E.M.C.D.D.A.

European Monitoring Centre
for Drugs and Drug Addiction

COUNCIL OF EUROPE

Pompidou Group

EMCDDA SCIENTIFIC REPORT

**Treatment demand indicator
Standard protocol 2.0:
Technical annex**

EMCDDA/2000

Contents

Abbreviations

ACMD	Advisory Council for the Misuse of Drugs, UK
CAD	Consultatiebureau voor Alcohol en Drugs (Consultation Bureau for Alcohol and Drugs), The Netherlands
CCAD	Comité de concertation alcool et autres drogues de la Communauté française de Belgique (Consultative Committee on Alcohol and other Drugs, French Community of Belgium), Brussels, Belgium
CEEC	Central and Eastern European Country
CPN	Community Psychiatric Nurse (UK)
DMD	Drug Misuse Database, University of Manchester, UK
DTRS	Drug Treatment Reporting System, Dublin, Ireland
EBIS	Einrichtungsbezogene Informations System (outpatient information system), Germany
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction, Lisbon, Portugal
GP	General Practitioner
IAV	Instelling voor Ambulante Verslavingszorg (Institute on Outpatient Addiction Care and Treatment), The Netherlands
ICD	International Classification of Diseases
ISCED	International Standard Classification of Education
IUS	Ind- og Udskrivning af Stofmisbrugere (Danish treatment registration system), Copenhagen
IVV	Informatievoorziening Verslavingszorg (Organisation Information Systems on Addiction Care and Treatment), Utrecht, The Netherlands; holder of LADIS, IVZ sub-unit
KETHEA	Therapy Centre for Dependent Individuals, Athens
LADIS	Landeslijke Alkohol en Drugs Informatiesysteem, Utrecht, The Netherlands; national system for collecting data on drug users in treatment
MEDAR	Medical Archive
OFDT	Observatoire Français des Drogues et des Toxicomanies (French Monitoring Centre for Drugs and Drug Addiction), Paris, France
PG	Council of Europe Co-operation Group to Combat Drug Abuse and Illicit Trafficking (Pompidou Group)
Reitox	Réseau européen d'information sur les drogues et les toxicomanies (European information network on drugs and drug addiction), network of EMCDDA national and European Commission focal points
RELIS-LINDDA	Réseau Luxemburgeois D'Information sur les Stupéfiants et les Toxicomanies (Luxemburgish Information Network on Drugs and Drug Addiction)
SEDOS	Stationäre Einrichtungsbezogene Dokumentations System (in-patient information system), Germany
SEIT	Sistema Estatal de Información Sobre Toxicomanias (Spanish State Information System on Drug Abuse)
SerTs	Servizi Tossicodipendenze (Services for Addicts), Ministry of Health, Rome
SESI	Service d'Etudes et de Systèmes d'Information (Studies and Information Systems Service), Ministry of Health, Paris
SPTT	Serviço de Prevenção e Tratamento da Toxicodependência (Prevention and Treatment of Drug Addiction Service), Lisbon, Portugal

Stakes	Sosiaali ja terveysalan tutkimus ja kehittämiskeskus (National Research and Development Centre for Social Welfare and Health), Helsinki, Finland
TDI	Treatment Demand Indicator
VAD	Vereniging voor alcohol en andere drug problemen (Association for Alcohol and Other Drug Problems), Flanders, Belgium
VLIS	Vlaams Informatie Systeem (Flemish Information System), Flanders, Belgium

1. Drug-treatment-monitoring systems in the EU Member States

State of development

During 1999, nearly all 15 EU Member States participated in a field trial to implement the Pompidou Group (PG)–EMCDDA Treatment Demand Indicator (TDI) Protocol ([1]) and provided treatment data for the reference year 1997. In some cases, no information was available or other problems arose.

Countries with no operational treatment-monitoring system include Austria, Portugal and Sweden:

- Portugal's treatment-monitoring system is still under construction. While such a system has been established within a major treatment organisation, further details are not yet available.

- In Austria, a national system is planned to cover all the items required by the Pompidou Group (PG)–EMCDDA Treatment Demand Indicator (TDI) Protocol core item list.

- Until 1997, only national, aggregated statistics covering less than one-third of all services for substance abusers provided by local social-service agencies was available in Sweden.

A second cluster of countries already has regional treatment-monitoring systems in place, but need to develop mechanisms and strategies to integrate these data into a national system.

- Belgium still registers data in regional databases and the mechanism to integrate the information into one central database is still under construction.

- In Italy, no nation-wide registration system yet exists, but first steps have been taken to integrate several regional systems. For the field trial, data from two regional monitoring systems were used.

- As a result of individual monitoring systems in England, Scotland and Wales, no national data were available from the United Kingdom. A national harmonisation process is in progress.

The third group of countries – including Germany, Luxembourg and the Netherlands – already has existing systems for monitoring the treatment of drug users. Slight modifications are needed to these systems to fulfil the requirements of the TDI Protocol core item list.

France uses different monitoring systems which do not allow the ongoing registration of treatment episodes. However, the data do not seem to differ very much from those of other EU countries. It has not yet been decided how or when the French system will be changed.

In the context of this project, each Reitox national focal points was asked to nominate a treatment-monitoring expert to represent their country. Most of the information in this chapter comes from these national experts, while other information comes from written sources, previous projects and from oral descriptions given at an experts meeting held in Lisbon in July 1998. All the focal points were asked to update the country descriptions given below on a regular basis.

([1]) EMCDDA Project CT.98.EP.10.

National representatives

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

Country	Representative	Address	Contact numbers
Belgium	Patrick Leurquin, Scientific Institute of Public Health ([a])	Rue Juliette Wytsman 14 B-1050 Brussels	Tel: +32 02 642 57 34 Fax: +32 02 642 54 10 e-mail: patrick.leurquin@ihe.be
Denmark	Lene Haastrup, National Board of Health	Amaliegade 13 DK-1012 Copenhagen	Tel: +45 33 911 601 Fax: +45 33 931 636 e-mail: lnh@sst.dk
Germany	Roland Simon, Institute for Therapy Research (IFT) ([a])	Parzivalstraße 25 D-80804 Munich	Tel: +49 89 360 804 60 Fax: +49 89 360 804 69 e-mail: simon@ift.de
Greece	Anna Kokkevi, University Mental Health Research Institute (UMHRI) ([a]) (project steering group)	74 Vassilisis Sophias Avenue GR-11 528 Athens	Tel: +30 1 722 51 09 Fax: +30 1 723 36 90 e-mail: akokke@mail.ariadne-t.gr
Spain	Ana Alvarez, Junta de Castilla y Leon	Avenida de Burgos E-47071 Valladolid	Tel: +34 983 413 676 Fax: +34 983 413 742 e-mail: ana.alvarez@crd.csbs.jcyl.es
	Gregorio Barrio and Luis Royuela, National Plan on Drugs	C/ Recoletos, 22 E-28 001 Madrid	Tel: +34 91 537 27 -96/ -97 Fax: +34 91 537 27 -88 e-mail: seit@pnd.mir.es
France	Christophe Palle, French Observatory for Drugs and Drug Addiction (OFDT) ([a])	105, Rue Lafayette F-75110 Paris	Tel: +33 1 53 201 616 Fax: +33 1 53 201 600 e-mail: cpalle@ofdt.fr
	Sergine Tellier, Ministère de l'emploi et de la solidarité	7, Place des martyrs du lycée Buffon F-75014 Paris	e-mail: sergine.tellier@sante.gouv.fr
Ireland	Mary O'Brien, Health Research Board ([a])	73 Lower Baggot Street Dublin 2 Ireland	Tel: +353 1 676 11 76 Fax: +353 1 661 18 56 e-mail: mary@hrb.ie
Italy	Giovanni Nicoletti, Ministry of Health	Via della Sierra Nevada, 60 I-00144 Roma	Tel: +39 06 599 44 220/-221 Fax: +39 06 599 44 296 e-mail: misa.gn@mclink.it
Luxembourg	Alain Origer, Department for Socio-therapeutic Action, Ministry of Health ([a])	1, Rue du Plebiscite L-2341 Luxembourg	Tel: +352 404 740 Fax: +352 404 705 e-mail: alain.origer@reitox.net
Netherlands	Anton W. Ouwehand, Organisation Care Information Systems (IVZ/IVV) (project steering group)	Randehoeve 231 Postbus 504 NL-3990 GH Houten	Tel: +31 30 635 82 20 Fax: +31 30 635 82 30 e-mail: ton.ouwehand@ivv.nl
Austria	Alfred Uhl, Ludwig Boltzmann Institute for Addiction Research	Mackgasse 7-11 A -1237 Vienna	Tel: +43 1 1888 25 33 158 Fax: +43 1 1888 25 33 138 e-mail: alfred.uhl@api.or.at
Portugal	Paula Marques, Prevention and Treatment of Drug Addiction Service (SPTT)	Av. Columbano Bordalo Pinheiro, 87-2 P-1070 Lisboa	Tel: +351 21 723 5600/ 5633 Fax: +351 21 727 1599 e-mail: sptt@esoterica.pt

Country	Representative	Address	Contact numbers
Finland	Ari Partanen, National Research and Development Centre for Social Welfare and Health (Stakes) ([a])	Siltasaarenkatu 18 PO Box 220 FIN-00531 Helsinki	Tel: +358 93 967 24 76/ +358 40 510 63 83 Fax: +358 93 967 24 97 e-mail: ari.partanen@stakes.fi
Sweden	Vera Segraeus, National Board of Institutional Care	Drottninggatan 29 S-10326 Stockholm	Tel: +46 8 45 34 019 Fax: +46 8 45 34 050 e-mail: sis.ungdok@mbox300.swipnet.se
	Roger Holmberg, National Board of Health and Welfare	Socialstyrelsen S-10630 Stockholm	Tel: +46 8 783 33 65 Fax: +46 8 783 32 24 e-mail: roger.holmberg@sos.se
United Kingdom	Patsy Bailey, Statistics Division 2D, Skipton House	80 London Road Elephant and Castle London SE1 6LH UK	Tel: +44 (0)20 7972 5551 Fax: +44 (0)20 7972 5662 e-mail: pbailez@doh.gov.uk
Steering Group	Julian Vicente, European Monitoring Centre for Drugs and Drug Addiction (EMCDDA)	Rua da Cruz de Santa Apolónia 23–25 P-1149-045 Lisboa	Tel: +351 21 811 30 23 Fax: +351 21 .813 79 43 e-mail: julian.vicente@emcdda.org
Steering Group	Tim Pfeiffer, IFT	Parzivalstraße 25 D-80804 Munich	Tel: +49 89 360 804 66 Fax: +49 89 360 804 69 e-mail: pfeiffer@ift.de

Note:

([a]) Reitox national focal point

Table 2. Overview of national treatment-monitoring systems

Country	Inhabitants (millions)	Estimated number of PDA (thousands)	Monitoring system	Year established	Total number of treatment units	Treated persons covered by sources/system	Number of treated persons included per year
Belgium	10.1 ([a])	20–25	*national*: under construction	not applicable	not applicable	not applicable	not applicable
			regional: VAD (Flanders)	1980 1988	84 SO (MEDAR) 8 SR (VLIS)	100% 100%	3,550 SO 800 SR
			regional: CCAD (French Community); based on Pompidou Group Definitive Protocol	1992	35 SO 39 SR 10 SL	80% 30% 30% *Total*: 65–70%	2,400 all
			local: ADDIBRU (Brussels)	1997	12 SO 3 SR	80% 80%	2,500 all
Denmark	5.3	13	IUS	1996	n.a.	3,400 SR 90–95%	n.a.
Germany	81.5	100–150 (hard-drug addicts)	EBIS/SEDOS	SO 1980 (EBIS) SR 1994 (SEDOS)	1,100 SO 300 SR	550 SO = 50% of SO 120 SR = 40% of SR	20,000 SO (100,000 including other substances) 2,500 SR (12,500 including other substances)
Greece	10.3	n.a.	National Treatment Demand Reporting System, based on Pompidou Group Definitive Protocol plus additional items	1994	10 SO 6 SR	70% 50%	around 600
Spain	39.4	130 (hard-drug addicts)	SEIT	1987	421 SO	About 90% of the public and privately subsidised SO	42,300 SO (opiates or cocaine only)

Country							
France	58.2	160 heroin addicts	November Survey	1987	1,100 SR/SO (200) GS (500 hospitals, 400 social services)	100% of specialised centres; coverage for hospitals and social centres n.a.	65,000 SR/SO number of treated persons in GS not available
Ireland	3.6	5 ([b])	Drug Treatment Reporting System (DTRS); based on Pompidou Group Definitive Protocol	1990	45 SO/SR (detoxification included)	100% SO 100% SR 100% SL 0% GP *Total*: 80%	3,100 SO 1,200 SR 400 SL 154 SP
Italy	57.5	250–280 heroin users	Servizi Tossicodipendenze (SerTs)	1985	490 SO	95% of SO	131,700 SO
Luxembourg	0.4	2	RELIS-LINDDA; similar to Pompidou Group Definitive Protocol	1994	2 SO 3 SR 2 SL	47%	400 SO 400 SR 500 SL *Total*: 280–400
Netherlands	1.6	25–27 (hard-drug addicts)	LADIS	1986	22 SO/SL (130 units) 13 SR 20 SP	100% (25,202 unique persons) 50% (3,500 by referral SL/SO) 0% 75–80% of total number of problem drug users	25,200 SL/SO 2,000 SR 480 SP
Austria	8.1	10–30	Under construction	not applicable	150 SO/SR	not applicable	not applicable
Portugal	10.5	n.a.	SPTT statistics, two-day census (November)	n.a.	n.a.	43 SO 7 OS	200,000 subsequent treatment demands (1997)

Country						
Finland	5.1	5–10 Based on Pompidou Group Definitive Protocol	pilot testing in 1996	76 SO 47 SR <100 SL 6 SP (?)	n.a.	9,000 first treatment demands (1997) 41,300 SO 8,500 SR
Sweden	8.0	14–20 DOK	n.a.	365 SO 360 SR 405 SL	66 voluntary-care units 15 compulsory-care units	1,767 persons in voluntary care 797 persons in compulsory care
United Kingdom	49.1 ([c])	47 treated DMD total: 150–200	1986 (local) 1990 (national)	650 SO/SR/GP	about 95% of the treatment and care facilities in all regions in England plus Scotland and Wales	26,000 SO/SR/GP (new episodes per six-month period)

Notes:

([a]) 1996 figure

([b]) persons treated for problem drug use in1996

([c]) England only, 1996 figure

GO = general outpatient treatment centre

GP = General Practitioner

GR = general residential treatment centre

GS = general services

n.a. = not available

OS = other services

PDA = Person Drug Addicts

SL = specialised low-threshold unit/drop-in/ street agency

SO = specialised outpatient treatment centre

SP = specialised unit in prison

SR = specialised residential treatment centre

Table 3. Overview of national definitions and processes

Country	Monitoring system	Total number of treated persons per year	Definition of treatment episode	Case definition	Double counting avoided?

Country	Monitoring system	Total number of treated persons per year	Definition of treatment episode	Case definition	Double counting avoided?
Belgium	*national*: under construction	not applicable	not applicable	not applicable.	not applicable
	regional: VAD (Flanders)	3,550 SO 800 SR	beginning and end of treatment	person admitted for treatment during the calendar year	yes, at centre level since 1997
	regional: CCAD (French Community):	2,400	beginning and end of treatment	person admitted for treatment during the calendar year	yes, at centre level since 1997
	local: ADDIBRU (Brussels)	2,500	beginning and end of treatment	person admitted for treatment during the calendar year	yes, at centre level since 1997
Denmark	IUS	n.a.	beginning and end of treatment	person admitted for treatment at a treatment centre during the calendar year	yes, using unique civil-service numbers
Germany	EBIS	20,000 SO (100,000 including other illegal substances)	beginning and end of treatment	ICD 10 diagnosis	partly, within centres
	SEDOS	2,500 SR (12,500 including other illegal substances)	beginning and end of treatment	ICD 10 diagnosis	information from clients for first treatment
Greece	National Treatment Demand Reporting System	about 600	as Pompidou Group Definitive Protocol	drug user requesting treatment for his/her problem	fully avoided within each treatment centre as well as between treatment centres using an anonymous identification code

Country	Monitoring system	Total number of treated persons per year	Definition of treatment episode	Case definition	Double counting avoided?
					(date of birth; third letter of first name of mother and of father; gender)
Spain	SEIT	42,300 SO (opiate or cocaine users only)	Beginning of treatment. In case of drop-out, time since last admission: six months	all persons admitted to treatment because of abuse or dependence of listed psychoactive substances are registered	mostly identification at regional level
France	November Survey	65,000 SR/SO number of treated persons in GS not available	persons treated in November	all persons who receive treatment or who are still in contact with a specialised centre in November because of drug problems are registered	mostly
Ireland	Drug Treatment Reporting System (DTRS)	3,100 SO 1,200 SR 400 SL 154 SP	number of episodes is not recorded; just one contact per client per annum is counted. A count is carried out each year between 1 January and 31 December	a case is a person who receives treatment for problem drug use (excluding alcohol as a primary drug) during the calendar year 1 January to 31 December	partly, within centres; for methadone treatment a scripting control is obligatory
Italy	Servizi Tossicodipendenze (SerTs)	131,700 SO	any therapeutic or rehabilitation procedure, whether pharmacological or not, even if performed outside the service	all addicts receiving treatment in the public services in the year	partly; treatment only for local residents
Luxembourg	RELIS-LINDDA	400 SO 400 SR 500 SL *Total*: 280–400	registered admission for HRC drug-related problems	problem HRC drug use	yes, identification used
Netherlands	LADIS	25,200 SO 2,000 SR 100 SL	beginning and end of contact/treatment; end of contact/treatment also means six months with no contact	all persons in contact with an outpatient centre for drug problems are registered; one record is one subscription	yes, on all levels using nationally unique code

Country	Monitoring system	Total number of treated persons per year	Definition of treatment episode	Case definition	Double counting avoided?
Austria	under construction	480 SP not applicable	not applicable	not applicable	not applicable
Portugal	SPTT, Two-day census (November)	200,000 subsequent treatment demands (1997) 9,000 first treatment demands (1997)	n.a.	n.a.	n.a.
Finland	Based on Pompidou Group Definitive Protocol	46,000 (general substance abusers)	period a patient is in treatment in a residential treatment unit	person treated in treatment unit for substance abuse, central drug treatment units	partly, using personal-identification code
Sweden	DOK	1,767 voluntary care 797 compulsory care (1996)	period from day of intake until day of discharge	every period of treatment	LINO code: year of birth – initials – day of birth (institutional and central level)
United Kingdom	DMD	26,000 SO/SR/GP (new episodes per six months)	at first presentation and if no contact for six months	all persons in contact with a treatment/counselling centre because of drug problems are registered	mostly; identification at regional level

Notes:

n.a. = not available

GO: general outpatient treatment centre   SL = specialised low-threshold unit/drop-in/ street agency

GP: General Practitioner   SO = specialised outpatient treatment centre

GR: general residential treatment centre   SP = specialised unit in prison

GS = general services   SR = specialised residential treatment centre

National epidemiological situation and monitoring systems

Austria ([2])

Epidemiological situation

No information received.

Overview of Austria's monitoring system

In Austria, most treatment facilities maintain some statistics to document their activities. This information is partly published in the centres' annual reports. However these reports do not aggregate to national statistics and since there is no documentation standard, many of these systems are not comparable.

Institutions that fulfil a function under the Austrian narcotics law ('Treatment instead of Punishment') and receive funds from the Federal Ministry of Health have for many years been required to complete a very short standard form documenting their activities to the Ministry.

Since health in Austria falls within the competence of the nine federal states, all aspects not related to the narcotics law or to university institutions are the responsibility of the states. As they pay for many of the facilities within their boundaries, they are therefore in a position to ask for annual treatment data as well. Some states demand more detailed information from their institutions than others.

In close cooperation with the Austrian national focal point (Österreichisches Bundesinstitut für Gesundheitswesen – ÖBIG), the Ludwig Boltzmann Institute for Addiction Research was commissioned to develop a national documentation system for non-residential drug therapies. The contract consisted of two distinct components:

- to revise and improve the Ministry of Health's existing standard form for collecting treatment-demand information which had been heavily criticised and to adapt it as closely as possible to European standards (such as the PG–EMCDDA TDI); and

- to develop a larger instrument that could form the basis for an extended national documentation form within some form of national documentation system. This will also follow European standards as closely as possible. How this will be implemented will be decided once the draft has been presented and discussed by the treatment facilities, the state authorities and the national authorities in autumn 2000.

State of implementation

In Austria, a treatment-monitoring system has been under development for some years. The system will contain a core item set based on the TDI Protocol and a unit form to describe each treatment unit. A unique identifier devised according to the recommendations given in the final report on procedures to avoid double counting in drug-treatment reporting systems (PADCTRS) will be used to avoid double counting ([3]). There is an ongoing process of discussion between political institutions at national and Länder level and representatives from the treatment field. It is planned to follow the PG–EMCDDA TDI Protocol as closely as possible.

([2]) Information in this section refers to the feasibility study and final report of EMCDDA project CT.97.EP.07, August 1998.

([3]) See Origer, A. (1996) Procedures to avoid double counting in drug-treatment reporting systems. Final report, Luxembourg: Ministry of Health, and Chapter 5 below.

Belgium ([3])

Epidemiological situation

Number of inhabitants

Region	1 January 1995	1 January 1996
Belgium	9,206,296	9,233,278
Flanders	5,582,989	5,596,928
Brussels region	665,909	666,206
Wallonia	2,958,333	2,970,144
of which German Community	58,208	58,298

Estimated number of drug addicts

There are no recent official estimates from Belgian sources. De Zwart and Mensink mention an estimated 10,000 to 15,000 addicts in Belgium ([4]).

Estimated number of treatment demands

No integrated system for registering demands for drug treatment currently exists in Belgium and there are thus no accurate estimates of treatment demands. Different systems exist within the different Communities and vary in terms of the number and range of services that participate.

The following sections discuss the situation in Flanders only as the other regions did not provide information.

In Flanders, about 850 persons have been treated in specialised residential treatment centres (therapeutic communities and crisis-intervention centres), 90% of them for illicit drug-taking. Figures from other residential treatment centres (psychiatric hospitals) are not published.

In all of Flanders' 85 outpatient treatment centres (centres for mental health), 9.3% of the total patient group (N= 45,730) – a total of 4,253 persons – presented for dependence on (licit and illicit) substances. The proportion of illicit drug users in this figure is unknown ([5]).

National care system for drug addicts

In Flanders, treatment for people with illicit drug problems is offered by a variety of services. Since 1992 to 1993, a growing number of new services have been established and existing services have increased both the quantity and range of the treatment they offer.

The specialised residential therapeutic communities and crisis-intervention centres provide in-patient treatment for a limited number of persons. Other residential treatment centres (psychiatric hospitals) which have traditionally focused on alcohol problems have also begun to treat illicit drug use.

In all of the 85 centres for mental health, help for problems related to dependence on (licit and illicit) products is available. Between 5 and 10 services attract the major proportion of all those seeking such help. Since 1992 to 1993, day-care centres have also played a role in treatment mainly by working with illicit drug users.

In 1996, it was decided to create nine medico-social relief centres (low-threshold services) for illicit drug users. To date, only four such centres are operational in Flanders.

General practitioners (GPs) seem often to treat illicit drug users, although it is unclear to what extent users rely on these doctors.

([4]) de Zwart, W. M., Mensink, C. (1995) *Jaarboek verslaving 1995, over gebruik en zorg cijfers*, Bohn Stafleu Van Loghum.

([5]) Samenwerkingsplatform Federatie van diensten voor Geestelijke Gezondheidszorg – Verbond der Medisch-Sociale Instellingen, Registratiegegevens Centra voor Geestelijke Gezondheidszorg 1995, Gent, 1996.

Overview of Flanders' monitoring system

The monitoring system used in Flanders only draws data from the eight specialised residential treatment centres. These centres – three therapeutic community centres and five crisis-intervention centres – have used the Vlaams Informatie Systeem (VLIS) registration system since 1988. At the end of 1996, the Flemish Minister of Health launched a new project to develop a registration system for all treatment facilities dealing with licit and illicit drugs. This project is being developed by the Vereniging voor alcohol en andere drug problemen (Association for alcohol and other drug problems – VAD).

In Belgium, drug addicts tend to apply for care to three types of services:

- institutions specialising in drug addiction;
- mental-health centres; and
- general practitioners.

The breakdown between these three services varies from region to region.

Several monitoring systems exist in Belgium. The Comité de concertation alcool et autres drogues de la Communauté française de Belgique (CCAD), VLIS and ADDIBRU are used by specialised centres, and the MEDARD and PSYFILE systems by mental-health services. No consensual system exists for GPs.

State of implementation

In 1996, a working group composed of representatives of the CCAD, VLIS, PSYFILE, MEDARD and ADDIBRU systems proposed that the following items be systematically collected by the various monitoring systems and services:

- identification of treatment centre (type);
- patient number code;
- date (of start) of treatment;
- age;
- gender;
- residence (postal code);
- civil status;
- main drug used (primary drug);
- main diagnosis (maximum of three);
- main problem(s) (maximum of three);
- first (or subsequent) contact(s) with the centre;
- source of referral;
- current living status (with whom);
- current living status (where);
- nationality;
- highest educational level reached;
- secondary drugs (1 and 2);
- main source of income; and
- professional situation (employment status).

It was agreed that each of these items should be defined precisely to allow the results to be

compared since codes and definitions may vary from one system to another. Inclusion criteria (what is meant by 'drug addict', 'care applicant', 'patient' and so on) are still be defined.

As a result of this agreement, the ADDIBRU software was modified in Brussels with effect from 1 January 1997. ADDIBRU registration includes, among others, two additional items from the Pompidou Group's Multi-city Study ([6]):

- currently injecting; and
- ever injected.

Other items from the Multi-city Study are not included.

Number of participants

Eight centres are participating in the actual registration of treatment cases. The project will integrate data from the specialised residential treatment centres, the centres for mental health, the psychiatric hospitals and the medico-social relief centres in Flanders, about 150 centres in total.

Coverage of the monitoring system

The VLIS registration covers treatment facilities with a RIZIV convention. While the system provides sectoral coverage (kind of treatment), it does not cover all treatment centres globally. The new project aims to cover all specialised treatment centres, both in-patient and outpatient.

Definition of treatments/treatment episode

A 'treatment episode' is defined as the period during which a patient stays in an in-patient treatment centre. This period starts on the day the patient is taken into treatment and ends when the person leaves, with or without the consent of the centre. When a person returns to the centre, a new treatment episode starts.

Preventing or controlling double counting

Within the Vlis-dc system double counting is only controlled at the level of each separate institution. A patient returning to the same treatment centre in the same year receives the same file number. There is no control for double counting at coordinating-institution level.

Denmark ([7])

Epidemiological situation

Estimated number of drug addicts

In Denmark, the number of problem drug users is estimated at roughly 12,500 out of a population of 5.3 million.

National care system for drug addicts

During the last few years, there have been great changes in the treatment available to drug abusers. While the treatment sector has been allocated considerably more resources, new legislation in this area has clearly placed the responsibility for all types of treatment of drug abusers with the counties. The county drug-abuse treatment centres – and, in some areas, municipal centres – now send clients to outpatient treatment, in-patient treatment, methadone-supported treatment and drug-free treatment, usually at both private and public institutions.

([6]) The Multi-city Study was begun in the 1980s as a collaborative exercise among several major European cities facing increasing drug problems in order to develop common methods to assess these problems.

([7]) Information in this section refers to the feasibility study and final report of EMCDDA project CT.97.EP.07, August 1998.

Overview of Denmark's monitoring system

New in-service training opportunities and increased support for research have facilitated developments in treatment. On 1 January 1996, a new national register of drug abusers in treatment – Ind- og Udskrivning af Stofmisbrugere (IUS) – was established by the National Board of Health in cooperation with the Department of Psychiatric Demography at the Psychiatric Hospital in Århus, the Association of County Councils in Denmark, the Ministry of Health and the treatment centres. In the first phase, the numbers of persons undergoing treatment for drug abuse together with a description of their situation and characteristics when they commence treatment will be accessible. In a later phase, the register will include other information, gradually providing more in-depth information about the scope and development of the problems.

State of implementation

The register includes all persons that the county or municipal centres have sent for treatment for drug abuse, irrespective of whether the treatment is outpatient, day or residential in-patient, methadone-supported or drug-free.

Finland (⁸)

Epidemiological situation

No information received.

Overview of Finland's monitoring system

The Finnish national focal point pilot tested the treatment-demand reporting system in September 1996. Forty-six treatment centres participated in the project, of which only four units treated drug problems exclusively. The reporting form used was almost identical to the original Pompidou Group Definitive Protocol and data collection lasted for about three months. In general, the participating treatment centres had a positive attitude towards the project. Data will continue to be collected at national level by intake workers and therapists when a client contacts a service with a treatment demand. The focal point will receive the individual data which will be identified through an anonymous code only decipherable by the treatment unit. The coverage of treatment services will vary depending on the area.

Currently, statistical data on all outpatient treatment centres (information on substance-abuse treatment in general as drug abuse cannot be separated) are available at the national focal point. Information following the structure of the Pompidou Group Definitive Protocol is available on a voluntary basis from 30% of units. In addition, a census of intoxicant-related cases is taken in every social and health service (in-patient and outpatient) unit every four years. The one-day census provides information about the client's social background, the treatment and the substance abused. The census is implemented by the Social Research Unit for Alcohol Studies of the National Research and Development Centre for Social Welfare and Health (Stakes).

About 80% of in-patient treatment units are included in the social-welfare care register. These units provide general information on treatment, but drug abuse can be separated out using International Classification of Diseases (ICD) 10 codes on a voluntary basis. ICD 10 codes are used only in 50% of cases. Information following the structure of the Pompidou Group Definitive Protocol is available on about 35% of units. This system also works on a voluntary basis.

In Finland, all GPs that have legally prescribed narcotic drugs (mentioned in the narcotics decree) to their patients can be identified.

(⁸) Information in this section refers to the feasibility study and final report of EMCDDA project CT.97.EP.07, August 1998.

Because Finland's drug-treatment information system is still being developed and the data are not yet analysed in depth, more detailed questions concerning coverage and quality cannot yet be answered.

State of implementation

No information received.

France (⁹)

Epidemiological situation

Number of inhabitants

There are 58,200,000 inhabitants in France.

Estimated number of drug addicts

An estimated 160,000 heroin addicts have already been, or about to be, treated.

Estimated number of treatment demands

There are about 70,000 treatment demands per year in specialised centres (outpatient, in-patient, prison units).

National care system for drug addicts

This section describes only the specialised structures for drug addicts directly financed by the state (General Health Department, Department of Social Action) as a result of a law of 31 December 1970. Other specialised organisations are financed by departmental councils, municipalities, private donations and so on.

Specialised care and harm-reduction structures

Specialised structures designed to provide care for drug addicts were implemented by the 31 December 1970 law. This law also guarantees free and anonymous care for those who want it, both for withdrawal treatment in public-health establishments and treatment in specialised care structures set up for drug addicts. The treatment facilities created by the 1970 law are specific structures compared to those monitoring patients in the psychiatric sector, or those providing treatment for alcoholic patients. 60% are run by associations, and 40% by public hospitals.

The following care structures are currently in operation:

- specialised outpatient drug-addiction-treatment centres (ensuring global treatment for drug addicts);

- specialised in-patient drug-addiction-treatment centres (residential therapeutic centres and therapeutic communities);

- permanently manned host areas, therapeutic-relay apartment networks, host-family networks and transitional or emergency housing run by specialised drug-addiction treatment centres;

- specialised drug-treatment centres operating in prisons; and

- low-threshold centres (providing information, syringe exchange, hygiene and rest facilities, and medico-social services).

Since January 1995, all specialised centres have been able to prescribe methadone for those addicted to opiates while general practitioners can only intervene by relay. General practitioners in urban areas, however, have been able to treat drug addicts with Subutex®, a substitution product containing high doses of buprenorphine, since February 1996.

(⁹) Information in this section refers to the final report of Reitox sub-task 3.2, July 1997.

In addition to the low-threshold centres, the harm-reduction and drug-prevention policy usually provides tools such as drug-prevention kits, syringe-exchange programmes and automated syringe-distribution and recovering machines.

Specialised drug-prevention and integration structures

The following drug-prevention structures exist:

- 'listening' areas for young people or their parents (providing information, offering an initial host area for those experiencing problems, those at risk of drug addiction, drug users, their families and those around them);

- emergency housing centres ('sleep-ins') for drug addicts at risk (ensuring emergency housing at night, and offering advice on health and social issues during the day);

- integration workshops (to help rehabilitate drug addicts both socially and professionally);

- permanent social and legal services (providing information and legal advice about civil order and or criminal problems relating to drug laws and the consequences of drug addiction); and

- QIS, a prison programme providing social help to drug users and other addicts to prepare them for leaving prison

Overview of France's monitoring system

The November survey has been conducted each November since 1987. The survey is a census of all those undergoing treatment for drug addiction during November – whether the treatment was started before or during that month – in specialised centres, hospital services or social services.

Regional services are responsible for gathering the data and checking the questionnaires in their region. The national analysis is conducted by the Studies and Information Systems Service (SESI) of the Ministry of Health.

Participating centres

The participating centres include:

- specialised outpatient/in-patient centres, treatment units in prison:

- public general and psychiatric hospitals; patients seen during day-time consultations are excluded, except where these are psychiatric consultations or consultations specifically for drug addiction which are included in the survey; and

- in-patient centres for social rehabilitation not specialised in drug treatment, clubs and other organisations run by teams of drug-prevention workers.

