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2004 NATIONAL REPORT TO THE EMCDDA
by the Reitox National Focal Point

Denmark
New Development, Trends and In-Depth Information on Selected Issues

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 autumn of 2004 and is the ninth report submitted to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). The report is available in a Danish and an English version and has been prepared in accordance with the guidelines set out by the EMCDDA.

The report provides a description of the 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.

Sociologist Kari Grasaasen is responsible for the epidemiology chapter in cooperation with Eva Hammerby, head of section, while Hans Henrik Philipsen, Head of Section, has prepared the part describing prevention. Helle Petersen, MD, has prepared the chapter on buprenorphine. 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 Interior and Health as well as the counties. The Danish member of the EMCDDA’s Scientific Committee, special consultant Anne-Marie Sindballe, and the Advisory Drugs Committee under the National Board of Health contributed comments and constructive criticism. Birgitte Neumann, the National Board of Health, was responsible for layout, design and proof reading.

November 2004

Else Smith
Head of Centre

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Summary

The current drug situation in Denmark

The most recent estimate on the number of drug abusers made by the National Board of Health shows that in 2001, there were 25,500 drug abusers in Denmark. More than 6,000 of them are estimated to be cannabis abusers only. From 1996 to 2001, the number of drug abusers has increased by 6,000 persons, equalling 24%. The statistics do not comprise experimental drug use, but provide an estimate on the number of persons with a more constant drug use, which causes them to suffer from physical, mental and/or social injury. Actual drug addicts are thus included in the estimates, including the stabilised drug addicts (addicts in methadone treatment)

No population surveys have been made on the prevalence of experimental drug use in the adult population since 2000. However, results from the most recent surveys and regional hearings suggest that the increase in the experimental use of illicit drugs observed from the mid-'90s and onwards has levelled off, and that experimental drug use today is high, however stabilised. Cannabis continues to be the most prevalent drug, and amphetamine, cocaine and ecstasy, in that order, are also being tried by relatively many people.

Experimental use of illicit drugs is still a phenomenon primarily taking place during the years of adolescence, which is substantiated by the various population surveys and regional hearings. The drug use is seen in age groups from 14-30 years and peaks among 16-19-year-olds.

Although experimental cannabis appears to have stabilised, we see an increasing trend in the damaging effects from cannabis use these years. An increasing number of individuals, in particular those recently admitted for treatment, embark on drug treatment with cannabis as their main problem, and the data on drug-related hospitalisations in psychiatric wards show that the persons entering the system with drug-related problems are increasing. The problems of polydrug use and use of central stimulants also have become more apparent in drug treatment and among the drug-related hospitalisations in psychiatric wards, although this increase is not as distinct as that of cannabis. For the first time, this year's report has included figures on visits to casualty departments with intoxification caused by illicit drugs. Due to current registration practice, these figures do not provide the full picture, but should be viewed as a minimum indicator. However, there is a clear tendency towards an increasing number of serious intoxifications caused by cannabis as well as central stimulants over recent years.

The reasons for the documented increase in problems related to cannabis and central stimulants should be seen in the light of the increase in experimental use of these drugs throughout the '90s in particular, the consequences of which are now becoming apparent. Another thing is that the improved treatment capacity and the better and more targeted treatment programmes also contribute to more people seeking treatment. From 2002 to 2003, there has been an almost 14% increase in the number of persons undergoing treatment for drug abuse, and as many as 34% of all drug abusers receiving treatment in 2003 have not been treated previously and are thus "new" to the treatment system.

Mortality statistics prepared by the National Commissioner of Police show a stable level since the mid-'90s. In 2003, 245 drug-related deaths were registered. A vast majority of these deaths occur after intoxification caused by one or several drugs, and the majority of the intoxifications are related to opioids.

There are distinct gender differences between men and women in the experimental use, abuse and damaging effects resulting from the use of illicit drugs. Men account for an over-representation in all statistical material and survey results such as population surveys, in the treatment register, in data on drug-related psychiatric diagnoses, intoxifications caused by illicit drugs and among the drug-related deaths.

New developments within prevention, treatment and harm reduction

On a local as well as a regional and governmental level in Denmark, efforts are being intensified within preventive intervention and harm reduction, such initiatives being launched to curb the development within experimental use, and reduce the harm resulting from abuse of illicit drugs. Local and regional initiatives are being launched in the attempt to step up network operations among key personnel such as street level workers, SSP, the county alcohol and drug consultants, and activities to build competencies and re-qualification via feature days and courses are on the increase. Furthermore, new and additional local network projects are being launched to focus on prevention in the commercial party settings and on the youth educational programmes. The counties and municipalities are hiring an additional number of "drug and alcohol squads", ie local groups of young people who visit schools and educational institutions as well as disseminate information and enter into a dialogue with the pupils.

More and more counties have performed drug and alcohol prevention via local music festivals, where key personnel from various areas have cooperated on the establishment of a "stand" or provided open services on counselling and a "chat". As was the case in 2003, the Roskilde Festival focused on the fight against drugs in 2004, where the Festival's "no-to-drugs"- attitude was very clearly marked via large screen spots, the festival programme, postcards, T-shirts, the Festival website, bus ads, and via handout of factual information about drugs .

The Government's action plan – "The Fight against Drugs" – which was launched in October 2003, comprises various initiatives that are meant to maintain and improve the current initiatives vis-a-vis drug abuse. The action plan includes, among others, a major model municipality project "Drugs out of town", but also a number of suggestions within treatment, control and harm reduction.

As mentioned earliers, there has been an increase in the number of persons undergoing treatment for drug abuse. As at 1 January 2003, a treatment guarantee was launched, according to which the county is committed to initiate treatment of a drug abuser in need of help within 14 days. In most counties, the treatment guarantee has made the waiting lists superfluous, and the number of treatment slots for drug abusers has increased. Apart from the *actual* treatment of the drug abuser, various projects are being completed in the form of outreach work aiming at social and health care support to the most addicted drug abusers. In order to minimise transmission of infectious diseases among the drug abusers, most counties now offer them syringes and needles free of charge,

New drugs and new legislation

The National Board of Health is still instrumental in the intensive monitoring of drugs on the illicit market. One of the goals is that deliberations on control measures and bans can be implemented when new drugs appear on the market. Following the medical recommendations of the National Board of Health, the drugs Ibogain and Tabernanthe iboga were placed on the restricted lists effective 3 December 2003. Amyl nitrate and Isobutyl nitrate ("Poppers") were prohibited as of 18 February 2004, and finally 5-Meo-DIP was prohibited as of 3 March 2004..

A number of Acts have been adopted in 2003/2004. New maximum penalties were added to the Danish Criminal Code, with the maximum penalty for aggravating drug crime being increased to 24 years. Also, in May 2004, the Danish Parliament adopted amendments to the Euphoriant Substances Act, whereby *fines* may now be imposed instead of a *warning*.

Thematic chapters on buprenorphine, treatment as an alternative to punishment and public nuisance

The thematic chapter on "Buprenorphine" deals with the issues surrounding buprenorphine as a substitution substance in Denmark. The thematic chapter on "treatment as an alternative to prison" provides an outline of the regulatory provisions, guidelines and practices when drug abusers are offered and receive drug abuse treatment under the institutions of the Danish Prison and Probation Service. Finally, the thematic chapter also deals with the issue of "public nuisance", the cannabis clubs and the efforts to legalise Christiania in Copenhagen.

1 Trends and new developments

1.1 Overview/summary

In Denmark, drug policies are based on a combination of a ban against the use of drugs, persistent and targeted preventive intervention, multi-pronged coordinated treatment programmes and effective control activities. Drug abuse is perceived as a complex problem requiring cooperation across professional boundaries and sectors, for which reason the efforts of local, regional and central authorities are required.

At a governmental level, the current drug policy is defined, developments controlled and monitored, local and regional research and intervention supported, and the prevalence of drugs monitored. Finally, the State must collaborate with other authorities and organisations at an international level.

The Ministry of the Interior and Health is responsible coordinating operations at a governmental level and also oversees the governmental tasks associated with treatment within the health care sector and preventive intervention, including questions pertaining to medical treatment such as substitution treatment, HIV-infection/hepatitis and drug abuse. *The Ministry of Social Affairs* is responsible for the social treatment programmes, which is assisted by private organisations and funds as well as voluntary organisations and the Council for the Socially Marginalised People. *The Ministry of Justice* has the main responsibility for supervision and policing and for the Prison and Probation Service, including drug abusers in prison. *The Ministry of Tax Affairs* is responsible for inspecting precursors and is the head of the customs authorities

The counties and municipalities are responsible for treatment and prevention and are therefore responsible for the actual intervention and for providing relevant programmes. The Association of County Councils makes sure that the counties work together and that their interests in relation to the law, the state and the local authorities are protected. Furthermore, a large majority of the municipalities have established collaboration between school, social authorities, and law enforcement authorities in support of local preventive initiatives aimed at establishing direct contact with the young.

1.2 National strategy in the fight against drugs – Legal framework

In October 2003, the Government published a cross-ministerial action plan under the heading “The fight against drugs”. The action plan was prepared by a ministerial committee and laid down targets and the means to achieve concrete results in the areas of prevention, social treatment, medical treatment, law enforcement and treatment of criminal drug abusers as well as international collaboration.

One of the main elements of the action plan is that the Government will support and stimulate local preventive efforts by granting funds for specific collaboration with one municipality in each county. This collaboration must take place within the framework of a 3-year model municipal project “Drugs out of town”.

The overall goal of the model municipality project is to reduce the prevalence of drugs in the local community via local and coordinated initiatives. The more specific goals of the model municipality project are significantly to limit the availabil-

ity of drugs and to reduce the number of young people experimenting with and taking drugs, and drastically to reduce the amount of acute damage such as intoxification, drug-released psychosis and violence, to achieve early preventative intervention in relation to young people heading for drug abuse, and to ensure effective preventive intervention for children living in families with drug abuse problems (see also chapter 3).

The chapter on law enforcement in this action plan deals with international law enforcement collaboration, which the Government aims at intensifying and extending as part of its efforts to prevent and combat organised drug crime. The action plan further states that the fight against organised drug crime will also involve a focus on the biker community in Denmark, as well as consistent action against young people's drug abuse in restaurant and recreational settings. Finally, the action plan deals with renewed efforts to stop the overt cannabis trade in Christiania.

In connection with and as a follow-up to the action plan, a number of initiatives have been launched and a number of law amendments passed. Together, they lay down the priorities and initiatives within law enforcement as described in the action plan. For further details, please refer to the section on recent legislation and to Chapter 13 which describes the work being carried out in Christiania.

Control measures to fight drugs are the responsibility of the police and customs authorities. Their activity is aimed at individuals and organisations behind national and international illicit drug trafficking, but also at drug trafficking in the streets. Another aspect is the law on drugs used for the illicit manufacturing of drugs (precursors), which is based on EU rules on the control of manufacture and trade of certain goods used for the illicit manufacturing of narcotic and psychotropic drugs.

1.3 New legislation

The Danish Criminal Code provisions on the possession of drugs are set out in the Euphoriant Substances Act and in Section 191 of the Danish Criminal Code.

On 10 October 2003, the Danish Parliament passed Act no. 433 – an amendment to the Act on the Surrender of Offenders and the Act on Surrender of Offenders to Finland, Iceland, Norway and Sweden (Implementation of EU framework decision on the European arrest warrant, etc). This law came into force on 1 January 2004.

Section 10 a of the Act on the Surrender of Offenders was amended so that, subject to certain conditions, the surrender of an individual for prosecution or punishment in an EU member state need not be restricted to cases where the offence is punishable by Danish law (requirement of double punishability) if one of the offences mentioned in Section 10a (subsection 1) (1)-(32), including illicit trade in drugs, has been committed.

On 31 March 2004, the Danish Parliament adopted Act no. 218 – an amendment to the Danish Criminal Code and the Danish Administration of Justice Act (Amendment to maximum penalties and provisions on determining penalties), etc. The law came into force the day after its notification in the Danish Legal Gazette. The Act provided that the maximum penalty pursuant to Section 191 of the Danish Criminal Code should be raised from 6 and 10 years' imprisonment to respectively 10 and 16 years' imprisonment with up to 24 years in particularly aggravating drug cases.

Finally, on 27 May 2004, the Danish Parliament adopted Act no. 175 of 2004 – an amendment to the Euphoriant Substances Act and the Danish Corrections Act (Intensified action against drugs, etc). The Act came into force on 1 July 2004 and included a new provision in Section 3 (subsection 1) 2nd sentence in the Euphoriant Substances Act whereby violations of the Euphoriant Substances Act as a rule will be punishable by a fine and not just a warning. This amendment of the Act means the end of the former practice of issuing warnings for the possession of drugs for own use, in that such offences will now normally be punishable by a fine. In a circular issued by the Public Prosecutor it is stated that a warning can only be issued in special cases, where on the basis of a specific judgement it is considered more appropriate to apply this type of sanction. Such warnings may be given only in exceptional circumstances in accordance with the former guidelines, i.e. normally only in the case of first-time offenders unless the offence involves the possession of cannabis. The amendment means that a warning will be issued if such a sanction is judged in the circumstances to be more justifiable than a fine, or if the issuing of a fine would cause more administrative trouble than is reasonable in relation to the nature of the case. Finally, social considerations may speak in favour of using a warning, where the use of a drug is judged to be the result of heavy addiction.

Furthermore, Section 3 (subsection 2) of the Euphoriants Act was amended under the above act, whereby it is deemed a significantly aggravating circumstance if drugs are sold, or offered free of charge with the view subsequent sale, in restaurants, discotheques or similar places typically attended by children or young people.

The Public Prosecutor's circular no. 35 of 1 July 2004 provides that the aim of the amendment is to raise the level of punishment so that the sale of drugs in restaurants and other places typically attended by children or young people will always be punishable with a prison sentence. Compared to the prison sentences passed today, the amendment further aims at increasing sentences by 1/3 when drugs are distributed in the places mentioned above.

Guaranteed social treatment against drug abuse

On 1 January 2003, the Act amending the Social Services Act (Guaranteed social treatment for drug abuse) came into force. According to the Act, county authorities must provide social treatment for drug abusers no later than 14 days after referral to the county. Also, the drug abuser has the right to choose between public and private approved treatment services similar to those offered by the county. The Act subjects the implementation of the scheme to monitoring for evaluation purposes. In the evaluation it will be determined whether the effects of the proposed scheme are consistent with the intentions of the law. Based on this evaluation, a report will be prepared and after a hearing in the other authorities and organisations, the report will be submitted to the Social Committee of the Danish Parliament after the Law has been in effect for three years.

Every month, the Association of County Councils will collect data from the counties, the City of Copenhagen, and Frederiksberg Municipality in order to check how the Act on the Social Treatment Guarantee is being administered.

As a follow-up to the amendment of Section 85 of the Social Services Act on guaranteed treatment for drug abuse, provisions have been laid down in pursuance of Section 110 of the Social Services Act for the preparation of quality standards to be

used in the treatment of drug abuse. These rules have been set out in a Consolidated Act of 26 May 2004. The Consolidated Act came into effect on 1 July 2004 and further details are given in Guideline no. 47 of 26 May 2004.

Pursuant to the Section 1 of the Consolidated Act, the County Council must lay down quality standards for the social treatment of drug abusers provided by the county under Section 85 of the Social Services Act. The regulation also applies if a local council, as per agreement with the county council, has taken over all of or part of the treatment service provided to the municipality's citizens, i.e. that the county council lays down quality standards. The delegated municipality need therefore not lay down its own standards, but must adhere to the quality standards set out by the county council.

Section 2 of the Consolidated Act specifies what tasks within drug abuse treatment should as a minimum be contained in the quality standards. The county council must inform the municipality of future intervention against drug abuse, and make sure that any children living at home with a drug abuser receive maximum attention.

According to the Section 3 of the Consolidated Act, the county council must also inform the citizens of the quality standards stipulated by the county for specific in-patient services provided. The county council must follow up on these quality standards and check that the in-patient services provided concur with the quality standards set by the county council.

The county council must have its first quality standards in place by 31 December 2004. The quality standards must be reviewed at least every second year. User representatives and their families may be involved in the preparation and revision of the quality standards.

New drugs on the restricted lists

Effective 3 December 2003, the drugs Ibogain og Tabernanthe iboga were added to list B under the Euphoriant Substances Act , whereas, effective 18 February 2004, the drugs amyl nitrite and isobutyl nitrite were added to list E under the Act. Effective 3 March 2004, the substance 5-MeO-DIPT was added to list B under the Act. These drugs were added to the lists following the National Board of Health's professional recommendation, and the use of the drugs must from now on be restricted to medical or scientific purposes.

1.4 Budget and public expenditure

Special pilot projects aimed at drug abusers in methadone treatment will be completed in 2004/2005, following which evaluation results will be submitted. Follow-up on the reserved funds for a rise in quality in the drug abuse area will be carried out by the Knowledge and Communication Centre for the Socially Marginalised People. A publication on practice in this area is currently under preparation.

An amount of Euro 1.2 million has been set aside in the budgets for 2004-2007 to provide treatment to young drug abusers. A part of this amount will be set aside as a fund municipalities, counties, etc. can apply to.

In order to increase and improve the treatment provided to young people under 18 suffering from serious drug problems, the budget for 2004 has reserved funds of

Euro 1.3 million. It has also been agreed to draft a Bill on a municipal obligation to prepare action plans for young drug abusers under the age of 18. The bill will be introduced in the autumn. In this as in other areas, it is necessary to intensify inter-disciplinary action, and the aim of the bill is to ensure that the municipalities and their existing in-patient and out-patient services for children and young people reflect the necessary professional know-how on the treatment of drug abuse. Therefore, the county drug abuse centres need to be involved in these cases.

In the distribution of grants the aim is to support projects trying to develop new working methods in relation to establishing and maintaining contact to young people individually and to groups of young people with drug abuse problems.

Municipal and county accounts and budgets show a steep increase in the funds reserved for the treatment of drug abuse since 1995. In the 2004 budget, Euro 104.1 million was reserved. the corresponding figures for 1995 were Euro 30.2 million.

County accounts include expenditure on methadone treatment. This figure, however, is included as a non-specified part of county expenditure for hospital and social services, for which reason it is not included in the figures above on activity falling under the Social Services Act.

Each year, an amount of Euro 6.4 million is set aside on the Budget for the improvement of social services provided to drug abusers. These funds are meant to secure broader and stronger intervention in the area, including the initiation of projects for the most addicted drug abusers, prevention and development of treatment programmes, etc. for the younger drug abusers who take ecstasy and amphetamine, etc. This intensified work includes the collection of empirical data, studies of treatment efficacy, quality assurance, information and communication activity as well as vocational training.

The drug abuser treatment guarantee is financed via targeted social grants: Euro 14.7 million in 2003, Euro 19 million in 2004, and Euro 13.3 million each year in the coming years.

The special intervention for young cannabis users and the agreement to table a bill on municipal obligation to prepare action plans for young drug abusers are covered in the above.

In 2004, the government expects to grant funds of approximately Euro 726,000 for the prevention of drug abuse. These funds will be used for information activities, development and analysis projects, teaching, etc. These activities will be carried out by, among others, the National Board of Health in collaboration with other authorities, organisations, groups and individuals. Other activities financially supported by the Ministry of the Interior and Social Affairs will be carried out by local authorities, unions, associations, etc. Furthermore, the National Board of Health has been granted Euro 2 million for the period 2004-2006 for the implementation of the model municipal project with the title “Drugs out of town”. Euro 2 million has been earmarked to support the participating municipalities and Euro 780,000 has been granted to the National Board of Health to finance its work before, during and after the project, including the intensified development and communication of information and teaching material.

In 2001, Government grants of Euro 5.4 million were given over a 3-year-period to a project for intensified psycho-social support to drug abusers receiving methadone treatment and Euro 1.3 million for a project with intensified outreach social and medical intervention for heavily addicted drug abusers in Copenhagen. Furthermore, Euro 19.5 million over a 4-year-period has been set aside for the completion of the government action plan against drug abuse "The fight against drugs", including the above mentioned Euro 2.8 million

In the Psychiatry Budget for 2003-2006, special grants of Euro 6 million have been reserved over a 4-year-period to strengthen social and socio-psychiatric intervention for people with co-morbidity.

1.5 Social and cultural context

During the Parliamentary year of 2003/2004, members of the Opposition introduced a bill with the following aims: Counsellors should be appointed for pregnant drug abusers to ensure that this group receives adequate social and therapeutical support and the best possible conditions for the unborn child.

In general, the counties give high priority to the pregnant drug abuser who contacts the authorities and asks for help. Furthermore, individuals in public service are under a special obligation to notify the municipality if in the course of their work they hear of a pregnant woman with serious drug problems. The bill was rejected. However, during the debate, the Minister of Social Affairs argued that there might be extraordinary reasons for maintaining the pregnant woman in treatment out of consideration for the unborn child, and as a result, what is being considered is to include the category pregnant drug abusers in a revision of Section 80 of the Danish Social Services Act on support and contact personnel assigned to individuals suffering from mental illnesses.

During a trial period, the Ministry of Social Affairs and selected municipalities and counties collected data and experience from support and contact-personnel schemes for the homeless, drug abusers and alcoholics. This experience will be included in the deliberations on the bill for the above revision during the Parliamentary year 2004-2005.

Also during the Parliamentary year of 2003/2004, the Opposition introduced a bill with the following aims: Treatment guarantee to be issued to drug abusers under 18 with the treatment supplied by the counties. The bill was rejected. The reason was that in the budgets for 2004-2007 it was decided to intensify intervention targeted at drug use by young people under the age of 18 as part of intervention against negative social inheritance. This was done by changing the Social Services Act, pursuant to which the municipalities are under an obligation to prepare action plans for young people under the age of 18 with drug problems, and by setting aside funds under the 2004 grants for increased treatment intervention targeted at drug abusers under the age of 18.

During the parliamentary year 2003-2004, members of the Opposition introduced for the second time a bill to legalise cannabis. During the discussion of the bill, it became clear that there was a majority against the bill. In its action plan to combat drug abuse, "The fight against drugs", the Government rejects the idea of drug injection rooms, legalisation of cannabis, and prescribed heroin as being too far-reaching and in contravention of the core of Danish drugs policy. And with regard

to legalising cannabis and setting up drug injection rooms, the Government's view is that such action would be in conflict with international drug conventions.

2 Drug use in the population

2.1 Overview/summary

Cannabis is the most prevalent illicit drug in Denmark. According to the latest national population survey, 42% of the population between 16 and 44 years of age have tried experimenting with cannabis at some time and 10% have done so within the past year. By comparison, around 3% of the same age group have tried illicit drugs other than cannabis within the past year. Amphetamine is the second most prevalent drug after cannabis among the young as well as in the population in general (SUSY 2000).

Typically, young people aged between 16 and 24 are the ones who experiment with drugs. 20% of this age group are cannabis users (have smoked within the past year), and 6% are current amphetamine users. As regards cocaine, mushrooms and ecstasy, 2-3% of young people between 16 and 24 are actual users of these drugs, whereas less than 1% are actual users of heroin and LSD. Population surveys conducted on the habits of young people show no correlation between parents' low social status and drug use. However, among people aged 31-44, the majority of users of cannabis and other drugs are found among those who are outside the labour market: the unemployed and people on early retirement pensions[1].

From the mid-90s and until early 2000, there was a clear increase in the experimental use of various illicit drugs – both in the population in general, and especially among the young adults and the very young (15 and16-year-olds). Figures from the most recent national school and youth surveys summarized below suggest that the experimental use of cannabis and other illicit drugs now appears to have stabilised, albeit at a high level. A quarter of all school children in the 9th grade have tried smoking cannabis, while 3-4% of them have tried amphetamine, cocaine or ecstasy (Hibell et al 2004, unpublished). Among 16 to 20-year-olds, 36% have tried cannabis, and 9% are current users (smoked cannabis within the past month). 7% within the same age group have tried amphetamine (The National Board of Health et al. 2004, unpublished).

Generally, young people appear to accept the presence of drugs, and drugs have spread into many different youth milieus and cultures all over the country. And this is despite the fact that young people are well aware of the damaging effects of drugs. Among 16 to 20-year-olds, 9 out of 10 say that they believe there is a health risk in regular cannabis use. The fact that over 1/3 of people in the same age group have tried smoking cannabis bears witness to young people's willingness nevertheless to take the risk involved in experimenting with cannabis.

