



E.M.C.D.D.A

European Monitoring Centre
for Drugs and Drug Addiction

IFT

Institut für Therapieforschung

FINAL REPORT

Conduct a field trial of implementation of a standard protocol to collect information on treatment demand in the EU Member States

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Abbreviations

CCAD	Comité de Concertation sur l'Alcool et les autres Drogues de la Communauté française de Belgique, Belgish monitoring system (French Community)
CEEC	Central and Eastern European Countries
DGPNSD	Delegación del Gobierno para el Plan Nacional sobre Drogas, Spain
DMD	Drug Misuse Database, United Kingdom
DSM	Diagnostic and Statistic Manual
DTRS	Drug Treatment Reporting System, Ireland
EBIS	German out-patient centre-based documentation system
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
ICD	International Classification of Diseases
IFT	Institute for Therapy Research, Institut für Therapieforschung, Munich
ISCED	International Standard Classification of Education
IUS	Danish drug register
IVV	Organisation Information Systems on Addiction Care and Treatment, holder of LADIS, IVZ sub-unit, Netherlands
IVZ	Organisation Care Information Systems, Netherlands
KE.TH.E.A.	Greece treatment service in greater Athens area
LADIS	Nation-wide system for the collection of data on drug users in treatment, Netherlands
LBI	Ludwig Boltzmann Institut, Austria
NFP	National Focal Point, institutions and national departments which form the REITOX-network
NHS	National Health Service
OFDT	Observatoire Français des Drogues et des Toxicomanies, France
PG	Council of Europe's Pompidou Group
REITOX	Reseau Europeen d'Information sur les drogues et les Toxicomanies, Network of EMCDDA Focal Points
RELIS-LINDDA	Luxembourgish Information Network on Drugs and Drug Addiction
SEDOS	German in-patient centre-based documentation system
SEIT	Spanish State Information System on Drug Abuse
S.P.T.T.	Serviço de Prevenção e Tratamento da Toxicodependência, Portuguese health care and specialised treatment service for drug addiction
STAKES	National Research and Development Centre for Social Welfare and Health, Finland
TDI	Treatment Demand Indicator
VAD	Belgish monitoring system (Flanders)

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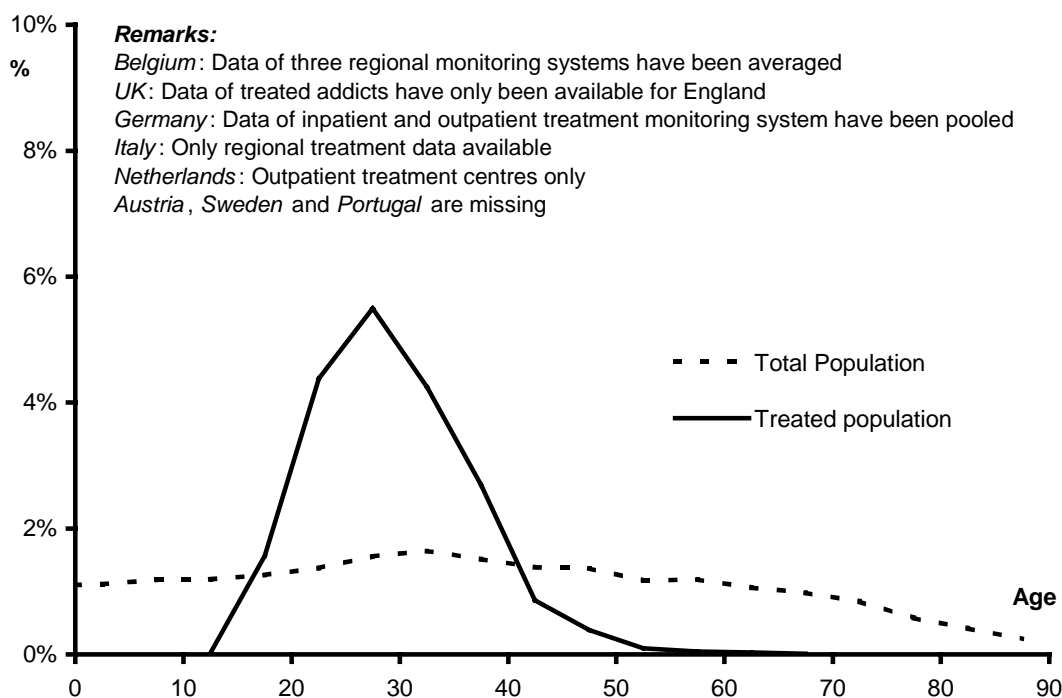
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Summary: Treated drug addicts in the EU – characteristics and main trends

Characteristics of treated population

Nearly 132,000 treatments have been reported from all EU member states in 1997. Despite the fact that double counting of clients could not be avoided in some countries this sample allows to draw a comprehensive picture of the treated drug using population in the EU for the first time. In all countries men form the majority of clients treated for illicit drug use. About three out of four treated persons are men, some countries like Greece, Italy and Spain report even higher figures of more than 80%, in Ireland their share is slightly lower than in other countries (69%). The mean age differs between 32.0 years in Denmark and 24.4 years in Ireland. However, these figures are influenced by the age distribution of the general population which is lower in Ireland than in other European countries. The average age of all registered persons is about 28.2 years, no considerable difference in ages can be observed between men and women.

Figure 1. Age distribution of treated drug users in the EU and the general population

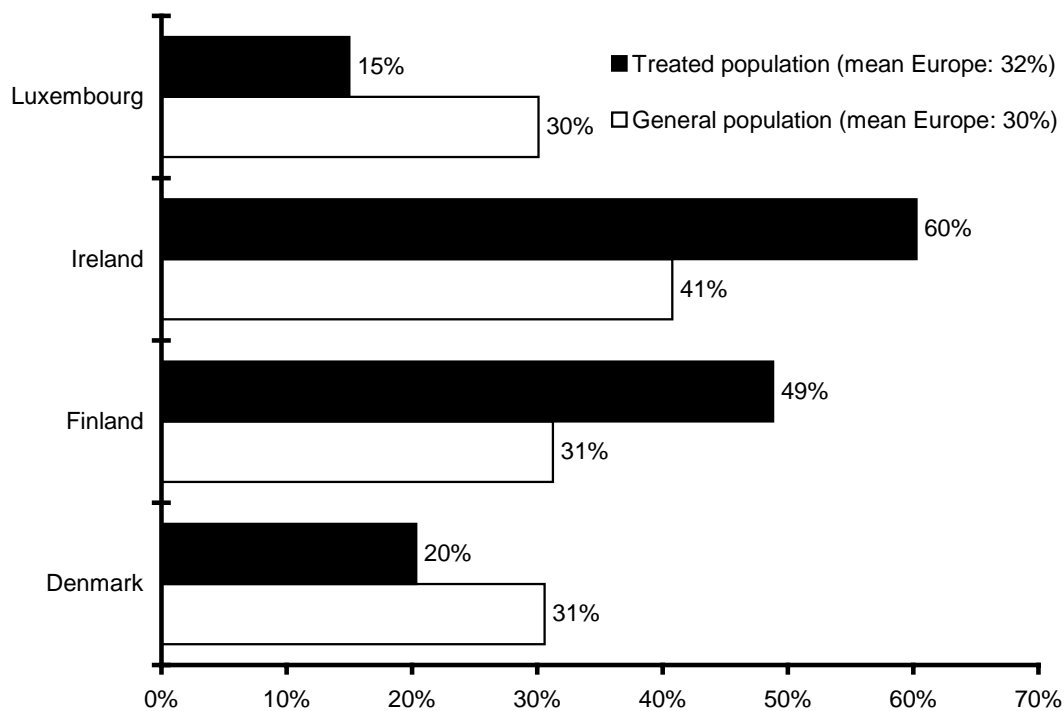


Source: TDI Field Trial 1998 (Reporting year: 1997)

Compared to the general population of EU member states the age distribution of treated drug users in the EU differs considerably (see Figure 1). While only 15% of the general population are between 20 and 30 years old nearly 50% of all treated drug addicts belong to this age group. Additionally only 7% of the treated population are older than 40 years or younger than 15 years. Altogether drug use is mainly a problem of a well defined age group. As Figure 2 shows considerable differences concerning the share of young clients under 25 years can be observed in EU member states while the distribution of the general population is more or less comparable. As mentioned before the Irish population is younger compared to other countries and accordingly the mean age of treated drug users is lower. However, as it can be seen from Figure 2 differences in age distribution of treated clients can only partly be explained by the distribution of the general population. A possible explanation for this phenomenon may be a cohort effect: within “older” drug scenes in countries like Luxembourg

a higher number of drug users can be found who already got some years older since they started drug use.

Figure 2. Percentage of age group <25 years (treated vs. general population)



Source: TDI Field Trial 1998 (Reporting year: 1997)

When discussing differences of age distributions one has also to take into account that in countries, where inpatient treatment institutions are a considerable part of the monitoring system the average age of clients tends to be higher.

Main drug

With the exception of Finland where stimulants are the main reason for treatment demands, opiates are responsible for most treatments in all participating countries. Their average share of main diagnoses among the treated population mostly fluctuates between 80% and 90%. Only the Netherlands where data exclusively arose from outpatient treatment units and a historically grown less dangerous route of administration dominates among users (smoking the drug) and the Flemish community of Belgium reported percentages below 80%.

The combination of information like the example given above (for the Netherlands: combination of route of administration, characteristics of the monitoring system and main drug among treated clients) illustrates the usefulness of a comparable set of items which allows interpretation of data against the background of additional information. Combining individual items with hints and information arising from others allows to explain cultural differences, to identify inconsistencies in data or to monitor specific developments expanding from one country to another.

Still the share of clients who report cocaine as their main drug is quite low compared to opiate type drugs. Nevertheless some countries report considerable figures of cocaine users like the Netherlands (22%), Luxembourg (11%) or Spain (9%). Also in Germany (7%), the Flemish community of Belgium (5%) or Italy (5%) cocaine is mainly responsible for drug related problems among a considerable group of treated drug users. Information provided by European drug experts indicate growing importance of cocaine as primary drug. Additionally one has to take into account, that especially among opiate users cocaine is quite popular as

a secondary drug and it may be due to the methodology of treatment monitoring systems that clients who report opiate as well as cocaine use are mostly registered as opiate users.

Stimulants as the main drug are very popular in Finland (36%), the Flemish community of Belgium (14%) and England (10%). Also Ireland (6%) and the Netherlands report (5%) considerable numbers of persons who are mainly treated for stimulant related problems.

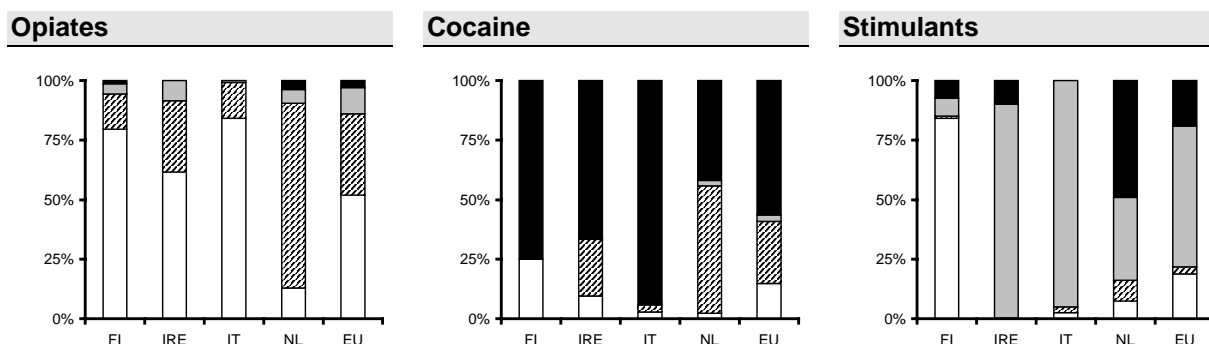
Cannabis as a main drug is on a permanent increase. Meanwhile 18% of all Dutch clients show up for cannabis related problems mainly and also many other countries like French and Flemish communities of Belgium (13% resp. 21%), Finland (18%), outpatient treatment centres in Germany (17%) or France (12%) report growing numbers of addicts whose main drug is cannabis.

Secondary drugs

Another result arising from more detailed data analysis is information about secondary drugs among different groups of drug users. Clients whose main drug is of opiate type tend to use more than one opiate. Also cocaine and cannabis use are frequent among this group: The average percentage of additional cannabis use among clients with an opiate type main drug lies between 25% and 35%. Exceptions are the Netherlands, where the share of cannabis single diagnoses is much lower and Greece, where three out of four users also use cannabis beside their opiates the share of cocaine as a secondary drug fluctuates very much. In the Netherlands 60% of the clients with opiates as their main reported secondary cocaine use, 34% in Spain, about 20% in the French community of Belgium and Italy and more than 15% of primary opiate users treated in German outpatient treatment centres. Again, a specific result could be obtained for Finland where stimulants are much more popular also as an additional drug than in other countries (31%).

Intravenous drug use

An analysis of injection behaviour among treated clients allows insights into risk behaviour of the target population. Having a closer look at the usual route of administration of the main drug shows that a considerable share of clients prefers to inject their main drug. Up to 82% of all registered clients in an individual country apply their drug intravenously. However, this statements requires a break-down by types of main drug to identify risk behaviour among certain groups of users. As one can obtain from the data, injecting the drug is most frequent among opiate users. Nevertheless, smoking the drug ("chasing" style) becomes more and more popular in EU countries. In the Netherlands there is a well known and well established tradition of smoking opiate type drugs (61%) but considerable percentages in this category have also been reported from Spain (58%), the French community of Belgium (49%), Ireland (30%) and England (29%). Recently a switch towards smoking opiates among young drug users has been reported by experts from different European countries. Treatment information that was recently made available also confirms this development in single European countries. However, future data collection will allow more detailed analysis of this development.

Figure 3. Route of administration stratified by different drugs in selected EU member states


□ inject	▨ smoke / inhale	▤ eat / drink	■ sniff
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Country	inject	smoke/inhale	eat/drink	sniff	others	not known	N
Opiates (%)							
Finland	78	15	4	1		2	569
Ireland	62	30	8	<1			3,850
Italy	79	14	1		<1	6	5,271
Netherlands	10	61	5	3	1	21	3,131
Europe	50	31	10	3	<1	6	77,802
Cocaine (%)							
Finland	20			60		20	5
Ireland	10	24		67			42
Italy	3	3	<1	90	<1	4	675
Netherlands	2	37	2	29	3	28	1,387
Europe	14	23	3	52	1	9	7,767
Stimulants (%)							
Finland	82	1	7	7		2	960
Ireland		<1	90	10			295
Italy	2	2	76		2	18	50
Netherlands	6	7	29	41	1	15	324
Europe	20	3	55	19	1	9	4,571

Source: TDI Field Trial 1998 (Reporting year: 1997)

Remarks: Percentages <1 refer to percentage rates between 0.0 and 0.5; category "not known" has been excluded from graphs; European mean has been calculated as (unweighted) arithmetic mean of all delivered data

Among other groups of users injecting the drug is not very popular, again Finland makes an exception where 82% of all stimulant users inject their drug. Considerable percentages of intravenous use has also been reported among clients with a cocaine type main diagnosis.

Analyses of differences in injection behaviour have to be carried out very carefully. Whereas in Finland this risk behaviour still exists even if it can not be observed among the "classical" European opiate users (due to cultural differences) intravenous drug use seems to be really declining in the Netherlands where this route of administration only reaches maximum percentages up to 10% (stratified user groups by main drug). This assumption is underlined by the fact that 41% of all registered Dutch clients used to inject their drug in the past. In the reporting year 1997 comparable percentages of users who stopped intravenous drug use could only be observed in the French community of Belgium (45%), Germany (41%) and Ireland (40%). Future data collection including the category "ever injected but not currently" will allow to analyse an eventual shift towards less risky forms of applications.

Social situation

Following the definition as laid down in the TDI standard protocol most registered drug users in the EU live in stable accommodations (55%-96%). With the exception of Denmark, where about half of the treated clients live alone or with their child(ren), most clients still live together with their parents, their partners (like about 30% of the clients in Germany) or friends (which is quite popular in Luxembourg and the Brussels region of Belgium). These data underline the fact, that in many cases problems related to illicit drug use also affect families of drug users and by this makes their involvement in the treatment process more important. However, the social role of a drug user's family seems to be different in individual countries. While the connection between drug user and family of origin seems to play a more important role in more or less traditional societies like Ireland or Greece the data suggest a more limited social role of the family in countries like Denmark. The prolongation of a phase in life, where youth and young adults live with their family of origin shows a delay in the personal development of many drug users at least in practical terms.

Assumptions about previous treatments have to be drawn very carefully due to the fact that not enough is known about avoidance of double counting in individual countries by now, but it can be obtained from the data that overall most of the clients have already been treated before.

Methodological aspects of data on treated drug addicts in the EU

National and regional treatment monitoring systems allow good and representative access to information about problematic drug use in EU member states.

The target population are all clients registered in national or regional treatment monitoring systems in EU member states, regardless of age and gender in 1997 or 1998. Collected data include demographic data like gender, age, living status and labour status. Drug and treatment specific data covered main and secondary drugs, previous treatments or route of administration (see TDI core item list for a comprehensive overview on collected items).

First standards including a common set of core items to collect treatment information in a comparable way have been defined by European experts. The TDI standard protocol will be officially published in the first half of the year 2000 and by this further support the implementation of the European database on treatment of drug users in the EU.

At the moment roughly 132,000 treatment demands are registered annually in national and regional monitoring systems which have delivered information to the EMCDDA, including at least 45,000 first treatments. This data basis is going to be improved by a growing number of countries which collect treatment information according to recently defined European standards. Also first countries from Central and Eastern Europe began to follow these common standards.

Obviously limitations in comparability still arise from national differences in different definitions (e.g. for stable vs. unstable living situation) but these problems are going to be solved in future revisions of the data collection guidelines. Also national health care systems and characteristics of different monitoring systems lead to differences in coverage of drug users, data collection and interpretation.

Future tasks will also be to make this data accessible for interested persons and to further improve data collection and comparability. Evaluation checks are also planned for the future.

1 Project framework

1.1 Introduction - Treatment monitoring for epidemiological purposes

Treatment monitoring systems are one of the information sources in the field of drug epidemiology and demand reduction, which can give valuable information on the scale and characteristics of the drugs phenomenon as well as on measures taken against these problems. These data can be collected with limited financial effort within treatment services, as information on treated persons is available and collected also for treatment needs. Information can be rather complete, as experts such as social workers and therapists fill in the relevant questionnaires. Data on treated drug users are already available in many countries of the European Union and also in part of the Central and Eastern European Countries (CEEC). Some of the treatment monitoring systems have existed for more than 10 years and cover between 40% and nearly 100% of national specialised drug treatment centres.

The purpose of the data collection done by the EMCDDA is to provide comparable, reliable and anonymous information on the number and characteristics of people starting treatment for their drug use in the Member States. Information on the dimensions and profile of problem drug users and their patterns of drug use (injection, multiple drug use) can be used to identify patterns in the use of services, assess resource needs, and plan and evaluate services for drug users. It also provides an indirect indicator of trend in problem drug use and is a rich basis for more in-depth assessments of the prevalence of problematic drug use (Hartnoll 1998).

Within the planning of the EMCDDA treatment demand plays an important role as an indicator. It is one of five epidemiological key indicators (Hartnoll 1998) which are introduced in the coming years. As the harmonisation of these data continues the resulting figures will become more and more comparable.

1.2 The Pompidou Protocol as a first European standard

In 1994, based on collaborative pilot projects in 11 European cities from 1989 to 1992 the Pompidou Group of Epidemiology Experts in Drug Problems published a definitive protocol for drug treatment reporting systems (Hartnoll 1994). This also utilised work done on behalf of different indicators within the Multi-City-Project from 1982 onwards.

Many topics and needs of treatment reporting systems are covered by this first example of a Pan-European standard instrument. More than twenty cities are using this protocol and many national systems are either entirely (e.g. Ireland, Greece) or at least partly (e.g. The Czech Republic, Denmark, Belgium) based on this protocol. For 1996 22 cities from all over Europe (Amsterdam, Athens, Bratislava, Bucharest, Budapest, Copenhagen, Cyprus, Dublin, Gdansk, Geneva, Liège, Ljubljana, Malta, Orenburg, Prague, Rome, St. Petersburg, Sofia, Szeged, Varna, Warsaw and Zagreb) provided their data on a total of 29,000 treatment demands.

1.3 Former studies and previous EMCDDA projects

Some national systems (e.g. in Germany, the Netherlands and Spain) had been developed independently of the Pompidou Group, some of them already had a rather long history on their own when Pompidou started. Therefore, the EMCDDA core item list on treatment could not simply be a copy of the Pompidou protocol. This was used, however, as a reference and basis for discussion and development.

Experiences from national or semi-national systems running in different European countries were also taken into account. Special attention has been put on specific methodological problems like the avoidance of double-counting for the definition of "treatment".

This protocol is based on a series studies done on behalf of the EMCDDA:

- in sub-task 3.2 of the REITOX work plan for 1996/97a first draft of a core item list for treatment was developed in a group of experts, who were responsible for national monitoring systems in some of the EU member states (Simon & Tauscher, 1997). The basis of the draft has been the Definitive Protocol developed by the Pompidou Group (Hartnoll, 1994)
- in sub-task 3.1 of the REITOX work-plan for 1996/97 a quality check was done for several items of the Pompidou Protocol concerning missing values and inconsistencies between items (Kokkevi, 1997a)
- a specific project worked on the classification of treatment organisations and units. It finished with the development of a questionnaire, which included the respective categories (Kokkevi, 1997b)
- the problem of double-counting of persons which were treated more than once per year in the same or different units (double-counting) was discussed by a specific project, which reviewed the different solutions found in Europe and gave instructions how to solve this problem (Origer, 1996).
- in a feasibility study in 1998 an expert group including representatives from the field of treatment monitoring from all EU member states agreed on a core set of items and gave an overview on the state of development of treatment monitoring in the EU (Simon & Pfeiffer, 1998). A steering-group including a Pompidou expert worked on the comparability between the Pompidou and the EMCDDA standards.

