutland, from which it is reported that an increasing number of young people have started to use ecstasy.

The geographic distribution of the drugs appears to be extensive, given that the type of drugs used in the various counties are 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. Most of the drugs are viewed as easy to get and quantities available are increasing.

Several counties are experiencing a decreasing age of initiation as regards cannabis as well as experimenting with other illicit drugs. Cannabis is being used all the way down to the age of 12 years, whereas other drugs such as amphetamine and cocaine are being tried among the 15-25-year-olds. The county of West Zealand has discovered that an increasing number of young people are surpassing the cannabis debut and starting directly on experimenting with other drugs.

The most common users of cannabis and/or other drugs continue to be boys. Furthermore, the weakest young people still tend to be the group using drugs. This group include youngsters who have failed to complete primary and secondary school, who have not engaged in any kind of further education, young people without work, young people placed in institutional settings, young people from homes with addiction problems and young people who have no social network.

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. The county of West Zealand reports that amphetamine is administered by young people who have no money, whereas cocaine is the drug used by those with a permanent job and a regular income to pay for their use. Some areas report that the group smoking cannabis and /or experimenting with other illicit drugs primarily consists of young people from business schools and technical schools.

4 counties reports about drugs in immigrant environments, where 1st and 2nd generation immigrants use and sell drugs during the weekends or take anabolic steroids as part of their work-out training activities.

Cannabis and benzodiazepines still tend to be the most commonly used. Reports are received on an increasing secondary use of cocaine, one of the reasons being falling prices for the drug.

### 2.2.4. Qualitative study on experimental use

During the autumn of 1999, the National Board of Health had a qualitative survey conducted on the young people's attitudes and experiences with illicit drugs "Young people and their use of drugs" (Sundhedsstyrelsen 2000). The survey focused on, among other things, new trends on the drugs scene and on potential new groups, new substances, and new social and cultural patterns in the young people's drug habits. The survey was based on 56 qualitative interviews of young people in party and educational environments – users as well as non-users were interviewed. The results from the survey are described in last year's report. In this report, we will merely point out the main conclusions of the survey, which are:

- The use of illicit drug has become mainstream and the prevalence of them is not merely limited to subcultural groups such as the hip/hop or techno environments.
- There seems to be a more liberal attitude towards illicit drugs among ordinary young people.
- The youth culture is undergoing social and cultural changes today. The euphoriant drug culture is gradually developing into an increasing tolerance towards illicit drugs backed by the young people's language, rules, habits and preferences.

### 2.2.5. Specific groups: prisoners

Once a year, the Danish Prison and Probation Service compiles the number of drug addicts in prison. This is a census report, which is typically made in November or December. The drug addicts are defines as "individuals who have used one or several euphoriant substances more than only a few times within the past 6 months prior to imprisonment". More seriously deprived drug addicts are defined as individuals who have been habitual drug users of drugs other than cannabis, perhaps in combination with cannabis. For practical reasons, the Prison and Probation Service has not made analysis for 2001, but has chosen instead to wait until February 2002.

The number of drug addicts relative to the total number of prisoners has been increasing regularly for a number of years, ie from 23% in 1985 to 36% in 1997. From 1997 to 1999, the proportion was unchanged, but again in 2000 there appears to be a minor increase to 38%. In the recent study from February 2002, the proportion was 37% (see table 2.2.9 of the annex). Table 2.2.9 demonstrates that the number of deprived drug addicts relative to the total number of prisoners increased from 37% in 1985 to 52% in 2000. The 2002 survey does not indicate how many drugs addicts can be characterised as seriously deprived, which is explained by the fact that relatively many reports point out that the frequency of drug use is unknown (Unpublished data from the Danish Prison and Probation Services 2002).

The number of injecting drug addicts has varied, but the percentage in 2002 was 17%. In 2002, a little more than half of the drug addicts in prison (51%) had been sentenced due to "general crime", ie crime other than violation of the drugs act.

## 2.3. Problem drug use

Making an estimate of the number of drug addicts is subject to much uncertainty. First, the estimate depends on the definition of a drug addict; second, the estimate depends on the methods and data material applied. The number of heavy drug addicts in Denmark is estimated to total approximately 14,000 (Haastrup 1999a). The present estimate of the National Board of Health is based on the capture/recapture method, which is a well-known method. The method is used together with extracts from the national register of drug addicts in treatment, provided by the National Board of Health and the National Registry of Patients. Both extracts are based on data from 1996. A more elaborate description of the capture/recapture survey is provided in the Annual Report for 2000.

### 2.3.1. Capture–recapture undersøgelse i København

Furthermore, in 1998 a local capture-recapture survey was conducted. The objective of the survey was to achieve a more reliable estimate of drug addicts in Copenhagen. The survey was based on register extracts from the following registers: the National Commissioner's Office register of charges of violation of the Euphoriant Substances Act, the municipality of Copenhagen's status and research register of drug addicts in Copenhagen undergoing treatment for drug addiction in Copenhagen, as well as the National Registry of Patients of persons admitted to both somatic and psychiatric hospital wards.

The survey concludes that in the City of Copenhagen there are currently an estimated 4,000 persons addicted to heroin and other opiates. There are, furthermore, 2,000 persons with drug addiction problems, but alcohol addiction or mental problems are the predominant factors throughout their lives (Schmidt & Sælan 1999).

### 2.3.2. Risk behaviours

The National Board of Health register on clients admitted to treatment contains information provided by the clients on sharing of syringes/needles. Out of the number of clients admitted to treatment in 2001, 18% report having had this type of risk behaviour ever. 5% had had it within the past month. Among the admitted clients, who had not previously been admitted to treatment, 9% reported having shared syringes ever, whereas 4% reported having done so within the past month. Among the new clients admitted to treatment, a decline in the proportion of injecting heroin addicts is seen over time. If this development continues, progress will have been achieved in the fight against hiv, hepatitis, etc among heroin addicts (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 addicts 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 addicts under treatment have been retrieved from the National Board of Health register on drug addicts admitted to treatment, which was established in 1996. The Register includes the individuals referred to treatment for their drug addiction 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 2001.

**Table 3.1.1. Clients admitted to treatment for drug addiction in 2001.**

| **Number of clients admitted in 2001** | **4079** |
|---|---|
| Not previously t (%) | 31 |
| Men/Women ratio (%) | 77/23 |
| Average age men/women (%) | 31/31 |
| | |
| Opiates as primary drug (%)* | 62 |
| Cannabis as primary drug (%)* | 17 |
| Central stimulants as primary drug (%)* | 6 |
| | |
| Injecting drug addicts, previously treated (%) | 47 |
| Injecting drug addicts, not previously treated (%) | 25 |
| | |
| Salaried income (%) | 8 |
| Daily benefits (%) | 7 |
| Cash benefits (%) | 57 |
| Early retirement pension (%) | 12 |
| Other income and non-disclosed (%) | 16 |
| | 100% |
| | |
| Clients with own home (%) | 49 |
| Clients single men/women (%) | 76/62 |
| Number of children under the age of 18 years living at home | 496 |
| Number of children under the age of 18 years living outside home | 599 |
| | |
| Foreign nationality (%) | 6.2 |

*Percentage of those reporting a primary substance.
Source: The National Board of Health register on drug addicts admitted to treatment in 2001.

In 2001, a total of 4079 drug addicts were admitted to treatment in Denmark. This is a minor increase in relation to the 3,902 who were admitted in 2000. The total number of drug addicts who have been admitted to treatment during the year, increased by 23% from 8,215 in 2000 to 10,125 in 2001. (The total amount includes individuals who have continued treatment from 2000 and into 2001. A large part of this increase is attributable to technically improved treatment statistics, which means that only a minor share of the increase is real.

31% of the clients admitted in 2001 had not previously been admitted to treatment for drug addiction. Separate figures and a description of the "newcomers" will be provided later in this chapter.

**Type of addiction**

Heroin is the most frequently used drug, but cannabis, methadone and benzodiapines are also used by many. The distribution of the drugs used corresponds, by and large, to the distribution among the drug addicts who were admitted for treatment the previous year. The vast majority of drug addicts seeking treatment use several drugs. In 2001, 55% reported having used more than one drug prior to being admitted, which means that more than half of the clients admitted are suffering from poly-substance drug use before embarking on treatment.

The CNS stimulants, which have received much attention in relation to the young people's experimental use of drugs, appear only to a limited extent as a primary substance used by drug addicts under treatment. Only 3% report amphetamine, 2% report cocaine and 1% reports ecstasy[14] as their primary substance[15], which is more or less unchanged compared to 2000. These drugs were thus primarily used as supplementary drugs.

Cannabis was the primary drug for 17% of those admitted to treatment, however it is a very widespread secondary substance. 41% of those admitted to treatment in 2001 reported having used cannabis as a secondary substance.

**Age and gender distribution**

In 2001, drug addicts under treatment were made up of 77% men and 23% women, which to a large extent equals the gender distribution of the past years. In 2001, the average age on admission was 31 years for both genders. The average age on admission in the City of Copenhagen was, as in previous years, higher than the average figures on a national scale, ie 33.8% for women and 35.3% for men.

**Social background variables**

Data on variables of social background show a picture of a marginalized group of people as regards their connections to the labour market, education, housing situation and social life (See also key issue chapter 16 on social exclusion and reintegration)

[14] Here reported as MDMA or similar drug.

[15] Percentages were compiled on the basis of the part of the treatment population reporting one primary drug.

A vast majority of the clients live on transfer incomes, whereas merely 15% have connections to the labour market and half of these cash in unemployment benefits. A total of 26% have an educational level beyond that of primary and secondary school. 19% have left school before the final examination in the 9th form. The low educational level should be viewed on the background that most of them make their debut as drug addicts at a rather young age, cf the above.

.

Furthermore, drug addicts are in an unfavourable position when it comes to housing. A mere 49% have a dwelling of their own - as many as 7% are, in reality, homeless.

From a family perspective, a large number of both male and female drug addicts live as singles, which is unusual given that the majority of the group are young adults. In 2001, a total of 496 children lived together with a drug addict in treatment, whereas 599 children under the age of 18 lived in institutions away from their home.

**Foreign nationalities**

A small proportion of drug addicts in treatment are foreign nationals, totalling close to 6%. 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 addiction. 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 who have not previously been treated for drug addiction.**

| | 1999 | 2000 | 2001 |
|---|---|---|---|
| Clients who have not previously been treated | 1026 out of 3,429 (30%) | 1157 out of 3920 (27%) | 1278 out of 4079 (31%) |
| Men/women (%) | 74/26 | 77/23 | 76/24 |
| Average age men/women | 28/28 | 28/28 | 28/27 |
| Opioides as primary substance (%)* | 52 | 54 | 38 |
| Cannabis as primary substance (%)* | 31 | 30 | 33 |
| Central stimulants as primary substance (%)* | Not compiled | 14 | 11 |
| Injecting drug users (%) | 40 | 35 | 25 |

Source: The National Board of Health register on drug addicts under treatment in 1999, 2000 and 2001.
*Percentage of those reporting primary drug

As it appears in table 3.1.2, 31% of the clients admitted to treatment in 2001 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 2001, the gender distribution among the newcomers and the old clients under treatment was more or less the same.

**Primary substance 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 33% in 2001. This is a mild increase compared to the previous years, whereas the percentage was lower (26%) in 1996 as well as in 1997.

Among the 1112 newcomers with a reported primary substance use, only 38% report opioides as their primary substance, which is a decrease from 2000, when 54% reported opioides as the primary substance. 11% report having used a central 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 predominant drugs among the treatment population in the future, and the proportion of clients using opioides as their primary drug will be decreasing.

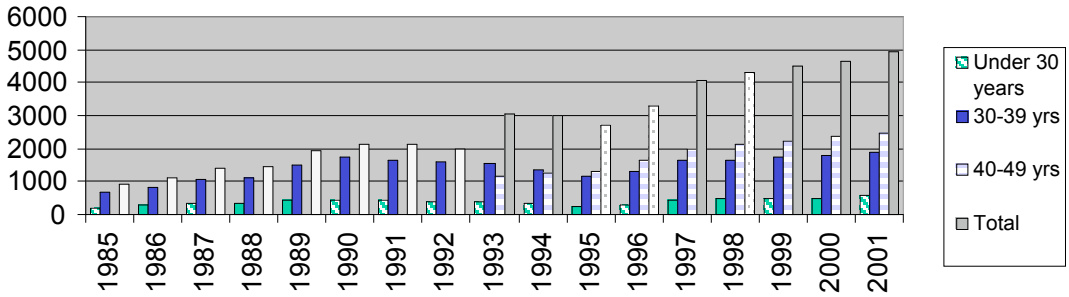
When considering the mode of heroin intake among the two "client groups" there are also variances, given that in 2001, 25% of those who have not previously been treated report having smoked heroin, whereas 45% of those who have previously been treated have injected the drug. Also, it appears that a smaller number of the newcomers in 2001 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 smoking heroin during the past few years has started to gain ground. The latter is substantiated 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 for longer than 5 months. Figure 3.1.1 shows the development in the number of drug addicts in substitution treatment with methadone from 1985 to 2001. This record does not include the number of clients in long-term methadone treatment in prison or people in treament without a social security number.

There has been a continued increase in the number of persons in long-term substitution treatment after the counties assumed responsibility for prescriptions, supply and control of methadone on 1 January 1996. During the years from 1993 to 1995, the number of persons in substitution treatment was a constant figure of 3,000 per year. Since then, the number of individuals subjected to long-term substitution treatment has gone up each year from 3276 in 1996 to 4937 in 2001.

**Figure 3.1.1. Individuals subjected to long-term methadone treatmen (more than 5 months) 1985-2001**



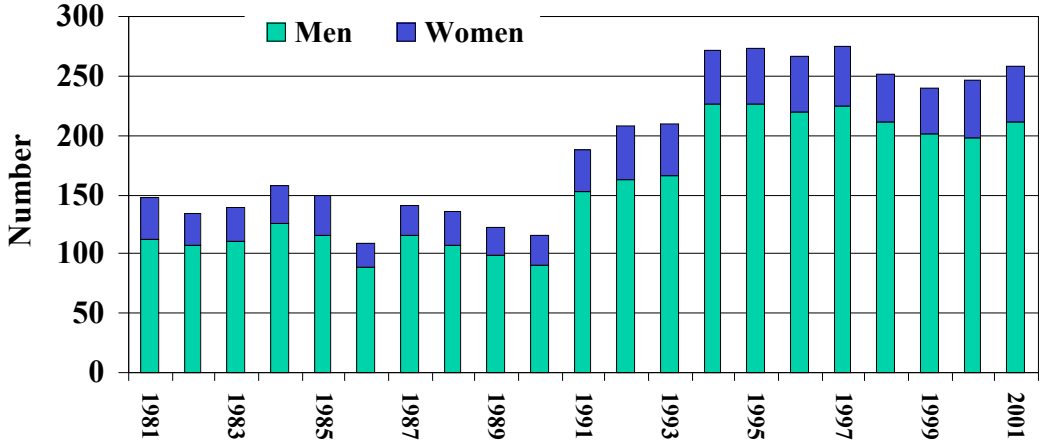

Until 1996, methadone registration was solely based on recipes. After the amendment of the act in 1996, statistics also included individuals who received methadone without a prescription from the county treatment centres. This has contributed to the major increase from 1996 to 1996.

The increase in the number of individuals subjected to long-term substitution treatment from 1996 also reflects changes in treatment services provided[16].

## 3.2. Drug-related mortality

The National Commissioner of Police has registered drug-related deaths since 1970 (Politiets Narkotikastatistik 2001).

**Figur 3.2.1 Drug-related deaths, broken down by gender, 1981-2001**




Source: Politiets Narkotikastatistik 2001.

[16] 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 (Embedslægeinstitutionen for København og Frederiksberg Kommuner 2001).

opioides and other drugs. Less than 1% of the deaths were caused by stimulants, including amphetamine, cocaine and ecstasy. The remaining deaths are caused by either diseases (6%), drowning or hanging (4%) and other causes (12%).

**Cause of Death Register, the National Board of Health**

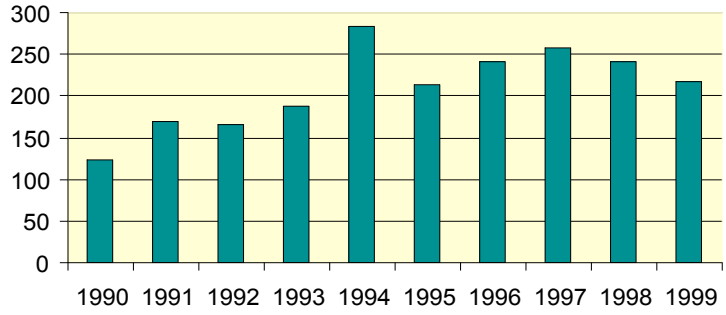
In addition to the National Commissioner's Register, the National Board of Health has a register on drug-related deaths in the so-called Cause of Death Register. This register includes deaths, which are defined as drug-related deaths based on European criteria. Given the common desire to perform benchmarking on the subject, there are restrictions as regards diagnosis groups included in the retrieval procedure. Consequently, drug addicts 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)[17].

In 1999[18] 217 deaths were registered, out of which men account for 72% (157). According to figure 3.2.3, which shows the development 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 artificial 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 1990-1999**




Source: Cause of Death Register (the National Board of Health)

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-

[17] Up until 1994, ICD8 codes were used, following which ICD10 codes were used instead.

[18] Data from 2000 and 2001 are not currently available.

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 Cause of Death Register at the National Board of Health.

Furthermore, the European definition of drug-related deaths used for the figures in the Cause of Death Register under the National Board of Health 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.

**Mortality and causes of death among drug addicts**

The most recent survey on mortality and causes of death among drug addicts in Denmark was conducted in 1999. The survey made use of a special treatment cohort, consisting of the drug addicts who were admitted for treatment in (Haastrup 1999b)[19]. These drug addicts were followed closely and compared with data on the drug addicts whose deaths the National Commissioner's Office registered as drug-related deaths in 1996, and who appeared also in the Registry of Causes of Death kept by the National Board of Health and in the Central National Registry.

The main findings of the survey were:

- Mortality in the treatment cohort was 15 times higher than estimated mortality in this age group.
- Excessive mortality is more pronounced among women than among men
- The mortality of opiate addicts is higher than that of other drug addicts.
- Mortality among injecting heroin users is higher than among addicts on smokeable heroin. (Generally, mortality rates were lower among drug addicts who had never injected than among the remaining addicts).

## 3.3. Drug-related infectious diseases

### Hiv/aids

Danish action against hiv is based on the voluntary principle, anonymity, openness, direct and honest information and security for individuals in their contact with the health authorities. The freedom of the individual is key. 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 information.

Table 3.3.1 shows the number of newly diagnosed hiv-positive intravenous-injecting drug users from 1992 to 2001. The number of newly diagnosed hiv-positive has varied from one year to another, as has the number of infected clients where the source of infection has been reported as being an injecting drug user.

[19] The survey conducted by the National Board of Health applied the same method as the cohort studies in other European countries.

**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 1992-2001.**

| | 1992 | 1993 | 1994 | 1995 | 1996 | 1997 | 1998 | 1999 | 2000 | 2001 |
|---|---|---|---|---|---|---|---|---|---|---|
| Number of newly diagnosed hiv positive, total | 380 | 331 | 298 | 304 | 268 | 273 | 211 | 282 | 258 | 302 |
| 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%) | 24 (9%) | 20 (8%) | 28 (9%) |
| Number of newly diagnosed aids cases, total | 209 | 239 | 236 | 214 | 158 | 109 | 73 | 72 | 51 | 71 |
| 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%) | 6 (8%) | 6 (12%) | 11 (15%) |

Source: Unpublished data from Statens Serum Institut.

In 2001, 9% (28 people) were newly diagnosed hiv positive intravenous-injecting drug users. This percentage has remained a more or less constant 10% during the past 10 years.

