



European Monitoring Centre
for Drugs and Drug Addiction

 **Sundhedsstyrelsen**
National Board of Health

**2007 NATIONAL REPORT (2006 data) TO THE
EMCDDA
by the Reitox National Focal Point**

DENMARK

**New Development, Trends and in-depth
information on selected issues**

Preface

This year's report on the drug situation in Denmark has been prepared by the National Board of Health, the Danish "Focal Point". The report was written in the autumn of 2007 to be submitted to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). The report is available in a Danish as well as an English version in accordance with EMCDDA guidelines.

The report provides an overview of the drug situation in Denmark. It is based on the most recent statistic and epidemiological data as well as current information on focus areas, projects, activities and strategies within drug prevention, harm reduction and treatment of drug users. In addition, the report provides an outline of applicable Danish law and politics within the drugs area.

Ms Kari Grasaasen, sociologist, has had the coordinating responsibility for the report and prepared the chapters on epidemiology. Ms Maria Winter Koch has prepared the chapter on prevention and Ms Helle Petersen, staff specialist, and Mr Christian Hvidt, senior hospital physician, have jointly prepared the chapter on interventions in relation to drug use. Mr Torsten Kolind has prepared the theme chapter on Drug Research in Denmark, and the Council for the Socially Vulnerable has prepared the theme chapter on this particular group of people as well as the chapter on intervention regarding social consequences. The remaining chapters of the report include written contributions from various units of the National Board of Health, the Danish Ministry of Justice, the Ministry of Social Affairs, the Ministry of the Interior and Health, and other cooperative partners.

The Danish member of EMCDDA's Scientific Committee, Ms Anne Marie Sindballe, expert consultant, and a reading panel appointed by the National Board of Health have provided their comments and constructive criticism. Set up and proofreading has been made by Ms Birgitte Neumann, the National Board of Health, and the English translation of the report has been made by Ms Anita Pontoppidan, LinguaMedica Medical Translation Agency.

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Summary

The current drug situation in Denmark

The most recent estimate on the number of drug users was made in 2006. This estimate shows that the number of drug users in Denmark is 27,000, of which more than 7000 are cannabis users alone. Compared to 2001, it appears that the estimated number of drug users has stabilised. The statistics do not include experimental drug consumption, but estimates the number of individuals with a more constant use of drugs leading to physical, mental and/or social injuries. Actual drug addicts are thus included in the estimates, including the drug addicts in substitution therapy.

Also, more recent, national surveys show overall that the prevalence of experimental use of cannabis as well as other illicit drugs among the young adults and adults is mildly decreasing. The curve now thus appears to be broken after drastic increases in the use of illicit drugs up through the late 1990s which were followed by stabilisation from 2000 and onwards. When considering the prevalence of each individual drug, cocaine appears to be the only one on its way up. Among the 16-24-year-olds a slight, however, significant rise in the use of cocaine is seen in these years (SUSY, whereas a contrasting drop is seen in the young people's use of other drugs, such as amphetamine and ecstasy. Cannabis as well as amphetamine, however, still continue to be more widespread than cocaine, followed by ecstasy in the order mentioned.

In 2007, a follow-up survey was made on the former ESPAD-surveys describing developments within experimental use of illicit drugs (together with alcohol and tobacco) among the 15-16-year-olds. Results from this more or less show the same level in 2007 as in 1999 and in 2003, and not the same decline among the very young as among the somewhat older.

There continues to be an increase in the number of drug users admitted for treatment, although during the past few years there has been a "halt" in the rising figures. A total of 13.441 persons were admitted for treatment for drug use in 2006, which is "merely" an increase of close to 1% compared to 2005. Previously, heavy increases have been seen in the number of persons admitted to drug treatment, ie 13.9% from 2002 to 2003 and 7% from 2003 to 2004. The number of drug users admitted for treatment for the first time in 2006 was 24% of all those who had been admitted in 2006 (1329 out of a total of 5426) persons.

Especially the young population accounts for the group of newcomers admitted to drug treatment, and typically, their problems revolve around drugs such as cannabis and/or central stimulants. In 2006, a little less than half (47%) of the young population between the age of 18 and 24 years used cannabis as their primary substance, whereas 14%, 7% and 3% of the young are being treated for the use of drugs such as amphetamine, cocaine and ecstasy, respectively. In addition to the increasing use of illicit drugs up through the 1990s, we must assume that increased treatment capacity, treatment guarantees and improved and more targeted treatment programmes contribute to the documented increase in newcomers in drug use treatment, which is also seen in treatment statistics.

Statistics on the psychiatric admissions suggest an increasing amount of hospitalised patients with drug diagnoses. Particularly the diagnoses relating to cannabis use. Thus, almost half (1040 out of a total of 2430) of the patients admitted for psychiatric treatment and diagnosed with a drug-related secondary diagnosis are cannabis users, and from 1997 to 2006, such admissions have doubled. Also the central stimu-

lants, including cocaine, are to an increasing extent the contributory factor of many psychiatric admissions, although the number of such admissions is significantly lower than the cannabis-related ones.

Statistics on visits to casualty wards due to poisoning from illicit drugs shows show around 1200-1400 poisonings annually. The young people typically present with poisonings caused by cannabis and central stimulants, whereas opioids and polydrug use typically are drugs causing poisoning among the older age groups. These figures are, however, minimum figures due to diverse registration practice and imprecise diagnostics.

A number of health-related problems and consequences follow in the wake of drug use. Mortality rates among drug users are extremely high, generally due to poisoning and diseases, ie HIV and hepatitis, and mortality rates among drug users released from prison are particularly high in those who have just been released. The drug-related deaths have been high, however constant for the past few years. Most drug-related deaths stated in police records (approximately 80% of them) are caused by poisoning, whereas the other deaths are a consequence of violence, accidents and diseases. Studies have shown that on average, 3.3 drugs are involved in each drug-related death (Steentoft 2005). The conclusion must be that (poison-invoked) deaths in essence are a result of polydrug use.

New developments within prevention, treatment and harm reducing initiatives

During recent years, the number of preventive initiatives and harm reducing interventions in Denmark have increased on a local and governmental level. The aim of these initiatives is to curb the development of experimental drug use as well as limit the damage caused by using illicit drugs. Regional and local drug prevention initiatives have been enhanced after the local government reform, according to which the municipalities are responsible for prevention and treatment of drug use after 1.1.2007.

Drug prevention is primarily performed on a cross sectoral basis, with intervention targeted at primary school level, commercial party settings and youth education programmes.

In the spring of 2007, the model municipal project "Drugs out of town" which was established in connection with the government's action plan referred as "The Fight against Drugs" from 2003, was completed. The 14 model municipalities have been engaged in prevention within 6 areas (primary school, youth education programmes, leisure and association settings, party settings, special residential areas and individual intervention programmes), all described in the guidelines provided to the model municipalities by the National Board of Health.

The experience gained from this model project has been, among others, that the municipalities are dedicated to working more systematically and cross-sectorally with drug prevention initiatives, but that there are also a variety of organisational and empirical issues to consider in order for these intentions to be fulfilled. Managerial, political and administrative support are required in order for prevention programmes to be accepted by front personnel and thus by community members. It is also necessary that drug prevention has a dedicated organisational focus with a clear delegation of responsibilities and framework for cross-sectoral work – in the model municipal project this has been achieved by appointing a cross-sectoral steering group and a coordinator in each municipality. It is also necessary to give the municipalities quick access to the most recent theoretical knowledge within the area – for instance

through professional guidance, educational and informative material, methods for monitoring the drug situation within the municipality and through competence development programmes.

In 2006, a national information campaign referred to as "Against Drugs" was once again launched on the musical festivals in collaboration with the National Board of Health and the trade association Festival Denmark. This campaign has been an annual event since 2003, and the idea is that the festival planners signalize a clear attitude towards the intake of drugs. Each year, the campaign evaluations have revealed that the campaign has gained an ever increasing foothold and a widespread acceptance of the message on a part of its audience.

As a result of the past years' political settlements on social reserve pooled funds, a number of initiatives have been launched for preventive and harm reducing measures for drug users. One of the agreements include special funds for the introduction of targeted health care programmes for most vulnerable drug users as well as other initiatives aiming at particularly vulnerable groups, including homeless drug users. Furthermore, special reserves have been set aside for enhanced efforts to help pregnant drug users as well as mentally ill drug users, ie the so-called "co-morbidity patients".

Also, special funds have been allocated to quality development of the medical treatment of drug users, including substitution treatment. In this connection, revised professional guidelines are estimated to be available by the end of 2007, the intention of such guidelines being to ensure uniform and acceptable quality from medical core services related to substitution treatment. Guidelines for prescription of addictive medication have also been revised, and buprenorphine is now being recommended as a first-choice preparation to be used in substitution treatment.

Furthermore, funds have been reserved for the focus on hepatitis C. In this connection, the National Board of Health prepared in the autumn of 2007 an action plan for the prevention of hepatitis C among drug users, with the plan providing recommendations and specific preventive instructions.

And finally, special funds have been reserved for 2006 and 2007 for the development of targeted programmes provided to young cannabis users.

New drugs and new legislation

The National Board of Health and the National Commissioner continue to monitor narcotic drugs on the illicit market in collaboration with the three institutes of forensic chemistry in Denmark. The aim is for discussions on control measures and bans to be implemented when new narcotic drugs appear on the market. Following recommendations from the National Board of Health, the drugs 2C-E, 2C-P, DOC, DOI and oripavin, were banned effective 8 April 2007, and can from that date only be used for medical and scientific purposes.

A number of new laws and administrative regulations have been carried out and implemented in 2007. Among others should be mentioned that as per July 2007, a zero limit was imposed on driving with narcotic drugs in the blood, which means that this has become a criminal offence. Also, an amendment was introduced in 2007 with a tightening of fines related to illegal possession of narcotic drugs for own use.

Theme chapters

The theme chapter on "vulnerable young people" describes the problems and intervention areas in relation to the very young who risk developing drug abuse. The theme chapter on "Drug Research in Denmark" focuses on the research made in Denmark since 2001 and provides examples with a short review of selected studies.

1 National policies and context

The national drug strategy in Denmark is based on a ban against any non-medical or non-scientific use of drugs combined with persistent and targeted efforts, multi-pronged and coordinated treatment programmes, as well as efficient control. In its action plan “The Fight against Drugs”, the Government has drawn up the basic conditions governing its response to drug abuse.

Drug abuse is a complex problem. Intervention must therefore be carried out on a broad front across professional and sector boundaries. This is a task to be tackled in collaboration with local, regional and central authorities within the health, social, legal and customs sectors.

The *Ministry of the Interior and Health* is responsible for coordinating the government's response centrally. The ministry is also responsible for controlling the legal use of drugs. It oversees as well the government's tasks associated with treatment within the healthcare sector and preventive intervention, including matters pertaining to medical treatment. *The Ministry of Social Affairs* is responsible for the government's social treatment programmes. *The Ministry of Justice* has the main responsibility for supervision and policing, including measures for drug users in prison. *The Ministry of Tax Affairs* is responsible for custom controls and inspecting precursors.

At a local level, the municipalities are responsible for their specific prevention and treatment programmes. The municipalities are thus assisted by the central authorities in such matters as monitoring, overall guidelines, documentation, knowledge sharing, etc.

1.1 New legal framework, including new drugs under control

Effective 2007, the following laws and administrative rules have been passed within the drugs area:

- To Act no. 451 of 22 May 2006 on the authorisation of health care personnel and on health care activity, was added the former Medical Practice Act's rules on physicians' right to prescribe addictive medication as part of the treatment provided to drug users.
- Act no. 1558 of 20 December 2006 on the the amendment of law enforcement etc became effective on 1 January 2007. The amendment sets out that an imprisoned drug user shall be entitled to treatment for his/her drug use free of charge unless he/she is expected to be released within 3 months or if he/she is considered unfit and motivated for treatment. Any treatment must to the widest extent possible be initiated no later than 14 days after the prisoner has submitted a request for such treatment to the Danish Prison and Probation Service.
- Ministerial order no. 58 of 18 January 2007 on Act on Social Services came into force on 1 January 2007 and is a consolidation of the previous order and subsequent amendments.
- Act. no. 524 of 6 June 2007 on the amendment of the Danish Traffic Services Act became effective on 1 July 2007. This amendment sets out a zero limit to driving with narcotic drugs in the bloodstream. This means that it is forbidden to drive with illicit drugs and illicit medication in the blood. The zero limit does not apply to drugs taken by the driver in compliance with legal prescription orders. The police are authorised to apply saliva and sweat samples as well as

eye inspection with a view to proving any suspicion of narcotic drug influence in connection with driving. The punishment for violating the zero limit equals that of drunken driving.

- Act no. 526 of 6 June 2007 on the change of fines in drug cases became effective on 1 July 2007. This amendment sets out that fines imposed on illegal possession of narcotic drugs for own consumption will be increased. The amendment also sets out that cases involving possession of narcotic drugs for own use to a wider extent than before shall be determined with a warning in cases where social conditions speak in favour of giving a warning and where the use of narcotic drugs is due to strong addiction to heroin.
- Act no. 542 of 6 June 2007 amending the Act on social services and the act on detention of drug users in treatment became effective on 1 July 2007. The Act sets out that the municipalities in connection with programmes supporting pregnant drug users in the form of 24-hour accommodation in accordance with Section 107, subsection 2, section 2 of the Social Services Act are obliged to offer pregnant drug users to sign a contract on treatment with an option of detention.
- Ministerial order no. 622 of 15 June 2006 became effective on 1 January 2007. According to this order, the municipal boards must, prior to 1 July 2007, have prepared a quality standard for social treatment for drug use in accordance with Section 101 of the Social Services Act
- Ministerial order no. 1651 of 13 December 2006 which is a consequence of the local government reform (see Section 1.3) became effective on 1 January 2007 and deals with a guarantee for social treatment to young drug users under the age of 18 in special cases.
- As a follow-up on the local government reform (see Section 1.3), the Ministry of Social Affairs has issued guidelines no 1-7 on 5 December 2006 for the Social Services Act. This is a consolidation of a large number of guidelines which previously were broken down by special target groups, including the particularly vulnerable.
- On 8 June 2007, the National Board of Health published revised guidelines on the prescription of addictive medication and treatment of drug users. The guidelines contain new medical recommendations concerning substitution treatment for opioid use, including new recommendations on the choice between methadone and buprenorphine. Due to buprenorphine's safety profile, the guidelines recommend that buprenorphine should be prescribed as the first choice and that as many opioid addicts as possible should be treated with buprenorphine. The guidelines also prove more detailed professional guidance in the initiation of treatment and dosage regimen.

In 2007, the following narcotic drugs have been subjected to control:

- As a result of the ministerial order no. 314 of 29 March 2007 on the amendment of ministerial order on narcotic drugs, it was provided that substances 2C-E (4-ethyl-2.5-dimethoxyphenethylamine), 2C-P (2.5-dimethoxy-4-propylphenethylamine), DOC (4-chlorine-2.5-dimethoxy amphetamine), DOI (4-iodine-2.5-dimethoxy amphetamine) and oripavine effective 8 April 2007 shall only be used for medical and scientific purposes.

1.2 National strategies within the drugs area

When the new Government signed an agreement in 2001, it was decided to strengthen the joint responsibility for the weakest groups in society. This decision

was subsequently followed up by general initiatives such as the signing of a number of agreements concerning social reserves, the preparation of action programmes "Our Common Responsibilities I" and "Our Common Responsibilities [in Danish: Det fælles ansvar] and the appointment of the Council for Socially Marginalised. In the next governmental agreement signed in 2003, intervention measures were expanded and were expressed in the action plan "Fight Against Drugs" which was presented by the Government in October 2003, and which has since formed the basis of the central authorities' efforts within drugs.

In the "Fight against Drugs", the Government set out that drug use must be met with consistent and sustained efforts to maintain and expand in terms of quality and quantity the existing efforts aiming at a higher degree to prevent the access of new drug users, help current drug users and come down on drug-related crime. The Government stated that this intervention should be carried out on a broad basis and thus reflects that social problems, drug use and drug crime are interrelated. The Government also stated that this is a task that needs to be solved jointly by central, regional and local authorities in close collaboration with the individual and his/her relatives, with private organisations and institutions as well as schools, associations and discotheques, etc in the surrounding environment.

In 2004, a political agreement was signed implying that as at 1 January 2007, a local government reform would be launched, basically changing the framework for the handling of local and regional tasks. In the drug area this means that the responsibility for prevention as well as for the social and medical drug use treatment has been passed on from the counties to the municipalities. Since the municipalities are also responsible for other social tasks, the reform has thus made it easier to coordinate the social and medical interventions within drug use.

As part of a strengthened effort to help pregnant drug users, the social reserves pooled fund settlement of 2007 allocated funds to improve the possibilities of retaining pregnant drug users in treatment and to develop methods for early tracing and enrolment in treatment. The pilot project will be developed in a number of municipalities and is planned to run over a period of 3 years.

1.3 Budget and funding arrangements

The information concerning the multi-annual government grants and pooled funds have been described in the annual reports of previous years. In this connection, it is worth mentioning that the government as a follow-up on "Fight against Drugs" in October 2003 agreed with a majority in the Danish Parliament to set aside DKK 145 million (19.3 million EUR) for the years 2004-2007 to implement a number of initiatives related to drugs. In order to boost this effort, the government and a majority of the Parliament agreed to set aside DKK 250 million (33.3 million EUR) for the years 2006-2009 for new initiatives related to drugs. Information about the new governmental funds includes the following:

- In 2007, approximately DKK 4.5 million (0.6 million EUR) of government funds are expected to be used for the prevention of drug use under the National Board of Health.
- Under the social reserve funds for 2007, a total of DKK 7.5 million (1 million EUR) and DKK 5 million (0.7 million EUR) have been set aside for the years 2008-2010 for health promoting and preventive model projects for the group of the most socially marginalised drug and alcohol users as well as the homeless.

- Under the social reserve funds for 2007, a total of DKK 5 million (1 million EUR) has been set aside for each of the years 2007-2010 to help pregnant drug users.
- Included in the psychiatry agreement for 2007-2019 a permanent grant of DKK 30 million (4 million EUR) annually has been set aside with the aim of maintaining the activity level achieved with the psychiatry agreement for 2003-2006. This makes it possible to continue projects launched in connection with the psychiatry agreement 2003-2006. This also applies to the projects targeted at the users with co-morbidities.

It has not been possible to state a special amount set aside for control activities within the drugs area.

As regards municipal expenditure, accounts and budgets show a heavy increase since 1995 in the funds reserved for social drug use treatment. Accounts for 2006 were thus stated at DKK 804 million (107.2 million EUR), whereas in 1995 amounts were stated at DKK 228.9 million (30.5 million EUR). Municipal expenditure for the prevention of drug use and the medical treatment of drug users cannot be retrieved separately from the municipal accounts and budgets.

As regards the treatment of drug users in prisons, a significant rise in allocated funds has been observed during recent years. Budget figures for 2001 were thus stated at DKK 6.2 million (0.8 million EUR) whereas in 2007, they were stated at DKK 57.4 million (7.7 mio EUR).

1.4 Drug policy in a social and cultural context

In the parliamentary year of 2006-2007, members of the opposition have set forth a bill on medically prescribed heroin for particularly heavy drug users. The bill has not yet been adopted. During this same parliamentary year, the Folketing has held a hearing on medically prescribed heroin.

2 Drug use in the population

The phenomenon of trying drugs is typically one associated with young people, and most of them stop at some point. The majority of those who try drugs do so on an experimental basis for a short period during their younger years. Surveys among the whole population indicate that the experimental use of drugs is highest in the 16-19 age group and that very few try drugs for the first time after the age of 20. In age groups over 40, only a small percentage has used any type of drugs within the last year (SUSY 2000 and 2005¹). By and large, it is the same group of young people who expose themselves to different kinds of risky behaviour. Studies document often, the same young people make up the group of heavy drinkers, smokers and cannabis users. Also, there appears to be a significant co-variation between having used cannabis and having used one or several illicit drugs.

Results from surveys in recent years suggest that the experimental use of cannabis and other illicit drugs in Denmark is historically high with the tendency toward falling prevalence among the young adults and adults. Recent population surveys show that 46% of the population between 16 and 44 years has at some point (ever) experimented with cannabis, and 13.5% within the same age group have at some point (ever) tried illicit drugs other than cannabis (SUSY 2005). There also seems to be a declining trend in the use of illicit drugs in general among the young adults aged 16-20 years (MULD). In 2006, around 30% of the 16-20-year-olds state having smoked cannabis, and around 10% of them have tried one or several illicit drugs.

When taking a look at the prevalence of each individual drug, cocaine, however, appears as the only drug on its way up. Among the 16-20-year-olds, there is a small, however significant rise in the use of cocaine these years (SUSY), whereas their use of other drugs such as amphetamine and ecstasy is comparatively lower. Both cannabis and amphetamine are, however, still more prevalent than cocaine, followed by ecstasy in the order mentioned.

In 2007, a follow-up-survey was conducted on the former ESPAD-surveys describing the development of the experimental use of illicit drugs (as well as alcohol and tobacco) among the 15-16-year-olds. The results from these surveys show that the level in 2007 is more or less the same as in 1999 and 2003, and obviously not the same decline among the very young as among the somewhat older.

The data and methods applied in the different surveys mentioned in the following chapters and describing the development of experimental use of illicit drugs among the adult population (SUSY), the young adults (MULD) and the very young (ESPAD) appear at the back of this report.

2.1 Consumption of illicit drugs in the population

No new surveys describing the experimental use of illicit drugs in the adult population have been made since 2005. The results reported here are based on the three most recent national health and morbidity surveys on self-reported consumption from 1994, 2000 and 2005 (SUSY 1994, SUSY 2000 and SUSY 2005)). All surveys have been carried out by the existing National Institute of Public Health (former DIKE). The analyses on the prevalence of drugs are based on the 16-44 –year-olds. The preva-

¹ SUSY stands for Sundheds- og Sygelighedsundersøgelse (Health and morbidity survey).

lence among people over the age of 44 is very limited, which is why the over 44 age group is not included in the analyses below.

Prevalence of cannabis

The results from the population surveys among 16-44 year-olds carried out in 1994, 2000 and 2005 indicate rises in the experimental use of cannabis up until 2000. After this, the figure levels off, with even a slight drop. If we look at current use (cannabis used within the last year), 8% of 16-44 year-olds in 2005 said that they had taken cannabis within the previous year. These figures were 7% and 10% in 1994 and 2000 respectively. The current use of cannabis reaches its peak in the young age groups, and subsequently tapers out at increasing age (table 2.1.1 of the annex). As regards the male group, the highest use of cannabis in 2005 appears among the 20-24-year-olds, whereas the 16-19-year-olds account for the group among women using cannabis.

Table 2.1.2. Percentage of 16-44 year-olds who have taken cannabis during the last month, last year and ever in 1994, 2000 and 2005

Cannabis used	1994	2000	2005
Last month	2	4	4
Last year (including last month)	7	10	8
Ever (including last year)	37	42	46

Kilde: Unpublished figures from SUSY 1994, SUSY 2000 and SUSY 2005

As the above table shows, the current use of cannabis has stagnated, even by a slight decline from 2000 to 2005 (cannabis used within the past year). Although there is also an increase from 1994-2005 in the percentage having tried cannabis ever, the results reflect that today, fewer people are cannabis users than in 2000, as the "current use" is considered as the most reliable target of prevalence².

Prevalence of other illicit drugs

As for the other illicit drugs considered together, a similar trend appears; an increasing experimental use among the 16-44-year-olds from 1994 to 2000 replaced by a small, however significant decrease from 2000 to 2005. Less than 3 % of the 16-44-year-olds report in 2005 that they are users of illicit drugs other than cannabis (used within the past year).

Table 2.1.3. Percentage of 16-44 year-olds who have taken last month, last year and at some point one or more illicit drugs other than cannabis in 1994, 2000 and 2005

Used one or several illicit drugs other than cannabis	1994 (n=2.521)	2000 (n=6.878)	2005 (n=4.440)
Last month	0.2	1.2	1.1
Last year (including last month)	0.5	3.4	2.7
Ever	4.4	11.3	13.5

Source: Unpublished figures from SUSY 1994, SUSY 2000 and SUSY 2005

² The category "ever" is a more inspecific target than "used last year" as the longer the time span around which a question revolves, the higher the probability that the respondent has either forgotten or tried to forget the event in question.

Prevalence of illicit drugs among the young adults

The table below focuses on the prevalence of various illicit drugs among "young adults" in the 16-24 age group in 2005. This is typically the age group which starts off using illicit drugs and where the prevalence of illicit drugs is largest.

Table 2.1.4. Percentage of 16-24 year-olds who have taken last month, last year and at some point one or more illicit drugs other than cannabis in 1994, 2000 and 2005

	Last month	Last year (including last month)	Ever
Cannabis	8.2	20.5	44.2
Amphetamine	1.4	4.0	11.2
Cocaine	0.8	3.3	8.0
Psilocybine mushrooms	0.0	0.9	4.8
Ecstasy	0.5	1.5	5.5
LSD	0.0	0.6	1.8
Heroin	0.1	0.2	0.6
Other drugs*	0.3	0.7	1.8
"Illicit drugs other than cannabis" total	2.0	5.3	14.2

Source: Unpublished figures from SUSY 2005

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

44% of young people under the age of 24 have tried cannabis at some time, with 21% currently taking it. In other words, they said that they had used cannabis within the last year. The prevalence of cannabis among young people in 2005 is at the same level as in 2000 (shown in table 2.1.5 of the annex).