1.4 Overview on steps taken in 1998

On the basis of the draft core item list for treatment developed during previous projects those countries who had not been involved in the discussion before were asked for support and participation. By written feedback on the basis of a questionnaire sent out by the co-ordinator of the project first information could be collected to gain an overall picture of the state of development in the EU member states. For each of the countries the National Focal Point was asked to nominate an expert for treatment monitoring.

The draft core item list for treatment and some methodological details were discussed at a meeting at the EMCDDA during July 6th and 7th, 1998. Also experts from some of the CEE countries participated, who were given the opportunity to include their specific needs and situation in the discussion at that stage. As three of the participating four countries are also in the pre-accession state to become members of the EU this is especially important.

For the selection of items for the draft core item list for treatment the basic criteria were defined as follows. They should:

1. be short but cover the most relevant aspects,
2. include information, which would, as far as possible, already be available from the participating systems. Efforts were made to avoid introducing new „interesting“ items which had not yet been shown to be applicable and reliable to collect,

3. form the basis for new monitoring systems to be developed in countries not yet operating a system.

After the expert meeting in 1998 a draft of the TDI protocol has been put together including the core item list for treatment as well as definitions and some methodological remarks. Where it was found appropriate definitions from the Pompidou protocol were used to further increase comparability. Recommendations have been given for the next steps which are necessary to implement the common standard in the EU Member States.

The revision of the TDI protocol including some comments and remarks made by national experts and representatives of EMCDDA and Pompidou Group was the first step of the next project and formed the basis for this year's field trial (see below).

2 The actual process of implementation and the 1999 field trial

2.1 New REITOX contracts and harmonisation process

In 1999 the contracts between EMCDDA and NFP included work on the harmonisation process of epidemiological key indicators as defined by the EMCDDA as basic tasks to be carried out by NFP for the first time. The first indicator to implement will be the TDI including further work on the treatment demand indicator (TDI) and its further implementation on national and European level.

The indicator of the demand for treatment by drug users is one of the priority indicators for the harmonisation process. The purpose of this indicator is to provide comparable, reliable and anonymous information on the number and characteristics of people starting treatment for their drug use. Information collected in the framework of this indicator can be used to identify patterns in the use of services, assess resource needs, and plan and evaluate services for drug users. Over and above that this indicator functions as an indirect indicator of trends in problem drug use and is a rich basis for more in-depth assessments of the prevalence of problematic drug use and the characteristics of drug users.

Beside the TDI the EMCDDA will reinforce the harmonisation of other epidemiological indicators; namely population surveys, drug related deaths, prevalence estimates of problematic drug use and infectious diseases among drug users. Altogether the collected data will lead to more powerful possibilities in demand reduction activities, help policy makers to base their decisions on epidemiological data, develop guidelines, give recommendations, etc. In general terms improvement of comparability of data between European member states will facilitate concerted actions against problems coming from drug related problems.

2.2 Targets of this project

The main tasks of this project consisted of

- a putting together a **standard protocol for the TDI** based on the results of former projects, recommendations and comments added during the last projects,
- b conducting a **field trial** to collect treatment data following this protocol and the core item list from all EU member states and subsequent analysis of the collected data (comparability, validity, availability)

The TDI protocol had been put together based on the core item list as agreed upon by EU treatment experts in 1998 and additional methodological paragraphs and comments coming from certain projects dealing with single aspects of the TDI during the last years (e.g. avoidance of double-counting or quality check of items).

The field trial has been initiated to get an impression of the current availability of the TDI data on European level and the state of the comparability of data between countries. This field trial forms the core of the implementation phase I of the TDI standard protocol and the core item list as defined in the protocol and allows to give detailed recommendations as well on national as on European level how to improve the whole process of harmonisation during the next months and years.

Setting up detailed workplans for each EU member state containing concrete steps for the implementation will be the important next step following an analysis of the field trial and the subsequent expert meeting. These workplans should define time-table,

costs and administrative as well as political requirements for the implementation.

Overall this project is centred around the implementation of the TDI as the first of the five epidemiological key indicators which will be harmonised during the next years. While former projects during the last years aimed at setting up the core item list and discussing it with all EU member states as well as with the PG experts now the process of implementation has started. Summarising the main results of former projects in the first version of the TDI standard protocol was an important milestone in the whole process of implementation.

2.3 Project participants and partners

The project was co-ordinated by R. Simon and T. Pfeiffer, IFT, Munich assisted by a steering-group composed of M. Donmall, University of Manchester, A. Kokkevi, University of Athens and Anton W. Ouwehand, IVZ, Utrecht. M. Stauffacher gave advice on behalf of the Pompidou Group to further ensure the comparability between the Pompidou and the EMCDDA standards.

National experts coming from the field of treatment monitoring provided data and information for their respective countries. For the whole implementation process the expertise of national representatives in this project is of central importance. They have to be at the same time:

- experts in the field of treatment monitoring in their country and
- have close and friendly relationship to the NFP and may be also other national institutions important in the process of implementation

Table 1. National experts and Steering Group Members for the implementation of the TDI

Country	Representative
Austria	Alfred UHL, LBI für Suchtforschung Martin BUSCH, NFP
Belgium	Patrick LEURQUIN, NFP
Denmark	Lene HAASTRUP, National Board of Health
Finland	Airi PARTANEN, Stakes
France	Christophe PALLE, NFP
Germany	Roland SIMON, NFP (project steering group)
Greece	Anna KOKKEVI, NFP (project steering group)
Ireland	Mary O'BRIEN, NFP
Italy	Giovanni NICOLETTI, Ministero della Sanità
Luxembourg	Alain ORIGER, NFP
Portugal	Paula MARQUES, SPTT
Spain	Ana ALVAREZ, Junta de Castilla y Leon
Sweden	Vera SEGRAEUS, National Board of Institutional Care Roger HOLMBERG, National Board of Health and Welfare
Netherlands	Anton W. OUWEHAND, IVZ/IVV (project steering group)
United Kingdom	Patsy BAILEY, Department of Health, Statistics Division 2D
Steering Group	Julian VICENTE, EMCDDA
Steering Group	Michael DONMALL, DMRU Manchester
Steering Group	Tim PFEIFFER, IFT Munich

Table 1 informs about the persons who have been nominated as national experts by NFP or who were members of the project steering group and participated in the field trial (see also chapter 7 for complete contact details).

2.4 Steps and Procedures

Phase 1 - Preparation of TDI Standard Protocol

The TDI protocol had been put together by the project co-ordinators taking into account the core item list as agreed upon in 1998 and additional methodological paragraphs and comments resulting from former projects. PSG members and EMCDDA co-ordinators had had possibilities to add comments or remarks.

Phase 2 - Nomination of national experts

In spring 1999 a formal letter had been sent out to NFP asking for the nomination of a national expert for the whole process of implementation of the TDI. This letter had been signed by the contracted project co-ordinators and EMCDDA co-ordinators. It included

- an introduction and the terms of reference for the project,
- informed about the aims of the project
- clarified the double role of the national representatives requiring expertise as well as a role in the decision making process in their country and
- pointed out that the representative is acting on behalf of the NFP

Phase 3 - Preparation of data collection

Based on the TDI protocol and the standard tables requested by the EMCDDA as part of the National Reports new standard tables have been designed for data collection.

Detailed guidelines informed how to fill in the tables and which data was needed. To ensure best availability of data it had been decided to ask for 1997 data. The tables allowed collection of data on the most important client characteristics.

Together with the guidelines and the revised version of the TDI standard protocol the new standard tables had been sent to all national experts and copied to NFP.

Phase 4 - Collection of aggregated data

On the basis of the standardised tables defined in phase 3 data had been collected from nearly all EU member states on the basis of the sources available nationally. In most cases reference period was 1997, in some cases 1998 or 1996. during the process of data collection the co-ordinators tried to clarify remaining questions with national experts and gave advice where needed and possible.

Phase 5 - Conducting a joint analysis of the information

The project co-ordinators analysed the material received in phase 4 in order to evaluate quality, reliability and comparability of data between the different countries. the results of this analysis can be found in chapter 1 and chapter 4 of this report.

Phase 6 - Conducting an expert meeting

The national experts for the Treatment Demand Indicator met at October 18th/19th 1999 in Lisbon. Results of the project have been discussed, national developments have been reported and further steps have been planned.

Enough space has been given to discuss problems of data collection and comparability. Single analyses of items served as examples how aggregation of data on a European level can look like in future. Methodological limitations and strategies to overcome them have been discussed in detail.

Special attention has been paid to give examples of how treatment data in single countries are used for different purposes. Treatment experts from Austria, Denmark, Germany, Spain and the United Kingdom gave short presentations illustrating the variety of possibilities how treatment data may be used.

- Gregorio Barrio and Luis Royuela from Spain illustrated, how the Spanish treatment monitoring system could be used to track developments in changing patterns of use. Treatment data from different Spanish regions allowed to analyse how changing injection behaviour starting in single regions has spread out over the country.
- Michael Donmall from the UK described how treatment related data are used within the national drugs plan as criteria for outcome evaluation.
- Lene Hastrup from Denmark showed, how data from treatment centres, police and mortality registers can be linked to understand the coverage and limitation of the different sources.
- Giovanni Nicoletti from Italy gave an impression of possibilities and limitations of making use of treatment data based on different regional systems.
- Roland Simon from Germany illustrated differences in characteristics of drug users treated in outpatient vs. inpatient treatment centres by making use of data from specialised treatment monitoring systems.
- Alfred Uhl from Austria gave an overview on limitations and political and other obstacles for the implementation of treatment monitoring on national level in his country.

These presentations have been considered very valuable by the participating experts. Covering a broad range of possible applications of treatment data illustrated the relevance of collecting information of treated drug users in EU member states.

An analysis of national workplans came to the conclusion, that most EU member states already established national expert working groups dealing with all aspects of the TDI implementation on national level. A more detailed analysis of national TDI workplans will be a central task of the next expert meeting.

The next expert meeting is planned for the first half of 2000. Results of a second TDI data collection, discussion of national workplans and further examples of the applicability of treatment data will be topics of this meeting.

2.5 Special topic: Registration of clients treated by general practitioners

When talking about treatment of drug addicts in specialised centres one has to take into account that the role of general practitioners in the field becomes more and more important. Especially substitution treatment is often carried out by GPs and the share of clients who are not treated by a specialised in- or out-patient centre is continuously growing. It can be assumed that in some countries even the majority of substitution treatments takes place in GPs practice.

Even if all experts agree in pointing out the necessity of inclusion of GP data in national or regional monitoring systems there are problems which are not easy to

overcome. Experts involved in the development and implementation of the TDI identified at least three fields which are considered to be problematic:

- a) *Technical aspects*. It has to be clarified how registration of GP data on national or regional level can be managed. Due to the fact that treatment data collection among GPs is not implemented in most countries several technical problems (e.g. form sheets, computer programs) have to be solved. Responsibilities have to be clarified between professional associations of GPs, national or regional institutions and professional institutions running the monitoring system.
- b) *Privacy laws*. Collection of extensive data about clients treated for drug related problems by GPs directly touches aspects of confidentiality and data protection. Collection of sufficient information has to be combined with solutions which are required by law. Ownership of data and data access have to be clarified as well.
- c) *Methodological aspects*. Due to the quantity of GPs solutions have to be found how a representative sample of GPs (definition of basic population is needed) can be included in routine data collection. Questions of data flow, quality control and coverage have to be answered and strategies will have to be developed to build up motivation among GPs to collect additional data. Maybe existing data sources already fulfil certain information needs and do only have to be analysed in a different or more comprehensive way.

Aspects mentioned above are not meant to be complete. Additional topics and problems do exist and may also need clarification. But this list seems comprehensive to get an idea of the variety of problems which make inclusion of GPs so difficult.

An important task to be discussed in the framework of the implementation of the TDI will be to develop strategies and ideas of how these problems can be solved. Before trying to implement the TDI and its core items in the field of GPs it would be a more pragmatic approach to have a closer look on national situations and try to get any drug-related information that is already available and try to include them in the annual reporting. At the moment the main interest is to eliminate the “white spot” of GPs in the field of monitoring treatment of clients with drug problems.

What would be general strategic lines to include already existing information in routine data collection and implement the TDI and its core items even in the field of GPs?

Already existing sources of information which allow rough estimates about the number of treatments carried out by GPs would be:

- **Data on prescribed pharmaceuticals** including pharmaceuticals used for substitution treatment like methadone, codeine or buprenorphine. Total figures on prescribed drugs only allow very rough estimates based on average daily doses and do not lead to information about characteristics of users. Nevertheless in most countries it would be an interesting information to get at least some information about the extend of treatments carried out by GPs.
- In some countries clients who receive substitution treatment are registered in a **central or regional database**. In such cases access to data is mainly a judicial and technical problem. Here it can be tried to include as much as possible from the TDI data set into the routine system.
- **Professional associations of doctors** often hold valuable data for own purposes. Also **health and social insurances** often have access to information that may be usable for purposes of treatment documentation. But even if a lot of

information and data is already collected and analysed, external access is often denied or extremely difficult and – what is even more relevant – none of these information sources has been constructed for epidemiological purposes. Further analyses and combination of different pieces of information would always be necessary to extract the relevant data.

As an additional source of information also **pharmacies** may be able to provide certain information, but this data will again not contain enough characteristics of users (nevertheless this source may help to identify certain patterns of use).

- Based on the assumption that it will not be possible to include all existing GPs in a working network of routine data collection for epidemiological purposes it seems to be a sensible solution to start with a sample of GPs. Experiences with this first sample may help to identify further problems as well as the development of concrete solutions to solve them.

At the moment treatment data of most countries does not cover GP data. Therefore field trials and single small studies on city or regional level would be useful first steps to start with documentation in this area. Another access would be to use limited data sets from routine systems for the control and administration of substitution treatment. A pragmatic approach would be to

- 1) identify existing data sources and describe their contents and possibilities to make use of them,
- 2) carry out a field trial or single (regional or city based) studies with systematic data collection.

Results of single studies in different countries may help to identify common problems as well as solutions and by this lead to concrete plans to implement routine data collection.

3 Results – General aspects

3.1 General remarks

Nearly all EU Member states participated in the field trial and provided treatment data for the reference period 1997. In some cases no information was available or problems arose due to several reasons. Some countries don't have an operational treatment monitoring system yet:

- in **Portugal** the treatment monitoring system is still under construction, according to the 1998 project Portugal has started a system of treatment monitoring within a big treatment organisation but further details on coverage of centres, patients etc. are not available at the moment
- also **Austria** has no running national system yet but plans to set up a system that covers all items required by the TDI core item list,
- until 1997 **Sweden** has only had national, aggregated statistics covering less than one third of all the services for substance abusers that are provided by the local social service agencies. A first report including selected specialised treatment centres will be available in the course of 1999,

A second cluster of countries already has existing regional treatment monitoring systems but has to develop mechanism and strategies to integrate these data to come to national results:

- **Belgium** still registers data in regional databases and the mechanism to integrate the information in one central database is still under construction,
- due to individual monitoring systems in England, Scotland and Wales no national data was available from the **United Kingdom** but the national harmonisation process is under development,
- also in **Italy** no nation-wide registration system exists but first steps have been taken to integrate several regional systems; for this field trial data from two regional monitoring systems have been used,

The third group of countries (e.g. Netherlands, Germany, Luxembourg, etc.) already has existing systems for monitoring the treatment of drug users. In all systems slight modifications and single changes are needed to fulfil the requirements of the TDI core items. Detailed information concerning the items can be found in chapter 4, page 25.

A special situation still exists in **France** because different system (survey in November) is run which doesn't allow an ongoing registration of treatments. However, the French data doesn't seem to differ very much from that of other countries. It has not been decided yet how or when the French system will be changed.

3.2 Overall availability of data

As one can see in Table 2 the overall availability of TDI core items was quite good among EU Member States. Even if some of the core items (date of treatment and year of birth) have not explicitly been registered in the field trial it can be stated that the most relevant items are available in the treatment monitoring systems of nearly all EU Member States.

Table 2. Overall availability of TDI core items

TDI core item	BE (Brussels)	BE (CCAD)	BE (VAD)	DK	EN	FI	FR	GE (EBIS)	GE (SEDOS)	GR	IR	IT	NL	LU	SP
1 Treatment centre type	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
2 Date of treatment (month)	not separately registered in the field trial														
3 Date of treatment (year)	not separately registered in the field trial														
4 Ever previously treated	x	x	x	x		x	x	x	x	x	x	x	x	x ¹	x
5 Source of referral	x	x	x		x	x	x	x	x	x	x	x	x		
6 Gender	x	x	x	x	x	x	x	x	x	x	x	x	x	2	x
7 Age	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
8 Year of birth	not separately registered in the field trial														
9 Living status (with whom)	x	x	x	x	x	(x) ³		x	x	x	x	x	x	x	
10 Living status (where)	x	x		x	(x) ⁵	x		x	x	x	x	x	x	x	
11 Nationality	x	x	(x) ⁴	x		x		x	x	x	x	x	x	x	x
12 Labour status	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
13 Highest educational level completed	x	x	x	x	x	x		x	x	x	x	x	x	x	x
14 Primary drug	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
15 Substitution a-d		(x) ⁵				(x) ⁵			(x) ⁶	(x) ⁵		(x) ⁵			
16 Usual route of administration (primary drug)		x	(x) ⁴	x	x	x				x	x	x	x	(x) ⁷	x
17 Frequency of use (primary drug)		x	(x) ⁴	x	x	x				x	x	x	x	(x) ⁸	
18 Age at first use of primary drug	9	x	(x) ⁴	x	x	x		10		x	x	x	11	(x) ¹²	x
19 Other (=secondary) drugs currently used	9	x	(x) ⁴	x	x	x		x		x	x	x	x	(x) ¹³	x
20 Ever / currently (last 30 days) injected	x ¹⁴	x	(x) ⁴		x	x	x	x	(x) ⁶	x	x	x	x	(x) ⁴	x

1 data on orientation after indexed treatment only

2 age/ gender breakdown only on mean age

3 more indicators and categories are used in Finnish data collection, making convergence quite difficult

4 data is available from 1998 on

5 information partly available

6 information already registered but not yet included in the report

7 data has to be confirmed

8 Due to the fact that almost all drug treatment demanders present a daily use of their primary drug, the RELIS protocol has been adapted in the light of past experience. Currently the protocol includes the following items: 1/day (7%) 2-4/day(51%) more than 4/day (33%) and more than once a week (9%). No changes are foreseen since another categorisation doesn't appear to be pertinent.

9 not available yet, should be calculated

10 age at beginning of problematic use is registered

11 age of onset or age of first use is not registered in LADIS. It could be discussed to use the LADIS item "length of period the primary problem lasted" in connection with the LADIS item "users age when he/she first registered".

12 Different age categories (10-13, 14-15, 16-17, 18-19, 20-21, 22-25, 26-33, >33). The RELIS data processing software would have to be updated in order to meet the TDI requirements (end 1999, if decided so).

13 Preference 1, 2 and 3 drugs are listed separately. A modification of the RELIS software could be applied in order to know combination patterns with the primary drug.

14 data should be confirmed

One important exception has to be made concerning item 15 “Already receiving substitution treatment”. This item had been introduced after the expert meeting in 1998 and is only partly available at the moment. Even in countries where at least some information concerning number of clients in substitution treatment is available this data only refers to methadone treatment in most cases and doesn’t allow any detailed insights into the whole picture of substitution treatment. At the moment there’s no country that is able to provide exhaustive information concerning substitution treatment. Those countries which provided some data on substitution treatment mainly reported information about selected groups, regional information or did not report whether these clients are representative for all clients treated for drug problems or not (e.g. Finland gave some information about 36 clients receiving methadone as substitution drug – but these clients have been the only persons for whom information concerning substitution treatment was available at all. So this data can not be used as an estimate for all persons treated for drug problems in Finland.)

Most of the other items were available in most EU Member States even if in some cases conversion into TDI categories has to be improved during next months. In some cases required information was not completely available but only in parts. However, in most cases national experts reported plans and concrete steps to solve these problems or announced revisions of national monitoring systems to fulfil TDI requirements in future. Some countries already changed their monitoring system according to the TDI core item list but due to the fact that the reference period for the field trial was 1997 these improvements don’t always appear in the results section. Where possible respective remarks have been added in Table 2.

Talking about availability of data here always means data according to the TDI core item list. Still data collection on national level should include more than the TDI (core) items. This item-set is only a very basic standard and does not allow sufficient insights in drug using populations for national purposes.

Included treatment centres

While nearly all out of the 12 countries which have national information available include data from out-patient services, only a minority of them do also cover residential treatment. Much less data are available for the other types of treatment centres. Only the French community of Belgium and England included data from GPs. Data from low-threshold agencies and prisons is rare as well.

Still the first target for a fast implementation of common standards in Europe must be the collection of data from out-patient treatment units. As these units usually also reach more drug users and are closer to the drug using population this makes sense also from an epidemiological point of view. The inclusion of residential treatment could be the next step.

Unfortunately GPs and low-threshold agencies, which are thought to be even closer to "normal" drug users are only included in a minority of the national treatment monitoring systems. It will also be necessary to develop this area of monitoring to reach a more complete picture of the situation in future.

Detailed information concerning single items can be found in chapter 4, page 25 of this report.

3.3 Availability of data according to 1998 results

In the framework of the 1998 feasibility study the project co-ordinators already asked for the availability of the core items as laid down in the preliminary version of the core item list for treatment demand. The information given one year ago may allow interesting insights in recent developments and give a more complete overview on the current situation.

Another aspect why this look back may be valuable is that information concerning some of the items have not separately been collected during the actual project (e.g. "date of treatment"). Especially in these cases last year's results may be of additional value. The estimates concerning the quality of national data may complete the overall impression of data availability and state of development assuming that no dramatic changes took place during the last months.

The following tables give an overview on the availability of the core items of the TDI in the national systems in spring 1998. A cross ('x') indicates, that this information was available directly or could be obtained by calculation and recoding from the national systems. In some instances years are indicating that information will be available in future. For some of the countries no information had been filled in for different reasons quite similar to those mentioned before (see 3.1).