In 1998, the proportion of the newly reported aids cases, where the source of infection was considered to be from intravenous-injecting drug use was 5% of all registered newly reported aids cases (4 out of a total of 73 people), in 1999 it was 8% (6 out of 72 people) and in 2000 12% (6 out of a total of 54 people). In 2001, this proportion increased to 15%. The proportion has been relatively steady over time, although it has been mildly increasing during the past few years.

**Hepatitis A, B and C**

In spite of minor fluctuations, there has been a drop in the number of acute cases of hepatitis throughout the population from 1995 to 2001. Similarly, there has been a drop in the number of acute cases of hepatitis, where the infected person was an injecting drug user (table 3.3.2).

In 2001, the proportion of individuals infected as a result of intravenous-injecting drug use was approximately 11% of all hepatitis-infected drug users. When considering the individual hepatitis groups separately, the infected persons with intravenous drug use made up 2% of all individuals infected with hepatitis A, 23% of all individuals infected with hepatitis B and 33% of all individuals infected with hepatitis C in 2001. Previously, individuals infected as a result of intravenous drug use made up a significantly larger proportion of those infected with hepatitis C – for the period 1992-2000, the percentage was 53-86%.

**Table 3.3.2. Acute cases of hepatitis A, B and C in the entire population and the proportion of intravenous injecting drug users among this group from 1992-2001.**

| | 1992 | 1993 | 1994 | 1995 | 1996 | 1997 | 1998 | 1999 | 2000 | 2001 |
|---|---|---|---|---|---|---|---|---|---|---|
| Number of hepatitis A, total | 172 | 227 | 144 | 103 | 105 | 115 | 86 | 88 | 67 | 64 |
| Number of hepatitis A with intravenous-injecting drug use (% of all diagnosed) | 1 (1%) | 24 (11%) | 6 (4%) | 1 (1%) | 2 (2%) | 0 | 0 | 0 | 0 | 1 (2%) |
| Number of hepatitis B, total * | 52 | 105 | 115 | 128 | 103 | 103 | 97 | 61 | 64 | 44 |
| Number of hepatitis B cases with intravenous-injecting drug use (% of all diagnosed) | 9 (17%) | 36 (34%) | 49 (43%) | 38 (30%) | 36 (35%) | 32 (31%) | 26 (27%) | 14 (23%) | 19 (30%) | 10 (23%) |
| Number of hepatitis C, total * | 31 | 65 | 56 | 67 | 31 | 28 | 25 | 14 | 17 | 6 |
| Number of hepatitis C cases with intravenous drug use (% of all diagnosed) | 23 (74%) | 49 (75%) | 38 (68%) | 39 (58%) | 20 (65%) | 21 (75%) | 15 (60%) | 12 (86%) | 9 (53%) | 2 (33%) |

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 made by the Funen and Copenhagen counties show that 60-80% of all drug addicts have been hepatitis B-infected, and that approximately 5% of them develop chronic hepatitis (Indenrigs- & Sundhedsministeriet 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 (Indenrigs- & Sundhedsministeriet 2002).

## 3.4. Other drug-related morbidity

### 3.4.1. Psychiatric co-morbidity

Table 3.4.1 shows the number of persons registered as receivers of psychiatric treatment (total of full-day, half-day and outpatient treatment) against use of opioides, cannabis, sedatives and hypnotics, cocaine, stimulants, hallucinogens and volatile solvents as well as multiple drug use during the period from 1994 to 2001 (primary and secondary diagnoses). As it appears in the table, the number of individuals receiving psychiatric treatment as a result of drug use went up from 2838 in 1994 to 4467 in 2001.

The number of individuals admitted with mental illnesses or disturbances as a result of cannabis use almost doubled from 1994 to 2001 in spite of a minor decrease in 1996 and 2000. From 2000 to 2001, the number of individuals admitted to hospitals with cannabis addiction as the primary diagnosis went up by 25% from 371 to 462 (Data not disclosed).

Also the number of individuals admitted following their use of CNS stimulants, hallucinogens and solvents almost doubled from 1994 to 2001.

During the entire period, diagnoses related to poly-substance use make up the largest group, and the proportion of poly-substance users has been steadily increasing from 27% in 1994 to 37% in 2001. The second most frequent diagnosis is related to cannabis, which accounts for 29% of the individuals admitted to psychiatric treatment with a drug diagnosis.

As in previous years, the differences in gender are clear in 2001 (data not disclosed). The men outnumber the women and thus account for 71% of all clients being treated for a drug diagnosis. They thus make up 84% of the cannabis addicts, 73% of the addicts on CNS stimulants and poly-substances and 69% of the opioide users admitted to treatment in psychiatric hospitals in 2001. These differences are similar to the gender differences observed on drug use throughout the population in general (see section 2.2). An exception to this, however, is the group of individuals admitted to treatment as a result of addiction to sedatives/hypnotics, where a mere 40% were men.

**Table 3.4.1. Individuals registered in psychiatric hospitals as a result of drug addiction, 1994-2001 (Primary and secondary diagnoses and the total of outpatient, full-day and half-day treatment).**

| Diagnosis code | Mental illnesses or disturbances caused by use of: | 1994 | 1995 | 1996 | 1997 | 1998 | 1999 | 2000 | 2001 |
|---|---|---|---|---|---|---|---|---|---|
| F11 | Opioides | 445 | 680 | 656 | 587 | 535 | 501 | 563 | 573 |
| F12 | Cannabis | 706 | 1065 | 944 | 1018 | 1096 | 1133 | 1100 | 1299 |
| F13 | Sedatives / hypnotics | 755 | 784 | 786 | 638 | 622 | 213 | 631 | 593 |
| F14-F18 | CNS stimulants, hallucinogens and solvents | 177 | 280 | 314 | 316 | 303 | 315 | 308 | 347 |
| F19 | Poly-substance use | 755 | 1058 | 1167 | 1255 | 1525 | 1756 | 1783 | 1655 |
| Total | | 2838 | 3867 | 3867 | 3814 | 4080 | 4287 | 4375 | 4467 |

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 opioides, 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 F19.x (primary or secondary diagnosis) was applied as retrieval criteria.

### 3.4.2. Contacts to emergency wards due to illicit drug use

During recent years, it has been assumed that an increasing number of individuals contact the emergency wards after having taken illicit drugs. In order to see whether it is possible to obtain additional information from the emergency wards in Denmark for monitoring purposes, the National Board of Health requested a special statistical report from the University Hospital of Odense (Larsen & Hansen 2001). The report includes the total number of persons aged 15 years and above, who have been treated for poisoning symptoms at the emergency ward of the University Hospital of Odense after having taken illicit drugs during the period 1.1.1990 to 30.6.2001. The results of this survey are not indicative of the situation on a national scale[20].

[20] The figures appearing in the survey reflect the minimum number of individuals contacting the emergency ward with poisoning symptoms after the intake of (illicit) drugs. For one, not all patients intoxicated /poisoned by a drug inform about their condition during the examination in the emergency ward, and

During the 11 1/2 years, a total of 1671 individuals were treated for poisoning symptoms after having taken (illicit) drugs. The majority (1403) were treated due to intake of opioides, ie in most instances heroin. The remaining 268 individuals were admitted to hospital due to intake of amphetamine and cocaine, cannabis, ecstasy and psilocybin mushrooms. The contacts resulting from ecstasy and euphoriant mushrooms predominantly took place during the last year of the period.

2/3 or more of the total number of poisoning cases, all depending on type of drug, was seen in men. The younger men in particular were the ones to suffer from poisonings with drugs such as amphetamine, cocaine, psilocybin mushrooms and ecstasy.

### 3.4.3.Drug users in the traffic

Each year, analyses are made on a number of blood samples collected from arrested, intoxicated road users in order to determine the presence of substances other than alcohol. These tests are made at the Department of Forensic Medicine in Copenhagen. Out of 218 analyses in 2000, 41% of the tests showed the presence of benzodiazepines, 37% cannabis, 18% heroin/ morphine, 12% cocaine and 12% amphetamine. In 1999, the presence of ecstasy (MDMA) was established for the first time and was found in 2% of the tests (Unpublished figures submitted by Anni Steentoft, Department of Forensic Chemistry, Institute of Forensic Chemistry, Copenhagen)[21].

secondly many of the patients have been taking several drugs, for which reason it is difficult to separate the injring drug.

[21] In 2000, the Danish Transport Research Institute, Holstebro police and Department of Forensic Chemistry at the Institute of Forensic Chemistry in Copenhagen launched a survey on medicine and drugs taken by road users (Denmark's Transport Research 2001). The survey illustrated the presence of medicin and illicit drugs among approximately 1000 road users stopped at random in the police district of Holstebro, where the police suspected no influence of drugs.

# Chapter 4 Social and Legal Correlates and Consequences

This chapter provides a description of the scope and development of drug offences in Denmark.

## 4.1. Social problems

"NO INFORMATION AVAILABLE". See key issue chapter 16 on social exclusion and re-integration.

## 4.2. Drug offences and drug-related crime

In Denmark, all crime linked to the possession, purchase, sale or other transfer of illegal drugs is registered. No recent statistics are available on the so-called secondary crime in connection with the use of illicit drugs.

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) and section 191a (handling of stolen goods) 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 bring charges against the offender, who may be sentenced to some kind of prison sentence, other sanction or acquittal. The National Centre of Investigative Support (NEC) established by the National Commissioner's Office registers charges and reports filed annually.

As it appears in table 4.2.1 below, the number of charges pressed since 1995 has remained at a relatively constant level, ie around 13,000 to 14,000. Similarly, the number of individuals charged since 1994 has been around 9,000. In 2001, a total of 13,143 charges were recorded. Out of the 9,858 people charged in 2001, 5,231 were charged for the first time.

**Table 4.2.1. Drug offences 1992-2001. Charges and number of people charged.**

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

Source: NEC 2002 and Politiets Narkotikastatistik 2001.

### Imprisonment for drug-related offences

Once a year, the Danish Prison and Probation Service registers the number of prisoners who are either charged or have received a prison sentence for drug offences[22]. Such drug offences include the direct use, possession, acquisition, manufacturing or distribution of euphoriant substances. This means violation of

[22] The Danish Prison and Probation Service did not make an estimate in November 2001, but instead in February 2002.

the Act on Euphoriant Substances, Section 191 of the Danish Criminal Code or

**Table 4.2.2 Prisoners who have been charged with or received a sentence for drug offences.**

| Census date | Non drug users engaged in drug offences | Drug addicts engaged in drug offences | Drug offences Total | Individuals engaged in drug offences in % of all prisoners |
|---|---|---|---|---|
| Apr. 85 | 290 | 305 | 595 | 18.8 |
| Feb. 86 | 272 | 387 | 659 | 18.4 |
| Sep. 87 | 290 | 326 | 616 | 19.1 |
| Oct. 88 | 364 | 372 | 736 | 20.5 |
| Sep. 89 | 403 | 423 | 826 | 23.4 |
| Oct. 90 | 385 | 423 | 808 | 22.6 |
| Nov. 91 | 434 | 461 | 895 | 24.2 |
| Dec. 92 | 475 | 511 | 986 | 27,6 |
| Nov. 93 | 488 | 493 | 981 | 27.3 |
| Dec. 94 | 509 | 521 | 1030 | 28.1 |
| Nov. 95 | 483 | 488 | 971 | 27.2 |
| Nov. 96 | 404 | 494 | 898 | 25.7 |
| Nov. 97 | 453 | 597 | 1050 | 29.7 |
| Nov. 98 | 491 | 607 | 1098 | 30.8 |
| Nov. 99 | 510 | 603 | 1113 | 30.9 |
| Nov. 00 | 452 | 631 | 1083 | 31.2 |
| Feb. 02 | 531 | 612 | 1143 | 33.1 |

Source: Unpublished figures from the Directorate under the Danish Prison and Probation Services 2002.

other regulations governing the procurement or attempt to procure drug illegally, including burglary and theft in pharmacies, medicine cabinets, paramedic vans and in doctor consultations as well as forged prescriptions, etc.

The number of prisoners which may be characterised as engaged in drug offences was 1143 in February 2002 or 33% of the total number of prisoners (See table 4.2.2). Out of the individuals engaged in drug offences, 54% were drug addicts, whereas the remaining 46% had committed drug offences without being users of euphoriant drugs.

The number of prisoners sentenced due to drug offences has, with a few exceptions, increased gradually over quite a few years. This applies to the group of drug addicts committing drug offences as well as the group of prisoners committing drug offences without also being drug users. (Unpublished figures from the Directorate under the Danish Prison and Probation Service 2002).

## 4.3. Social and economic costs of drug consumption

”NO INFORMATION AVAILABLE”

# Chapter 5 Drug Markets

This chapter provides a description of the drug market in Denmark. It also includes analyses on the contents of ecstasy pills, the origin of the drugs, prices, purity and statistics on police seizures.

## 5.1. Availability and supply

In its report ”Drug-related crime in Denmark 2001”, the National Commissioner of Police point out that Morocco continues to be the key producing country of cannabis in relation to the Danish market (NEC 2002). Spain and Holland are in this connection the most important transit countries. Smuggling from the East also takes place, as the higher quality (the THC value) in the cannabis produced in these countries provides a greater profit in spite of lower quantities and higher travelling expenses.

According to the National Commissioner of Police, the vast majority of heroin smuggled into Denmark comes from southwest Asia either via the traditional routes through Iran and Turkey or via newer routes through the central Asian states and Byelorussia. The new routes, however, do not appear to be applied in connection with smuggling to Denmark to the same extent as in connection with smuggling to other countries.

The Columbian drug cartels are still considered to account for approximately 80% of the world’s production of cocaine. According to the National Commissioner of Police, the massive efforts to combat cocaine smuggling in the US has meant that the producers have started to focus more on the European markets.

Both amphetamines as well as ecstasy seized in Denmark are assumed primarily to be produced in Holland and in Belgium. Typically, smuggling into Denmark is carried out over land across Germany (NEC 2002).

## 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 2002).

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.

The quantity of seized heroin, cocaine, lsd and cannabis dropped from 2000 to 2001, whereas the quantities of amphetamine and ecstasy increased dramatically during the same period. The reason for the sudden increase in amphetamine seized is that in 2001, four extraordinarily large seizures were made. As far as ecstasy is concerned, the large increase in the number of pills seized is explained by the exceptional seizure of 107,753 pills in 2001.

In spite of the drop in the quantity of cocaine seized, the police are certain that cocaine is still spreading. Their assumptions are backed by, among others, the increase in the number of seizures as well as the number of cases, in which criminal network operations have smuggled larger quantities of cocaine.

**Monitoring of illicit drugs trafficking at a user level**

Since 1995, drugs being illegally traded on a user level have 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 of samples analysed in "Street Plan project" in 2001**

In 2001, the data material in the Street Plan Project consists 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 2001.

Out of the 152 samples analysed in 2001, 44% included CNS stimulants such as amphetamine and cocaine. This percentage has varied throughout the years and reached its peak in 1999, when 50% of the samples either turned out to be amphetamine or cocaine. ”Ecstasy drugs”, ie the new designer drugs were established in 9% of the 152 samples

45% of all samples in 2001 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 1995 to today, given that 74% of all samples in 1995 contained heroin. One exception to this is in Aalborg police district, where only 15% of all samples contained heroin in 2001 (data not disclosed). In this district, the predominant drug is amphetamine, which thus accounts for 35% of all samples.

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

*In 1996, 1997, 1998 and 1999 , the percentages include reports from Elsinore police district.

Table 5.2.3 of the Annex shows the distribution between heroin base ("smokeable heroin") and heroin chloride (white heroin for injection) from 1996-2001. From 1996 the proportion of heroin base established among the heroin samples appears to increase steadily. In 2001, 91% of all heroin samples in Aarhus and 86% of all heroin samples in Copenhagen consisted of heroin base (data not disclosed). Odense continues to distinguish itself significantly from the rest of Denmark, with 79% of the heroin samples being established as heroin chloride.

## 5.3. Price/purity

Table 5.3.1 shows the purity of various drugs from 1996 to 2001 in samples collected under the Street Plan Project.

| Table 5.3.1. Purity of illicit drugs on a user level, 1996-2001 (Median). | | | | | | |
|---|---|---|---|---|---|---|
| | 1996* (n) | 1997* (n) | 1998* (n) | 1999* (n) | 2000 (n) | 2001 (n) |
| Heroin chloride | 73% | 82% | 80% | 79% | 68% | 60% |
| Heroin base | 43% | 32% | 31% | 30% | 40% | 48% |
| Amphetamine sulphate | 20% | 22% | 21% | 12% | 17% | 12% |
| Cocaine chloride | 65% | 64% | 57% | 61% | 42% | 48% |

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

*In 1996, 1997, 1998, and 1999, percentages include reports from Elsinore police district.

The median for purity of white/beige heroin chloride was between 68% and 82% in 1996-2000[23]. In 2001, it was 60% with a large variation interval from 11-82%. By contrast, the average purity at the end of the 1980s was 45%.

For heroin base, the median purity value was 48% in 2001. Compared to previous years, the purity of heroin base in 2001 was significantly higher, except from in 1996. As was the case with heroin chloride, the purity variation interval for heroin base was large (10-63%).

For amphetamine, purity was, with a few exceptions, relatively homogenous and low (12%). The variation interval was wide (1-63%), but only one-fifth contained more than 20% amphetamine. In 2001, purity was at the same level as in 1999, but lower than in 1996-1998.

In 2000, cocaine purity dropped significantly as opposed to the previous years, but in 2001, the drop came to a halt and purity remained at the same level as the year before, ie 48%. The variation interval in 2001 was large (6-83%).

There were no significant differences in purity of the individual illicit drugs seized in various parts of Denmark in 2001, as had been the case in previous years, but everywhere in the country the variation interval was large. All police districts were still coming across 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.

When comparing the samples of the Street Plan Project and the routine sampling[24] made 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 selling at street level or being of more ”inferior” quality than drugs handled in large weight quantities. Similarly, there are no differences between the routine samples and the Street Plan samples as regards the relative distribution of the drugs (Kaa et al 2002).

**Monitoring 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

[23] Since purity of most drugs is not distributed on a standard basis, this table applies median values rather than average purity. This also concurs with general practice at the institutions of forensic chemistry.

[24] 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.

chemistry established an ecstasy database on chemical analyses of ecstasy pills seized in Denmark[25].

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. Within the Nordic countries, chemical analyses are sent to Finland in order to provide a Nordic overview of the prevalence, trafficking and smuggling of ecstasy in order to launch investigative measures against the perpetrators who are active in more than one Nordic country.

In 2001, the institutes of forensic chemistry had examined a total of 148,268 tablets (Kaa 2002). Sizes and colours varied with white, beige or grey being the most predominant ones. The samples had 55 different logos with the Mitsubishi logo being the most frequent and tablets without any logo coming in second. Also the tablets varied as regards ingredients:

- 85% of the pills only contained MDMA
- approximately 11% of the pills contained MDMA and another stimulant drug, including amphetamine.
- 2% of the pills contained amphetamine only
- 2% of the pills contained MDE, DOB or PMMA+PMA.

As opposed to previous years when almost one-third of the tablets contained amphetamine, the number of ecstasy pills with amphetamine dropped significantly.

Also the drug concentration in the pills varied a great deal. For instance, in 2001, the quantity of MDMA varied per tablet from 1% to 54% of the tablet's weight.

**Prices**

Each year, the National Commissioner of Police provides an estimate of the drug prices on a street level in its report (NEC 2002). According to the report, the price for cannabis is typically between DKK50 and 80 per gram. The price for heroin is broken down into a price for white heroin, which is approximately DKK 1,200 per

[25] 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.

gram, whereas the price for brown heroin is approximately DKK 600 per gram. However, the prices vary considerably across the country. Amphetamine prices also differ around the country by an average price of approximately DKK 250 per gram.

According to the National Commissioner's Office, cocaine prices have stabilized on a street level, although the tendency is declining slightly. The average price is estimated at approximately DKK 700 per gram, but again with large variations on a national scale. The price for ecstasy is also declining with prices per tablet at DKK 50-125 in 2001 compared to DKK 100-150 in 2000.