2.2 Use of illicit drugs among the youth population

As mentioned already, it is in the younger age groups that the use of cannabis and other drugs is most prevalent. Consumption among the young from 16 to 20 is described in this section on the basis of the MULD 2000, MULD 2001, MULD 2002 and MULD 2004 studies. Consumption among 15 to16-year-olds is described on the basis of the ESPAD 1995, ESPAD 1999 and ESPAD 2003 studies. Finally, the Danish figures on the use of cannabis and ecstasy among the 15-year-olds from the

[1] For further results from the Health and Morbidity study of 2000, see tables in the Annex and in previous annual reports from the National Board of Health's series of publications.

international school children's survey, known as HBSC 2002 (see annex for a description of the surveys) are also included. Survey results consistently confirm that experimental use of drugs, although very prevalent, has levelled off over the past few years.

16-20-year-olds

Since 2000, the National Board of Health has conducted an annual study, "Monitoring young people's lifestyles and daily life" on the health and well-being of 16-20-year-olds, including their experience with illicit drugs. Table 2.2.1 provides the results from all four MULD studies.

Table 2.2.1. Percentage of 16-20 –year—olds who have tried illicit drugs in 2000, 2001, 2002 and 2003

	MULD 2000 (n=2046)			MULD 2001 (n=2090)			MULD 2002 (n=2041)			MULD 2003 (n= 1768)		
	Men	Women	**All**	Men	Women	**All**	Men	Women	**All**	Men	Women	**All**
Cannabis tried ever	37	27	32	38	29	33	41	34	37	42	31	36
Cannabis last month	14	5	9	13	6	9	12	5	8	13	7	9
Amphetamine tried ever	11	6	8	11	6	9	9	5	6	9	6	7
Ecstasy tried ever	5	3	4	6	3	4	4	3	3	4	4	4
Psilocybin mushrooms tried ever	5	1	3	7	3	5	5	2	4	4	2	3
Cocaine tried ever	4	2	3	5	3	4	4	2	3	5	4	4
LSD tried ever	2	0	1	3	1	2	1	1	1	1	1	1
Heroin tried ever	1	0	0	0	0	0	0	0	0	0	1	1
Smokeable heroin tried ever	1	1	1	1	0	1	1	0	1	1	1	1
"Other" drugs	2	1	1	2	1	1	3	2	3	2	2	2

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

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

Apart from a slight, but significant increase in the experimental use of "cannabis ever" over the different study years, there are no significant differences between the drug use figures for 2000, 2001, 2002, and 2003. This also applies to actual cannabis use.

More than one third of the young people in this age group report having tried smoking cannabis ever. Amphetamine is the second most frequently used drug. Depending on the study year, 6-8% of the young people have tried amphetamine ever. 3-4% have tried ecstasy ever, and use of ecstasy is thus about half as prevalent as amphetamine and more or less at the same level as use of psilocybin mushrooms and cocaine. Among 16 to 20-year-olds, there are also significant gender differences related to drug use. In almost all types of use, men account for a higher percentage than women.

15-16-year-olds

In 2003, a new ESPAD study was conducted. Previous comparable studies had been carried out in 1995 and 1999, and based on the findings in the various study years, it is possible to follow the trends in experimental use over time. As regards the 2002 HBSC study, this is the first time the issue of illicit drugs – cannabis and

ecstasy – has been included. All three studies were conducted among school children in the 9th grade.

The ESPAD studies show an increase in the experimental use of all illicit drugs among the 15-16-year-olds from 1995 to 1999. On the other hand, no significant increases appear from 1999 to 2003 as regards young people's use of illicit drugs. Today nearly a quarter of all 15 to16-year-olds have tried cannabis ever, and approximately 8% have tried cannabis within the past month. The findings of the ESPAD and HBSC studies both confirm that experimental use of cannabis among young Danish school children is high.

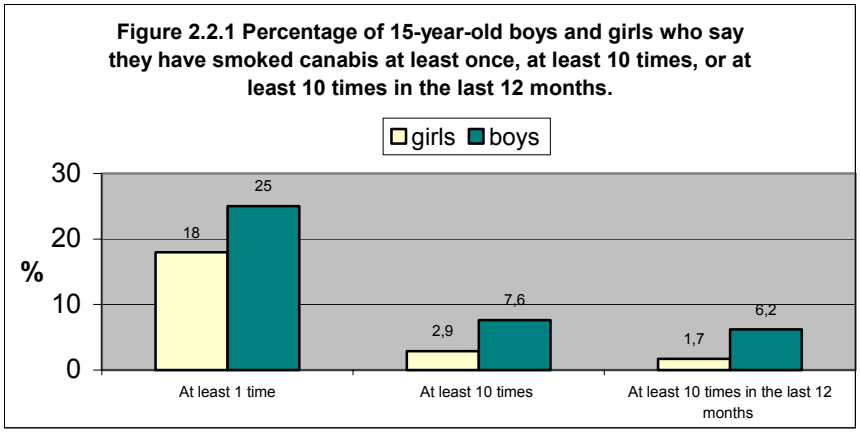
Table 2.2.2. Percentage of 15-16-year-olds who have used illicit drugs in 1995, 1999 and 2003 and among the 15-year-olds in 2002

	ESPAD	ESPAD	ESPAD	HBSC
	1995 (n=2234)	1999 (n=1548)	2003 (n=2519)	2002 (n=1418)
Cannabis tried ever	18.0	24.4	22.6	23.3
Cannabis last month	6.1	8.1	7.6	-
Amphetamine tried ever	1.6	4.0	4,0	-
Cocaine tried ever	0.3	1.1	1.8	-
Heroin (injection) tried ever	0.2	0.1	0.7	-
Smokeable heroin tried ever	1.5	1.3	1.0	-
Ecstasy tried ever	0.5	3.1	2.5	2.4
LSD tried ever	0.2	1.0	1.1	-
Psilocybine mushrooms tried ever	0.5	1.8	1.5	-
Sniffing tried	6.3	7.5	8.3	-

Kilder: Hibell et al. 1997, 2000 and unpublished figures from ESPAD 2003. Due,P, Holstein, BE, red. Skolebørnundersøgelsen 2002

There are major differences in the prevalence of cannabis among boys and girls. In the ESPAD 2003 study, 27% of the boys and just over 18% of the girls report having tried cannabis ever. Similarly, almost twice as many boys as girls had used cannabis within the past month (Sabroe & Fonager)[2]. These gender differences also appear in the HBSC study, albeit not quite as clearly. In 2002, 26% of the boys and 21% of the girls had smoked cannabis ever. As shown in figure 2.2.1 there are considerably more boys than girls among 15-year-olds who have tried cannabis more than once (HBSC).

[2] In the Danish reports following the ESPAD studies, Sabroe and Fonager make use of an extended study database compared to the international study, in that they include all 9th grade pupils, and not just the 15 to 16-year-old pupils.



Source: HBSC 2002

The figures "ever" and "within the last 12 months" are very close to each other, which could indicate that only very few smoked cannabis for the first time before they reached the age of 14 (HBSC). The starting age has also been studied in the ESPAD study, which shows that by far the majority smoke cannabis for the first time when they are 15 or 16 years old. Only very few try cannabis before they are teenagers. In comparison, young people's first experience with alcohol comes earlier with half of all young people having had their first drink before they reach their teens (ESPAD 2003).

As regards drugs other than cannabis, 8.3% of the study's 15 to 16-year-olds in 2003 had tried sniffing, whereas 4.0%, 2.5% and 1.8% respectively had tried amphetamine, ecstasy and cocaine. Parallel to the stabilisation of cannabis use there is a similar stabilisation in the experimental use of other drugs from 1999 to 2003.

2.3 Co-variation in drug use

Several studies of young people's use of drugs indicate that there is often a direct link between heavy alcohol consumption, daily tobacco smoking, regular cannabis use, and experimental use of other illicit drugs. One of the findings of the MULD study was that 65% of all boys who had tried smoking cannabis within the past year had been drunk at least three times within the past month. By comparison, only 28% of those who had never tried cannabis had been drunk in the past month. Similarly, 47-48% of those who had tried cannabis within the past year were daily smokers, whereas 10-12% of those who had never smoked cannabis were daily smokers (The National Board of Health and The Danish Cancer Society 2002).

When considering in particular the correlation in the use of illicit drugs, the MULD study confirms that there is a significant correlation between having used cannabis and having used one or several other illicit drugs. For instance, 58% of the boys who have smoked cannabis within the past month have tried one or several other drugs, whereas only 3% of those who have not tried cannabis within the past month have tried one or several other drugs. As for the girls, 42% of those who have smoked cannabis within the past month have also tried one or several other drugs, whereas only 2% of those who have not smoked cannabis within the past month have tried one or several other drugs (The National Board of Health and The Danish Cancer Society 2004). However, most young people who have tried cannabis ever have not tried other drugs.

So the "sum of vices" is not constant, given that in most cases it is the same group of young people who expose themselves to the various health hazards.

2.4 Regional hearings

Since 2000, the office of the medical examiner has, at the initiative of the National Board of Health, carried out regional hearings on a national scale in order to collect more information about the regional and local drug consumption situation.

The purpose of the regional hearings is to get an impression of trends as regards changed abuse patterns, new groups of experimenting young people, and possible new ways of administering the so-called "well-known" drugs. The hearings were conducted from May to September this year. Available summaries of the results from the regional hearings in 2004 give a general impression of the abuse situation on a national scale.

Most counties report that the situation is unchanged compared to last year. Cannabis continues to be the most prevalent illicit drug, and it is smoked at private parties, school parties, outside and in connection with parties at youth clubs as well as publicly in the streets. Employees in youth clubs report an increasing number of cases where they meet young people affected by cannabis and that regular use is becoming more frequent than before, starting usually in the 8th and 9th grades.

Reports point to a continued increase in the use of cocaine, and in certain places cocaine is reported to be the second most prevalent substance after cannabis. Cocaine appears to be becoming more widespread, among other reasons because it is getting cheaper. Most regions of the country report declining use of ecstasy, or that the problems related to this drug have levelled out. Only a few places report an increasing prevalence of ecstasy. Amphetamine, ecstasy and cocaine are used mostly "downtown" at discotheques and music functions.

People with close contact to the young believe that the motivating factor associated with young people's drug-taking is the need to gain self-esteem and social acceptance. Other motivating factors are young people's curiosity and the impression intoxication can give of "being in control of things". Also, the use of drugs has become more widely accepted in many milieus. Drug use is not a clandestine activity, but is socially accepted, also among the non-experimenting groups. It is accepted to be at a party where some people drink and others take drugs/pills.

The geographical spread of the drugs appears to be rather extensive, with only a marginal difference in the type of drugs used in the various counties. The fact is that experimental use of cannabis, cocaine, ecstasy, amphetamine and psilocybin mushrooms is seen in almost all the counties of Denmark. Less prevalent on a geographical scale is the experimental use of heroin, LSD, sniffing of solvents and lighter gas, anabolic steroids, sedatives, tranquillisers, poppers and khat. One county reports that cough medicine has been introduced as an intoxicating substance among young people. Boys tend to be more experimental than girls when it comes to the use of cannabis and other drugs.

Although reports in general agree that drug use is a phenomenon occurring across social boundaries and layers – including among normally well-functioning young people at the weekend - reports also focus on a special prevalence among the most socially unadjusted and marginalised young people. Among the socially unad-

justed are young people of a different ethnic origin than Danish, who use cannabis and experiment with anabolic steroids and cocaine.

Hard-core drug abusers still tend to use heroin in combination with alcohol, cannabis and benzodiazepines. Also reported is an increasing use of cocaine among drug abusers, with more and more users injecting the substance. Moreover, there is the secondary use of Rohypnol, mushrooms, amphetamine, and illicit methadone. Heroin abusers are reported as having increased their use of smokeable heroin instead of white heroin. These drugs seem to have become more available and easier for hardcore drug abusers to obtain.

2.5 Attitudes to drugs and drug users

An increasing number of studies report a wider acceptance of drugs among young people. The regional hearings report a wider acceptance of use, and both availability and use of drugs appear to be overt. The social acceptance of drugs among young people was already documented in the qualitative study conducted by the consultancy agency Advice Analyse for the National Board of Health in the late '90s. The attitude among young people is that "they will decide themselves".

The 2003 MULD study included a few questions which were intended to reveal young people's attitudes towards, as well their knowledge about, the damage caused by drugs. To the question whether the use of cannabis, pot and marihuana should be legalised, 1/3 of young people thought that it should be legalised, whereas half of them found that it should continue to be illegal. Almost 1/5 were "don't knows" on the question. The attitudes of girls and boys on the subject are more or less the same. On the other hand, young people are more firm in their belief when it comes to the use of hard drugs. More than 90% of young people think neither cocaine Nor heroin should be legalised. Again, the two genders more or less agree on this issue (The National Board of Health and the Danish Cancer Society 2004). Apparently, young people tend to be more critical in the case of hard drugs, whereas their attitude towards cannabis is more relaxed and liberal.

Young people are very well informed about the risks associated with using illicit drugs. However, the perception of just how dangerous drugs are varies somewhat. 86% of all 16 to 20-year-olds believe that it is possible to suffer harm by taking ecstasy just once or twice (2/3 of these believe there is a *great* risk, whereas 1/3 believe there is *some* risk). As far as cocaine is concerned, 83% of young people tend to have the same opinion of the dangers. 88% of young people believe that the regular use of cannabis, pot or marihuana can be associated with a risk. However, of these nearly 60% believe that there is a major risk associated with smoking cannabis regularly, whereas a little less than 30% think there is some risk.

The very young are also aware of the danger of drugs. Among the 15 to 16-year-olds, only 1-2% believe there is no or only a minor health risk in regular use of the illicit drugs. As many as 60-80% of the very young (Sabroe & Fonager 2004) believe that even the experimental use of drugs is dangerous and the use of drugs just once or twice is believed to be risky.

3 Prevention

3.1 Overview/summary

The primary aim of drug prevention in Denmark is to curb the use of cannabis and other illicit drugs as well as to take into account the problems facing the users of illicit drugs. Key elements in preventive intervention are to make sure that the drugs are difficult to get hold of and that the information level is high so as to generate attitude barriers against drug use.

At a governmental level, the National Board of Health is responsible for prevention in practice and it must, among others, support and stimulate the local preventive activities. Furthermore, it is the task of the National Board of Health via drug information targeted at the broad population to provide the young people, their parents and professionals working with children and young people with a high level of knowledge, and thus laying the basis for a negative attitude towards drugs. Finally, the National Board of Health's intervention also targets at high-risk groups, which implies support to the professionals in contact with the high-risk groups. The Board's drug preventive activity is to a large extent carried out in collaboration with county alcohol and drug consultants and the medical officers of health. This work includes model projects, development of information and teaching material on drugs, including a web site and the quarterly publication of a youth magazine. Furthermore, the Board arranges meetings, courses, seminars, etc. for professionals, volunteers and other key personnel engaged in drug problem activity.

In the counties and in the municipalities, intensified efforts are made to build up networks and cooperation in order for prevention activities to reach out to the target groups and in order to secure coordination and collaboration between the local and regional authorities. The county alcohol and drug consultants provide to a wide extent teaching and orientation programmes for the 6th-10th grades, their teachers and the pupils' parents. They also develop and produce informative and teaching material, which is subsequently distributed and used by the other counties. The counties and several municipalities in Denmark have entered into cooperation on the website www.netstof.dk aimed in particular at the pupils in the 8th and 9th grades. This cross-sectoral SSP collaboration aims at intercepting signals, including counteracting general or specific social problems for children and young people, suggesting and initiating activity preventing against drug abuse and crime.

3.2 Universal prevention

The school is found to be the most important institution to convey information about drugs. One of the obligatory subjects in the Danish primary school revolves around health, sexuality and family life.

The health class curriculum provides:

- that the pupils must gain an insight into the conditions and values affecting health, sexuality and family life
- that the pupils must gain an understanding of the significance of sexuality and family life to health as well as health and the environment
- the personal development of the pupils must be strengthened

- that the pupils develop means to be critical and to act in order to promote their own and other people's health.

No fixed guidelines exist for the form, content and scope of drug teaching. Drug information classes are normally placed at the 7th-9th grade. Typically, the individual class teacher will plan the curriculum. Many places, the SSP committee is instrumental in the drug information provided in primary school, and the role of the elementary school as regards drug informative work is supported by the state and the counties.

"Tackling – self-esteem, health and social life " – new teaching material for testing

In cooperation with the publisher Alinea, the National Board of Health was instrumental in importing, developing and testing a Danish version of the American teaching material "Life Skills Training". American research projects have shown that the material has a measurable effect in terms of reducing pupil use of drugs and tobacco. The Danish version of the material has been adapted to Danish conditions, and evaluation will show if this type of material has a measurable effect in Denmark. The National Board of Health cooperates with the National Institute of Public Health on a research-related evaluation of the material's functionality in Danish schools. In addition, prevention consultants from 6 counties will be participating in a project monitoring group. A total of 155 schools will participate in the project, of which 80 schools are intervention schools, ie the pupils are trained in "Tackling" and 75 schools are control schools. The feedback rate was approximately 45%.

The purpose of the teaching material is to strengthen the self-esteem of the young people, their social competencies and their attitudes towards tobacco, alcohol and drugs. The aim is to prevent against the use of tobacco and drugs, postpone initiation, and prevent against drug abuse. The material is intended to cover all the subjects dealt with in the classes.

The material may be used in the 7th grade (approximately 15 hours), the 8th grade (approximately 10 hours) and the 9th grade (approximately 5 hours). The material is meant to be used in the non-lesson subject of "health, sexuality and family life" and is undertaken by the class teacher without the involvement of external experts or guest teachers. The 7th grade material deals with the following issues: identity, making decisions, smoking, smoking and the body's reactions, alcohol, cannabis, commercials, violence in the media, how to tackle insecurity and nervousness, how to tackle one's anger, good communication, how to get into contact with other people, how to become self-secure and how to tackle conflicts.

The fundamental principle of the teaching material is the high level of pupil activity via pupil debates, exercises and homework. The teacher's role is primarily to act as organiser, chairman, communicator and counsellor.

The teaching material comprises a detailed teacher's guide and a student book for each form. In August/September 2004, the teachers participating in the test, will also participate in a 3-hour introduction course about the material and teaching methods at the County Teaching Centre.

As mentioned earlier, the teaching material is based on American material, "Life Skills Training" which has been developed over a number of years. Evaluations will show if this material has had any measurable effect in Denmark.

3.3 Family and Community

Regional and local activities

Pursuant to the Act on Public Social Security, the counties and municipalities are obliged to promote activities within prevention and health care services. The activities related to drugs are undertaken by the county alcohol and drug consultants.

In November 2003, the National Board of Health and the alcohol and drug consultants (counties and several major municipalities) entered into a focused collaboration agreement on the distribution of responsibilities and roles in relation to the Board's strategies and the counties'/municipalities' specified policies and action plans for preventive intervention. The parties are constantly cooperating on specific interventions, documentation programmes and model developments and arrange a number of informative meetings. The collaboration agreement will be renegotiated once a year.

Recent experience gained from local and regional projects indicates that the county's establishment of network cooperation with the educational institutions, youth clubs and restaurant/recreational settings is imperative in order for preventive interventions to be accepted by the target group. These networks cooperate in such a manner that coordination between counties and municipalities is secured. This applies in particular to the "new" intervention areas including the commercial recreational settings and youth education programmes which have not previously focused on prevention. Today, the majority of the counties have established key personnel networks collaborating with the municipalities. These networks act via local SSP (school, social authorities and police) contact personnel – but may also include other street plan workers and health coordinators. In addition to their municipal network, a few counties have also established networks in public administration. Most of the networks are handled by the county alcohol and drug consultants who are responsible for promoting network collaboration via newsletters, feature days, courses and inspiration meetings, etc.

In addition to the counties' establishment of key personnel network, several counties have intensified preventive intervention activities in elementary school and in other educational institutions. This includes the establishment of a "drug and alcohol corps" typically consisting of young people aged between 15 and 25 years who, following short-term training, visit the educational institutions and convey information as well as enter into a dialogue with the pupils.

The county alcohol and drug consultants provide to a wide extent teaching and orientation programmes for the 6-10th grades, their teachers and the pupils' parents. Furthermore, the consultants make sure that the county centres responsible for teaching always have teaching material and films, etc available to support the teachers' drug and alcohol classes in elementary school. A few counties have either on their own initiative or in collaboration with others embarked on developing and producing informative and educational material subsequently distributed and used by the other counties. Furthermore, the counties and municipalities have started

cooperation on the website www.netstof.dk, approaching in particular the pupils in the 8th and 9th grades.

Out of the 273 municipalities, a majority have entered into formal cooperation with schools, social authorities and police, also known as the SSP-cooperation. The SSP cooperation varies from municipality to municipality based on local conditions, but in general the aim of this cooperation is one of prevention and activity inspiration for the benefit of children's and young people's conditions in the municipality. This cross-sectoral cooperation is supposed to intercept signals, including to counteract general and specific poor well-being in children and young people, to suggest and initiate activities and to prevent against drug abuse and crime. The SSP may, for instance, be involved in schools' and youth clubs' work with drug information, launch street plan work and launch special projects that may capture young people facing problems of crime and abuse.

The fight against drugs – "Drugs out of town"

Following the Government's decision to intensify the common responsibility for drug abuse, a major action plan was drafted in October 2003 against drug abuse. The action plan "Drugs out of the town" consists of a variety of initiatives which together are supposed to maintain and expand responses to drug abuse by reducing the entry of new drug abusers, by helping current drug abusers and by coming down hard on drug-related crime. The most significant initiative in this action plan is the three-year development project under the heading: "Drugs out of town". In the social grants budget for 2004 and the Budget for 2004, an amount of EUR 2.8 million has been reserved, of which EUR 2 million have been set aside for 14 model municipalities, out of which amount EUR 135,000 will be transferred to development funds for the model municipalities.

From a governmental perspective, the aim is to support and stimulate local preventive intervention, for which reason the National Board of Health offers each model municipality an amount of EUR 135,000. The project closing date will be on 30 April 2007.

The aim of the model municipality project is to obtain effective prevention against drug abuse by involving all local forces, e.g. social and health care administration, police, parents, basic school, youth education, associations, party settings in a comprehensive and committing teamwork.

The overall goal of the project is to reduce the availability of illicit drugs and to bring down the young people's drug use and the resulting problems. The secondary goal of the project is to initiate systematic cooperation between relevant players within youth programmes and drugs policy in the model municipalities and via this cooperation establish targeted, co-ordinated and interdisciplinary projects in each of the 14 model municipalities.

The young people are the focus of preventive intervention. However, since the near environment plays a significant role for the young people's attitudes and behaviour, their parents and the adults working with the young people are also an important target group for preventive intervention. Prevention must comprise interventions that are general and targeted at the entire group of young people, but must also be targeted at children and young people who are particularly at risk, including the threatened young people and children living in families with abuse problems.

The environments and sectors that are most relevant to include in the preventive action against drug abuse will vary by municipality. In any event, each municipality must consider if it is possible to improve the action taken against drug abuse in relation to:

- basic school, including involvement of parents
- youth schools, clubs and associations for young people
- youth education
- party settings, including the commercial ones
- counselling services provided to young people in risk of drug abuse and their parents
- outreach work, early intervention and treatment of abuse problems in specific groups of deprived young people
- intervention vis-a-vis children in families with abuse problems
- exposed local environments

The National Board of Health has appointed a project secretariat to administer the central project management and coordination during the entire project period. The secretariat consists of 2 project employees whose tasks, among others, are to set up an empirical network for municipal coordinators, develop a map-out model to be used by the model municipalities, to develop and carry out training of the municipal coordinators, to provide professional and organisational support to the model municipalities, to prepare material and guidelines to the model municipalities and to head project evaluation in collaboration with an external evaluator.

Evaluation and map-out strategies in the municipalities require that each municipality is involved in and contributes to the evaluation by disclosing data and experience.

The overall job for the model municipalities is to initiate interdisciplinary and comprehensive preventive intervention and establish systematic cooperation between relevant local players within prevention. The National Board of Health recommends that the municipalities hire a coordinator who will contribute to organise a mapping out of the drug situation in the municipality together with the National Board of Health and an external evaluator, prepare a local project description, participate in the National Board of Health's coordinator training and empirical network for municipal coordinators, prepare interim status reports, communicate relevant prevention methods, prepare a media diary and maintain an ongoing dialogue and meeting activity with the players involved. It is vital to local intervention programmes that they are focused and systematic organisationally as well as professionally.

