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European Monitoring Centre
for Drugs and Drug Addiction

IFT
Institut für Therapieforschung

FINAL REPORT

Feasibility study on the implementation of the proposals given in the final reports of REITOX sub-tasks on improving the quality and comparability of treatment reporting systems

Development of a Core Item List for Monitoring the Treatment of Drug Misusers (CIT 1.0)

EMCDDA project CT.97.EP.07

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Summary

One out of three central epidemiological indicators proposed by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA; Hartnoll 1998) for future development is based on treatment reporting systems. These sources can give valuable information on the scale and characteristics of the drugs phenomenon as well as on measures taken against these problems. These data are collected with limited financial effort within treatment services in the framework of the routine work done there. Information can be rather broad, as experts such as social workers and therapists with an extensive professional background in addictions collect the relevant data. Data on treated drug users are already available in many countries of the European Union, which makes this project especially promising as far as the collection of harmonised, representative information on drug related problems all over the European Union is concerned.

This project is part of the systematic development of a harmonised treatment indicator which could be used by all EU member states and help to make results from national statistics more comparable in future. The EMCDDA, which is in charge of this process, has funded this project (grant number CT.97.EP.07).

The project has been co-ordinated by R. Simon and T. Pfeiffer (IFT, München). The steering group supporting the work was composed from M. Donmall (Drug Misuse Research Unit, Manchester), A. Kokkevi (UMHRI, Athens), A. W. Ouwehand (IVZ/IVV, Utrecht), M. Stauffacher (Pompidou Group) and J. Vicente (EMCDDA). Experts for treatment demand were nominated by most National Focal Points. Other Focal Points themself took part in this project. Nearly all EU National Focal Points have been involved in the project. In addition, representatives from The Czech Republic, Estonia, Hungary and Latvia were participating in the expert meeting.

The project started on the basis of results reached in former studies. Especially the following projects had an important impact:

- The Pompidou Definitive Protocol developed by the Pompidou Group of Epidemiology Experts (Hartnoll, 1994).
- In sub-task 3.2 of the REITOX work plan for 1996/97 a first draft of a Core Item List for Treatment (CIT version 0) was developed by a group of experts, who were responsible for national monitoring systems in some of the EU member states (Simon & Tauscher, 1997). The basis of the draft has been the Pompidou Definitive Protocol and national experiences.
- In sub-task 3.1 of the REITOX work-plan for 1996/97 a quality check was done for several items of the Pompidou Protocol concerning missing values and inconsistencies between items (Kokkevi, 1997a).
- A specific project worked on the classification of treatment organisation and units. It finished with the development of a questionnaire, which included the respective categories (Kokkevi, 1997b).
- The problem of double-counting of persons who were treated more than once per year in the same or different units (double-counting) was discussed by a specific project, which reviewed the different solutions found in Europe and gave instructions how to solve this problem (Origer, 1996).

The most relevant results of these studies have been included in this report. A central output is the Core Item List for Treatment (CIT version 1.0). Written feedback on the national situation and needs as well as the outcome of the discussion which took place at an expert meeting in Lisbon in July 1998 are the basis of this report. Also definitions and standards from different sources, especially from the Pompidou Protocol, have been integrated into this report.

On the basis of the CIT 1.0 a more formal agreement on common standards with the Pompidou Group should be reached. Actions will take place in autumn 1998 to reach this goal. The next steps then will be to start the implementation of the CIT in the EU Member States and in those Central and Eastern European Countries (CEEC), which find this possible and appropriate at this moment. In parallel a formal decision concerning the CIT should be taken by the EMCDDA or the Management Board. After this first implementation phase an evaluation will be necessary to check the reliability of the items and find solutions for any kind of problems arising at national level with the collection, processing or transferral of these data.

Zusammenfassung

Einer der drei zentralen epidemiologischen Indikatoren, die die Europäische Beobachtungsstelle für Drogen und Drogensucht (EBDD) zur Weiterentwicklung vorgeschlagen hat (Hartnoll, 1998), basiert auf Behandlungsinformations- und Reportingsystemen. Diese Art von Quellen können wichtige Informationen über Ausmaß und Merkmale der Drogenproblematik geben ebenso wie über Maßnahmen, die gegen diese Probleme ergriffen wurden. Die Daten werden mit relativ kleinem finanziellen Aufwand innerhalb von Behandlungseinrichtungen im Rahmen der Routinearbeit erhoben, die dort geschieht. Die Informationen können dabei relativ breit erfaßt werden, da Fachleute wie Sozialarbeiter und Therapeuten mit einem breiten professionellen Hintergrund zum Thema Abhängigkeit die entsprechenden Daten erheben. Daten über behandelte Drogenkonsumenten sind in vielen Ländern der Europäischen Union bereits vorhanden. Dies macht das Projekt besonders vielversprechend, was die Sammlung von harmonisierten repräsentativen Informationen über drogenbezogene Probleme in der Europäischen Union angeht.

Dieses Projekt ist Teil der systematischen Entwicklung eines harmonisierten und vergleichbaren Behandlungsindikators, der in allen EU-Mitgliedsländern Verwendung finden kann und dazu beitragen soll, die Ergebnisse nationaler Statistiken in Zukunft besser vergleichbar zu machen. Die EBDD, die diesen Entwicklungsprozeß leitet, hat das Projekt unter der Nummer CT.97.EP.07 finanziell gefördert. Es wurde koordiniert durch R. Simon und T. Pfeiffer (IFT, München). Die Projektgruppe, die die Arbeit unterstützt hat, setzte sich zusammen aus M. Donmall (Drug Misuse Research Unit, Manchester), A. Kokkevi (UMHRI, Athen), A. W. Ouwehand (IVZ/IVV, Utrecht), M. Stauffacher (Pompidou-Group) und J. Vicente (EMCDDA). Die meisten Nationalen Knotenpunkte nominierten Experten für den Bereich Behandlungsnachfrage, andere nahmen die Aufgabe selbst war. Nahezu alle Nationalen Knotenpunkte innerhalb der EU beteiligten sich an dem Projekt. Zusätzlich nahmen Vertreter aus Estland, Lettland, Tschechien und Ungarn an dem Expertentreffen teil.

Das Projekt wurde auf der Basis der Ergebnisse früherer Studien durchgeführt. Insbesondere die folgenden Projekte hatten einen wichtigen Einfluß

- Das definitive Pompidou-Protokoll, das von der Pompidou-Group of Epidemiology Experts entwickelt wurde (Hartnoll, 1994).
- In Sub-Task 3.2 des REITOX-Arbeitsplans 1996/1997 wurde ein erster Entwurf einer Core-Item-List for Treatment (CIT Version 0) von einer Gruppe von Experten entwickelt, welche für nationale Monitoringsysteme in einigen EU-Mitgliedstaaten verantwortlich waren (Simon und Tauscher, 1997). Die Grundlage dieses Entwurfs war das Protokoll der Pompidou-Gruppe und nationaler Erfahrungen.
- In Sub-Task 3.1 des REITOX-Arbeitsplans 1996/1997 wurde eine Qualitätsüberprüfung von einigen Items des Pompidou-Protokolls durchgeführt. Es ging dabei um fehlende Werte und Inkonsistenzen zwischen Items (Kokkevi, 1997a).
- Ein spezifisches Projekt beschäftigte sich mit der Klassifikation von Behandlungsorganisation und Behandlungseinheiten. Es endete mit der Entwicklung eines Fragebogens, der entsprechende Kategorien formulierte (Kokkevi, 1997b).
- Das Problem der Doppelzählung von Personen, die während eines Jahres mehr als einmal in der gleichen oder in verschiedenen Einrichtungen behandelt werden (Doppelzählung) wurde in einem speziellen Projekt erörtert. Dieses stellt eine

Übersicht verschiedener Lösungen dar, die in Europa gefunden wurden und gab Hinweise auf mögliche Lösungen (Origer, 1996).

Die wichtigsten Ergebnisse dieser Studien sind in diesem Bericht enthalten. Ein zentrales Ergebnis ist die Core-Item-List for Treatment (CIT Version 1.0). Schriftliche Rückmeldungen über die nationale Situation und Bedürfnisse ebenso wie das Ergebnis der Diskussionen auf einem Expertenmeeting in Lissabon im Juli 1998 sind Grundlage diese Berichts. Definitionen und Standards aus anderen Quellen, insbesondere aus dem Pompidou-Protokoll wurden ebenfalls in den Bericht integriert.

Auf der Grundlage der CIT 1.0 sollte zunächst ein formelles Übereinkommen über gemeinsame Standards mit der Pompidou-Gruppe erreicht werden. Entsprechende Aktivitäten werden im Herbst 1998 stattfinden. Die nächsten Schritte werden dann darin bestehen, die Implementierung des CIT in den EU-Mitgliedstaaten und in den Mittel- und Ost-Europäischen Ländern (MOEL) zu beginnen, die dies im Augenblick als möglich und sinnvoll ansehen. Parallel dazu sollte eine formale Entscheidung bezüglich der CIT durch die EBDD oder ihren Verwaltungsrat getroffen werden. Nach dieser ersten Imlementierungsphase wird eine Evaluation notwendig sein, um die Reliabilität der Items zu überprüfen und Lösungen für verschiedene Probleme zu finden, die auf nationaler Ebene bei der Sammlung, Verarbeitung und Weiterleitung dieser Daten entstehen.

1 Introduction

1.1 Treatment monitoring for epidemiological purposes

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

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

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

1.2 The Pompidou Protocol as a first European standard

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

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

1.3 Former studies and previous EMCDDA projects

Some national systems (e.g. in Germany, the Netherlands and Spain) had been developed independently of the Pompidou Group, some of them already had a rather long history on their own when Pompidou started. Therefore, the EMCDDA Core Item List on Treatment (CIT) could not simply be a copy of the Pompidou protocol. This was used, however, as a reference and basis for discussion and development. Experiences from national or semi-national systems running in different European countries were also taken into account. Special attention has been put on specific methodological problems like the avoidance of double-counting for the definition of "treatment".

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

- in sub-task 3.2 of the REITOX work plan for 1996/97a first draft of a Core Item List for Treatment (CIT) was developed in a group of experts, who were responsible for national monitoring systems in some of the EU member states (Simon & Tauscher, 1997). The basis of the draft has been the Definitive Protocol developed by the Pompidou Group (Hartnoll, 1994)
- in sub-task 3.1 of the REITOX work-plan for 1996/97 a quality check was done for several items of the Pompidou Protocol concerning missing values and inconsistencies between items (Kokkevi, 1997a)
- a specific project worked on the classification of treatment organisation and units. It finished with the development of a questionnaire, which included the respective categories (Kokkevi, 1997b)
- the problem of double-counting of persons which were treated more than once per year in the same or different units (double-counting) was discussed by a specific project, which reviewed the different solutions found in Europe and gave instructions how to solve this problem (Origer, 1996).

1.4 The targets of this project

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

On the basis of the draft Core Item list for Treatment (CIT) developed in the previous project those countries who had not been involved in the discussion before were asked for support and participation. By written feedback on the basis of a questionnaire sent out by the co-ordinator of the project first information could be collected to gain an overall picture of the state of development in the EU member states. For each of the countries the National Focal Point was asked to nominate an expert for treatment monitoring. In some cases this expert was part of the NFP. In some instances for different reasons no expert was available. In this case the co-ordinator used information from former studies or other sources asking the NFP for correction and feedback on specific information. In some cases no information could be found at all.

The draft version of the CIT protocol and some methodological details were discussed at a meeting at the EMCDDA on July 6th and 7th. Also experts from some of

the CEEC countries participated, who were given the opportunity to include their specific needs and situation in the discussion at that stage. As three of the participating four countries are also in the pre-accession state to become members of the EU this is especially important.

For the selection of items for the CIT the basic criteria were defined as follows. They should:

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

The revised CIT is presented in this report. Methodological details and definitions have been added. Where it was found appropriate definitions from the Pompidou Protocol were used to further increase comparability. Recommendations are given for the next steps which are necessary to implement the common standard in the EU Member States.

As a next step the EMCDDA has sent out a call for tender for the first phase of the implementation for the CIT. The REITOX contract between the national Focal Points and the EMCDDA for 1998/99 will include as a new responsibility for them to support the harmonisation of key indicators. The first indicator to implement will be the CIT and in 1999 some countries should start to revise or set-up their national system in accordance to the CIT. In future it is planned to do a reliability and validity check on an international multi-site basis to make sure, that the items used fulfil basic methodological requirements.

2 The state of development

2.1 Drug treatment monitoring in the Member States of the European Union

This chapter gives an overview on the developmental state of treatment monitoring in the drug field in the Member States of the European Union. For this project the National Focal Points were asked to nominate experts in treatment monitoring as representatives of their country. Most information which are found below originate from these experts. Other information come from written sources, previous projects and from oral descriptions given at the expert meeting in July 1998 in Lisbon. All National Focal Points were asked to correct their countries description before it was published here.

Table 1. Representatives of the EU Member States

Country	Representative
Austria	Alfred UHL, LBI für Suchtforschung
Belgium	Luc BILS, CCAD Mark VANDERVEKEN, CTB-ODB
Denmark	Lene HAASTRUP, National Board of Health
Finland	Ari VIRTANEN, NFP
France	Jean-Michel COSTES, NFP
Germany	Roland SIMON, NFP
Greece	Anna KOKKEVI, NFP
Ireland	Mary O'BRIEN, NFP
Italy	Giovanni NICOLETTI, Ministero della Sanità
Luxembourg	Alain ORIGER, NFP
Portugal	Artur Valentim, NFP
Spain	Camillo Vazquez, NFP
Sweden	Vera Segraeus, National Board of Institutional Care
Netherlands	Anton W. Ouwehand, IVZ/IVV
United Kingdom	Michael Donmall, Drug Misuse Research Unit

In chapter 2.2 an general overview is given on the situation in the EU countries concerning national treatment monitoring. In chapter 2.3 definitions and procedures used by the national systems are described in a systematic way. Chapter 2.4 gives a description of the situation in four CEEC countries: the Czech Republic, Hungary, Estonia and Latvia. As these countries are not yet members of the EU they are described in an own chapter. As they only started to participate middle of 1998 and information was not available for all of the CEEC countries it was therefore decided not to include these data in the overview tables given in chapters 2.2 and 2.3.