1. Treatment centre type

Where data are collected in the respective type of treatment centres, the information on the centre's type is available automatically.

		2. Date of Treatment Month¹														
Categories		AU	BE	DK	FI	FR	GE	GR	IR	IT	LU	NE	PO	SP	SW	EN
Date of treatment Month			x	x			x	x ²	x		x	x		x		x ³
Quality of data ¹			3				3	3	3		3	3				

¹ For some countries (shaded columns) the following tables can't be filled out due to several reasons which have been explained in above

² The information on the date of treatment is not known but only the date (year-month-day) of treatment demand, regardless of the fact whether the client will start treatment.

³ Regional data can identify the date of treatment, but at National level it can only be identified from which 6 month period the data relates to.

		3. Date of Treatment Year														
Categories		AU	BE	DE	FI	FR	GE	GR	IR	IT	LU	NE	PO	SP	SW	EN
Date of treatment Year			x	x			x	x ¹	x	x	x	x		x		x ²
Quality of data			3				3	3	3	3	3	3				

¹ The information on the date of treatment is not known but only the date (year-month-day) of treatment demand, regardless of the fact whether the client will start treatment.

² Regional data can identify the date of treatment, but at National level it can only be identified from which 6 month period the data relates to.

¹ Quality of the data registered (1= poor, 2=average, 3=excellent, 4= not known)

		4. Ever Previously Treated														
Categories		AU	BE	DE	FI	FR	GE	GR	IR	IT	LU	NE	PO	SP	SW	EN
	Never		x	x		x	x	x	x	x	x	x ¹		x		³
	Previously treated		x	x		x	x	x	x	x	x	x		x		³
	Not known		x	x		x	x	x		x ²	x		x			³
	Quality of data		2				3	3	3	3	3					

¹ since 1994

² no quality information available

³ likely that England will be able to provide this information after current strategic review – during 2000

		5. Source of Referral														
Categories		AU	BE	DE	FI	FR	GE	GR	IR	IT	LU	NE	PO	SP	SW	EN
	Self-referred		x ³			x ¹	x	x	x	(x) ⁴	x	x				x
	Family / Friends		x ³			x ¹	x	x	x		x	x				x
	Other drug treatment centre		x			x ¹	x	x	x		x	x				x
	GP		x			x ¹	x	x	x			x				x
	Hospital / other medical source		x			x ¹	x	x	x		x	x				
	Social services		x			x ¹	x	x	x		x	x				x
	Court / probation / police		x			x	x	x	x		x	x				x
	other		x			x	x	x	x		x	x				x
	Not known		x			x	x	x	x		x ²	x				x
	Quality of data		2				3	3		2	2-3	3				2

¹ Planned for 1997

² no quality information available

³ 2 first categories together

⁴ Only available in a sample of services (Pompidou study group on first treatment demand) and in some regional reporting systems

		6. Gender														
Categories		AU	BE	DE	FI	FR	GE	GR	IR	IT	LU	NE	PO	SP	SW	EN
	Male		x	x		x	x	x	x	x	x	x		x		x
	Female		x	x		x	x	x	x	x	x	x		x		x
	Not known							x	x		x	x		x		x
	Quality of data		3				3	3		3	3	3				3

		7. Age of Person at Start of Treatment														
Categories		AU	BE	DE	FI	FR	GE	GR	IR	IT	LU	NE	PO	SP	SW	EN
	Age		x	x		x ¹	x	x	x	x	x	x		x		x
	Quality of data		3				3	2		3	3	3				3

¹ age in November

		8. Year of birth														
Categories		AU	BE	DE	FI	FR	GE	GR	IR	IT	LU	NE	PO	SP	SW	EN
	Age		x	x		x	x	x			x	x		x		x ¹
	Quality of data		3				3	3			1	3				3

¹ information available on regional level (England)

9. Living Status (With Whom)															
Categories	AU	BE	DE	FI	FR	GE	GR	IR	IT	LU	NE	PO	SP	SW	EN
Alone		x	x			x	x	x	(x) ¹	x	x		x		x
With parents		x				x	x	x		x	x		x		x
Alone with child		x	x			x		x			x		x		
With partner (alone)		x	x			x	x	x		x	x		x		x
With partner and child		x	x			x	x	x			x		x		
With friends		x				x	x	x		x	x		x		
Other		x				x	x	x		x ²	x		x		x
Not known		x				x	x	x		x ²	x		x		x
Quality of data		2				2	3		2	3	3				3

¹ only available in a sample of services (Pompidou study group on first treatment demand) and in some regional reporting systems

² no quality information available

10. Living Status (Where)															
Categories	AU	BE	DE	FI	FR	GE	GR	IR	IT	LU	NE	PO	SP	SW	EN
Stable accommodation		x	x			x		x ³	(x) ¹	x	x		x ⁴		x
Unstable accommodation		x	x			x		x ³		x	x		x ⁴		x
Institutions (prison, clinic)		x	x			x		x ³		x	x		x ⁴		x
Not known		x				x				x ²	x				x
Quality of data		2				3			2	3	3				2

¹ Only available in a sample of services (Pompidou study group on first treatment demand) and in some regional reporting systems

² no quality information available

³ since 1998

⁴ for a sample of SEIT only

⁵ only available on regional level, different categories could be mapped into TDI categories

11. Nationality															
Categories	AU	BE	DE	FI	FR	GE	GR	IR	IT	LU	NE	PO	SP	SW	EN
National of this country		x	x			x	x	x		x	x		(x) ³		'00' ⁴
National of EU Member state		x	x			x				x	x		(x) ³		'00' ⁴
National of other countries		x	x			x	x	x ²		x	x		(x) ³		'00' ⁴
Not known		x				x	x	x		x ¹	x		(x) ³		'00' ⁴
Quality of data		2				1	3			3	3				

¹ no quality information available

² including EU Member states

³ only place of birth

⁴ likely from 2000 on

12. Employment															
Categories	AU	BE	DE	FI	FR	GE	GR	IR	IT	LU	NE	PO	SP	SW	EN
Regular employment ¹		x	x		x	x	x	x	(x) ²	x	x		x		x
Pupil / student		x	x		x	x	x	x		x	x		x		⁴
Economically inactive (Pensioners / Housewives, - men / Invalidity)		x	x		x	x				x	x		x		⁴
Unemployed			x		x	x	x	x		x	x		x		x
Other			x		x	x	x	x		x ³	x		x		x
Not known			x		x	x	x	x		x ³	x		x		x
Quality of data		1-2				2	2		2	3	3				3

¹ Full-time and part-time

² Only available in a sample of services (Pompidou study group on first treatment demand) and in some regional reporting systems

³ no quality information available

⁴ available on regional level

13. Highest educational level completed															
Categories	AU	BE	DE	FI	FR	GE	GR	IR	IT	LU	NE	PO	SP	SW	EN
Never went to school / never completed primary school		x	x			x	x	x	(x) ¹	x	x		x		
Primary school		x	x			x	x	x		x	x		x		
Secondary education		x	x			x	x	x ³		x	x		x		
Tertiary education		x	x			x	x	x		x	x		x		
Not known		x	x			x	x	x		x ²	x		x		
Quality of data		2-3				2	2			2	3				

¹ only available in a sample of services (Pompidou study group on first treatment demand) and in some regional reporting systems

² no quality information available

³ level reached, not necessarily completed full cycle

14. Primary drug															
Categories	AU	BE	DE	FI	FR	GE	GR	IR	IT	LU	NE	PO	SP	SW	EN
Opiates (total)		x			x	x	x	x	x ¹		x		x		x
Heroin			x		x	x	x	x	x ¹	x	x		x		x
Methadone			x		x	x	x	x	x ¹	x	x		x		x
other opiates			x		x	x	x	x	x ¹	x	x		x		x
Cocaine (total)		x			x	x	x	x	x ¹		x		x		x
Cocaine			x		x	x	x	x		x	x		x		x
Crack					x	x	x	x		x	x		x		x
Stimulants (total)		x			x	x	x	x	x ¹		x		x		x
Amphetamines			x		(x) ²	~	x	x	x ¹	x	x		x		x
MDMA and derivates			x		(x) ²	~	x	x	x ¹	x	x		x		x
other stimulants						~	x	x		x	x		x		x
Hypnotics and sedatives (total)		x			x	x	x	x	x ¹		x		x		x
Barbiturates					x		x		x ¹	x	x		x		x
Benzodiazepines			x		x		x	x	x ¹	x	x		x		x
others					x		x	x		x	x		x		x
Hallucinogens		x			x	x	x	x	x ¹		x		x		x
LSD			x			x	x	x		x	x		x		x
others						x	x	x		x	x		x		x

14. Primary drug															
Categories	AU	BE	DE	FI	FR	GE	GR	IR	IT	LU	NE	PO	SP	SW	EN
Volatile Inhalants (total)		x	x		x	x	x	x	x ¹	x	x		x		x
Cannabis (total)		x	x		x	x	x	x	x ¹	x	x		x		x
Other Substances (total)		x	x		x	x	x	x	x ¹	x	x		x		x
Quality of data		2				3	3		x ¹	3	3				3

¹ Item routinely collected in summarised figures at the national level (see Table Treat-an A of National Report

² since 1997

15. Route of administration (Primary drug)															
Categories	AU	BE	DE	FI	FR	GE	GR	IR	IT	LU	NE	PO	SP	SW	EN
Inject		x	x			x	x	x	x ¹	x	x		x		x
Smoke / inhale		x	x				x	x	x ¹		x		x		x
Eat / drink		x	x				x	x	x ¹		x		x		x
Sniff		x	x				x	x	x ¹		x		x		x
Others		x							x ¹	x	x		x		x
Not known		x	x			x	x	x	x ¹	3	x		x		x
Quality of data		2				1	3				3				2

¹ Items routinely collected in summarised figures at the national level only for intravenous use. All items available in Pompidou study group

16. Frequency of use (Primary drug)															
Categories	AU	BE	DE	FI	FR	GE	GR	IR	IT	LU	NE	PO	SP	SW	EN
Not used in past month / occasional		x	x				x	x	(x) ¹		x		x		x
Once per week or less		x	x				x	x		x	x		x		x
2-6 days per week		x	x				x	x		x	x		x		x
Daily		x	x				x	x		x	x		x		x
Not known		x	x				x	x		x	x		x		x
Quality of data		1					3		2	2-3	3				2

¹ These data are available in a sample of services (Pompidou study group on first treatment demand) and in some regional reporting systems

17. Age at first use of primary drug															
Categories	AU	BE	DE	FI	FR	GE	GR	IR	IT	LU	NE	PO	SP	SW	EN
Age at first use		x	x		(x) ²	(x) ³	x	x	(x) ¹	x			x		x
Quality of data		1-2					3		2	2					3

¹ only available in a sample of services (Pompidou study group on first treatment demand) and in some regional reporting systems

² only for some regions planned since 1997

³ age at start of problematic use available

18. Current secondary drug															
Categories	AU	BE	DE	FI	FR	GE	GR	IR	IT	LU	NE	PO	SP	SW	EN
Opiates (total)	x	(x) ¹			x	x	x	x	x ²		x		x		x
Heroin					x	x	x		x ²	x	x		x		x
Methodone					x	x	x		x ²	x	x		x		x
other opiates					x	x	x		x ²	x	x		x		x
Cocaine (total)	x	(x) ¹			x	x	x	x	x ²		x		x		x
Cocaine					x	x	x			x	x		x		x
Crack					x	x	x			x	x		x		x
Stimulants (total)	x	(x) ¹			x	x	x	x	x ²		x		x		x
Amphetamines					(x) ³	~	x		x ²	x	x		x		x
MDMA and derivates					(x) ³	~	x		x ²	x	x		x		x
other stimulants						~	x			x	x		x		x
Hypnotics and sedatives (total)	x	(x) ¹			x	x	x	x	x ²		x		x		x
Barbiturates					x		x		x ²	x	x		x		x
Benzodiazepines					x		x		x ²	x	x		x		x
others					x		x			x	x		x		x
Hallucinogens	x	(x) ¹			x	x	x	x	x ²		x		x		x
LSD						x	x			x	x		x		x
others					x	x	x			x	x		x		x
Volatile Inhalants (total)	x	(x) ¹			x	x	x	x	x ²	x	x		x		x
Cannabis (total)	x	(x) ¹			x	x	x	x	x ²	x	x		x		x
Other Substances (total)	x	(x) ¹			x	x	x	x	x ²	x	x		x		x
Quality of data	2					3	3			3	3				3

¹ Information is available on: age of debut, frequency of administration, usual route of administration for each drug used during the last month. If the drug user has been drug free during the last month, no information on preferred main/secondary drug type is available

² Item routinely collected in summarised figures at the national level (see Table Treat-an A of National Report

³ since 1997

19. Ever / currently (Last 30 days) injected															
Categories	AU	BE	DE	FI	FR	GE	GR	IR	IT	LU	NE	PO	SP	SW	EN
Currently injected	x	x			x	x	x	x	(x) ²	(x) ³	x		x		x
Ever injected, but not currently	x	(x) ¹			x	x	x	x		x	x		x		x
Never injected	x	x			x	x	x	x		x	x		x		x
Not known	x	x			x	x	x	x		x ⁴	x		x		x
Quality of data	2					2	3			2	3				2

¹ Ever shared equipment.

² These data are available in a sample of services (Pompidou study group on first treatment demand) and in some regional reporting systems

³ only in 1999

⁴ no quality information available

3.4 Methodological remarks

Documentation of data sources

The structure of the used data sources differs from country to country. Whereas some countries were able to give information based on nation-wide treatment monitoring systems with more or less known coverage rates others had to sum up data coming from regional systems (maybe with different methodological backgrounds and individual item sets) making interpretation of results very complicated. Detailed description of used data sources is of central importance. Otherwise comparisons between countries may be misleading. Especially if only regional data is available information has to be given how representative these data are for the entire country.

different data sources

detailed description of national data sources is necessary

The characteristics of available data sources which form the basis for the treatment documentation should include more details than information on coverage and number of included treatment centres. At least some information on basic mechanisms of data collection and analysis should be given or what the main purpose of the used monitoring system is. If regional information is used it would be helpful to get to know how data processing takes place or if there are differences between individual regional systems. This list of examples could easily be continued. It is necessary to have a basic "check list" which allows a clear identification of data sources and the main characteristics of the monitoring system. Examples of these descriptions can be found in the report of the 1998 feasibility study (Simon & Pfeiffer, 1998).

improved description of data sources

characteristics of monitoring systems

Distinction between inpatient and outpatient treatment centres

The distribution of treatment units included in the national (and regional) monitoring systems differs very much. In some countries only outpatient treatment facilities are covered by the monitoring system – other countries were not able to distinguish between inpatient and outpatient data and a third group mainly provided data coming from inpatient treatment centres.

different distribution of included treatment centres

Among experts it is a well known fact, that some characteristics of clients treated in one or the other category of treatment facilities differ very much. E.g. the mean age of drug users treated in inpatient centres is higher than for addicts who show up in outpatient centres.

different characteristics of clients (inpatient vs. outpatient)

This leads to the conclusion, that treatment data should be analysed separately for different categories of treatment centres. Otherwise it will be very difficult and in some cases impossible to interpret the collected data.

separation between inpatient and outpatient data where possible

Taking into consideration that great efforts have to be spend to collect treatment data on national level loss of information due to pooling of data which are not comparable should be avoided.

Another aspect is that it remains unclear, what kind of treatment centre is included in each of the sub-categories, e.g. how are centres categorised which offer outpatient as well as inpatient treatment? Maybe detailed guidelines including all possible types of treatment centres would allow a standardised categorisation (see Kokkevi 1997 for an example). On national level this work is part of the development of national equivalencies to fit the requirements of the TDI protocol and should be mentioned in the national workplan of the harmonisation process.

How are treatment centres categorised?

guidelines for categorisation

Definition of national equivalencies and convergence rules

As mentioned in the last paragraph it is of central importance to know what information is collected under which heading. Two basic possibilities can be identified:

- a) If a national or regional monitoring system already exists detailed convergence rules are needed like they have been defined for the relevant items of the Pompidou Protocol.
- b) In more general terms national equivalencies have to be defined to clarify which data or information can be found under which heading

definition of convergence rules

national equivalencies

But still in some cases national equivalencies and convergence rules won't solve the existing problems.

This is especially the case, if countries did define how to categorise a certain item but these categorisations don't fit into each other. E.g. one country defines „living with friend“ as a stable accomodation and others define it as „unstable accomodation“. In these cases a general agreement has to be found. Guidelines like for the categorisation of treatment centres may help to avoid these uncertainties.

guidelines are needed in some cases

Future data collection

It has to be clarified how data collection will be organised in future to avoid duplications on the one hand to ensure a systematic and ongoing data collection on the other hand. A basic approach would be to have

- a) a systematic and continuous data collection and
- b) an "ad hoc" data collection for specific topics (cannabis, women, adolescents, foreigners, risk behaviour, methadone issues).

Regarding the data collection itself, stratifications of variables may have to be reconsidered. Examples for useful stratifications are new vs. -old cases; type of drug (e.g. cannabis), patterns of use (combination of drugs), route of administration, social profiles, etc. For the main drug some of these stratifications are already made by the EMCDDA. Stratifications as well as changes in the „ad hoc“ data collection depend on the main focus of current EMCDDA work programmes or certain projects.

Requiring some basic methodological work an indicator of coverage may be developed, which could help to assess biases based on different proportions of treatment centre types represented in the monitoring systems or differences in regional distributions.

In future the collected data should be processed into a database which would be a powerful and flexible tool.

Revision of definitions of the TDI standard protocol

Even if the items of the TDI standard protocol will remain unchanged during the next years some of the methodological parts and definitions of the protocol should be revised and precised.

As mentioned before precise guidelines may help to improve comparability between countries. In some cases definitions as they can currently be found in the TDI protocol still allow individual interpretations. Uncertainties in single items (e.g. treatment centre type, living status, labour status) lead to conflicting definitions if categories are compared between countries. E.g. „living with friends“ is considered to belong to the „stable accomodation“-category of the TDI item „Living status (where)“ in one country whereas a second country codes it as being an „unstable accomodation“. As long as definitions allow contrary interpretation on national level these problems will occur and make comparisons between countries difficult.

avoidance of duplication

distinction between systematic and "ad hoc" data collection

future stratifications

indicator of coverage

European database

more precise definitions are needed in certain cases

different interpretation of TDI categories

Inclusion / exclusion of cases

A valuable information which has only answered very rarely would be to know how many cases have not been covered by single items. In some cases the number of registered cases for a certain item would allow to get an idea where possible problems or invalid information occur. In other cases one can only guess why only a few cases have been included in the reporting. Additional information concerning reasons why single cases have not been included or at least the number of missed (?), invalid (?) or unclear (?) cases would help to get a more realistic impression about the coverage of treatment monitoring systems and would help to improve them in future.

information about cases which aren't included

Missing cases

The proportion of missing cases differs from item to item and within items. What makes things even more difficult is that it is not always clear whether an item has been answered with "not known" or if no answer is available at all. Differences between countries will have to be analysed on national level to clarify why the proportion of cases with unknown results for a certain item is higher than for other ones. On European level a solution has to be found concerning item 15 (substitution treatment). Due to the fact that this item had been introduced after the expert meeting in 1998 it will take more time to implement this item in national systems. Therefore another availability check in 2000 may give information about the process and progress in implementation.

necessary distinction between unknown cases and cases with answer "not known"

clarification on national level

new availability check concerning item 15

4 Results – Detailed analyses following the items of the TDI core item list

4.1 General remarks

The following chapter describes the availability of every single item collected during the field trial and gives examples of how these data may be used or analysed.

The **figures** are usually **based on valid cases**, i.e. cases in the category „not known“ have been eliminated from the analysis. Additionally in some cases missing cases have been registered separately.

The **data-tables** usually **include all cases** that have been reported by the countries, including „not known“ categories. Nevertheless in some cases it remains unclear if clients reported in the „not known“ categories are really not known or if they are missing. This has to be clarified in future. Over and above that some tables totally lacked a „not known“ category, which caused some problems in single countries.

Percentages „<1“ represent real percentages between **0.0% and 0.5%**.

In most cases the graphs and tables are only given for selected main categories of drugs. This is due to the fact that the data collection lead to a huge amount of data making it impossible to carry out every thinkable analysis. Taking into consideration that this project should give an idea of what may be presented during the next years the selected graphs and figures seem to be sufficient. In general graphs and tables have been designed to allow an „European point of view“ which means, that all countries have been pooled in one graph. Single national information presented in an „European“ project wouldn't make sense due to the fact, that every national expert is expected to know more about his or her individual country than an external data-collector. European data collection and analysis should open new horizons and allow new or different insights. Single country profiles have been produced where they seemed to make sense or where they have been considered to be necessary.

Table 3. Main categories of drugs and included subcategories

Main category	Subgroups included
1. Opiates (total)	11 heroin 12 methadone 13 other opiates
2. Cocaine (total)	21 cocaine 22 crack
3. Stimulants (total)	31 amphetamines 32 MDMA and other derivatives 33 other stimulants
4. Hypnotics and Sedatives (total)	41 barbiturates 42 benzodiazepines 43 others
5. Hallucinogens (total)	51 LSD 52 others
6. Volatile Inhalants	
7. Cannabis (total)	
9. Other Substances (total)	

Table 3 clarifies which sub-categories of drugs are included in the main categories. So if results for „opiates“ are reported this always includes heroin, methadone and

other opiates as main drugs. In some cases this may be misleading but it has been tried to give additional information where needed.

The main aim of this project was to give an overview on the current state of implementation of the TDI in EU Member States. Over and above that this report also offers suggestions and gives examples how data analysis on European level may look like.

Scientific discussions of single item's results or explanatory notes why certain results look like they do have been neglected.

Following the purpose of this field trial it was more important if availability of data collected according to the standards set up by the TDI core item list would

- allow to put together a joint analysis,
- offer enough data to compare characteristics of clients treated for drug problems and registered by national monitoring systems,
- provide information about the state of the implementation of the TDI on national level and
- give an overview where improvements are necessary on European as well as on national level.