3.4 Selective/indicated prevention

Recreational settings

Concurrent with the increasing prevalence of drugs and party drugs in nightlife settings, central as well as local government have reacted by launching a number of initiatives targeted at limiting the availability of drugs in recreational settings and reducing the health damage caused by the drugs. Thus, during recent years, local

government has shown an increasing interest in establishing closer collaboration between players within the field (municipality, local police, restaurant owners). Each municipality has formulated its own drug and alcohol policy, in which the local commercial recreational setting is included as a pivotal focus area.

As mentioned above, one of the intervention areas is the project ”Drugs out of town” which addresses the commercial recreational settings. In addition to this project, which has been launched in 14 model municipalities, the majority of the Danish counties have implemented preventive intervention in 2004, focusing on the commercial recreational settings. The extent of intervention varies from a series of courses offered to doormen to large-scale local development projects involving restaurant associations, police, license authorities, fire services, tax and customs authorities, etc (see the EDDRA database for experience from the 6 Danish projects targeted at recreational settings: http://eddra.emcdda.eu.int/).

Roskilde Festival Against Drugs

After a positive evaluation of the Roskilde Festival Against Drugs in the autumn of 2003, it was decided to continue the work in 2004 and intensify it on the basis of the experience gained.

Roskilde Festival Against Drugs 2004 was planned on the basis of the experience gained in 2003 (see the EDDRA database on http://eddra.emcdda.eu.int/ (Roskilde Festival Against Drugs 2003)) The project in 2004 was adjusted as regards choice of information channels, and plans were made to expand activities with a peer counselling stand/care area, which was an important part of the original project proposal. This part, as it turned out, was not possible to put into effect. This was primarily due to the uncertainty on the project’s financial state of affairs. The peer counselling stand/care area was therefore not an issue in 2004. Roskilde Festival Against Drugs 2004 was, as it had been in 2004, based on a manifest demonstration of Roskilde Festival’s stance on drugs, using mass media campaigns, including the large screen spot before all concerts on the Festival’s largest scenes, the festival programme, postcards, T-shirts and the Festival’s website. As a new element, bus commercials were placed on all Festival shuttle buses between Roskilde Station and Roskilde Festival. Also in 2004, the demonstration of attitudes was combined with messages urging the festival guests to take a stance on the use of drugs and discuss it with friends. The rationale behind the project was to start a debate on the use of drugs in the target group. In order to qualify the debate and make sure that it was founded on theoretical knowledge that could inspire the young people not to use drugs, factual information was handed out to the guests during the entire festival.

The example of the Roskilde Festival was followed by several counties, which in 2004 carried out drug preventive interventions at local music festivals. In Vejle county, a network of SSP-consultants, sexual advisers, youth schools and volunteers were the initiators of a prevention stand under the name: “Pitstop” at the Jelling Festival. The stand was open to all young people who needed a counselling “chat” on, among others, drugs and alcohol.

4 Problem drug use

4.1 Overview/summary

More and more drug abusers seek treatment for their problem. Since the National Board of Health registered drug abusers admitted to treatment for the first time in 1996, the number of drug abusers in treatment has almost tripled. This increase should be seen in the light of increased treatment capacity and better-organised treatment programmes. Furthermore, the provision on a treatment guarantee for drug users, which came into force on 1.1.2003, is assumed to have an impact, given that a *request* for treatment now gives the *right* to treatment within a fortnight. Finally, the increase may be attributable to the fact that there has been an actual growth in the number of drug abusers in Denmark over the years, which probably means a relative increase in the number of individuals seeking treatment for their drug problem. In 2003, the National Board of Health applied the capture-recapture method to make an estimate on the total number of drug abusers in Denmark. The calculations showed that in 2001, there were 25,500 drug abusers in Denmark, while in 1996 the figure was 20,500. This calculation does not include experimental drug use, but estimates the number of people who use drugs more regularly, as a result of which they suffer physical, mental and/or social damage. The estimate includes cannabis users as well as users of central stimulants, opioids, etc., irrespective of manner of intake. Cannabis users alone are estimated to amount to 6,000 people out of the total estimated number of drug abusers in Denmark.

As regards the population of drug abusers, the proportion of the total drug-abusing population seeking treatment for their heroin abuse has dropped during recent years. On the other hand, there appears to be an increase in the number of drug abusers seeking treatment for use of cannabis and central stimulants. This increase is more distinct among those drug abusers seeking treatment for the first time. A little less than half (44%) of the "new" drug abusers seeking treatment for the problem use cannabis as the primary drug.

This chapter deals with the drug abusers receiving treatment for their abuse. The statistical data are primarily based on the National Board of Health's nationwide register on drug abusers receiving or having received treatment. The register includes persons referred by county/municipal centres for treatment for their problem. 5,134 persons were admitted for treatment in 2003, which brings the total number of persons being treated for their drug problem in 2003 to 12,317.

4.2 Profile of clients in treatment

Based on the data provided by the National Register on Drug Abusers receiving or having received treatment, it is possible to describe the persons seeking help for their drug problem and their drug use in general. The Register records whether treatment is provided on an out-patient or in-patient basis and the type of treatment (methadone, drug-free treatment, etc) provided to the client. Table 4.2.1 shows the various types of clients admitted in 2003.

Table 4.2.1. Clients treated for drug abuse, admitted in 2003	
Number of clients admitted to treatment in 2003	**5134**
Clients not previously treated (%)	34
Men/women (%)	77/23
Average age men/women (%)	31/32
Opioids as primary drug (%)*	50
Cannabis as primary drug (%)*	26
Central stimulants as primary drug (%)*	11
Injection , previously treated heroin abusers (%)	43
Injection, not previously treated heroin abusers (%)	26
In job %)	10
Unemployment benefits (%)	8
Cash benefits (%)	56
Early retirement pension (%)	13
Other income and undisclosed income (%)	13
Clients with own dwelling (%)	52
Clients single men/women (%)	78/66
Number of children under the age of 18 living at home	649
Number of children under the age of 18 living away from home	571
Foreign citizenship (%)	5,2

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

*Percentage of those reporting a primary drug.

In 2003, 5,134 persons were admitted for treatment in Denmark. This is a 19% increase compared to the 4,310 who were admitted in 2002. The total number of drug abusers who were treated during the year rose by 13.8% from 2002 to 12,317 persons in 2003. (The total number includes persons who continued treatment from 2002 and into 2003).

34% of those admitted in 2003 had not previously been treated for their drug problem. A special calculation and description of these "newcomers" will be provided separately in this chapter.

Use by substance

Heroin continues to be the most frequently used drug among the clients in treatment, with cannabis, methadone, and benzodiazepines, however, being used by many clients as well. A vast majority of drug abusers seeking treatment use several drugs. 43% reported in 2003 that they had used more than one drug prior to admission, which means that almost half of those admitted for treatment are multi-drug users before starting treatment.

The central stimulants that are the focus of young people's experimental use of drugs are only moderately represented as the primary drug for addicts in treatment. Only 6% report amphetamine, 3% report cocaine and 1% report ecstasy[3] as their primary drug[4], which, however, is a slight increase compared to 2002. These drugs are thus being used as a supplement.

Cannabis was the primary drug for 26% of those admitted to treatment, but it is also a very widely used secondary drug. 24% of those admitted in 2003 report using cannabis as a secondary drug.

[3] Here recorded as MDMA or similar.

[4] The percentages are calculated as that part of the treatment population who have reported a primary drug.

Distribution of age and gender

In 2003, there were 77% men and 23% women among the drug addicts undergoing treatment, which more or less corresponds to the gender distribution over the previous years. In 2003, the average age on admission was 31 for men and 32 for women.

Social background variables

The information on social background variables reflects a marginalised group as regards its affiliation to the labour market, education, housing situation and social life.

A majority of the clients are on benefit income; only 10% of the group have a connection to the labour market, and over half are on unemployment benefits. In all, 29% have completed an education after elementary school (primary and secondary school), and 17% left elementary school before the 9th grade. The low educational level should be seen in the light of the fact that the age of drug initiation is rather young for most drug abusers, see above.

The housing situation of drug abusers is also very poor. Only 52% have their own home – as much as 5% are actually homeless.

As regards family, a large proportion of male as well as female drug abusers were single, which is unusual for a group consisting primarily of young adults. A total of 649 children lived together with an addict in treatment in 2003, whereas 571 children under the age of 18 had been removed from the home.

Foreign citizens

A minority of the drug abusers in treatment are foreign citizens, a little over 5%. The proportion of clients of foreign nationality in treatment more or less corresponds to the representation of foreign nationality in the population as a whole.

Newcomers in treatment

The national register on drug addicts in treatment provides information as to whether or not the clients have previously been admitted to treatment. Information about the newcomers is particularly interesting, since this group reflect recent trends in the type and distribution of drugs, methods of administration in relation to age groups, etc. In other words, it is possible to follow new trends over time as regards drug abuse and the recruiting of new drug abusers. Table 4.2.2 below provides information about the various types of newcomers.

Table 4.2.2. Clients admitted for treatment each year, and who have not been treated previously for drug addiction.

	2000	2001	2002	2003
Clients who have not been treated earlier	1157 out of 3920 (27%)	1278 out of 4079 (31%)	1364 out of 4310 (32%)	1745 out of 5134 (34%)
M/W (%)	77/23	76/24	78/22	76/24
Average age M/W	28/28	28/27	28/29	28/28
Opioids as primary drug (%)*	54	38	35	28
Cannabis as primary drug (%)*	30	33	39	44
Central stimulants as primary drug (%)*	14	11	15	18
Injection, heroin addicts (%)	35	25	23	25

Source: The National Board of Health's register on drug addicts in treatment in 2000, 2001, 2002 and 2003
*Percentage of those reporting a primary drug.

As shown in table 4.2.2, 34% of the clients admitted in 2003 had not previously been treated. Not surprisingly, the average age was significantly lower among the newcomers than the average age of the treatment population in general. In 2003, distribution of gender among new and old addicts undergoing treatment was more or less the same.

Primary drug and manner of intake

There is a significantly larger proportion among the newcomers reporting cannabis as their primary drug compared to those who have been admitted to treatment before. The share of newcomers reporting cannabis as the primary drug was 44% in 2003. This is an increase compared to the two previous years.

Among the 1745 newcomers who have reported a primary drug, only 28% use opioids as their primary drug, which is a decline compared to 2002 when 35% used opioids as the primary drug. 18% report having used a central stimulant as the primary drug (in this case amphetamine, cocaine or ecstasy), which is a higher share than among the treatment population as a whole. This suggests that the central stimulants will gain ground in the treatment population in the future, whereas the proportion of clients using opioids as a primary drug will taper off.

As regards heroin used among the two "client groups", there is a difference in the method of administration, in that 25% of those who have not been treated earlier report having injected the drug, whereas 43% of those who have been treated earlier, had been injecting heroin in 2003. The difference in method of administration between the two client groups may be explained either by a "shorter abuse career" or that smokeable heroin has gained ground during recent years.

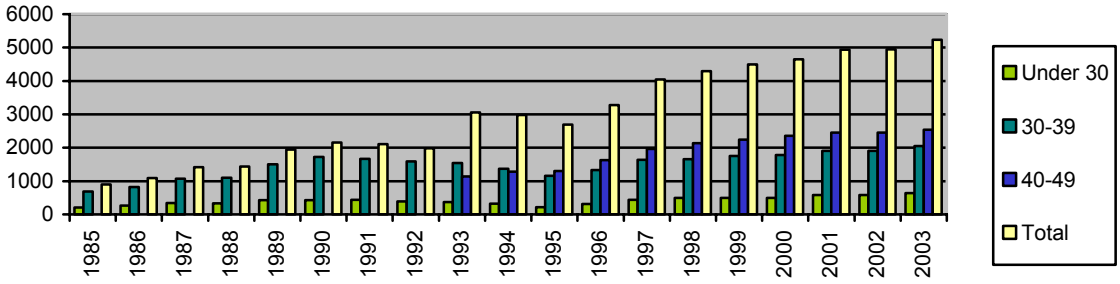
4.3 Methadone treatment and prescription

Since 1985, the National Board of Health has registered the number of clients in long-term methadone treatment, i.e. more than 5 months. Figure 4.3.1 illustrates the development in the number of drug addicts under the age of 50 in substitution treatment with methadone in December each year during the period from 1985 to

2002[5]. The figures do not include clients in long-term methadone treatment under the Prison and Probation Services or clients without a Danish civil registration number (CPR-nr.) undergoing treatment[6].

The increase in the number of individuals in long-term substitution treatment has continued after the counties took over prescription, dispensing and control with methadone as per 1.1.1996. During the years from 1993 to 1995, the figures stabilised at approximately 3,000 per year. Since then, the number of individuals in long-term substitution treatment has gone up each year from 3276 in 1996 to 5229 at the end of 2003.

Figure 4.3.1. Persons in long-term methadone treatment (more than 5 months) 1985-2003



Based on figures from the prescription register, information about the number of clients in methadone treatment under the Prison and Probation Service and the number of clients undergoing treatment without a Danish civil registration number, the estimate of the number of persons in substitution treatment with methadone in 2003 is 5800.

Until 1996, methadone registration was solely based on prescription. After the law was amended in 1996, statistics started to include those receiving methadone from the county treatment centres without a preceding prescription. This accounts for the large increase from 1996 to 1997. The increase in the number of persons undergoing long-term substitution treatment from 1996 is also due to changes in the treatment programmes[7]. In addition to methadone, buprenorphine is now used in substitution treatment. The number of individuals treated with buprenorphine is a little less than 500 (the National Board of Health's register on drug abusers in treatment, 2003).

[5] Prescription statistics also include prescriptions for indicators other than drug abuse (such as palliative treatment). However, these prescriptions are believed to be limited in number, when it comes to long-term prescription (more than 5 months) to persons under the age of 50 years.

[6] In 2001, a total of 351 clients were undergoing long-term methadone treatment among the prisoners in Danish prisons and approximately 200 were receiving methadone on a substitute number (i.e. without providing a Danish civil reg. no). According to the Prison and Probation Service and the National Board of Health the figure in 2003 is unchanged.

[7] See also the report published by the Medical Officer of Health, City of Copenhagen, on positive and negative effects from the counties taking over prescription, dispensing and control of methadone, and the social and medical treatment from 1.1.1996 (the Medical Officer of Health in Copenhagen and Frederiksberg 2001).

5 Drug-related treatment

5.1 Overview/summary

This chapter describes the various types of treatment and results from the analyses of the information reported by in-patient institutions under DanRis (The Danish Registration and Information System – Dansk Registrerings- og Informations-System). The chapter also deals with the preliminary results from a study conducted in Denmark on whether linking a comprehensive psycho-social intervention to methadone treatment may have a more profound effect on methadone clients' quality of life than is presently the case.

5.2 Treatment systems

The county drug use centres are jointly responsible for social and medical drug treatment. These centres refer drug users for all kinds of drug addict treatment, be it slow withdrawal, out-patient treatment, substitution treatment, in-patient treatment, and irrespective of whether treatment is provided in the county's own institutions or at a private institution.

Treatment is normally provided as out-patient treatment, to which in-patient treatment may be added if there is a need for a change of environment and/or more intensive work. Treatment may be medically assisted and should always be accompanied by psycho-social counselling based on the social action plan. The care and socially oriented intervention targeted at the most addicted drug abusers in particular takes place more and more via drop-in centres.

As part of the treatment, detoxification of the addict is carried out free of charge in private and public institutions and treatment centres, either by initiating drug-free treatment for drug abuse or by imprisonment.

Slow withdrawal is implemented either as out-patient treatment or as in-patient treatment. Both types of treatment are normally provided after contact with a county counselling centre, to which referral is made for the patient to talk to various treatment providers. Outpatient treatment could, for instance, be a session once a week during slow withdrawal with follow-up supportive sessions. These out-patient services could be followed up by in-patient treatment.

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

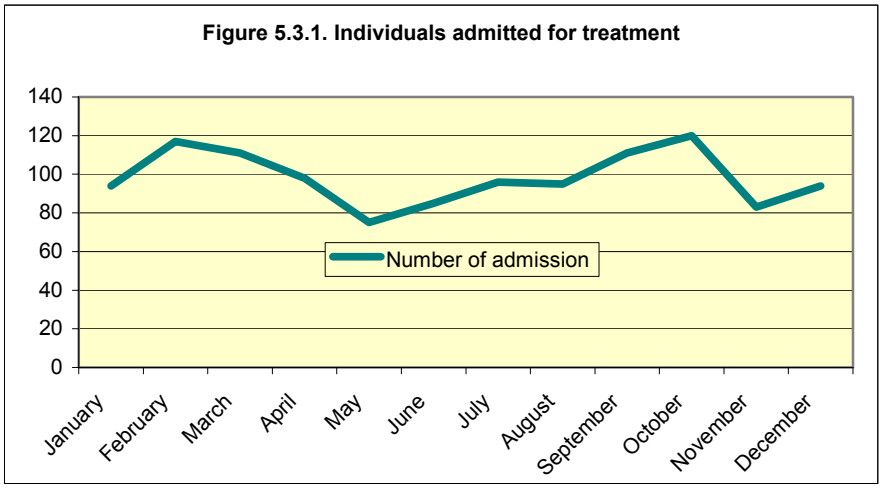
The vast majority of in-patient services provided to drug users are intended to deal with drug use combined with social problems.

5.3 In-patient treatment

Today, there are approximately 40 in-patient institutions. The reason why a precise figure cannot be given is that throughout the year, institutions open and close on an ongoing basis. In 2003, 34 of these institutions submitted data on days-in-treatment per client, completion rates and a number of other data – including data on client addiction as determined by the European Addiction Severity Index (Eu-

ropASI) – to the Danish Registration and Information System (DanRIS). Of these institutions, 4 were publicly financed, whereas the rest were private institutions or owned by trust funds. 31 institutions provided drug-free treatment as their primary service, whereas a few institutions provide care and/or stabilisation (including methadone stabilisation) as their primary service.

Figure 5.3.1 illustrates the number of individuals admitted per month to the 34 in-patient institutions.

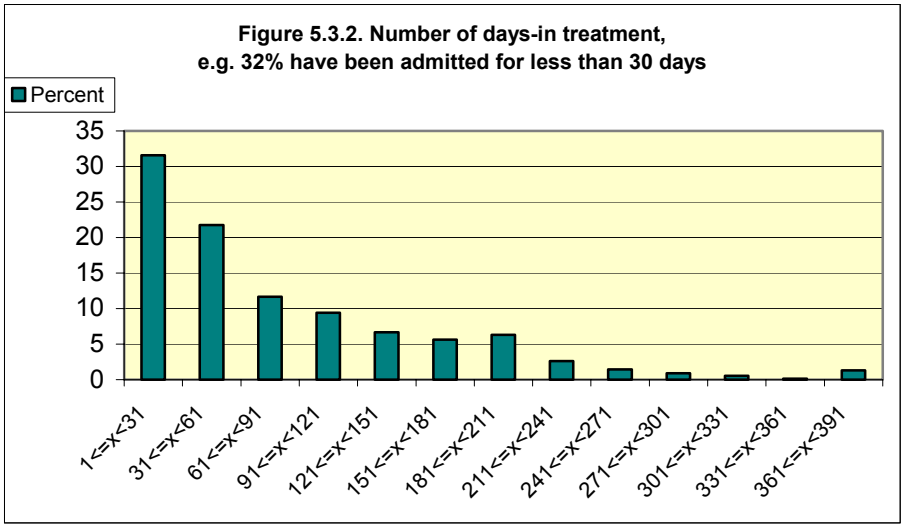


Source: Centre for Drug and Alcohol Research, DanRIS 2004.

In 2003, 1179 individuals were registered as admitted for in-patient treatment at the 34 in-patient institutions (the figure above shows number of admissions). Whether these figures fully reflect the number of admissions is currently being verified, but it seems that the actual figure is somewhere between 13-1400. In-patient treatment is defined as treatment stretching beyond the detoxification period and where the person stays at an in-patient institution. As shown, 75-120 clients were admitted each month in 2003. The most active months are February, March and September, October

Of the 1179 individuals, 862 had completed treatment during the winter/spring, 2004 (data reported February-May). Of these 862 people, 36% had completed treatment. Not until late in 2004 will it be possible to tell how many of the 1179 clients actually completed treatment. This figure is expected to be somewhat higher (probably between 40-43%).

Figure 5.3.2 illustrates the number of days-in-treatment at the 34 institutions for the 862 individuals who had completed the treatment programme.



Source: Centre for Drug and Alcohol Research, DanRIS 2004.

The figure shows that 32% were admitted for less than 31 days. Around 2/3 were admitted less than 91 days. Among those who were admitted less than 31 days, 85% discontinued treatment. ½ Among those who were admitted less than 91 days, 79% discontinued treatment prematurely. Among those admitted for more than 90 days, 67% completed treatment.

The DanRIS system registers different groups admitted to treatment: where they come from (from prison, somatic hospital, psychiatric hospital, or preparatory treatment), whether treatment is an alternative to a prison sentence, and whether the client is a pregnant woman. The table 5.3.1 shows that 79 of the 1179 individuals came directly from prison, and 94 had started treatment as an alternative to a prison sentence (53% of these people came directly from prison). This group has been described elsewhere. 15 clients came directly from somatic hospital. This group had a significant over-representation of women. Due to the small size of the group, there are no other significant differences compared to other addicts admitted for in-patient treatment. However, this group seems to have considerable physical, mental and family problems as well as alcohol problems, but are less involved in crime.

Table 5.3.1. Different groups admitted to treatment

	From prison n – 79	Alternative S78 n – 94	From somatic ward n – 15	From psychiatric ward n = 35	From preparatory n = 304	Pregnant n= 9
Age	*29.7	29.2	33.7	31.6	*31.1	29.4
Women	*16.0%	13%	*47%	34%	23%	*100%
Completed	30.2%	31.3%	30.8%	25%	34.9%	50%
Problem:						
Drugs	*0.37	*0.1	0.37	0.43	*0.50	0.39
Alcohol	0.16	*0.14	0.33	0.29	0.21	0.10
Crime	*0.36	*0.42	0.19	0.29	0.27	0.30
Economy	0.87	0.89	0.83	0.81	0.89	0.94
Family	0.31	0.34	0.43	*0.48	0.40	0.46
Network (share)	0.30	0.33	0.34	*0.43	*0.37	0.39
Mental	*0.39	*0.42	0.53	*0.62	0.49	0.54
Physical	0.34	0.30	0.52	*0.51	0.36	0.25

*significant difference from others admitted to treatment. Problem score 1=major problem and 0=minor problem

Not surprisingly, those discharged from a psychiatric ward (n=35) were, apart from being more physically and socially impaired in general, also considerably more mentally indisposed. Only 25% of them completed treatment. It is worth noting that those who were referred for treatment from preparatory treatment programmes did not manage any better than the rest. However, they also had much heavier drug problems and were part of a different network than the rest. An analysis of the contents of the preparatory programme is needed. Pregnant women still make up a very small category in drug-free treatment. In 2003, 9 women were recorded as being in drug-free in-patient treatment. These 9 women had major social and mental problems, and yet half of them completed treatment (half of the 6 – the others were still in in-patient treatment at the time of reporting in April).

Out of the above 34 in-patient institutions, the programme/method orientation was as follows: 7 Minnesota institutions (12-step treatment), 22 socio-educational institutions (of which 3 were Christian), 2 hierarchically designed therapeutic communities (Phoenix House), 2 care institutions (methadone stabilisation) and 1 Narcanon (Narcotics Anonymous). The current trend is that the new institutions are not defined as Minnesota institutions. Furthermore, an increasing number of these institutions no longer use the word "Minnesota" or "12-step" when describing their concept. As a result, the number of Minnesota institutions in Denmark has dropped compared to the number only a few years ago. Most of the institutions provide short-term relapse treatment services, and two of the socio-educational institutions are particularly oriented towards family treatment**.**

5.4 Drug-free treatment

The out-patient drug-free treatment is divided into the following different services: a) Out-patient drug-free treatment which must be considered as drug-free post-treatment for drug addicts admitted for in-patient treatment, b) out-patient drug-free treatment targeted at a slightly younger, less addicted group, c) out-patient drug-free local treatment, including a combination of dedicated out-patient drug-free treatment and a special local flat-sharing scheme offered to a small group on the same drug-free treatment programme (Sørensen 2003).

Analysis of how many clients are drug free after having completed drug-free treatment shows that the differences between in-patient and out-patient drug-free treatment are insignificant. The effect seems to be more linked to the organisation of the treatment projects, integration and professional implementation than a question of whether treatment is provided on an out-patient or in-patient basis. This was supported by a study of 67 heroin addicts in out-patient drug-free local treatment, under which 25% were still drug free one year after termination of treatment. The group was in most respects comparable to heroin addicts admitted for traditional Danish drug-free in-patient treatment and the proportion of drug-free clients does not differ from that observed in several Danish follow-up studies on heroin addicts admitted for in-patient treatment.