State of implementation

Number of participants

About 200 specialised centres, 500 hospitals and 400 social centres are linked to the state health scheme.

Coverage of the monitoring system

The system is national in coverage.

Definition of treatments/treatment episodes

Inclusion criteria:

- specialised centres: all those undergoing (or beginning) treatment in November;

- non-specialised centres (hospitals and social services): all those undergoing drug-addiction-related treatment in November (for current as well as previous drug use); and

- regular, long-term illicit drug users and licit substance misusers.

Exclusion criteria:

• alcohol addicts (alcohol as the main substance used).

Preventing or controlling double counting

To avoid double counting, hospitals and social services ask whether the patient is simultaneously undergoing treatment in a specialised centre during the November survey. But there is no means of avoiding double-counting at individual level.

Germany (¹⁰) [10]

Epidemiological situation

Number of inhabitants

Germany has 81,500,000 inhabitants.

Estimated number of drug addicts

There are an estimated 100,000–150,000 'hard'-drug addicts in Germany.

National care system for drug addicts

Around 1970, when the drugs problem first came to prominence in Germany, drug addicts were initially treated in existing outpatient centres designed for alcoholics. Later, increasing numbers of special counselling centres were created specifically for drug addicts.

According to a survey by the Federal Ministry for Health, there are just under 1,100 outpatient counselling centres. In contrast to the early days, there are now far fewer centres specialising exclusively in counselling drug addicts. Nevertheless, the majority of centres have a certain bias towards treating alcoholics or drug addicts. This has been calculated as giving a total treatment density of approximately 72,000 inhabitants per counselling centre.

The outpatient centres carry out an extremely comprehensive and diverse range of measures oriented both towards the individual and towards more general aspects of psychosocial work to assist drug addicts. Work with individual cases consists above all of measures to make contact with users, for example through outreach social work in the drug scene, via practical support services such as emergency beds, contact shops, tea shops, and so on, and through crisis interventions, diagnostic measures and psychosocial counselling on an individual or group basis or including partners and family members. A whole series of centres also carry out psychotherapy oriented towards abstinence, or including methadone substitution. The standard range of therapeutic work and services includes preparing clients for treatment at other centres, negotiating this treatment and accompanying the clients, especially into residential detoxification.

For some years, health-policy considerations have also been applied to revalue outpatient activities to care for people with drug-induced illnesses. As regards services to drug addicts, low-threshold and follow-up services after detoxification have been received far more positively recently alongside more traditional approaches. This has greatly broadened the spectrum of different aid services and provides a more adequate response to the different problems and needs of addicts.

Throughout Germany, there are approximately 400 residential centres for treating drug addiction. Most of these are specialised clinics and therapeutic communities, or specialised departments of psychiatric clinics, some of which have concentrated, particularly in the past few years, on carrying out withdrawal treatments. According to the findings of the Stationäre Einrichtungsbezogene Dokumentations System (SEDOS) system of documenting residential centres, introduced in 1994, approximately 20% of residential centres specialise in treating drug addicts.

(¹⁰) [10] Information in this section refers to the final report of Reitox sub-task 3.2, July 1997.

In contrast to the wider scope of the work of specialised outpatient centres, the residential specialised centres concentrate almost exclusively on withdrawal treatments.

Methadone substitution as a form of treatment for drug addiction is regulated by the Ruling on the Prescription of Dangerous Drugs. The core of these guidelines is discrimination according to indications; substitution with methadone can only form part of the treatment if certain highly specific indications apply. If other substances are used – particularly codeine and dihydrocodeine – for patients in public-health insurance plans, only the less detailed rules of the Prescription Ruling are relevant; for the private patients, not even these rules apply.

The basic number of methadone-substituted patients is around 35,000. The number of patients on substitution with codeine products is about 20,000 (1995 figure). Nationally, about 2,400 general practitioners in independent practice are authorised to give substitution treatment to patients in public-health insurance plans, and about half of these do so. As the regulations are different for private patients there are no further details on the number of doctors who offer substitution therapy outside the group authorised for settlement under public-health insurance plans. The number of doctors who use codeine or dihydrocodeine as an alternative or adjunct in substitution treatment is quite unknown.

A number of outpatient substitution centres and other specialised substitution-therapy centres exist in Germany, particularly in urban areas. However, compared with the figures for doctors in independent practice, very little substitution treatment is carried out in these specialised centres.

The inadequate monitoring of methadone prescription and the complete lack of monitoring of codeine products in Germany is particularly deplorable.

Overview of Germany's monitoring system

Outpatient care

Besides the relatively small-scale (local) systems, the main system for gathering information about the treatment of drug addiction through outpatient centres is the Einrichtungsbezogene Informations System (EBIS) data-collection system, run by the Institute for Therapy Research since 1980.

EBIS gathers information about those receiving care in outpatient-counselling and treatment centres for problems with legal or illegal addictive substances. Approximately half the 1,091 centres of this type in the Federal Republic participate in EBIS. Once a year, tabular data are obtained from these centres on those undergoing treatment, their problems, the nature of the care they receive, and some of the treatment outcomes. These data are compiled from the whole of the Federal Republic and are published in annual reports.

The EBIS system has been run continuously since 1980 and is supported financially by the Federal Ministry for Health. The data from EBIS reveal long-term trends and basic information relating to the drug users treated. With approximately 60 items of data per person treated, EBIS is the most comprehensive routine source of information on people in Germany with addiction problems.

In-patient care

As with outpatient care, there are various information systems available to describe the treatment of drug addicts as in-patients in specialised clinics. At national level, the SEDOS system, also run by the Institute for Therapy Research, is the main gatherer of data on the treatment of alcoholics and drug addicts in residential facilities.

SEDOS has been in existence since 1994. At present, around 180 in-patient centres participate, including specialised clinics for drug addicts and/or alcoholics, psychiatric centres and transitional institutions such as hostels. In 1995, the second annual evaluation of SEDOS was presented, containing data on 17,000 people from 106 in-patient treatment centres treated that year.

Besides EBIS and SEDOS, which are used throughout Germany, a number of smaller regional information-gathering systems are being developed. The statistical board of the German Council on Addiction Problems has ensured that the questionnaires these systems use are compatible so that the information they collect can, in principle, be combined.

State of implementation

Number of participants

- 550 outpatient centres (EBIS);

- 150 in-patient centres (SEDOS).

Coverage of the monitoring system

45–50% (both EBIS and SEDOS).

Definition of treatments/treatment episode

A 'treatment episode' is defined as the period a patient stays in an in-patient treatment centre. This period starts on the day the patient is taken into treatment and ends when the person leaves, with or without the consent of the centre. When a person returns to the centre, a new treatment episode starts.

Handling to prevent or control double counting

Within the EBIS and SEDOS systems there is only control for double counting on the level of each institution separately. There is no control for double counting on an upper-institution level.

Greece ([11])

Epidemiological situation

No information received.

Overview of Greece's monitoring system

In May 1994, the Greek national focal point carried out a pilot study to test the application of the adapted and translated Pompidou Group Definitive Protocol which is identical to the original protocol with very few questions added to it. The implementation of the pilot study was satisfactory and as a result the Greek focal point established the National Treatment Demand Reporting System in co-operation with Greek treatment services to study the numbers and characteristics of drug users asking for treatment. The staff of all existing treatment services in the country agreed to participate in developing the reporting system. Those working in the treatment services were trained to administer the protocol at the first contact a drug user would have with the counselling unit of each service.

Since then, the Treatment Demand Reporting System has operated on a routine basis, and data concerning drug users requesting treatment for their drug problem are collected, avoiding duplication of individuals within or between treatment centres. An anonymous code – consisting of the date of birth of the client, the third letter of the first name of the mother, the third letter of the first name of the father and the client's gender – is used to prevent double counting. The protocols are completed by trained interviewers at the first contact the client has with the treatment service and are sent in paper-based form to the focal point at the end of each month. Following the statistical analysis of individual data, feedback is given to the treatment services once a year.

State of implementation

The reporting system is now in its sixth year of development. However, it covers less than 50% of the total number of treatment demands in the country, because not all treatment

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([11]) Information in this section refers to the feasibility study and final report of EMCDDA project CT.97.EP.07, August 1998.

services available in Greece continue to participate in the system. In the second semester of 1995, two major treatment services in the greater Athens area – the Therapy Centre for Dependent Individuals (KETHEA) and 18 ANO – stopped providing the necessary information to the focal point for reasons of confidentiality. However, in the same period two pilot methadone-substitution programmes began operating and providing data to the system. The successful implementation of these programmes led to their further continuation and expansion.

A total of nine treatment centres participate in the reporting system: two residential of which one is an in-patient psychiatric hospital and one a therapeutic community; and seven non-residential.

Ireland ([12])

Epidemiological situation

Number of inhabitants

The population of Ireland is 3.6 million with just over one million people living in Dublin ([13]).

Estimated number of drug addicts

It is difficult to estimate the number of drug users as no prevalence estimates have been completed to date.

Estimated number of treatment demands

The number of drug users presenting to the treatment services is estimated to be 4,000 ([14]).

National care system for drug addicts

The aim of Ireland's drug policy is to maintain people in, or restore people to, a drug-free lifestyle. Health promotion is emphasised in drug-prevention programmes provided by the education and health services. While a drug-free society is the ultimate ideal, it is acknowledged that this is not an option for many drug users, at least in the initial stages of treatment. Consequently, a pragmatic approach is taken and as well as providing a number of treatment options, the importance of minimising risk behaviours is stressed in harm-reduction programmes.

Drugs issues have become politically important in Ireland in recent years. The fight against drug trafficking and drug abuse was a major theme of the Irish Presidency of the European Union in the latter half of 1996, focusing on reducing the supply of drugs and preventing and treating addiction. Tougher legislative measures were introduced to curb the supply of, and demand for, drugs, including seven-day detention, restrictions on the right to silence in drug-trafficking cases, the seizure of criminal assets and changes in existing bail laws. In addition, police numbers were increased, extra court judges appointed and extra prison places provided.

Overview of Ireland's monitoring system

The Drug Treatment Reporting System was piloted in Dublin and London in 1989 under the auspices of the Pompidou Group of the Council of Europe. The system has been in operation in the Greater Dublin area since 1990 and data collection was extended to the whole country at the beginning of 1995.

The system provides information on socio-demographic data, problem drug use and risk behaviours.

([12]) Information in this section refers to the final report of Reitox sub-task 3.2, July 1997.

([13]) 1996 census.

([14]) 1995 data.

State of implementation

Number of participants

Approximately 30 centres throughout the country participate. Some of these centres make very few returns to the reporting system because the majority of their clients are treated for alcohol addiction. Most services are statutory specialised non-residential services. Others include statutory and voluntary specialised residential centres. Centres based in the general services and prisons are not yet well represented in the system.

Coverage of the monitoring system

Since 1995, the monitoring system has collected information from drug-treatment services, statutory and voluntary, at national level. Since problem drug use is mainly concentrated in Dublin in certain socially deprived areas, the bulk of the data returns are from the capital. General practitioners providing treatment to drug users are not currently well represented in the system. Treatment provided in prisons as well as hospital in-patient data are not well covered either. The data are a good reflection of the number of clients making use of drug treatment services in the community.

Definitions

- Case: for the purpose of the system, a case is a person who receives treatment for his or her drug use at a treatment centre during the calendar year 1 January to 31 December. If a person starts treatment more than once during the same year at the same centre, then only the earliest treatment in that year is counted.

- Treatment: treatment includes non-medical as well as medical interventions. It is broadly defined and includes detoxification as well as interventions aimed at reducing drug-related harm. Treatment is any activity which is targeted directly at people who have problems with their drug use, and which aims to improve the psychological, medical or social state of individuals who seek help for their drug problems. It does not include requests for social assistance only, interventions solely concerned with the physical complications of drug use, contacts by telephone or contact with the family only.

Handling to prevent or control double counting

All treatment data in the reporting system are anonymous and because confidentiality is thus assured, this would appear to be one of the reasons for the good response rate. Whereas double counting is avoided within centres, there could be double counting between centres and, therefore, of cases in the system as a whole, although this is less likely since the introduction of the Methadone Treatment List. This list, which is very closely monitored, is a registration system of all those receiving methadone for detoxification or maintenance and is kept centrally at the National Drug Treatment Centre.

Italy ([15])

Epidemiological situation

No information received.

Overview of Italy's monitoring system

In Italy, the main routine reporting system – Servizi Tossicodipendenze (Services for Addicts – SerTs) – focuses on data from public services. A similar private-sector system (mainly consisting of therapeutic communities) is being developed, but because of administrative problems, coverage of the system is still too restricted. However, since most (if not all) private-sector clients are referred by public services, information about these patients is also available.

([15]) Information in this section refers to the feasibility study and final report of EMCDDA project CT.97.EP.07, August 1998.

SerTs is co-ordinated by the Ministry of Health and has been operational since 1991. It was revised in 1997. A similar data-collection system (but with a more limited set of items and a different timescale) was co-ordinated by the Ministry of the Interior's Standing Drug Monitoring Centre on Drug Addiction between 1985 and 1996.

Over 500 treatment centres complete standardised forms and send them to the Ministry twice a year (punctual prevalence report) or once a year (annual report) for inclusion in SerTs. The system was paper based until 1995, but now the services can choose whether to use paper or electronic forms which can be sent via e-mail to the central server. In some regions, such as Lombardy, Lazio, Emilia-Romagna, the local authority collects the data itself – sometimes through electronic systems, which are able to 'extract' items from databases located in the treatment units – and, following a quality-control procedure, sends them on to the Ministry.

Future aims are to have individualised records, standardise the software for data collection and data transfer and increase the information to be collected. However, national experts expect that further expansion of the items collected, as foreseen in the PG–EMCDDA TDI core item list, will raise at least three main problems:

- because of the large number of units covered, data quality could decrease;

- a time-consuming agreement procedure between the national and the regional level will be required; and

- feasibility studies into collecting additional data will have to be undertaken to test the treatment units' compliance as far as individual data collection is concerned.

State of implementation

As far as case definition is concerned, clients to be counted are those 'in treatment' at established times: 15 June and December for the punctual prevalence report; and the whole year for the annual report. The word 'treatment' refers to any therapeutic and rehabilitation procedure – whether pharmacological or not – performed by the service, even outside the premises (this allows information about clients in prisons, therapeutic communities or hospitals to be collected).

The problem of double counting has only been specifically assessed in those regions where individual data-based systems have been implemented. However, since for many years severe restrictions existed (mainly due to rules in substitution-treatment prescriptions) for access to clients outside the 'residence unit' (the service located in the residence district) this problem has to date had a limited impact.

Luxembourg ([16])

Epidemiological situation

No information received.

Overview of Luxembourg's monitoring system

Established in 1994, the Luxemburgish Information Network on Drugs and Drug Addiction (RELIS-LINDDA) is based on a standardised data protocol including 24 core items and over 60 sub-items. 95% of the Pompidou Group Definitive Protocol's items are integrated in the standard protocol. A second protocol, the Actualisation Protocol, is completed each time a previously known drug addict is re-registered after a period of one year following the previous registration. Finally, a third protocol including only the identification code, the name of the institution and the date of admission is used if a previously known addict is re-registered in the course of the year following his or her previous registration. This system provides

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([16]) Information in this section refers to the feasibility study and final report of EMCDDA project CT.97.EP.07, August 1998.

updated quality data and allows for the institutional careers of drugs addicts to be followed up with minimal effort.

RELIS-LINDDA relies on the so-called 'institutional contact indicator' which means that the data-providing network includes all specialised drug-treatment institutions, police forces and custodial institutions. Efforts are currently being made to include general practitioners and emergency rooms in the information network.

In terms of prevalence estimation and assessing the impact of specific demand-reduction or law-enforcement interventions – as well as planning new drug-care institutions – RELIS-LINDDA is a nationwide, reliable and highly topical monitoring tool.

Since 1994, the Luxemburgish focal point has been commissioned to design and implement a drug-treatment-reporting system according to the requirements of the EMCDDA and information needs at national level. Initiated by the Luxemburgish focal point and adopted by all members of the 'Mondorf Group' – which currently includes the Ministers of Health of the Länders of Saarland and Rheinland-Pfalz (Germany), the Grand-Duchy of Luxembourg, the President of the region of Lorraine (France) and, since 1994, a governmental representative of the German-speaking Community of Belgium – the project proposed in the framework of task 6.1 of the 1996 to 1997 Reitox work programme focuses on designing and implementing an inter-regional reporting system of epidemiological data in the field of drug addiction based on the existing RELIS-LINDDA network.

The project, renamed TRANS-RELIS in the course of its implementation, currently involves the above-mentioned member regions of the 'Mondorf Group'. Originally, the main objectives of the project intended to fulfil sub-tasks 3.1, 3.2 and 4.2, task 5, of the 1996 to 1997 Reitox work programme covered:

- harmonising and evaluating the applicability, at international level, of the RELIS-LINDDA protocol on which the Luxemburgish information network is based;

- developing, harmonising and rationalising an inter-regional reporting system;

- sharing administrative and human resources and research activities in the field of drugs and drug addiction as well as developing a joint reflection regarding information and prevention strategies, in order to avoid duplication of effort; and

- actively developing communication tools, and devising new and improving the existing telemetric infrastructures used by different participants.

TRANS-RELIS not only provides a wide range of high-quality epidemiological data within the five participating regions, but also, by means of an easy-to-use anonymous identification code to avoid double counting, allows the 'institutional careers' of drug addicts at inter-regional level to be followed up. This kind of data is of paramount importance for evaluating treatment impact and effectiveness and for planning specialised and non-specialised drug-care networks. Needless to say, the opportunity provided by TRANS-RELIS to assess treatment impact has led to some major opposition from the field.

The TRANS-RELIS network has been fully operational since May 1998, following the final agreement of the National Commission for Informatics and Liberties (CNIL), the French data-protection authority, regarding the use of the algorithm-based nine-digit code used to identify registered drug addicts anonymously.

State of implementation

Handling to prevent or control double counting

In order to avoid double counting and to follow up drug users' careers, RELIS-LINDDA is based on a nine-digit numerical code obtained by inputting three variables (attributors) into a code calculator developed by the focal point itself. The three variables are:

- gender: 01/02;

- date of birth: for example, 10051967; and

- country of birth.

This technical device is both time- and cost-effective because it relies on a simple HP calculator that runs an attributor-to-code transcription programme based on a 28-step algorithm.

It is not possible to extract any individual information about the person to whom the code belongs and the transformation key is unknown to participating field institutions and to all members of the focal point. Even if the calculation algorithm were to be discovered, it would not be possible to perform a backwards calculation. Each contact person in the participating field institutions has such a calculator and produces the code directly. Reliability in terms of data protection has recently been recognised by the CNIL.

One of the main assets of this procedure is that no personal data can be inferred directly from the identification code. The inputting and encoding procedures are carried out by the field institutions themselves. The focal point thus receives individualised data (reporting protocols) without any identifying information or attributors on the persons registered – which is undoubtedly the major concern of the field institutions.

Netherlands [17]

Epidemiological situation

Number of inhabitants

In the Netherlands there are 15,493,889 inhabitants.

Estimated number of drug addicts

There are an estimated 25,000 to 27,000 hard-drug addicts.

Estimated number of treatment demands

In 1996 there were 23,025 outpatient demands for drug treatment [18].

National care system for drug addicts

In the Netherlands, outpatient treatment is provided by the Institutes on Outpatient Addiction Care and Treatment (IAVs). These IAVs consist of 17 former Consultation Bureaus for Alcohol and Drugs (CADs) with about 100 branches and 15 low-threshold services. The IAVs offer a variety of treatment and care options to drug users, ranging from detoxification to substitution programmes, pharmacotherapy, counselling, other forms of psychotherapy, aftercare, social work and rehabilitation programmes [19].

Overview of the Netherlands' monitoring system

In the Netherlands, outpatient care and treatment is provided by the IAVs and one Municipal Health Organisation (Amsterdam). The IAVs consist of 17 former CADs with about 110 branches and 15 independent low-threshold services. Most of these organisations are now multi-addiction centres. They offer a variety of treatment and care options to problem alcohol and drug users, ranging from detoxification to substitution programmes, pharmacotherapy, counselling, other forms of psychotherapy, aftercare, social work, low-threshold activities and rehabilitation programmes. The Netherlands has one of the most developed and sophisticated treatment systems for drug addicts in Europe [20].

The Landeslijke Alkohol en Drugs Informatiesysteem (LADIS) is the nationwide system for collecting data on drug users in treatment. The Organisation Information Systems on Addiction Care and Treatment (IVV), which has recently become part of the Organisation

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[17] Information in this section refers to the final report of Reitox sub-task 3.2, July 1997.

[18] Ouwehand, A.W., et al. (1997) *Key figures LADIS 1996*, Houten: Organisation Information Systems on Addiction Care and Treatment.

[19] Trimbos Institute (1996) *National report: The Netherlands 1996*, Utrecht: Trimbos Institute.

[20] Ibid.

Care Information Systems (IVZ), holds this system. Data storage and analysis is centralised at the IVV and provides a control for double counting since the registration year 1994 at institutional as well as national level. Allocation of a unique code to each client enables such corrections. This coding system is built into a tailor-made software programme for the addiction centres called ADDICTIS. This institutional information system is used by all centres in the Netherlands and improves and protects the uniform data collection by standardised automatic delivery to LADIS.

LADIS became operational in 1986. By 1988, all former CADs were participating in the system and all low-threshold services now participate in LADIS as well. Currently, LADIS covers about 90% of outpatient treatment and care for alcohol, drug and gambling problems. The Municipal Health Organisation in Amsterdam will start regular delivery of information in 1998 and the IVV aims at full coverage in the near future. In-patient treatment activities are not (yet) included in the system, although action is being taken to combine information as soon as possible. Most drug clients are referred to in-patient clinics by an outpatient clinic. Therefore more than half of all in-patient clients are already in the LADIS system. In 1997, 25,202 persons were registered for drug problems, about 75% to 85% of all estimated problem hard-drug users in the Netherlands ([21]).

Every year, the IVV produces a number of publications based on the LADIS system. These include a yearbook, *Key Figures*, published each spring, several books on client profiles, such as *Women and Drugs*, *Hard-drug users*, *Cannabis users* and *Ecstasy users*, and several studies on alcohol problems. In 1997, a study called *TrendWise* was published in which 10 years of national data from LADIS were analysed and estimates given for treatment demand in 2006 in the Netherlands ([22]). In the Netherlands, the Ministry of Health, Welfare and Sport has decided to organise a national drug monitor in which all relevant information on drugs, drug abuse, drug-related problems and drug treatment will be combined. The LADIS information will be an important part of this national monitor.

State of implementation

Preventing or controlling double counting

From the registration year 1994, double counting has been controlled in the LADIS system at national level by allocating one unique code to each client.

Portugal ([23])

Epidemiological situation

Description of the national care system for drug addicts

The Prevention and Treatment of Drug Addiction Service (SPTT) is the most important Portuguese health-care and specialised treatment service for addiction to illicit drugs. The SPTT is a department of the Ministry of Health and is part of the national health service. It includes 40 specialised outpatient treatment centres covering the whole country, five detoxification centres, three day-care centres and two therapeutic communities.

In the public sphere, two national health service hospitals – one in Lisbon and one in Oporto – offer specialised treatment services for drug addicts in their psychiatric departments. General practitioners also counsel drug users.

Overview of Portugal's monitoring system

The SPTT produces information in two ways.

([21]) National drug policy paper, VWS 1996.

([22]) For more information, see http://www.ivv.nl/.

([23]) Information in this section refers to the feasibility study and final report of EMCDDA project CT.97.EP.07, August 1998.

- Data are collected by all the treatment centres during the year for inclusion in the administrative monitoring system that collects data for the SPTT annual report. This system does not collect data by patient, but by occurrence. 'First treatment demand' and 'Subsequent treatment demands' are among the indicators used. In 1997, there were about 9,000 first treatment demands and about 200,000 subsequent demands.

- The administrative monitoring system does not provide information about the characteristics of clients. For that purpose, a two-day survey is carried out every November of all patients examined in those two days. Most of the indicators of the PG–EMCDDA TDI Protocol core item list are included in the survey questionnaire.

A common protocol of the SPTT's specialised outpatient treatment centres and some health centres has been established for administering methadone prescribed by the specialised centres in these health centres.

State of implementation

National health service hospitals and health centres do not have a drug-treatment monitoring system. The number of private-sector organisations is increasing and the SPTT has a protocol with some private residential therapeutic communities (professional and religious) for treatment admissions. Information on patients in private organisations is, however, not available.

Spain ([24])

Epidemiological situation

Number of inhabitants

In Spain there are 39,395,153 inhabitants of which 19,320,620 are male and 20,074,533 female ([25]).

Estimated number of drug addicts

There are roughly 130,000 drug addicts ([26]).

Estimated number of treatment demands

The notified number of treatment demands in 1995 was 42,317.

National care system for drug addicts

The different patterns of drug use as well as socio-demographic and personal profiles of drug users determine a variety of interventions and centres providing care. There are three main types of intervention:

- specific programmes including outpatient treatment centres, hospital detoxification units, day treatment centres, residential treatment centres and opiate substitution programmes;

- harm-reduction programmes distributing health kits, providing syringe exchange, promoting lower-risk practices and behaviour, vaccinating against hepatitis, providing tuberculosis detection and control, AIDS prevention, and so on; and

- social and legal support programmes.

Overview of Spain's monitoring system

The Spanish State Information System on Drug Abuse (SEIT) was established in 1987. It uses three indirect indicators to reflect the health effects of drug use:

- treatment;

([24]) Information in this section refers to the final report of Reitox sub-task 3.2, July 1997.

([25]) 1991 census.

([26]) Last-30-day's use of hard drugs.

- emergencies; and

- mortality.

From 1987 to 1995, all three indicators referred exclusively to opiates or cocaine. In order to be more flexible and comprehensive, starting in 1996 the system was modified to include all psychoactive substances able to generate dependence. Changes introduced in the treatment indicator took into account the Pompidou Group Definitive Protocol.

In addition to the SEIT monitoring system, periodical surveys are carried out of patients attending drug-treatment services. These studies provide a better knowledge of the social and health characteristics of drug users from a sample of SEIT patients.

State of implementation

Participating centres

Participating centres include those that provide outpatient care for drug users, including prison units, from which only outpatient cases are recorded. Hospital and other types of residential treatments are excluded, as are information and advice activities, syringe exchange and other low-threshold programmes.

All public and subsidised private centres report cases. Other non-subsidised private outpatient centres may form part of the system and report cases. In practice, there are two main categories of centres:

- specific centres for drug treatment; and

- mental health centres or other health services.

Number of participants

In 1995, 421 outpatient centres notified cases to the system.

Coverage of the monitoring system

SEIT coverage is national, but based on the regional systems of the various Autonomous Communities.

Definitions

- Admission to treatment for psychoactive substance use: number of people per year admitted to outpatient treatment for abuse of or dependence on psychoactive substances (defined list of substances).

Preventing or controlling double counting

Double counting is eliminated at regional level. Those admitted to treatment during the same year in the same Autonomous Community are counted only the first time they attend a centre. For this purpose, cases are identified by a personal code made up of two letters from each of the client's two family names, gender, date and place of birth.

Sweden ([27])

Epidemiological situation

No information received.

Overview of Sweden's monitoring system

Currently, Sweden has no national documentation system covering all drug-treatment units. In 1998, the Ministry of Health asked the Board of Social Welfare to investigate this matter and the Swedish national focal point, government representatives and other key persons discussed the issue.

([27]) Information in this section refers to the feasibility study and final report of EMCDDA project CT.97.EP.07, August 1998.

The existing documentation system created by the Institute for Development of Knowledge about Treatment of Alcohol and Drug Misusers (IKM) and the National Board of Institutional Care (SiS) covers only a small part of the treatment system, but is expected to grow in the coming years. It includes practically all TDI core items and much more. Although not representative, information from the DOK monitoring system is used to provide some idea about clients in the Swedish treatment system. There is almost total coverage from Sweden's second city, Gotheburg, a middle-sized city, Sundsvall, and from sparsely populated areas.

To institute a national monitoring system in Sweden would require a political mandate and resources to build up a support system.

State of implementation

The DOK system contains all information about compulsory treatment, but not much is known about other types of treatment. Although Sweden has an extensive network of treatment facilities, only data from about 15% of all clients are recorded in the monitoring system. One possibility might be to make estimates based on typical clients or treatment centres. Satisfactory information about the reliability or representativeness of recorded data, as well as satisfactory coverage of the national monitoring system, is, however, currently not in sight.

United Kingdom ([28])

Epidemiological situation ([29])

Number of inhabitants

There are an estimated 48,707,459 inhabitants in England ([30]).

Estimated number of drug addicts

There were 37,164 notified drug addicts in 1995, although the real total is estimated at around 100,000.

Estimated number of treatment demands

In the six months to the end of September 1995 there were 24,661 new agency episodes:

- 3,263 in national health service-funded general practice;

- 1,538 in community-based statutory drug services;

- 5,081 in non-statutory community-based drug services;

- 521 in in-patient Drug Dependency Units;

- 1,780 in out-patient Drug Dependency Units;

- 759 in residential rehabilitation services; and

- 1,719 in other agencies.

National care system for drug addicts

The treatment and care system for drug users in England is based on a broad range of service provision including primary health care, specialised health and social care provided by a national network of Community Drug Teams, as well as in-patient (hospital based) and residential facilities (therapeutic communities) for acute detoxification, or other prescribing, and rehabilitation. Low-threshold services, such as syringe exchanges and outreach facilities, are now widely established and service provision within prisons is being developed. Prescribing substitution drugs (normally oral methadone) from statutory community-based drug services is widespread. These prescriptions may take the form of short-term

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([28]) Information in this section refers to the final report of Reitox sub-task 3.2, July 1997.
([29]) The following section refers to England only.
([30]) Mid-1994 estimate.

detoxification, but are commonly longer term to keep dependent drug users in touch with services. Much of the philosophy behind English drug-treatment policy arose from a report issued by the Advisory Council on the Misuse of Drugs (ACMD) in 1988 stating that, 'the spread of HIV is a greater danger to individual and public health than drug misuse'.

On this basis, drug units accept the need to work with people who will continue to use drugs, concentrating on maintaining service contact and minimising individual and public harm while still ultimately promoting abstinence. As many prescribing drug units are now working to capacity, general practitioners are increasingly expected to play their role in the community-based prescribing of substitution drugs.

More recently, and with the appointment of the Anti-Drugs Co-ordinator (or Drugs Tsar) and his assistant (Deputy Tsar), policy has become more explicitly broad based ([31]). Aiming for, 'a healthy and confident society increasingly free from the harm caused by the misuse of drugs', policy has broadened from a public-health focus to encompass four areas:

- young people;

- communities;

- treatment; and

- availability.

Overview of the UK's monitoring system

Formerly only the Addicts Index was available to measure the number of drug users seeking treatment. This list was limited to those dependent on certain opiates or cocaine who were seen by a doctor. However, a more extensive database was required to include more drugs and more agencies than the Addicts Index. The Department of Health saw the need to implement a system that would allow those responsible for policy and service planning to respond effectively to changing trends in drug use and to ensure that appropriate services are developed to meet their needs. In 1982, the ACMD recommended that local problem drug teams should be set up which would also collect information in a form capable of collation at both regional and national levels to enable a wider picture to be obtained. In 1984, the Department of Health and Social Security issued a circular (HC(84)14) asking the national health service to review the prevalence of drug misuse locally and report back on the situation. In 1986, a drug-misuse database (DMD) was developed by the Drug Research Unit (DRU) of the University of Manchester. In 1989, the Department of Health commissioned the DRU to adapt the database for use in other regions.

The DMD has now been established in each of the English health regions, as well as in the Isle of Man, Scotland and Wales. The national network is co-ordinated by the DMRU along with the Department of Health.

State of implementation

Participating centres

The following agencies routinely report:

- general practice, national health service-funded;

- community-based drug service, statutory;

- community-based drug service, non-statutory;

- Drug Dependency Unit, in-patient;

- Drug Dependency Unit, outpatient;

- residential rehabilitation services; and

([31]) See UK Government (1998) *Tackling drugs to build a better Britain: The government's 10-year strategy for tackling drug misuse*, London: The Stationery Office.

- hospital drug clinics.

The following agencies report in some areas:

- police surgeons;
- some hospital outpatient and in-patient facilities;
- day-care services;
- national health service psychiatric wards;
- accident and emergency wards;
- private in-patient or outpatient facilities;
- probation offices;
- prison medical service; and
- syringe-exchange schemes.

Number of participants

A minimum of 600 (probably closer to 700) separate agencies are known to report to the DMD (1995 figures). This does not include general practitioners as individual GPs are not recorded as separate agencies.

Coverage of monitoring system

All District Health Authorities in all eight regions in England plus Scotland and Wales.

Definition of treatments/treatment episodes

Individuals are reported to the DMD when they present to a service with a new episode – in other words they present for the first time or re-present after an interval of at least six months with a drug problem (physical, social, psychological or legal). These new episodes are reported regardless of whether any treatment is to be given. Individuals using alcohol as their primary drug are not reported.

Preventing or controlling double counting

To avoid making multiple counts of individual drug users who may be known to more than one agency, the DMD uses clients' initials, date of birth and gender as a unique code; hence, without comprising confidentiality, the system can provide accurate estimates of the number of individual drug users presenting to services at local and regional level.

2. State of implementation

Implementation of the TDI Protocol

Implementation in countries with an existing treatment-monitoring system

Implementing the TDI Protocol data set in national treatment-monitoring systems will require support from the EMCDDA in several ways.