# 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 surveys, police surveys 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.

## 6.1. Cannabis

Cannabis has always been the most widespread illegal substance in Denmark. Thus, approximately 10% of the Danish population aged between 16 and 44 years has been smoking cannabis within the past year, whereas approximately 3 % had tried other illicit drugs within the past year. The typical consumption 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 addicts. 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. The group of somewhat older drug addicts, however, rarely report cannabis as their primary drug, but more as a very important secondary drug.

## 6.2. Synthetic drugs

Surveys 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 proliferation also appears to be on the increase up through the 1990s. The proportion of pupils in the 9$^{th}$ grade (see chapter 15) who report having tried amphetamine ever increased from 1.6% in 1995 to 4% in 1999. Around 10% of the young people between 16 and 24 years of age report having tried amphetamine ever in both SUSY 2000 and MULD 2001. Reports submitted from regional hearings also back the suspicion on more extensive prevalence.

### Amphetamine

Amphetamine, however, does not play a major role as a primary substance among drug addicts under treatment. In 2001, merely 3% of all drug addicts 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 addicts under treatment.

Police statistics on amphetamine seized during the same period reveal major fluctuations year by year. In 2001, four extraordinary seizures were made which makes it difficult to say anything about a general tendency. Amphetamine is available all over the country in most police districts and counties

Results from the Street Plan Project suggest a drop in purity of amphetamine 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. Only 4% of all ecstasy pills analysed in 2001 contained amphetamine. In comparison 7% of all ecstasy pills analysed in 2000, 22% in 1999, 28% in 1998 and 15% in 1997 contained amphetamine. It is not clear why the percentage of amphetamine in ecstasy pills has dropped so drastically.

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

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

**LSD**

There is a small, however apparently increasing prevalence of lsd in Denmark. Police statistics on seizures show a small increase during recent years in numbers as well as quantities. Previous investigations of prevalence of lsd in the population show that its presence has been so limited that it has been hardly measurable. However, in the population survey from 2000, almost 2% of the 16-24-year-olds reported having tried lsd ever.

**6.3. Heroin/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 the 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 surveys.

Opioides are still the most used substance group among addicts under treatment. However, still a fewer number of people report opioides as their primary drug among those who have not previously been admitted to treatment, which might imply that the use of opioides in time will reduce among addicts 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. There might be a trend towards falling purity of heroin chloride, however it is still purer than in the 1980s. On the other hand, there is a tendency towards increasing purity of heroin base.

### 6.4. 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. This could be explained by the fact that the massive efforts to combat cocaine smuggling in the USA have rendered the European market more attractive resulting in larger prevalence and falling prices.

Similarly, regional hearings report about continued prevalence of cocaine among experimenting young people and as a secondary drug among addicts. The assumptions on an increase in cocaine presence on the market are also substantiated by surveys conducted on the experimental use among the 15-16-year-olds over the past 5 years. Results from population surveys confirm that the presence of cocaine is increasing. 4-5% of the young people aged under 25 years have tried cocaine. The use of cocaine in this age group is only superseded by cannabis and amphetamine.

### 6.5. Multiple use

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

Around half of the clients admitted to treatment report being poly-substance users where cannabis, amphetamine, cocaine, alcohol, etc. are included as a secondary addiction to a primary substance. Similarly, a majority of the patients admitted to drug-related psychiatric treatment are poly-substance 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 surveys, from the treatment register, from regional hearings and data on drug-related psychiatric admissions concur with this observation. Also, all population surveys demonstrate that cannabis is the most widespread drug. Data from several regional studies and from the regional hearings also indicate a lower age of initiation for smoking cannabis (see key issue chapter 15).

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 surveys 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 addicts under treatment.

Ecstasy is not as widespread as amphetamine, in spite of the massive media coverage on the presence of the drug. This is documented in population surveys as well as most of the regional hearings. Ecstasy also appears rarely as a drug used by addicts under treatment. However, this does not concur 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 maintain that opioides, including heroin, are the most frequently used drugs among addicts. Heroin is also the most frequently appearing drug 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 opioide addicts among newcomers under treatment suggest that a drug problem involving CNS substances as the primary drug is about to develop.

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 survey from 1999 and in several of the regional hearing feedbacks from 2002.

The most significant characteristic of experimental users and addicts is that the men outnumber the women. This is established in all population surveys, 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 appears from the various population surveys 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.

The MULD 2000 survey and several regional surveys find that the same young people are the ones to expose themselves to the risks associated with experimental use of cannabis and other illicit drugs, daily smoking and excess consumption of alcohol (see chapter 15).

At the same time, the regional hearings report about wide social diversification as regards drug use. This coincides with the observation that there is no coherence between low social status and young people's use of euphoriant substances.

## 7.2. Methodological limitations and data quality

### Monitoring use of illicit drugs in the population

Until the middle of the 1990s, there was no tradition nor were there any specific guidelines in completing surveys on the population's use of drugs. Concurrently with increasing international cooperation on monitoring the drug scene, standards have now been developed to facilitate national comparison of developments over time as well as European comparisons. The National Board of Health aims at using the European standards in the years to come in order to improve the basis for comparison over time, which is already the case with the ESPAD surveys (see chapter 15), the MULD surveys as well as the Health and Morbidity Survey 2000. In order to be able to describe a trend or development in the use of illicit drugs in the population over time, it is crucial that such surveys are repeated at regular intervals. It is highly likely that in the future, respondents will be asked about their attitudes towards drugs and their possibilities of getting hold of the drugs ("availability").

A new initiative was launched when the National Board of Health and The Danish Cancer Society made a survey in 2000 on the lifestyle and the daily lives of the 16-20-year-olds. Questions about their use of illicit drugs were included in the survey which also asked questions about, among others, tobacco and alcohol. This survey was repeated in 2001 and will be repeated every year until 2005 when the necessity of annual monitoring activities will be reconsidered. The results from the surveys in 2000 and 2001 are outlined in chapter 2.

As it is also described in chapter 2, the regional hearings have contributed to qualifying the information about the use of drugs among the population, although this information more assumes the nature of “soft data” and therefore cannot stand alone.

**New estimates on drug addiction in Denmark**

The National Board of Health is presently having new estimates made on the number of drug addicts in Denmark. These estimates will be provided in the annual report for 2003. Based on the recommendations from the European Monitoring Centre for Drugs and Drug Addiction, such estimates will be made on a more regular basis in the years to come.

**Qualification of registers**

Concurrently with the implementation of a European standard for registration of drug-related deaths, the National Board of Health, the National Commissioner of Police and the Institutes of forensic chemistry are working on adjusting code practice and definitions which will be able to qualify the National Commissioner’s Register on drug-related deaths and causes of death.

As something quite new, this report includes data from the National Commissioner’s Register as well as from the Cause of Death Register under the National Board of Health. In addition, ongoing qualification will be made of the National Board of Health register on drug addicts entering treatment.

**Research project on excess mortality following prison release**

In 2002, Peer Brehm Christensen, specialist consultant, PhD, Odense University Hospital, and the National Board of Health launched a register research project on the mortality among drug addicts during the period after their release from prison. The objective was to study whether drug addicts under treatment are more likely to die during the period immediately after release. The study is based on the hypothesis that while in prison, drug addicts reduce drug use considerably and as a result are more prone to taking an overdose if administering the same dose as before their imprisonment. The study is based on a Scottish study, according to which mortality appeared to be 35 times higher two weeks after release from prison than the rest of the time outside prison. The material, on which the study takes it starting point, is the National Board of Health Register on drug addicts admitted to treatment in consolidation with the Criminal Registry of the National Commissioner of Police.

**Research project on psychiatric illnesses and cannabis addiction**

As it appears from the figures provided on addiction diagnoses from the Psychiatric Central Registry (see chapter 3), an increasing number of cannabis users had contact to psychiatric treatment services. However, there is some uncertainty as to whether Danish cannabis addicts suffer from disorders other than their addiction such as schizophrenia, depression etc. Furthermore, it has not been clearly established how addiction might be interlinked with other psychopathology, ie whether psychological problems are caused by addiction, or whether cannabis is used by people who already are mentally unstable.

On consolidation of the registers so far it appears that 27.5% of those who have been treated for cannabis addiction within the health care system at some time have been subjected to psychiatric treatment with diagnoses other than those

who are directly related to addiction (ie F1x diagnoses). There are thus factors indicating a high prevalence of mental illnesses among those who are heavy cannabis addicts.

From the summer of 2002, a PhD project was launched from the Department of Psychiatric Demography at the Psychiatric Hospital in Aarhus, Risskov, under the management of Mikkel Arendt (psychologist), with the aim of further outlining the relationship between prevalence of mental illnesses and cannabis addiction. As part of this project, 200-300 young people between 18 and 25 years who have contacted the hospital for their cannabis dependency will be examined for their mental problems. Similarly, a group of 18-25 year-old psychiatric patients will be examined for the presence of cannabis addiction. The project will be carried out in cooperation with interested institutions engaged in treatment of drug addicts and with psychiatric wards from the counties in Jutland. The groups will be re-examined after 3 years and furthermore be followed for a number of years in various registers.

**Admission to emergency wards**

In order to monitor the injuries suffered by people taking illicit drugs, the National Board of Health would like to work with qualification of data provided on individuals contacting emergency wards due to poisoning as a result of intake of illicit drugs. As part of this project, the National Board of Health requisitioned special statistics on the poisoning cases recorded at the emergency ward of Odense University Hospital over a 10-year-period. The results of this work are described in chapter 3. The next few years, several initiatives will be launched to identify the scope and development of the number of poisonings caused by the intake of illicit drugs.

**The ecstasy database**

In connection with monitoring of the new synthetic drugs in Denmark, the National Board of Health, the National Commissioner of Police and the three institutes of forensic chemistry have cooperated on the establishment of a national ecstasy database. The database was inaugurated on 1 May 2001 and is updated regularly with the results from analyses on samples collected from all ecstasy seizures in Denmark. In addition to the information on potential new drugs emerging on the market, the database makes it possible to follow the development of the ingredients in the ecstasy pills, their concentration, appearance and logo. The results of the analyses in 2001 are described in chapter 5.

## Chapter 8 Strategies in Demand Reduction at National Level

Please refer to chapters 1 and 9.

# Chapter 9 Prevention

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
- Social welfare measures must be ready to provide assistance to addicts.

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 addiction 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. ...

For organisation and co-ordination within national structure please refer to chapter 1.

For expenditures on prevention in Member States please refer to chapter 1 and 14.

## 9.1. School programs

School is regarded as the most important institution for drug information. Drug information constitutes part of the curriculum in the primary and lower secondary school under the compulsory subject “Health, sex and family”.

The objects clause of the health-related curriculum emphasizes:

- that the pupils gain an insight into the conditions and values affecting health, sexuality and family life
- that the pupils achieve an understanding of the significance of sexuality and family life for health and for the interaction between health and environment
- that the pupils are supported in their personal development
- that the pupils develop the qualifications to take a critical stance and act in order to promote their own health and that of others.

No firm guidelines have been laid down for the form, contents and scope of a drugs curriculum. Drugs classes are often placed in the 7th - 9th grade. Normally, it is up to each class teacher to organise the teaching of this subject.

In many towns and cities, the local SSP Committee (formalised co-operation between the school, the social services and the police) contributes to drugs information in the primary and lower secondary schools. An SSP committee acts as a formalised link across sectors and consists of representatives from schools, social administration and police.

**Government involvement in relation to Danish schools**

At state level, the National Board of Health assumes active responsibility for drug prevention. One of the Board's tasks is to support and stimulate the local prevention activities, including school information projects.

The National Board of Health operates with two prevention strategies meant to complement each other: the broad, nationally targeted information campaigns and the narrow activities targeted at high-risk groups.

The broad, national drugs information is supposed to provide the young, their parents and professionals working with children and young people a high level of insight so as to ensure that a vast majority of the entire population takes a negative attitude towards drugs and dissociates itself from experimental drug use. It is perceived of utmost importance for the attitude barrier to be maintained by means of available informative material on current drugs; for key persons and the press to be informed on an ongoing basis and, in particular, for each new vintage of young people to be well-informed on a continuous basis via systematic information in school.

Initiatives vis-à-vis high-risk groups start with groups who, in addition to information, need a social framework and opportunities for development as alternatives to drug use. In this field, the National Board of Health particularly focuses on cooperation with the professionals who are in contact with the high-risk groups.

Drug prevention activities are developed in cooperation with the National Board, of Health, the county alcohol and drug counsellors, the medical officers of health and the advisory drug committee appointed by the National Board of Health. These activities emerge in the form of projects, development of informative and instructive material on cannabis and on various types of drugs as well as through meetings, courses and seminars for practitioners (school teachers, educators, etc), volunteers and other key figures working with drug problems at a local level.

Topical information about drugs is an ongoing issue of the magazine, UNG (Young) published by the Committee for Health Information and distributed at no charge 4 times a year to all school pupils in Denmark in the 8th-10th grades (14-17 years of age). Drug-related problems are also discussed in VITAL, a magazine dealing with drug prevention and distributed 4 times a year to

interested professionals, administrators and politicians.

**Identification of schoolbased drug prevention activities**

The National Board of Health has embarked on a project, the purpose of which is to map the prevention activities carried out in primary and secondary school. The first phase involves a pilot project aiming at developing a suitable data collection method (question to be asked, existing municipal network and organisation) for identification purposes. The pilot project will be carried out in approximately 25 municipalities in two selected counties. The pilot project is expected to be finalised in 2002.

**Regional plan**

According to the Danish Health Insurance Act, the counties and municipals are obliged to further local preventive and health promoting programs. The work with drugs is particularly administered by the county alcohol and drug counsellors.

A number of counties have established their own preventive councils engaged in, among other things, drug addiction problems. A number of large municipalities have also hired counsellors to deal with the preventive measures related to euphoriant substances. The county alcohol and drug counsellors provide a curriculum to the $6^{th}$-$10^{th}$ grades, their teachers and parents. The services range from help and guidance to teachers in planning their classes to large-scale campaigns of a local or regional nature. The alcohol and drug counsellors prepare their own material and training activities – sometimes with the support of the National Board of Health and others, the aim being to start a debate and to change the attitudes of the pupils. Furthermore, they make sure that the county centres/educational centres always are stocked with the training material and films for the teachers to use in their classes on drugs in the primary and secondary school. Also the parent corps must start a debate at parent meetings among the other parents about children and young people's attitudes towards alcohol and other drugs.

**Example: Project ''Parent teams – dealing with alcohol and other drugs"**

The project known as "Forældrekorps - om alkohol og andre rusmidler" [Parent teams – dealing with alcohol and other drugs] was initiated by the Department of Prevention and Health in Funen County in order to attract parents' attention to their responsibilities in connection with young people and drugs, including lowering the age of drug initiation. The county chose 15 schools to participate in the project. Each school set up their own parent team consisting of up to 10 parents and an employee connected to the school. The parent teams were to participate in a course divided into three modules, with the emphasis being on knowledge, attitudes, common social responsibility, communication and knowledge collection as well as documentation of the experience gained by the parent team. After the course and on the basis of their own experience and attitudes, the 15 parent teams were to act as supervisors to the young people at the local school. Also, the parent teams were to start a debate at the parent meetings on the attitudes of children and young people towards alcohol and other drugs.

The overall goal:

- To make the parent of pupils in the 6th-9th grades aware of their roles as frontrunner and coach in relation to children and young people's use of alcohol and other drugs.

The interim goals of the project:

- That the parents of the parent team participated in a course on alcohol and other drugs. During the course, they were asked to think about their role as parents in relation to different scenarios surrounding young people and drugs.
- That the parent team held 1-2 sessions during the project to discuss alcohol and other drugs with the students of the school and their parents. In doing so, the parents who were members of the parent team would initiate a dialogue between peers (parent-to-parent communication). It was considered very important that the parents together defined what they thought was reasonable in relation to the young people and alcohol.
- That during 2001, the school should prepare a drugs policy, which was to be communicated to parents and students.

Results/collection of experience shows:

- That two-thirds of the parents participated in all three course sessions, and one-third of the parents participated in two out of three course sessions. Participation in two out of three course sessions does not seem to have any influence on the parents' opinion about the course. The parents found that the course was of suitable duration (75%) and that the course was informative, comprehensible and relevant. The course in general was considered as being very good or good by all the participants. The members of the parent team had gained more knowledge about alcohol, and had become more conscious about age of initiation. Also the members found that the project had had an influence on the attitudes of the other parents and their interest in the subject.
- That all parent teams have launched 1-2 sessions in the form of feature activities for parents and students at the school, many have used lectures from peer group counsellors. The members of the parent team generally find that the sessions were successful and contributed to a debate on attitudes, which could form the basis of further parent cooperation. More than half of the members of the parent team find that the project has had an effect on the young people's attitude towards alcohol. The more extensive knowledge about young people and alcohol has provided a more in-depth understanding of their attitudes towards alcohol and their awareness of age of initiation.
- That the schools have not yet formulated an alcohol policy for the schools in 2001. The project is interesting, given that it focuses on the often unused resources inherently laid down in involving parents actively in preventive measures. During this project, the parents have

had a very favourable approach to the form of the project, which could be used successfully in the future.

The project has been submitted to the EDDRA database (http://www.reitox.emcdda.org:8008/eddra/)

**Example ”Generationernes forsamlingshus” [“The generation community centre”]**

”Generationernes forsamlingshus” is a pilot project in Ribe county aiming at the 9th-10th grade students’ (15-16-year-olds) parents and students who are about to start youth education. Empirically it turns out that when the students change from one education (primary and secondary school) to the other (youth education), new consumption habits and patterns emerge. The pilot project builds on top of the projects ”Forældre Back-up [Parent Back-up] – a key person group” and ”Parent Tjekup” [Parent Checkup] (see the annual reports 1999 and 2001). Both projects are based on the peer ”young-meets-young” model, with only parents debating and conveying their experience to other parents about being a parent to a child/teenager.

Project goal:

- Based on the experience gained in the “Parent back-up” and “Parent Check-up projects to test a controlled debate form as a tool for the generations to meet and debate about attitudes and responsibilities in connection with young people’s consumption of drugs.

The community centre meetings were held as traditional debate meetings in the evening, when students and parents each formulate their own scenarios, which they would like to debate with the other party in plenum. The two generations go to separate rooms where they formulate questions on the basis of a brief summary and return to plenum with questions they would like to ask their “counterpart”. When the generations gather again, the parent group and the student group then take turns in asking and answering each other’s questions. The process is controlled by a student and by one from the “Parent Check Up group”.

The pilot project will be evaluated in questionnaires distributed to parents and to students as well.

**Example: Drug prevention projects in production schools**

On the basis of a survey conducted on the use of drugs in youth educational institutions in northern Jutland county in 2001 it turned out that drug use in production schools was considerably higher than among young people in, for instance, business colleges and high schools, and the county then launched in 2001/2001 prevention measure in a series of production schools in Arden, Dronninglund, Hjørring, Pandrup, Nibe, Skagen and Støvring municipalities (The survey and the work involved is part of the county’s participation in the “Development project on ecstasy prevention in two “model counties”).

Project goals were:

- to map and identify possibilities and barriers to launching appropriate prevention in the schools.

- to strengthen the students'/participants' personal and social competencies in order to enable them to make relevant decisions in connection with drugs and to sharpen their awareness around friends' and family's influence on their choices.

All projects have focused on the connection between youth culture/party culture and drugs.

The projects have been different in their contents and have involved activities such as news broadcasting, short fiction films, theatre shows, doll theatre, fashion shows, production of advertising films and presentation boards. The projects in the schools lasted from one day to one week and ended in a presentation of what they had made.

Based on previous good experience with gender divided classes, boys and girls were split up into groups. The first experience gained is that especially the boys benefited from the gender divided teaching in the form of more openness in connection with discussing addiction problems.

The projects have been completed in cooperation with the schools' teachers who often act as counsellors for the students. The projects are expected to be evaluated at the beginning of 2003.