For the other illicit drugs such as amphetamine, cocaine and ecstasy, which are the second most prevalent drugs after cannabis no increase has been seen since 2000. It may seem, however, as if there is a trend towards a "shift" in the type of drugs chosen during this period, when fewer were choosing drugs like amphetamine and ecstasy and more were choosing cocaine. This trend is high-lighted in Table 2.1.6.

Table 2.1.6. Percentage of the 16-24-year-olds who have a current use of cocaine, amphetamine and ecstasy in 2000 and 2005

16-24 years	SUSY 2000			SUSY 2005		
	Men	Women	Total	Men	Women	Total
Amphetamine tried within the past year	8.6	3.0	5.6	6.5	2.4	4.1
Cocaine tried within the past year	4.3	1.3	2.7	5.4	1.9	3.3
Ecstasy tried within the past year	3.1	1.5	2.2	3.1	0.4	1.5

Source: SUSY 2005, Unpublished figures provided by the National Institute of Public Health

As the table above shows, 5.6% of 16-24 year-olds in 2000 said that they had used amphetamine within the last year, while this was the case for 4.1% in 2005. In the case of ecstasy, 2.2% of 16-24 year-olds in 2000 said that they had used ecstasy within the last year, while this percentage had dropped in 2005 to 1.5%. Given that

this was accompanied by a rise in the proportion of people who said that they had used cocaine between 2000 and 2005, there may be a trend towards a shift in the drugs being chosen by this age group.

Significantly more young men than women are currently using amphetamine, cocaine and ecstasy. In fact, the current use of ecstasy in particular was very limited among young women in 2005.

The conclusion which can be drawn then is that there was no increase in prevalence among 16-24 year-olds during these years, either for the use of cannabis or other illicit drugs. On the other hand, trends were observed towards a slight shift in the drugs these young people were choosing, with the use of cocaine on the way up, while the use of amphetamine and ecstasy was falling.

Frequency of use of illicit drugs

In the SUSY survey in 2005, those who were currently using cannabis or other illicit drugs within the previous month were asked how many times they had taken drugs. There was a total of 9% of 16-24 year-olds who had used cannabis and/or other illicit drugs during the previous month. Just under 70% of these used the drug 1-3 times. The remainder took drugs more frequently (18% used drugs 4-9 times and 12% more than 10 times during the previous month). When it comes to indications of how frequently drugs are taken, the figures are very small, which is why there is a great deal of uncertainty about these results.

Most of those who used drugs during the previous month only took cannabis. An analysis was carried out to see if there is a difference in frequency for those only using cannabis and those using other illicit drugs, but no difference was indicated between these two groups. It must be emphasised however that the group who used illicit drugs other than cannabis during the previous month was very small.

Regional differences in the use of illicit drugs

Regional comparisons were made during the SUSY surveys in terms of the prevalence of illicit drugs. The results clearly highlighted that the prevalence of illicit drugs is by far the biggest in the Copenhagen region and less prevalent in other regions. In the Copenhagen region, the number of 16-24 year-olds who have tried both cannabis and the other illicit drugs is up to double the number, compared with young people in other regions. The same trend towards regional differences is also shown in the 25-34 age group, even though this difference is not at all as striking among young people under the age of 24.

2.2 Drug use in the school and youth population

As shown above, the younger age groups are those which account for the most prevalent use of cannabis and other drugs. In this section, reporting on use among the 16-20-year-olds is based on the "MULD"-surveys from 2000 to 2006 that show that the experimental use of illicit drugs in this age group is stable during the period, however with signs of falling prevalence during recent years.

Table 2.2.1 below shows results from MULD surveys during those particular years. The figures over the years suggest a significant decrease in the use of cannabis among young people aged between 16 and 20 years from 2000 to 2006. Furthermore, there appears to be a minor, however still significant decrease in the use of amphetamine and psilocybine mushrooms from 2004 to 2006. For the other drugs,

the figures indicate stability and a slight drop in the use, although they may also reflect arbitrary fluctuations and non-significant differences throughout the period.

Table 2.2.1. Percentage of 16-20 year-olds who have tried illicit drugs, 2000-2006

	MULD 2000 (n=2046)	MULD 2001 (n=2090)	MULD 2002 (n=2041)	MULD 2003 (n=1768)	MULD 2004 (n=1772)	MULD 2006 (n=1964)
Cannabis tried ever	32	33	37	36	36	27**
Cannabis last month	9	9	8	9	7	6
Amphetamine tried ever	8	9	6	7	6	5
Ecstasy tried ever	4	4	3	4	4	3
Psilocybine mushrooms tried ever	3	5	4	3	3	1
Cocaine tried ever	3	4	3	4	4	4
LSD tried ever	1	2	1	1	1	1
Heroin tried ever	0	0	0	1	0	1
Smokeable heroin tried ever	1	1	1	1	1	1
"Other" drugs	1	1	3	2	2	2

Source: MULÐ—surveys 2000 – 2006. The Danish Cancer Society and the National Board of Health

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

** The figures for *Cannabis tried ever (MULD 2006)*, are calculated in the same way as in the previous years. The number of "not available" answers in 2006 are, however, significantly larger than the previous years. If the "not available" answers are excluded from the calculation, this gives a percentage of 32.4 %

Around 30% of the young people aged between 16 and 20 years report in 2006 that they have tried to smoke cannabis at some point (ever), and 10% have tried one or several drugs. Amphetamine ranks second after cannabis as the most frequently used substance used by 5%. Then follow cocaine and ecstasy that have been tried by 4 and 3%, respectively.

Among the 16-20 year-olds there are clear gender differences in the use of drugs, in that approximately twice as many boys as girls have tried drugs. Totally speaking, 13% of the boys and 7% of the girls between 16 and 20 years in 2006 report having tried one or several drugs other than cannabis. As regards cannabis alone, 39% of the boys and 28% of the girls report having tried the drug.

Starting age

The latest SUSY analyses on the experimental use of illicit drugs confirm earlier survey results showing that almost everyone who experiments with illicit drugs starts using them before the age of 20 (SUSY 2005).

Prevalence of illicit drugs among the 15-16-year-olds

Ongoing surveys have been made on the experimental use of illicit drugs among the very young. The ESPAD surveys that have been conducted in 1995, 1999, 2003, and 2007 show an increase in the experimental use of cannabis and other illicit drugs among the 15-16-year-olds from 1995 to 1999. Then comes a stability in use up until 2007, however with small, but significant increases in the experimental use of cannabis, ecstasy and cocaine from 2003 and onwards.

As shown in the table below, a little less than ¼ of the 15-16-year-olds has tried cannabis ever, and approximately 10% has tried cannabis within the past month. Concurrently with the ESPAD results on the use of cannabis, the results from HBSC (Survey: Health Behaviour in school-aged Children) confirm the high level of experimental use of cannabis among the very young Danish school children. As regards ecstasy and amphetamine, these drugs have been tried by 5% of the young population,

whereas cocaine has been tried by 3%. The gender differences still apply in the experimental use of illicit drugs among the 15-16-year-olds and in general, more boys than girls have tried the different drugs. Only ecstasy has been tried by almost as many girls as boys.

Table 2.2.2. The percentage among the 15-16-year-olds who have tried illicit drugs in 1995, 1999, 2003, and 2007 as well as the 15-year-olds in 2002

	ESPAD	ESPAD	ESPAD	HBSC	ESPAD
	1995	1999	2003	2002	2007
	(n=2234)	(n=1548)	(n=2519)	(n=1418)	(n=881)
Cannabis tried ever	18.0	24.4	22.6	23.3	25.5
Cannabis tried last month	6.1	8.1	7.6	-	10.6*
Amphetamine tried ever	1.6	4.0	4.0	-	5.0
Cocaine tried ever	0.3	1.1	1.8	-	3.2*
Heroin (injection) tried ever	0.2	0.1	0.7	-	0.5
Smokeable heroin tried ever	1.5	1.3	1.0	-	-
Ecstasy tried ever	0.5	3.1	2.5	2.4	5.2*
LDS tried ever	0.2	1.0	1.1	-	1.1
Psilocybine mushrooms	0.5	1.8	1.5	-	1.1
Tried sniffing	6.3	7.5	8.3	-	6.1**

Sources: ESPAD 1995 (1997); ESPAD 1999 (2000); ESPAD 2003 (2004); HBSC 2002; unpublished figures from ESPAD 2007

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

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

Table 2.2.2 illustrates the developments in experimental use of the various drugs among the 15-16-year-olds from 1995 and up until today. As regards some of the drugs, the percentages appear to be rising drastically from 2003 to 2007. The interpretation of figures, however, must take into account that apart from cannabis, the percentages are low and that variations on a few individuals may lead to large changes in percentages.

Compared to previous years, this year's random sampling was slightly less extensive. The reason is that a higher number of schools than usual did not want to participate. Class participating rates, however, reached last year's level of 90%.

3 Prevention

The main aim of drug prevention is to limit the number of new drug users. Prevention is therefore one of a total of four intervention areas in the drugs policy: prevention, treatment, harm reduction and supply control. The following main principles have been set out in the government's action plan against drug abuse ("Fight against Drugs" 2003): it must be *broad-based*, which means include several intervention areas; it must be *comprehensive*, which means include both alcohol and illicit drugs, and it must be *targeted at standards and behaviour*.

Since the local government reform that became effective from 1 January 2007, the main responsibility for prevention has been undertaken by the municipalities. With the local government reform, the former county structure was abolished. Today, the municipal authorities are close to their citizens - and prevention, in particular, benefits from the new structure. Locally, it is possible to plan universal as well as selective prevention in schools, local recreational programmes, in collaboration with associations, restaurants, bars, discotheques and in special residential settings.

The National Board of Health assists the municipalities with activities such as monitoring, overall formulation of guidelines, documentation, knowledge sharing, etc.

Drug prevention activities in the municipalities are often based on cross-agency cooperation among schools, social services and the police, known as SSP cooperation. There are major variations from one local authority to the next, but part of SSP's work involves picking up signals, tackling social problems affecting children and young people. It also proposes and implements activities that will help to prevent drug abuse and crime. The SSP consultants have set up a national "SSP council" acting as a contact and knowledge sharing body for the consultants, who work with an existing network of alcohol and drug consultants.

The National Board of Health's job as part of the prevention effort is to support local prevention work by producing informative material and through projects for developing methods (the current project is "Drugs out of town"), as well as by providing advice to other authorities.

3.1 Universal prevention - schools

Primary school is the key intervention area for universal prevention as it provides the opportunity to make contact with more or less every child and young person and their parents. There is a general obligation in primary schools to promote prevention and health education as part of the compulsory subject on health, sexuality and family life. Teaching about alcohol and drugs may be included in this lesson, but it is up to the individual school and class teacher to assess whether and how the subject of drugs should be dealt with in the lesson or at parents meetings. This means that there are no fixed guidelines on the form, content and scope of the teaching about drugs. This subject is very often taught in grades 6-9, with the individual teacher organising the lesson. Alcohol and drug counsellors support this work, to a certain extent. The SSP organisation has drawn up, in an ever-increasing number of municipalities, a local teaching programme for alcohol and drug abuse prevention.

In its guidelines for model municipalities in the "Drugs out of town" campaign, the National Board of Health has drawn up a series of research-based principles, which should be used as the basis for organising the school's drug prevention activities. Some of the recommendations made include schools drawing up a general policy on

alcohol and drug abuse, establishing cooperation with the parents in order to delay when children start drinking alcohol and to prevent them from experimenting with drugs, as well as schools teaching about the subject according to evidence-based principles

Teaching material "Tackling - self-esteem, health and social life"

In cooperation with the publisher Alinea, the National Board of Health has been instrumental in importing, developing and testing a Danish version of the American research-based teaching material "Life Skills Training", called "Tackling" in Danish. 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 is cooperating with the National Institute of Public Health on a research-related evaluation of the material's use in Danish schools. In addition, prevention counsellors from 6 counties will be participating in a project monitoring group. Around 150 schools are taking part in the project, with half of them being intervention schools and the other half control schools.

The purpose of the teaching material is to boost young people's self-esteem, their social skills and develop a positive healthy attitude with regard to tobacco, alcohol and drugs. The aim is to raise the starting age and prevent drug and alcohol abuse. The material's basic principle is to have a high level of pupil involvement, which is one of the key requirements for it to have any impact. The material may be used in 7th grade (approximately 25 hours), 8th grade (approximately 20 hours) and 9th grade (approximately 10 hours). The teaching is carried out by the teacher without any external experts or guest teachers. Teachers therefore attend an introduction course and then a follow-up course a year later.

Tackling 1 and Tackling 2 were published in 2005 and 2006, respectively. Tackling 3 is expected to be tested in 2003. It is expected that the results of the research project will be available by the end of 2007.

Youth education

There has been an increasing focus on alcohol and drug prevention in youth education institutions in recent years. Work is being done, in particular, on implementing alcohol and drug abuse policies and advice for young people at secondary schools, business schools, technical colleges and production colleges. Activities are based in particular on the experiences from the methodology-development project which the National Board of Health, Aarhus and North Jutland counties ran between 2000 and 2003 ("Development project on ecstasy prevention"), as well as on the survey by the Danish Institute for Upper Secondary Education: "Party culture and drugs in upper secondary schools", 2004. The main intervention principles are described in the National Board of Health's guidelines for model municipalities in the "Drugs out of town" campaign from 2005.

3.2 Prevention in the community

The drug corps – young-to-younger

In 2003, the City of Copenhagen launched a project known as "The drug guides". The project concept was to initiate a dialogue between the young and the younger. Young students are trained as drug guides who provide drug training free of charge to the 7-10th grades and in youth education classes. Teaching is based on the pupil's experiences, thoughts and attitudes towards drugs. Via a dialogue, the guides try to capture the attitudes and knowledge of the pupils in order for the latter to become more conscious of their selection/deselection of drugs. In addition to the class ses-

sions, other functions are held together with the SSP consultants. The project was evaluated in February 2007. This evaluation shows that 78% of the municipal schools have been visited by the guide and that a majority of the pupils find that the visits have given them new knowledge and that they have become more aware of the problem of group pressure.

"Drugs out of town" campaign

The "Drugs out of Town" project launched in a number of model municipalities is a follow-up on the government's action plan "Fight against Drugs" from 2003. The model project comprises 14 selection municipalities from all over Denmark and the objective of it is

- to reduce the availability of drugs
- to reduce the number of young people using drugs and the injuries following from the use, such as poisoning, drug-released psychoses and violence
- To launch systematic collaboration between relevant players within the field of youth and drug programmes and thereby targeted, coordinated and cross-sectoral activities.

The project was carried out between the National Board of Health and the selected municipalities during the period 2004-2007. The project was finalised on 30 April 2007.

Each municipality has received grants in the amount of DKK 1 million (0.1 million EUR) for the employment of a coordinator and for the launching of various activities during the project period.

The model municipalities have been engaged in alcohol and drug preventive initiatives in elementary school, youth education programmes, leisure and association settings, party environment, special residential settings and targeted programmes for children in drug user families and young cannabis users.

The municipal efforts have to a wide extent been based on empirical methods. In support of this work, the National Board of Health prepared a number of guidelines under the headline "Drugs out of Town" describing the central principles of working with drug prevention and describing the settings in which drug prevention should take place. In the folder "Prevention in party settings - on alcohol and drugs" ["Forebyggelse i festmiljøer - om alkohol og stoffer"] from February 2006, it has been described how prevention can be planned and implemented in party settings.

At the start of the 2006/2007 school year, the National Board of Health distributed material on the use of cannabis among young people ("Om hash og unge") to all the schools in the country. The material is to be used at parent meetings in grade 8, for instance, and is intended to give the group of parents the opportunity to discuss cannabis and if possible, to find common standards.

All 14 model municipalities have given priority to activities aimed at improving professional staff's skills. For example, the municipalities are running courses for staff who encounter young people in different places within the municipality. One example is the *Course on the conversation about cannabis*, which is targeted at teachers, SSP counsellors, club workers, educationalists, student counsellors, social counsellors, etc. from public and private institutions, who want to be able to tackle cannabis-related problems that young people have.

The majority of the model municipalities have organised the drug preventing initiatives under the social administration, including representation of other administrative offices in the steering groups which were established in connection with the project.

Almost half of the model municipalities have organised their local projects in close collaboration with the municipality's SSP organisation. The local basis and coordination of drug prevention are some of the project's key objectives, and the municipal organisation is thus a good example of how cross-administrative initiatives function from decision makers to "do'ers".

The National Board of Health has established a network with 14 model municipalities, with the two parties meeting 4 times annually. The purpose of this network is to secure inter-municipal exchange of experience, and has turned out to be invaluable in their work with the project. In addition to the network, the model municipalities have used each other on an ad hoc basis in specific project solutions, sparring within technical issues and exchanging materials such as guidelines on how to adopt a drug policy in schools and after-school recreational settings.

The National Board of Health concluded this project in April 2007. The overall experience gained has been documented in an evaluation report "Drugs out of town - evaluation of 14 model municipal projects and in the folder "Drug prevention in practice - examples from 14 municipalities' work with Drugs out of Town", involving "best practice" in the model municipalities.

As it turns out, there is a great will in the municipalities to work more systematically and cross-sectorally with drug prevention, however a number of organisational and technical requirements need to be fulfilled in order for this to succeed. It requires support from the management, politically as well as administratively for prevention to extend to the front staff and thereby the citizens. It is also necessary that any drug prevention activities have a clear organisational structure with a clear allocation of responsibility as well as a cross-sectoral framework - in the model municipality project, this has been implemented by having a cross-sectoral steering group and a coordinator in each municipality. It is also necessary to make the most recent drug news available - through professional guidance, educational and informative material, methods for monitoring the drug situation in the municipality and through competence development programmes. The intention is to disseminate project experience throughout Denmark.

3.3 Selective and indicated prevention

Preventive activities in the nightlife environment have been stepped up with closer cooperation between the main players involved in this area (municipalities, police and restaurant owners). The municipalities' licensing boards are using, to a greater extent, plans for restaurants as a means of prevention in a nightlife environment, and are working closely with restaurant owners' organisations. Courses are offered in a number of counties and municipalities for restaurant owners and people working in the nightlife environment, and cooperation among the players involved promotes shared attitudes on limiting the use and sale of drugs. The "Drugs out of town" campaign has also given these activities a boost.

Festival danmark Against Drugs

The cooperation the National Board of Health has had with the Roskilde Festival since 2003 has expanded hugely, to the extent that it now covers 14 festivals linked to the sector organisation Festival danmark ([www. festivaldanmark.dk](http://www.festivaldanmark.dk)), where the au-

dience is made up of young people. It is therefore involved with the Tænk Selv! – Against Drugs campaign.

The festivals have good experience of using the material, which comprises printed and electronic messages in the form of folders, go-cards, bus adverts, large-screen ads and billboards. The festivals have statements in their programmes and are now adopting a common stance against drugs. Some festivals are saying they are pleased that the National Board of Health and Festival Danmark are involved in launching the campaign, as it will increase its impact. Surveys among those attending the Roskilde Festival in 2006 showed that nearly 90% had seen the campaign, while 34% had discussed the messages with others, and a good 95% of the public thought it was a good idea for the festival to come out against drugs.

There is a counselling service "Are you experienced?" running at the Roskilde Festival at the same time as the campaign, with young people offering advice to other young people, which targets, in particular, the section of the audience that will still take drugs, in spite of all the efforts. The aim is to reduce the harm caused and provide advice. The advice is given by the "Backstagers", which includes young people who have previous experiences themselves with drugs. The Ministry of Social Affairs has given financial support to this part of the activities. The young people offer water, fruit, condoms, relaxation and a chat, as well as also being able to provide information about drugs.

SMS and youth magazines

Prevention activities are constantly changing their messages in order to gain the target group's sympathy, which is highlighted, for instance, through producing magazines for young people and newspapers with prevention messages. In 2006 a joint SMS-based prevention initiative referred to as SMASH (SMS+HAS) was launched between the former West Jutland County and Frederiksberg municipality. SMASH (SMS + HASH) has been developed as an anonymous support and counselling project for young cannabis users, intended to reduce the harmful effects, provide information and support to help them stop smoking cannabis. The prevention units in Ringkøbing, Ribe and Frederiksborg counties have been involved in the development with technical consultancy, and the project is financed by public funds and a major grant from a private foundation (Trygfonden).

A website has also been set up (www.smash.name), where people can find information about cannabis, withdrawal symptoms, treatment, as well as read stories about other users. The project is mainly based on being able to subscribe to 2 SMS packages. One package (hashfacts) mainly gives factual information about cannabis, while the other tries to motivate and support young people who are keen to stop taking drugs. Young people can also receive personal coaching via text messages to help them stop or reduce their use of cannabis. This service is free to young people who use it. The project has been launched in the former West Zealand county, Ringkøbing county, Ribe county and North Jutland county as well as Frederiksberg Municipality. The project was evaluated externally by the University of Southern Denmark in January 2007 ("Smash - an evaluation report"). This report shows that the users are pleased with the sms messages. The messages are received with more attention than mass campaigns from TV and are perceived as being discreet and personal. Also, the messages have a function in relation to starting, maintaining and developing a changing process.

Parent meetings when young people sniff gases or solvents

In 2006, a number of accidents involving sniffing of gases and organic solvents attracted a great deal of focus. The National Board of Health recommends that information on sniffing is based on two overall findings: First of all, sniffing often occurs episodically in a limited local area as "fashionable trend" among the very young (12-15 years). (See prevalence of sniffing in section 2.2). Secondly, it has been successfully established on a local basis that often, it is possible to stop such episodes by cooperating with *the adults* of the children's local environment and by having the adults enter into a dialogue with the children and young people involved. As gases and organic solvents are still available in many ordinary products, the National Board of Health recommends that information is provided with caution to avoid any unintentional advertising effect. As a result, the National Board of Health advises against universal information and media campaigns targeting at young people regarding this subject.

In order to strengthen local efforts against sniffing, the National Board of Health published in the autumn of 2007 new material on sniffing of gases and organic solvents. The material aims at providing factual information to parents and professionals, thereby providing them a basis for intervening into their children's or teenager's sniffing problem. The material describes how schools and local key persons can tackle it when sniffing emerges in the community. Also, the material provides some tools (summons, PowerPoint presentation, hand-outs to parents) that can be used at parent meetings on drugs in order to make it easier for teachers, club leaders or others to hold such a meeting in the local community if sniffing becomes a problem. The material is distributed to local people in all municipalities.

4 Problem drug use

The most recent estimate on drug users in Denmark dates back to 2005 (made in 2006). The number of drug users in Denmark is estimated to be 27,000. Out of this figure, approximately 7,300 are estimated to be cannabis users. Comparable figures from 2001 and 2003 suggest that the estimated number of drug users in Denmark during the period has stabilised. The estimate is made using the capture-recapture method in accordance with the guidelines set out by the European Monitoring Centre for Drugs and Drug Abuse. The calculations thus adhere to European standards for such estimates.

The number of drug users in treatment has increased steadily since the National Board of Health for the first time in 1996 started registering drug users admitted for treatment. The number of individuals treated has almost tripled from 1996-2006, which presumably is a result of the introduction of the treatment guarantee and a resulting increased treatment capacity.

Out of the 13,441 persons treated in 2006, a total of 5,426 people have been admitted for treatment in 2006. Out of the 1,229 newly admitted clients which have not previously been treated, a falling proportion take opioids as their primary drug. Cannabis and central stimulants, however, are still on the uprise and now account for half and more than one fourth, respectively, of all newly admitted clients which have not previously been enrolled in the treatment system.

4.1 Estimated number of drug users in Denmark

As mentioned above, the most recent estimate on the number of drug users in Denmark was made in 2005³. There is a great deal of uncertainty involved in estimating the number of drug users. The estimate is dependent, in one respect, on the definition of a drug user, and in another respect, on which methods and data material the estimate is based.

As in previous years, a capture-recapture model has been used to carry out the new estimate⁴. The estimate is carried out based on the National Patient Register (LPR) and the national register of drug users who are receiving or have received treatment (SIB). The procedure used has been to analyse how many people are recorded in the National Patient Register with a drugs-related diagnosis⁵. An analysis is then carried out of how many of these people are also listed in the SIB.

The estimates on the number of drug users from 1996 to 2005 are shown in table 4.1.1. As the calculations of estimates throughout the years are based on "live" registers, an adjustment has been made on the estimates from 1996 to 2003 in connection with the 2005 estimates.

³ A special publication on the estimate is being produced in "Nye tal fra Sundhedsstyrelsen" (New figures from the National Board of Health) for November 2006.

⁴ This method is recommended by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) in order to be able to carry out comparisons across countries.

⁵ The extract codes F11.1, F11.2, F11.9, F12.1, F12.2, F12.9, F14.1, F14.2, F14.9, F15.1, F15.2, F15.9, F19.1, F19.2, F19.9 are used in this case.