There is generally considerable willingness at national level for systems to follow adequate European standards. If the TDI Protocol is defined as such by the EMCDDA, implementing its core item list in national systems will require both time and administrative and local commitment, but will not pose too many problems at technical level. Many of the items can already be provided by the national systems, and some necessary changes will be introduced during the routine revision process. The EMCDDA will need to take a clear position on the importance of implementing European standards because decisions about national systems are typically taken by groups of experts who require convincing of the need for changes.

A formal paper from the EMCDDA demonstrating its interest in this treatment indicator, as well as some form of contract between the EMCDDA and the national organisations running the systems, would be helpful in the implementation period. The support of the relevant national representatives on the EMCDDA Management Board is also required.

Implementation in countries creating a new system

Not all EU countries already have a drug-treatment-monitoring system. For those Member States that are creating such an instrument, the TDI should be used as a minimum standard from which to start which will be extremely useful during the system's development phase. More details, categories and items can be added to the TDI core item list at national level. The experts participating in this project and the systems they represent will help to implement national systems in other countries.

Implementation in Central and Eastern Europe

A special situation is found in the Central and Eastern European countries (CEECs). Some of these states are already collecting treatment data and may be able to deliver data based on the TDI Protocol fairly quickly. Others are just beginning to set up such a system or are concentrating their efforts on other political fields. According to the decisions of the 1998 Cardiff summit, it will be especially important for the CEECs to follow the TDI standards as soon as possible.

Overview of the state of implementation of the TDI Protocol

In this context, the 'state of implementation' always refers to the availability of data according to the TDI core item list. Data collection at national level should, however, include more than just the TDI items. This item set is only a very basic standard and does not allow sufficient insights into drug-using populations for national purposes.

The results of the field trial to implement a standard protocol ([32]) demonstrate that most of the TDI Protocol core items were available in most of the 15 EU Member States, even if in some cases their adaptation to the TDI categories needed to be improved. In other cases, the required information was only partially available. However, in general the national experts reported plans and concrete steps to solve these problems or announced revisions of the

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([32]) EMCDDA Project CT.98.EP.10.

national monitoring systems to fulfil the TDI Protocol requirements in future. Some countries had already changed their monitoring system in line with the TDI core item list, but because the reference period for the field trial was 1997, these improvements do not always appear in the tables below. Where possible, explanatory remarks have been added in Table 1 below.

One major exception has to be made concerning item 15, 'Already receiving substitution treatment'. This item was introduced after the expert meeting in Lisbon in 1998, and is only partially available at the moment. Even in countries where at least some information concerning the number of clients in substitution treatment is available, in most cases these data only refer to methadone treatment and do not allow any detailed insights into the global picture of substitution treatment. Currently, no country is able to provide exhaustive information concerning substitution treatment. Those countries that provided some data on substitution treatment mainly reported information about selected groups, regional information or did not report whether these clients are representative of all clients treated for drug problems or not (for example, Finland gave some information about 36 clients receiving methadone as a substitution drug, but as information concerning substitution treatment was only available for these clients these data cannot be used as an estimate of all persons treated for drug problems in Finland).

Treatment centres covered

While nearly all of the 12 Member States which have national information available include data from outpatient services, only a minority of them also cover residential treatment. Much less data are available for other types of treatment centres. Only the French community of Belgium and England included data from general practitioners. Data from low-threshold agencies and prison units are also rare.

The first target for the rapid implementation of common standards in Europe must be the collection of data from outpatient treatment units. As these units usually reach more drug users and are closer to the drug-using population than centres providing inpatient care or even GPs, this makes sense also from an epidemiological point of view. Including 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 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.

Table 1. Overall availability of TDI Protocol core items in the EU Member States

TDI Protocol core item	A	B	DK	FIN	F	D	EL	IRL	I	L	P	E	S	NL	UK
1. Treatment-centre type		xx	x	x	x	x	x	x	x	x		x		x	x
2. Date of treatment – month					Not separately registered										
3. Date of treatment – year					Not separately registered										
4. Ever previously treated		xx	xx	xx	xx	xx	x	xx	x	xx		xx		x	
5. Source of referral		xx		xx	xx	x	xx	xx	xx	(a)				xx	x
6. Gender		x	x	x	x	x	x	x	x	(b)		x		x	x
7. Age		x	x	x	x	x	x	x	x	x		x		x	x
8. Year of birth					Not separately registered										
9. Living status (with whom)		xx	x	(x) (c)		xx	xx	xx	x	x				xx	x
10. Living status (where)		xx	xx	xx		xx	xx	xx	x	x		x			(x) (d)
11. Nationality		xx	xx	xx		xx	x	xx	x	x		xx		xx	
12. Labour status		xx	xx	xx	x	xx	x	xx	xx	x		xx		xx	x
13. Highest educational level completed		xx	xx	xx		xx	xx	xx	xx	x		xx		xx	
14. Primary drug		x	x	x	x	x	X	x	x	x		x		x	x
15. Already receiving substitution treatment		(x) (d)		(x) (d)		(x) (e)	(x) (d)		(x) (d)						
16. Usual route of administration (primary drug)		x	x	x			x	x	x	(x) (f)		xx		xx	xx
17. Frequency of use (primary drug)		x	x	x			x	x	x	(x) (g)				x	x
18. Age at first use of primary drug		x	x	x		(h)	x	x	x	(x) (i)		x		(j)	x
19. Other (=secondary) drugs currently used		x	x	x		x	x	x	x	(x)(k)		x		x	x
20. Ever injected/currently (last 30 days) injecting		xx		xx	xx	x	x	x	xx	(x) (l)		xx		xx	x

Notes:

(a) Data on orientation after registered treatment only.

(b) Age/gender breakdown only on mean age.

(^c) More indicators and categories are used in Finnish data collection, making conversion quite difficult.

(^d) Information partly available.

(^e) Information already registered, but not yet included in the report.

(^f) Data to be confirmed.

(^g) As almost all drug-treatment clients present with daily use of their primary drug, the RELIS protocol has been adapted in the light of past experience. Currently, the protocol includes: 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 does not appear to be pertinent.

(^h) Age at beginning of problem use is registered.

(ⁱ) Different age categories are used (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 to meet the TDI requirements.

(^j) Age at onset or age at first use is not registered in LADIS. The LADIS item 'length of period the primary problem lasted' in connection with the LADIS item 'user's age when he/she first registered' could be used.

(^k) 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.

(^l) Data to be confirmed.

Availability of data per item

The following tables give an overview of the availability of the TDI Protocol core items in the national systems in 1997. All data represented here for 1997 refer to the results of the field trial to implement the standard protocol. 'X' indicates that this information was available directly or could be obtained by calculation and recoding from the national systems. In some instances, years indicate that information will be available in future.

The following tables cannot be completed for some countries for several reasons.

Information from Belgium is based on three different monitoring systems, so any given availability should not be interpreted as availability at national level.

Tables are to be completed with 1998 data for the following edition scheduled for 2000.

1. Treatment-centre type

Where data are collected in the respective centres, information on the centre's type is available automatically (see also Chapter 3 below).

2. Date of treatment – month															
Categories	Year	A	B	DK	FIN	F	D	EL	IRL	I	L	P	E	S	NL	UK
Date of treatment – month	1997						not separately registered								
	1998														
Quality of data ([a])			3				3	3	3		3				3

Note:

([a]) 1= poor, 2=average, 3=excellent, 4= not known.

3. Date of treatment – year															
Categories	Year	A	B	DK	FIN	F	D	EL	IRL	I	L	P	E	S	NL	UK
Date of treatment – year	1997						not separately registered								
	1998														
Quality of data			3				3	3	3		3				3

4. Ever previously treated															
Categories	Year	A	B	DK	FIN	F	D	EL	IRL	I	L	P	E	S	NL	UK
Never	1997		x	x	x	x	x	x	x	x	x		x		x
	1998														
Previously treated	1997		x	x	x	x	x	x	x	x	x		x		x
	1998														
Not known	1997		x	x	x	x	x		x		x		x		
	1998														
Quality of data			2				3	3	3	3	3				3

5. Source of referral																
Categories	Year	A	B	DK	FIN	F	D	EL	IRL	I	L(a)	P	E	S	NL(b)	UK
Self-referred	1997		x		x	x	x	x	x	x					x	x
	1998															
Family/friends	1997		x		x	x	x	x	x	x					x	x
	1998															
Other drug-treatment centre	1997		x		x	x	x	x	x	x					x	x
	1998															
GP	1997		x		x	x	x	x	x	x					x	x
	1998															
Hospital/other medical source	1997		x		x	x	x	x	x	x					x	(c)
	1998															
Social services	1997		x		x	x	x	x	x	x					x	(c)
	1998															
Court/probation/police	1997		x		x	x	x	x	x	x					x	x
	1998															
Other	1997		x		x	x	x	x	x	x					x	x
	1998															
Not known	1997		x		x	x		x	x	x					x	x
	1998															
Quality of data			2				3	3		2	2–3				3	2

Notes:

(a) Data on orientation after registered treatment is available, requested item not.

(b) The category 'GP' is not separately registered in LADIS.

(c) Data for the categories 'Hospital/other medical source' and 'Social services' could not be individually identified and are within the category 'Other'.

6. Gender																
Categories	Year	A	B	DK	FIN	F	D	EL	IRL	I	L	P	E	S	NL	UK
Male	1997		x	x	x		x	x	x	x	x		x			
	1998															
Female	1997		x	x	x		x	x	x	x	x		x			
	1998															
Not known	1997		x		x				x				x			
	1998															
Quality of data			3				3	3		3	3				3	3

7. Age																
Categories	Year	A	B	DK	FIN	F	D	EL	IRL	I	L	P	E	S	NL	UK
Age	1997		x	x	x	x	x	x	x	x	x		x		x	x
	1998															
Quality of data			3				3	2		3	3				3	3

8. Year of birth																
Categories	**Year**	**A**	**B**	**DK**	**FIN**	**F**	**D**	**EL**	**IRL**	**I**	**L**	**P**	**E**	**S**	**NL**	**UK**
Age				not separately registered in the field trial												
	1998															
Quality of data			3				3	3			1				3	3

9. Living status (with whom)																
Categories	**Year**	**A**	**B**	**DK**	**FIN**	**F**	**D**	**EL**	**IRL**	**I**	**L**	**P**	**E**	**S**	**NL**	**UK**
Alone	1997		x	x			x	x	x	x	x				x	x
	1998															
With parents	1997		x				x	x	x	x	x				x	x
	1998															
Alone with child	1997		x	x			x	(a)	x	x	x (b)				x	(c)
	1998															
With partner (alone)	1997		x	x			x	x	x	x	x				x	x
	1998															
With partner and child	1997		x	x			x	x	(d)	x	x (b)				x	(c)
	1998															
With friends	1997		x	x			x	x	x	x	x					(c)
	1998															
Other	1997		x				x	x	x	x	x				x	x
	1998															
Not known	1997		x	x			x	x	x						x	x
	1998															
Quality of data			2				2	3		2	3				3	3

Notes:

(a) The category 'Alone with child' does not exist in the Greek Protocol and was coded as 'Other'.

(b) No information on living status with children, only number of own children.

(c) Data for the category 'Alone with child' could not be individually identified and 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'.

(d) The category 'With partner and child(ren)' is not available separately.

10. Living status (where)																
Categories	**Year**	**A**	**B**	**DK**	**FIN**	**F**	**D**	**EL(a)**	**IRL**	**I**	**L**	**P**	**E**	**S**	**NL (b)**	**UK**
Stable accommodation	1997		x	x			x	x	x	x	x				x	
	1998															
Unstable accommodation	1997		x	x			x	x	x	x	x				x	
	1998															
Institutions (prisons, clinics)	1997		x	x			x	x	x	x	x					
	1998															
Not known	1997		x	x			x	x	x						x	
	1998															
Quality of data			2				3			2	3				3	2

Notes:

(a) The question was combined with the previous ('Living status (with whom)') as one. This had already been changed in 1999.

(^b) Stability of living status is not accounted for in LADIS and a proxy measure was used where the LADIS categories 'Having an own home or renting one and living in parental home' were transferred to the TDI category 'Stable accommodation'.

11. Nationality																
Categories	**Year**	**A**	**B**	**DK**	**FIN**	**F**	**D**	**EL**	**IRL**	**I**	**L**	**P**	**E**	**S**	**NL**	**UK**
National of this country	1997		x	x	x		x	x	x	x	x		x		x	
	1998															
EU national	1997		x	x	x		x	x	x	x	x		x		x	
	1998															
National of another country	1997		x	x	x		x	x	x	x	x		x		x	
	1998															
Not known	1997		x	x	x		x		x				x		x	
	1998															
Quality of data			2				1	3			3				3	

12. Labour status																
Categories	**Year**	**A**	**B**	**DK**	**FIN**	**F**	**D**	**EL**	**IRL**	**I**	**L**	**P**	**E**	**S**	**NL (^a)**	**UK**
Regular employment	1997		x	x	x	x	x	x	x	x	x		x		x	x
	1998															
Pupil/student	1997		x	x	x	x	x	x	x	x	x		x		x	(^b)
	1998															
Economically inactive (^c)	1997		x	x	x	x	1	x	x	x	x		x		x	(^b)
	1998															
Unemployed	1997		x	x	x	x	x	x	x	x	x		x		x	x
	1998															
Other	1997		x	x	x	x	x	x	x	x	x		x		x	x
	1998															
Not known	1997		x	x	x		x	x	x	x			x		x	x
	1998															
Quality of data			1–2				2	2		2	3				3	3

Notes:

(^a) 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' were used; the LADIS category 'On welfare' was used for the TDI category 'Unemployed'.

(^b) Data for the categories 'Pupil/student' and 'Economically inactive' could not be individually identified and are within the category 'Other'.

(^c) The category 'Economically inactive' did not exist in 1997, but had already been changed in 1999.

13. Highest educational level completed																
Categories	**Year**	**A**	**B**	**DK**	**FIN (^a)**	**F**	**D**	**EL**	**IRL (^b)**	**I**	**L (^c)**	**P**	**E**	**S**	**NL**	**UK**
Never went to school/never completed primary school	1997		x	x	x		x	x	x	x	x		x		x	
	1998															
Primary level of education	1997		x	x	x		x	x	x	x	x		x		x	
	1998															

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Categories	Year	A	B	DK	FIN	F	D	EL	IRL	I	L	P	E	S	NL	UK
Secondary level of education	1997	x	x	x			x	x	x	x	x		x		x	
	1998															
Higher level of education	1997	x	x	x			x	x	x	x			x		x	
	1998															
Not known	1997	x	x	x			x	x	x	x			x		x	
	1998															
Quality of data			2–3				2	2		2					3	

Notes:

([a]) The category 'Not known' might also include some cases from categories 1 and 2, because in Finnish data collection there is also a category 'Other' 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.

([b]) The category 'Not known' includes clients with an unknown educational level and clients who are still in education; information collected is the educational level reached rather than the educational level completed.

([c]) The RELIS protocol provides data on 'Started school level' and 'Completed school level'. The 'Never went to school or never completed primary school level' includes persons who started primary school and, before completion, were sent to specialised education institutions because of their inability to meet the requirements of the primary school courses.

14. Primary drug																
Categories	**Year**	**A**	**B**	**DK**	**FIN**	**F**	**D**	**EL**	**IRL**	**I**	**L**	**P**	**E**	**S**	**NL**	**UK**
Opiates (total)	1997		x	x			x	x	x	x			x		x	x
	1998															
Heroin	1997		x	x			x	x	x	x			x		x	x
	1998															
Methadone	1997		x	x			x		x	x			x		x	x
	1998															
Other opiates	1997		x	x			x	x	x	x			x		x	x
	1998															
Cocaine (total)	1997		x	x			x	x	x	x			x		x	x
	1998															
Cocaine	1997		x	x			x		x	x			x		x	x
	1998															
Crack	1997						x		x	x			x		x	x
	1998															
Stimulants (total)	1997		x	x			x	x	x	x			x		x	x
	1998															
Amphetamines	1997		x	x					x	x			x		x	x
	1998															
MDMA and derivatives	1997		x					x	x	x			x			x
	1998															
Other stimulants	1997		x				x	x					x		x	x
	1998															
Hypnotics and sedatives (total)	1997		x	x			x	x	x	x			x		x	x
	1998															
Barbiturates	1997		x						x	x			x		x	x
	1998															
Benzodiazepines	1997		x	x				x	x	x			x		x	x
	1998															

Categories	Year	A	B	DK	FIN	F	D	EL	IRL	I	L	P	E	S	NL	UK
Others	1997		x						x				x		x	x
	1998															
Hallucinogens	1997		x	x			x	x	x	x			x		x	x
	1998															
LSD	1997		x	x				x	x	x			x		x	x
	1998															
Others	1997												x		x	x
	1998															
Volatile inhalants (total)	1997		x	x			x	x	x				x		x	x
	1998															
Cannabis (total)	1997		x	x			x	x	x	x			x		x	x
	1998															
Other substances (total)	1997		x	x			x	x	x	x			x			x
	1998															
Quality of data			2					3	3				3		3	

15. Already receiving substitution treatment ([a])																	
Categories		**Year**	**A**	**B**	**DK**	**FIN**	**F**	**D**	**EL**	**IRL**	**I**	**L**	**P**	**E**	**S**	**NL**	**UK**
Heroin	Yes	1997															
		1998															
	No	1997									x						
		1998															
	Not known	1997															
		1998															
Methadone	Yes	1997		x							x						
		1998															
	No	1997		x							x						
		1998															
	Not known	1997		x							x						
		1998															
Other opiates	Yes	1997															
		1998															
	No	1997									x						
		1998															
	Not known	1997															
		1998															
Other substances	Yes	1997															
		1998															
	No	1997									x						
		1998															
	Not known	1997															
		1998															
Quality of data				2					1	3						3	2

16. Usual route of administration (primary drug)																
Categories	Year	A	B	DK	FIN	F	D	EL	IRL	I	L	P	E	S	NL	UK
Inject	1997		x	x				x	x		x		x		x	x
	1998															
Smoke/inhale	1997		x	x				x	x		x		x		x	x
	1998															
Eat/drink	1997		x	x				x	x		x		x		x	x
	1998															
Sniff	1997		x	x				x	x		x		x		x	x
	1998															
Others	1997		x					x					x		x	x
	1998															
Not known	1997		x	x				x			x		x		x	x
	1998															
Quality of data			2			1	3								3	2

17. Frequency of use (primary drug)																
Categories	Year	A	B	DK	FIN	F	D	EL	IRL	I	L	P	E	S	NL	UK
Not used in past month/used occasionally	1997		x	x				x	x						x	x
	1998															
Used once per week or less	1997		x	x				x	x						x	x
	1998															
Used 2–6 days per week	1997		x	x				x	x						x	x
	1998															
Used daily	1997		x	x				x	x						x	x
	1998															
Not known	1997		x	x				x							x	x
	1998														x	x
Quality of data			1					3		2	2–3				3	2

18. Age at first use of primary drug																
Categories	Year	A	B	DK	FIN	F	D	EL	IRL	I	L	P	E	S	NL	UK
Age at first use	1997		x	x				x	x				x			x
	1998															
Quality of data			1–2					3		2	2					3

19. Other (= secondary) drugs currently used																
Categories	Year	A	B	DK	FIN	F	D	EL	IRL	I	L	P	E	S	NL	UK
Opiates (total)	1997		x	x			x	x	x				x			x
	1998															
Heroin	1997		x	x				x	x	x			x		x	x
	1998															
Methadone	1997		x	x				x	x				x		x	x

Categories	Year	A	B	DK	FIN	F	D	EL	IRL	I	L (a)	P	E	S	NL	UK
	1998															
Other opiates	1997		x	x					x	x			x		x	x
	1998															
Cocaine (total)	1997		x	x		x			x				x			x
	1998															
Cocaine	1997		x	x					x	x			x		x	x
	1998															
Crack	1997								x				x		x	x
	1998															
Stimulants (total)	1997		x	x		x			x				x			x
	1998															
Amphetamines	1997		x	x					x	x			x		x	x
	1998															
MDMA and derivatives	1997		x						x				x			x
	1998															
Other stimulants	1997								x				x		x	x
	1998															
Hypnotics and sedatives (total)	1998		x	x		x	x	x					x			x
	1998															
Barbiturates	1997		x						x	x			x		x	x
	1998															
Benzodiazepines	1997		x	x					x	x			x		x	x
	1998															
Others	1997								x				x		x	x
	1998															
Hallucinogens	1997		x	x		x			x				x			x
	1998															
LSD	1997		x	x					x	x			x		x	x
	1998															
Others	1997												x			x
	1998															
Volatile inhalants (total)	1997			x		x			x				x			x
	1998															
Cannabis (total)	1997		x	x		x	x	x	x				x		x	x
	1998															
Other substances (total)	1997		x	x		xx			x				x			x
	1998															
Quality of data			2			3	3				3				3	2

20. Ever injected/currently (last 30 days) injecting																
Categories	Year	A	B	DK	FIN	F	D	EL	IRL	I	L (a)	P	E	S	NL	UK
Currently injecting	1997		x			x	x	x	x	x			x		x	x
	1998															
Ever injected, but not currently	1997		x			x	x	x	x	x			x		x	x
	1998															
Never injected	1997		x			x	x	x	x	x			x		x	x
	1998															

Not known	1997	x	x	x	x	x	x
	1998						
Quality of data		2	2 3	2		3	2

Note:

([a]) Data available from 1998.

'Wish list' of relevant additional items

The following items were proposed as potential additional items for the TDI Protocol core item list by various experts. They may be interesting for further national research and could be implemented for national purposes.

Treatment-related items

- type of treatment;

- type of health service;

- characteristics of the staff; and

- type of treatments offered (methadone maintenance, treatment with other drugs, counselling).

Further epidemiological information

- type of region;

- code for area of residence;

- place of living;

- route of administration (secondary drugs);

- age at first use (secondary drugs);

- age at first injection;

- current poly-drug user;

- health problems;

- number of non-fatal overdoses;

- total number of admissions in specialised in-patient drug institutions;

- HIV status;

- hepatitis B/C status;

- main source of income (earned income, social funds, relatives, other sources including illegal sources); and

- legal situation.

General information

- client co-operation (very good, good, moderate, poor);

- client understanding (very good, good, moderate, poor); and

- ever previously treated by the same institution.

3. Detailed analyses of the TDI Protocol core items

General remarks

This chapter describes the availability of every item collected during the field trial to implement the standard protocol and gives examples of how these data may be used or analysed.

The figures are usually based on valid cases, meaning that cases in the category 'Not known' have been eliminated from the analysis. In some instances, missing cases have been registered separately.

The following tables usually include all cases 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 must be clarified in future. Over and above that, some tables lacked a 'Not known' category, which caused some problems.

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 because a huge amount of data was collected making it impossible to carry out every possible analysis. Taking into consideration that this project should give an idea of what may be presented during the next few years, the selected graphs and figures seem to be sufficient. In general, graphs and tables have been designed to provide a 'European perspective' meaning that data from all countries have been pooled in one graph. Single national information presented in a 'European' project would not make sense since 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 were considered necessary.

Table 1. Main categories and subcategories of drugs

Main category	Subcategories 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 1 clarifies which subcategories of drugs are included in the main categories. If results for 'opiates' are reported, these will therefore always include heroin, methadone and other opiates as the main drugs. In some cases, this may be misleading and additional information is given where needed.

The main aim of this project was to give an overview of the current state of implementation of the TDI Protocol in the 15 EU Member States. This chapter also offers suggestions and gives examples of how future data analysis at European level may look.

Scientific discussions of single-item results or explanatory notes why certain results are as they are not included here.

In the context of the field trial it was more important for the data collected according to the standards set out in the TDI core item list to:

- allow a joint analysis to be made;

- offer enough information to compare the characteristics of clients treated for drug problems and registered by national monitoring systems;

- provide information about the state of implementation of the TDI Protocol at national level; and

- give an overview of where improvements should be made at both European and national level.

Overall, the results are quite satisfying, even if some items are only just beginning to be implemented or are still being implemented. It is surprising to see how much has been done since the core item list was approved by the expert's meeting in 1998. Several countries have already taken changes and the requirements of the TDI Protocol into consideration.

If a certain country is excluded from the analysis of a particular item with no explanatory remark this is usually because such information was not presented by the country concerned.

Treatment-centre type

Table 2 below summarises the information given concerning the composition of the national data sources ([33]). It provides valuable insights into the different countries' monitoring systems.

- One difference among the monitoring systems concerns the proportion of in-patient and outpatient treatment centres reporting to the system, underlining the need to separate these data accordingly.

- It would be helpful to add an additional column estimating the proportion of cases covered by the monitoring system nation-wide.

- A column giving the total number of every type of treatment centre in the country would also be useful. Where this information cannot be given, an appropriate estimate (with explanatory remarks) would be sufficient as well.

([33]) All data given in the table were provided in summer 1999.

Table 2. Composition of national data sources

Country	Covered Y/N ([a])	number of units covered ([b])	% of units covered ([c])	% of cases covered ([d])
Belgium (Brussels)				
1. outpatient treatment centres	Y	10	100	74
2. in-patient 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 Community)				
1. outpatient treatment centres	Y	23	?	53
2. in-patient 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 Community)				
1. outpatient treatment centres	Y	83	80	82
2. in-patient 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. in-patient treatment centres				
3. low-threshold/drop-in/street agency				
4. general practitioners				
5. treatment units in prison				
England				
1. outpatient treatment centres	Y			
2. in-patient treatment centres	Y			
3. low-threshold/drop-in/street agency	Y			
4. general practitioners	Y			
5. treatment units in prison	N			
Finland				
1. outpatient treatment centres	Y	37	34	75
2. in-patient 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
France				
1. outpatient treatment centres	Y	256		
2. in-patient treatment centres	Y			
3. low-threshold/drop-in/street agency	N			
4. general practitioners	N			
5. treatment units in prison	Y	15		
Germany (SEDOS, in-patient data)				

Country	Covered Y/N ([a])	number of units covered ([b])	% of units covered ([c])	% of cases covered ([d])
1. outpatient treatment centres	N		36	100
2. in-patient 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)				
1. outpatient treatment centres	Y	455	36	100
2. in-patient 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. in-patient treatment centres	Y	7	64	
3. low-threshold/drop-in/street agency				
4. general practitioners	N			
5. treatment units in prison				
Ireland				
1. outpatient treatment centres	Y	42	78	74
2. in-patient 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			
Italy				
1. outpatient treatment centres	Y	50	10	88
2. in-patient 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. in-patient 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			
Netherlands				
1. outpatient treatment centres	Y	110	95	95
2. in-patient treatment centres				
3. low-threshold/drop-in/street agency				
4. general practitioners				
5. treatment units in prison				
Portugal				
1. outpatient treatment centres				
2. in-patient treatment centres				

Country	Covered Y/N ([a])	number of units covered ([b])	% of units covered ([c])	% of cases covered ([d])
3. low-threshold/drop-in/street agency				
4. general practitioners				
5. treatment units in prison				
Spain				
1. outpatient treatment centres	Y	435	85	94.2
2. in-patient 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
Sweden				
1. outpatient treatment centres				
2. in-patient treatment centres				
3. low-threshold/drop-in/street agency				
4. general practitioners				
5. treatment units in prison				

Notes:

Blank cells indicate data not available.

? = not known

([a]) Do units in each category report to the monitoring system?

([b]) Number of units in each category reporting to the monitoring system.

([c]) Estimated proportion of each type of treatment unit (of all those existing in the country) covered by the monitoring system.

([d]) Proportion of the cases/episodes reported to the monitoring system from each type of treatment unit. These figures should add up 100%.

Remarks

- In Belgium, data are still collected by four regional monitoring systems (Brussels region, Flemish Community, French Community and German-speaking Community). To date it is not possible to calculate national figures, but national data on treatment demand are provided from 1999 onwards.

- The collection of treatment data in Finland is based on the voluntary participation of treatment centres. An estimate of the treatments which are not included is not possible since the total number of treatments is not known. The available data cover 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 their main drug have been included in the data collection, but all these clients have also been treated for severe problems related to illegal drug use. 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.

- France still has no ongoing treatment-monitoring system. French information is based on data from the November survey, an annual survey of 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 in-patient treatment centres.

- As some characteristics of clients treated in in-patient centres differ greatly from those of drug users treated in outpatient facilities (for example, 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 in-patient data used for this field trial is only a certain sample from the SEDOS system.

- In Ireland, a feasibility study has been carried out by the Drug Misuse Research Division of the Health Research Board to determine the feasibility of including GPs and prisons in the monitoring system and, if endorsed, to implement the inclusion of both groups.

- There is currently no national monitoring system for the treatment of drug users in Italy. But national experts and politicians have already begun to discuss developing solutions to fit European requirements. For the 1999 field trial, data from two regional monitoring systems were used. Data inconsistencies and empty cells are mainly the result of differences in regional (case) definitions or differences in categories.

- The Dutch data do not include any in-patient treatment units, but cover nearly all outpatient treatment facilities in the Netherlands. Only a few outpatient treatment centres are not included in the system, but it can be assumed that those clients who appear in these centres are also registered in the Dutch monitoring system LADIS due to their additional contacts with treatment units which do report to the system. Double counting has been eliminated. The data include 6,407 unique clients who fit the criteria defined in the TDI Protocol. This is roughly 25% of all unique drug users registered in LADIS in 1997.

- Portugal has begun a system of treatment monitoring within a major treatment organisation. Further details on coverage of centres, patients and so on are not yet available.

- The precise number of centres in Spain is not known, therefore the figure for '% of units covered' is only an estimate.

- Until 1997, Sweden only had national, aggregated statistics covering detoxification in in-patient, healthcare clinics and care and treatment in residential centres. The latter represent less than one-third of all services for substance abusers provided by the local social-service agencies. Most of the care and treatment today is given in outpatient format. From 1998, Sweden collected data directly from these local agencies in order to obtain a full picture of the number of clients in various forms of care. Unfortunately, these data cannot be broken down into type of substance abuse, since that is not recorded in these agencies' data systems, but only on gender and age groups. In 1999, however, Sweden also inaugurated a system for regular (annual) data collection from all the specialised treatment units for substance abusers known to the social services department of the National Board of Health and Welfare. 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 TDI Protocol.

- In the United Kingdom, separate treatment-monitoring systems are run in England, Scotland and Wales. Although the different systems are very similar, no way has been found to provide data for all of the UK (except Northern Ireland, since there is no existing treatment-monitoring system in Northern Ireland yet). Because of the limited time available, only data from England were used in this field trial. Double counting was eliminated at regional level where possible. The English data do not cover the whole 12-month period because data on drug misuse are collected every six months. The information given is for the period April to September 1997.

Ever previously treated
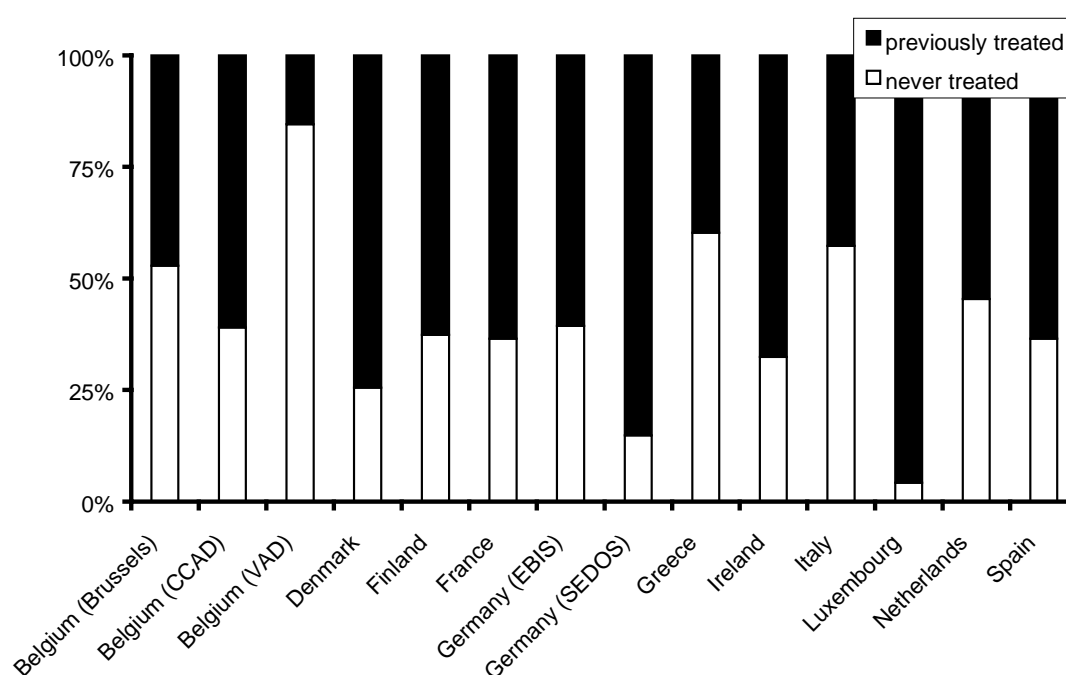
Country	% never treated before	% previously treated	% not known	number
Belgium (Brussels)	34	30	36	1,544
Belgium (CCAD)	11	33	56	1,681
Belgium (VAD)[a]	85	15	0	2,105
Denmark	25	71	4	4,583
Finland [b]	36	60	5	2,765
France	36	61	4	15,078
Germany (EBIS)	39	61	0	11,570
Germany (SEDOS)	14	83	3	1,775
Greece	60	40	0	570
Ireland	31	65	4	4,910
Italy [c]	57	43	0	6,059
Luxembourg	4	91	5	
Netherlands	45	55		6,407
Spain	36	62	2	52,440

Notes:

Blank cells indicate data not available.

