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Treatment Demand Indicator

Implementation of data quality and analysis of aggregated data in the EU member states

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1. Preface

The present report is the result of one-year work on treatment demand indicator at the EMCDDA.

The Treatment demand indicator' (TDI) is one of the EMCDDA longest established and most comprehensive tools for monitoring the drug problem. Knowing more about who is seeking treatment for drugs, and where, is a crucial measure of trends and prevalence in problem drug use. It also allows countries to assess the potential future need for drug treatment services.

Objective of the indicator is to provide comparable and reliable information on the number and characteristics of people treated for their drug use. Specific Guidelines, agreed among all member states were defined in a long process started in 1996 and finished in 2001, with the formal adoption of a joint EMCDDA/Pompidou Group Protocol: (EMCDDA/Pompidou Group Protocol version 2.0)¹.

Several steps were followed:

- Identification and in-depth analysis of existing national reporting systems
- Development of working agreed standards (use of Pompidou Group protocol as reference)
- Assessment of feasibility and extensive field-testing
- Formal Adoption by Scientific Committee (Dec 2000), Management Board (2001) and Council Regulation (2001)

The information included in the TDI is the following:

- Drug Treatment: 5 types of centre
- Time and area of reporting
- Substances (main and secondary drugs)
- Patterns of use (route of administration, frequency, age at first use, etc.)
- Socio-demographic information

Data are collected in an aggregated form and provided through excel sheets (by each type of centre and by country); it means that every centre type (outpatient, inpatient, low threshold, GPs, prison, others) in each country (15 MS + Norway) should provide data on treatment demand. Data are then entered in the database (EISDD - Epidemiological Information System on Drug Data).

¹ (http://www.emcdda.eu.int/multimedia/project_reports/situation/treatment_indicator_report.pdf)

The main achievements in the last three years have been the implementation of the TDI Protocol with a first field testing on 11 countries (2000), a first broad data collection of around 170 000 clients, mostly from outpatient treatment centres (over 80%) on 12 countries (2001), a second data collection of around 150 000 clients, over 80% from outpatient treatment centres on 10 countries (2001)

The collected data were entered in the EISDD Data Management on data provided in 2001 and 2002, then detailed feedback provided to countries.

The first outputs of the treatment demand data were used for the EMCDDA Annual Reports, in particular the section on Treatment Demand (2001, 2002, 2003), but also with contributions to the special issues on poly-drug use, on drug and alcohol use among young people aged 12-18 and social exclusion among problematic drug users; treatment demand data were also used for the section on Infectious Diseases (data on injection). Treatment demand data are finally the basic information source for the project on incidence, which is to be presented during this expert meeting.

Considerable progress has been made, although some constraints still remain regarding data quality, in particular the limitations on data coverage (geographical, by centre type and on the total number of clients), the large amount of missing and unknown data; other specific problems also found on internal consistency.

The limitations concerning the analysis are mainly due to fact that data is only in an aggregated form; furthermore up to now data mainly cover outpatient treatment centres and not other types of centre; because coverage is different country by country data on outpatient is not totally comparable.

In order to make more use of data and provide interpretation of the collected information the addition of contextual information is very important (social situation in a country or specific geographical area, developments in legislation) as well as qualitative research able to provide in depth information and reasons for trends and patterns of use.

In order to better identify the limitations in data quality and possible solutions a specific project has been carried out. Aim of the project was to produce a broad assessment on quality of 2000 and 2001 data and a first analysis of the main information included in the TDI.

As follow the final results of the project is presented, as well as the identified limitations and the recommendations for the newt period.

2. Methodological introduction

The TDI protocol is the result of the developmental work undertaken by the Pompidou Group (Hartnoll R. 1994; Stauffacher M., Kokkevi A., 1999) the study of the national experiences' in particular in Germany, The Netherlands, Spain and United Kingdom and specific projects run by the EMCDDA²

In 1999, harmonisation of the treatment indicator became a task of the EMCDDA and National Focal Points. The final version of the TDI protocol was published in December 2000. All Member States are officially required to start and develop a harmonisation process with the other Member States and the EMCDDA/PG standard. The TDI protocol represents a stride forward in the harmonisation process. In recent years Member States focused their work on the TDI implementation.

Data are now collected through three instruments, based on excel sheets³:

- Table 3
- Table 4
- TDI (24 excel sheets) by centre type (5 are the centre types where we collect data)

Table 03 is made up of three parts:

- the characteristics of persons starting drug treatment in the previous year,
- the methodological references and
- the type of treatment centres included.

The structure of table 04 is similar to table 03. Table 04 shows the evolution of drug treatment data from 1990 to the most recent year reported, but it is not broken down by gender.

The tables show information related with the characteristics of persons starting treatment. Data for all treatments and for first treatments are shown as a total and are also broken down by gender. The table includes information on the following parts:

- the number of treatment cases/demands

² See bibliographic references on the countries experiences and EMCDDA projects.

³ See Annex 1 – Data collection tools

- sex distribution
- proportion of males and females
- mean age
- age distribution with number of cases in each age group and number of cases with missing information on age
- injection behaviour
- main drugs used
- proportion of persons who inject each primary drug.

The methodological information includes the complete reference for the data:

- year covered
- method of data collection
- geographical coverage
- type of centres covered
- definition of first treatment
- definition of treatment
- information on how double counting is controlled
- other remarks related with the data.

The Excel file for the set of TDI tables is made up of 24 spreadsheets parts and additional information is included:

- number of units reporting to the information system
- number of units in the country
- proportion of units covered
- proportion of cases/episodes reported to the monitoring system with regard to the total number of cases admitted to drug treatment in the country
- by each of the five types of treatment centres defined by the TDI protocol:
 - outpatient treatment centres
 - inpatient treatment centres
 - low threshold/drop-in/street agencies
 - general practitioners
 - treatment units in prison

The set of TDI tables was designed to collect more detailed information on the characteristics of clients starting treatment. All the tables, except for the first two, are completed with numerical data.

- 1 Source
- 2 Centre Type
- 3 Previously treated
- 4 Source of referral
- 5 Age by gender
- 6 Living status (with whom)
- 7 Living status (where)
- 8 Nationality
- 9 Labour status
- 10 Educational level
- 11 First drug by ever treated
- 12 14.1 Primary drug by age (men)
- 13 Primary drug by age (women)
- 14 Primary drug by age (total)
- 15 Substitution treatments a-d
- 16 Route of administration
- 17 Frequency of use (primary drug)
- 18 Age at first use of primary drug
- 19 Other drugs used
- 20 Other drug used by age (men)
- 21 Other drug used by age (women)
- 22 19.3 Other drug used by age (total)
- 23 Ever / currently (last 30 days) injected any drug
- 24 Primary drug by ever / currently (last 30 days) injected any drug

Each table, except for the first one, is made up of 2- or 3-dimensional cross tabulation tables as well as methodological information concerning the data.

Using these tables, information was collected on admissions to treatment for problematic drug use in almost all European Countries. Information is available for both 2000 and 2001. The purpose at this stage is to determine:

- the quality of the information collected and
- if the data can be compared at the European level.

In the analysis phase all the Excel spreadsheets containing tables with data for 2000 and 2001 were checked for errors. Some errors were detected in all countries. Each time an error was detected the data analysis was delayed.

The data from the set of TDI tables were reorganized and transformed so that they could be analysed using SPSS.

Data on outpatient treatment centres in 10 Member States were included in the database for analysis: Denmark, Germany, Greece, Spain, Ireland, Italy, Luxemburg, the Netherlands, Sweden, and Finland. Most Member States for these countries were available. Data from the UK were reported, but only three tables were completed:

7. Age by gender

16. Route of administration

20.1 Primary drug by ever / currently (last 30 days) injected any drug.

In addition, the data-reporting period was not annual. The data for Table "16. Route of administration" does not fit the TDI definition for the route of administration.

A detailed analysis on coverage was done and it is reported in the Annex 2 – Data quality and coverage by country.

The descriptive study of outpatient treatment data required stratification by Member States; only countries with 30 or more cases for the variable analysed were included in the analysis. Summary tables were designed for the general characteristics of clients, both for all treatments and for first treatments. The tables show the total number of cases and the number of cases for each drug.

3. Results: main findings

The TDI makes it possible to obtain treatment data for 5 types of treatment centres (outpatient treatment centres, in-patient treatment centres, low threshold/drop-in/street agencies, general practitioners, and treatment units in prison). The TDI protocol states that it is essential to identify clearly the types of treatment centres involved in order to increase the comparability of treatment data among countries. For this reason, the protocol establishes that to improve the comparability of treatment data among countries, all basic types of treatment centres should be distinguished and reported separately.

Since many countries report data only from outpatient centres the analysis will refer basically to these centres. Marginal comments will be made regarding data on treatments carried out in inpatient treatment centres.

The graphics on the main finding are reported in the Annex 3 – Main Findings

- The most important sources of referral for treatment were self-referrals. Family/friends and health/social services were also important sources of referral in some countries. (Figure 1).
- Approximately 3 out of 4 persons treated in outpatient centres in all Member States were men. The proportion of men varied by the drug motivating treatment (primary drug). Men made up the largest proportions of those treated for cocaine, cannabis and opiates, and the smallest proportions of those treated for hypnotics/sedatives and stimulants. (Figures 2, 3, 4, 5, 6, 7)
- The mean age of those treated varied greatly by country. In 2001, the mean age of clients admitted to treatment in outpatient centres varied between 24.8 and 32.9 years. Persons in treatment for the first time were, on average, younger than the group of all persons treated. The mean age varied by the drug motivating treatment (primary drug). Persons treated for hypnotics/sedatives and opiates tended to be older, while those admitted for cocaine or cannabis were younger. (Figures 8, 9).

- Most reported cases had completed primary or secondary level education; it should be noted, however, that differences in the organisation of educational systems in different countries may influence how this variable is classified. In 2001, the proportion of persons treated in outpatient centres, who had less than secondary level education varied between 21.3% in Germany and 75.1% in Finland. (Figure 10).
- Most clients treated for drugs were unemployed or in other situations. In 2001, among persons treated in outpatient centres, the proportion of employed persons varied widely among countries, from 9.1% in Denmark to 41.4% in Germany. (Figure 11).
- Most of those treated lived alone or with family/friends. In 2001, the proportion of persons treated in outpatient centres who lived alone varied between 7.8% in Greece and 71.8% in Denmark. (Figure 12).
- Most of those treated lived in stable accommodation. In 2001, the proportion of persons treated in outpatient centres who lived in unstable accommodation varied between 3.2% in Germany and 14.4% in Sweden. (Figure 13).
- Over 90% of those treated were EU nationals. In 2001, the proportion of foreigners (nationals of non-EU countries) varied from 1.2% in Finland to 7.7% in the Netherlands. (Figure 14).
- Although the opiates (mainly heroin) have become somewhat less important in recent years, they continue to be the drug motivating the largest number of treatments. In 2001, the proportion of outpatients among whom opiates were the motivation for treatment varied between 25.5% in Sweden and 86.1% in Greece. (Figure 15).
- In most countries, *cannabis* derivatives were the drug group motivating the second largest number of treatments, although in the Netherlands and Spain this was the case for cocaine. (Figure 15).
- The *stimulants* (mainly amphetamines) were responsible for a substantial proportion of treatments in Sweden (32.2% among outpatients in 2001),

where they were the drug group motivating the largest number of treatments, and in Finland (29.4%). (Figure 15).

- In recent years, the proportion of current injectors has decreased among persons receiving treatment for drugs. In 2001, less than half of those treated in outpatient centres were current injectors in all countries, ranging from 8.7% in the Netherlands to 47.7% in Finland. Among those who have ever injected drugs, however, the figures rise considerably, ranging from 28.7% in the Netherlands to 70.4% in Greece. (Figure 16).
- If cases are stratified by primary drug, the highest proportions of current injectors are seen in persons treated for heroin; a considerable proportion of persons treated for amphetamines in Finland, Sweden and United Kingdom are also current injectors. (Figures 17, 18).
- The youngest mean age of beginning drug use was seen among those treated for cannabis, and stimulants, and the oldest, among those treated for methadone, opiates other than heroin or methadone, and hypnotics/sedatives. (Figure 19).
- With regard to the route of heroin administration, in most countries the injected route continues to predominate, although it has begun to give way to the pulmonary route. In 2001, the pulmonary (smoked) route was the main route of administration among those treated in outpatient centres in two countries: the Netherlands (82.4% preferred to smoke heroin) and Spain (68.4%). (Figure 20).
- Among those treated for cocaine, the intranasal route (sniffed) predominates, except in the Netherlands where most (61%) of those treated for cocaine in outpatient centres in 2001 smoked this drug. (Figure 21).
- The main route of administration of the amphetamines varied widely by country. Among persons treated in outpatient centres in 2001, injectors predominated in Finland (75%) and Sweden (49%), sniffers in the Netherlands (48.9%), and users of the oral route in Spain (66.5%). (Figure 22).