There are, however, examples of out-patient drug-free projects, in which 10-15% were still drug free one year after having terminated treatment, although the group was more or less comparable to other drug-free in-patient treatment.

5.5 Medically assisted treatment

In Denmark, substitution treatment includes methadone and to a considerably smaller extent buprenorphine. Out-patient psycho-social intervention as outlined below is the intervention used in relation to substitution treatment.

The aim with substitution treatment and related psycho-social interventions is the same as with drug-free treatment: improved functional level, improved quality of life and social integration. As regards treatment in general, substitution treatment clearly aims at harm reduction.

The methadone project

At present, a study is being conducted in Denmark on whether supplementary psycho-social intervention related to methadone treatment might have a more profound effect on the methadone receivers' quality of life than is the case today. Supplementary psycho-social intervention distinguishes itself from standard intervention in the following areas:

- each caregiver is assigned 7-8 methadone receivers as opposed to 20-40 under standard psycho-social intervention. This should mean more direct contact with the caregivers/counsellors than is seen today
- every project has a permanent contact person
- a physical framework (like drop-in centres) is added to the projects, including various recreational facilities that are available every day, often for several hours. This is also different from standard intervention programmes
- methadone handout is more flexible. In general the aim is for the methadone dose, method of administration and handout to take up as little time as possible in the daily routine. As a result, some get a choice between receiving methadone as injection, tablets or medicine. Other places offer the addicts the option of saving their dose for a larger weekend dose
- more focus on action plans, monitoring and user involvement than is normally seen, and
- finally, a large number of the projects are considerably more focused on employment.

Two follow-up groups were established: a) a standard group of 221 methadone receivers who, in addition to getting their methadone, were offered sessions with a counsellor as required (often once or twice a month), but otherwise none of the services mentioned above, and b) a non-standard group consisting of 92 methadone receivers who were all been offered inclusion in the comprehensive psycho-social programme. The two groups have the same characteristics in almost all areas, including age and gender distribution, education, housing and being provided for, with addiction scores reaching 7 out of 8 as determined by The European Addiction Severity Index. The large group has a higher alcohol factor than the standard group – albeit on a moderate scale.

Three main groups of methadone receivers have been identified. First of all, it is the group of very severely addicted individuals consists of older drug abusers with severe mental, physical and social problems, with most of them receiving early retirement pension and having a fixed abode. The basis of income and housing are irrelevant effect parameters in this group. The primary problems facing this group of abusers are the physical, mental and social problems that may often be considered as primary. Secondary abuse exists, but on a relatively moderate scale. It is a

group difficult to establish contact with, and the first phase often focuses on establishing and maintaining contact on a reasonable basis.

The methadone maintenance group consisting of the middle-aged (around 40) methadone receivers with more than half receiving early retirement pension and having a fixed abode. This group of abusers suffers from physical, mental as well as social problems, which no doubt should be linked to their use of drugs. This characteristic separates them from the severely addicted. This group is the easiest to keep in contact with, because they are worn out from "life in the street". However, it is also a more passive and perhaps "institutionalised" group than group 3, the next group.

The "younger" methadone receivers include methadone receivers aged between 34-36. The housing situation of this group of users is unstable, several of them receive daily cash benefits and few of them have, although ever-changing, some connection with the labour market. This group reflects the heaviest users of illicit drugs and therefore has the highest crime rate. Their physical and mental problems are still relatively limited. This is a group where it is expected that focus on secondary drug abuse, employment/work, achievement of qualifications and reduction of social problems could prevent these individuals from ending in the two first categories. This is a group that can be difficult to maintain contact with, because they are difficult to motivate for treatment, because they are still capable of coping with "life in the street".

The relevance of effect parameters and interventions depends on which of the above three categories we are dealing with. Undoubtedly, it will be possible to identify different motives for undergoing treatment in the three groups. This will also be analysed in the project. In general, there is an equal distribution of these three methadone-receiver categories in the non-standard as well as the standard groups. On the other hand, strong internal variations appear in the standard as well as the non-standard group. The non-standard group thus consists of four separate projects that are rather different. It is interesting to see that the different projects quite automatically – almost intuitively – have chosen to focus on intervention strategies matching the needs of their users. Those who primarily work with the severely addicted abusers focus on achieving their confidence and contact. Those who primarily work with abusers from the maintenance group focus on stabilisation and social skills. Finally, those who work intensively with the younger group of methadone users are more focused on integration and normalisation.

5.6 Intervention for children and young people with abuse problems

In March 2004, the Association of County Councils published a report under the heading "Intervention status for children and young people with abuse problems".

This status report shows that the counties provide constructive and comprehensive intervention vis-à-vis children and young people with abuse problems. When organising their work in this area, all counties take the three target groups described in the report into consideration and make available the same types of services, with local variations reflecting local conditions.

The working group behind the report recommends that there should be only one contact with the treatment system in future, that services provided to children and

young people with abuse problems should be organised in a flexible manner and in contact with young people, and that the existing out-patient and in-patient programmes offered to children and young people should be better at handling abuse problems. Reference is made to the full report: "Status for indsatsen over for børn og unge med misbrugsproblemer" on the following website http://www.arf.dk.

6 Health correlates and consequences

6.1 Overview/summary

A number of health problems and consequences follow in the wake of drug abuse. Drug abusers have high mortality rates due to intoxification and illnesses, including HIV and hepatitis. Furthermore, drug abusers are a marginalised group in terms of housing, social life and financial income, which again affects their general health.

New studies have been carried out to identify various health problems following from drug use. One particular study examined mortality rates among drug abusers released from prison, and showed that these drug abusers run a high risk of dying shortly after their release. A special study on mortality among drug abusers in general concludes rather positively that the average age at death has gone up by 7 years over the past 6 years and is as high as 42. The increasing average age at death reflects the fact that the drug abuse population has generally become older. Another study has been conducted on pregnancies and abortions among female drug abusers, and shows that the frequency of spontaneous abortions and the mortality rates of liveborn children are both significantly higher than in the population in general.

In order to examine the number of individuals contacting the country's casualty departments due to intoxification after the use of illicit drugs, special statistics have been compiled on cases of intoxification registered on the somatic and psychiatric casualty departments. The fact that far from all intoxification cases are reported means that these statistics provide minimum figures only. However, the statistics show that a significant number of individuals are poisoned from illicit drugs, and that the number has increased moderately over the past four years. The cause of intoxification is normally the hallucinogens and central stimulants used among the very young, whereas opioids, including heroin and methadone, are the main causes of intoxification among slightly older drug abusers.

6.2 Drug-related deaths and mortality among drug abusers

Since 1970, the National Commissioner of Police has registered drug-related deaths (Danish Police Drug Statistics 2002). The register contains reported deaths requiring medico-legal autopsy. This could, for instance, be individuals found dead, sudden unexpected death, accidents, homicide and suicide. Deaths caused by intoxification and death resulting from accidents with the individual having taken drugs will thus be reported to the police.

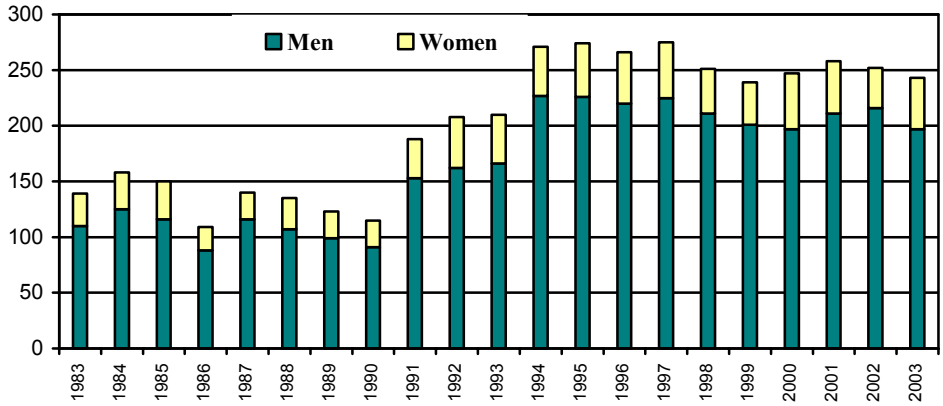
Similar to the police register, the National Board of Health has the Cause of Death Register containing data on drug-related deaths. The register contains data on deaths defined as drug-related deaths based on EU criteria. Given the desire for inter-country comparability, restrictions have been made on the diagnosis groups included in the retrieval procedure.

The differences between figures in the two registers are explained by the differences in death populations and differences in the definition of drug-related death. The police, for instance, only register deaths where a medico-legal autopsy has been performed, whereas deaths in general in Denmark are registered in the National Board of Health's Cause of Death Register.

The National Commissioner's Register

The National Commissioner's death statistics (figure 6.2.1) show a slight decline in the late '80s and a significant increase in the '90s. In 2003, 245 drug deaths were registered, of which men accounted for 80% (197) and 20% (48) were women. This is a minor decrease compared to 2002 when 252 drug-related deaths were registered.

Figure 6.2.1. Drug-related deaths by gender, 1983-2003



Source: Police Drug Statistics 2003

Out of the 245 deaths in 2003, 81% (198) were caused by intoxification with one or more drugs. 30% (60 out of 198) were caused by intoxification with heroin/morphine or heroin/morphine in combination with another drug (37 with heroin alone, 10 with heroin + alcohol, 8 with heroin + other drug, and 2 with heroin + cocaine), whereas 49% (97 out of 198) were caused by intoxification with methadone or methadone in combination with another substance (64 with methadone alone, 29 with methadone + other drug, 4 with methadone + Ketogan®). Six deaths were caused by intoxification with either cocaine or amphetamine.

The drug-related deaths that were not caused by intoxification (47 out of 245) were mainly caused by violence, accidents or diseases.

Until the late '80s, the majority of deaths occurred among persons living in Copenhagen, but since the early 1990s, the picture has changed. Out of the 245 deaths in 2003, 113, 99 and 33 respectively of the deaths occurred on Zealand, Jutland and Funen. This is a markedly different geographic distribution from previous years.

The average age at death increased during the period. In 1993, the average age at death in these types of cases was 33, whereas by 2003, the age had increased to 38. The average age at death for men and women is the same.

The National Board of Health's register

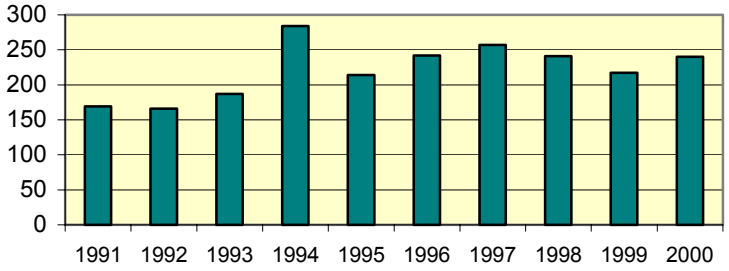
In its register, the National Board of Health includes deaths caused by injurious use of drugs, dependency and drug psychoses as well as deaths caused by intoxification (suicide and accidents)[8].

[8] Up until 1994, ICD8 codes were applied. Since 1994, the ICD10 codes have been applied.

In 2000[9], 240 deaths were recorded, which is a minor increase from 1999 when 217 deaths were recorded. Men account for 73% (175). Figure 6.2.2, which illustrates the trends up through the 1990s, shows a slightly increasing tendency to begin with, following which it appears to drop towards the end of the decade. The major fluctuation in 1994 is artificially created and is caused by a temporary adjustment in coding practices.

The National Board of Health's register on drug-related deaths shows that in 2002, the average age at death for women was 45.8 and for men 39.5, the average age for both together being 41.2.

Figure 6.2.2 Drug related deaths 1991-2000



Source: National Board of Health's cause of death register

The European definition of drug-related death used in the figures from the National Board of Health's Cause of Death Register does not include deaths caused by road accidents or other accidents caused by the deceased having been under the influence of drugs at the time of the accident. These deaths, on the other hand, are included in the police register.

Examination of drug abuse deaths and years of life lost

In 2004, the National Board of Health conducted a study of the causes of death among drug abusers known to the treatment system from 1996 – 2002[10]. The study is based on material from the National Register on Drug Abusers receiving or having received drug treatment, the Cause of Death Register and the Central Personal Register (CPR).

The deaths defined by the EMCDDA as drug-related make up approximately 50% of all deaths among drug abusers during the period 1996-2000. Out of the 363 drug-related deaths, 83% of the deaths (300) were caused by intoxification accidents or intoxification with an unspecified intention. Opiates other than methadone account for 53% (158) of the deaths caused by intoxification. 835 people who were not undergoing treatment for drug abuse were, during the same period, categorised as having suffered a drug-related death. Among the remaining 365 deaths, accidents, violence, intentional harm and injurious events accounted for more than 40% of the deaths.

[9] Data from 2001 and onwards are not yet available.
[10] New figures from the National Board of Health. 2004:14. Deaths among drug abusers, 1996-2002

Drug abusers' average age at death has gone up from 34.8 in 1996 to 41.9 in 2002, which means that the drug abusing population has become older. Although the average age has increased by seven years during the period, drug abusers still die at a very young age compared to the rest of the population. The population's average age at death has gone up from 74.2 to 75.6 during the same period. From the above average ages at death, it can be calculated that the total years of life lost in Denmark due to drug abuse is 40,745.

The causes of the increasing average at death among drug abusers may be the improved treatment capacity, and the fact that an increasing number of drug abusers have embarked on a long-term treatment programme. Furthermore, it appears that injection misuse among the young people has decreased. The arrival of smokeable heroin has reduced injection abuse and thus the risk of intoxification and infectious diseases. Finally, there seem to be a decreasing number of drug abusers in the treatment system who share syringes and needles, which per se is a harm reducing element in relation to infections among drug abusers.

Drug abusers and mortality after release from prison

In 2002, a register research project was completed on mortality among drug abusers in the period following their release from prison[11]. Special consultant, Ph.D. Peer Brehm Christensen, Odense Universitetshospital, was the investigator on the project, which was conducted in collaboration with the National Board of Health. The objective was to examine whether the mortality rate among drug abusers undergoing treatment tends to increase after they have been released from prison. The project was carried out by merging the National Board of Health's register on drug abusers undergoing treatment, the police register on drug-related deaths, and the National Commissioner's register on criminal offences.

A cohort of drug abusers identified from these three registers during the period 1996-2001 was thus assembled. The register on criminal offences retrieved data on all imprisonments of more than 7 days' duration. Among the 16,573 drug abusers in the cohort, the mortality rate was 11.2% (1868). 59.5 % (1118) of the deaths were caused by an overdose. The mortality rate among just those undergoing treatment was 2.38/100 person year compared to an estimated mortality rate of 0.20/100 person year in the population, with adjustments being made for gender and age. Within two weeks after release from prison, the mortality rate was 30/100 person year, more than 10 times higher than average. Deaths caused by an overdose accounted for 89%, and the mortality rate was highest among young drug abusers and injecting drug abusers.

These results indicate that drug abusers during their first weeks after release from prison are more likely to die than other drug abusers. A contributory cause might be that drug abusers' tolerance towards drugs is reduced during their stay in prison. After release, drug abusers will often take the same amount of drugs as before imprisonment, which results in an overdose.

6.3 Intoxification caused by illicit drugs

A considerable number of persons who come into casualty departments in Denmark do so because of intoxification after having taken illicit drugs. These visits

[11] Peer Brehm Christensen. "Dødelighed blandt stofmisbrugere efter løsladelse fra fængslet". Unpublished 2004.

are registered in the National Board of Health's national patient register (LPR - Landspatientregister). However, the National Board of Health believes that the registration does not record all cases of intoxification, one of the reasons being different coding practices and daily routines in the casualty departments. The National Board of Health and the Institute of Psychiatric Demography in Aarhus, represented by Mikkel Arendt, psychologist, and Lone Fjordback, MD, have prepared a list of intoxification cases registered in LPR in the years 1999-2003[12]. These cases have been categorised by the different types of illicit drugs. Since not all cases are registered, the numbers provided in the list should be considered as conservative. This means that there are actually more drug abusers in contact with the casualty departments due to intoxification caused by illicit drugs than are actually registered and entered in the list.

Data retrieved from the LPR include patients with intoxification as an action diagnosis registered in the somatic or psychiatric wards as well as patients who have been hospitalized with intoxification symptoms without having been in contact with a casualty department.

Table 6.3.1 shows the magnitude and development of intoxications[13] and intoxofications registered according to the different illicit drugs from 1999 to 2003. From 2000, coding practices were amended to the effect that it became possible to specify intoxofication caused by amphetamine and khat.

Table 6.3.1. Trends in hospital contacts following intoxication and intoxofication caused by illict drugs from 1999 to 2003

	Code*	1999	2000	2001	2002	2003
Heroin	T40.1	249	255	240	174	192
Other opioids	T40.2	35	35	44	48	51
Methadone	T40.3	5	11	19	39	26
Opioids	F11.0	67	80	67	53	65
Opioids, total		**356**	**381**	**370**	**314**	**334**
	T40.6A	*	2	14	21	12
Ecstasy	T40.6B	9	75	67	60	83
Amphetamine	T43.0A	*	2	24	43	54
Cocaine	T40.5+F14.0	45	51	78	65	80
Other central stimulants	F15.0	58	48	53	47	63
Central stimulants, total		**112**	**178**	**236**	**236**	**292**
Euphoriant mushrooms	T40.6C	7	5	10	8	3
LSD	T40.8	3	3	12	2	1
Hallucinogens	F16.0	10	15	16	5	5
Hallucinogens, total		**20**	**23**	**38**	**15**	**9**
Cannabis	T40.7+F12.0	97	102	164	122	142
Polydrug use and unspecified	T40.4+T40.6 +T40.6W +F40.6X +T40.9+F19.0	541	632	571	657	685
Intoxications and intoxification, total		**1126**	**1316**	**1379**	**1344**	**1462**

*New codes were introduced in 2000 and 2004

[12] Mikkel Arendt, psychologist. and Lone Fjordback, MD, *Forgiftningstilstande og uønskede reaktioner forårsaget af psykoaktive stoffer på danske skadestuer.* Unpublished 2004.

[13] Within psychiatry, the term "acute intoxication" is applied to diagnose mental illnesses and behavioural disturbances caused by psychoactive substances. This term does not clearly distinguish between intoxication and intoxification in the biomedical sense of the word, but with a precision to the fourth decimal place, complications of a varying degree can be stated for intoxications (uncomplicated, with physical trauma, with other somatic complications, with delirium, with perception problems and with coma).

As can be seen from the table, there have been between 1126 and 1462 cases annually of intoxifications caused by illicit drugs from 1999-2003. There was an increase in the number of intoxifications during the period. As regards the central stimulants, amphetamine and cocaine as well as cannabis, the increase is significant, whereas there has been a minor drop in the total number of opioids registered. However, these figures should be considered with some reservation due to under-registration and erroneous source material.

A total of 6627 intoxifications were registered throughout the five years studied. The majority of intoxifications, almost 90%, were treated in the somatic casualty departments, and the remaining 11% in the psychiatric casualty departments.

As regards gender and age distribution, twice as many men as women were registered with intoxification during the five years studied. As regards age, most of the intoxification cases with opioids, not surprisingly, occur primarily among persons over the age of 30 and are extremely rare among the very young. In contrast, intoxification caused by hallucinogens and central stimulants primarily occurs among the young. Intoxification caused by hallucinogens and central stimulants occurs respectively in 73% and 56% of all cases registered among young people under 24 years of age. An exception is cocaine, where the over 30s account for 40% of intoxification cases. A little over 500 intoxifications during the study period took place among the under-20s.

6.4 Drug-related infectious diseases

HIV/aids

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

Table 6.4.1 in the Annex shows the number of newly diagnosed HIV positives and the proportion of these who were intravenous drug abusers over the past 10 years[14]. The number of newly diagnosed HIV positive individuals has varied over the years as has the number of infected persons where the source of infection is assumed to be intravenous drug use. In 2003, 9% (24 persons) were registered as intravenous drug users. This percentage has remained more or less the same, i.e. around 10%, over the past 10 years.

The share of newly reported AIDS cases where the source of infection is considered to be intravenous drug use has also been relatively stable at around 10%. In 2003, there were 30% newly reported AIDS cases connected with intravenous drug use, which was 11 out of a total of 37 persons.

[14] The figures from previous years have been adjusted and updated, which is the reason why they differ slightly from the figures provided in preceding annual reports.

Hepatitis A, B og C

Despite minor fluctuations, there seems to have been a decline in the number of registered acute hepatitis cases in the Danish population as a whole over the past five years (table 6.4.2 of the Annex). During the same period, the proportion of acute cases of hepatitis where the infected person was an intravenous drug user has been approximately 1% for hepatitis A, varied between 18% and 43% for hepatitis B, and varied from 29% to 85% for hepatitis C. The number of reported cases, however, is so small that these percentages should be considered with some reservation.

6.5 Co-morbidity and drug abusers in psychiatric treatment

In 2003, 3422 persons were admitted to psychiatric hospitals with a drug-related primary or secondary diagnosis compared to 2685 persons in 1995. During the period 1995-2003, a more than 50% increase was seen in the number of persons admitted to psychiatric hospitals with a drug-related secondary diagnosis from 1150 to 1844 (table 6.5.2), whereas the number of persons admitted with drug-related primary diagnoses fluctuated between 1500 and 1650 throughout the period (table 6.5.1).

The number of persons admitted with a primary diagnosis related to the use of cannabis appears to be increasing as well, although the fluctuations in this case are relatively large. The trend becomes clearer in secondary diagnoses related to cannabis, with the number of persons increasing linearly from 431 persons in 1995 to 759 persons in 2003. The same linear increase is seen up until 2002 in the number of persons admitted with a primary as well as a secondary diagnosis related to cocaine. However, from 2002 to 2003, there is a dramatic increase with twice as many persons admitted with a primary or a secondary diagnosis related to cocaine.

Throughout the period, persons with primary diagnoses related to polydrug use make up the largest group, which was increasing steadily up until 1999. The second largest group includes persons with cannabis-related primary diagnoses, which in 2003 was more than 20% of the persons undergoing psychiatric treatment with a drug-related primary diagnosis. At the same time, the proportion of persons with opioid-related primary diagnoses dropped steadily throughout the period.

Table 6.5.1 shows the number of persons registered as receivers of psychiatric treatment (whether in-patient, day treatment or out-patient treatment) as a result of their use of drugs or volatile solvents. The ICD-10 classification system has been used and the diagnoses F11.x to F16.x and F18.x to F19.x (primary diagnosis) have been used as retrieval criteria.

Table 6.5.1. Persons registered with drug-related primary diagnoses in psychiatric hospitals, 1995-2003										
Diagnosis code	**Mental condition or disturbance caused by the use of:**	**1995**	**1996**	**1997**	**1998**	**1999**	**2000**	**2001**	**2002**	**2003**
F11	Opioids	322	319	273	273	227	227	189	172	156
F12	Cannabis	312	304	279	314	317	270	327	364	333
F13	Sedatives/ hypnotics	283	315	239	212	204	205	199	182	159
F14	Cocaine	7	12	15	21	23	23	31	36	65
F15	Central stimulants other than cocaine	85	94	82	82	71	76	75	109	99
F16	Hallucinogens	23	23	25	17	26	18	21	14	9
F18	Solvents	9	11	3	5	10	2	6	2	10
F19	Multiple or other psychoactive drugs	494	569	586	705	758	749	732	726	747
Persons with primary diagnoses, total		1535	1647	1502	1629	1636	1570	1580	1605	1578

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

Table 6.5.2. Persons registered with drug-related secondary diagnoses in psychiatric hospitals 1995-2003										
Diagnosis code	Mental condition or disturbance caused by the use of:	**1995**	**1996**	**1997**	**1998**	**1999**	**2000**	**2001**	**2002**	**2003**
F11	Opioids	166	176	178	134	146	190	204	208	201
F12	Cannabis	431	427	477	524	566	584	637	691	759
F13	Sedatives / hypnotics	330	327	259	247	253	283	257	266	307
F14	Cocaine	8	8	17	13	15	17	19	34	61
F15	Central stimulants other than cocaine	46	67	56	53	58	52	58	56	73
F16	Hallucinogens	6	6	7	4	11	9	11	10	2
F18	Solvents	9	7	6	4	9	7	7	13	12
F19	Multiple or other psychoactive substances	238	297	314	418	534	566	485	574	679
Persons with secondary diagnoses, total		1150	1225	1240	1335	1506	1630	1593	1747	1844

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

Table 6.5.2 shows the number of persons registered as receivers of psychiatric treatment (whether as in-patient, day treatment or out-patient treatment) as a result of their use of drugs or volatile solvents. The ICD-10 classification system has been used and the diagnoses F11.x to F16.x and F18.x to F19.x (secondary diagnosis) have been used as retrieval criteria. Since a patient may have several drug-related secondary diagnoses, the "total" category is not a summation of the figures listed above.

