



European Monitoring Centre
for Drugs and Drug Addiction

 Sundhedsstyrelsen
National Board of Health

**2005 NATIONAL REPORT TO THE
EMCDDA
by the Reitox National Focal Point**

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

Preface

This year's National Report on the drug situation in Denmark has been prepared by the Danish "Focal Point" under the National Board of Health. The report has been drafted during the autumn of 2005 and is the tenth report submitted to the European Monitoring Centre for Drugs and Drug Addiction (the EMCDDA). The report is available in a Danish as well as an English version and has been written in accordance with EMCDDA guidelines.

The report provides an overview of the drug situation in Denmark. It is based on the most recent statistical and epidemiological data as well as current information on intervention areas, projects, activities and strategies pursued within drug prevention, harm reduction and drug abuse treatment. In addition, the report contains descriptions of current legislation and policies on drugs.

Ms Kari Grasaasen, sociologist, has prepared the epidemiological chapters in the report as well as the thematic chapter dealing with gender and drugs. Mr. Hans Henrik Philipsen, head of section, has prepared the chapters describing prevention, and Ms Anne-Marie Sindballe, senior consultant at the National Board of Health has written the thematic chapter on drug policy in relation to alcohol policy. Ms Johanne Korsdal Sørensen and Ms Kari Grasaasen have together prepared the thematic chapter describing recreational use of drugs. The remaining chapters of the report include contributions from the National Board of Health's Office of Statistics, the Ministry of Justice, the Ministry of Social Affairs, and Ministry of the Interior and Health, the counties and other collaboration partners.

The Danish member of the EMCDDA's Scientific Committee, Ms Anne-Marie Sindballe and a reading panel appointed by the National Board of Health have provided their comments and constructive criticism. Layout and proofreading has been carried out by Ms Birgitte Neumann, the National Board of Health, and Ms Anita Pontoppidan, LinguaMedica, is responsible for translating the report into English.

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*Else Smith
Director
National Centre for Health Promotion and Prevention*

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Summary

The current drug situation in Denmark

The most recent estimate on the number of drug abusers made by the National Board of Health shows that in 2001, there were 25,500 drug abusers in Denmark. Out of this figure, a little over 6,000 are estimated to be cannabis abusers. From 1996 to 2001, the number of drug abusers has gone up by 5,000 persons, equalling 24%. The figures do not comprise experimental use of drugs, but estimates the number of persons with a more constant use of drugs resulting in physical, mental and /or social injuries. Actual addicts are thus included in the estimates, including the stabilized drug addicts (those receiving methadone treatment) as well.

No population surveys on the prevalence of experimental drug use have been made within the adult population in Denmark since 2000. However, the results from the most recent school surveys conducted among the young teens, the young adults and regional hearings suggest that the increase in the experimental use of illicit drugs observed from the mid-1990s and onwards has stagnated and that the experimental use today appears to have reached a “historically high”, however stable level. Cannabis continues to be the most prevalent illicit drug, whereas amphetamine, cocaine and ecstasy in the order mentioned are also used by many young people.

Experimental use of illicit drugs remains to be a phenomenon primarily taking place in the years of youth, which appears from the various population studies and the regional hearings. Drug use exists primarily in the age groups from 15-30 years, and peaks among the 16-24-year-olds.

Although the experimental use of cannabis appears to have stabilised, there continues to be an increase in the damaging effects resulting from cannabis use in these years. An increasing number of young people, especially the ones receiving treatment, enter the treatment system with cannabis and amphetamine-like drugs as the main problem of their abuse. Also the data collected on drug-related hospitalisations due to mental illnesses points towards an ever-increasing number of persons being admitted with cannabis-related problems. Problems associated with polydrug use and the use of amphetamine-like drugs are increasingly prevalent within drug treatment and among the drug-related mental hospitalisations, although the increase in relation to this type of drug use is not quite as radical as the one seen in cannabis. The statistical material on emergency ward visits where poisoning from illicit drugs is the cause of the visit shows that there is a clear tendency towards an increase in serious poisoning cases caused by illicit drugs and, in particular, by cannabis and amphetamine-like drugs, whereas poisoning resulting from opioids and polydrug use typically hits the older generation. Due to the existing registration practice and imprecise diagnoses, these figures are merely considered to be of a conservative nature.

The reasons for the documented increase in problems related to cannabis and the amphetamine-like drugs as it is seen in drug treatment and from other sources during recent years are most likely the increase in the experimental use of these drugs in particular during the 1990s, which now appears as the actual consequences. Another thing is that the improved treatment capacity and more targeted treatment services are considered to be the cause of the documented increase. From 2003 to 2004 alone, persons registered for receiving treatment for their drug abuse accounted for almost 14%. From 2003-2004, this increase had

been minimised to 2%. The less dramatic increase in the contacts to the treatment system could imply a “saturation level” in relation to the treatment places offered and the treatment requirements among the drug abusers in Denmark. On the other hand, as much as 33% of the entire drug abuse population in 2004 had not received treatment earlier and are thus considered by the treatment system to be “new” clients. The young drug abusers still make up an ever increasing share of all the drug abusers receiving treatment.

The Death Statistics prepared by the National Commission of Police reveals a relatively stable level of approximately 250 drug-related deaths since the mid 1990s. The past year, however, there appears to be an increase, and in 2004, 275 drug-related deaths were registered. By far the majority of these deaths are caused by poisoning with one or several drugs, and most of the poisoning cases result from opioids.

New developments within prevention, treatment and harm-reduction

During recent years, prevention initiatives and harm-reducing programmes have increased in numbers on a regional as well as a governmental level. These initiatives are supposed to restrain the development of experimental use and to limit the damage caused by abuse of illicit drugs. New and additional local network projects that are more targeted and meant to prevent especially within the commercial party settings and youth education are being launched, and increasing cross-sectoral and interdisciplinary networks are being formed among the professionals to prevent against drugs and alcohol on a local as well as a regional basis.

On a national scale, initiatives have been launched to import, develop and test the US teaching material “Life Skills Training” in the Danish elementary schools. The aim of testing this material is to strengthen the self-esteem of the young people, their competencies and positive health behaviour in terms of tobacco, alcohol and drugs. The fundamental educational principle of the material is high pupil engagement through discussions, exercises and homework.

In connection with the Government’s 2003 action plan, a model municipal project referred to as “Drugs out of town” has been launched. The overall objective of the model municipal project is to reduce drug prevalence through locally established and coordinated intervention; more specifically, the project aims at curbing drug availability and prevalence among the young people as well as to reduce the number of acute injuries. The 14 municipalities engaged in the project focus on preventive intervention in elementary school, and in party settings, youth education, counselling, outreach work, special residential areas, fitness centres and children in families with abuse problems.

An additional number of counties are carrying out drug and alcohol prevention at local musical festivals. As in the years 2003 and 2004, this year’s Roskilde Festival focused on drugs, making the Festival’s stance on drugs abundantly clear through large-screen spots, the festival programme, postcards, t-shirts, the festival website, bus commercials and handout of factual information on drugs. In 2005, a national project involving various festival planners and subsidised by the National Board of Health was launched under the name *festivaldanmark against drugs*.

The number of drug abusers receiving treatment is increasing steadily. As a follow-up on the introduction of a treatment guarantee for drug abusers in 2003, a law has been passed as at 1 October 2005 providing treatment guarantee for young people under the age of 18 in special cases. The intention of the law is to ensure that the local authority acts quickly and expediently in order for young people to receive treatment for their abuse. A special fund has been reserved for 2006 and 2007 for the development of targeted programmes offered to young cannabis abusers.

New drugs and new legislation

The National Board of Health continues to be instrumental in monitoring drugs abused on the illicit market. The aim of this work is, among others, to consider whether control measures and bans can be implemented when new drugs surface on the market. Following professional recommendation from the National Board of Health, 5-Meo-DIP was forbidden as of 3 March 2004, and 5-Meo-DMT was forbidden as of 1 December 2004. In 2005, 2C-D has been prohibited as of 2005.

A number of new laws have been adopted and implemented in 2004/2005. As of April 2005, free hepatitis A and B vaccination has been offered to injecting drug users and their relatives, and as mentioned previously, as of 12 October 2005 a treatment guarantee has been introduced to young drug abusers under the age of 18. As a direct consequence of the regional reform effective 1 January 2007 and relating to the drug area, a number of health laws have been adopted and will be implemented concurrently with the regional reform.

The thematic chapter on "Gender differences in alcohol and drug abuse" treats the differences in prevalence and intervention areas between gender. The thematic chapter on "Drug policy in relation to alcohol, tobacco and doping" provides and outline on drug policy in Denmark specifically and in relation to areas involving alcohol, tobacco and doping.

1 New developments and trends

1.1 Overview and summary

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 services as well as efficient control. In its action plan “The Fight against Drugs”, the Government has drawn up the basic conditions governing its responses to drug use.

Drug use is a complex problem. Intervention must therefore be made on a broad scale across professional and sector bounds. This is a task to be solved in collaboration with local, regional and central authorities within the health, social, legal and customs area.

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

The counties and municipalities are responsible for treatment and prevention. The counties and local authorities are assisted by central authorities in monitoring, overall guidelines, documentation, knowledge communication, etc.

1.2 New legal framework, including new drugs under control

In 2005, the following laws and administrative regulations have been passed within the drugs area:

- By ministerial order no. 160 of 7 March 2005 on free hepatitis vaccine for injecting drug users and their families a scheme was introduced as at 1 April 2005, according to which injecting drug users are offered free vaccine against hepatitis A and hepatitis B. The families of injecting drug users, i.e. individuals in the household and permanent sexual partners, if any, outside the household are also provided free vaccine against hepatitis B.
- By Act no. 326 of 18 May 2005 on the administration of the European Community's directives on drug precursors, rules on control have been set out, including the access of control authorities to companies and on maximum terms of punishment.
- By law no. 331 of 18 May 2005 on the amendment of law on social services, the Minister of Social Affairs has, effective 1 October 2005, been authorised to lay down rules on guaranteed social treatment of drug users under the age of 18 in special cases.

- On 1 January 2007, the reform of the Danish regional map described briefly in the section on “Institutional framework, strategies and policies” below, will be implemented. As a consequence of the regional restructuring, a number of necessary laws have been passed. Those of significance to the drugs area all becoming effective concurrently with the regional reform are:
 - Act no. 573 of 24 June 2005 on social services. The act contains, among others, rules on social treatment for the cure of drug use.
 - Act no. 546 on 24 June 2005, the National Health Act. The act contains, among others, rules on the medical treatment of drug use.
 - Act no. 545 of 24 June 2005 on the amendment of various laws within the health and certain other sectors. The law provides amendments to, among others, the Medical Profession’s Act on the right of doctors to prescribe narcotic drugs as part of their treatment of individuals suffering from drug use.
- In 2005, the following narcotic drugs are subject to control:
 - By ministerial order no. 1118 of 19 November 2004 on the amendment of ministerial order on narcotic drugs, it was set out that the drug 5-MeO-DMT (5-Methoxy-N,N-dimethyltryptamine) as of 1 December 2004 can only be used for medical and scientific purposes.
 - By order no. 69 of 21 January 2005 on the amendment of order on narcotic drugs, it was set out that the drug 2C-D (2.5-dimethoxy-4-methylphenethylamine) as of 2 February 2005 can only be used for medical and scientific purposes.

1.3 Institutional framework, strategies and policies

In 2004, a political agreement was signed whereby it was laid down that as of 1 January 2007, a reform of the Danish regions will be implemented, which basically will change the conditions for administering the local and regional tasks. The laws that are necessary to implement the regional reform, and which have all been passed by the Danish Parliament (Folketinget), have been mentioned above in section 1.2. The consequences of the regional reform to the national drug strategy is that the responsibility for prevention as well as the social and medical treatment of drug users will be transferred to the regions.

As described in the 2004 National Report, the Copenhagen Metropolitan Police Force carried out the hitherto largest raid against the cannabis trade at “Christiania” on 16 March 2004 as a reaction to the overt cannabis trading that had been going on for a large number of years on the premises. On 26 July 2005, the Copenhagen Metropolitan Police has reported that status of the intervention at Christiania on 16 March 2004 is that 52 persons were convicted of possession of cannabis with a view to selling or contributing to selling. The 52 persons were convicted of possession of a total quantity of approximately 500 kg of cannabis.

1.4 Budget and public expenditure

The information on the annual budget funds and pooled reserves appear in the 2204 National Report. As far as new government grants are concerned, it should be mentioned that:

- In 2005, a total amount of DKK 3.7 million (Euro 495,000) in government funds are expected to be used for the prevention of drug abuse. Furthermore, the National Board of Health has been granted DKK 20.8 million (Euro 2.8 million) for the period 2004-2006 for the implementation of the model municipal project with the title “Drugs out of town”.
- In 2005, and for the subsequent years, a total of DKK 1.5 million (Euro 200,000) has been set aside for follow-up on the legislation governing regional commitments to drawing up action plans for young people with drug abuse problems.
- In 2005, provisions have been made for DKK 1.6 million (Euro 214,600), in 2006 DKK 9.5 million (Euro 1.2 million) and in the following years DKK 7.2 million (Euro 965,900) for the follow-up on the legislation dealing with guaranteed social treatment of young drug abusers in special cases.
- In the 2005, DKK 43.2 million (Euro 5.8 million) and DKK 42.2 million (Euro 5.7 million) were reserved in the Budget for the improvement of social activities offered to drug abusers in each of the following years.
- In 2005, DKK 15.4 million (Euro 2 million) and DKK 9.2 million (Euro 1.2 million) for the following years have been set aside for the development of services aiming at young cannabis drug abusers.

It has not been possible to state a separate amount for control strategies in the drugs area.

As regards expenditure on a local and regional basis, the local and regional account and budgets show a steep increase since 1995 in the funds reserved for social drug abuse treatment. The 2005 budget makes provisions for DKK 757 million (Euro 102 million). By comparison, the figures from 1995 were DKK 228.9 million (Euro 30.7 million). The local and regional expenses incurred in relation to prevention of drug abuse and the medical drug abuse treatment cannot be retrieved from the local and regional accounts and budgets.

1.5 Social and cultural context

In the 2004-05 parliamentary year, members of the Opposition tabled a motion for legalisation of cannabis. A large majority voted against the bill at the 1st reading of it. The bill did not reach the 2nd reading, nor did it reach a final vote. Another bill tabled during the parliamentary year of 2004-2005 was the introduction of drug injection rooms. That bill was rejected by a parliamentary majority at the 2nd reading. The government rejects any legalisation of cannabis, establishment of drug injection rooms and medical prescription of heroin, considering such action to be far too lenient and, as far as legalisation of cannabis and the establishment of drug

injection rooms are concerned, also in contravention of the international drug conventions as well as with the core of the Danish drugs policy.

2 Drug use in the population

2.1 Overview and summary

Cannabis is the most prevalent illicit drug in Denmark. According to the latest national population survey, 42% of the population between 16 and 44 years of age have tried experimenting with cannabis at some point in time and 10% have done so within the past year. By comparison, around 3% of the same age group have tried illicit drugs other than cannabis within the past year. Amphetamine is the second most prevalent drug after cannabis among the young as well as in the population in general (SUSY 2000)¹.

From the mid-90s and until early 2000, there has been a distinct increase in the experimental use of various illicit drugs – both in the population in general, and especially among the young adults and the very young (15 and 16-year-olds). Figures from the most recent national school and youth surveys summarized below suggest that the experimental use of cannabis and other illicit drugs now appears to have stabilised, albeit at a high level. One-fourth of all school children in the 9th grade have tried smoking cannabis, whereas cocaine, ecstasy and amphetamine have been tried by 2-4% of the very young (Hibell et al 2004, unpublished and ESPAD 2003). Among the 16 to 20-year-olds, 36% have tried to use cannabis, and 7% are current users (have smoked cannabis within the past month). 6% in the same age group have tried amphetamine, whereas 4% have tried cocaine (MULD 2004).

The phenomenon of trying drugs is typically one associated with youth, 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 young years. Studies among the entire population suggest that the experimental use of drugs peaks at the age group of the 16-19-year-olds, and that the over-40's age group only make up a small percentage of those who have used any kind of drugs within the past year (National Board of Health, 2002).

As described in the *2004 National Report*, there is a general trend that the same young adults are those who expose themselves to the various health hazards. Studies document that often extensive alcohol use, daily use of tobacco, cannabis smoking and experimenting with other illicit drugs is often connected to the same young people. Also, there is a significant co-variation between having used cannabis and having used one or several other illicit drugs. For instance, among the 16-20-year-olds, 58% of the boys who have been smoking cannabis within the past month have tried one or several other drugs whereas only 3% who have not smoked cannabis within the past month have tried several other drugs. As far as the girls are concerned, 42% of those who have been smoking cannabis within the past month have also tried one or several other drugs, whereas only 2% of those who have not smoked cannabis within the past month have tried one or several other drugs (National Board of Health and The Danish Cancer Society 2004).

¹ For more detailed results from the SUSY-survey in 2000, see tables in the Annex and previous annual reports from the National Board of Health publication series.

2.2 Drug use in the school and youth population

The younger age groups are those who account for the most prevalent use of cannabis and other drugs. Consumption among the 16-20-year-olds is described in this section on the basis of the MULD 2000, MULD 2001, MULD 2002, MULD 2003 and MULD 2004 studies. Consumption among the 15-16-year-olds is more elaborately described in last year's *2004 National Report* on the basis of ESPAD 1995, ESPAD 1999 and ESPAD 2003 and HBSC 2002. This chapter will only deal with the main results from these surveys among the very young people.

The study results, however, concur that the experimental use of drugs has stagnated over the past few years, but that it is also relatively widespread.

16-20-year-olds

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

Table 2.2.1. The percentage of 16-20-year-olds who have tried illicit drugs, 2000 – 2004.

	MULD 2000 (n=2046)	MULD 2001 (n=2090)	MULD 2002 (n=2041)	MULD 2003 (n=1768)	MULD 2004 (n=1772)
Cannabis, lifetime prevalence	32	33	37	36	36
Cannabis last month	9	9	8	9	7
Amphetamine, lifetime prevalence	8	9	6	7	6
Ecstasy lifetime prevalence	4	4	3	4	4
Psilocybinsvampe lifetime prevalence	3	5	4	3	3
Cocaine lifetime prevalence	3	4	3	4	4
Lsd lifetime prevalence	1	2	1	1	1
Heroin lifetime prevalence	0	0	0	1	0
Smokeable heroin lifetime prevalence	1	1	1	1	1
"Other" drugs	1	1	3	2	2

Source: (Sundhedsstyrelsen og Kræftens Bekæmpelse 2002 og 2003 [The National Board of Health and the Danish Cancer Society 2002, The National Board of Health and the Danish Cancer Society 2003] and unpublished figures from MULD 2003.

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

Apart from a slight, but significant increase in the experimental use of "cannabis, lifetime prevalence" [having tried cannabis at some point in time] over the different study years, there are no significant differences between the drug use figures for 2000, 2001, 2002, 2003, and 2004. This also applies to the current use of cannabis, except from a small, however significant drop in actual use from 2003 to 2004.

More than one third of the young people in this age group report having tried smoking cannabis at some point. Amphetamine is the second most frequently used drug after cannabis. Depending on the study year, 6-9% of the young people have

tried amphetamine at some point. 3-4% have tried ecstasy at some point, and use of ecstasy is thus about half as prevalent as amphetamine and more or less at the same level as use of psilocybin mushrooms and cocaine. Among 16 to 20-year-olds, there are also significant gender differences related to drug use. In almost all types of use, men account for a higher percentage than women. A special analysis of these gender differences is outlined in Chapter 11 of this report.

15-16-year-olds

Ongoing studies have been made on the experimental use of illicit drugs among the very young. the ESPAD-surveys carried out in 1995, 1999 and 2003 show an increase in the experimental use of cannabis and other illicit drugs among the 15-16-year-olds from 1995 to 1999. However, no significant increases were seen from 1999 to 2003.

At present, almost one-fourth of the 15-16-year-olds have tried cannabis at some point, and approximately 8% have tried cannabis within the past month. As regards the use of cannabis, the ESPAD and HBSC surveys reach the same conclusion on the high level of experimental use of cannabis among the very young Danish school children.

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

	ESPAD	ESPAD	ESPAD	HBSC
	1995	1999	2003	2002
	(n=2234)	(n=1548)	(n=2519)	(n=1418)
Lifetime prevalence, cannabis	18.0	24.4	22.6	23.3
Cannabis last month	6.1	8.1	7.6	-
Lifetime prevalence, amphetamine	1.6	4.0	4.0	-
Lifetime prevalence, cocaine	0.3	1.1	1.8	-
Lifetime prevalence, heroin (injection)	0.2	0.1	0.7	-
Lifetime prevalence, smokeable heroin	1.5	1.3	1.0	-
Lifetime prevalence, ecstasy	0.5	3.1	2.5	2.4
Lifetime prevalence, LSD	0.2	1.0	1.1	-
Lifetime prevalence, psilocybin mushrooms	0.5	1.8	1.5	-
Tried sniffing	6.3	7.5	8.3	-

Source: Hibell et al. 1997, 2000 and unpublished figures from ESPAD 2003, Pernille Due og Bjørn E. Holstein, 2002.

Starting age has also been studied in the ESPAD study, which shows that by far the majority smoke cannabis for the first time when they are 15 or 16 years old. Only very few try cannabis before they are teenagers. In comparison, young people's first experience with alcohol comes earlier, with half of all young people having had their first drink before they reach their teens (ESPAD, 2003).

As shown in table 2.2.2, the stabilised use of cannabis walks hand in hand with a stabilisation of experimental use of other drugs from 1999 to 2003.

The very young also account for major differences in the prevalence of illicit drugs among boys and girls. See Chapter 11 in this report.

2.3 Regional hearings

Since 2000, the office of the medical examiner has, at the initiative of the National Board of Health, carried out regional hearings on a national scale in order to collect more information about the regional and local drug consumption situation. The hearing procedure has involved the medical examiner, who with an overall questionnaire has carried out interviews of centrally placed personnel within drug use in one or several of the county regions. The results of the hearings are thus based on “soft” input from, among others, local drug use counsellors, SSP-workers, police, emergency wards, and from the social administration, prison and probation service and within treatment services. Some of the information is also provided by school teachers and/or club workers who work closely with the young.

The purpose of the regional hearings is to get an impression of trends as regards changed abuse patterns, new groups of experimenting young people, and possible new ways of administering the so-called “well-known” drugs. The hearings were conducted from May to September this year.

The summaries given below of the results of the regional hearings in 2005 give a general impression of the abuse situation on a national scale and are thus based on qualitative information obtained during the spring 2005.

Most counties report that the situation remains more or less the same compared to last year. The young people are experimental users of cannabis and amphetamine-type stimulants, with these drugs being used at private parties, in public settings, streets and lanes. The more persistent consumption is seen most frequently among the socially vulnerable young people, where interrupted schooling, no affiliation to the labour market, crime and general poor well-being is a part of these young people’s daily lives.

A number of counties report on extensive and increasing cannabis problems and a decreasing starting use. This drop cannot be documented in the national school surveys made over the years. As it appears from the ESPAD-survey from 2003, a large majority of the youngsters start smoking cannabis when they are 15-16 years of age (Sabroe and Fonager 2004). Also an increasing number of young cannabis users are seen in the treatment system. The increase in young cannabis users receiving treatment is also confirmed by figures appearing in a special list from the National Board of Health’s register on drug users receiving treatment, in which an increase in most counties is seen in the past few years (National Board of Health 2005b).