Based on similar study results from young people's use of CNS substances in, among others, production schools, Vejle county has held competency courses for the schools' key personnel in cooperation with the "young-meet-young" workers connected to the county.

The production schools make up an alternative to young people aged between 16 and 25 years. The schools were and are still established on a municipal initiative, and in several places, two or more municipalities cooperate on the operation of a production school. The basis for the learning process at the schools is a number of workshops with practical work (kitchen, carpenter/joiner, metal, data, etc). The objective of the schools is to strengthen the students' personal and professional skills and prepare them for another education and work. The production schools distinguish themselves from most other school forms in that they have a continuous intake and very big variations in the duration of the stay of the individual participants. A typical stay is of approximately six months' duration, but 25% stay at the production school for more than a month and 25% for more than six months. 45% of the pupils have interrupted a more mainstream type of education. The Act on production schools stipulates that the stay must not exceed one year. In Denmark, there are 97 production schools, which in addition to the basic funds granted by the municipality receive government grants.

### 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.

There is no full overview of all local prevention activities.

**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 addiction. 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).

In relation to the expenditures on prevention in Member States please refer to chapter 1. and 14).

**9.4. Other programmes**

**Peer-to-peer approaches**
**Example: "The Caravan"**

Project "Vognen" [the Caravan] was initiated by the county of Northern Jutland as part of the overall "Development project on ecstasy prevention" launched by the Ministry of Health due to increasing use of ecstasy, amphetamine and other illicit drugs among Danish young people.

The “Caravan” project is a targeted peer initiative in the party settings in four holiday resorts in the county of northern Jutland. Under the motto “take a break in the caravan”, young people took care of other young people and gave them information from three mobile homes, which were placed close to the party settings in the towns in question. The “Caravan” was open during all summer months of 2001 between 11 pm and 7 am on Thursdays, Fridays and Saturdays.

The overall project goal was:

- To reduce the entry of new users of ecstasy and similar drugs among young people in the county of northern Jutland. At the same time, the aim was also to reduce the entry of new heavy alcoholics within the same target group.

The interim project goals were:

- To start a debate by offering the young people an anonymous and serious conversation on drugs and other problems in easily accessible and safe surroundings with a qualified peer employee at a time when the young people are affected by the atmosphere and therefore are in the mood to have an opinion about and receive information on drugs, and:
- To test the applicability of the peer method in a mobile prevention unit located close to the party settings with the aim of conveying experience gained to strengthen the efforts made in other counties and to obtain experience about what should be required of the young counsellors and how to optimise a qualifying course program.

Results:

- 400 young people visited “the Caravan”, most of the visitors being boys. All the visits made to ”the Caravan” were recorded on report forms. From these forms, it appears that the young people primarily used “the Caravan” as a possibility of dialogue and receiving care and then information about the project as well as a chat about drugs and attitudes towards parties, drugs and alcohol. Some of the visitors received advice on problems stretching beyond drug problems, for instance parents’ divorce, broken hearts and local fights. A few were referred to other organisations within the municipal system. Everybody was offered the possibility of taking a break from the party, getting a cop of coffee and talking with other young people who were sober. The “Caravan” project succeeded in establishing contact to the target group and through informative dialogue challenged the young people’s perception of drugs. By its presence in the areas, the project also inspired to a local debate on drugs.
- Experience gained from the ”Caravan” project could be used in the continuing prevention intervention using the peer approach in party settings. The qualified peer worker is young at heart and at mind. It is an advantage that the workers are a few years older than the target group in that they may come across as being more trustworthy and act as role models. The workers must be open-minded and curious, perhaps have had experiences with drugs themselves, but should have

a firm opinion about the problem and be able to remember how it was to party all night. The introductory course should prioritise teambuilding between the young workers given that working together and being creative in developing the project concept and in difficult situations is indeed necessary if the young workers are to add success to the project. During the course, the workers must be informed about whom they should refer to in special crisis situations. During the project itself, work distribution must be unambiguous between the project parties. The project leaders must always be available in order to supervise the peer workers and to give them professional support during the project period.

These are the preliminary results from the ”Caravan” project. The project will be subjected to in-depth evaluation at the end of the overall "Development project on ecstasy prevention” during 2003. The project is described in the EDDRA database (http://www.reitox.emcdda.org:8008/eddra/)

**Community programmes**

Denmark’s housing sector traditionally operates across sectors, involving citizens, institutions, private as well as public with the aim of citizen and user involvement and co-influence. However, no projects or pilot projects have been established to address drug problems specifically.

Out of the 275 Danish municipalities (as at 1 January 2003: 271 municipalities), a vast majority has formalised their cooperation with school, social administration and the police in what is called the SSP-cooperation. This cooperation differs between municipalities based on local conditions, but in general it is a preventive and activity promoting function established for the benefit of the children and the young people living in the municipality. This cross-sectoral cooperation aims at intercepting signals, and to combat any general and specific poor treatment of children and young people, to suggest and launch activities and to prevent against any drug addiction and criminal activity. The SSP may, for instance, be part of the drugs information work performed by schools and youth clubs, launch street work and create special projects to identify young people in danger of ending in crime and addiction settings.

**Example: "Natteravnene" [Night Ravens]**

The “Night Ravens” are a number of local organisations consisting of parents and other adults who on a voluntary basis and with out special authorisation walk the streets of their community, typically in the towns during the late hours of the nights in the weekends. Their goal is to establish a safe environment and show informal concern for the young people who are walking the streets by night. The “Night Ravens” work on the principle that they always walk in groups of 3, wearing a uniform of yellow jackets; they never walk into pubs, discothèques and clubs; nor do they interfere in riots or provide actual counselling which is left to professionals.

Originally, the concept behind the “Nigh Ravens” was established in cooperation with Swedish voluntary associations and a large Scandinavian insurance company assisting in setting up the associations.

The organisations are made up of a local board, which together with local private individuals sponsor the financial basis for the day-to-day operation. The establishment of a "Night Raven" organisation is always done following the acceptance and support from the local municipality, the police and SSP committees.

During the four-year period, in which the "Night Ravens" have existed, the number of local organisations has gone up to 105 in Denmark and 5 in Greenland by a total of more than 4,000 members (September 2002). A number of cities/municipalities have shown an interest in the ongoing project.

**Telephone help-lines**

Telephone aid is an integral part of the service provided by a number of the county counselling centres. Anonymous phone calls are accepted. The service is free and may be used at regular hours in the daytime during weekdays. The telephone help line is part of the overall counselling service and is both targeted at the drug addicts and their relatives encountering specific problems and at teachers and other professionals participating in information campaigns on drug addiction problems. Due to a low number of calls to the various telephone counselling services providing specific ecstasy counselling, the telephone help lines have now been included in the normal opening hours of the addiction centres. It is not a telephone service offered on a national basis – nor does it provide round-the-clock services.

**Mass media campaigns**

Based on the professional concept that it is difficult to reach the very small minority experimenting with drugs through a mass media campaign and that drug information must be conveyed in a dialogue with local networks in order to influence attitudes, the official Denmark has not initiated any mass media campaigns within the drugs field. No national campaigns were held in 2002.

**Internet**
**Example:**
**www.mindblow.dk**

As part of the information about drugs provided on a national level, the National Board of Health has set up an independent web-site on drugs containing factual information on drug effects and risks described in drug pamphlets published by the National Board of Health, training material, articles and a "wheel of fortune" where the young people can test their knowledge about drugs. (www.sst.dk)

The primary target group includes young people at the age of 15-25 years, which has determined the design of the site and the language communication form. The secondary target group includes teachers and relatives of young (potential) users. The address of the website is: www.mindblow.dk.

**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).

This year www.netstof.dk was updated in a new version, containing, among other things 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.

**Eksempel: Internet/SMS projektet "Need a break"**

In order to launch preventive measures on the young people's use of drugs- with a focus on ecstasy, Ribe county held a future workshop in 2001 with young people from the county's youth educational institutions in order to have their input on what could be important focus areas in relation to the young people, drugs and lifestyle. The outcome of the future workshop formed the basis of efforts designed as a continuous competition with various tasks, where the young people could submit project proposals for activities to be carried out.

Overall goal:

- To turn around the young people's use of drugs through personal determination to minimise the number of young people dropping out of their education or who, one way or the other, do not fit into a social network. Another goal is to make decision-makers, adults and institutions more aware of their roles in relation to the young people and the way in which their social lives develop.

Interim goals:

To draw the young people's attention to:

- People who mean something to them during adolescence
- The mechanisms that result in experimental drug use
- Why we are different
- Where to get help if (you can't handle it yourself)

The method to be tested during this pilot project involves the young people via the Internet and SMS messages via the mobile phone. In contrast to the normal projects targeted at youth educations which break into an educational curriculum and the educational annual plans, the projects will, apart from an introductory joint meeting, apply 15 minute and lunch breaks, use SMS messages to inform that a new assignment/competition is on its way. The pupils sign up for the project via the website in order for them to receive SMS-messages. The project assignments will contain information about drugs, various self-tests (is it ok to/is it not ok to...?), parent testing (what do you think your parents would say if....?) contact persons and other help personnel, the solution to last week's assignment and solutions received. The website will be accessible beyond the campaign period so that the young people – and the adults (teachers) – will still be able to enter the site and seek information.

The project will be subjected to internal evaluation.

# Kapitel 10 Reduction of Drug Related Harm

The fact that not all drug addicts are interested in treatment, that many relapse into addiction and the Danish tradition of caring for all weak citizens irrespective of the causes for their social and health-related problems, means that various harm reduction activities are of key significance, cf Part 33 of the Social Welfare Act.

**Definitions 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 addicts 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, “users’ rooms” for addicts (low threshold services) syringe exchange programs and social support at home.

**Current public/professional discussion**

As mentioned in chapter 1, a group of experts, including representatives from the health care and social sector as well as the justice system, was appointed in September 2001 with he aim of identifying focus areas for the most deprived drug addicts. The expert report was submitted in February 2002 and contained, among others, recommendations related to reduction of drug-related harm (Indenrigs- & Sundhedsministeriet 2002):

- As regards the spreading of infectious diseases, the expert group recommended that drug addicts should be offered free vaccination against hepatitis B and that the National Board of Health should produce an action plan to reduce the presence of hepatitis C, for which disease there is no vaccine.

- As regards the establishment of users’ rooms – ie specially designed, monitored premises, in which the injecting drug user can administer their drug without stress and under hygienic conditions- one member of the expert group was clearly in favour such rooms. The unambiguous support from this one member was based on the philosophy that a fundamental element in social policy is harm reduction, for which reason no stone should be left unturned when it comes to improving the living conditions of the very weak groups. The other members of the group would not reject or direct oppose the idea of establishing drug injection rooms, but could only give more or less cautious and hesitant support for such rooms, given that they were not sure that it would materially influence the health-related and social condition of the drug addicts using the rooms. The majority also found that the funds that would need to be reserved for such rooms could be used better for different types of treatment, for instance intensified psycho-social projects and for other low-threshold services. The expert group would not take a stance on

the issue of compatibility of injection rooms with international drug conventions. The Danish government has subsequent signified, that the introduction of user's rooms in Denmark is incompatible with the UN drug conventions, which only allow use of drugs for medical and scientific purposes. The International Narcotics Control Board (INCB) shares this view.

- The expert group found that outreach health care services are an important element to reduce drug-related harm inflicted on the most deprived drug addicts who in quite a few cases, in spite of their obvious needs, have no strength to avail themselves of the health care services provided or fail to fit into the framework of such services. The expert group emphasized that it was important that the planning of outreach health care services is made in close cooperation with already existing local planning of activities on a street level.

- The expert group pointed out that clean syringes had a significant harm reducing effect in the form of reduced risk of infections.

## 10.1. Description of interventions

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 addicts.

### Outreach project in Copenhagen

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 (Indenrigs- & Sundhedsministeriet 2002).

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 addict 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 addict and to establish contact to drug addiction 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.

At present, the project employs 4 outreach social workers, 5 nurses, 1 doctor and 2 social and health assistants.

**”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 (Indenrigs- og Sundhedsministeriet 2002).

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 2001, the now abolished Narcotics Council made an inquiry in all counties and the Copenhagen and Frederiksberg municipalities on whether syringe exchange schemes and dispensing schemes had been established (Narkotikarådet 2001). Based on the replies, the Narcotics Council came to the conclusion that approximately 1 million syringes are handed over the counter each year in Denmark (Indenrigs- & Sundhedsministeriet 2002).

In 10 of the counties and in the Copenhagen and Frederiksberg Municipalities, exchange schemes had been established. In the 4 remaining counties, 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 (Narkotikarådet 2001).

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 (DKK 5-10 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.

**City of Copenhagen**

In 2001, the City of Copenhagen dispensed 375,171 syringe tool sets, 525,922 needles and 29,642 syringes through pharmacies, shelters and from a so-called needle bus. The number of tool sets and needles increased only mildly compared to 2000, whereas the number of syringes dispensed dropped a trifle (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.

**Dissimination of information / educational material: Example J-kie cards)**

In 2001, 400,000 small colourful cards designed by Danish artists were handed out free of charge to intravenous injecting drug users in Copenhagen together with a syringe/needle set. The 100 different cards contained information about the body, risk of infections, drugs, injecting technique, and rights related to increasing one's knowledge and competencies among drug users in an attempt to prevent against infections diseases. The evaluation demonstrated that the cards conveyed clear and important information. The entire project amounted to approximately Euro 26,000, exclusive of reprinting of 2nd card issue, which was a result of user demand (the project can be seen at the EDDRA database at: www.reitox.emcdda.org:8008/eddra/).

**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) (Indenrigs- & Sundhedsministeriet 2002).

**Vaccines**

In March 1999, the Directorate under the Prison and Probation Service laid down that intravenou

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 hepatitis B vaccination to all drug addicts free of charge. This vaccination is given at the counselling centres, treatment centres or at the general practitioner's. The drug addicts have received a very colourful brochure, which has also been distributed to the various institutions in contact with the drug addicts.

**Prevention of drug related overdoses**

According to the records of the National Board of Health, no particular projects have at present been launched in Denmark to prevent drug addicts from overdosing. In 2002, a research project has been launched on excess mortality resulting from ODs among newly released addicts in prison. This project has been described in detail in chapter 7.

**Drop-in centres**

There are a number of drop-in centres solely to be used by female prostitute drug addicts. 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). During recent years, similar 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 addicts and former drug addicts", 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.

### 10.2. Standards and evaluations

"NO INFORMATION AVAILABLE".

# Chapter 11 Treatments

## 11.1 ”Drug-free” treatment and health care at national level

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 addiction 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. Financing of the treatment program is shared between the county and the municipality of the addict’s registered address, each paying 50%. From 1 January 2002 financing rules will be 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.

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.

### Detoxification, slow withdrawal and weaning

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.

### Critiria of admission to drug-free treatmen

The vast majority of the in-patient treatment services provided to drug addicts are targeted at drug addiction accompanied by social problems.

However, where treatment is offered to psychiatric patients who, apart from their psychiatric diagnosis such schizophrenia, also are diagnosed as drug addicts (“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 addicts outside the psychiatric system is provided in the social system.

In-patient treatment of drug addicts is assumed to be provided as part of county services under Section 93, (ss 1 and 2) of the Danish Social Services Act and other care-related and supportive housing alternatives are provided under Sections 91 and 94; other housing alternatives are provided under the law on social tenant housing, etc.

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 addicts who in most cases either are or have been opioid/heroin addicts.

Today, there are 40-45 actual in-patient institutions. The reason for the inexact figures is that these institutions come and go. 7-10 of these institutions are publicly financed. The remaining in-patient institutions are mostly privately owned institutions or owned by a fund. Only a few, if any at all, are owned by individuals.

Out of the 36 institutions participating in a current survey (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 addiction to a minimum and establishing an everyday life with social and employment activities which may help them form a structure and develop social competencies.

36 of the 40-45 abovementioned institutions participating in the current survey on in-patient treatment of drug addicts in Denmark (DANRIS) have capacity for 864 patients (April 2002). The normal number of patients is between 10 and 40 admitted drug addicts (some more, some less). If capacity were fully utilised at all times, the counties would have to pay an annual amount of approximately DKK 250 million for treatment in the 36 institutions. Utilisation of capacity is presently being studied, but appears to be between 60-80%. The private institutions appear to be more expensive than the public ones. However, it is difficult to compare treatment expenditure in two types of organisation that have completely different conditions and which to some extent also address different types of drug addicts.

**Programs and methods**

The above 36 in-patient institutions offered the following program/methods: 16 Minnesota institutions (12-step treatment), 13 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 36 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 addicts 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 addicts.

Most of the institutions offer a detoxification 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?**

When considering the severity of drug addition, the first 1312 drug addicts registered in the in-patient treatment study (DANRIS) cover a very wide sprectre of drug addicts 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 addicts in methadone stabilisation treatment. The least deprived is the group of drug addicts who, up until in-patient treatment, were clean for at least 30 days (detoxified before in-patient treatment). In between this group, there is a group of younger drug addicts who are severely deprived in terms of drugs and criminal offences, but they are not physically nor mentally deprived; there is a group of elderly addicts who are particularly physically deprived, a group whichi is particularly mentally deprived, etc.

**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 an in-patient treatment stay.

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.

The tendency the last year has been for fewer drug addicts to be referred to drug-free in-patient treatment, whereas it is tried alternatively to provide outpatient drug-free projects. However, these types of projects are still relatively limited in Denmark. Outpatient drug-free projects are distinguished as follows: a) Outpatient drug-free projects which must be considered as drug-free post treatment for drug addicts 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 and is expected to be completed in the autumn of 2002.

**Example "Goodbye cannabis"**

"Goodbye Cannabis "is an outpatient day treatment service in Viborg County provided to young people aged between 15 and 18 years with a cannabis addiction.

Goal:

- To add via reflexion knowledge and insight to the course participant in order to obtain recognition of and interest in change of one's own life situation.

Focus:

- Motivation to stop smoking cannabis.
- Knowledge about the damage caused by cannabis, mentally as well as socially.
- Knowledge about causal relationship of addiction.
- Reflexion on one's own life and the changes imminently resulting from stopping cannabis use.
- Practice tools to function without cannabis use.
- Support to choose a positive way of living and to test oneself in different situations.

The course form is group oriented, changing between class sessions, conversation, individual exercises and physical training. The first module consists of a specific treatment provided by the same attendant. The second module consists of a general part focusing on the client's own life situation and higher understanding of the relation between the body and the mind. The course is offered to 8 participants and runs over a period of 16 weeks.

**Example: "Rus-Navigatørerne" [Drug Navigators]**

**"Rus-Navigatørerne"** is a new (late 2001) treatment and counselling service provided by the Copenhagen County Treatment Centre for Drug Addicts (known in Denmark as the KABS) primarily to young people aged between 18-25 years, who do not consider themselves as being drug addicts. The young people are typically those who are heavy weekend users of cannabis, ecstasy, mushrooms, lsd, cocaine, amphetamine, alcohol etc. This service to the young people is supplemented with a service to their closest family.

This project has an overall approach and focus, with the focus being more than just the young people's use of drugs. Activities range from counselling, group programs, individual sessions, and support to "user defined activities" such as excavations, adventure, sports, etc. Furthermore, the project applies the "peer group method" as well as their network. This service also includes the county's open telephone counselling "Free Support". Personnel group includes, among others, a social worker, psychologist, teachers and a doctor.

The aim of the "Rus-Navigatørerne" is to provide an alternative treatment and counselling service to the young people, whose everyday lives are threatened by various dependency problems, school drop-out, unemployment and family problems. The service is provided to the entire Copenhagen County (18 municipalities).

**Effects from drug-free treatment**

In a study conducted on 829 drug addicts in drug–free treatment from 2000 it was discovered that 36% had completed treatment as planned (Pedersen 2000). This group of 829 individuals included only drug addicts who had completed

detoxification and had started actual drug-free treatment. The admission period for the 829 addicts was 211 days, median 166 (Pedersen 1999). Drug addicts who dropped out of treatment had been hospitalised for an average of 147 days, median 119. Drug addicts who completed the treatment were admitted on average for 297 days, median 260.