- MDMA and other derivatives, hypnotics/sedatives and the hallucinogens were mainly administered by the oral route, and cannabis by the pulmonary route (smoked).
- Most of those admitted to treatment for abuse or dependence on heroin, cocaine, or hypnotics/sedatives had used the primary drug daily or almost daily (2-6 times/week) during the 30 days previous to treatment admission. In the case of those treated for amphetamines, most had used this drug 2 or more times per week, but among those treated in outpatient centres in 2001, the proportion of daily users did not exceed 50% in any country. In the case of cannabis and MDMA and other derivatives, the frequency of use was variable, but was less than in the case of the previously mentioned drugs. (Figures 23, 24, 25 & 26).
- Among persons treated for heroin, the most frequently mentioned secondary drugs were cannabis, cocaine (especially in the Netherlands and Spain), and hypnotics/sedatives. Among those treated for cocaine, the most frequent secondary drugs were alcohol, cannabis and stimulants; among those treated for amphetamines, the most frequent were cannabis, alcohol, cocaine and MDMA and other derivatives; and among those treated for cannabis, the most frequent were alcohol, amphetamines and cocaine. (Figures 27, 28, 29, 30).
- The profile of persons receiving drug treatment for the first time was somewhat different from that of all persons treated: family/friends are more important as a source of referral, the mean age is younger, the proportion of current injectors is smaller, and, the opiates are less important as a primary drug than cannabis, cocaine and the stimulants. (Figures 8, 31, 32, 33).
- The profile of persons treated in inpatient centres was somewhat different from those treated in outpatient centres. Among those treated in inpatient centres, there was a smaller proportion of persons who had never been treated before (first-ever treatments), of self-referrals, and of persons referred by family/friends or by court/probation/police; there was a larger proportion of referrals by health/social services, and of persons living alone, in unstable accommodation, and unemployed. Likewise, among inpatients there was a larger proportion of persons treated for opiates or stimulants and a smaller

proportion of those treated for cannabis, and the proportion of current injectors was higher. (Figures 34, 35, 36, 37,38, 39, 40).

4. Outpatient Treatment Centres

4.1 Number of reported cases

Nine countries reported cases of drug treatment admissions in outpatient treatment centres in 2000: Finland, Germany, Greece, Ireland, Italy, Luxembourg, the Netherlands, Spain, and Sweden. The number of cases reported ranged from 249 in Luxembourg to 45,508 in Spain (Table O/1.0). Eight countries reported cases in 2001: Denmark, Finland, Germany, Greece, the Netherlands, Spain, Sweden and United Kingdom. The number of cases reported by country varied widely, from 1,340 cases in Sweden to 46,522 in Spain (Table O/1.1).

4.2 First treatment and previously treated

The TDI protocol states that for each person treated, information should be obtained on whether they have ever been received previous treatment. In this context, the category 'never' refers to a client who has never received treatment for drug misuse at any centre anywhere. He or she is thus making a first-ever treatment demand. The category 'Previously treated' refers to a client who has received treatment for drug misuse at some point in the past, either from the current treatment centre or from another treatment centre.

Trends in the number of persons admitted to first-ever treatment constitute a more sensitive indicator of how drug problems are evolving than trends in the total number of persons treated. Furthermore, trends in the characteristics of those receiving first-ever treatment show changes earlier than trends in the characteristics of all persons treated. The information systems in most Member States obtain this information by directly asking patients if they have received previous treatment.

Most clients reported by outpatient centres have previously been treated. The proportion of persons treated for the first time ranged from 32.3% in Finland to 55.3% in Greece in 2001, and from 4.2% in Luxembourg to 56.3% in Greece in 2000. In general, the proportion of those treated for the first time in the great majority of countries varied between 35% and 55% (Table O/1.0 - Table O/1.1).

If countries reporting fewer than 30 cases are eliminated, the proportion of persons receiving first-ever treatment in 2001 was higher among those treated for cannabis (range: 52.8%-84.6%), cocaine (range: 53.2%-66.6%), or stimulants (range: 29.7%-79.5%) than for those treated for hypnotics/sedatives (range: 16%-74.9%) or opiates (range: 19.8%-51.1%) (Tables O7/1.1, O2/1.1, O7/1.1, O3/1.1, O4/1.1, O1/1.1). Among those treated for opiates, the country with the largest proportion of persons receiving first-ever treatment was Greece (51.1%), while the countries with the smallest proportion were Finland (19.8%) and Spain (22.9%) (Table O1/1.1).

Among those treated for cocaine, the countries with the largest proportion of those receiving first-ever treatment were Spain (66.6%) and Sweden (66.7%), while the countries with the smallest proportion were Germany (53.2%) and the Netherlands (53.6%) (Table O2/1.1).

Among persons treated for stimulants, the countries with the largest proportions of persons never treated before were Spain (79.5%) and the Netherlands (74.4%), while the country with the smallest proportion was Finland (29.7%) (Table O3/1.1).

Among those treated for hypnotics/sedatives, the countries with the largest proportion of persons treated for the first time were Sweden (74.9%) and the Netherlands (74.5%), and the countries with the smallest proportion were Finland (16%) and Germany (37.7%) (Table O4/1.1).

Finally, among those treated for cannabis, the countries with the largest proportion of those treated for the first time were Spain (84.6%) and Greece (81.9%), and the country with the smallest proportion was Finland (52.8%). All countries were above the 50% of new treatments (Table O7/1.1).

In 2000, the proportion of those receiving first-ever treatment was larger among those treated for cannabis (range: 58.9%-95.8%), cocaine (range: 54%-76%), or stimulants (range: 33.2%-84.7%) than for those treated for hypnotics/sedatives (range: 18.4%-76.4%) or opiates (range: 20%-52.2%) (Tables O7/1.0, O2/1.0, O7/1.0, O3/1.0, O4/1.0, O1/1.0).

Among those treated for opiates, the country with the largest proportion of persons treated for the first time was Greece (52.2%), while the countries with the smallest proportion were Italy (20%) and Spain (24.3%) (Table O1/1.0).

Among those treated for cocaine, the countries with the largest proportion of persons receiving first-ever treatment were Italy (76%) and Spain (67%), and the countries with the smallest proportion were Germany (56.6%) and the Netherlands (54%) (Table O2/1.0).

Among those treated for stimulants, the countries with the largest proportion were Italy (84.7%) and Spain (81.6%), and the country with the smallest proportion was Finland (32.3%) (Table O3/1.0).

Among those treated for hypnotics/sedatives, the countries with the largest proportion were the Netherlands (76.4%) and Italy (74.2%), and the countries with the smallest proportion were Finland (18.4%) and Germany (36.8%) (Table O4/1.0).

Finally, among those treated for cannabis, the countries with the largest proportion of those receiving first-ever treatment were Greece (95.8%) and Spain (86.2%), and the country with the smallest proportion was Finland (58.9%) (Table O7/1.0).

4.3 Source of referral

The TDI protocol establishes that for each treatment, the most important source or service that referred the patient for treatment should be indicated; this variable is classified into 8 categories: self-referred, family/friends, another drug-treatment centre, general practitioner, hospital/other medical source, social services, court/probation/police, and other.

The source of referral provides some insight into the client's motivation for treatment as well as the structure of, and co-operation among, different professional drug-service agencies or private initiatives. This item is not cross by the drug that motivated treatment.

In 2001, among all persons treated, the most frequent source of referral to outpatient treatment was self-referred, except in Greece, where it was family/friends. The

proportion of self-referred persons ranged from 31.4% in Greece to 47.8% in Sweden. Another important source of referral was the health and social services. The proportion in this category ranged from 13.7% in Greece to 32.1% in Sweden. Finally, in some countries like the Netherlands, the courts/probation/police played an important role as a source of referral to treatment (in 2001, 32.1% of clients admitted to treatment were referred by this source). The countries with the largest proportion of clients referred by other services (health/social services or court/probation/police) were the Netherlands (52.5%) and Germany (43.4%), and the country with the lowest proportion was Greece (19.4%) (Table O/1.1). In all countries, the importance of family/friends as a source of referral is larger among those receiving first-ever treatment. In fact, self-referral was the most frequent source in three countries with information on this variable (Finland, Ireland, and the Netherlands), while family/friends was the most frequent source in two countries (Germany and Greece). The proportion of self-referred persons receiving treatment ranged from 19% in Greece to 45.7% in the Netherlands (Table O/2.1).

The situation was quite similar in 2000. Among all persons treated, the proportion of those who were self-referred ranged from 34.4% in Ireland to 65.1% in Luxembourg, and the proportion of those referred by health/social services ranged from 13.4% in Italy to 27% in Finland. The countries with the largest proportion of clients referred by these services were Ireland (45.2%), the Netherlands (44.3%) and Germany (42.3%), and the countries with the smallest proportion were Greece (14%) and Luxembourg (17%) (Table O/1.0). In all countries, the importance of family/friends as a source of referral was larger among those receiving first-ever treatment. Self-referral was the most frequent source in four countries with information on this variable (Finland, Ireland, Italy, the Netherlands), and family/friends in one (Greece). The proportion of treatments that were self-referred ranged from 26.1% in Greece to 57.6% in Italy. The proportion of persons referred by family/friends ranged from 6.1% in the Netherlands to 49.9% in Greece. Finally, the proportion of those referred by health/social services ranged from 13.4% in Italy to 37.5% in Ireland (Table O/2.0).

4.4 Socio-demographic characteristics

4.4.1 Gender

In both 2001 and 2000, about 3 of every 4 persons admitted to treatment in any of the Member States were men. In 2001, the proportion of men ranged between 67.6% in Sweden and 84.3% in Spain, and in 2000, between 71% in Ireland and 84.3% in Spain (Tables O/1.0, O/1.1). Among those admitted to first-ever treatment, the situation was quite similar. In 2001 the proportion of men ranged between 64% in Sweden and 84.3% in Spain, while in 2000 it ranged between 65.1% in Sweden and 86.3% in Italy (Tables O/2.0, O/2.1).

The proportion of men varied depending on the drug that motivated treatment (the primary drug). If countries with fewer than 30 reported cases are eliminated from the analysis, it can be seen that in 2001 the highest proportion of men was found among those treated for cannabis (range: 78.1%-90%), opiates (range: 64%-83.6%) and cocaine (range: 76%-86.7%), and the lowest proportions among those treated for hypnotics and sedatives (range: 41.3%-73.1%) and stimulants (range: 59%-79.7%) (Tables O1/1.1, O2/1.1, O3/1.1, O4/1.1, O7/1.1).

In 2000, the largest proportion of men is found among those treated for cocaine (range: 85.1%-89.6%), cannabis (range: 77.8%-90%) and opiates (range: 67.4%-83.4%), and the smallest proportions among those treated for hypnotics and sedatives (range: 42.5%-72.5%) and stimulants (range: 49%-81.7%) (Tables O1/1.0, O2/1.0, O3/1.0, O4/1.0, O7/1.0).

4.4.2 Age

The mean age of clients admitted to treatment in 2001 ranged between 24.8 and 32.9 years. The highest mean age was in the Netherlands (32.9 years) and Sweden (31.3 years), and the lowest, in Finland (24.8 years) and Germany (26.5 years). Clients aged 20-29 years made up the largest age group in Denmark, Finland, Germany, Greece, Sweden and United Kingdom, while those aged 30-39 years were the largest group in the Netherlands and Spain. Those treated for the first time were younger on average than all those treated (range: 22.2-30.7); the highest mean age of persons receiving first-ever treatment was seen in the Netherlands (30.7) and Sweden (30.2), and the lowest, in Finland (22.2) and Germany (23.8) (Tables O/1.1, O/2.1).

The mean age of clients admitted to treatment in 2000 ranged between 25.1 and 32.2 years. The countries with the highest mean age in this group were the Sweden (32.2.), Netherlands (31.9) and Italy (31.3), and those with the lowest mean age were Finland (25.1 years) and Ireland (25.3 years). The largest number of clients were in the 20-29 year age group in Sweden, Finland, Germany, Greece, Ireland, and Luxembourg, and in the 30-39 year age group in Italy, the Netherlands, and Spain. Among those receiving first-ever treatment, the mean age was younger than in all persons treated (range: 22.3-31.8). The countries with the highest mean age in this group were Sweden (31.8.), the Netherlands (29.6) and Italy (28.3), and those with the lowest were Finland (22.3) and Ireland (23.3) (Tables O/1.0, O/2.0).