2.1.1 Austria

In Austria a treatment monitoring system is under development since some years. Its introduction was decided upon in 1997. The system will contain an core item set based on the EMCDDA CIT and an unit form. An unique identifier according to the recommendations given in the final report on PADCTRS will be used to avoid double counting. Still there is an ongoing process of discussion between political institutions at national and Laender level and representatives from the treatment field. It is planned to follow the EMCDDA CIT as closely as possible

In Austria most treatment facilities keep some statistics to document their activities to their private and public sponsors. Those information are partly published in their annual reports but the annual reports are not aggregate to a national statistics and since there is no documentation standard, many of these systems are not even comparable.

Those institutions that fulfil a function within the Austrian Narcotics Law ("Treatment instead of Punishment") and receive funds from the federal ministry of health have been required for many years to document their activities to the ministry according to a very short standard form.

Since health is within the competence of the 9 federal states, all aspects that are not related to the narcotics law or to University institutions are state responsibility. Because of this the states pay for many of the facilities within their boundaries and therefore are in a position to ask for annual data as well. Some states demand more detailed information from their institutions and some collect much less information.

In close co-operation with the Austrian focal point the Ludwig-Boltzmann-Institute for Addiction Research was commissioned with a contract to develop a national documentation system for non-residential drug therapies. The project is to be finished by the end of August 1998. The contract consists of two distinct components.

- One is to revise and improve the existing standard form, the ministry of health uses, since this form had been heavily criticised in practise and since the ministry thought that it would make sense to adopt to European standards (EMCDDA CIT) as close as possible.
- The other is to develop a larger Instrument that could be the basis for an extended national documentation form within something like a national documentation system. The latter is to be as closely oriented to European Standards too (EMCDDA CIT and TUF). The decision how this is going to be implemented is postponed after the draft has been presented officially and has been discussed by the treatment facilities, the state authorities and the national authorities in this autumn, after the draft is presented to them.

The Austrian focal point and the Ludwig-Boltzmann-Institute for Addiction Research are considering ways to include unique identifiers according to the recommendations given in the final report on PADCTRS to exclude double counting of treatment demands. At the moment it cannot be realistically foreseen if this approach will be successful. This will largely depend on the reaction of all involved parties and if the strategy is considered in line with the Austrian data protection law by the responsible lawyers in the ministry.

2.1.2 Belgium

In Belgium, drug addicts by and large present for care to three types of services: in-

stitutions specialised in drug addiction, mental health centres and general practitioners. The breakdown between these three types varies from one region to another.

Various monitoring systems are currently running in Belgium. Some modifications have been made to improve comparisons.

The monitoring systems « CCAD », « VLIS » or « ADDIBRU » are used by specialised centres, « MEDARD » or « PSYFILE » by outpatient mental health services, and recently the RPM-MPG (minimal psychiatric data) in the inpatient health services. There is no similar monitoring system in use for general practitioners.

In 1996, a regional working group with representatives of the different monitoring system used in the country, developed an agreement on a list of core items. The procedure for implementation is still ongoing.

2.1.3 Denmark

In Denmark the number of problematic drug users is estimated at roughly 12.500 out of a population of 5.3 million. A register on drug abusers named IUS was founded in 1996.

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

In addition, new in-service training opportunities and increased support for research have supported the development of treatment. In this connection, on 1 January 1996 a new national register of drug abusers in treatment was established by the National Board of Health in co-operation with the Department of Psychiatric Demography at the Psychiatric Hospital in Aarhus, the Association of County Councils in Denmark, the Ministry of Health and the treatment centres. In the first phase it will be possible to see the numbers of persons undergoing treatment for drug abuse with a description of their situation and characteristics when they commence treatment. In a later phase it is intended that the register should be collated with other information, gradually providing more in-depth knowledge of the scope and development of the problems.

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

2.1.4 Finland

The Finnish Focal Point had its pilot testing of the treatment demand reporting system in September 1996. Forty-six treatment centres participated in the pilot project, out of which only four units are specialised in treating only drug problems. The reporting form which has been used was almost identical to the original Pompidou Treatment Demand Protocol. Data collection lasted for about three months. In general, treatment centres had a positive attitude towards the project. It is planned that data will be collected at national level by intake workers and therapists at the treatment demand contact of the client with the service. The Focal Point will be receiving individual data which will be identified through an anonymous code only to be decoded by the treatment unit. The coverage of treatment services will vary depending on the area.

At the moment statistical data on all out-patient treatment centres (general information on treatment of substance abusers; drugs abuse can't be separated) is available at the National Focal Point. Information according to Pompidou Treatment Demand Protocol is available on a voluntary basis on 30% of units (STAKES, National Drug Monitoring Centre). Besides over mentioned systems there exists a census of intoxicant-related cases in every social and health service (inpatient and outpatient) units every four years. The one-day census comprises of information about the social background of the patient, the treatment and the substance abused (drugs: cannabis, amphetamine, other narcotic drugs). The census is being implemented by the STAKES / Social Research unit for alcohol studies. Concerning the inpatient treatment centres about 80% of treatment units are within the social welfare care register. These are general information on treatment but drug abuse can be separated by ICD-10 codes on a voluntary basis. Thus ICD-10 codes are used only in 50% of the cases (STAKES / Statistics and Registers unit). Information according to the Pompidou Treatment Demand Protocol is available on about 35% of units. This system works on a voluntary basis too.

In Finland it is possible to identify all general practitioners that have legally prescribed narcotic drugs (mentioned in the Narcotics Degree) to patients.

Because the drug information system is just in a developing stage and the data are not analysed in depth more detailed questions concerning coverage and quality are too difficult to answer.

2.1.5 France

Specialised structures, designed to provide care for drug addicts were implemented by a law passed on December 31, 1970. This law also guarantees free and anonymous care for those who want it, both for withdrawal in public health establishments and treatment in specialised care settings set up for drug addicts; 60% of it is run by associations, and 40% by public hospitals. This is a more specific structure, compared to monitoring patients in the psychiatric sector, or compared to treatment provided for alcoholic patients.

The following is provided:

- Specialised out-patient drug addiction treatment centres (ensure global treatment for drug addicts).
- Specialised in-patient drug addiction treatment centres (residential therapeutic centres and therapeutic communities).
- Permanently staffed host areas, therapeutic-relay apartment networks, host family networks and transitional or emergency housing, run by specialised drug addiction treatment centres with or without available housing.
- Specialised drug treatment centres operating in prisons.
- Low threshold centres for addicts (information, syringe exchange, hygiene, rest, medical-social services).

Since January 1995, all of the specialised centres have been able to initiate prescribing methadone for drug addicts on opiates, when general medicine can only intervene by relay. Treating drug addicts with Subutex, a substitute product (high doses of Buprenorphine) has been possible by general practitioners in cities since February 1996.

Above and beyond the «low threshold centres», the harm reduction prevention policy for drug addicts usually offers prevention tools such as prevention kits, syringe exchange programs, and automated syringe distribution/collection machines. In this context emergency housing centres for drug addicts Integration workshop, programmes in prison and other help is offered.

The French monitoring system is different from all the other participant systems. The November survey has been conducted each year during the month of November since 1987. Before 1987, a different survey was conducted. This survey is a census: every person undergoing treatment for drug addiction during November in specialised centres, hospital services, or social services is included. They could have begun their treatment before November or during November.

The regional services are in charge of gathering the data and checking the questionnaires in their region. The national analysis is conducted by the «Studies and Information systems Service» (SESI) of the Ministry of Health.

2.1.6 Germany

At the start of the drugs problem in Germany, around 1970, drug addicts were initially treated in already established out-patient centres designed for alcoholics. Later more and more specialised counselling centres were created for drug addicts. According to a current survey by the Federal Ministry for Health there are at present around 1,100 out-patient counselling and treatment centres available. The majority of the centres have a focus towards the treatment of alcoholics or drug addicts.

For some years, considerations of health policy have also been applied to evaluate out-patient activities to care for people with drug-induced illnesses. Low-threshold services has increased in importance during the last years not only in methadone treatment programmes.

Throughout Germany, there are at present approximately 300 residential centres for the treatment of drug addiction. Most of these are specialised clinics and therapeutic communities, or specialised departments of psychiatric clinics.

Methadone substitution as part of treatment for drug addiction is regulated by the Ruling on the Prescription of Dangerous Drugs. The core of these guidelines is discrimination according to indications; substitution with methadone can only form part of the treatment if certain highly specific indications apply. In the case of other substances , particularly codeine and dihydrocodeine for patients in public health insurance plans, only the less specific rules of the Prescription Ruling apply; no such rules apply to private patients.

Besides the relatively small (local) systems, the main system for gathering information about treatment of drug addiction through out-patient centres is a data-collection system called EBIS, which is run by the IFT Institute for Therapy Research since 1980. EBIS gathers information about people who are being cared for in out-patient counselling and treatment centres because of problems with legal or illegal addictive substances. Approximately half the 1091 such centres in the Federal Republic are participating in this voluntary information system. EBIS has been run continuously since 1980 and is financially supported by the Federal Ministry for Health. The data from EBIS reveal long-term trends and basic data relating to the drug users treated. With approximately 60 items of data per person treated, EBIS is the most comprehensive routine source of information on people with addiction problems in Germany. It covers more than 100.000 clients per year of which about 20.000 are drug addicts

At a national level, a system called SEDOS run by the IFT is the main collector of data on the treatment of alcoholics and drug addicts in residential facilities. The SEDOS information system has been in existence since 1994. At present around 150 in-patient centres are involved in it. These are specialist clinics for drug addicts and/or alcoholics, psychiatric centres and transitional institutions such as hostels. For 1995, the second annual evaluation for SEDOS was presented, containing data on 17,000 people from 106 in-patient treatment centres who were treated that year.

There is an increasing willingness of other treatment organisations to collaborate with EBIS and SEDOS in order to built up a more comprehensive national database on treated persons. Additional data could add another 10-20% to the information at hands in EBIS and SEDOS.

2.1.7 Greece

In May 1994, the Greek REITOX Focal Point carried out a pilot study to test the ap-

plication of the adapted and translated Pompidou Treatment Demand Protocol, which is identical to the original Pompidou protocol with very few questions added to it. The implementation of the pilot study was satisfactory and for this reason the Greek REITOX Focal Point established the National Treatment Demand Reporting System, in co-operation with the treatment services in Greece, with the aim to study the size and the characteristics of drug users asking for treatment. The staff of all existing treatment services in the country agreed to participate in the development of the reporting system. People working in the treatment services were trained to administer the protocol at the first contact a drug user would have with the counselling unit of each service.

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

The reporting system is in its fifth year of development now. It covers less than 50% of the total number of treatment demands in the country, because not all treatment services available in Greece continue to participate in the system. In the second semester 1995 two major treatment services in greater Athens area (KE.TH.E.A. and 18 ANO) stopped providing the necessary information on the treatment demand indicator to the Greek Focal Point for reasons of confidentiality. However, in the same period two Pilot Methadone Substitution Programmes started operating and providing data into the system. The successful implementation of the Substitution Programmes led to their further continuation and expansion.

Finally, concerning the typology of the treatment centres participating in the reporting system, they are nine in total, two residential of which one inpatient psychiatric hospital and one therapeutic community, and seven non-residential.

2.1.8 Ireland

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

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

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

The Reporting System provides information on socio-demographic data, problem drug use and risk behaviours but it does not record the number of episodes. The definitions are as follows: ALL TREATMENT CONTACTS (all clients receiving treatment during a given year between 1 January and 31 December; if a client happens to have more than one episode of treatment in a given year this is not recorded) and FIRST TREATMENT CONTACTS (clients who have never previously been treated for drug misuse problem, anywhere).

There are approximately thirty centres throughout the country. Some of these centres make very few returns to the reporting system because the majority of their clients are treated for alcohol addiction. Most services are statutory specialised non-residential. Other services include statutory and voluntary specialised residential centres. Centres based in the general services and prisons are not as yet well represented in the system. All information given is based on data from the National Drug Treatment Reporting System i.e. clients, who receive treatment for problem drug use. There is almost complete coverage of treatment provision by the Reporting System, that is, except for treatment provided by general practitioners and units in prison. A study is currently underway with a view to rectifying this.

2.1.9 Italy

In Italy the main routine reporting system is based on the data collection about clients of the public service premises (Services for addicts - also known under the acronym of *SerT*s). A similar system on the private sector (mainly consisting of therapeutic communities) is still being implemented since a few years, but, owing to administrative problems, coverage of the system is still too low; however, since most (if not all) of the clients of the private sector are referred to the different centres by the public service, a series of information about these patients is also available.

As far as the public service is concerned, the actual system is co-ordinated by the Ministry of Health and is active since 1991 (revised 1997); however, a similar data collection (but with a more limited set of items and a different timing of data collection) has been co-ordinated by the Standing Drug Monitoring Centre on Drug Addiction of the Ministry of the Interior and was active from 1985 to 1996.

In the Monitoring system of the Ministry of Health the various premises (over 500) fill standardised forms and send them to the Ministry twice a year (punctual prevalence report) or once a year (annual report); the system was paper based until 1995, since then the units have the choice to fill the paper forms or an electronic version of them, which can be sent through E-mail to the central server. In some Regions (such as Lombardia, Lazio, Emilia-Romagna), the local authority collects by itself the data (in some instances through electronic systems, which are able to "extract" items from individual based data-bases located in the units) and send them afterwards to the Ministry, after performing some kind of quality assurance procedure.

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

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

Future aims are to implement individual data into data collection, standardise the software for data collection and data transfer and to enlarge the information to be collected . However, national experts expect that further enlargement of items collected, as foreseen in the draft European core item list, will raise at least three main problems: 1. Owing to the large number of units covered, data quality could be decreased; 2. A time-consuming agreement procedure between the national and the regional level will be required 3. Feasibility studies on collecting additional data will have to be done, in order to test the treatment units compliance as far as individual data collection is concerned.