The estimate does not include experimental drug use, but estimates the number of people who use drugs more regularly, as a result of which they suffer harmful physical, mental and/or social effects. Actual drug addicts are therefore included in the estimate, as well as stabilised drug addicts (e.g. those being treated with methadone). Users of cannabis and users of central stimulants, opioids, etc. are included in the estimate.

Table 4.1.1. Estimate on the number of drug users in Denmark from 1996-2005

	1996	1998	2001	2003	2005
Estimate on no. of drug users in DK	20,331	24,431	25,410	26,358	26,979
95 % confidence interval	± 1,602	± 1,943	± 1,781	± 1,585	± 1,589

Source: Sundhedsstyrelsen [National Board of Health] 2006

If we taken into account the statistical uncertainty associated with these estimates, the estimated number of drug users appears as unchanged during the period from 2001 to 2005. The statistical uncertainty in the estimates for every year has been calculated as a 95% confidence interval. This means in 2005 that the calculated number of drug users is 26,979 +/- 1,589. The number of drug users in 2005 is therefore estimated at 27,000. 7,300 of these are estimated as being cannabis users only.

In recent years the "population" of drug users receiving treatment, which is one of figures used for calculating the estimate, has changed (the treatment population is described in the next section). There seems to be an actual, proportional decrease in the number of drug users seeking treatment for opioids/heroin addiction, while there is an increasing number of users seeking treatment for addiction to cannabis and central stimulants. This shift is particularly apparent among the "new" recipients of drug addiction treatment. This shift must presumably also have an influence on the drug-using population in that more people nowadays are addicted to cannabis and central stimulants than before, while fewer are addicted to opioids/heroin.

4.2 Drug users in treatment

Based on the information from the register of drug users receiving treatment, it is possible to describe the people seeking help for their drug addiction and the nature of their addiction. The Register records whether treatment is provided on an outpatient or inpatient basis and the type of treatment (methadone, drug-free treatment, etc.) provided to the client. Table 4.2.1 shows some selected characteristics of the clients admitted in 2006.

Table 4.2.1 Clients admitted for treatment for drug use in 2006

Number of clients admitted for treatment in 2006	5426
Number not treated previously (%)	24
Share of men/women (%)	76/24
Average age men/women (%)	32/33
Opioids as primary drug (%)*	43
Cannabis as primary drug (%)*	24
Central stimulants as primary drug (%)*	12
Injection, previously treated heroin users (%)	30
Injection, non-previously treated heroin users (%)	17
On payroll (%)	13
Daily cash benefits (%)	2
Cash benefits (%)	46
Early retirement pension (%)	14
Other income and uninformed income (%)	16
Own dwelling (%)	55
Single men/women (%)	72/63
Number of children living at home, under the age of 18 yrs	469
Number of children not at home, under the age of 18 yrs	374
Foreign citizenship (%)	6.4

Source: The National Board of Health's register on drug users admitted for treatment

*Rate of those who report a primary drug.

In 2006, a total of 5,426 drug users were admitted for treatment in Denmark. This is an increase of 3.8% compared to the 5,228 who were admitted in 2005. The overall number of drug users admitted for treatment during the year rose from 2005 to 2006 by 0.9% to 13,441 persons (the total number includes the group of people who continued treatment from 2005 and up through 2006).

24% of those admitted in 2006, had not previously been admitted for treatment for drug use. This is a decline from 30% in 2005, however with the decline mainly being explained by new local government structures meaning extraordinarily many discharges from certain Copenhagen institutions and subsequent admissions to other institutions. A special list and description of "newcomer" will be provided later in this chapter.

Abuse by substance

Heroin and other opioids are still the most frequently used drugs among the clients in treatment, but especially cannabis is used today by many seeking treatment. . A vast majority of drug users seeking treatment use several drugs. 42% reported in 2006 that they had used more than one drug prior to admission, which means that almost half of those admitted for treatment are polydrug users before starting treatment.

The central stimulants that are the focus of young people's experimental use of drugs appear only moderately as the primary drug for users admitted for treatment in 2006 . Only 6% report amphetamine, 5% report cocaine and 1% report ecstasy⁶ as their primary drug⁷, which is more or less the same as in 2004 and 2005. These drugs are therefore being used mainly as a supplement. Cannabis was the primary drug for

⁶ Here stated as MDMA or similar.

⁷ The percentages are calculated on the treatment population who has reported a primary drug.

24% of those admitted for treatment, but it is also a very widely used secondary drug. 20% of those admitted in 2004 reported using cannabis as a secondary drug.

Distribution of age and gender

In 2006, there were 76% men and 24% women among the drug addicts undergoing treatment, which more or less corresponds to the gender distribution over the previous years. In 2006, the average age on admission was 32 for men and 33 for women.

Social background variables

The information on social background variables reflects a marginalised group in terms of its relation to the labour market, education, housing situation and social life.

A majority of the clients are on benefit income; only 12% of the group have a job, and almost half of them are on unemployment benefits. In all, 18% have completed an education beyond elementary school (primary and secondary school), and 14% left elementary school before the 9th grade. The low level of education should be viewed in light of the fact that most start taking drugs at a very young age, see above. The housing situation of drug abusers is also very bad. Only 55% have their own home – as many as 5% are actually homeless. As regards family circumstances, a large proportion of both male and female drug users were single, which is unusual for a group consisting primarily of young adults. A total of 469 children lived together with an addict admitted for treatment in 2004, whereas 374 children under the age of 18 had been removed from the home.

Foreign citizens

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

New recipients of treatment

The national register of drug addicts receiving treatment provides information as to whether or not the clients have previously been admitted for treatment. Information about newly admitted users is particularly interesting since this group reflects recent trends in the type and distribution of drugs, modes of administration in relation to age groups, etc. In other words, it is possible to follow new trends over time in terms of drug addiction and the recruitment of new drug users. Table 4.2.2 below provides information about the various types of new recipients.

Table 4.2.2. Clients admitted for treatment during the year and who have not been treated for their drug use earlier						
	2001	2002	2003	2004	2005	2006
Clients who have not been treated earlier	1278 out of 4079 (31 %)	1364 out of 4310 (32 %)	1745 out of 5134 (34 %)	1696 out of 5212 (33 %)	1578 ud af 5228 (30 %)	1329 out of 5426 (24 %)
M/W (%)	76/24	78/22	76/24	77/23	75/25	76/22
Average age M/W	28/27	28/29	28/28	27/28	27/28	27/27
Opioids as primary drug (%)*	38	35	28	24	19	15
Cannabis as primary drug (%)*	33	39	44	47	46	50
Central stimulants as primary drug (%)*	11	15	18	23	20	27
Injection (%)	25	23	25	21	19	18

Source: The National Board of Health's register on drug users admitted for treatment in 2001-2006
 *Percentage of those reporting primary drug.

As it appears from table 4.2.2, 24% of the admitted clients in 2006 had not been treated earlier. The decline in the rate of newcomers is primarily explained by the restructuring of treatment in the City of Copenhagen. Not surprisingly, the average age was significantly lower among the newcomers than the average age of the treatment population as a whole. In 2006, the gender distribution among and new and old addicts admitted for treatment was by and large the same.

Primary drug and mode of administration

There is a significantly larger proportion of new recipients of treatment reporting cannabis as their primary drug compared to those who have been admitted for treatment before. The percentage of new recipients of treatment reporting cannabis as their primary drug was 51% in 2006. This is an increase compared to 2005.

Among the 1,329 new recipients who reported a primary drug, only 15% used opioids as their primary drug, which is a decline compared to 2005 when 19% used opioids as their primary drug. 27% reported having used a central stimulant (in this case, amphetamine, cocaine or ecstasy), which marked an increase compared to 2005, and a higher proportion than among the treatment population as a whole.

As regards the mode of administration for heroin among the two "client groups", there is also a difference, as 18% of those who have not previously received treatment report having injected the drug, whereas 34% of those who have previously received treatment have injected heroin in 2006. The different modes of administration between the two client groups may be explained by a "shorter career of use" and by the new opioid users primarily taking smokeable heroin.

Young people receiving drug treatment

Young drug users are making up an ever-increasing share of all drug users receiving treatment. Updated figures are given below, as part of an extension to the special survey carried out by the National Board of Health in autumn 2005, based on an extract from the National Board of Health's register of drug users receiving treatment (Sundhedsstyrelsen 2005b).

From 2003 to 2006, the number of young adults aged between 18 and 29 years receiving treatment increased from 4,466 to 4,706, corresponding to a rise of 5.4%. By comparison, the total number of people receiving treatment rose by 9.1%. When comparing the youth population receiving drug addiction treatment with the total number of Danish youngsters in the same age group, a figure of 4,706 means that 6 out of every 1,000 young people aged between 18 and 29 years were receiving treatment in 2006 which is the same figure as in 2005.

As it appears from table 4.2.3, what is characteristic of the youth population is that, to an increasing extent, cannabis and other central stimulants are the main problems of their addiction. In 2003 and 2006, the number of under 30s seeking treatment for cannabis addiction exceeded those seeking treatment for heroin addiction. However, heroin is becoming a lesser problem among young people receiving treatment. The overall number of young people under 30 seeking treatment for their heroin addiction has dropped throughout the survey period from 746 persons in 1997, 493 in 2003 and 119 in 2006. A decrease corresponding to 84%.

Table 4.2.3 Distribution of main substance for clients admitted in 2003 and 2005 with a known primary drug (percentage)

	2003		2006	
	18 – 24—year-olds	All recipients of treatment	18-24-year-olds	All recipients of treatment
Cannabis	46.0	25.6	47.1	24.5
Heroin	15.3	30.2	5.8	13.8
Amphetamine	12.7	5.8	14.1	6.4
Cocaine	5.8	4.4	7.4	4.7
Ecstasy	4.0	1.2	2.7	0.9
Other opioids	4.8	20.1	3.4	28.8
Benzodiazepines	1.7	2.1	1.1	1.1
LSD	0.0	0.0	0.1	0.1
Other	9.8	10.5	18.4	19.9

Source: The National Board of Health's register on drug users receiving treatment

Particularly among the 18-24-year-olds seeking treatment it appears that cannabis and the central stimulants such as amphetamine, cocaine and ecstasy make up the main problem of their use.

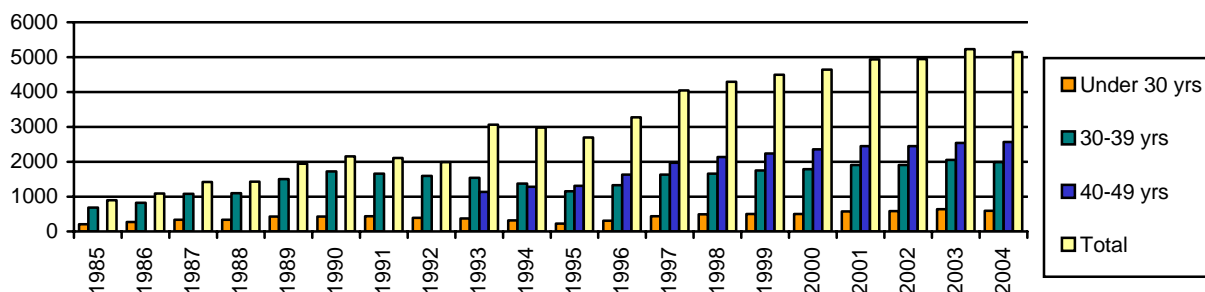
4.3 Methadone treatment and prescription

Since 1985, the National Board of Health has registered the number of clients in long-term methadone treatment, i.e. for more than 5 months. Figure 4.3.1 illustrates the trend in the number of drug addicts under the age of 50 receiving substitution treatment with methadone in December each year during the period from 1985 to 2004⁸. This figure does not include persons receiving long-term treatment under the Prison and Probation Service and persons without a civil registration number (CPR-

⁸ 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 prescriptions (more than 5 months) for people under the age of 50.

number) receiving treatment⁹. At present there are no figures available on persons receiving methadone substitution treatment for 2005 and 2006. However, when looking at trends over the past few years, there are no major fluctuations from 2004 and onwards.

Figur 4.3.1 Persons in long-term methadone treatment (more than five months) 1985-2004



Source: The National Board of Health

As illustrated in figure 4.3.1, the increase in the number of individuals in long-term substitution treatment has continued after the counties took over prescription services, dispensing and control of methadone as of 1 January 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 from 3,276 in 1996 to 5,129 in 2004. Until 1996, methadone registering was only based on prescriptions made.

On the basis of the records from the prescription register, data on the number of people receiving methadone treatment in the Prison and Probation Service and the number of clients receiving treatment without any civil registration number [CPR-no.], 5,700 people were receiving substitution treatment with methadone in 2004.

Following the amendment of the law in 1996, statistics included the persons who were given methadone without the county treatment institutions providing a prescription beforehand. This has caused the vast increase from 1996 to 1997. The increase in number of persons receiving long-term substitution treatment from 1996 also reflects the changes of treatment programmes. Apart from methadone, buprenorphine is used as substitution treatment. In 2004, more than 600 persons received buprenorphine substitution treatment (Sundhedsstyrelsen [National Board of Health] 2005a). The National Board of Health's revised guidelines on the prescription of addictive drugs published on 8 June 2007 and described in detail in chapter 5.1 and 7.1 strongly recommends that buprenorphine should be used instead of methadone.

⁹ In late 2004, a total of 333 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) - (information received by telephone from Datapharm in August 2005).

5 Drug-related treatment

Following the local government reform of 2007, the responsibility for the social as well as the medical treatment of drug users has been transferred from the former counties to the new 98 municipalities. Therefore, as of January 2007 the municipalities are responsible for the visitation to all kinds of drug-related treatment, be it slow withdrawal, outpatient treatment, substitution treatment or inpatient treatment. By far the majority of all drug-related treatment is targeted at drug use closely linked with social problems. The municipality must ensure the requisite coherence between the medical treatment and the related psycho-social services targeted at the social problems that the drug user may also have.

The treatment focusing on a person's social problems should lead to the person being referred to either day or outpatient treatment or hospitalisation. The social treatment must be initiated within a period of no more than 14 days. This time limit will be counted from the first personal contact regarding the wish for treatment. Drug users referred to treatment are entitled to choose between public treatment programmes and certified private treatment programmes of a nature similar to the one, to which they were referred. Normally, they are offered outpatient treatment which can be supplemented with hospitalisation if there is a need for a change of environment and/or more intensive care. The treatment can either be medically supported and has to be accompanied by psycho-social counselling based on the treatment plan.

The medical treatment for drug use primarily includes examination of and treatment for drug use/addiction. Furthermore, the medical treatment of drug users includes an examination of any physical and mental problems associated with the drug use as well as a guarantee of treatment. The indication of substitution treatment with opioids is also based on a medical assessment.

In connection with the local government reform, the National Board of Health has prepared revised guidelines on the prescription of addictive drugs and on substitution treatment of opioid addictive persons, with such guidelines being adapted to the new framework of drug use treatment. The guidelines became effective from June 2007, and the highlights of the guidelines are described below in chapter 5.1.

5.1 Treatment system

The municipal treatment programmes are targeted at various conditions related to use of one or several illicit drugs. The clinical picture is often complex, and the choice of relevant treatment programmes requires an assessment from different sources. Therefore, also a medical assessment must be included in connection with the launch of drug use treatment.

As of January 2003, drug users aged 18 years and over have been guaranteed social treatment for drug addiction. According to the guarantee, drug users may request to be put on a treatment programme no later than 14 days after contacting the county. A sort of free choice was also introduced, whereby the drug user can choose between treatment programmes provided by either public or private institutions. As a follow-up to the treatment guarantee, a ministerial order was issued together with guidelines on quality standards for social treatment of drug addiction. All county councils and municipal boards in the delegation municipalities had drawn up quality standards governing the treatment of drug addiction provided by the county.

The Social Services Act of May 2005 stipulates that in special cases, the Minister of Social Affairs is authorised to establish rules on the guarantee of social treatment for drug users under the age of 18 years. The Minister of Social Affairs issued a ministerial order on the conditions for applying such treatment. The purpose of the law is for the county to immediately arrange for the young person to be admitted for treatment for drug addiction. Young people with serious drug use problems must be put on a treatment programme within 14 days of contact, in the same way as adult drug users are provided with social treatment.

For each treatment path, a medical treatment plan must be prepared. The treatment plan must support the overall action plan which takes into account the health-related as well as the socially related condition and which for the basis of the collaborative process with the drug user. The medical treatment plan must account for the actual aim of the medical treatment and any agreements made in this connection.

The medical treatment of drug users has been an area characterised by much diversity, primarily due to the difference in medical background and the organisational framework of the treatment programmes. As a result of the agreement on reservation of social funds in 2004, the government thus received support to reserve funds for carrying out quality standard procedures and development of the substitution treatment. In practice, the National Board of Health has launched a progressive review of the entire field of medical treatment of drug users receiving substitution treatment. This work will result in new medical guidelines at the end of 2007. The purpose of the guidelines is to support and strengthen the overall action through guidelines for the substitution treatment itself and a description of the medical core services associated with the treatment. The guidelines are expected to contribute to securing consistent quality on an acceptable level. For further details, please see chapter 7.4.

5.2 Support and contact person scheme

As of 1 October 2006, the Social Services Act has been amended in order to expand the support and contact person scheme so that the programme, which is currently restricted to those suffering from mental disorders, can also be offered to the most disadvantaged homeless people, alcoholics and drug users. The purpose of expanding the scheme is to provide the most socially vulnerable and isolated addicts and homeless people with the opportunity to establish and maintain contact with the outside world when they want to and need to, allowing them to use the opportunities available in society, as well as the other established programmes.

This amendment to the law concerning the expansion of the target group eligible for programmes and a support and contact person scheme is being monitored to assess whether the impact of expanding the target group for the support and contact person scheme coincides, in actual practice, with the intention of the proposal, meaning that the new target groups are receiving the programme. At the same time, every effort will be made to take specific measurements of the proposal's impact. In connection with monitoring of the law, the implementation of the scheme will be evaluated in the municipalities.

5.3 Inpatient treatment

Specific data on inpatient treatment can be obtained through the monitoring system DanRIS which has been under development since 2000. The number of inpatient institutions registered at DanRIS was 40 in 2006, which is a minor increase in the number of registered inpatient treatment institutions for drug users over the past few

years. 34 institutions reported data in 2006 and 5 institutions reported data partially in 2006. Those who did not report data or only reported them partially had either technical problems following their transfer to a new municipality or were on their way to closing in 2006. The 40 inpatient institutions cover a vast majority of the institutions treating drug addicts in Denmark (estimated to more than 90% of the drug addicts admitted for treatment). The remainder involves a few very small institutions which do not receive clients from the public treatment system.

The table below shows the development of admissions during the first six half months from 2004 to 2006.

Time	N	Age	Women
1st half 2004	731	32,7	27 %
2nd half 2004	691	32,4	23 %
1st half 2005	716	32,8	27 %
2nd half 2005	527	32,7	24 %
1st half 2006	623	33,1	26 %
2nd half 2006	473	33,1	26 %
All	3761	32,9	26 %

Source: Centre for Alcohol and Drug Research, Danish Registration and Information System, DanRIS.

The number of referrals is always lower during the second half year than during the first. This may be attributable to economy, but also to the fact that the institutions do not register their clients in the database until they have been discharged. As it appears, the number of admissions are rather constant during the first three half years, whereas this seems to change drastically the last half year of 2005 and well into 2006 with a major reduction in number of admissions. If the reduction is made on a yearly basis, the number of drug users admitted for inpatient in 2004 is 1422 in 2004, 1243 in 2005, and 1096 in 2006. This equals a reduction of 23%.

In May 2007, DanRIS published its Annual Report 2006 - STOF. The annual report contains a complete service catalogue for each institution (type of services provided to whom, number of therapists, their seniority and education, prices, etc). In addition, different types of users are identified and described based on type of drug and scope of drug use prior to admission and a forecast on the effect of their treatment. An analysis of the various *groups* of users treated shows, among others, that 63% of the drug users who were heavy consumers of opiates and tranquillizers/sedatives in the month leading up to their admission discontinue inpatient treatment. On the other hand, it also appears that "only" 39% of the drugs users with a low to moderate consumption of illicit drugs in the months leading up their admission discontinue inpatient treatment. Out of the drug users who had severe problems in relation to drugs, crime, social, mental and physical functions in the month leading up to their admission to an inpatient institution, 62% discontinue the inpatient treatment, whereas "only" 39% of the drug users who had less to moderate problems in relation to drugs, crime, social, mental and physical functions more frequently complete inpatient treatment.

5.4 Study into the effect of the treatment guarantee

In December 2006, a study was conducted into the outpatient treatment of drug users in Denmark. One of the objectives of the study was to assess whether or not the treatment guarantee for drug users was observed, including whether or not the 14-day rule for initiation of treatment was met, and which type of services were offered as well as the intensity of them. The study included a review of 443 cases selected at random from 13 counties and 5 municipalities. The material is considered to provide a reasonable overview of the outpatient treatment provided to drug users in Denmark.

In almost all counties and municipalities involved in the study, the observation was that the 14-day rule under the treatment guarantee was observed to a large extent. However, to some extent, misinterpretations of the guarantee provisions exist, or there is not sufficient knowledge of the guidelines, which means that the reporting to the study is most likely erroneous which may have an impact on the study results. Overall, the treatment guarantee was observed in only 59% of the cases. In 23 of the cases, the treatment guarantee was exceeded by more than 1-30 days, whereas in 11% of the cases, a period of 30-60 day lapsed before treatment was provided. In 8% of the cases, the treatment guarantee period was exceeded by more than 60 days.

As regards treatment duration, the study results indicated that 13.5% of the clients terminate their treatment within the first month of treatment, normally by not appearing or being transferred to something else (another county, another treatment unit, prison, etc). When between 2 and 5 months have passed after start of treatment, 25.5% of the drug users receiving outpatient treatment have not shown up for treatment.

In summary, the intensity of treatment develops in two opposing directions. On the one hand, intensity is reduced for a large group of clients - those who discontinue treatment as planned and who go through a very short process. This group is increasing. On the other hand another group is on the uprise, and treatment provided to this group intensifies. This is the group that remains in treatment. An increasing number who previously received ad hoc and outpatient treatment are now referred to drug-free treatment. The reason for this could be that the visitators have found it necessary to have a somewhat longer visitation process. In the meantime, another programme of a less intensive nature has been initiated.

5.5 Initiatives for improved quality of drug use treatment

Based on the study carried out by the Centre for Alcohol and Drug Research on the status of the treatment guarantee to drug users and based on the regulative monitoring of the treatment guarantee, the Minister of Social Affairs has introduced a number of initiatives to ensure overall improvement of the quality of the drug use treatment. Such initiatives deal with the validity of the reports on observing the treatment guarantee, improved quality in case handling, training of case handlers, involvement of user and family organisations and other key players in a national healthcare network and a qualitative evaluation of treatment contents. A total of DKK 10 million (1.3 million EUR) has been set aside for the next 3 years to complete the initiatives.

5.6 Pregnancy, drug use and treatment

Centre for Alcohol and Drug Research at Aarhus University, has conducted a qualitative study based on interviews of 26 women whose alcohol and drug use in connection with or prior to their pregnancy released a number of programmes of a more or less intensive nature, predominantly in the form of special programmes provided by the maternity units, programmes involving drug use treatment and different social activities. These special programmes have more specifically been provided as outpatient programmes for the control of the woman's drug and alcohol use, programmes intended to support and prepare the woman for her role as a parent and inpatient treatment programmes.

Not unexpectedly, the results indicate that the women's physical health, including their nutritional condition was generally poor, and their mental condition generally influenced by problems such as depression, anxiety and suicidal thoughts. In social terms, the group was characterised by low education, transfer income making up their financial platform and a weak social network. Their upbringing has also, to a large extent, been characterized by physical and mental disorders and/or their parents' drug use, and they have themselves started their drug use career at an early age. Many of the women lived in unstable relationships and many of them in violent relationships when they became pregnant. The majority of the biological fathers are also drug users at the time of the woman's pregnancy, and have not or have only had very little contact with the child after it was born.

Most of the women were interested in receiving help and support, but have entered the programmes with some ambivalence. One of the reasons is their fear that the child and/or other children living at home will be removed; the fear and/or previous experiences of being met with negative attitudes from the professional world and the fear or previous experiences of not being involved in treatment plans and decisions, including decisions on future interventions.

In spite of their social problems and their drug use, these women have decided to go ahead with their pregnancy before their first contact with their physician or midwife. To a large extent, pregnancy/having a child/becoming a mother is considered an event leading to a change of lifestyle, including changes in drug use and thus the creation of a stable and normal life.

Intensified action in support of pregnant drug users

In the social reserve pooled funds settlement for 2007 it was decided to amend the law on retention of drug users receiving treatment, whereby the municipal board is obliged to ensure that pregnant drug users receiving inpatient treatment receive a contract on retention. This amendment came into force on 1 July 2007. As part of the agreement, it was also decided to set aside funds over a 4-year-period with the pooled amount being spent on intensified action in support of pregnant drug users. The funds will be granted to a number of municipalities in their work of establishing projects with this purpose. The pooled funds will be announced as funds open for applications during the autumn of 2007.