Among the group of young ethnics, it appears that the use of cannabis and, on a more local basis, the use of khat is increasing. In addition to this it is being reported that ethnic young people and 2nd generation immigrants to a higher degree than before are involved in the selling of cannabis and other illicit drugs.

The streetworkers, who are close to the young people, report on heavily increasing use of prescribed sleeping medicine and tranquillizers (benzodiazepines and valium) as well as rohypnol among the young. One county has reported about coughing medicine such as dexophan being mixed with alcohol and used as an enubriating substance among the youngsters. Sniffing of solvents is still seen to a

minor extent among the very young, albeit this type of drug use is reported periodically as coming and going.

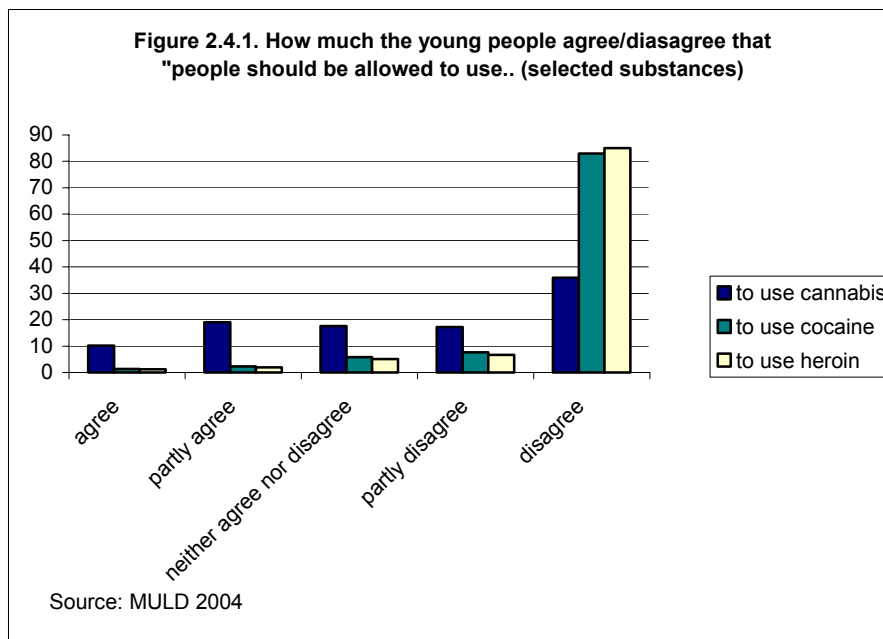
It is being reported that preventive measures are focusing on drugs and may minimise the use of drugs locally. On the other hand, it is being reported that undefined and diverse attitudes among the professionals – for instance towards the *aspect of legalisation* and *dangerousness* of the drugs – contributes to much uncertainty among the young adults as to how dangerous they perceive drugs to be and the risk factors related to the use of the illicit drugs.

As regards the known users, there is the general impression that they are in a miserable state from a health perspective, but that most of the drug users are in contact with the treatment system. Reports state increasing intravenous drug use with methadone and an increasingly widespread polydrug use. Finally, it appears that LSD has been “reintroduced” and that it is “in” among drug users.

2.4 Attitudes towards drugs and drug use among young people

Several surveys report on an acceptance of drugs among the young. The regional hearings report on major acceptance of use and the availability as well as the use of the drugs appears to be overt. A qualitative survey from 1999 (National Health Board 2000) points out that many young people accept the use of drugs (except from heroin).

The strict regulations providing that the possession, selling, buying of drugs, etc., is prohibited, are often put to public debate, as is the issue of the individualistic approach by the young people towards prohibition. In order to illustrate the young people’s acceptance of a social regulation versus the individual choice of drug use, the 16-20-year-olds in the MULD survey 2004 were asked whether they agreed/disagreed with the statements “People should be allowed to use... (selected drugs).” Cannabis, cocaine, and heroin were chosen as sample drugs in order to represent the spectrum in terms of prevalence among young adults (cannabis being the most prevalent, heroin the less prevalent), trends (cocaine has started to gain ground during recent years) and dangerousness (cannabis as moderately risky, cocaine and heroin as high-risk drugs in terms of addiction and poisoning).



As it appears in figure 2.4.1, there is a majority among the young people against the free choice of use – and thus in favour of limiting availability. This applies to cannabis with 29% agreeing fully or partially that people should be allowed to use cannabis, whereas more than half of them (53%) disagree fully/partially. This becomes even more pronounced for cocaine and heroin, with only 3% agreeing fully/partially that people should be allowed to use these drugs. In other words, the young people’s views are differentiated and distinguish between cannabis and other drugs.

There is a slight tendency towards boys and the 18-20-year-olds agreeing a bit more with the statement that people should be allowed to use drugs than the girls and the under 18s, but the differences are not pronounced (not shown).

The young people’s knowledge about the risk associated with the use of illicit drugs is also large. However, the perception of just how dangerous the various drugs are differs. 83% of the young 16-20-year-olds believe that it is possible to inflict harm upon oneself if taking ecstasy only once or twice (2/3 believe that there is a *major* risk, whereas 1/3 believes there is *some* risk). As far as cocaine is concerned the same perception of danger signals prevails among 82% of the young people. 92% of them believes that a regular use of cannabis, pot or marihuana may be associated with a risk. However, among this group, 67% believe that smoking cannabis regularly is associated with a large risk, whereas 25% have narrowed it down to some risk (MULD 2004).

The perception of ”dangerousness” associated with drug abuse is high among the younger part of this age group, and then starts to taper off when they reach the age of 20. This is also being documented in the ESPAD survey as described in last year’s annual report. Only 1-2% of the 15-16-year-olds believe that there is no or only a very small risk to suffer any harm from a regular use of the illicit drugs. The experimental use of drugs is perceived as being dangerous, and the use of drugs merely once or twice is perceived as risky among 60-80% of the very young (Sabroe & Fonager 2004).

3 Prevention

3.1 Overview and summary

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

At a governmental level, the National Board of Health is responsible for prevention in practice and it must, among others, support and stimulate the local preventive activities. Furthermore, it is the task of the National Board of Health via drug information targeted at the broad population to provide the young people, their parents and professionals working with children and young people with a high level of knowledge, and thus pave the way for a negative attitude towards drugs. Finally, the National Board of Health's intervention also targets at high-risk groups (selective and indicated prevention), which implies support to the professionals in contact with the high-risk groups. The Board's drug preventive activity is to a large extent carried out in collaboration with county alcohol and drug counsellors and includes development of model projects, development of information and teaching material on drugs, websites, and meetings, courses and seminars for professionals, volunteers and other key personnel engaged in drug problem activity.

In the counties and in the municipalities, intensified efforts are made to build up networks and cooperation in order for prevention activities to reach out to the target groups and in order to secure coordination and collaboration between the local and regional authorities. The county alcohol and drug counsellors provide to a wide extent teaching and orientation programmes for the 6th-10th grades, their teachers and the pupils' parents. They also develop and produce informative and teaching material, which is subsequently distributed and used by the other counties. Drug prevention in the municipalities is primarily carried out via the cross-sectoral SSP collaboration (School, social services and police) which aims at intercepting signals, including counteracting general or specific social problems for children and young people, suggesting and initiating activity preventing against drug abuse and crime.

3.2 Universal prevention - school

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

The health class curriculum provides:

- that the pupils must gain an insight into the conditions and values affecting health, sexuality and family life
- that the pupils must gain an understanding of the significance of sexuality and family life to health as well as health and the environment
- the personal development of the pupils must be strengthened
- that the pupils develop means to be critical and to act in order to promote their own and other people's health.

No fixed guidelines exist for the form, content and scope of drug teaching. Drug information classes are normally placed at the 7th-9th grade. Typically, the individual class teacher will plan the curriculum. As mentioned in the summary, the alcohol and drug counsellors and local SSP committees contribute to providing information about drugs in elementary school. In addition to these information and teaching programmes in primary school, the involvement of the parents is highly prioritised. Social functions involving parents as well as pupils are some of the most frequently applied methods to approach drug prevention in basic school settings.

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

In cooperation with the publisher Alinea, the National Board of Health was instrumental in importing, developing and testing a Danish version of the American teaching material “Life Skills Training”. American research projects have shown that the material has a measurable effect in terms of reducing pupil use of drugs and tobacco. The Danish version of the material has been adapted to Danish conditions, and evaluation will show if this type of material has a measurable effect in Denmark. The National Board of Health cooperates with the National Institute of Public Health on a research-related evaluation of the material’s functionality in Danish schools. In addition, prevention consultants from 6 counties will be participating in a project monitoring group. A total of 152 schools will participate in the project, of which 79 schools are intervention schools, ie the pupils are trained in “Tackling” and 73 schools are control schools.

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

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

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

The teaching material comprises a detailed teacher’s guide and a student book for each form. Teachers participating in the test, will also participate in an introduction course and a follow-up course one year after.

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

3.3 Prevention in the community

Regional and local intervention

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

In November 2003, the National Board of Health and the alcohol and drug counsellors (counties and several major municipalities) entered into a focused collaboration agreement on the distribution of responsibilities and roles in relation to the Board’s strategies and the counties’/municipalities’ specified policies and action plans for preventive intervention.

Today, the majority of the counties have established key personnel networks in collaboration with the municipalities. These networks operate via local contact personnel within SSP, but will also at times involve other street plan workers and health coordinators. Most of the networks are handled by the county alcohol and drug counsellors who are responsible for promoting network collaboration via newsletters, feature days, courses and inspiration meetings, etc. In addition to the counties’ establishment of key personnel network, several counties have intensified preventive intervention activities in elementary school and in other educational institutions. This includes the establishment of a “drug and alcohol corps” typically consisting of young people aged between 15 and 25 years who, following short-term training, visit the educational institutions and convey information as well as enter into a dialogue with the pupils.

This year, Frederiksberg Municipality and People’s Health Copenhagen have established a *drug and alcohol corps* consisting of, among others, medical students providing relevant knowledge on drugs and alcohol to the pupils of the 7-10th grade, youth education and parent gatherings. These drug guides are trained in a *method* using a young-to-younger dialogue technique which also comprises professional information about drugs and alcohol. The service is free and is arranged together with teachers at all levels in accordance with the needs of the target group.

Natteravnene (“Night Ravens”)

In 1998, the Night Ravens parent patrol was established in Denmark. The Night Ravens group is one of the oldest local voluntary prevention activities with approximately 7,000 active “night ravens” distributed across 163 local unions (incl. 5 in Greenland and 1 in the Faroe Islands). The Night Ravens cooperate with, among others, SSP-consultants all over Denmark and their main function is to be seen at night at thus instil safety. Young people contact a Night Raven anonymously with problems of various kinds. The Night Ravens are not particularly focused on the use of drugs. All local unions are affiliated with Natteravnenes Landssekretariat (“The National Night Raven Secretariat”) (www.natteravnene.dk).

“Drugs out of town”

Following the Government’s decision to intensify the common responsibility for drug abuse, a major action plan was, as has been outlined in last year’s report, drafted in October 2003 against drug abuse. The most significant initiative in this action plan is the three-year development project under the heading: “Drugs out of town”. The overall objective of the model municipality project is to reduce the prevalence of drugs in the local community through locally identified and coordinated special efforts. The more specific aim of the model municipality project is to curb the availability of drugs and the number of young people who try to use drugs considerably as well as to reduce the number of acute damaging effects such as poisoning, drug-induced psychoses and violence dramatically and to ensure early intervention in relation to young people heading for addiction and to focus on prevention in relation to children in drug using families. The model project includes preventive intervention of a universal, selective and indicated type.

In the social grants budget for 2003 and the Budget for 2004, an amount of DKK 20.8 million (Euro 2.8 million) has been reserved, of which DKK 15 million (Euro 2 million) have been set aside for 14 model municipalities, out of which amount 1 million (Euro 134,040) will be transferred to development funds for the model municipalities. This project is expected to end on 30 April 2007². From December 2004 to April 2005, the model municipalities have carried out a mapped analysis of each model municipality. The analysis was made on the basis of data sheets including information from the municipality, focus group interviews with individuals working with young adults from 15-20 years of age and an internet-based questionnaire distributed among the 15-20-year-olds in the municipality. Data from these sources was consolidated into a report describing the drugs situation in the individual model municipalities based on the themes of availability, prevalence and problem perception. Generally, the mapping of activities shows the same prevalence in the municipalities as on a national level (shown in Chapter 2), but with less geographic variations. In addition, the report also points to relevant focus areas in the local work with “Drugs out of town”.

Some of the intervention areas on which the municipalities have chosen to focus in their project descriptions (within the framework of the overall project description for the “Drugs out of town” project (see 2004 National Report) are the primary school and party settings (e.g. development of drug and alcohol policies), counselling for young people, outreach work in relation to the groups of young people in special residential areas, exercise centres and children in families with abuse problems. A municipality has chosen to collaborate with Jydske Dragonregiment [Regiment of Dragoons in Jutland] and target its activities at the almost 400 young men (recruits) living in the barracks. Most of the planned activities include the development of competence-generating courses to front personnel.

In May 2005, the National Board of Health issued a number of guidelines to the model municipalities in order to support local drug preventive intervention. The guidelines were meant to provide the municipalities with a brief outline of the

² See also 2004 National Report and www.sst.dk/Forebyggelse/Faglige_omraader/Narkotika/Kampagne.aspx?lang=da.

principles recommended in connection with drug preventive intervention. These recommendations are widely based on current and research-based knowledge in effective methods to implement drug prevention.

During the project, the National Board of Health expects to incorporate best practice examples from the model municipalities' work with "Drugs out of town" to the guidelines. A revised version of the guidelines is estimated to be ready in April 2007. The guidelines have also been distributed to Danish Regions, county drug and alcohol counsellors, county nurses, medical officers, SSP-consultants and various collaboration partners.

3.4 Selective and indicated prevention – Party settings

The increasing interest among local authorities in establishing closer contact with the relevant players (municipality, local police force and restaurant owners) has continued in 2005 with a higher degree of experience being exchanged among the major cities. In the "Drugs out of Town" project (see 2004 National Report), 12 out of the 14 participating municipalities have planned preventive activities in nightlife settings. Concurrent with the increasing prevalence of drugs and party drugs in nightlife settings, central as well as local government have reacted by launching a number of initiatives targeted at limiting the availability of drugs in recreational settings and reducing the health damage caused by the drugs.

In addition to this project in 14 model municipalities, the majority of Danish counties have taken part in implementing preventive intervention vis-a-vis commercial party establishments. The extent of intervention varies from a series of courses offered to doormen to large-scale local development projects involving restaurant associations, police, license authorities, fire services, tax and customs authorities, etc³.

Roskilde Festival/Festivaldanmark Against Drugs

Having once again received positive evaluations in 2004, Roskilde Festival Against drugs decided to continue and expand its work in 2005 to include the sister association Festivaldanmark that counts 15 festivals in addition to Roskilde Festival⁴.

The expanded campaign resulted in a joint website and materials including: logo, statement, Go-cards (electronic as well as printed), car streamers, badges, posters and fact folders on drugs.

The experience gained from the Roskilde Festival Against Drugs 2004 made up the platform of that of 2005 and adhered to the same concept⁵. Roskilde Festival's attitude towards drugs was highlighted through mass media communication aiming at arousing debate among the participants. A statement in the Festival programme and on the website, large screen spots before concerts on the major scenes and bus commercials were some of the elements with maximum effect. Subsequent

³See the EDDRA database for experience from the 6 Danish projects targeted at recreational settings: <http://eddra.emcdda.eu.int/>.

⁴ See <http://www.festivaldanmark.dk/index.asp?page=253>.

⁵ See EDDRA database at <http://eddra.emcdda.eu.int/> ("Roskilde Festival Against Drugs 2004").

evaluations received from festival participants show that 80% are aware of Roskilde Festival's attitude towards drugs, 29% have discussed it with their friends, and 93% agree that it is a good idea that the festival has this attitude.

In parallel with the main program, a special "care room" was established in 2005 for drug users at Roskilde Festival. This care room consisted of a bus placed at the festival, where former drug users from the Drug Counselling project provided counselling and information to drug users under the heading "Are you experienced". The activity was financed by the Danish Ministry of Social Affairs.

See also chapter 13 on recreational use of drugs.

3.5 Risk groups and families

Prevention targeted at families with children in pre-school age contains a number of activities based on legislation within the social and health care services.

During the first 2 years of the lives, families are offered approximately 4-8 home visits made by a health visitor. If the planned number of visits are not enough, the health visitor will arrange for additional visits. During these visits, the nurse will discuss and check the child's motoric and emotional well-being and development, including contact between mother and child. Several municipalities and counties provide activities focusing on children in abuse-ridden families. Intervention activities give priority to preparing action guidelines with the institutions, etc. which is supposed to ensure expedient cooperative support to these children. This is done through outreach work in local institutions, schools and social administration.

The Danish Social Services Act allows for municipalities to provide special counselling and support services to families who are socially marginalised. The municipalities are committed, in particular, to intervene if children live under socially endangered conditions. This safeguarding of social welfare is considered to have a preventive effect.

The "Family Team" project in Frederiksborg County consists of employees who have an education within social services, health care or psychology, and who either have or are currently taking a family therapeutical education within integral systemic therapy. *The objective* of this project is to remedy problems in families, where it is believed that such problems originate from or are enhanced by the fact that one or several of the family members have or have had drug use problems. *The target group* is families and their relatives. *The methodology* includes, but is not limited to, interviews with couples, interviews with children, network meetings, meetings with network personnel about the children, family groups, including groups of children and adolescents, groups of young adults of drug users, groups of parents of young drug users, partner groups. Furthermore, the project involves those who have signed up for "early intervention, i.e. motivating preparatory conversations with pregnant women and mothers who have given birth. The project consults with internal and external collaboration partners.

The overall conclusion retrieved from the evaluation of the groups of children and young people shows that a majority of the participating children and young people perceive it to be extremely helpful that they are taken seriously and that their problems may be addressed through conversations with professional adults. To

some of the parents, this type of intervention has led to a more stable relationship with their spouse and motivation to seek treatment for their drug use problems.

The objective of the HUP Project (HUP: Helhed, Ungdomsuddannelserne, Psykosociale problemer) from Storstrom County is to prevent against dropping out of the youth educational institutions. The method involves developing and disseminating psycho-social and personal counselling to pupils at the youth educational institutions combined with the development of local peer networks, i.e a cross-sectoral collaboration project, as well as development and identification of coordinated activities between educational youth counsellors, student counselling and psycho-social counselling (indicators for referral), including development of referral procedures. Counselling services will be established in 4 youth education towns in Storstrom County with the intent being to relieve the young people of their problems and make sure that they stick to their educational path. The project is also meant to develop local, interdisciplinary cooperation in services provided to young people, document their problems, and document prevention against drop-out. The project is planned to be evaluated by an external group.

The rationale behind launching the HUP project is primarily to increase the share of young people with an education providing them with business competencies. All too many drop out of the educational system. The political goal is for 95% of a class to complete a business education, however reality is that 75% of a class complete an education (figures from 2003). Previous experience from the county pilot project with open anonymous counselling for 300 young people (cooperation between youth educational institutions in Nakskov and Nykøbing Falster and Storstrom County Youth Centre in Vordingborg) have given good results with counselling that has aimed at the young education seeking people with psycho-social problems (including drug use problems) (See chapter 7).

4 Problem drug use

4.1 Overview and summary

More and more drug abusers seek treatment for their problem. Since the National Board of Health registered drug abusers admitted to treatment for the first time in 1996, the number of drug abusers in treatment has almost tripled. This increase should be seen in the light of increased treatment capacity and better-organised treatment programmes. Furthermore, the provision on a treatment guarantee for drug users, which came into force on 1.1.2003, is assumed to have an impact, given that a *request* for treatment now gives the *right* to treatment within a fortnight. Finally, the increase may be attributable to the fact that there has been an actual growth in the number of drug abusers in Denmark over the years, which probably means a relative increase in the number of individuals seeking treatment for their drug problem.

In 2004, a total of 5,212 persons were admitted to treatment, which means that a total of 13,161 people received treatment for drug use in 2004. As regards the population of drug abusers, the proportion of the total drug-abusing population seeking treatment for their heroin abuse has dropped during recent years. On the other hand, there appears to be an increase in the number of drug abusers seeking treatment for use of cannabis and amphetamine-like substances. This increase is more distinct among drug users seeking treatment for the first time, and dramatically on the increase among the young ones receiving treatment. The data is primarily based on the National Board of Health's register on drug abusers who receive or have received treatment. The register includes the persons who have been referred to drug abuse treatment by the county/municipal centres.

This chapter provides an outline of the results retrieved from the National Board of Health's register on drug abusers receiving treatment. Also, this chapter describes a special study conducted in the spring of 2005 on young drug abusers receiving treatment together with the extent and development of substitution treatment with methadone.

In 2003, the National Board of Health applied the capture-recapture method to make an estimate on the total number of drug abusers in Denmark. The calculations showed that in 2001, there were 25,500 drug abusers in Denmark, while in 1996 the figure was 20,500. This calculation does not include experimental drug use, but estimates the number of people who use drugs more regularly, as a result of which they suffer physical, mental and/or social damage. The estimate includes cannabis users as well as users of central stimulants, opioids, etc., irrespective of manner of intake. Cannabis users alone are estimated to amount to 5,000 people out of the total estimated number of drug abusers in Denmark. No estimates have been made on the number of drug abusers in Denmark since 2003. Detailed results and descriptions of estimates from 2003 have not been included in this chapter. For a more detailed description, please see the 2003 National report.

4.2 Profile of clients in treatment

Based on the data provided by the National Register on Drug Abusers receiving or having received treatment, it is possible to describe the persons seeking help for their drug problem and their drug use in general. The Register records whether

treatment is provided on an out-patient or in-patient basis and the type of treatment (methadone, drug-free treatment, etc) provided to the client. Table 4.2.1 shows the various types of clients admitted in 2004.

Tabel 4.2.1. Clients receiving treatment for drug abuse, admitted in 2004	
Number of clients admitted to treatment in 2004	5212
Clients not previously treated (%)	33
Men/women (%)	77/23
Average age men/women (%)	32/31
Opioids as primary drug (%)*	47
Cannabis as primary drug (%)*	27
Central stimulants as primary drug (%)*	12
Injection , previously treated heroin abusers (%)	40
Injection, not previously treated heroin abusers (%)	21
In job (%)	10
Unemployment benefits (%)	3
Cash benefits (%)	56
Early retirement pension (%)	12
Other income and undisclosed income (%)	10
Clients with own dwelling (%)	56
Clients single men/women (%)	76/66
Number of children under the age of 18 living at home	688
Number of children under the age of 18 living away from home	512
Foreign citizenship (%)	5,8

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

*Percentage of those reporting a primary drug.

In 2004, 5,212 persons were admitted for treatment in Denmark. This is a 2% increase compared to the 5,134 who were admitted in 2003. The total number of drug abusers who were treated during the year rose by 7% from 2003 to 13,161 persons in 2004. (The total number includes persons who continued treatment from 2003 and into 2004).

33% of those admitted in 2004 had not previously been treated for their drug problem. A special calculation and description of these "newcomers" will be provided separately in this chapter.