Overall the results are quite satisfying even if some items are at the beginning or in the middle of implementation. On the other hand it was surprising how much has been done since the core item list has passed the expert's meeting. Several countries already took changes and requirements of the TDI into consideration. As mentioned before availability of data can be obtained from Table 2. So if a certain country's data can not be found in the analysis chapter a quick look at Table 2 may clarify if the respective item will be available in near future or not.

If a certain country is excluded from the analysis of a certain item and no additional remark explains why the data is missing this is usually due to the fact that such information has not been presented by the respective country.

4.2 Item 1: Treatment centre type

Table 4 summarises the information which had been given concerning the composition of the national data sources. It provides valuable insights into the differences of monitoring systems between countries.

- As mentioned before the monitoring systems differ concerning the proportion of inpatient and outpatient treatment centres reporting to the system underlining the necessity to separate the data accordingly.
- It would be helpful to add an additional column giving an estimate of the proportion of how many cases are covered by the monitoring system nation-wide.
- A column giving the total number of every type of treatment centre in the country would be useful. Where this information can't be given an appropriate estimate (with explaining remarks) would be sufficient as well.

Table 4. Characteristics of national treatment monitoring systems

Country	Covered Y/N ^a	N of units covered ^b	% of units covered ^c	% of cases covered ^d
Belgium (Brussels)¹				
1. outpatient treatment centres	Y	10	100	74
2. inpatient treatment centres	Y	7	100	26
3. low threshold / drop-in / street agency				
4. general practitioners	(Y)	1 (network of general practitioners)		
5. treatment units in prison	(Y)	1 (network of general practitioners)		
Belgium (French)¹				
1. outpatient treatment centres	Y	23	?	53
2. inpatient treatment centres	Y	7	?	37
3. low threshold / drop-in / street agency	Y	2	?	5
4. general practitioners	Y	3	?	5
5. treatment units in prison	Y	1	?	<1
Belgium (Flemish)¹				
1. outpatient treatment centres	Y	83	80	82
2. inpatient treatment centres	Y	10	10	18
3. low threshold / drop-in / street agency	N			
4. general practitioners	N			
5. treatment units in prison	N			
Denmark				
1. outpatient treatment centres		?	100	
2. inpatient treatment centres				
3. low threshold / drop-in / street agency				
4. general practitioners				
5. treatment units in prison				
England²				
1. outpatient treatment centres	Y			
2. inpatient treatment centres	Y			
3. low threshold / drop-in / street agency	Y			
4. general practitioners	Y			
5. treatment units in prison	N			

Country	Covered Y/N ^a	N of units covered ^b	% of units covered ^c	% of cases covered ^d
Finland³				
1. outpatient treatment centres	Y	37	34	75
2. inpatient treatment centres	Y	24	52	22
3. low threshold / drop-in / street agency	N			
4. general practitioners	N			
5. treatment units in prison	Y	4	17	3
France⁴				
1. outpatient treatment centres	Y	190		
2. inpatient treatment centres	Y	50		
3. low threshold / drop-in / street agency	N			
4. general practitioners	N			
5. treatment units in prison	Y	16		
Germany (SEDOS, inpatient data)⁵				
1. outpatient treatment centres	N		36	100
2. inpatient treatment centres	Y	22	6-8	100
3. low threshold / drop-in / street agency	N			
4. general practitioners	N			
5. treatment units in prison	N			
Germany (EBIS, outpatient data)⁵				
1. outpatient treatment centres	Y	455	36	100
2. inpatient treatment centres	N			
3. low threshold / drop-in / street agency	(Y)			
4. general practitioners	N			
5. treatment units in prison	N			
Greece				
1. outpatient treatment centres	Y	2	29	
2. inpatient treatment centres	Y	7	64	
3. low threshold / drop-in / street agency				
4. general practitioners	N			
5. treatment units in prison				
Ireland⁶				
1. outpatient treatment centres	Y	42	78	74
2. inpatient treatment centres	Y	10	19	23
3. low threshold / drop-in / street agency	Y	2	4	4
4. general practitioners	N			
5. treatment units in prison	N			
Italy⁷				
1. outpatient treatment centres	Y	50	10	88
2. inpatient treatment centres	Y	19	1	6
3. low threshold / drop-in / street agency	N			
4. general practitioners	N			
5. treatment units in prison	Y	5	2	6
Luxembourg				
1. outpatient treatment centres	Y	4	100	
2. inpatient treatment centres	Y	2	100	
3. low threshold / drop-in / street agency	Y	1	50	
4. general practitioners	N			
5. treatment units in prison	N			

Country	Covered Y/N ^a	N of units covered ^b	% of units covered ^c	% of cases covered ^d
The Netherlands⁸				
1. outpatient treatment centres	Y	110	95	95
2. inpatient treatment centres				
3. low threshold / drop-in / street agency				
4. general practitioners				
5. treatment units in prison				
Portugal⁹				
1. outpatient treatment centres				
2. inpatient treatment centres				
3. low threshold / drop-in / street agency				
4. general practitioners				
5. treatment units in prison				
Spain¹⁰				
1. outpatient treatment centres	Y	435	85	94,2
2. inpatient treatment centres	N			
3. low threshold / drop-in / street agency	N			
4. general practitioners	N			
5. treatment units in prison	Y	30	20	5,8
Sweden¹¹				
1. outpatient treatment centres				
2. inpatient treatment centres				
3. low threshold / drop-in / street agency				
4. general practitioners				
5. treatment units in prison				

^a Covered Y/N: Do units in each category report to the monitoring system?

^b N of units covered: Number of units in each category reporting to the monitoring system

^c % of centers covered: Estimated proportion of each type of treatment unit (of all existing in the country) covered by the monitoring system

^d % of cases: Proportion of the cases/episodes reported to the monitoring system coming from each type of treatment unit. It should add up 100%

Remarks

- ¹ In **Belgium** data are still collected by four regional monitoring system (Brussels region, French community, German community and Flemish community). Until now it was not possible to calculate national figures but it is planned to provide national data on treatment demand from 1999 on.
- ² In the **United Kingdom** separate treatment monitoring systems are run in Wales, Scotland and England. Even if the different systems are very similar no way had been found to provide data for the entire UK (except Northern Ireland, due to the fact that there is no existing treatment monitoring system in Northern Ireland yet). Due to the limited time available only data coming from England has been used in this field trial. Double counting has been eliminated at regional level where possible. The English data does not cover the whole 12 month period due to the fact that data on drug misuse is collected every six months. The information is given for the period April to September 1997.
- ³ The collection of treatment data in **Finland** is based on voluntary participation of the treatment centres. An estimate of the treatments which are not included is not possible due to the fact that the total number of treatments is not known. The available data covers a period of 7.5 months of 1998 for most of the participating units. However, in some cases only 2.5 months are covered. Over and above that some clients with alcohol as the main drug have been included in the data

collection but all of them clients have also been treated for severe problems related to illegal drugs. This leads to a quite high proportion of cases in the „other substances“ category of the tables that summarise drug related information and unfortunately no further information regarding the type of drug is given for these persons.

- 4 **France** still has no ongoing treatment monitoring system. The French information is based on data coming from the November survey, a yearly conducted survey among specialised treatment centres covering about 95% of all treatment units and about 15,000 drug users (including 1,350 drug users in prisons). Unfortunately it is not possible to distinguish between outpatient and inpatient treatment centres. It is planned to make a proposal for a national treatment monitoring system in the course of 1999 but nevertheless it will take some more years (until 2001 minimum) to implement a new system. The distribution of treatment centres refers to 1998 (source: Ministère de l'emploi et de la solidarité).
- 5 Due to the well known fact that some characteristics of clients treated in inpatient treatment centres differ very much from those of drug users treated in outpatient treatment facilities (e.g. age distribution) it has been decided to divide the **German** data into two separate files. Nevertheless data from GPs and prisons are not included in the German data. Information given by low threshold services or street agencies might be included in the outpatient monitoring system but cannot be analysed separately. The inpatient data which had been used for this field trial is only a certain sample of the SEDOS system.
- 6 In **Ireland** a feasibility study has been carried out by the Drug Misuse Research Division, Health Research Board to determine the feasibility of inclusion of GPs and prisons in the monitoring system and if endorsed, to implement the inclusion of both groups. This is currently under way.
- 7 There is no national monitoring system for the treatment of drug users in **Italy** at the moment. But national experts and responsible politicians already started the discussion process to develop solutions to fit European requirements. A pilot study is planned at the end of 1999. For this 1997 field trial data coming from two regional monitoring systems has been used. Data inconsistencies and empty cells are mainly due to differences in regional (case) definitions or differences in categories.
- 8 The **Dutch** data does not include any inpatient treatment units but covers nearly all outpatient treatment facilities in the Netherlands. Only few outpatient treatment centers are not included in the system but it can be assumed that those clients who show up in these centers are also registered in LADIS (the Dutch monitoring system) due to their additional contacts with treatment units which do report to the system. Double counting has been eliminated. The data includes 6,407 unique clients (person) who fit into the criteria for the treatment demand indicator as defined in the TDI protocol. This is roughly 25% of all unique drug users registered in LADIS in 1997.
- 9 **Portugal** has started a system of treatment monitoring within a big treatment organisation. Further details on coverage of centres, patients etc. are not available at the moment.
- 10 The precise number of centres in **Spain** is not exactly known, therefore the figure of „% of units covered“ is only a proxy estimate.

- ¹¹ Until 1997 **Sweden** has only had national, aggregated statistics that cover detoxification in inpatient, healthcare clinics and care and treatment in residential centers. The latter kind of services represent less than one third of all the services for substance abusers that are provided by the local social service agencies. Most of the care and treatment today is given in outpatient format. So from 1998 Sweden collected data directly from these local agencies, in order to get the full picture of the number of clients in various forms of care. Unfortunately these data can not be broken down on type of substance abuse, since that is not recorded in these agencies' data systems, but only on gender and age groups. From 1999, however, Sweden has also inaugurated a system for regular (yearly) data collection from all the specialised treatment units for substance abusers that are known by the social services department at the National Board of Health and Welfare. A first report of this project will be published in the middle of autumn 1999. From this register it is planned to select those units that have a high proportion of drug abusers, to begin to build a system for continuous reporting on the Treatment Demand Indicator.

4.3 Item 4: Ever previously treated

Figure 4. Treatment contact details: Previous treatments.

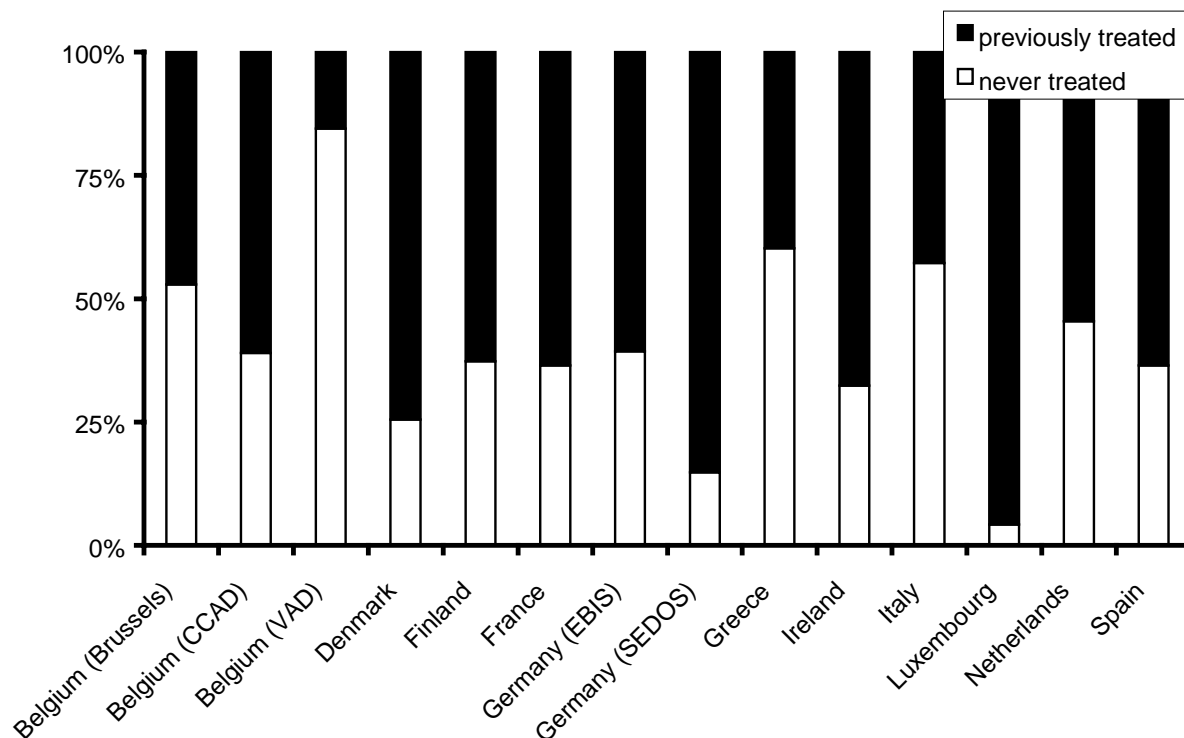


Table 5. Treatment contact details: Previous treatments (data)

Country	%	never treated before	previously treated	not known	N
Belgium (Brussels)		34	30	36	1,544
Belgium (CCAD)		11	33	56	1,681
Belgium (VAD) ¹		85	15		2,105
Denmark		25	71	4	4,583
Finland ²		36	60	5	2,765
France		36	61	4	15,078
Germany (EBIS)		39	61		11,570
Germany (SEDOS)		14	83	3	1,775
Greece		60	40		570
Ireland		31	65	4	4,910
Italy ³		57	43		6,059
Luxembourg		4	91	5	?
Netherlands		45	55		6,407
Spain		36	62	2	52,440

¹ ever previously treated in the same treatment centre for the same problem; outpatient treatment centres only

² N (missing)=97; „not known“ category in the table includes the number of answers „not known“ and „N (missing)“ includes totally missing answers

³ partly structural limitations due to impossible distinction between prevalent and incident cases

Remarks

Not much is known about different registration of primary or subsequent treatments if no additional information concerning control for double-counting or definition of treatment episodes is given together with the data. This item is quite close to the problem of double-counting which remains unsolved in a couple of countries. In some countries control for double-countings does only take place on treatment centre level which does only allow to give information if a certain person has been treated in the same centre for the same problem ever before or not. Other countries allow to control for double counting on regional or national level.

4.4 Item 5: Source of referral

Figure 5. Treatment contact details: Source of referral

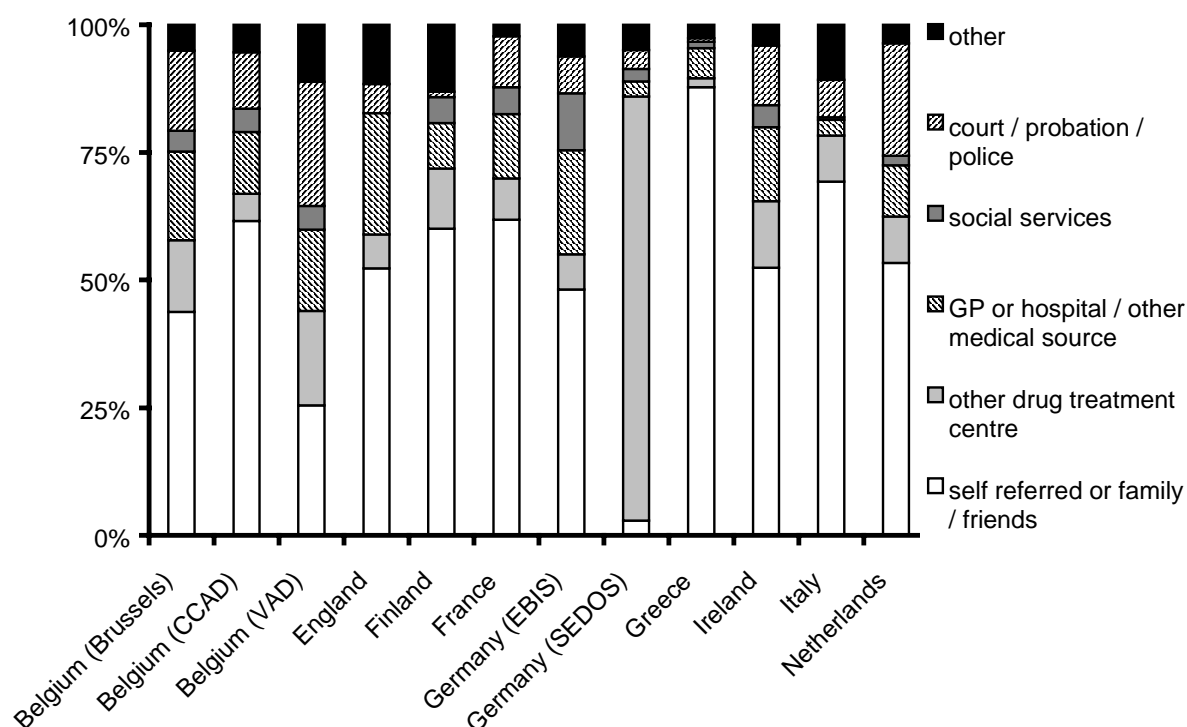


Table 6. Treatment contact details: Source of referral (data)

Country	%	self referred or family/friends	other drug treatment centre	GP/hospital/other medical source	social services	court probation police	other	not known	N
Belgium (Brussels)		41	13	16	4	15	5	7	1,544
Belgium (CCAD)		58	5	11	4	10	5	5	1,681
Belgium (VAD) ¹		25	18	16	5	24	11		2,560
England ²		47	6	21		5	10	10	21,996
Finland ³		59	12	9	5	1	13	1	2,785
France		61	8	12	5	10	2	2	15,035
Germany (EBIS) ⁴		48	7	20	11	7	6		56,352
Germany (SEDOS)		3	83	3	2	4	5		1,724
Greece		86	2	6	1	1	3	1	570
Ireland		51	13	14	4	11	4	2	4,910
Italy		69	9	3	1	7	11	1	6,059
Luxembourg	data on orientation after indexed treatment is available, requested item not								
Netherlands ⁵		52	9	10	2	22	4	2	6,407

¹ categories „self referred“ and „family/friends“ can not be separated

² data for categories „Hospital / other medical source“ and „Social services“ could not be individually identified, they are within category "Other"

³ N (missing)=77; as a source of referral the category „social services“ includes only child protection services in social services. Other social services are included in category „other“, because one of the Finnish data collection categories ("other social and health care services") doesn't allow to distinguish between social and health care services

⁴ data also include clients with main diagnosis alcohol, pathological gambling, eating disorders, etc.

⁵ category GP is not separately registered in LADIS

Remarks

The extreme differences between the data of both German treatment monitoring systems lead to the idea, that the type of treatment centre has an important impact on the results of this item. It can be assumed, that the situation in other countries will not differ very much from the German situation and underlines that it does not make very much sense to pool inpatient and outpatient information.

Some of the item's sub-categories are not available in a few countries but due to the fact that single categories have been pooled for the analysis this does not lead to serious problems.

The categorisation of „social services“ seems to be problematic in Finland and England but information have been given how to deal with the problem (concerning individual identification or services included in this category see footnotes).