6 Health correlates and consequences

A number of health-related problems and consequences follow in the wake of drug use. Drug users have very high mortality rates generally because of poisoning and other diseases, including HIV and hepatitis, and drug users who are released from prison have particularly high mortality rates shortly after their release. As far as drug-related deaths are concerned, the rates have been high, however, constant throughout the past few years. Most of the drug-related deaths recorded in police records (approximately 80% of them) are caused by poisoning, whereas the remainder is caused by violence, accidents and diseases. Studies indicate that on average, 3.3 drugs are involved in each drug-related death (Steentoft 2005). Thus, in essence, drug-related deaths are caused by poisoning resulting from polydrug use.

Drug users are often infected with blood-borne infectious diseases caused by intravenous drug use and sexual activity without condom. Based on the various studies (Fuglesang 2000) it is estimated that up to 75% of the drug users are infected with Hepatitis C, whereas approximately 35% are infected with Hepatitis B. Less than 5% are infected with HIV.

Mental disorders in drug users is a well-known element, given that drug use often appears with actual mental disease or mental problems in the form of panic reactions, anxiety attacks, depressions and personality disturbances, etc. Statistics on psychiatric admissions indicate that a little less than 4000 patients per year receive psychiatric treatment and that drug use is an accompanying factor at the hospitalisation (co-morbidity).

To study the scope of contacts at the Danish emergency wards resulting from poisoning after intake of illicit drugs, special statistics have been compiled on the poisonings recorded at the somatic and psychiatric emergency wards. The fact that far from all poisoning cases are reported means that these statistics provide minimum figures only. The figures indicate that around 1200 persons per year are taken to the casualty wards as a result of poisoning with illicit drugs. The drugs causing poisoning are normally hallucinogens and central stimulants among the very young, whereas opioids, including heroin and methadone, are the main causes of poisoning among slightly older drug users.

6.1 Drug-related deaths and mortality rate among drug users

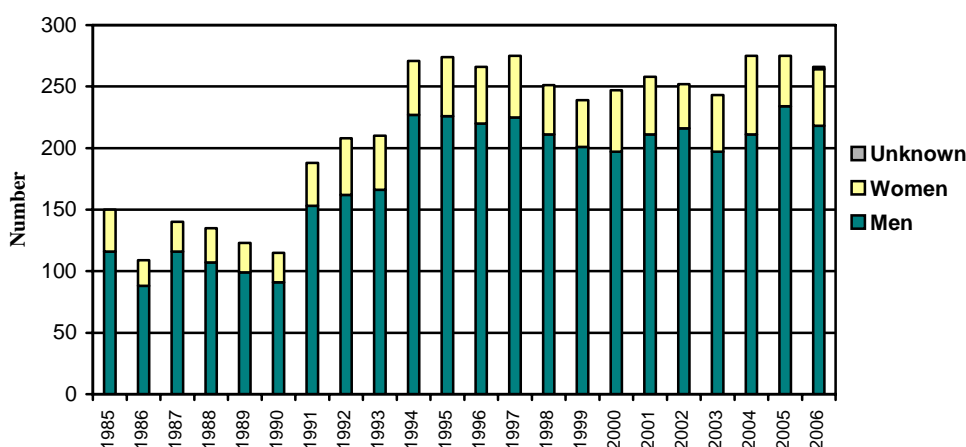
Since 1970, the National Commissioner of Police has registered drug-related deaths. The register contains reported deaths requiring a forensic post mortem. This happens, for instance, in the case of individuals found dead, sudden unexpected death, accidents, homicide and suicide. Deaths caused by poisoning and resulting from accidents where the individual has taken drugs will therefore be reported to the police. Along with 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 comparison, restrictions have been made as to the diagnosis groups included in the collection 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 forensic post mortem has been performed, whereas deaths in general in Denmark are registered in the National Board of Health's Cause of Death Register.

The Nationals Commissioner's Register

The death statistics in the National Commissioner's Register (Figure 6.1.1) show a slight downward trend in the late 1980s and a significant increase in the 1990s (see Table 6.1.1 in the Annex). In 2006 266 drug-related deaths were registered, 82% of which involved men (218) and 17% were women (46) (gender not registered in 2 cases). The number of drug-related deaths in 2004 and 2005 were at the same level as last year's figure of 275, ie slightly higher than in 2006. But the number of drug-related deaths has fluctuated over the last ten years between 239 (1999) and 245 (2003) at one end of the scale, and 275 (1997, 2004 and 2005) at the other end of the scale.

Figure 6.1.1. Drug-related deaths broken down by gender, 1985-2006



Source: Rigspolitiet [National Commissioner's drug statistics] (2007)

Out of the 266 deaths in 2006, 83% (221) were caused by poisoning with one or more drugs. As Table 6.2.1 below shows, 38% (83 out of 221) were caused by poisoning with heroin/morphine or heroin/morphine in combination with another drug, whereas 42% (92 out of 221) were caused by poisoning with methadone or methadone in combination with another drug. Twelve of the deaths from poisoning in 2006 were caused by poisoning with either cocaine or amphetamine. Out of the 266 drug-related deaths, 45 cases were not caused by poisoning, but some other type of drug-related death - such as violence, accident or disease.

Table 6.1.2. Number of deaths caused by poisoning among drug users in the relevant years, grouped according to the assumed main cause of death. Percentage given in brackets

	1991	1997	2002	2003	2004	2005	2006
Heroin/morphine	94 (57)	153 (71)	76 (30)	60 (30)	81 (38)	77 (37)	83 (38)
Methadone	51 (31)	46 (21)	72 (41)	97 (49)	95 (44)	89 (43)	92 (42)
Other	9 (12)	17 (8)	27 (15)	41 (31)	38 (18)	40 (20)	46 (21)
Poisoning, total	164 (100)	216 (100)	175 (100)	198 (100)	214 (100)	206 (100)	221 (100)

Source: Rigspolitiet [National Commissioner's drug statistics]

In 2004 the number of deaths due to poisoning under the "Other" category included the following: Amphetamine: 1, Ecstasy/ecstasy-type substances: 2, Cocaine: 2

In 2005 the number of deaths due to poisoning under the "Other" category included the following: Amphetamine: 1, Cocaine: 2, Codeine: 2, Ketobemidone: 7, Other opioids (strong): 4, Antidepressants: 4

In 2006 the number of deaths due to poisoning under the "Other" category included the following: Other opioids (strong): 7, amphetamine: 6, cocaine: 6, ketobemidone: 5, ecstasy/ecstasy-like.: 1, antidepressants: 1

Table 6.1.2. also shows how the pattern of deaths caused by poisoning, recorded in the police register in the years 1991, 1997 and from 2002 onwards, has evolved. Viewed overall, in every year, opioids (heroin/morphine and methadone) account for by far the majority of deaths caused by poisoning.

During this period, however, there has been a dramatic change observed in the "patterns" of deaths caused by poisoning because, within the group of deaths due to poisoning by opioids, there has been a striking fall in the proportion of deaths where heroin/morphine is indicated as the primary cause of poisoning, accompanied by just as marked a rise in the proportion of deaths where methadone is indicated as the primary cause of poisoning. The proportion of deaths, however, is at the same level during the period 2004-2006.

It also shows that the proportion of deaths where "another" substance is indicated as the primary cause of poisoning has risen over the years. The "Other" group includes substances such as Ketogan, amphetamine, cocaine, antipsychotic drugs and anti-depressants.

It is important to emphasise that it is *the* drug featuring as a drug category in the left column of Table 6.2.1., which is the primary cause of poisoning. In the case of most deaths due to poisoning, there are several substances which contribute to the poisoning, i.e. more than one drug was found in a lethal dose. Similarly, other drugs which may also be detected in the dead person and often contribute to the cause of death, such as benzodiazepines, alcohol, etc., are not listed. A relevant study made by the three institutes of forensic chemistry points out that on average, 3.3 drugs are involved in registered deaths caused by poisoning, which documents a prevalent polydrug use among those who die.

Of the total number of 266 drug-related deaths in 2006, 124, 104 and 38 deaths occurred on Zealand, Jutland and Funen, respectively. The geographical distribution of the deaths in 2005 was 135, 105 and 35 deaths occurring on Zealand, Jutland and Funen, respectively. In other words, almost the same geographical distribution as in 2005 and 2006.

The average age of death has risen in recent years but now appears to be stagnating. In 1993 the average was 33 years, while in 2006 it had risen to 39.2 years, the same average age as in 2004. The average of death for men is 38.5 years and 39.9 years for women.

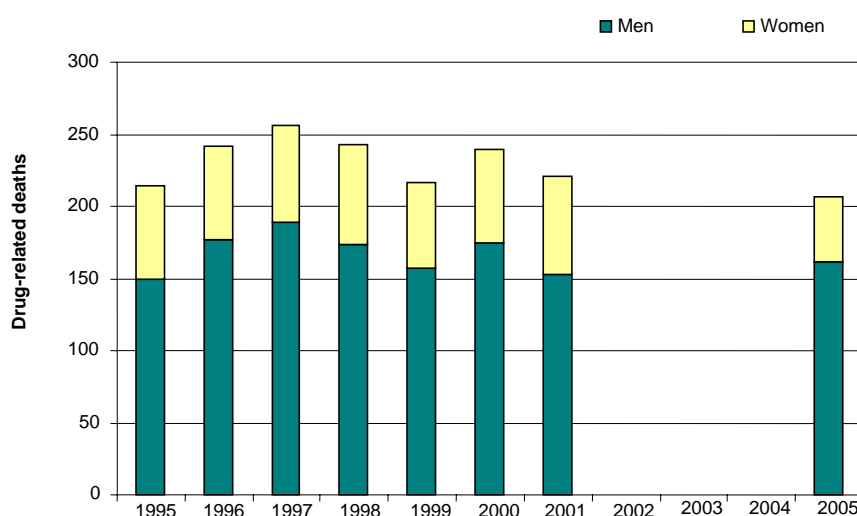
The National Board of Health's register

Figure 6.1.2 shows the development of drug-related deaths registered in the National Board of Health's Cause of Death Register for the period 1995-2005¹⁰. The register applies the European definition of drug-related deaths. Therefore, deaths caused by injurious use of drugs, addiction and drug psychoses as well as deaths caused by poisoning (intentional and unintentional poisoning) have been included.

Deaths caused by traffic accidents or other accidents resulting from the deceased having been influenced at the moment of the accident have not been included. These deaths are, on the other hand, included in the police register based on reports submitted by the forensic institutes.

¹⁰ Figures for 2002-2004 are still not available, but are planned to be published this year.

Figure 6.1.2 Drug-related deaths 1995-2005



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

When considering the entire period from 1995-2005, the number of deaths fluctuate between 200 and 250. The number reaches a bottom low 2005 with only 207 deaths being registered. The proportion of men, however, is higher in 2005 than at any other time earlier during the period. In 2005, men accounted for 78% (161) of all drug-related deaths - in the other years during the same period, the proportion fluctuates between 69 and 74%.

6.2 Poisoning caused by illicit drugs

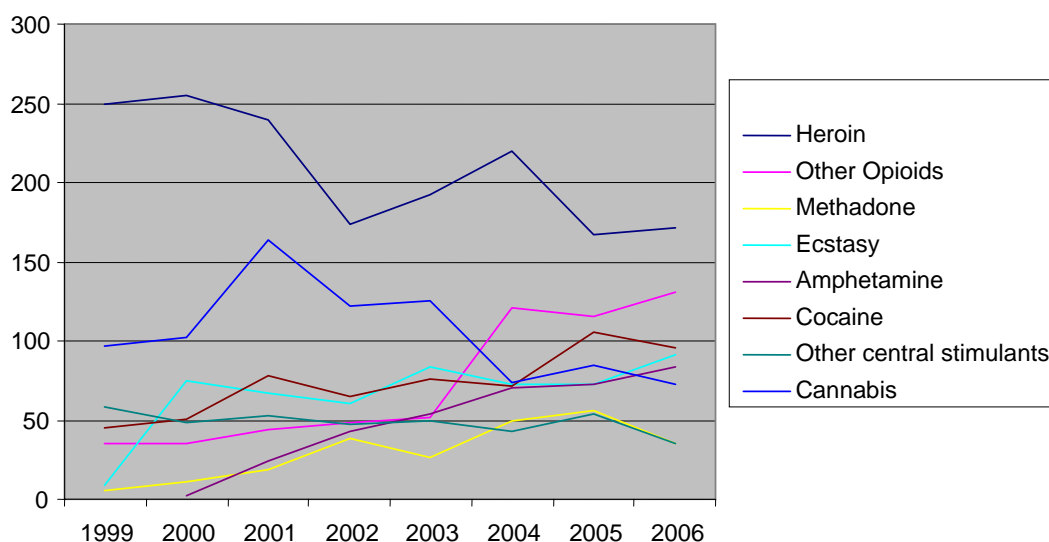
Data from the LPR (the National Patient Register) includes patients with poisoning as the main diagnosis, registered in the somatic or psychiatric casualty departments as well as among patients who have been hospitalized with poisoning symptoms and not first having been in contact with a casualty ward. Table 6.2.1 of the annex shows the scope and development of the registered intoxications¹¹ and poisoning with the various illicit drugs from 1999 to 2006. From 2000, coding practice was altered making it possible to specify poisoning with amphetamine and khat.

From 1999 to 2006, between 1126 and 1437 cases have been registered with poisoning caused by illicit drugs. This marks an increase in the number of poisoning cases throughout the period up until 2003, following which a slight drop is observed in relation to all drugs. During the entire period from 1999 to 2006, the central stimulants account for an increasing number of poisoning cases. As mentioned, the figures should be interpreted with some reservation due to diagnostic and other sources of error.

¹¹ Within psychiatry, the term "acute intoxication" is applied to the diagnosis of mental illnesses and behavioural disturbances caused by psychoactive substances. This term does not clearly distinguish between intoxication and poisoning in the biomedical sense of the word, but with a precision to the fourth decimal place, complications of a varying degree can be indicated for intoxication (uncomplicated, with physical trauma, with other somatic complications, with delirium, with distorted perception and with coma).

A total of 10,364 cases of poisoning were recorded during the first 8 study years. A vast majority of these cases, almost 90%, were treated in somatic departments, and the remaining 10% in psychiatric wards. As regards gender distribution, a little more than double as many men as women have been registered with poisoning during the 8 study years.

Figure 6.2.1 Developments in the number of hospital contacts after intoxication and poisoning caused by illicit drugs from 1999-2006*



Source: National Patient Register under The National Board of Health

*The figures from 2006 are preliminary.

As table 6.2.2 below indicate most of the cases of poisoning are caused, not surprisingly, by opioids among persons over 30 years of age and are extremely rare among the very young. On the other hand, cases of poisoning caused by hallucinogens and central stimulants are most frequently seen in the young people. 69% and 59% of all cases of poisoning caused by hallucinogens and central stimulants, respectively, are registered among young people under the age of 24. 1676 (17%) of all cases involving poisoning during the study period have occurred among young people under the age of 20 years. Cannabis poisoning is the most frequent cause among the young.

Table 6.2.2. Contacts to hospital after intoxication and poisoning caused by the various illicit drugs during all 8 study years broken down by different age groups

	>20 years	20-24 years	25-29 years	30 år plus
Opioids	120	308	489	2017
Central stimulants	553	535	316	448
Mushrooms and hallucinogens	62	53	20	32
Cannabis	246	231	140	189
Polydrug use and unspecified	695	716	556	2292
Total	1676	1843	1521	4978

Source: National Patient Register under The National Board of Health

As regards cocaine which is a central stimulant, this drug accounts rather exceptionally for many of the cases of poisoning among the slightly older population, with persons older than 30 years make up 38% of the cases of poisoning (not shown).

6.3 Drug-related infectious diseases

HIV/AIDS

Action taken in Denmark against HIV is based on the principle of voluntariness, anonymity and openness, providing direct and honest information and security for individuals in their contact with the health authorities. HIV testing is voluntary and people who are HIV-infected are reported anonymously. The HIV reporting system includes age, gender, information about any earlier HIV test and risk behaviour, as well as the presumed method of infection. Cases of AIDS are reported by name and personal data.

Table 6.3.1 in the Annex shows the number of newly diagnosed HIV positive patients and the proportion of these who were intravenous drug users over the past 10 years¹². The number of persons newly diagnosed as HIV positive has varied from year to year, as has the number of infected persons where the source of infection is assumed to be intravenous drug use. In 2006, 5% (11 persons) of those newly diagnosed as HIV positive were registered as intravenous drug users. This percentage has remained more or less the same, i.e. around 10%, over the past 10 years. In 2006, 6% of the reported AIDS cases were established in intravenous drug users, which constituted 3 out of a total of 47 persons.

Hepatitis A, B and C

Despite minor fluctuations, there seems to have been a decline in the number of registered acute hepatitis cases in the Danish population as a whole over recent years (Table 6.3.2 in the Annex). During the same period, the proportion of acute cases of hepatitis where the infected person has been an intravenous drug user has been approximately 1% for hepatitis A, varying between 6% and 35% for hepatitis B and 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. As hepatitis C is most often asymptomatic in the acute phase, the number of cases of hepatitis C reported is a gross underestimation of the actual incidence of hepatitis C. Consequently, from 2004 and onwards the number of cases of chronic hepatitis C reported are also included in the register.

Studies into the spread of infectious diseases

As part of categorising, harmonising and mapping the incidence of infectious diseases among drug users in the EU, the National Board of Health supported a research project in 2004, 2005 and 2006, which studied the spread of infectious diseases among drug users¹³. There was also an analysis of the incidence of HIV, hepatitis B and C among drug-related deaths recorded in the National Commissioner's Register for drug-related deaths, based on reports from forensic institutions. Provisional results from the study on infectious diseases among those whose deaths were caused by drugs in 2006 have now been prepared and are reproduced here.

¹² 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. Statens Serum Institut.

¹³ The initiative for the study was taken in the *national key indicator group for infectious diseases* and a member of the group, special consultant Dr Peer Brehm Christensen is the project leader for the study. The results of the study for 2004 have been published in the *European Journal of Epidemiology* 2006;21:383-387.

During the post mortems carried out on 266 suspected drug-related deaths in 2006, blood samples were taken from 205 people (equivalent to 77% of the total), out of whom 191 (93%) could be tested for one or several markers.

The analysis results showed that 61% of those examined tested positive for hepatitis C antibodies, while 38% were positive for hepatitis B (anti-HBc) and 17% were protected against hepatitis B (anti-HBs positive), as a result of vaccination. HIV infection was indicated in 2 % of cases. The results were almost the same as in 2005 (HCV 58%, HBV 35% and HIV 4%).

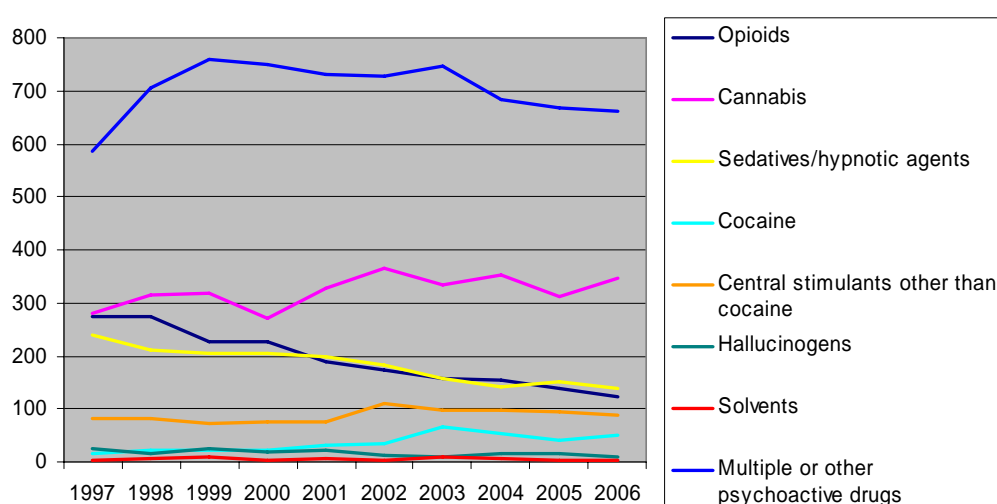
The studies mentioned give rise to the interpretation that the incidence of hepatitis B and C among drug users for the past three years remains more or less the same and that the incidence of HIV infection among drug users is unchanged and relatively low. Only a minor fraction of those infected is known by the reporting system and as far as hepatitis C is concerned, "only" 9% were reported to the Medical Officer's Institution for acute or chronic hepatitis C.

6.4 Co-morbidity and drug users in psychiatric treatment

Mental disorders in drug users is a well-known phenomenon, given that drug use often appears together with actual mental illness or mental problems in the form of panic reactions, anxiety attacks, depressions and personality disturbances, etc.

In 2006, a total of 3,849 persons were admitted to psychiatric hospitals with a drug-related primary or secondary diagnosis (co-morbidity). This is a slightly higher number than in previous years. The number of hospitalisations caused by *secondary diagnoses* alone and related to drug use are still rising, with 2,430 persons being hospitalized in 2006. The number of persons admitted to hospital with drug-related *primary diagnoses in 2006* was 1,419 persons, which is the same level as in 2005. Hospitalisation resulting from co-morbidity is shown in the tables of the annex and illustrated in the figure below.

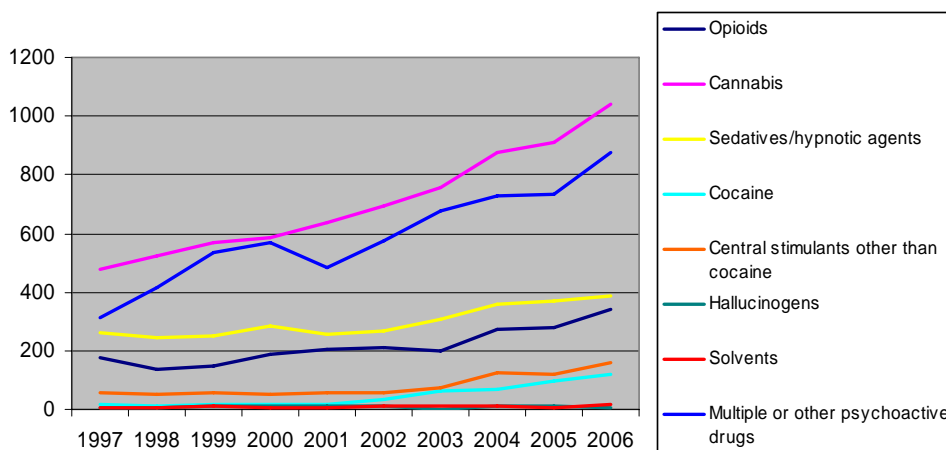
Figur 6.4.1. Persons registered with drug-related primary diagnoses in psychiatric hospitals 1997-2006



Source: Unpublished figures from the Psychiatric Central Register at the Dept of Psychiatric Demography at Institut for Psykiatrisk Grundforskning, Psychiatric Hospital, Århus

During the entire period, persons with primary diagnoses in relation to "polydrug use" make up the largest group, and they have increased in numbers throughout the years, however with annual fluctuations. The second most prevalent group throughout almost the entire period are the persons with cannabis-related primary diagnoses which in 2006 comprised almost 25% of the persons receiving psychiatric treatment for a drug-related primary diagnosis. At the same time, the proportion of people with opioid-related primary diagnoses dropped steadily throughout the period.

Figure 6.4.2. Persons registered with drug-related secondary diagnoses in psychiatric hospitals 1997-2006



Source: Unpublished figures from the Psychiatric Central Register at the Dept of Psychiatric Demography at Institut for Psykiatrisk Grundforskning, Psychiatric Hospital, Århus

In the case of secondary diagnoses that are related to cannabis, the number of persons has gone up steadily throughout the years from 477 persons in 1997 to 1040 persons in 2006, which is more than a doubling during the period. Also, a regular increase in the number of persons admitted to hospital with a secondary diagnosis is seen in relation to cocaine and other central stimulants, although the number is significantly lower than compared to the hospitalisations related to cannabis. Hospitalisations with a secondary diagnosis related to "polydrug use" is considerable and accounts for 1/3 of the overall number of drug-related hospitalisations with a secondary diagnosis related to drugs.

7 Responses to Health Correlates and Consequences

Drug abuse must, in a number of cases, be regarded as a chronic condition or disorder, which can by no means automatically expect to be cured by making the person drug-free, but where treatment and other measures can alleviate and reduce the harmful effects.

Reducing the harmful effects is an integral element in the drugs policy. In terms of waging an uncompromising battle against drug abuse, the existing programmes for reducing the harmful effects may very well seem paradoxical, but are regarded, all the same, as being pragmatic and sensible. This applies, for instance, to providing methadone prescriptions, supplying clean syringes and needles and water ampoules, providing cleaning fluids in prisons, as well as low-threshold programmes in the form of drop-in centres for drug users.

However, if the requirements for reducing the harmful effects need to be even more far-reaching in terms of their quality, this raises the basic question as to whether any overall limit should be set for harm-reducing measures, with the good intention of meeting drug users half way, and if this should happen, whether this limit should be set while rightly taking into account other social factors. A totally consistent pursuit of this intention to reduce the harmful effects leads to a direct contradiction with the drugs policy's actual fundamental basis: opposing all non-medical and non-scientific use of drugs. This is why the government is rejecting measures such as introducing drug injection rooms.