Use by substance

Although heroin once had a strong foothold, cannabis has now become the substance most frequently used among the clients receiving treatment. However, heroin, methadone and benzodiazepines are also used by many. A vast majority of drug abusers seeking treatment use several drugs. 44% reported in 2004 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 amphetamine-like substances that are the focus of young people's experimental use of drugs are only moderately represented as the primary drug for addicts in treatment. Only 7% report amphetamine, 5% report cocaine and 1%

report ecstasy⁶ as their primary drug⁷, which, however, is a slight increase compared to 2002. These drugs are thus being used as a supplement.

Cannabis was the primary drug for 27% of those admitted to treatment, but it is also a very widely used secondary drug. 25% of those admitted in 2004 report using cannabis as a secondary drug.

Distribution of age and gender

In 2004, there were 77% men and 23% women among the drug addicts undergoing treatment, which more or less corresponds to the gender distribution over the previous years. In 2004, the average age on admission was 32 for men and 31 for women.

Social background variables

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

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

The housing situation of drug abusers is also very poor. Only 56% have their own home – as much as 6% are actually homeless.

As regards family, a large proportion of male as well as female drug abusers were single, which is unusual for a group consisting primarily of young adults. A total of 688 children lived together with an addict in treatment in 2004, whereas 512 children under the age of 18 had been removed from the home.

Foreign citizens

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

Newcomers in treatment

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

⁶ Here recorded as MDMA or similar.

⁷ The percentages are calculated as that part of the treatment population who have reported a primary drug.

Table 4.2.2. Clients admitted to treatment during the year, and who have not been admitted to drug abuse treatment earlier

	2000	2001	2002	2003	2004
Clients who have not been treated earlier	1157 out of 3920 (27%)	1278 out of 4079 (31%)	1364 out of 4310 (32%)	1745 out of 5134 (34%)	1696 out of 5212 (33%)
M/W (%)	77/23	76/24	78/22	76/24	77/23
Average age M/W	28/28	28/27	28/29	28/28	27/28
Opioids as primary drug (%)*	54	38	35	28	24
Cannabis as primary drug (%)*	30	33	39	44	47
Central stimulants as primary drug (%)*	14	11	15	18	23
Injection, heroin addicts (%)	35	25	23	25	21

Source: The National Board of Health's register on drug addicts in treatment in 1999, 2000, 2001 and 2002.
*Percentage of those reporting a primary drug.

As shown in table 4.2.2, 33% of the clients admitted in 2004 had not previously been treated. Not surprisingly, the average age was significantly lower among the newcomers than the average age of the treatment population in general. In 2004, distribution of gender among new and old addicts undergoing treatment was more or less the same.

Primary drug and mode of administration

There is a significantly larger proportion among the newcomers reporting cannabis as their primary drug compared to those who have been admitted to treatment before. The share of newcomers reporting cannabis as the primary drug was 47% in 2004. This is an increase compared to the two previous years.

Among the 1696 newcomers who have reported a primary drug, only 24% use opioids as their primary drug, which is a decline compared to 2003 when 28% used opioids as the primary drug. 23% report having used an amphetamine-like substance as the primary drug (in this case amphetamine, cocaine or ecstasy), which is a higher share than among the treatment population as a whole. This suggests that the amphetamine-like substances will gain ground in the treatment population in the future, whereas the proportion of clients using opioids as a primary drug will taper off.

As regards heroin used among the two "client groups", there is a difference in the mode of administration, in that 21% of those who have not been treated earlier report having injected the drug, whereas 40% of those who have been treated earlier, had been injecting heroin in 2003. The difference in mode of administration between the two client groups may be explained either by a "shorter abuse career" or that smokeable heroin has gained ground during recent years.

Young people receiving drug treatment

The young drug users make up an ever increasing share of all drug abusers receiving treatment. This appears from a special study conducted by the National Board of Health in the spring of 2005 based on data retrieved from the Board's register on drug abusers receiving treatment (Sundhedsstyrelsen 2005b). The

objective of the study has been to assess the number and development of 18-29-year-olds registered in the treatment during the years from 1996 to 2003.

All counties in Denmark experience an increase in young people receiving treatment under the age of 30 years during the study period, although the increase covers major differences from one county to the other. Counties west of the Great Belt tend to account for a larger share of the young adults under the age of 30 receiving treatment compared to the overall number, whereas the youth population in general accounts for a lower share of the overall drug use population in the counties located east of the Great Belt.

From 2002 to 2003, the number of young adults aged between 18 and 29 years receiving treatment increases from 3,813 to 4,466, corresponding to 17.1%. By comparison, the total number of persons receiving treatment rose by 12.6%. When comparing the youth population receiving treatment with the total number of Danish youngsters in the same age group, 4,466 equals that 6 out of 100 young people aged between 18 and 29 years receive treatment in 2003.

What is characteristic of the youth population is that, to an increasing extent, cannabis and other amphetamine-like substances are the main problems of their abuse. In 2002 as well as in 2003, the number of under 30s seeking treatment for their cannabis abuse exceeded those seeking treatment for heroin abuse. In spite of this trend, heroin still ranks second on the list of the most used primary drug. However, heroin is becoming a lesser problem among the young people receiving treatment. The overall number of young under 30s seeking treatment for their heroin abuse has dropped throughout the study period from 746 persons in 1997 to 493 in 2003, corresponding to 33%.

The 18-24-year-olds in particular account for the increase among those seeking treatment for their abuse of cannabis and the amphetamine-like substance, including cocaine and ecstasy, as the main addiction problem .

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

	18 – 24-year-olds	All receiving treatment
Cannabis	46.0	25.6
Heroin	15.3	30.2
Amphetamine	12.7	5.8
Cocaine	5.8	4.4
Ecstasy	4.0	1.2
Other opioids	4.8	20.1
Benzodiazepines	1.7	2.1
LSD	0.0	0.0
Other	9.8	10,5

Source: The National Board of Health's on drug users receiving treatment in 2003.

Table 4.2.3 shows that there is a distinct difference in the young adult's type of drug abuser compared with the treatment population as such and shows in particular that drugs such as cannabis, amphetamine, cocaine and ecstasy are more

prevalent among those young drug abusers seeking treatment than in the overall treatment population where the most "popular" drug is heroin.

4.3 Methadone treatment and prescription

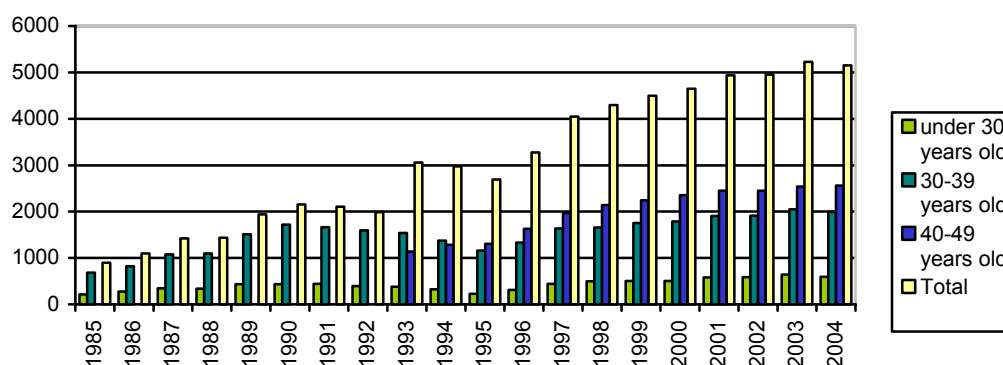
Since 1985, the National Board of Health has registered the number of clients in long-term methadone treatment, i.e. more than 5 months. Figure 4.3.1 illustrates the development in the number of drug addicts under the age of 50 in substitution treatment with methadone in December each year during the period from 1985 to 2004⁸. The figures do not include clients in long-term methadone treatment under the Prison and Probation Services or clients without a Danish civil registration number (CPR-nr.) undergoing treatment⁹.

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, dispensing and control with methadone as per 1.1.1996. During the years from 1993 to 1995, the figures stabilised at approximately 3,000 per year. Since then, the number of individuals in long-term substitution treatment has gone up each year from 3276 in 1996 to 5129 at the end of 2004. From 2003 to 2004 there is a minor decrease with 5229 receiving treatment with methadone at the end of 2003.

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

Until 1996, methadone registration was solely based on prescription. After the law was amended in 1996, statistics started to include those receiving methadone from

Figure 4.3.1. Persons in long-term methadone treatment (more than 5 months) 1985-2004



the county treatment centres without a preceding prescription. This accounts for the large increase from 1996 to 1997. The increase in the number of persons

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 prescription (more than 5 months) to persons under the age of 50 years.

⁹ In 2001, 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).

undergoing long-term substitution treatment from 1996 is also due to changes in the treatment programmes. In addition to methadone, buprenorphine is now used in substitution treatment. In 2004, the number of individuals treated with buprenorphine as substitution treatment is a little over 600 (Sundhedsstyrelsen 2005b).

5 Drug-related treatment

5.1 Overview and summary

The responsibility for the social and medical treatment of drug abuse has been gathered in the county abuse centres. These centres refer clients to all kinds of drug abuse therapy, be it slow withdrawal, outpatient treatment, substitution treatment and in-patient treatment, and whether or not treatment is made at the county's own institutions or in a private institution. By far a majority of treatment against drug abuse is targeted at drug abuse with close links to social problems.

As of 1 January 2003, drug users aged 18 years and above were guaranteed social treatment for the drug use. According to the guarantee, a drug user may demand that he/she receives an offer for treatment no later than 14 days after having contacted the county. Also a type of free choice was introduced, according to which the drug user can choose between treatment programmes provided by either public or private institutions. As a follow-up on the treatment guarantee, a ministerial order was issued together with quality standard guidelines within social treatment of drug use. Before the end of 2004, all county councils and municipal boards in the delegation municipalities have drawn up quality standards governing the treatment of drug abuse provided by the county.

5.2 Treatment system

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

As part of the treatment, slow withdrawal is provided by private and public institutions and treatment centres by the introduction to drug-free treatment. By imprisonment, an assessment of the person's drug situation is made and subsequently a decision regarding a possible slow withdrawal or treatment is made.

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

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

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

Young drug users

In order to target and strengthen the work with young drug users, the municipalities were required to prepare action plans effective 1 January 2005 for young adults under the age of 18 with treatment-requiring addiction. The municipalities must involve the county abuse centre as well as the young person and his/her family in this work.

As a follow-up on the agreement on the realisation of the social funds reserved for social services for 2005, the Danish Parliament adopted an amendment of the Social Services Act as of 12 May 2005, which provides that in special cases the Minister of Social Affairs shall be authorised to set out rules on the guarantee of social treatment of drug users under the age of 18 years. The law will be enforced on 1 October 2005.

The law provides that the municipality must immediately arrange for the young person to be admitted to treatment for drug addiction. Young people with serious drug use problems must receive a treatment programme within 14 days of contact similar to the manner, in which adult drug users are secured social treatment.

Furthermore, DKK 15.4 million (Euro 2.1 million) has been set aside in 2005 and DKK 9.2 million (Euro 1.2 million) in of the years of 2006 and 2007 for the development of programmes targeted at young cannabis abusers. The aim is to strengthen the trend which in recent years has been seen in the municipalities. The youngest cannabis users are often a group with a number of social problems, with drug use being only one of them. Intervention activities must therefore focus on the range of social problems experienced by young people and be carried out in close collaboration between counties and municipalities.

Support and contact person scheme

By the enforcement of the Danish Social Services Act in 1998, a support and contact person scheme (SKP) was introduced to meet the needs of people suffering from a mental disorder. The scheme provides that municipalities are obliged to assign a support and contact person to the most socially vulnerable and isolated persons with mental disorders who have major unmet social needs. A revision of the provision in the social services act has been postponed until the parliamentary year of 2006-2007. In conjunction with the upcoming revision, experience from pilot projects with support and contact personnel assigned to homeless drug and alcohol users will be included in the deliberations.

5.3 Inpatient treatment

Special information about inpatient treatment may be collected from the monitoring system DanRIS which has been developed since 2000.

In 2004, 44 inpatient institutions were registered at DanRIS. 37 institutions submitted reports on data in 2004. Those who did not submit data were new institutions and are expected to do so in 2005. These inpatient institutions cover the majority of institutions treating drug addicts in Denmark (estimated at more than 90% of the drug addicts registered for inpatient treatment). A few religious and very small institutions remain.

In 2004, 1520 different personal identification numbers were registered in DanRIS. In 2003, the figure was 1172. This increase can hardly be explained by new and

additional institutions on in DanRIS. Other explanations could be that the institutions have improved their registering procedures and this could be interpreted as a result of increased referrals. In any event, the number of drug addicts referred to inpatient treatment has not dropped since 2004.

In July 2005, the annual report under the title “DanRis 2004 – Stof [Drugs] was published. Apart from describing just how vulnerable the drug addicts are and how many who complete treatment, the annual report also contains a comprehensive service catalogue for each institution (which services to whom, how many therapists, their seniority and education, prices, etc.)¹⁰.

There appears to be a need for special ”service catalogues”, and this one will be the first one within this area, in which it is possible to compare prices, services, treatment methods, etc to the burden that drug addicts may constitute, their completion rate, etc.

5.4 Substitution treatment – expanded psycho-social support to heroin addicts in methadone treatment.

In 2000, the government launched two 3-year studies financed by social reserve funds of a total of DKK 50 million (Euro 6.7 million). The first study, to which DKK 40 million (Euro 5.4 million) was granted, dealt with increased psycho-social support to heroin addicts in methadone treatment. The second study, to which DKK 10 million (Euro 1.3) was granted, dealt with more medical action to the most deprived drug abusers. The studies have been conducted during the period 2001-2004. They have now been subject to evaluation, and the results appear to be promising in terms of more psycho-social support and medical action in order to achieve a positive effect for the most deprived drug abusers.

The study on increased psycho-social support to drug abusers in methadone treatment has confirmed that methadone treatment per se reduces the abuse of illicit drugs and criminal behaviour. When combining methadone treatment with standard psycho-social support, the abusers’ drug and crime problems are reduced even further.

As far as drugs and crime are concerned, increased psycho-social support does not provide better results than the standard support. On the other hand, when it comes to reducing the abusers’ physical, mental and social problems, it turns out that increased psycho-social support is a whole lot more effective. This is evidenced when considering the group with problems in at least two of these three areas – i.e. the mental, physical and social area. Among those who received increased psycho-social support, the share dropped among them who belonged to this group by 57%. In the control group receiving standard support, the share of them who belonged to the group dropped by 13%.

The Danish study results concur with foreign studies on the findings that methadone treatment combined with increased psycho-social support is much more effective than methadone treatment combined with standard psycho-social support, and that increased psycho-social support pays off from a financial perspective.

¹⁰ This catalogue can be downloaded from the internet <http://www.danris.dk/english/default1.asp>.

Based on these study results, the Centre for Drug and Alcohol Research recommends that in future, methadone treatment be combined with increased psycho-social support in the form of extended use of support and contact personnel schemes and extended access to drop-in centres.

After its thorough review of the question of treatment with medically prescribed heroin, the Centre for Drug and Alcohol Research discusses the concerns associated with this type of treatment. The Centre maintains that the establishment of a treatment system similar to the one under the Dutch study would be so expensive that it would not compare with the advantages and that, in addition, it will be difficult to transfer the Dutch experience in this area to Danish conditions.

As mentioned in section 5.5, the results from the two study projects are now available in two reports.

The first report has been prepared on the basis of a quantitative study on whether increased psycho-social support is more effective than the standard one which has been practised throughout the past 5-10 years. Two comparable groups were set up, out of which one received standard support, whereas the other with 126 methadone users received increased support. In this case, increased support was characterised by significantly more intensive care (more talks, higher access to therapists), more coordination (including helping the clients contact relevant authorities) and significantly more written documentation. Furthermore, the increased support was associated with significantly less control (fewer urine samples).

The methadone receivers who were given increased support achieved a significantly higher degree of effect, especially within the psycho-social problems. This was reflected in the fact that 52% of those who received increased support obtained a visible effect from treatment, whereas those who received standard support accounted for 34%. For instance, 18% of the methadone receivers who were given standard support had suicide thoughts at their first interview. During the follow-up interview this rate had dropped to 14%. For the methadone receivers receiving standard support, 25% had suicide thoughts during their first interview. At the follow-up interview, this rate had dropped to 6%. The report also relates the results to international research, including the Dutch heroin study. The report concludes by setting up 20 recommendations to the future methadone treatment.

The results from the qualitative study show that by introducing some kind of support contact personnel to the most vulnerable drug abusers, it is possible to coordinate the many different types of activities aiming at the individual user to a much higher extent than in standard treatment. Furthermore, the projects and treatment personnel have succeeded in diminishing the role of methadone in overall treatment intervention and instead upgrading the psycho-social element of treatment to be a central element, which also is a contrast to the general situation of standard treatment. The evaluation shows that increased psycho-social intervention generates a high degree of integration between the intentions of treatment and the empirical universe of the user. In this connection, the users' most important experience is the feeling of being treated respectfully, being involved realistically in their own treatment and receiving help to get an otherwise chaotic life to appear less chaotic. Again, these are experiences that are different from the users' experience with standard methadone treatment. Finally, user involvement has proven to be extremely difficult to introduce in the project. In particular, the use of the user involvement methods applied so far have only had poor results.

The report is introduced by focusing on the areas that may characterise increased psycho-social intervention. And it is concluded in four recommendations of future methadone treatment which are extensions of the recommendations given in the quantitative study.

6 Health correlates and consequences

6.1 Overview / summary

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

Studies have been carried out over the last few years, which identify various health problems resulting from drug use. As described in last year's *National Report on the Drug Situation in Denmark 2004*, there is a particularly high mortality rate among drug abusers released from prison, within a short time after their release (Christensen 2004). A special study highlighted that the mortality rate among drug abusers is ten times higher compared to among the normal population. In addition to this, among drug abusers who have been in prison, a mortality rate has been noted that is another ten times higher in the first 14 days after release from prison, compared to among drug abusers in general.

Similarly, a study carried out by the Medical Officers of the Copenhagen and Frederiksberg municipalities, in collaboration with the National Board of Health, showed that the number of spontaneous abortions and the mortality rate among female drug abusers' babies born alive are significantly higher than among the rest of the population (Embedslægeinstitutionen for Københavns og Frederiksberg Kommuner)¹¹. Female drug abusers miscarry 2.5 times more frequently than the background group. Furthermore, the mortality rate of female drug abusers' children born alive is three times higher than that of the background group, especially during the first two years of life. Finally, the study showed that 6% of live born children were born with withdrawal symptoms.

As was also referred to in last year's report, a study was carried out in 2004 into the number of *good years of life lost* among drug abusers (Sundhedsstyrelsen 2004a)¹². The main findings from this study showed that the average age of death for drug abusers has risen by 7 years from 1996 to 2002, which means that the drug abusing population is becoming increasingly older. In spite of the rise in the average age of death, drug abusers are continuing to die at a very young age, compared to the rest of the population. The average life expectancy, calculated as the age of death, has risen among the population from 74.2 to 75.6 during the same period. Based on the average age of death given above, it can be calculated that the number of years of life lost due to drug abuse is 40,745.

In order to examine the number of individuals visiting the country's casualty departments suffering from poisoning after taking illicit drugs, special statistics have been compiled, for the second year in a row, for poisoning cases registered at somatic and psychiatric casualty departments. The fact that far from all poisoning cases are reported means that these statistics provide minimum figures only.

¹¹ The study results and methods were described in the 2004 annual report on the drug situation in Denmark.

¹² The study results and methods were described in the 2004 annual report on the drug situation in Denmark.

However, the statistics show that a significant number of individuals are poisoned from illicit drugs every year and that the number has increased slightly over the past four years. The causes of 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 abusers.

6.2 Drug-related deaths and mortality rate among drug abusers

Since 1970, the National Commissioner of Police has registered drug-related deaths. The register contains reported deaths requiring a medico-legal autopsy. This could, for instance, be 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.

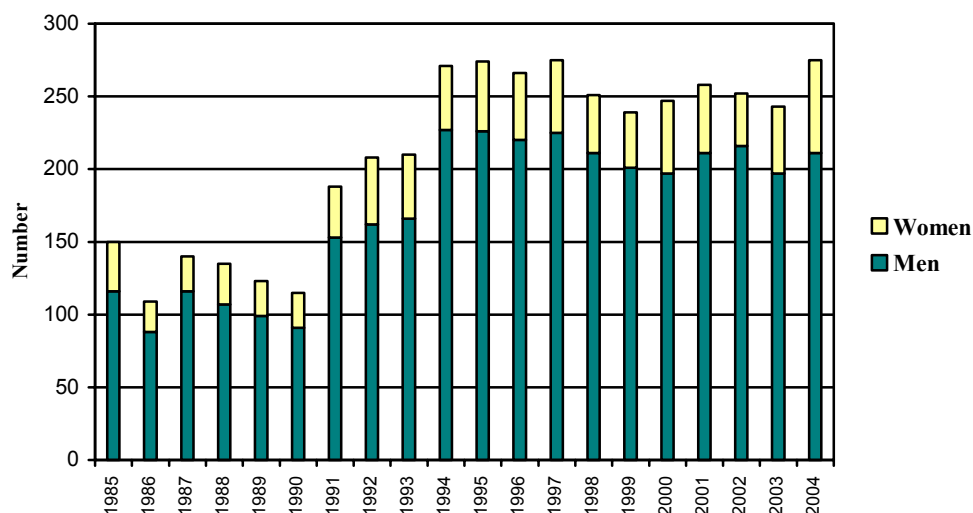
Similar to the police register, the National Board of Health has the Cause of Death Register containing data on drug-related deaths. The register contains data on deaths defined as drug-related deaths based on EU criteria. Given the desire for inter-country comparison, restrictions have been made on the diagnosis groups included in the collecting procedure. The latest available data extracted from the national Cause of Death Register comes from 2000.

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

The National Commissioner's Register

The death statistics in the National Commissioner's Register (figure 6.2.1) show a slight downward trend in the late 1980s and a significant increase in the 1990s (see table 6.2 in the Annex). In 2004 275 drug-related deaths were registered, with men accounting for 80% (197) of them and women 20% (48). This is a rise on 2003 when 245 drug-related deaths were registered.

Figure 6.2.1. Drug-related deaths by gender, 1985-2004



Source: Rigspolitiet 2004 [Police Drug Statistics 2004].

Out of the 275 deaths in 2004 78% (214) were caused by poisoning with one or more drugs. As table 6.2.1 below shows, 38% (81 out of 214) were caused by poisoning with heroin/morphine or heroin/morphine in combination with another drug, whereas 44% (95 out of 214) were caused by poisoning with methadone or methadone in combination with another substance. Five deaths in 2004 were caused by poisoning with either cocaine, ecstasy or amphetamine. The drug-related deaths that were not a result of poisoning (61 out of 275) were mainly caused by violence and accidents, as well as illnesses.

Table 6.2.1. Number of deaths among drug abusers caused by poisoning in the current year, grouped according to the assumed main cause of death. Percentage given in brackets.