6.6 Pregnancy and birth among drug abusers in Denmark

In collaboration with the National Board of Health, the Medical Officers of Copenhagen and Frederiksberg municipalities have conducted a register study on the number of pregnancies among female drug abusers undergoing treatment in Denmark from 1990 to 2001[15]. The purpose of the study was to provide the best possible estimate on the number and development of pregnancies among female drug abusers during the period, broken down by abortions and children, with a view to then preparing preventive intervention targeted at this special group of drug abusers. Data have been retrieved from the National Board of Health's register on drug abusers registered as undergoing treatment, the Birth Register, the Abortion Register, and the National Patient Register (LPR), and finally, the CPR Register (register of civil identification no.). Furthermore, a special control group was retrieved from the background population in order to compare the number of pregnancies, abortions and children among the female drug abusers with the remaining part of the population.

[15] Pregnancies and births among female drug abusers in Denmark 1990-2001. the Medical Officers of Health for Copenhagen and Frederiksberg, 2004.

Findings from the study show that female drug abusers are more at risk of having abortions than females in general, and that their children have a higher mortality rate than children born to the background group. The figures show that the female drug abusers miscarry 2.5 times more frequently than the background group. Furthermore, the mortality rate of female drug abusers' children born alive is three times higher than that of the background group, especially during the two first years of life. Finally, 6% of the liveborn children were born with withdrawal symptoms. That is 518 children during the period 1996-2001. Half of these children were born to mothers who were not undergoing drug abuse treatment in the period before or after birth.

Female drug abusers give birth to nearly the same number of children as the rest of the female population, i.e. 1.6 to 1.7 children per woman. This in spite of the fact that they are some of the most deprived women and in most instances unable to take care of their children. Female drug abusers typically have a short school education, a poor connection with the labour market, and their upbringing has been characterised by abuse, violence, crime and incest. These conditions, in turn, affect the children of drug abusers negatively. The report points out that intervention which includes improved contraception guidance to younger female drug abusers and contraception plan is required in order to reduce the human and socioeconomic impact following in the wake of drug abuser pregnancies.

7 Responses to Health Correlates and Consequences

7.1 Overview/summary

The fact that not all drug abusers are interested in treatment, that many suffer relapses and that traditionally, Denmark cares for all its weak citizens, no matter what the causes of social and health-related problems, means that harm reducing initiatives are of central importance, see Part 33 of the Social Services Act.

As a supplement to treatment intervention, the National Board of Health has consistently aimed at harm reduction and harm minimisation for those drug abusers who are unlikely to become drug free in the short or the long term. Harm reduction means a decrease in the damage resulting from life as a drug abuser incurred by the individual him/herself, by close relatives and by society. Harm reduction also means the improvement of the drug abuser's functional ability and development potential. Harm reduction interventions could, for instance, be services such as outreach street-level work, drop-in centres for current abusers (low threshold services), syringe exchange programmes, and social support at home. Qualitatively much more far-reaching requirements such as drug injection rooms, legalisation of cannabis, and prescribed heroin, is being rejected by the Government in its action plan to combat drug abuse as being too far-reaching and in contravention of the core of Danish drugs policy. And with regard to legalising cannabis and setting up drug injection rooms, the Government's view is that such action would be in conflict with international drug conventions.

7.2 Harm reduction initiatives in "The fight against drugs"

The Government's cross-ministerial action plan, "The Fight Against Drugs", proposes, among other things, that based on the evaluation of a pilot project of health care intervention targeted at the most severely addicted drug abusers, the Government will consider the need for and possibility of providing such services as permanent schemes in particularly affected city areas. Furthermore, as regards a smaller group of older, heavily addicted and injecting drug abusers the Government will consider the launch of a methadone injection scheme which is currently running as a pilot project.

The Government will also prioritise the introduction of early and free vaccination of injecting drug users against hepatitis B, similar to the scheme under which injecting drug users vaccinated against hepatitis B with a combined hepatitis A and hepatitis B vaccine can be vaccinated free of charge against hepatitis A. The Government will also launch a scheme of free vaccination to relatives of injecting drug users against hepatitis B and initiatives to curb hepatitis C infection. Additionally, the Government prioritises the initiation and completion of a quality assessment of methadone treatment as the basis for future quality assurance and development in line with the interventions planned within this area of the health care sector in general.

In connection with the Government's action plan, also financial support has been granted to a number of projects on outreach work in the streets, e.g. a project in Copenhagen for the most severely addicted drug abusers. The aim of the project is

to support the building of networks and to improve contact with the public authorities. To this end, a corps of volunteers has been established. Furthermore, effective 1 January 2003, the Government has launched a two-year project with support and contact personnel for the most severely addicted drug abusers. The Government will continue its efforts, politically as well financially, to support stronger outreach initiatives, including street-level work, for instance carried out by volunteers. The Government plans to launch projects on competence development in outreach and contact-generating work.

7.3 Prevention of drug-related deaths

From October 2001 - 2004, Copenhagen local government has conducted a project of intensified health care services for heavily addicted drug abusers.

This project aims at tracking down and establishing contact with the homeless and the abusers who more or less temporarily live in the streets or who are registered in some type of dwelling for the homeless. The project expects contact with approximately 50 constantly changing persons out of a target group of approximately 500 persons (The Danish Ministry of the Interior and Health). The project is based on the assumption that social intervention is crucial for the achievement of health-related goals. The intervention must therefore motivate the individual abuser to change his/her situation and to assume responsibility for his/her own life. The outreach work will include establishing contact with social workers as well as shelters. Furthermore, efforts will be made to encourage drug abusers to contact treatment services as well as to prepare individual social action plans for them.

The health care services covered by this project include diagnosis, treatment and follow-up on HIV, hepatitis, local infections, fungus, other skin infections, urinary tract infections and treatment of ulcers and other injuries. These health-care services are provided at a treatment institution with experts in medical and drug abuse issues. The project employs 4 outreach social workers, 5 nurses, 1 doctor and 2 social and health care assistants.

7.4 Prevention and treatment of drug-related infectious diseases - syringe programmes

Syringe programmes are a preventive measure targeted at injecting drug users with the aim of giving them clean needles so they can avoid HIV and other blood-borne infections.

A study conducted by the Council for the Socially Marginalised People in September 2003 shows that in 10 of the counties and in the Copenhagen and Frederiksberg municipalities needle exchange schemes had been established. In the 3 remaining counties and in the regional municipality of Bornholm there were no such schemes. In most of the counties with needle exchange schemes it was a pharmacy that administered the scheme either by dispensing/sales at the pharmacy or with the pharmacy running the “operation” of one or several dispensing machines with clean needles in public sites or toilets. In a few areas, dispensing was also done from drop-in centres, boarding houses or shelters. Almost everywhere with an exchange scheme had established some system for collection of used needles/syringes or a needle box.

In most areas, no user payment was charged for receiving needles/syringes from the pharmacies, but user payment was charged in two areas for needles/syringes

from dispensing machines. Eight of the counties and the Copenhagen and Frederiksberg municipalities dispensed measuring cups together with the syringes and needles – several places with cleaning serviettes and cotton wool (for more information on the report, please see: www.udsatte.dk).

Used needles are collected from needle boxes set up around Copenhagen, and volunteers from the User association do a great job of collecting used needles and syringes from the street. In Copenhagen municipality about 3000 kg of used needles and syringes are collected annually from collection points and other public collection boxes.

7.5 Interventions related to psychiatric co-morbidity

The number of individuals suffering from a mental illness combined with abuse is increasing. People with this type of co-morbidity are some of the most vulnerable in Danish society (see chapter 6). The complexity of the diagnosis and the behaviour of the those suffering from co-morbidity make it difficult to decide who should have administrative responsibility for the treatment – the psychiatric treatment system or the drug abuse treatment institutions. The psychiatry agreement 2003-2006 provides that this group must receive high priority in terms of intervention. And everybody agrees with the recommendation – set out in a statement from the expert group on interventions related to the most severely addicted drug abusers – that the primary responsibility for treatment of this group should be placed in the psychiatric treatment system, and that this recommendation should be incorporated into future intervention plans. The Government has also agreed with local government that support should be granted to projects that fit in with the recommendations of the expert group statement (see chapter 16 of the annual report 2003).

In 2004, the Copenhagen County inaugurated a new laboratory referred to as KASA (Københavns Amts Special Ambulatorium) with experts in psychiatry and abuse treatment. This out-patient treatment centre provides medical treatment for mental illnesses as well as drug abuse. Among other things, this means that the mentally ill drug abuser no longer to needs to go to different places to get their methadone and anti-psychotic drugs. The treatment centre also provides activities such as psychotherapy, social activities as, for instance, food groups, café, physical exercise and other activities, as well as lectures and teaching for users as well as their relatives. KASA is manned by an inter-disciplinary team consisting of a doctor, a psychologist, a social worker, a social and health care assistant, nurses and social education workers experienced in psychiatry and abuse treatment. The treatment centre also has a small research facility manned by a consultant doctor and a researcher. Their job is to collect data on the work of the centre, and document as well as evaluate new methods in treatment (www.kabs.dk).

8 Social correlates and consequences

8.1 Overview/summary

Several indicators show that there is a correlation between drug use and problematic social and economic living conditions and consequences. The fact is that in terms of housing, family life, financial and educational conditions, drug abusers undergoing treatment are much more disadvantaged than other groups in society.

Furthermore, there is a correlation between drug abuse and crime. The Danish Prison and Probation Service thus reports that a large portion of the inmates have drug abuse problems. The findings of the most recent drug and alcohol study in the institutions of the Prison and Probation Service show that the illicit drugs are far more prevalent among their clientele than in the population in general (Kramp et al. 2003). ¾ of the probation service's clientele have tried cannabis, more than half of them have tried central stimulants such as cocaine and amphetamine, while 1/3 have tried heroin and/or morphine preparations.

The study results also showed that more than half, i.e. 56%, of the probation service's clientele, are abusers, while 67% are drug abusers[16] or problem users[17] of drugs and alcohol. Many of these individuals are polydrug users.

Heroin/morphine abusers are rarely the ones to commit serious crime. Opiate abusers and cannabis abusers are typically convicted of violating the Euphoriant Substances Act, which normally means shorter prison sentences than the remaining abuser groups. Central stimulant abusers are more frequently charged and convicted of serious drug crime, i.e. violation of the provisions laid down in the Danish Criminal Code.

8.2 Social exclusion and problems

Drug abusers are subject to considerable social exclusion. A look at the social, housing and educational situation of drug abusers undergoing treatment makes it clear that these people are a marginalised group compared to others. They are more often homeless, their education has often been shorter, and they are more often provided for via cash benefits and early retirement pensions than is normal in the general population. Those particularly at risk in relation to drug abuse are children from families where there is abuse, violence and neglect, who are early starters on alcohol and cannabis; young immigrants who are poorly integrated; refugees with traumatic experiences behind them; mentally frail individuals; the mentally ill; and the homeless.

[16] Drug abuse is defined as the intake of the drug twice a week or more in the week prior to imprisonment/registered supervision. Alcohol abuse is defined as the intake of 11 drinks or more daily in the 6 months prior to imprisonment/registered supervision, 10 situations of inebriation or more in the month prior to imprisonment/registered supervision and/or ongoing treatment for alcohol abuse.

[17] Problem drug use is defined as the intake of the drug once a week or less in the month prior to imprisonment/registered supervision. Problem alcohol use is defined as the intake of 6-10 drinks daily in the 6 months prior to imprisonment/registered supervision and/or 5-9 situations of inebriation in the month prior to imprisonment/registered supervision.

8.3 Drug-related crime

Ongoing registration is carried out on reports filed, charges and sentences passed under the Euphoriant Substances Act, which primarily deals with possession and sale of small quantities of drugs, and under the criminal code's Section 191 (s 1) (sale), (s 2) (smuggling), which deal with more serious drug crime, and Section 290, which deals with receiving stolen goods – including receiving stolen goods from drug crime.

Charges resulting from violation of drug legislation

The police may raise charges leading to prison sentences, other sanctions, or acquittal. The National Commissioner of Police registers the number of reports filed and charges raised on an annual basis.

In 2003, 14,316 charges were registered, which is an increase compared to recent years. The number of charges raised since 1999 had been relatively stable around 13,000. Since 1994, the number of persons charged had been between a little more than 8,000 and 10,000 annually. No figures are available on the number of persons charged in 2003.

Table 8.3.1 Drug crime 1993-2003. Charges and number of persons charged

	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
Charges, total	18,604	15,155	14,654	14,371	13,454	14,251	12,928	13,178	13,143	13,025	14,316
Persons charged	12,421	9,536	9,008	8,678	8,234	8,900	9,424	9,899	9,858	10,021	-

Source: Unpublished figures from NEC (Nationalt Efterforskningscenter) 2004

As at 20 December 2002, there were a total of 2440 prisoners in Denmark. Of this number, 493 (20.2%) were convicted of violating Section 191 of the Danish Criminal Code or the Euphoriant Substances Act.

Correlation between abuse and crime

No new information has emerged on the patterns of correlation between abuse of various drugs and their involvement in different violations of laws and types of crime since the completion of the Drug and Alcohol Study of 2002 (Kramp et al, 2003). In addition to the summary in this chapter, reference is made to the results of the 2002 Drug and Alcohol Study outlined in the National Board of Health's "National Report on the Drug Situation in Denmark 2003".

Drug abuse in prison

The Danish Prison and Probation Service reports that procedures for the registration of drug abuse in states prisons and local prisons are currently under revision. The former annual returns (known as the drug census) will no longer be prepared, but will be replaced by a module in the client system of the Probation Service. The former returns were made on one given day of the year. The new figures will be maintained on an ongoing basis for all imprisonments in the institutions under the Prison and Probation Service. The new returns (like the former ones) will describe the volume of illicit drug abuse among prisoners prior to their imprisonment in one of the Service's institutions, and the first returns are expected in the summer of 2005.

8.4 Economy and expenditure on social intervention

It is difficult to get a complete picture of the costs incurred for society as a result of crime and the social problems following from drug abuse. However, specific state financing and funds have been reserved to support special social intervention in this field. For a further description of this financing, see chapter 1.

9 Responses to Social correlates and Consequences

9.1 Overview/summary

The treatment system has focused more and more on the users' housing situation as an integral part of comprehensive intervention. A number of services have been provided to drug addicts in treatment over the past years which have contributed to reducing homelessness among drug addicts. These services aim at different target groups characterised by varying degrees of resourcefulness. The housing services include intermediate accommodation (halfway houses) for abusers undergoing drug-free treatment, care collectives for terminally-ill clients, joint tenancies receiving special grants, accommodation training services, special flats in mainstream residential areas.

During the 1990s, the Government focused on reducing expulsion from the labour market by establishing the "spacious labour market" and asserting "companies' social responsibility". The idea is to obtain closer collaboration between the public sector and the companies (partnerships) on reducing expulsion from the labour market and re-integrating the long-term unemployed, i.e. the marginalised groups, including drug abusers. Throughout the 1990s, drug abusers were among those unemployed who received very little attention in local government activation programmes. In recent years, several employment projects and programmes have been launched, targeting drug abusers in order to promote their entry into the labour market. As regards the description of the social reintegration this chapter will focus on the situation in Copenhagen, which is the city with most experience of intervention programmes.

Drugs and alcohol studies conducted by the Prison and Probation Service have shown that a considerable number of prisoners have drug abuse problems. In recent years there has been an increasing focus on the special need of this group of inmates, and this has led to the establishment of special units dedicated to drug abusers. A formalised partnership has been established between the Ministry of Social Affairs and the Directorate of the Prison and Probation Service in order to coordinate and handle the treatment service and support the after care-service for drug abusers in prison.

A number of treatment, contract and motivation departments have been established in several closed and open state prisons. As a new initiative, the Service has set up a motivation department and a treatment department for female prisoners and motivation departments for men, partly manned by external therapists. Furthermore, motivation departments and motivation courses have been established in collaboration with external treatment institutions – the so-called import model. Moreover, two departments in a closed state prison for men and one department in an open prison have set up treatment departments for drug abusers, in which actual abuse treatment is offered by external therapists. Finally, in 2003, the Service set up a – semi-open – treatment department.

Drug abusers in long-term substitution treatment can continue their treatment during their imprisonment. In the institutions under the Prison and Probation Service this possibility is being utilised to an increasing extent. As a harm reduction intervention drug users in prisons and local prisons have access to cleaning liquid. The

purpose is to give the injecting drug users who share needles and syringes with other drug users the chance to clean them in order to reduce the risk of transmitting diseases such as HIV and hepatitis B.

9.2 Social Reintegration

In the social grants budgets for 2002 and 2003, funds were reserved for socially vulnerable groups. These funds were to be used for the establishment of temporary and permanent accommodation services, including the necessary housing support corresponding to each individual's needs. Furthermore, focus will be placed on halfway-house accommodation and alternative nursing homes. During the first two project years, up to 100% will be granted in subsidies for construction and operating costs, following which direct governmental grants will decline by 20 per cent annually. State subsidies will cease after the 6th year, and the annual amounts by which the subsidies are reduced will be carried forward to the general block grants. The aim of the action plan for the weakest groups is the establishment of 300 new accommodation units. The funds reserved for the socially vulnerable groups consist of a general application fund and a reserve fund for the larger cities (Copenhagen, Frederiksberg, Odense, Århus, Ålborg and Esbjerg). On the basis of the establishment of the general application fund in February 2003 and recommendations after negotiations with the cities, it is estimated that the number of new accommodation units will be approximately 185, plus housing grants. As regards the achievement of additional temporary accommodation units and permanent dwellings, the Government will continue to support the establishment of new accommodation units for vulnerable groups, including drug abusers, via budget funds.

The majority of the users registered as undergoing treatment (72%) report that they have their own home. Compared to the country as a whole, where only 50% of drug abusers undergoing treatment have their own home, this figure is high. The reason why the proportion of those with their own home is relatively high in Copenhagen is that there are more older drug addicts in Copenhagen. It seems as if "homelessness" drops with increasing age among drug addicts.

A large part, 18%, live periodically under temporary conditions, in rented rooms, stay with their families and friends. Many drug addicts who have their own home, may find it difficult to live in it and adapt to the general housing milieu and look after their flat. The drug abuser's daily life is often controlled by here-and-now priorities, where looking after the flat has second priority. It is important to teach the users how to look after their flat and get everyday life to function, and how to socialise with other people outside the drug abuse environment – things often strongly wished for by drug abusers. The transition from a life dominated by drugs and contact with the drug-abuse environment to a "clean existence" may prove difficult in the old flat, just as it might be difficult to start a new life in another flat – or even find one. Many terminate their tenancy when they are admitted for drug-free treatment, and rehabilitation will often include support to find a new flat and, in particular, to set up a new network in relation to the new housing situation.

Special homes are flats out among ordinary flats, to which Copenhagen Municipality has the right of referral. In addition to these flats, council houses are offered under the accommodation programme for drug addicts in accordance with special social criteria. Generally, it is difficult for other flat occupiers or local shop owners to accept drug addicts as their neighbours – no matter whether they are in institutions, accommodation units with or without 24-hour coverage, or individual tenan-

cies. However, there have also been a number of positive experiences, where collaboration has been established between department boards and janitors in order to get integration to work. For instance, there are several departments in council houses, with which the Copenhagen Municipality has signed agreements for special homes to which professional supervision is attached for a limited number of drug addicts.

Work, cash benefits and education

As part of the national labour market reform "More people in work", the Government is endeavouring to improve the chances of connection to the labour market for the most vulnerable groups of cash benefit recipients, including drug abusers. Already at this point, there are several examples to prove that it can make a difference to do something special for the most vulnerable groups of cash benefit recipients. As part of the Government's new action plan against drug abuse, "The fight against drugs", an analysis will be initiated on the characteristics of the most vulnerable group of cash benefit recipients, i.e. the most vulnerable of the cash benefit recipients who are not ready for the labour market and who have been receiving cash benefits for a long time. The analysis will thus uncover the extent, need and results from the work done so far. Previous initiatives carried out for this target group will also be included in the analysis.

Experiences from Copenhagen Municipality regarding job market integration

The majority of those registered as undergoing treatment in Copenhagen Municipality live on some kind of transfer income. 30% have been approved for early retirement pension, 46% are cash benefit recipients or are receiving rehabilitation grants. The rest include unemployment benefit recipients and persons under education as well as persons in ordinary jobs. A census among users undergoing treatment in January 2004 showed that 11% were self-providers in ordinary jobs. This applied to 8% of the users admitted to substitution treatment and to 20% of the users admitted to drug-free treatment.

The educational level of the drug abusers undergoing treatment is generally low, and many of them have limited job experience. 63% have no commercial education, 10% have a professional education , and 14% have received short-term or medium-term further education. Less than 1% have had long-term further education. Basically, the majority of the drug abusers are a long way away from the labour market.

Since 1999, Copenhagen Municipality has focused on testing several methods through a number of projects aimed at integrating marginalised groups of users in long-term substitution treatment in various forms of subsidised employment and education/rehabilitation programmes. This is a group which is predominantly on benefits, they are socially isolated, and they need to overcome many barriers if they are to get a real job, which many of them dream of doing. Two of these projects ("Spirillen" and "Fram") have been evaluated and are described in the EDDRA database: http://eddra.emcdda.eu.int/).

At the city out-patient treatment centre of Bellahøj (for users in long-term substitution treatment) a labour market project, "Arbejdsbasen" (the Work Base) has been running as a service for out-patient users who need help to try out their chances on the labour market through traineeships, job training or activation programmes. The

project is meant to support each individual user in their programme. During the year that the project ran, 17 users among the approximately 100 out-patients at the treatment centre signed up for the project. 12 of the users succeeded in starting a programme. 2 of the users found a job on their own initiative.

The project results showed that the job resources of the out-patient target group are limited, but also that several users actually benefited from the project. Most of the users involved required active and persistent support as well as a great deal of effort to get them into contact with the work place (traineeship) or the activation project, and to keep the user active and overcome social and other difficulties.

The experience gained from the existing programmes is that if the goal is to enable the user to provide for him/herself, the users will benefit most from programmes with a clear job perspective, and where the conditions take on the form of the labour market, even though the users' resources are not quite sufficient to cope with a full working day.

In general, the "success rate" of the specially planned employment is low when success is measured on the number of individuals empowered to provide for themselves or on the way to self-provision, for instance via rehabilitation programmes. Between 10% and 15% of the programmes started in the course of a year, ended the following year with self-provision or rehabilitation.

Experiences from Copenhagen Municipality regarding education through rehabilitation

Drug addicts generally have an educational backlog, and for many of them, the move away from passively receiving state benefits and inactivity during everyday life requires "a resocialisation" in several ways before they can change this pattern. In this connection, educational rehabilitation, whether as education to achieve qualifications or via long-term job support at a work place, may be what will give drug addicts the necessary social and educational competence. Rehabilitation grants provided under an agreed business plan is therefore very relevant for this group of people. In Copenhagen Municipality, between 5% and 10% of all drug addicts are cash benefit recipients under a rehabilitation programme. This, however, applies more frequently to the persons undergoing drug-free treatment than to people receiving substitution treatment, but the option is available for both target groups.

Experience shows that we are dealing with long-term processes with the individual user, that the users have completely different backgrounds for participating in the projects, and that the benefit they gain also differs. So there is a need for differentiated activity and employment options for this group of citizens. For instance, there is a need for protected jobs for drug abusers.

Furthermore, there appears to be a need for services for users who are incapable of returning to the labour market. Typically, this would be users who have no alternative to their life in front of the TV, in the coffee room in the institution, or on the street corner or bench, because of their strange behaviour, appearance, etc., and because they are scared stiff of normal everyday life in the community. For this group, the treatment institutions need options that could match these users' special situation and desires, perhaps in the form of a "high school" on the users' terms, perhaps led by volunteers and in connection with drop-in centres for drug abusers.

Health project and contact centre in Copenhagen

Over the past three years, the Copenhagen Municipality has run two projects, the "Health project" and the "Contact centre", through which it has reached out to homeless drug abusers who lack sufficient energy to avail themselves of the services already available. Part of the aim of this outreach work has been to investigate this group's situation in terms of social relations, drug abuse and health, as well as to contribute to these users making use of the existing services.