In its efforts to maintain and improve the already existing harm reducing programmes and to improve entirely new programmes, the Danish government has, via the social reserve pooled funds for 2006, set aside funds for the establishment of the so-called "Vesterbro-pulje". The local forces at Vesterbro in Copenhagen, the centre of the capital's "drug scene", may apply for grants for locally based initiatives. Broadly speaking, the aim was to improve conditions for the drug users and reduce the problems facing the drug environment at Vesterbro. With the granting of the pooled funds for Vesterbro in August 2006, the Ministry of the Interior and Health set aside funds for a three-year study of "health suites". These suites provide a setting in which relevant health care programmes, social counselling and drop-in functions, etc are combined. Theoretically, the "health suite" would basically contain all the elements associated with drug injection rooms, except for the permission to take illicit drugs, which means that the government must reject this as being too radical. The project will take the form of a partnership agreement between the City of Copenhagen and the local forces of Dugnad Center Vesterbro.

In 2007, new initiatives for the health care activities in relation to drug use described below have been initiated from a central body or from the Copenhagen Region. The reason is probably that the new municipalities outside the Copenhagen area have had a bigger need for becoming firmly rooted in the new local entities in connection with the structural reform rather than prioritising the launch of projects and new initiatives.

7.1 Prevention of drug-related deaths

Trial with dispensing of "antidote", Naloxone

In 2007, the City of Copenhagen launched a pilot project, the aim of which is to clarify whether it is possible and makes sense to have a group of drug users treat overdose cases in other drug users by intramuscular administration of an "antidote" (Naloxone). Experience from other European capitals suggest that this may reduce the number of deaths caused by overdoses.

A trial has been planned to dispense Naloxone to the permanent users of the "health suite". The drug users included in the project will receive training in diagnostics and assessment of poisoning, in the general principles for treatment of overdose cases, in the administration of Naloxone and the importance of calling for emergency medical assistance. Also, they will be instructed to stay at the emergency scene until the ambulance arrives and to provide first-aid while waiting.

The project participants will be supervised on a current basis and be assisted by doctors and nurses working in the "health suites". It is also provided in the project that the drug user acts as the doctor's assistant.

Buprenorphine – a safer substitution agent

The National Board of Health's revised guidelines of 8 June 2007 (described in chapter 5) on the prescription of addictive medication contain changed recommendations for the choice of drug in substitution treatment. The Board urges doctors to prescribe buprenorphine instead of methadone. The use of buprenorphine is safer. This means that the need for control of the drug users is reduced. However, more important is the fact that the risk of poisoning will be much lower than it is today. Based on experience from abroad, this recommendation is expected to contribute to a drastic reduction in the number of drug-related deaths.

7.2 Prevention of infectious diseases among drug users

Intravenous drug users, their co-habitants and regular sexual partners, if any, belong to the particularly vulnerable group who are offered a free hepatitis vaccine, cf ministerial order no. 746 of 29 June 2006.

Syringe programmes are a broad preventive measure used throughout the country, targeted at injecting drug users, intended to provide them with clean syringes thereby avoiding HIV and other blood-borne infections. In order to strengthen the continued efforts to prevent infectious diseases among drug users, two new initiatives were launched in 2006/2007: a new action plan for the prevention of hepatitis C and a study of new methods to identify antiviral treatment administered to HIV positive drug users. The two initiatives are described below.

Action plan for the prevention of hepatitis C among drug users

The social reserve pooled funds agreement adopted by the Government and the pooled funds parties in 2006 set out that a number of initiatives had to be taken to retain and further build on the current efforts to combat drug use, including an ambition to improve the efforts to curb drug use and the serious injuries inflicted on the drug users themselves, their relatives and the surrounding community. It was decided that the efforts to combat hepatitis C among drug users should be spread out nationally. As a result, the National Board of Health has prepared an action plan describing the current preventive intervention against hepatitis C among drug users and

suggests new specific initiatives, through which this work can be intensified. In the action plan it is recommended that the efforts to combat hepatitis C among drug users on a national scale should be intensified through the initiation of two local initiatives mentioned below:

- The municipalities must ensure that the work (for instance by appointing a coordinator) is organised in such a manner that the target group is provided measures *systematically* in the form of: 1) information and counselling on prevention against blood-borne infections to drug users, whether or not they are diagnosed as infected or not; 2) screening for hepatitis A, B and C as well as HIV; 3) vaccination against hepatitis A and B, and finally 4) Referral to treatment.
- The municipalities must ensure that for each of the treatment institutions used by the municipalities, an annual status on the implementation of the action plan is made in order to facilitate the evaluation of the programmes provided in terms of prevention, examination and treatment.

The target group consists of all the intravenous drug users admitted for treatment as are those drug users who have only injected drugs once and as such do not see themselves as actual intravenous drug users.

The objective of the action plan is primary as well as secondary prevention, given that screening and counselling must arouse an awareness in the infected as well as the non-infected of the infection risk in general and that a clearing of the virus in the body when treating those who are already infected will reduce the risk of these drug users transmitting the virus to non-infected persons. Another objective is to initiate appropriate treatments to HIV-infected persons with a need and to point out that vaccination against hepatitis A and B will protect the general health of those who are HCV-infected.

Study of the antiviral treatment for HIV-positive drug users

Having received funds from the Danish Ministry of the Interior and Health, the special institution at Forchhammersvej has conducted a study into the methods that may optimise antiviral treatment given to HIV-positive drug users.

The objective of the study is to learn if through more thorough education in the HIV disease among the infected drug users can improve their ability to follow the antiviral treatment (better compliance). Many of the HIV-positive drug users know only very little about the HIV disease, and by increasing their knowledge about the disease and its treatment, it might be possible to reduce the medication dose. The staff at Forchhammersvej also needs to enhance their competencies in relation to the disease and its treatment. In addition to education in diseases and treatment, the staff will be trained in "Motivating talks" in order to better communicate about the disease with the HIV-positive drug users. The project is carried out in close collaboration with the regional departments of infectious medicine and is planned to terminate after 2 years.

7.3 Measures related to psychiatric co-morbidity

As a result of the psychiatry agreement for 2003-2006, pooled funds were set aside for particularly prioritised areas. One of the areas included the users who also suffer from a mental disease, ie the so-called "co-morbid drug users" who belong to the most vulnerable. From these pooled funds, nine specific projects targeted at the co-morbid drug users have received grants for the establishment of special outpatient

units, the establishment of a clinic, the introduction of new treatment methods, the development of collaboration, etc. As a result of the psychiatry agreement for 2007-2010, permanent funds have been set aside with the aim of maintaining the activity level achieved through the psychiatry agreement for 2003-2006. This enables the regions to carry on the projects launched under the psychiatry agreement for 2003-2005 as well as the projects for the co-morbid drug users.

In the Copenhagen Region, outpatient treatment programmes have been improved for co-morbid patients. The special outpatient unit handling the treatment of drug users with severe psychiatric problems has had a capacity for 25 patients. From the summer, 2006, an outreach psychosis team was established with room for 100 users with psychiatric disorders. The plan for this treatment programme was to cooperate closely with the district psychiatric service as well the drug use treatment services. When in doubt on where to place a drug user with co-morbidity, the further treatment of him/her will be determined by a visitation unit, including representatives from the psychiatric and the drug use treatment service. As of 1 August 2007 almost 50 patients have been accepted for the programmes, approximately 10 patients appear on a waiting list. It is expected that this scheme will lead to qualified treatment of drug users with a psychiatric disorder. However, it is considered important that in the long term, a constructive collaboration with the district psychiatric centres as well as the drug use centres can be established so that the more successfully treated users, no longer chaotic patients, can be transferred to treatment at these centres.

7.4 Measures related to other health issues

Pooled funds for health care programmes provided to the most vulnerable drug users

The parties supporting the pooled fund agreement have set aside DKK 28 million (3.7 million EUR) for the period 2006-2009 for the launch of targeted health care programmes for the most vulnerable drug users. Following the professional evaluation of the applications received, the National Board, the funds have been allocated to cities such as Copenhagen, Odense, Esbjerg, Aarhus, and Guldborgsund municipalities.

It is expected that *on the one hand* the projects will lead to generally improved health in the target group, *on the other* facilitate access to relevant health care programmes and *finally* to counteract structural obstructions to the improvement of the health condition in homeless drug users (bridge building and continuity in treatment). This must primarily take place through a combination of socially related Street Level Projects and health care enabling the most marginalised drug users to be met by health care programmes targeted at this type of drug users in particular.

In mid-2007, the projects in most of the municipalities are gaining ground - however with some inter-municipal variation in accordance with local requirements. In general, the municipalities report of large support to the projects from a political as well as a user perspective, and the preliminary knowledge gained so far suggests that the new health care programmes are highly in demand by the target group and cover a hitherto uncovered need.

Pooled funds for health care promotion and prevention

The parties supporting the pooled funds settlement have also set aside DKK 22.5 million (3 million EUR) for the years 2007-2010 to strengthen health care promotion and preventive measures in relation to the most vulnerable alcohol and drug users as well the homeless. A supportive element of the project will be to establish health care

programmes for this group of people together with potential change environments. The pooled funds will be provided during the autumn of 2007.

New guidelines for the medical treatment of drug users

Based on the government's pooled funds settlement for 2004, an amount has been set aside to carry out quality assurance and development of substitution treatment. In practice, the National Board of Health has launched an overall review of the medical treatment of drug users in substitution treatment. This review will lead to the publication of new medical treatment guidelines before the end of 2007. The purpose of the guidelines is to support and strengthen the overall activities through guidelines for the substitution treatment itself as well as a description of the health-related problems seen in drug users and the medical core services associated with the treatment. The guidelines are expected to contribute to an improvement of the often very poor physical and mental condition resulting from a life as a drug user and to ensure consistent quality of treatment at an acceptable level.

The guidelines will instruct in how to assess and treat mental and physical problems related to drug use, prevention of unwanted pregnancy, contraceptive counselling and prevention against sexually transmitted diseases as well as treatment of pregnant drug users.

The guidelines and related recommendations are prepared on the basis of currently available international and national documentation within the area. They have been prepared in collaboration with expert working groups from clinical practice, the National Board of Health's expert panel and a reference group appointed for this particular purpose, including representatives from the Ministry of the Interior and Health, the Ministry of Social Affairs, Local Government Denmark (LGDK), the Medical Officer's Institution in Copenhagen, Danish Society for Addictive Medication, Centre for Alcohol and Drug Research, The Association of Locally Employed Doctors and the Prison and Probation Services.

The guidelines and their recommendations must contribute to ensuring a consistent and acceptable quality of the most significant medical core services associated with substitution treatment of opioid addicts. In the long term, the guidelines and their recommendations will also form the basis for ongoing quality development and be the focus of organisational planning of treatment in the municipalities.

8 Social correlates and consequences

Several studies show that there is a correlation between drug abuse and problematic social and economic living conditions and their consequences. The fact is that in terms of housing, family life, financial and educational conditions, drug users undergoing treatment are much more disadvantaged than other groups in society (see Chapter 4).

Studies also show that many of the young people developing an addiction problem also have many problems in their family and social life, as well as with their working life, education and their life as a young person in general (Videns- og Formidlingscenter for Socialt Udsatte [Danish Centre for Research on Social Vulnerability] 2006).

8.1 Social exclusion and problems

Social exclusion is a well-known phenomenon among drug users. A look at the social, housing and educational situation of drug users undergoing treatment makes it clear that these people are a marginalised group compared to others. They are much 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 terms of drug abuse are children from families where there is abuse, violence and neglect, who start taking alcohol and cannabis early on, young immigrants who are poorly integrated, refugees with traumatic experiences behind them, mentally frail individuals, the mentally ill and the homeless.

Young people with social and addiction problems

Since last year, no new surveys have been conducted on the social problems related to young people's drug use. A survey carried out by the Danish Centre for Research on Social Vulnerability in 2006 (Videns- og Formidlingscenter for Socialt Udsatte [the Danish Centre for Research on Social Vulnerability] 2006), the very young people who subsequently develop drug use are early in contact with the social authorities and administrations in the municipalities. These young people come into contact with social services as a result of serious educational, work-related and housing problems. Consequently, according to the municipalities' assessments, the problems of *some* of these young people arose as part of their drug abuse, but for the large majority of them, they faced these problems in their everyday lives long before they actually started using drugs. The growing focus on young people with social problems and addiction problems has resulted, according to the survey, in many municipalities establishing in recent years extensive initiatives aimed at generating contacts, providing advice and reaching out.

Treatment register data also indicate that there are roughly 2,000 children under the age of 18 who either live at home with their parents or are placed outside the home, where one or both parents at the same time have been admitted for treatment. The number of children registered to be living in drug addict families has been on the rise over the last few years, and these young people are at a high risk of encountering social problems and developing a possible addiction later on in life.

8.2 Drug-related crime

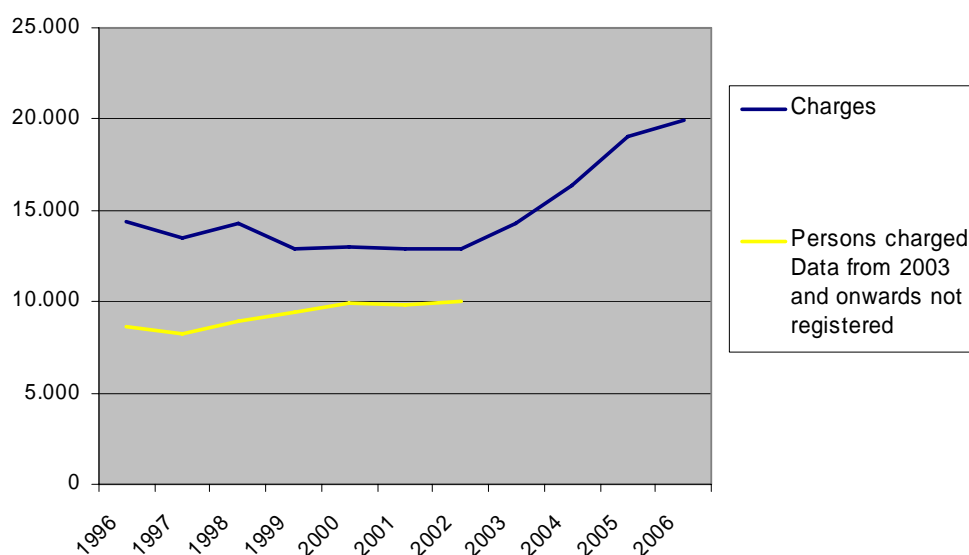
Records are kept of reports filed, charges and sentences passed under the Euphoriant Substances Act, which primarily deals with possession and sale of small quanti-

ties of drugs, and under the criminal code's Section 191 (subsection 1) (sale), (subsection 2) (smuggling), which relate to 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 bring charges leading to prison sentences, other sanctions or acquittal. The National Commissioner of Police registers the number of reports filed and charges brought on an annual basis.

Figure 8.2.1. Drug-related crime 1996-2000.
Charges and number of persons charged



Source: Police drug statistics 2007

In 2006, a total of 19,900 charges were made in connection with violation of the drug legislation (see table 8.2.1 of the Annex). The number of charges has gone up steadily from 2003 and until today. In comparison, the number of charges was lower and relatively stable, ie 13,000 charges per year from 1999-2002. Since 1994, the number of persons charged has been between approximately 8000 to 10,000 annually. Data on the number of persons charged from 2003 and onwards are not available.

8.3 Drug use in prisons

Since the Alcohol and Drug survey conducted in 2002 (Kramp et al 2003) no new survey data have been disclosed to describe the patterns of coherence between use of various drugs and the involvement of such drugs in violation and different types of crime. The results of the survey in 2002 showed that $\frac{3}{4}$ of the Prison and Probation Service clientele has tried cannabis, more than half of them have tried central stimulants such as cocaine and amphetamine, whereas $\frac{1}{3}$ has tried heroin and/or mor-

phine substances. Half of the Prison and Probation Service's clientele has an actual use drugs (use of alcohol included) ¹⁴.

A new registration module in the Prison and Probation Service's client system was introduced on 1 October 2004. This module contains records of all the new inmates' use of drugs in prison. With the introduction of a treatment guarantee for drug users under the Prison and Probation Service as of 1 January 2007, the module was expanded with a number of further data. The Prison and Probation Service has thus developed and tested an IT-supported documentation matrix which is to support case handling locally and which is being used as a control tool for registration of drugs and alcohol in the Prison and Probation Service institutions.

As of September 2007, it will be possible for the Prison and Probation Service to register developments within the number of users and their rate of burden and motivation.

Another module in client registration is the electronic report submitted to the National Board of Health and the number of methadone prescriptions written to inmates. The scope of drug users in substitution treatment with methadone among inmates is described in Chapter 4 in this report.

¹⁴ Drug abuse is defined as the consumption of drugs twice a week or more in the month prior to imprisonment/registered supervision. Alcohol abuse is defined as the consumption of 11 drinks or more daily in the 6 months prior to imprisonment/registered supervision, 10 incidences of inebriation or more in the month prior to imprisonment/registered supervision and/or ongoing treatment for alcohol abuse.

9 Responses to social correlates and consequences

It is the task of the Ministry for Social Affairs and the Ministry of Employment to coordinate measures aimed at the social integration (social inclusion as a whole) of drug users. There has been no special organisation set up to deal with this; instead, these two ministries are responsible for coordinating and implementing action initiatives, aimed at drug users as one of the target groups among the "socially vulnerable" group, which includes measures for social integration. The Ministry of Social Affairs is coordinating measures with the programme "Det fælles ansvar II" (Shared responsibility II) (Socialministeriet [Ministry of Social Affairs] et al. 2006). The Ministry of Employment is focusing on the socially vulnerable receiving cash benefits as part of the government's "Nye veje til arbejde" (New ways to work) programme (Socialministeriet og Beskæftigelsesministeriet [Ministry of Social Affairs and Ministry of Employment] 2006), where a considerable section of the target group is involved in drug and/or alcohol abuse.

The overall aim of this measure is to support socially vulnerable groups in taking the necessary steps towards employment in various forms, as well as to focus on improving the individual's quality of life and personal skills. The purpose is to create better opportunities for self-help, better opportunities for becoming part of a social network and having a better daily structure (Socialministeriet [Ministry of Social Affairs et al] 2006). Overall, it is about the government stepping up its efforts further and adding initiatives and financial resources. These resources must be partly used to overcome the barriers facing the socially vulnerable, including drug users, in terms of creating a closer association with the general labour market. Measures are being targeted at the individual drug user, the private labour market and local social workers.

In recent years, a number of programmes of a temporary as well as a permanent nature have been established. The aim of these programmes is to support drug users in establishing a stable housing situation. Activities targeted at improving housing conditions are generally considered as an important measure to achieve social integration, both as a means and as an end to the means.

In accordance with Section 111 of the Social Services Act, the municipality is obliged to offer drug users a social action plan, with goals and strategies being discussed together with the individual drug user as regards his/her future housing situation, financial situation and other situations in life. Thus, the local case handlers are those with the action competence to begin with in terms of social integration of the drug users in a number of areas.

The national strategy concerning criminal drug users is based on treatment being administered by the social authorities to a large extent. Treatment initiatives launched by the Prison and Probation Service should primarily be motivating and uncover needs. However, where participation in such a programme may be difficult for safety reasons, the Prison and Probation Service should aim at providing relevant treatment during imprisonment. On 1 January 2007, the Prison and Probation Service was given a treatment guarantee in relation to the drug users who are considered eligible and motivated for treatment and who at the time of seeking treatment are facing 3 months' estimated legal penalty as a minimum.

9.1 Social reintegration

Homelessness and accommodation services

In accordance with Section 110 of the Social Services Act, reception centres are temporary housing programmes aiming at homeless people with severe social problems. The reception centres work with "home training", preparing and supporting this group of people to establish themselves in their own home.

Since 1 July 2005 the municipalities have had the opportunity to enter agreements with general accommodation organisations for leasing empty general flats for use as re-integration flats. These flats can be offered to drug users who, for instance, have stayed in a reception centre, an inpatient treatment institution or other type of accommodation and who have been receiving support from the accommodation programme for a period of two years. After the re-integration period, the lease continues on normal terms.

Some drug users either do not fit into or do themselves feel comfortable in traditional dwellings in spite of social grants, and for this group, permanent flats have been created under the Non-Profit Housing Act called "alternative houses".

In accordance with Section 108 of the Social Services Act, there are also "alternative care homes", which offer long-term accommodation to drug users who are unable to manage in their own home and who can be accommodated in general care homes for the elderly due to abuse, dementia or problem behaviour. "Alternative care homes" are set up by the counties, often in connection with a reception centre.

Social skills and network building

A great deal of the social work carried out with drug users takes place at drop-in centres. These programmes offer physical care (rest, food and warmth), social care (opportunity to create a social community) and support for change. The activities at these drop-in centres have developed in recent years and today, more network-inspiring and activating activities are being offered. In the government programme "Det fælles Ansvar II", plans are made to develop these activities further.

A focus area targeted at social skills and network building for drug users is an extension as per 1 October 2006 of a programme involving support and contact personnel (SKP), cf Section 99 of the Social Services Act which previously was only provided to the most isolated mentally ill. The main feature of this scheme is its long-term aim of reaching out to drug users and establishing contacts, followed up by help in resolving user-specific and user-defined problems, including direct help with everyday living, (re)building a social network and (re-)establishing contact with the social authorities. The SKP scheme is performed without the involvement of authorities, and the users can participate in anonymity.

Education and employment programmes

Many drug users perform poorly at school and only have a very basic education when they leave school. Opportunities for catching up on lost schooling after leaving school are good in Denmark, especially through the regional Adult Education Centre (VUC). There are special programmes for those who are poor at reading; it is possible to complete the basic primary education by taking subjects separately, as well as take the school leaving certificate or Higher Preparatory Exam at secondary level at night school, either as single subjects or as a special course. There are also day-time secondary school programmes offering education of a non skills-based nature. The aim of this is to increase the individual's general and technical knowledge and skills,

thereby increasing their ability and desire to take responsibility for their own lives and to actively take part in society

In the case of long-term unemployed drug users and other socially vulnerable people, who have spent a long or medium-length period in education, the government is planning to develop special vocational training programmes with a guaranteed job (Socialministeriet [Ministry of Social Affairs] et al. 2006). The aim is for them to be able to brush up on their technical skills in the area they used to work so that as many chances are created as possible in terms of offering them access to employment.

Employment programmes and benefits

Clean drug users are usually offered the same job-creation programmes as other cash benefit recipients or the unemployed. Drug users receiving longer-term substitution treatment are mainly offered activity and social programmes, often linked to an addiction centre or drop-in centre.

To facilitate the transition from a back-to-work programme to actual employment, a fund has also been set up for establishing mentor schemes at drop-in centres, where a person associated with the drop-in centre helps vulnerable users to find a job, supporting them with advice and guidance about how to apply for a job. The mentor should also ease the burden for the company of the difficulties which can be associated with employing someone with particular problems. This fund contains DKK 10 million (1.3 million EUR) per year for four years. Companies are also offered temporary cover via a fund containing DKK 5 million (0.7 million EUR) per year over four years. The intention of this is to make sure that the employer does not suffer any loss if the employee happens to be absent.

9.2 Prevention of drug-related crime

As part of the Government's social reserve pooled funds settlement for 2006, the Prison and Probation Service has been allocated resources for a number of initiatives, including setting up two new treatment units and a follow-up treatment unit in selected prisons, as well as a number of outreach initiatives relating to drug users in prisons across the country. This is a wide-ranging initiative intended for inmates wishing to become totally "clean" and those preferring substitution treatment, mainly with methadone.

These initiatives have been implemented in accordance with the political intention of the settlement. In 2007, status will be made on the initiatives and the challenges of the next few years will be considered. At present it looks as if the inmates have welcomed the new treatment programmes, given the relatively high number of persons seeking treatment.

To improve the transition between a stay in prison and subsequent release, the Ministry of Social Affairs issued a set of guidelines in 1998 about cooperation between social services and the Prison and Probation Service's institutions and departments. But this cooperation has hardly ever worked at all, even though the need for coordination is great. Implementing measures, including treatment cycles, goes completely by the wayside if there is no handover on release (Ramsbøl 2003). In February 2006, the Ministry of Social Affairs issued ministerial order no. 81 concerning the municipalities' duty to coordinate action plans with the Probation and Prison Service for certain groups of people. According to this order, the Prison and Probation Service must

contact the municipality four weeks before a person is released to coordinate action plans, and the municipality is responsible for following up on the referral.

It has turned out to be difficult to establish cooperation between the municipalities and the Prison and Probation Service, which mainly is attributable to factors such as structural changes as a result of the local government reform. The Ministry of Social Affairs, the Ministry of Housing and the Directorate of the Prison and Probation Service will in future focus on coordinating the action plans with a view to improving quality.

To support the implementation of both the new and older legislation, the Ministry of Social Affairs, Ministry of Employment and Directorate for the Prison and Probation Service jointly set up in 2006 a three-year project, intended to develop, test and describe the methods for handling these people properly on their release. There are three prisons, a number of municipalities, departments from the Prison and Probation Service and addiction centres involved in the project, which are some of the key players in terms of coordinating this measure.