	1991	1997	2002	2003	2004
Heroin/morphine	94 (57)	153 (71)	76 (30)	60 (30)	81 (38)
Methadone	51 (31)	46 (21)	72 (41)	97 (49)	95 (44)
Other	9 (12)	17 (8)	27 (15)	41 (31)	38 (18)
Total due to poisoning	164 (100)	216 (100)	175 (100)	198 (100)	214 (100)

Source: Rigspolitiet 2004 [Police Drug Statistics 2004].

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

Table 6.2.1. 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 have been changes 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.

It also shows that the proportion of deaths where "another" substance is indicated as the primary cause of poisoning has risen over the years, although a drop in these deaths was observed from 2003 to 2004. The "Other" group includes substances such as Ketogan, amphetamine, cocaine, anti-psychotic drugs and anti-depressants.

It is important to emphasise that it is the *substance* or *substances* featuring as substance categories in table 6.2.1., which are the primary cause of poisoning, that are included in the overview. In the case of most deaths due to poisoning, there are several substances which contribute to the poisoning, i.e. more than one substance was found in a lethal dose. Similarly, other substances 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.

Of the total number of 275 drug-related deaths in 2004, 137, 110 and 28 deaths occurred on Zealand, Jutland and Funen respectively. The geographical distribution of the deaths in 2003 was 13, 99 and 33 on Zealand, Jutland and Funen respectively. The rise in the number of drug-related deaths from 2003 to 2004 occurred therefore on Zealand and Jutland, whereas there was a slight drop in drug-related deaths on Funen from 2003 to 2004.

The average age of death has risen in recent years. In 1993 the average of death was 33, while in 2004 it had risen to 38 – the same average age as in 2003. The average of death for men and women is more or less the same.

The National Board of Health's register

In its register the National Board of Health includes deaths caused by harmful use of drugs, dependency and drug psychoses, as well as deaths caused by poisoning (suicide and accidents)¹³.

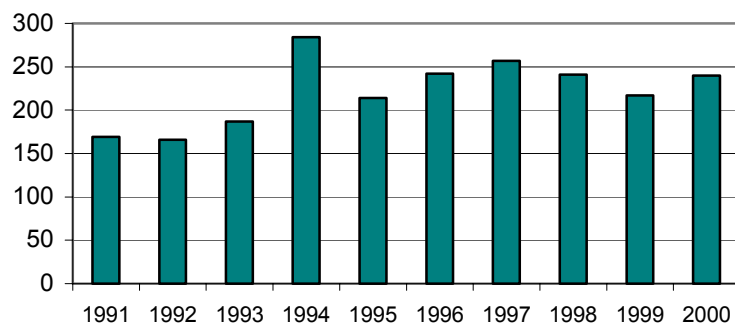
In 2000¹⁴ 240 deaths were recorded, which is a slight increase from 1999 when 217 deaths were recorded. Men account for 73% (175) of these deaths. Figure 6.2.2, which illustrates the trends throughout the 1990s, shows a slight upward trend to begin with, then it appears to drop off towards the end of the decade. The major fluctuation in 1994 is artificially created and is caused by a temporary adjustment in coding practices.

The National Board of Health's register on drug-related deaths shows that in 2000 the average age of death for women was 45.8 and for men 39.5, which gives an average age for both together of 41.2.

¹³ Up until 1994 ICD8 codes were applied. Since 1994 the ICD10 codes have been applied.

¹⁴ Data from 2001 and onwards is not available at the moment.

Figure 6.2.2. Drug-related deaths 1991-2000



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

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

6.3 Poisoning caused by illicit drugs

Data taken from the LPR (National Patient Register) includes patients with poisoning as a main diagnosis registered in somatic or psychiatric casualty departments, as well as patients who have been hospitalised with symptoms of poisoning without having visited a casualty department.

Table 6.3.1 shows the extent and development of intoxication¹⁵ and poisoning registered as involving different illicit drugs from 1999 to 2004. From 2000 coding practices were amended so that it became possible to specify poisoning caused by amphetamine and khat.

¹⁵ 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).

Table 6.3.1. Trend in hospital visits following intoxication and poisoning caused by illicit drugs from 1999 to 2004

	Kode*	1999	2000	2001	2002	2003	2004 ¹⁶
Heroin	T40.1	249	255	240	174	192	221
Other opioids	T40.2+ T40.2A + T40.2B	35	35	44	48	52	120
Methadone	T40.3	5	11	19	39	26	50
Opioids	F11.0	67	80	67	53	55	49
Opioids, total		356	381	370	314	325	440
Designer drugs (excl. ecstasy)	T40.6A + T43.8A	*	2	14	21	12	15
Ecstasy	T40.6B + T43.6B	9	75	67	60	83	73
Amphetamine	T43.0A + T43.6A	*	2	24	43	54	69
Cocaine	T40.5+F14.0	45	51	78	65	76	71
Other central stimulants	F15.0	58	48	53	47	50	43
Central stimulants, total		112	178	236	236	275	271
Euphoriant mushrooms	T40.6C + T40.9A	7	5	10	8	3	10
LSD	T40.8	3	3	12	2	1	2
Hallucinogens	F16.0	10	15	16	5	4	6
Hallucinogens, total		20	23	38	15	8	18
Cannabis	T40.7+F12.0	97	102	164	122	125	74
Polydrug use and unspecified**	T40.4+T40.6 +T40.6W+T40.6X +T40.9+F19.0	541	632	571	657	704	466
Intoxication and poisoning, total		1126	1316	1379	1344	1437	1269

Source: Sundhedsstyrelsen 2005d [National Patient Register].

*New codes were introduced in 2000 and 2004.

**A number of new subcodes for polydrug use and unspecified poisoning were introduced from 2004. These are as follows: T404A, T409A, T409B, T409C, T409D, T409X, T409Z.

As can be seen from the table, there have been between 1,126 and 1,437 cases annually, involving poisoning caused by illicit drugs from 1999-2004. There has been an increase in the number of poisoning incidents over the period, apart from in the years 2003 to 2004, when there was a slight drop overall for all substances.

¹⁶ The figures for 2004 are preliminary, and have been taken from the National Patient Register (LPR) per 6.7.2005.

There is however a sharp rise in the number of poisoning cases involving opioids from 2003 to 2004. From 1999 to 2003, a sharp rise can be seen in the number of poisoning cases involving central stimulants, whereas there is a slight drop from 2003 to 2004. However, these figures should be considered with some reservations due to under-registration and erroneous source material.

A total of 7,871 poisoning incidents were registered during the six years studied. The overwhelming majority of poisoning incidents, almost 90%, were treated in somatic casualty departments, with the remaining 10% or so treated in psychiatric casualty departments. As regards gender distribution, twice as many men as women were registered as suffering from poisoning during the six years studied.

Table 6.3.2 Hospital visits after intoxication and poisoning caused by various illicit drugs throughout the 6 years of the study, distributed according to different age groups.

Age group	>20	20-24	25-29	30 and over
Opioids	81	240	386	1478
Central stimulants	359	379	236	332
Mushrooms and hallucinogens	43	39	12	18
Cannabis	194	189	131	175
Polydrug use and unspecified	537	584	470	1990
Total	1214	1431	1235	3693

Kilde: Sundhedsstyrelsen 2005d [National Patient Register].

As table 6.3.2. shows, it is not surprising that the most poisoning cases involving opioids predominantly occur in people over the age of 30 and is extremely rare among the very young. On the other hand, poisoning cases involving hallucinogens and central stimulants occur most frequently among the young. 71% and 57% of all poisoning cases involving hallucinogens and central stimulants respectively are registered to people under the age of 24. Some 1,200 (15%) of all the poisoning cases during the study period occurred among young people under 20. Poisoning cases involving cannabis are most frequent among young people.

Cocaine is an exception among central stimulants in terms of being responsible for many poisoning cases among slightly older people as well, with people over 30 accounting for 39% of poisoning cases (not shown).

6.4 Drug-related infectious diseases

HIV/AIDS

Measures taken in Denmark against HIV are based on the principle of being voluntary, anonymous and open, providing direct and honest information and security for individuals in their contact with the health authorities. HIV testing is voluntary and persons who are HIV-infected are reported anonymously. The HIV reporting system 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 6.4.1 in the Annex shows the number of newly diagnosed HIV positive patients and the proportion of these who were intravenous drug abusers over the past 10 years¹⁷. The number of newly diagnosed HIV positive persons has varied over the years as has the number of infected persons where the source of infection is assumed to be intravenous drug use. In 2004 4% (13 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.

The proportion of newly reported AIDS cases where the source of infection is considered to be intravenous drug use has also been relatively stable at around 10%. In 2004 7% of newly reported AIDS cases affected intravenous drug users, which was 4 out of a total of 57 cases.

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 the past five years (table 6.4.2 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 18% and 43% 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 the number of cases of chronic hepatitis C are also included.

Studies into the spread of infectious diseases

To be able to "measure" the incidence of infectious diseases among drug abusers, special studies have been carried out on "groups" or populations of drug abusers.

The latest study on the spread of HIV, hepatitis B and C, as well as on the incidence of risk behaviour among drug abusers seeking treatment was carried out in Copenhagen in 1997 (Fuglsang 2000). The study confirmed that drug abusers are infected, to a large extent, by infectious diseases transmitted via blood and that there was a high incidence of risk behaviour, both in terms of sharing needles and sexual activity without using condoms. A total of 3.4% (9/265) were HIV positive, 64% (158/247) had hepatitis B and 75% (198/264) had hepatitis C. The study also concluded that overall, all drug abusers were infected by hepatitis C and/or hepatitis B and/or HIV over the course of ten years, and that there was a need for a multi-strand preventive action aimed at reducing the incidence of infectious diseases among drug abusers to a minimum (information campaigns, testing, needle-exchange schemes and vaccinations).

As part of categorising, harmonising and mapping the incidence of infectious diseases among drug abusers in the EU, the National Board of Health supported a research project in 2004 and 2005, which studied the spread of infectious diseases

¹⁷ 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.

among drug abusers¹⁸. It also looked at 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 medico-legal institutions. Provisional results from the study on infectious diseases among those whose deaths were caused by drugs in 2004 have now been prepared and are reproduced here.

During the post mortems carried out in the case of 299 suspected drug-related deaths, a blood sample was taken from 78%, of which 92% could be analysed. As mentioned in section 6.2 above, 275 drug-related deaths were registered in Denmark in 2004¹⁹.

The analysis results showed that 51% of those examined tested positive for hepatitis C antibodies, while 35% 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 4% of cases.

The study into infectious diseases among drug-related deaths started, therefore, in 2004 and is provisionally planned to run over the next four years.

Efforts will be made to improve both the reporting procedure (to include only drug-related deaths) and the testing procedure (so that several blood samples can be used for analysis) in the coming years.

Although it is not possible to make a direct comparison between the two populations of drug abusers mentioned, based on the study results indicated above, a conservative deduction can be made that the incidence of hepatitis B and hepatitis C among drug abusers has now fallen and that the incidence of HIV infection among drug abusers has remained unchanged and is relatively low. The reasons for this are probably connected with the fact that the use of injection among drug abusers has dropped, there is a generally better level of hygiene (syringe-exchange schemes, provision of needles) and lastly, there has been an increase in the number of vaccination programmes for drug abusers.

6.5 Co-morbidity and drug abusers in psychiatric treatment

In 2004 a total of 3,583 persons were admitted to psychiatric hospitals with a drug-related primary or secondary diagnosis, compared to 2,872 persons in 1996. During the period 1996-2004, a 40% increase was seen in the number of persons admitted to psychiatric hospitals with a drug-related secondary diagnosis, from 1,235 to 2,074 (table 6.5.2), whereas the number of persons admitted with drug-related primary diagnoses fluctuated between 1500 and 1650 throughout the same period (table 6.5.1).

¹⁸ 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 study's provisional findings have not been published.

¹⁹ This study includes 24 more deaths than the final recorded number, which is due to the fact that blood samples were taken during the post mortem, before there were forensic chemical analyses which could provide the basis for classifying deaths as being drug-related. As the study into infectious diseases is based on anonymity, it was not possible to exclude these 24 deaths later on (which later turned out not to be drug-related deaths), which is why they are included in the study results for 2004.

The number of persons admitted with a primary diagnosis related to the use of cannabis appears to be increasing as well, although the fluctuations in this case are relatively large. The trend becomes clearer in secondary diagnoses related to cannabis, with the number of persons increasing from 427 persons in 1996 to 873 persons in 2004, which is more than double. The same linear increase is seen up until 2002 in the number of persons admitted with a primary as well as a secondary diagnosis related to cocaine. However, from 2002 to 2003, the figure doubles, while from 2003 to 2004 the number of persons admitted with a primary or a secondary diagnosis related to cocaine is more or less stable.

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

Table 6.5.1. Persons registered with drug-related primary diagnoses in psychiatric hospitals, 1996-2004.

Diagnosis code	Mental condition or disturbance caused by the use of:	1996	1997	1998	1999	2000	2001	2002	2003	2004
F11	Opioids	319	273	273	227	227	189	172	156	155
F12	Cannabis	304	279	314	317	270	327	364	333	354
F13	Sedatives / hypnotics	315	239	212	204	205	199	182	159	143
F14	Cocaine	12	15	21	23	23	31	36	65	53
F15	Central stimulants other than cocaine	94	82	82	71	76	75	109	99	98
F16	Hallucinogens	23	25	17	26	18	21	14	9	17
F18	Solvents	11	3	5	10	2	6	2	10	5
F19	Multiple or other psychoactive drugs	569	586	705	758	749	732	726	747	684
Persons with primary diagnoses, total		1647	1502	1629	1636	1570	1580	1605	1578	1509

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

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

Table 6.5.2. Persons registered with drug-related secondary diagnoses in psychiatric hospitals 1996-2004.

Diagnosis code	Mental condition or disturbance caused by the use of:	1996	1997	1998	1999	2000	2001	2002	2003	2004
F11	Opioids	176	178	134	146	190	204	208	201	271
F12	Cannabis	427	477	524	566	584	637	691	759	873
F13	Sedatives / hypnotics	327	259	247	253	283	257	266	307	359
F14	Cocaine	8	17	13	15	17	19	34	61	66
F15	Central stimulants other than cocaine	67	56	53	58	52	58	56	73	123
F16	Hallucinogens	6	7	4	11	9	11	10	2	13
F18	Solvents	7	6	4	9	7	7	13	12	11
F19	Multiple or other psychoactive drugs	297	314	418	534	566	485	574	679	728
Persons with secondary diagnoses, total		1225	1240	1335	1506	1630	1593	1747	1844	2074

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

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

7 Responses to Health Correlates and Consequences

7.1 Overview/summary

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

As a supplement to treatment intervention, many years of effort have been aimed at harm reduction and harm minimisation for the groups of drug abusers who are unlikely to become drug-free in the short or longer term. Harm reduction means a decrease in the harm resulting from life as a drug abuser inflicted on the individual him/herself, on close relatives and on society. Harm reduction also means the improvement of the drug abuser's functional ability and development potential. Harm-reduction measures could include, for instance, services such as street-based outreach work, drop-in centres for current abusers (low threshold services), syringe exchange programmes and social support at home. A recent study from 2004 showed that 10 of the counties, along with Copenhagen and Frederiksberg municipalities (out of 14 counties, including Bornholm's regional authority) have syringe exchange schemes.

Much more far-reaching initiatives aimed at harm reduction in the form of injection rooms, legalisation of cannabis and heroin on prescription are rejected by the government as part of their action plan against drug abuse as being too radical and in contravention of its core drug policy. The suggestion of legalising cannabis and setting up injection rooms seems to contravene international drug conventions as well.

7.2 Prevention of drug-related deaths

A number of efforts and attempts at increased efforts on the healthcare front have been directed at severely addicted drug abusers. In cities, part of the drug treatment programme offered includes information about the risks of overdose. As part of the service offered, people are requested to call Falck emergency services in the event of an overdose. The police are not involved when Falck is called out to an overdose incident.

In Danish prisons a great deal of attention is focused on the risk of what is known as "relapse deaths". This term is used to mean deaths that may occur when a user, for a variety of reasons, has taken a break from regular opioid abuse, for instance, after completing a term in prison, and the person in question resumes opioid abuse taking the same dose as before.

Among other measures is the *Esbjerg model* used in Esbjerg prison since 2002, based on cooperation between Esbjerg prison, Esbjerg police, Esbjerg's municipal youth centre, the Esbjerg Prison and Probation Service and the Ribe county abuse centre, to offer criminal drug abusers the chance to take part in a treatment programme during their time in Esbjerg prison. The intention is to encourage the individual prisoner to receive treatment to come off drugs after they have completed their term in prison or possibly at an earlier time. In addition, a course

has been introduced as part of the treatment where prisoners are informed about how to avoid taking an overdose. The treatment course lasts 8 weeks and comprises group and one-to-one discussions with the treatment worker. After 8 weeks a specific treatment programme is drawn up in cooperation with the prisoner, taking into account the individual's situation. In 2005 this treatment model was introduced in Aarhus, Odense and Slagelse prisons²⁰.

7.3 Prevention and treatment of drug-related infectious diseases

Syringe programmes are a broad preventive measure targeted at injecting drug users, intended to provide them with clean syringes so that they can avoid HIV and other blood-borne infections.

Furthermore, as from 1 April 2005, injecting drug users have been offered free vaccination against hepatitis A and hepatitis B. Free vaccination against hepatitis B will also be offered to injecting drug users' relatives, i.e. people living in their household, as well as established sexual partners not living in their household.

From the mid 1990's cleaning liquid via dispensers in the prisons have been available.

7.4 Measures related to psychiatric co-morbidity

The number of individuals suffering from mental illness combined with drug abuse is increasing. The complexity of the diagnosis and the behaviour of those suffering from co-morbidity make it difficult to decide who should have administrative responsibility for the treatment – the psychiatric treatment system or drug abuse treatment institutions. Under the psychiatry agreement 2003-2006, a special fund of DKK 45 million (EUR 6 million) has been set aside over 4 years to support the social measures and psychosocial measures applied to people with co-morbidity. This group must receive high priority in terms of intervention. Everyone also agrees with the recommendation – set out in a statement from the expert group on intervention involving the most severely addicted drug abusers – that the primary responsibility for treatment of this group and the organisation of any intervention should be placed on the psychiatric treatment system, and that this recommendation should be incorporated into future intervention plans. The Government has also agreed with local government that support should be granted to healthcare projects that fit in with the recommendations of the expert group statement (see chapter 16 of the 2003 annual report).

Vista Balboa

One example of a special initiative taken to deal with people suffering from co-morbidity is Vista Balboa in Odense municipality. Vista Balboa is a programme for people with mental illness and involved in drug abuse, as well as with low social and personal self-esteem. The Vista Balboa programme can accommodate around 32 people. The programme includes outreach work, social support and care, as well as psychiatric treatment and drug treatment. The programme comprises an outreach team with five workers, self-contained flats with two workers and a drop-in centre

²⁰ See also http://www.ribeamt.dk/graphics/SOCIAL_OG_SUNDHED/Dokumenter/Publikationer/Esbjergmodellen.pdf.

with four workers. There is a full-time manager and two consultant psychiatrists who cover eight hours a week.

The evaluation carried out in April 2005 shows that Vista Balboa contacted a core target group, which was made up of people suffering from severe mental illness, drug abuse and low social and personal self-esteem. A total of 65 users were referred to Vista Balboa in the period 2002-2004. Most users are men, with an average age of 38. Users are referred from a wide range of partner institutions. While many of the users were referred from the support contact scheme when Vista Balboa was set up, most are now referred from the District Psychiatric Centre (DPC), Psychiatric Department (UOH) and Psycholegal Department (SHF). There has been a rise in the number of users with a court treatment referral. Almost all users have been diagnosed with schizophrenia.

Where there were no changes in the users' mental state and drug abuse profile, there was, in contrast, a significant reduction in the level of bed occupancy in psychiatric wards. There were also far more users than usually observed in other studies, who had a connection with Vista Balboa one year after being referred there.

7.5 Intervention related to other health issues and consequences

Prevention and limitation of drug-related traffic accidents

In 2000 the government at the time set up the "Committee for simplifying the setting of penalties for drink-driving", which, apart from reviewing the traffic legislation provisions for driving under the influence of alcohol, also intended to review the provisions concerning drivers affected by drugs and medication. This committee expects to submit its report before the end of 2005²¹.

Measures aimed at pregnant drug abusers and their children

As described in last year's report, the Medical Officers for the Copenhagen and Frederiksberg municipalities carried out a national study in 2004 "Pregnancies and births among female drug abusers in Denmark 1990-2001".

This study shows overall that these vulnerable women usually have the same number of children as the rest of the population, i.e. 1.6-1.7 children, but suffer about two and a half times more abortions. In the case of live births, there is a three times greater mortality rate among drug abusers' children, especially in the first 2 years of life, compared with the population in general. The study also concluded that there was a need for targeted, systematic contraceptive measures for drug abusers and vulnerable young people in general.

One example of a measure targeted at drug abusers in relation to pregnancy and children, both at a preventive and treatment level, is the Family Outpatient Clinic in Copenhagen. The period when this measure was being implemented coincided with the above study and the results from it are clearly reflected in the statistics.

²¹ See also the 2002 annual report for the latest study and the "Guardian angel - against drugs in night life" project in 2001.

The Family Outpatient Clinic at the Hvidovre Hospital and Rigshospitalet is a special cross-discipline department for pregnant women affected by alcohol and drug abuse and for families with small children experiencing problems with alcohol and drug abuse. The purpose is to prevent the children's development from being harmed by alcohol and drugs, both before and after birth, as well as to prevent unplanned and unwanted pregnancies. It operates on an open referral basis, providing easy access to advice and treatment, without any waiting time, with the focus on early intervention. The staff includes doctors, midwives, psychologists, social workers and office staff. The Family Outpatient Clinic comes under the maternity department, but also works with the neonatal and paediatric departments. This clinic also has a close, formalised working relationship with the primary social and health sectors and with other relevant professional bodies. The action programme includes counselling, substitution treatment, detox treatment as an inpatient or outpatient, pregnancy checks, psychosocial support/treatment, observation and treatment of newborns, follow-up baby checks with a doctor and psychologist, follow-up treatment for mothers and babies (e.g. in a professional day centre), social relief measures, abortion counselling, abortions, contraception following a birth and abortion, outreach work, cross-discipline/cross-sector cooperation, etc.

The Family Outpatient Clinic is visited by around 100 pregnant women every year and has about 200 children aged between 0 and 6 registered for outpatient follow-up. The Family Outpatient Clinic's involvement has reduced the number of children born with congenital defects, the number of children with developmental disorders, as well as the number who are exposed to neglect and physical abuse. All children are discharged with a set of support measures arranged in conjunction with the social services' family department, and the follow-up baby checks make sure that there is a professional network for children to prevent problems with their development, as well as neglect and physical abuse. Some of the women decide to have an abortion after seeking advice (10-15%) and all women receive contraception before being discharged from the hospital.

In August 2005 the National Board of Health sent out a document entitled "Omsorg for gravide og småbørnsfamilier med rusmiddelproblemer" (Care for pregnant women and families with young children affected by alcohol and drug problems), which provides a description of the Family Outpatients Clinic's intervention model. This book is targeted at all professionals dealing with pregnant women, children, families with children, alcohol and drug problems and those that are vulnerable socially. It was also sent to maternity departments and midwife clinics in Denmark, requesting them to make a special effort in the case of those affected by alcohol and drug abuse and their children.