Preliminary 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 40%).

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' follow-up has come to a close, but has not yet been evaluated.

Two years after having completed treatment – either as withdrawal or completed the program – 3% of the 326 individuals had died. Of the remaining 316, 19% were still clean (Unpublished report from Centre for Alcohol and Drug Research). The 81% who had had a relapse had not been constant drug addicts for the past 2 years. Many of the relapse cases had been clean for some periods. Thus, between 30 and 40% of the 316 addicts were clean at any time, while between 20 and 40% of the 316 addicts were constantly in methadone treatment. Those who were the heaviest addicts, experienced periods with massive addiction and periods with a considerably more moderate addiction pattern.

**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

**Substitution treatment and outpatient psycho-social program**

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.

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.

**The effect of substitution treatment**

Preliminary results from a Danish study show that methadone appears to reduce heroin addiction by 50% (Pedersen 2001). However, benzodiazepine use/addiction and cannabis use/addiction appears to increase in drug addicts admitted to methadone treatment.

**Psycho-social counselling**

During the winter of 2000-2001, 212 methadone clients from 6 addiction centres and 149 former drug addicts (at least clean for 1 month) were interviewed. The 212 methadone clients were representative of the methadone clients admitted to the 6 centres as regards gender, age and time admitted to methadone treatment. The table below shows the services provided to the total of 361 clients the past 14 days before the interview in a total of 8 areas.

**Table 11.2.1. The percentage of methadone clients and clean former heroin addicts receiving different kinds of services within the past 14 days.**

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

*Former drug addicts 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)

**Effect of the psycho-social support**

The effect of the substitution treatment should probably be closely linked with the quantity and quality of the psycho-social support offered to drug addicts. 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 addiction than the methadone clients receiving psycho-social support. This per se is not conclusive evidence of the importance of psycho-social support.

**The methadone project and expanded 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 addicts under methadone treatment. The study is conducted in Aarhus Country, Aarhus Municipality, the county of western Zealand and the City of Copenhagen. 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.

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

**Diversion of substitution drugs Secondary drug use**

In the Danish study mentioned above, the following self-reported secondary drug use was found in 165 methadone clients the past month leading up to the interview:

- 11% had not had any secondary drug use 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 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 addicts 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 addicts. 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 addicts 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.

**Consequences of diversion**

Secondary drug use does not automatically have a negative influence on the treatment of the drug addict. A few years ago, however, a drug addict could risk being “administratively phased out” of drug treatment or loose 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 common most approach today is that it serves no purpose to force drug addicts into escalating addiction with an ensuing increase in criminal behaviour and risk of drug-related death.

## 11.3. After-care and re-integration

Having successfully been treated under in-patient treatment services, a number of integration services are available. 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 addict 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 addict - 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 addicts 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 addicts, 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 addicts. Today, there are more than 70 drop-in centres, of which most where established during the second half of the 1990s.

A survey was made on drop-in centres for drug addicts and former drug addicts in 2001 at 64 drop-in centres all over Denmark (Grytnes et al. 2001). The survey 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 addicts (n=14). Here, 95% of the users are former drug addicts. 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% alcoholics, 20% active drug addicts, 10% former drug addicts, 10% methadone receivers and 20% other. And finally d) drop-in centres for active drug addicts (n=9). This group includes 80% active drug addicts, 10% methadone receivers and 10% alcohol addicts. 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 survey are mentioned below.

The drop-in centres for former drug addicts 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 addicts. 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 addicts. 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 addicts 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 survey, 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 gives room for social company – to many 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.

**Drug addicts in prison**

See chapter 2.2 and 12.

# Chapter 12 Interventions in the Criminal Justice System

The Prison and Probation Service in Denmark undertakes to impose society's sanctions as well as prison sentences. The Prison and Probation Service has 22 *departments and 8 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 addicts 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 addiction 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 inmates 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 prisons or – in the case of shorter sentences – in one of the approximately 40 local prisons. As it is mentioned in sections 2.2 and 2.4 of this report, it is estimated that more than one-third of all inmates have addiction problems. During the past ten years, focus has been turned towards the inmates' special needs and on drug addiction as a criminogenous factor. This has led to the establishment of special prison units for drug addicts, new alternatives to prison sentences, etc. These initiatives are described further in section 12.1.

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 addicts.

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 addicts appears to develop favourably. The results of an external study of the quality of the cooperation will be presented during the first six months of 2003.

**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 social work. The national strategy is that treatment of criminal drug addicts 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.

**12.1. Assistance to drug users in prisons**

Medical interventions

**Abstinence oriented treatments**

Physically dependent drug addicts 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**

**Special prison departments or forms**

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. In addition, the Prison and Probation Service has two departments in a closed state prison for men, in which actual addiction treatment is offered via external personnel.

It is expected to establish a motivation department and a treatment department for female inmates at the turn of the year as well as a few motivation departments for men. Finally, funds have been granted for the establishment of yet another –semi-open – treatment department for men from 2003.

The contract prison departments are primarily intended for drug addicts who feel motivated to stop their drug addiction and who would like to be assisted in their decision. The inmates 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. At the same time, 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 inmates and the staff, and that the departments have a supervisor with a psychiatric or a psychological background and participates in tripartite sessions with the inmates and staff.

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 addicts 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 (until 1 July 2001, Section 49 (s2) of the Danish Criminal Code) or in connection with (parole) release.

The drug-free departments are intended for non-drug addicts as well as for former drug addicts 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.

**Import model**

Since September 1997, criminal drug addicts have been offered treatment for the addiction as part of their prison sentence in a large closed state prison with deprived criminals. The treatment is undertaken by a private treatment institution in close cooperation with prison personnel after the Minnesota model's 12-step program.

To begin with, it was considered a pilot project, but the results of the project were so positive that prior to the expiry of the pilot project period it was decided to expand the scheme with yet another treatment department in the same prison, which means hat there are now two treatment departments with room for 30 addicts. The formal decision to make the service a permanent one was made in February 2000.

**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.

**Upcoming initiatives**

A decision has been made to establish a motivation department for women in the country's largest local prison and a (semi-open) treatment department for women in an open prison. These units will be operated according to the import model in close cooperation with an external treatment institution, which applies the Italian CEIS model in a version adapted to Danish conditions. Attempts are being made to have the initiative supported financially by the Ministry of Social Affairs.

Furthermore, it has been decided that during 2002 and 2003, two motivation departments will be established together with another treatment department for men. One of the motivation departments will primarily be run with internal staff, whereas the other motivation department and treatment department will by run in accordance with the import model.

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 addiction 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.

**Substitution treatment**

Drug addicts 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 inmates in prisons, local prisons and hostels.

**Harm reduction measures**

Drug addicts 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.

**Community links**

As mentioned above, formalised collaboration has been established – 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 addicts 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 inmates 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.

**12.2. Alternatives to prison for drug dependent offenders**

**Objectives, organisation, funding and professional resources**

Trial scheme including suspended sentence on the condition of treatment

During the period from 1995-2002, three counties have experimented with suspended sentence on condition of treatment as an alternative to an unconditional prison sentence of between 6 and 12 (18) months. The initial evaluations resulting from the experiment were positive. However, the results of a study on completion and criminal recidivism from the autumn of 2001 were of such limited success that it has now been decided to stop the study.

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

Drug addicts be – 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 1 July 2001 laid down in Section 2 of the Danish Criminal Code). This option is offered to more than 150 drug addicts per year.

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 normal 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 addicts 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 budgets to the effect that the drug addicts 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 addiction. 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 addicts 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 addicts 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 on the two treatment departments in the state prison of Vridsløse, however, suggest that the problems related to re-integration services are decreasing.

Experimental project with suspended sentence

As mentioned in 12.2.a) a survey on completion and criminal recidivism from the autumn of 2001 showed so poor results that it has been decided to stop the project by the end of 2002. Only one-third of the project participants succeeded in completing the alternative program, and criminal recidivism was more than 80%. One of the reasons for this is the very rigid time frame for the various phases of treatment (limited possibilities for allowing for individual treatment needs), and that the pilot project scheme since its beginning in 1995 has become a poorer alternative for the addicts than other alternatives (the § 78 scheme and/or treatment during imprisonment).

**Statistics and research**

Client survey

A survey conducted among all prisoners on 23 February 1999 showed that a majority of the imprisoned drug addicts 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 survey

During the autumn of 2001, the Prison and Probation Service conducted an extensive survey on the addiction patterns of inmates as well as supervised clients. The data collected are currently being processed, and the outcome of the survey will be available at the beginning of 2003. The survey is expected to increase our knowledge significantly about addiction patterns of the inmates prior to and during imprisonment.

Introduction of new statistics in the area

From November 2000, a registration was launched of all the treatment initiatives initiated by the Prison and Probation Service, or in the planning of which the Service actively participates. The first statistical results are expected to be published at the end of 2002.

The new registration renders it more feasible to have access to requested data in the future, including in combination with the drug survey mentioned above.

Survey on the treatment departments at the state prison of Vridsløse

Within the next year, a more in-depth survey will be conducted on the two treatment departments as a follow-up on the previous evaluation and survey on recidivism.

Survey 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 addicts. An external survey 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 survey are expected to be publicised during the first six months of 2003.

**Training**

Teaching about drug addiction 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 addiction.

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 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 addiction 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 addiction. 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, 36 in-patient institutions will participate in DANRIS. On 1 June 2002 DANRIS had received approximately 1000 entries of drug addicts. A website has been established at the address www.crf-au.dk/danris, where it is possible to follow the project. Entry of information from the institutions is made regularly, and the project expects to receive information from all institutions during the autumn of 2002.

**Evaluation of programs**

Evaluation of prevention and treatment programs is a popular issue with politicians, administrators, practitions and citizens. Recent years' restructuring and resources conveyed 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 addicts.

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 addiction. 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 addicts (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 surveys

covers a wide field. Actual scientific evaluations are rare, given the shortage of resources and competencies.

# Chapter 14 Demand reduction expenditures on drugs in 1999

## 14.1. Concepts and definitions

This chapter deals with expenditure on treatment and prevention (demand reduction) in Denmark in 1999. The year of 1999 has been chosen to compare the expenditure of other nations.

### 14.2.1. Organisation

### 14.2.2.Interaction between public and private expenditure

In1999, treatment and prevention was organised in the same manner as today[26]. Reference is therefore made to chapter 1 for a description of the organisation and disstribution of responsibility at a central as well as a regional/local level.

### Treatment

The treatment of drug addicts is typically made in a public-private mix as regards organisation and financing. The social and medical treatment of drug addicts is the responsibility and task of the public sector. The public social treatment services are, however, supplemented by voluntary organisations and privately owned organisations. This combination ensures a broad spectrum of services offering flexible, untraditional and alternative treatment and care. It is thus characteristic that the providers of social treatment services are public as well as private treatment institutions, whereas the buyer of the service typically is a public authority. The public sector often buys treatment slots in the private treatment institutions, but also has a number of treatment slots themselves (Mehlbye 1997).

### Prevention

The public authorities are responsible for initiating prevention measures. National prevention activities are launched by the National Board of Health, which documents the development of drug prevalence and injuries related to addiction, prepares informative material/campaigns and supports the county/municipal operations through supplementary educational activities, financial support, participation in network, etc. The prevention measures thus include governmental information services such as local direct support to individual persons and smaller groups of a more specific targeted approach. However, there are also examples of private organisations participating in prevention activities. For instance in 1999, the Lions Clubs in Denmark produced on their own initiative material to be used in classes on drugs in the primary and secondary schools. This material was also lended to the county centres. Quite a few former addicts offer to come to the schools and give talks about their own experiences, but this type of work is not administered by a national coordinating organisation.

[26] However, in 2001, the Ministry of Health was merged with the Ministry of Interior, and in 2002, the National Narcotics Council was abolished.

### 14.2.3. Funding sources and responsibility

Reference is made to chapter 1 for a description of the units responsible for allocation and use of budget, since the organisation in 1999 was the same as it is today.

### 14.3. Expenditures at national level

Basicly, the counties and municipalities are responsible for financing their own drug addiction projects.

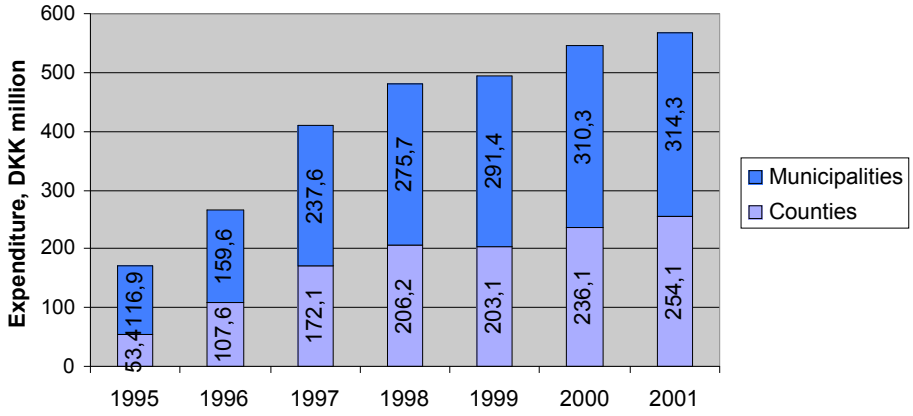
In 1999, financing of drug addiction treatment was shared between counties and municipalities (with each of them paying approximately 50% of expenditure). A minor share of the counties' and municipalities' expenditure on housing offered to drug addicts was, however, financed by the drug addicts themselves. However, the state granted a 100% refund of expenditure incurred by the counties and municipalites to certain groups of refugee addicts.

The annual account of the counties include expenditure for methadone treatment. The expenditure is, however, included as a non-specified portion of the counties' expenditure on hospitals and health care insurance and therefore not included in the statement below which include expenditure for activities pursuant to the Act on Social Services.

The annual accounts of the counties and municipalities contain statements on the expenses and income generated from treatment of drug addicts pursuant to the Act on Social Services (see figure 14.3.1.). The statements include expenses for in-patient treatment with treatment being provided in temporary dwellings as well as expenses for daily treatment and outpatient treatment services. Furthermore, the statements include expenses for personal aid, nursing and care services etc, and treatment provided in connection with housing services. Expenses for personal necessities (allowances) and expenses for paying salary to individuals working in protected environments and in activity and social projects are also included.

Expenditure on the individual measures provided pursuant to the Act on Social Services have not been specified further. From 2002, however, there has been a further breakdown of expenditure with daily treatment services and in-patient treatment services provided to drug addicts being specified separately. Furthermore, the statements show the portion of own payment made by drug users availing themselves of dwelling services.

**Figure 14.3.1. Net operating expenditure, counties and municipalities, 1995-2001**




Source: Unpublished figures from Ministry of the Interior and Health.

As it appears in figure 14.3.1, the net operating expenditure in the counties and municipalities on drug addicition increased during the period from 1995 to 2001. The highest increase was during the period from 1995 to 1997 when the operating expenditure more than doubled. Total net operating expenditure in 1999 amounted to DKK 494.5 million.

**Expenditure on prevention**

On the 1999 budget, DKK 6.2 million was reserved for prevention measures administered at a central level (Sundhedsstyrelsen 1999). The funds reserved were used for information activities, development and analysis activities, teaching etc. The use of funds comprised measures launched by the National Board of Health as well as measures carried out in cooperation with other authorities, organisations, groups, and individuals as well as measures financially backed by the Ministry of Health and carried out by the local authorities, associations, cooperative societies, etc. Statements on the total expenditure incurred by the counties and the municipalities on regional and local prevention do not exist.

**Other expenditure**

In addition to the expenditure incurred by the state, the counties and the municipalities in conncetion with drug-realted prevetion measures, it should be noted that the counties as well as the municipalities carry out activities to a wide extent and allocate funds which normally will not be included in such a statement, e.g. teaching about drug abuse in the primary and secondary school, collaboration between schools, the social authorities, and the police in connection with prevention interventions against drugs, and payment of a number of welfare benefits to the drug addicts related to their drug abuse. It must therefore be assumed that the actual expenditure connected with the demand reduction measures are higher than the above mentioned.

## 14.4. Expenditures of specialised drug treatment centres

| | |
|---|---|
| | ”NO DATA AVAILABLE” |
| **14.5. Conclusions**<br><br>**14.5.1. Problems on information and future research** | At present, there exists no complete economic analysis on demand reduction measures targeted at drug addicts. This might be due to the many problems related to collecting comparative figures across counties and municipalities. When studying the total expenditure and costs of counties and municipalities, some amounts are stated as net figures (including state refunds) others are gross figures (excluding state refunds), which renders comparability difficult. At the same time it is not possible to separate expenditure on, for instance, drug addiction treatment from other expenditure, for instance expenditure on in-patient treatment of groups other than drug addicts. This applies in particular to the counties, in which drug addiction from an organisational, physical and budgetary perspective was placed together with treatment of alcoholics. |
| **14.5.2. Global estimation of ”Demand reduction expenditures on drugs”**<br><br>**14.6. Methodological information** | Due to lack of data, it is not possible to estimate the overall expenditure incurred in Denmark on demand reduction programs targeted at drug addiction in 1999. Registration of the relevant information has been improved considerably during the past year, and there is every likelyhood that the total expenditure can be calculated within a number of years. |
| **Limits in data available** | See above. |
| **Main studies and research** | ”NO DATA AVAILABLE” |
| **Bibliographical references** | Please see the bibliographical references listed at the back of this report. |

# Chapter 15 Drug and Alcohol Use Among Young People aged 12-18

## 15.1. Prevalence, trends and patterns of use

This chapter presents the use of illicit drugs, including the use in combination with alcohol among the very young people. This chapter will describe the prevalence of use, trends and patterns of use as well as the social and health-related consequences.

### Youngsters under the age of 15 - 7th to 8th grades

In Denmark there is no tradition for conducting national surveys on the drug use of young people aged less than 15 years. As a result, the knowledge we have on this age group is obtained from regional surveys.

### 15.1.1. Consumption of illicit drugs

In Copenhagen, young people in the 7th grade in 1999/2000 were questioned about their use of drugs and alcohol (København Kommune 2002)[27]. Out of the 13-14-years-olds (7th grades) 8% had tried to smoke cannabis – approximately 7% of the girls and approximately 10% of the boys. Around 20% had been offered the drug. Out of the same group, 1.5% reported having smoked cannabis within the past month.

In a survey on juvenile delinquency in 1999 conducted among 8$^{th}$ grades in Gladsaxe, Allerød and the rural districts in northern Jutland, the young people were also questioned about their use of cannabis (Balvig 2000). Out of the 14-15-year-olds, 12% reported having tried cannabis, whereas 5% said that they had tried cannabis 3 times or more. However, the figures resulting from the surveys conducted in the three areas were very different in that 13.9% in Gladsaxe had tried cannabis, 19.7% in Allerød had tried cannabis and 7.8% in the rural districts in northern Jutland had tried cannabis.

In the survey from Copenhagen, only a very few of the 13-14-year-olds had tried drugs other than cannabis. Out of this number, most had tried sniffing (3.5%), whereas 1.6% and 1.3% had tried amphetamine and ecstasy, respectively. Around 4% had been offered sniffing, whereas 5% had been offered amphetamine and 5% had been offered ecstasy (København Kommune 2002).

Among the 13-14-year-olds in Copenhagen, the survey discovers no changes from 1990/1991 to 1999/2000 in the percentage of those who have tried cannabis. The same applies to the proportion of those who were offered the drug (København Kommune 2002). As regards the other illicit drugs, there appears to an increase among those who have tried such drugs and those who have been offered them, but no significance test on the increases has been made. Among the 14-15-year-olds, the Balvig report finds that in all the three geographical areas of the survey – in spite of their differences – there is an increase in proportions of those who have tried cannabis from 1989-1999 (Balvig 2000).

[27] A description of the surveys is provided in the annex of this report.