10 The illicit drug market

The police seizure statistics provide no totally clear 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 each of the years. This means that seizure statistics give a very rough indication of the *prevalence* of drugs on the illicit market and are just as much an indication of *police activity*.

Results from special forensic chemical analyses carried out in Denmark over recent years show that there are major variations in the purity of the active ingredients in illicit drugs on the market¹⁵. The variation is seen in the more traditional drugs such as heroin, amphetamine and cocaine, and in the new synthetic drugs typically found in ecstasy pills. As the concentration and contents of the drugs therefore are often unknown, this implies a special risk upon intake.

10.1 Drug supply and demand

The National Commissioner of Police gathers information about the countries which produce and distribute the illicit drugs seized in Denmark. As in previous years, Morocco is still the key country where cannabis is produced for the Danish market, with Spain, Portugal and the Netherlands being the key distribution countries. As regards heroin, the vast majority comes to Denmark from Afghanistan, whereas amphetamine and ecstasy seized in Denmark are produced primarily in the Netherlands and Belgium. Cocaine is produced mainly in South America and usually distributed via the Netherlands and Spain.

As regards the availability of the drugs, seizure statistics show that the various illicit drugs are spread all over Denmark. Almost all police districts report of seizure of the various drugs. In addition, drug use consultants in Denmark and survey results confirm the easy access to drugs and that drugs are offered to a wide extent.

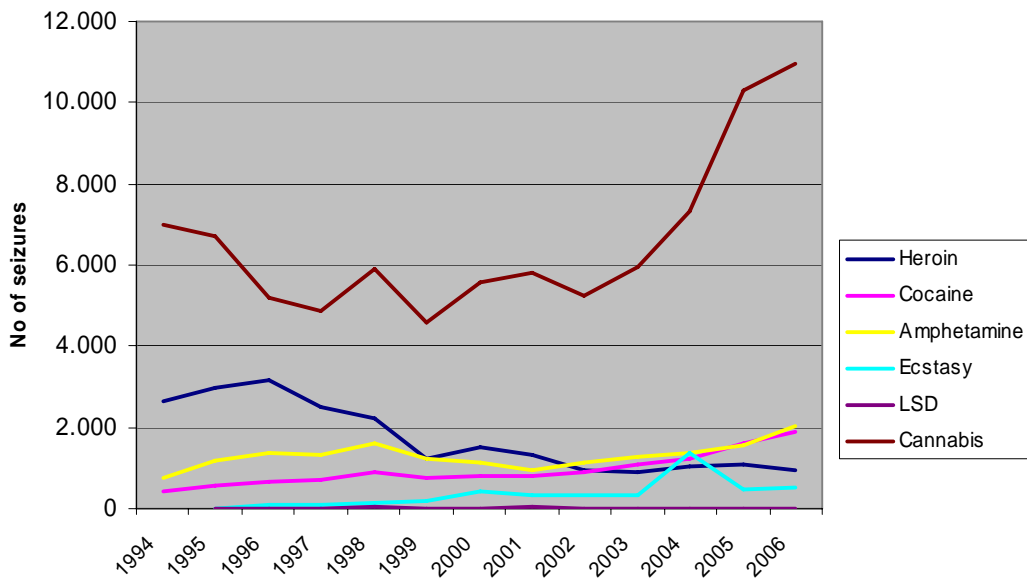
10.2 Drug seizures

Police and customs keep ongoing records of the quantity of illicit drugs seized and the number of seizures of illicit drugs made at borders, airports and ports in connection with major investigations, as well as street-level confiscations. The data on seizures is regularly reported to the National Centre of Investigation (NCI) which compiles and publishes annual statistics based on this data (Rigspolitiet [Police drug statistics] 2007).

Police statistics indicate that the number of seizures of most drugs have gone up in recent years. This applies in particular to drugs such as cannabis, amphetamine and cocaine. This increase may reflect an increasing supply of the drugs, but could also be the result of more intensified police action in 2006.

¹⁵ Results from the special forensic analyses are based on random samples from the "Street Level Project" and from the project on monitoring of prevalence of ecstasy pills mentioned later in this chapter.

Figure 10.2.1 Drug seizures, 1994-2006



Source: Rigspolitiet [Police drug statistics] 2007

As regards the quantity seized, large fluctuations appear for most drug types each year. From 2005 to 2006, cannabis, amphetamine and cocaine are the drugs seized in rising quantities. For instance, the quantity of cocaine seized increased from 57 kilos in 2005 to 76 kilos in 2006. In 2006 as in previous years, individual seizures of the various drugs accounted for large quantities. (See table in the Annex of quantities and number of various drugs seized).

10.3 Purity, drug concentration and prices

In Denmark, drugs seized are analysed with a view to monitoring developments within drug purity and concentration and to follow the introduction of new drugs on the market. The results from the "Street Level Project" and the "Ecstasy Project" are described in detail below.

Monitoring illicit drug dealing at user level

The data material of the Street Level Project consists of small seizures collected on a random sampling basis by 5 police districts in Denmark (Copenhagen, Aarhus, Odense, Aalborg and Esbjerg) which are submitted for analysis to the institutes of forensic chemistry¹⁶. Table 10.3.2 of the Annex shows the distribution of types of drugs seized in Denmark from 1996 to 2006.

¹⁶ See also the prevalence of methamphetamine in ecstasy pills later on in the chapter. The Street-Level Project does not include cannabis or other cannabis products. In addition, ecstasy has not been included in the Street-Level Project since 2003 and is now monitored independently. See "Monitoring of ecstasy pills on the market" in the next section

Out of the 203 samples analysed in 2006, 64% consisted of central stimulants, amphetamine and cocaine (Lindholst et al 2007). During recent years, the presence of central stimulants - especially cocaine - has increased steadily, whereas the presence of heroin has been falling. 33% of all samples in 2006 on a national scale involved heroin. By comparison, 74% of the samples analysed at the start of the project in 1995 was heroin.

In Copenhagen and in Aarhus, heroin is the most prevalent drug (53% and 35%), whereas amphetamine dominates the drug markets of Aalborg, Esbjerg, and Odense (61%, 46%, and 41%, respectively).

The presence of metamphetamine has generally been increasing during recent years. In 2006, only 1% of the samples in the Street Level Project contained metamphetamine, which is a drop compared to 2005 when as much as 5% of the samples contained metamphetamine¹⁷. Another 3% of the samples contained different drug mixtures and not any euphoriant drugs.

Table 10.3.3 in the Annex shows the distribution between heroin base ("smokeable heroin") and heroin chloride (white heroin for injection) from 1996-2006. The heroin base continues to be the predominant drug among heroin samples on a national level. In 2006, the distribution of heroin base and heroin chloride was 65% and 35%, respectively. Throughout the years, there has been a trend towards Odense distinguishing itself from other parts of the country by being dominated by the white heroin. In 2006, all heroin samples from Odense contained the white heroin for injection purposes.

Purity of drugs

Table 10.3.4 shows the purity of various drugs from 1996 to 2006 in the samples analysed from the Street Level Project

Table 10.3.4 Purity of illicit drugs on a user level 1996-2000 (Median of active drug) ¹⁸											
	1996*	1997*	1998*	1999*	2000	2001	2002	2003	2004	2005	2006
Heroin chloride	64%	71%	70%	69%	59%	52%	50%	64%	63%	67%	53%
Heroin base	43%	32%	31%	30%	40%	48%	25%	25%	22%	28%	18%
Amphetamine sulphate	15%	16%	15%	9%	12%	9%	13%	9%	9%	10%	7%
Cocaine chloride	58%	57%	51%	54%	37%	43%	36%	37%	24%	25%	18%

Source: Kaa et al. 1996-2006; Lindholst et al. 2007

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

As shown in table 10.3.4, the purity of drugs changes throughout the years. The general trend is that purity of the various drugs has dropped from 1996 to 2006. This applies to all drugs except from heroin chloride, the purity of which is more or less constant, however with annual fluctuations.

¹⁷ See also the prevalence of methamphetamine in ecstasy pills later on in the chapter.

¹⁸ 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.

Over the years, there have been no fundamental differences observed in the purity of the individual illicit drugs seized in the various parts of Denmark, and there has been a large range of variation seen overall. 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.

Monitoring of ecstasy pill prevalence

Since 2001 the National Board of Health, in collaboration with the National Commissioner of Police and the three institutes of forensic chemistry, have been monitoring the prevalence of ecstasy pills in Denmark. Analysis samples of ecstasy pills seized and sent by the police districts to one of the three institutes of forensic chemistry are collected, analysed and described in terms of drug concentration, composition and appearance¹⁹. A quarterly update of the analysis results and a more extensive annual report are available at the National Board of Health's website: www.sst.dk.

In 2006, a total of 21,641 ecstasy pills from 356 seizures were sent from police districts to the institutes of forensic chemistry (Retskemisk afdeling, Århus Universitet 2007). According to the National Commissioner of Police, a total of 22,465 ecstasy pills were collected in 2005 from 513 seizures. In spite of the intention to send pills from every ecstasy seizure for chemical analysis, "only" 69% of the total number of ecstasy pills seized in 2006 were sent and analysed.

The variation of ecstasy on the market as regards contents and appearance is large. Since the start of monitoring in 2001, a total of 480 different variations of ecstasy pills have been identified (Århus Universitet 2007). In 2006 alone, 82 different ecstasy pills have been identified. Most of the pills are white, beige or grey and almost always round. However, the pills may also be square, triangle or formed as four-leave clovers and many new colours of the pills appear. Among the samples in 2005, 45 different logos were found, and 15 of these logos had not been seen earlier. Cherries, Star and Maltese Cross are by far the most frequent logos among the samples. Many of the logos are only seen in one variant, whereas other pills with the same logo are found in several variants. For instance, when monitoring started, 46 variants of pills were discovered with a Mitsubishi logo. The pills vary in diameter, colour, weight, height, type and quantity of active substance.

New ingredients

"New" and dangerous drugs continue to surface - in Denmark and in the rest of Europe. In 2005, a total of 8 new ingredients were identified in the pills. In 2006, no new drugs are found. In the spring of 2007, a new hallucinogenic resurfaces, the so-called DOI, and it is now included in the drug legislation following recommendation from the National Board of Health²⁰.

From 2005, the number of mixtures and drug combinations in ecstasy pills increases drastically. From 2001 to 2004, between 85% and 96% of the pills contained MDMA (ecstasy) alone, whereas MDMA alone was "only" contained in 43% of the pills in

¹⁹ The database is not restricted to pills with MDMA (ecstasy), but all pills seized with a non-professional appearance, assessed according to logo, colour and pressing. The database also contains pills, where subsequent chemical analyses show the presence of synthetic substances or other euphoriant not normally present in medicines.

²⁰ List of analyses made in the first quarter of 2007. www.sst.dk

2005 and 63% in 2006. In 31% of the pills in 2006, the pills contain a mix of MDMA and amphetamine or metamphetamine. 1% of the pills contained amphetamine as the only active substance.

High and low concentration

The concentration of the different types of active substances in the pills varies a great deal, which poses a major risk of poisoning on intake. In 2006, the quantity of MDMA varies between 1 mg and 132 mg per tablet with an average quantity of MDMA of 51 mg. Although pills with a very high concentration have been seen throughout the years since 2001, the average quantity of MDMA in the individual pill has dropped to between 10 and 20 mg. As something new in 2006, several samples with crystallised ecstasy have been found. The crystals appear in bags and have turned out to contain very strong and concentrated MDMA.

All other things being equal, ecstasy on the market appears to be unpredictable in terms of strength, ingredients and substance combinations.

The systematic ecstasy monitoring service in Denmark appears to be well-informed of the type of ecstasy pills on the Danish market, and what such pills contain. However, it is estimated that the more than 20,000 ecstasy pills seized in 2006 only account for approximately 5% of the total quantity of pills distributed and sold on the Danish market (Århus Universitet 2007).

Prices

The National Commissioner of Police estimates that the street price for cannabis is around DKK 50 (6.7 EUR) per gram and has not basically changed for many years. The price per gram for selling heroin on the streets is estimated to be between DKK 800 and 1200 for white heroin and between DKK 500 (66.7 EUR) and 700 (93.3 EUR) for brown heroin. This is slightly higher than one year ago and there are also still large variations around the country. Cocaine prices are estimated to be stable with a street price of DKK 500-700 (67-93 EUR) per gram. In the case of amphetamine, the street price per gram is estimated at between DKK 150 (20 EUR) and 250 (33 EUR), while the price for an ecstasy pill is estimated at between DKK 30 (4 EUR) and 50 (7 EUR), which marks a slight drop from previous years. As regards prices for the different drugs, there are large variations within the country, and it should be noted that the price level for trading in drugs on a street level follows the standard market forces and therefore may vary in relation to factors such as supply and demand.

11 Vulnerable groups of young people

In the guidelines and general provisions set out in the Social Services Act, the target groups falling under the joint description of *socially vulnerable groups* are characterized as follows: Socially vulnerable groups comprise the homeless and some of the most marginalized mentally ill, prostitutes, drug and alcohol users, incest victims, citizens with serious eating disorders, women exposed to violence, etc". In other informal legal and political documents, the socially vulnerable groups of adults are also defined as individuals with impaired physical and/or mental functional ability, individuals with special social problems and individual who are threatened by social exclusion.

The term social exclusion basically covers adults, but in Denmark there is no given age limit as to these different *groups* of socially vulnerable. Legislation in general distinguishes between children and adults at the age of 18 years, however there are exceptions. For instance, cases involving children, and in cases on placement away from home, provisions apply stretching beyond the age of 18 and until the individual turns 24 years. This makes it difficult to define whether or not the *socially vulnerable young people* are adults or children.

Vulnerable children are also characterized as *risk children*. The symptoms of risk include poor schooling, poor social adaptation, loneliness and a weak social network, consumption of drugs and alcohol, no hobbies and a weak family background. Especially girls may display eating disturbances and stress as symptoms. Young people who are particularly vulnerable are the ones who have often been placed away from home, young criminals, self-damaging, drug users and young people with negative experiences from activation in a business context (Jørgensen 2006). Risk children have experiences that are very similar to those of the vulnerable adults as described in the guidelines of the Social Services Act.

This chapter will focus on the terms relating to the vulnerable young people and describes the efforts to help this group in Denmark.

11.1 Vulnerable groups of young people

As mentioned above, no statistics and figures exist on the number of young people fitting the description of particularly vulnerable, nor the scope of special groups of vulnerable individuals. However, studies in young people's problems point out that between 15 and 20% of the young people today are considered as belonging to the risk group of *vulnerable young people* (Jørgensen 2002). Special groups of children and young people will in most cases be categorised as vulnerable young people, although this may be symptoms or consequences of being vulnerable.

Risk children.

Within the group of risk children, there are different types of children who are eligible for receiving social attention (Jørgensen 2005).

- *Neglected children*, experiencing gross and continuous neglect on the part of their parents.
- *Children with impaired functions*, and with various handicaps or specific learning difficulties, development, behavioural or affective disturbances (ADHD, OCD, Tourette, Asperger, osv.)
- *Children placed away from home* in institutions or in care families.
- *Children in abuse families*, in which alcohol as well as drugs are involved

- *Maladjustment in school*, with mobbing or feeling alone being the result
- *Children of an ethnic origin other than Danish.*
- *Children of mentally ill parents*
- *Children with poor health*, including smoking, alcohol consumption and psycho-somatic symptoms of stress.

Children and young people in abuse families

In general, drug and alcohol use in a family may lead to the children of the family developing similar abuse patterns. Children of parents with an abuse problem risk running into emotional and behavioural problems as a result of their parents' abuse, and they risk becoming abusers themselves and difficulties in completing an education and retaining a job. Therefore, Denmark also places a special focus on these children, and in these years dedicated programmes are being developed, some of them via self-help groups.

From the National Board of Health's register on drug users admitted for treatment it is possible to retrieve data on the children whose parents have been admitted for treatment. In 2005, a total of 3,000 children under the age of 18 years have been registered, with one drug user having custody of the child, and these figures have been stable over the past three years. 46% of these children (1450) are placed away from home, whereas 54% of them either live with or regularly see the drug using parent. As regards alcohol use, which is far more prevalent than drug use, it is estimated that approximately 140.000 children in Denmark live in families with an alcohol problem. Out of these approximately 60,000 are children whose mother or father have been hospitalized with an alcohol-related diagnosis.

According to the Ministry of Social Affairs, the children of abusers account for a little less than 10% of the children placed away from home. In 2004, 15,082 children were placed away from home, and out of this figure 6,459 (46%) lived in foster families. Approximately 1% of all children in Denmark under the age of 18 has at some point been placed away from home. The placement rate increases by the child's age and thus only 0.52% of the youngest (0-9-year-olds) did not live at home.

Homeless young people

A national survey from 2007 conducted by SFI - The National Research Centre for Welfare - shows that "younger adults" account for a major part of the homeless in Denmark. Almost one fourth of all homeless are under the age of 30 years. 13% are between 18 and 24 years, and 11% are between 25 and 29 years (Benjaminsen & Christensen, 2007)

A less comprehensive survey (Elbæk & Højte Jensen, 2006) showed that the proportion of women in the group of young homeless individuals in care homes account for 42%. However, something could indicate that the homeless women, especially the younger women are better at keeping in contact with their family and friends than the men. This survey also provides that one-third of the homeless have a sentence for violation of the law, of which approximately half of them have served a prison sentence. This is primarily the case among the homeless men. In the same study, almost one-fifth of the homeless report suffering from a diagnosed mental disorder. As far as their use of cannabis is concerned, almost two-thirds report of regular drug use, whereas one-fourth report of daily consumption.

11.2 Drug use among the groups of children and young people

There is widespread consensus among municipal employees that the children and young people who develop abuse problems have many other problems, including problems relating to their families and peers, identity problems and problems associated with their home, school, education and a job. As a result, many of the young people are known by the local social administration many years before the abuse problem surfaces, and some young people are not discovered until their drug use starts to escalate or emerges together with crime, self-destructive action and thoughts or other dramatic events.

Thus, there are no specific figures on the prevalence of drug use among the vulnerable children and young people. Special school surveys, however, have shown that family patterns, economy, and family care have an influence on whether or not young people start taking drugs. Special analyses from the ESPAD survey from 2003 showed that in families where the one adult was a biological parent, a higher percentage of the young people had started early with drug use. Furthermore, the share of early drug use was 2-4 times as high among young people who lived in a new family context as among those who lived in stable core families. And finally, the analysis showed that parental care and the parents' relations to their children is of significance to whether or not the children start taking illicit drugs at an early age. Early drug use increases the risk of subsequent abuse.

11.3. Vulnerable groups with special treatment requirements

Mental disorders among young abusers

A special target group among young people with drug abuse problems includes a group of people suffering from concomitant mental problems. Registration in the Addiction Severity Index (ASI) by treatment institutions in 2006 shows that the young people under the age of 30 years and admitted for drug use treatment are more inclined to presenting with mental problems than the drug users over the age of 30. The average severity for men under 30 years is 0.48 of 1.0 compared to 0.46 for those over 30 years. For women, the severity rate is 0.55 for those under 30 years and 0.47 for the over 30s group.

Ethnicity

Social workers emphasize a special problem in the care system in relation to young people of an ethnic background other than Danish, given that the members of this group do not appear in the social system. Nevertheless, surveys show that children and young people from ethnic minorities have the same problems as children and young people of Danish origin. (Ehrenreich & Pihl Hansen 2006).

A survey on abuse problems among Danes and non-Danes show that abuse problems emerge at the same age, ie in the teenage years (Rahbæk et al 2005). The survey also points out that during the period surveyed (1996-2003) the number of ethnic minorities receiving drug use treatment has grown disproportionately, which means that the numbers in this group are higher than in the group of Danish nationals. While the ethnic Danes index has grown from 100 in 1996 to 277 in 2003, the development for ethnic minorities has gone up from 100 to 314.

11.4 Programmes and treatment of vulnerable young people

As previously mentioned, the standard perception among case handlers and social workers in the municipalities is that abuse problems among children and young people often surface later in their lives and then as symptoms of other social problems. This is why many of the programmes are provided from an overall perspective. It is

recommended that efforts include the involvement of the young people's network, harm reduction, motivation work and drug reduction.

Efforts should also be made to provide a wide range of programmes in order for the young people to choose programmes matching their specific situation. In this work special attention will be paid to outreach work and activities with a contact-establishing element, and once contact has been made, to build bridges and establish coordination to help the young people on in life. The most frequently applied measures for this group of vulnerable young people are contact person schemes and placement away from home.

Treatment programmes

Treatment programmes provided to vulnerable young people are normally outpatient programmes established close to the young person's address. According to surveys, the most appropriate treatment and special social programmes dedicated to vulnerable young people are best applied under the following concepts:

- **First young, then abuser** - often drug abuse is only one of the young person's problems, and the young person predominantly needs the same type of programme as other young vulnerable users.
- The young people also need a durable and credible **adult contact** capable of gaining the young person's confidence, is patient and able to establish contact to the public system.
- This system may establish contacts - via **outreach work** - for the target group and not wait for the young person to make contact him/herself.
- Once contact has been established, the young person must receive **help all the way through**.
- Finally, the young person must be given the opportunity to meet constructive and positive **role models** who can help making life accessible and attractive to the person in question.

12 Drug-related research in Denmark

12.1 Research structures

The government-financed research initiatives within drugs are implicitly reflected in the research grants allocated by various ministries as well as their evaluation. A majority of the research carried out under these auspices can be characterised as applied research and often it is based on evaluations of public services.

Thus, the Ministry of the Interior and Health has the government responsibility for preventive intervention and treatment intervention in the health care sector, including the medical treatment. The focus here is to collect data on the population's health and morbidity, including the scope and development in the population's use of illicit drugs. Such data are provided by the SUSY-surveys dealing with health and morbidity in Denmark and performed by the State Institute for Public Health (SIF) and The University of Southern Denmark, the MULD reports which include monitoring of young people's lifestyle and everyday life, with this report being financed by the National Board of Health and the Danish Cancer Association, and finally the ESPAD surveys that are conducted by the Institute of Epidemiology and Social Medicine in Aarhus and co-financed by the National Board of Health.

The purposes of these surveys is to obtain data material to be used in health care planning and prioritisation of health care promotion and prevention as well in the studies of other research groups. Furthermore there are projects such as the "Drugs on a Street Plan", and the special ecstasy monitoring project, both projects operating as a cooperative project between the National Commissioner of Police, the National Board of Health and the three institutes of forensic chemistry in Denmark. These projects monitor developments within drugs on the illicit market, including frequency and prevalence of drugs, drug concentration, introduction of new drugs, etc. The results also form the basis of large part of the research and epidemiological studies conducted by the institutes of forensic chemistry.

As regards the governmental initiatives in terms of social treatment programmes, the Ministry of Social Affairs is responsible for this. Research made under the auspices of the Ministry of Social Affairs is primarily targeted at evaluation of social programmes in order for these programmes to build on measuring of effect, research-based knowledge and documentation to a maximum extent. This research is very user and methodology oriented and is related to evaluations of specific services such as trials with new projects.

Under the socio-scientific faculty at the University of Aarhus, the Centre for Alcohol and Drug Research (CRF) carries out a number of evaluating and monitoring tasks for the Ministry of Social Affairs, such as the Methadone Study described below or DANRIS which is a registration and monitoring system of inpatient institutions in Denmark treating drug users. The CRF is also a research body which receives DKK 6 million (0.8 million EUR) from the annual Bill and which runs actual interdisciplinary research within alcohol and drugs (basic research as well as applied research) specifically within the drugs area. CRF's scientific research, theoretical development and teaching profile include issues such as control, treatment, prevention and consumption. CRF also trains PhDs within the drugs area.

The majority of the Danish drug research activities originating from the various ministries' programmes and needs are thus oriented towards applied research and aim at evaluating and monitoring data collection, primarily of public social and health care

services in relation to treatment of drug users. Actual theory-controlled and theory-developing research in drugs exists as an overall are combined at CRF. In addition, there are also unique research projects, including PhD projects in various Danish university institutes. Most important in this context is psychology, sociology, anthropology, law, medicine.

In Denmark, the evaluating and monitoring research and data collection are often included in the political decision-making process via recommendations in evaluation reports, methodology tests, hearings and expert councils.

Limitations to research in Denmark

Compared to other countries within the EU, Denmark is a small country in terms of population, which is also reflected in the number of universities and, again, in faculties, in which drug-related research could be performed. This may sometimes make it difficult to establish research environments, as it is often the same researchers involved and the same ones to generate new knowledge within the area. Furthermore, no education in Denmark is targeted at drugs. Researchers within drugs come from established fields such as psychology, law, anthropology, sociology and medicine and have often had to make their own way to achieve expert competencies within the field.

12.2 Danish research projects of significance since 2000

As described above, a large part of the drug-related research is user-oriented and based on assignments given by public authorities who thereby wish to improve and inform about public services. This is also reflected in the evaluation and research projects described in this section. The selection of the special projects described below has primarily been made on the basis of the total budgets of the evaluation and research projects and on a wish to spread the themes.

In addition to the selected 5 projects described below there are a number of different research projects and PhD projects within the drugs field in Denmark. A large part of them are placed under the Centre for Alcohol and Drugs Research at Aarhus University and can be downloaded from <http://www.crf-au.dk>. They include a focus on: treatment of drug users, psychopathology and psycho-diagnostics, drug policy and recreational drug use among young people.