During the period 1 August 2001 to 1 January 2004, 542 users were registered. It is noticeable that only 35% (192 users) of the drug users had their last address in Copenhagen Municipality. 50% had their last address somewhere else in Denmark, and 15% were foreigners. In other words, 2/3 of the users have been assisted in returning to services in their own municipality or their home country.

In 81% of the cases, the staff believed that the users were addicted to drugs (and/or alcohol). Among the 35% of the users who had their last address in Copenhagen, more than 59% (113 users) were registered as undergoing treatment in Copenhagen Municipality on 1 January 2004. The main reason why there is a difference between the estimated number of drug addicted users and the number of users admitted to treatment is that users who solely drink alcohol are not registered in the same system as drug addicts, and therefore it is estimated that treatment services have been provided to the majority of the Copenhagen users who live on the streets.

9.3 Prevention of drug-related crime

The national strategy provides that treatment of criminal drug abusers should, as far as possible, be handled by the social authorities. Treatment initiatives under the Prison and Probation Service must primarily be aimed at motivating and uncovering the needs of the abusers. However, in the cases where external treatment cannot be provided for security reasons, the Prison and Probation Service must, as far as possible, be able to offer relevant treatment during imprisonment.

New treatment initiatives

As part of the social grants budget in 2003, the Prison and Probation Service was granted resources to further develop treatment of drug abusers in the Prison and Probation Service institutions. The grant should be seen as the first step on the way to the introduction of an actual treatment guarantee for prisoners in the institutions under the Prison and Probation Service. In connection with the agreement, it is stated what projects will be started, but insofar as resources allow, further upgrading of treatment services will be made so as to get as close to a treatment guarantee as possible. The projects launched will be evaluated at a later date.

Total grants resulting from budget are:

2004	2005	2006	2007	Total
EUR 2.2 mill.	EUR 2.4 mill	EUR 2.4 mill	EUR 2.4. mill	EUR 9.4. mill

Initiatives to be launched under the social grants budget agreed:

- A department for opioid drug abusers following the import model. Treatment must be drug-free. It has been decided to establish this treatment in the Horsens

State Prison (a closed prison) in collaboration with the private foundation of Hjulsøgård. Treatment is based on socio-educational principles.

- A department for prisoners who have completed treatment, but who will be in prison for a long time before expected release. This department will be established in Vridsløselille State Prison (a closed prison) in collaboration with the private foundation of Kongens Ø. The department will receive prisoners from all the treatment departments in the Prison and Probation Service.
- The development of a treatment programme and establishment of a treatment department for abusers of central stimulants and cannabis in collaboration with the county treatment system. The development of this programme will be carried through in collaboration with the Funen County Treatment Centre, and the department will be established in the Nyborg State Prison (a closed prison).
- The dissemination of the motivation project, the "Esbjerg model" (for further details, please see the EDDRA database: http://eddra.emcdda.eu.int/) to a further three counties/three local prisons. The three "new" local prisons in this project, apart from Esbjerg local prison, will be Aarhus, Odense and Slagelse local prisons.
- The carrying through of a pilot project which is meant to upgrade treatment activity in the contract prison departments. The pilot project has been established at the Sondre Omme State Prison (an open prison) in collaboration with the private foundation known as Springbrættet (Springboard).

Every treatment programme provided for drug abusers under the Prison and Probation Service must be evaluated by the end of 2005 to determine whether the number of treatment places under the Prison and Probation Service is sufficient and how appropriate the programmes are.

Launch of new registration

Since 1 November 2000, the Prison and Probation Service has registered the number of drug abusers admitted to treatment under the Prison and Probation Service. As part of this documentation routine, follow-up has been done on the treatment programmes already launched. Since it has taken time to incorporate registration into the institutional routines, the data available are unfortunately incomplete and the following conclusions must therefore be viewed with some reservation.

During the first three years, 387 abusers were enrolled into a programme, of which 211 succeeded in completing it prior to the status report in October 2003. By far the majority (93%) of the registered abusers are men, most of them (84%) being between 18 and 34 years of age, and a little more than half of them have been treated previously. Two-thirds are opioid abusers. A little more than half of them are undergoing treatment in the Prison and Probation Service's own institutions, while 24% are being treated in private institutions and 21 percent in county institutions.

Out of the 211 completed cases, a little less than half of them (46%) completed treatment, while the rest discontinued treatment before completion. The completion rate includes a large proportion (74%) of completed substitution treatment programmes and a small portion (40 %) of completed drug-free programmes.

There is no overall coherence between *type* of abuse and completion rate; however there are some indications that central stimulant abusers have found it easier to complete drug-free treatment than opioid abusers.

The completion rate was higher for treatments taking place under county auspices (63%) compared to treatment provided in private institutions or in the Prison and Probation Service's own institutions (41-43%). This is not because the counties receive fewer opioid abusers or that they employ substitution treatment to a greater extent – two factors that might otherwise have affected the result.

Whether treatment was completed or discontinued, there was a clear correlation between starting treatment and the abuser's own feeling of a positive development within a number of subjective parameters such as physical and mental health, the possibility of getting a job, the possibility of remaining drug-free for at least a year, and family relationships. Only in relation to the chances of getting a job and remaining drug-free was there more positive feed-back from those who completed treatment than from those who discontinued it.

Since April 2004, the Prison and Probation Service has revised and updated the BASK (Treatment of drug abusers in the Prison and Probation Service) registration system, because the allocation of a number of budgeted grants has resulted in new requirements for documentation in relation to the projects within the area of treatment of drug abuse. The first summary of these new data is expected to be available during the autumn of 2004.

10 Drug market

10.1 Overview/summary

The police seizure statistics provide no unequivocal picture of trends in the prevalence of the various drugs over time. Major fluctuations exist in the quantity of drugs seized over the years, but often such statistical fluctuations reflect the fact that individual major seizures have been made in one particular year. So seizure statistics give merely a rough indication of the prevalence of drugs on the illicit market and are just as much an indication of *police activity*. However, there is a clear trend over the past few years towards the various illicit drugs being seized in almost all police districts in Denmark, from which we must conclude that the drugs are available throughout the country.

Results from special forensic chemical analyses in Denmark show that there are major variations in the concentration and purity of the active ingredients in illicit drugs on the market[18]. In 2003, unusually large variations were discovered in the quantity of the active ingredient MDMA in various ecstasy pills, which increases the risk of intoxification. The range of variation in the purity of heroin, cocaine and amphetamine is also large, though not so different from previous years. This large range of variation in purity and concentration in the various drugs is seen all over the country.

In 2003, no new drugs were discovered among the analysed seizures. Methamphetamine, however, has become more and more common on the illicit market – both alone and in combination with amphetamine. Furthermore, in 2003, a drug sample with MDMA mixed into a powder sample of heroin was seen for the first time.

A look at the various drugs confiscated on the streets (in the random-sampling street-level project) shows that there has been a clear tendency in recent years for heroin base (for smokeable heroin) to be seized more often than white heroin (for injection purposes). Samples of cocaine have increased drastically at street-level and now far exceed the number of amphetamine samples. However, there are still significant differences as to which drug is the most common in the various towns. Amphetamine dominates in Aalborg, heroin and cocaine dominate in Copenhagen, whereas heroin dominates in Aarhus as well as Esbjerg.

10.2 Drug routes to Denmark

The National Commissioner of Police report, "Report on organised crime in Denmark, 2003", states that Marocco is still the most important producing country for cannabis sold on the Danish market (National Commissioner of Police, 2004). Spain and the Netherlands continue to be the most important distribution routes, but there are signs that new people – for example, Poles and persons with affiliations to street gangs – are trying to gain a foothold in the Danish cannabis market. As regards heroin, the National Commissioner of Police maintains that the vast majority comes to Denmark from South West Asia, whereas amphetamine and ecstasy seized in Denmark are presumed to have been produced primarily in the Netherlands and Belgium. Whilst amphetamine and ecstasy are mostly seized at

[18] Results from the special chemical analyses are based on drug samples from the Street-Level Project and the monitoring of ecstasy pills referred to later in this chapter

the borders, cocaine is to a large extent seized in Danish airports with international flight connections.

10.3 Seizures and the drugs on the illegal marked

Police and customs keep ongoing records of the quantity of illicit drugs seized and the number of seizures of illicit drugs made at the borders, airports and ports in connection with major investigations as well as street–level confiscations. The data on seizures are regularly reported to the National Centre of Investigative Support (NEC) which prepares and publishes annual statistics on them (Police drug statistics 2004).

Table 10.3.1 in the Annex shows the development in quantity and number of seizures of heroin, cocaine, amphetamine and cannabis from 1991-2003. From 1995 and onwards, the statistics also include the quantity and number of seizures of ecstasy and LSD. The table shows major fluctuations in the quantity of drugs seized within most drug types in individual years.

The table also shows that the number of heroin seizures has dropped by more than 70% since 1996 when they peaked. The quantity of heroin seized shows no clear tendency, but in 2003 it hit a rock bottom of 16.3 kg. The number of seizures of cannabis rose from 2002 to 2003, and the quantity rose from 2635 kg to 3829 kg. The number of amphetamine and ecstasy seizures is more or less constant, whereas the quantities seized for the two drugs increased drastically from 2002 to 2003. The number of cocaine seizures has increased linearly from 1999 to 2003. However, although the quantity of cocaine seized over the past few years has dropped, a total of 104 kg of heroin was seized in 2003, which is the highest quantity since 1991. There were, however, a few major seizures in 2003.

Monitoring of illicit drug trading at user level

The aim of the project known as the "Street Level Project" is on the one hand to follow the development of prices and drug concentrations as indicating the relation between supply and demand on the illicit drug market, and on the other to identify the presence of "hazardous drugs" and assess the frequency and location of high-concentration drugs. The ongoing monitoring is also intended to follow the introduction of new drugs on the illicit drug market.

The data material from the Street-Level Project in 2003 consists of random-sample minor seizures from 5 police districts in Denmark (Copenhagen, Aarhus, Odense, Aalborg and Esbjerg), which were submitted for analysis at the institutes of forensic chemistry[19]. Table 10.3.2 shows the distribution of drug types seized in the country as a whole from 1996 to 2003[20].

Of the 188 samples analysed in 2003, 52% consisted of the central stimulants amphetamine and cocaine. As regards cocaine, the proportion of cocaine samples from the street-level project has increased drastically since the project started, whereas the proportion of amphetamine samples has remained stable over the years.

[19] Forensic analysis registers the identity of the illicit drug and any additives. In addition, the sample's purity and weight are determined.

20 The Street-Level Project does not include cannabis or other cannabis products.

The amount of methamphetamine has increased compared to previous years, and that is why from this year it has been listed separately in the table below. 4% of the total number of samples consisted of methamphetamine. Another 4% of the samples contained mixtures of substances, including a few samples of a combination of methamphetamine and amphetamine. For the first time since the project started, there was a powder sample containing MDMA (ecstasy) mixed with heroin. The sample comes from a seizure in Esbjerg.

39% of all samples in 2002 were heroin. Heroin is still the most prevalent drug in Denmark. However, on a national scale there appears to be a drastic fall in the proportion of heroin samples from 1996 to today since 57% of all samples in 1996 were heroin. In Copenhagen, heroin and cocaine are the most prevalent drugs (each with 45% of all samples), whereas amphetamine is the most prevalent drug in Aalborg (65% of all samples). In both Aarhus and in Esbjerg heroin is the most prevalent drug (in 44% and 38% of samples, respectively).

Table 10.3.2. Breakdown of drug types at user-level 1996-2003

	1996* n =212	**1997*** n = 217	**1998*** n = 208	**1999*** n = 216	**2000** n = 188	**2001** n = 152	**2002** n = 198	**2003** n = 188
Heroin	57%	60%	56%	45%	44%	45%	40%	39%
Amphetamine	23%	26%	17%	23%	17%	22%	24%	20%
Cocaine	14%	9%	23%	27%	24%	22%	30%	32%
Ecstasy	3%	1%	<1%	3%	7%	9%	2%	-
Methamphetamine**	-	-	-	-	-	-	-	4%
Other euphoriants/drug mixtures	1%	1%	1%	1%	5%	1%	3%	4%
Non-euphoriants	2%	3%	1%	<1%	3%	1%	2%	1%
Total	100%	100%	100%	100%	100%	100%	100%	100%

Source: Kaa et al. 1997, Kaa et al. 1998, Kaa et al. 1999, Kaa et al. 2000, Kaa et al. 2001, Kaa et al. 2002, Kaa et al. 2003, Kaa et al.2004.
*In 1996, 1997, 1998 and 1999 figures were included from the Elsinore police district.
**The number of samples containing pure methamphetamine has increased drastically from 2002-2003, which is the reason why the drug is listed in its own category in the table. Methamphetamine occurs rarely and sporadically in previous years, and is listed under the category "other euphoriants/drug compounds" until 2003. Over the entire period the latter category contains the samples, in which methamphetamine is found in combination with other drugs.

Table 10.3.3 in the Annex shows the distribution between heroin base ("smokeable heroin") and heroin chloride (white heroin for injection) from 1996-2003. From 1996 and to today, the proportion of heroin base registered among the heroin samples has increased. In 2003, the breakdown between heroin base and heroin chloride was 84% and 16%, respectively, on a national scale. Neither in Copenhagen nor in Aarhus were there any heroin chloride samples, but only samples with heroin base. In Odense, there were an equal number of heroin chloride and heroin base samples, which represents an increase in the proportion of heroin base samples compared to previous years.

Table 10.4.1 shows the purity of the various drugs from 1996 to 2003 in the random samples seized under the Street-Level Project. From 1996 to 2003, the median purity of white/beige heroin chloride was between 50% and 71%, and in 2003,

it was 64%. The range of variation was high – from 34 - 81%. There is no significant difference in the purity of heroin chloride in 2003 compared to previous years.

Table 10.4.1 Purity of illicit drugs at user-level 1996-2003 (Median of active substance)[21, 22]

	1996*	1997*	1998*	1999*	2000	2001	2002	2003
Heroin chloride	64%	71%	70%	69%	59%	52%	50%	64%
Heroin base	43%	32%	31%	30%	40%	48%	25%	25%
Amphetamine sulphate	15%	16%	15%	9%	12%	9%	13%	9%
Cocaine chloride	58%	57%	51%	54%	37%	43%	36%	37%

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, Kaa et al. 2003, Kaa et al.2004
*In 1996, 1997, 1998 and 1999 figures were included from the Elsinore police district.

For heroin base, the median purity was 25% in 2003. The purity of the heroin base is no different from 2002, but in both these years, purity is significantly lower than in 2001 and 2000. The range of variation in purity in 2003 was, like that of heroin chloride, enormous (1-76%).

Amphetamine purity, as in previous years, was low. The median was 13% and the range of variation wide (2-34%). Purity in 2003 was at the same level as in recent years, but lower than in the middle of the 1990s.

No significant differences have been seen in cocaine purity in recent years. Median purity in 2003 was 37%, and the range of variation in 2003 was large (7-81%).

In 2003, as in previous years, there was no significant difference in the purity of the individual illicit drugs seized in the various parts of the country, but everywhere the range of variation was wide. In every police district, there were always drugs of low as well as high purity on the market at the same time. It was not possible to pinpoint periods of the year when purity was particularly high or low for any of the drugs.

A comparison between samples collected under the Street-Level Project and routine samples[23] tested at the institutes of forensic chemistry shows, as in previous years, no differences in heroin, amphetamine or cocaine purity. This means that there is no sign that drugs are being diluted prior to being sold at the street-level or are of "poorer" quality than drugs traded in larger quantities (Kaa et al. 2004).

Monitoring of ecstasy pills on the market

In 2001, monitoring of drugs was further extended when the National Board of Health, in collaboration with the National Commissioner of Police and the three

22 Since the purity in most drugs is not evenly distributed, these percentages show the median value of purity rather than the average value. This is consistent with the practice in the institutes of forensic chemistry.
23 The departments of forensic chemistry regularly analyse routine samples for the Ministry of Justice. Typically, these samples are received in connection with evidence in court trials and are therefore not representative in respect of geographic spread, location, weight/quantity, time of collection, etc. The samples often come from major seizures and therefore do not necessarily reflect the quality and distribution of drugs at a user level.

institutes of forensic chemistry, set up an ecstasy database including forensic analyses of ecstasy pills seized in Denmark[24].

The ecstasy database systematically collects analysis samples from all ecstasy seizures made in Denmark. This means that large as well as small seizures are included. The pills are described in terms of drug concentration, drug compound 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. A quarterly update of the analysis results and a more extensive annual report is, however, available at the National Board of Health's website: www.sst.dk.

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

In 2003, a total of 61,420 pills were sent to the institutes of forensic chemistry for analysis (Kaa 2004). Among these, there were an estimated 81 different kinds of pill broken down by appearance and content.

As regards appearance, the pills are often white, beige or grey, and almost always round. However, 25% of the 81 different types of pill in 2003 had different colours (red/orange, blue, green or yellow). Among the samples in 2003, there were 44 different logos, with Smiley being the most prevalent one, followed by Rolex, Pound and Bacardi. Half of the logos only had one variant, whereas the other half had several variants. For instance, in 2003, there were 12 different types of pills with a Smiley logo, while there were 7 variants with a Rolex logo. Since the start of the project, however, Mitsubishi is the logo with most variants (25 different variants). Pills with the same logo may vary in diameter, colour, weight, height, type and quantity of active ingredient.

Of the 44 logos counted in 2003, 15 had not been seen before. These logos were Donald Duck, Flower, Bow and arrow, Dolphin, Doll, Felix, Volkswagen, Lacoste crocodile, etc., Osama Bin Laden, Pound, R, Roadrunner, Bull, xXx.

In contrast to previous years, no new and "unknown" ingredients were found in the pills in 2003. The vast majority (96%) of the pills in 2003 only contained MDMA. Only 1% of the pills contained MDMA and another stimulant (MDE), whereas 1% did not contain MDMA, but another active ingredient (MDA, DOB, 5-MeO-DIPT, PMA or PMMA). In 2003, the mixture of PMA and PMMA was seen again in the same pill type (in one of the 25 Mitsubishi variants) as in 2001. 5-Meo-DIPT, which was found in a capsule for the first time in 2002, was found in an octagonal tablet in 2003.

I 2003 pills were found with both the highest and lowest concentrations of MDMA (1-159 mg) ever seen. The average amount of MDMA per pill in 2003 was 65 mg, which is not so very different from previous years.

[24] The database is not restricted to pills with MDMA (ecstasy), but all pills seized with a non-professional appearance, determined via logo, colour and pressing. The database also contains pills, where analysis shows the presence of synthetic substances or other euphoriants not normally present in medicines.

Prices

In 2003, the forensic chemists very seldom received any information about drug prices in connection with the Street-Level Project, and it is therefore difficult to provide an overview of the price level.

The National Commissioner of Police estimates that the street price for cannabis is around DKK 50 per gram. The average price per gram of heroin when sold in the streets is estimated to be between DKK 1,200 and 1,400 for white heroin, and DKK 600 for brown heroin. Cocaine prices are estimated to be declining slightly, with an average street price of DKK 600 per gram. Amphetamine street prices per gram are estimated to be approximately DKK 250, whereas the price for an ecstasy pill is estimated to be in the range of DKK 50-100. As regards these prices for the various drugs, there are major variations in different parts of the country[25].

[25] Unpublished from NEC, July 2004. Estimated prices as at 1.1.04.

11 Buprenorphine, treatment, misuse – and prescription practice

11.1 Introduction

Until 1999, methadone was the only drug that could be used in substitution treatment in Denmark. Once buprenorphine was registered in 1999, substitution treatment of opioid addicts took on an extra nuance. The pharmacological profile of buprenorphine is much more appropriate than methadone in the treatment of certain abuser groups, which has led to better substitution treatment in general. Observations made in Danish practice and in foreign studies indicate that buprenorphine will play a bigger role in substitution treatment in Denmark in the years to come.

11.2 Treatment with Buprenorphine

Buprenorphine has been registered for substitution treatment of opioid addiction since May 1999 and has been used ever since in substitution treatment (Petersen et al.2000). The legal framework governing treatment of drug abusers is laid down in a number of laws related to the health and social services, and medical treatment with Buprenorphine is specifically regulated via Section 5f, and Section 6 in the "Act on medical practice" (Act no. 435, Act no. 944, Act no. 267, Act no. 272) and the National Board of Health's circular of 2003 on the prescription of addictive medicine (the National Board of Health 2003a).

Guidelines for substitution treatment with Buprenorphine

Substitution treatment must always be accompanied by psycho-social intervention targeted at the drug abuser's physical, mental and social situation. The National Board of Health's circular of 2003 on the prescription of addictive medicine stipulates the indications for treatment with buprenorphine and methadone as follows:

- Prescription of substitution treatment with buprenorphine or methadone must be consistent with a medical treatment plan, which again is part of a larger social action plan
- The decision to provide substitution treatment must be viewed in the light of whether or not substitution treatment is relevant in relation to realising the goals of these plans.

Furthermore, there are a number of additional considerations and conditions that need to be fulfilled. To begin with, the drug abuser must have an addiction to opioids as defined in WHO's ICD-10: "Mental and behavioural disorders due to use of opioids" (F.11.2). Moreover, the drug abuser must have expressed a wish for treatment. This means that treatment is voluntary, and that the desire for this type of treatment (substitution treatment) has to be given considerable weight. Finally, other relevant treatment alternatives must be considered. Substitution treatment is a demanding type of treatment, during which the drug abuser and the treatment institution are bound together in committed collaboration for an unknown, but often very long time period.

Due to its low toxicity and its probably lower addictivity, buprenorphine is recommended as the first choice of medicine for younger and new, primarily opioid-dependent drug abusers who have not previously received treatment. For detoxification from abuse of short-term-acting opioids, buprenorphine is thus believed to be an appropriate medicine. Withdrawal symptoms during detoxification are moderate, irrespective of whether buprenorphine treatment is terminated abruptly or phased out over days or weeks. When detoxifying individuals under methadone treatment, the methadone dose should be reduced to 20-40 mg, and buprenorphine should not be administered until 24 hours after the most recent methadone dose in order to avoid any provocation of withdrawal symptoms.

Methadone is generally recommended as substitution treatment for pregnant women with an opioid addiction. Since experience with the use of buprenorphine during pregnancy is limited, pregnant women under substitution treatment with buprenorphine are therefore recommended to switch to methadone during pregnancy. However, the nature of obstetric treatment required may mean it is advisable for pregnant women under stable buprenorphine treatment to continue such treatment.

Who may prescribe substitution treatment?

The treatment of patients with drug abuse problems is subject to special conditions, in that substitution treatment with buprenorphine or methadone can only be provided by doctors employed in the municipality or in the Prison and Probation Service. A few prescriptions as part of short-term withdrawal treatment (approximately 10 days) may, however, be made by any doctor (the National Board of Health 2003a).

The right to subscribe addictive medicines as part of substitution treatment with buprenorphine and methadone of drug abusers may in particular circumstances and by agreement be delegated to another doctor, including a general practitioner. The Medical Examiner must be informed of such delegation. In practice, delegation og substitution treatment to a general practitioner will most often occur in the context of long-term stable treatment of a drug abuser with a high functional level, i.e. stable both socially and in the level of addiction. Should the general practitioner wish to terminate the substitution treatment, the delegating doctor must again take over responsibility for the treatment (The National Board of Health 2003a).

Drug abusers treated with buprenophine

As mentioned in chapter 4, there are an estimated 25,500 drug abusers in Denmark. The vast majority of these abusers are assumed to be addicted to heroin or other opiodes. In 2003, there were 12,317 individuals undergoing treatment for drug abuse, of which 4370 were undergoing drug-free treatment (The National Board of Health 2003).

Methadone continues to be the most common method of long-term, even life-long, treatment for drug addicts, aimed at having a stabilising physical, mental and psychosocial effect. In 2003, there were thus 5064 drug abusers in substitution treatment with methadone and 484 drug abusers in substitution treatment with buprenorphine (the National Board of Health 2003b).

There are several reasons why methadone continues to be the dominant substitution drug in Denmark. One reason is the long “methadone tradition” – stretching back

to 1970 – among both drug abusers and doctors. Also there is the general assumption that buprenorphine is a kind of "light methadone", particularly suitable for younger people and individuals who are not too addicted, and this general view has limited the number of drug abusers in treatment with buprenorphine. Furthermore, the great difference in price has meant that buprenorphine is primarily used for short-term substitution treatment (buprenorphine has been up to 8 times more expensive than methadone, but during recent years the price has fallen somewhat).