The mean age varied depending on the drug motivating treatment (primary drug). If the countries with fewer than 30 reported cases are eliminated from the analysis, it can be seen that in 2001 the highest mean age was found among those treated for hypnotics/sedatives (range: 31-42.1) and opiates (26.1-36) and the lowest among those admitted for hallucinogens (range: 22.2-25.5) or cannabis (range: 19-26.5). The mean age of those treated for cocaine (range: 26.3-30.9) or stimulants (range: 23.1-30.5) was between that of the two previously mentioned groups (Tables O1/1.1, O2/1.1, O3/1.1, O4/1.1, O5/1.1, O7/1.1).

If the countries with fewer than 30 reported cases are eliminated from the analysis, it can be seen that in 2000 the highest mean age was found for those treated for hypnotics/sedatives (range: 25.9-42.2) and opiates (25.7-34.8) and the lowest for those admitted for hallucinogens (range: 22-22.5) or cannabis (range: 21.3-26.5). The mean age of those treated for cocaine (range: 28.3-30.4) was between that of the two previously mentioned groups (Tables O1/1.0, O2/1.0, O3/1.0, O4/1.0, O5/1.0, O7/1.0).

4.4.3 Highest educational level completed

The TDI protocol stipulates that for each person treated information should be obtained on the highest educational level completed, classified into 4 categories: never went to school/never completed primary school, primary level of education, secondary level of education, and higher level of education.

Education is another key socio-economic category. Employment in the EU Member States depends heavily on educational level.

Among all persons treated in 2001, most of the reported cases were had completed the primary level of education (Denmark, Finland, Netherlands, Sweden) or secondary level of education completed (Germany, Greece, Spain); it should be noted, however, that the different way that educational systems are organized in each country may influence how this variable is categorized. The proportion of those treated who had less than secondary level of education ranged between 75.1% in Finland and 21.3% in Germany (Table O/1.1). The results for those receiving first-ever treatment were quite similar (Tables O/2.1).

The situation in 2000 was similar to that of 2001. Most of the reported cases had completed the primary level of education (Finland, Ireland, Luxembourg, the Netherlands and Sweden) or the secondary level of education (Germany, Greece, Italy and Spain). The proportion of those treated with less than secondary level of education ranged between 76.9% in Finland and 20.7% in Italy (Tables O/1.0). The results for those receiving treatment for the first time were quite similar (O/2.0).

4.4.4 Labour status

The TDI protocol instructs that information should be obtained on the labour status of each person treated. This variable is classified into 5 categories: regular employment, pupil/student, economically inactive (pensioners, house-wives/-men, invalids), unemployed, and other.

Labour status provides key information about the client's economic and social integration and his or her daily life. Categories such as irregular, illegal or other forms of employment, which are unusual in social statistics but are not uncommon among drug addicts, are especially difficult to work with. For this reason, only broad categories have been used, and someone in irregular employment is coded as 'unemployed' or 'other'.

Among all persons treated in 2001, most clients treated for drugs were classified in the categories of 'unemployed' or 'other'. The proportion of employed persons varied widely among countries, ranging from 9.1% in Denmark to 41.4% in Germany. Likewise among those receiving first-ever treatment, less than half were employed, ranging from 13.3% in Denmark to 47.4% in Spain (Tables O/1.1, O/2.1).

The situation in 2000 was similar. Among all persons treated for drugs, most clients were classified as 'unemployed' or 'other'. Among all persons treated, most clients treated for drugs were not employed or working, but rather were unemployed or in other situations. The proportion of employed persons varied widely among countries, from 13.2% in Finland to 46% in Italy. Likewise, among those receiving first-ever treatment, only a minority were employed, ranging from 14.7% in Denmark to 44.7% in Spain (Tables O/1.0, O/2.0).

4.4.5 Living status (with whom)

The TDI protocol states that it should be noted with whom each person in treatment lives, classifying this variable into 7 possible categories: alone, with parents, alone with child, with partner (alone), with partner and child(ren), with friends, or other.

Living status refers to the current situation (30 days prior to the start of treatment) of the person admitted to drug treatment. If the situation has changed within those 30 days, the living status immediately prior to treatment contact is used.

The primary purpose of the 'with whom' aspect is to assess the social contacts or social integration of the drug user. It does not address the question of quality of accommodation.

Among all those treated in 2001, most persons lived alone (Denmark, the Netherlands) or with family/friends (Greece, Sweden). The proportion of those living alone varied between 71.8% in Denmark and 7.8% in Greece. The proportion of those living with family/friends varied between 88% in Greece and 28.2% in Denmark (Tables O/1.1). In 2000, the most frequent category in all countries for which information was available (Greece, Ireland, Italy, Luxembourg, the Netherlands) was living with family/friends. However, the proportion of cases in this category varied between 51.4% in the Netherlands and 86% in Greece. The proportion of those living alone varied between 6.3% in Ireland and 48.6% in the Netherlands (Tables O/1.0).

4.4.6 Living status (where)

The TDI protocol stipulates that each person treated should report where he or she lives, classified into 3 possible categories: stable accommodation, unstable accommodation, or institutions (prison, clinic).

Living status refers to the current situation (30 days prior to the start of treatment) of the person admitted to drug treatment. If the situation has changed within these 30 days, the living status immediately prior to treatment contact should be entered. The 'where' aspect stresses the stability of the living situation.

Among all those treated in 2001, most persons in countries with information on this variable lived in stable accommodation (Denmark, Finland, Germany, Greece, the Netherlands and Sweden). The proportion of cases in this category varied between 76.3% in Sweden and 96% in Greece. The proportion of treated persons living in unstable accommodation varied between 3.2% in Germany and 14.4% in Sweden. Finally, some countries like Germany (17.4%) and Sweden (9.3%) had a relatively large proportion of persons living in institutions. In Greece, however, this proportion was minimal (0.2%) (Tables O/1.1). In 2000, living in stable accommodation was also the most frequent category for all countries with available information (Finland, Germany, Greece, Luxembourg, the Netherlands), with the exception of Italy. However, the proportion of cases in this category varied from 18.8% in Italy, to 56.3% in Luxembourg, to 96.1% in Greece. Some countries like Italy (51.2%), Luxembourg (22.5%) and Germany (14.5%) had a relatively large proportion of persons living in institutions. In Greece, however, this proportion was minimal (0.0%) (Tables O/1.0).

4.4.7 Nationality

The TDI protocol stipulates that nationality should be indicated for each person treated, classified into 3 possible categories: national of the reporting country, EU national, or national of another country. This item is considered relevant for both national and European figures, as drug problems are more prevalent among minorities in several places. As minorities vary greatly in different countries (sometimes it is the nationality, sometimes the ethnic origin and sometimes the language spoken that differs from the majority), only very basic categories are used here.

Among all persons treated in 2001 in countries with information on this variable (Denmark, Finland, Germany, Greece, the Netherlands, Spain and Sweden), the vast

majority (over 90%) of persons admitted to treatment were nationals of some EU country. However, the proportion of foreigners (nationals of a country not belonging to the EU) ranged from 1.2% in Finland to 7.7% in the Netherlands. The countries with the largest proportions of foreigners were the Netherlands, Sweden and Germany (Tables O/1.1). The situation was similar in 2000. The proportion of foreigners in countries with available information (Finland, Germany, Greece, Ireland, Italy, Luxembourg, the Netherlands, Spain) ranged between 0.3% in Ireland and 7.5% in Germany. The countries with the largest proportions of foreigners were Germany, the Netherlands and Italy (Tables O/1.0).

4.5 Primary drug

The TDI protocol^{Error! Bookmark not defined.} requires that each person treated should indicate the primary drug.. The main drug is defined as the drug that causes the client the most problems, and should be classified into one of the following categories: 1. Opiates (11 heroin, 12 methadone, 13 other opiates), 2. Cocaine (21 cocaine, 22 crack), 3. Stimulants (31 amphetamines, 32 MDMA and other derivatives, 33 other stimulants), 4. Hypnotics and sedatives (41 barbiturates, 42 benzodiazepines, 43 others), 5. Hallucinogens (51 LSD, 52 others), 6. Volatile inhalants, 7. Cannabis, 8. Other substances.

This item is of key importance. It can be based on problems as defined by clients or on short diagnoses based on the ICD 10. Alcohol may not be recorded as the primary drug, and clients whose primary drug is alcohol are not recorded. For users of 'speedball', heroin is recorded as the main drug and cocaine as a secondary drug. If the exact substance is not known (such as amphetamines or MDMA and its derivatives), the generic category (for example, 'stimulants (total)') is recorded.

Where prescribed drugs are mentioned, it is essential that psychological, social or medical problems are directly caused by the substance.

Among all persons treated in 2001 in countries with available information (Denmark, Finland, Germany, Greece, the Netherlands, Spain, Sweden and United Kingdom), the drug group that motivated the largest number of treatments was the *opiates*, except in the case of Sweden, where it was stimulants. The proportion of treatments

motivated by opiates varied between 86.1% in Greece and 25.5% in Sweden. In four countries (Greece, Spain, Germany and the Netherlands), the opiates were the motivating cause of over 50% of treatments. In Denmark, Greece, the Netherlands, Spain and Sweden, the opiate most commonly mentioned as the primary drug was heroin, but in Finland opiates other than heroin or methadone were mentioned more often than heroin.

In most countries, the drug group motivating the second largest number of treatments was *cannabis* derivatives, although in the Netherlands and Spain it was cocaine and in Sweden it was the opiates. The proportion of treatments motivated by cannabis varied between 7.9% in Spain and 30.3% in Finland. In Finland, Germany and Sweden, treatments for cannabis represented over 25% of all reported treatments.

Cocaine was the primary drug motivating treatment for a relatively large proportion of treatments only in the case of the Netherlands (29,9%) and Spain (19,8%); in these two countries, it was the second drug group with regard to number of treatments. The proportion of treatments motivated by cocaine varied between 29.9% in the Netherlands and 0.1% in Finland. Although there is little information in this regard, the type of cocaine motivating most treatments is usually cocaine chlorhydrate, with few treatments motivated by crack.

Stimulants were responsible for a considerable proportion of treatments in Sweden (32.0%), where they were the drug group that motivated the largest number of treatments, and in Finland (29.4%). Amphetamines were the stimulants most frequently involved in both countries. The proportion of treatments for stimulants varied between 32.0% in Sweden and 0.4% in Greece.

The *hypnotics/sedatives* were not responsible for a large volume of treatments, except in Sweden (13.5%). In all countries the substances most frequently involved were the benzodiazepines. Barbiturates have practically disappeared as a reason for seeking treatment. The number of treatments motivated by *hallucinogens* was minimal in all countries, ranging from 0.0% in Denmark to 0.8% in Germany. The situation is similar with regard to *volatile inhalants*, whose proportion varied between 0.0% in the Netherlands and 0.3% in Finland. Finally, the residual group of *other psychoactive substances* is hardly represented in any country, except for Denmark (13,1%) (Table O/1.1).

With regard to first-ever treatments, the situation is quite different, with the opiates generally becoming less important, and cannabis, cocaine and stimulants more so. In fact, in 2001, among those treated for the first time, opiates were responsible for the largest number of treatments in just two countries (Greece and Spain), while cannabis was the primary drug in four countries (Denmark, Finland, Germany and Sweden) and cocaine in one (the Netherlands). The proportion of treatments for cannabis ranged between 48.4% in Finland and 17.5% in Spain; the proportion of treatments for opiates between 79.5% in Greece and 20.3% in Finland; the proportion of treatments for cocaine between 34.6% in the Netherlands and 1.1% in Greece, and the proportion of treatments for stimulants between 27% in Finland and 0.6% in Greece (Table O/2.1).

The situation was similar for the year 2000. In all countries where information was available (Finland, Germany, Greece, Ireland, Luxembourg, Italy, the Netherlands, Spain and Sweden), the drug group that motivated the largest number of treatments was the *opiates*. The proportion of treatments motivated by opiates ranged between 90% in Greece and 28.9% in Sweden. In six countries (Greece, Spain, Luxembourg, Ireland, Italy and Germany), the opiates were responsible for over 50% of treatments. In all countries heroin was the opiate most frequently cited as the primary drug. In most countries the drug group responsible for the second largest number of treatments was *cannabis* derivatives, although in the Netherlands and Spain it was cocaine and in Finland and Sweden it was stimulants. The proportion of treatments motivated by cannabis ranged between 6.5% in Spain and 25% in Sweden. In Sweden, Germany and Finland treatments for cannabis represented over 20% of all reported treatments.