[a] Ever previously treated in the same treatment centre for the same problem; outpatient treatment centres only.

[b] N (missing) =97; the 'Not known' category in the table includes the number of answers 'not known'; 'N (missing)' includes totally missing answers.

[c] Partly structural limitations due to impossible distinction between prevalent and incident cases.

Remarks

Not much is known about the registration of primary or subsequent treatments if no additional information about controls for double counting or the definition of treatment episodes is provided 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 counting only takes place at treatment-centre level which only allows information to be given about whether a certain person has ever been treated in the same centre for the same problem before or not. Other countries have controls for double counting at regional or national level.

Source of referral
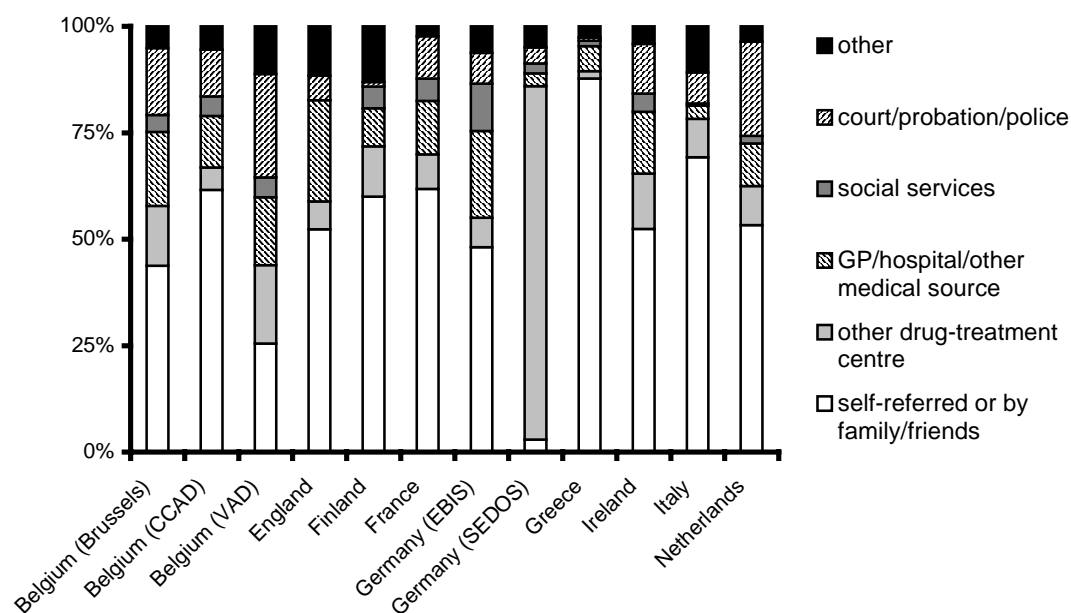
Country	% self-referred or by family/ friends	% other drug-treatment centre	%GP/hospital/ other medical source	% social services	% court/ probation/ police	% other	% not known	number
Belgium (Brussels)	41	13	16	4	15	5	7	1,544
Belgium (CCAD)	58	5	11	4	10	5	5	1,681
Belgium (VAD) ([a])	25	18	16	5	24	11		2,560
England ([b])	47	6	21		5	10	10	21,996
Finland ([c])	59	12	9	5	1	13	1	2,785
France	61	8	12	5	10	2	2	15,035
Germany (EBIS) ([d])	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														
Netherlands (e)	52	9		10	2		22	4				2		6,407

Notes:

Blank cells indicate data not available.

(a) The categories 'Self-referred' and 'Family/friends' cannot be separated.

(b) Data for the categories 'Hospital/other medical source' and 'Social services' could not be individually identified and are within the category 'Other'.

(c) N (missing)=77; as a source of referral the category 'Social services' includes only child-protection social services. Other social services are included in the category 'Other', because one of the Finnish data-collection categories ('Other social and health care services') does not allow social and health-care services to be distinguished.

(d) Data also include clients whose main diagnosis is alcohol, pathological gambling, eating disorders, and so on.

(e) The category 'GP' is not registered separately in LADIS.

Remarks

The extreme differences between the data of the two German treatment-monitoring systems suggests 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 that in Germany and underlines that it does not make much sense to pool in-patient and outpatient information.

Some of the item's sub-categories are not available in a few countries, but because 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 England and Finland, but information has been given on how to deal with the problem (see footnotes).

Age distribution (34)

Age	B (a) %	B (b) %	B (c) %	D (d) %	D(e) %	DK %	E %	EL %	EN %	F %	FIN %	I (f) %	IRL %	L %	NL %
<15	<1	1	2	1	<1	<1	<1	<1	1	<1	1	<1	1	<1	<1
15–19	2	11	26	13	4	4	5	9	13	4	20	4	26	3	9
20–24	18	25	23	26	28	16	19	17	27	17	28	20	34	12	18
25–29	30	31	17	24	33	19	30	26	27	29	21	27	19	27	24
30–34	28	17	11	14	16	20	26	25	18	28	13	26	12	31	20
35–49	14	8	8	14	16	17	13	13	8	14	7	17	5	23	15
40–44	4	3	6	3	1	15	4	5	4	5	6	4	2	4	8
45–49	1	1	4	3	1	7	1	2	2	2	3	1	1		3
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
number	1,544	1,534	2,973	11,626	1,331	4,580	52,185		570	21,996	15,063	2,844	6,059	4,910		6,407

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(34) Data for men and women have been pooled.

not known	81					255			18 (^{g})		24
$\bar{x}$ **(M)**		27.0	25.8	28.3	32.0	29.7	29.6		27.3	29.8	24.7	28.8
$\bar{x}$ **(F)**		28.4	30.9	29.1	32.0	28.8	27.2		24.5	29.4	23.3	27.3
$\bar{x}$ **(T)**		26.4	27.2	28.7	32.0	29.3	29.3		26.6	29.6	24.4	28.5

Notes:

Blank cells indicate data not available.

(^{a}) Age distribution ends at >=60.

(^{b}) CCAD (French community).

(^{c}) VAD (Flemish community); age distribution ends at >=55.

(^{d}) EBIS (outpatient); age distribution ends at >=60; uses different age categories (30–39, 40–49, 50–59).

(^{e}) SEDOS (in-patient); age distribution ends at >=60; uses different age categories (30–39, 40–49, 50–59).

(^{f}) Mean age is calculated on the basis of Lazio region data only.

(^{g}) = N (missing).

Age distribution (all countries)
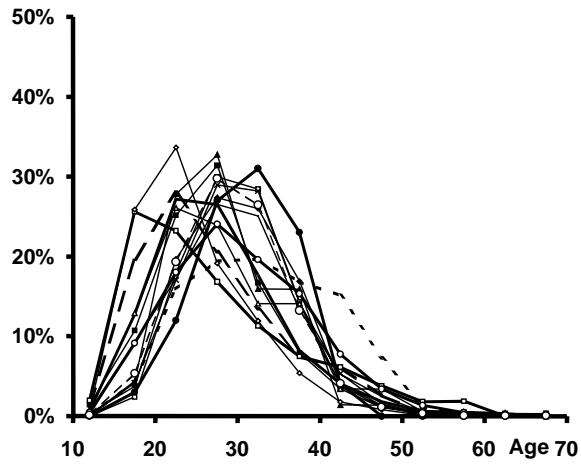
Age distribution (cluster 1)

Belgium (Brussels)
France
Greece
Italy
Netherlands
Spain

Age distribution (cluster 2)

Belgium (VAD)
England
Finland
Germany (EBIS)
Ireland

Age distribution (cluster 3)

Belgium (CCAD)
Denmark
Germany (SEDOS)
Luxembourg
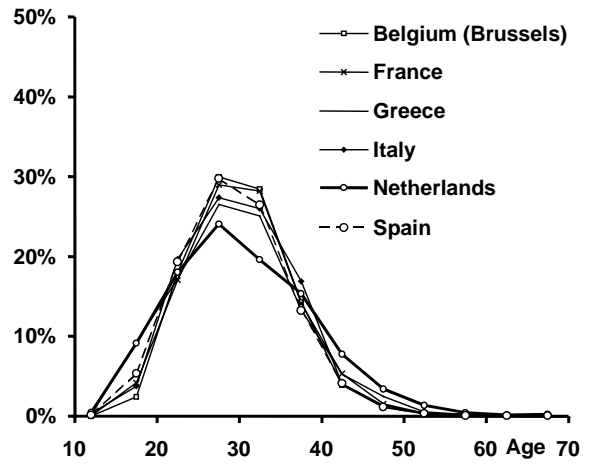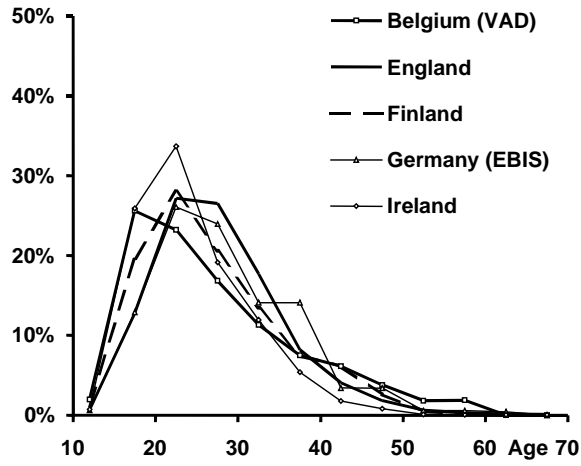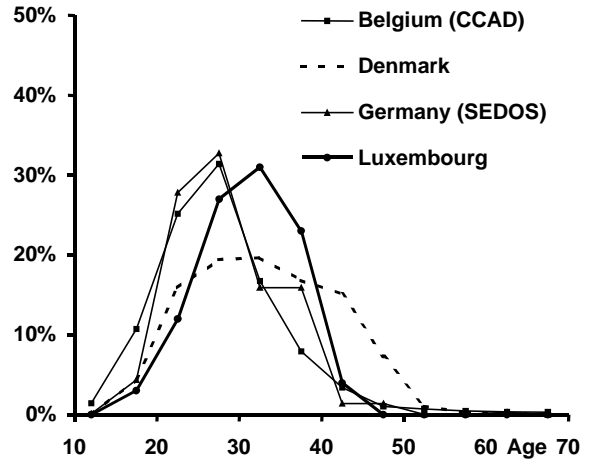
Remarks

Again, a separation between different treatment-centre types would be valuable here. Currently, the given mean age only reflects that of the treated drug-using population, but this figure is distorted by the proportion of in- and outpatient treatment centres reporting to the monitoring system. It is a well-known fact that the age distributions of clients treated in outpatient treatment centres differ markedly from those treated in in-patient centres.

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

Living status (with whom)
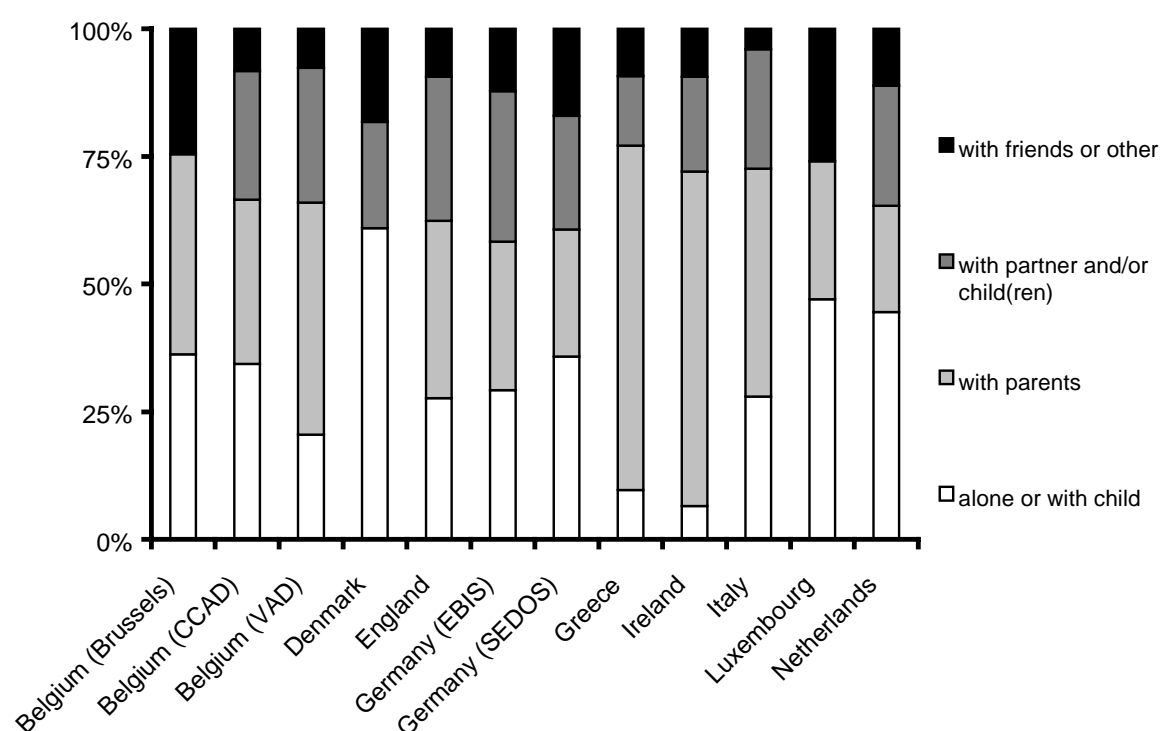
Country	alone or with child %	with parents %	with partner and/or child(ren) %	with friends or other %	not known %	number
Belgium (Brussels) ([a])	29	31		19	21	1,544
Belgium (CCAD)	31	29	23	7	10	1,681
Belgium (VAD) ([b])	20	45	26	8		2,731
Denmark ([c])	55		19	16	10	4,580
England ([d])	14	18	15	5	48	21,996
Finland ([e])						
Germany (EBIS) ([f])	29	28	29	12	2	12,600
Germany (SEDOS)	35	24	22	17	3	1,331
Greece ([g])	10	67	14	9	1	570

Ireland ([h])	6	62	18	9	5	4,910
Italy ([i])	28	45	23	4		2,625
Luxembourg	47	27	6	20		
Netherlands ([j])	41	19	22	10	8	6,407

Notes:

Blank cells indicate data not available.

([a]) The category 'Alone or with child' also includes 'With partner and/or child(ren)'; the category 'Other' includes living in an institution (e.g., prison).

([b]) The 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 at raw-data level; the category 'With friends' is not available.

([c]) The categories 'With parents' and 'Other' are empty.

([d]) Data for the category 'Alone with child' could not be individually identified and are within the category 'Alone'; data for the category 'With partner and child(ren)' are within the category 'With partner'; data for the category 'With friends' are within the category 'Other'; the English category 'Parents and partner' is also within the category 'Other'; ignoring the large number of unknown cases may be misleading in the bar graph.

([e]) An accurate conversion of Finnish categories is not possible and would lead to a misleading interpretation.

([f]) The category 'With partner and child(ren)' consists of 'With child(ren) and other' data.

([g]) The category 'Alone with child' does not exist in the Greek Protocol and was coded as 'Other'.

([h]) The category 'With partner and child(ren)' is not available separately.

([i]) Item not covered by the Lazio region monitoring system.

([j]) The category 'With friends' is not registered in LADIS.

Remarks

As can be seen from the above footnotes, this item and its categories appear much more problematic than other items. The detailed breakdown of these categories requires changes and modifications in nearly all countries.

The chosen way of reporting this item solves some of the current problems since the pooled categories have been constructed which makes 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)'.

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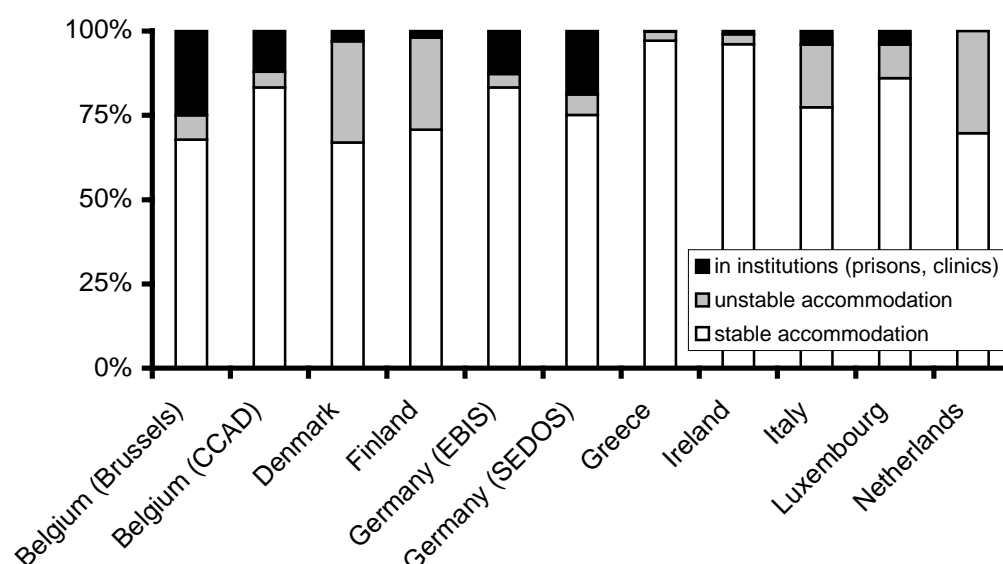
Country	stable accommodation %	unstable accommodation %	in institutions %	not known %	number
Belgium (Brussels) ([a])	57	6	21	16	1,544
Belgium (CCAD)	79	4	11	6	1,681
Denmark	64	29	3	4	4,580
Finland ([b])	69	27	2	2	2,828
Germany (EBIS)	81	4	12	3	11,627
Germany (SEDOS)	71	6	18	6	1,775
Greece ([c])	96	3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

Notes:

Blank cells indicate data not available.

([a]) 'Living with friends' is included in the category 'Stable accommodation'.

([b]) N (missing)=34; 'Living with friends' is included in the category 'Unstable accommodation'; 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 they were in prison.

([c]) The question was combined with 'Living status (with whom)'.

([d]) Item not covered by the Lazio region monitoring system.

([e]) The stability of the living status is not accounted for in LADIS and a proxy measure was used where the LADIS categories 'Having an own home or renting one and living in the parental home' were transferred to the TDI category 'Stable accommodation'; 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 accommodation'.

Remarks

This item seems to be quite problematic as nearly nothing is known of how countries assign data to these categories.

What becomes clear is that the definition given in the TDI Protocol is not sufficient to guarantee comparability between countries. For example, the category 'Living with friends' has been transferred to two different and contrary categories in two cases. Combining this with the other item accounting for living status or calculating proxy estimates demonstrates that the categories of this item will have to be more clearly specified.

Conversion rules defining national equivalences are of central importance if broad (constructed) categories like 'Stable accommodation' and 'Unstable accommodation' are to be compared.

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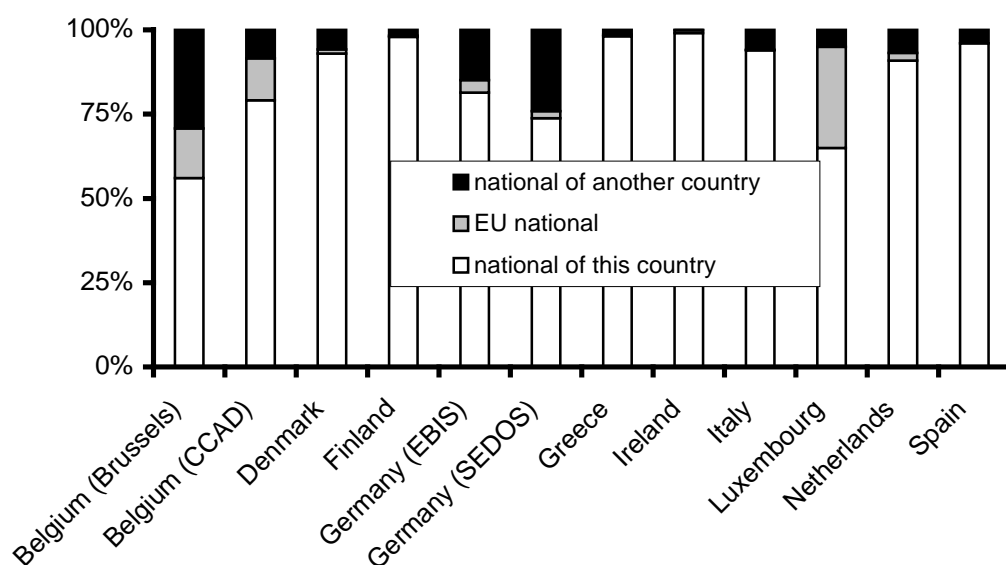
Country	National of this country %	EU national %	national of another country %	not known%	number
Belgium (Brussels)	47	12	25	16	1,544
Belgium (CCAD)	77	12	8	3	1,681
Denmark	93	1	6	<1	4,580
Finland ([a])	97	<1	2	1	2,779
Germany (EBIS)	35	2	6	57	11,627
Germany (SEDOS)	69	2	23	6	1,775
Greece	98	1	1		570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

Notes:

Blank cells indicate data not available.

([a]) N (missing)=83

([b]) RELIS data differentiate between native Luxemburgers and naturalised citizens (% of nationals = sum of both). There is no breakdown by gender on a routine basis.

Remarks

Nationality seems to be one of the items which are easily available. Assignment to TDI categories does not seem problematic.

Labour status
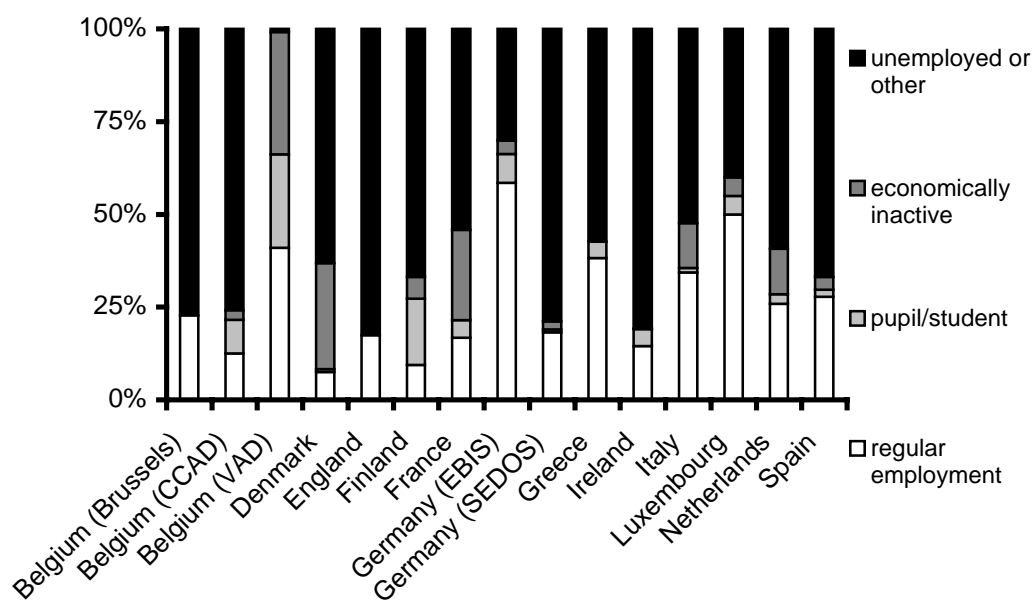
Country	regular employment %	pupil/ student %	economically inactive %	unemployment or other %	not known %	number
Belgium (Brussels) (^{a})	8			28	64	1,544
Belgium (CCAD) (^{b})	12	8	2	70	7	1,681
Belgium (VAD) (^{c})	40	24		33	3	2,933
Denmark	7	1	27	61	4	4,580
England (^{d})	15			71	14	21,996
Finland (^{e})	9	17	6	64	4	2,803
France (^{f})	17	5	24	54		14,684
Germany (EBIS) (^{g})	57	8	3	29	3	11,627
Germany (SEDOS) (^{h})	18	1	2	77	2	1,775
Greece (^{i})	38	4		57	1	570
Ireland (^{j})	14	4	<1	78	3	4,910
Italy (^{k})	32	1	11	50	5	6,059
Luxembourg (^{l})	50	5	5	40		
Netherlands (^{m})	23	2	11	54	9	6,407
Spain (^{n})	25	2	3	61	8	52,440

Notes:

Blank cells indicate data not available.

(^{a}) The categories 'Pupil/student' and 'Economically inactive' are not available; only main source of income is registered; the category 'Unemployed' means 'Never worked' (10%) and the category 'Other' represents occasional work (18%).

(^{b}) 17% 'Other'.

(^{c}) The category 'Economically inactive' includes 'Unemployed'.

(^{d}) Data for the categories 'Pupil/student' and 'Economically inactive' could not be individually identified and are within the category 'Other' (5%).

(^{e}) N(missing)= 59; the 'Economically inactive' category does not include invalids who are in the category 'Other' (4%).

(^{f}) 18% 'Other'.

91

(^g) 8% 'Other'.

(^h) 9% 'Other'.

(ⁱ) 2% 'Other'; the category 'Economically inactive' did not exist in 1997, but had already been changed in 1999.

(^j) 3% 'Other'.

(^k) 6% 'Other'.

(^l) 12% 'Other' (including occasional work).

(^m) 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 categories 'Pension' and 'No personal income' were used; the LADIS category 'On welfare' was used for the TDI category 'Unemployed'; the fit of the other categories was rather self-evident.

(ⁿ) 9% 'Other'.

Remarks

'Labour status' is one of the items which requires slight modifications in definitions or guidelines on how to transfer different labour situations to the TDI categories.

Two countries used 'Main source of income' as a proxy estimate for labour status because this item is not registered in their national systems.

Some of the percentage rates in the 'Other' category are quite high, indicating that a considerable number 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 of the items that makes it easy to give examples of how data from treatment-monitoring systems can be combined with other statistics. For example, this item allows direct comparisons to be made with general statistics, such as unemployment rate among a country's population. This would allow comparisons to be made of the economic and/or social status of clients treated for drug problems and the general population.

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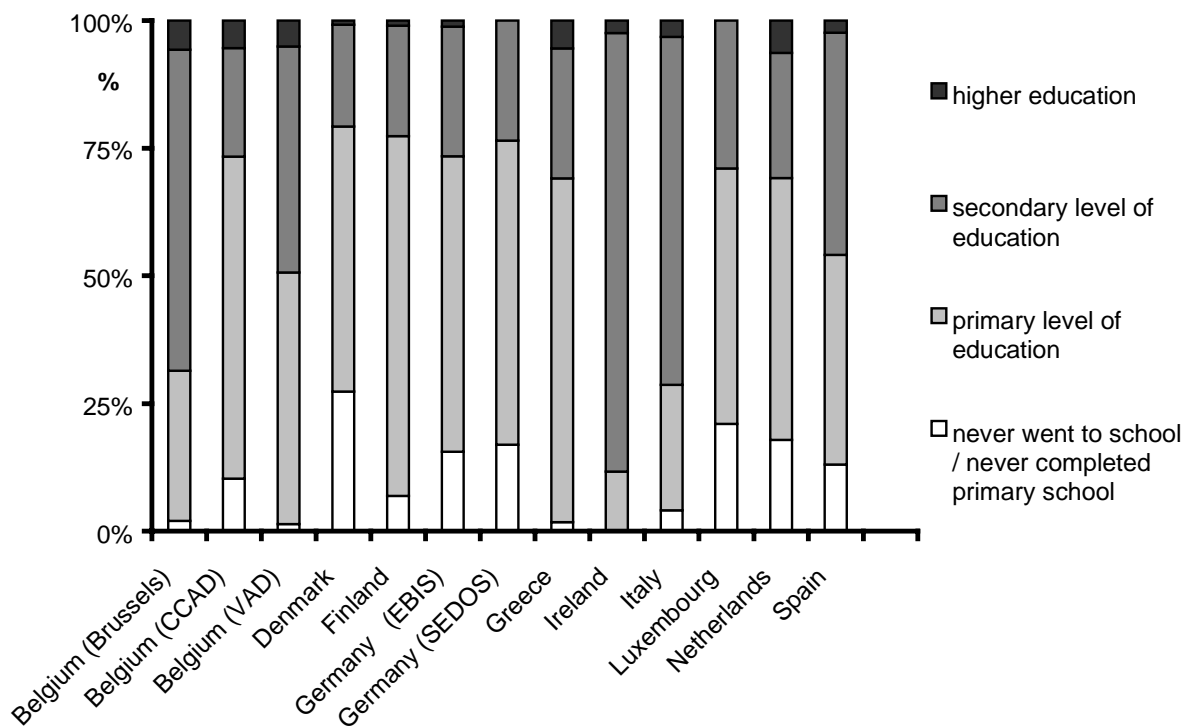
Country	never went to school/never completed primary school %	primary level of education %	secondary level of education %	higher level of education %	not known %	number
Belgium (Brussels)	1	12	26	2	58	1,544
Belgium (CCAD)	8	48	16	4	25	1,681
Belgium (VAD) ([a])	1	36	32	4	27	2,953
Denmark	21	40	15	1	24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

Notes:

Blank cells indicate data not available.

([a]) 'Not known' includes special schools for the handicapped, not-completed school programmes, part-time schooling and so on.

([b]) N(missing)=102; the category 'Not known' in the highest educational level might also include 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.

([c]) The category 'Higher level of education' is from a different table than the other data.

([d]) The category 'Not known' includes clients with an unknown educational level (n=457) and those still in education (n=202); the information collected is the educational level reached rather than the educational level completed

([e]) The RELIS protocol provides data on 'Started school level' and 'Completed school level'. 'Never went to school or never completed primary school level' includes those who started primary school and, before completion, were orientated to specialised education institutions because of their inability to meet the requirements of primary-school courses.

Remarks

Educational systems differ greatly among EU Member States. To avoid problems arising from the unsystematic assignment of national item categories to TDI categories it was suggested to use the International Standard Classification of Education (ISCED) as a standard for transferring items. These classifications are an example of internationally 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 special schools for the handicapped or additional studies to improve 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.