**Young people aged 15-17 years – 9th grade**

In 1999 a follow-up on the ESPAD survey from 1995 was made (Hibell et al. 1997, 2000). The survey describes the prevalence of illicit drugs among the 15-17-year –olds in the 9th grade.

In 1999, 24% of the young people between 15-16-years of age reported having tried cannabis ever (table 15.1.1). This was a significant increase from 1995, when the corresponding figure was 18%. In 1999, approximately 8% had used cannabis within the past month; this applied to approximately 6% in 1995.

There are major differences in the prevalence among boys and girls. In 1999, 31% of the boys and a little above 22% of the girls reported having tried cannabis ever. The boys are the ones who make up the increase from 1995 to 1999. Similarly, almost double as many boys as girls had used cannabis within the past month in 1999 (Sabroe & Fonager 2002).

As regards availability, more than 74% of the 15-17-year-olds were certain that they could easily buy cannabis if they were interested (Sabroe & Fonager 2002)[28].

**Table 15.1.1. Experience with illicit drugs among 15-16-year-olds in 1995 and 1999.**

| | ESPAD 1995 (n=2234) | ESPAD 1999 (n=1548) |
|---|---|---|
| Cannabis tried ever | 18.0 | 24.4 |
| Cannabis past 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 |

Source: Hibell et al. 1997, 2000.

As regards drugs other than cannabis, 7.5% of the 9th grades in 1999 had tried sniffing, whereas 4.0% and 3.1% had tried amphetamine and ecstasy, respectively. Concurrently with the increase in use of cannabis, an increase was found in the proportion of those who had been experimenting other drugs from 1995 to 1999. Thus, significant increases appear in the proportion of those who

[28] In the Danish reports on the ESPAD surveys, Sabroe and Fonager use an extended base of study compared to the international surveys, as they include all students in 9th grade and not just the 15 –16-year–olds

have tried amphetamine, ecstasy, psilocybin mushrooms and in the proportion of boys who have tried crack and cocaine, and in the proportion of girls who had tried lsd (Sabroe & Fonager).

**Young people aged 16 and 17 years**

In 2000 as well as 2001, the National Board of Health and the Danish Cancer Society conducted a representative survey on the lifestyles and daily routines of the 16-20-year-olds. The survey questioned the young people about their experience with drugs. Table 15.1.2 shows the feedback provided by the 16 and 17-year-olds.

22% of the 16-year-olds and 29% of the 17-year-olds reported having tried smoking cannabis ever. 7% of the 16-year-olds and 10% of the 17-year-olds had smoked cannabis within the past month.

**Table 15.1.2. Experience with illicit drugs among the 16-17-year-olds (%).**

| | All | |
|---|---|---|
| | 16-year-olds | 17-year-olds |
| Tried drugs ever (cannabis, heroin, ecstasy or similar drugs)) | 22 | 29 |
| Tried cannabis ever | 22 | 29 |
| Cannabis within the past month | 7 | 10 |
| Tried amphetamine ever | 3 | 8 |
| Tried ecstasy ever | 2 | 3 |
| Tried psilocybin mushrooms ever | 2 | 4 |
| Cocaine tried ever | 1 | 3 |
| Lsd tried ever | 0 | 2 |
| Heroin tried ever* | 0 | 1 |
| Sniffing | 3 | 4 |
| "Other drugs" tried ever** | 1 | 1 |

Source: Unpublished figures from the MULD 2001 survey.

*Smokeable heroin. No 16-17-year-olds had tried white heroin.

**The category "Other drugs" includes GHB, various medicinal products, etc.

Apart from cannabis and amphetamine, the 16 and 17-year-olds' experience with drugs is very limited. In the survey, 3% of the16-year-olds and 8% of the 17-year-olds had tried amphetamine, whereas 3-4% had tried sniffing and 2-3% had tried ecstasy (Unpublished figures from MULD 2001).

**Age of initiation**

In the ESPAD survey, a majority report that they were 14-15 years of age when they tried to smoke cannabis for the first time (Sabroe and Fonager 2002). In the MULD 2001survey most of them report (76%) that they were 15 years or more when they first started to use a drug other than cannabis (Unpublished figures from MULD 2001).

In comparison, most of the respondents (60%) in the MULD survey reported their initiation of drinking alcohol to be when they were 13-14-years of age, whereas most of them (56%) were drunk for the first time when they were 14 or 15 years

(Unpublished figures from the MULD 2001). In ESPAD 1999 a majority of the 15-16-year-olds started drinking alcohol up to the age of 14 years, whereas most of them were drunk for the first time when they were 14 years. (Sabroe & Fonager 2002).

### 15.1.2. Drug use and alcohol

Numerous surveys conducted on young people's use of drugs and alcohol indicate that often the young people who are heavy drinkers also smoke cannabis and experiment with hard drugs. In the MULD 2000 survey there is close correlation between cannabis smoking and alcohol consumption to the effect that 44% of the 16-17-year-olds who had been smoking cannabis within the past year had also exceeded the drinks limit of 14 and 21 drinks for girls and boys, respectively, per week. Among the boys and girls who had not smoked cannabis within the past year, only 13% had exceeded the maximum drinks limit. There also appears to be close correlation between early initiation of drinking alcohol and cannabis consumption (Sundhedsstyrelsen & Kræftensbekæmpelse 2002).

It also appears from the ESPAD 1999 survey that there is a connection between the use of drugs. Sabroe and Fonager find significant correlations between frequency of cannabis smoking and the frequency of alcohol consumption and frequency of having been drunk. For instance, at least 73% of those who had tried smoking cannabis had been drunk more than 10 times the past year. In comparison only 25-20% of the young people who had never smoked cannabis had been drunk more than 10 times the past year (Sabroe & Fonager 2002).

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

### 15.1.3. Environment

**Friends and family**

A large number of the surveys conducted on young people's use show that there is a close correlation between use of drugs and friends' use of drugs. According to the ESPAD survey, those who have friends that have tried cannabis are more likely to try the drug themselves. Most of them who had tried cannabis, received the drug from somebody they knew (Sabroe & Fonager 2002). Similarly, the MULD 2000 survey discloses significant correlations between having tried cannabis or other drugs and having friends in the family and/or among acquaintances who have tried (Unpublished figures from MULD 2001). The young people's attitude towards drugs is thus indeed influenced by acquaintances' and family's use of drugs. As regards friends, however, there may be a connection where the friends are chosen on the basis of common interests and habits. As regards the family, the correlation may be attributable to the fact that the person has been raised and brought up in the same environment and under the same conditions.

On the other hand, the ESPAD 1999 survey shows almost no correlation between the parents' educational level and the young people's cannabis use or

their experimenting with ecstasy and amphetamine. Also there appears to be no correlation between the family economy and the young people's experimenting with drugs (Sabroe & Fonager 2002)[29].

**Education**

As regards the young people's educational background, numerous studies find differences between the youth educations even when allowing for age and gender differences. The MULD 2000 survey thus establishes that among girls and boys aged between 16 and 18 years, most of the ones who have tried drugs are those outside the traditional youth education programmes (production high schools, free youth education programmes, young people on sabbatical leave, unemployed, regular jobs). Then follows the 16-18-year-olds commercial colleges (business college basic program, apprenticeships, social and health care schools, agricultural schools) and finally the high school education programmes (Sundhedsstyrelsen & Kræftensbekæmpelse).

Regional studies conducted by Aarhus County and Ribe County among the 16-19-year-olds show that cannabis smoking is a more frequent phenomenon and that in comparison with higher preparatory examination, high schools and the business colleges, a vast majority of the students in technical schools have tried ecstasy (Ribe Amt 2000, Villumsen 2001). The same pattern emerges in a study conducted by Frederiksberg Municipality in 2000 among the 16-20-year-olds with the higher preparatory and technical schools distinguishing themselves as regards cannabis, amphetamine and ecstasy – this survey, however, does not allow for age and gender differences among the different education programmes (Frederiksberg Kommunes Rådgivningscenter 2001). A study conducted in northern Jutland finds that the young people have tried illicit drugs – even when allowing for gender (Emerek 2001).

### 15.1.4. Perceptions about risks, benefits and image of specific drugs

Numerous studies report more widespread acceptance of the drugs among young people. The regional hearings also report about higher acceptance of use – it is no longer a clandestine act, but is taken/smoked openly. This is consistent with a qualitative analysis carried out by the consulting agency Advice for the National Board of Health in 1999, where many find it ok to smoke cannabis or try other drugs. Drug users are thus not stigmatised – drug addiction is associated with heroin addiction and socially deviating behaviour. Young people's attitude towards drug use is that "it is one's own business" (Sundhedsstyrelsen 2000). In a study conducted by Aarhus County among the 16-19-year-olds, 60% very much agree or agree that "it is the individual person's own decision whether or not to use ecstasy" (Villumsen 2001).

As regards the young people's perceptions of drug risks, 22-26% of the ones interviewed for the ESPAD survey in 1999 found that the risk of smoking cannabis a couple of times was large, 35% found that the risk associated with smoking cannabis sometimes was large, whereas approximately 74% found that

[29] See the analysis on the correlation between the 16-30-year-olds' drug use and their parent's social status in chapter 2.

regular smoking of cannabis was very risky. The young people who had themselves tried smoking cannabis found it less risky than other young people (Sabroe & Fonager 2002).

In the survey conducted in the county of northern Jutland among the 16-19-year-olds, 79% of those who had not tried cannabis find that cannabis is very or rather risky, whereas 38% of those who have tried cannabis find that it is very or somewhat risky (Emerek 2001).

In the same survey conducted in northern Jutland, 81% of all the young people found that ecstasy is extremely harmful. Among those who had tried ecstasy and who did not feel like trying again, 76% found that ecstasy is very harmful, whereas 46% of those who had tried ecstasy and would like to try it again found that ecstasy is very harmful. In response to the statement “you can never be sure what ecstasy contains”, 97% of those who had not used ecstasy, 96% of those who had used ecstasy and who did not feel like trying again, and 88% of those who had used ecstasy and would like to try again, very much agree or agree (Emerek 2001).

Generally, most young people (76%-92% depending on type of drug) perceive drugs other than cannabis to be very harmful. However, there is a tendency to diminish the risk among those who have tried the drugs. In comparison only 16-19% of the 15-17-year-olds in the ESPAD survey found that there is a major risk associated with drinking 5 or more drinks once or twice each weekend.

### 15.2. Health and social consequences

#### school

School attendance is also affected by the young people’s use of alcohol and drugs. This applies to their self-evaluated performance, grades, absence and their perception of school. The MULD 2001 survey sets out that school or leisure work performance in around 20% of the 16-17-year-olds decreased as a result of their use of drugs. As regards the influence of alcohol on the young people’s performance, only approximately 15% of the 16-year-olds found that their performance had been influenced by their alcohol consumption, whereas around 30% of the 17-year-olds had had the same problem (Unpublished figures from MULD 2001).

In their ESPAD 1999 survey, Sabroe and Fonager discover a correlation between experience with cannabis smoking, absence from school and average marks. As regards the girls, there appeared to be a significant correlation between experience with cannabis smoking and a mark average of less than 8 and absence due to illness or shirking school (Sabroe & Fonager 2002).

The same coherence is established between marks under 8 and experience with ecstasy and/or amphetamine – but only for the girls. The ESPAD survey also establishes coherence between both genders’ experimenting with ecstasy and/or amphetamine and absence due to shirking school (Sabroe & Fonager 2002).

In relation to the young people’s relation to school, there are no national results, but the study conducted in Copenhagen establishes a correlation between

school fatigue and cannabis smoking within the past month (Københavns Kommune 2002). Balvig arrives at a similar conclusion in his study of youth delinquency in 1999. He finds that 53% of the young people who have used cannabis 3 times or more are not interested in or definitely do not like going to school (Balvig 2000). The conclusions made, however, do not reflect any causal relationship – it is highly likely that those who are tired of school are the ones to be attracted by cannabis, and not the other way around.

**Crime**

Several studies have looked into the possible connection between criminal activity and addiction. In most of the studies, there appears to be a connection, although a causal relation is difficult to establish. The survey on the 16-19-year-olds' use of drugs in Aarhus County established a correlation between having been involved in theft, vandalism, violence/assault and the use of illicit drugs (Villumsen 2001). Also, the survey conducted by the county of western Zealand on the 16-19-year-olds' drug habits establishes a significant correlation between participation in criminal activity and regular use of either cannabis, ecstasy, mushrooms or amphetamine (Emerek 2001).

The Balvig study on the criminal activity of 14-15-year-olds establishes a strong coherence between cannabis smoking and criminal activity. The survey finds that 28% of the young people who have been using cannabis 3 times or more are repeat criminals – which means that they have committed relatively serious theft 3 times or more – whereas the repeat criminals only make up 2.6% of the sample size population (Balvig 2000). Balvig also finds that the more criminally oriented individuals have been drinking alcohol considerably more often than the less criminal ones. However, as in the case of the young people and school fatigue, one should abstain from jumping to conclusions as regards causal relationship, since it is also likely that crime leads to drug addiction and to heavy alcohol consumption. Another possibility is that crime and drug use are linked to the same background elements.

### 15.2.2. Health-related consequences

**Deaths and overdoses (ODs)**

When it comes to young people under the age of 18 years, mortality rates are extremely low. The statistics on drug-related deaths prepared by the National Commissioner of Police[30] for 2001 include no dead persons aged 15-19 years. In 1999 and 2000, there are no drug-related deaths among the age category under 18 years. Among the heavily discussed "ecstasy deaths", where the drug addict took ecstasy or a drug which he or she thought to be ecstasy, no deaths appear among the young people under the age of 18 since registration started in 1998 (the National Board of Health's own records).

**Hospital emergencies**

The National Board of Health has no national records on hospital emergencies following the intake of illicit drugs. In the MULD 2001 survey, 6% of the 16-17-year olds report having been to hospital because they had used drugs, whereas 8% and 9% of the 16-17-year-olds, respectively, had been to the emergency ward or the hospital after having been drinking alcohol. (Unpublished figures

[30] See section 3.2 in chapter 3 for a presentatin of the figures.

from MULD 2001).

**Demand for treatment**

Among the 4079 drug addicts admitted to treatment in 2001, 3 persons were aged under 15 years and 284 persons were between 15 and 19 years old. The 2 out of 3 aged under 15 years were admitted to treatment for the first time, whereas 201 out of the 15-19-year-olds were admitted to treatment for the first time. Out of all the young people admitted to treatment in 2001, individuals under the age of 20 years made up approximately 7%, and they made up approximately 16% of those who had not previously been admitted to treatment (statistics prepared by the National Board of Health). Often, the young people with drug problems under the age of 18 years will not be referred to treatment institutions for drug addiction. Typically, they will be referred to socio-educational institutions, from which no records exist.

**Mental illnesses**

As regards mental illnesses, statistics produced by the Department of Psychiatric Demography show that 13 young people between the age of 12 and 14 years and 73 young people aged 15-17 years in 2001 received psychiatric treatment (outpatient, full day or part-day treatment) for drug-related diagnoses. Among the 12-14-year-olds, a majority (8) had mental illnesses or disturbances due to cannabis use, whereas a majority (35) among the 15-17-year-olds had mental illnesses or disturbances caused by the use of several different or unknown drugs. Then follows disorders as a result of cannabis use (33) (Unpublished figures from the Department of Psychiatric Demography, Institute of Psychiatric Basic Research, Psychiatric Hospital in Aarhus).

**15.3. Demand and harm reduction responses**

See the programs described under chapter 8.

**Harm reduction programs**

No specific harm reduction programs exist for the young people under the age of 18.

**15.4. Methodological information**

**15.4.1. Limits in data available**

As mentioned above, Denmark has no tradition for asking the young people about their use of drugs before 9$^{th}$ grade, which corresponds to an age group of 15-16 year-olds. Therefore, the material on prevalence among young people under the age of 15 years is very limited and covers only, where available at all, municipal or regional conditions.

**15.4.2. Bibliographical references**

See the general bibliography of the annual report and the description of studies referred to.

# Chapter 16 Social Exclusion and Re-integration

## 16.1. Definitions and concepts

In the Danish socio-political debate, the loss of income has been viewed as the key cause of social problems and as a decisive criterion for the allocation of social services. After a period with recession in the 1970s and 1980s, a new group of poor people emerged, out of which many were excluded from the labour market. During the 1990s, the concept of social exclusion became a pivotal issue in the socio-political debate. The concept included a variety of groups which were different in their way of acting, their appearance and lifestyle and who attracted the attention of society by falling through the safety net and the services provided by the welfare state.

In connection with social meetings held in 1993, the Danish Ministry of Social Affairs gave the following definition of socially excluded and endangered groups: “That as a result of long-term mental illness, addiction or similar problems, this group isolates itself in relation to the ambient society. They are unable to realise the magnitude and nature of their problems and therefore decline any offer to receive treatment. They display extremely deviant behaviour followed by conflicts, crime and similar problems”. Alcohol and drug addicts as well as mental illnesses were seen as dominant problems among the excluded groups. Other problems, such as prostitution were of minor significance only. What the groups had in common is “that they are people who are socially disabled, and who are not socialised to manage on their own in a normal community.” (Ussing Bømler 2000).

The concept of social integration has two meanings. You can talk about integration via the economic system through work or public procurement or via the political system through democratic rights. The other meaning of the concept is about integration into civil life, about affiliation developed through social interaction between human beings and groups. Affiliations providing identity and making the person feeling important and which occur as a result of participating in social life.

The drug addicts risk social exclusion due to unemployment, housing problems, criminal activity or chaotic behaviour. Furthermore, the drug addict is subject to suspicion and therefore risks rejection by the normal community, parts of the social sector, by the family, by other drug addicts and other excluded groups – merely as a result of their addiction. Drug addiction is treated as demonised behaviour creating a barrier to the communities that “normally” create identity, acceptance and a feeling of belonging (Jöhncke 1997). This does not mean that all drug addicts are socially excluded. Some drug addicts live a normal socially integrated life, some have had a family and a job, but have lost contact to both, others have always been living in a socially endangered situation. What is needed is differentiated social integration and corresponding differentiated goals for the initiatives necessary to promote integration and counteract social exclusion.

### 16.1.1.Issues arised or discussed regarding social exclusion in relation to drugs

#### The most deprived drug addicts

The “most seriously deprived” drug addicts have been the attention of much focus during recent years. The pivotal point of the debate has been how they could achieve a more dignified life and avoid the worst injuries associated with a chaotic life involving addiction and living in the streets, injuries from injections, begging and prostitution to pay for drugs. The debate has been accentuated by the question of prescription of medically prescribed heroin for drug addicts. The activities that have been tabled as possible solutions involve outreach street work, users’ rooms, trials with medically prescribed heroin for the most deprived, trials with injectable methadone, improvement of the psycho-social contents of substitution treatment as well as flexible permanent housing, where it is permitted to take illicit drugs.

#### Exclusion from society’s aid system

Another issue of the debate on the most deprived drug addicts has been the flexibility and selective mechanisms of the aid systems. Several people have pointed out that the institutions of the welfare state have a tendency to sort out the turbulent, the chaotic, those who fail to comply with the “norms of the normal society (Järvinen 1998; Brandt 1995; Brandt 1997). The aid systems are being criticised for adjusting to a behavioural code adapted to the citizens of a “normal” society, a set of norms, which “the misfits” find it difficult to comply with. Furthermore, the specialisation of the treatments provided lead to deselection and a rejection of those with very complex problems. The selection process is a result of the fact that specialisation of treatment programs, professional ambitions and narrow norms are prioritised above taking care of the individual human being in need of care and flexibility (Järvinen 1998; Brandt 1995; Brandt 1997).