4.5 Item 7: Age distribution (men and women pooled)

Figure 6. Socio-demographic information: Age distribution (men and women pooled)

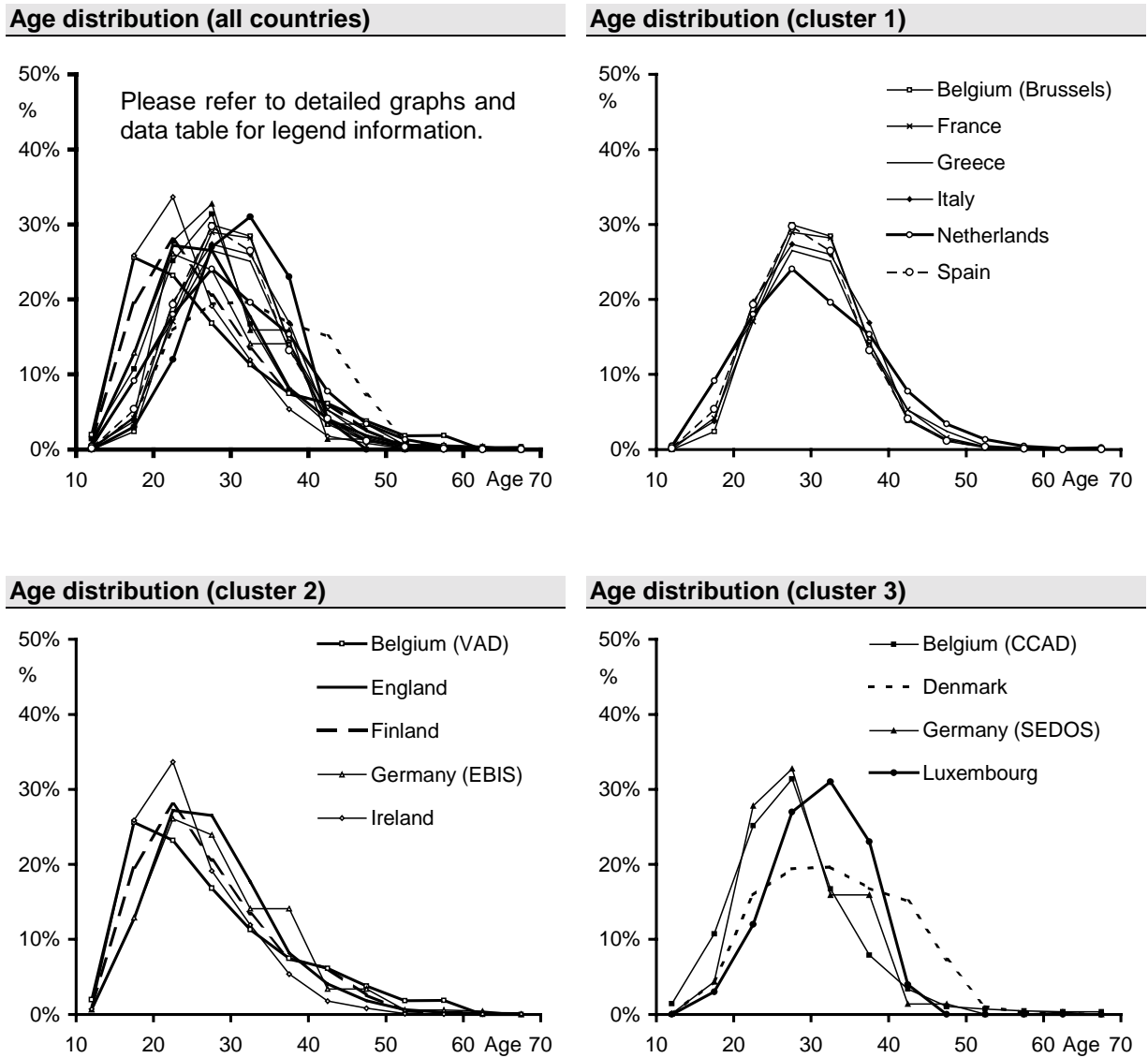


Table 7. Socio-demographic information: Age distribution (data)

Age	%	BE ¹	BE ²	BE ³	DK	EN	FI	FR	GE ⁴	GE ⁵	GR	IR	IT ⁶	LU	NL	SP
<15	<1	1	2	<1	1	1	<1	1	<1	<1	1	<1	<1	<1	<1	<1
15-19	2	11	26	4	13	20	4	13	4	9	26	4	3	9	5	
20-24	18	25	23	16	27	28	17	26	28	17	34	20	12	18	19	
25-29	30	31	17	19	27	21	29	24	33	26	19	27	27	24	30	
30-34	28	17	11	20	18	13	28	14	16	25	12	26	31	20	26	
35-49	14	8	8	17	8	7	14	14	16	13	5	17	23	15	13	
40-44	4	3	6	15	4	6	5	3	1	5	2	4	4	8	4	
45-49	1	1	4	7	2	3	2	3	1	2	1	1		3	1	
50-54	<1	1	2	1	1	<1	<1	1	<1	1	<1	<1		1	<1	
55-59	<1	<1	2	<1	<1	<1	<1	1	<1	<1	<1	<1		<1	<1	
60-64	<1	<1		<1	<1	<1	<1	<1	<1	<1	<1	<1		<1	<1	
>=65		<1		<1	<1	<1	<1			<1	<1	<1		<1	<1	
N	1,544	1,534	2,973	4,580	21,996	2,844	15,063	11,626	1,331	570	4,910	6,059	?	6,407	52,185	
not known	81					18 ⁷				24					255	
\bar{x} (M)		27,0	25,8	32,0		27,3		28,3		29,6	24,7	29,8		28,8	29,7	
\bar{x} (F)		28,4	30,9	32,0		24,5		29,1		27,2	23,3	29,4		27,3	28,8	
\bar{x} (T)		26,4	27,2	32,0		26,6		28,7		29,3	24,4	29,6		28,5	29,3	

¹ Brussels; age distribution ends at >=60

² CCAD (French community)

³ VAD (Flemish community); age distribution ends at >=55

⁴ EBIS (outpatient); age distribution ends at >=60; different age categories (30-39, 40-49, 50-59)

⁵ SEDOS (inpatient); age distribution ends at >=60; different age categories (30-39, 40-49, 50-59)

⁶ mean age is calculated on the basis of Lazio region data only

⁷ = N (missing)

Remarks

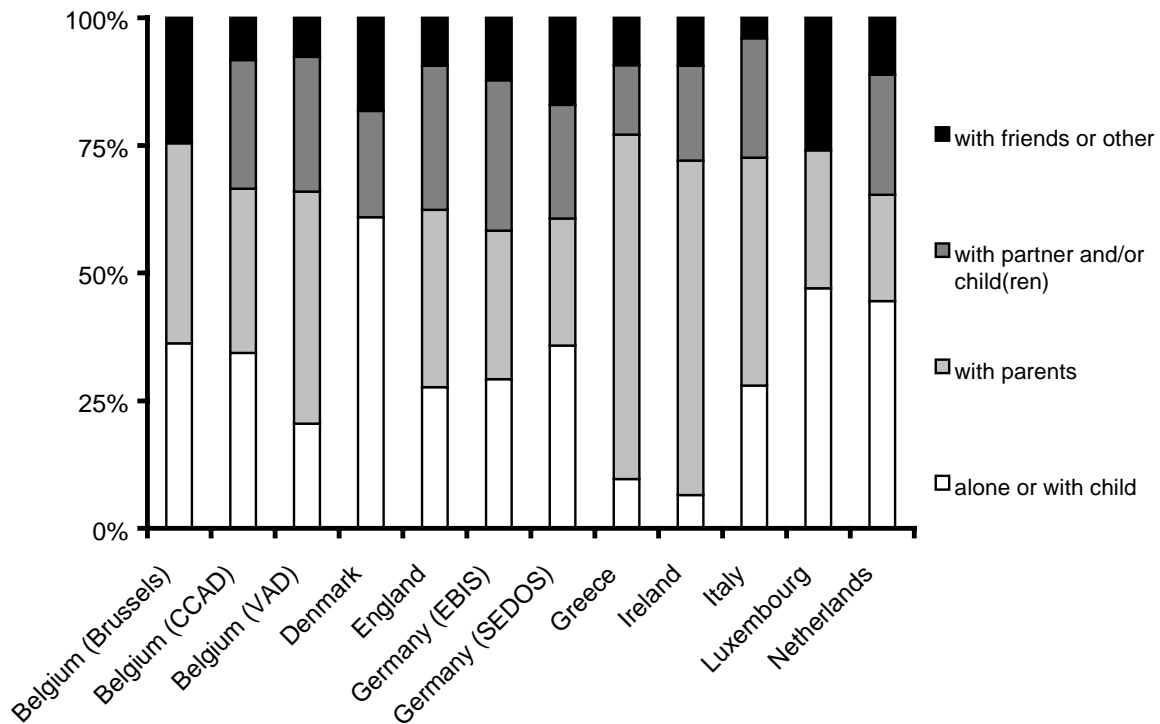
Again a separation between different treatment centre types would be valuable. At the moment the given mean age only reflects a mean age of the treated drug using population but this figure is distorted by the proportion of inpatient / outpatient treatment centres reporting to the monitoring system. It is a well known fact, that age distributions of clients treated in outpatient treatment centres and those who are treated in inpatient centres differ very much.

Different groups of countries with more or less similar age distributions can be identified. This may be caused by similar distributions of in- and outpatient treatment services in the monitoring systems..

A problem which has to be solved in future are differences between intervals of the age categorisation. In most cases this is only related to the last category which is not very problematic. In single cases also modifications concerning ranges of categories are necessary.

4.6 Item 9: Living status (with whom)

Figure 7. Socio-demographic information: Living status (with whom)



Remarks

As one can easily see from the footnotes of the data table this item and its categories seem to be much more problematic than others. The detailed breakdown of this item's categories requires changes and modifications in nearly all countries.

The chosen way of reporting this item solves some of the present problems due to the fact that pooled categories have been constructed which make slight uncertainties disappear.

The categories of this item seemed to be defined quite clearly making an assignment of national data to TDI categories quite clear – especially in comparison to the related item „Living status (where)“.

Table 8. Socio-demographic information: Living status (with whom) (data)

Country	%	alone or with child	with parents	with partner and/or child(ren)	with friends or other	not known	N
Belgium (Brussels) ¹		29	31		19	21	1,544
Belgium (CCAD)		31	29	23	7	10	1,681
Belgium (VAD) ²		20	45	26	8		2,731
Denmark ³		55		19	16	10	4,580
England ⁴		14	18	15	5	48	21,996
Finland ⁵							
Germany (EBIS) ⁶		29	28	29	12	2	12,600
Germany (SEDOS)		35	24	22	17	3	1,331
Greece ⁷		10	67	14	9	1	570
Ireland ⁸		6	62	18	9	5	4,910
Italy ⁹		28	45	23	4		2,625
Luxembourg		47	27	6	20		?
Netherlands ¹⁰		41	19	22	10	8	6,407

¹ category „alone or with child“ also includes „with partner and/or child(ren)“; category „other“ includes living in an institution (e.g. prison)

² category „with parents“ also includes living with other family; „other“ includes living in an institution; „with partner (alone)“ and „with partner and child(ren)“ are already pooled on raw data level; category „with friends“ is not available

³ categories „with parents“ and „other“ are empty

⁴ data for category „alone with child“ could not be individually identified, so they are within category "alone", data for category „with partner and child(ren)“ are within category "with partner", data for category „with friends“ are within category "other"; English category "parents and partner" is also within category "other";

ignoring the large number of unknown cases may be misleading in bar graph

⁵ an accurate convergence of Finnish categories is not possible and would lead to misleading interpretation

⁶ category „with partner and child(ren)“ consists of „with child(ren) and other“ data

⁷ category „alone with child“ does not exist in the Greek Protocol and was coded as „other“

⁸ category „with partner and child(ren)“ is not available separately

⁹ item not covered by the Lazio region monitoring system

¹⁰ category "with friends" is not registered in LADIS

4.7 Item 10: Living status (where)

Figure 8. Socio-demographic information: Living status (where)

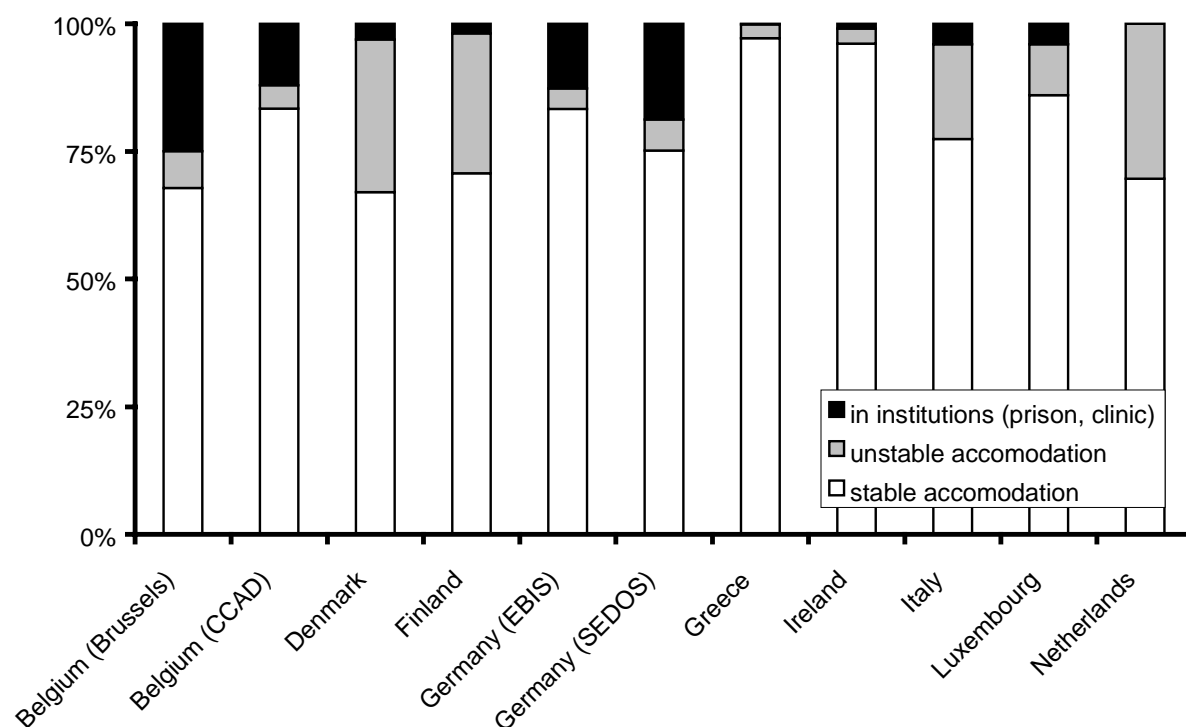


Table 9. Socio-demographic information: Living status (where) (data)

Country	%	stable accomodation	unstable accomodation	in institutions	not known	N
Belgium (Brussels) ¹		57	6	21	16	1,544
Belgium (CCAD)		79	4	11	6	1,681
Denmark		64	29	3	4	4,580
Finland ²		69	27	2	2	2,828
Germany (EBIS)		81	4	12	3	11,627
Germany (SEDOS)		71	6	18	6	1,775
Greece ³		96	3	<1	1	570
Ireland		91	3	1	5	4,910
Italy ⁴		77	19	4		2,665
Luxembourg		86	10	4		?
Netherlands ⁵		59	26		15	6,407

¹ „living with friends“ included in category „stable accomodation“

² N (missing)=34; „living with friends“ included in category „unstable accomodation“; other Finnish categories have been converted; prisoners are not included in the „institutions“ category because according to Finnish instructions prisoners have given the living status before prison)

³ the question was combined with „Living status (with whom)“

⁴ item not covered by the Lazio region monitoring system

⁵ the stability of the living status is not accounted for in LADIS; because of that a proxy measure was used were the LADIS categories "having an own home or renting one and living in the parental home" were transferred in the TDI category „stable accomodation“, the TDI category "in institutions" is not registered in LADIS; a number of LADIS categories such as "roaming; living in pension houses etc." were transferred to the TDI category: "unstable accomodation"

Remarks

This item seems to be quite problematic due to the fact that nearly nothing is known of how countries make their assignments to the categories.

What becomes clear, is that the definition as given in the TDI standard protocol is not sufficient to guarantee comparability between countries. Serving as an example the category „living with friends“ has been transferred into two different and contrary categories in two cases. Combination with the other item accounting for the living status or calculation of proxy estimates illustrate that the categories of this item will have to be precised.

Convergen rules defining national equivalencies are of central importance if broad (constructed) categories like „stable accomodation“ and „unstable accomodation“ will be compared.

4.8 Item 11: Nationality

Figure 9. Socio-demographic information: Nationality of treated persons

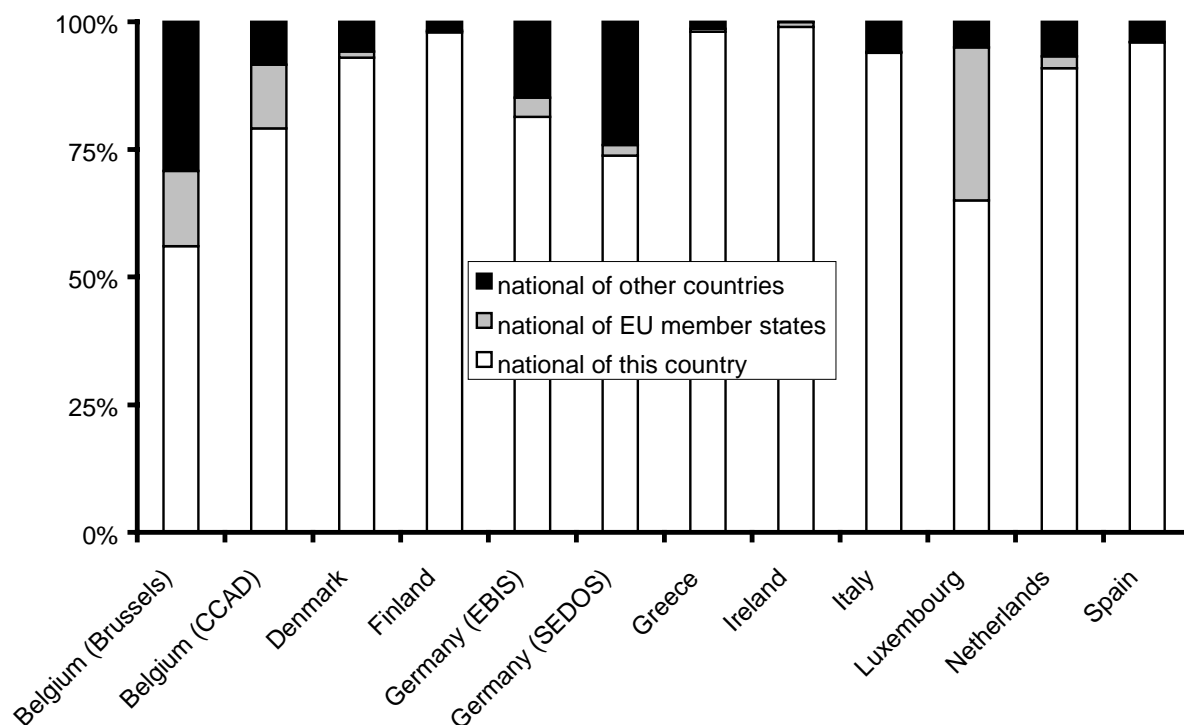


Table 10. Socio-demographic information: Nationality of treated persons (data)

Country	% national of this country	% national of EU member state	% national of other country	% not known	N
Belgium (Brussels)	47	12	25	16	1,544
Belgium (CCAD)	77	12	8	3	1,681
Denmark	93	1	6	<1	4,580
Finland ¹	97	<1	2	1	2,779
Germany (EBIS)	35	2	6	57	11,627
Germany (SEDOS)	69	2	23	6	1,775
Greece	98	1	1		570
Ireland	98	1	<1	1	4,910
Italy	94	<1	6		6,059
Luxembourg ²	65	30	5		?
Netherlands	88	2	7	4	6,407
Spain	83	<1	3	13	52,440

¹ N (missing)=83

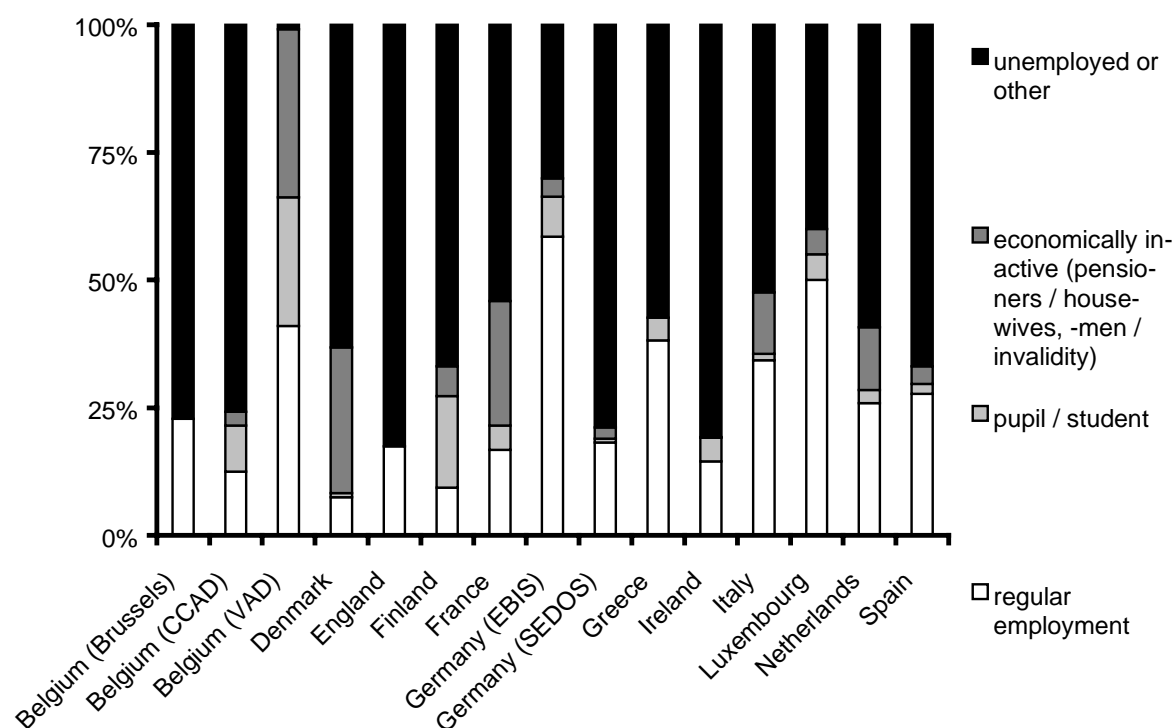
² RELIS data make a difference between native Luxemburgers and naturalised citizens (% of nationals = sum of both). No breakdown by gender on a routine basis.

Remarks

The nationality aspect seems to be one of the items which are easily available. Assignment to TDI categories does not seem to cause problems.

4.9 Item 12: Labour status

Figure 10. Socio-demographic information: Labour status of treated persons



Remarks

„Labour status“ is one of the items which require slight modifications in definitions or guidelines informing about how to transfer different labour situations into TDI categories.

Two countries used the „main source of income“ as an proxy estimate for the labour status due to the fact that the needed item is not registered in the national systems.

Some of the percentage rates in the „other“ category are quite high indicating, that an considerable amount of cases could not clearly be assigned to one of the TDI categories. An assumption might be that this category includes „occasional work“ which is somewhere in between regular work and unemployment. Again it would be very valuable to know how national items have been transferred.

Labour status is one the items which make it easy to give examples how data from treatment monitoring systems can be combined with other statistics. E.g. this item allows direct comparisons with general statistics, e.g. unemployment rate among a country's population. This would allow to compare the economic and/or social status of clients treated for drug problems and the general population.