2.1.10 Luxembourg

Established in 1994, the Luxembourgish Information Network on Drugs and Drug Addiction (RELIS-LINDDA) is based on a standardised data protocol including 24 core items and over 60 sub-items. 95% of the Pompidou protocol's items are integrated in the standard protocol. A second protocol namely «*Actualisation protocol*» is completed each time a previously known drug addict is re-indexed after a period of one year following the previous indexation. Finally a third protocol including only the identification code, the name of the institution and the date of admission is used if a previously known addict is re-indexed in the course of the year following his previous indexation. This registration system allows for updated quality data and for a follow up of institutional careers of drugs addicts by means of a minimum work load.

RELIS-LINDDA relies on the so called « *institutional contact indicator* » which means that the data providing network includes all specialised drug treatment institutions, police forces as well as custodial institutions. Efforts are currently made to reach participation of general practitioners and emergency rooms in the information network.

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

In order to avoid multiple counting and to allow for a follow up of drug users' careers, RELIS-LINDDA is based on a 9-digit numerical code obtained by indating the 3 variables (attributors) namely: Gender: 01/02, Date of birth: ex 10051967, Country of birth into a focal point proper code - calculator. This technical device was developed by the focal point's itself. The solution found is very time and cost effective because it relies on a simple HP calculator that runs a attributor-to-code transcription programme based on a 28 step algorithm.

There is no way to extract any individual information on the person the code belongs to and the transformation key is unknown to participating field institutions and to all members of the focal point. Even if one should discover the calculation algorithm he or she would be unable to do a backwards calculation. Each contact person of the participant field institutions disposes of such a calculator and produces the code by himself . The reliability in terms of data protection has recently been recognised by the National Commission for Informatics and Liberties (CNIL) of France.

One of the main assets of the described procedure is that no personal data can be inferred directly from the identification code. The indata and encoding procedures are carried out at the very level of the field institutions. Thus the Focal Point receives individualised data (reporting protocols) without getting any identificative information or attributors on the indexed persons which is undoubtedly one the major preoccupation of field institutions.

Since 1994, the Luxembourgish focal point has been commissioned to design and to implement a drug treatment reporting system according to the requirements of the EMCDDA and the information needs at the national level. Initiated by the Luxembourgish REITOX Focal Point and adopted by all members of the „Mondorf Group", which currently includes the ministers of Health of the Laenders of Saarland (Germany), and Rheinland-Pfalz (Germany), the Grand-Duchy of Luxembourg, the President of the region of Lorraine (France) and since 1994, a governmental representative of the German speaking Community of Belgium the project proposed in the

framework of Task 6.1 (REITOX 96/97 work programme) focuses on the design and the implementation of an inter-regional reporting system of epidemiological data in the field of drug addiction based on the yet existing national data reporting network RELIS-LINDDA.

The project renamed TRANS-RELIS in the course of its implementation currently involves the mentioned member regions of the „Mondorf Group“. Originally, the main objectives of the project intended to fulfil part of the REITOX 96/97 work programme covering sub-tasks 3.1/3.2/4.2/task 5 :

- harmonisation and evaluation of the applicability, at the international level, of the RELIS/LINDDA protocol which the Luxembourgish information network is based on,
- development, harmonisation and rationalisation of an inter-regional reporting system,
- sharing of administrative and human resources and research activities in the field of drugs and drug addiction as well as the development of a joint reflection regarding information and prevention strategies, in order to avoid multiplication of efforts,
- active development of communication tools, conception and improvement of telemetric infrastructures used by different participants.

TRANS-RELIS does not only provide a wide range of high quality epidemiological data within the five participating regions but also allows by means of an easy-to-handle anonymous identification code to avoid multiple counting, the follow up of «institutional careers» of drug addicts at an inter-regional level. This kind of data is of paramount importance if it comes to the evaluation of treatment impact and effectiveness and the planning of specialised and non-specialised drug care networks. Needless to add that the opportunity provided by TRANS-RELIS to assess treatment impact has lead to some major opposition from the field level.

The TRANS-RELIS network is fully operational now since May 1998, following the final agreement of the French data protection authority (CNIL) as regards the use of the algorithm based 9 digit code used to anonymously identify indexed drug addicts. An overall evaluation report of the 2 years implementation phase will be available in the course of 1999.

2.1.11 Netherlands

In the Netherlands, outpatient care and treatment is provided by the Institutes on Outpatient Addiction Care and Treatment (OAC´s) and one Municipal Health Organisation (Amsterdam). The OAC's consist of 17 former Consultation Bureaus for Alcohol and Drugs (CAD), with about 110 branches, and 15 independent low threshold services. Most of these organisations are now multi-addiction centres. They offer a variety of treatment and care options to problematic alcohol and drug users, ranging from detoxification to substitution programmes, pharmacotherapy, counselling, other forms of psychotherapy, aftercare, social work, low threshold activities and rehabilitation programmes. The Netherlands have one of the most developed and sophisticated treatment systems for drug addicts in Europe (*National report: the Netherlands 1996*, Utrecht, The Netherlands: Trimbos Institute).

LADIS is the nation-wide system for the collection of data on drug users in treatment. The system-holder is IVV (Organisation Information Systems on Addiction Care and Treatment) which has recently become part of the IVZ-organisation(Organisation Care Information Systems). Data storage and analysis is centralised at IVV and allows a control for double counting since the registration year 1994 at an institutional as well as on a national level . Allocation of a unique code to each client enables such corrections. This coding system is build in a special tailor-made softwareprogram for the Addiction Centres called ADDICTIS. This institutional information system is used by all centres in the Netherlands. It improves and protects the uniform data-collection by standardised automatic delivery to LADIS.

LADIS started in 1986. By 1988, all former CAD´s were participating in the LADIS system. Apart from the former CAD´s, all low threshold services now participate in LADIS. At the moment, LADIS covers about 90% of the outpatient treatment and care on Alcohol, Drugs and Gambling problems. The Municipal Health Organisation Amsterdam will start regular delivering of information in 1998. The IVV aims at full coverage in the near future. The inpatient activities are not (yet) in the system. Action is undertaken to combine information as soon as possible. Most drugclients are referred to inpatient clinics by an outpatient clinic. Therefore more than half of all the inpatient clients are already in the LADIS system. In 1997 25,202 unique persons were registered for drug problems. This covers about 75-85% of all estimated problematic harddrug users in the Netherlands (National Drugpolicypaper VWS 1996)

Every year IVV publishes a number of publications based on the National System LADIS. Around April there is a yearbook publication "Key-Figures". Next to that several books on Profiles of Clients such as "Women and Drugs, Harddrug users, Cannabis users and Ecstasy-users" and several studies on Alcohol-problems have been published. In 1997 a study was published called "TrendWise" in which ten years of national data from LADIS are analysed and estimates are given for the treatment demand in the year 2006 in the Netherlands. IVV has a website http://www.ivv.nl which contains all relevant information. In the Netherlands the Ministry of Health, Welfare and Sport has decided to organise a national drugmonitor in which all relevant information on drugs, drug abuse, drug-related problems and drugtreatment will be combined. The LADIS information will be an important part of this National Drugmonitor.

2.1.12 Portugal

S.P.T.T.(Serviço de Prevenção e Tratamento da Toxicodependência) is the most important Portuguese health care and specialised treatment service for drug addiction (only for illicit drugs). S.P.T.T. depends on the Ministry of Health and is part of the National Health Service. It includes 40 specialised out-patient treatment centres covering all the country, 5 detoxification centres, 3 day-care centres and 2 therapeutic communities. In S.P.T.T. information is produced in two ways:

1. The administrative monitoring system that collects data for the Annual Report of S.P.T.T. That information is gathered by all the centres during the year and provides data about the performance of the centres. That system doesn't collect data by patient, but by occurrence. "First Demand Treatment" and "Following Demand Treatments" are part of the indicators of that monitoring system. In 1997 there were about 200.000 "Following Demand Treatments" and about 9.000 "First Demand Treatments".
2. The administrative monitoring system doesn't provide information about the characteristics of the patients. For that purpose a survey is carried out during two days in the month of November of each year. That survey is a census of two days because it is answered by all patients that are examined in these two days. Most of the indicators of the "Core Item List" are included in the questionnaire of that survey.

In the public sphere there are also two hospitals of the National Health Service (one in Oporto and another in Lisbon) where specialised treatment services for drug addiction exist in the psychiatric departments. In the health centres of the National Health Service, the general practitioners are also engaged in the counselling of drug users. Recently a common protocol of specialised out-patient treatment centres of S.P.T.T. and some of the health centres has been established for the administration of methadone in these health centres under prescription of the specialised centres.

There isn't any monitoring system about drug treatment in these hospitals and in the health centres. A lot of organisations are growing in the private sphere. S.P.T.T. has a protocol with some private residential therapeutic communities (professionals and religious ones) to welcome patients. There isn't any information about patients in private organisations.

2.1.13 Spain

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

- Specific programmes: outpatient treatment centres, hospital detect units, day treatment centres, residential treatment centres and opiate substitution programmes.
- Harm reduction programmes: distribution of health kits, syringe exchange, promotion of lower risk practices and behaviour, vaccination against hepatitis, tuberculosis detection and control, AIDS prevention, etc.
- Social and judicial support programmes

The Spanish State Information System on Drug Abuse (SEIT) was established in 1987. It uses three indirect indicators that reflect the health effects of drug use: treatment, emergencies and mortality. From 1987 to 1995 all three indicators referred exclusively to opiates or cocaine. In order to be more flexible and comprehensive, the system was modified in 1996 to include all psychoactive substances with dependence potential. Changes introduced in the treatment indicators took into account the protocol of the treatment demand indicator of the Pompidou Group.

In addition to the SEIT monitoring system, there is a programme of periodical surveys of patients attending drug treatment services. These studies provide a better knowledge of social and health characteristics on the drug use phenomenon, in a sample of SEIT patients.

2.1.14 Sweden

Currently in Sweden there is no documentation system covering all treatment units. This year the Ministry has given an assignment to the Board of Social Welfare to investigate this question. This autumn the Swedish Focal Point will discuss the matter with representatives from the government and selected key-persons.

The existing documentation system created by IKM (Institute for Development of Knowledge about Treatment of Alcohol and Drug Misusers) and National Board of Institutional Care (SiS) covers only a smaller part of the treatment system until now, but probably it will grow in the coming years. It includes practically all Core Items and much more. To give some idea about clients in the Swedish treatment system information from the DOK system is given (knowing that it is not representative). Anyway there is almost total coverage from the second city in Sweden, Gotheburg, one middle-city, Sundsvall, and from sparely-populated areas.

To install a monitoring system in Sweden on a national level we need a political assignment and resources to build up a support system. Today we can not give any more concrete information on options and changes.

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

2.1.15 United Kingdom

The treatment and care system for drug users in England is based on a broad range of service provision including primary health care, specialised health and social care provided by a national network of Community Drug Teams, as well as inpatient (hospital based) and residential facilities (therapeutic communities) for acute detox, or other prescribing, and rehabilitation. Low threshold services, such as syringe exchanges and outreach facilities, are now widely established and service provision within prisons is being developed. The prescribing of substitute drugs (normally oral methadone) from statutory community based drug services is widespread. These prescriptions may take the form of short term detoxification, but are commonly longer term, the aim being to keep dependent drug users in touch with services. Much of the philosophy behind English drug treatment policy arose from a report issued by the ACMD in 1988 stating that, "*The spread of HIV is a greater danger to individual and public health than drug misuse"*.

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

More recently, (see Government White Paper, Tackling Drugs: to build a better Britain, 1998), and with the appointment of the Anti-Drugs Co-ordinator and his assistant ("Tzar and Deputy Tzar"), policy has become more explicitly broad based. Aiming for, "a healthy and confident society increasingly free from the harm caused by the misuse of drugs", policy has broadened from a public health focus to encompass the four areas of: young people, communities, treatment and availability.

Formerly only the Addicts Index (closed in 1997) was available to measure the number of drug users seeking treatment. This was limited to those dependent on certain opiates or cocaine who were seen by a doctor. However, a more extensive database was required to include more drugs, more agencies and more relevant information. The Department of Health saw the need to implement a system that would allow those who are responsible for policy and service planning to respond effectively to the changing trends in drug use, and to ensure the appropriate services are developed to meet their needs. In 1982 the ACMD recommended that local problem drug teams should be set up which would also collect information in a form capable of collation at both regional and national levels to enable a wider picture to be obtained. In 1984 the Department of Health and Social Security issued a circular (HC(84)14) which asked the National Health Service to review the prevalence of drug misuse locally and report back on the situation. In 1986 the Drug Misuse Database (DMD) was developed by the Drug Misuse Research Unit (DMRU) at the University of Manchester. In 1989 the Department commissioned DMRU to adapt DMD for use in other Regions. A DMD has now been established in each of the English Health Regions, as well as in Scotland, Wales and the Isle of Man. The National Network is coordinated by the DMRU along with the Department of Health.

The following agencies routinely report:

- General practice; NHS funded
- Community based drug service: statutory
- Community based drug service: non-statutory
- Drug Dependency Unit in-patient
- Drug Dependency Unit out-patient
- Residential rehabilitation
- Hospital drug clinics

The following agencies report in some areas

- Police surgeons
- Some hospital out-patient and in-patients.
- Day care services
- NHS Psychiatric wards
- Accident and emergency wards
- Private in-patient or out-patient facilities
- Probation offices
- Prison medical service
- Syringe Exchange Schemes

Approximately 700 separate agencies are known to report to the DMD. This does not include General Practitioners as individual GPs are not recorded as separate agencies.

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

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

Whilst the DMDs are regionally based, subsets of the data are downloaded to the Department of Health every six months, from which national statistical analyses are produced. Currently each six month bulletin (for England) describes about 26,000 new episodes of problem drug use.