The HMS survey

The HMS survey for the homeless, abusers and mentally ill was a research and evaluation project conducted in 2000-2003 of a consortium consisting of the Institute of Governmental Research [Anvendt Kommunal Forskning – AKF], Project Outside [Projekt Udenfor], Bispebjerg Hospital, Center for Research in Social Work [Center for Forskning i Socialt Arbejde], and the Copenhagen Communication Centre [Formidlingscenter Storkøbenhavn]. The project was financed by the Ministry of Social Affairs in the amount of DKK 6.5 million (0.7 million EUR).

The survey looked into the public programmes provided to individuals who have major problems with being homeless, being abusers and/or suffering from mental illnesses. The survey was part of the Ministry of Social Affairs' evaluation programme of social services, and the aim was to generate new research-based knowledge within the individual socio-political areas. The project was a result of a general focus on homelessness, drug addiction, mental diseases, etc being interrelated and not an isolated feature.

The survey was conducted in five different regions in Denmark and consisted of three different sub-surveys. The first was an ethnographic survey of these people's life situation and the significance of public institutions in their everyday lives and personal development. The second included focus group interviews of the professional staff and their ability to perceive their clients' problems as well as to confront them with selected cases taken from the ethnographic sub-survey. The final survey was an interview focusing on cooperation structures between municipalities and counties, institutions and administrative offices as well as public and private programmes within the area. It was concluded from the survey that the public programmes provided to the homeless, abusers and mentally ill were mostly of a high quality, but that basically in the relevant public service bodies there was a lack of overall understanding of the connection and coordination of the individual programmes offered to this group of people within the entire programme range. The survey provided a theoretical platform in terms of organisational sociology which made it possible to understand these research results.

The methadone project

The methadone project was an evaluation and research project financed by the Ministry of Social Affairs at an amount of 6 million (0.8 million EUR) and was carried out from 2002-2005 by the Centre for Alcohol and Drug Research, at Aarhus University. Methadone treatment is widespread in Denmark. Almost half of the drug users receiving treatment are given methadone, and the purpose of the methadone project was to study whether expanded psycho-social efforts in relation to drug users in methadone treatment could improve the treatment programme.

The methadone project was initiated as an alternative to a Danish study in prescribed heroin. The project included a quantitative effect evaluation and a qualitative process evaluation. The quantitative evaluation included a comparison of persons in standard methadone-supported treatment, and persons in methadone treatment with expanded psycho-social support. Structured admission interviews were conducted of 436 persons receiving methadone treatment, of which 296 took part in the follow-up survey approximately a year and a half after the first interview. When subtracting the persons who died between the two interviews, 72% of the persons participated in the follow-up interviews. The qualitative part of the evaluation project consisted of a total of 98 semi-structured qualitative interviews of users, therapists, leaders, and collaborative partners, case record reading and approximately 2 months of observation studies in the four sub-projects.

The project concluded that elaborate psycho-social activities are much more effective than standard treatment when it comes to treating a psycho-social burden. For instance, users receiving elaborate support were much less suicidal than the group that had received standard treatment. Also it was established that projects involving a support contact person to help the most disadvantaged user provides far larger benefits when coordinating the various types of intervention offered to the individual user. The project related the results to international research, including the Dutch heroin trial and concluded with a number of specific recommendations for the future methadone treatment, for instance a weekly talk with the case handler, high degree of accessibility to therapists, a therapist-client ratio not exceeding 1:20, use of case management strategies, and drop-in programmes for the most disadvantaged users.

The Ringsted Project

The Ringsted Project was an evaluation and research project initiated by the Faculty of Law at the Copenhagen University and financed by Inge and Asker Larsens fund at DKK 4.3 million (0.8 million EUR). The project ran from 2001 – 2004 and has been

involved in a research trend explicitly focusing on young people, illicit drugs and alcohol

The project included the study of a selected model town called Ringsted which is located in the southern part of Zealand. The town has 30,000 inhabitants and applied a socio-psychological aspect in the study of the young people's risk behaviour associated to the use of euphoricants (tobacco, alcohol, cannabis and other types of drugs) as well as their criminal activity viewed in relation to their lifestyle and conditions of life. The intention was to consider possible local preventive action. Data collection took place over a period of 3 years with comprehensive quantitative and qualitative material being reviewed.

The quantitative part consisted of a questionnaire survey of all the 11-24-year-olds in Ringsted (the response rate was a total of 67%) prepared at a two-year interval and less extensive questionnaire surveys related to a sub-project. The qualitative part consisted of nightlife observations (7-900 hours) and taped interviews with 81 persons in the nightlife, in youth clubs, school classes, a cannabis club, café life, and interviews with centrally located public employees and others. The results showed that 42% of the young population was engaged in one or several types of risk behaviour defined as: daily smoking of tobacco (19%), drunk at least once a month (22%), used drugs within the past 12 months (17%) and violations of the penal code within the past 12 months (2%). This risk behaviour was indeed associated with the frequency of going to parties and with the young persons' ideas of how widespread risk behaviour is among their peers.

The focus of the project was to study whether conformity forces (to behave in the same manner as how one thinks the majority behaves) are stronger than non-conformity forces. This last insight was used in the related "Ringsted Study". Here, it turned out that the use of simple methods, according to which there are different ways to make the young people aware of the majority of misunderstandings (the idea that other young people are involved in more risk behaviour than is actually the case) may reduce the young people's risk behaviour, including cannabis consumption. The conclusions of the study which incidentally received *The European Crime Prevention Award* have been used to establish the Knowledge Centre for Social Awareness at the Copenhagen University.

Infectious diseases among drug users

Infectious diseases among drug users is a monitoring and research project which so far will be running from 2004 to 2009 and be supported by the National Board of Health in the amount of DKK 100,000 (13,333 EUR) annually. The project leader is Peer B. Christensen, PhD, Odense University Hospital.

As part of the mapping and monitoring of infectious diseases among drug users in the EU, the project sets out to study the prevalence of infectious diseases among drug users. The aim is also for the research project to contribute to qualifying the health related activities offered to drug users. Another objective is to identify the presence and development of HIV, hepatitis B (HBV) and hepatitis C (HCV) among the drug-related deaths registered in the National Commissioner of Police's register on drug-related deaths following reports from the institutes of forensic chemistry. The results are based on blood samples collected from the drug-related deaths that are registered (approximately 275 per year). The results so far have shown that almost 60% of those examined had positive antibodies to HCV, around 35% were HBV-positive and HIV-infection was diagnosed in approximately 4%. Approximately 17% were protected against HBV as a result of vaccination.

The research project showed that it is possible to monitor virus-borne hepatitis and HIV among individuals who are dead as a result of suspected drug-related circumstances. Furthermore, the project showed that the presence of HCV and HBV among drug users is decreasing and that the presence of HIV infection among drug users is unchanged and relatively low. Finally, a larger presence of virus-borne hepatitis was demonstrated among treatment naïve drug users than in non-treatment naïve drug users. See also this year's study results in Chapter 6.

In extension of the above project, a partially related research project has been prepared. Focus is placed on mortality among released drug users within the first 14 days after their release compared to mortality among other drug users. This is a register survey primarily of persons receiving drug use treatment and for the years 1996-2001. The register survey covered 62% of the estimated drug using population. First of all, the research project showed that mortality rates among released drug users was significantly higher (equalling 13/100 person-years) than mortality rates among drug users receiving treatment (2,4/100 person-years). Furthermore, 92% of the deaths among drug users within the first 14 days after their release was caused by an overdose, whereas overdoses accounted for 68% of the deaths among drug users after the first 14 days. The study has thus shown that drug users that are released from prison have a higher risk of dying from an overdose and that methadone treatment should be considered an option to reduce this risk.

Prison projects

At the Centre for Alcohol and Drug Research at Aarhus University, 4 research and evaluation projects have been running since 2004 with a focus on the treatment in prison. Three of them have been financed by the Prison and Probation Service (1.1 million/0.14 million EUR) and by the Ministry of Social Affairs (DKK 500,000/66,666 EUR). The fourth project is solely research-based. These projects reflect an increased interest in treatment of imprisoned drug users on a European scale.

The three financed projects have: a) described the contents and seen the effect of the contract department set up in Danish prisons, b) developed a self-evaluation model for drug use treatment in prisons, and c) studied the establishment, development and effect of motivation and treatment programmes specifically targeted at women. The last research project d) reviews methadone-supported psycho-social treatment and cannabis treatment provided to drug users in prisons as part of the treatment guarantee established as of 1 January 2007.

The projects have applied structured interviews of inmates who have provided their input to effect evaluations. And semi-structured interviews have been conducted with inmates as well as employees with the purpose of process evaluations, organisational analyses and the mapping of treatment-related services. The results from the first project documented that already at the beginning of their imprisonment, it is possible to identify certain groups of high-risk prisoners. The other project demonstrated that it is possible to establish satisfactory monitoring of treatment in prisons by using a self-evaluation model in spite of the prison's often limited experience in this area. The third project concluded that motivation and retention of women in a drug-free treatment programme largely depends on external factors such as prison structures and organisation of treatment. Finally, the last and current research project has shown that the governmental treatment guarantee combined with increased focus on control and punishment in the prisons resulting in therapists being confronted with a number of unforeseen dilemmas, which again results in rather varying practices influenced by a particular situation.

12.3 Collection and dissemination of research results

The National Board of Health has the overall responsibility for monitoring the development of drug use in Denmark. This means that the National Board of Health often initiates and (partially) finances surveys with a view to monitoring the developments on use and abuse as well as document the health care aspects following in the wake of abuse. A number of the registers under National Board of Health are also used for research into drug abuse and are often the basis for the epidemiological research in the area. In addition, the Ministry of Social Affairs is responsible for the entire social domain, including drug use treatment and supports in particular the treatment-related research projects.

Reports and journals

When it comes to disseminating research results, this will often take place in special publications. Important journals and annual reports dealing with drug abuse (in particular this annual report on the drug situation in Denmark) provide results on an ongoing basis and report about current research. One of the scientific journals within the drug use area is *Nordisk alkohol & narkotikatidsskrift (NAT)* - a Nordic socio-scientific and socio-medical alcohol and drug research journal, the objective of which is to present Nordic drug research, strengthen the contact between Nordic and international research and contribute to the political debate. NAT is publicized in Danish, Norwegian and Swedish 6 times a year. Another journal dealing with drugs is the Danish journal publicising articles solely within alcohol and drugs. STOF aims at building a bridge between research and practice and is published twice a year.

In addition, the scientific journals mentioned below publicize drug-related articles.

- *Matrix*. Psychotherapeutic journal. Peer reviewed. In Danish.
- *Nordic psychology*. Peer reviewed. In English.
- *Nordisk Tidsskrift for Psykoterapi*. Nordic psychology. Peer reviewed. In Danish.
- *Psyke&Logos*: Psychological journal. Peer reviewed. In Danish.
- *Social Kritik*. Socio-scientific magazine. Not peer-reviewed. In Danish.
- *Sygdom & Samfund*. Interdisciplinary based on medical anthropology. Peer reviewed. In Danish.
- *Ugeskrift for læger*. Medical journal. Peer-reviewed. Primarily in Danish.

Websites

In addition there are a number of websites primarily accounting for Danish evaluation and research results within drugs such as

Anvendt Kommunal Forskning (AKF) [Danish Institute of Governmental Research]: <http://www.akf.dk/>

Dansk psykolog Forenings Selskab for Misbrugspsykologi [Danish Association for Abuse Psychology]: <http://www.misbrugsnet.dk/faqliqt/faqliqt.html>

Det Nationale Forskningscenter for Velfærd (SFI) [The National Research Centre for Welfare]: <http://www.sfi.dk>

Socialministeriets udsatte enhed [The Social Ministry's Unit for the Vulnerable]: <http://www.vfcudsatte.dk/>

Statens Institut for Folkesundhed <http://www.si-folkesundhed.dk/>

Website of the National Board of Health: <http://www.sst.dk>

Conferences and theme days

As final input, national and local conferences and theme days are regularly arranged in Denmark with the focus on drugs and alcohol issues in practice. Often researchers are invited to attend and they communicate their expertise to the practitioners. For instance, the Centre for Alcohol and Drug Research arranges an annual communication day which is open to all who may be interested. There are also a variety of social, legal and health-related journals communicating research-related knowledge to practitioners and with the researchers some times writing popular articles about drugs.

A list of the drug-related articles publicised by Danish researchers in international journals with peer review and Danish publications are attached as appendix to this chapter.

Appendix for chapter 12

Drug-related articles of Danish researchers publicized in 2006 in international journals with peer-review. The list is based on searches in PubMed, Embase, Google Scholar, Web of Science, Social Sciences Citation Index, PsycINFO, using the search words: *substance, Denmark*.

1. Andersen, D. and Järvinen, M. (2006) Skadesreduktioner - idealer og paradokser. *NAT (Nordisk alkohol- og narkotikatidsskrift)*, **23**, 305-323.
2. Anderson, P. (2006a) Drug and alcohol policy at the global level. *Drug and Alcohol Review*, **25**, 485-487.
3. Anderson, P. (2006b) Global use of alcohol, drugs and tobacco. *Drug and Alcohol Review*, **25**, 489-502.
4. Christensen, P. B., Hammerby, E. and Bird, S. (2006) Mortality among Danish Drug Users released from Prison. *International Journal of Prisoner Health*, **2**, 13-19.
5. Christensen, P. B., Kringsholm, B., Jytte, B., Thomsen, J., Cowan, S., Stein, G., Jürgensen, G., Grasaasen, K., Georgsen, J. and Pedersen, C. (2006) Surveillance of HIV and Viral Hepatitis by Analysis of Samples from Drug Related Deaths. *European Journal of Epidemiology*, **21**, 383-387.
6. Fridell, M. and Hesse, M. (2006) Psychiatric severity and mortality in substance abusers. A 15 year follow-up. *Addictive Behaviors*, **31**, 559-565.
7. Fridell, M., Hesse, M. and Billsten, J. (2006a) Criminal behaviour in antisocial substance abusers between 5 years follow-up and 15 years follow-up *The American Journal on Addictions*, **16**, 559-565
8. Fridell, M., Hesse, M. and Johnson, E. (2006b) High Prognostic Specificity of Antisocial Personality Disorder in Patients with Drug Dependence. *The American Journal on Addictions*, **15**, 227-232.
9. Hesse M., Broekaert E., Fridell M., Rapp R.C. and Vanderplasschen W. (2006): Case management for substance use disorders . *Cochrane Database of Systematic Reviews* 2006 -:**4** Article Number CD006265.
10. Hesse, M. (2006a) The Beck Depression Inventory in patients undergoing opiate agonist maintenance treatment. *British Journal of Clinical Psychology*, **45**, 417-425.
11. Hesse, M. (2006b) The Readiness Ruler as a measure of readiness to change poly-drug use in drug abusers. *Harm Reduction Journal*, **3**.
12. Hesse, M. and Fridell, M. (2006) Psykosociale interventioner i stoffri behandling for opiatmisbrug. *NAT (Nordisk alkohol- og narkotikatidsskrift)*, **23**, 133-145.
13. Hesse, M. and Pedersen, M. U. (2006) Antisocial personality disorder and retention: A systematic review. *Therapeutic Communities: The International Journal for Therapeutic and Supportive Organizations*, **27**, 495-504.

14. Hesse, M., Thylstrup, B. and Fridell, M. (2006) Narcissismens mange ansigter. *Nordisk Tidsskrift for Psykoterapi*, **23**, 336-354.
15. Johansen, A., Rasmussen, S. and Madsen, M. (2006) Health behaviour among adolescents in Denmark: influence of school class and individual risk factors. *Scand J Public Health*, **34**, 32-40.
16. Osler, M., Nordentoft, M. and Andersen, A. (2006) Childhood social environment and risk of drug and alcohol abuse in a cohort of Danish men born in 1953. *Am J Epidemiol*, **163**, 654-61.
17. Steentoft, A., Teige, B., Holmgren, P., Vuori, E., Kristinsson, J., Hansen, A., Ceder, G., Wethe, G. and Rollmann, D. (2006) Fatal poisoning in Nordic drug addicts in 2002. *Forensic Sci Int*, **13**, 148-56.
18. Vind, L. (2006) En organisations sociologisk tilgang til indføring af evidensbaseret praksis i misbrugsbehandlingen. *NAT (Nordisk alkohol- og narkotikatidsskrift)*, **5**, 223-241.

Publications for the methadone project

Asmussen, V. (2006) On whose terms? User participation in Danish methadone maintenance treatment. In *Drug Users and Spaces for Legitimate Action. NAD no. 49* (Eds, Anker, J., Asmussen, V., Kouvonen, P. and Tops, D.) NAD-Publications, Helsinki.

Asmussen, V. and Kolind, T. (2005) Udvidet psykosocial indsats i metadonbehandling. Resultater fra en kvalitativ evaluering af fire metadonforsøgsprojekter, Center for Rusmiddelforskning, Århus.

Hesse, M. (2006a) The Beck Depression Inventory in patients undergoing opiate agonist maintenance treatment. *British Journal of Clinical Psychology*, **45**, 417-425.

Hesse, M. (2006b) The Readiness Ruler as a measure of readiness to change poly-drug use in drug abusers. *Harm Reduction Journal*, **3**

Kolind, T. (2007) Form or content. The application of user perspectives in treatment research. *Drugs: education, Prevention and Policy*, **14**, 261-275.

Pedersen, M. U. (2005) *Heroin-afhængige i metadonbehandling. Den medicinske og psykosociale indsats*, Centre for Alcohol and Drug Research, University of Aarhus, Aarhus

Pedersen, MU & Hesse, M. (accepted). Enhanced services and reduced control in methadone maintenance. In: *International Journal of Mental Health and Addiction*.

Publications for the Ringsted Project

Balvig, F., Holmberg, L. og Sørensen, AS. (2005): Ringstedforsøget. Livsstil og forebyggelse i lokalsamfundet, Jurist- og Økonomiforbundets Forlag, København. 454 s.

Balvig, F. og Holmberg, L. (2006): Er forebyggelse risikabel? I: Ungdomsforskning, nr. 4, årg. 5, 9-17.

Publications for the homeless project

Brandt, P. og Kirk, M. (2003) Billeder fra hverdagen. En dokumentarisk-analytisk fremstilling af den sociale indsats overfor hjemløse, misbrugere eller sindslidende personer, som den ses af de, der arbejder i feltet, AKF Forlaget, København.

Ebsen, F., Henriksen, J. og Rieper, O. (2003) Hænger det sammen. Sammenhængen i indsatsen for mennesker med hjemløshed, misbrug og/eller sindslidelse som problem, AKF Forlaget, København

Høgsbro, K., Bovbjerg, K., Smith, L., Kirk, M. og Henriksen, J. (2003) Skjulte livsverdener. En etnografisk undersøgelse af forholdene for mennesker med hjemløshed, misbrug og sindslidelse som problem, AKF Forlaget, København.

Høgsbro, K., Brandt, P., Ebsen, F., Thomsen, O. and Nordentoft, M. (2003) Brugerne, de professionelle og forvaltningen, AKF-forlaget, København.

Publications for infectious diseases

Christensen, P. B., Hammerby, E. and Bird, S. (2006) Mortality among Danish Drug Users released from Prison. *International Journal of Prisoner Health*, **2**, 13-19.

Christensen, P. B., Kringsholm, B., Jytte, B., Thomsen, J., Cowan, S., Stein, G., Jürgensen, G., Grasaasen, K., Georgsen, J. and Pedersen, C. (2006) Surveillance of HIV and Viral Hepatitis by Analysis of Samples from Drug Related Deaths. *European Journal of Epidemiology*, **21**, 383-387.

Publications for the prison project

Asmussen, V. and Kolind, T. (Fortcomming). Drug policy in Danish prisons: control and treatment. In *The Social Organization of Drug Policies: Patterns, Determinants and Consequences* (Eds, Asmussen, V., Bjerger, B. and Pedersen, E. H.) Aarhus Universitetsforlag, Århus.

Asmussen, V., Kolind, T. and Nielsen, B. (2006) *Selvevaluering af stofmisbrugsbehandling i fængsler og arresthuse*, Center for Rusmiddelforskning, Århus.

Dahl, H. and Pedersen, M. U. (2006) *Kvinder i motivations- og stofmisbrugsbehandling i Vestre Fængsel og Horserød Statsfængsel*, Center for Rusmiddelforskning, Århus.

Pedersen, M. U. and Lodahl, L. (2007) *Evalueringen af indsatsen på fem kontraktafdelinger*, Center for Rusmiddelforskning, Århus.

Annex

List of references

- Bach, H. B. & Boll, J. (2003). De svageste kontanthjælpsmodtagere—Barrierer for beskæftigelse. København, Socialforskningsinstituttet.
- Banjaminen, L, Christensen, I (2007). Hjemløshed i Danmark 2007. National Kortlægning.
- Christensen, P. Brehm (2004, upubliceret). Dødelighed blandt stofmisbrugere efter løsladelse fra fængsel.
- Ehrenreich, D. & Pihl Hansen, S. (2006). Undersøgelse af unge under 18 år med misbrugsproblemer. Udgivet af Videns- og Formidlingscenter for Socialt Udsatte.
- Ehrenreich, D. (2005). Rum til at være: Dilemmaer ved omsorg for værestedbrugere med alkoholmisbrug. København, Videns- og Formidlingscenter for Socialt Udsatte.
- Elbæk, O. & Højte Jensen, M. (2006). Ung og hjemløs. Udgivet af Videns- og Formidlingscenter for Socialt Udsatte.
- Elbæk, O. & Tilia, G. (2005). Vidensfunktionen på hjemløshedsområdet: Lovgivning med relevans for udslusning fra hjemløseområdet. Esbjerg, Videns- og Formidlingscenter for Socialt Udsatte. Indhentet fra <http://www.hjemloeshed.dk/page521.asp> d. 31. august 2006.
- ESPAD (1997). The 1995 ESPAD report – Alcohol and Other Drug Use Among Students in 26 European Countries. CAN og Pompidou Group, Stockholm.
- ESPAD (2000). The 1999 ESPAD report – Alcohol and Other Drug Use Among Students in 30 European Countries. CAN og Pompidou Group, Stockholm.
- ESPAD (2004). The 2003 ESPAD report – Alcohol and Other Drug Use Among Students in 30 European Countries. CAN og Pompidou Group.
- ESPAD (2007, unpublished). The 2007 ESPAD report – Alcohol and Other Drug Use Among Students in 36 European Countries. CAN og Pompidou Group.
- Fuglsang, Thomas m.fl. (2000) Udbredelsen af hiv og hepatitis B og C blandt københavnske stofmisbrugere. Ugeskrift for Læger, 3. juli 2000.
- Jørgensen, P. (1993) Risikobørn: Hvem er de – Hvad gør vi? Udgivet af Socialministeriet / Det tværministerielle Børneudvalg.
- Jørgensen, P. (2002). Risikobørn i Danmark - status over en 10-årig indsats. Social Kritik.
- Jørgensen, P. (2005) Risikobørn. <http://www.leksikon.org/art.php?n=4928>
- Jørgensen, P. (2006) Risikobørn og unge, anno 2006. Oplæg i Oksbøl. http://www.ifsp psyk.dk/grafik/per_schultz.ppt
- Kramp, P., Gabrielsen, G., Lund, A., Reventlow, A. & Sindballe, A. (2003). Rusmiddelundersøgelsen. Misbrug blandt Kriminalforsorgens klientel.

Kriminalforsorgen, København. Kriminalforsorgen 2006, personlig meddelelse.

Kaa, E., Johansen M., Müller I.R., Rollmann, D. (2005). Narkotika på gadeplan 2004. Retskemisk Institut, Aarhus Universitet, Københavns Universitet & Odense Universitet.

Kaa, E., Johansen M., Müller I.R., Rollmann, D. (2006). Narkotika på gadeplan 2005. Retskemisk Institut, Aarhus Universitet, Københavns Universitet & Odense Universitet.

Kaa, E., Nielsen, E. & Simonsen K.W. (1997). Narkotika i illegal forhandling på brugerniveau 1996. Retskemisk Institut, Aarhus Universitet, Københavns Universitet & Odense Universitet.

Kaa, E., Nielsen, E. & Simonsen K.W. (1998). Narkotika i illegal forhandling på brugerniveau 1997. Retskemisk Institut, Aarhus Universitet, Københavns Universitet & Odense Universitet.

Kaa, E., Nielsen, E., Simonsen K.W., Rollmann, D. (1999). Narkotika i illegal forhandling på brugerniveau 1998. Retskemisk Institut, Aarhus Universitet, Københavns Universitet & Odense Universitet.

Kaa, E., Nielsen, E., Simonsen K.W., Rollmann, D. (2000). Narkotika i illegal forhandling på brugerniveau 1999. Retskemisk Institut, Aarhus Universitet, Københavns Universitet & Odense Universitet.

Kaa, E., Nielsen, E., Simonsen K.W., Rollmann, D. (2001). Narkotika på gadeplan 2000. Rapport til Sundhedsstyrelsen.