#### Integration into the labour market

Apparently, Danish drug addicts have, to a wider extent than drug addicts in other parts of Europe, been excluded from the labour force and lived on public welfare (Stauffacher 1998). Rehabilitation and other employment promoting activities have been reserved for former addicts for a number of years. Drug dependent individuals in substitution treatment have been considered active addicts, and have therefore been excluded from employment programs. Since the majority of drug users in treatment in Demark have been referred to substitution treatment, this kind of treatment has been an obstacle to integrating the individual into the labour market. The group has been “preserved” by municipal case handlers as well as by the educational staff in the treatment system, irrespective of the person’s resources and wishes. During recent years, the integration into the labour market, the educational system and into employment promoting activities provided to long-term unemployed in substitution treatment has been placed on the agenda in the treatment sector as well as within employment promoting programs (Familie- og Arbejdsmarkedsforvaltningen 2000; Jöhncke 2001; Christiansen 2002).

#### Alternative punishments

Crime and drug addiction are closely interrelated. Offences against property, violation of the drugs act, affiliation to criminal environments is an integral part of the daily lives of many drug addicts. The majority of drug addicts in Denmark receive at some point in time a prison sentence, more than one third of the inmates in Danish prisons use drugs, and the number of them is increasing.

Therefore, it is a constant challenge to the prison and probation service and to the prisons how it is avoided to retain the imprisoned drug addicts in a criminal career and continued drug addiction during their stay

### 16.1.2. Groups seen as particularly vulnerable regarding drug use

Use of drugs does not automatically lead to drug dependency, and drug dependency is not the same as being socially excluded, even though most of the drug addicts live through shorter or longer periods of endangered social integration. Drug dependency can be seen as a progressive process, during which physical and mental dependency develops, with the risk of social decline including less contact to family, network, employment and use of alternative sources of income as well as offences against property, drug trafficking and prostitution.

Those who use drugs and whose social integration is most at risk for other reasons or whose personality, identity or mental stability is vulnerable.

**Problematic adolescence**

Drug addicts are often children who have had a difficult adolescence, children who grow up in families with addiction problems, violence and neglect (Christoffersen 1999). These are children and young people with very poor experiences at school, young people who do not fit into the school system, and who start at an early age to smoke tobacco, drink alcohol and use drugs.

**Immigrants and refugees**

The immigrants and refugees are a group of people, whose integration into the Danish system is difficult in many ways. This group is not generally considered a risk group in terms of drug addiction, but it contains two risk groups. One group includes the young immigrants who define themselves as being excluded from the Danish society, without having any alternative to their adolescent environment. This group would typically count young men who are about to be expelled from the immigrant society without an “acceptable” entry ticket to the Danish society. This group take it to the edge and experiment with illicit drugs without having any clear norms as to how they should deal with them. A survey made in 1997 showed a more frequent and uncritical use than expected among young immigrants in one of the major provincial towns in Denmark (Wittrup 1997). Another group includes the refugees arriving in Denmark as victims of torture or with other traumatic experiences. These persons may have started their addiction prior to their arrival in Denmark, may have developed mental disturbances and may find it difficult to be accepted by “their own”. (Jessen-Petersen, personal memo).

**Mentally vulnerable people**

Mentally vulnerable people and the mentally ill are often socially isolated and lack social competencies to function. They seek out the open street scenarios or the easily accessible addiction environments. They have no barriers against testing and experimenting with mentally destabilising drugs, although their mental condition is far from strong. Often, the use of drugs worsens their condition, but many are retained in their addiction in spite of hereof.

**Homeless**

The homeless who are often burdened with problems other than their homelessness will run into the drug milieu in shelters and in the street, where

they may feel affiliation of one kind or the other. As a result of their isolated and exposed position in society, the homeless will be at risk of becoming addicts and of developing experimental use into actual drug dependency. Among the homeless there are various subcultures relating to various addiction patterns. In this context the opiate addicts will often have the lowest status (Børner Stax 1999).

## 16.2. Drug use patterns and consequences observed among socially excluded population

### The homeless

The group of homeless people in Denmark make up a mixed group of people with severe problems, mental disturbances, drug, alcohol and medicine addiction and long-term homelessness/unemployment. Among the homeless registered living in the shelters in the City of Copenhagen, approximately 40% are believed to be drug addicts, with some of the shelters housing as many as up to 80% drug addicts (Aston Lisberg 2002). The majority is made up of opiate addicts who are also addicted to benzodiazepines, cannabis and alcohol. A large portion is undergoing substitution treatment with methadone. During recent years, cocaine has seriously started to become introduced at the shelters.

### The mentally ill

Drug addiction and mental disturbances and illnesses often walk hand in hand. It is estimated that approximately 10% of the drug addicts suffer from a severe chronic mental illness such as schizophrenia or other long-term psychotic conditions. The total number of people is estimated to be between 1000-1500, of which at least one third live in the Copenhagen area (Narkotikarådet 1999). There is an over-representation of foreigners, including immigrants/refugees, when viewed relative to the background population (Jessen-Petersen, personal memo 2002). The refugees/immigrants are not otherwise over-represented among registered drug addicts in Denmark.

The mentally ill drug addicts, the socalled double diagnosis patients, are the poorest and most excluded group in the community. The majority of those who seek treatment for their addiction are opiate addicts with a secondary use of cocaine. Apart from these drugs, this group will use whatever is the cheapest and most easily accessible. Within the past few years, cocaine is especially prevalent among patients in the psychiatric treatment institutions and in the environment where the mentally ill seek contact and company. A special outpatient institution in Copenhagen for this group of patients reports that 70-80% of the clients use cocaine, which has been documented via urine samples (Jessen-Petersen, personal memo).

Drug addiction is also a growing problem in the psychiatric treatment system, in which it is reported that between 50 and 60% of the patients are addicts (the Ministry of the Interior and Health 2002). The reasons for the growing addiction among the mentally ill are described as follows (Frøkjær Thomsen 1998):

- increased availability of drugs (including drug trafficking in the psychiatric wards)
- drug addiction has become part of everyday life in the communities, to which the psychiatric patients have access

- the drugs are being used to change atmospheres, and as a counterweight to antipsychotic treatment.

Studies from the beginning of the 1990s have shown that the double diagnosis patients make up a majority of the homeless and they are often paid a lower pension than other mentally ill when they apply for pension grants (Narkotikarådet 1999). However, this appears to be changed for the better during the past few years (Jessen Petersen, personal memo).

The treatment provided to this group of people is often limited, given that they are often rejected by either the psychiatric system or the drug addiction treatment system. Addicts with mental illnesses are often rejected by the addiction treatment system as well as by psychiatrists, allegedly because none of the professional systems are in a position to provide "the right service" which leads to the phenomenon of "revolving door patients" (Jessen Petersen 1994). Notwithstanding that addiction and associated problems take up much space in the psychiatric treatment system, this group of patients is often under-diagnosed. (Søberg Hansen 2000).

**Prostitutes**

On the face of it, street and drugs prostitution make up only a minor portion of prostitution in Denmark. Street prostitution is primarily only seen in the larger cities. Reden (the Nest) in Copenhagen, Odense and Aarhus, which are in contact with all the drug prostitutes in the street were in contact with 375 prostitutes in Copenhagen in 1999, 175 in Odense and 70 in Aarhus. An estimate on the number of all prostitutes in Denmark at the end of 2001 lies between 5450 and 7800 people. (Kongstad 2001). The open prostitution among drug addicts thus only accounts for approximately 10 per cent of the total amount of prostitution. According to data provided by Reden in Copenhagen, the majority of the girls are opiate addicts, quite a few are undergoing substitution treatment, some inject drugs on a secondary basis, and many use other illicit drugs.

## 16.3. Relationship between social exclusion and drug use

### 16.3.1. Indicators of social exclusion

Own home, education and self-support in Denmark are central indicators of social integration, marginalisation or exclusion. The population in general have their own dwelling and housing standards have increased significantly during the past 50 years. The educational level has increased in general with a fewer number of people belonging to the "residual group" who are those who never passed an exam qualifying for a job. Employment frequency rates are high with approximately 80% among men and approximately 70% among women.

A benchmarking analysis has been made on the general population in Denmark in comparison with drug addicts admitted to treatment in 2000, broken down by addiction patterns and ethnical background. The comparison revolves around dwelling situation, self-support and educational level. The data concerning drug addicts under treatment have been retrieved from the register of the National Board of Health, which contains information about the drug addicts upon admission to treatment. Data concerning the general population have been retrieved from Danmarks Statistik

Drug addicts under treatment are hardly representative of the drug addict. /drug users in Denmark. Typically, most of the drug addicts wait between 5-10 years from their addiction starts and until they subject themselves to treatment, and at this point the social decline has often set in. In many cases, the reason for subjecting oneself to treatment is that the person in question finds him/herself in a chaotic situation and is no longer in a position to control his/her life. The analysis provided below will thus draw a more sombre picture of the exclusion/integration of drug addicts than if the analysis included all drug users in Denmark.

| Table 16.3.1. Homelessness. Percentage of those who have no place to live. Live in shelters, live in the street. | | | | | |
|---|---|---|---|---|---|
| General population. 17-65 years N=3450740 | Treatment population N=8193 | Treatment population under 25 years/cannabis primary drug N=456 | Treatment population under 25 years/opiate as primary drug N=571 | Treatment population 25 years and above/cannabis as primary drug N=464 | Treatment population 25 years and above/opiate as primary drug N=4941 |
| 0,1-0,3 % | 11 % | 3 % | 15 % | 6 % | 12 % |

Source: Estimates from the Ministry of Social Affairs on the number of homeless, 2000. Danmarks Statistik, Statistical Year Book 2001, Table 42 "Population figures broken down by gender and age in counties, 2001". The National Board of Health register on drug addicts admitted to treatment.
Note: Having no place to live is a rough indicator of "homelessness" in that it does not allow for the "functionally homeless", who are defined as them who cannot function in their own home even if they had one.

| Table 16.3.2. Self-support. Most significant source of income. | | | |
|---|---|---|---|
| | Cash benefits | Pension | Salary/ other income |
| Gen. population 18-24 yrs. N=438.877 | 3,4 % | 0,7 % | Working general population 16-66-yrs. 78 % |
| Gen. population 25-29 yrs. N=1.359.522 | 5,1 % | 12,7 % | |
| Cannabis as primary drug under 25 yrs. N=456 | 57 % | 1 % | 14 % |
| Cannabis as primary drug 25 yrs. and above N=464 | 55 % | 8 % | 11 % |
| Cocaine, ecstasy, Lsd as primary drug under 25 yrs. N=83 | 49 % | - | 28 % |
| Cocaine, ecstasy, Lsd as primary drug 25 yrs and above. N=64 | 53 % | 5 % | 14 % |
| Opiate as primary drug under 25 yrs. N=571 | 77 % | 2 % | 7 % |
| Opiate as primary drug 25 yrs. and above N=4941 | 52 % | 31 % | 6 % |
| Addict with ethnical Danish background 25 yrs. and above N=5689 | 51 % | 29 % | 7 % |
| Immigrant/refugees who are addicts 25 yrs. and above N=455 | 70 % | 11 % | 9 % |

Source: Danmarks Statistik, Statistical Year Book 2001, Table 176, "Receivers of cash benefits 1999", table 182, "Receivers of early retirement pension 2001". The National Board of Health register on drug addicts admitted to treatment.

| Table 16.3.3. Education. Highest completed education. | | | |
|---|---|---|---|
| | Fund. school/ 8th-9th grade "residual group" | High school/ short, medium or long-term vocational education | Business colleges |
| Gen. population 30-39 yrs. | 26 % | 33 % | 40 % |
| Gen. population 60-69 yrs. | 52 % | 15 % | 32 % |
| Gen. population 30-69 yrs. total | 35 % | 27 % | 38 % |
| Cannabis as primary drug under 25 yrs. N=456 | 43 % | 7 % | 5 % |
| Cannabis as primary drug 25 yrs. and above N=464 | 39 % | 9 % | 14 % |
| Cocaine, ecstasy, Lsd as primary drug under 25 yrs. N=64 | 44 % | 5 % | 10 % |
| Opiate as primary drug under 25 yrs. N=571 | 56 % | 3 % | 6 % |
| Opiate as primary drug 25 yrs. and above N=4941 | 53 % | 8 % | 11 % |
| Addict with ethnical Danish background 25 yrs. and above N=5689 | 42 % | 7 % | 12 % |
| Immigrant/refugee who is an addict 25 yrs. and above N=455 | 35 % | 19 % | 6 % |

Source: Danmarks Statistik, Statistical Year Book 2001, table 96 "Highest completed education broken down by age and gender 2000". The National Board of Health register on drug addicts admitted to treatment.

No matter the primary drug, manner of intake and ethnical background, drug addicts under treatment deviate significantly from the general population on selected parameters such as housing, education and self-support.

A distinctive feature is that drug addicts are far more homeless, they belong in higher numbers to the residual group and they are more frequently supported via cash benefits and pensions than the population in general.

Within the group of drug addicts under treatment there are, however, variances in the degree of exclusion / integration in some of the parameters. Those who use opiates as their primary drug or who are experienced injecting drug users, are in a more excluded position within all parameters than the other groups. This applies no matter age. This pattern has been prevalent in Denmark since juvenile drug use emerged in the 1960s. Opiate addiction and injection are associated with low status, also among the addicts themselves.

The drug addicts who use cannabis or cocaine, ecstasy or Lsd as their primary drug are not as frequently homeless, belong less frequently to the residual group

and are more frequently able to provide for themselves than the drug addicts who use opiates or a substitution drug as their primary drug. The differences are seen among those under the age of 25 as well as those above. There are probably different subcultures among the drug addicts, although the pattern might also be a “career path” starting with cannabis and party drugs and moving over to a more persistent use of opiates, a career which is typically followed by loss of home, work, etc.

Drug addicts with a background as refugees/immigrants who are undergoing treatment, are predominantly 1st generation immigrants, and the majority of them use opiates as their primary drug. They deviate from the other drug addicts under treatment in being a bit more self-supporting and they have more frequently completed a commercial education supplementary to their fundamental schooling. The reason for this could be that refugees to a wide extent are a resourceful group, but often they have a past of persecution and traumatic experiences which render them physically vulnerable and socially deviating, expelled from their own group and consequently particularly prone to becoming drug addicts.

Immigrants/refugees also differ from the Danish drug addicts in that they more frequently receive cash benefits and less frequently early retirement pension. This could be explained by the two groups being of different age, but could also reflect that the social authorities are more cautious when allocating pension to this group or their affiliation to Denmark does not justify the payment of such benefits.

### 16.3.2. Data from research on social exclusion and drug use

#### Social inheritance and drug addiction

The Danish registers provide unique opportunities to investigate the social and family background of drug addicts. A register based process survey performed by the Institute of Social Research on children born in 1966, studied the consequences of various risk factors during childhood and how the children manage as juveniles and as adults. The children born in 1966 were followed from 1979-1993. (Christoffersen 1999).

During the survey it was found that 0.18% of the girls and 0.23% of the boys born in 1966 had been hospitalised with a drug-related diagnosis during the follow-up period. This is a “conservative” result compared with the many individuals who become drug addicts, but the correlations established between risk factors during childhood and ensuing drug addiction are considered to be representative of the group of drug addicts and to be nationwide.

The risk of developing drug addiction is particularly large in families characterised by violence, addiction problems and crime. Actual mental illnesses are rare and cannot, on the basis of this limited material, be linked with drug addiction within the childhood generation. Alcoholic parents as well as parents with a drug addiction increase the risk of the children becoming like them. The children most at risk are the ones placed outside their home. The results support the theory that drug addiction primarily is a socially acquired and historically cultural phenomenon affecting the children who have been massively subdued

during their childhood. Their home has relatively often been characterised by abuse and violence. There is every likelihood that the child or young person who later on has become a drug addict, has also been subject to sexual and physical abuse. Being placed in an in-patient institution might be the introduction to an environment whereby the risk of children becoming drug addicts increases. However, calculations show that risk factors such as violence in the family, parents' addiction, certain mental illnesses and crime only explain why a minority of the addicts become addicts.

**Homelessness, drug addiction, and social exclusion**

A survey followed up on a cohort of 1007 persons registered in the homeless institutions, crisis centres and re-establishment centres of the City of Copenhagen in 1988-1989 (Børner Stax 1999). The follow-up included a study of each individual's status in a number of registries in 1990 and 1996. Information was gathered on address, supporting basis, family relations, relations to the labour market, experience with drugs and crime, and finally causes of death. The registry survey was supplemented with personal interviews.

The survey showed that one-third of the sample population had been in contact with euphoriant drugs, mostly among the men and mostly among those who had been living in shelters and re-establishment centres. Among the homeless, the drug addicts made up a particularly excluded group. The drug addicts displayed much higher "mobility", ie more and shorter stays than the other homeless in the shelters. One explanation could be that the drug addicts are immediately expelled and quarantined when caught in using drugs at the shelter, which means that the drug addicts have had to "wander between shelters". Another explanation could be that the drug addicts are expelled by the other homeless. There appears to be a certain amount of tension among the various groups using the shelters, ie the alcohol and cannabis addicts, the pill addicts and the "drug addicts", where the other residents characterise the drug addicts as a "problematic" group (Børner Stax 1999).

## 16.4. Political issues and reintegration programmes

Experience gained from a comprehensive social pilot and development program in Denmark from 1988-1991 (the SUM program) showed that the socio-political programs did not sufficiently reach out to the weakest groups as did the programs targeted at this group, and that local community projects aimed at integrating the weak groups of the local society could not fulfil their goals. This was the basis for placing the living conditions of the excluded groups on the political agenda during the 1990s. Central pooled funds were established to strengthen the programs for social well being and housing in order to improve the conditions of the homeless and other excluded groups. These funds were meant to stimulate the work of public as well as private organisations. They were supposed to be used for, among others, social dwellings to the most socially deprived groups.

**Alternative dwellings**

The main focus has been on establishing dwellings and social programs that were targeted and able to include the excluded groups. The overriding principles are the inviolability of the home and security of tenure as well as adaptation of

the home and the community in accordance with the users' needs. In practice, the drug use of the residents has become accepted to an increasing extent in housing communities established for special target groups such as mentally ill drug addicts, although this has not been adopted by central government. Most recently, funds have been reserved for allocation of grants to "crooked homes for crooked individuals" which may be characterised as "homes that begin where the possibilities for normal dwellings stop" (Lorang Sørensen 2001).

**Allocation of dwellings by social criteria**

In some parts of the country, including the City of Copenhagen, social criteria have been formulated as a quota, by which apartments in subsidized dwellings are allocated. This ensures that persons who have social problems and who are not in a position to acquire their own dwelling, may be given a home in a normal complex of apartments.

**The active line and "the flexible labour market"**

The long-term unemployed have only gained little from the increase in employment rates during the 1990 (Larsen et. al. 2001). As a result, the Social Reform of 1998 launched the Active Line of social policy by adapting the act on active social policy which linked the cash benefit services with the right and duty to subject to activation, and it paved the way for grants to flexible jobs and light jobs offered to individuals with reduced working capacity. The dividing line runs down through unemployed with or without problems other than unemployment, where the municipalities estimated that approximately two-thirds of the cash benefit recipients have problems other than unemployment, ie physical, mental or social problems and addiction problems. One-third of the cash benefit recipients are on average in active job services, which leaves no jobs to especially people with complex problems who are at risk of social exclusion (Larsen et al.2001).

During the 1990s, concerted efforts have been made to counteract exclusion from the labour market by establishing the "flexible labour market" and emphasizing "the companies' social responsibility". This is an invitation to closer cooperation between the public sector and the enterprises (partnerships) on counteracting exclusion from the labour market and (re) integrating long-term unemployed, including the excluded group of unemployed. The new phenomenon is that that drug addicts have been mentioned in this context, and there are projects targeted at this group within this program, however they are typically the ones who are most difficult to integrate.

**Treatment instead of punishment**

Increased political focus has been diverted to the fact that there is no point in having drug addicts serve their sentence in a traditional manner in prisons and local prisons, and that imprisonment should be utilised to start up treatment (the Ministry of Social Affairs and the institutions and departments of the Prison and Probation Service 1998). Up through the 1990s, prison sentences have increasingly been converted to treatment and various methods are at present being tested in order to reach a more appropriate link between treatment and punishment. Different experimental programs have been launched to render it possible for drug addicts to become drug-free and live in a drug-free environment while they are in prison, to serve their sentence in a drug-free environment,

known as the import model with treatment institutions working in the prison departments. The recent, more comprehensive studies that have received public grants have been developed by an association of former addicts (Clean House) who on a voluntary basis will contact the inmates during their imprisonment and establish a network and a social rehabilitation program for them after their time in prison.