Table 11. Socio-demographic information: Labour status of treated persons (data)

Country	% regular employment	pupil/student	economically inactive	unemployment or other	not known	N
Belgium (Brussels) ¹	8			28	64	1,544
Belgium (CCAD) ²	12	8	2	70	7	1,681
Belgium (VAD) ³	40	24		33	3	2,933
Denmark	7	1	27	61	4	4,580
England ⁴	15			71	14	21,996
Finland ⁵	9	17	6	64	4	2,803
France ⁶	17	5	24	54		14,684
Germany (EBIS) ⁷	57	8	3	29	3	11,627
Germany (SEDOS) ⁸	18	1	2	77	2	1,775
Greece ⁹	38	4		57	1	570
Ireland ¹⁰	14	4	<1	78	3	4,910
Italy ¹¹	32	1	11	50	5	6,059
Luxembourg ¹²	50	5	5	40		?
Netherlands ¹³	23	2	11	54	9	6,407
Spain ¹⁴	25	2	3	61	8	52,440

¹ categories „pupil/student“ and „economically inactive“ are not available, only main source of income is registered; category „unemployed“ means „never worked“ (10%) and category „other“ represents occasional work (18%)

² 17% „other“

³ category „economically inactive“ includes „unemployed“

⁴ Data for categories „pupil/student“ and „economically inactive“ could not be individually identified, they are within category "other" (5%)

⁵ N(missing)= 59; "economically inactive" category does not include invalids in Finnish data collection, except they would be in the category "other" (4%)

⁶ 18% „other“

⁷ 8% „other“

⁸ 9% „other“

⁹ 2% „other“; category „economically inactive“ did not exist in 1997 (already changed in 1999)

¹⁰ 3% „other“

¹¹ 6% „other“

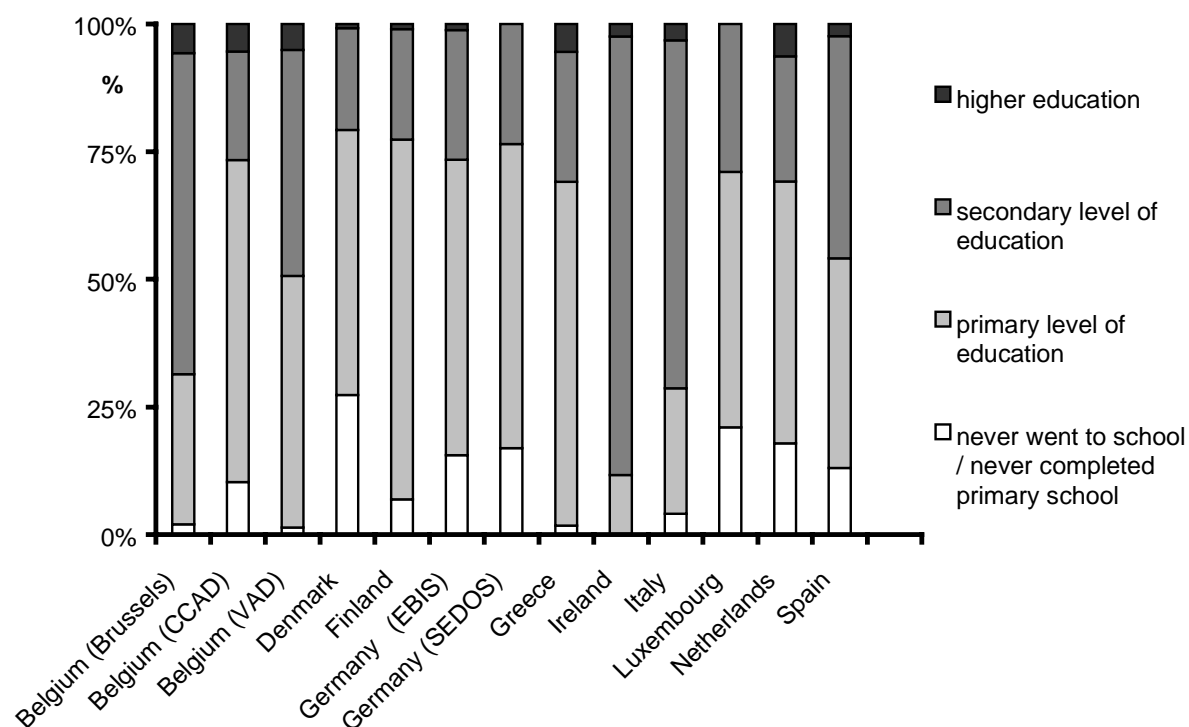
¹² 12% „other“ (including occasional work)

¹³ 5% „other“; different categories of the LADIS variable "source of income" were used, for the TDI category "regular employment" the LADIS category "income/small businessman etc." was used, for the TDI category "economically inactive" the LADIS category "pension" and "no personal income" was used as an indicator; the LADIS category "on welfare" was used as an indicator for the TDI category "unemployed"; the fit of the other categories was rather self evident

¹⁴ 9% „other“

4.10 Item 13: Highest educational level completed

Figure 11. Socio-demographic information: Highest educational level completed



Remarks

As a well known fact educational systems differ very much between countries. To avoid problems arising from an unsystematical assignment of national item-categories into TDI core item categories it had been suggested in the TDI standard protocol to use the ISCED scales as an utility to transfer items in a standardised way. These scales can serve as an example of international accepted standards leading to comparable classifications. Where possible similar international standards should be found or defined for other items.

Nevertheless some slight uncertainties remained concerning the categorisation of specialised schools for handicapped people or additional studies improving ones qualifications. In one case the reported item differs from the requested one (educational level „reached“ instead of „completed“) but as long as no better solution can be provided this may serve as an appropriate proxy estimate.

Table 12. Socio-demographic information: Highest educational level completed (data)

Country	% never went to school / never completed primary school	primary level	secondary level	higher education	not known	N
Belgium (Brussels)	1	12	26	2	58	1,544
Belgium (CCAD)	8	48	16	4	25	1,681
Belgium (VAD) ¹	1	36	32	4	27	2,953
Denmark	21	40	15	1	24	4,580
Finland ²	6	60	18	1	15	2,760
Germany (EBIS) ³	13	49	21	(1)	17	13,596
Germany (SEDOS)	16	58	23		3	1,775
Greece	2	67	25	5	1	570
Ireland ⁴	<1	10	74	2	14	4,818
Italy	4	23	64	3	6	6,059
Luxembourg ⁵	21	50	29			?
Netherlands	14	41	20	5	19	6,407
Spain	12	38	40	2	8	52,440

¹ „not known“ includes special school for handicaped people, not completed school programme, part time school, ...

² N(missing)=102; Category "not known" in highest educational level might include also some cases from categories 1 and 2, because in Finnish data collection there is also a category "other" (60 cases) which includes some particular forms of training where primary school might be in the background; however, it cannot be defined accurately enough to be separated into these two categories

³ category „higher education“ comes from a different table than other data

⁴ category „not known“ includes clients with unknown educational level (n=457) and clients who are still in education (n=202); information collected is education level *reached* rather than education level *completed*

⁵ The RELIS protocol provides data on "started school level" and "completed school level". "Never went to school or never completed primary school level" include persons who started primary school and, before completion, were orientated to specialised education institutions because of their disability to meet the requirements of primary school courses.

4.11 Item 14: Primary drug (age distribution)

Figure 12. Drug-related information: Primary drug by age (opiates; cannabis)

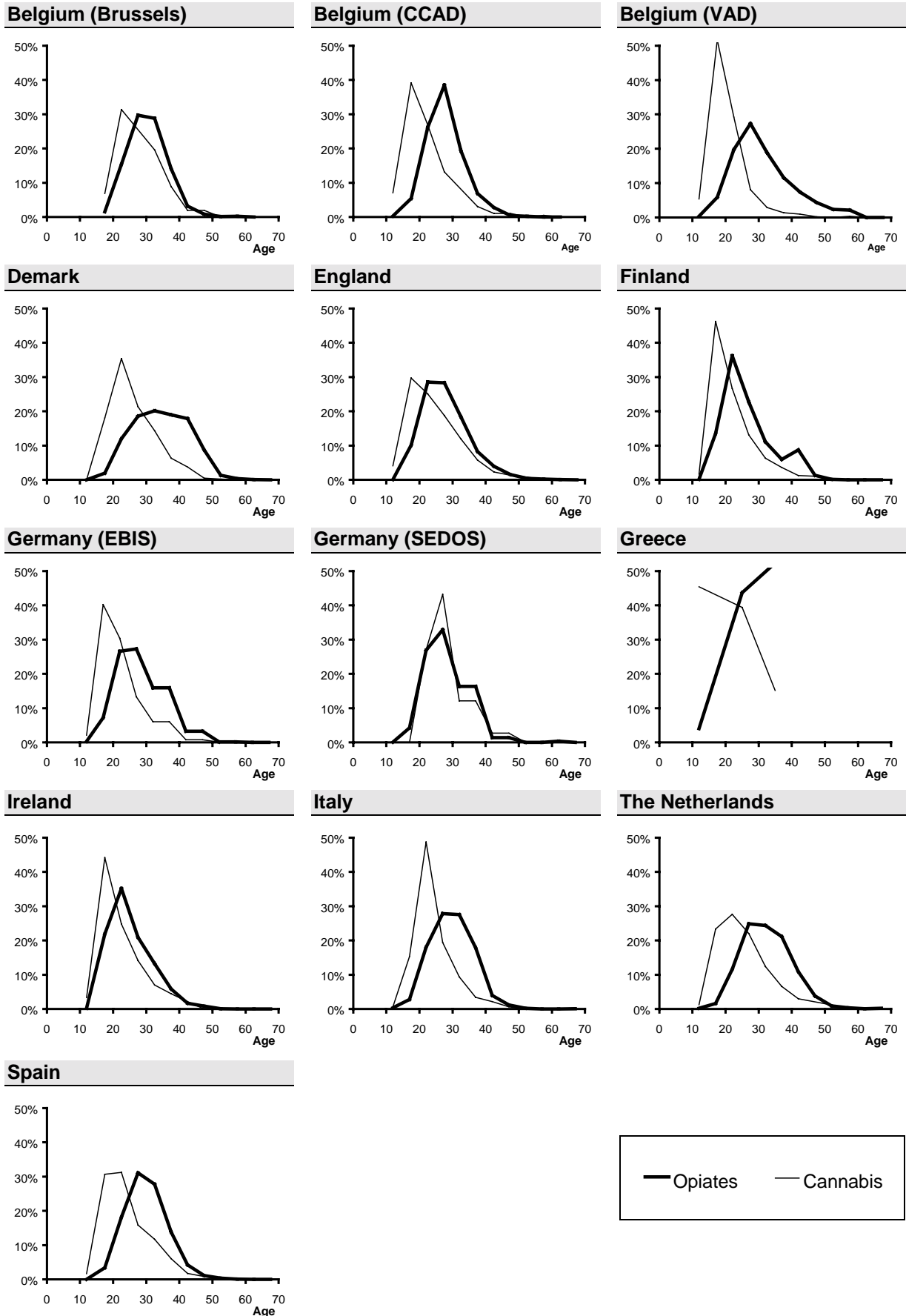


Table 13. Drug-related information: Primary drug by age (opiates; cannabis; cocaine; stimulants) (data)

Country	Age	20-24		30-34		40-44		50-54		60-64		N
	<15	15-19	25-29	35-39	45-49	55-59	>=65					
Primary drug: Opiates (%)												
Belgium (Brussels) ¹		2	16	32	31	15	3	1	<1	<1		1,108
Belgium (CCAD)	<1	5	26	38	19	7	3	<1	<1			1,001
Belgium (VAD) ¹	0	6	20	27	19	12	7	4	2	2		937
Denmark		2	12	19	20	19	18	9	1	<1	<1	3,204
England	<1	10	29	28	18	8	4	2	<1	<1	<1	15,680
Finland	<1	14	36	23	11	6	9	1	<1			585
Germany (EBIS) ²	<1	7	27	27	16	16	3	3	<1	<1	<1	7,954
Germany (SEDOS) ²	<1	4	27	33	16	16	1	1	<1	<1	<1	1,158
Greece ³		4	44		52							476
Ireland	<1	22	35	21	13	6	2	1	<1	<1	<1	3,888
Italy	<1	3	18	28	28	18	4	1	<1	<1	<1	5,272
Netherlands	<1	2	12	25	24	21	11	4	1	<1	<1	3,132
Spain	<1	3	18	31	28	14	4	1	<1	<1	<1	44,201
Primary drug: Cannabis (%)												
Belgium (Brussels) ¹		7	33	27	20	9	2	2				98
Belgium (CCAD)	7	39	27	13	8	3	1	1		1		197
Belgium (VAD) ¹	5	52	29	8	3	1	1	<1		<1		521
Denmark	<1	18	35	21	14	6	4	1	<1			398
England	4	30	25	19	12	6	2	1	1	<1	0	1,934
Finland	2	46	27	13	6	4	1	1				473
Germany (EBIS) ²	2	40	30	13	6	6	1	1	<1	<1	<1	1,976
Germany (SEDOS) ²	0	0	27	43	12	12	3	3	0	0	0	37
Greece ³		45	39		15							66
Ireland	3	44	25	14	7	4	2					516
Italy	1	15	49	19	9	3	2	1			<1	320
Netherlands	1	23	28	22	12	7	3	2	1	<1	<1	1,177
Spain	2	31	31	16	12	6	2	1	<1	<1	<1	2,208
Primary drug: Cocaine (%)												
Belgium (Brussels) ^{1,4}												
Belgium (CCAD)		2	32	33	14	12	2	4	2			57
Belgium (VAD) ¹		13	24	25	22	9	3	2		2		169
Denmark		30	30			30		10				10
England	1	10	22	27	23	12	4	2	1	<1	<1	925
Finland			100									5
Germany (EBIS) ²	<1	5	23	31	18	18	3	3	<1	<1		830
Germany (SEDOS) ²	0	6	31	32	15	15	1	1	0	0	0	88
Greece ³		not reliable, N=2										
Ireland	0	24	43	19	10	2	0	2	0	0	0	42
Italy		7	18	32	8	17	10	4	2	1	1	257
Netherlands	<1	5	22	29	20	13	6	2	1	<1	<1	1,387
Spain	<1	7	23	27	24	13	4	1	<1	<1	<1	4,625
Primary drug: Stimulants (%)												
Belgium (Brussels) ^{1,4}		4	24	31	21	10	7	1	2			107
Belgium (CCAD)	4	35	39	14	6		2					51
Belgium (VAD) ¹	2	42	35	10	4	2	3	1	1	<1		479
Denmark		14	41	20	13	7	5					76
England	<1	18	27	25	17	7	4	2	<1	<1	<1	2,230
Finland	0	13	30	27	18	6	4	1	<1		<1	971
Germany (EBIS) ⁵												
Germany (SEDOS) ⁵												
Greece ³		not reliable, N=1										
Ireland	1	49	38	7	4	1	<1	0	0	0	0	298
Italy		13	56	11	5	11	2	2				55
Netherlands	2	37	28	13	9	5	3	2	1	<1	<1	324
Spain	1	37	38	13	6	2	2	1	<1		<1	568

¹ different age distribution (ends at >=55)² different age distribution (30-40; 40-50; 50-60; >=60)³ different age distribution (<=19; 20-29; >=30)⁴ „cocaine“ and „stimulants“ are not distinguishable⁵ not calculated

Remarks

As already mentioned in section 4.5 (Item 7: Age distribution (men and women pooled)) in some countries the intervals of the age distributions differ from TDI requirements. The same phenomenon can be seen in this cross-table.

Graphs are only presented for opiates and cannabis as primary drugs. These two groups of clients may serve as prototypes for (different?) types of drug users. Nevertheless information is also available for many other drug sub-types.

Still drug addicts who show up for opiate related problems form the largest group of all registered clients. Analyses for some other drug-types may become more difficult due to small sample sizes and lacking reliability of data.

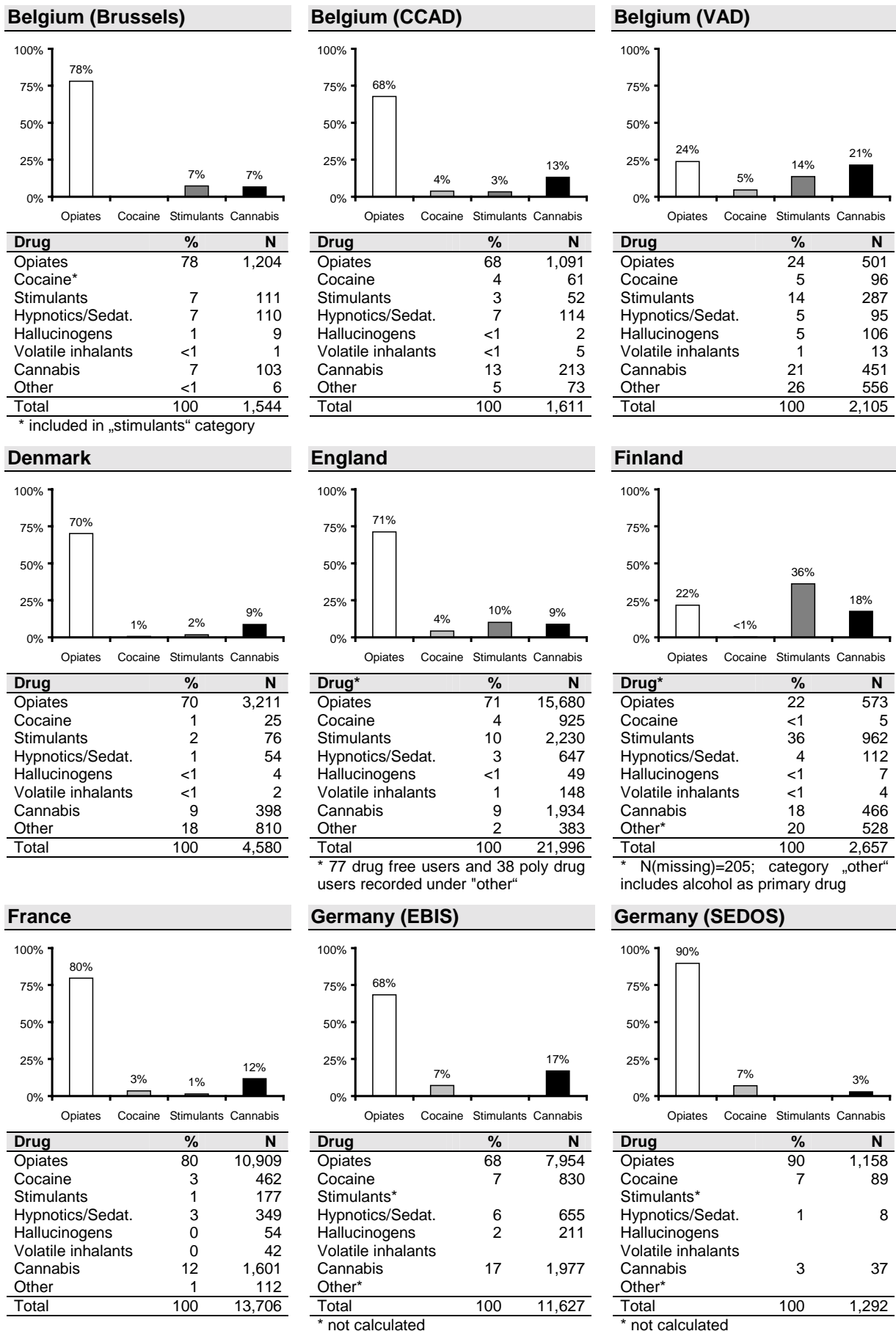
For this analysis individual country profiles have been given preference. This seemed to be the best solution to give an overview on the current situation in EU Member States. Pooling of data or calculation of means would have lead to loss of information and data quality. On the other hand differences in shape or height of country profiles again reflect differences in proportions of treatment centre types reporting to the monitoring system.

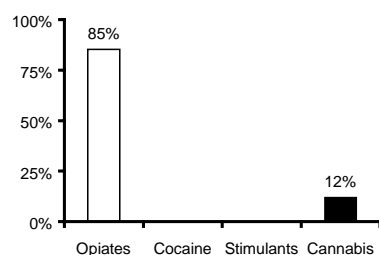
The primary drug of treated and registered clients is available in all participating countries. If certain countries are not included that is due to the fact that the data has been collected via cross-tables. This may have lead to the situation that the main drug is available but can not be stratified by the second item asked for (like it's the case in Luxembourg).

In future different stratifications e.g. by route of administration, new vs. old cases, etc. would be interesting. Like in prior tables describing age distributions a category „not known“ should be added.