Primary drug (age distribution)

Belgium (Brussels)
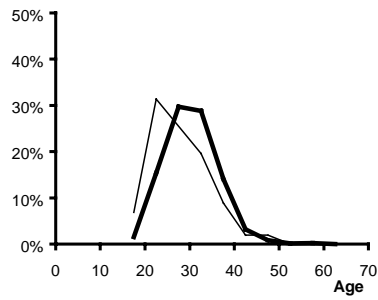
Belgium (CCAD)
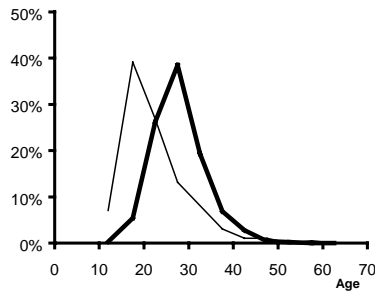
Belgium (VAD)
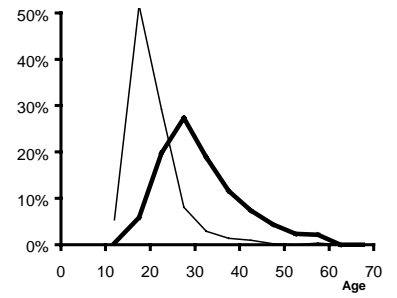
Denmark
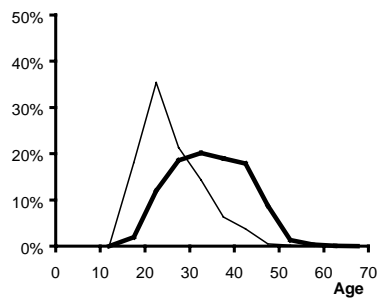
England
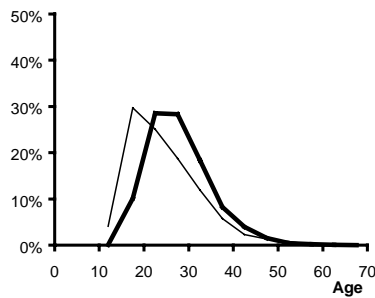
Finland
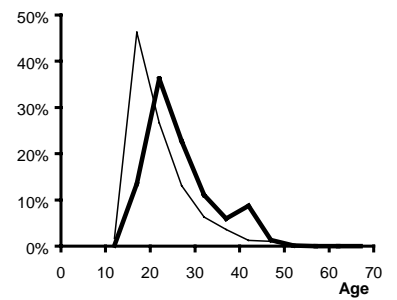
Germany (EBIS)
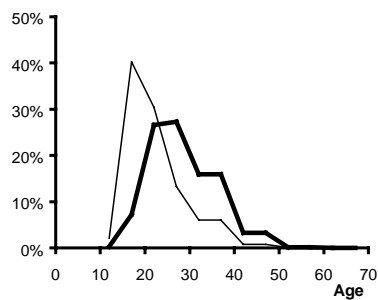
Germany (SEDOS)
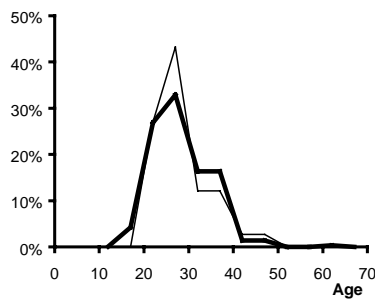
Greece
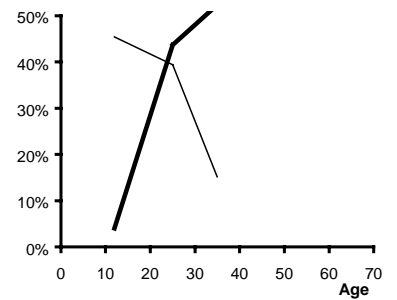
Ireland
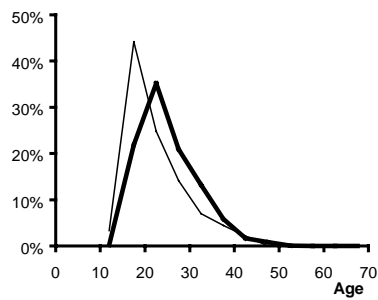
Italy
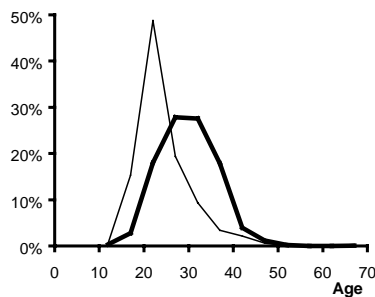
Netherlands
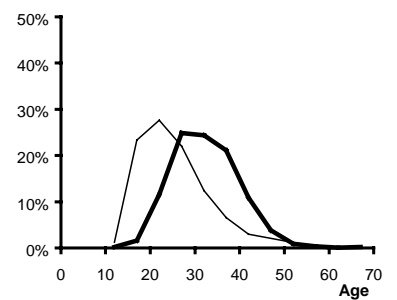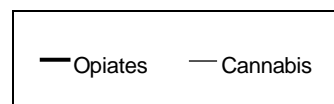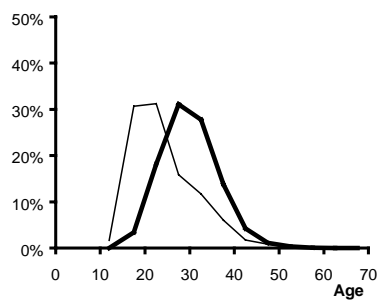
Spain

Opiates —— Cannabis ——

94

Country	Age												Number
	<15	15–19	20–4	25–9	30–4	35–9	40–4	45–9	50–4	55–9	60–4	>=65	
Primary drug: opiates (%)													
Belgium (Brussels) [a]		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) [a]	0	6	20	27	19	12	7	4	2	2			937
Denmark		2	12	19	20	19	18	9	1	<1	<1	<1	3,204
England	<1	10	29	28	18	8	4	2	<1	<1	<1	<1	15,680
Finland	<1	14	36	23	11	6	9	1	<1				585
Germany (EBIS) [b]	<1	7	27	27	16	16	3	3	<1	<1	<1		7,954
Germany (SEDOS) [b]	<1	4	27	33	16	16	1	1	<1	<1	<1		1,158
Greece [c]		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	<1	5,272
Netherlands	<1	2	12	25	24	21	11	4	1	<1	<1	<1	3,132
Spain	<1	3	18	31	28	14	4	1	<1	<1	<1	<1	44,201
Primary drug: cannabis (%)													
Belgium (Brussels) [a]		7	33	27	20	9	2	2					98
Belgium (CCAD)	7	39	27	13	8	3	1	1		1			197
Belgium (VAD) [a]	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	0	1,934
Finland	2	46	27	13	6	4	1	1					473
Germany (EBIS) [b]	2	40	30	13	6	6	1	1	<1	<1	<1		1,976
Germany (SEDOS) [b]	0	0	27	43	12	12	3	3	0	0	0		37
Greece [c]		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) [a, d]													
Belgium (CCAD)		2	32	33	14	12	2	4	2				57
Belgium (VAD) [a]		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	0	925
Finland			100										5
Germany (EBIS) [b]	<1	5	23	31	18	18	3	3	<1	<1			830
Germany (SEDOS) [b]	0	6	31	32	15	15	1	1	0	0	0		88
Greece [c]						not reliable, N=2							
Ireland	0	24	43	19	10	2	0	2	0	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	1,387

Country	<15	15–19	20–4	25–9	30–4	35–9	40–4	45–9	50–4	55–9	60–4	>=65	Number
Spain	<1	7	23	27	24	13	4	1	<1	<1	<1		4,625
Primary drug: stimulants (%)													
Belgium (Brussels) ([a, d])		4	24	31	21	10	7	1	2				107
Belgium (CCAD)	4	35	39	14	6		2						51
Belgium (VAD) ([a])	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	0	2,230
Finland	0	13	30	27	18	6	4	1	<1			<1	971
Germany (EBIS) ([e])													
Germany (SEDOS) ([e])													
Greece ([c])					not reliable, N=1								
Ireland	1	49	38	7	4	1	<1	0	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

Notes:

Blank cells indicate data not available.

([a]) Different age distribution (ends at >=55).

([b]) Different age distribution (30–40; 40–50; 50–60; >=60).

([c]) Different age distribution (<=19; 20–29; >=30).

([d]) 'Cocaine' and 'stimulants' are not distinguishable.

([e]) Not calculated.

Remarks

As in the section 'Age distribution', here the intervals of the age distributions also differ from TDI requirements in some countries

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

Yet drug addicts who attend treatment for opiate-related problems form the largest group of all registered clients. Analyses of other drug types may be more difficult due to small sample sizes and the lack of reliable data.

For this analysis, individual country profiles have been given preference. This seemed to be the best way of providing an overview of the current situation in the EU Member States. Pooling data or calculating means on the basis of several countries would have led to loss of information and data quality. On the other hand, differences in shape or height of country profiles in the graphs again reflect differences in the 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 it is because the data have been collected via cross-tabulations. This may have led to the main drug being available but not stratified by the second item (as with Luxembourg).

In future, different stratifications – for example, by route of administration, new versus old cases, and so on – would be interesting. As in the previous tables describing age distributions, a 'Not known' category should be added.

Primary drug (per country)

Belgium (Brussels)
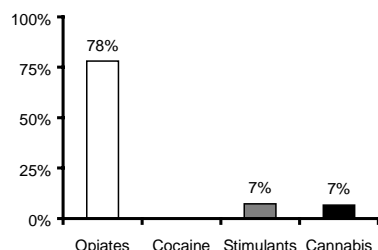
Drug	%	N
Opiates	78	1,204
Cocaine ([a])		
Stimulants	7	111
Hypnotics/sedatives	7	110
Hallucinogens	1	9
Volatile inhalants	<1	1
Cannabis	7	103
Other	<1	6
Total	100	1,544

([a]) included in 'stimulants' category

Belgium (CCAD)
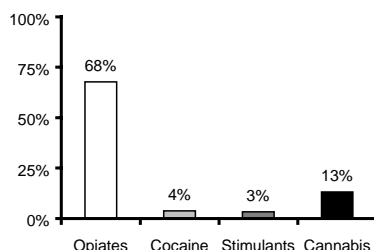
Drug	%	N
Opiates	68	1,091
Cocaine	4	61
Stimulants	3	52
Hypnotics/sedatives	7	114
Hallucinogens	<1	2
Volatile inhalants	<1	5
Cannabis	13	213
Other	5	73
Total	100	1,611

Belgium (VAD)
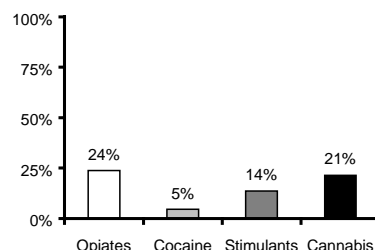
Drug	%	N
Opiates	24	501
Cocaine	5	96
Stimulants	14	287
Hypnotics/sedatives	5	95
Hallucinogens	5	106
Volatile inhalants	1	13
Cannabis	21	451
Other	26	556
Total	100	2,105

Denmark
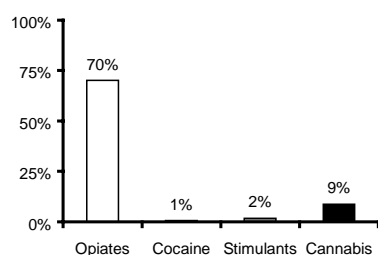
Drug	%	N
Opiates	70	3,211
Cocaine	1	25
Stimulants	2	76
Hypnotics/sedatives	1	54
Hallucinogens	<1	4
Volatile inhalants	<1	2
Cannabis	9	398
Other	18	810
Total	100	4,580

England
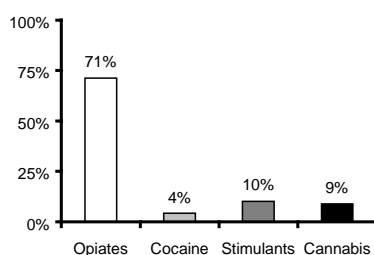
Drug ([a])	%	N
Opiates	71	15,680
Cocaine	4	925
Stimulants	10	2,230
Hypnotics/sedatives	3	647
Hallucinogens	<1	49
Volatile inhalants	1	148
Cannabis	9	1,934
Other	2	383
Total	100	21,996

([a]) 77 drug-free users and 38 poly-drug users recorded under 'Other'

Finland
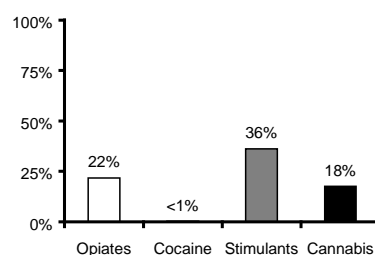
Drug ([a])	%	N
Opiates	22	573
Cocaine	<1	5
Stimulants	36	962
Hypnotics/sedatives	4	112
Hallucinogens	<1	7
Volatile inhalants	<1	4
Cannabis	18	466
Other ([a])	20	528
Total	100	2,657

([a]) N (missing)=205; category 'Other' includes alcohol as primary drug

France
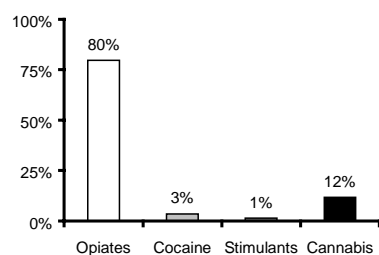
Drug	%	N
Opiates	80	10,909
Cocaine	3	462
Stimulants	1	177
Hypnotics/sedatives	3	349
Hallucinogens	0	54
Volatile inhalants	0	42
Cannabis	12	1,601
Other	1	112
Total	100	13,706

Germany (EBIS)
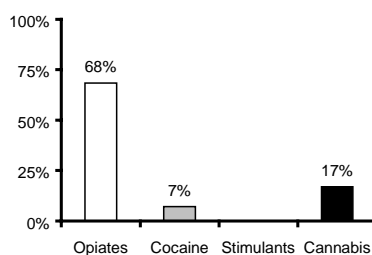
Drug	%	N
Opiates	68	7,954
Cocaine	7	830
Stimulants ([a])		
Hypnotics/sedatives	6	655
Hallucinogens	2	211
Volatile inhalants	0	0
Cannabis	17	1,977
Other ([a])		
Total	100	11,627

([a]) not calculated

Germany (SEDOS)
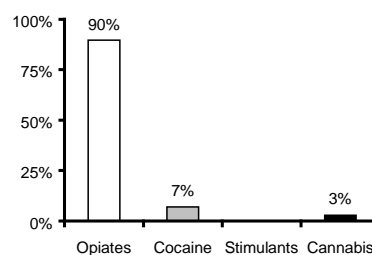
Drug	%	N
Opiates	90	1,158
Cocaine	7	89
Stimulants ([a])		
Hypnotics/sedatives	1	8
Hallucinogens	0	0
Volatile inhalants	0	0
Cannabis	3	37
Other ([a])		
Total	100	1,292

([a]) not calculated

Greece
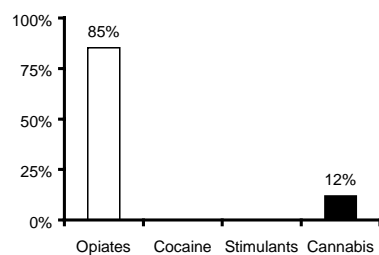
Drug	%	N
Opiates	85	476
Cocaine ([a])		
Stimulants ([a])		
Hypnotics/sedatives	3	16
Hallucinogens ([a])		
Volatile inhalants ([a])		
Cannabis	12	66
Other ([a])		
Total	100	558

([a]) figures not reliable

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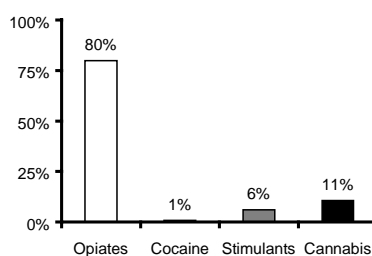
Drug	%	N
Opiates	80	3,905
Cocaine	1	42
Stimulants	6	299
Hypnotics/sedatives	2	75
Hallucinogens	1	26
Volatile inhalants	1	27
Cannabis	11	518
Other	<1	2
Total	100	4,894

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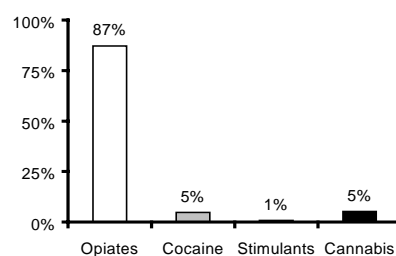
Drug	%	N
Opiates	87	5,272
Cocaine	5	292
Stimulants	1	50
Hypnotics/sedatives	1	82
Hallucinogens	<1	2
Volatile inhalants	<1	1
Cannabis	5	319
Other	<1	30
Total	100	6,048

Luxembourg
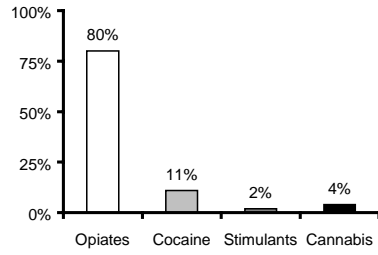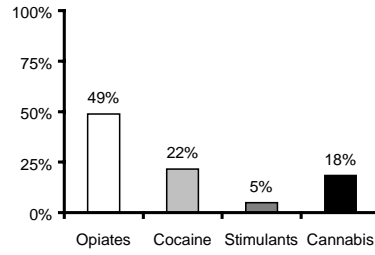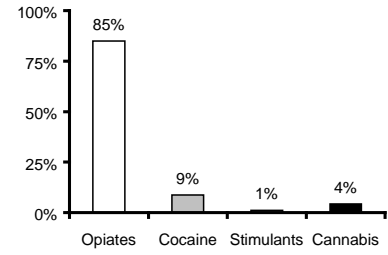
Drug ([a])	%	N
Opiates	80	
Cocaine	11	
Stimulants	2	
Hypnotics/sedatives	1	
Hallucinogens	0	
Volatile inhalants	0	
Cannabis	4	
Other	1	
Total	100	

([a]) RELIS provides data on 'preference 1, 2, 3 substances' and breakdown data by IV and non-IV use blank cells: not available

Netherlands

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

Spain

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

Remarks

These figures provide an overview of 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. The large figures for opiate and cannabis users make further stratifications or detailed analyses interesting.

With single exceptions (for example, Finland which has a very high proportion of stimulant users) the figures look quite similar and may prompt scientists to analyse single drugs (such as cannabis) in more detail. See the section 'Primary drug (age distribution)' for additional remarks.

Usual route of administration (primary drug)
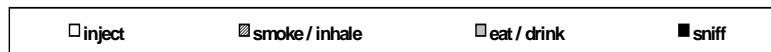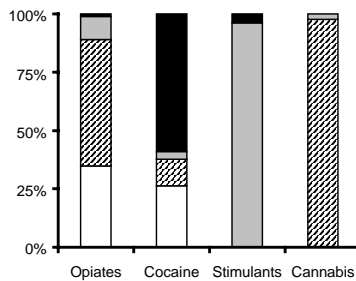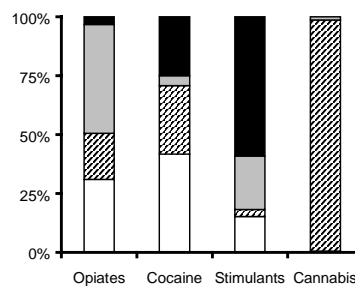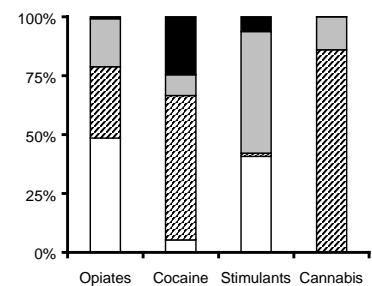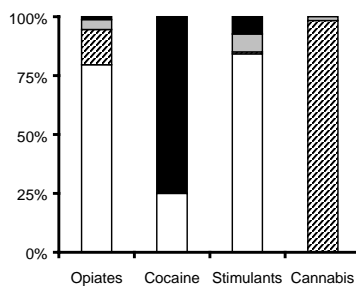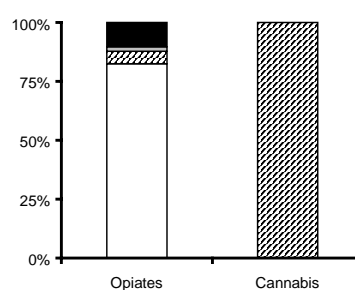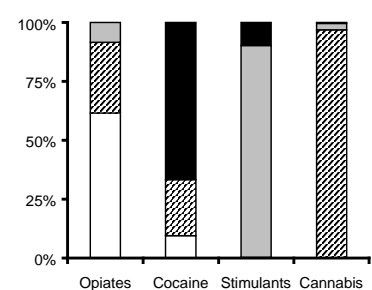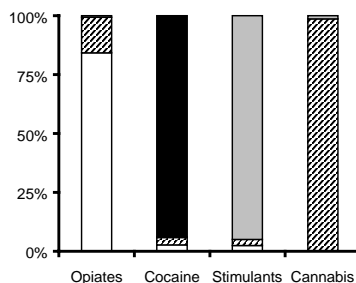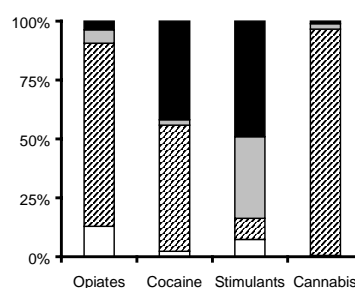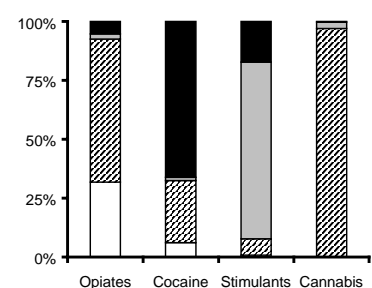
Remarks

This item gives useful information concerning patterns of use and possible problems related to certain routes of administration (such as injecting). Considerable differences can be seen among countries. Analyses carried out at national level may explain some of these differences and give valuable information on how or why consumption habits have changed or may be influenced.

Additional remarks are necessary to allow a realistic interpretation of the data. For example, the proportion of opiate users receiving methadone is of interest as this sub-group will increase the share in the 'Eat/drink' category.

Country	inject	smoke/inhale	eat/drink	sniff	others	not known	number
Primary drug: opiates (%)							
Belgium (CCAD)	31	49	9	1		10	1,091
Denmark ([a])	30	19	44	3		4	3,211
England ([b])	47	29	20	1	<1	4	15,680
Finland ([c])	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 ([c])	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 ([c])	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 ([c])	0	98	2	0		<1	462
Greece		100					66
Ireland		97	3	<1			508

Country	inject	smoke/inhale	eat/drink	sniff	others	not known	number
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

Notes:

Blank cells indicate data not available.

([a]) 44% of all registered opiate users receive or use methadone causing the high figure in the 'Eat/drink' category.

([b]) Either one or two routes of administration have been registered; if the route includes 'Injected' it has been included as 'Inject'; 'Oral and smoke' and 'Oral and snort' have been grouped in the category 'Others'; 18% methadone users among opiate users cause the high figure in the 'Eat/drink' category.

([c]) No category 'Other' exists in Finnish data collection; the category 'Inject' might be emphasised 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.

Frequency of use (primary drug)

Clients using opiates as primary drug

Clients using cocaine as primary drug

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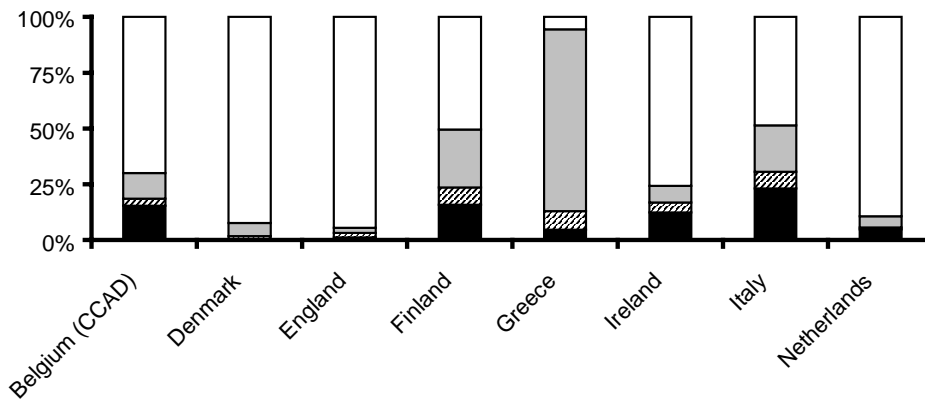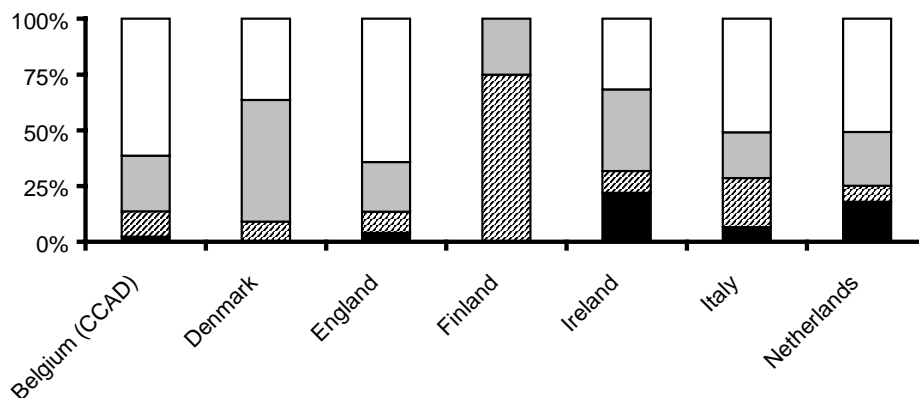
Clients using stimulants as primary drug

Clients using cannabis as primary drug

■ not used in past month/used occasionally   ▨ used once a week or less
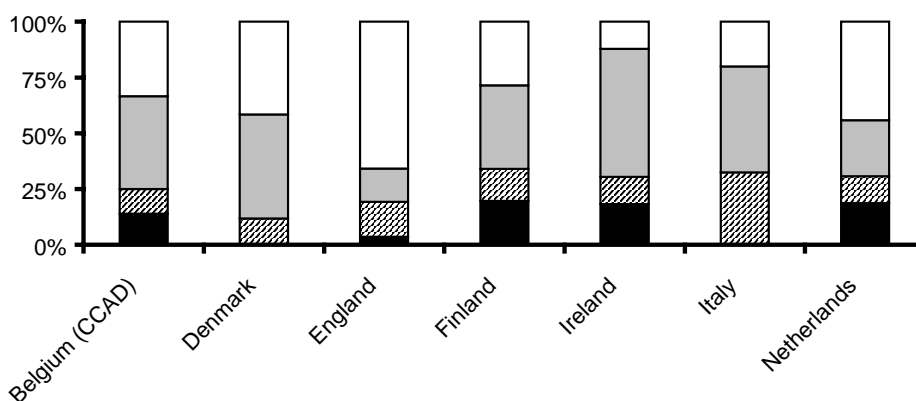
▨ used 2-6 days per week   ☐ used daily
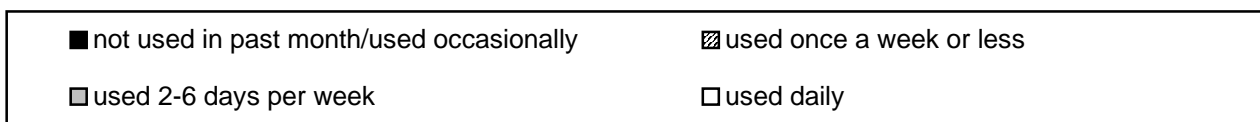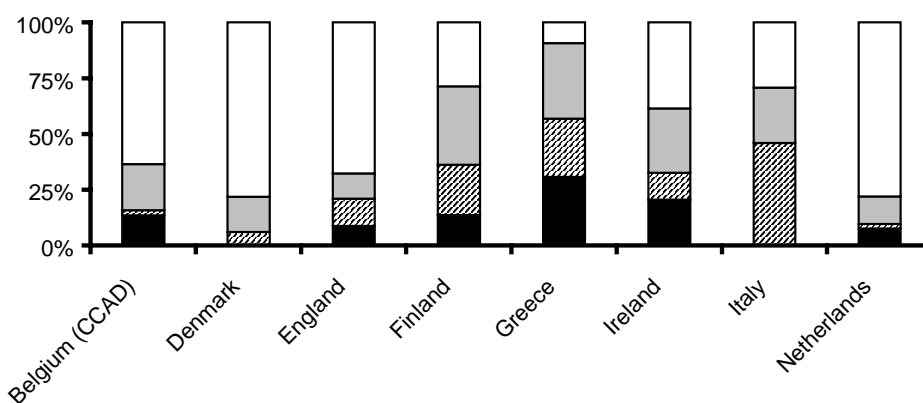
Country	not used in past month/used occasionally	used once a week or less	used 2–6 days per week	used daily	not known	number
Primary drug: opiates (%)						
Belgium (CCAD)	13	3	10	59	16	1,091
Denmark	<1	1	5	86	7	3,256
England	1	2	2	88	7	15,680
Finland	15	8	25	50	2	525
Greece	5	8	81	5	1	476
Ireland	12	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

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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

Note:

Blank cells indicate data not available.

Remarks

This item is strongly moderated by the drug the registered clients prefer. It is evident that opiate users tend to use their drug daily, whereas there are great differences in use for other drugs. Here the habits of consumption differ among countries whereas they are quite comparable for opiate users.

Combination with or stratification by the items 'Usual route of administration', 'Main drug' or 'Other (=secondary) drugs currently used' may give a quite exhaustive picture of different patterns of use in the EU Member States as well as comparable habits and trends.
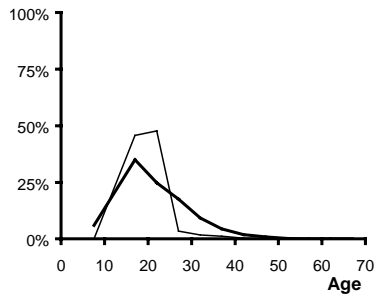
Nevertheless, some countries (such as France and Germany) do not register the frequency of use or have many empty cells among their data sheets or high proportions of 'unknown' cases.
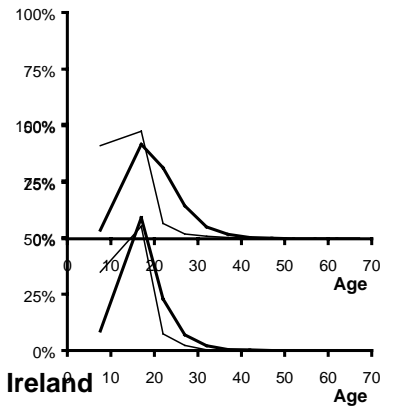
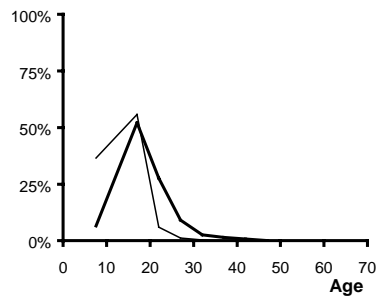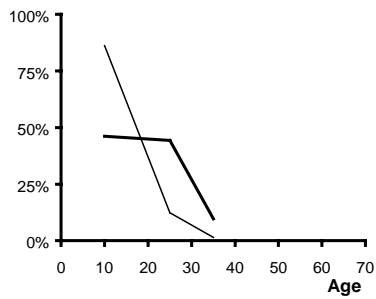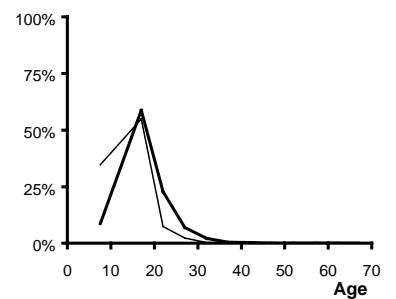# Age at first use of primary drug

Belgium (CCAD)
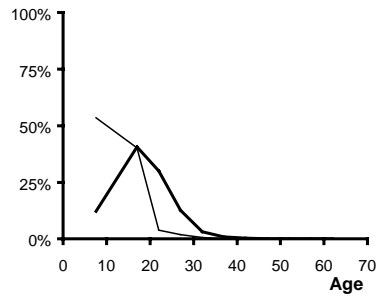
Denmark

England

Finland

Greece

Ireland

Italy
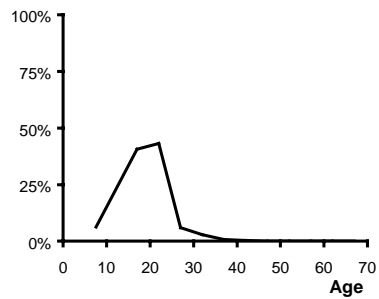
Spain
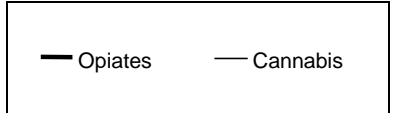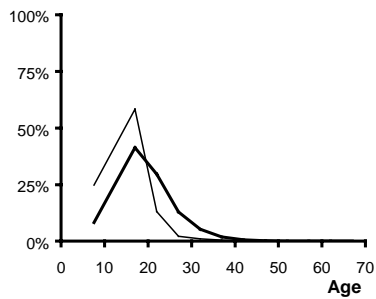
—— Opiates **——** Cannabis

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Country	Age												Number
	<15	15–19	20–4	25–9	30-4	35–9	40–4	45–9	50–4	55–9	60–4	>=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 ([a])	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 ([a])	73	27											65
Ireland	35	55	7	2	<1	<1	<1						464
Italy													
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 ([b])													
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 ([a])													
Ireland	13	71	12	3	1		<1						280
Italy	51	32	17										41
Spain	8	66	18	5	1	1	1		<1	<1			535

Notes:

Blank cells indicate data not available.

([a]) Different age distribution (30–40; 40–50; 50–60; >=60).

([b]) Not reliable (N=1).

Remarks

Careful analysis of this item may allow certain 'at risk' age periods (which are more or less well known in some cases) to be identified, but a considerable number of countries are still unable to report this item as required by the TDI Protocol.

Germany registers the 'Start of problem use' which is slightly different from the category requested by the TDI Protocol. Luxembourg uses different age categories and the Netherlands has an item that gives information on the 'Mean length of period for which the primary problem lasted' which is similar to the German definition.

Other (=secondary) drugs currently used

Proportion of other (=secondary) drugs among clients using opiates as their primary drug

Legend: other opiates, cocaine, stimulants, cannabis, other substances
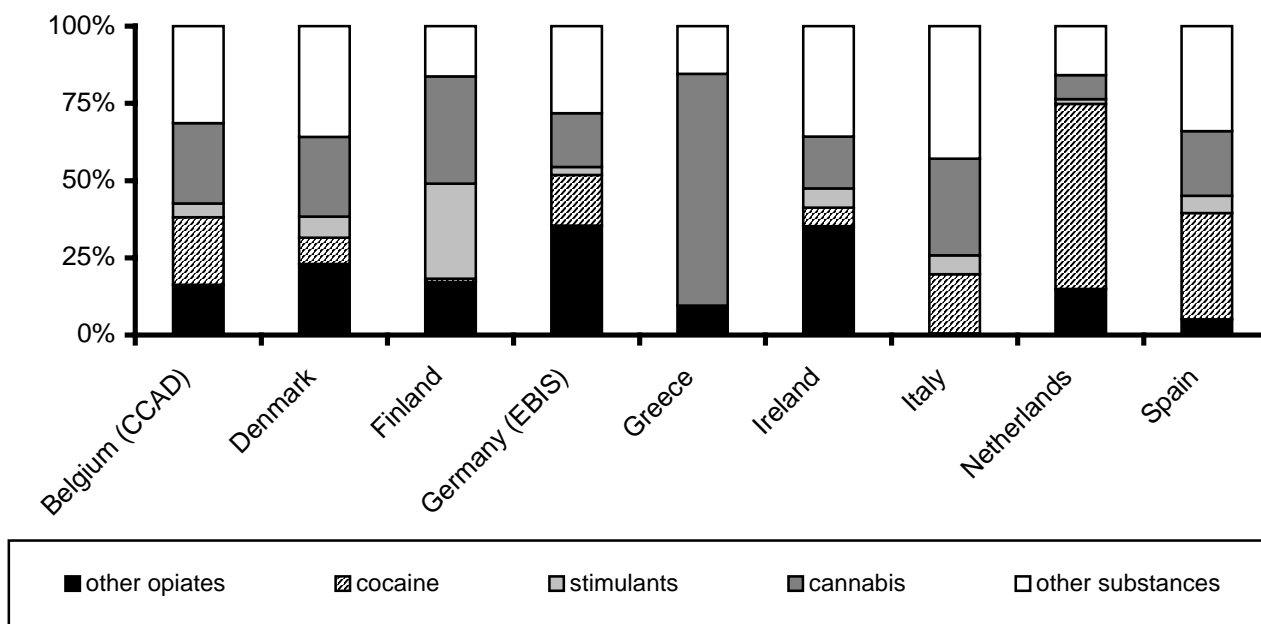
Country	other opiates %	cocaine %	stimulants %	cannabis %	other substances %	among other, mainly	number (a)
Proportion of other (=secondary) drugs among clients using opiates as primary drug							
Belgium (CCAD)	16	22	4	26	31	hypnotics (21%)	883
Denmark	23	9	7	26	36	hypnotics (23%)	4,419
Finland	17	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 using cocaine as primary drug							
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							

Ireland	17		41	22	20	alcohol (10%)	103
Italy	42	1	30	.	27	hallucinogens (20%)	836
Netherlands	22	<1	6	26	45	alcohol (31%)	41
Spain	12	<1	15	27	46	alcohol (31%)	5,859

Notes:

Blank cells indicate data not available.