Kaa, E., Nielsen, E., Rollmann, D., Breum Müller I., Findal Andersen M. (2002). Narkotika på gadeplan 2001. Rapport til Sundhedsstyrelsen.

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

Kaa, E., Nielsen, E., Rollmann, D., Breum Müller I., Findal Andreasen M., Johannsen M. (2004). Narkotika på gadeplan 2003. Rapport til Sundhedsstyrelsen.

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

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

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

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

MULD-rapport 2001 nr. 2 (2003). Unges Livsstil og Dagligdag 2001 – geografiske forskelle og ligheder. Sundhedsstyrelsen og Kræftens Bekæmpelse.

MULD-rapport 2002 nr. 3 (2004). Unges livsstil og dagligdag 2002 – aldersforskelle i sundhedsvaner og trivsel. Sundhedsstyrelsen og Kræftens Bekæmpelse.

MULD-rapport 2003 nr. 4 (2005). Unges livsstil og dagligdag 2003. Sundhedsstyrelsen og Kræftens Bekæmpelse.

MULD-rapport 2004 nr. 5 (2005). Unges livsstil og dagligdag 2004. Sundhedsstyrelsen og Kræftens Bekæmpelse.

MULD-rapport nr. 6 (2007). Unges livsstil og dagligdag 2006. Sundhedsstyrelsen og Kræftens Bekæmpelse. .

Rahbæk, H., Hvenegård, K., & Als Thomsen, J. (2005). Stofmisbrug blandt etniske minoriteter i Danmark. Udgivet af Als Research.

Rambøll Management (2006). Brugerundersøgelse af aktivitets- og beskæftigelses-tilbud for socialt udsatte. Odense, Styrelsen for Social Service.

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

Retskemisk Afdeling, Århus Universitet (2002). Ecstasy i Danmark 2001. Rapport til Sundhedsstyrelsen 2002.

Retskemisk Afdeling, Århus Universitet. Ecstasy i Danmark 2002 (2003). Rapport til Sundhedsstyrelsen 2003.

Retskemisk Afdeling, Århus Universitet (2004). Ecstasy i Danmark 2003. Rapport til Sundhedsstyrelsen 2004.

Retskemisk Afdeling, Århus Universitet (2005). Ecstasy i Danmark 2004. Rapport til Sundhedsstyrelsen 2005.

Retskemisk Afdeling, Århus Universitet (2006). Ecstasy i Danmark 2005. Rapport til Sundhedsstyrelsen 2006.

Retskemisk Afdeling, Århus Universitet (2007). Ecstasy i Danmark 2006. Rapport til Sundhedsstyrelsen 2007.

Rigspolitiet (2007). Narkotikastatistik 2006. Rigspolitiet, NEC (Nationalt Efterforskningsstøttecenter), København.

Rådet for Socialt Udsatte (2004). Elementer til en aktivitets- og beskæftigelsesplan for socialt udsatte. København, Rådet for Socialt Udsatte.

Socialministeriet og Beskæftigelsesministeriet (2006). Nye veje til arbejde—Hjælp til sindslidende og andre udsatte grupper. Regeringen, København.

Socialministeriet, Ministeriet for flygtninge, indvandrere og integration, Beskæftigelsesministeriet, Finansministeriet og Indenrigs- og Sundhedsministeriet (2006). Det fælles ansvar II—Regeringens 2. handlingsprogram for de svageste grupper. Regeringen, København.

Steenoft, A. et al. (2005). Forgiftningsdødsfald blandt narkomaner i 2002. Ugeskrift for læger 167/18, 2. Maj 2005.

Sundhedsstyrelsen (2005a). Stofmisbrugere i behandling 2004. Nye tal fra Sundhedsstyrelsen.

Sundhedsstyrelsen (2005b). Unge stofmisbrugere i behandling 1996 – 2003. Nye tal fra Sundhedsstyrelsen.

Sundhedsstyrelsen (2006). Nye tal fra Sundhedsstyrelsen. Stofmisbrugere i Danmark 1996-2005. November 2006.

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

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

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

Videns- og Formidlingscenter for Socialt udsatte (2006). Undersøgelse af unge under 18 år med misbrugsproblemer.

Zeeberg, H. & Lautrup, C. (2005) Støtte til udstødte: Forsøg med SKP ordning til isolerede misbrugere og hjemløse. København, Videns- og Formidlingscenter for Socialt Udsatte.

Århus Universitet, Retskemisk Afdeling (2007). Det danske ecstasymarked – et strategisk perspektiv. Rapport til Rigspolitiet 2007.

Websites

Festival Danmark www.festivaldanmark.dk

Hash rådgivning via sms www.smash.name [Cannabis counselling via sms]

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

Anvendt Kommunal Forskning (AKF) www.akf.dk [Danish Institute of Governmental Research]

Dansk psykolog Forenings
Selskab for Misbrugspsykologi www.misbrugsnet.dk/fagligt/fagligt.html [no English website]

Det Nationale Forskningscenter for Velfærd (SFI) www.sfi.dk [Centre for Welfare State Research]

Socialministeriets udsatte enhed www.vfcudsatte.dk [Danish Centre for Research on Social Vulnerability]

Statens Institut for Folkesundhed www.si-folkesundhed.dk [National Institute of Public Health]

Rigspolitiet www.politi.dk [The National Commissioner of Police]

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

Studies used

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

A national survey conducted in 1994 among a representative segment of the population aged 16 and above. The survey included questions on a variety of health issues. A sample population of 6,000 individuals was selected at random from the central personal registry. The question on use of euphoriant drugs was put to the 16-44 age group, which included a total of 2,521 people. The data was collected based on personal interviews conducted 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) 2000 (Kjøller & Rasmussen 2002)

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

”Sundhed og Sygelighed i Danmark 2006 – og udviklingen siden 1987” Statens Institut for Folkesundhed (SIF) 2006 (Note by Niels Kr. Rasmussen and Ola Ekholm, sept 2006)

A national survey conducted from May 2005 to March 2006 among a representative segment of the population aged 16 and above. The survey included, as in 1994 and 2000, questions on a variety of health issues. The sample population of a total of 21,832 persons was selected at random. The data was collected based on personal interviews conducted in the respondents' homes. In addition, the respondents were provided with a questionnaire, which they themselves were requested to fill in and submit. In the self-assessment questionnaire, the questions on drugs were put to all age groups. Interviews were carried out with 14,566 persons – a total response rate of 66.7%. The self-assessment questionnaire was completed by 51.5% of the selected respondents.

”Unge Livsstil og Dagligdag 2000 – forbrug af tobak, alkohol og stoffer” (MULD 2000), Sundhedsstyrelsen og Kræftens Bekæmpelse 2000 (Sundhedsstyrelsen & Kræftens Bekæmpelse 2002)

In 2000, the National Board of Health and the Danish Cancer Society conducted a representative survey on the lifestyles and daily routines of 16-20 year-olds. The survey included questions on young people's use of drugs, including their experiences with illicit drugs. 3,048 young people aged between 16 and 20 were chosen according to systematic selection. Data was collected via questionnaires sent out by post. The response rate was approximately 70%.

”Unge Livsstil og Dagligdag 2001 – geografiske forskelle og ligheder” (MULD 2001), Sundhedsstyrelsen og Kræftens Bekæmpelse, (Sundhedsstyrelsen & Kræftens Bekæmpelse 2003)

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

”Monitorering af unges livsstil og dagligdag 2002” (MULD 2002), Sundhedsstyrelsen og Kræftens Bekæmpelse

In 2002, the National Board of Health and the Danish Cancer Society conducted a representative survey on the lifestyles and daily routines of 16-20 year-olds. 2,041 young people aged between 16 and 20 were chosen according to systematic selection. Data was collected via questionnaires sent out by post. The response rate was approximately 70%.

”Monitorering af unges livsstil og dagligdag 2003” (MULD 2003), Sundhedsstyrelsen og Kræftens Bekæmpelse

In 2003, the National Board of Health and the Danish Cancer Society conducted a representative survey on the lifestyles and daily routines of 16-20 year-olds. 1,768 young people aged between 16 and 20 were chosen according to systematic selection. Data was collected via questionnaires sent out by post. The response rate was approximately 60%.

”Monitorering af unges livsstil og dagligdag 2004” (MULD 2004), Sundhedsstyrelsen og Kræftens Bekæmpelse

In 2004, the National Board of Health and the Danish Cancer Society conducted a representative survey on the lifestyles and daily routines of 16-20 year-olds. 1,772 young people aged between 16 and 20 were chosen according to systematic selection. Data was collected via questionnaires sent out by post. The response rate was approximately 58%.

”Monitorering af unges livsstil og dagligdag 2006” (MULD 2006), Sundhedsstyrelsen og Kræftens Bekæmpelse

Again in 2006, the National Board of Health and the Danish Cancer Society conducted a representative survey on the lifestyles and daily routines of 16-20-year-olds. 1,964 young people aged between 16 and 20 were chosen according to systematic selection. Data was collected via questionnaires sent out by post. The response rate was approximately 68 %.

”The 1995 ESPAD report – Alcohol and Other Drug Use Among Students in 26 European Countries” 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 survey was conducted in 1995 on young people and their relationship with drugs. The survey was carried out in Denmark among a representative segment of 15-16 year-olds in 9th grade at randomly selected “folkeskoler”, private schools and continuation schools. Data collection was performed by handing out the questionnaires to the interviewees in the classrooms. A total of 2,234 pupils participated in Denmark, which equals a response rate of approximately 90%

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

In 1999, the survey from 1995 was repeated among a representative segment of 15-16 year-olds in 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 1,548 pupils participated in Denmark, which equals a response rate of approximately 91.7%

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

In 2003, the surveys from 1995 and 1999 were repeated among a representative segment of 15-16 year-olds in 9th grade at randomly selected “folkeskoler”, private schools and continuation schools. Data collection was performed by handing out the questionnaires to the interviewees in the classrooms. A total of 2,519 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)

This report 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 2,545.

The 2007 ESPAD report - Alcohol and Other Drug Use Among Students in 36 European Countries " CAN and Pompidou Group (unpublished)

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

“Rusmiddelforbruget – i folkeskolens afgangsklasse og udviklingen fra 1995-1999” Institut for Epidemiologi og Socialmedicin, Aarhus Universitet (Sabroe & Fonager 2002)

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 1,750.

Unge erfaringer med rusmidler – i 2003 og udviklingen siden 1995. Institut for Epidemiologi og Socialmedicin, Aarhus Universitet (Sabroe & Fonager 2004)

This report is based on the Danish ESPAD 2003 study. 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 2,978.

Skolebørnsundersøgelsen 2002. Health Behaviour in school-aged Children (HBSC). Pernille Due & Bjørn E. Holstein 2003)

This report describes 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 use of cannabis and ecstasy among 15-year-olds. The study was conducted as an anonymous questionnaire handed out in the classrooms of the "folkeskoler" (elementary schools). The random sample included 1,418 young people.

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Table 2.1.1. Percentage of women and men in the various age groups who have tried cannabis within the last year in 1994, 2000 and 2005

		1994 N=2.521	2000 n=6.887	2005 n=4484	Denmark-s population in age groups in 2005
16-19-year-olds	Men	19	29	23	123124
	Women	10	20	19	116648
20-24-year-olds	Men	14	24	26	147943
	Women	9	12	16	144598
25-29- year-olds	Men	8	16	17	173681
	Women	5	6	5	172033
30-34- year-olds	Men	9	10	10	193537
	Women	2	3	3	190643
35-39- year-olds	Men	6	8	5	210636
	Women	2	2	2	203290
40-44- year-olds	Men	5	4	4	204212
	Women	2	2	2	197524
All 16-44 year-olds	Men	10	14	11	1053133
	Women	5	6	6	1024736
	All	7	10	8	2077869

Source: SUSY 1994, SUSY 2000, SUSY 2005

Table 2.1.3.1. Percentage of 16-44 year-olds who have tried one or more of the various illicit drugs within the last month, last year and at some point in 2006 (n=4440)

	Last month	Last year (last month included)	Ever
Amphetamine	0.4	1.3	9.9
Cocaine	0.6	1.9	6.8
Psilocybine mushrooms	0.1	0.4	4.7
Ecstasy	0.1	0.5	3.3
LSD	0.0	0.1	1.9
Heroin	0.1	0.2	0.7
Other drugs*	0.1	0.2	1.2
"hard" drugs, total**	1.1	2.7	13.5

Source: Unpublished figures from SUSY 2005

*The category "Other" drugs covers GHB, various medicines, etc.** An overall category for "used and illegal drugs other than cannabis".

Tabel 2.1.3.2. Percentage of 16-24 year-olds who have tried one or more of the various illicit drugs within the last month, last year and at some point in 2000 and 2006

	Last year	
	2000	2006
Cannabis	19.7	20.5
Amphetamine	5.7	4.0
Cocaine	2,7	3.3
Psilocybine mushrooms	2.1	0.9
Ecstasy	2.3	1.5
LSD	0.6	0.6
Heroin	0.2	0.2
Other drugs*	1.0	0.7
"Illicit drugs other than cannabis" Total	7.7	5.3

* Source: Unpublished figures from SUSY 2000 and SUSY 2006.

*The category "Other" drugs covers GHB, various medicines, etc.** An overall category for "used and illegal drugs other than cannabis".

Table 6.1.1. Drug deaths 1981-2006. Distribution by gender

Year	Total	Men	Women	Year	Total	Men	Women
1981	148	113	35	1994	271	227	44
1982	134	107	27	1995	274	226	48
1983	139	110	29	1996	266	220	46
1984	158	125	33	1997	275	225	50
1985	150	116	34	1998	250	210	40
1986	109	88	21	1999	239	201	38
1987	140	116	24	2000	247	197	50
1988	135	107	28	2001	258	211	47
1989	123	99	24	2002	252	216	36
1990	115	91	24	2003	245	197	48
1991	188	153	35	2004	275	211	63
1992	208	162	46	2005	275	234	41
1993	210	166	44	2006	266*	218	46

Source: Rigspolitiet [Police Drug Statistics] 2006

*Gender not informed for 2 persons

Table 6.2.1. Trend in hospital visits following intoxication and poisoning caused by illicit drugs from 1999 to 2006									
	Kode*	1999	2000	2001	2002	2003	2004	2005	2006²¹
Heroin	T40.1	249	255	240	174	192	220	167	171
Other opioids	T40.2 +T40.2A +T40.2B	35	35	44	48	52	121	115	131
Methadone	T40.3	5	11	19	39	26	50	56	35
Opioids	F11.0	67	80	67	53	55	49	60	45
Opioids, total		356	381	370	314	325	440	398	382
Designer drugs (excl. ecstasy)	T40.6A + T43.8A	*	2	14	21	12	15	3	6
Ecstasy	T40.6B +T43.6B	9	75	67	60	83	73	72	91
Amphetamine	T43.0A + T43.6A	*	2	24	43	54	70	73	84
Cocaine	T40.5 +F14.0	45	51	78	65	76	71	103	96
Other central stimulants	F15.0	58	48	53	47	50	43	43	35
Central stimulants, total		112	178	236	236	275	272	294	312
Euphoriant mushrooms	T40.6C +T40.9A	7	5	10	8	3	10	6	13
LSD	T40.8	3	3	12	2	1	2	8	11
Hallucinogens	F16.0	10	15	16	5	4	6	9	4
Hallucinogens, total		20	23	38	15	8	18	23	28
Cannabis	T40.7 +F12.0	97	102	164	122	125	74	82	73
Polydrug use and unspecified	T40.4 +T40.6 +T40.6W +40.6X +T40.9 +F19.0	541	632	571	657	704	469	422	475
Intoxications and poisoning, total		1126	1316	1379	1344	1437	1273	1219	1270

Source: The National Board of Health's National Patient Register (LPR)

*New codes were introduced in 2000 and 2004.

**From 2004, a number of new subcodes for polydrug use and unspecified poisoning have been introduced. These include the following: T404A, T409A, T409B, T409C, T409D, T409X, T409Z.

²¹ The figures for 2006 are provisional and retrieved from the LPR (National Patient Register) in June 2006. The final figures for 2006 may therefore change in subsequent statistics.

Table 6.3.1. Number of newly diagnosed HIV positive and AIDS diagnosed individuals in the entire population and the percentage of intravenous drug users among this group 1996-2006²²

	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Number of newly diagnosed HIV positive patients, total	269	273	213	287	260	319	289	270	306	264	244
Number of newly diagnosed HIV positive patients with intravenous drug use (% of all diagnosed)	25 (9%)	30 (11%)	14 (7%)	26 (9%)	20 (8%)	31 (10%)	31 (11%)	24 (9%)	13 (4%)	17 (6%)	11 (5%)
Number of newly diagnosed AIDS cases	159	109	74	75	58	71	45	39	61	44	47
Number of newly diagnosed AIDS cases with intravenous drug use (% of all newly diagnosed)	18 (11%)	11 (10%)	4 (5%)	7 (9%)	7 (12%)	10 (14%)	4 (9%)	11 (28%)	4 (7%)	4 (9%)	3 (6%)

Source: Unpublished data from the State Serum Institute

Table 6.3.2. Registered number of acute cases of hepatitis A, B and C in the entire population and the percentage of intravenous drug users among them 1996-2006

	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Number of hepatitis A	107	115	86	88	81	61	84	70	241	48	42
Number of hepatitis A with intravenous drug use (% of all diagnosed)	0	0	0	0	0	0	1 (1%)	0	1 (<1%)	1 (<1%)	0
Number of hepatitis B, total*	100	101	94	57	63	49	62	36	43	30	18
Number of hepatitis B with intravenous drug use (% of all diagnosed)	35 (35%)	30 (30%)	24 (26%)	13 (23%)	20 (32%)	12 (24%)	12 (19%)	7 (19%)	9 (21%)	3 (11%)	1 (6%)
Number of hepatitis C, total*	28	26	21	13	15	6	5	7	8/317*	1/308	6/300
Number of hepatitis C with intravenous drug use (% of all diagnosed)	20 (71%)	20 (77%)	12 (60%)	11 (85%)	9 (60%)	3 (38%)	1 (50%)	2 (29%)	3/243 (37%/77%)	0/225 (0%/73%)	5/223 (83%/74%)

Source: Unpublished data from the State Serum Institute. For 2006 data, the date of compilation is 1 June 2006

*Cases with acute hepatitis B and C include a certain generic volume

** acute/chronic hepatitis C cases.

²² The figures compiled for 2005 are per 1 June 2007.

Table 6.4.1. Persons registered with drug-related secondary diagnoses in psychiatric hospitals 1997-2006

Diagnosis code	Mental illnesses or disorders caused by the use of:	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
F11	Opioids	273	273	227	227	189	172	156	155	138	123
F12	Cannabis	279	314	317	270	327	364	333	354	312	347
F13	Sedatives /hypnotic agents	239	212	204	205	199	182	159	143	150	140
F14	Cocaine	15	21	23	23	31	36	65	53	42	49
F15	Central stimulants other than cocaine	82	82	71	76	75	109	99	98	93	87
F16	Hallucinogens	25	17	26	18	21	14	9	17	16	10
F18	Solvents	3	5	10	2	6	2	10	5	3	3
F19	Multiple or other psychoactive drugs	586	705	758	749	732	726	747	684	668	660
Persons with primary diagnoses, total		1502	1629	1636	1570	1580	1605	1578	1509	1422	1419

Source: Unpublished figures from the psychiatric central register at the department of psychiatric demography of the Institute for Psychiatric Basic Research, Psychiatric Hospital, Aarhus

Table 6.5.1 shows the number of persons registered as recipients of psychiatric treatment (either full-day, half-day or outpatient treatment) as a result of drug use or volatile solvents. ICD-10 codes have been used, and the diagnoses F11.x til F16.x og F18.x til F19.x (primary diagnosis) used as retrieval criteria.

Table 6.4.2. Persons registered with drug-related secondary diagnoses in psychiatric hospitals 1997-2006

		1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
F11	Opioids	178	134	146	190	204	208	201	271	280	341
F12	Cannabis	477	524	566	584	637	691	759	873	908	1040
F13	Sedatives /hypnotic agents	259	247	253	283	257	266	307	359	367	385
F14	Cocaine	17	13	15	17	19	34	61	66	97	118
F15	Central stimulants other than cocaine	56	53	58	52	58	56	73	123	120	162
F16	Hallucinogens	7	4	11	9	11	10	2	13	14	8
F18	Solvents	6	4	9	7	7	13	12	11	8	18
F19	Multiple or other psychoactive drugs	314	418	534	566	485	574	679	728	736	874
Persons with secondary diagnoses, total		1240	1335	1506	1630	1593	1747	1844	2074	2102	2430

Source: Unpublished figures from the psychiatric central register at the department of psychiatric demography of the Institute for Psychiatric Basic Research, Psychiatric Hospital, Aarhus. Table 6.5.21 shows the number of persons registered as recipients of psychiatric treatment (either full-day, half-day or outpatient treatment) as a result of drug use or volatile solvents. ICD-10 codes have been used, and the diagnoses F11.x til F16.x og F18.x til F19.x (secondary diagnosis) used as retrieval criteria. Since a patient may have several drug-related secondary diagnoses, the "total" category is not a summation.

Table 8.2.1 Drug-related crime 1996-2006. Charges and number of persons charged

	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Charges, total	14,371	13,454	14,251	12,928	12,956	12,902	12,851	14,272	16,390	19,037	19,900
Charged persons	8,678	8,234	8,900	9,424	9,899	9,858	10,021	-	-	-	

Source: Rigspolitiet [Police Drug Statistics] 2006

Table 10.3.1. Drug seizures 1994 – 2006

	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Heroin													
Kg	29.0	37.4	61.4	37.9	55.1	96.0	32.1	25.1	62.5	16.3	37,5	27.0	28.9
Number of seizures	2,666	2,973	3,161	2,509	2,199	1,230	1,499	1,304	966	894	1041	1064	927
Cocaine													
Kg	29.9	110.1	32.0	58.0	44.1	24.2	35.9	25.6	14.2	104.0	32.3	57.0	76.2
Number of seizures	417	569	659	723	885	744	780	815	881	1095	1207	1615	1,901
Amphetamine													
Kg	12.6	40.0	26.7	119.4	25.2	31.6	57.1	160.6	34,9	65,9	63.0	195,0	79.4
Number of seizures	747	1,167	1,386	1,324	1,609	1,250	1,152	954	1,134	1,264	1,388	1,573	2,022
Ecstasy													
No		2,115	15,261	5,803.	27,039	26,117	21,608	150,080	25,738	62,475	38,096	44,195	22,712
Number of seizures		9	84	110	143	197	444	331	340	322	1388	461	540
LSD													
Doss		1,282	262	381	105	83	1,108	156	38	22	483	1201	521
Number of seizures		6	16	15	24	15	18	29	8	7	13	12	8
Cannabis													
Kg	10,665	2,414	1,772	467	1,572	14,021	2,914	1,763	2,635	3,829	1,758	1,4062	1,035
Number of seizures	6,995	6,710	5,187	4,886	5,904	4,569	5,561	5,788	5,234	5,942	7,313	10,287	10,962

Source: Rigspolitiet (Police Drug Statistics) 2006

Table 10.3.2. Distribution between drug types on a user level 1996-2006

Year	1996*	1997*	1998*	1999*	2000	2001	2002	2003	2004	2005	2006
	n=212	n=217	n=208	n=216	n=188	n=152	n=198	n=188	n=200	n=196	n=203
Heroin	57%	60%	56%	45%	44%	45%	40%	39%	33%	34%	33%
Amphetamine	23%	26%	17%	23%	17%	22%	24%	20%	29%	23%	34%
Cocaine	14%	9%	23%	27%	24%	22%	30%	32%	34%	36%	30%
Ecstasy**	3%	1%	<1%	3%	7%	9%	2%	-	-	-	-
Metamphetamine***	-	-	-	-	-	-	-	4%	1%	5%	1%
Other euphor- ants/drug combina- tions	1%	1%	1%	1%	5%	1%	3%	4%	3%	1%	2%
Non-euphoriant	2%	3%	1%	<1%	3%	1%	2%	1%	-	2%	1%
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Source: Kaa et al. 1996-2005; Lindholst et al. 2007

* In 1996, 1997, 1998 and 1999 figures were included from Elsinore Police District

** Ecstasy was excluded from the "Street-Level Project" from 2003 and is now monitored independently. See "Monitoring of ecstasy pills on the market" in the next section.

***The number of samples containing pure methamphetamine has increased dramatically from 2002, which is 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 euphoriant/drug compounds" until 2003. Over the entire period the latter category contains the samples in which methamphetamine is found in combination with other drugs.

10.3.3. Distribution between heroin base and heroin chloride from 1996 – 2006

	1996*	1997*	1998*	1999*	2000	2001	2002	2003	2004	2005	2006
	(n=120)	(n=30)	(n=118)	(n=97)	(n=82)	(n=69)	(n=80)	(n=73)	(n=66)	(n=66)	(n=66)
Heroin base	70%	68%	72%	71%	61%	77%	76%	84%	77%	76%	65%
Heroin chloride	30%	32%	28%	29%	39%	23%	24%	16%	23%	24%	35%

Source: Kaa et al. 1996-2005; Lindholst et al. 2007

* In 1996, 1997, 1998 and 1999 figures were included from Elsinore Police District.