4.12 Item 14 (continued): Primary drug (per country)

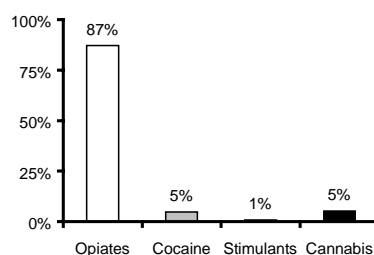
Figure 13. Drug-related information: Selected primary drugs by countries



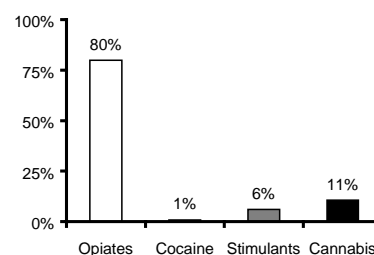
Greece

Drug	%	N
Opiates	85	476
Cocaine*		
Stimulants*	3	16
Hypnotics/Sedat.		
Hallucinogens*		
Volatile inhalants*		
Cannabis	12	66
Other*		
Total	100	558

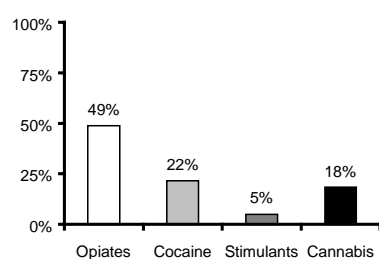
* figures not reliable

Italy

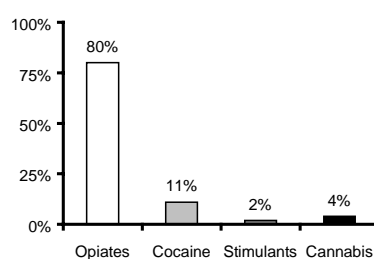
Drug	%	N
Opiates	87	5,272
Cocaine	5	292
Stimulants	1	50
Hypnotics/Sedat.	1	82
Hallucinogens	<1	2
Volatile inhalants	<1	1
Cannabis	5	319
Other	<1	30
Total	100	6,048

Ireland

Drug	%	N
Opiates	80	3,905
Cocaine	1	42
Stimulants	6	299
Hypnotics/Sedat.	2	75
Hallucinogens	1	26
Volatile inhalants	1	27
Cannabis	11	518
Other	<1	2
Total	100	4,894

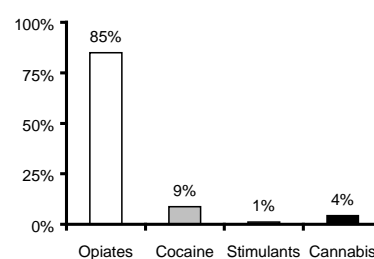
The Netherlands

Drug	%	N
Opiates	49	3,131
Cocaine	22	1,387
Stimulants	5	324
Hypnotics/Sedat.	3	207
Hallucinogens	3	179
Volatile inhalants	<1	2
Cannabis	18	1,177
Other	0	0
Total	100	6,407

Luxembourg

Drug*	%	N
Opiates	80	
Cocaine	11	
Stimulants	2	
Hypnotics/Sedat.	1	
Hallucinogens		
Volatile inhalants		
Cannabis	4	
Other	1	
Total	100	

* RELIS provides data on "preference 1, 2, 3 substances" and breakdown data by iv and non-iv use

Spain

Drug	%	N
Opiates	85	44,523
Cocaine	9	4,647
Stimulants	1	584
Hypnotics/Sedat.	1	263
Hallucinogens	<1	85
Volatile inhalants	<1	16
Cannabis	4	2,214
Other	<1	108
Total	100	52,440

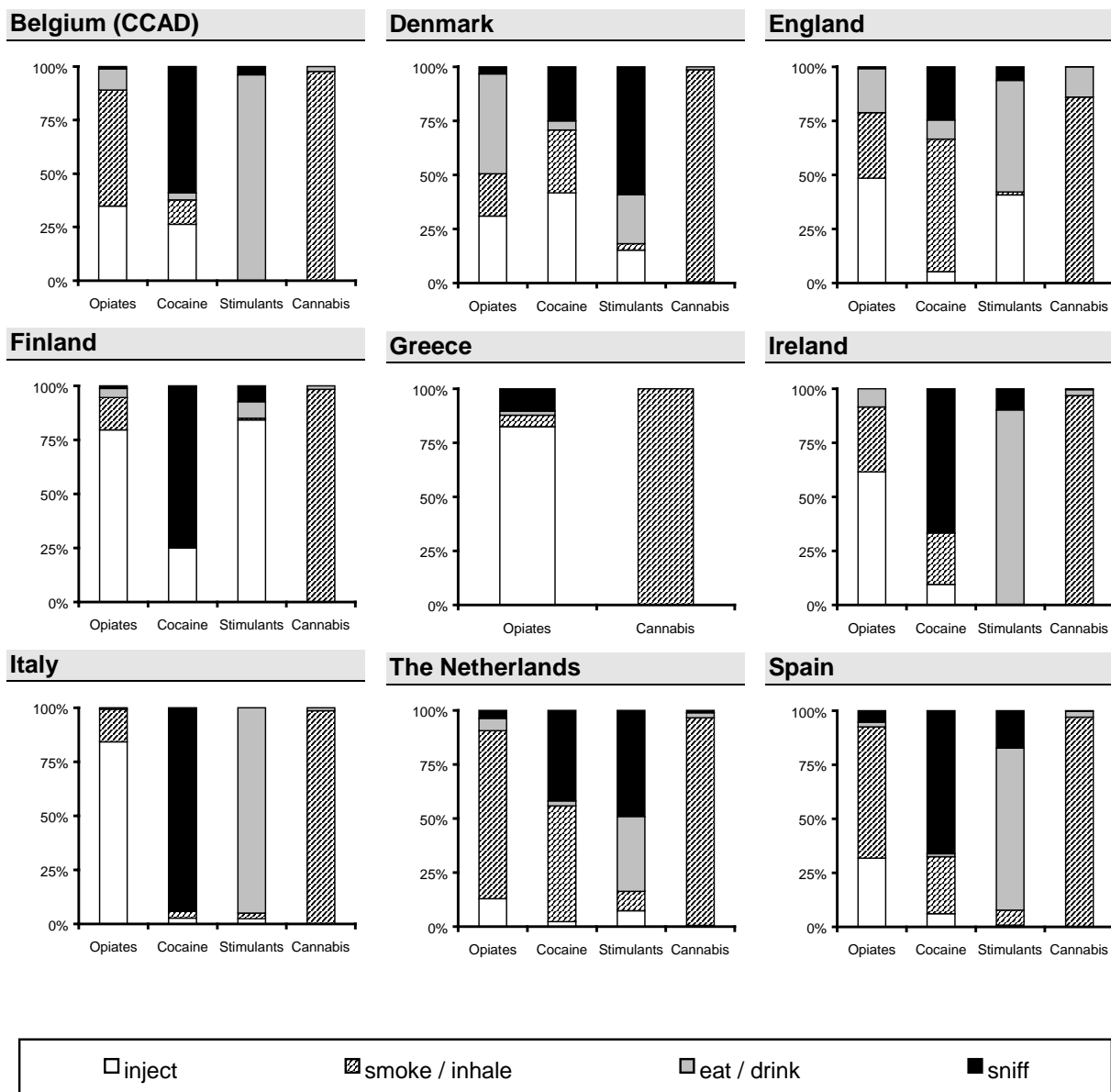
Remarks

These figures allow an easy overview on the distribution of primary drugs used by clients registered by the national monitoring systems. For some drugs the number of registered clients is very small. Again opiates, cocaine and cannabis usually account for more than 90% of all clients. Especially the large figures of opiate and cannabis users make further stratifications or detailed analyses interesting.

With single exceptions (e.g. Finland with a very high proportion of stimulant users) the figures look quite similar and may arouse scientist's curiosity to analyse single drugs (e.g. cannabis) more detailed. See „Item 14: Primary drug (age distribution)“, page 47 for additional remarks.

4.13 Item 16: Usual route of administration (primary drug)

Figure 14. Drug-related information: Usual route of administration - selected primary drugs by countries



Remarks

This item gives useful information concerning habits of use and possible problems related to certain routes of administration (e.g. injecting). Considerable differences could be obtained between countries. Analyses carried out on national level may explain some of these differences and give valuable information how or why consumption habits have changed or may be influenced.

Additional remarks are necessary to allow a realistic interpretation of the data. E.g. the proportion of persons receiving methadone among opiate users is of interest due to the fact that this sub-group will increase the share in the eat/drink category.

Table 14. Drug-related information: Usual route of administration - selected primary drugs by countries (data)

Country	inject	smoke/inhale	eat/drink	sniff	others	not known	N
Primary drug: Opiates (%)							
Belgium (CCAD)	31	49	9	1		10	1,091
Denmark ¹	30	19	44	3		4	3,211
England ²	47	29	20	1	<1	4	15,680
Finland ³	78	15	4	1		2	569
Greece	82	5	2	10		1	476
Ireland	62	30	8	<1			3,850
Italy	79	14	1		<1	6	5,271
Netherlands	10	61	5	3	1	21	3,131
Spain	30	58	2	5	1	4	44,523
Primary drug: Cocaine (%)							
Belgium (CCAD)	26	11	3	59			61
Denmark	40	28	4	24		4	25
England	5	56	8	23	<1	8	925
Finland ³	20			60		20	5
Greece							
Ireland	10	24		67			42
Italy	3	3	<1	90	<1	4	675
Netherlands	2	37	2	29	3	28	1,387
Spain	6	26	1	64	<1	3	4,647
Primary drug: Stimulants (%)							
Belgium (CCAD)			96	4			52
Denmark	13	3	20	51		13	76
England	36	1	46	6	1	10	2,230
Finland ³	82	1	7	7		2	960
Greece							
Ireland		<1	90	10			295
Italy	2	2	76		2	18	50
Netherlands	6	7	29	41	1	15	324
Spain	1	7	73	17	<1	3	584
Primary drug: Cannabis (%)							
Belgium (CCAD)		98	2				213
Denmark	1	95	1	0		3	398
England		77	12	<1	<1	10	1,934
Finland ³	0	98	2	0		<1	462
Greece		100					66
Ireland		97	3	<1			508
Italy	0	71	1	0	0	28	312
Netherlands	<1	70	2	1	1	26	1,177
Spain	<1	90	3	<1		7	2,214

¹ 44% of all registered opiate users receive or use methadone, this causes the high figure in the „eat/drink“ category

² either one or two routes of administration have been registered; if route includes "injected" it has been included as "inject"; "oral and smoke" and "oral and snort" have been grouped in category "others"

18% methadone users among opiates (footnote added due to particularly high share)

³ no category "other" exists in Finnish data collection; category "inject" might be emphasized slightly more than other categories, because in the case of several routes given in the same answer, the category "inject" was selected as the primary route of administration

4.14 Item 17: Frequency of use (primary drug)

Figure 15. Drug-related information: Frequency of use (primary drug opiates)

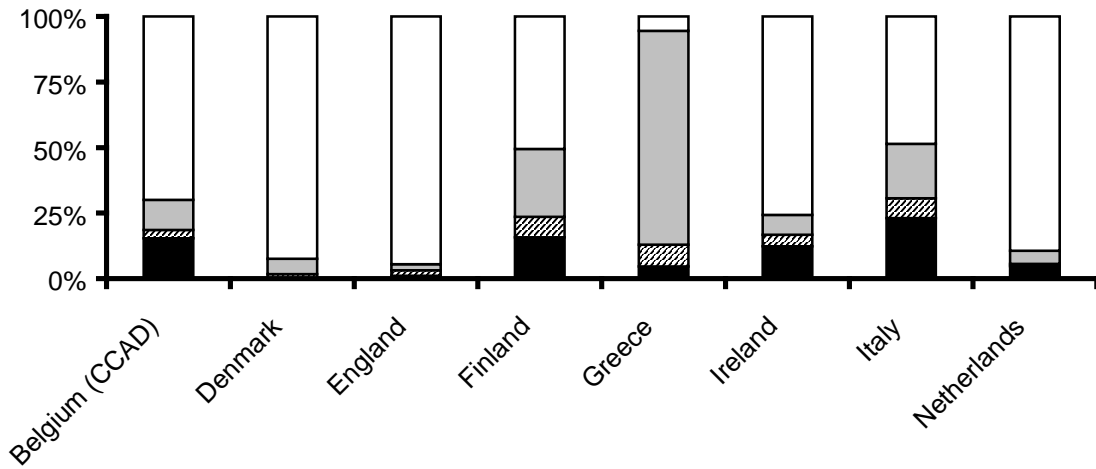


Figure 16. Drug-related information: Frequency of use (primary drug cocaine)

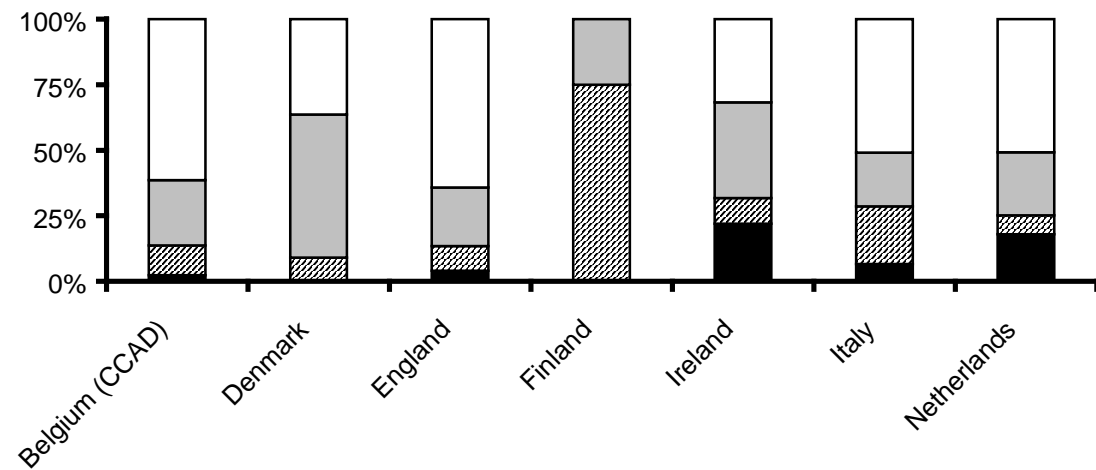


Figure 17. Drug-related information: Frequency of use (primary drug stimulants)

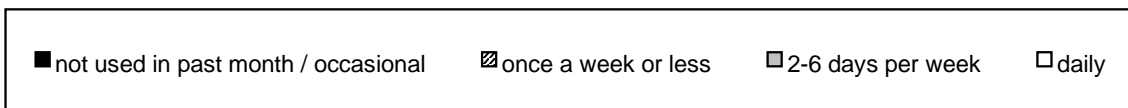
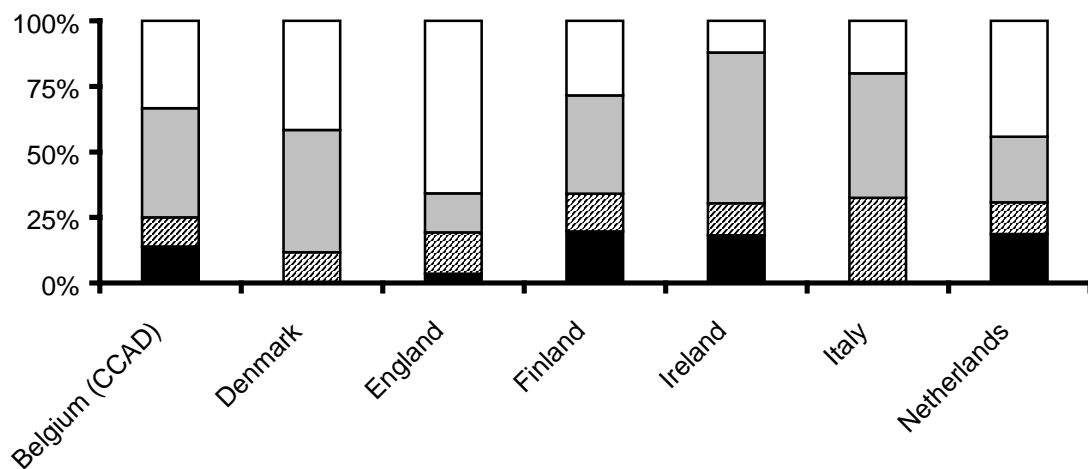
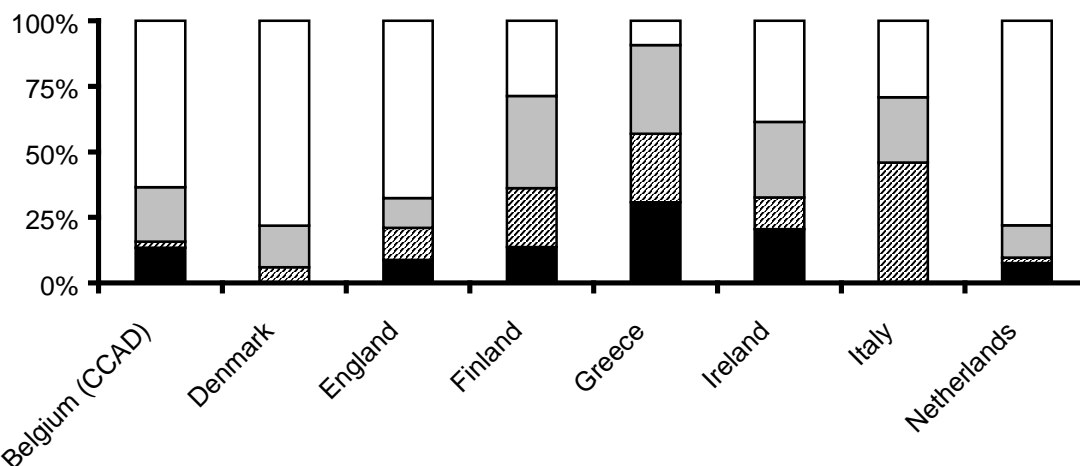


Figure 18. Drug-related information: Frequency of use (primary drug cannabis)**Table 15. Drug-related information: Frequency of use for selected primary drugs (data)**

Country	not used in past month/ occasional	once a week or less	2-6 days per week	daily	not known	N
Primary drug: Opiates (%)						
Belgium (CCAD)	13	3	10	59	16	1,091
Denmark	<1	1	5	86	7	3,256
England	1	2	2	88	7	15,680
Finland	15	8	25	50	2	525
Greece	5	8	81	5	1	476
Ireland	12	4	8	76		3,555
Italy	22	7	19	45	7	5,271
Netherlands	4	1	4	80	10	2,879
Primary drug: Cocaine (%)						
Belgium (CCAD)	2	8	18	44	28	61
Denmark		8	48	32	12	25
England	4	9	21	59	8	925
Finland		60	20		20	5
Greece						
Ireland	22	10	37	32		41
Italy	6	20	18	45	11	291
Netherlands	17	7	23	48	5	1,224
Primary drug: Stimulants (%)						
Belgium (CCAD)	10	8	29	23	31	52
Denmark		9	37	33	21	76
England	3	14	13	57	14	2,230
Finland	19	14	36	27	4	882
Greece						
Ireland	18	12	58	12		280
Italy		26	38	16	20	50
Netherlands	18	12	24	43	4	277
Primary drug: Cannabis (%)						
Belgium (CCAD)	11	2	17	53	16	213
Denmark		6	15	73	7	398
England	8	11	10	60	12	1,934
Finland	13	21	33	27	5	448
Greece	30	26	33	9	2	66
Ireland	20	12	29	39		488
Italy		44	24	28	3	216
Netherlands	7	2	12	75	4	1,083

Remarks

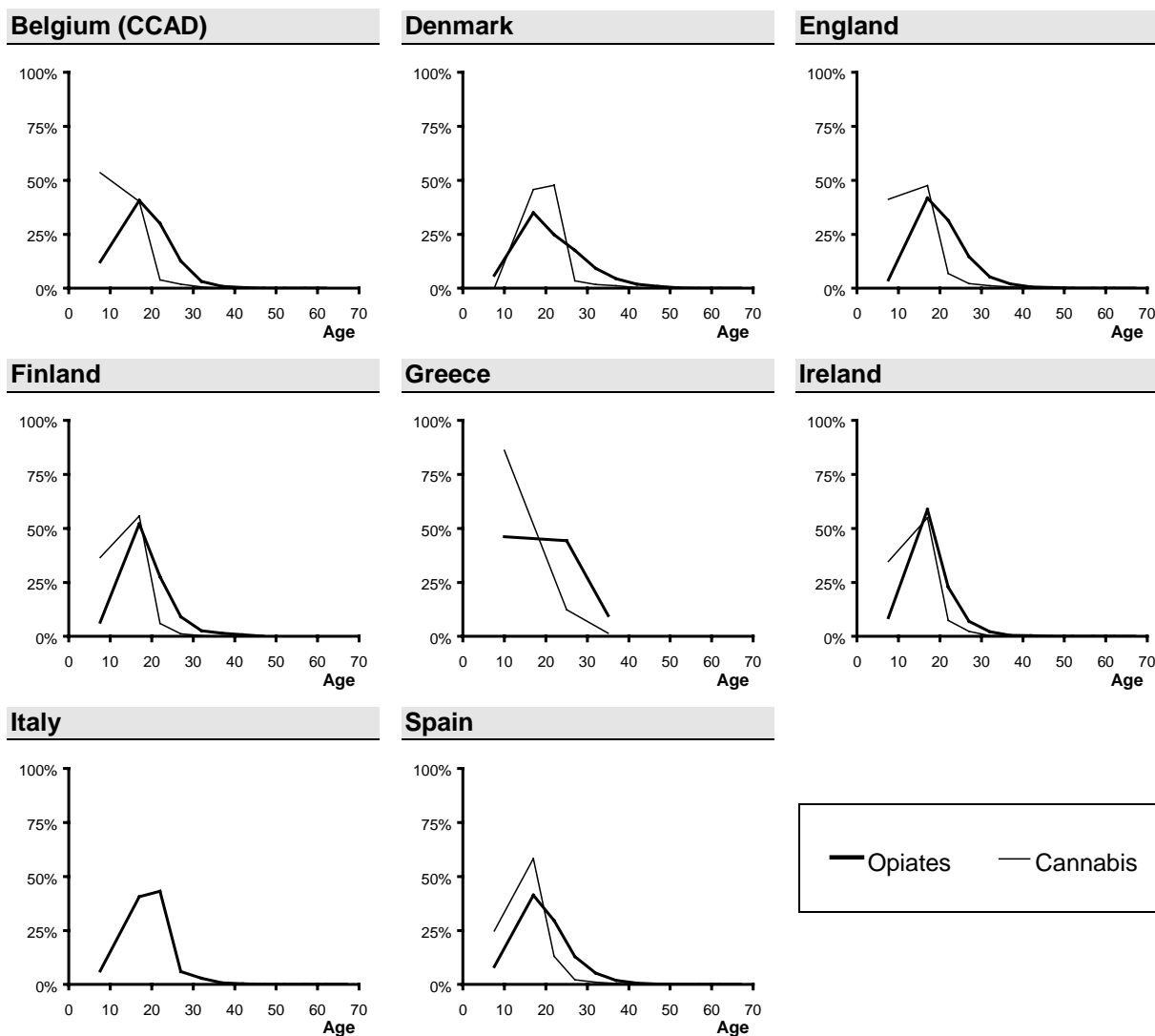
This item is strongly moderated by the drug the registered clients prefers. It is evident that opiate users tend to use their drug daily whereas great differences can be obtained for other drugs. Here the habits of consumption differ between countries whereas they are quite comparable for opiate users.

Combination with or stratification by items „Route of administration“, „Main drug“ or „Other (=secondary) drugs currently used“ may give quite exhaustive impressions about different patterns of use in EU Member States as well as comparable habits and trends.

Nevertheless some countries do not register the frequency of use (e.g. Germany, France) or have many empty cells among their data sheets or high proportions of „unknown“ cases.

4.15 Item 18: Age at first use of primary drug

Figure 19. Drug-related information: Age at first use of primary drug (opiates; cannabis)



Remarks

Careful analysis of this item may allow to identify certain age periods „at risk“ (which are more or less well known in some cases) but still a considerable amount of countries is not able to report this item as required by the TDI.

Germany registers the „beginning of problematic use“ which is slightly different from the item as requested by the TDI core item. Luxembourg has different age categories and The Netherlands have an item that gives information on the „mean length of period the primary problem lasted“ which is similar to the German definition.