The Prison and Probation Service never initiates substitution treatment with buprenorphine. However, individuals who were being treated with buprenorphine prior to imprisonment, will normally be able to continue treatment with this drug.

As mentioned above, drug abusers undergoing treatment with buprenorphine are usually characterised by being younger and not too addicted, and only in rare cases will substitution treatment be of longer duration.

The annual medicine statistics issued by the Danish Medicines Agency show that general consumption of buprenorphine in Denmark in recent years for the age group between 20 and 50 has changed. Although the number of individuals undergoing treatment has been declining, the number of 24-hour doses has been rising. This is consistent with the fact that buprenorphine is being used as substitution treatment to an increasing extent and more 24-hour doses per person are required (Hesse 2003).

Since buprenorphine was licensed for substitution treatment in 1999, the number of drug abusers in substitution treatment with buprenorphine has gone up gradually, primarily due to the large increase in the number of drug abusers in substitution treatment in general, but also due to the increased use of buprenorphine in substitution treatment.

The percentage of individuals offered buprenorphine as substitution treatment is 10% of the total substitution treatment for opioid addiction in Denmark (The National Board of Health 2003b; Schering-Plough 2004).

No formal training is provided in buprenorphine treatment. However, doctors and nurses in the county treatment institutions for drug abusers have been trained to some extent in collaboration with the pharmaceutical industry, at major symposiums in collaboration with a society for medical science (Danish Society for Addictive Medicine), and to a lesser extent locally in the individual institutions.

Currently, no evaluation or special study/research project is being conducted on the use of buprenorphine as a substitution drug in the treatment of drug abusers in Denmark.

11.3 Abuse of buprenorphine

The National Board of Health's national register on drug abusers who are receiving or have received treatment regularly monitors admissions for treatment for illicit abuse in Denmark.

The register contains information about the drugs for which treatment is sought. In the register, the treatment-seeking drug abuser can state up to 14 different drugs,

and of these it is possible to register the primary drug (the drug preferred by the client) as well as secondary drugs (the National Board of Health 2003b).

In 2003, 6.3% reported having used buprenorphine in the month prior to their admission to treatment. The number of contacts where the drug abuser has sought treatment with buprenorphine stated as the primary drug makes up 1% of the total.

Regional differences have been registered with buprenorphine, whether as the primary drug or the secondary drug, being used more frequently in the provinces than in the city regions. This may primarily be ascribed to the differences in treatment programmes offered by each county, and that admission to treatment in general is easier in the major cities.

The overall conclusion is that buprenorphine apparently plays no major role as an abuse drug among drug abusers seeking treatment in Denmark.

A small number of people are reported as using buprenorphine by sniffing the drug or by injecting it. The general impression, however, is that buprenorphine is taken as instructed, i.e. as a lozenge under the tongue.

There are no special harm-reducing interventions in relation to buprenorphine. Abuse of buprenorphine is included in the general harm-reducing intervention in Denmark, including, among other things, easy access to treatment, relatively easy access to free syringes and outreach street-work.

Benzodiazepines, cocaine and alcohol, which in general are frequently abused drugs, are most likely also to be used with buprenorphine. The illicit use of buprenorphine is probably very limited.

It goes without saying that the group of buprenorphine abusers is difficult to describe. Observations from the drug scene and the treatment centres, however, report that buprenorphine is primarily purchased illegally by persons who wish to detoxify themselves from a opiate abuse without coming into contact with the treatment system (Hesse 2003).

Clients in substitution treatment with buprenorphine are generally prepared just to take the recommended and prescribed buprenorphine dose. In addition, if a dose adjustment is required, they have relatively easy access to a doctor. It is therefore estimated that the number of clients who wish to conceal a secondary drug abuse of buprenorphine is low.

Reported health correlations

No reporting system or systematic registration has been established for injuries, if any, resulting from buprenorphine abuse. In general, the high prevalence of somatic health problems caused by drug abuse is associated with intravenous drug use and therefore rare as a result of buprenorphine abuse.

No routine toxicology screening is carried out for buprenorphine on drug-related deaths caused by intoxification in general. However, the Institute of Forensic Chemistry in Copenhagen performs routine screening for buprenorphine on deaths caused by intoxification, and the Institute points out that in 2002, there were only a very few cases (two out of a total of 140 deaths) where buprenorphine was detected

(Steentoft, personal memo). However, there are no cases of registered death by intoxification where the intoxification was caused by buprenorphine alone.

No specific studies, evaluation, or training have been conducted in relation to buprenorphine abuse.

12 Alternatives to prison targeting to drug using offenders

12.1 Introduction

The objective of the Prison and Probation Service is to prevent against crime. This means that the treatment provided by the Prison and Probation Service must aim at enabling the convicted offender to lead a life free of crime.

The assumption is that improved terms of living, from a health as well as social perspective, will – all other things being equal reduce any tendency to commit criminal offences. The treatment of drug abusers under the Prison and Probation Service does therefore not solely aim at the known and/or presumed criminogenous factors, but aims more broadly at improving the conditions of life for the convicted offenders. The Prison and Probation Services prioritises the broad approach for both active and previous drug abusers in order to secure drug-free environments in the prisons. Where safe and appropriate it is possible to pass a sentence on alternative punishment, ie serving a sentence in a treatment institution outside the prison or local prison.

The treatment schemes provided by the Prison and Probation Service are based on the principle that the mainstream treatment system must step in. The reason for this is that the Prison and Probation Service with its relatively limited client base would not be able to build up sufficiently differentiated treatment programmes of a quality similar to that provided by the mainstream treatment system. Only in those cases where considerations for law enforcement or security exclude any use of external treatment programmes need the Prison and Probation service provide relevant treatment to the widest extent possible.

Treatment targeted at criminal drug abusers must to a wide extent allow for individual needs, and the treatment launched with assistance from the Prison and Probation Service must be organised so as to ensure that the drug abuser abstains from committing new crime.

This means that the Prison and Probation Service in a specific case must work actively to procure relevant treatment programmes from the county and municipal authorities. Prisoners motivated for treatment should either be offered treatment as imprisonment conditional on treatment outside prison under Section 78 of the Danish Corrections' Act or in connection with parole/release.

Danish policy as regards the treatment of offending drug abusers is described in the "The Fight Against Drugs" – the Government's action plan to combat drug abuse (October 2003)

12.2 Law basis and the visitation rules

The legal authority to treatment-related imprisonment was introduced in the Criminal Code in 1973 and is laid down today in Section 78 of Act no. 435 of 31 May 2000 on serving a prison sentence, etc. Section 78 of this Act, the Danish Corrections' Act, paves the way for a prison sentence to be served in a treatment institu-

tion when the convicted offender needs special treatment or care which to a large extent can be provided in the relevant treatment institution.

The provision allowing for treatment in an institution pursuant to Section 78 of the Danish Corrections Act may become relevant in relation to more specific target groups and in special situations and only where in the interest of the prisoner and in accordance with the purpose of the punishment it is found that an institutional environment other than prison should be applied. Treatment under Section 78 of the Danish Corrections Act is made conditional upon the convicted offender providing his/her previous consent to this type of facility. Alternative imprisonment has become an option for humane as well as crime-preventive reasons. First of all, it is desirable that the convicted offender, although serving a prison sentence, receives required treatment. Secondly it serves a purpose that the prisoner receives a treatment likely to improve this person's chances of managing a life without crime after release and thus utilize a sentence period to have the convicted offender treated for crime-promoting factors such as drug or alcohol abuse.

The convicted offender may be placed in a treatment institution outside the auspices of the Prison and Probation Services as well as in the hostels run by the Prison and Probation Service.

Consolidated Act no. 571 of 5 July 2002 on the placement of convicted offenders to an institution, etc. outside prison or local prison (Section 78 Act) and the associated circular no. 94 of 16 May 2001 on the admission of convicted offenders in institution outside prison or local prison specify the rules of implementation.

The request for serving a sentence under Section 78 of the Danish Corrections Act must be filed either by one of the departments of the Prison and Probation Service in freedom, by a local prison or by a treatment institution. Prior to its submission or approval by the Ministry of Justice, the Directorate of the Prison and Probation, an agreement must be made with the requested institution and, where possible, advance payment guarantee must be issued by the county or municipality, in which the convicted offender resides.

The parent institution

A parent institution is one of Denmark's 13 prisons. If the sentence has been served in a prison, from which the drug abuser is transferred to a Section 78 prison, this prison would typically be the parent institution. As a parent institution, the prison must issue a certificate of residence to the convicted offender, carry out calculation of punishment if imprisonment has not already been initiated, treat any possible issues on recall or transfer from the institution to the parent prison or an alternative prison or local prison, recommend revocation of Section 78 judgement to the Directorate if the drug abuser has breached the terms of sentence and treat any issues on parole, pardoning and parole from secure custody.

Furthermore, the referring party and the imprisoned drug abuser must prepare an action plan, ie a plan to be followed upon termination of the sentence and the time after release under Section 2 (s 2) the rules of the Danish Corrections Act. During the Section 78 placement, the action plan should be coordinated with the home municipality of the convicted offender and where necessary the county abuse centre so as to ensure consistency between the action plans of the Prison and Probation Service and the county/municipal authorities.

The possibility of serving a sentence under Section 78 will typically be considered as part of the plans for re-integration of the prisoner into society. Reintegration is prepared and organised under action plan work during imprisonment and will primarily be used in cases where, in addition to the reintegration efforts, there is a need for treatment of either abuse and/or social and personal problems.

If a – typically short-term – convicted offender who is sentenced to a treatment institution under Section 78 is still at liberty after the order, this person will often be placed directly in a treatment institution already from the start of his sentence. In certain instances, the referral and case procedures are the same as described above. The Director of Prison and Probation Services appoints a prison to be the parent prison.

The Prosecution

In certain instances, the Prosecution must be heard before any decisions are made on a Section 78 sentence. This applies in particular if the person has committed an offence against persons or offences of a generally hazardous nature, has committed a sexual offence as well as offences of a particularly aggravating or professional nature, where the institutions under the Prison and Probation Service would be under an obligation to hear the Prosecution in connection with the question on temporary leave. Normally, the Prosecution will be sympathetic towards Section 78 placement.

Supervision and social authorities

Basically, one of the Prison and Probation Service departments in freedom will be responsible for supervision. The department's work of supervising a Section 78 prisoner will typically be to make sure that the drug abuser complies with the terms stipulated for that particular person. This is typically terms of observing the institutional rules, follow the treatment or the activities provided at the institution, not to leave the institution unless this has been agreed with the staff and not to commit new offences. If the Probation Officer finds that the person in question violates the terms stipulated for his/her stay at the treatment institution, he or she will be recalled or transferred to the parent institution. The same applies if the drug abuser is expelled from the treatment institution, eg if he/she violates the terms stipulated for his/her stay.

Finally, if the drug abuser so wishes, he/she shall immediately be recalled – if he/she has been placed directly in the treatment institution after the start of the sentence – transferred to the parent institution.

Furthermore, the supervisory authority must in collaboration with the parent institution, cf above, prepare the release of the drug abuser as an integral part of the action plan, and establish contact to the social authorities, apply for financial benefits in connection with his/her release, apply for financial compensation for expenditure to after-treatment, etc. In connection with the considerations on a possible parole, pardoning or parole from security custody, the Supervision must provide a statement to the parent institution and suggest terms of release, including the duration of a possible supervision. This type of imprisonment is paid by the drug abuser's local municipality.

Public debate

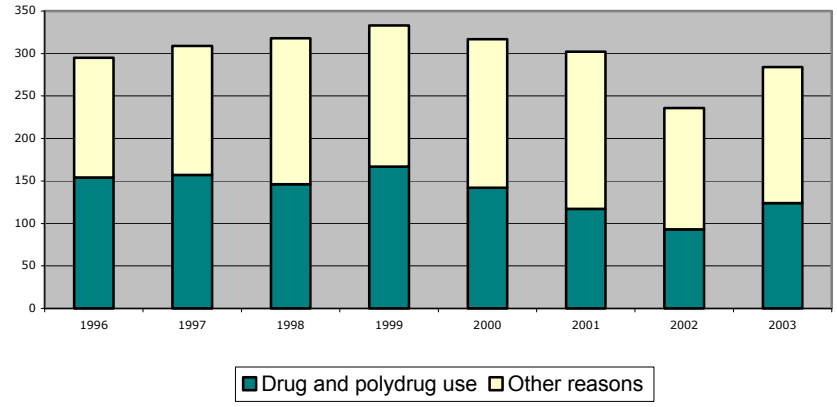
Sentencing drug abusers to prison conditional upon treatment has not given rise to a special debate in the media. In Denmark, the attitude towards drug abusers - including criminal drug abusers – being subjected to treatment is generally positive. The debate in the media has focused on the problems involving drugs in prisons and the measures to be taken to cut down on the prevalence of drugs in the prisons.

12.3 Interventions

The idea of having certain convicted offenders serve their sentence in a treatment institution rather than in prison has been applied since 1985. Since the middle of the '90s, approximately 300 people have served their sentence in treatment, with approximately half of these treatments being founded on drug abuse.

The figure below shows the development in the us of imprisonment conditional upon treatment in general and compared to the number of imprisonments based on the indication of drug and polydrug use. It should be noted that the figure includes Section 78 placements at the hostels of the Prison and Probation Service as well as at the inpatient institutions in the mainstream treatment system. Approximately 1/4 of these imprisonments were served at the Prison and Probation Service's own hostels, whereas the remaining sentences were served at the inpatient institutions outside the Prison and Probation Service.

Figure 12.3.1. Section 78 placements



Source: The Prison and Probation Service statistics 2001, 2002 and 2003.

The Danish Corrections Act does not specify the types of institutions to be used for sentences conditional upon treatment. In practice, socio-educational inpatient institutions are used within the mainstream treatment system, including private treatment institutions. Many of these institutions apply the Minnesota-based treatment principles. Also, the Prison and Probations Service's own hostels are used.

Since Denmark introduced treatment guarantee in 2002 for drug abusers, the Prison and Probation Services has not had any problems finding treatment slots for drug abusers that were placed in a treatment institution.

The staff employed in the institutions used by the Prison and Probation Service are primarily people with a socio-educational background. The key part of the personnel are social teachers. There are also social workers, psychologists and doctors. The Minnesota-based treatment institutions use to a wide extent former drug abusers as therapists. They have often completed therapist training. In the Prison and Probations Service's own hostels, the staff are typically educational assistants, social workers and prison officers.

Guidelines for proper treatment

In 2000, the Prison and Probation Service published "Principles governing the treatment of drug abusers under the Prison and Probation Service". These principles contain a description of the overall principles governing drug treatment in the Prison and Probation Service. The Prison and Probation Service finds it of great importance that the principles for treatment of drug abusers appear as an integral part of the Service's general principle programme and must be able to be used in the daily work routine by staff at all levels. The overall treatment principles must lead to a joint commitment to the treatment activities carried out in all institutions and by the staff at the Prison and Probation Service, create a framework for development, including the development of professional competencies with the staff at the Prison and Probation Service, secure equal possibilities for treatment services provided to the entire clientele of the Prison and Probation Service, improve relations to and collaboration with the mainstream treatment system, secure a balancing between punishment and crime preventive treatment, generate visibility as regards the Prison and Probation Service's policy on treatment provided to the public, clients/inmates and staff, optimisation of resources, and provide the management/managements with a control and measurement tool.

These principles does not only apply to the treatment of drug abusers, but also to the treatment services provided by the Prison and Probation Service in general, and they have been sent to the Service's collaboration partners within the mainstream treatment system.

Treating applications for a Section 78 placement always includes a judgement of the nature of the offence and the length of the sentence in relation to security and the general sense of justice. When this has been established, the motivation of the convicted offender as well as his/her ability to complete treatment is assessed. Apart from this, there are no restrictions facing the target group of drug abusers; all abusers, irrespective of kind of abuse, the person's age, gender or other conditions will be considered eligible for treatment. Thus, the important thing is not to be drug free, under detoxification, in substitution treatment or active abuser in order to be deemed eligible for treatment. The whole idea of the scheme is that the treatment programme must match the needs of the individual, which is in line with the Prison and Probation Service's treatment policy.

12.4 Quality Assurance

The institutions under the Prison and Probation Services report all placements under Section 78 regularly to the Directorate of Prison and Probation Services. These reports show that in 2003, there were 124 individuals placed on the indication of drug abuse and polydrug use. During the previous years, approximately ¾ of these persons were placed in municipal and county institutions, etc. whereas the rest were placed in the hostels under the Prison and Probation Service. The reports are

being put into an internal system and a more detailed debriefing is currently under preparation.

A study conducted by the Centre for Alternative Social Analysis on the consequences of the Section 78 scheme, which ran over a 2-year period from 1998 to 2000, shows that repeat offences occurring within 2 years was significantly higher for the group of drug abusers than for the other placements. 53% of the drug abusers committed repeat offences compared to 44% of all those placed under the Section 78 scheme. The study also revealed that the drug users had a lower completion rate than the other groups.

For the drug users, repeat offence rates varied significantly between those who start at liberty, and the drug abusers enrolled in the programme from imprisonment. Those who started at liberty reached an average repeat offence rate as low as 44%, whereas those who were placed under Section 49 (s 2) after a stay in prison accounted for a repeat offence rate that was 21% higher than the average rates. The authors of the study believed that the reason for the different rates was that starting the programme at liberty means that the individual was already enrolled in the treatment programme and had been so for a long time. Consequently, the offenders under the Section 49 (s 2) scheme were highly motivated to complete their sentence programme as part of the treatment.

Throughout the study it was observed that the drug abusers are not placed under Section 49 (s 2) until late in their careers, which could be explained by a relatively late motivation for treatment (which is consistent with the experience made in the remaining society). The study points out that it is a well-known fact that it is often difficult to fight one's way out of drug addiction, and that many abusers will have to go through numerous treatments before they succeed (if at all). The drug abusers' results in the repeat offence study must be assessed on the basis of these factors.

DanRIS

In 2003, a total of 287 persons were placed in a treatment institution under Section 78 of the Danish Corrections Act. 124 of them were placed on the indication of drug abuse/polydrug use. A large portion of them were placed in institutions affiliated with DanRIS (the Danish Registration and Information System). An outline of the convicted offenders placed in institutions under the DanRIS-system is provided below.

In 2003, a total of 1179 different persons were registered as enrolled in inpatient treatment in at least one of the 34 inpatient institutions submitting data this year to DanRIS . For 94 of them, ie 8% of the whole group, the treatment is an alternative to prison (Section 78). The figure may be a trifle higher, but the overall picture of 8% being enrolled in inpatient treatment, appears to be realistic.

The 94 Section 78 clients were significantly younger than other clients in inpatient treatment (29.1 years compared to 32.5 years), and the number of women among them was significantly lower (12 % compared to 28%) . Out of the 94 who were registered in 2003, 64 had completed the programme since the recent update in March-April 2004. They had on average been enrolled for 91 days, which is no different from the drug abusers in inpatient treatment in general. Among these 64 people, 31% completed treatment as planned, whereas the remaining group accounted for 37%. The difference is not statistically significant. A look at the factors

of gender and age shows that slightly fewer Section 78 clients complete treatment as planned than others – but not significantly fewer.

Upon initiation of treatment, 87 of the 94 have completed the structured interview, EuropeASI (European Addiction Severity Index). In general, their use of drugs and alcohol has been lower the past 30 days up to enrolment than other clients in inpatient treatment, which might be due to the fact that most of them arrive directly from prison (53% are reported as arriving directly from prison). The fact is also that the Section 78 clients also feel significantly less addicted to drugs and alcohol on enrolment at the inpatient institution than other clients. As far as crime is concerned, they perceive their situation as much more problematic than others, with a significant need for help within this particular problem severity area. They are significantly less depressive than other clients, and they receive much less prescription medication at the start of their inpatient stay. In general, they appear to be less mentally impaired (ie much less suicidal), with their general appearance, however, seeming somewhat "pushy" (more violent – however this is not significant). There are no differences in the physical or social problem areas of Section 78 clients compared to the other clients enrolled in inpatient treatment. In summary, the Section 78 clients can be compared with the other inpatient clients by comparing their total EuropASI severity ratings as shown in the table below

Table 12.4.1. Eight problem areas

	Inpatient, others n = 774	**Inpatient, Section 78 n = 87**	
Drugs	0.47	0.41	p,01
Alcohol	0.22	0.14	p,01
Crime	0.25	0.42	p,0000
Family	0.37	0.34	
Other network	0.34	0.33	
Economy	0.88	0.89	
Mental	0.48	0.42	p,03
Physical	0.36	0.30	

Minimum score is 0 and maximum score i 1 (maximum severity). Severity does not necessarily mean that the abuser currently has a large consumption of drugs or has committed criminal offences (although this may increase severity significantly). It may also mean that the individual experiences problems in relation to drug abuse (for instance, needs help to remain drug free) or that the individual is waiting to serve a sentence.

As it appears, the Section 78 clients have less drug, alcohol and mental problems, whereas their crime severity score is higher. This high rate includes those arriving directly from prison, but most of all and rather significantly, these individuals report needing help to resolve their situation in this particular area.

13 ”Public nuisance” definitions, trends in policies, legal issues and intervention strategies

13.1 Introduction

Danish law sets out a number of rules, the aim of which is to protect the general public against behaviour perceived as disturbing the public order. The rules are primarily of a general nature and thus not targeted at behaviour associated with drug trafficking and abuse. Although the general legislation pertaining to disturbance of peace and order is vital, this chapter will only deal with the drug-related parts of the law, including the initiatives on a future legalisation of the autonomous community “Christiania”. However, a brief introductory outline of the general legislation will be provided in the lines below.

Pursuant to Act no. 444 of 9 June 2004 on police activities, it is the task of the police to prevent and stave off disturbance of the public order. The law sets out a number of provisions, according to which the police may intervene so as to prevent and avoid any risk of disturbing the public order.

A number of general rules have also been stipulated on public order in the local police regulations applicable to public streets, roads or squares and public places, to which public access is granted. From the local police regulations it appears, among others, that it shall be prohibited to use any conduct that may be deemed capable of disturbing the public order or cause any inconvenience to other individuals present or to the neighbours.

Furthermore, the more general rules include Consolidated Act no. 163 of 11 March 2003 on restaurant and hotel business, etc as subsequently amended. According to the Act, it is deemed an offence if a person in a restaurant, hotel, and other dining facilities, to which public access is granted, uses a conduct that is deemed capable of disturbing the public order or causing any inconvenience to other individuals present.

In addition, Danish law has set out rules and launched initiatives more targeted at protecting against disturbance of the public order via behaviour associated with drugs trafficking and abuse.

One of the resulting laws is Act no. 471 of 7 June 2001 on the prohibition against visitors in certain localities, also know as the “Cannabis Club Act”, according to which the police may impose an injunction on visitors in certain premises subject to the fulfilment of more specified conditions. One of the requirements is that the injunction must be addressed to an undertaking systematically carrying out punishable offences and which is capable of causing inconvenience and insecurity in the neighbours.

Another element in policing of public order relates to the area in Copenhagen known as ”Christiania” (autonomous community) where overt cannabis trading has been going on for a number of years now. The pivotal focus of the government’s new policy on Christiania is to normalise the area as a part of Copenhagen. Normalising the area would mean, among others, an establishment of the normal infra-

structure, change of ownership to land and buildings at Christiania, refurbishment and modernisation of the buildings that will remain on the area and stop the overt cannabis trafficking.

In this connection, police intervention at Christiana has been intensified drastically in order to stop the overt cannabis trade and create a basis for normal, uniformed patrolling in the area.

13.2 Legislation regulating specifically drug-related disturbance

The Act no. 471 of 7 June 2001 on the prohibition against visitors in certain premises, also known as ”the Cannabis Club Act” renders it possible for the police to impose an injunction against receiving visitors or staying as a visitor in or in the immediate vicinity of premises in which activities are conducted in a manner that systematically involves punishable action and which are capable of causing inconvenience and insecurity in the neighbourhood.

The purpose of the Act is to ensure that more efficient action can be taken against the so-called cannabis clubs and other kinds of organised, criminal activity associated with certain premises and which is capable of causing inconvenience and insecurity in the neighbourhood.

The Danish Rental Act was amended accordingly so as to add to the Act a special provision allowing for the termination of a lease in the event that the police has issued an injunction and the lessor or other person is punishable for having received visitors in the premises.

The rationale behind the legislation

The rationale behind the Act was that in the years before the Act was adopted, the police had seen a significant increase in the number of so-called “cannabis clubs”, particularly in Copenhagen and other major cities.