(^{a}) Number of single diagnoses.

Remarks

This item completes the information about patterns of use among drug users. Nearly all clients report having used more than one drug. Knowledge about patterns of use are valuable for several professionals working in the drug field, especially for assessing risk arising from an (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 cross-tabulation of primary and secondary drugs still offers many possibilities for analysing the data. Such a range of possible analyses requires clear ideas of how an analysis will be carried out and what kind of information is required.

In some countries, a very detailed breakdown of drugs leads to very small sample sizes which do not allow for reliable data analysis. As a result, only main drug types have been analysed, but the data still allow for a closer examination of single aspects if needed.

Ever injected/currently (last 30 days) injecting
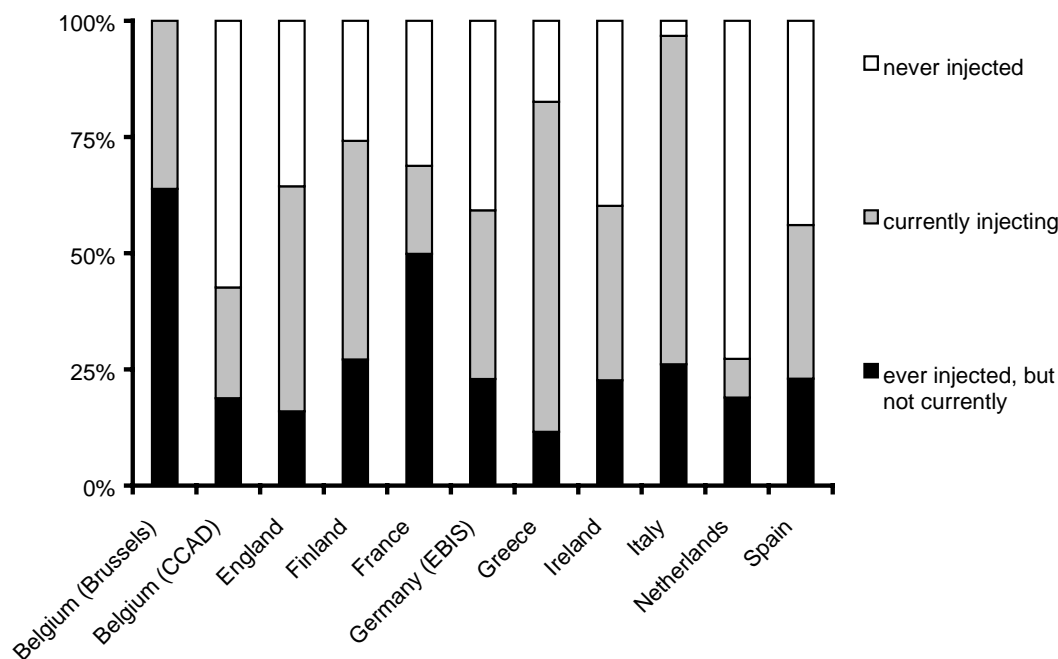
Country	ever injected, but not currently %	currently injecting %	never injected %	not known %	number
Belgium (Brussels) ([a])		36	64		412
Belgium (CCAD)	45	19	15	21	1,681
England ([b])	29	39	13	19	21,996
Finland ([c])	24	44	25	7	2,437
France	29	17	46	8	14,939
Germany (EBIS)	41	36	23		5,869
Greece	17	71	12		570
Ireland	40	38	23		4,504
Italy	3	64	24	9	4,795
Netherlands	41	5	11	43	6,407
Spain	33	25	17	25	52,440

Notes:

Blank cells indicate data not available.

([a]) Data should be confirmed.

([b]) 'Currently injecting' means in the last four weeks.

([c]) N(missing)=425; the overall percentage of 'Not known' and missing values was very high.

Clients using opiates as primary drug (total)
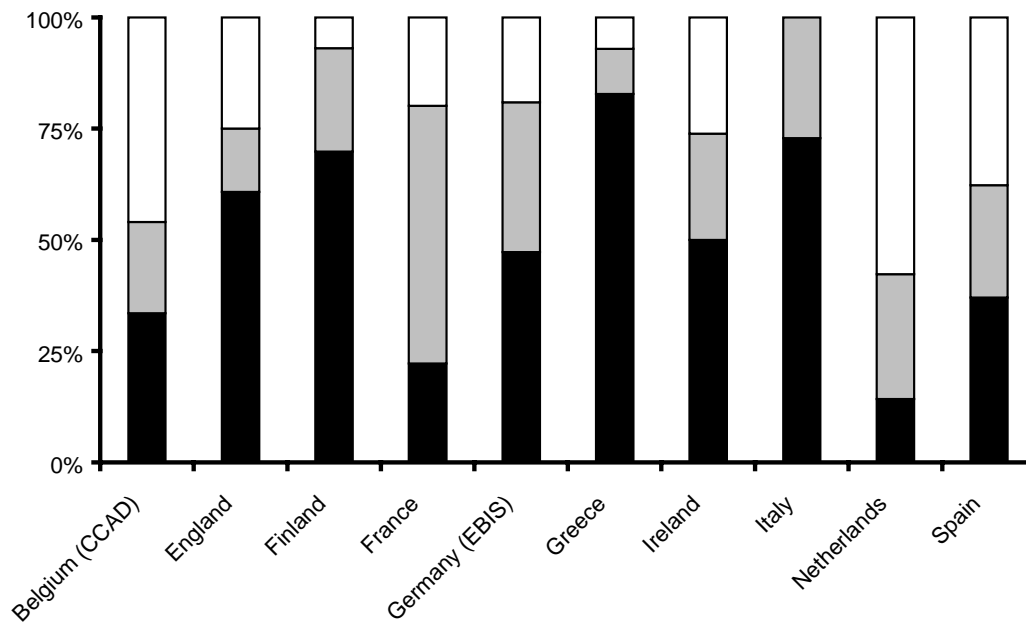
Clients using cannabis as primary drug

Legend: ■ Currently injecting ■ Ever injected, but not currently □ never injected
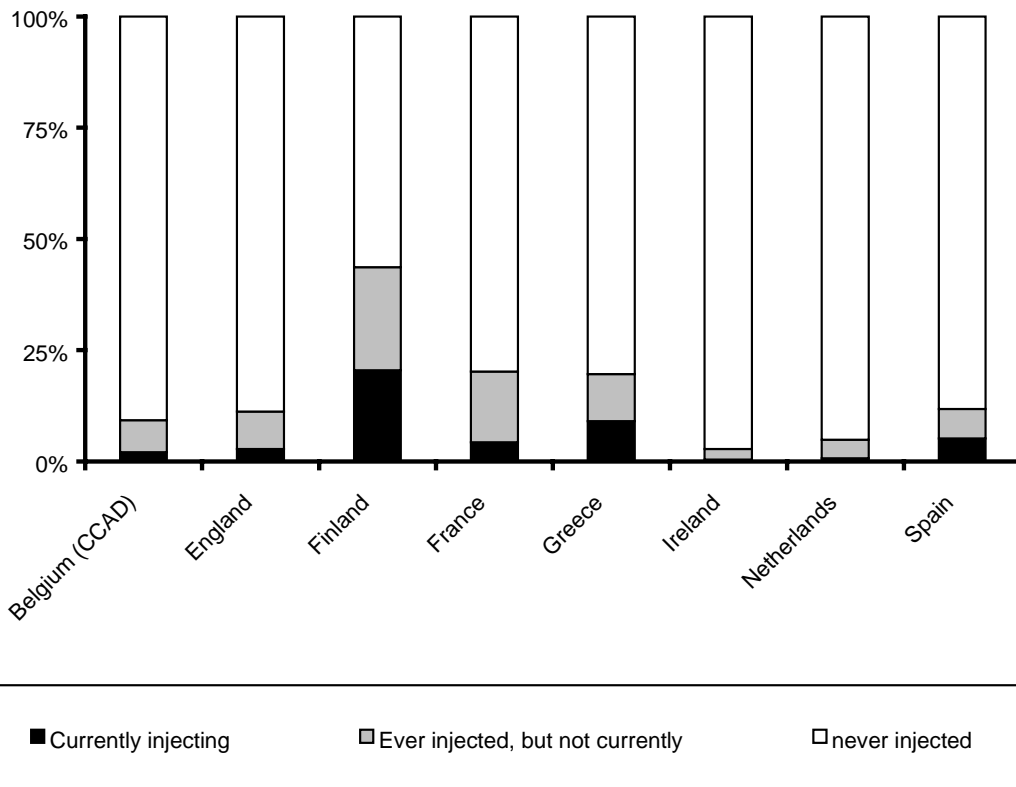
Country	ever injected, but not currently %	currently injecting %	never injected %	not known %	N
Primary drug: opiates					
Belgium (CCAD)	19	27	37	16	1,091
England	15	49	21	15	15,680
Finland	22	68	7	3	530
France	53	20	19	8	11,736
Germany (EBIS)	26	37	37		4,683
Greece	11	82	7		476
Ireland	21	51	27		3,282
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

Note:

Blank cells indicate data not available.

Remarks

The item concerning the injection behaviour 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.

As a result, nearly all countries were able to provide information on health aspects and corresponding prevention activities. The stratification by drug types offers detailed insights into differences among drugs and/or countries.

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

The stratification by primary drug allows differences in risk behaviour to be identified according to differences in preferred drugs.

4. Translation rules for the Treatment Demand Indicator Protocol

The following tables are taken from the final report of Reitox sub-task 3.2 (July 1997) and may therefore not reflect the latest state of development in individual countries. All national experts and focal points are asked to complete and update their translation rules list.

For all tables, blank cells indicate that the variable or category of variable does not exist in the national database and is therefore not applicable.

Belgium (Flemish Community)

	Core items (EMCDDA)	Monitoring system (national language)	Monitoring system (English)
1	**Treatment-centre type**	therapeutic community, crisis-intervention centre, outpatient treatment centre	therapeutic community, crisis-intervention centre, outpatient treatment centre
	• outpatient treatment centre		
	• in-patient treatment centre		
	• low threshold/drop-in/street agency		
	• general practitioner		
	• treatment units in prison		
2	**Date of treatment – month**	datum opname	date of start of treatment (dd/mm/yy)
3	**Date of treatment – year**	datum opname	date of start of treatment (dd/mm/yy)
4	**Ever previously treated**	– ambulante hulpverlening (al dan niet ambulante hulpverling gevolgd, juist voor de opname in dit centrum): – aantal residentiële behandelingen (aantal opnamen in curatieve of residentiële instellingen juist voor de opname in dit centrum)	partly constructed from two separate variables: – outpatient treatment just before this treatment; – number of residential treatments just before this treatment
	• never	geen zekere informatie	no reliable information
	• previously treated	indien juist voor de behandeling andere behandeling heeft plaatsgehad kan dit ingevuld worde	if the patient has been treated just before this treatment then information is available
	• not known	meestal 'not known'	in other cases (most cases) not known
5	**Source of referral**	verwijzer echelon en verwijzer sector	Information constructed from the variables 'referral level' and 'referral sector'
	• self-referred	Mantelzorg	self-referred
	• family/friends	Mantelzorg	family and friends
	• other drug-treatment centre		(information not available)
	• GP	Medisch	medical

	• hospital/other medical source	Medisch	medical
	• social services	Sociaal	social
	• court/probation/police	gerechtelijk/justitieel	judicial
	• other	Andere	other
	• not known	Onbekend	not known
6	**Gender**	Geslacht	gender
	• male	Man	male
	• female	Vrouw	female
	• not known		
7	**Age at start of treatment**	(opnamedatum – geboortedatum)	(date at start of treatment – date of birth)
8	**Year of birth**	Geboortedatum	date of birth (dd/mm/yy)
9	**Living status (with whom)**	verblijfplaats bij opname	Place of living at start of treatment
	• alone	alleen (eventueel met eigen kinderen)	Alone/alone with child
	• with parents	bij ouders	with parents
	• alone with child		
	• with partner (alone)	samenwonend (al dan niet gehuwd)	Living with partner (alone and with child)
	• with partner and child(ren)		
	• with friends	(geen info)	(information not available)
	• other	bij andere familie verbleef dan laatste 3 mnd in gevang;	was living with other family but spent last three months in prison;
		verbleef dan laatste 3 maand in resid. cent.;	was living with other family but spent last three months in a residential centre;
		andere	other
	• not known		
10	**Living status (where)**		
	• stable accommodation		
	• unstable accommodation		
	• in institutions (prison, clinic)		
	• not known		
11	**Nationality**	Nationaliteit (elk land heeft zijn code)	nationality (each country has a code; grouping is possible if required)
	• national of this country		
	• EU national		
	• national of another country		
	• not known		

12	**Labour status**	Beroepsniveau	level of employment before start of treatment
	• regular employment	Arbeider, kleine zelfstandige, thuiswerker onder arbeidscontract/bediende/kader/vrij beroep/bedrijfsleider	employee, labour force, manager
	• pupil/student	Huismoeder/student	housewife/student (one category)
	• economically inactive (pensioners, housewives/-men, invalids)	Huismoeder/student	housewife/student (one category)
	• unemployed	nooit gewerkt	never worked
	• other	Ander	other
	• not known	Onbekend	not known
13	**Highest educational level completed**	Studieniveau	highest educational level
	• never went to school/never completed primary school	niets afgemaakt	did not finish any level
	• primary level of education	lager onderwijs	primary school
	• secondary level of education	lager secund/hoger secundair	lower scondary and higher secondary
	• higher education	hokt/holt	short- and long-term higher education
	• not known	Andere/unbekend	not known
14	**Primary drug**	Voornaamste product	
	• Opiates (total) ▫ heroin ▫ methadone ▫ other opiates	Opiaten	opiates
	• Cocaine (total) ▫ cocaine ▫ crack	Cocaïne	cocaine
	• Stimulants (total) ▫ amphetamines ▫ MDMA and other derivatives ▫ other stimulants	Opwekkende medicatie	stimulants
	• Hypnotics and sedatives (total) ▫ barbiturates ▫ benzodiazepines ▫ others	Dempende medicatie	hypnotics and sedatives
	• Hallucinogens (total) ▫ LSD ▫ others	Hallucinogenen	hallucinogens
	• Volatile inhalants	Snuifmiddelen	volatile inhalants
	• Cannabis (total)	Cannabis	cannabis
	• Other substances (total)	Andere	other

15 Already receiving substitution treatment

- heroin
  - yes
  - no
  - not known

- methadone
  - yes
  - no
  - not known

- other opiates
  - yes
  - no
  - not known

- other substances
  - yes
  - no
  - not known

16 Usual route of administration (primary drug)	(geen informatie)	(no information)

- inject

- smoke/ inhale

- eat/ drink

- sniff

- others

- not known

17 Frequency of use (primary drug)	Frequentie	
• not used in past month/ used occasionally	niet in het laatste jaar/ minder dan 1x per maand	not used in last year/used less than once a month
• once per week or less	1 tot 4 maal per maand/ 1x per week	used 1 to 4 times a month/once a week
• 2–6 days per week	1 tot 6 keer per week	used 1 to 6 times per week
• daily	Dagelijks	used daily
• not known	Onbekend	not known
18 Age at first use of primary drug	Leeftijd eerst gebruik voornaamste product	age at first use of primary drug
19 Other (=secondary) drugs currently used	Leeftijd eerst gebruik voornaamste product	age at first use of primary drug
• Opiates (total) □ heroin □ methadone □ other opiates	Opiaten	opiates
• Cocaine (total) □ cocaine □ crack	Cocaine	cocaine

	Core items (EMCDDA)		
	• Stimulants (total) ▫ amphetamines ▫ MDMA and other derivatives ▫ other stimulants	Opwekkende medicatie	stimulants
	• Hypnotics and sedatives (total) ▫ barbiturates ▫ benzodiazepines ▫ others	Dempende medicatie	hypnotics and sedatives
	• Hallucinogens (total) ▫ LSD ▫ others	Hallucinogenen	hallucinogens
	• Volatile inhalants	Snuifmiddelen	volatile inhalants
	• Cannabis (total)	cannabis	cannabis
	• Alcohol as secondary drug (total)	alcohol	alcohol
	• Other substances	andere	other
20	**Ever injected/currently (last 30 days) injecting**	(geen informatie)	(no information)
	• ever injected, but not currently		
	• currently injected		
	• never injected		
	• not known		

France

	Core items (EMCDDA)	Enquête de novembre (français)	November survey (French)
1	**Treatment-centre type**	centre spécialisé, hôpital	specialised hospital centre
	• outpatient treatment centre		
	• in-patient treatment centre		
	• low threshold/drop-in/street agency		
	• general practitioner		
	• treatment units in prison		
2	**Date of treatment – month**		
3	**Date of treatment – year**		
4	**Ever previously treated**	Premier recours au titre de la toxicomanie dans l'année	first treatment demand related to drug addiction in the last year
	• never	oui	yes
	• previously treated	non	no
	• not known	ne sais pas	not known

5	**Source of referral**	Origine de la prise en charge	
	• self-referred	le patient lui-même	self-referred
	• family/friends	la famille ou les amis	family/friends
	• other drug-treatment centre	un autre centre spécialisé	other drug-treatment centre
	• GP	un médecin généraliste ou spécialiste	general or specialised practitioner
	• hospital/other medical source	un hôpital	hospital
	• social services	un service social	social services
	• court/probation/police	dans le cadre d'une mesure judiciaire dont l'injonction thérapeutique	court-ordered measure including 'court-ordered therapeutic treatment'
	• other	autres cas	other
	• not known	sans information	not known
6	**Gender**	Sexe	gender
	• male	masculin	male
	• female	féminin	female
	• not known		
7	**Age at start of treatment**		
8	**Year of birth**	année de naissance	year of birth
9	**Living status (with whom)**		
	• alone		
	• with parents		
	• alone with child		
	• with partner (alone)		
	• with partner and child(ren)		
	• with friends		
	• other		
	• not known		
10	**Living status (where)**		
	• stable accommodation		
	• unstable accommodation		
	• in institutions (prison, clinic)		
	• not known		
11	**Nationality**	Nationalité	nationality
	• national of this country	française	French
	• EU national	étrangère de la CEE	EU national

	• national of another country	étrangère hors de la CEE	national of another country
	• not known		
12	**Labour status**	Activité	activity
	• regular employment	emploi salarié stable;	stable salaried employment;
		emploi salarié à durée déterminée;	short-term salaried employment;
		travailleur indépendant ou libéral	(liberal) professional person
	• pupil/student	élève, étudiant, stagiaire non-rémunéré	pupil, student
	• economically inactive (pensioners, housewives/-men, invalids)	autres inactifs;	other inactive people;
		militaires du contingent	national servicemen/-women
	• unemployed	chômeur n'ayant jamais travaillé;	unemployed (never worked);
		chômeur ayant déjà occupé un emploi	unemployed (previously worked)
	• other		
	• not known	sans information	not known
13	**Highest educational level completed**		
	• never went to school/never completed primary school		
	• primary level of education		
	• secondary level of education		
	• higher education		
	• not known		
14	**Primary drug**	Produits primaires ayant motivé la demande de soins (deux max.) ([a])	primary substance having motivated the treatment (two max.) ([a])
	• Opiates (total) ▫ heroin ▫ methadone ▫ other opiates	▫ héroïne ▫ morphine, opium ▫ dérivés de codéine ▫ buprénorphine en dehors d'une prescription ▫ méthadone en dehors d'une prescription	▫ heroin ▫ morphine, opium ▫ codeine derivatives ▫ non-prescribed buprenorphine ▫ non-prescribed methadone
	• Cocaine (total) ▫ cocaine ▫ crack	▫ cocaïne ▫ crack	▫ cocaine ▫ crack
	• Stimulants (total) ▫ amphetamines ▫ MDMA and other derivatives ▫ other stimulants	▫ amphétamines ▫ ecstasy	▫ amphetamines ▫ ecstasy
	• Hypnotics and sedatives (total) ▫ barbiturates	▫ barbituriques ▫ benzodiazépines	▫ barbiturates ▫ benzodiazepines

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		□ benzodiazepines □ others	□ autres hypnotiques et tranquillisants	□ benzodiazepines □ other hypnotics and sedatives
	•	Hallucinogens (total) □ LSD □ others	LSD et autres dysleptiques	LSD and others
	•	Volatile inhalants	colles et solvants	glues and solvents
	•	Cannabis (total)	Cannabis	cannabis
	•	Other substances (total)	autres substances; antidépresseurs	other substances; antidepressants
15		**Already receiving substitution treatment**		
	•	heroin □ yes □ no □ not known		
	•	methadone □ yes □ no □ not known		
	•	other opiates □ yes □ no □ not known		
	•	other substances □ yes □ no □ not known		
16		**Usual route of administration (primary drug)**		
	•	inject		
	•	smoke/ inhale		
	•	eat/ drink		
	•	sniff		
	•	others		
	•	not known		
17		**Frequency of use (primary drug)**		
	•	not used in past month/ used occasionally		
	•	once per week or less		
	•	2–6 days per week		
	•	daily		
	•	not known		
18		**Age at first use of primary drug**		age at first use of primary drug
19		**Other (=secondary) drugs currently used**	produits actuellement consommés (au cours du dernier mois) (trois max.)	currently used (last month) substances (three max.)

- Opiates (total)
  - heroin
  - methadone
  - other opiates

▫ héroïne	▫ heroin
▫ morphine, opium	▫ morphine, opium
▫ dérivés de codéine	▫ codeine derivatives
▫ buprénorphine en dehors d'une prescription	▫ non-prescribed buprenorphine
▫ méthadone en dehors d'une prescription	▫ non-prescribed methadone

- Cocaine (total)
  - cocaine
  - crack

▫ cocaïne	▫ cocaine
▫ crack	▫ crack

- Stimulants (total)
  - amphetamines
  - MDMA and other derivatives
  - other stimulants

▫ amphétamines	▫ amphetamines
▫ ecstasy	▫ ecstasy

- Hypnotics and sedatives (total)
  - barbiturates
  - benzodiazepines
  - others

▫ barbituriques	▫ barbiturates
▫ benzodiazépines	▫ benzodiazepines
▫ autres hypnotiques et tranquillisants	▫ other hypnotics and sedatives

- Hallucinogens (total)
  - LSD
  - others

LSD et autres dysleptiques — LSD and others

- Volatile inhalants

colles et solvants — glues and solvents

- Cannabis (total)

Cannabis — cannabis

- Alcohol as secondary drug (total)

- Other substances

autres substances; antidépresseurs — other substances; antidepressants

20 Ever injected/currently (last 30 days) injecting

Administration intraveineuse de produit — intravenous administration of substances

- ever injected, but not currently

oui, antérieurement (pas durant les 30 derniers jours) — yes, previously (prior to the last 30 days), but not currently

- currently injected

oui, actuellement (durant les 30 derniers jours) — yes, currently (last 30 days)

- never injected

non — no

Note:

([a]) In practice, the first substance noted is considered the main drug and the two others the secondary drugs. There is also a question on current methadone, Subutex® or other substitution treatment.

Germany

	Core items (EMCDDA)	EBIS (national language)	EBIS (English)
1	**Treatment-centre type**	keine Fragestellung, definiert durch das Monitoring-System	EBIS only includes outpatient treatment centres which may also include a small number of low-threshold centres
	• outpatient treatment centre		
	• in-patient treatment centre		
	• low threshold/drop-in/street agency		
	• general practitioner		
	• treatment units in prison		
2	**Date of treatment – month**	Betreungsbeginn, Monat	beginning of treatment, month
3	**Date of treatment – year**	Betreungsbeginn, Jahr	beginning of treatment, year
4	**Ever previously treated**	Jemals zuvor suchtbezogene Hilfe beansprucht (G1)	ever previously treated because of drug-related problems (G1)
	• never	Nein	no
	• previously treated	Ja	yes
	• not known	(keine Eintragung)	(no entry)
5	**Source of referral**	Vermittlung durch (G18)	referral by... (G18)
	• self-referred	ohne Vermittlung	no referral
	• family/friends	Angehörige/Freunde/Bekannte	relatives/friends/acquaintances
	• other drug-treatment centre	Fachklinik; Substitutionsambulanz; Suchtberatungsstelle	specialised hospital; substitution-ambulance; drug-counselling centre
	• GP	ärztliche, psychotherapeutische Praxis	GPs, psychotherapeutic practice
	• hospital/other medical source	sonstiges Krankenhaus	other hospital
	• social services	Beratungsstelle der Straffälligenhilfe;	counselling centre for offenders;
		Beratungsstelle der Wohnungslosenhilfe;	counselling centre for homeless people;
		Schuldnerberatungsstelle;	counselling centre for debtors;
		sonstige Fachberatungsstelle;	other specialist services;
		Wohlfahrtsstelle/Pfarramt/Bahnhofsmission;	welfare office/ priest's office/charitable organisation for helping needy rail travellers;
		Arbeitsamt/ Sozialamt/ Jugendamt	employment exchange/social-welfare office/youth-welfare department
	• court/probation/police	Straßenverkehrsbehörde;	road-traffic department;
		Polizei/Zoll;	police/customs office;
		Staatsanwaltschaft/Gericht;	public prosecutor's office/court; juvenile court service/probation

		Jugendgerichtshilfe/Bewährung shilfe; JVA (incl. Sozialdienst)	service; prison (including social service)
	• other	Kategorien Nr.: 7, or 10, or 11, or 17, or 18, or 26	category 7, 10, 11, 17, 18 or 26
	• not known	(keine Eintragung)	(no entry)
6	**Gender**	Geschlecht	gender
	• male	Männlich	male
	• female	Weiblich	female
	• not known		
7	**Age at start of treatment**	Alter	age
8	**Year of birth**	Geburtsjahr	year of birth
9	**Living status (with whom)**	Alleinlebend (G13); Wenn nicht alleinlebend, zusammen (...)(G13a) ([a])	living alone; if not, then living together with (...)
	• alone	Alleinlebend, ja (G13)	living alone, yes
	• with parents	Alleinlebend, nein (G13) und mit Elternteil G13a)	living alone, no and with parent
	• alone with child	mit Kindern und mit PartnerIn	with children and with partner
	• with partner (alone)	mit PartnerIn; mit Kindern; mit Elternteil; mit andern Angehörigen; mit Freunden/Bekannten; mit sonstigen Personen	with partner; with children; with parent; with friends/acquaintances; with other persons
	• with partner and child(ren)	mit PartnerIn and mit Kindern	with partner and children
	• with friends	mit Freunden/Bekannten	with friends/acquaintances
	• other	mit sonstigen Personen	with other persons
	• not known	(Kein Eintrag)	(no entry)
10	**Living status (where)**		
	• stable accommodation		
	• unstable accommodation		
	• in institutions (prison, clinic)		
	• not known		
11	**Nationality**	Staatsangehörigkeit	nationality
	• national of this country	Deutsch	German
	• EU national	EU-Länder	EU national
	• national of another country	Andere	other
	• not known	(kein Eintrag)	(no entry)
12	**Labour status**	Beruflicher Status (G15), wenn Erwerbsperson, derzeit... (G15a); Einkommenssituation (G16) ([a])	employment status, if employed, current income

• regular employment	mit Vollzeit-, Teilzeit-beschäftigung (G15a)	full-time/part-time employment
• pupil/student	Schüler/Student (G15)	pupil/student
• economically inactive (pensioners, housewives/-men, invalids)	Hausmann /-frau (G15); Rentner/Pensionär (G15); sonstige Nichterwerbspersonen (G15)	houseman/-wife; pensioner; other unemployed persons
• unemployed	arbeitslos gemeldet (G15a) oder arbeitsuchend gemeldet (G15a)	registered as unemployed or looking for a job
• other	mindestens einen Eintrag in anderen Kategorien der Items G15/G15a oder G16	at least one valid value of other categories in G15 or G15a or G16
• not known	(kein Eintrag)	(no entry)
13 Highest educational level completed	Höchster Schulabschluß (G9)	highest educational level completed
• never went to school/never completed primary school	kein Schulabschluß	never completed school
• primary level of education	Sonderschulabschluß oder Hauptschulabschluß	completed special school or lower secondary school
• secondary level of education	Mittlere Reife oder Polytech-nische Oberschule	completed secondary school or polytechnic school
• higher education	Fachhochschulreife oder Hochschulreife	completed higher professional school or grammar school
• not known	andere Kategorien oder (kein Eintrag)	other categories or (no entry)
14 Primary drug	Hauptdiagnose (G22a/b)	primary diagnosis
• Opiates (total) ▫ heroin ▫ methadone ▫ other opiates	Opioide ▫ Heroin ▫ Methadon ▫ Codein oder andere opiathaltige Mittel	opiates ▫ heroin ▫ methadone ▫ codeine or other opiates
• Cocaine (total) ▫ cocaine ▫ crack	Kokain ▫ Kokain ▫ Crack	cocaine ▫ cocaine ▫ crack
• Stimulants (total) ▫ amphetamines ▫ MDMA and other derivatives ▫ other stimulants	Andere Stimulantien	other stimulants
• Hypnotics and sedatives (total) ▫ barbiturates ▫ benzodiazepines ▫ others	Beruhigungsmittel oder Schlafmittel	hypnotics or sedatives
• Hallucinogens (total) ▫ LSD ▫ others	Halluzinogene ▫ LSD ▫ Mescaline oder sonstige Halluzinogene	hallucinogens ▫ LSD ▫ mescaline or other hallucinogens
• Volatile inhalants	Flüchtige Lösungsmittel	volatile inhalants
• Cannabis (total)	Haschisch oder Marihuana	hash or marijuana
• Other substances (total)	Andere psychotrope Substanzen	other psychotropic substances

Substanzen

15 Already receiving substitution treatment

- heroin
  ▫ yes
  ▫ no
  ▫ not known

- methadone
  ▫ yes
  ▫ no
  ▫ not known

- other opiates
  ▫ yes
  ▫ no
  ▫ not known

- other substances
  ▫ yes
  ▫ no
  ▫ not known

16 Usual route of administration (primary drug)	Hauptdiagnose (G22a/b/c/d)	primary diagnosis (G22a/b/c/d)
• inject	Gegenwärtiger oder jemaliger i.v.-Konsum	currently or ever injected
• smoke/ inhale		
• eat/ drink		
• sniff		
• others		
• not known		

17 Frequency of use (primary drug)

- not used in past month/ used occasionally

- once per week or less

- 2–6 days per week

- daily

- not known

18 Age at first use of primary drug	Alter bei Beginn der Störung (G22e)	age when drug use (main diagnosis) became problematic, not comparable with TDI definition

19 Other (=secondary) drugs currently used	Diagnosen (G22a/b)	diagnosis (G22a/b)
• Opiates (total) ▫ heroin ▫ methadone ▫ other opiates	Opioide ▫ Heroin ▫ Methadon ▫ Codein oder andere opiathaltige Mittel	Opiates ▫ heroin ▫ methadone ▫ codeine or other opiates
• Cocaine (total) ▫ cocaine ▫ crack	Kokain ▫ Kokain ▫ Crack	cocaine ▫ cocaine ▫ crack

- ▫ crack

- **Stimulants (total)**   Andere Stimulantien   other stimulants
  - ▫ amphetamines
  - ▫ MDMA and other derivatives
  - ▫ other stimulants

- **Hypnotics and sedatives (total)**   Beruhigungsmittel oder Schlafmittel   hypnotics or sedatives
  - ▫ barbiturates
  - ▫ benzodiazepines
  - ▫ others

- **Hallucinogens (total)**   Halluzinogene   hallucinogens
  - ▫ LSD   ▫ LSD   ▫ LSD
  - ▫ others   ▫ Mescaline oder sonstige Halluzinogene   ▫ mescaline or other hallucinogens

- **Volatile inhalants**   Flüchtige Lösungsmittel   volatile inhalants

- **Cannabis (total)**   Haschisch oder Marihuana   hash or marijuana

- **Alcohol as secondary drug (total)**   Alkohol   alcohol

- **Other substances**   andere psychotrope Substanzen   other psychotropic substances

20 Ever injected/currently (last 30 days) injecting   Diagnose (G22a/b/c/d)   diagnosis (G22 a/b/c/d)

- ever injected, but not currently   jemaliger i.v.-Konsum   ever injected

- currently injected   gegenwätiger i.v.-Konsum   currently injected

- never injected   weder jemaliger i.v.-Konsum noch gegenwätiger i.v.-Konsum   neither ever injected nor currently injecting

- not known

Note:

([a]) Because of the combination of more than one Item, sequential data analysis is required. Proposal: 1. Pupil/Student, 2. Economically inactive, 3. Regular employment, 4. Casual work, 5. Unemployed.