Cocaine was responsible for a relatively large number of treatments only in the Netherlands (28.7%) and Spain (18.2%); in these two countries it was the drug responsible for the second largest number of treatments. The proportion of treatments motivated by cocaine varied between 28.7% in the Netherlands and 0.3% in Finland. Although little information is available on this point, the type of cocaine motivating most treatments is usually cocaine chlorhydrate, with few treatments for crack.

The *stimulants* were responsible for a considerable proportion of treatments in Finland (30.6%) and Sweden (28.2%), where they were the drugs causing the second largest number of treatments. The most frequently involved stimulants in this

country were amphetamines. The proportion of treatments for stimulants varied between 30.6% in Finland and 0.5% in Greece.

The *hypnotics/sedatives* were responsible for a large number of treatments in Sweden. The proportion of these drugs varied between 0.6% in Italy and 14.1% in Sweden. The substances giving rise to treatment demand in this group were usually the benzodiazepines in all countries. Barbiturates have practically disappeared as a reason for treatment.

The number of treatments for *hallucinogens* was minimal in all countries, varying between 0.1% in Spain and Italy and 0.8% in Germany. The situation with *volatile inhalants* was similar, with the proportion varying between 0.0% in Greece, the Netherlands, and Spain and 0.7% in Ireland. Finally, the residual group of *other psychoactive substances* was hardly represented in any country, except for Germany (2.8%). (Table O/1.0).

The situation with regard to persons in first treatment is somewhat different from that of all persons treated. The opiates are less important among persons in first treatment, while cannabis, cocaine and stimulants are more so. In fact, in 2000 among those treated for the first time, the opiates were the group of substances that motivated the largest number of treatments in four countries where information was available (Luxembourg, Greece, Ireland, Spain), while cannabis was responsible for the largest number of treatments in two country (Finland and Sweden) and cocaine in another (the Netherlands). No information was available for Italy. The proportion of treatments for cannabis varied between 39% in Finland and 13.2% in Greece; the proportion of treatments for opiates, between 87.5% in Luxembourg and 28.5% in the Netherlands; the proportion of treatments for cocaine between 33.8% in the Netherlands and 0.6% in Finland, and the proportion of treatments for stimulants between 28.3% in Finland and 0.6% in Greece (Table O/2.0).

4.6 Injection of any drug

The TDI protocol^{Error! Bookmark not defined.} states that each person treated should provide information on their experience with regard to injection of any drug, classifying this variable into 3 possible categories: ever injected, but not currently; currently injecting; or never injected

Here, injection behaviour with regard to all drugs is taken into account, regardless of whether the substances are primary or secondary drugs. This item gives a good indication of risk behaviour. This is of particular importance with regard to the transmission of infectious diseases (hepatitis, HIV) as well as other diseases and injuries and issues of harm reduction. Injection for medical purposes (such as for diabetes) is excluded. 'Currently injecting' refers to whether a client has injected any drug at least once in the past 30 days. The reference point for the 30-day period of use is the start of treatment, in other words the first face-to-face session.

In 2001, among all persons admitted to treatment for any drug, the current injectors were the smallest group in all countries, varying between 8.7% in the Netherlands and 47.7% in Finland. However, if we consider the proportion of those treated who have injected drugs at any time in their lives, the figures increase substantially, becoming the largest group in four countries (Denmark, Finland Greece and United Kingdom), while in three other countries (the Netherlands, Spain and Sweden) this group does not reach 50% of those treated. The proportion of lifetime injectors varied between 70.4% in Greece and 28.7% in the Netherlands (Table O/1.1). If we consider only those receiving first-ever treatment, it can be seen that the proportion of current injectors is smaller than in the group of all those treated, varying between 7.4% in the Netherlands and 35.5% in Greece. In three countries (the Netherlands, Sweden and Spain) this figure is less than 10%. With regard to the proportion of lifetime injectors, the figures increase, but only exceed 50% in Greece, varying between 18.2% in Spain and 57.8% in Greece (Table O/2.1). If cases are stratified by primary drug, it can be observed that, in 2001, the only group in which a substantial proportion of current injectors is found in all countries is persons treated for heroin (range: 14.2%-68.9%), and those treated for amphetamines in Finland (55.7%), United Kingdom (39.7%) and Sweden (32.8%). The proportion of current injectors was also found to be higher than 5% among those treated for methadone in Denmark (29.2%), Spain (12.2%) and the Netherlands (7.7%), among those treated for opiates other than heroin or methadone in Finland (81.1%), Denmark (38.3%), the Netherlands (20.5%), United Kingdom (19.2%) and Spain (17.7%), among those treated for cocaine in Denmark (23.4%) and Spain (5.3%), among those treated for cannabis in Finland (12.9%), for hypnotics/sedatives in the Netherlands (5.1%), and for other psychoactive substances in the Netherlands (7.1%) (Tables O11/1.1, O12/1.1, O13/1.1, O2/1.1, O31/1.1, O4/1.1, O7/1.1 & O9/1.1).

In 2000, the proportion of current injectors among all those admitted to treatment for any drug varied between 6.3% in Germany and 74% in Luxembourg. However, if the proportion of persons treated who have ever injected drugs is considered, the figures rise substantially, becoming the largest group in all countries with available information (Finland, Germany, Greece, Ireland, Italy and Luxembourg), except for the Netherlands, Sweden and Spain (Table O/1.0). If only persons receiving treatment for the first time are considered, the proportion of current injectors is smaller than in all persons treated, ranging from 5% in the Netherlands to 81.5% in Italy. With regard to the proportion of lifetime injectors, the figures increase, exceeding 50% in Finland, Greece, Italy and Luxembourg. The only group of persons among whom a substantial proportion of current injectors is found in all countries is those treated for heroin (range: 12.8%-80.3%), and those treated for amphetamines in Finland (57.5%) and Sweden (42.7%). The proportion of current injectors is larger than 5% among those treated for methadone in Ireland (21%), the Netherlands (13.2%) and Spain (11.2%), among those treated for opiates other than heroin or methadone in Finland (80%), Ireland (25.7%) Spain (24.1%) and the Netherlands (8.6%), among those treated for cocaine in Italy (13.8%) and Spain (7.9%), among those treated for cannabis in Finland (12.1%), for hallucinogens in Spain (7.7%), for stimulants in the Netherlands (5.2%), among those treated for MDMA and other derivatives in Finland (18.5%) and Spain (5.2%), and for other psychoactive substances in the Netherlands (7.1%) (Tables O11/1.0, O12/1.0, O13/1.0, O2/1.0, O3/1.0, O31/1.0, O32/1.0, O5/1.0, O7/1.0 & O9/1.0).

4.7 Age of first use of primary drug

From the epidemiological point of view, age of first use is an indicator of the age at which the risk of starting to use a specific substance is greatest. Tracking long-term trends may help in developing preventive activities.

In 2001 the youngest mean age of first use was seen among those treated for cannabis (range: 15.1-16.5 years), stimulants (range: 17.9-18.9) and hallucinogens (19.5 in Spain) (Tables O7/1.1, O3/1.1 & O5/1.1). The highest mean age of first use was found among those treated for methadone (range: 25.2-26.8), opiates other than heroin or methadone (range: 22-30.7), and hypnotics/sedatives (range: 21-29.4) (Tables O12/1.1, O13/1.1 & O4/1.0). Persons treated for heroin (range: 19.1-22) or

cocaine (range: 21.3-21.7) were in an intermediate position (Tables O11/1.1 & O2/1.1).

Among persons receiving first-ever treatment, the mean age of first use was quite similar. For example: heroin (19.4-22.8), stimulants (18-19.2), cocaine (21.9 in Spain) and cannabis (15.3-16.6). Among those receiving first treatment for heroin, the countries with the lowest mean ages of first use were Finland (19.4) and Greece (20.3). Among those treated for the first time for stimulants: Denmark (18.0) and Spain (18.7). Among those treated for cannabis: Denmark (15.3) and Greece (15.7) (Tables O11/2.1, O2/2.1, O3/2.1 & O7/2.1).

In 2000, the youngest mean age of first was also found among those treated for cannabis (range: 15.4-18.3), stimulants (range:17.4-19) and hallucinogens (18.9 in Spain). The oldest mean age of first use was found among those treated for methadone (range: 21.8-26.4), opiates other than heroin or methadone (range: 13.7-31.9), and sedatives/sedatives (range: 15.7-31.2). Persons treated for heroin (range: 15.9-21.8) or cocaine (range: 21.6-22.2) were in an intermediate position (Tables O7/1.0, O3/1.0, O5/1.0, O12/1.0, O13/1.0, O4/1.0, O11/1.0 & O2/1.0). Among those receiving first-ever treatment for heroin, the countries with the lowest mean age of first use were Ireland (19.3) and Finland (19.8); among those receiving first treatment for stimulants: Italy (14.5) and Finland (18.7); and among those receiving first treatment for cannabis: Finland (15.3) and Ireland (16.0) (Tables O11/2.0, O3/2.0 & O7/2.0).

4.8 Length of use of primary drug

The negative effects of drug use often increase over time. The duration of drug use can be calculated on the basis of the age of first use and the age at start of treatment.

In 2001, the primary drug groups with the longest duration of use were hypnotics/sedatives (range: 7.1-12.8 years) and opiates (range: 5.5-11.2 years). Those treated for cannabis had the shortest length of use (range: 3.5-10.1 years). Cocaine (range: 5.1-7.6), stimulants (range: 4.4-11.9 years), and hallucinogens (6.1 years in Spain) were in an intermediate position. The country with the longest duration of use for the opiates was Spain (11.2 years); in the case of the

hypnotics/sedatives it was Sweden (12.8) and Finland (10); for stimulants, Sweden (11.9); for cocaine, Spain (7.6); and for cannabis, Denmark (9.0). The countries with the shortest length of use were, for the opiates, Finland (5.5); for hypnotics/sedatives, Spain (7.1); for stimulants, Spain (4.4); for cocaine, Denmark (5.1); and for cannabis, Greece (3.5). Persons receiving first-ever treatment generally had a shorter length of use; the range for opiates, for example was 4.2-9.4 years, and for cannabis, 3.4-9 years. (Tables O1/1.1, O2/1.1, O3/1.1, O4/1.1, O5/1.1, O7/1.1).

In 2000, the primary drug groups with the longest duration of use were opiates (range: 5.6-14.7 years) and hypnotics/sedatives (range: 6.6-10.5 years). Persons receiving treatment for hallucinogens (3.6 years in Spain), and stimulants (range: 4.3-7.2) had the shortest length of use. Those treated for cannabis (range: 5.9-10.7 years) and cocaine (range: 7-8 years) were in an intermediate position. The country with the longest duration of use for opiates was Luxembourg (14.7 years); for hypnotics/sedatives, it was Sweden (10.9); for stimulants, Sweden (13.2); for cocaine, Italy (8.0); and for cannabis, Italy (8.2). The countries with the shortest length of use were, for opiates, Finland (5.6); for hypnotics/sedatives, Spain (6.6); for stimulants, Spain (4.3) and Ireland (4.3); for cocaine, Spain (7.0) and for cannabis, Greece (5.9) and Finland (5.9). (Tables O1/1.0, O2/1.0, O3/1.0, O4/1.0, O5/1.0, O7/1.0) Persons in treatment for the first time generally had a shorter length of use; the range for opiates, for example, was 3.9-9 years, and for cannabis, 4.2-8.7 years. (Tables O1/2.0, O2/2.0, O3/2.0, O4/2.0, O5/2.0, O7/2.0).

4.9 Usual route of administration of primary drug

The TDI protocol establishes that each person treated should report the usual route of administration of the primary drug, classified into 5 possible categories: inject, smoke/inhale, eat/drink, sniff, or others.

Injecting drugs represents a primary form of risk behaviour for drug users. It is of particular importance with regard to infectious diseases (hepatitis, HIV) as well as other diseases and injuries, and reducing injecting behaviour is the aim of many harm-reduction programmes. This category refers to the usual route of administration of the primary drug.