The Family Outpatients Clinic has set up, in cooperation with the Danish YWCA's Reden organisation, another example of a prevention project "Forebyggelse af graviditeter hos stofbrugende kvinder i København" (Preventing pregnancies among female drug users in Copenhagen). A healthcare worker (doctor or midwife) comes every Wednesday evening from 18.00 – 20.00 to "Reden" and is available to anyone who uses this organisation. The focus in this "consultation" is on contraceptive advice, the provision of free contraception, pregnancy testing, abortion advice, admission for an abortion, etc. If a pregnant woman decides to continue with her pregnancy, they make sure that the woman immediately goes for relevant treatment and pregnancy check-ups. Provisional results from this project show that a large number of women have received advice and been supplied with

contraception. There have also been many women who have taken pregnancy tests and many pregnancies were detected early enough for the women to have been able to opt for an abortion, which most of them did. In addition, many of the women used the project for a variety of health-related problems.

The project was financed for the first 3 years by the Medical Officers for Copenhagen and Frederiksberg municipalities and just by Copenhagen municipality since 1 September 2004. The project is provisionally financed until 31.12.2005.

Finally, the National Board of Health and Copenhagen municipality have financed a quality develop project, which is aimed at ensuring that all women seeking treatment for drug abuse are given advice and offered relevant contraception treatment. Experiences from this project will be published in early 2006.

8 Social correlates and consequences

8.1 Overview/summary

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

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

The study results also showed that more than half of the probation service's clients are abusers (including alcohol abuse)²². There is also a wide incidence of polydrug use.

It is rare for heroin/morphine abusers to commit serious crimes. Opiate abusers and cannabis abusers are typically convicted of violating the Euphoriant Substances Act, which normally means they receive shorter prison sentences than the remaining abuser groups. Central stimulant abusers are more frequently charged and convicted of serious drug crimes, i.e. violation of the provisions laid down in the Danish Criminal Code.

8.2 Social exclusion and problems

Drug abusers are subject to considerable social exclusion. A look at the social, housing and educational situation of drug abusers undergoing treatment makes it clear that these people are a marginalised group compared to others. They are 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 are early starters on alcohol and cannabis, young immigrants who are poorly integrated, refugees with traumatic experiences behind them, mentally frail individuals; the mentally ill and the homeless.

²² 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.

8.3 Drug-related crime

There is an ongoing record kept of reports filed, charges and sentences passed under the Euphoriant Substances Act, which primarily deals with possession and sale of small quantities of drugs, and under the criminal code's Section 191 (s 1) (sale), (s 2) (smuggling), which 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.

In 2004 a total of 16,390 charges were brought, which marked a significant increase compared with 2003. Between 1999 and 2002 the figure was relatively stable at around 13,000 per year. Since 1994, the number of persons charged has been between a little more than 8,000 and 10,000 annually. No figures are available on the number of persons charged from 2003 onwards.

Table 8.3.1 Drug crime 1994-2004. Charges and number of persons charged

	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Charges, total	15,155	14,654	14,371	13,454	14,251	12,928	13,178	13,143	13,025	14,316	16,390
Persons charged	9,536	9,008	8,678	8,234	8,900	9,424	9,899	9,858	10,021	-	-

Source: Rigspolitiet 2005 [National Commissioner of Police's drug statistics 2005, www.politi.dk]

Correlation between abuse and crime

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

Drug abuse in prison

The Prison and Probation Service advised in June 2005 that a new registration system was introduced from 1 October 2004 for recording all new prisoners in the Prison and Probation Service's prisons and jails. One module in this register contains a record of the new prisoners' abuse of alcohol and drugs in the period before their imprisonment. This means that it is compulsory for prison staff, as part of the registration procedure, during the registration interview, to note the *new prisoners'* abuse of cannabis and other illicit drugs in the last month before their imprisonment, along with the extent/frequency of their use and finally, their method of taking the drugs.

The registration system is in the process of being set up and running, which means that there is no valid data available in a transition period. However, it is expected that an annual report detailing the abuse of drugs and alcohol throughout the whole

of 2005 by new inmates inside the Prison and Probation Service's prisons and jails will be available during 2006.

There is another module in the registration system for reporting electronically to the National Board of Health the number of methadone prescriptions issued to prisoners. The findings from this feature in chapter 4 of the present report.

8.4 Economic impact and expenditure on social intervention

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

9 Responses to social correlates and consequences

9.1 Overview/summary

It is the task of the Ministry for Social Affairs and Equal Rights and the Ministry of Employment to coordinate measures aimed at the social integration (social inclusion as a whole) of drug abusers. 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 abusers as one of the target groups among the "socially vulnerable" group, which includes measures for social integration.

The Ministry for Social Affairs and Equal Rights coordinates its effort in relation to the "Det fælles ansvar" (Shared responsibility) programme and the Ministry for Employment has just focused its efforts on helping the socially vulnerable in an initiative targeting groups that are "at the margin of the labour market", as part of the Government's "More people in work" programme.

It is common for drug abusers to often have had only a short period of schooling, with many leaving school without any qualifications. It is estimated among drug abusers in treatment that two thirds of them have no kind of vocational training. It is mainly drug-free users with good school qualifications that are able to continue with further training as part of a social integration process. This will usually be part of job retraining, based on a commercial plan, devised by a municipal social worker. This opportunity is often offered to drug abusers who can remain clean, but is offered much less to users who are on a stable substitution treatment programme.

Counties and municipalities are responsible for financing by far the largest part of the measures aimed at the social integration of drug abusers. Between them it is the municipalities which are primarily responsible for this part of the measures, while the counties finance their treatment and offer temporary accommodation in the form of shelters, in accordance with Section 94 of the Social Services Act.

Under Section 111 of the Social Services Act, the municipality is obliged to offer drug abusers a social action plan, where targets and a strategy can be agreed on an individual basis for the individual drug abuser, in terms of the person's future accommodation and employment situation and other aspects of their life. This means that the municipality social worker is the initial coordinator involved in the drug abusers' social integration.

The national strategy provides that treatment of criminal drug abusers should, as far as possible, be handled by the social authorities. Treatment initiatives under the Prison and Probation Service must primarily be aimed at motivating and identifying the needs of the abusers. However, in cases where external treatment cannot be provided for security reasons, the Prison and Probation Service must, as far as possible, be able to offer relevant treatment during imprisonment. As part of the social grants budget in 2003, the Prison and Probation Service was allocated resources from the Ministry of Social Affairs to introduce a proper guarantee of treatment for prisoners in Prison and Probation Service institutions.

9.2 Social reintegration

Homelessness and accommodation services

In general, there is a great deal of attention focused in Denmark on reducing the level of homelessness among drug abusers. Based on data from treatment, we know that around 1 in 10 drug abusers seeking treatment is homeless, with many others as well living in highly unstable circumstances (Sundhedsstyrelsen 2005a). In recent years a number of programmes, both temporary and permanent, have been set up, intended to support homeless drug abusers in their search for stable living conditions. This seems to be an important measure on the road to social integration, as well as a means and end in itself.

This is particularly the case in cities like Copenhagen, Aalborg and Aarhus, but also applies to provincial towns like Viborg. It is less widespread in thinly populated areas or in areas where there is a large supply of chargeable accommodation. Generally, these programmes are set up for drug abusers so that they are reserved for this target group, which means that those from other vulnerable groups are typically excluded from the accommodation programmes, apart from, though, where reception centres and shelters are concerned.

In general, all counties run reception centres and temporary accommodation programmes, in accordance with Section 94 of the Social Services Act, which are aimed at homeless people with difficult social problems, with drug abusers across the country representing a significant, although varying part of this user group. Some reception centres turn away drug abusers, but this is usually in areas where there are several to choose from, so that the target groups can be shared among them. The reception centres provide residents with accommodation training, a way of preparing them or supporting them so that they can function in their own flat in the shorter or longer term. There are workers attached to several of these reception centres whose job is to help their residents prepare for living in permanent flats belonging to the general stock of flats, usually built under the Non-profit Housing Act, which makes it possible to receive housing benefit, thereby reducing the rent.

Furthermore, there is a growing number of accommodation programmes of a longer-term nature being set up, but still temporary, in accordance with Sections 91 and 92 of the Social Services Act. In this instance, drug abusers are a recognised target group. The accommodation provided under the sections of this act for drug abusers is mainly a type of halfway house for abusers who have discharged themselves as clean from day treatment, which means that they are in post-treatment accommodation where the aim is social integration, with the halfway house representing a step on the way to this.

There are also "alternative care homes", which is accommodation for older drug abusers who are ill and unable to look after themselves in their own home or on the streets, but who cannot be placed in a general care home for the elderly. Money has been allocated from the socially vulnerable groups fund to set up 83 "alternative care homes", including reception centres in southern Funen and St. Dannesbo in Funen county, Overmarksgårdene in Vejle county, the reception centre in Ribe county, the Østervang reception centre in Aarhus county and Kongens Ø private foundation, Helsingør. These involve long-term placements. Alternative care homes can be set up therefore under Section 92 of the Social Services Act, where the

target group comprises people who, due to their significantly impaired long-term physical or mental functional ability, require extensive help in terms of general, everyday functions, care or treatment, and cannot have these needs met any other way. Section 92 of the Social Services Act is applied, even if the accommodation is set up in connection with a type of accommodation specified under Section 94 of this act.

There are also accommodation programmes set up under Section 91 for drug abusers who are mentally ill. Usually the Section 91 accommodation is aimed at specific target groups, unlike the Section 94 accommodation, which is more temporary in nature, but where different target groups can be accommodated together, to a greater extent.

In a 3-year trial project that has just been completed, involving drug abusers receiving substitution treatment, it has been shown that it is possible to reduce the level of homelessness among drug abusers. It appeared that an improvement in living conditions was one of the social factors that was a positive development during the trial (Pedersen 2005). Those whose living conditions were unstable at the start of the trial had, in most cases, managed to get their own flat or achieve a stable living situation by the end of it.

9.3 Education programmes

Many drug abusers perform poorly at school and only have a very basic education when they leave school. In Denmark there are very good opportunities available for catching up on neglected education after leaving school. There are special programmes for those who are poor at reading; there is the opportunity 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 day-time secondary school programmes offering socially vulnerable groups instruction in a number of basic skills, including reading, writing and arithmetic. The majority of all these programmes are not, however, specifically geared towards drug abusers, but it is possible for drug abusers to have access to them. Drug abusers are not excluded from the general programmes or from programmes aimed at a broader target group; if anything, many times they exclude themselves from these programmes. There *are*, in fact, programmes run, specifically geared towards drug abusers who have neglected their education in a "protected" environment, but they are few and far between.

Based on an experience from Viborg county, where mini day-time secondary schools were set up for drug abusers in the county, in cooperation with the local branch of the AOF (Workers' Educational Association), focusing on improving basic educational skills, those attending were difficult to motivate and had problems maintaining their interest, and the programme became more and more like a drop-in centre rather than an educational program. It was then decided to close the programme and offer an activity and social programme instead of an educational one.

9.4 Employment programmes and benefits

Drug abusers predominantly live off social benefits. About 50% of drug abusers in treatment receive one type or other of cash benefit, most as a passive benefit, with 20% receiving an early retirement pension. There seems then to be major barriers preventing drug abusers from becoming reintegrated in society through work. A study has just been published on the "weakest social benefit claimants in Denmark" (Socialforskningsinstituttet 2004), which showed that 22% of the weakest claimants, who have been receiving benefits continuously for the last four years are involved in cannabis or drug abuse. This means that this group is strongly over-represented among long-term benefit claimants, as drug abusers only account for a very small proportion of the population. Nearly a third of these 22% have been involved in a programme for dealing with their abuse, mainly a treatment programme, but none of these programmes was judged by the municipalities as being successful. In the municipalities' view, most of the weakest social benefit claimants lacked personal skills such as motivation, initiative, concern, regular attendance, interpersonal skills and the will to learn new things, which are important skills when companies are looking to employ people who are also unskilled. The municipalities felt that drug abusers, along with immigrants, were actually the group that had the most difficulty in acquiring these skills. The report concludes that this is the area which presents the municipalities with a major challenge in terms of devising measures that can improve these groups' chances.

The Council for Socially Marginalised People has produced the document "Elementer til en aktivitets- og beskæftigelsesplan for socialt udsatte" (Elements for an activity and employment plan for socially marginalised people) as one measure with this in mind. This initiative was also inspired by the fact that the Government's employment reform programme "More people in work" will mean a reduction in the opportunities for benefits with the cutbacks in and a cap on benefits, which should apparently encourage them to look for work. But this would especially hit those vulnerable groups that did not have the skills to be able to find employment on the normal job market. The alternative employment plan initiated by the Council for Socially Marginalised People has resulted from the fact that DKK 4 million (Euro 0.54 million) have been earmarked in 2005 and DKK 3 million (Euro 0.4 million) in the following 3 years for special projects aimed at mobilising the socially marginalised²³.

There are also individual programmes geared towards drug abusers receiving substitution treatment. For instance, there are 3 programmes in the Copenhagen municipality: Skiftesporet, Spirillen and Hotellet, as well as in other individual provincial municipalities²⁴.

As it is difficult, however, to motivate and maintain drug abusers' interest, it is necessary to have a large "client base" for these programmes. As a result, an employment programme in Viborg involving computer renovations, called Loke Erhverv, was discontinued as it was "a losing battle trying to keep the thing going" all the time.

²³http://www.servicestyrelsen.dk/publikationer_og_databaser/nyhedsbrev/nr7/4.html.

²⁴ Consult the EDDRA database at: <http://edra.emecda.eu.int/>.

Drug abusers who are clean are usually offered programmes aimed at getting people back to work, with a vocational slant, and can take part in programmes geared towards other benefit claimants and unemployed people.

Drug abusers receiving longer-term substitution treatment are mainly offered activity and social programmes, often linked to an abuse centre or drop-in centre. These programmes are not directly job-orientated, but are more a form of protected employment, which in the long term can, in some cases, lead to ordinary employment, but will have for most people the purpose of social inclusion and of meeting the needs for a "a structured daily life determined by time and place and of allowing them to have social contact with other people during the day" (Larsen 2005).

However, the Government's "More people in work" employment programme, also for groups "at the margin of the job market" has stipulated more stringent requirements for producing job plans and having contact interviews every three months for the most vulnerable benefit claimants (Arbejdsmarkedsstyrelsen 2005 [National Labour Market Authority]). This can mean a greater requirement for drug abusers to get involved in activities, and possibly for them to participate in a treatment programme, if they are to retain their benefits. Mentor schemes have also been set up to support this, which have only been used to a limited extent thus far.

9.5 Counselling programmes

There are usually counselling programmes available for drug abusers, advising them on how to handle their public debts, such as tax debts, a loan for a flat deposit, etc., as well as private debts, but not debts owed to drug barons, dealers, etc. However, it has been difficult within the valid regulations on debt relief to provide specific help to drug abusers or other socially vulnerable people with debts, even if it turned out that a major public debt which has accumulated is one of the main barriers preventing them from taking up employment, as the person concerned will then be asked to start paying back the debt when they begin working (Socialforskningsinstituttet) [The Danish National Institute of Social Research]). DKK 100 million (Euro 13.4 million) have been earmarked over the next 4 years to remove the debt burden from the socially disadvantaged, and it is expected that a bill will be introduced in late 2005.

Family counselling is usually provided by the institutions where the drug abusers are being treated. Some counties have special programmes aimed at drug abusers with children. There are also self-help groups for relatives. In the larger municipalities there are family houses where drug abusers can also have access to counselling.

Women's crisis centres are widespread in Denmark. But there are very few of them which female drug abusers can have access to. The argument for this is that there are usually children and teenagers staying with the women at these centres, so they do not want to let active drug abusers or drug abusers receiving substitution treatment in, allowing them to influence their children and teenagers.

9.6 Prevention of drug-related crime

As part of the Government's social grants settlement for 2003, the Prison and Probation Service carried out an assessment of the total treatment capacity

available and the total treatment requirement. The assessment of this requirement, which was carried out in May 2005, showed that there still is not sufficient treatment capacity to be able to introduce a treatment guarantee.

As a result, the Prison and Probation Service has drawn up a list of several initiatives which will be necessary to implement in order to be able to fulfil a treatment guarantee. The issue of financing has still not yet been clarified. It is anticipated that, if these initiatives can be implemented in 2006, it will be possible to introduce a real treatment guarantee by 1 January 2007.

In 2004 several departments in the Prison and Probation Service were interested in setting up motivation projects in the prisons, similar to the four projects already implemented in Esbjerg, Odense, Aarhus and Slagelse. This has led to a further 10 motivation projects being set up, all on request.

10 Drug market

10.1 Overview/summary

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 one particular year. This means that seizure statistics give merely a rough indication of the prevalence of drugs on the illicit market and are just as much an indication of *police activity*. However, there is a clear trend from the seizure statistics over the past few years indicating that the various illicit drugs are being seized in almost every police district in Denmark, from which we must conclude that drugs are available throughout the whole country.

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 market²⁵. This large range of variation in the purity of the different drugs is observed across the whole country.

A look at the various drugs confiscated on the streets (as part of the random-sampling Street-Level Project) shows that there has been a clear tendency in recent years for heroin base (for smokable heroin) to be seized more often than white heroin (for injection purposes). Samples of cocaine have increased dramatically at street level and now far exceed the number of both heroin and amphetamine samples. However, there are still significant differences in terms of which drug is the most common in the various towns. For instance, amphetamine is predominant in Aalborg, Odense and Esbjerg, heroin and cocaine in Copenhagen, whereas heroin is predominant in Aarhus.

As in 2003, no new, unknown drugs were discovered among the seizures analysed in 2004. But the active hallucinogen PCP (phencyclidine) was seen for the first time in early 2005, contained in an ecstasy pill analysed during the first quarter of 2005. Methamphetamine, MED and MDA have become increasingly more common on the illicit market – both alone and in combination with MDMA.

10.2 Drug accessibility and demand

As was mentioned at the start, the seizure statistics show that the various illicit drugs are widespread across the whole of Denmark. This is corroborated by information from abuse counsellors and results from surveys, which confirm that drugs are easy to get hold of and are widely available on offer.

According to ESPAD 2003, as many as 80% of 15-16 year-olds would be able to buy cannabis if they wanted to. When asked during the study *where* they could buy cannabis from, 60% named at least one place where it would be possible to get it. A large proportion of them (40%) mentioned that it was possible to buy it at discos,

²⁵ Results from the special chemical analyses are based on drug samples from the Street-Level Project and the monitoring of ecstasy pills referred to later in this chapter.

in cafes and other "outside places", and almost the same number were familiar with areas where cannabis was taken and where there was a pusher selling cannabis.

As regards the other illicit drugs, half of 15-16 year-olds thought it would be difficult, if not impossible for them to buy these drugs.

The ease of access to drugs has also been reported from the regional hearings that have taken place in 2005. Drugs seem to be available at private parties, discos, inside and outside parties in youth clubs, as well as in all sorts of public places (see chapter 2 for more information on this).

Drug routes to Denmark

There is no new information about the countries which produce and distribute the illicit drugs seized in Denmark. As was stated in the annual report *The drug situation in Denmark 2003*, Morocco is still the most important producing country for cannabis sold on the Danish market, according to the National Commissioner of Police, with Spain and the Netherlands continuing to be the most important distribution routes. As regards heroin, the vast majority still comes to Denmark from South West Asia, whereas amphetamine and ecstasy seized in Denmark are presumed to have been produced primarily in the Netherlands and Belgium. (National Commissioner of Police 2004).

10.3 Seizures

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

Table 10.3.1 in the Annex shows the trend in quantity and number of seizures of heroin, cocaine, amphetamine and cannabis from 1992-2004. From 1995 onwards, the statistics also include the quantity and number of seizures of ecstasy and LSD. The table shows major fluctuations in the quantity of drugs seized within most drug types in individual years.

The table shows that the number of heroin seizures has risen from 894 cases in 2003 to 1,041 cases in 2004. There is no apparent trend in terms of the quantity of heroin seized over recent years, but the figure for 2004 was 37.5 kg, which was up on 2003, when the quantity of heroin seized hit its lowest level ever of 16.3 kg. The number of seizures of cannabis rose from 5,942 in 2003 to 7,313 in 2004, whereas the quantity of cannabis seized dropped from 3,829 kg to 1,757 kg during the same period. As regards amphetamine, a slight rise in the number of seizures was observed from 2003 to 2004. At the same time, the quantity of amphetamine seized during this period remained steady. There was also a rise in the number of seizures of ecstasy pills from 2003 to 2004, but there was a significant drop in the actual number of ecstasy pills seized from 62,475 in 2003 to 38,096 in 2004. The number of cocaine seizures has increased steadily since 1999, reaching 1,207 in 2004. During the same period, major fluctuations were observed in the quantity of cocaine seized. In 2004 32 kg of cocaine was seized, which marked a significant drop compared to 2003, when a total of 104 kg of cocaine was seized. In 2003 there were just a few seizures involving large quantities.

Monitoring illicit drug dealing at user level

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

The data from the Street-Level Project in 2004 consisted of random sample minor seizures from 5 police districts in Denmark (Copenhagen, Aarhus, Odense, Aalborg and Esbjerg), which were submitted for analysis at institutes of forensic chemistry²⁶. Table 10.3.2 shows the distribution of drug types seized in the country as a whole from 1996 to 2004.²⁷

Of the 200 samples analysed in 2004 63% consisted of central stimulants, amphetamine and cocaine. As regards cocaine, the proportion of cocaine samples from the Street-Level Project has increased dramatically since the project started in 1995, whereas the proportion of amphetamine samples has been rising since 2000.

The prevalence of methamphetamine has increased over the last few years. But the samples from the Street-Level Project showed a drop in the proportion from 2003 to 2004, when methamphetamine accounted for 4% and 1% respectively of the samples²⁸. A further 3% of the samples contained different combinations of drugs, including flunitrazepam.

33% of all samples taken in 2004 across the country contained heroin. This indicates a dramatic fall in the proportion of heroin samples between 1995 and now, when 74% of all samples in 1995 contained heroin. For the first time since the project started, cocaine has become the most prevalent drug, accounting for 34% of all samples in 2004. 29% of all samples in 2004 contained amphetamine. In Copenhagen heroin and cocaine are the predominant drugs (57% and 36%), while cocaine is the most prevalent in Aarhus (40%), with amphetamine predominant in Odense, Aalborg and Esbjerg (49%, 46%, 36%).

²⁶ Forensic analysis registers the identity of the illicit drug and any additives. In addition, the sample’s purity and weight are determined.

²⁷ 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.

²⁸ See also the prevalence of methamphetamine in ecstasy pills later on in the chapter.

Table 10.3.2. Breakdown of drug types at user level 1995-2004

Year	1995 n = 203	1996* n = 212	1997* n = 217	1998* n = 208	1999* n = 216	2000 n = 188	2001 n = 152	2002 n = 198	2003 n = 188	2004 n = 200
Heroin	74%	57%	60%	56%	45%	44%	45%	40%	39%	33%
Amphetamine	16%	23%	26%	17%	23%	17%	22%	24%	20%	29%
Cocaine	9%	14%	9%	23%	27%	24%	22%	30%	32%	34%
Ecstasy**	-	3%	1%	<1%	3%	7%	9%	2%	-	-
Methamphetamine***	-	-	-	-	-	-	-	-	4%	1%
Other euphoriant/ drug combinations	-	1%	1%	1%	1%	5%	1%	3%	4%	3%
Non- euphoriant	>1%	2%	3%	1%	<1%	3%	1%	2%	1%	-
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%	

Source: Kaa et al. 1996, Kaa et al. 1997, Kaa et al. 1998, Kaa et al. 1999, Kaa et al. 2000, Kaa et al. 2001, Kaa et al. 2002, Kaa et al. 2003, Kaa et al. 2004, Kaa et al. 2005

*In 1996, 1997, 1998 and 1999 figures were included from the 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.