2.2 Overview on national treatment monitoring systems

SR: specialised residential treatment centre
SO: specialised outpatient treatment centre
SL: specialised low threshold unit/ drop-in/ street agency
SP: specialised in prison
PDA: Person Drug Addicts
GR: general residential treatment centre
GO: general outpatient treatment centre
GP: General practitioners
OS: other services

Table 2. Overview on national treatment monitoring systems

Country	Inhabitants (million)	Estimated number of PDA (thousand)	Name of Monitoring System		Monitoring System started in (year)	Total number of treatment units in the country	treated persons covered by the sources/ the system	number of treated persons included per year
Austria	8,1	10-30	under construction			150 SO/SR	n.a.	n.a.
Belgium	10,1 (1996)	20 -25	National: under construction					
			VAD (Flanders):	regional	1980 1988	84 SO (MEDAR) 8 SR (VLIS)	100% 100%	3,550 SO 800 SR
			CCAD (French Community): Pompidou Protocol	regional	1992	35 SO 39 SR 10 S	80% 30% 30% total: 65-70%	2,400 all
			Brussels:	local	1997	12 SO 3 SR	80% 80%	2,500 all
Denmark	5,3	13	Register of drug abusers		1996	n.a.	3400 SR 90-95%	n.a
Finland	5,1	5-10	Pompidou Protocol		pilot testing in 1996	76 SO 47 SR <100 SL 6 SP (?)	41,300 SO 8,500 SR	--
France	58,2	160 heroin addicts	November-Survey (Census), SESI		1987	1,100	100 % of specialised centres;	65,000 SR/SO

Country	Inhabitants (million)	Estimated number of PDA (thousand)	Name of Monitoring System	Monitoring System started in (year)	Total number of treatment units in the country	treated persons covered by the sources/ the system	number of treated persons included per year
					SR/SO (200) GS (500 hospitals, 400 social services),	coverage for hospitals and social centres n.a.	number of treated persons in GS not available
Germany	81,5	100 - 150 hard-drug addicts	EBIS /SEDOS (National Monitoring System for the Outpatient / Inpatient Advisory and Treatment Facilities in Germany)	SO 1980 (EBIS) SR 1994 (SEDOS)	1100 SO 300 SR	550 SO = 50% of SO 120 SR = 40% of SR	20,000 SO (100,000 including other substances) 2,500 SR (12,500 including other substances)
Greece	10,3	not available	Pompidou Protocol plus additional items	1994	10 SO 6 SR	70% 50%	around 600
Ireland	3,6	5 (persons treated for problem drug use in 1996)	Drug Treatment Reporting System (DTRS) Pompidou Protocol	1990	45 SO/SR (detox included)	100% SO 100% SR 100% SL 0% GP total: 80 %	3,100 SO 1.200 SR 400 SL 154 SP
Italy	5753	250 - 280 heroin users	Ministry of Health Public Services Clients Annual Report	1985	490 SO	95% of SO	131,700 SO
Luxembourg	0,4	2	RELIS-LINDDA close to Pompidou Protocol	1994	2 SO 3 SR 2 SL	47%	400 SO 400 SR 500 SL 280-400 total
Netherlands	15,6	25 - 27 (hard-drug addicts)	LADIS (The Dutch National Alcohol and Drugs Information System	1986	22 SO/SL (130 units)	100% (25,202 unique persons)	25,200 SL/SO

Country	Inhabitants (million)	Estimated number of PDA (thousand)	Name of Monitoring System	Monitoring System started in (year)	Total number of treatment units in the country	treated persons covered by the sources/ the system	number of treated persons included per year
					13 SR 20 SP	50% (3,500 by referral SL/SO) 0% **75-80%** of total number of problematic drug users	2,000 SR 480 SP
Portugal	10,5	n.a.	S.P.T.T. statistics November survey (census)	n.a.	n.a.	43 SO 7 OS	200,000 Following treatment demands (1997) 9,000 First treatment demands (1997)
Spain	39,4	130 (hard-drug addicts)	SEIT (Spanish State Information System on Drug Abuse)	1987	421 SO	About 90% of the public and private subsidised SO	42,300 SO (opiates or cocaine only)
Sweden	8,0	14-20	DOK	n.a.	365 SO 360 SR 405 SL	66 voluntary care units 15 compulsory care units	1,767 persons in voluntary care 797 persons in compulsory care
United Kingdom	49,1 (England, 1996)	Treated 47 total: 150-200	DMD (Drug Misuse Database)	1986 (Local) 1990 (National)	650 SO/SR/GP	about 95 % of the treatment and care facilities in all regions in England plus Wales and Scotland	26,000 SO/SR/GP (new episodes per 6 month)

2.3 Overview on national definitions and processes

SR: specialised residential treatment centre
SO: specialised outpatient treatment centre
SL: specialised low threshold unit/ drop-in/ street agency
SP: specialised in prison
GR: general residential treatment centre
GO: general outpatient treatment centre
GP: General practitioners
OS: other services

Table 3. Overview on national definitions and processes

Country	Name of Monitoring System	Total Number of Treated Persons per Year	Definition of Treatment Episode	Case-Definition	Double counting avoided
Austria	under construction	n.a.	n.a.	n.a.	n.a.
Belgium	National under construction				
	VAD (Flanders) regional	3,550 SO 800 SR	Beginning and end of treatment	person admitted for treatment during the calendar year	yes, at centre level since 1997
	CCAD (French Community): regional	2,400	idem	idem	idem
	Brussels local	2,500	idem	idem	idem
Denmark	Register of drug abusers		Begin and end of treatment	person admitted for treatment at a treatment centre during the calendar year	yes using unique civil service numbers
Finland		46,000 (general substance abusers)	Period a patient is in treatment in the residential treatment unit.	Persons treated in treatment units for substance abuse central drug treatment units	Personal identification code (partly)
France	November-Survey (Census), SESI	65,000 SR/SO	Persons who are treated in November (Census)	All persons who get or who are still in contact with a specia-	mostly (census!)

Country	Name of Monitoring System	Total Number of Treated Persons per Year	Definition of Treatment Episode	Case-Definition	Double counting avoided
	sus), SESI	number of treated persons in GS not available	vember (Census)	lised centre in month Novem-ber because of drug problems are registered	(census!)
Germany	EBIS SEDOS	20,000 SO (100,000 including other substances) 2,500 SR (12,500 including other substances)	Beginning and end of treatment	ICD-10 Diagnosis	partly within centres info from clients for first treatment
Greece	Treatment Demand Indica-tor	about 600	Pompidou	drug user requesting treatment for his/her problem	fully avoided within each treatment cen-tre as well as bet-ween treatment cen-tres using an anony-mous identification code (date of birth; third letter of first na-me of mother as well as of father; sex)
Ireland	Drug Treatment Reporting System (DTRS)	3,100 SO	the number of episodes is not recorded	A case is a person who re-ceives treatment for problem drug use (excluding alcohol as	partly within centres

Country	Name of Monitoring System	Total Number of Treated Persons per Year	Definition of Treatment Episode	Case-Definition	Double counting avoided
	based on Pompidou	1.200 SR 400 SL 154 SP	Just one contact per client per annum is counted. A count is carried out each year between 1. Jan and 31. Dec.	a primary drug) during the calendar year 1. January to 31 December	for methadone treatment a scripting control is obligatory
Italy	Ministry of Health Public Services Clients Annual Report	131,700 SO	Any therapeutic or rehabilitation procedure, whether pharmacological or not, even if performed outside the service	All addicts receiving treatment in the public services in the year	partly treatment only for local residents
Luxembourg	RELIS-LINDDA	400 SO 400 SR 500 SL 280-400 total	indexed admission for HRC drug related problems	problematic HRC drug use	yes id used
Netherlands	LADIS (The Dutch National Alcohol and Drugs Information System	25,200 SO 2,000 SR 100 SL 480 SP	At the begin and end of contact/treatment. End of contact/treatment also means 6 months no contact	All persons who get in contact with a outpatient centre for drug problems are registered one record is one subscription	yes, on all levels nationally unique code used
Portugal	S.P.T.T.	200,000 Following treatment demands (1997)	n.a.	n.a.	n.a.

Country	Name of Monitoring System	Total Number of Treated Persons per Year	Definition of Treatment Episode	Case-Definition	Double counting avoided
	two day census (November)	9,000 First treatment demands (1997)			
Spain	SEIT (Spanish State Information System on Drug Abuse)	42,300 SO (opiates or cocaine only)	Begin of treatment. In case of drop-out, time since last admission: 6 month	All persons admitted to treatment because of abuse or dependence of listed psychoactive substances are registered	mostly id at the level of the regions
Sweden	DOK	1,767 voluntary care 797 compulsory care (1996)	period from day of intake until day of discharge	every period of treatment	LINO-code: year of birth - initials - day of birth (institutional and central level)
United Kingdom	DMD (Drug Misuse Database)	26,000 SO/SR/GP (new episodes per 6 month)	At first presentation and if no contact for 6 months	All persons who get in contact with a treatment/counselling centre because of drug problems are registered	mostly id at the level of the regions

2.4 Treatment monitoring in CEEC countries

2.4.1 Czech Republic

The information on drugs and drug users in the Czech Republic is regularly collected from the national network of health and non-medical treatment and contact centres and through repeated representative epidemiological surveys, data on health consequences through obligatory reports on infectious diseases (hepatitis, HIV) and sentinel system of data collection on non-fatal emergencies.

Police data on seized drugs and persons, including data on the purity of drugs and their price are collected from the NADH and Customs Administration, information about accused persons and persons sentenced for drug delinquencies is gathered from the Public Prosecution.

The information on the incidence of problem drug users (First Treatment Demands), has been gathered in the Czech Republic through a routine reporting system since 1 January 1995. The establishment and operation of this information system was entrusted to the Hygienic service of the Czech Republic.

The database of the treatment / contact centres included more than 250 facilities from the whole Czech Republic at the end of 1997. The database was gradually consolidated and regularly updated. The information about the incidence of problem drug users is gathered on a quarterly basis through a form of the POMPIDOU Group.

Death certificates are processed nation-wide by the Institute of Health Information and Statistics (IHIS).

The Hygienic Station of the City of Prague regularly 3 - 4 times a year processes recent information from the area of drug epidemiology, other recent information on drug issues and summaries of the Czech and foreign literature on individual areas of drug issues. The material is distributed free of charge to all hygienic stations in the Czech Republic, T/C centres and at least once a year also to all district drug co-ordinators in the Czech Republic.

The representative surveys and prevalence studies provide regular information sources on the scope of drug use in the whole population and especially in the population of school children and at the same time they bring overall information on drugs and attitudes towards them.

Drug information system was complemented with the qualitative research of the drug scene, especially in the population of „hidden“ drug users which was carried out within the international „Rapid Assessment“ project.

The collection of recent information called „The Drug Scene in the City of Prague“ is prepared in Prague each year. It covers the basic characteristics of the drug scene in the Czech Republic and Prague from the point of view of the NADH, summary of incidence of problem drug users in Prague for the past years, researches and studies on drugs, preventive anti-drug activities, experience from T/C centres, characteristics of the criminal activity committed in relation with opiates and psychotropic substances and information on the drug policy on the local level.

Local information systems are created by individual drug co-ordinators in districts

and city quarters and they use local data of the Police of the Czech Republic, data of hygienic stations on the incidence of the problem drug users in the district and the results of the national epidemiological surveys and information from the local T/C centres and other health care facilities.

Despite the existence of the relatively reliable information on the trends of the problem users and kinds of used drugs, we still miss data on their prevalence and especially information on deaths either directly or indirectly related to drug use. There is a real assumption that the problem with monitoring of the prevalence of problem users can be definitely solved by the introduction of their register, more efficient records on deaths will result in better co-ordination of activities of health care services and the Police of the Czech Republic, including higher availability and standardisation of toxicological examination.

The national record keeping will require relatively strong efforts in the area of so far very scattered activities in Drug Demand Reduction. The same applies to the information on the specialisation and competence of people providing these services. The list of experts and their co-workers and projects in the field of drugs would make the mutual communication and information flow easier.

2.4.2 Estonia

Drug abuse became an alarming social, health care and criminal problem in Estonia only during the last few years. According to the data of the Estonian Medical Statistical Bureau the number of drug abusers who applied for the treatment doubled in 1996 and the quick tendency has continued in 1997. In total 1,059 drug addicts were treated in the Estonian health care clinics in 1997 (prevalence rate 73 per 100,000 population). 72% of them were injecting opiate addicts. The use of opiates is mostly spread among Russian speaking young males while Estonians mainly use cannabis and stimulants.

Unfortunately the available treatment does not correspond to the increased demand. Often the addicts do not have regular employment. Only minority of those, who are not insured by Sick Fund, are able to pay for treatment. For the rest of addicts the treatment of their dependency is practically inaccessible. They could get only emergency assistance.

As a response to drug problems Estonian Parliament ratified UN drug conventions in 1996. The new Narcotics Drugs and Psychotropic Substances Act entered into enforce on 1 November 1997. Alcoholism and Drug addiction prevention programme for the years 1997-2007 was approved at the session of the Government of Republic on 25 November 1997. The Estonian Foundation of Prevention of Drug Addiction will implement different tasks of the national programmes. Some of these tasks are collection and distribution of drug related information, conduction of studies and surveys, training of health care and social service specialists and developing of treatment services for drug addicts. In the framework of the national programme the foundation will introduce close collaboration with the Public Health Department of the Ministry of Social Affairs, Interdisciplinary Council of the National Programme, Ministers Committee on Drug Policy, Department of Social Welfare and Health Care Services of Tallinn municipality, universities and research centres.Co-operation with the Baltic States, Nordic countries and European drug information network is of the same importance.

There is no central data collecting (monitoring) system on the treatment demand and structure of drug users in Estonia. The information about the current drug abuse situation is based on the treatment data of medical statistics reports of health care institutions.

This year we have prepared the Estonian version of core data for drug treatment reporting system. We used the Pompidou group's form and instructions as model.

In September we are going to begin with data collection in five bigger psychiatric clinics (Tallinn Wismari Hospital, Tartu University Psychiatric Clinic, Tartu A-clinic, Sillamäe Hospital and Narva Hospital).