4.9.1 Heroin

In 2001, heroin use by the injected route predominated in most countries. This was the case in Finland (88% of those treated for heroin favoured this route), Sweden (63.8%), Denmark (57.4%), Greece (55.6%) and United Kingdom (54%). However, the pulmonary route (smoked) predominated in two countries: the Netherlands (82.4% mainly smoked heroin) and Spain (68.4% smoked). The proportion of smokers is beginning to become important in all countries, ranging from 10.2% in Finland to 82.4% in the Netherlands. The proportion of heroin smokers is higher than 20% in all countries with information on this variable, except for Finland. The proportion of sniffers is less than 5% in all countries, except for Greece (22.7%) and Denmark (7.1%). Among those receiving first-ever treatment for heroin, smokers predominated in the Netherlands (80.3%), Spain (75.7%) and Denmark (51.4%), while injectors predominated in Finland (76%), Greece (51%) and Sweden (49.1%). The proportion of smokers was higher than 30% in all countries with available information, except for Finland (18%) and Greece (26.4%). The proportion of sniffers exceeded 5% in Greece (22.5%), Denmark (10.1%) and Spain (6.5%). The proportion of those who used heroin by other routes did not exceed 5% in any country. (Tables O11/1.1, O11/2.1).

In 2000, heroin use by the injected route predominated in most countries. This was the case in Italy (89.5% of those treated for heroin preferred this route), Finland (80.8%), Luxembourg (77.4%), Sweden (71.4%), Ireland (66.9%), and Greece (62.1%). However, the pulmonary route (smoked) predominated in two countries: the Netherlands (80.4% favoured heroin use by smoking) and Spain (66% smoked). A substantial proportion of smokers is beginning to be seen in all countries, ranging from 10.4% in Italy to 80.4% in the Netherlands. The proportion of sniffers is lower than 5% in all countries, except for Greece (22.5%) and Spain (5%). Among persons receiving first-ever treatment for heroin, smokers predominate in the Netherlands (82.4%), Spain (74.3%) and Ireland (51.9%), while injectors predominate in Finland (70.7%), Italy (68.2%), and Greece (54.1%). The proportion of smokers was higher than 30% in all countries with available information, except for Greece (20.6%) and Finland (27.2%). The proportion of sniffers exceeded 5% in Greece (25.3%) and Spain (6.9%). (Tables O11/1.0, O11/2.0).

4.9.2 Cocaine

In 2001, only four countries provided data on this variable for at least 30 cases (Denmark, the Netherlands, United Kingdom and Spain). Sniffers predominated in Spain (69.8%) and Denmark (50%), and smokers in the Netherlands (61%) and United Kingdom (60.7%). The proportion of injectors was less than 5% in the Netherlands, United Kingdom and Spain, but was 27.8% in Denmark. Among those treated for the first time, there was a predominance of sniffers in Spain (75.5%) and of smokers in the Netherlands (52%). The proportion of injectors in this group was virtually nil (1.5% in Spain and 0.6% in the Netherlands). (Tables O2/1.1, O2/2.1).

In 2000, only three countries provided data on this variable for at least 30 cases (Italy, the Netherlands and Spain). Sniffers predominated in Spain (70.2%), while smokers predominated in the Netherlands (60.1%) and Italy (53.4%). The proportion of injectors was less than 5% in the Netherlands and Spain, but was 29.3% in Italy. Among those receiving treatment for the first time, there was predominance of sniffers in Spain (76.1%) and of smokers in Italy (73.2%) and the Netherlands (52.1%). There were very few injectors in this group (2.2% in Italy, 1.9% in Spain and 0.9% in the Netherlands). (Tables O2/1.0, O2/2.0).

4.9.3 Amphetamines

In 2001, the principal route of administration among persons treated for amphetamines varied greatly by country. Injectors predominated in Finland (73.5%) and Sweden (53%), while sniffers made up the largest group in Denmark (70.4%) and the Netherlands (48.9%), and those using the oral route predominated in Spain (66.5%) and United Kingdom (52.9%). While not the predominant route, there were a substantial proportion of users of the oral route among amphetamine users in all countries, especially in Sweden (37.6%), the Netherlands (33.3%) and Denmark (20.4%); of injectors in United Kingdom (39.8%), of sniffers in Spain (25.3%) and Finland (15.5%); and of smokers in the Netherlands (11.3%). Among those receiving first-ever treatment for amphetamines, the situation was quite similar to that of all persons treated. There was a predominance of injectors in Finland (60.2%), of sniffers in Denmark (72.5%) and the Netherlands (49%), and of users of the oral route in Spain (66.5%) and Sweden (52.3%). Injectors made up a substantial group in Sweden (30.3%), although in general they represent a smaller proportion of users among persons in first treatment than in all persons treated (Tables O31/1.1, O31/2.1)

In 2000, the predominant route of administration among those treated for these substances also varied greatly by country. Injectors predominated in Finland (75%) and Sweden (49.1%), while users of the oral route predominated in Italy (100%) and Spain (62.5%). In the Netherlands the proportion of sniffers and users of the oral route was the same (40.3%). While not the predominant route, there was a substantial proportion of users of the oral route in all countries, especially in Sweden (39.9%) and Finland (13%); and of sniffers in Spain (29.5%) and Finland (11.4%). Among those treated for the first time for amphetamines, the situation was quite similar to that of all persons treated. There was a predominance of injectors in Finland (62.6%), of sniffers in the Netherlands (47.7%), and of users of the oral route in Spain (65.7%) and Sweden (60%). In addition, there was a substantial group of injectors in Sweden (27.7%), although in general they represent a smaller proportion of users among persons in first treatment than in all persons treated (Tables O31/1.0, O31/2.0).

4.9.4 MDMA and other derivatives

In 2001, the main route of administration among persons treated for these substances was the oral route in all countries with available information (range: 76.8%-99.4%). However, the Netherlands reported a considerable proportion of smokers (17.1%). The situation among those in first treatment was quite similar to that of all persons treated. (Tables O32/1.1, O32/2.1).

In 2000, the main route of administration in those treated for these substances was also the oral route (range: 72%-98.4%). In the Netherlands, however, a substantial proportion of smokers was detected (19.5%). The situation among those in first treatment was quite similar to that of all persons treated (Tables O32/1.0, O32/2.0).

4.9.5 Hypnotics and sedatives

In 2001, the oral route predominated among those treated for these substances in all countries with available information (range: 95.2%-98.1%). The situation among those in first treatment was quite similar to that of all persons treated (Tables O4/1.1, O4/2.1),

In 2000, the oral route was also the main route of administration among those treated for these substances (range: 83.3%-100%). In Italy, however, a considerable proportion of injectors was detected (16.7%). The situation among those in first treatment was quite similar to that of all persons treated (Tables O4/1.0, O4/2.0).

4.9.6 Cannabis

In 2001, smoking was the main route of administration among those treated for cannabis in all countries with available information (range: 93.6%-99.4%). The next most important route of administration was the oral route, which made up 5.2% of treatments in Sweden, 3.8% in Denmark and 2.2% in Spain. The situation among those in first treatment was quite similar to that of all persons treated (Tables O7/1.1, O7/2.1).

In 2000, smoking was also the main route of administration (range: 96.3%-100%). The next most important route of administration was the oral route, which made up 2.6% of treatments in Spain, 2.2% in Ireland and 1.9% in the Netherlands. The situation among those in first treatment was quite similar to that of all persons treated. (Tables O7/1.0, O7/2.0).

4.9.7 Hallucinogens

Spain was the only country with more than 30 cases treated for hallucinogens and which had information about the administration route. In 2001, the main route of administration in persons treated for hallucinogens in Spain was the oral route (76.9%), followed by smoking (19.2%). The situation among those in first treatment was quite similar to that of all persons treated (Tables O5/1.1, O5/2.1).

Spain was the only country with more than 30 cases treated for hallucinogens, which had information about the administration route. In 2000, the main route of administration in persons treated for hallucinogens in Spain was the oral route (88.5%). The situation among those in first treatment was quite similar to that of all persons treated (Tables O5/1.0, O5/2.0).

4.10 Frequency of use of primary drug

The TDI protocol stipulates that each person treated should report the frequency of use of the primary drug, classified into 4 possible categories: not used in past month/used occasionally, used once per week or less, used 2–6 days per week, or used daily.

The frequency of use of the primary drug is an indicator of the severity of drug use. This item refers to the 30 days prior to the start of treatment. If the client is drug free

or has not used his or her primary drug in the past 30 days, this is coded as 'not used in past month/used occasionally'.

4.10.1 Heroin

In 2001, most persons admitted to treatment for heroin abuse or dependence had used this drug during the 30 days prior to treatment admission either daily (range: 32.7%-82.3%) or 2-6 times/week (range: 7%-32.7%). In almost all countries the proportion of daily users exceeded 70%, except in Finland (32.7%) and Sweden (54%). Surprisingly, 25.8% and 14.3% of persons treated in these two countries, respectively, reported that they had not used heroin in the previous month or had done so only occasionally. Among those admitted to treatment for heroin for the first time, the situation is similar and there is generally a predominance of daily users of this drug (range: 27.1%-84.3%). In Finland, however, there is a predominance of persons using the drug 2-6 times/week (39.6%) (Tables O11/1.1, O11/2.1).

In 2000, the same as in 2001, most of those admitted to treatment for heroin abuse or dependence had used this drug during the 30 days prior to treatment admission either daily (range: 47.6%-89%) or 2-6 times/week (range: 3.9%-30%). In almost all countries the proportion of daily users exceeded 50%, except in Finland (47.6%). In some countries there is also a considerable proportion of persons treated who declare that they have not used heroin during the previous month or have done so only occasionally: 24.2% in Ireland, 19.6% in Italy, 14.6% in Sweden, 13.9% in Finland and 11% in Greece. Among those admitted to treatment for heroin for the first time, the situation is similar and daily users of this drug predominate (range: 54.5%-89.5%). Persons using heroin 2-6 times/week make up a substantial group in Finland (38%), Italy (28.1%) and Greece (24.1%) (Tables O11/1.0, O11/2.0).

4.10.2 Cocaine

In 2001, in countries reporting more than 30 cases which have information on the frequency of cocaine use (Denmark and the Netherlands), most of those treated used cocaine daily (Denmark 37.8% and the Netherlands 55.7%) or 2-6 times per week (Denmark 18.5% and the Netherlands 37.8%). The situation among those in first treatment was similar (Tables O2/1.1, O2/2.1).

In 2000, in countries reporting more than 30 cases and with information on the frequency of cocaine use (Italy and the Netherlands), daily users made up the largest group in the Netherlands (53.9%), but not in Italy, where 48.5% of those treated

reported using the drug once a week or less. The situation among those in first treatment was similar (Tables O2/1.0, O2/2.0).

4.10.3 Amphetamines

In 2001, most of those treated used amphetamines 2 or more times per week (range: 51.9%-82.1%), however the proportion of daily users did not exceed 50% in any country. The situation among those in first treatment was similar (Tables O31/1.1, O31/2.1).

In 2000, there was a predominance of persons using amphetamines 2 or more times per week (range: 58,9%-100%) in all countries. The situation among those in first treatment was similar (Tables O31/1.0, O31/2.0).

4.10.4 MDMA and other derivatives

In 2001, in the two countries that reported more than 30 cases and had information on this variable (the Netherlands and Sweden), persons treated for MDMR and other derivatives were divided into two practically equal groups with regard to frequency of use: those who used 2 or more times per week (range: 55.5%-48.9%) and those who used once a week or less. The proportion of daily users was substantial in the Netherlands (29.6%), but not in Sweden (2.8%). The situation among those in first treatment was similar (Tables O32/1.1, O32/2.1).

In 2000, there were four countries with more than 30 cases and information on the frequency of use (Finland, Ireland, Italy and the Netherlands). The proportion of daily users was considerable in the Netherlands (29.1%), but not in Ireland (8.4%), Finland (3.8%) or Italy (0%). Persons who used these drugs once or less a week were the largest group in Italy (96.8%) and Finland (61.5%), whereas most persons treated for these drugs used them 2 or more times per week in the Netherlands (57%). In Ireland, there were about the same number of users in each group. The situation among those in first treatment was similar (Tables O32/1.0, O32/2.0).

4.10.5 Hypnotics and sedatives

In 2001, three countries had more than 30 cases with available information on the frequency of use of this drug group (Finland, the Netherlands and Sweden). In all three, there was a clear predominance of daily users among those treated for hypnotics/sedatives (range: 65.7%-87.1%). The situation among those in first treatment was similar (Tables O4/1.1, O4/2.1).