A ”cannabis club” is a room, from which cannabis is sold and/or in which cannabis is smoked. The information then provided by the police suggested that several places were involved in organised selling of drugs as well as handling of stolen goods l. Police information also suggested that to a wide extent there was a connection between the “cannabis clubs” and the biker and street gang environment .

Furthermore, the police had information that these “cannabis clubs” were regularly visited by young people under the age of 18 and that 15-year-olds had been seen in the clubs as well.

Prior to the adoption of the law, the police had tried to fight the ”cannabis clubs” by intensifying police intervention against the clubs. However, this showed that although intervention to some extent could prevent against the problems associated with the “cannabis clubs”, it could not quite solve it. The reason was that police interventions under the rules applicable at the time had to be targeted at individuals in particular rather than against the cannabis club activities in general.

Based on these conditions, the Government found that in consideration of the police as well as the residential dwellers, priority should be given to ensuring that more effective intervention could be made against the almost shop-like, systematic

crime that was being perpetrated in the ”cannabis clubs”, etc given that these types of criminal activity were known to cause insecurity in the neighbourhood and was capable of furthering general brutalisation and criminal behaviour in the near environment. On this basis, a bill was proposed and, as mentioned earlier, adopted on 7 June 2001.

Conditions of imposing injunctions

According to Section 1 (s 1) of the law, a number of conditions must be fulfilled in order for the police to issue an injunction. An injunction may thus only be issued on the condition that if in certain premises activities are carried out in a manner systematically involving punishable action and capable of causing inconvenience and insecurity in the neighbourhood. Also it is a condition that the person in charge of the premises receives a warning prior to the issue of an injunction.

As regards the expression *“systematically involving punishable action”* it is mentioned that it is not required that anybody has been punished for offences committed as part of the actual punishable action, or that somebody later have been punished for it. However, evidence must be produced that activities systematically involving punishable action are being carried out.

It is also pointed out that the term *”systematical”* implies that the activity in question must be carried out frequently and regularly. Also, the criminal offences must be of a rather significant magnitude and the activity – without necessarily having to be commercial – appearing as a significant objective for using the premises in addition to possible residential use or other legal use.

In order to impose an injunction, the activity in question must be carried out in a manner ”*which is capable of causing inconvenience or insecurity in the neighbourhood*”. From the circular order related to the Act it appears that on the assessment hereof, allowance should be made for whether the activity being carried out in the premises furthers a behaviour which is in fact capable of affecting the near environment in a manner that typically causes insecurity in the neighbourhood and furthers overall brutalisation of the near environment.

In the commentary on the bill it is stated that the conditions will normally be fulfilled if in the premises cannabis or drugs are being sold, or if more comprehensive and organised procuring or prohibited gambling is taking place which in a similar manner may significantly contribute to a near environment characterised by crime, abuse and/or violent behaviour.

An injunction can only be imposed if such an injunction is directly related to the activity in question. The activity involving punishable offences must thus be associated with the reception of customers/visitors in the premises as is the case with the activities mentioned above. An injunction imposed on visitors can therefore not be used against the commercial business because the company violates certain environmental provisions on production, even though the punishable offences are capable of causing insecurity in the near environment.

An injunction can only be imposed if the police have already warned the person who has the premises at his disposal (the owner, or, if the activity is carried out in rented premises, the lessor or sublessee). If an association or other legal body acts

as lessor, the warning must be given to the person authorised to represent the association.

A ban does not only apply to the premises, but also to the immediate surroundings. This also means that the stairs and outdoor premises, etc – for instance a garage or outhouse – built next to the premises and linked together with them – will be comprised by a ban.

Violation of the Cannabis Club Act

Pursuant to Section 4 (s1) of the Act, violation of a ban shall be punishable by a fine. If the offence is repeated, punishment may be raised to imprisonment for up to 4 months. If a person once again violates a ban after having been punished for the same, the offence, in accordance with the general commentary on the proposal, will be punished by imprisonment. Negligent offences may be punishable as well.

It follows from the general rules on mens rea (intent and negligence) and complicity that he who disposes of the premises will, under the circumstances, be liable for punishment, although it is not the person himself who has received visitors on the premises.

In the event that visitors are met in the premises under such circumstances that the mens rea (intent or negligence) is fulfilled, such persons will be informed that an injunction has been imposed, and the rules of mens rea deemed to be fulfilled if the persons in question appear again at the premises.

13.2 Intervention at Christiania

Christiania comprises an area of approximately 34 acres of Christianshavn in the middle of Copenhagen. This area, which comprises the majority of the former Bådsmandsstræde Barracks and the former Ammunition Area, is owned by the Ministry of Defence.

The armed forces left this area in the early summer of 1971. Shortly after, the area was illegally occupied by activists, and on 26 September 1971, the autonomous community of Christiania was "founded". On 1 April 1976, the Ministry of Defence initiated proceedings with the aim of having the occupants evicted. This case ended on 2 February when the Danish Supreme Court upheld the ruling of the Danish High Court that the occupants of Christiania should leave the area immediately. The ruling, however, was never enforced. In February 1978, the Danish Parliament decided to draw up a local plan for the area. In the meantime, the community was allowed to exist under special conditions which were announced in the Danish Official Gazette. The closing of Christiania was regularly put to debate in the Danish Parliament in the subsequent years, but these debates never really led to any change in the policy on Christiania.

Throughout a large number of years, overt cannabis trade has been taking place in Christiania. Trading activities have been carried out from a number of booths which were erected in the socalled "Pusher Street". Furthermore, it has for some years now not been possible to perform ordinary uniformed policing in the area, given that this has often resulted in confrontations with people at Christiania.

As regards police intervention, it was decided in October 1995 – based on the confrontations with the police at Christiania – to reassess police intervention and de-

fine a new overall, long-term strategy with the aim of normalising conditions at Christiania so that they were more in line with the rest of Copenhagen.

The aim was, through police actions, to stop the overt cannabis trade and to apply systematic investigation routines to unveil organised drug crime structures. Another objective was to maintain police presence in the area and thus create a basis for normal police patrolling at Christiania.

In 2002, the situation at Christiania was discussed between the Ministry of Justice and Copenhagen Metropolitan Police Force with a view to intensifying intervention. As a result of these discussions, police intervention was increased, and in 2002 – by utilising the presence of police forces on account of the Danish EU chairmanship - a very large number of police raids were carried out against cannabis trafficking at Christiania. Also initiatives were launched as regards a more active and direct dialogue between the police and Christiania.

The police raids uncovered numerous crime structures and networks, including relations to the biker environment. A large number of criminal proceedings were heard and considerable seizures made.

As regards the overt cannabis trade, the police, however, learned that the cannabis trade at Christiania only had a limited and short-term effect given that cannabis trade activities were resumed already a few hours after a police raid had ended.

The police also assess the large-scale cannabis trade to be the key reason why the police had such difficulties in completing ordinary patrol routines in Christiania.

Report on Christiania

On 6 May 2003, the Minister of Justice and the Minister of Defence submitted a report on Christiania, from which it appears that the Government has reached the overall conclusion that in spite of police intervention throughout the past years, it has not been possible to create the basis for normal, uniformed police patrolling and that normalisation of the conditions in the area and police intervention vis-a-vis the overt cannabis trade have more or less proven futile. Moreover, it reads that throughout the past year, several criminal structures have been revealed, including relations to the biker environment. Finally, the report points out that actual legalisation of the area within the current framework is deemed to require extraordinarily high police resources, most likely for a period of longer duration.

The report states that the pivotal focus of the government's new policy is a normalisation of the area as a part of Copenhagen – and as an integral and accessible part of Christianshavn – for the benefit of all citizens. It is also stated that a normalisation will, among others, require the establishment of a normal infrastructure, change of ownership of land and buildings at Christiania, refurbishment and modernisation of the buildings remaining on the premises and termination of the overt cannabis trade.

13.3 Evaluation of the regulatory effect

Cannabis clubs

No national surveys have been conducted on the effect of the Cannabis Club Act, but on 24 June 2003, the Ministry of Justice - after having heard the Commissioner

of the Copenhagen Police – submitted its reply to question no. 3699 from the Danish Parliament on whether the Act had effectively contributed to fighting the cannabis clubs in Copenhagen, or whether there was a need for further action.

In the reply submitted by the Ministry of Justice, it was stated that the Commissioner had informed the Ministry of Justice that since the Act was adopted, 95 cannabis clubs were registered in Copenhagen, of which only 30 cannabis clubs exist. It was also stated that the Commissioner had reported that a large part of the cannabis clubs had already closed when the police started to look into whether crime was being committed, and when searches were made and charges raised for violating the Euphoriant Substances Act. Other cannabis clubs continued operations until they were shut down by administrative intervention, either having been given a warning or – for only a few of them – after an injunction had been imposed. The Commissioner also reported that during the period after the Act had come into force and up until June 2003, 26 warnings were issued and 9 injunctions imposed in Copenhagen, and the court passed a number of sentences on violation of injunction. Finally, the Commissioner's report stated that the Commissioner has informed the Ministry of Justice that in the Commission's opinion, the current legislation is a useful and adequate intervention tool in the combat against cannabis clubs, and there appears to be no basis for recommending additional intervention as regards the cannabis clubs.

Since the Cannabis Club Act came into force, certain police districts report that once an injunction has been imposed pursuant to the Act, the cannabis has been sold outdoors instead. This is often done by the person at the address of the closed cannabis club refers visitors to a park or square nearby where the visitor will be able to buy cannabis from persons affiliated with the closed cannabis club.

In these cases, the police have searched the persons on the spot and searched the area, and on several occasions they have found large quantities of cannabis hidden in trees and bushes close to where the person is standing.

An injunction under the Cannabis Club Act comprises receiving and staying in or "in the immediate vicinity of" the premises in question. This means staying in stairways or in outdoor areas of end-to-end buildings. An injunction under the Cannabis Club Act will thus not comprise a nearby park or square.

On this basis, the police have in certain instances issued an injunction against certain individuals, whereby they have been barred from staying in areas under the rules described in section 13.3, according to which – pursuant to the bylaws of certain police districts – can be imposed a long-term injunction against staying in certain areas.

Christiania

As a follow-up on the Christiania report, the Copenhagen Metropolitan Police has carried out a large number of raids at Christiania. The purpose of these raids has primarily been to seize any cannabis on the premises and to arrest the dealers. From January to April 2004, the police made 182 arrests at Christiania and 142 charges were raised for violation of the Euphoriant Substances Act under Section 191 of the Danish Criminal Code. During the same period, the police seized 76.5 kg cannabis, 21.4 kg other narcotic substances and 14.654 joints as well as approximately DKK 198,000.

Furthermore, activities have been launched in the area surrounding Christiania in order to deal with the problems in this area. The aim of these activities is also to prevent against cannabis dealing at Christiania and to make it difficult to buy and sell cannabis at Christiania. The rationale behind this is that throughout the past years it has been observed that Christiania's near environment to an increasing extent has been negatively affected by developments, and thus that it is not only Christiania which is a problem for the police, but also the area surrounding it. Traffic and parking facilities that can be ascribed to the conditions at Christiana thus pose a problem to the police as well.

Therefore, Copenhagen Municipality and the police have launched targeted interventions at the problems mentioned above. This has resulted in more permanent traffic control in the area surrounding Christiania where the police – in addition to actual traffic control – have used drug dogs and searched individuals and vehicles for the presence of cannabis at times of the day when cannabis sales were known to be particularly widespread.

Furthermore, periodical patrolling of special areas has been carried out around Christiana with police dogs, and drug dogs, with the intent of demonstrating police presence in the near environment and at the same time uncovering cannabis depots, if any.

Finally, on 16 March 2004, the Copenhagen Metropolitan Police conducted one of its hitherto largest raids against cannabis trade at Christiania. This raid was the culmination of several months' investigation in cannabis dealers and the men pulling the strings. The raid took place at Christiania, but also at several other addresses in Copenhagen and Zealand, and more than 50 persons were arrested and charged with, primarily, cannabis trade. 46 persons were remanded in custody. After this raid it turns out that the overt cannabis trade at Christiania has decreased somewhat. On 30 April 2004, the first sentence was passed in this whole case complex. The person in question was sentenced to 2 years and 6 months' imprisonment for dealing in cannabis.

14 Annex

14.1 List of references

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14.2 Websites

County websites on drugs: www.netstof.dk

The Association of County Councils: www.arf.dk

Centre for Drug and Alcohol Research: www.crf.au.dk

Danris: www.danris.dk

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

The Danish Crime Prevention Council: www.crimprev.dk

The Danish Ministry of Justice: www.jm.dk

Copenhagen County – Treatment centre for drug abusers www.kabs.dk

Mindblow: www.mindblow.dk

Police Drug Statistics: www.politi.dk

The Council for the Socially Marginalised People: www.udsatte.dk

The National Institute of Public Health: www.si-folkesundhed.dk

The National Board of Health: www.sst.dk

14.3 Supplementary tables

Table 2.1.1. The percentage of women and men in the various age group who have tried cannabis within the past year in 1994 and 2000				
		1994 n=2.521	2000 n=6.887	Denmark's population in the age groups in 2000
16-19-year-olds	Men	19	29	115,366
	Women	**10**	**20**	**111,110**
20-24- year-olds	Men	14	24	172,217
	Women	**9**	**12**	**167,570**
25-29- year-olds	Men	8	16	194,097
	Women	**5**	**6**	**189,304**
30-34- year-olds	Men	9	10	212,026
	Women	**2**	**3**	**202,174**
35-39- year-olds	Men	6	8	206,094
	Women	**2**	**2**	**197,150**
40-44- year-olds	Men	5	4	189,995
	Women	**2**	**2**	**183,597**
All 16-44 year-olds	Men	10	14	1,089,795
	Women	**5**	**6**	**1,050,905**
	All	7	10	2,140,700

Source: Kjøller & Rasmussen 2002 and Statistics Denmark

Table 2.1.2.The percentage of the 16-44-year-olds who last month and last year have used one or several illicit drugs other than cannabis in 1994 and 2000.		
Used one or several of the illicit drugs other than cannabis	1994 (n=2.521)	2000 (n=6.878)
Last month	0.2	1.2
Last year (last month included)	0.5	3.4

Source: Unpublished figures from SUSY 1994 and SUSY 2000

Table 2.1.3. The percentage of the 16-44-year-olds who have tried one or several of the various illicit drugs within the last month, last year and ever in 2000 (n=6878)			
	Last month	Last year (last month included)	Ever
Amphetamine	0.6	2.2	8.4
Cocaine	0.4	1.4	3.8
Psilocybin mushrooms	0.2	0.8	3.7
Ecstasy	0.2	0.7	1.7
LDS	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 covers GHB, various medicine, etc.
** An aggregate category including ”used an illicit drug other than cannabis”.

Table 2.1.4. The percentage of the 16-24-year-olds who have tried one or several of the various illicit drugs within the last month, last year and ever in 2000 (n=1786)

	Last month	Last year (last 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
” Illicit drugs other than cannabis ”total	2.9	7.7	14.0

Source: Unpublished figures from SUSY 2000

*The category ”Other” drugs covers GHB, various medicines, etc

Table 6.4.1. Number of newly diagnosed HIV positive and AIDS diagnosed individuals in the entire population and the number of intravenous drug users among this group 1993-2003.

	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
Newly diagnosed HIV positive persons, total	331	298	304	268	273	212	285	260	319	290	266[26]
Newly diagnosed HIV-positive with intravenous drug use (% of all newly diagnosed)	24 (7%)	28 (9%)	34 (11%)	25 (9%)	30 (11%)	13 (6%)	26 (9%)	20 (8%)	31 (10%)	32 (11%)	24 (9%)
Newly diagnosed AIDS cases	239	237	213	159	109	74	76	57	72	43	37
Newly diagnosed AIDS-positive with intravenous drug use (% of all newly diagnosed)	21 (9%)	24 (10%)	28 (13%)	18 (11%)	11 (10%)	4 (5%)	7 (9%)	7 (12%)	11 (15%)	4 (9%)	11 (30%)

Source: Unpublished data from the State Serum Institute.

[26] The figures that are compiled for 2003, are from 25 August 2004.

Table 6.4.2. Registered number of acute cases of hepatitis A, B and C in the entire population and the percentage of intravenous drug users among them , 1993-2003

	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
Hepatitis A cases, total	227	145	103	107	115	86	88	81	61	84	70
Hepatitis A cases with intravenous drug use (% of all diagnosed)	24 (11%)	6 (4%)	1 (1%)	0	0	0	0	0	0	1 (1%)	0
Hepatitis B cases, total*	105	115	112	101	101	94	58	63	47	63	34
Hepatitis B cases with intravenous drug use (% of all diagnosed)	36 (34%)	49 (43%)	39 (35%)	36 (36%)	30 (30%)	25 (27%)	13 (22%)	20 (32%)	11 (23%)	11 (18%)	12 (35%)
Hepatitis C cases, total*	65	84	36	28	26	21	13	15	6	5	7
Hepatitis C cases with intravenous drug use (% of all diagnosed)	49 (75%)	61 (73%)	27 (75%)	20 (71%)	20 (77%)	13 (62%)	11 (85%)	9 (60%)	3 (38%)	4 (80%)	2 (29%)

Source: Unpublished data from the State Serum Institute. The 2003 data have been complied as at 25 August 2004.
*Among the acute hepatits B and C, there is a certain intersection.

Table 10.3.1. Drug seizures 1991-2003

	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
Heroin													
Kg	30.8	38.5	28.2	29.0	37.4	61.4	37.9	55.1	96.0	32.1	25.1	62.5	16.3
Number of seizures	1,735	2,405	2,941	2,666	2,973	3,161	2,509	2,199	1,230	1,499	1,304	966	894
Cocaine													
Kg	39.6	21.4	11.1	29.9	110.1	32.0	58.0	44.1	24.2	35.9	25.6	14.2	104.0
Number of seizures	144	184	228	417	569	659	723	885	744	780	815	881	1095
Amphetamine													
Kg	23.6	73.6	11.7	12.6	40.0	26.7	119.4	25.2	31.6	57.1	160.6	34.9	65.9
Number of seizures	1,345	1,323	1,111	747	1,167	1,386	1,324	1,609	1,250	1,152	954	1,134	1,264
Ecstasy													
Kg					2,115	15,261	5,803	27,039	26,117	21,608	150,080	25,738	62,475
Number of seizures					9	84	110	143	197	444	331	340	322
LSD													
Doses					1,282	262	381	105	83	1.108	156	38	22
Number of seizures					6	16	15	24	15	18	29	8	7
Cannabis													
Kg	1,703	2,152	1,273	10,665	2,414	1,772	467	1,572	14,021	2,914	1,763	2,635	3,829
Number of seizures	9,222	9,870	10,938	6,995	6,710	5,187	4,886	5,904	4,569	5.561	5,788	5,234	5,942

Source: Police Drug Statistics 2003.

10.3.3. Breakdown of heroin base and heroin chloride from 1996 – 2003

	1996* (n =120)	1997* (n =30)	1998* (n =118)	1999* (n =97)	2000 (n =82)	2001 (n =69)	2002 (n=80)	2003 (n=73)
Heroin base	70%	68%	72%	71%	61%	77%	76%	84%
Heroin chorid	30%	32%	28%	29%	39%	23%	24%	16%

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 g Kaa et al. 2003, Kaa et al. 2004
*In 1996, 1997, 1998 and 1999 figures were included from Elsinore Police District.

14.4 List of Tables

14.5 List of figures

14.6 Applied studies

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

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

"Sundhed og Sygelighed i Danmark 2000 – og udviklingen siden 1987" Statens Institut for Folkesundhed (SIF), (Kjøller & Rasmussen 2002). [Health and morbidity in Denmark 2000 and since 1987]
A national study was conducted in three data collection rounds in February, May and September 2000 among a representative segment of the Danish population aged 16 and above. The study included as in 1994, questions on a variety of health issues. The sample population of a total of 22,486 persons was selected in three random sampling rounds. Data collection was performed as personal interviews in the homes of the respondents. In addition, the respondents were provided with a questionnaire, which they themselves were requested to fill in and submit. In the self-administered questionnaire, the questions on drugs were put to all age groups. Interviews were made with 16,690 persons – a total response rate of 74.2%. The self-administered questionnaire was completed by 63.4% of the selected respondents.

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

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

"Monitorering af unges livsstil og dagligdag 2002" (MULD 2002), Sundhedsstyrelsen and Kræftens Bekæmpelse, unpublished. [see above]
In 2001, the National Board of Health and the Danish Cancer Society once again conducted a representative study on the lifestyles and daily routines of young people aged 16-20 years. The sample population of ¤ young people between the age of 16 and 20 years was selected systematically. Data collection was made on the basis of questionnaires. The response rate was approximately 70%.

Monitorering af unges livsstil og dagligdag 2003" (MULD 2002), Sundhedsstyrelsen and Kræftens Bekæmpelse, unpublished.
Again in 2003, the National Board of Health and the Danish Cancer Society conducted a representative study on the lifestyles and daily routines of young people aged 16-20 years. The sample population of 1768 young people aged between 16 and 20 was selected systematically. Data collection was made on the basis of questionnaires.

"The 1995 ESPAD report – Alcohol and Other Drug Use Among Students in 26 European Countries" (ESPAD 1995), CAN and Pompidou Group (Hibell et al. 1997)
As part of a joint European study (The European School Study Project on Alcohol and Other Drugs) a national school study was conducted in 1995 on the young people and their relationship with drugs. The study was conducted among a representative segment of 15-16-year-olds in 9th grade at randomly selected "folkeskoler", private schools and continuation schools. Data collection was performed by handing out the questionnaires to the interviewees in the classrooms. A total of 2234 pupils participated in Denmark, which equals a response rate of approximately 90%.

The 1999 ESPAD report – Alcohol and Other Drug Use Among Students in 30 European Countries" (ESPAD 1999), CAN and Pompidou Group (Hibell et al. 2000).
In 1999, the study from 1995 was repeated among a representative segment of 15-16-year-olds in 9th grade at randomly selected "folkeskoler", private schools and continuation schools. Data collection was performed by handing out the questionnaires to the interviewees in the classrooms. A total of 1548 pupils participated in Denmark, which equals a response rate of approximately 90%.

The 2003 ESPAD report – Alcohol and Other Drug Use Among Students in 30 European Countries" (ESPAD 1999), CAN and Pompidou Group (unpublished).
In 2003, the studies from 1995 and 1999 were repeated among a representative segment of 15-16-year-olds in 9th grade at randomly selected "folkeskoler", private schools and continuation schools. Data collection was performed by handing out the questionnaires to the interviewees in the classrooms. A total of 2519 pupils participated in Denmark, which equals a response rate of approximately 89.2%

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

ESPAD 1995 and included pupils in the 9th grade. Therefore, in addition to the 15-16-year-olds, pupils aged 14-17 were also included, since they attend the 9th grade as well. The number of participating pupils thus increased to 2545.

"Rusmiddelforbruget – i folkeskolens afgangsklasse og udviklingen fra 1995-1999" Institut for Epidemiologi og Socialmedicin, Aarhus Universitet (Sabroe & Fonager 2002). [Drug consumption in the 9th grade, and development from 1995-1999]
This report is based on the Danish ESPAD 1999 study (see above). This report, however had expanded its random sampling base in comparison to ESPAD 1999 and included pupils in the 9th grade. Therefore, in addition to the 15-16-year-olds, pupils aged 14-17 were also included, since they attend the 9th grade as well. The number of participating pupils thus increased to 1750.

Unges erfaringer med rusmidler – i 2003 og udviklingen siden 1995. Institut for Epidemiologi og Socialmedicin, Aarhus Universitet (Sabroe & FOnager 2004) [Young people's experience with drugs and alcohol in 2003 and developments since 1995]
This report is based on the Danish ESPAD 2003 study (see above). This report, however had expanded its random sampling base in comparison to ESPAD 2003 and included pupils in the 9th grade. Therefore, in addition to the 15-16-year-olds, pupils aged 14-17 were also included, since they attend the 9th grade as well. The number of participating pupils thus increased to 2978.

Skolebørnsundersøgelsen 2002. Health Behaviour in school-aged Children (HBSC). Pernille Due & Bjørn E. Holstein 2003)
This report the Danish part of the WHO study on the health of children and young people. For the first time, it has been included in a study to investigate the question of the 15-year-olds' use of cannabis and ecstasy. The study was conducted as an anonymous questionnaire handed out in the class room of the "folkeskoler" (elementary schools). The random as regards the drug use questions was 1418.