Table 16. Drug-related information: Age at first use of primary drug (opiates; cannabis; cocaine; stimulants) (data)

Country	Age <15		20-24		30-34		40-44		50-54		60-64		N
		15-19		25-29		35-39		45-49		55-59		>=65	
Primary drug: Opiates (%)													
Belgium (CCAD)	12	41	30	13	3	1	<1	<1					836
Denmark	6	35	25	18	9	4	2	1	<1	<1			2,473
England	4	42	31	15	5	2	1	<1	<1	<1	<1		10,946
Finland	6	52	28	9	3	1	1						540
Greece ¹	46	44	10										459
Ireland	9	59	23	7	2	<1	<1	<1	<1				3,613
Italy	6	41	43	6	3	1	<1	<1	<1				4,980
Spain	8	41	30	13	5	2	1	<1	<1	<1	<1	<1	42,786
Primary drug: Cannabis (%)													
Belgium (CCAD)	53	40	4	2	1								159
Denmark		46	48	3	2	1	<1						348
England	41	48	7	2	1	1	<1	<1	<1				1,349
Finland	37	56	6	1	<1		<1						432
Greece ¹	73	27											65
Ireland	35	55	7	2	<1	<1	<1						464
Italy	not available												
Spain	25	58	13	2	1	<1	<1	<1					2,073
Primary drug: Cocaine (%)													
Belgium (CCAD)	10	37	34	12	2	5							41
Denmark	4	58	13	21		4							24
England	5	35	27	19	8	3	1	1	<1	<1			681
Finland	33	67											3
Greece ²													
Ireland	5	35	43	11	3	3							37
Italy	20	38	21	11	5	1	1	1	<1		<1		271
Spain	5	37	28	16	9	3	1	<1	<1	<1	<1		4,455
Primary drug: Stimulants (%)													
Belgium (CCAD)	22	56	17	2	2								41
Denmark	20	57	18	5									60
England	13	51	21	9	4	1	<1	<1		<1			1,366
Finland	12	54	22	7	3	1	<1	<1					874
Greece ¹	not available												
Ireland	13	71	12	3	1		<1						280
Italy	51	32	17										41
Spain	8	66	18	5	1	1	1		<1	<1			535

¹ different age distribution (30-40; 40-50; 50-60; >=60)

² not reliable (N=1)

4.16 Item 19: Other (=secondary) drugs currently used

Figure 20. Drug-related information: Other drugs currently used (among clients with primary drug opiates)

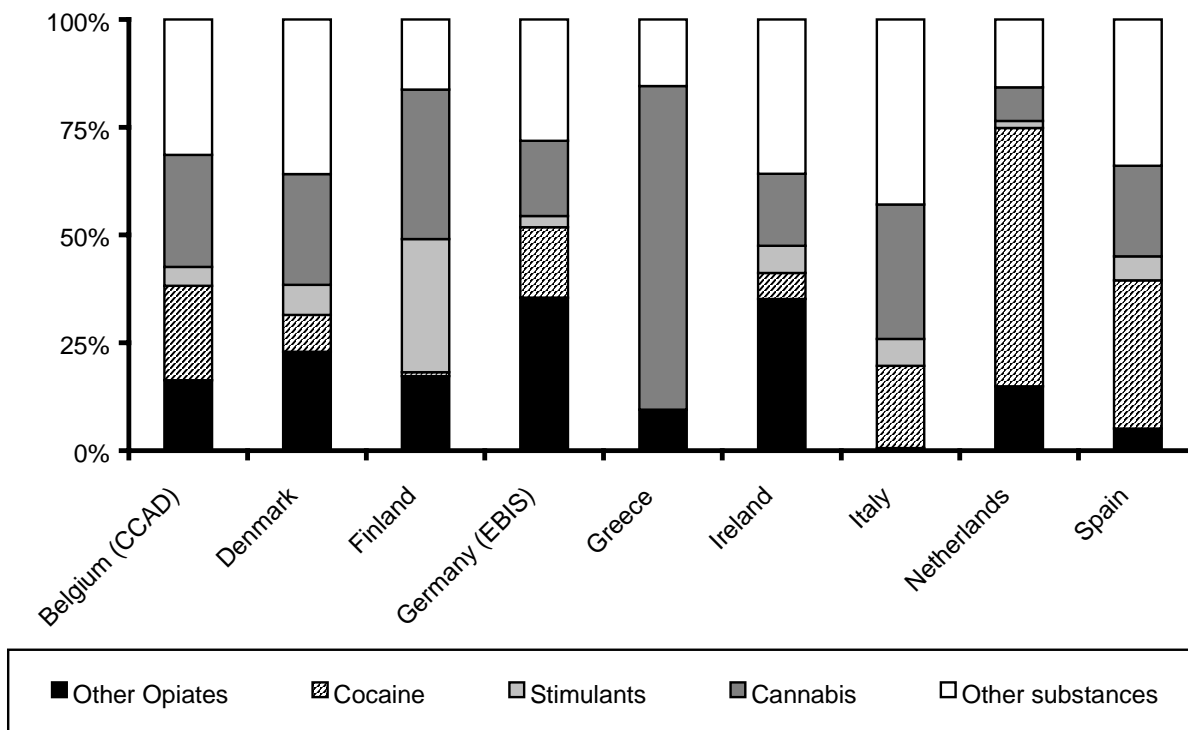


Table 17. Drug-related information: Other drugs currently used (data)

Country	% Other opiates	Cocaine	Stimulants	Cannabis	Other substances	among other: mainly	N*
Proportion of other (=secondary) drugs among clients with primary drug: opiates							
Belgium (CCAD)	16	22	4	26	31	Hypnotics (21%)	883
Denmark	23	9	7	26	36	Hypnotics (23%)	4,419
Finland	17	1	31	35	16	Hypnotics (8%)	522
Germany (EBIS)	35	16	3	17	28	Alcohol (9%)	27,391
Greece	9			75	15	Alcohol (7%)	369
Ireland	35	6	6	17	36	Hypnotics (33%)	2,913
Italy	1	19	6	31	43	Hypnotics (34%)	4,159
Netherlands	15	60	2	8	16	Alcohol (9%)	2,043
Spain	5	34	6	21	34	Hypnotics (15%)	59,642
Proportion of other (=secondary) drugs among clients with primary drug: cocaine							
Belgium (CCAD)	45	0	7	24	24	Hypnotics (14%)	58
Denmark	40	0	4	28	28	Hypnotics (14%)	57
Finland	0	0	67	0	33	Alcohol (33%)	3
Germany (EBIS)	14	36	5	18	28	Alcohol (10%)	2,912
Greece	not available						
Ireland	17		41	22	20	Alcohol (10%)	103
Italy	42	1	30		27	Hallucinog. (20%)	836
Netherlands	22	<1	6	26	45	Alcohol (31%)	41
Spain	12	<1	15	27	46	Alcohol (31%)	5,859

* Number of single diagnoses

Remarks

This item completes the information about patterns of use among drug users. Nearly all clients report to have used more than one drug. Knowledge about patterns of use are valuable for several professionals working in the drug field, especially for risk assessment arising from (uncontrollable) combination of effects.

Nearly all countries were able to report at least some information about secondary drugs. Differences could be found concerning the number of secondary drugs registered by the system.

Unfortunately information about drug subtypes are quite rare but still crosstabulation of primary and secondary drugs offers many possibilities to analyse the data. This amount of possible analyses requires clear ideas how an analysis will be carried out and what kind of information is needed.

In some countries a very detailed breakdown of drugs leads to very small sample sizes which do not allow any reliable analysis of data any more. Again, due to this analysis has been done for main drug types only but still the data allows a closer examination of single aspects if it is needed.

4.17 Item 20: Ever/currently (last 30 days) injected

Figure 21. Drug-related information: Injection behaviour by countries

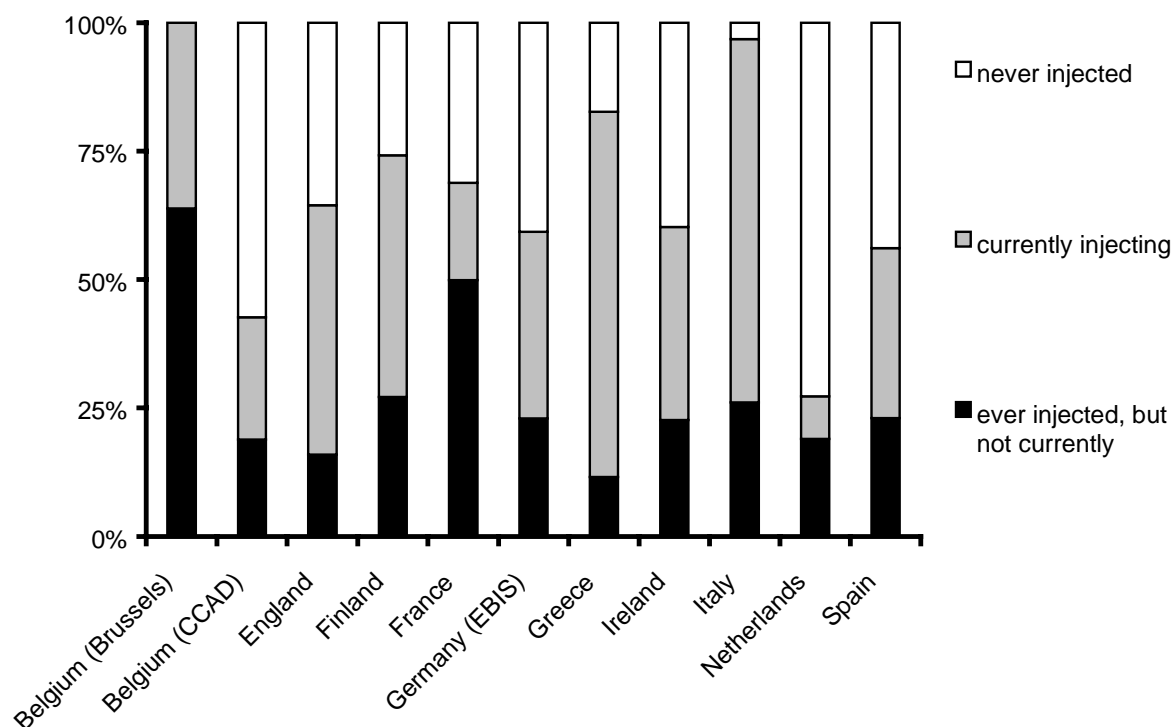


Table 18. Drug-related information: Injection behaviour by countries (data)

Country	%	never injected	currently injecting	ever injected, but not currently	not known	N
Belgium (Brussels) ¹		64	36			412
Belgium (CCAD)		15	19	45	21	1,681
England ²		13	39	29	19	21,996
Finland ³		25	44	24	7	2,437
France		46	17	29	8	14,939
Germany (EBIS)		23	36	41		5,869
Greece		12	71	17		570
Ireland		23	38	40		4,504
Italy		24	64	3	9	4,795
Netherlands		11	5	41	43	6,407
Spain		17	25	33	25	52,440

¹ data should be confirmed

² „currently injecting“ means last 4 weeks

³ N(missing)=425; the overall percentage of „not known“ and totally missing values was considerably high

Figure 22. Drug-related information: Injection behaviour (primary drug opiates)

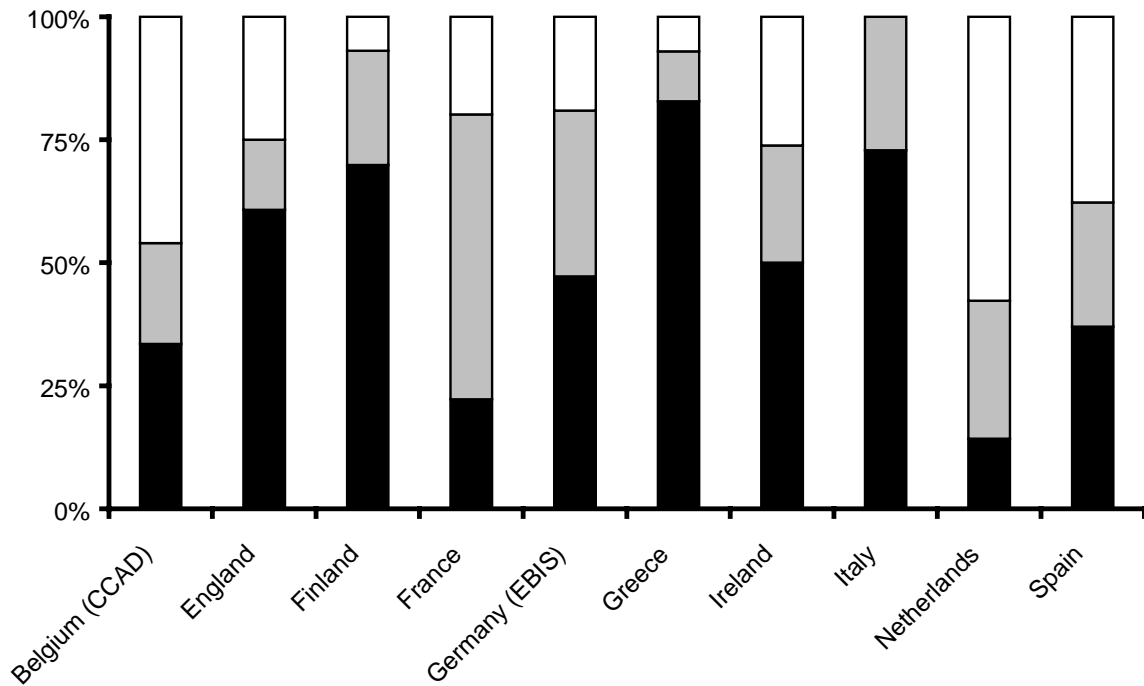


Figure 23. Drug-related information: Injection behaviour (primary drug cannabis)

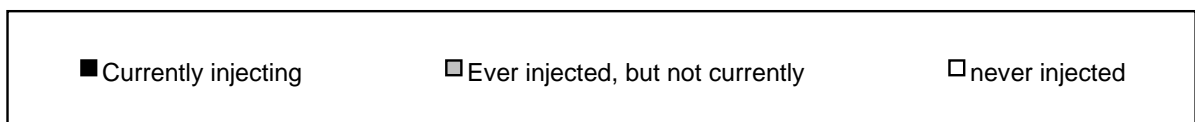
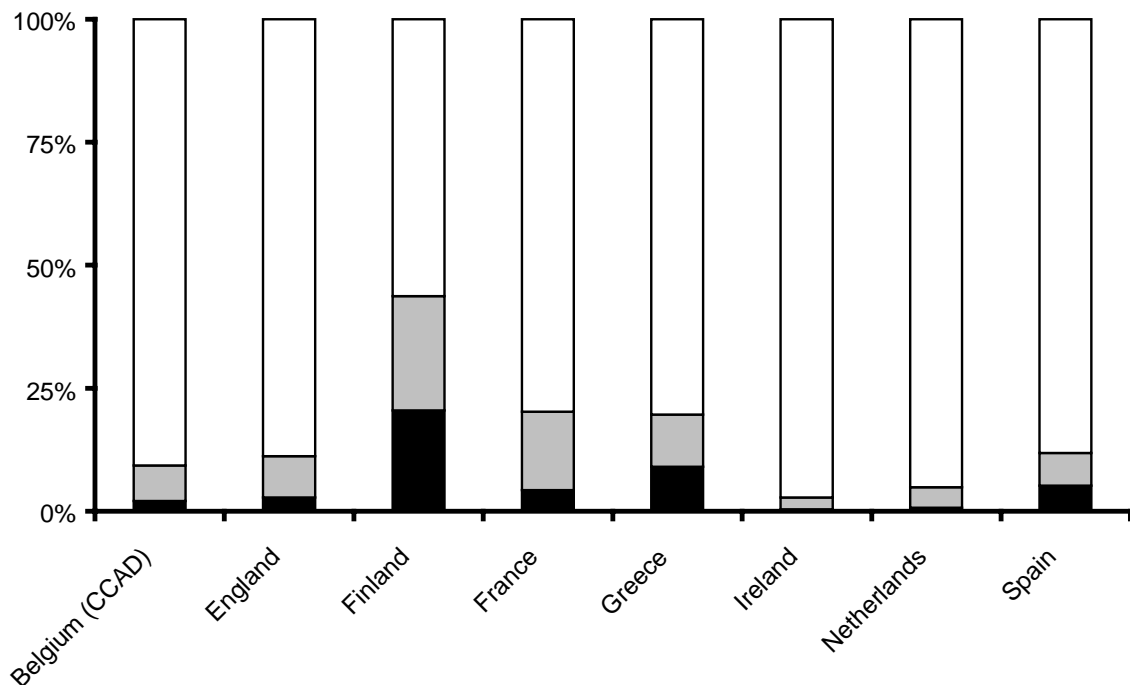


Table 19. Drug-related information: Injection behaviour (primary drug opiates; cocaine; stimulants; cannabis) (data)

Country	% ever injected, but not currently	currently injecting	never injected	not known	N
Primary drug: Opiates					
Belgium (CCAD)	19	27	37	16	1,091
England	15	49	21	15	15,680
Finland	22	68	7	3	530
France	53	20	19	8	11,736
Germany (EBIS)	26	37	37		4,683
Greece	11	82	7		476
Ireland	21	51	27		3,282
Italy	25	68	<1	7	4,503
Netherlands	18	9	36	37	3,131
Spain	19	28	28	25	44,523
Primary drug: Cocaine					
Belgium (CCAD)	7	23	43	28	61
England	6	9	63	23	925
Finland	40	20	20	20	5
France	30	17	48	5	463
Germany (EBIS)	20	36	44		1,659
Greece					
Ireland	13	5	82		39
Italy		20	54	26	91
Netherlands	4	1	51	43	1,387
Spain	7	11	56	26	4,647
Primary drug: Stimulants					
Belgium (CCAD)			88	12	52
England	9	33	35	23	2,230
Finland	29	60	8	3	861
France	19	14	62	6	181
Germany (EBIS)	9	12	79		305
Greece					
Ireland	3	<1	96		284
Italy		4	64	32	28
Netherlands	8	3	49	40	324
Spain	6	7	64	23	584
Primary drug: Cannabis					
Belgium (CCAD)	7	2	82	9	213
England	6	2	64	28	1,934
Finland	21	19	52	8	414
France	14	4	72	9	1,639
Germany (EBIS)					
Greece	11	9	80		66
Ireland	2	<1	97		496
Italy		1		99	88
Netherlands	2	<1	43	55	1,177
Spain	5	4	64	27	2,214

Remarks

The question concerning the injection behavior of treated clients is of central importance. The proportion of drug users injecting their drug has a direct impact on health problems among the drug taking population.

Corresponding to its importance from the point of view of health aspects and prevention activities nearly all countries were able to provide respective information. The stratification by drug types offers detailed insights into differences between drugs and / or countries.

Taking into consideration that the behavior itself and not the drug is mainly responsible for subsequent health problems it is of less importance to give information about which drug is injected.

The stratification by primary drug allows to identify differences in risk behavior according to differences in preferred drugs.

5 Conclusions

Most aspects have already been mentioned in prior sections. Therefore only a short overview will be given concerning necessary improvements and recommendations for next steps of the implementation.

➤ *Recommendations concerning definitions (TDI Standard Protocol)*

- Some definitions of the TDI standard protocol like “Living status (where)” or “Labour status” need very detailed information concerning national conversion rules to avoid uncertainties and incomparabilities between countries.

➤ *Necessary improvements on data level (availability, comparability)*

- Where no data or only parts of the required information are available explanations should be given what the problem is, what will be done to solve the problem, which information is available, and what steps are planned to reach a final solution. These questions have already been asked during this field trial but could have been more detailed in some cases.

➤ *Recommendations for next data collection*

- Data will be collected divided by treatment centre types.
- Agreements have to be reached concerning necessary stratification of routine data collection tables and co-ordination with the already existing data collection by the EMCDDA using EMCDDA standard tables to avoid duplications and confusion.

The TDI data collection will gradually become part of the ongoing routine data collection procedure. It will help to establish a routine data collection of treatment information following a common standard as it is laid down in the TDI Standard Protocol. In future this will allow to reduce the collection of treatment data for the REITOX national reports to the minimum. While we might not yet totally be able to avoid duplication of work between the TDI project and the standard REITOX national reports in 2000, it should be tried to keep it as small as possible. A transition period will be necessary, until the new data collection procedures for treatment information have been totally validated. It is anticipated that from 2001 on EU treatment data will only be collected by a routine procedure following the TDI.

- Detailed assignment rules should inform how national data is transferred into TDI categories and explain differences. In the framework of REITOX Specific Project 3.2 (Simon & Tauscher, 1997) “translation rules” have already been collected. These will have to be updated. Additionally examples of such national equivalencies can be found in last year’s report (Simon & Pfeiffer, 1998).

➤ *Recommendations on national level*

- It would be of interest to have as much examples as possible, how the TDI is implemented under different circumstances. This would allow to benefit from experiences already made in other countries and help to avoid mistakes or problems.
- This requires a tight documentation of steps taken, steps planned, problems, possible solutions and progress reports by each of the participating countries. Maybe some “prototypes” of settings can be identified like “existing system and its adaption”, “construction of a new system” or “changing a different – but already existing – system”.
- As much information about definitions, conversion rules, inclusion and exclusion of cases, missings, coverage rates, etc. should be given

➤ *Recommendations concerning future data analysis*

- As mentioned above there should be a broad ongoing data collection, comparable from year to year which enables to analyse trends over time.
- Additionally additional items may be collected to deal research questions of certain focused interest, on the other hand a more detailed analysis of the future “standard tables” may possibly be sufficient to answer many of these more detailed questions (that is what first experiences made during the field trial suggest)

➤ *Next Steps*

- Revision of the TDI standard protocol (definitions, editorial work: should be done until March 2000)
- Definition of standard tables and co-ordination with the ongoing data collection (EMCDDA Annual Report)
- Set-up of a “help-desk” for countries changing their system or setting up a new system
- Try to get minimal information from every country, even from those without an existing monitoring system (e.g. regional data, concepts of a future system, etc.)
- Expert meeting, leading to exchange of experiences made and problems encountered during data collection for the field trial
- Exchange with experts working on harmonisation of other epidemiological key indicators
- Definition of concrete next steps for implementation of the TDI

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