In 2000, there were five countries with more than 30 cases and available information on the frequency of use of the primary drug (Finland, Ireland, Italy, the Netherlands and Sweden). In four of these countries there was a clear predominance of daily users (range: 56.5%-89%); Italy was the exception, where the largest group was made up of those who used these drugs once a week or less (80%). This again raises doubts about the nature validity of the Italian data. The situation among those in first treatment was similar (Tables O4/1.0, O4/2.0).

4.10.6 Cannabis

In 2001, five countries reported more than 30 cases with information on the frequency of use of cannabis. Most of these treated were daily users in Denmark (76.9%) and the Netherlands (81.4%). In the other three countries the proportion of daily users varied between 19.1% in Greece and 33.4% in Sweden. The situation among those in first treatment was similar (Tables O7/1.1, O7/2.1).

In 2000, six countries reported more than 30 cases with information on the frequency of use of cannabis. Daily users made up the largest group only in the Netherlands (81.2%). In the other four countries, the proportion of daily users varied between 21.9% in Finland and 38.4% in Ireland. The situation among those in first treatment was similar. (Tables O7/1.0, O7/2.0).

4.11 Use of secondary drugs

The TDI protocol states that each person treated should report the use of drugs other than the primary drug, classifying them into the same categories as used for the primary drug.

This item is of central importance. It includes up to four drugs, in addition to the primary drug, which cause problems for the client. This information might provide more realistic figures on multiple drug use. The category can be based on problems defined by clients or on short diagnoses based on the ICD 10. Alcohol may be included as a secondary drug. For users of 'speedball', heroin is recorded as the main drug and cocaine as a secondary drug. If the exact substance is not known (for example, amphetamines or MDMA and its derivatives), the generic category (such as 'stimulants (total)') is recorded. Where prescribed drugs are mentioned, it is essential that psychological, social or medical problems are directly caused by the substance.

4.11.1 Heroin

In 2001, cannabis was the secondary drug most frequently mentioned by those treated for heroin in Denmark (58%), Greece (50.9%), Sweden (30.3%) and Finland (27%), while cocaine was the most common secondary drug in Spain (55.8%) and the Netherlands (46.7%). It should be noted that the use of cannabis as a secondary drug was very infrequently mentioned among those treated for heroin in the Netherlands. Cocaine was mentioned as a secondary drug in a considerable proportion of persons treated for heroin in Denmark (24.5%) and Greece (17.8%), but was hardly mentioned at all in Finland and Sweden.

The use of hypnotics/sedatives was mentioned in a considerable proportion of those treated for heroin in Greece (45.5%), Denmark (31%), Sweden 24.9% and Spain (15%). In almost all cases, the hypnotics/sedatives mentioned were benzodiazepines. The use of opiates other than heroin was mentioned in a considerable proportion of those treated in Denmark (50.6%), Finland (22.1%), and the Netherlands (14.7%). Users generally mentioned opiates other than heroin or methadone, except in the Netherlands, where the most commonly mentioned opiate as a secondary drug was almost always methadone. Alcohol use was mentioned in a sizeable proportion of those treated for heroin in Denmark (26.7%) and Spain (20.3%). Finally, the use of stimulants (primarily amphetamines) was mentioned in a relatively large proportion of those treated in Finland (27%), Sweden (14.7%) and Denmark (13.6%). In other countries, however, drugs belonging to this group were infrequently mentioned. (Tables O11/1.1)

In 2000, cannabis was the most frequently mentioned secondary drug in Greece (67.4%) and Italy (7.7%), while this was the case for cocaine in Spain (52%), Luxembourg (51.1%) and the Netherlands (44.7%), and for hypnotics/sedatives in Sweden (23.4%) and Ireland (23.3%). It should be noted that the use of cannabis was hardly mentioned as a secondary drug among those treated for heroin in the Netherlands. Cocaine was hardly mentioned at all as a secondary drug in Finland, Greece and Sweden.

In addition to the two countries, Sweden and Ireland, in which hypnotics/sedatives were the most frequently cited secondary drugs, they were also mentioned in a considerable proportion of those treated for heroin in Greece (49.4%), Luxembourg (20.3%) and Spain (16.1%). In practically all cases, the hypnotics/sedatives mentioned were benzodiazepines. The use of opiates other than heroin was mentioned in a considerable proportion of those treated in Luxembourg (19.5%) and

Sweden (15.9%). In Luxembourg the opiate mentioned most frequently was methadone, and in Sweden, opiates other than heroin or methadone. Alcohol was mentioned in a considerable proportion of those treated for heroin in Spain (19.6%). Finally, the use of stimulants was mentioned by a substantial proportion of those treated in Finland (28.3%), Sweden (14.5%) and Luxembourg (11.3%). These drugs were barely mentioned, however, in the other countries. (Tables O11/1.0, O11/2.0).

4.11.2 Methadone

In 2001, three countries (Denmark, the Netherlands and Spain) reported 30 or more cases with information on this variable. The most frequently cited secondary drugs among those treated for methadone were other opiates, cannabis, hypnotics/sedatives, alcohol and cocaine. Opiates other than methadone were the secondary drugs most often mentioned in Denmark (56.7%) and the Netherlands (28.3%), while cannabis was more often mentioned in Spain (17%). The most frequently mentioned opiate was heroin. The use of cannabis was also mentioned by a large proportion of those treated in Denmark (50%), but not in the Netherlands (3.5%). Cocaine was also mentioned as a secondary drug in a considerable proportion of those treated in Spain (15.9%) and the Netherlands (10.3%). The use of hypnotics/sedatives (mainly benzodiazepines) was mentioned by a substantial proportion of those treated in Denmark (40%). Alcohol use was mentioned in a considerable proportion of those treated in three countries (range: 10.9%-20%) (Tables O12/1.1, O12/2.1)..

In 2000, four countries (Ireland, Italy, the Netherlands and Spain) reported 30 or more cases with information on this variable. The most frequently cited secondary drugs among those treated for methadone were other opiates, cannabis, hypnotics/sedatives, alcohol and cocaine. Opiates other than methadone were the most commonly mentioned secondary drugs in Ireland (43.2%) and the Netherlands (31%), while this was the case for alcohol in Italy (31.6%) and cocaine in Spain (15.5%). The most frequently mentioned opiate was heroin. Cannabis was mentioned by an important proportion of those treated in Ireland (14.8%) and Spain (12.7%). Cocaine was also cited as a secondary drug in an important proportion of those treated in the Netherlands (9.9%). The use of hypnotics/sedatives (mainly benzodiazepines) was mentioned in a considerable proportion of those treated in Italy (26.6%), Ireland (15.9%) and Spain (12.2%) (Tables O12/1.0, O12/2.0)..

4.11.3 Opiates other than heroin and methadone

In 2001, five countries (Denmark, Finland, the Netherlands, Spain and Sweden) reported 30 or more cases with information on this variable. The most commonly cited secondary drugs among those treated were other opiates, hypnotics/sedatives, alcohol, and cannabis. The opiates (mainly heroin) were the secondary drugs most often mentioned in Denmark (44.8%) and the Netherlands (13.8%); the hypnotics/sedatives in Finland (26.9%) and Sweden (16.3%); and alcohol in Spain (19.3%). The use of cannabis was mentioned in a considerable proportion of those treated in Denmark (25.9%), Finland (17.7%) and Spain (13.3%), but not in the Netherlands (2.3%). Cocaine was also mentioned as a secondary drug in a sizeable proportion of those treated in Spain (18.9%), the Netherlands (13.8%) and Denmark (10.3%). The use of hypnotics/sedatives (mainly benzodiazepines) was mentioned in a considerable proportion of those treated in Denmark (36.2%) and Spain (14.4%). Alcohol consumption was mentioned by an important proportion of those treated in Denmark (15.5%) (Tables O13/1.1, O13/2.1)..

In 2000, six countries (Finland, Ireland, Luxembourg, the Netherlands, Spain and Sweden) reported 30 or more cases with information on this variable. The secondary drugs most often cited among those treated were hypnotics/sedatives, cocaine, alcohol, and cannabis. The hypnotics/sedatives (mainly benzodiazepines) were the most frequently mentioned drugs in Ireland (34.1%), Finland (26.9%), and Sweden (14.9%); cocaine in Luxembourg (31.4%) and Spain (24.6%); and alcohol in the Netherlands (9.8%). Cannabis use was mentioned in a substantial proportion of those treated in Spain (19.6%), and Finland (16.6%). The use of hypnotics/sedatives (mainly benzodiazepines) was mentioned in a sizeable proportion of those treated in Spain (14.6%). Alcohol consumption was mentioned by an important proportion of those treated in Spain (14.6%) (Tables O13/1.0, O13/2.0).

4.11.4 Cocaine

In 2001, two countries (the Netherlands, and Spain) reported 30 or more cases with information on this variable. The secondary drugs mentioned most often among those treated for cocaine were alcohol, cannabis and stimulants. Alcohol was the most commonly cited secondary drug in Spain (34.2%) and the Netherlands (15.4%). Cannabis was the most often cited secondary drug in Spain (34.2%). The use of stimulants was cited in 13.8% in Spain. The opiates (mainly heroin) were mentioned in a not inconsiderable proportion of those treated in the two countries (9.6% in Spain and 25.7% in the Netherlands) (Tables O2/1.1, O2/2.1).

In 2000, two countries (the Netherlands, and Spain) reported 30 or more cases with information on this variable. The most frequently cited secondary drugs among those treated for cocaine were alcohol and cannabis. Alcohol was the secondary drug most frequently mentioned among those treated in Spain (39.7%) and the Netherlands (20.6%). Cannabis was cited by 32.5% of those treated in Spain, and in 15.5% of those treated in the Netherlands. Other drugs mentioned in an important proportion of those treated were stimulants (11.6% in Spain and 6.6% in the Netherlands); opiates (17.3% in the Netherlands and 10% in Spain) (Tables O2/1.0, O2/2.0) mainly heroin.

4.11.5 Amphetamines

In 2001, five countries (Denmark, Finland, the Netherlands, Spain and Sweden) reported 30 or more cases with information on secondary drug use among those treated for amphetamines. The most commonly cited secondary drugs were cannabis, alcohol, cocaine, and MDMA and other derivatives. Cannabis was the most frequently mentioned secondary drug in Finland (48.1%), Spain (51.5%) and Sweden (41.3%), and was the most cited secondary drug in Denmark (49.4%). In the Netherlands, however, cannabis was mentioned by a much smaller proportion of those treated for amphetamines (15.3%). Alcohol was the most frequently cited drug in Denmark (53.2%) and was in second place in Spain (40.9%). In the Netherlands, in contrast, cocaine was the secondary drug most often mentioned (17.8%). The proportion of those treated who mentioned cocaine ranged between 0% in Finland and 37.1% in Spain. MDMA and other derivatives was also cited by a certain proportion of those treated in all five countries (range: 5.2%-31.6%), and the same occurred in the case of hypnotics/sedatives (range: 2.5%-27.3%) and the opiates (range: 3.2%-16.1%) (Tables O31/1.1, O31/2.1).

In 2000, five countries (Finland, Italy, the Netherlands, Spain and Sweden) reported 30 or more cases with information on secondary drug use among those treated for amphetamines. The most often cited secondary drugs were cannabis, alcohol, and cocaine. Cannabis was the most often cited secondary drug in Finland (42.4%) and Sweden (34.9%), and was the second most cited drug in Spain (36.9%) and the Netherlands (15.2%). Alcohol was the most often mentioned drug in Spain (37.5%). Finally, cocaine was the most commonly cited drug in Italy (28%), and MDMA and other derivatives in the Netherlands (23.2%) (Tables O31/1.0, O31/2.0).

4.11.6 MDMA and other derivatives

In 2001, three countries (the Netherlands, Spain and Sweden) reported 30 or more cases with information on secondary drug use among persons treated for MDMA and other derivatives. The most often cited secondary drugs were cannabis, cocaine, alcohol and amphetamines. Cannabis was the most frequently cited secondary drug in all three countries (range: 23.3%-48.5%). Cocaine was the most often cited secondary drug in Spain (38.1%) and the Netherlands (22.1%), while this was the case for amphetamines in Sweden (37.5%). The proportion of those treated who mentioned alcohol varied between 12.8% in the Netherlands and 36% in Spain (Tables O32/1.1, O32/2.1).