Table 10.3.3 in the Annex shows the distribution between heroin base ("smokable heroin") and heroin chloride (white heroin for injection) from 1995-2004. From 1995 until now, the proportion of heroin base registered among the heroin samples has increased. In 2004 the breakdown between heroin base and heroin chloride was 77% and 23% respectively, on a national scale.

In Odense samples containing heroin chloride only were found, whereas samples containing only heroin base were found in Esbjerg. In both Aarhus and Copenhagen samples containing heroin base are mainly predominant.

Table 10.3.4 shows the purity of the various drugs from 1995 to 2004 in the random samples seized during the Street-Level Project. From 1996 to 2004, the median purity of white/beige heroin chloride was between 50% and 71%, and in 2004 it was 63%. The range of variation was high – from 24 - 78%. There is no significant difference in the purity of heroin chloride in 2004 compared to previous years.

Table 10.3.4. Purity of illicit drugs at user level 1995-2004 (Median of active substance)^{29, 30}

	1995	1996*	1997*	1998*	1999*	2000	2001	2002	2003	2004
Heroin chloride	68%	64%	71%	70%	69%	59%	52%	50%	64%	63%
Heroin base	34%	43%	32%	31%	30%	40%	48%	25%	25%	22%
Amphetamine sulphate	26%	15%	16%	15%	9%	12%	9%	13%	9%	9%
Cocaine chloride	68%	58%	57%	51%	54%	37%	43%	36%	37%	24%

Source: Kaa et al. 1996, Kaa et al. 1997, Kaa et al. 1998, Kaa et al. 1999, Kaa et al. 2000, Kaa et al. 2001, Kaa et al. 2002, Kaa et al. 2003, Kaa et al. 2004, Kaa et al. 2004.

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

For heroin base, the median purity was 22% in 2004. The purity of the heroin base is no different from 2002 and 2003, but in all these three years, purity is significantly lower than in 2001 and 2000. The range of variation in purity in 2004 was, like that of heroin chloride, large (7-65%).

Amphetamine purity in many samples, as in previous years, was low. The median was 9% and the range of variation wide (1-59%). Purity in 2004 was at the same level as in recent years, but lower than in the middle of the 1990s.

Cocaine purity was significantly lower than in previous years, with the median at 24% in 2004. As in previous years, however, the range of variation in 2004 was large (6-79%).

In 2004 as in previous years, there was no significant difference in the purity of the individual illicit drugs seized in the various parts of the country, but everywhere the range of variation was wide. In every police district, there were always drugs of low as well as high purity on the market at the same time. It was not possible to pinpoint periods of the year when purity was particularly high or low for any of the drugs.

Monitoring of ecstasy pills on the market

In 2001 monitoring of drugs was further extended when the National Board of Health, in collaboration with the National Commissioner of Police and the three institutes of forensic chemistry, set up an ecstasy database using forensic analyses of ecstasy pills seized in Denmark³¹.

30 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.

31 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 euphoricants not normally present in medicines.

The ecstasy database systematically collects analysis samples from all ecstasy seizures made in Denmark. This means that large as well as small seizures are included. The pills are described in terms of drug concentration, drug composition and appearance. The database is a closed database, which only the National Commissioner of Police, the National Board of Health and the institutes of forensic chemistry have access to. A quarterly update of the analysis results and a more extensive annual report are, however, available at the National Board of Health's website www.sst.dk.

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

In 2004 35,254 ecstasy pills were sent by the police districts to the institutes of forensic chemistry for chemical analysis (Kaa 2005). Police districts seized a total of 38,096 ecstasy pills in 2004 in 505 seizure operations. 93% of the ecstasy pills seized by the police in 2004 were therefore analysed by the institutes of forensic chemistry. It was estimated that in 2004 there were 113 different types of pills among the pills analysed, based on appearance and content. The "variation" in ecstasy tablets on the market appears then to have become greater, as there were "only" 81 different types of pills found in 2003.

As regards appearance, the pills are often white, beige or grey, and almost always round. However in 2004, pills in a variety of shapes were seen, including squares, triangles and four-leaf clovers. There were also pills in more colours than in previous years (red/orange or green). In 2003 1 in 4 pills were coloured, whereas in 2004 this figure was 2 in 3. There were 47 different logos found among the samples taken in 2004, with Armani being by far the most common logo (most samples), followed by Ferrari, Stjerne and Sommerfugl. About half of the logos only come in one version, while the other half come in several. For instance, in 2004 11 different types of pills were found with the Mitsubishi logo and 10 different types of pills with the Smiley logo. Since the start of the project, Mitsubishi (34 versions) and Smiley (24 versions) have come in the most versions every year. Among the 47 logos found in 2004 13 of them had not been seen before. Pills with the same logo can vary in terms of their diameter, colour, weight, height, type and quantity of active substance.

As regards ingredients, there were no new, "unknown" ingredients found in pills in 2004. However, methamphetamine is being seen with greater frequency in pills, either alone or in combination with MDMA. Similarly, there has been an increasing number of pills seen containing MDA along with MDMA or both together with MDMA and MDE. The vast majority (85%) of pills in 2004 contained only MDMA. 14% of pills contained MDMA and another stimulant, whereas less than 1% did not contain MDMA, but another active ingredient (methamphetamine).

In 2004 pills were found with both the highest and lowest concentrations of MDMA (1-130 mg) ever seen. The average amount of MDMA per pill in 2004 was 68 mg, which is not so very different from previous years.

At the time of writing (June 2005), the first quarterly review of the ecstasy pills analysed in 2005 has been carried out. This shows major changes in the

ingredients, compared with the whole of 2004, the main trends of which will be described below. The results for the first quarter in 2005 are based on 125 samples.

The proportion of pills containing only MDMA has fallen significantly since 2004, while the proportion of pills where MDMA is seen in combination with MDA, MDE or methamphetamine has risen sharply. In 2004 85% of the pills analysed contained only MDMA, as mentioned above, whereas in the first quarter of 2005 this is the case for a "mere" 42% of pills. 22% of the pills analysed in the first quarter of 2005 contain amphetamine and/or methamphetamine on its own or in combination with other active substances. This was the case for just 8% of the pills throughout the whole of 2004. Compared with the whole of 2004, there is a rise being observed in 2005 in the number of ecstasy pills containing three different active substances at the same time.

In addition to this, a pill was identified during this analysis in the first quarter of 2005 containing the active hallucinogen PCP (phencyclidine) in combination with methamphetamine. PCP has not been seen in ecstasy pills in Denmark before and is a hallucinogenic compound that can cause severe poisoning, even in small doses.

For more information about the content of ecstasy pills, go to www.sst.dk.

This rapid, systematic monitoring of ecstasy in Denmark must be regarded as providing a good overview of what types of ecstasy pills are available on the domestic market and of what they contain. Furthermore, all the active ingredients in ecstasy pills analysed from 2001 onwards are now covered by drugs legislation. 2C-B was banned in 2001, 2C-I and PMMA in 2002 and 5-MeO-DIPT was banned in 2004. At the moment in 2005, 2C-D has also been banned.

Prices

In 2004 forensic chemists very seldom received any information about drug prices in connection with the Street-Level Project, and it is therefore difficult to provide an overview of the price level.

The National Commissioner of Police estimates that the street price for cannabis is around DKK 50 (Euro 6.7) 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 1,000 (Euro 107.2-134) for white heroin and DKK 500 (Euro 67) for brown heroin. This is slightly lower than one year ago and there are also still large variations around the country. Cocaine prices are estimated to be declining slightly, with an average street price of 00-600 (Euro 67-80) per gram. Amphetamine street prices per gram are estimated to be approximately DKK 250 (Euro 33.5), whereas the price for an ecstasy pill is estimated to be in the range of DKK 50-125 (Euro 6.7-16.8). There are major variations in different parts of the country in terms of prices for the various drugs (Rigspolitiet 2004a [National Commissioner of Police]).

11 Gender differences in alcohol and drug abuse

11.1 Introduction

In recent years there has been a focus on the different attitudes men and women have to health and illness and their different lifestyles, as well as the consequences of this. There have also been numerous studies carried out documenting significant differences in risk behaviour between men and women, as well as in diet and exercise patterns, smoking and drinking habits, etc. This also applies, to a large extent, to the use of drugs, where men stand out as the "stronger sex" in terms of widespread drug abuse - in every age group. This disparity between the sexes with regard to the use and abuse of illicit drugs is also reflected in the impact on their health. For instance, more men than women seek treatment for their abuse, are admitted to casualty departments due to poisoning and die as a result of drug abuse.

As a result, attempts have also been made over the past few years to target preventive measures in the fight against alcohol and drug abuse at young men and women, although these experiences are limited and not very widespread nationally.

This chapter will describe gender-related aspects in terms of the use and abuse of illicit drugs and its consequences, as well as the preliminary experiences of targeting preventive measures at the different sexes.

11.2 Use of drugs among men and women

If we look at the extent of experimenting with different illicit drugs, it is usual to have more or less significant differences in every age group in terms of the extent that illicit drugs are taken among the sexes.

The results from ESPAD studies over the years show significant differences between boys and girls in terms of experimenting with cannabis. The difference between the sexes in terms of experimenting with other illicit drugs is even more striking, with almost twice as many 15-16 year-old boys than girls having tried amphetamine and ecstasy at some time in 2003.

Table 11.2.1 shows the difference among 15-16 year-old boys and girls in terms of experimenting with illicit drugs in 2003, as well as with solvent abuse and taking tranquillisers and sleeping pills. In the case of every illicit drug, more boys than girls have tried the various substances. The only area bucking this trend is sedatives. In this area slightly more girls than boys are taking sedatives. But the difference is not significant.

Table 11.2.1. Percentage of 15-16 year-old boys and girls who have tried solvent abuse or taken sedatives and illicit alcohol and drugs in 2003.

	Boys	Girls
	ESPAD 2003 n=1504	ESPAD 2003 n=1474
Cannabis, lifetime prevalence	28	19
Cannabis taken last month	11	6
Amphetamines, lifetime prevalence	5	3
Ecstasy	4	2
Cocaine, lifetime prevalence	2	2
Heroin (injection), lifetime prevalence	1	1
Heroin (smoking), lifetime prevalence	1	1
LSD lifetime prevalence	2	1
Psilocybin mushrooms, lifetime prevalence	3	1
Sniffed solvents, lifetime prevalence	9	7
Taken sedatives*	9	10

Sources: Hibell et al. ESPAD 2003.

* Either prescribed and/or OTC

The level of experimenting with illegal drugs increases with age, with the largest rise among boys (Sundhedsstyrelsen og Kraeftens Bekaempelse 2005). 42% of boys and 35% of girls between the ages of 16 and 20 have tried cannabis or other drugs at some time, with cannabis being by far the most widespread substance. This widening use with age is indicated by the fact that 17% of 16-year old and 55% of 20-year old boys have tried cannabis or other drugs. The increase among girls is from 21% at the age of 16 to 45% at the age of 20.

The three drugs which have been tried most among 16-20 year-olds, apart from cannabis, are, for boys, amphetamine (8.2%), ecstasy (5.3%) and cocaine (5.1%), whereas for girls, amphetamine (5.3%), ecstasy (3.3%) and the sniffing of solvents (3.3%) have been tried the most.

Finally, there are more boys than girls currently taking illicit drugs. Twice as many boys (10%) as girls (5%) between the ages of 16 and 20 admit to having taken cannabis within the last month, while 7.3% of boys and 5.0% of girls have tried drugs other than cannabis during the last month. The current use of illegal drugs also increases with age.

11.3 Differences in health

The study's findings on the extent of the use of illicit drugs consequences among young people basically show that there are more boys than girls both experimenting with drugs (taken at some time) and currently using them (taken last month). Not surprisingly, this disparity is also reflected in the health-related and social consequences and "repercussions" resulting from abuse. There are more men than women both seeking treatment for their abuse and admitted as inpatients in

casualty departments due to poisoning from illicit drugs. Finally, there are more men than women who die with a drug-related cause of death.

Men and women undergoing drug abuse treatment

There was a total of some 5,000 people registered as receiving treatment for their drug abuse in 2004, with three-quarters of these men (77%) and one quarter women (23%) (Sundhedsstyrelsen 2005a [National Board of Health]).

As described in Chapter 4, there has been a significant rise over the last few years in the number of people under 30 receiving treatment for their drug abuse. From 2002 to 2003, the number of young people receiving treatment rose by 17% (from 3,813 to 4,466). As a comparison, the total number of drug abusers rose by a good 12%. This rise in the number of young people receiving treatment is observed both among men and women. However, the number of women is slightly more than the number of men, with this trend particularly evident among the 18-24 age group. In other words, young women have had slightly more access to treatment over the last few years. This has been the trend from 2002 onwards (Sundhedsstyrelsen 2005c [National Board of Health]) (data not shown).

Poisoning from illicit drugs

If we look at the data in the national patient register for the number of visits to Denmark's casualty departments between 1999 and 2004, due to poisoning resulting from taking illicit drugs, we can also see large differences between the genders (Sundhedsstyrelsen 2005d). As mentioned in Chapter 6, the results must be considered with certain reservations, as there is an element both of under-reporting and erroneous source material.

Out of the total number of 7,871 poisoning cases registered during the 6 years of the study two thirds (67%) involved men and one third (33%) women. The difference between the sexes in the number of registered poisoning cases is slightly less in the younger age groups. For instance, the ratio is 60%/40% among men and women in the under 20 age group and 72%/28% among men and women in the 20-29 age group.

There are no different "patterns" in the poisoning cases among men and women. The different substances causing the poisoning are distributed more or less equally and in proportion to the distribution according to gender for poisoning cases in general.

Drug-related deaths

There is also a majority of men whose deaths are drug-related. Out of the 275 drug-related deaths registered in 2004 211 (77%) involved men and 64 (23%) women. Over the last few years there has been a reasonable rise in the number of drug-related deaths among women. In 2003, out of a total of 245 registered deaths 197 (80%) were men and 48 (20%) women. And out of a total of 252 deaths in 2002 216 (86%) were men and 36 (14%) women.

We can see overall that men suffer, to a much larger extent, health consequences resulting from their use and abuse of illicit drugs. When it comes to the need for treatment and the number of deaths related to drug abuse, over the last few years, however, the trend has been for women to account for a slightly higher proportion in the statistics.

11.4 Preventive measures targeted at men and women

There is no "tradition" in Denmark of targeting preventive measures at men and women or boys and girls respectively. Based on a questionnaire sent to alcohol and drug counsellors in the various counties in spring 2005, only North Jutland county reported any experiences with drug and alcohol abuse prevention measures targeted in this way. They organised specially prepared courses for girls and boys at the production schools (providing schooling and training for young people) in the county.

During the "test county" project aimed at ecstasy prevention in 2002, all 14 production schools ran gender-specific alcohol and drug abuse prevention courses. The reason for focusing particularly on production schools was that a study on the consumption of and attitudes towards alcohol and drugs among young people attending youth education institutions in North Jutland county showed that young people at production schools had a much higher consumption of drugs than, for instance, young people attending upper secondary school or business colleges. During the process it also became evident that alcohol and drugs and problems of abuse occupy a large part of the lives of those attending production schools. In the case of students attending these schools, many have even experimented with drugs, while others have drug abuse problems in their lives with boyfriends and girlfriends, parents, brothers and sisters or friends involved in drug abuse. Ultimately, some of these students point to alcohol and drugs as a means of escaping from their complicated family lives, from failure at school and in the education system, or as an absolute must to maintain their social life.

The aim of the prevention project in production schools was to contribute to a greater understanding and awareness of the individual habits, culture and consumption patterns among students. The young people were to discuss and reflect on the party culture, youth culture, the influence of their friends, their family's influence, barriers affecting their future, pros and cons of stopping taking cannabis or other drugs. They were to work in *gender-based groups*. This requirement in these projects originated from the desire to gather experiences, during this test period, with preventive measures based on gender. The assumptions were that, in the case of alcohol and drugs, both sexes often have some distinct habits, traditions and cultures, reflected in the way they talk about this subject. By dividing the students according to their sex, they wanted to give them the chance not just to learn what is special about being young nowadays, but also what is special about being a young woman or a young man. There was an assumption that it is easier to be aware of your own habits/behaviour with regard to alcohol and drugs if the focus is gender-specific. Students were made to work together, dealing with a subject which was very sensitive for many of them, because they had many negative experiences of abuse in their families.

Based on experiences from the project, it became evident that, apart from the fact that working in gender-specific groups had established new contacts and a network in the school, it also gave many students the feeling that they were not alone with their problems. The students talked a great deal about alcohol and drugs and they became a lot more aware of their own attitudes and those of the group members. The project also helped to dispel taboos about having problems with alcohol and drugs.

In the boys' group in particular, it was more relevant to talk about alcohol and drugs in terms of their own and others' experiences of abuse and problems with them. Many boys felt a sense of relief at being able to break down the barrier and talk about their own experiences, feeling that they were not the only ones with these problems. The girls were already, for the most part, good at talking to each other before this, and knew a lot about each other's problems. But in this case too, experiences showed that some problems could be resolved by operating in gender-specific groups. At the start of the project, the girls' relations with each other at the schools were, in most cases, rather delicate. They found it easy to fall out with each other and many girls were made to feel left out. During the project a stronger sense of solidarity was created among the girls, and through new contacts and a new network at school, more of the girls felt that they were not the only ones with these problems.

As a follow-up to the "test county" project in 2002, the Foldbjerg Centre, along with North Jutland county set up in 2004/2005 another project about girls and their well-being at two production schools. A special course is run every week for 2-3 months at these schools for girls, where the instructors taking part have worked with different topics dealing with women today, women and drugs and alcohol, female friends, relationships, keeping fit, sexuality and the role of mothers. The reason for this project, as in the case of the "test county" project, was because girls and boys feel different about things and have different habits when it comes to matters like health, alcohol and drugs. The project focused in particular on the girls' network and on an understanding of what it means to be a girl in modern Denmark. Other experiences from this project also showed that through discussion, girls increased their awareness of their identity, their own social network and became more accommodating and more attentive to their attitudes to different subjects.

Following on from this project in North Jutland, there is now an idea/instruction leaflet being produced for production schools and other youth education institutions.

As was mentioned at the beginning, it is not usual to promote gender-related prevention in Denmark. However, the experiences from North Jutland may seem to show that it may be beneficial to use gender-related prevention in special circumstances and situations.

12 Drug policy in relation to alcohol, tobacco and doping

12.1 Introduction

In Denmark, drug prevention and prevention of alcohol and tobacco problems walk hand in hand, especially when we are dealing with young people as a target group. Also, treatment offered to curb alcohol and drug use appears to be united within various areas. However, since the drugs area holds a special legal position in terms of regulation and control, a large part of the various activities are specific, first and foremost – of course – in terms of control.

12.2 National prevention programmes

Currently, there are three national prevention programmes: one programme of a generic nature, one specific drugs programme and one specific doping programme. The specific drugs programme deals with the overall drugs policy, including treatment and law enforcement.

The government's general preventive initiatives embraces drugs as a sub-element, and similarly drugs plus alcohol and tobacco are linked together in the preventive part of the specific drug action plan.

Prevention programme

The government's prevention programme from 2002, "*Sund hele livet – de nationale mål og strategier for folkesundheden 2002-10*" [*Healthy all you life – the national goals and strategies of public health 2002-10*] focuses on the risks factors believed to be the most significant causes worth preventing against in the major public diseases and causes of death. The risk factors have thus been prioritised from a prevalence criterion. This list includes smoking and alcohol, but not illicit drugs. The list also includes the risk factors: smoking, alcohol, food, physical activity, obesity, accidents, working environment, environmental factors. These risk factors are related to the 8 public diseases: age diabetes, preventable cancer diseases, cardiovascular diseases, osteoporosis, musculo-skeletal diseases, allergy diseases, mental illnesses and chronic obstructive pulmonary disease (COPD).

However, as regards the target group of young people, alcohol, tobacco and illicit drugs are mentioned as significant risk factors: "serious health problems facing young people are especially associated with accidents, start of tobacco and alcohol use, violence, use of illicit drugs and suicide attempts. Also, health problems at this age are particularly related to well-being and life-style". (Ministry of the Interior and Health 2002b). References are made to epidemiological studies suggesting a "clear correlation between extensive use of alcohol, experimental use of illicit drugs and smoking among a minor group of the young people" (Sundhedsstyrelsen 2002b [National Board of Health]) and the studies concur that the drugs culture among young people is an area to be dealt with and that alcohol, tobacco and drug use should be the key indicators of health in this target group.

Action plan against drug use

In October 2003, the government launched the "*Fight against drugs – action plan against drug use*". As the title implies, the plan aims specifically against illicit drugs, but it is also mentioned that the "use of legal and illicit drugs are interlinked in the manner that especially the young with heavy alcohol consumption are also the ones to be experimenting with drugs". The section on *prevention* elaborates further that "an important part of the early prevention against drug use will be to procrastinate any start of alcohol use and in general, limit the young people's alcohol consumption (Indenrigs- og Sundhedsministeriet 2003 [The Ministry of the Interior and Health]). The same section states that there is a clear correlation between having excess consumption of alcohol and tobacco and having tried drugs, and that in particular, an early start of alcohol and tobacco is a signal that problems with drugs may arise. On this basis it is concluded that targeted drug prevention therefore in certain contexts must be included as part of the overall drug prevention. In the section, it is also established that the preventive intervention, among others, must take an overall approach, i.e. comprise drugs on a broad scale.

Quite a large part of the specific proposals for prevention programmes use the general term of drugs (which comprise alcohol as well as illicit drugs, but not tobacco). It is thus recommended that municipalities as well as schools formulate a drug policy and work with prevention in party settings with a "combined aim of keeping drugs out of public entertainment; of securing "responsible serving" in relation to the young and to minimize acute intoxication injuries" (Indenrigs- og Sundhedsministeriet 2003 [the Ministry of the Interior and Health]).

This draft programme proposal on the part of the Danish government to take a broader view at drugs in targeted prevention intervention has been followed up by the National Board of Health's guidelines to the municipalities taking part in "Drugs out of town". This is a major prevention initiative included in the government's drug action plan and it is being conducted in collaboration with the state (the National Board of Health) and 14 municipalities. Initially, the guidelines instruct that the preventive intervention must aim at the young people's use of alcohol as well as drugs (and tobacco) under the following commentary: "It is a common feature in all Danish surveys that young people who start early to drink alcohol and have a heavy consumption of alcohol, are clearly more exposed to start experimenting with illicit drugs later on. Many young people experiment with illicit drugs in a situation where they are drunk. Prevention against early alcohol experience and excessive alcohol use in young people are therefore significant elements in this drug preventive programme. Furthermore, the prevention projects that have documented results have successfully integrated alcohol and drug prevention, in some cases also tobacco. These are the results, on which these guidelines are based."