**Treatment elements aiming at re-integration within the normal measures provided to drug addicts under treatment**

Drug-free treatment typically applied a phase model, in which resolution, detoxification, stabilisation and social rehabilitation follow after each other. The concept is that stabilised drug abstinence is a precondition for being part of socially integrating programs, including rehabilitations programs applying education, own dwelling, work and a family.

Substitution treatment is typically provided together with drop-in centre services, care providing services, nursing services and other ”harm reduction ” measures. The psycho-social support provided to this group has to a large extent aimed at combating further social decline and only in rare instances has it aimed at social integration.

Drug-free treatment is taking a different turn with the goal of social rehabilitation being included as early as during the initial phases of the treatment. Substitution treatment is also undergoing changes to the effect that the psycho-social support is given more weight and social integration is set as a goal depending on the client’s resources and track record. The full life, also the life lived outside the drop-in centre, is being included.

The social action plan and the treatment plan are statutory management tools. These plans must be produced in cooperation with the therapist and the client. The plans include short and long-term goals, grants for rehabilitation services, help in finding a suitable abode, future goals for being drug-free, employment, etc. The plan can be seen as a contract between the client and the treatment sector and society. However, it is a tool, which is used in different ways in society, and major sections of the treatment system do not find it useful. The plan is being criticised for not being adapted to the unpredictability characterising the lifestyle of drug addicts and for working against the spontaneous contact between the therapist and his/her client.

**Special re-integration programs aimed at former drug addicts and evaluation results**

**Coherent treatment and post-treatment programs**

Aalborg municipality, which enjoys the privileges of being a small, coherent geographic unit has developed a well-functioning consistent treatment concept over the past 10-15 years, which follows and supports the drug addict through a rehabilitation program. The program includes outreach work, pre-treatment, including social services provided to methadone users, in-patient treatment, and ongoing contact to outpatient supportive services, work or other employment, continuity in outpatient support and affiliation with self-help groups among local former addicts.

Aalborg municipality’s coherent program was evaluated in 1997 (Aalborg Kommunes Ungdomscenter 1997). The target group of the study included

everybody who had participated in a drug-free treatment program in 1992-1996, and who had received post-treatment. The number of people amounted to 50 at the time of the study. 11 people withdrew from the study, of which 3 relapsed into drug addiction, whereas 8 persons continued to be clean. The 39 former drug addicts participating in the treatment program had the following history: 1 (normal social integration), 13 (endangered social integration), 25 (socially excluded). 31 were injecting drug users, 23 were on a methadone program. The majority of the men were aged between 35 and 50 years (average age of 37) whereas the majority of the women were aged between 25 and 40 years (average age 32). At the time of the study, the majority had been clean for more than 1 year. 9 were self-providing, 13 in the middle of an education or rehabilitation, 5 working as volunteers, 4 unemployed and 4 still under treatment. In spite of their previous instability and homelessness, almost all of the participants had succeeded in getting their own home, improved contacts to family and friends and to non-drug users. Supportive factors mentioned as being of greatest importance are the self-help groups, but the follow-up and continuity throughout the program, including the outpatient post-treatment has had a major impact on the rehabilitation process and the continued drug-free situation.

**Section 78 of the Danish Act on Enforcement of Punishments**

There has been an increase in the use of Section 49 (s 2) of the Danish Criminal Code (now section 78 of the Danish Act on Enforcement of Punishments), an act that renders it feasible to enrol into a treatment program rather than serve one's sentence in prison. The section of the act has been evaluated (Hagemann and Olsen 2001).

During the period from 1990 to 1999, a total of 2115 persons were granted permission to serve their prison sentence in accordance with Section 49 (s 2). Out of this group, the drug addicts made up approximately 50% (988). 95% of these individuals had previously been punished compared to 78% of all Section 49 (s 2) prisoners. The majority was single, only one-third had their own dwelling, the majority belonged to the residual group of the education system and had had a short-lived, if any at all, affiliation to the labour market. 91% lived off transfer income at the beginning of the imprisonment. It was thus a group of addicts subject to threatened social integration who were granted permission to serve their sentence on the condition of treatment.

The effect of the program for the period 1990-1999 was measured on the completion of the program, recidivism and termination of criminal activity:

- 74% of the drug addicts completed the program against 80% of the others.
- 53% of the drug addicts subjected to recidivism within the first two years against 44% of the others. This, however, was modified by the fact that only 43% of the drug addicts who were released at the beginning subjected to recidivism.
- 29% of the drug addicts had not committed new crime 5 years after the end of the program against 39% of all prisoners.

In general it is believed that the use of Section 49 (s 2) of the Criminal Code has a crime-lowering effect when comparing with groups serving their sentences in local prisons or prisons.

**Drug addicts' integration into the labour market**

Since the end of the 1990s, several initiatives and programs have been launched to further the long-term unemployed's, including the drug addicts' access to the labour market. Throughout the 1990s, the drug addicts have belonged to the group of unemployed people who have had low priority in municipal activation programs. During recent years, however, employment projects and programs have been launched for drug addicts or for groups including drug addicts.

The "Active Again Project" – is a two-year project financed by the Ministry of Social Affairs with the aim of collecting and gaining experience in activation of marginalized groups. The target group includes recipients of cash benefits with massive problems other than unemployment, addiction, mental illnesses etc. 8 municipalities are participating in the project. The projects support the participants all the way, and are staffed by, among others, former addicts. Evaluation of the project has not yet been finalised.

In 1999, the City of Copenhagen launched special activation and realisation projects for methadone users, also known as the FRAM and SPIRILLEN projects[31]. The projects were launched to break the isolated and passive life of the group and to improve their ability to be self-supporting. The FRAM pilot project (1999-2000) had a dual purpose. The first one was to identify the barriers for drug addicts under methadone treatment to be able to obtain salaried employment. The other was to start a debate on methadone users' integration into the labour market. Concurrently and subsequently, the project was evaluated and the project participants, the treatment and activation services interviewed about its progress (Jöhncke 2001). The target group had to be stabilised in methadone treatment without any secondary drug use, with a permanent address and had to be able to speak and read Danish. Participation in the project was voluntary. The project included a total of 45 participants, but since it proved difficult to recruit to the project, the qualification requirements were reduced to including participants who were not necessarily stable. 14 (out of 45) started to follow courses and an education, 9 were enrolled into activation programs, and 5 were given a normal job.

The evaluation showed that methadone users by no means could be categorised as "weak", professionally or intellectually malfunctioning in comparison with other groups who needed support to get started on an education or employment. What is more common are emotional problems and difficulties with social contacts, loneliness and isolation, low confidence in own abilities which turned out to be barriers to the methadone users. Stigmatisation and contempt were the general attitudes experienced by this group and its contact with the remaining society.

[31] Both projects are described in the EDDRA database.

The project paved the way for this group to enter into the activation system, whereas the highest barrier appeared in the treatment system.

Since its beginning (1999) and up to and including 2001, the Spirillen project has had 45 participants. Two success criteria have been established, of which one is that 50% of the participants qualify for and start on a more targeted commercial education or employment. This was achieved by 19% of the participants. The second success criterion was that 90% receive a plan for the nearest future. This, however, was only achieved for 40% of the participants. The experience gained under the Spirillen project is furthermore that it is difficult to recruit new participants and to retain the ones enrolled. The Spirillen project also experienced that the treatment sector staff referring the participants to the project did not actively support the methadone users to join an activation program.

## 16.5. Methodological information

### 16.5.1. Limits in available data

Research into the drug addicts' affiliation to the labour market, to social and political systems is scarce, and only a few studies are available on the everyday lives of the drug addict with a focus on relations to the community surrounding them. There are quite a few finalised and current ethnographic / qualitative studies on the conditions of the most deprived groups. The data available on the social integration of the drug addict are typically registration data or data collected in connection with evaluations of treatment programs or reports from civil servant or expert committees.

In general it applies that we only have life historical knowledge about the drug addicts who get into contact with the treatment or penal system, and as far as the subject on social integration is concerned, we have very little knowledge about the group who has kept away from authority contact.

### 16.5.2. Main studies and research

The most noteworthy research made within the issue of social exclusion / integration and drug addiction includes:

- a study on mental illness and drug addiction (Jessen-Petersen 1994) from 1991, which has just been repeated and about to be revised.
- social inheritance and drug addiction (Christoffersen 1999).
- Stigmatisation of drug addicts (Jöncke 1997, 2001).

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# Annex

**Table 2.2.5. Percentage of 16-44-year-olds who report in 2000 having tried one or several of the different illicit drugs within the past month, last year and ever.**

| | Past month | Past year (past 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** | 1.2 | 3.4 | 11.3 |

Source: Unpublished figures from SUSY 2000.
*The category “Other” drugs cover GBH various medicinal products, etc.
** A consolidated category including ”used an illicit drug other than cannabis”.

**Table 2.2.8. The percentage who have tried cannabis and amphetamine among the five age groups from 16-20 years (n=2090).**

| | Tried cannabis ever | Tried amphetamine ever |
|---|---|---|
| 16-year-olds | 22 | 3 |
| 17-year-olds | 29 | 8 |
| 18-year-olds | 36 | 9 |
| 19-year-olds | 39 | 11 |
| 20-year-olds | 43 | 15 |
| All | 33 | 9 |

Source: Unpublished figures from MULD 2001.

**Table 2.2.9. Drug addicts in prison 1985-2002.**

| | All drug addicts | | | More heavily deprived drug addicts | |
|---|---|---|---|---|---|
| | Number of drug addicts | Proporion of all inmates (%) | Average age | Number of most heavily deprived drug addicts | Proportion of drug addicts in prison (%) |
| Apr. 85 | 734 | 23 | 27.4 | 274 | 37 |
| Feb. 86 | 902 | 25 | 27.9 | 404 | 45 |
| Sep. 87 | 861 | 27 | 27.8 | 356 | 41 |
| Oct. 88 | 923 | 26 | 28.0 | 421 | 46 |
| Sep. 89 | 953 | 27 | 28.3 | 408 | 43 |
| Oct. 90 | 970 | 27 | 28.9 | 398 | 41 |
| Nov. 91 | 1,002 | 27 | 28.8 | 386 | 39 |
| Dec. 92 | 1,081 | 30 | 29.0 | 498 | 46 |
| Nov. 93 | 1,109 | 31 | 29.4 | 463 | 42 |
| Dec. 94 | 1,088 | 30 | 29.4 | 532 | 49 |
| Nov. 95 | 1,195 | 33 | 29.6 | 566 | 48 |
| Nov. 96 | 1,216 | 35 | 29.4 | 621 | 51 |
| Nov. 97 | 1,282 | 36 | 30.1 | 682 | 55 |
| Nov. 98 | 1,267 | 36 | 30.1 | 663 | 54 |
| Nov. 99 | 1,296 | 36 | 30.6 | 657 | 51 |
| Nov. 00 | 1,316 | 38 | 30.8 | 689 | 52 |
| Feb. 02 | 1,268 | 37 | 30.7 | Undisclosed | Undisclosed |

Source: Directorate of the Prison and Probation Service 2002.

| Table 5.2.1. Drug seizures 1990-2001. | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | **1990** | **1991** | **1992** | **1993** | **1994** | **1995** | **1996** | **1997** | **1998** | **1999** | **2000** | **2001** |
| **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 |
| 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 |
| **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 |
| Number of seizures | 157 | 144 | 184 | 228 | 417 | 569 | 659 | 723 | 885 | 744 | 780 | 815 |
| **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 |
| 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 |
| **Ecstasy** | | | | | | | | | | | | |
| Stk. | | | | | | 2,115 | 15,261 | 5,803 | 27,039 | 26,117 | 21,608 | 150,080 |
| Number of seizures | | | | | | 9 | 84 | 110 | 143 | 197 | 444 | 331 |
| **Lsd** | | | | | | | | | | | | |
| Doses | | | | | | 1,282 | 262 | 381 | 105 | 83 | 1,108 | 156 |
| Number of seizures | | | | | | 6 | 16 | 15 | 24 | 15 | 18 | 29 |
| **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 |
| 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 |

Source: NEC 2002.

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

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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3. Figure 3.2.2 Geographical breakdown of drug-related mortality rates.
4. Figure 3.2.3 Drug related deaths 1990-1999.
5. Figure 14.3.1 Net operating expenditure, counties and municipalities 1995-2001.

## Applied surveys

(The surveys below are described in the order in which they appear in the report). An approximate brief English translation is provided in brackets []. The surveys have not otherwise been translated into English.

**"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 survey conducted in 1994 among a representative segment of the population aged 16 and above. The survey included questions on a variety of health issues. A sample population of 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 survey was conducted in three data collection rounds in February, May and September 2000 among a representative segment of the Danish population aged 16 and above. The survey included as in 1994, questions on a variety of health issues. The sample population of a total of 22,486 persons was selected in three random sampling rounds. Data collection was 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]**
In 2000, the National Board of Health and the Danish Cancer Society conducted a representative survey on the lifestyles and daily routines of the 16-20-year-olds. The survey 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 performed in such a manner that the interviewees received a questionnaire by post. The survey achieved a response rate of approximately 70%.

**"Monitorering af unges livsstil og dagligdag 2001" (MULD 2001), Sundhedsstyrelsen and Kræftens Bekæmpelse, unpubliced. [see above]**

In 20001, the National Board of Health and the Danish Cancer Society once again conducted a representative survey on the lifestyles and daily routines of young people aged 16-20 years. The sample population of 3048 young people between the age of 16 and 20 years was selected systematically. Data collection was performed in such a manner that the interviewees received a questionnaire. The survey achieved a response rate of approximately 70%.

**"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 conducted a qualitative survey on the young people's drug culture for the National Board of Health. The survey 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.

**"Rapport om unges brug af rusmidler fra 1990 til 2000" København Kommune i 1999/2000 (Københavns Kommune 2002). [Report on young people's use of drugs from 1990 to 2000].**

In 1999/2000, The Danish Family and Labour Market Administration and the Copenhagen Health Administration conducted a questionnaire survey on young people's use of drugs. The survey was conducted among a representative segment of the 7$^{th}$-9$^{th}$ grades and pupils in high schools in the City of Copenhagen. Data collection was performed by handing out the questionnaire to the interviewees in the classrooms and their teacher being responsible for collecting the questionnaires upon completion. The survey received 2054 completed questionnaires, which equals an average response rate of 85%. Similar surveys had been conducted in 1990/1991 and in 1994/1995, which the results from the1999/2000 survey are compared with.

**"RisikoUngdom - Ungdomsundersøgelsen 1999" Det Kriminalpræventive Råd and Københavns Universitet (Balvig 2000). [Youth at risk]**

In 1999, the Danish Crime Prevention Council and the Copenhagen University conducted a questionnaire survey on, among others, crime committed by young people and their use of drugs. The survey was conducted among 70 8$^{th}$ grades in 30 Danish "folkeskoler" in Gladsaxe, Allerød and rural districts of northern Jutland. Data collection was performed by handing out the questionnaires to the interviewees in the classrooms. The survey received 916 completed questionnaires, which equals a response rate of 87%. Previously in 1979, similar surveys had been conducted in Gladsaxe and in 1989/1990 in Gladsaxe, northern Jutland and Allerød, which the results from the1999/2000 survey are compared with.

**"The 1995 ESPAD report – Alkohol 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 survey (The European School Survey Project on Alcohol and Other Drugs) a national school survey was conducted in 1995 on the young people and their relationship with drugs. The survey was conducted among a representative segment of 15-16-year-olds in 9$^{th}$ 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 – Alkohol and Other Drug Use Among Students in 30 European Countries" (ESPAD 1999), CAN and Pompidou Group (Hibell et al. 2000).**

In 1999, the survey from 1995 was repeated among a representative segment of 15-16-year-olds in 9$^{th}$ 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]**
This reports is based on the ESPAD 1995 survey. However, this report is based on a sample including also 14- and 17-year-olds in 9th grade. This extended the number of participating pupils to 2545.

**"Rusmiddelforbruget – i folkeskolens afgangsklasse og udviklingen fra 1995-1999" Institut for Epidemiologi og Socialmedicin, Aarhus Universitet (Sabroe & Fonager 2002). [Young people and drugs]**
This reports is based on the ESPAD 1999 survey. However, this report is based on a sample including also 14- and 17-year-olds in 9th grade. This extended the number of participating pupils to 1750.

**"Præsentation af talmaterialet fra undersøgelse af rusmiddelbrug og –kendskab hos unge på ungdomsuddannelser" Ribe Amt 1999 (Ribe Amt 2000). [Survey on drugs in Ribe County 1999]**
In 1999, the drug counsellors in Ribe County conducted a questionnaire survey on the 16-19-year-old's use of drugs. The survey was conducted among a representative segment of young people attending youth education in the county. Data collection was performed by drug counsellors handing out the questionnaires to the interviewees in the classrooms. The survey received 1371 completed questionnaires, which equals a response rate of 100%.

**"Unge og Rusmidler - en undersøgelse af de 16-19 åriges rusmiddelerfaringer på ungdomsuddannelser i Århus Amt 2001" Århus Amt 2001 (Villumsen 2001). [Survey on young people's experiences with drugs in 2001]**
As part of Aarhus County's cooperation with the National Board of Health in connection with a development on ecstasy prevention, the county conducted a questionnaires survey in 2001 on the 16-19-year-olds's use of drugs. The survey was conducted among a representative segment of the young people attending youth education in the county. Data collection was performed by handing out the questionnaire to the interviewees in the classroom. The survey received 1198 completed questionnaires, which equals a response rate of 85%.

**"Rusmiddelundersøgelsen 2000 – Rusmiddelbrug og -holdninger blandt unge på ungdomsuddannelserne i Frederiksberg Kommune" Frederiksberg Kommune 2000 (Frederiksberg Kommunes Rådgivningscenter 2001). [Use of and attitudes towards drugs among young people attending youth education in Frederiksberg Municipality]**
In 2000, Frederiksberg Municipality Counselling Centre conducted a questionnaire survey among a representative segment of young people attending youth education in the municipality. Data collection was performed by handing out the questionnaires to the interviewees in the classrooms. The survey received 904 completed questionnaires, which equals a response rate of approximately 90%.

**"De unge og rusmidlerne – Holdninger til og forbrug af rusmidler. En undersøgelse med særligt henblik på ecstasy blandt de 16-19 årige på ungdomsuddannelser i Nordjyllands Amt" Nordjyllands Amt 2000 (Emerek et al. 2001). [Attitudes towards the use of drugs – in particular ecstasy]**
As part of the cooperation between the county of northern Jutland and the National Board of Health in connection with a development project on ecstasy prevention, the county conducted a questionnaire survey in 2001 on the 16-19-year-old's use of drugs. The survey was conducted among a representative segment of young people attending youth education in the county. Data collection was performed by handing out the questionnaires to the interviewees in the classroom. The survey received 1493 completed questionnaires from the selected age group, which equals a response rate of approximately 80%.

**"Stof til Debat – Holdninger til forbrug af rusmidler. En undersøgelse omkring tobak, alkohol, hash, ecstasy, svampe og amfetamin blandt 16-19 årige på ungdomsuddannelser i Vestsjællands Amt" Vestsjællands Amt 2001 (Olsen & Licht 2002). [A survey on tobacco, alcohol, cannabis, ecstasy, mushrooms and amphetamine among 16-19-year-olds in youth education environments in the County of West Zealand].**
In 2001, the addiction centre in the West Zealand County conducted a questionnaire survey on the 16-19-year-old's use of drug. The survey was conducted among a representative segment of the young people attending youth education in the county. Data collection was performed by handing out the questionnaire to the interviewees in the classrooms. The survey received 1647 completed questionnaires, which equals a response rate of approximately 94%.