2.4.3 Hungary

The institutions in Hungary where the Treatment Demand Indicator is used are in transition, getting complementary finances and staff, that enables them to work in specialised teams, providing care for drug-addicts. This is a network of 27 dispensaries for addicts and 6 non-residential centres with specialised care exclusively for drug addicts. They have been developed recently uniformly on the basis of the common principal of “SUPPORT”, i.e. to provide addicted persons with any kind of help needed counting on their bio-psycho-social background with the aim to free them from addiction, with abstinence consequently.

There are six drug-specialised residential centres (with competence for the whole country) providing methadone (or other) substitution programmes in Hungary.

In the moment the system collects an aggregated, minimal core dataset (age, gender, substance(s) used, mode of administration, frequency of use, patients’ turnover and logistics data) on patients, re-requesting or starting treatment in anyone of the above institutions during a given year; and age distributions regarding a December, 31 census of registered patients.

Without having an individualised database with the introduction of a personal identifier into the system, it is impossible to ensure procedures to avoid double counting at this stage, others than minimal ones on the intra-institutional level. The data collecting programme itself has been introduced less than five years ago which means that new, technically still not prepared, institutions join the reporting system each year. However, a recognisable advantage of the system is its nation-wide character, allowing whole-country assessment.

Following the appearance of PG “Guidelines on Treatment Demands”, as well as the EMCDDAs “Final Report on Procedures to avoid double counting in drug treatment reporting systems”, there were two proposals submitted to modify data-collection. The need for modification of the data-collection system has been acknowledged and is under review.

Provision of necessary finances by the governmental/central health administration, elaboration by professionals, and persuasion of acceptance by the Focal Point of a proposal for an individually based nation-wide data-collecting system consistent with the national data-protection law, with the above mentioned standardised international documents, as well as with the “Core Item List for Monitoring the Treatment of Drug Misusers”, recommended by the EMCDDA are prerequisites for being able to keep up with the European standard in data-collection regarding problem drug use. At least the introduction of the Pompidou questionnaire uniformly for any type of treatment institutions in the country should be reached as a first step.

2.4.4 Latvia

The Latvian monitoring system is still under construction. Under responsibility of the national health service a drug register exists since 1993 but it is still in a state of flux.

At the moment information of several organisations and institutions are provided to the National Focal Point which is based in the Centre for Drug Abuse Prevention and Treatment as a part of the organisational and methodical department. The centre's organisational and methodical department directly collects information on drug abusers treatment, follow-up and rehabilitation, collaborates with General statistics and health information institutions on relevant drug statistics, and with Ministries of Interior and Justice responsible bodies on drug related criminal information. The centre is funded by the government and acts on State, districts' and local (cities and country) level. The organisational and methodical department co-ordinates activities of specialised medical institutions, narcology units in general health care institutions, educational, social bodies and non-governmental organisations in preventive programmes. International co-operation with other CEEC countries takes place in the framework of the PHARE project.

In addition to the work of the National Focal Point the Health statistics, Informatics and Medical Technology Centre and the Medical Statistics Bureau collect general health data, mortality data and health services data. Delinquencies related to drugs, illicit trafficking and seizures, drug related deaths, vital statistics and offences general statistics are collected by the Drug Enforcement Bureau, Ministry of Interior, Forensic Medicine Centre and Central Statistical Bureau of Latvia. Criminological Investigations Centre, Ministry of Education and Science and NGO's according to their responsibility and functions provide operational information related to drug issues.

3 The EMCDDA Core Item List for Treatment CIT

3.1 General remark concerning methodological aspects

As can be seen in the description of the national treatment monitoring systems in the EU member states the architecture and structure of the national systems is closely linked to the different structures of the national and regional care systems for drug addicts. These circumstances account for the different developments and realisations of the national treatment monitoring systems. Nevertheless, it is of some note that despite this, there is remarkable similarity and consonance in important features between the major systems.

The CIT has developed as a minimum data set, a short list of items which are on one hand relevant, reliable and useful from an epidemiological point at view and which could be collected in as much EU member states as possible with limited efforts. Therefore in the first draft of the CIT only those items were included, which already could be filled in with information by more than half of the participants.

While some questions can be used as they are, the CIT It is not thought as a questionnaire by itself. Some items could only be defined at an intermediate level, which means, that national data have to be translated to this level. A good example might be school education. Each country has its own peculiar system. Therefore the CIT has used the categories "primary school", "secondary school" and "tertiary school". Each country has to translate this into its national educational system, before data on drug users can be transferred according to the CIT items.

The CIT is the first step, as it defines a common set of items. The next step will be to define crosstabs and breakdowns e.g. within the national annual report for the EMCDDA on the basis of these items to deliver comparable data from each of the Member States to the EMCDDA.

The technical implementation of a national treatment monitoring system cannot be solved here. It can be paper based or - more up to data - based on electronic data processing. In practice the decision will depend on administrative requirements, technical education of staff and funding. Also legal restrictions still are not the same in Europe. Especially the question, is personal data can be collected nationally, if an identifier is used, which does not allow to identify a person, is still answered different in different countries. Especially parts of the recommendations given in the chapter on double-counting cannot be followed if the legal situation does not allow this.

Because of this one of the most important tasks *before* the development of an common Core Item List was to clarify and understand the different definitions of the *subjects* of the monitoring systems and the different *methods* to handle the subjects within the systems. This clarifying and understanding is essential for interpreting and comparing data on drug treatment of the different countries.

3.2 The Core Item List on Treatment CIT

3.2.1 The selection of core items

Independent of the relevance of the items themselves, the main point of interest is the *current* or *feasible* availability of central information within the existing monitoring systems. A pragmatic approach has been adopted in which the selection of the following items has been steered by availability. The list can be further developed and extended in future. At the beginning of this development, it is necessary to be modest in order to be successful in as many countries as possible.

The starting-point of the Core Item List was the already existing European list of core items which is used in the Pompidou Multi City Project (Pompidou Protocol) and the different item lists which are used by the participating monitoring systems. Altogether more than 50 different items were discussed during the course of work of this subtask. After discussion and selection, this has been reduced to a Core Item List of 18 items.

Items were excluded, which were not available in more than 50% of the participating systems. It was generally accepted, that the items included in the national systems had proved useful and usable, while many others during the history of the different systems had to be changed or skipped. Further interesting items, which are either not currently available in the majority of the systems or whose transmission from the national into the European system is problematic, were shifted to a „Wish List". These items are currently **not** part of the core items but should considered relevant for future discussions and developments. This Wish List is to be found in the annex of this report. Also items concerning treatment itself, e.g. duration, number of contacts and result, could be included in future. This would allow also to collect basic information on treatment as well as on the epidemiological situation in the same procedure. On the following pages the items of the EMCDDA Core Item List on Treatment are described including definitions, categories and some information on the rationale for their inclusion.

The proposed Core Item List covers three different areas:

- **Treatment contact details**
  Information in this area is mostly needed to organise and evaluate other information. It allows selection of comparable types of centres, age cohorts or reporting periods
- **Socio-demographic information**
  Socio demographic variables are simple indicators of the social position of drug users, giving information on the extent of marginalisation and problems for integration.
- **Drug related information**
  This is the central or key information which describes treated persons by substance and patterns of use.

3.2.2 Treatment contact details

1 Treatment Centre Type

1. outpatient treatment centres
2. inpatient treatment centres
3. low threshold / drop-in / street agency
4. general practitioners
5. treatment units in prison

A clear definition of the types of treatment centres involved is seen as essential to increase comparability of treatment data between countries. At present the data are collected from different types of treatment centres and the samples of drug users covered therefore differ accordingly. To improve the current comparability of treatment data between countries at least the three basic types of treatment centres „Outpatient“, „Inpatient“ and „Low-Threshold“ should be separated forthwith.

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2 Date of Treatment Month

3 Date of Treatment Year

The dates of treatment are seen as essential for creating trend analyses over time and to separate free time periods for reports. Even if there is no focusing on first treatments (as per Pompidou-Group) this enables a dynamic analysis of the treatment data.

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4 Ever Previously Treated

1. never
2. previously treated
0. not known

This item makes it possible to estimate the incidence of cases as well as client flow through treatment services. In the future additional information on this area could be useful, e.g. type and number of previous treatments.

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5 Source of Referral

0. not known
1. self referred
2. family / friends
3. other drug treatment centre
4. GP
5. hospital / other medical source
6. social services
7. court / probation / police
8. other

This item should give some information on the client’s motivation for treatment as well as on the structure and co-operation of different professional drug service agencies or private initiatives. It allows for estimates of double counting, where this cannot be done at a personal level.

The "Source of Referral" refers to the most important source for this client.

3.2.3 Socio-demographic information

6 Gender

1. male
2. female
0. not known

Basic epidemiological information

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7 Age

Basic epidemiological information

---

8 Year of Birth

Basic epidemiological information, especially necessary to analyse cohort specific and historic effects in drug problems.

If an unique code is used in a country for each client to rule double-counting of persons who are treated twice in the same year, usually the date birth including day and month is needed to calculate this code .

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9 Living Status (with whom)

1. alone
2. with parents
3. alone with child
4. with partner (alone)
5. with partner and child(ren)
6. with friends
7. other
0. not known

The „with whom“-aspect mainly should assess the social relations or integration of the clients.

10 Living Status (where)

1. stable accommodation
2. unstable accommodation
3. in institutions (prison, clinic)
0. not known

The „where"-aspect additionally stresses the stability of the living situation. Because of different cultural context in the European countries e.g. concerning the different role of the family, the term has to be left more vague and general than the other items.

11 Nationality

1. national of this country
2. national of EU-member-states
3. national of other countries
0. not known

This item is seen as relevant for both national and European figures as drug problems increase in minorities in several places. As minorities are very different in different countries (sometimes nationality differs from the majority, sometimes ethnic origin, sometimes language) only very basic categories are used here.

12 Labour status

1. regular employment
2. pupil / student
3. economically inactive (pensioners, housewives, -men / invalidity)
4. unemployed
5. other
0. not known

This item gives central information about the client's economic and social integration with great importance for the structuring of daily life. However, at present it is very difficult to standardise the different forms of employment within the different European countries, especially concerning those categories which are unusual in social statistics such as irregular, illegal or other forms of employment that are characteristic of drug addicts.

13 Highest educational level completed

1. never went to school / never completed primary school
2. primary level of education
3. secondary level of education
4. higher education
0. not known

Education is another important socio-economic category of data about the clients. The finding of jobs mainly depends on the educational level.

The International Standard classification of Education ISCED should be used to translate national classifications into item 12 (see annex)

3.2.4 Drug-related information

13 Primary Drug

1. Opiates (total)

11 heroin

12 methadone

13 other opiates

2. Cocaine (total)

21 cocaine

22 crack

3. Stimulants (total)

31 amphetamines

32 MDMA and other derivates

33 other stimulants

4. Hypnotics and Sedatives (total)

41 barbiturates

42 benzodiazepines

43 others

5. Hallucinogens (total)

51 LSD

52 others

6. Volatile Inhalants

7. Cannabis (total)

9. Other Substances (total)

This item is of central importance. The main drug is defined as the drug which causes the client most problems. It should be noted that there are important differences between the systems in defining this category (see chapter 3.1).

In the case of drugs of substitution (such as methadone (1) and other substances (2) these are classified as the main drug but should be differentiated in being „administered for substitution“ and „other drug misuse“ for clarification. For users of ‘Speedball’ heroin should be recorded as the main drug and cocaine as a secondary drug.

If the exact substance is not known (e.g. amphetamines or MDMA and derivates) the generic category (e.g. stimulants (total)) should be recorded.

Alcohol may not be recorded as the primary drug. Clients whose primary drug of misuse is alcohol should be excluded.

14 Route of Administration (primary drug)

1. inject
2. smoke / inhale
3. eat / drink
4. sniff
5. others
0. not known

This item represents the main area of risk behaviour for drug users concerning their main drug. It is of particular importance with regard to infectious diseases (hepatitis, HIV) as well as other diseases and injuries, and the reduction of injecting behaviour is the aim of many harm reduction programmes. This is particularly important for systems that do not use ICD-diagnoses, in estimating the severity of addiction. The "Route of Administration" refers to the route of administration of the primary drug.

15 Frequency of Use Primary Drug

1. not used in past month / occasional
2. once per week or less
3. 2 - 6 days per week
4. daily
0. not known

This item gives further information on the consumption of the main drug and is particularly useful for systems not using ICD-diagnoses in estimating the severity of addiction. This item is also helpful in identifying the patterns of consumption of drug addicts.

"Frequency of use" refers to the last 30 days before the treatment demand. If the client is drug free or has not used his/her primary drug in the past 30 days it has to be coded as "not used in past month / occasional".

16 Age at First Use of Primary Drug

This item represents additional relevant information concerning the drug use of the main drug. It is of great importance with regard to the duration of drug-use as well as to the development of understanding about the beginning of an individual’s drug use.

17 Current Secondary Drugs

1. Opiates (total)

11 heroin

12 methadone

13 other opiates

2. Cocaine (total)

21 cocaine

22 crack

3. Stimulants (total)

31 amphetamines

32 MDMA and other derivates

other stimulants

4. Hypnotics and Sedatives (total)

41 barbiturates

42 benzodiacepines

43 others

5. Hallucinogens (total)

51 LSD

52 others

6. Volatile Inhalants

7. Cannabis (total)

8. Alcohol as secondary drug (total)

9. Other Substances (total)

This item is of central importance. It should be noted that there are important differences between the systems in defining this category (see chapter 3.1). Up to four additional drugs should be described in order to get more realistic figures of multiple drug use.

Alcohol may be included as a secondary drug.

In the case of drugs of substitution (such as methadone (1) and other substances (2) these are classified as the secondary drugs but should be differentiated in being „administered for substitution“ and „other drug misuse“ for clarification. For users of ‘Speedball’ heroin should be recorded as the main drug and cocaine as a secondary drug.

If the exact substance is not known (e.g. amphetamines or MDMA and derivates) the generic category (e.g. stimulants (total)) should be recorded.

18 Ever / Currently (last 30 days) injected

1. Ever injected, but not currently
2. Currently injected
3. Never injected
0. Not known

This item also represents an important area of risk assessment of drug users (see item 14). In addition to item 14 this gives a good indication of risk behaviour in identifying the injection of drugs other than the main drug. It 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 should be excluded (diabetes etc.). "Currently injected" refers to whether a client has injected any drug at least once in the past 30 days.