Ireland

	Core items (EMCDDA)	Monitoring system
1	**Treatment-centre type**	outpatient/in-patient/low-threshold/GP/prison
	• outpatient treatment centre	
	• in-patient treatment centre	
	• low threshold/drop-in/street agency	
	• general practitioner	
	• treatment units in prison	
2	**Date of treatment – month**	month of treatment contact
3	**Date of treatment – year**	year of treatment contact
4	**Ever previously treated**	

- never   never received treatment for drug misuse at any centre anywhere
- previously treated   received treatment at some point in the past either from this centre or from any other centre
- not known   not known/no answer

5   Source of referral

- self-referred   approach for treatment made by client him/herself
- family/friends   family/friends
- other drug-treatment centre   other centre
- GP   general practitioner
- hospital/other medical source   hospital
- social services   social services
- court/probation/police   court/probation/police
- other   referral from another source
- not known   not known/no answer

6   Gender

- male   male
- female   female
- not known   no answer

7   Age at start of treatment   age

8   Year of birth   date of birth – day, month, year

9   Living status (with whom)

- alone   living alone
- with parents   with parental family
- alone with child   alone with child (added in 1998)
- with partner (alone)   with partner
- with partner and child(ren)
- with friends   with friends
- other   other
- not known   not known/no answer

10   Living status (where)

- stable accommodation
- unstable accommodation
- in institutions (prison, clinic)
- not known

11   Nationality

- national of this country — Irish
- EU national — EU Member State
- national of another country — non-EU
- not known — not known/no answer

12 Labour status

- regular employment — part-time/full-time gainful employment
- pupil/student — pupil/student (added in 1998)
- economically inactive (pensioners, housewives/-men, invalids)
- unemployed — not gainfully employed
- other — other
- not known — not known/no answer

13 Highest educational level completed — highest educational level reached

- never went to school/never completed primary school — never went to school/never completed primary school (data from age left school)
- primary level of education — primary school completed (from age left school)
- secondary level of education — secondary school completed (from age left school)
- higher education — reached third level
- not known — not known/no answer

14 Primary drug

- Opiates (total) — opiates (total)
  - heroin — heroin
  - methadone — methadone
  - other opiates — other opiates
- Cocaine (total) — cocaine (total)
  - cocaine — cocaine
  - crack — crack
- Stimulants (total) — stimulants (total)
  - amphetamines — amphetamines
  - MDMA and other derivatives — MDMA and other derivatives
  - other stimulants — other stimulants
- Hypnotics and sedatives (total) — hypnotics and sedatives (total)
  - barbiturates — barbiturates
  - benzodiazepines — benzodiazepines
  - others — others
- Hallucinogens (total) — hallucinogens (total)
  - LSD — LSD
  - others — others
- Volatile inhalants — volatile inhalants
- Cannabis (total) — cannabis (total)
- Other substances (total) — other substances (total)

15 Already receiving substitution treatment

- heroin
  - yes
  - no
  - not known

- methadone
  - yes
  - no
  - not known

- other opiates
  - yes
  - no
  - not known

- other substances
  - yes
  - no
  - not known

16   Usual route of administration (primary drug)

- inject   inject/skin pop

- smoke/ inhale   smoke

- eat/ drink   eat/drink

- sniff   sniff

- others   other

- not known   not known/no answer

17   Frequency of use (primary drug)

- not used in past month/ used occasionally   not used in past month

- once per week or less   once per week or less

- 2–6 days per week   2–6 days per week

- daily   daily

- not known   not known/no answer

18   Age at first use of primary drug   age at first use of primary drug

19   Other (=secondary) drugs currently used

- Opiates (total)   opiates (total)
  - heroin   - heroin
  - methadone   - methadone
  - other opiates   - other opiates

- Cocaine (total)   cocaine (total)
  - cocaine   - cocaine
  - crack   - crack

- Stimulants (total)   stimulants (total)
  - amphetamines   - amphetamines
  - MDMA and other derivatives   - MDMA and other derivatives
  - other stimulants   - other stimulants

- Hypnotics and sedatives (total)   hypnotics and sedatives (total)
  - barbiturates   - barbiturates
  - benzodiazepines   - benzodiazepines
  - others   - others

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- Hallucinogens (total)
  - ▫ LSD
  - ▫ others

  hallucinogens (total)
  - ▫ LSD
  - ▫ others

- Volatile inhalants

  volatile inhalants

- Cannabis (total)

  cannabis (total)

- Alcohol as secondary drug (total)

  alcohol as secondary drug (total)

- Other substances

  other substances (total)

20 Ever injected/currently (last 30 days) injecting

- ever injected, but not currently

  ever injected at any time in the past

- currently injected

  currently injecting (past month)

- never injected

  ever injected – no

- not known

  not known/no answer

Netherlands

	Core items (EMCDDA)	Monitoring system (national language)	Monitoring system (English) ([a])
1	**Treatment-centre type**	Soort instelling	
	• outpatient treatment centre		
	• in-patient treatment centre		
	• low threshold/drop-in/street agency		
	• general practitioner		
	• treatment units in prison		
2	**Date of treatment – month**	Maand van hulpverlening	
3	**Date of treatment – year**	Jaar van hulpverlening	
4	**Ever previously treated**	Ooit eerder hulp ontvangen	
	• never	Nee	
	• previously treated	Ja	
	• not known	Onbekend	
5	**Source of referral**	Aanmelding via	entered by
	• self-referred	cliënt zelf	
	• family/friends	directe omgeving	
	• other drug-treatment centre	Verslavingszorg	
	• GP	algemene gezondheidszorg	health care
	• hospital/other medical source	algemene gezondheidszorg	health care
	• social services	gemeenschaps- voorzieningen	
	• court/probation/police	justitie	justice

	• other	anderszins	
	• not known	onbekend	
6	**Gender**	Geslacht	
	• male	man	
	• female	vrouw	
	• not known	onbekend	
7	**Age at start of treatment**	Leeftijd tijdens start hulpverlening	
8	**Year of birth**	Geboortejaar	
9	**Living status (with whom)**	Leefsituatie	living condition
	• alone	alleenstaand	single
	• with parents	met ouder(s)	with parent(s)
	• alone with child	met kind(eren)	with child(ren)
	• with partner (alone)	met partner	with partner
	• with partner and child(ren)	met partner en kind(eren)	with partner and child(ren)
	• with friends	met ander(en)	with other(s)
	• other	met ander(en)	with other(s)
	• not known	onbekend	
10	**Living status (where)**		
	• stable accommodation		
	• unstable accommodation		
	• in institutions (prison, clinic)		
	• not known		
11	**Nationality**	Nationaliteit	
	• national of this country	Nederlands	
	• EU national	land van de EU	
	• national of another country	land buiten de EU	
	• not known	onbekend	
12	**Labour status**	Bron van inkomsten	source of income
	• regular employment	regulier werk	wages or independent
	• pupil/student	studiefinanciering	scholarships
	• economically inactive (pensioners, housewives/-men, invalids)	AOW/pensioen geen eigen inkomen uitkering	pension/no income; social benefits
	• unemployed	AOW/pensioen geen eigen inkomen uitkering	pension/no income; social benefits
	• other	anders	

	• not known	onbekend	
13	**Highest educational level completed**	Opleidingsniveau afgerond	finished education
	• never went to school/never completed primary school	geen	none
	• primary level of education	lager onderwijs	lower
	• secondary level of education	voortgezet onderwijs	
	• higher education	tertiair onderwijs	
	• not known	onbekend	

14 Primary drug — Primaire problematiek — primary problem

- Opiates (total) — Opiaten (totaal)
  - heroin — heroïne — ▫
  - methadone — methadon — ▫
  - other opiates — overige opiaten — ▫
- Cocaine (total) — Cocaine (totaal)
  - cocaine — cocaine — ▫
  - crack — crack — ▫
- Stimulants (total) — Stimulerende middelen (totaal)
  - amphetamines — amfetaminen — ▫
  - MDMA and other derivatives — ecstacy — ▫ ecstasy
  - other stimulants — overige stimulerende middelen — ▫
- Hypnotics and sedatives (total) — Medicijnen (totaal)
  - barbiturates — barbituraten — ▫
  - benzodiazepines — benzodiazepinen — ▫
  - others — overige medicijnen — ▫
- Hallucinogens (total) — Hallucinaten (totaal)
  - LSD — LSD — ▫
  - others — overige hallucinaten — ▫
- Volatile inhalants — Vluchtige middelen — volatile substances
- Cannabis (total) — Cannabis (totaal)
- Other substances (total) — Overige middelen (totaal)

15 Already receiving substitution treatment

- heroin
  - yes
  - no
  - not known
- methadone
  - yes
  - no
  - not known
- other opiates
  - yes
  - no
  - not known
- other substances
  - yes
  - no

	▫ not known		

16 Usual route of administration (primary drug) — Wijze van gebruik — methods of drug use

- inject — spuiten — intravenous
- smoke/ inhale — roken — smoking
- eat/ drink — slikken/drinken — swallowing/drinking
- sniff — snuiven — snorting
- others — anders — other
- not known — onbekend

17 Frequency of use (primary drug) — Frequentie gebruik

- not used in past month/ used occasionally — niet meer van toepassing/onregelmatig
- once per week or less — wekelijks
- 2–6 days per week — meer malen per weerk
- daily — dagelijks
- not known — onbekend

18 Age at first use of primary drug

19 Other (=secondary) drugs currently used

- Opiates (total) — Opiaten (totaal)
  - ▫ heroin — ▫ heroine — ▫
  - ▫ methadone — ▫ cocaine — ▫
  - ▫ other opiates — ▫ overige opiatem — ▫
- Cocaine (total) — Cocaine (totaal)
  - ▫ cocaine — ▫ cocaine — ▫
  - ▫ crack — ▫ crack — ▫
- Stimulants (total) — Stimulerende middelen
  - ▫ amphetamines — ▫ amfetaminen — ▫
  - ▫ MDMA and other derivatives — ▫ ecstacy — ▫ ecstasy
  - ▫ other stimulants — ▫ — ▫
- Hypnotics and sedatives (total) — Medicijnen (totaal)
  - ▫ barbiturates — ▫ barbituraten — ▫
  - ▫ benzodiazepines — ▫ benzodiazepinen — ▫
  - ▫ others — ▫ overige medicijnen — ▫
- Hallucinogens (total) — Hallucinaten (totaal)
  - ▫ LSD — ▫ LSD — ▫
  - ▫ others — ▫ overige hallucinaten — ▫
- Volatile inhalants — Vluchtige middelen — volatile substances
- Cannabis (total) — Cannabis (totaal)
- Alcohol as secondary drug (total)
- Other substances — Overige middelen (totaal)

20 Ever injected/currently (last 30 days) injecting — Spuiten

	• ever injected, but not currently	ooit gespoten	
	• currently injected	spuit nog	
	• never injected	nooit gespoten	
	• not known	onbekend	

Note:

(^a) English translations are only given where the category differs from that given in column 1.

Spain

	Core items (EMCDDA)	Monitoring system (national language)	Monitoring system (English)
1	**Treatment-centre type**	centro de tratamiento (V 3) (sólo centros ambulatorios)	treatment centre (V 3) (outpatient centres only)
	• outpatient treatment centre		
	• in-patient treatment centre		
	• low threshold/drop-in/street agency		
	• general practitioner		
	• treatment units in prison		
2	**Date of treatment – month**	fecha de admisión a tratamiento (mes) (V 2)	date of admission for treatment (month) (V 2)
3	**Date of treatment – year**	fecha de admisión a tratamiento (año) (V 2)	date of admission for treatment (year) (V 2)
4	**Ever previously treated**	realización previa de algún tratamiento por la droga principal (V 12)	ever previously treated because of the primary drug (V 12)
	• never	no (2)	no
	• previously treated	sí (1)	yes
	• not known	desconocido (9)	not known
5	**Source of referral**		
	• self-referred		
	• family/friends		
	• other drug-treatment centre		
	• GP		
	• hospital/other medical source		
	• social services		
	• court/probation/police		
	• other		
	• not known		

6	**Gender**	sexo (V 5)	gender (V 5)
	• male	hombre (1)	male
	• female	mujer (2)	female
	• not known	desconocido (9)	not known
7	**Age at start of treatment**	fecha de nacimiento (V 6) (edad calculada)	birth date (V 6) (age calculated)
8	**Year of birth**	fecha de nacimiento (año) (V6)	birth date (year) (V6)
9	**Living status (with whom)**		
	• alone		
	• with parents		
	• alone with child		
	• with partner (alone)		
	• with partner and child(ren)		
	• with friends		
	• other		
	• not known		
10	**Living status (where)**		
	• stable accommodation		
	• unstable accommodation		
	• in institutions (prison, clinic)		
	• not known		
11	**Nationality**	no registrada. Aproximación: lugar de nacimiento (V 7)	not available. Proxy: place of birth (V7)
	• national of this country	nacido en España	born in Spain
	• EU national	nacido en un país de la UE	born in an EU Member State
	• national of another country	nacido en otro país	born in another country
	• not known	Desconocido	not known
12	**Labour status**	situación laboral principal en el momento de la admisión a tratamiento (V 17)	main employment situation when starting treatment (V 17)
	• regular employment	contrato laboral indefinido/ temporal (2,3)	permanent/temporary work contract
	• pupil/student	estudiante/ opositor (8)	student/preparing for exams
	• economically inactive (pensioners, housewives/-men, invalids)	incapacitado permanente/ pensionista/ labore del hogar exclusivamente (7,9)	permanent invalid/pensioner/house work exclusively
	• unemployed	parado no habiendo trabajado antes/ parado habiendo trabajado antes (5,6)	unemployed never worked/unemployed worked previously
	• other	servicio militar o prestación social sustitutoria/ trabajo sin sueldo para la familia/ otra	compulsory military service or social service/unpaid family work/other

situación (1,4,10)

• not known	desconocido (99)	not known

13 Highest educational level completed — máximo nivel de estudios completado (V 18) — highest educational level completed (V 18)

- never went to school/never completed primary school — no sabe leer ni escribir/ no aprobó estudios primarios (1,2) — unable to read or write/never completed primary studies
- primary level of education — estudios primarios (3,4) — primary studies
- secondary level of education — estudios secundarios/ formación profesional de grado medio (5,6) — secondary studies/intermediate-level professional training
- higher education — estudios universitarios/ otros estudios superiores (7,8,9) — university studies/other tertiary studies
- not known — desconocido (99) — not known

14 Primary drug — droga principal por la que es admitido a tratamiento (V 10) — primary drug for which admitted to treatment (V 10)

- Opiates (total) — opiáceos (1000) — opiates
  ▫ heroin — ▫ heroína — ▫ heroin
  ▫ methadone — ▫ lista detallada de opiáceos naturales y sintéticos — ▫ detailed list of natural and synthetic opiates
  ▫ other opiates — ▫ otros opiáceos — ▫ other opiates

- Cocaine (total) — cocaína (2100–2188) — cocaine
  ▫ cocaine — ▫ cocaína (presentaciones detalladas) — ▫ cocaine (detailed forms)
  ▫ crack — ▫ base libre de cocaína — ▫ crack

- Stimulants (total) — estimulantes (2200–2988) — stimulants
  ▫ amphetamines — ▫ anfetaminas — ▫ amphetamines
  ▫ MDMA and other derivatives — ▫ MDMA y otros derivados de la feniletilenamina — ▫ MDMA and detailed list of derivatives
  ▫ other stimulants — ▫ lista detallada / ▫ otros estimulantes — ▫ other stimulants

- Hypnotics and sedatives (total) — hipnóticos y sedantes (3000) — hypnotics and sedatives
  ▫ barbiturates — ▫ barbitúricos — ▫ barbiturates
  ▫ benzodiazepines — ▫ benzodiazepinas — ▫ benzodiazepines (detailed list)
  ▫ others — ▫ otros — ▫ others

- Hallucinogens (total) — alucinógenos (4000) — hallucinogens
  ▫ LSD — ▫ LSD — ▫ LSD
  ▫ others — ▫ lista detallada / ▫ otros — ▫ detailed list / ▫ others

- Volatile inhalants — sustancias volátiles (5000) — volatile substances
  ▫ lista detallada — ▫ detailed list
  ▫ otros — ▫ others

- Cannabis (total) — cañabais (6000) — cannabis

- Other substances (total) — otras sustancias psicoactivas (8000) — other psychoactive substances

15 Already receiving substitution treatment

- heroin
  ▫ yes
  ▫ no
  ▫ not known

- methadone
  ▫ yes

▫ no
▫ not known

- other opiates
  ▫ yes
  ▫ no
  ▫ not known

- other substances
  ▫ yes
  ▫ no
  ▫ not known

16 Usual route of administration (primary drug) | vía más frecuente de administración de la droga principal en los últimos 30 días antes de ser admitido a tratamiento (V 13) | most frequent route of administration of primary drug during the last 30 days before treatment admission (V 13)

- inject | inyectada (5) | inject

- smoke/ inhale | fumada/ inhalada (2,3) | smoke/inhale

- eat/ drink | oral (1) | oral

- sniff | esnifada en polvo (4) | sniff powder

- others | otras (6) | others

- not known | desconocida (9) | not known

17 Frequency of use (primary drug)

- not used in past month/ used occasionally

- once per week or less

- 2–6 days per week

- daily

- not known

18 Age at first use of primary drug | año de inicio del consumo de la droga principal (edad calculada posteriormente) (V 11) | year of first use of primary drug (age calculated afterwards) (V 11)

19 Other (=secondary) drugs currently used | otras drogas (máximo 4) consumidas en los últimos 30 días antes de ser admitido a tratamiento (V 14) | other drugs (maximum four consumed during the last 30 days before treatment admission (V 14)

- Opiates (total) | opiáceos (1000) | opiates
  ▫ heroin | ▫ heroína | ▫ heroin
  ▫ methadone | ▫ lista detallada de opiáceos | ▫ detailed list of natural and
  ▫ other opiates | naturales y sintéticos | synthetic opiates
  | ▫ otros opiáceos | ▫ other opiates

- Cocaine (total) | cocaína (2100–2188) | cocaine
  ▫ cocaine | ▫ cocaína (presentaciones | ▫ cocaine (detailed forms)
  ▫ crack | detalladas) | ▫ crack
  | ▫ base libre de cocaína |

- Stimulants (total) | estimulantes (2200–2988) | stimulants
  ▫ amphetamines | ▫ anfetaminas | ▫ amphetamines
  ▫ MDMA and other derivatives | ▫ MDMA y otros derivados de la feniletilenamina | ▫ MDMA and detailed list of derivatives
  ▫ other stimulants | ▫ lista detallada | ▫ other stimulants
  | ▫ otros estimulantes |

Core items (EMCDDA)		
• Hypnotics and sedatives (total) ▫ barbiturates ▫ benzodiazepines ▫ others	hipnóticos y sedantes (3000) ▫ barbitúricos ▫ benzodiazepinas ▫ otros	hypnotics and sedatives ▫ barbiturates ▫ benzodiazepines (detailed list) ▫ others
• Hallucinogens (total) ▫ LSD ▫ others	alucinógenos (4000) ▫ LSD ▫ lista detallada ▫ otros	hallucinogens ▫ LSD ▫ detailed list ▫ others
• Volatile inhalants	sustancias volátiles (5000)▫ ▫ lista detallada ▫ otros	volatile substances ▫ detailed list ▫ others
• Cannabis (total)	cañabais (6000)	cannabis
• Alcohol as secondary drug (total)	alcohol (7000)	alcohol
• Other substances	otras sustancias psicoactivas (8000)	other psychoactive substances
20 Ever injected/currently (last 30 days) injecting	tiempo transcurrido desde que se inyectó por última vez cualquier sustancia psicoactiva (V 15)	time span since last injection of any psychoactive substance (V 15)
• ever injected, but not currently	más de 30 días (3,4,5,6,7,8)	more than 30 days
• currently injected	menos de una semana/ menos de un mes (1,2)	less than one week/one month
• never injected	nunca se ha inyectado (9)	never injected

United Kingdom

Core items (EMCDDA)	UK monitoring system (DMD)
1 Treatment-centre type	agency type
• outpatient treatment centre	
• in-patient treatment centre	
• low threshold/drop-in/street agency	
• general practitioner	
• treatment units in prison	
2 Date of treatment – month	date of contact
3 Date of treatment – year	date of contact
4 Ever previously treated	not collected
• never	(proxy) ([a])
• previously treated	(proxy) ([a])
• not known	
5 Source of referral	referral from
• self-referred	self

•	family/friends	family/ friend
•	other drug-treatment centre	regional drug service (doctor, nurse specialist, psychologist, social worker, probation officer, other);
		Community Drug Team/Project (Community Psychiatric Nurse (CPN)/nurse, social worker, probation officer, counsellor/drug worker, psychologist, health promotion/education officer, health visitor, doctor, volunteer, other);
		other drug agency (statutory drug agency, non-statutory/voluntary drug agency, therapeutic community)
•	GP	GP
•	hospital/other medical source	accident and emergency;
		psychiatric department;
		hospital outpatient;
		maternity/ante-natal clinic;
		other hospital department;
		psychologist;
		CPN;
		health visitor;
		other nurse;
		health centre;
		alcohol-treatment unit
•	social services	social services
•	court/probation/police	court;
		probation;
		police;
•	other	solicitor;
		prison officer;
		employer;
		job centre;
		school;
		community health council;
		other
•	not known	not known

6 Gender — male/female

•	male	male
•	female	female
•	not known	

7 Age at start of treatment — age at date of contact (from date seen and date of birth)

8 Year of birth — date of birth

9 Living status (with whom) — living with

•	alone	alone
•	with parents	with parents
•	alone with child	(children recorded elsewhere)

• with partner (alone)	with partner
• with partner and child(ren)	(children recorded elsewhere)
• with friends	not collected

• other	with drug user(s);
	 with non-drug user(s);
	 with partner;
	 with parent and partner;
	 with parent(s)/drug user(s);
	 with partner/drug user(s);
	 with parent(s)/non-drug user(s);
	 with partner/non-drug user(s);
	 with other family member/drug user(s);
	 with other family member/non-drug user(s);
	 with strangers/drug user(s);
	 with strangers/non-drug user(s)

• not known	not known

10 Living status (where)

- stable accommodation
- unstable accommodation
- in institutions (prison, clinic)
- not known

11 Nationality   not collected

- national of this country
- EU national
- national of another country
- not known

12 Labour status   employment status

• regular employment	employed
• pupil/student	student
• economically inactive (pensioners, housewives/-men, invalids)	retired; housewife; in prison;
• unemployed	unemployed
• other	invalid; prostitute
• not known	not known

13 Highest educational level completed   not collected

- never went to school/never completed primary school
- primary level of education
- secondary level of education

- higher education
- not known

14 Primary drug   main drug

- Opiates (total)   ▫ opiates unspecified
  ▫ heroin
  ▫ methadone   ▫ heroin unspecified (inject)
  ▫ other opiates   ▫ heroin illicit (smoke)
                                              ▫ heroin diamorphine

                                              ▫ methadone unspecified
                                              ▫ methadone mixt (dtf)
                                              ▫ methadone linctus
                                              ▫ methadone 5mg tabs
                                              ▫ methadone 10mg tabs
                                              ▫ methadone suppositories
                                              ▫ methadone (Physeptone®) amps

                                              ▫ morphine
                                              ▫ opium
                                              ▫ dihydrocodeine (DF118)
                                              ▫ dextromoromide (Palfium®)
                                              ▫ dipianone (Diconal®)
                                              ▫ pethidine
                                              ▫ hydromorphone
                                              ▫ oxymorphone
                                              ▫ hydrocodone
                                              ▫ oxycodone
                                              ▫ levorphanol
                                              ▫ phenazocine
                                              ▫ piritramide
                                              ▫ codeine tabs
                                              ▫ dextropropoxyphene (Distalgesic®)
                                              ▫ pentazocine (Fortral®)
                                              ▫ buprenorphine (Temgesic®)
                                              ▫ codeine unspecified
                                              ▫ opiate containing compounds
                                              ▫ nalbuphine
                                              ▫ alphaprodine
                                              ▫ anileridine
                                              ▫ ethoheptazine
                                              ▫ fentanyl
                                              ▫ phenoperidine
                                              ▫ opiate mixture unspecified
                                              ▫ codeine linctus
                                              ▫ gees linctus
                                              ▫ collis-brown
                                              ▫ phensedyl
                                              ▫ actifed
                                              ▫ kaolinmorphine
                                              ▫ other opiates

- Cocaine (total)
  ▫ cocaine   ▫ cocaine unspecified

- crack

- cocaine hydrochloride powder

- cocaine smokeable
- cocaine hydrochloride smokeable
- cocaine hydrochloride aerosol

- **Stimulants (total)**
  - amphetamines
  - MDMA and other derivatives
  - other stimulants

- stimulants unspecified

- amphetamines unspecified
- amphetamine (illicit)
- amphetamine (pharmaceutical)
- methadrine
- dexadrine
- dexamphetamine syrup
- dexamphetamine smokeable
- methamphetamine amps
- drinamyl

- MDMA
- MDA

- appetite suppressants unspecified
- diethylproprion (Tenuate®, Dospan® etc.)
- phenmetrazine (Preludin®)
- fenfluoramine (Ponderax®)
- mazindol (Teronac®)
- phenteramine (Duromine® etc.)
- methylphenidate (Ritalin®)
- pemoline
- prolintane
- fencamfamin (Reactivan®)
- caffeine (pro-plus)
- other stimulants unspecified

- **Hypnotics and sedatives (total)**
  - barbiturates
  - benzodiazepines
  - others

- sedatives unspecified

- barbiturates unspecified
- amylobarb (Tuinal®)
- pentobarb (Nembutal®)
- quinalbarb (Seconal®)
- phenobarb (Luminal®)
- butobarb (Soneryl®)
- heptabarb (Medomin®
- cyclobarb (Phanodorm®)
- hexobarb (Evidorm®)
- barbitone unbranded
- methylphenobarbitone

- benzodiazepines unspecified
- diazepam (Valium®)
- chlordiaz (Librium®)
- nitrazepam (Mogadon®)
- lorazepam (Ativan®)
- clobezam (Fris®)
- chlorazepate (tranquilliser)

- ketazolam (anxon)
- medazepam (Nobrium®)
- oxazepam (Serenid®)
- flurazepam (Dalmane®)
- temazepam
- triazolam (Halcion®)
- lormetazepam (Noctamid®)
- prazepam (Centrax®)
- bromazepam (Lexotan®)
- flunitrazepam
- chlormezanone (Trancopal®)
- loprazolam
- alprazolam

- anti-histamines unspecified
- hydroxyzine
- cyclizine (Valloid®)
- promethazine
- non-barbiturate, non-benzodiazepine, hypnotic sedative unspecified
- methaqualone (Mandrax®)
- chlormethiazole (Heminevrin®)
- meprobamate etc.
- zopiclone
- propranolol (Inderal®)
- chloral derivatives
- glutethimide
- mephenesin
- methylpentylnol (Oblivon d)
- methylprylone (Noludar®)
- oxyprenolol hydrochloride (Trasicor®)
- other sedatives

- **Hallucinogens (total)**
  - LSD
  - others

- hallucinogens unspecified

- LSD

- mescaline
- psilocybin mushrooms
- phencyclidine (PCP)
- ketamine

- **Volatile inhalants**
  - solvents unspecified
  - glue
  - butane gas
  - amyl nitrate
  - acetone
  - aerosols
  - cleaning fluids

- **Cannabis (total)**
  - cannabis unspecified
  - cannabis (herbal)
  - cannabis (resin)
  - cannabis oil

- **Other substances (total)**
  - tobacco unspecified
  - cigarettes
  - alcohol unspecified

- ▫ beer or cider
- ▫ wines
- ▫ spirits
- ▫ alcohol mixt
- ▫ other drugs unspecified
- ▫ minor analgesics
- ▫ major tranquilliser unspecified
- ▫ chlorpromazine (Largactil®)
- ▫ anti-depressants
- ▫ anti-diarrhoea, anti-emetic
- ▫ naltrexone
- ▫ antabuse
- ▫ clonidine
- ▫ steroids

15 Already receiving substitution treatment

- heroin
  - ▫ yes
  - ▫ no
  - ▫ not known

- methadone
  - ▫ yes
  - ▫ no
  - ▫ not known

- other opiates
  - ▫ yes
  - ▫ no
  - ▫ not known

- other substances
  - ▫ yes
  - ▫ no
  - ▫ not known

16 Usual route of administration (primary drug)   route of administration (main drug)

• inject	inject
• smoke/ inhale	smoke/inhale
• eat/ drink	oral
• sniff	sniff/snort
• others	smoke and inject;
	sniff and smoke;
	inject and snort;
	oral and inject;
	inhale (solvents);
	oral and smoke;
	oral and sniff/ snort;
	per rectum
• not known	not known

17 Frequency of use (primary drug)   frequency (main drug)

• not used in past month/ used occasionally	monthly;
	occasional

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- once per week or less

  weekly/weekends/recreational

- 2–6 days per week

  not collected

- daily

  daily

- not known

  not known

18 Age at first use of primary drug   age at first use (main drug)

19 Other (=secondary) drugs currently used drug 2, drug 3, drug 4, drug 5/alcohol

- Opiates (total)
  ▫ heroin
  ▫ methadone
  ▫ other opiates

▫ opiates unspecified

▫ heroin unspecified (inject)
▫ heroin illicit (smoke)
▫ heroin diamorphine

▫ methadone unspecified
▫ methadone mixt (dtf)
▫ methadone linctus
▫ methadone 5mg tabs
▫ methadone 10mg tabs
▫ methadone suppositories
▫ methadone (Physeptone®) amps

▫ morphine
▫ opium
▫ dihydrocodeine (DF118)
▫ dextromoromide (Palfium®)
▫ dipianone (Diconal®)
▫ pethidine
▫ hydromorphone
▫ oxymorphone
▫ hydrocodone
▫ oxycodone
▫ levorphanol
▫ phenazocine
▫ piritramide
▫ codeine tabs
▫ dextropropoxyphene (Distalgesic®)
▫ pentazocine (Fortral®)
▫ buprenorphine (Temgesic®)
▫ codeine unspecified
▫ opiate containing compounds
▫ nalbuphine
▫ alphaprodine
▫ anileridine
▫ ethoheptazine
▫ fentanyl
▫ phenoperidine
▫ opiate mixture unspecified
▫ codeine linctus
▫ gees linctus
▫ collis-brown
▫ phensedyl

- actifed
- kaolinmorphine
- other opiates

- **Cocaine (total)**
  - cocaine
  - crack

- cocaine unspecified
- cocaine hydrochloride powder

- cocaine smokeable
- cocaine hydrochloride smokeable
- cocaine hydrochloride aerosol
- heroin diamorphine

- **Stimulants (total)**
  - amphetamines
  - MDMA and other derivatives
  - other stimulants

- stimulants unspecified

- amphetamines unspecified
- amphetamine (illicit)
- amphetamine (pharmaceutical)
- methadrine
- dexadrine
- dexamphetamine syrup
- dexamphetamine smokeable
- methamphetamine amps
- drinamyl
- MDMA
- MDA

- appetite suppressants unspecified
- diethylproprion (Tenuate®, Dospan® etc.)
- phenmetrazine (Preludin®)
- fenfluoramine (Ponderax®)
- mazindol (Teronac®)
- phenteramine (Duromine® etc.)
- methylphenidate (Ritalin®)
- pemoline
- prolintane
- fencamfamin (Reactivan®)
- caffeine (pro-plus)
- other stimulants unspecified

- **Hypnotics and sedatives (total)**
  - barbiturates
  - benzodiazepines
  - others

- sedatives unspecified

- barbiturates unspecified
- amylobarb (Tuinal®)
- pentobarb (Nembutal®)
- quinalbarb (Seconal®)
- phenobarb (Luminal®)
- butobarb (Soneryl®)
- heptabarb (Medomin®)
- cyclobarb (Phanodorm®)
- hexobarb (Evidorm®)
- barbitone unbranded
- methylphenobarbitone

- benzodiazepines unspecified
- diazepam (Valium®)
- chlordiaz (Librium®)

- nitrazepam (Mogadon®)
- lorazepam (Ativan®)
- clobezam (Fris®)
- chlorazepate (tranx)
- ketazolam (anxon)
- medazepam (Nobrium®)
- oxazepam (Serenid®)
- flurazepam (Dalmane®)
- temazepam
- triazolam (Halcion®)
- lormetazepam (Noctamid®)
- prazepam (Centrax®)
- bromazepam (Lexotan®)
- flunitrazepam
- chlormezanone (Trancopal®)
- loprazolam
- alprazolam

- anti-histamines unspecified
- hydroxyzine
- cyclizine (Valloid®)
- promethazine
- non-barbiturate, non-benzodiazepine, hypnotic sedative unspecified
- methaqualone (Mandrax®)
- chlormethiazole (Heminevrin®)
- meprobamate etc.
- zopiclone
- propranolol (Inderal®)
- chloral derivatives
- glutethimide
- mephenesin
- methylpentylnol (Oblivon d)
- methylprylone (Noludar®)
- oxyprenolol hydrochloride (Trasicor®)
- other sedatives

- **Hallucinogens (total)**
  - LSD
  - others

- hallucinogens unspecified

- LSD

- mescaline
- psilocybin mushrooms
- phencyclidine (PCP)
- ketamine

- **Volatile inhalants**

- solvents unspecified
- glue
- butane gas
- amyl nitrate
- acetone
- aerosols
- cleaning fluids

- **Cannabis (total)**

- cannabis unspecified
- cannabis (herbal)
- cannabis (resin)

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		□ cannabis oil

- Other substances
  - □ tobacco unspecified
  - □ cigarettes
  - □ alcohol unspecified
  - □ beer or cider
  - □ wines
  - □ spirits
  - □ alcohol mixt
  - □ other drugs unspecified
  - □ minor analgesics
  - □ major tranquilliser unspecified
  - □ chlorpromazine (Largactil®)
  - □ anti-depressants
  - □ anti-diarrhoea, anti-emetic
  - □ naltrexone
  - □ antabuse
  - □ clonidine
  - □ steroids

20 Ever injected/currently (last 30 days) injecting — ever injected/ currently (past four weeks) injected

- ever injected, but not currently — ever injected

- currently injected — injected in the past four weeks

- never injected

- not known — not known

Note:

([a]) 'Proxy' = question not asked, but information is retrievable from the system at regional (not national) level depending on how long the system has been in operation.