Programme against doping

Anti Doping Danmark (ADD) is a programme launched in collaboration between the government and the sports organisations. The objective of the programme is to strengthen the basic values within elite sports as well as more broad, public sports.

Another objective of the programme is to spearhead principles and research, set up a framework for effective doping control in various sports milieus as well as place Denmark as one of the leading countries in international doping work by securing requisite doping control of high quality, carry out visible campaigns and strengthen

the debate on sports values as well as initiate research on doping. The chairman of the organisation is appointed by the Danish minister of cultural affairs.

Prevention against doping is thus carried out within an organisational framework (and governmentally within a different ministerial area) other than that of tobacco, alcohol and illicit drugs, because it indeed requires cooperation with the sports organisations. Anti Doping Danmark's campaigns (one of them being www.doping.dk) also includes information about various illicit drugs (cannabis, illicit drugs, opioides).

Treatment

As far as treatment of abuse is concerned, various laws apply: alcohol treatment is founded in Section 16 of the Danish Hospitals Act, whereas treatment of drug abuse is founded in Section 85 of the Danish Services Act in relation to treatment of social drug abuse and in Section 16 b of the Danish Hospital Act and Section 5 f of the Danish Medical Professions Act as regards the medical drug abuse treatment (substitution treatment). No specific laws apply to treatment of tobacco dependency (smoke cessation programmes), however, the Danish health care system will typically allow some kind of grant.

Governmental reports

The most recent report on treatment "Den offentlige indsats på alkoholområdet" [Public initiatives to reduce alcohol abuse] (Indenrigs- og Sundhedsministeriet og Amtsrådsforeningen 2002 [The Danish Ministry of the Interior and Health and Danish Regions]) has reviewed the activities provided to encounter alcohol problems and includes a total of 22 recommendations. The report deals with polydrug use in relation to two target groups: persons with a secondary use of medicine (benzodiazepines) and young people drinking alcohol and taking drugs. The programmes provided to these groups, however, is not dealt with explicitly in the recommendations of the report.

From the expert group report on "Programmes provided to the most marginalised drug users" (Indenrigs- og Sundhedsministeriet 2002a [the Danish Ministry of the Interior and Health]) it appears that the most marginalised drug users are often polydrug users. The recommendations of the expert group, however, only deal with drug abuse, given that the task set before the group was to "assess the needs for and advantages and disadvantages of possible further harm-reducing measures offered to the most marginalised drug users".

On a local level, treatment programmes for alcohol, drug and polydrug users are often consolidated in one joint organisation (see section 12.4.).

12.3 Background

It is often discussed whether the illicit drugs, particularly cannabis, are something quite different from the culturally accepted and estimated alcohol – or whether there are more similarities than differences. This discussion has been carried out since "the modern drug problem" appeared at the end of the 1960s. Be it the differences or the similarities, their focus depends to a high degree on the perspective, i.e. whether it is interesting to apply

- the historic perspective
- the legislative perspective (regulation and crime fighting)

- the health perspective (epidemiology, damaging effects resulting from use)
- the social perspective (abuse background and consequences, including consequences from stigmatisation)
- sub-cultural perspectives (user and client groups)

Cannabis versus alcohol as a generation conflict

Until the end of the 1960s, the drug use problem was very limited in Denmark. The relatively few abusers (of opium, morphine, synthetic analgetics, amphetamine, etc. were typically adults and the drugs were procured through fake prescriptions or pharmacy thefts.

However, from around 1965, the "modern drug problem" surfaced in Denmark as well as in a number of other western countries. This problem was particularly characterised by young people starting to experiment with drugs and their use of drugs was associated with the new antiauthoritarian and anti-conservative youth culture. Political interest, international orientation, rock music and new drugs such as cannabis, LSD, opium, amphetamine were important elements in this youth culture, and the drugs – especially cannabis – were symbols of the young people's liberation from their parents' generation. In the inter-generational debate, cannabis (and other drugs) were emphasized as the young people's alternative drug and symbolically opposed to alcohol, which was perceived to be the drug of parents/the establishment. These opposing elements can still be seen in the public debate on the legalisation of cannabis.

Illicit organised market

To begin with, the delivery of drugs took was carried out in connection with the young people's increased travelling activity abroad and through pharmacy thefts, etc. However, it did not take before an international and illicit market was established, which has also led to an ongoing tightening of laws, longer sentences on account of drug crime and increased international police cooperation for the past 40 years. From a legal and a market perspective, there is thus a very distinct difference between the illicit drugs (totally prohibited or only permitted for medical and scientific purposes) and the legal drugs referred to as alcohol and tobacco. This difference in regulation plays a major role in the political, legal and media debate, where the fact that the drugs are forbidden renders them a special position.

Organisation

Since the emergence of modern drug use, the efforts to combat drug use have been organised on a cross-sectoral and interdisciplinary basis. The first governmental report on the "teen drug abuse" problem was released by the ministers of internal, judicial, social, educational and foreign affairs in January 1969.

Following the aforementioned 1969 report, a special "contact committee of teen drug abuse" was appointed with its own secretariat. In 1978, the tasks of this committee were expanded to include alcohol, and the governmental coordinating intervention thus covered drugs as well as alcohol up until 1990.

From 1990, the coordinating tasks on a governmental level have been handled by the Danish Ministry of the Interior and Health, and the most recent governmental action plan against drug abuse has been prepared by an interdisciplinary group of ministers consisting of the Minister of Finance, the Minister of Justice, the Minister of Cultural Affairs, the Minister of Education and the Minister of the Interior and Health with the latter being the coordinating "drug minister".

Professionally, the National Board of Health deals with counselling and drug monitoring as well as governmental prevention initiatives. The Board handles similar tasks relating to tobacco and alcohol. On a governmental level, there has thus in these areas been a joint organisational framework surrounding the efforts to combat alcohol and drugs since 1978, and since 2001, tobacco has been included in this framework.

Addiction as the common core

The debate on addiction being the fundamental problem of abuse in general – be it alcohol, stimulants, cannabis, opioids, tobacco and perhaps also ludomania, sex, over-eating – arrived in full scale in Denmark in the 1980s, when a number of inpatient institutions working under the “Minnesota model” were established on a private initiative. A private national association referred to as The Danish Centre of Alcoholism and other Addiction Diseases was founded in 1983 with the primary goal of conveying information and guidelines. This association collects information about all types of addiction, but the attitude has not been reflected in official policies.

Epidemiological background

A fundamental rationale behind coordinating prevention activities to combat alcohol and drug abuse is the epidemiological surveys that demonstrate that there is a correlation between these behavioural patterns, cf quotes from the various action programmes.

This well-documented correlation has been established in many studies throughout the years. In one of the most recent studies on young people’s health behaviour, it is suggested that a much larger share of those who have tried cannabis among the 16-20-year-olds are heavy consumers of alcohol and/or tobacco than among those who haven’t been drunk or have tried smoking:

Table 12.3.1 Correlation between smoking, large consumption of alcohol and cannabis among the 16-20-year-olds. Percentage.

	Alcohol habits		Smoking habits		Cannabis use	
	Not drunk the past month	Drunk ≥ 3 times last month	At some point	Daily	Never	Yes, last year
Drunk ≥ 3 times last month	-	-	38	60	28	65
Daily smoker	14	35	-	-	10	48
Cannabis the past year	8	45	9	56	-	-

Source: MULD-report 2, 2003.

There is also a clear correlation between having started particularly early on drinking alcohol (before the age of 13, which is the case in 12% of the 15-16-year-olds) and an increased risk of trying drugs:

Table 12.3.2 Correlation between age of starting drinking alcohol (drunk for the first time) and use of illicit drugs in 15/-16-year-olds. Percentage.

		Drunk for the first time		
		≤12 yrs	13 yrs	14+ yrs
Smoked cannabis ≥6 time	Boys	36	21	7
	Girls	36	7	2
Taken amphetamine ≥ once	Boys	18	8	2
	Girls	13	5	2
Taken ecstasy ≥ once	Boys	12	6	1
	Girls	8	2	1

Source: Danish ESPAD, Sabroe S, Fonager K, 2003.

Typically, a similar correlation is seen between the use of cannabis and other illicit drugs, but also between early starting age (before the age of 14, which is the case in 6% of the 15/16-year-olds) and use of other illicit drugs (not shown).

A qualitative study conducted in 2000 describes the drug culture among young people from different perspectives, and this study also documents that amphetamine-like substances and cannabis are often taken together with alcohol in the young people's drug culture (National Board of Health 2000).

Polydrug use across legal and illegal substances

Viewed from a different angle of the drug perspective, i.e. among the group of abusers, extensive polydrug use is observed, and thus an overlap between abuse of alcohol and illicit drugs. Hence, among the drug users receiving treatment, only 30% report having used one substance during the period prior to treatment. Cannabis is the most prevalent drug, followed by heroin and then by alcohol (Sundhedsstyrelsen 2005a [National Board of Health]). These studies do not include smoking of tobacco, but empirically, by far a majority of the drug users are also heavy smokers.

A map-out study on drug users under the prison and probation services not only showed an excessively large majority of abusers among prison and probation clientele. It also showed that the majority of the abusers were polydrug users. In particular, a majority of the abusers used various illicit drugs, and 1/5 were alcoholics. However, a rather large group of alcohol users who did not take any illicit drugs could be excluded (Kramp m.fl. 2003).

12.4 Coordination and organisation

Within the prevention area, the Ministry of the Interior and Health has an overall, coordinating responsibility with regard to drugs, alcohol and tobacco.

Concurrently, the National Board of Health is the public health authority which will provide the professional expertise and perform certain practical tasks in all three areas. As mentioned earlier, the projects launched to combat doping are administered specifically by the organisation Anti Doping Danmark.

The counties and municipalities are those responsible for the specific prevention and treatment intervention and within this area, considerable coordination is carried out in relation to the young, especially as regards alcohol and drugs (to a certain extent also tobacco) and coordination within the treatment area.

Decentralised organisation of preventive intervention

In the counties, preventive intervention is typically administered by "alcohol and drug counsellors" who, as the term implies, handle tasks in relation to the two abuse areas. The various intervention activities are carried out across sectors and the municipalities are supported in their preventive work. Prevention against tobacco, e.g. development of tobacco cessation programmes, is also handled by the counties, but is placed within the health care system and often separated from alcohol and drug preventive intervention.

In the municipalities, preventive intervention aiming at alcohol and drugs is typically carried out within the framework of the SSP cooperation (cooperation between school, social/health care authorities and the police – a majority of the municipalities has a special SSP consultant). Preventive intervention aims particularly at children and teens and their parents, and may also comprise tobacco programmes. In addition, there are a number of specific tobacco initiatives, which are supported by several private associations and by specific governmental projects.

Decentralised organisation of treatment intervention

Treatment of alcohol and drug abuse is a regional responsibility (after the regional reform which becomes effective 1.1.2007, the local responsibility will be vested in the new, larger municipalities). Most of the counties have a joint organisation handling the treatment of abusers, with no distinction being made between alcohol and/or drug problems.

There may be a division into sub-institutions. A few counties have separate organisations dealing with alcohol and drug abuse treatment. The majority of the privately owned treatment institutions have either alcohol or drug abusers as their target clientele, with some of the institutions, however, providing treatment to both groups. Two alcohol treatment institutions also provide treatment for ludomania.

The conclusion is that the overall, national policies and action plans tend to link intervention in relation to drugs, alcohol and tobacco. Local practice has developed in the direction of integrating alcohol and drugs in the preventive and treatment intervention, whereas the intervention on tobacco and doping primarily is carried out under different auspices.

13 Recreational use of drugs

13.1 Introduction

This chapter deals with recreational use of drug in Denmark. The descriptions are based on two national qualitative studies (Sundhedsstyrelsen 2000 and Sørensen 2003). In addition, status reports produced as a result of a survey in the autumn of 2005 are included from employees in counties and municipalities working with young people and drugs. The data provided in these status reports are thus based on information from, among others, therapists, youth consultants, SSP-employees and others who are engaged in activities aiming at drugs. All qualitative sources are useful sources for the understanding of recreational drug use, but should also be viewed with caution, given that they merely reflect individual considerations and statements. Finally, a number of examples and scenarios are described on preventive intervention in Denmark the past few years, which has received particular focus in music and party settings.

13.2 Recreational use of drugs

Recreational use can be defined as "periodical" and time limited use performed at certain events, settings and in different phases of life. Recreational use does not necessarily mix with daily routines of education and work, but can gradually develop into more problematic use with social, mental and physical implications, including addiction. In this connection, the term of recreational use of drugs is applied to describe use which takes place in certain situations and contexts, i.e. "party settings". Recreational use of drugs means – in relation to the individual drug experiment – increased risk of acute damage and of development of a more massive abuse and actual addiction.

Cannabis and amphetamine-like drugs such as amphetamine, cocaine and ecstasy as well as hallucinogens (especially psilocybin mushrooms) and sedatives are the substances typically applied in a recreational context and which are often taken in combination with alcohol. As documented in repeated school surveys, youth surveys and population surveys on the experimental use of drugs, the most prevalent illicit drug is cannabis, followed by amphetamine, cocaine and ecstasy (ESPAD, MULD, SUSY)³². The young people using drugs on a recreational basis are young people from all social walks of life. It is not a homogenous group, but many different groups of young people who use drugs in many different recreational settings (Sundhedsstyrelsen 2000, Sørensen 2003).

The following lines provide results from an ethnographic user survey focusing on recreational drug use and risk handling in the techno-environment (Sørensen 2003).

Normally, the various illicit drugs are tested and combined within the same intoxication period. It is generally accepted to use the "quick drugs" such as amphetamine, cocaine and ecstasy in order to overcome fatigue, feel the "rush" and step into a condition of euphoria. This is how these people party all night and maintain their ecstatic mode. When they no longer need to feel the euphoric high – often in connection with post-partying – they take more sedating drugs or

³² Results from these studies are described in chapters 2 and 11.

medicines such as cannabis or benzodiazepines of different kinds. Recreational users of drugs point out that it is important for them to take drugs together with friends they know well, as it makes them feel safe that somebody is watching them, and that it is possible to make use of each other's experiences, intoxication, etc. Also many young people state that it is important for them to have somebody, with whom they can share their drug experience.

In addition to the need for intoxication and overcoming of fatigue, the *risk* of using the drugs in itself is also an important motivation factor to some of the recreational drug users. The reason is that adolescence is a phase, during which the individual is trying to create an individual identity of detachment from the family. More radical experiences are often contributory to firmly establishing the young people's identity, and therefore the risk of taking drugs and thus to some, the assurance of a forceful effect of the drug, is an essential part of the motivation to try the drugs.

It is characteristic to recreational drug users that they do not consider their use as being problematic. They state that they are in control of their consumption and that it is limited to taking place during holidays or other days off only. Also they state that their use is *periodical*, and that taking drugs is part of being young and partying out and that as a result, their habit at some point in time will stop. Use of illicit drugs can be compared to general intake of alcohol which can also be considered as recreational use, given that it is associated with recreational activities.

The young people do not consider themselves as abusers, but they emphasise: that they are in control of their use and the risks following from taking drugs. Recreational users of drugs dissociate themselves heavily from drug addicts (those injecting heroin) and abuse that starts to control everyday life. This dissociation in relation to the heavy abusers resembles risk projection. By dissociating oneself from the high-risk group of injecting drug users, recreational users of drugs shift the risk of using drugs to addicts, and the recreational use in this context appears as being relatively harmless. Furthermore, young people in the techno environment will often dissociate themselves from the mainstream alcohol and discotheque culture, which they consider to be boring, whereas the techno environment and recreational use of drugs (seen from a user perspective) is included in the creation of a more special and thus more unique identity. Recreational users of drugs make sure that their use of drugs does not have any influence on their education and their working life. As mentioned, the above is based on the study: *Unges rekreative stofbrug og risikovurdering* [Young people's recreational use of drugs and risk assessment], which focuses on the users' perspectives of recreational use of drugs and risk handling based on the techno environment.

User establishments and the scope of recreational use

While earlier the use of drugs to a large extent was associated with defined youth cultures and cultures originating from the music culture after the youth revolution of the 1960s, drug use today is less linked to certain sub-cultures or groups. The illicit drugs are taken before going out. Recreational use of drugs is most prevalent in the various music and party settings, be it town parties, dancing parties, festivals, concerts, raves, discotheque functions, private parties/after parties, tourist areas, etc.

In the study *Unges brug af illegale rusmidler*, "today's" use of drugs is described in relation to various *drug use scenes*. These scenes are defined as places or social

events and settings where illicit drugs are part of the way, in which the young people meet. The party and the experience are pivotal of each of the different drug use scenes (Sundhedsstyrelsen 2000 [National Board of Health]). The many music and rock festivals account for a rather considerable drug scene among the young people (*Festival and concert scene*). Here, it is possible to party for days on end and the combination of different drugs renders it possible to keep awake and form an environment around tents and music experiences. Special techno parties and raves is another drug experience scene (*Techno parties/raves scene*) where the use of illicit drugs are particularly associated with the music and with dancing the whole night through. Finally, the study also includes the “nightlife of the cities” as the dominant drug experience scene (*City scene*). Various illicit drugs are taken when the young people enter the nightlife and start partying.

Results from the most recent national school and youth studies are described in chapters 2 and 11 in this report and will not be outlined any further. It should, however, be mentioned that the level of experimental use among the young people has reached a historically high level, but there has been no increase during recent years. Among the 16-20-year-olds, 40% of the boys and 33% of the girls have tried cannabis at some point, whereas 12% of the boys and 10% of the girls have tried an illicit drug other than cannabis in 2004 (MULD 2004).

Concurrently with the results from the school and youth studies, the feedback from various counties and municipalities does not imply any changes in the experimental use of illicit drugs among young people. Some of the reports suggest that the use of cocaine is a bit on the uprise, and that in some places, cocaine is more popular than amphetamine and ecstasy. Also the use of cannabis is reported to be increasing, whereas the use of mushrooms is reported to be decreasing. Several counties report on the use of rohypnol, which is most likely explained by the fact that benzodiazepines are being used, among others, as “downers” in connection with public as well as private after parties. A few counties report that young people of an ethnic origin other than Danish use cannabis and khat. Several counties and municipalities report on an apparently widespread acceptance of the use of drugs, which are taking place, in particular among the young people. Furthermore, the counties report on mental damage, anxiety and different types of mental disturbances appearing as a result of drug use.

13.3 Activities to curb recreational use of drugs

Since the 1900s, various activities have been launched in Denmark for young recreational drug users. One of the first projects was the National Board of Health’s website on drugs and their side-effects. During the period 2002-2002 a development project (titled: “Udviklingsprojekt om ecstasyforebyggelse i to modelamter”) was launched in collaboration with the National Board of Health, the counties of northern Jutland and Aarhus. The objective of the model county project was to initiate broad intervention activities to prevent against the use of ecstasy and similar drugs among the young people and to convey any experience gained to the other counties of the country. The project identified three main intervention areas: prevention through municipal drug policies, at the young educational institutions and in party settings. A number of different activities were initiated and completed, involving local key personnel networks from the municipalities, youth educational institutions, local police and restaurant owners. A few municipalities have now formulated their own local drug policy, according to which the local, commercial party environment is a central focus area.

The interventions under the development project which were carried out in party settings included especially courses for restaurant owners and employees at discotheques in Aarhus as well as the county of northern Jutland. The courses are supposed to provide more in-depth knowledge of drugs and poisoning, first aid, conflict management and collaboration with the police and other authorities. A “No Tolerance” guide was prepared against drugs and a special website to communicate the message was designed. The guide contains specific guidelines for preventive layout of the physical framework, the image of the drug-free restaurant, proposals to strengthen internal cooperation, and first-aid to guests affected and/or poisoned by drugs. The guide has been disseminated to key persons across Denmark. Also, a little experience was gained from the peer information targeted at the young adults under the age of 25 years in the party settings.

Apart from the model-development-projects, other counties and municipalities throughout the years have launched a number of initiatives with the purpose of restraining the development of using the illicit drugs in the party settings, among others. These initiatives are described below.

In 1998, the *Night Ravens* “parent patrol” was established in Denmark. The Night Ravens is one of the oldest activities in relation to party settings. There continues to be an ongoing collaboration between parents and SSP personnel around the country. At present, there are approximately 7000 active Night Ravens. The Night Ravens are parent groups of three persons walking round during the night in places where the young people will hang out in order to keep an eye on them and help if problems arise. The most important function of the Night Ravens is to be seen in the nightlife, thereby inspiring to a feeling of security. Young people may approach the group anonymously with problems of a diverse nature. The Night Ravens do not focus specifically on the use of drugs.

Since 2002, the National Board of Health has been cooperating with the country’s largest music festival, Roskilde Festival, on attitudes and preventive intervention against drugs (*Roskilde Festival against Drugs*). During the festival days each year, festival participants are met with extensive amounts of informative material and mass media campaigns as a supplement to the already established harm-reducing and controlling measures at the festival. The mass media campaigns in the form of large-screen spots before all concerts at the largest scenes of the festival, the festival programme, postcards, t-shirts and bus ads on all festival buses has aimed at generating attention and debate about drugs, and by providing targeted, factual information about drugs, the debate has sought to qualify and further support the young people in not to take drugs.

In 2005, the National Board of Health launched the project called *Festival Denmark against Drugs* involving various festival planners.

The Backstagers is a privately owned peer counselling service provided to young men with drug problems. The project is financed by the Ministry of Social Affairs. The Backstagers themselves are from 17-27 years of age, and most of them have themselves experienced destructive use for a period or have been directly dependent on various drugs. The Backstagers advise young people on substances and drugs on the basis of their own experience and they distribute information as well as inspire to debate on attitudes towards drugs among young people. The Backstagers will contribute to reducing damage and risk associated with young people’s use/abuse of drugs. Furthermore, the Backstagers are instrumental in

establishing contact between young people with a need for and a will to obtain professional counselling as well as various treatment services.

In 2002, the Backstagers ran a campaign under the heading "Banen" [the Line] in Copenhagen nightlife. The campaign was spread on folded copies of 100 Krone bills and aimed at the young people taking cocaine and amphetamine. "Banen" informed about the risk of taking cocaine and gave advice as to what to do if things go wrong. "Banen" was communicated to the young people in their own language and with brief captivating questions such as: Do you feel a tickling under your skin? Following which an explanation was given on the risks and what could be done to reduce the harm.

Are you experienced is the title of a new preventive initiative from the Backstagers at the 2005 Roskilde Festival near the electronic music scene. Here, the Backstagers had placed an old graffiti-painted bus with a sign saying: Are you experienced? Chill out & info about drugs. Inside the bus, the Backstagers were ready to talk to the young people about drugs and the risk of using them as well as informing them about harm-reduction. They distributed flyers describing drug effects and the risks involved. Furthermore, water and fruit was available in the bus and at the metropol scene during the concerts.

In Holstebro, the concept of "Safe nightlife" has been developed with the purpose of dealing with the restaurant owners' responsibilities as well as the young people's appearance in town. In this connection, a competition has been launched among the doormen who will be awarded a prize for finding the highest number of young people using or selling drugs. Also, the county has launched telephone counselling services for young people to contact. Another project involves the use of SMS (*Smash*) targeted at young people who would like to opt out of a perhaps incipient abuse. Also in this case, it is important to dissociate oneself strongly from the use of drugs, as it is believed that clear principles voiced by adults have a major preventive effect and that this may bring down the young people's use of drugs. Furthermore, letters of concern are mailed to parents whose children are suspected of taking drugs.