3.3 Definitions and methodological guidelines

In this chapter central terms are defined and guidelines for data collection, processing and transfer to the EU level are given. Where possible, formulations of the Pompidou protocol were used (Pompidou Group, 1994) in order to keep and increase comparability between the CIT and the Pompidou Protocol.

3.3.1 Which "cases" should be included ?

Rationale

A clear case definition is a requirement for the comparability of drug treatment monitoring data between countries and even within countries. In general the medical care system is using a clear case definition (as diagnoses based on ICD) but the social care system works on less operational definitions.

State of development

At the present at an European level there is no uniform definition of relevant cases which should be included in the drug monitoring system. Whereas in Germany and partly in Belgium cases are only included if there is an ICD diagnosis, in the UK and The Netherlands all persons in contact with a counselling centre because of their drug problems are registered on the basis of the drugs used within a certain period of time. While in practice many of those people might well 'qualify' for diagnosis concerning drug addiction, some bias may result from these different procedures. In future a multi-site study project should help to evaluate this possible problems in comparability.

Definition

For the purposes of treatment demand reporting, a case is *a* ***person, who starts treatment for their drug use at a treatment centre*** during the calendar year, January 1 to December 31. If a person starts treatment more than once during the same year at the same centre, then only the earliest treatment demand in that year is counted.

If census is done instead of an ongoing documentation of treated cases, a case is someone who is receiving treatment for his/her drug use on the date specified in the census.

The operational definitions of „drug", „treatment", "start of treatment", „treatment centre", are given below.

3.3.2 What means "treatment" here ?

Rationale

A treatment demand for an drug treatment is reflecting several factors for each of the treated persons but also for the statistics of treatment demands. There must be :

- drug users
- a treatment offer
- a demands for this offer

This makes clear that the type of treatment offered (e.g. only high threshold drug-free programmes or methadone maintenance) and registered makes a difference when it comes to the total number of drug users in treatment. The data should be as complete as possible, i.e. they should include all types of treatment offered.

State of development

In most cases outpatient care is documented pretty good, while low-threshold, street-work and similar field are reflected much less by the available data. As concepts of treatment change the comparability becomes even more difficult in future. At the moment a simple distinction is made between out-patient, inpatient and low-threshold types of treatment. A further differentiation has been discussed and might be further developed (Kokkevi, 1997b).

Definition

„Treatment“ is any activity which is targeted directly at people who have problems with their drug use, and which aims to ameliorate the psychological, medical or social state of individuals who seek help for their drug problems. This activity will often take place at specialised facilities for drug users, but may also take place in general services offering medical/psychological help to people with drug problems.

This is a broad definition which includes:

- interventions aimed at reducing drug-related harm amongst active users, as well as those whose primary goal is detoxification and abstinence;
- non-medical as well medical interventions;
- short-term crisis interventions or informal advice, counselling or support, as well as more structured longer-term programmes.

However, it excludes:

- contacts at general services involving requests for social assistance only;
- contacts where drug use is not the reason for seeking help;
- imprisonment per se (though it includes admissions to drug treatment programmes in prison or to treatment as an alternative to prison);
- interventions solely concerned with the physical complications of drug misuse (e.g. overdoses or infections treated at a hospital);
- contacts by telephone or letter only;
- contact with family only.

3.3.3 When treatment "starts" ?

Rationale

A common understanding, when a treated person is counted is necessary for comparability of results between countries. If in one country each demand is counted, while in another country the first or even the second contact between drug user and therapist or social worker has to take place before counting, comparability is not given. Sometimes only treatment really starts out of three which have been demanded before.

State of development

In practice data in many systems are only collected after the second meeting with the drug user took place. In this way it is tried to ensure more complete and reliable data because the first contact often doesn't give sufficient room for data collection. Another solution can be to collect the most basic data at the first meeting (sex, age, ..) and to complete other information at a later session.

Definition

Every person should be included at least after a second direct contact took place. For persons, who only had one single contact with the unit at least the total number is needed. More useful would be a minimum data set also for this group.

Only treatments, where direct contacts took place at least once are considered as "started". Sole demands for treatment have to be excluded.

3.3.4 What "drugs" should be included ?

Rationale

While drugs like cannabis and ecstasy are used quite frequently, substances like heroin of cocaine are used in most countries much less often. If comparability of numbers and characteristics of drug users is aimed at, a common understanding is needed, which drugs have to be included by national systems.

State of development

In most countries rather specific information on used psychotropic substances is available. Only in the case of ecstasy not always detailed information is already there. In some countries drug treatment and treatment of alcohol problems is done by the same centres. In these cases it is important to include only those persons, who have a primary drug problem in the common statistics.

Definition

The following substances are included in the system. Alcohol may not be recorded as the primary drug. Clients with alcohol as primary drug should be excluded.

In the case of drugs of substitution (such as methadone (1) and other substances (2) these are classified as the main drug but should be differentiated in being „administered for substitution“ and „other drug misuse“ for clarification. For users of ‘Speedball’ heroin should be recorded as the main drug and cocaine as a secondary drug. If the exact substance is not known (e.g. amphetamines or MDMA and derivates) the generic category (e.g. stimulants (total)) should be recorded.

Table 4. Drugs to be included

Groups of substances	**Substances**
Opiates	heroin methadone other opiates
Cocaine	cocaine crack
Stimulants	amphetamines MDMA and other derivates other stimulants
Hypnotics and Sedatives (total)	barbiturates benzodiazepines others
Hallucinogens (total)	LSD others
Volatile Inhalants	
Cannabis	
Other Substances	

3.3.5 What is the "first" treatment?

Rationale

The very first time a person seeks treatment because of his or her drug use and the problems arising from this can be used as an basic information for the calculation of incidence. This is the number of new cases of drug users, which develop in a certain period of time. Only in this case no problems with multiple counting of a person because of being treated (and registered) by several units in the same period do not arise.

State of development

Each of the national systems offers this information. Depending on the legal and technical situation in some countries it is based on a central register of treated drug addicts. Only if a person who starts treatment is not included in this register, it is defined as a "first treatment". In those countries, where a register doesn't exist, either the treatment organisations can check or the drug user himself is asked if he had been in treatment before. The bias caused by this different procedures seems to be not too big.

Definitions

The very first time a person starts a special treatment because of drug problems during his or her life.

3.3.6 When a "subsequent treatment" has to be registered after the first one?

Rationale

After the first treatment took place it is not known, if the person has stopped drug use, has changed substances or patterns of use. Therefore also subsequent treatments are important to register. They offer information on the prevalence of drug problems. In order to ensure comparability between countries it is necessary to use similar definitions for the beginning and the end of these subsequent treatments. They directly influence the number of cases registered.

The most difficult aspect here is to define, when a former treatment is finished and therefore a new treatment has to be registered. If e.g. treatment is seen as an ongoing lifelong process and a person is treated by the same unit over the years, only a first treatment will be documented. If, on the other side, automatically after 6 month a treatment finished and a new treatment is started according to the systems´ rules if the same persons just continues to come to the treatment unit, a total different picture arise.

There is a close link between this subject and the problem of double-counting.

State of development

Many systems use a maximum fixed time-period without contacts. However, these periods vary between 60 days (Germany) and six months (Netherlands, UK and others). The definition of end of treatment also varies. For example in Ireland treatment length is only registered for one year, whereas in the other monitoring systems longer treatments may be identified.

A general rule, when a treatment episode is finished and when a new treatment is started, is not existing yet in Europe.

Definition

A no common standard has been developed yet, each system should define as clear and operational as possible who the end of a treatment is defined and under what conditions a persons demanding treatment is registered as a new treatment again.

3.3.7 Avoidance of double counting

Double counting is controlled to a certain extent within all systems, but the methods vary. A nation-wide control on the basis of uniform personal codes is done for example in Luxembourg, Denmark and in the Netherlands, which can rule out nearly all double counts within the last year. Only cases with incorrect identifiers might then result in double counting. A limited control only at the treatment centre level is carried out in the Flemish part of Belgium, and in France and Germany. In Spain and the UK double counting can be controlled at a regional level.

The methods used in the different countries to avoid double counting have been described and analysed in-depth by a project co-ordinated by the Focal Point of Luxembourg and called „*Procedures to avoid double counting in drug treatment reporting systems*“ (Origer, 1996).

An overview on the different methods to define a personal identifier used in the national systems is given in chapter II of the report. This chapter as well as chapter V including recommendations is included in the annex.

3.3.8 Which types of treatment centres should be included ?

Rationale

A clear definition of the types of participating treatment centres is essential to increase comparability of data between countries. If data are collected from different types of treatment centres the samples of drug users from each county also differ. The inclusion of methadone maintenance programs for example increases the proportion of drug addicts reached and might change the characteristics of the described population as well It is also important to be clear as to whether the systems include or exclude clients with primary alcohol problems.

In each country, as many treatment centres as possible should be recruited to participate. One factor that will influence the selection of centres, will be their willingness to participate, and practical constraints such as resources. However, it is very important that careful attention is paid to the question of the proportion of treatment centres that are covered, and how representative in terms of the types of treatment that are available in the country , and their geographical distribution and catchment (referral) areas. If it is not possible to achieve comprehensive coverage, then the aim should be to include a cross-section of the major treatment modalities found.

State of development

Several projects have been started in Europe and in the United States to develop a more complete and useful categorisation of treatment centres. They are closely linked to a broad description of treatment measures and concepts in this field. As no final categorisation has been produced yet at least a basic distinction should be made between different types of centres which are offering treatment related data. The following types of services help to classify treatment centres :

1. Specialised Residential
    - hospital inpatient units
    - therapeutic communities
    - other specialised residential (specify)
2. Specialised Non-residential
    - hospital outpatient treatment centres
    - structured day care centres / day hospitals
    - local health / social service centres
    - low threshold / drop-in / street agencies
    - other specialised non-residential (specify)
3. Based in General Services
    - inpatient psychiatric hospitals
    - outpatient mental health care centres
    - primary health care services/ general practitioners

- residential social care facilities
- non-residential social care facilities
- other non-specialised residential (specify)
- other non-specialised non-residential (specify)

(4) Treatment Units in Prison

A nearly complete description of the treatment centres can be given e.g. with the help of the Treatment Unit Form (TUF) as proposed by Kokkevi (1997b) in the final report of REITOX sub-task 6.1. The revised versions of the TUF cover the following areas:

TUF - A (9 sections):

a. Identification information
b. Treatment Unit/programme characteristics
c. Treatment planning/approach/goals/services
d. Assessment of clients
e. Completion of treatment
f. Staffing
g. Finances
h. Evaluation
i. Changes in the treatment unit/program.

TUF - B (6 sections):

a. Identification information
b. Low threshold treatment unit/program characteristics
c. Staffing
d. Finances
e. Evaluation

Changes in the treatment unit/program.

Definition

A treatment centre is an agency which provides treatment as defined above to people with drug problems. treatment centres can be based within structures which are medical or non-medical, governmental or non-governmental, public or private, specialised or not. They include inpatient detoxification units, outpatient clinics, drug substitution programmes (maintenance or shorter-term), therapeutic communities, counselling and advice centres, street agencies, crisis centres, drug treatment programmes in prisons, and special services for drug users provided within general

health or social care facilities. Although treatment centres are often staffed by qualified professionals, in this context, „treatment“ includes services provided by persons who are accepted to have appropriate therapeutic skills but who lack formal qualifications. They do not include hospital emergency rooms, nor general health or social care facilities who see drug misusers who contact them for help with other problems.

Three basic types of treatment centres should be distinguished in data collection and data transfer and covered as much as possible by national sources: „Outpatient “, „Inpatient/ residential“ and „Low-Threshold services “. Even if a low-threshold centre follows an outpatient type of work organisation the data have still to be registered as low-threshold.

Special treatment organisations in prisons and treatment by General Practitioners are also important but only limited information is available for this area in most of the countries. Where general practitioners play an important role in treating drug misusers, for example in prescribing methadone efforts should be made to cover them. This may raise practical problems because GP’s are relatively numerous, tend to work as individuals or in small groups, and are widely distributed across the city or country. It may only be possible to collect very basic data (for example through a methadone registration system). In situations where general practitioners or other non-specialist professionals are not involved in treatment in any systematic way, it may be very difficult to include them, though this does not matter if they receive few treatment demands. If it is possible to identify a small number of general practitioners or other non-specialist agencies who see a significant number of drug misusers, then it’s worth trying to enlist their participation.

The definition of „treatment centre“ also raises questions of coverage with regard to interventions such as needle exchanges or outreach projects. Schemes which are purely concerned with making syringes available or with disseminating information should generally not be considered as treatment centres. If, however, these activities are part of a wider service that offers counselling, health care and other help to people with drug problems, then they should be included if possible. There may be practical problems in collecting data. the goal of these low threshold projects is to make themselves as acceptable and accessible as possible to clients who may be suspicious of helping agencies. They thus avoid asking too many questions or using formal assessment procedures. It is thus difficult for them to record statistical data systematically and they may be reluctant to participate in a reporting system. The best compromise may be to collect only very basic data from these projects.

3.3.9 How to improve the quality of data in the whole process ?

The quality of the data collected in each of the member states depends on the work done at several levels:

- as much treatment centres as possible should participate
- if single centres of even types of centres are underrepresented, possible biases caused by this should be evaluated
- data collection done at the treatment centre should be done complete, thoroughly, reliable and continuously
- data transfer should take place in time and well organised

The sample of treatment centres participating in the national system of data collection should be as good as possible. While the participation of all centres is often impossible for practical and financial reasons, this would be the best solution in terms of completeness and representativity.

The organisation of data collection in each country depends on the national structures, the institutions involved and technical means available. As details are very different only global comments are possible here. Everything possible has to be done for the persons working at the treatment centres

- to make data collection and input as simple as possible
- to help them avoid errors by training, manuals, user friendly software and other support
- to offer also for them meaningful output of data collection
- to give feedback where possible and useful to them
- to make them feel and behave responsible on the data collection at the level they work on

In REITOX sub-task 3.1, which has been co-ordinated by the Greek Focal Point, a study was carried out to improve the reliability of data collected by treatment demand reporting systems (Kokkevi, 1997a).