In 2000, four countries (Finland, Italy, the Netherlands and Spain) reported 30 or more cases with information on secondary drug use among those treated for MDMA and other derivatives. The most commonly cited secondary drugs were cannabis, cocaine and alcohol. Cannabis was the most often cited secondary drug in the Netherlands (27.5%) and Sweden (38.9%), and was the second most cited drug in Spain (40%) and the Finland (16.1%). Alcohol was the most frequently cited drug in the Netherlands (27.5%), and the third most frequently cited one in Spain (38.3%) and Finland (12.9%). Cocaine was the most often cited in Spain (42.5%) and was also mentioned in a considerable proportion of those treated in the Netherlands (20.9%). In Finland the most often cited drugs were amphetamines (54.8%), and in Italy, the hypnotics/sedatives (32%) (Tables O32/1.0, O32/2.0).

4.11.7 Hypnotics/Sedatives

In 2001, three countries (Finland, the Netherlands and Spain) reported 30 or more cases with information on the use of secondary drugs among persons treated for hypnotics/sedatives. The most often cited secondary drugs among those treated were alcohol (range: 25.4%-28.3%), cannabis (range: 2.1%-17.3%) and opiates (range: 4.8%-14.5%) (Tables O4/1.1, O4/2.1).

In 2000, seven countries (Finland, Germany, Ireland, Italy, the Netherlands, Spain and Sweden) reported 30 or more cases with information on the use of secondary drugs among those treated for hypnotics/sedatives. The most often cited secondary drugs among those treated for these drugs were alcohol (range: 19.9%-37.6%), cannabis (range: 3.6%-33.3%), opiates (range: 1.8%-17.9%) and cocaine (range: .0%-18%) (Tables O4/1.0, O4/2.0).

4.11.8 Cannabis

In 2001, six countries (Denmark, Finland, Greece, the Netherlands, Spain and Sweden) reported 30 or more cases with information on secondary drug use among persons treated for cannabis. The most often cited secondary drugs were alcohol, amphetamines, cocaine and opiates. Alcohol was the most frequently cited secondary drug in three countries (17.1% in the Netherlands, 27.3% in Spain, and 34.4% in Finland) and was in second place in 28.9% in Denmark and in third place in Sweden (18.6%). Stimulants, mainly amphetamines, were the most often cited secondary drugs in Denmark (33.3%) and Sweden (39.9%), while this was the case for heroin in Greece (17.5%) (Tables O7/1.1, O7/2.1).

In 2000, seven countries (Finland, Greece, Ireland, Italy, the Netherlands, Sweden and Spain) reported 30 or more cases with information on secondary drug use among those treated for cannabis. The most commonly cited secondary drugs were alcohol, stimulants (amphetamines and MDMA). Alcohol was the most often cited secondary drug in Finland (29.7%), the Netherlands (16.2%) and Spain (25.3%), and was the second most cited drug in Italy (28.8%), Sweden (18.7%) and Ireland (12.8%). Opiates was the most frequently cited drug in Italy (97.5%) and Greece (16.7%). Stimulants was the most often cited in Ireland, mainly MDMA and other derivatives, (45.1%) and in Sweden, mainly amphetamines, (31.3%). Cocaine was in second place in Spain (20.5%) and the Netherlands (9.7%) and benzodiazepines in Greece (14.6%) (Tables O7/1.0, O7/2.0).

5. Inpatient Treatment Centres

5.1 Number of reported cases

In 2000, five countries reported cases of admission to treatment for drugs in inpatient centres: Finland (1018 cases), Greece (468), Ireland (1035), Luxembourg (180) and Sweden (1136). (Table O-I/1.0). In 2001, reports were received from four countries: Denmark (444 cases), Finland (1264), Greece (1494) and Sweden (2266) (Table O-I/1.1). ■

5.2 First treatment or previously treated

In 2001, most clients reported by inpatient centres in Sweden (77.7%), Denmark (74.6%) and Finland (79.2%) had been previously treated. In Greece, however, less than half the cases had been previously treated (46.1%) (Table O-I/1.1)

Most clients reported by inpatient centres in 2000 in Luxembourg (96.1%), Finland (84.5%) and Sweden (82.8%) had been previously treated. However, in Ireland (39.4%) and Greece (40.2%), the proportion was less than half (Table O-I/1.0).■

5.3 Source of referral

In 2001, among all persons treated, the most frequent source of referral to inpatient treatment in Finland (57.2%) and Sweden (52.3%) was health/social services, followed by self-referrals, while in Greece it was family/friends (45.8%), followed by self-referrals (32.8%) (Table O-I/1.1).■

The situation was somewhat different in 2000. In Greece (66.1%) and Luxembourg (82.1%), self-referrals predominated, whereas in Finland (55.5%), Sweden (48.1%) and Ireland (36.1%), the most frequent source of referral was health/social services. Family/friends and court/probation/police were generally more important sources of referral among those receiving first-ever treatment (Table O-I/1.0, O-I/2.0).■

5.4 Sociodemographic characteristics

5.4.1 Gender

In 2001, the proportion of men varied from 70.7% in Finland to 88.1% in Greece. Among persons admitted to treatment for the first time, the situation was quite similar. In 2000, the proportion of men varied from 71.0% in Sweden to 86.3% in Greece (Tables O-I/1.1 & O-I/2.1)

5.4.2 Age

In 2001, the mean age of clients admitted to treatment varied from 26.3 years in Greece to 31.9 years in Sweden. Most clients were in the 20-29 year age group. The mean age of those treated for the first time was younger than that of all persons treated (range: 24.0-30.8 years) (Tables O-I/1.1).

In 2000, the mean age of clients admitted to treatment varied from 23.6 years in Ireland to 32.2 years in Sweden (Tables O-I/1.0).

5.4.3 Highest educational level completed

In 2001, among all persons treated, most cases reported from Finland, Sweden and Denmark had completed the primary level of education, whereas in Greece most had completed the secondary level. In any case, the proportion of inpatients who had primary or lower educational level varied widely (range: 26.4% in Greece to 73.3% in Finland). These differences may well be partly due to differences among the different educational systems or to differences in how the same educational level is classified. (Tables O-I/1.1).

In 2000, most cases reported from Finland, Sweden, and Luxembourg had completed the primary level of education; in contrast, in Greece and Ireland, most persons had secondary education. The proportion of inpatients with primary education or lower varied widely by country (range: 30.3% in Greece to 73.7% in Finland) (Tables O-I/1.0).

5.4.4 Labour status

In 2001, among all persons treated, most inpatients were unemployed or in other situations. In any case, the proportion of those employed varied among countries, from 5.1% in Denmark to 14.7% in Greece. Likewise, among those in first treatment, only a minority were employed, ranging from 8.6% in Denmark to 19% in Sweden (Tables O-I/1.1, O-I/2.1).

The situation in 2000 was similar. Among all persons treated, most were unemployed or in other situations. The proportion of employed persons varied among countries, from 6.1% in Finland to 23.7% in Luxembourg. Among persons in first

treatment as well, only a minority were employed, ranging from 11.5% in Finland to 25.3% in Ireland (Tables O-I/1.0, O-I/2.0).

5.4.5 Living status (with whom)

Among all inpatients treated in 2001, most lived alone (Denmark, Sweden) or with family/friends (Greece). The proportion of persons living alone varied between 6.5% in Greece and 77.5% in Denmark. The proportion of those living with family/friends varied between 22.5% in Denmark and 86.3% in Greece. In 2000, the most frequent category in Finland, Greece, Ireland and Luxembourg was living with family/friends; in Sweden, in contrast, it was living alone. The proportion of cases in this category varied between 6.7% in Ireland and 64% in Sweden (Tables O-I/1.1, O-I/1.0).

5.4.6 Living status (Where)

Among all persons treated in 2001, most inpatients in all countries with information on this variable lived in stable accommodation (Denmark, Finland, Greece and Sweden). The proportion of inpatients living in unstable accommodation varied between 2.6% in Greece and 31.1% in Sweden. Sweden had a relatively large proportion of persons living in institutions (18.1%). In 2000, the most frequent category in all countries with information available (Finland, Greece, Luxembourg and Sweden) was also living in stable accommodation. The proportion of inpatients in unstable accommodation varied between 6.2% in Greece and 31.8% in Finland. Some countries like Luxembourg (18.1%) and Sweden (14.5%) had a relatively large proportion of persons living in institutions (Tables O-I/1.1 O-I/1.0).

5.4.7 Nationality

Among all persons treated in 2001 in all countries with information on this variable (Denmark, Finland, Greece and Sweden), most (over 90%) of persons admitted to treatment were nationals of an EU country. The proportion of foreigners (nationals of non-EU countries) ranged from 1.1% in Finland to 9.6% in Sweden.. The situation was similar in 2000. The proportion of foreigners in countries with information available (Finland, Greece, Ireland, Luxembourg and Sweden) ranged from 0.4% in Ireland to 8.6% in Luxembourg (Tables O-I/1.1, O-I/1.0).

5.5 Primary drug

Among all persons treated in 2001, in three of the four countries with information (Denmark, Greece and Sweden), the drug group motivating the largest number of treatments was the *opiates*. In contrast, in Finland it was the *stimulants* (37.7%). The proportion of treatments motivated by opiates varied between 92% in Greece and 33% in Finland. In Denmark (45.2%), Greece (91.6%) and Sweden (39.6%) the most commonly cited opiate as the primary drug was heroin, but in Finland (17.6%) the number of persons citing opiates other than heroin or methadone was larger than those who cited heroin as the primary drug. In Denmark (17%) and Greece (4.9%), the drug group motivating the second largest number of treatments was *cannabis* derivatives, whereas in Sweden it was the stimulants. The proportion of treatments motivated by cannabis varied between 4.9% in Greece and 18.9% in Finland. The *stimulants* were responsible for a considerable number of treatments in Sweden (38.7%) and Finland (37.7%). The most frequently involved stimulants in both countries were amphetamines (Tables O-I/1.1).

The situation is somewhat different with regard to first-ever treatments, in which the opiates are generally less important than cannabis or stimulants. In fact, in 2001 among inpatients treated for the first time, the opiates were the group of substances that motivated the largest number of treatments in Denmark and Greece, while this was the case for the stimulants in Finland and Sweden. The proportion of treatments for cannabis varied between 7.6% in Greece and 27.2% in Finland; the proportion of treatments for opiates, between 26.7% in Finland and 89.7% in Greece; and the proportion of treatments for stimulants, between 0.1% in Greece and 40.8% in Sweden (Tables O-I/2.1).

The situation in 2000 was similar to that of 2001. In Greece, Ireland, Luxembourg and Sweden, the drug group motivating the largest number of treatments among all persons treated was the *opiates*, while in Finland it was the *stimulants*. The proportion of treatments motivated by opiates varied between 28.4% in Finland and 94.2% in Greece. In all countries, the opiate most commonly cited as the primary drug was heroin. In Greece and Ireland the drug group responsible for the second largest number of treatments was *cannabis* derivatives, while in Finland it was the opiates; in Sweden, the stimulants; and in Luxembourg, cocaine. The proportion of treatments motivated by cannabis varied between 3.8% in Greece and 38.8% in

Ireland. *Cocaine* was responsible for an important proportion of treatments only in Luxembourg (6.3%). The *stimulants* motivated a substantial proportion of treatments in Finland (44.3%) and Sweden (34.7%). The amphetamines were the most frequently involved stimulants in Sweden and Finland. The *hypnotics/sedatives* were responsible for 9.8% of treatments among inpatients in Finland and 7.6% in Sweden (Table O-I/1.0).

With regard to first-ever treatments, the situation is somewhat different, with the opiates generally losing importance to cannabis and the stimulants. In fact, in 2000, among inpatients treated for the first time, the opiates were the substance group motivating the largest number of treatments in Greece, while this was the case for cannabis in one country, Ireland (43.5%), and for the stimulants in Finland (39.5%) and Sweden (37.2%). The proportion of treatments for cannabis varied between 6.1% in Greece and 43.5% in Ireland; the proportion of treatments for opiates between 90.4% in Greece and 24.2% in Finland and the proportion of treatments for stimulants between 0.4% in Greece and 39.5% in Finland (Table O-I/2.0).

5.6 Injection of any drug

In 2001, over 50% of those admitted to treatment for any drug in inpatient centres were current injectors in Greece (61.4%), Finland (57.5%) and Sweden (52.9%). In contrast, current injectors made up only 33.9% of this group in Denmark. However, if we consider the proportion among those treated who have ever injected drugs, the figures rise substantially, exceeding 80% in Greece, Finland and Sweden, and reaching 62.4% in Denmark. If we consider only those treated for the first time, it can be seen that the proportion of current injectors is lower than in all persons treated, ranging between 16.1% in Denmark and 58.6% in Greece. With regard to the proportion of lifetime injectors, the figures increase, exceeding 60% in Greece, Finland and Sweden, and reaching 48.3% in Denmark (Table O-I/1.1, O-I/2.1).