Levels of education

Table 1: Levels of education in the European Union according to the International Standard Classification of Education (ISCED)

Country	ISCED 1 Primary level of education	ISCED 2/ISCED 3 Lower/upper secondary level of education	ISCED 5, 6, 7 Higher education
België/Belgique Vlaamse gemeenschap	Lager onderwijs Buitengewoon onderwijs	1ste graad: A, B (year 2: Beroepsvoorbereidend) Buitengewoon onderwijs	Hoger onderwijs buiten de universiteit: Korte type, Lange type Universiteit
Communauté française	Enseignement primaire Enseignement spécial	Enseignement secondaire: Type II: Cycle inférieur année 1–2: Professionnel, Technique, Général Type I: Cycle d'observation (année 2: Professionnel)	Enseignement supérieur non-universitaire: Type court Type long Université

Country	ISCED 1 Primary level of education	ISCED 2/ISCED 3 Lower/upper secondary level of education	ISCED 5, 6, 7 Higher education
		Enseignement special:	
		2de graad: Algemeen, Kunst, Technisch, Beroeps	
		3de graad: Algemeen, Kunst, Technisch, Beroeps	
		Deeltijds	
		Buitengewoon onderwijs	
		Enseignement secondaire:	
		Type II: Cycle inférieur année 3–5:	
		Professionnel, Technique, Général	
		Cycle supérieur: Professionnel, Technique, Général, Année préparatoire	
		Type I: Cycle d'orientation: Général, Technique de transition, Technique de qualification, Professionnel, Année préparatoire	
		Enseignement à horaire réduit	
		Enseignement spécial	
Danmark	Grundskole year 1–6	Grundskole year 7–9 or year 7–10	Korte videregående uddannelser
		(including year 8–10 Efterskole)	Mellemlange videregående uddannelser
	Special education	Special education	Bacheloruddannelser
		(Voksenuddanelse (part-time))	Kandidatuddannelser
		Individuelle uddannelser: EGU, FUU	(Voksenuddanelse (part-time))
		Erhvervsfaglige uddannelser:	
		Erhvervsududdannelser, social- og sundhedsuddannelser, landbrugs søfartsuddannelser, CCC	
		Gymnasiale uddannelser	
		(Voksenuddanelse (part-time))	
Deutschland	Grundschulen	Hauptschulen	Fachschulen
	Sonderschulen	Integrierte Klassen	Schulen des Gesundheitswesens
		Realschulen	Fachhochschulen
		Gesamtschulen	Universitäten
		Gymnasien year 1–6	Weiterbildung
		(all: including year 1–2: Orientierungsstufe)	
		Sonderschulen	

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Country	ISCED 1 Primary level of education	ISCED 2/ISCED 3 Lower/upper secondary level of education	ISCED 5, 6, 7 Higher education
		Berufsschulen (Duales System) Berufsaufbauschulen Fachgymnasien Fachoberschulen Berufsfachschulen Gesamtschulen Gymnasien year 7–9	
Greece	Dimotiko (primary school)	Gymnasion TES: Technical and vocational school TEL: Technical and vocational lykeion EPL: Integrated lykeion GEL: General lykeion IEK: Institute of vocational training (1 year) EPL: Vocational training (1 year)	Technological education establishments: 14 institutions Universities: 18 institutions: technical universities, medical school, dentistry schools, agricultural schools Other university schools Post-graduate studies
España	Colegios de educación general básica (EGB) ano 1–5	Colegios de educación general básica (EGB) ano 6–8 Institutos de formación profesional (VTI): Formación profesional de primer grado Formación profesional de secundo grado Institutos de bachillerato unificado y polivalente (BUP) Curso de orientación universitaria (COU): pruebas de acceso a la universidad	Universidades: Escuelas Universitarias Escuelas Técnicas Superiores Facultades
France	Ecoles élémentaires	Collèges: 3e générale, 3e d'insertion, 3e technologique, lycées professionnels Ecoles spécialisées Lycées: BAC général, BAC technologique, BT Lycées professionnels: BEP ou CAP, BAC professionnel	Grandes écoles Ecoles spécialisées Universités: UFR-Santé, UFR-Lettres-Arts-Sciences humaines-Sciences-droit-sciences économiques IUT, IUP, BTS
Ireland	First level: National schools Non-aided private schools Special schools	Junior cycle (Junior certificate): Vocational schools Community and comprehensive schools Voluntary secondary schools	Regional Technical Colleges (and Dublin Institute of Technology) Universities (including teacher training)

Country	ISCED 1 Primary level of education	ISCED 2/ISCED 3 Lower/upper secondary level of education	ISCED 5, 6, 7 Higher education
		Private schools Special schools all: year 1–3	Private third level
		Junior cycle (Leaving certificate): Vocational schools, Community and comprehensive schools, Voluntary secondary schools, Private schools, Special schools all: year 4–6 (including year 4: transition year) Special schools: year 4–5 Apprenticeship training: FAS, CERT, TEAGASC Post-leaving certificate Private business schools	
Italia	Scuole elementari Educazione speciale	Scuole medie Educazione speciale Scuolo magistrali Instituti magistrali Licei artistici Instituti d'arte Instituti professionali Instituti technici Licei classici, scientifici, linguistici	Academie Università ed instituti universitari: corsi di laurea, corsi di diploma universitario, scuole dirette a fini speciali
Luxembourg	Enseignement primaire	(Lower secondary schools general:) Lycée général (Lower secondary vocational:) Lycée technique (Upper secondary schools general:) Lycée général (Upper secondary vocational:) Régime technique Régime de technicien Régime professionnel	(Higher non-university:) BTS IST/SERP/IEES (Higher university:) Supérieur universitaire: including continuation of studies abroad
Nederland	Basisonderwijs: year 3–8	Voortgezet onderwijs: VBO, MAVO, HAVO year 1–3, VWO year 1–3 (all: year 1: Gemeenschappelijk brugjaar) VSO year 1–3 Voortgezet onderwijs: LLW, MBO, HAVO year 4–5,	Hoger onderwijs: HBO, WO Post-doctoraal: Tweede fase, Post-doctoraal, AIO

Country	ISCED 1 Primary level of education	ISCED 2/ISCED 3 Lower/upper secondary level of education	ISCED 5, 6, 7 Higher education
		VWO year 4–6 VSO year 4–6	
Österreich	Voksschule Sonderschule year 1–4	Hauptschule Allgemeinbildende höhere Schulen – Unterstufe Sonderschule year 5–9 Polytechnischer Lehrgang Berufsschule und Lehre Berufsbildende und Lehrerbildende mittlere Schulen Berufsbildende und Lehrerbildende höhere Schulen Allgemeinbildende höhere Schulen – Oberstufe Oberstufenrealgymnasium	Sonstiger nichtuniversitärer Sektor Fachhochschulen Kunsthochschulen Universitäten
Portugal	Compulsory basic school: general school: 1st cycle year 1–4 2nd cycle year 5–6 Educação especial	Compulsory basic school: general school: 3rd cycle (Certificate of degree) year 7–9 Educação especial Vocational school courses Secondary courses: general and technological courses Educação especial	Polytechnic higher education (Licenciatura, Masters degree, Doutoramento)
Suomi/Finland	Primary: Peruskoulun ala-aste (comprehensive schools, lower stage) year 1–6	Lower secondary: Peruskoulun yläaste (comprehensive schools, upper stage) year 7–9 Upper secondary: Ammatilliset opplilaitokset (vocational and professional education) Lukio (upper secondary schools)	Lower tertiary: Ammattikorkeakoulut (AMK) (polytechnics) Ylopistot (universities): Alempi Korkeakoulututkinto (Bachelors) Ylempi Korkeakoulututkinto (Masters) Lisensiaatti (licentiate) Tochtorin tutkinto (doctorate)
Sverige	Grundskola year 1–6 Utlands, Sär- och Specialskola (Swedish schools aboad, special schools) Vuxenutbildning och folkbildning	Grundskola year 7–9 Utlands, Sär- och Specialskola Vuxenutbildning och folkbildning Gymnasieskola: Nationelle program, Specialkurser	Grundläggande högskoleutbildning: Program, Fristäende kurser Forskarutbildning: Licenciat, Doktor

Country	ISCED 1 Primary level of education	ISCED 2/ISCED 3 Lower/upper secondary level of education	ISCED 5, 6, 7 Higher education
United Kingdom (England and Wales)	Primary schools (including special education) (key stage 1 and key stage 2) First schools, Middle schools year 1–2 Private education	Vuxenutbildning och folkbildning Comprehensive schools (including special education) years 1–3 (key stage 3) (including Middle schools year 3–4) Grammar and secondary schools years 1–3 (key stage 3) Private education	Further education (FE) sector colleges years 3–4: Sub-degree HND/HNC/NVQ4 Higher education (HE) institutions (universities and colleges): Sub-degree HND/HNC/NVQ4, First Degree, Masters, Doctorate
Northern Ireland	Primary schools	(Lower secondary schools general:) Grammar schools Secondary schools	Private education
Scotland	Primary schools	(Lower secondary schools general:) Secondary schools Comprehensive schools (including special education) years 4–5 (key stage 4): GCSE/Foundation or intermediate GNVQs/NVQ 1 or 2 Grammar and secondary schools years 4–5 (key stage 4) Further education (FE) sector colleges years 1–2 School sixth forms Adult-education centres all: GCE A level/advanced GNVQ/NVQ3 Private education (Upper secondary schools general:) Secondary schools Further education college Grammar schools	Sub-degree higher education First degree/post-graduate higher education Further education Higher education

Sources:
OECD (1996), European Commission (1996).

Remarks

- ISCED 0 = early-childhood education not included;

- higher education: ISCED 5 = non-universitary tertiary level of education; ISCED 6 = universitary tertiary level of education: first stage; ISCED 7 = universitary tertiary level of education: second stage, post-graduate;

- for Luxembourg, Northern Ireland (UK) and Scotland (UK) less detailed information is available due to the use of European Commission (1996) and not OECD (1997) as for the other EU countries. No clear references are made to the ISCED levels of education, so here 'estimates' are presented only;

- 1–3 years = theoretical year(s) of study within the type of educational programme/institution (not the theoretical duration of total study career, for example from year 1 primary education to year 17 university);

- information about private education and special education is not available for each country.

5. Procedures to avoid double counting

Introduction ([35])

In the framework of the EMCDDA's 1996 epidemiology work programme, the Luxemburgish focal point was contracted to undertake a comparative study of national encoding systems and procedures to avoid double counting in drug-treatment reporting systems (PADCTRS).

In 1993, in addition to establishing the Reitox national focal point, Luxembourg began implementing a multi-sectorial and nation-wide PADCTRS which, although now fully operational, still requires some quality improvement.

In 1995, the focal point began to design the framework for an inter-regional reporting system involving the border areas of Belgium, France and Germany, and thus experienced at first hand the heterogeneity of regional and national encoding procedures. The information network became effective in1997.

The experience gained during these projects allowed basic guidelines to be drawn up to develop multiple-counting control procedures at various levels. These guidelines will serve as a starting point for more a detailed analysis of existing PADCTRS and for recommendations towards their implementation or improvement.

A secure time- and cost-effective PADCTRS ([36])

Double/multiple counting in drug-treatment-demand reporting systems

Multiple counting within reporting systems is caused by one individual (client/patient) having more than one institutional contact within more than one institution during a specified reporting period. Multiple counting may therefore occur at intra- and/or inter-institutional level.

The main objective of a PADCTRS is to avoid multiple counting at both these levels in order to provide reliable information on the number of drug addicts registered at institutional level during a specified period in the most cost- and time-effective way. The PADCTRS must thus be related to persons and not only to episodes or treatment demands. This supposes that codes or attributors allocated to patients are based on identifying variables which should be as differentiating as possible in order to minimise false (soft) double counting as defined in the next section.

As well as providing more accurate information on prevalence of institutional contacts (for example, with treatment centres, agencies, law-enforcement institutions, etc.), data on the overlap in cases reported by different institutions participating in the national data-reporting system also provide information on the extent and pattern of multiple institutional contacts, which may be relevant to service providers and planners. Individual-related identification codes are useful for monitoring patterns of institutional contacts over successive years and allow a client's present situation to be updated each time he or she is registered by a participating institution.

The exact nature of the identification code is not relevant, nor is it possible to create a code that is 100% successful in eliminating multiple counting, as there will always be some cases where the required input is missing or inaccurately recorded, or where different individuals present the same attributors and thus share the same identification code. A second objective

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([35]) Based on Origer, A. (1996) *Procedures to avoid double counting in drug-treatment reporting systems. Final report*, Luxembourg: Ministry of Health.

([36]) Ibid.

is, therefore, to minimise the probability of erroneous matching of codes to obtain a reasonably accurate count of the number of individuals registered at institutional level.

Hard matching/soft matching – probability of redundancy

Effective (hard) matching occurs when one and the same person is registered by different treatment institutions, or several times by the same institution, within the specified reporting period. False (soft) multiple counting refers to at least two different persons who for various reasons share the same client-identification code.

False (soft) multiple counting mainly relies on data-collection and data-entry errors, as well as on the number and differentiating weight of the input data (attributors). For example, a client-identification code based on gender, date of birth and country of birth may be the same for twins or for persons of the same gender born on the same day in the same country. If the initials of these persons were to be added to the code, it might be possible to differentiate them.

When a transformation key based on a given calculation algorithm is used, multiple counting may occur if, for example, the algorithm is based on numeric fields or sums. The client-identification code of the attributor '2 [gender]/23.01.67 [date of birth]/LU [country of birth]' could match the attributor '2/23.10.67/LU' if the algorithm calculates the sum of the month of birth (0+1=1 and 1+0=1) instead of taking each number into account separately.

Multiple counting due to code redundancy (soft matching) mainly refers to algorithm-based encoding procedures or, more generally, to every code calculation that relies on a limited number of characters and/or numbers. The only calculation procedure that totally avoids this kind of bias is the use of 'unlimited' ongoing identification numbers. In the case of a 10-digit code, for instance, the redundancy probability refers to the number of possible combinations of 10 (0 to 9) units. Considering an alphanumerical code including two characters and five digits, the redundancy probability corresponds to the total number of combinations between two (A to Z) units and five (0 to 9) units. In other words, there cannot be more codes than possible combinations of the variables of which it is composed.

In practice, however, combinations are even more limited than the theoretical possibilities. If the identification code includes, for example, the whole year of birth, there will be less than four (0 to 9) combination possibilities (10.9.87) because, for the time being, it is unlikely that there will be drug addicts born either in 1920 or in 1990. Most registered clients were born between 1950 and 1985, which gives only 45 possible combinations.

Ongoing client-identification numbers are institution-related. Patients, when they enter treatment, are allocated a unique but partly arbitrary code since it does not exclusively rely on a proper identification variable. The procedure described here does not allow multiple counting to be detected at inter-institutional level. The intra-institutional multiple-counting control also appears to be problematic, unless there is a routine as, for instance, an alphabetical search on each patient admitted to check if the latter has already undergone treatment in the centre concerned. In this case, the formerly allocated identification number could be applied once again, which, however, happens to be a very heavy and time-consuming routine with very limited effectiveness.

Checking procedures

To avoid false multiple counting, encoding systems have to include systematic checks when double counting occurs. One possibility is to establish a centralised nation-wide database programmed to detect false multiple counting. If an existing code is introduced, the database will not only provide the file or the reporting form of the person concerned, but will also perform an internal check on a differentiating package of variables – such as employment status, marital status – and in case of false double counting, will automatically create a new file which will be opened each time the code associated with the specified variable package occurs. Other original checking routines are described in the presentations of the national systems of Sweden and the UK.

The data set must include variables that do not change over time. The most suitable data are gender, date of birth and country of birth. Unfortunately, these data are often used to calculate the identification code and are precisely the same in case of double counting. Using the marital status of the client is also quite unreliable; the same data of the parents would be more indicated, for instance, as there is a greater chance that these data will remain stable over time. Person-related identification variables which do not change during time and which are easily accessible are very limited and should be used in the most effective way.

Checking routines should also deal with encoding errors due, for instance, to phonetic equivalences or typing errors when data are input. The UK's 'soft-matching' routine checks for one difference in any one digit of the numerical codes 30 and 31 – but not 29 and 30 – 13 and 30 (because they sound alike in English) and any one difference in the character codes MD and MB, plus reverse digits and characters such as 10 and 01 or MD and DM.

Coverage of PADCTRS

The operational level of existing PADCTRS, as well as the number and specification of data providers (user rate) within the health and law-enforcement network, need to be identified.

The operational level may be local, regional or national. While there may be different PADCTRS at the first two levels, they should enable a harmonised encoding at national level. To this end, it is essential that the local or regional attributors or identification codes are based on the same input variables, or at least include a core input data set which can be used to calculate a national client-identification code detecting multiple counting at the three operational levels mentioned above.

Regarding either the local, regional or national operational levels, the effectiveness and pertinence of a PADCTRS greatly depend on the number of users (data providers). If the data given by the PADCTRS is used for TDI-based prevalence estimations, the network of data providers should include specialised treatment centres as well as general hospitals, emergency rooms, psychiatric departments, general practitioners and so on. There is no need to add that if the level is the institutional contacts indicator, the network should include law-enforcement institutions which usually have quite a critical approach towards data-reporting systems on drug addicts and vice versa.

Data protection and exclusivity of the client-identification code

The client-identification code may be exclusively created for health institutions (such as treatment centres) or centralised data-management institutions (public-health board, focal point, etc.) to index drug-treatment demands.

PADCTRS could also adopt an existing code like an individual national registration number (as in Denmark), the social-security number or a personal-identification number from an existing patient register. One problem with this type of code is that direct links between the identification code and the person concerned can be made at various levels by institutions or persons who should not have access to this kind of data (such as government ministries, social-security departments, law-enforcement agencies, and so on). A drug addict might refuse to provide personal data, knowing that his social-security number is on the reporting protocol ([37]).

These problems are not found with a PADCTRS-specific code as the equivalences between nominal data and the identification code is only known by centralised data managers. This is not even a necessity if the algorithm used is only known by the system designer and the attributor-to-code transcription occurs at field level. Consequently, there should of course be

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([37]) The fact that the date of birth was included in the first version of the reporting protocol has provoked major objections from field institutions in Luxembourg.

no other identifying variables on the reporting protocol if transmitted to the data-management level in a non-aggregated format.

Encoding procedures and encoding flow

The final encoding level relies on the type of identification code. If, for example, the code used is a national registration number, there will be no distinction between the field level and the data-management level as the final client-identification code will be given directly by the patient himself and will be put on the data protocol before being transmitted to the focal point or other national database. On the one hand, this happens to be an easy access code whose use should minimise gaps in client identification due to missing input variables (such as date of birth); on the other hand, it unfortunately raises some major issues concerning confidentiality.

A PADCTRS-specific code allows for intermediate encoding levels. An example of a three-level encoding flow is the transmission of an input-variable-based attributor (such as 2/10.05.67.M) from the treatment level to the data-management level to provide a regional or national client-identification code (as in the UK). There could, of course, be more than one intermediate level which would increase security by creating a bottom-up information dependency with the data-management level only being able to calculate the final client-identification code if the treatment level has transmitted the attributor to intermediate level 1 (the regional data-collecting agency). Neither the treatment level nor level 1 will know the final identification code and, most important of all, the data-management level will not be aware of the attributor generally containing high identifying data (such as date of birth).

A third possibility, even more time- and cost-effective, would be for the algorithm-based encoding to occur directly at field level (as in Luxembourg). A technical device (code calculator) that calculates a final identification code on the basis of input data (attributor) can be provided directly to treatment institutions. Data protocols will be sent to the central data-management level which, in this case, will be neither aware of the transformation algorithm nor of the equivalences between the code and personal attributor.

Availability of input data (attributor)

The variables the client-identification code is based on, have to be easily accessible. Thus the gender and date of birth of a person appear to be good attributor variables because the first is apparent and the second is usually known by the client him or herself. The initials of the client's parents or his or her city of residence are, for instance, more ambiguous. The parents could be unknown or the patient could alternatively provide the initials of his or her real parents or those of step- or foster parents; the city of residence might be taken to be the usual place of residence or the official registered address (risking errors in data collection based on file research). It is essential that the attributor variables be explicit and unequivocal in order to avoid false double counting.

Regarding national registration numbers (social-security number, identity-card number, and so on), there are similar problems in terms of availability. In this case, there is no need to provide personal-attributor variables, but the registration number itself might be unknown. Homeless people often have no social-security number; non-native people may have no identity card; or the identification number may not fit in the specific encoding field of the national registration database.

The design of a PADCTRS-specific code also relies greatly on data-collection methods. In terms of data (attributor) availability, it makes a difference whether a reporting form is completed during a face-to-face interview or whether data are simply extracted from personal files. The date and country of birth are usually known by the interviewee, but the same information might not figure in the personal file.

Confidentiality and psychological impact

In the case of a PADCTRS-specific code, the confidentiality of the data collected appears to be more efficient since no other institution is aware of the exact nature of the code, nor do any of them have access to the coding list as the only information they are provided with is of non-nominative statistic nature (i.e., national report on drugs and drug addiction).

Both institutions and clients are concerned about data confidentiality and data protection. At the field-institution level (data providers), data-protection insurance is one of the most important issues in deciding whether or not to participate in a centralised reporting system. The data-management level must provide clear guidelines for protecting confidentiality and avoiding abuse of delivered data. Hence, the exact definition of the identification code used tends to be the most critical issue as field institutions are bound to medical or professional confidentiality rules which usually do not allow them to reveal any identifying information on their clients. The respective rights and the procedures to follow rely on the specific national data-protection legislation.

The identifying weight of a client-identification code has to be carefully measured. There may be codes from which personal information can directly be inferred, such as date of birth, gender or city of residence. At a centralised data level this information might be irrelevant, although at local or regional level it might lead to the full identification of a person. Knowing the initials, the date of birth and the city of residence of an addict who happens to live in a small town of 1,000 inhabitants raises some serious questions about his or her anonymity. No identifying data should possibly exceed the field institution level or reach any intermediate encoding level.

The geographical area in which a PADCTRS operates defines its nature and encoding requirements. In smaller countries, even a nation-wide client-identification code must be highly confidential and include a minimum of identifying variables. The most relevant solution in this particular case would be an algorithm-based transcription of a usually high identifying attributor at the level of the field institutions themselves.

On the whole, it should be borne in mind that no PADCTRS should be imposed on field institutions. Even if the latter have no other choice than to agree (in the case of state institutions) to collect and provide data, the quality of these data will depend largely on the consensus between information providers and information managers as well as on the motivation of the agents responsible for data collection in the respective field institutions.

It is essential to discuss these matters of confidentiality carefully with the field institutions concerned and to define mutual interests to involve the participating levels in an active way. There may be strong resistance from field institutions and it certainly takes time to develop a relationship based on mutual trust among the different information levels, but it appears to be the only way to ensure good-quality data and to avoid the burn-out of reporting systems and the respective PADCTRS.

Transmission procedures

Another issue, closely related to data-protection insurance, is the way in which the identification code, or the reporting form that contains it, is transferred from the field-institution level to the final data-management level. There is a range of transmission alternatives.

- Data can, for example, reach the focal point or any other data-management agency in aggregated form (as in Italy and Sweden) or as an individual data-reporting protocol (as in Luxembourg and Greece). In the first case, the encoding and multiple-counting checks occur at earlier levels (national board of health, state health statistics department, epidemiological research institutes, and so on).

- If the data transmission is paper-based (or on floppy disk, CD-ROM, etc.), the codes can be handed over personally (as in Luxembourg), sent through the post or faxed to the data-management institution.

- Computer-based transmission can use electronic mail or other telemetric facilities whether within a local area network (LAN) or a wide area network (WAN) and the data may then be transmitted and stored in encrypted form.

Despite the time effectiveness of computer-based transmission, field institutions seem to prefer the paper-based approach for reasons of security, even if they are aware of the risks. Regular mail, for example, may be lost more easily than e-mail attachments. The point is that electronic mail within a WAN is generally considered to be more exposed to non-authorised persons than is regular mail. The physical collection of reporting protocols or other data supports by field institutions is, of course, very secure, but hardly feasible in wider networks including an important number of treatment centres.

Recommendations for implementing or modifying national PADCTRS

The development and implementation of PADCTRS stress that original solutions need to be found to meet specific and sometimes unique national requirements. A one-level algorithm-based encoding system applied on an inter-institutional scale, providing the focal point with non-aggregated data, might be a realistic mid-term objective in Luxembourg, but is very unlikely to be established within the same time period in countries such as Germany or France, where legal requirements on data protection appear to be far more binding.

The design of national PADCTRS cannot and must not shape one optimal and overall applicable system; rather, its development appears to be a context-related problem-solving task that requires as much methodological expertise as innovative achievement. As a matter of fact, assessing the quality of PADCTRS is a fairly delicate, if not impossible, task since the ground on which these systems are supposed to develop and the conditions they are bound to are rarely the same from one country to another.

The present analysis has shown that implementing PADCTRS requires a holistic approach that cannot be based on a defined set of methodological recommendations. The descriptors which have been dynamically defined and refined and their use as a possible conceptual tool towards the establishment or adaptation of multiple-counting routines appears to be the only general recommendation that can be made. This chapter does not intend to evaluate or compare the quality of national PADCTRS. Nevertheless, attention must be paid to some important additional items.

A first issue that must be stressed is the implication of different types of PADCTRS on epidemiological drug research. In others words, it is important to consider what type of PADCTRS allows or facilitates what kind of drug research. This question should be clearly analysed prior to the implementation or even the modification of any PADCTRS for it partly defines the features required of the data-reporting system itself.

One of the major tasks of PADCTRS-supported reporting systems is to produce more reliable estimates of drug prevalence. They, however, have to offer a wider range of applications, especially for research activities that require records to be linked among independent data sources. Studies that aim to monitor those demanding drug treatment in a given environment during a specified time period – as, for instance, case-finding or capture–recapture studies – require person-related and thus unique identification codes. If the time period appears to be less relevant, the specification of the chosen environment certainly is, for it defines the coverage or the user rate of a given PADCTRS code. As a matter of fact, the representativeness of these studies exactly fits the number of institutions that use the respective identification code.

From regional studies on drug-treatment episodes within a defined type of treatment agency to the nation-wide monitoring of drug-related institutional contact indexing, a fairly significant range of PADCTRS can be applied. A nation-wide and cross-sectorial PADCTRS obviously shapes the requirements of most drug studies; a more limited PADCTRS exclusively designed for a specific study might be preferred for financial or practical reasons. The final

decision is methodological but must take account of the national legal context regarding data protection and the existence or not of previous codification systems at national level.

Another important topic which should be discussed here is precisely the link between the national legal data-protection requirements, PADCTRS-supported reporting systems and the somewhat hidden opportunity of service quality control the latter might offer.

The limited framework of this chapter does not allow for an analysis of national legislation on data protection. However, in addition to the status and legal situation of both data management and data providers, the national legislation will clearly play a major role when devising and implementing a national PADCTRS.

Data-management agencies within a governmental structure have considerably different requirements and constraints than do, for instance, non-governmental organisations (NGOs). On the other hand, data providers may depend on governmental funding and thus often have no other choice than to co-operate in terms of data delivery and ensuring minimum quality standards.

If these relationships do not exist between the relevant information producing and processing levels, the feasibility and operationality of data-reporting systems, besides the legal context, depend greatly on the common definition of mutual interests and benefits. These are not necessary defined in terms of financial rewards, but mostly refer to 'value-added' data feedback to data producers; data that might enable field institutions, for instance, to locate gaps in their treatment offers and possibly to improve quality standards. It should be stressed that this negotiation process is supported by at least two factors:

- the awareness of all actors involved that there is at least one common objective – the long-term improvement of drug-treatment services; and

- their awareness of a common constraint – reciprocal dependence whether in terms of financial funding or updated data income.

Long-term agreements must be compliant enough to allow any amendments to promote or maintain the active involvement of data providers.

Surprisingly, this data feedback to field institutions, although often representing a formal requirement of the latter, may also be one of the main impediments to establishing PADCTRS. From a long-term perspective, the delivered data, if accurately processed, might be used for assessing the quality and effectiveness of treatment agencies involved in a given network. Even if this particular aspect may be less visible to the actors at first sight, it will most likely emerge if the given reporting system offers the opportunity to register those demanding treatment (cases, not episodes) over a long time period.

An intra- and inter-institutional PADCTRS such as is currently applied in Luxembourg permits addicts to be followed up not only during a specific reporting period or within a given type of health-care institution, but also provides updated data on all institutional contacts a specific person may have established since 1994. This anonymous follow-up provides reliable information on drug careers as well as on the impact, influence or effectiveness of the treatments received.

This information could possibly be used to pressure field institutions and might finally interfere in the funding process. Thus, institutions that do provide patient-related data put themselves in a somewhat awkward position by exposing themselves to possible quality controls or criticism which had been avoided until then as there were no reliable evaluation criteria.

The most effective solution, but undoubtedly not the easiest one, is openly to discuss these matters from the very beginning and to devise other quality-assessment criteria to be taken into account ([38]). The data-management level must be fully aware of the complexity of its

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([38]) Abstinence and the number of post-treatment institutional contacts are not always, and not the only, indicators of the therapeutic effectiveness of a treatment or intervention.

status and objectives. In addition to the ongoing negotiations with data providers, data-management actors face another responsibility which is defined in terms of political impact.

The interest of policy-makers generally focuses on prevalence data which are considered an indicator of the quality of political strategies towards demand reduction. Public opinion often exclusively refers to prevalence estimates to approve of governmental drug and drug-addiction policies. Since in most EU countries there is a kind of scientific monopoly regarding reliable national prevalence data, the final estimate largely depends on the quality and coverage of the data collected as well as on the methodological framework the given data-management actors have chosen or are obliged to work within. Establishing a high-quality information network including nation-wide PADCTRS, or even merely improving an existing reporting system, will not only have immediate consequences on the prevalence figure, but will also have a major political impact even if the real number of drug addicts has not actually increased. The final outcome will be considered, but not necessarily the way that led to it.

PADCTRS applied at European level (^{39})

Preliminary remarks

- Austria, Belgium, Denmark, France, Germany, Greece, Ireland, Italy, Luxembourg, the Netherlands, Portugal, Spain, Sweden and the United Kingdom participated in the study.

- National PADCTRS are presented in alphabetical order except for Austria, France, Ireland and Spain which do not currently use any standard PADCTRS.

- Table 1 presents an overall picture of national PADCTRS with reference to the main descriptor categories:

    | ***** | guaranteed; |
    | **** | guaranteed, but possible improvements; |
    | *** | medium level of development; |
    | ** | low level of development; |
    | * | only very specific and limited applications; and |
    | () | no information given. |

(^{39}) Based on Origer, A. (1996) *Procedures to avoid double counting in drug-treatment reporting systems. Final report*, Luxembourg: Ministry of Health.

Table 1. Overall descriptor analysis of national PADCTRS

Descriptors	B	D	DK	E	GR	I ([1])	LU	NL	SW	UK
	1992	1980	1996	1987	1994	1992	1994	1988	1993	1992
Double/multiple counting (inter-institutional)	***	**	*****	*****	****	***	*****	****	*****	*****
'Hard' matching	***	*	****	**	****	***	****	****	****	****
'Soft' matching	*	*	****	****	()	***	****	()	****	*****
Checking procedures	*	*	*****	****	no	no	*****	()	*****	*****
Treatment-demand level (health sector)	****	***	***	****	***	no	***	****	****	****
Non-health institution level	0%	0%	0%	0%	0%	***	****	*	****	****
Operational level of PADCTRS (national/regional/local)	***	****	*****	***	*****	*****	*****	*****	*****	*****
PADCTRS specific code	yes	yes ([2])	no	yes	yes	yes	yes	yes	no	yes
Identifying weight of final PADCTRS code	***		**	***	***	****	*****	*****	***	*****
Other identifying variables on the protocol	yes	yes	no	no	no	n.a.	no	no	no	no
Encoding procedures and encoding flow	***	****	****	*****	****	***	*****	****	****	****
Encoding device (algorithm-based transcription)	no	no	yes	no	–	no	yes	yes	–	yes
Availability of input data (attributor)	****	****	****	****	****	****	****	****	****	****
Confidentiality and psychological impact	****	*****	***	****	****	n.a.	*****	****	***	****
Transmission procedures	*** ([2])	**** ([2])	*** ([3])	**** ([2])	**** ([3])	n.a. ([2])	***** ([3])	**** ([2])	n.a. ([2])	**** ([2])

Notes:

n.a.= not applicable

– = not available

([1]) As already stated, the Italian Focal Point has only aggregated data income of patients at treatment centres. The only personal information they collect is on individuals reported for personal drug use by the police to local authorities which establish links with public and private facilities. For this purpose, they use a PADCTRS specific code

([2]) Personal institution-related intake number that allows no multiple counting control.

([3]) The Swedish focal point does not use a PADCTRS code. It does not have access to personal identity numbers due to personal integrity requirements, but only to aggregated data. From time to time the focal point uses information from the Patient Register (PAR) which is described here.

Source: Origer, A. (1996) *Procedures to avoid double counting in drug-treatment reporting systems. Final report*, Luxembourg: Ministry of Health.