3.3.10 Data collection in the national systems

Of course many national monitoring systems use more and different information for their administration than is reflected in the CIT. However, each country can be more complete or more specific in details, as long as it is able to transmit the relevant information into the items of the CIT. Even within each item the countries can use as many categories as they want, as long as they are able to translate them into the European standard categories. A reliable method of routinely extracting these core data from the national sources will be necessary. Those items, which are only locally or nationally relevant for the organisation of the data collection (code of treatment centre, client code, etc.) are not discussed here.

One of the most important tasks within the development of the core items is the consequent testing of the definite availability of all requested information. Each country has to define rules of translation for the national reporting system and/or sources to the CIT. These rules also allow a more fundamental interpretation of the different core information and help to develop to a common understanding of the items between the different countries. In the annex two examples of such translations rules can be found. They have been developed for The Netherlands and the United Kingdom in the framework of the REITOX sub-task 3.2 1997.

It is essential that the treatment data have to be interpreted in terms of the context in which they are collected. As already pointed out there are still fundamental differences concerning for example the handling of double counting and the different ways of defining a case. These have to be taken into account especially for the comparison of the statistical data.

3.3.11 Data transfer from different systems to the CIT

Double counting is controlled to a certain extent within all systems, but the methods vary. A nation-wide control on the basis of uniform personal codes is done for example in Luxembourg, Denmark and in the Netherlands, which can rule out nearly all double counts within the last year. Only cases with incorrect identifiers might then result in double counting. A limited control only at the treatment centre level is carried out in the Flemish part of Belgium, and in France and Germany. In Spain and the UK double counting can be controlled at a regional level.

The methods used in the different countries to avoid double counting have been described and analysed in-depth by a project co-ordinated by the Focal Point of Luxembourg and called „*Procedures to avoid double counting in drug treatment reporting systems*“ (Origer, 1996).

3.3.12 Ethical issues

There is no intention to develop a central database of individual treatment demands. All raw data are collected, analysed and retained by the cities in terms of accepted ethical standards. Only aggregated statistical data are pooled and analysed for comparative purposes.

Within cities, it is vital that reporting systems follow, and are seen to follow, clearly stated guidelines on confidentiality and protection of the rights of treatment centres, staff and clients. These guidelines should adhere to the accepted codes that govern data protection, privacy and research in the various countries. Access to the raw data must be restricted to authorised staff only. The uses of the data and procedures for publishing results should be discussed by those involved (service providers, managers, policy makers, researchers etc.) and agreed in advance.

4 State of availability of data for the CIT

4.1 Availability per country

The following tables give an overview on the availability of the items of the CIT in the national systems. A cross (´x´) indicates, that this information is available directly or can be obtained by calculation and recoding from the national systems. In some instances years are indicating that information will be available in future. For some of the countries no information is filled in for different reasons

- **Austria** is just in the state of setting up a national system which will be able to deliver all CIT items as requested. Which centres will be included and details on the implementation can be given at a later point of time

- **Finland** has done a feasibility study on the implementation of a treatment monitoring system recently on the basis of the Pompidou protocol which is quite close to the CIT. The results are favourable and next steps towards implementation can be expected.

- **Portugal** has started a system of treatment monitoring within a big treatment organisation. Further details on coverage of centres, patients etc. are not available at the moment.

- **Sweden** can offer a broad variety of information based on not more than 15% of the total number of treatment centres. Changes in this status are not to be expected soon.

Specific problems also exist in two other countries.

- **France** collects data on treated persons by a survey conducted each November. An ongoing registration system doesn't exist.

- **Belgium** offers some information, but still is working on the integration of three regional monitoring systems into a national one. It has to be mentioned, that some of the available information are not really available for the national level at the moment.

All other countries already have a national database which can be used as a source for the CIT. Methodological differences and details which might reduce comparability also between these countries are described in chapter 2.2 and 2.3.

4.1 Availability per type of treatment centre

While 10 out of the 11 countries which can have national information available include data from out-patient services, only 8 also cover residential treatment. Much less data are available for the other types of treatment: 3 countries have included GPs, 4 low-threshold agencies and 4 prisons. In practice this means, that the first target for a fast implementation of common standards in Europe must be the collection of data from out-patient treatment units. As these units usually also reach more drug users and are closer to the drug using population this makes sense also from an epidemiological point of view. The inclusion of residential treatment could be the next step.

Unfortunately GPs and low-threshold agencies, which are thought to be even closer to "normal" drug users are included only in a minority of countries in the national treatment monitoring systems. It will be necessary also to develop this are of monitoring to reach a more complete picture of the situation in future (table 5)

Table 5. Availability of data for the CIT in different areas of treatment[1]

Types of units	AU	BE	DE	FI	FR	GE	GR	IR	IT	LU	NE	PO	SP	SW	UK	Total
Outpatient treatment centres		*x*			*x*	*x*	*x*	*x*	*x*	*x*	*x*		*x*		*x*	*10*
Inpatient treatment centres		*x*	*x*		*x*	*x*	*x*	*x*		*x*	*'97/ '98*				*x*	*8*
Low-threshold / Drop-in/ Street agency								*x*		*x*	*x*					*4*
General Practitioner		[2]						*x*		*x*					*x*	*3*
Treatment units in prison		[2]				*x*				*x*	*'97/ '98*		*x*		*'99*	*4*

[1] *For some countries (shaded columns) this table can't be filled due to several reasons which have been explained in 4.1*
[2] *Item available but data not delivered*

4.3 Availability per item

The selection of items for the CIT versions 1.0 was based on the fact, that more than 50 % of the national systems were able to deliver the information defined already now. The overview on the availability of data per item in table 6 shows, that there are still considerable differences. While some information is available nearly for every country, for other items there are still big gaps to fill.

On the total the result of this overview is quite favourable. For most of the items those 11 countries, which already have a running system can deliver data for nearly all categories defined. Only item 11 (nationality) and 17 (age of first use) show a more limited data basis.

Table 6. Availability of data for the CIT per item

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

2. Date of Treatment Month[1]															
Categories	**AU**	**BE**	**DE**	**FI**	**FR**	**GE**	**GR**	**IR**	**IT**	**LU**	**NE**	**PO**	**SP**	**SW**	**UK**
Date of treatment Month		*x*	*x*			*x*	*x*[2]	*x*		*x*	*x*		*x*		*x*
Quality of data[a]		*3*				*3*	*3*	*3*		*3*	*3*				*3*

[1] *For some countries (shaded columns) the following tables can't be filled out due to several reasons which have been explained in 4.1*

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

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

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

4. Ever Previously Treated															
Categories	**AU**	**BE**	**DE**	**FI**	**FR**	**GE**	**GR**	**IR**	**IT**	**LU**	**NE**	**PO**	**SP**	**SW**	**UK**
Never		*x*	*x*		*x*	*x*	*x*	*x*	*x*	*x*	*x*[1]		*x*		*'99*
Previously treated		*x*	*x*		*x*	*x*	*x*	*x*	*x*	*x*	*x*		*x*		*'99*
Not known		*x*	*x*		*x*	*x*	*x*	*x*		*x*[2]	*x*		*x*		*'99*
Quality of data		*2*				*3*	*3*	*3*	*3*	*3*	*3*				*3*

[1] *since 1994*

[2] *no quality information available*

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

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

[1] *Planned for 1997*
[2] *no quality information available*
[3] *2 first categories together*
[4] *Only available in a sample of services (Pompidou study group on first treatment demand) and in some regional reporting systems*

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

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

[1] *age in November*

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

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

[1] *only available in a sample of services (Pompidou study group on first treatment demand) and in some regional reporting systems*
[2] *no quality information available*

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

[1] *Only available in a sample of services (Pompidou study group on first treatment demand) and in some regional reporting systems*
[2] *no quality information available*
[3] *since 1998*
[4] *for a sample of SEIT only*

11. Nationality															
Categories	**AU**	**BE**	**DE**	**FI**	**FR**	**GE**	**GR**	**IR**	**IT**	**LU**	**NE**	**PO**	**SP**	**SW**	**UK**
National of this country		x	x			x	x	x		x	x		(x)[3]		'99[4]
National of EU Member state		x	x			x				x	x		(x)[3]		'99[4]
National of other countries		x	x			x	x	x[2]		x	x		(x)[3]		'99[4]
Not known		x				x	x	x		x[1]	x		(x)[3]		'99[4]
Quality of data		2				1	3			3	3				

[1] *no quality information available*
[2] *including EU Member states*
[3] *only place of birth*
[4] *including country*

12. Employment (last 6 Months)															
Categories	**AU**	**BE**	**DE**	**FI**	**FR**	**GE**	**GR**	**IR**	**IT**	**LU**	**NE**	**PO**	**SP**	**SW**	**UK**
Regular employment[1]		*x*	*x*		*x*	*x*	*x*	*x*	*(x)*[2]	*x*	*x*		*x*		*x*
Pupil / student		*x*	*x*		*x*	*x*	*x*	*x*		*x*	*x*		*x*		*x*
Economically inactive (Pensioners / Housewives, -men / Invalidity)		*x*	*x*		*x*	*x*				*x*	*x*		*x*		*x*
Unemployed			*x*		*x*	*x*	*x*	*x*		*x*	*x*		*x*		*x*
Other			*x*		*x*	*x*	*x*	*x*		*x*[3]	*x*		*x*		*x*
Not known			*x*		*x*	*x*	*x*	*x*		*x*[3]	*x*		*x*		*x*
Quality of data		*1-2*				*2*	*2*		*2*	*3*	*3*				*3*

[1] *Full-time and part-time*
[2] *Only available in a sample of services (Pompidou study group on first treatment demand) and in some regional reporting systems*
[3] *no quality information available*

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

[1] *only available in a sample of services (Pompidou study group on first treatment demand) and in some regional reporting systems*
[2] *no quality information available*
[3] *level reached, not necessarily completed full cycle*

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

[1] *Item routinely collected in summarised figures at the national level (see Table Treat-an A of National Report*
[2] *since 1997*

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

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

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

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

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

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

[2] *only for some regions planned since 1997*

[3] *age at start of problematic use available*

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

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

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

[3] *since 1997*

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

[1] *Ever shared equipment.*
[2] *These data are available in a sample of services (Pompidou study group on first treatment demand) and in some regional reporting systems*
[3] *only in 1999*
[4] *no quality information available*

5 Implementation of the CIT

5.1 Formal Procedures

The following procedures are proposed in order to continue the process of harmonisation at the EU statistics on treatment of drug addicts.

1. Until end of 1998 an agreement between the EMCDDA and the Pompidou Group should be reached on a common Core item List. As the CIT 1.0 is based on the Pompidou protocol and experts from the Pompidou group have participated in this project the necessary fine tuning should not be difficult.
2. Start to implement the CIT in all countries of the EU and - where possible - of the CEEC. Bilateral negotiations between the EMCDDA and the NFP should take place to decide on steps, timetable and milestones.
3. The scientific board should be involved in the further discussion of the CIT. For countries, where a national monitoring system already exists, the translation rules have to be defined (see examples in the annex, UK and The Netherlands).
4. Results and problems of this first implementation phase should be evaluated in a research project in 1999.
5. Based on a decision of the Management Board and the feedback from the scientific Scientific Committee the CIT should be formally adopted as EMCDDA standard at the end of 1999.
6. From 2000 on formally each EU member state should be obliged to follow the common standard.
7. A revision of the list should be planned for 1.1.2002 and afterwards every 5 years. This gives the opportunity to include new relevant items or to modify data on the basis of changing requirements.
8. While using the CIT it should be taken care that a textbook on definitions and procedures is maintained. Questions which arise during this process and the answers following should be included to increasingly define the items as good as possible.

5.2 Implementation in countries with an existing system

The implementation of the data set in the national systems will need support from the EMCDDA in several ways:

There is generally a considerable willingness for the national systems to follow adequate European standards. If the CIT is defined as such by the EMCDDA the implementation of the list in the national systems will need some time, as well as administrative and local commitment, but will cause not too many problems at a technical level. Many items can already be provided by the systems, and some necessary changes will be introduced during normal national revisions. A clear position of the EMCDDA will be necessary, because the decisions about the national systems are typically taken by a group of experts, who may have to be convinced that changes are needed.

A formal paper from the EMCDDA concerning their interest in this treatment indicator as well as some form of contract between the EMCDDA and the national organi-

sations running the system will be helpful for the implementation period. Also the support of the national representative in the Management Board is required.

5.3 Implementation in countries starting a new system

Not all EU countries already have a running treatment monitoring system in the field of drug addiction treatment. For those who are going to start such an instrument , the CIT should be used as a minimum standard from which to start. This will be extremely useful as a way to the development. More details, categories and items can be added to this list at a national level. The participating experts and the systems they come from offer their help to implement a national system in other countries.

5.4 Implementation in CEEC countries

A special situation is given in the CEEC countries. Some of them are already collecting treatment data. They might be able rather fast to deliver data based on the CIT. Others are just in the beginning of setting up such an system or are concentrating their efforts at the moment on other political fields . According to the decisions of the Cardiff summit for the pre-accession countries it would be especially important to follow the standards as soon as possible.

5.5 Test and revision

From a large number of studies which could be carried out in this field, some seem to be more promising and helpful than others in increasing comparability between European treatment monitoring systems:

- Reliability tests could be carried out in parallel in different countries based on the core items. Inter-rater reliability and test-re-test reliability could be studied in this way.
- After some period of field testing and everyday use of the data a study should be done to prove the validity and comparability of the items. Most relevant will be a comparison of data on problematic drug use based on diagnoses (ICD 10) and based on the drug offered by the user.