Finally, the Government's action plan as described in chapter 3 has led to the special model municipality project "*Drugs out of town*". Almost all 14 model municipalities have been interested in launching special intervention activities in party settings. Reference is made to Chapter 13 for details on such interventions.

Annex

List of references

Ahrent, M. & Fjordback, L (2004, unpublished). Forgiftningstilstande og uønskede reaktioner forårsaget af illegale stoffer på danske skadestuer. Undersøgelse for Sundhedsstyrelsen 2004.

Arbejdsmarkedsstyrelsen (2005). På kanten af arbejdsmarkedet – spørgsmål og svar om indsatsen, maj 2005.

Asmussen, Vibeke & Torsten Kolind (2005): Heroin-afhængige i Metadonbehandlingen. Den medicinske og psykosociale indsats. Århus, Center for Rusmiddelforskning, Århus Universitet.

Christensen, P. Brehm (2004, unpublished). Dødelighed blandt stofmisbrugere efter løsladelse fra fængsel.

DanRIS (Dansk Rehabiliterings- og Informationssystem – Status 2005 (Note: Mads Uffe Pedersen, CFR).

Embedslægeinstitutionen for København og Frederiksberg Kommuner (2001). Stofmisbrugere i metadonbehandling i København efter den 1. januar 1996. København og Frederiksberg Kommuner, København.

Embedslægeinstitutionen for København og Frederiksberg Kommuner, Familie- og Arbejdsmarkedsforvaltningen i Københavns Kommune og Retsmedicinsk Institut ved København Universitet (2003). Stofrelaterede dødsfald i København 1997 til 1999. København og Frederiksberg Kommuner, København.

Embedslægeinstitutionen for København og Frederiksberg Kommuner (2004). Graviditeter og fødsler blandt stofmisbrugere i Danmark 1990-2001.

Fuglesang, Thomas m.fl. (2000). Udbredelsen af hiv og hepatitis B og C blandt københavnske stofmisbrugere. Ugeskrift for Læger, 3 juli 2000.

Haastrup, L. (1999a). Skøn over antal dødsfald blandt stofmisbrugere og over antal stofmisbrugere i Danmark. Nye tal fra Sundhedsstyrelsen, 3, pp. 13-18.

Haastrup, L. (1999b). Dødelighed og dødsårsager blandt stofmisbrugere indskrevet i behandling i 1996. Nye tal fra Sundhedsstyrelsen, 3, pp. 1-12.

Hesse M. Thiesen H. Behandling med buprenorfin i Danmark. Nordisk Alkohol- & Narkotikatidsskrift 2003; vol 20 (5): 362-5.

Hibell, B., Andersson, B., Bjarnason, T., Kokkevi, A., Morgan, M., & Narusk, A. (1997). The 1995 ESPAD report – Alcohol and Other Drug Use Among Students in 26 European Countries. CAN & Pompidou Group, Stockholm.

Hibell, B., Andersson, B., Ahlström, Balakireva, O., S., Bjarnason, T., Kokkevi, A., & Morgan, M. (2000). The 1999 ESPAD report – Alcohol and Other Drug Use Among Students in 30 European Countries. CAN & Pompidou Group, Stockholm.

Hibell et al. (2004, unpublished). The 2003 ESPAD report.

Indenrigs- og sundhedsministeriet (2002a). Indsatsen for de hårdest belastede stofmisbrugere. Februar 2002.

Indenrigs- og Sundhedsministeriet (2002b). De nationale mål og strategier for folkesundheden 2002-10. Regeringen. September 2002. pp 15-16.

Indenrigs- og Sundhedsministeriet (2003). Kampen mod narko – handlingsplan mod narkotikamisbrug. Regeringen. Oktober 2003.

Indenrigs-, Justits-, Social-, Undervisnings- og udenrigsministeren (1969) Redegørelse for foranstaltninger mod ungdomsnarkomanien, januar 1969.

Indenrigs- og Sundhedsministeriet og Amtsrådsforeningen (2002). Den offentlige indsats på alkoholområdet. Rapport fra en arbejdsgruppe nedsat af indenrigs- og Sundhedsministeriet og Amtsrådsforeningen.

Kaa, E. (2002). Ecstasy i Danmark 2001. Retskemisk Afdeling, Aarhus Universitet, Århus.

Kaa, E. (2003). Ecstasy i Danmark 2002. Retskemisk Afdeling, Aarhus Universitet, Århus.

Kaa, E. (2004). Ecstasy i Danmark 2003. Retskemisk Afdeling, Aarhus Universitet, Århus.

Kaa, E. (2005). Ecstasy i Danmark 2004. Retskemisk Afdeling, Aarhus Universitet, Århus.

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. Retskemisk Institut, Aarhus Universitet, Københavns Universitet & Odense Universitet.

Kaa, E., Nielsen, E., Simonsen K.W. & Rollmann, D. (2002). Narkotika på gadeplan 2001. Retskemisk Institut, Aarhus Universitet, Københavns Universitet & Odense Universitet.

Kaa, E., Nielsen, E., Simonsen K.W. & Rollmann, D. (2003). Narkotika på gadeplan 2002. Retskemisk Institut, Aarhus Universitet, Københavns Universitet & Odense Universitet.

Kaa, E., Nielsen, E., Simonsen K.W. & Rollmann, D. (2004). Narkotika på gadeplan 2003. Retskemisk Institut, Aarhus Universitet, Københavns Universitet & Odense Universitet.

Kjøller, M. & Rasmussen, N.K. (2002). Sundhed og Sygelighed i Danmark 2000 – og udviklingen siden 1987. Statens Institut for Folkesundhed, København.

Kjøller, M., Rasmussen, N.K., Keiding, L., Petersen, H.C. & Nielsen, G.A. (1995). Sundhed og Sygelighed i Danmark 1995 – og udviklingen siden 1987. Dansk Institut for Klinisk Epidemiologi, København.

Kramp, P., Gabrielsen, G., Lund, A., Reventlow, A. & Sindballe, A. (2003). Rusmiddelundersøgelsen. Misbrug blandt Kriminalforsorgens klientel. Kriminalforsorgen, København.

Larsen, J. (2002) Marginale mennesker i marginale rum 2002. Citeret i ”på kanten af arbejdsmarkedet – spørgsmål og svar om indsatsen”, Arbejdsmarkedsstyrelsen, maj 2005

Lov nr. 435 af 14. juni 1995 om ændring af lov om sygehusvæsenet, Lov om udøvelse af lægegering samt lovbekendtgørelse nr. 944 af 16. oktober 2000 om social service (Serviceloven), Lovbekendtgørelse nr. 267 af 12. april 2000 om retssikkerhed og administration på det sociale område.

Lov om udøvelse af lægegering, LBK nr. 272 af 19/04/2001.

Pedersen, M. (2005). Heroinafhængige i metadonbehandling, den medicinske og psykosociale indsats. Århus Universitet: Center for Rusmiddelforskning.

Pedersen & Dahl (2003). Ambulant stoffri nærbehandling. Aarhus Universitet: Center for Rusmiddelforskning.

Petersen, H Skauge, Svejsøe, J. og Ege, P. Buprenorphine and 1- α - acetylmethadol (LAAM). New drugs for the substitutional treatment of opioid dependence. Ugeskrift for Læger 2000; 162: 6553-6.

Rigspolitiet (2004a). Rapport om organiseret kriminalitet i Danmark. Rigspolitiet, København.

Rigspolitiet (2004b). Narkotikastatistik 2003. Rigspolitiet, NEC (Nationalt Efterforskningstøttecenter), København.

Sabroe, S. & Fonager, K. (1996). Unge og Rusmidler – En undersøgelse af 9. klasses elever. Udgivelse nr. 39. FADL's Forlag, København.

Sabroe, S. & Fonager, K. (2002). Rusmiddelforbruget – i folkeskolens afgangsklasse og udviklingen fra 1995-99. Udgivelse nr. 40. FADL's Forlag, København.

- Sabroe, S. & Fonager, K. (2004). Unge erfaringer med rusmidler – i 2003 og udviklingen siden 1995. Udgivelse nr. 50. FADL's Forlag, København.
- Schering-Plough A/S (marts 2004). Nyhedsbrev Subutex-buprenorphin.
- Schmidt, D. & Sælan H. (1999). Hvor mange stofmisbrugere er der i København?. Rapport fra Forebyggelsesudvalget vedrørende stofmisbrug og hiv-smitte, København.
- Socialforskningsinstituttet (2004). De svageste kontanthjælpsmodtagere – barrierer for beskæftigelsen. SFI; 03:27.
- Stentoft, A. (2004), Personlig meddelelse.
- Sundhedsstyrelsen (1999). Narkotikasituationen i Danmark. Årsrapport til det europæiske center for overvågning af narkotika og narkotikamisbrug, EMCDDA. Sundhedsstyrelsen, København.
- Sundhedsstyrelsen (2000). Unge brug af illegale rusmidler – en kvalitativ undersøgelse. Udarbejdet af konsulentfirmaet Advice A/S for Sundhedsstyrelsen.
- Sundhedsstyrelsen (2003). Nye tal fra Sundhedsstyrelsen: Stofmisbrugere i Danmark 1996, 1998, og 2001. Sundhedsstyrelsen, København.
- Sundhedsstyrelsen (2003). Cirkulære om ordination af afhængighedsskabende lægemidler. CIR nr. 12 af 13/01/2003.
- Sundhedsstyrelsen (2004). Narkotikasituationen i Danmark 2003. Årsrapport til det europæiske center for overvågning af narkotika og narkotikamisbrug, EMCDDA. Sundhedsstyrelsen, København.
- Sundhedsstyrelsen (2004). Narkotikasituationen i Danmark 2004. Årsrapport til det europæiske center for overvågning af narkotika og narkotikamisbrug, EMCDDA. Sundhedsstyrelsen, København.
- Sundhedsstyrelsen (2004a). Dødsfald blandt stofmisbrugere 1996 - 2002. Nye tal fra Sundhedsstyrelsen.
- Sundhedsstyrelsen (2004b). Stofmisbrugere i behandling 2003. Nye tal fra Sundhedsstyrelsen.
- Sundhedsstyrelsen (2005a). Stofmisbrugere i behandling 2004. Nye tal fra Sundhedsstyrelsen.
- Sundhedsstyrelsen (2005b). Unge stofmisbrugere i behandling 1996 – 2003. Nye tal fra Sundhedsstyrelsen.
- Sundhedsstyrelsen (2005c, unpublished). Udskrift fra Sundhedsstyrelsens behandlingsregister. September 2005.
- Sundhedsstyrelsen (upubliceret 2005d). Udtræk fra Landspatientregisteret. August 2005.

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

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

Sundhedsstyrelsen & Kræftens Bekæmpelse (2004, unpublished). Resultater fra MULD 2004.

Sørensen, Johan Korsdal (2003). Unge rekreative stofbrug og risikovurdering. Århus Universitet: Center for Rusmiddelforskning.

Sørensen & Dahler-Larsen (2003). Behandling af unges misbrug af ”feststoffer”. Aarhus Universitet: Center for Rusmiddelforskning.

Sørensen (2004). Behandling af misbrugere med tilbagefald. Aarhus Universitet: Center for Rusmiddelforskning.

Websites

Anti Doping Danmark www.doping.dk

Danris www.danris.dk

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

Festivaldanmark www.festivaldanmark.dk

Natteravnene (“Night Ravens”) www.natteravnene.dk

County of Ribe www.ribeamt.dk

National Commissioner of Police www.politi.dk

The Danish National Institute of Social Research www.sfi.dk

The National Board of Social Services www.servicestyrelsen.dk

The National Board of Health www.sst.dk

The National Board of Health – site about drugs for young people
www.mindblow.dk

Supplementary tables

Table 2.1.1 The percentage of women and men in the various age group who have tried cannabis within the past year in 1994 and 2000

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

Source: Kjølner & Rasmussen 2002 and Statistics Denmark.

Table 2.1.2. The percentage of the 16-44-year-olds who last month and last year have used one or several illicit drugs other than cannabis in 1994 and 2000.

Used one or several of the illicit drugs other than cannabis	1994 (n=2.521)	2000 (n=6.878)
Last month	0.2	1.2
Last year (last month included)	0.5	3.4

Source: Unpublished figures from SUSY 1994 and SUSY 2000.

Table 2.1.3 The percentage of the 16-44-year-olds who have tried one or several of the various illicit drugs within the last month, last year and ever in 2000 (n=6878).

	Last month	Last year (last month included)	Lifetime prevalence
Amphetamine	0.6	2.2	8.4
Cocaine	0.4	1.4	3.8
Psilocybin mushrooms	0.2	0.8	3.7
Ecstasy	0.2	0.7	
LDS	0.1	0.3	1.4
Heroin	0	0.1	0.6
Other drugs*	0.3	0.6	1.7
"hard" drugs, total**	1.2	3.4	11.3

Source: Unpublished figures from SUSY 2000.

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

** An aggregate category including "used an illicit drug other than cannabis".

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

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

Source: Unpublished figures from SUSY 2000.

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

Table 6.2. Drug deaths 1981-2004. Distribution by gender.

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

Source: Rigspolitiet 2004 [National Commissioner’s Drug Statistics 2004, National Investigative Support Centre]

Table 6.4.1. Number of newly diagnosed HIV positive and AIDS diagnosed individuals in the entire population and the number of intravenous drug users among this group 1994-2004.

	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Newly diagnosed HIV positive persons, total	298	304	268	273	212	285	260	319	290	266	300
Newly diagnosed HIV-positive with intravenous drug use (% of all newly diagnosed)	28 (9%)	34 (11%)	25 (9%)	30 (11%)	13 (6%)	26 (9%)	20 (8%)	31 (10%)	32 (11%)	24 (9%)	13 (4%)
Newly diagnosed AIDS cases	237	213	159	109	74	76	57	72	43	37	57
Newly diagnosed AIDS-positive with intravenous drug use (% of all newly diagnosed)	24 (10%)	28 (13%)	18 (11%)	11 (10%)	4 (5%)	7 (9%)	7 (12%)	11 (15%)	4 (9%)	11 (30%)	4 (7%)

Source: Unpublished data from Staten Serum Institut [the State Serum Institute].

* The figures compiled for 2003 are from 24 August 2005.

Table 6.4.2 Registered number of acute cases of hepatitis A, B and C in the entire population and the percentage of intravenous drug users among them 1994-2004

	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Hepatitis A cases, total	145	103	107	115	86	88	81	61	84	70	240
Hepatitis A cases with intravenous drug use (% of all diagnosed)	6 (4%)	1 (1%)	0	0	0	0	0	0	1 (1%)	0	1 (<1%)
Hepatitis B cases, total*	115	112	101	101	94	58	63	47	63	34	45
Hepatitis B cases with intravenous drug use (% of all diagnosed)	49 (43%)	39 (35%)	36 (36%)	30 (30%)	25 (27%)	13 (22%)	20 (32%)	11 (23%)	11 (18%)	12 (35%)	9 (20%)
Hepatitis C cases, total*	84	36	28	26	21	13	15	6	5	7	7/282* *
Hepatitis C cases with intravenous drug use (% of all diagnosed)	61 (73%)	27 (75%)	20 (71%)	20 (77%)	13 (62%)	11 (85%)	9 (60%)	3 (38%)	4 (80%)	2 (29%)	3/212 (43%/75%)

Source: Unpublished data from Statens Serum Institut [the State Serum Institute].

The 2003 data have been compiled as at 25 August 2004.

*Among the acute hepatitis B and C, there is a certain intersection.

** acute/chronic hepatitis C cases.

Table 10.3.1 Drug seizures 1992-2004.

	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Heroin													
Kg	38.5	28.2	29.0	37.4	61.4	37.9	55.1	96.0	32.1	25.1	62.5	16.3	37.5
Number of seizures	2,405	2,941	2,666	2,973	3,161	2,509	2,199	1,230	1,499	1,304	966	894	1041
Cocaine													
Kg	21.4	11.1	29.9	110.1	32.0	58.0	44.1	24.2	35.9	25.6	14.2	104.0	32.3
Number of seizures	184	228	417	569	659	723	885	744	780	815	881	1095	1207
Amphetamine													
Kg	73.6	11.7	12.6	40.0	26.7	119.4	25.2	31.6	57.1	160.6	34.9	65.9	63.0
Number of seizures	1,323	1,111	747	1,167	1,386	1,324	1,609	1,250	1,152	954	1,134	1,264	1,388
Ecstasy													
Kg				2,115	15,261	5,803	27,039	26,117	21,608	150,080	25,738	62,475	38,096
Number of seizures				9	84	110	143	197	444	331	340	322	1388
Lsd													
Kg				1,282	262	381	105	83	1,108	156	38	22	
Number of seizures				6	16	15	24	15	18	29	8	7	
Cannabis													
Kg	2,152	1,273	10,665	2,414	1,772	467	1,572	14,021	2,914	1,763	2,635	3,829	1,758
Number of seizures	9,870	10,938	6,995	6,710	5,187	4,886	5,904	4,569	5,561	5,788	5,234	5,942	7,313

Source: Rigspolitiet 2004 [National Commissioner's Drug Statistics 2004, National Investigative Support Centre].

10.3.3 Breakdown of heroin base and heroin chloride from 1996 – 2004

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

Kilde: Kaa et al. 1997, Kaa et al. 1998, Kaa et al. 1999, Kaa et al. 2000, Kaa et al. 2001, Kaa et al. 2002 g Kaa et al. 2003, Kaa et al. 2004, Kaa et al. 2005

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

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Applied studies

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

“Sundhed og sygelighed i Danmark 1994 og udviklingen siden 1987” Dansk Institut for Klinisk Epidemiologi 1994 (now SIF) (Kjoeller et al. 1995). [Health and morbidity in Denmark 1994 and since 1987]

A national study conducted in 1994 among a representative segment of the population aged 16 and above. The study included questions on a variety of health issues. A sample population of 6000 individuals was selected at random from the central personal registry. The question on use of euphoriant drugs was put to the age group of 16-44-year-olds, in which group a total of 2521 persons were included. The data collection was performed as personal interviews at home. A total response rate of 78% was achieved.

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

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

“Unge Livsstil og Dagligdag 2000 – forbrug af tobak, alkohol og stoffer” (MULD 2000), Sundhedsstyrelsen and Kræftens Bekæmpelse (Sundhedsstyrelsen & Kræftens Bekæmpelse 2002). [Monitoring the lifestyles and daily routines of young people – consumption of tobacco, alcohol and drugs]

In 2000, the National Board of Health and the Danish Cancer Society conducted a representative study on the lifestyles and daily routines of the 16-20-year-olds. The study included questions on the young people’s use of drugs, including their experiences with illicit drugs. The sample population of 3048 young people between the age of 16 and 20 years was selected systematically. Data collection was made on the basis of questionnaires. The response rate was approximately 70%.

“Unge Livsstil og Dagligdag 2001 – geografiske forskelle og ligheder” (MULD 2001), Sundhedsstyrelsen and the Danish Cancer Society (Sundhedsstyrelsen & Kræftens Bekæmpelse 2002). [Monitoring the lifestyles and daily routines of young people – geographical differences and similarities]

Once again in 2001, the National Board of Health and the Danish Cancer Society conducted a representative study on the lifestyles and daily routines of 16-20-year-olds. The sample population of 3048 young people between the age of 16 and 20 years was selected systematically. Data collection was made on the basis of questionnaires. The response rate was approximately 70%.

“Monitorering af unges livsstil og dagligdag 2002” (MULD 2002), Sundhedsstyrelsen and Kræftens Bekæmpelse, unpublished. [see above]

In 2001, the National Board of Health and the Danish Cancer Society once again conducted a representative study on the lifestyles and daily routines of young people aged 16-20 years. The sample population of young people between the age of 16 and 20 years was selected systematically. Data collection was made on the basis of questionnaires. The response rate was approximately 70%.

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

Again in 2003, the National Board of Health and the Danish Cancer Society conducted a representative study on the lifestyles and daily routines of young people aged 16-20 years. The sample population of 1768 young people aged between 16 and 20 was selected systematically. Data collection was made on the basis of questionnaires. The response rate was approximately 60%.

Monitorering af unges livsstil og dagligdag 2003” (MULD 2004), Sundhedsstyrelsen and Kræftens Bekæmpelse, unpublished.

Again in 2004, the National Board of Health and the Danish Cancer Society conducted a representative study on the lifestyles and daily routines of young people aged 16-20 years. The sample population of 1772 young people aged between 16 and 20 was selected systematically. Data collection was made on the basis of questionnaires. The response rate was approximately 58%.

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

As part of a joint European study (The European School Study Project on Alcohol and Other Drugs) a national school study was conducted in 1995 on the young people and their relationship with drugs. The study was conducted among a representative segment of 15-16-year-olds in 9th grade at randomly selected “folkeskoler”, private schools and continuation schools. Data collection was performed by handing out the questionnaires to the interviewees in the classrooms. A total of 2234 pupils participated in Denmark, which equals a response rate of approximately 90%.

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

In 1999, the study from 1995 was repeated among a representative segment of 15-16-year-olds in 9th grade at randomly selected “folkeskoler”, private schools and continuation schools. Data collection was performed by handing out the questionnaires to the interviewees in the classrooms. A total of 1548 pupils participated in Denmark, which equals a response rate of approximately 90%.

The 2003 ESPAD report – Alcohol and Other Drug Use Among Students in 30 European Countries” (ESPAD 1999), CAN and Pompidou Group (unpublished).

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

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

This reports was based on the Danish input to the ESPAD 1995 study (see above). This report, however had expanded its random sampling base in comparison to ESPAD 1995 and included pupils in the 9th grade. Therefore, in addition to the 15-16-year-olds, pupils aged 14-17 were also included, since they attend the 9th grade as well. The number of participating pupils thus increased to 2545.

“Rusmiddelforbruget – i folkeskolens afgangsklasse og udviklingen fra 1995-1999” Institut for Epidemiologi og Socialmedicin, Aarhus Universitet (Sabroe & Fonager 2002). [Drug consumption in the 9th grade, and development from 1995-1999]

This report is based on the Danish ESPAD 1999 study (see above). This report, however had expanded its random sampling base in comparison to ESPAD 1999 and included pupils in the 9th grade. Therefore, in addition to the 15-16-year-olds, pupils aged 14-17 were also included, since they attend the 9th grade as well. The number of participating pupils thus increased to 1750.

Unge's erfaringer med rusmidler – i 2003 og udviklingen siden 1995. Institut for Epidemiologi og Socialmedicin, Aarhus Universitet (Sabroe & FONager 2004) [Young people's experience with drugs and alcohol in 2003 and developments since 1995]

This report is based on the Danish ESPAD 2003 study (see above). This report, however had expanded its random sampling base in comparison to ESPAD 2003 and included pupils in the 9th grade. Therefore, in addition to the 15-16-year-olds, pupils aged 14-17 were also included, since they attend the 9th grade as well. The number of participating pupils thus increased to 2978.

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

This report the Danish part of the WHO study on the health of children and young people. For the first time, it has been included in a study to investigate the question of the 15-year-olds' use of cannabis and ecstasy. The study was conducted as an anonymous questionnaire handed out in the class room of the “folkeskoler” (elementary schools).