In 2000, among all inpatients admitted to treatment for any drug, the proportion of current injectors varied between 14.6% in Ireland and 89.8% in Luxembourg. However, if we consider only persons that have ever injected drugs, the figures rise considerably, ranging from 30.5% in Ireland to 96.6% in Luxembourg. Persons treated for the first time have a smaller proportion of current injectors than do all

persons treated, varying between 10.4% in Ireland and 75.6% in Greece (Table O-I/1.0, O-I/2.0).

6. Comparison with persons treated in outpatient centres

In 2001, as compared with persons treated in outpatient centres, those treated in inpatient centres had a smaller proportion of those who had never been treated before (first-ever treatments), of self-referrals, and of persons referred by family/friends or by court/probation/police. The proportion of persons referred by health/social services was larger among inpatients.

With regard to sociodemographic characteristics, persons treated in inpatient centres had a larger proportion of persons who lived alone, who had unstable accommodation, and who were unemployed. With regard to age and sex, the direction of the differences varied depending on the country. The mean inpatient age was higher than that of outpatients in Finland and Sweden, was similar in Denmark, and was lower in Greece. The proportion of females was lower in Greece and Sweden, similar in Denmark and higher in Finland. No major differences with regard to educational level were observed, except in the case of Sweden where the proportion of persons with primary education or lower was larger among inpatients than among outpatients. With regard to the primary drug, inpatients generally had a higher proportion of persons treated for opiates or stimulants and a smaller proportion of persons treated for cannabis. In addition, the proportion of current injectors was higher among inpatients than among outpatients. The differences were similar among those treated for the first time (Table O-I/1.1, O-I/2.1).

In 2000, the situation was less consistent than in 2001. The proportion of persons never treated before (first-ever treatments) was smaller in inpatient centres than in outpatient centres in Finland and Sweden, was larger in Ireland, and was similar in Greece and Luxembourg. With regard to the source of referral, the situation was also inconsistent. Among inpatients, the proportion of self-referrals was smaller than among outpatients in Finland and Ireland, was larger in Greece and Luxembourg, and was similar in Sweden. The proportion of persons referred by family/friends was lower in inpatients, except in Ireland. Finally, the proportion of those referred by

health/social services was larger among inpatients than among outpatients in Finland and Sweden, was similar in Ireland, and was smaller in Greece and Luxembourg. With regard to sociodemographic characteristics, there was a larger proportion of persons who lived alone, in unstable accommodation, were unemployed (except in Sweden in the latter case), and a smaller proportion of females. With regard to age, the direction of the differences varied depending on the country. The mean age of inpatients was higher than that of outpatients in Finland, similar in Sweden and Luxembourg, and lower in Greece and Ireland. Finally, with regard to educational level, the proportion of inpatients with primary level education or lower was smaller than that of outpatients in Finland, Ireland and Luxembourg, and was larger in Greece and Sweden. With respect to the primary drug, inpatients generally had a larger proportion of persons treated for stimulants and a smaller proportion of those treated for cannabis. The direction of the differences between inpatients and outpatients with regard to the proportion of those treated for opiates was different depending on the country: in Greece, Luxembourg and Sweden it was higher among inpatients, but in Finland and Ireland it was higher among outpatients. Finally, the proportion of current injectors was generally higher among inpatients than among outpatients, although in Ireland the opposite was observed. The differences between inpatients and outpatients were similar among persons receiving treatment for the first time (Table O-I/1.0, O-I/2.0).

7. Discussion and Limitations

Treatment-monitoring systems are one of the major information sources for drug epidemiology and demand reduction. A network of treatment centres (public and private) is available in all Member States.

Treatment information is not available from all the Member States. In recent years, not all countries have implemented the TDI or modified their current treatment indicators to converge with TDI. The results presented in this paper show that it will take more time for Member States to fully implement and harmonise their treatment indicator with the TDI, and that the objective of achieving national indicators that are compatible and comparable with the TDI has not yet been reached. Less than half of countries lack information on drug treatments, for a variety of reasons. Other

countries have not made the changes needed to make their indicator 100% compatible with the TDI.

It is well known that differences in the availability and use of drug treatment services could bias these results. Most countries have different kinds of treatment facilities. The network of drug treatment centres has changed in the last decade; methadone programmes have expanded, and new low threshold services have made treatment entry easier. These changes in treatment services have affected treatment figures and also affect the problem of double counting.

Differences in coverage among Member States affect data comparability. Not all countries fill in the table with information on treatment units. From the information available, we know that 11 countries report data for outpatient treatment centres, but that coverage is higher than 70% of these centres in just five of these countries. Another group of countries cover only 30-40% of these centres, while in other countries coverage is under 20%. Another question is whether the network of treatment centres is extensive enough to meet all treatment demands. Six countries have reported inpatient data, two low threshold data, two GPs data, and two treatment units in prisons data. Thus, not only do almost all Member States need to make data available on some types of treatment units, but also most countries have yet to reach full coverage of their outpatient centres. (Table 1, Figure F).

After analysing the methodological information reported by the Member States, it can be concluded that each country's definition of what constitutes a treatment case/episode is, if not the same, at least acceptably compatible with the TDI definition (Table 2). As far as item compatibility is concerned, there are several problems: not all Member States are covering the entire core set of items of the TDI protocol. How can we consider including additional information items when some countries are not yet collecting information on items already included in the TDI protocol? A few Member States have not modified the items that do not fit the TDI definitions and categories. These countries must adapt these items and categories before their data on drug users can be considered compatible with the TDI items. (Table 3).

TDI collects information on persons who start treatment for their drug use at a treatment centre during a given period of time. (one calendar year). Each person should be counted only once in the period. The level of control of double counting is

not the same in all Member States. There are countries at all levels of the scale. At the bottom of the scale, the countries with no control of double counting, others with a very limited control, a few with control of double counting at treatment centre level, others with control at regional level and the rest with national control, at the top of the scale. It is difficult to know exactly how double counting is affecting the data. (Table 4).

It is difficult to calculate the percentages due to inconsistencies in the tables, as can be seen by examining the steps necessary to calculate the percentage of clients admitted to treatment for a particular drug. First, there are seven different tables in which the primary drug is crossed with other variables. Second, there is a problem with the design of the tables because they do not include missing cases. Third, because of the aforementioned problem, the totals by type of drug are different in each table. In order to calculate the percentages, however, a single denominator is needed for each drug, rather than a different total for each calculation related with the same drug. Thus, it is necessary to examine all the tables to find the one that does not have any missing cases and determine the true number of admissions to treatment for each primary drug. This is the number that should be used to calculate the percentages. In some cases this was not possible, so it was necessary to use the number with the smallest number of missing cases. The TDI tables will need to be modified to correct this problem and facilitate automatic calculation of the percentages.

The number of missing cases for each item is another limitation related with the reporting method used to send data to the EMCDDA. This problem is due not only to the design of the Excel spreadsheets but also to the difficulty of filling in the tables, as it is quite easy to make errors when entering data. More information is needed about the quality of each of the items. The number of missing cases for many variables is often unknown.

The tables include the number of missing cases for the primary drug. The primary drug as defined in the TDI protocol refers to the drug that causes the client the most problems, based on problems as defined by clients or based on ICD-10 diagnoses. Therefore it may be appropriate to include the category "not known" in the tables.

In most countries, the tables are not internally consistent. For example, the row totals for each drug should be the same in all the tables for a particular country, but

this is often not the case, due to problems with the design of the tables or with the definition of what constitutes “not known”.

8. Conclusions

It is essential that treatment-related data be interpreted in the context in which they are collected. As already mentioned, differences in definitions still exist and these differences must continue to be taken into account.

In addition, the quantity and type of treatment services offered provide important background information.

Finally, we conclude that there are significant deficiencies in the way many of the National Focal Points report treatment data to the EMCDDA. For example, tables are often not completely filled in, information on coverage and methodology is not provided or is incomplete, there are data entry errors, etc. Although the National Focal Points are making an effort to comply with the TDI protocol, much remains to be done to improve the quality of the data..

More detailed research is needed about the characteristics of clients treated for their problematic drug use in the European Union. We need to keep in mind how data will be used when making recommendation as to how the data collection system should be modified. If more detailed information is needed to study characteristics, trends and new patterns of use of clients admitted to drug treatment, the problems related with the reporting system should be resolved as soon as possible.

9. Recommendations

The great efforts of the Member States to develop the TDI protocol should be highlighted. It should also be pointed out that, despite these efforts, the quality and reliability of the TDI data in Member States need to be improved. As has been shown in this report, the quality of the data in some countries is deficient. The National Focal Points are required to harmonise the TDI, as was agreed by all the Member States experts.

More detailed information about characteristics of the drug treatment network is needed. This information would facilitate the interpretation of data analysis. Also, Member States and new Members should carry out a validation study to assess the validity and quality of drug treatment data.

It is difficult to understand why some countries include information on drug treatments in the national report, but do not report TDI tables or tables 03 and 04. Making more use of the data and disseminating the results more widely are likely to motivate improvements in the quality of data reported, although the limitations of some drug treatment data reported should be kept in mind.

At the Manchester meeting in March 2003, a proposal was made to develop a toolkit showing examples of how some Member States have managed to improve data coverage and quality. Such an instrument would be very useful for other countries that continue to have problems and for those that are in an initial stage. Information on their activities would greatly contribute to the development of a global picture on this issue. Although measures that are valid in one country are not necessarily appropriate elsewhere, the toolkit could be used as a starting point. It should also be noted that the most important factors in reaching complete coverage are the legal framework, the political situation and the regional organisation. These factors differ enormously among countries and are difficult to modify.

Member States are at different stages of developing the TDI and so may have different priorities, as has been clearly pointed out in this report. It is desirable to concentrate initial efforts on outpatient and inpatient data and to improve the coverage of agencies and clients from these two types of centres. By no means does this imply that countries should focus only on these two types of centres. Rather, these should be the priority so that some comparable treatment data will be available at the European level. Improved data collection for the other types of treatment units should be developed in a second phase.

There is general agreement that the tables for reporting treatment data are difficult to fill in. This task is difficult and takes many hours; the probability of error is high, and cross checking the tables is a complex process. Because of such problems, modifications of the reporting system are needed. The spreadsheet should be simplified. It is not easy to find a successful solution for all countries. Probably the

best way to avoid internal inconsistency and facilitate completion of the tables is to make the structure of the tables more uniform. A working group of Member States may be able to reach agreement on a solution.

Although it will not be easy to solve all the problems involved in the reporting system, some recommendations are outlined below. Obviously some of them will be easier to implement than others.

First, small but important changes need to be made to the tables. Consideration should be given to adding a new column and row for missing cases and modifying the formulas to allow zeros in all the cells. It is critically important to distinguish between information not available and zero cases for a specific item.

The second recommendation consists of eliminating some tables because the information contained can be found in other tables, and of adding other tables into two to obtain more detailed information on some variables. Specifically,

Eliminate:

Table "4. Previously treated"

Table "7. Age by gender" (The same data can be found in tables 14.1,2,3).

Table "19.1,2,3 Other drugs by age"

Table "20. Ever injected"

Add:

Table "9. Living status (with whom)" by all and first treatment

Table "10. Living status (where)" by all and first treatment

Table "11. Nationality" by all and first treatment

Table "14. 1st drug by ever treated" by gender

Table "20.1 Ever injected (drugs)" by gender

and Implement changes recommended in the first proposal.

The third recommendation is to assure internal consistency and completion of the tables by making their structure more uniform. We are very much in favour of this option. This means there would be two main tables, one for all treatments and the other for first treatments. Each of them would have three dimensions. The TDI items would be in the banner (columns), the primary drug in the stub (rows), and gender in the layer (third dimension).

The fourth and final recommendation is to create a databank on National Treatment Demand. That is, Member States should report individual records to the EMCDDA. Even though this is quite complicated, we are convinced that the databank will ultimately be essential. Given the problems with the current system, however, it is probably best to postpone implementation of this proposal until a later date.

The TDI should be used to establish a standard baseline for comparisons. All the results presented in this report lead to the same conclusion. This is a major challenge that will not be easy to achieve. The EMCDDA and the National Focal Points have a long way to go until this becomes a reality.

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