6 Bibliography

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7 Annex

7.1 The „Wish List“ of relevant additional items

Table 7. Additional items proposed for the CIT by different experts

Treatment-related items
Type of Treatment
Type of Health Service
Characteristics of the staff
Type of treatments performed (methadone maintenance, treatment with other drugs, counselling)
Further epidemiological information
Type of Region
Code for Area of Residence
Place of Living
Route of Administration (Secondary Drugs)
Age of First Use (Secondary Drugs)
Age of First Injection
Current polydrug-user
Health Problems
Number of non fatal Overdoses
Total number of admissions in specialised inpatient drug institutions
HIV status
Hepatitis B/C status
Main Source of Income (earned income, social funds, relatives, other sources inclusive illegal sources)

Legal Situation
General information
Client co-operation (very good, good, moderate, poor)
Client understanding: (very good, good, moderate, poor)
Ever previously treated by the same institution

7.2 Procedures to Avoid Double Counting (PADCTRS)

Introduction, Chapters II and V and table taken from:

Origer, A. (1996). *EMCDDA Epidemiology Work Programme 1996. Procedures to Avoid Double Counting in Drug Treatment Reporting Systems. Final report.* Ministere de la Sante, Grand-Duchy of Luxemburg, Luxemburg

Introduction

In the framework of the EMCDDA Epidemiology Work Programme 1996, the Luxembourgish Focal Point (LFP) has been charged to perform a comparative study on national encoding systems and **P**rocedures to **A**void **D**ouble **C**ounting in **D**rug **T**reatment **R**eporting **S**ystems, hereinafter referred to as **PADCTRS.**

In addition to the set up of the national focal point, Luxembourg has started to implement a multi-sectorial and nation wide PADCTRS in 1993 which is now fully operational but still in a state of development in terms of quality improvement.

In 1995, LFP started to design the outlines of an inter-regional reporting system involving border regions of Germany, France and Belgium, and thus has experienced the heterogeneity of regional and national encoding procedures Since the project has reached founding by the EMCDDA in the framework of REITOX work programme 96/97 the information network will become effective by the beginning of 1997.

The experience gained during the above mentioned projects has allowed to draw up basic guidelines to the development of multiple counting control procedures at various levels. These guidelines should serve as a starting point of more detailed analysis of existing PADCTRS and the recommendations towards their implementation or improvement.

Main Description of a Secure Time and Cost Effective PADCTRS

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

Multiple counting within reporting systems is basically due to the fact that one individual (client / patient) may have more than one institutional contact within more than one institution during a specified reporting period. This entails that multiple counting may appear at an **intra-institutional** and/or at an **inter-institutional level.**

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

As well as providing more **accurate** information on institutional contact prevalence (e.g. treatment centres, agencies, law enforcement institutions, etc.), data on the **overlap in cases reported** by different institutions, participating in a national data reporting system also provides information on the extent and pattern of multiple insti-

tutional contacts, which may be relevant to service providers and planners. Individual related identification codes are indeed useful for monitoring patterns of institutional contacts over successive years and give the opportunity to update a client's present situation each time she/he is indexed by one of the information network participating institutions.

The exact nature of an identification code is not relevant, nor is it possible to create a code that is 100% successful in eliminating multiple counting, as there will always be some cases where the required input-information is missing or inaccurately recorded, or where different individuals present the same attributors and thus the same identification code. Thus, a second objective is to minimise the probability of **erroneous matching** of codes so as to obtain a reasonably accurate count of the number of individuals indexed at institutional level.

B.- Hard matching / soft matching - probability of redundancy :

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

The occurring of false (soft) multiple counting mainly relies on **data collecting and data entry errors,** as well as on the number and the **differentiating weight of the input data** (attributors). (e.g. a client identification code based on gender, date of birth and country of birth may be the same for twins or persons who are born the same day in the same country and belong to the same gender for instance). If the initials of these persons were added to the code, it might be possible to differentiate them.

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

Multiple counting due to **code redundancy** (soft-match) mainly refers to algorithm based encoding procedures or more generally to every code calculation that relies on a limited number of characters and /or numbers. The only code calculation procedure that totally avoids this kind of bias is the use of « unlimited » ongoing identification numbers. In case of a ten-digit code, for instance, the redundancy probability refers to the number of possible combinations of 10 (0 to 9) units. Considering an alphanumerical code including 2 characters and 5 digits the redundancy probability corresponds to the total number of combinations between 2 (A to Z) units and 5 (0 to 9) units. In other words, there cannot be more codes than possible combinations of variables which compose it.

In practice however, combinations are even **more limited** than the theoretical given possibilities. If the identification code includes for example the whole year of birth, there will be less than 4 (0 to 9) combination possibilities (10.9.8.7) because, for the time being, there are very few chances to meet drug addicts who were born either in 1920 or in 1990. Actually, most of indexed patients were born between 1950 and 1985, which leaves only 45 possible combinations at this precise level.

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

C.- Checking procedures :

To avoid false multiple counting, encoding systems have to include systematic checks when double counting occurs. One could imagine a centralised national wide data base programmed to detect false multiple counting (Luxembourg 1997). If a yet existing code is introduced, the database should not only **provide the file or the reporting form** of the concerned person but will also have to perform an **internal check on a differentiating package of variables** as for instance employment status, martial status of the parents, etc., and in case of false double counting, automatically create a new file (bis) which will be opened each time the code associated to the specified variable package occurs. Other original checking routines are described in the UK's and in the Sweden's system presentation.

The set of data must include **variables that do not change in the course of time**. The most adequate data are of course the gender, the date of birth, the country of birth. Unfortunately these data are often used to calculate the identification code as well and are precisely the same in case of double counting. The use of martial status of the client her- or himself are quite unstable; the same data of the parents would be more indicated for instance. Person related identification variables which do not change during time and which are easily accessible are very limited and have to be used in the most effective way.

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

D.- Coverage of PADCTRSs :

Basically we have to distinguish the **operational level of existing PADCTRSs** as well as the **number and specification of data providers** (user rate) within the health and law enforcement network.

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

Regarding either local, regional or national operational levels, the effectiveness and

pertinence of a PADCTRS highly depend on the **number of users** (data providers). If the data given by PADCTRS is used for **treatment demand indicator based prevalence estimations**, the network of data providers should include specialised treatment centres as well as general hospitals, emergency rooms, psychiatric departments, general practitioners, etc. No need to add that if the aimed level is the **institutional contacts indicator**, the network has to include law enforcement institutions which have usually a quite critical approach towards data reporting systems on drug addicts and vice versa.

F.- Data protection and exclusivity of the client identification code

The used client identification code may be **exclusively created** for health institutions (e.g. treatment centres) or centralised data management institutions (public health board, focal point, etc.) (e.g. Luxembourg) to index drug treatment demands.

PADCTRSs could also adopt an already existing code like the individual **national registration number** (e.g. Denmark), the **social security number** or a personal identification number from a yet existing « **Patient Register** ». One inconvenience of this type of code is that at various levels there exists direct links between the identification code and the concerned person which can be made by institutions or persons who should not have access to this kind of data (e.g. Ministries, Social Security, Law enforcement agencies, etc.). One could easily imagine that a drug addict might refuse to provide personal data, knowing that his social security number figures on the reporting protocol. (Even merely the fact that the date of birth has figured on the first version of the reporting protocol has resulted in major objections from field institutions in Luxembourg)

The use of a PADCTRS-specific code does not come across the above mentioned problems for the equivalencies between nominal data and the identification code is only known by centralised data managers. This is not even a necessity if the **used algorithm** is exclusively known by the system designer and the attributor-to-code transcription occurs at the field level. Consequently there should of course be no other identificative variables on the reporting protocol if transmitted to the data management level in a non-aggregated format

G.- Encoding procedures and encoding flow :

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

A PADCTRS-specific code allows for **intermediate encoding levels**. An example of a three level encoding flow is the transmission of an input variables based attributor (e.g. 2/10.05.67.M) from the treatment level to the data management level, which will thus provide a regional or a national client identification code (UK). There could of course be more than one intermediate level which would increase the security by creating a **down-up information dependency** - data management level can only calculate the final client identification code if the treatment level has transmitted the attributor to intermediate level 1 (e.g. regional data collecting agency). Neither the

treatment level, nor level 1 will know the final identification code and most important of all, the data management level is not aware of the attributor generally containing high identificative data (e.g. date of birth).

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

I. - Availability of input data (attributor)

The variables the client identification code is based on, have to be **easily accessible**. Thus the gender and the date of birth of a person appear to be good attributor variables because the first is apparent and the second is usually known by the client himself. Initials of the parents or city of residence are for instance more ambiguous. The parents could be unknown or the patient could alternatively provide the initials of his/her real parents or those of eventual stepparents; the city of residence might be considered to be the usual place of living or the official registered address (error risks especially in data collection based on file research). It is essential that the **attributor variables are explicit and univocal** in order to avoid false double counting.

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

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

J. - Confidentiality and psychological impact :

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

Basically both, institutions and clients are concerned about the question of **data confidentiality and data protection.** At the field institution level (data providers), data protection insurance is one of the most important issues in the decision process as to participate in a centralised reporting system or not. The data management level has to provide clear guidelines for protecting confidentiality and avoiding abuse of delivered data. Hence, the exact definition of the used identification code generally happens to be the most critical issue as field institutions are bound at all events to medical or professional secret rules which usually do not allow them to reveal any

identificative information on their clients. The respective rights and the procedures to follow rely on the **national data protection legislation** which discussion would take us to far in the restricted framework of this paper.

The **identificative weight of a client identification code** has to be carefully measured. You may have codes from which personal information can directly be inferred, such as date of birth, gender or city of residence for instance. At a centralised data level this information might be irrelevant, however at a local or regional level, it might allow the full identification of a person. Knowing the initials, the date of birth and the city of residence of an addict who happens to live in a small town of 1000 inhabitants raises some serious questions about his/her **anonymity. No identificative data should possibly exceed the field institution level or even reach any intermediate encoding level.**

The geographical area in which a PADCTRS operates basically defines its nature and encoding requirements. In smaller country even a national wide client identification code has to be highly confidential and include a minimum of identificative variables. The most indicated solution in this particular case would be an **algorithm based transcription** of a usually high identificative attributor at the very level of field institutions.

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

It is essential to discuss these matters of confidentiality carefully with the concerned field institutions, to define **mutual interests** aiming to involve the participating levels in an active way. Strong resistance from field institutions may be expected. It certainly takes time to develop a **relationship based on mutual trust** between the different information level, but it appears to be the only way to ensure good quality data and to avoid the burnout of reporting systems and respective PADCTRSs.

K.- Transmission procedures :

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

Data can for example reach the focal point or any other data management agency in **aggregated form** (e.g. Sweden, Italy) or on the other hand in the form of an individual data reporting protocol (Greece, Luxembourg). In the first case the encoding and the multiple counting checks occur at former levels (National Board of Health, State Health Statistics Department, Epidemiological Research Institutes, etc.)

If the data transmission is **paper based** (or on floppy disk, CD-ROM, etc.), the codes can be personally handed (Luxembourg), sent by post or faxed to the data management institution. **Computer based transmission** can have recourse to electronic mail or other telemetric facilities whether within a **Local Area Network (LAN)** or a **Wide Area Network (WAN)** and the data may then be **transmitted** and **stored** in an **encrypted format** or not. Despite the time effectiveness of computer based trans-

mission, field institutions seem to prefer the paper based approach for matters of security even if they are aware of the subjectiveness of their statement. Regular mail may indeed be lost easier than e-mail attachment. The point is that electronic mail within a WAN is generally considered to be more exposed to non authorised persons than regular mail actually is. The physically collection of reporting protocols or other data supports at field institutions is of course very secure but hardly feasible in wider networks including an important number of treatment centres

Recommendations towards the Implementation or Modification of National PADCTRS

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

One should clearly understand that the design of national PADCTRSs can not and must not shape one optimal and overall applicable system; its development far more appears to be a context related problem solving task that requires as much methodological expertise than innovative achievement. As a matter of fact, quality assessment of PADCTRS happens to be a fairly delicate, if not an impossible task since the ground on which these systems are supposed to develop and the conditions they are bound to are rarely the same from one country to another.

The present analysis has shown that the implementation of PADCTRS requires a holistic approach that cannot be based on a defined set of methodological recommendations. The descriptors which have been defined and refined in a dynamic approach and their use as a possible conceptual tool towards the set-up or the adaptation of multiple counting routines appear to be the only general recommendation that might be stated. This paper does not intend, to evaluate or to compare the quality of national PADCTRSs; it basically describes their components (descriptors) and stresses out the possible and often predicable consequences of their interaction. Nevertheless, one should pay attention to some important additional items.

A first topic that has to be stressed are the implications of different types of PADCTRS on drug epidemiology research. In others words, considering the question to know what type of PADCTRS allows or facilitate what kind of drug research activities. This question should be clearly measured, previously to the implementation or even the modification of PADCTRSs for it partly defines the required features of the data reporting system itself.

One of the major assignments of PADCTRS supported reporting systems happens to be the opportunity to produce more reliable drug prevalence estimation. They, however, have to offer a wider range of applications, especially in the field of research activities that require record linkage among independent data sources. Studies that aim at the monitoring of drug treatment demanders in a given environment during a specified time period as for instance case finding studies or capture - recapture studies require person related and thus unique identification codes. If the time period appears to be less relevant, the specification of the chosen environment certainly is, for

it defines the coverage or the user rate of a given PADCTRS code. As a matter of fact, the representativity of these studies exactly fits the number of institutions that use the respective identification code.

From regional studies on drug treatment episodes within a defined type of treatment agencies to nation wide monitoring of drug related institutional contact indexing, a fairly important range of PADCTRS can be applied. A nation wide and cross sectorial PADCTRS obviously shapes the requirements of most drug studies; a more limited PADCTRS exclusively designed for a specific study might be preferred for financial or practical reasons. The final decision is of methodological nature but certainly has to include the legal national context regarding data protection and the existence or not of previous codification systems at the national level.

Another important topic which should be discussed in the framework of this paragraph is precisely the link between the legal requirements in terms of national data protection, PADCTRS supported reporting systems and the somehow hidden opportunity of service quality control the latter might be offering.

The limited framework of this report did not allow for a refined analysis of national legislation on data protection. However, in addition to the status and the legal situation of both, data management and data providers, the national legislation clearly plays the major part in the decision process towards the conception and the implementation of national PADCTRS.

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

If these relationships in terms of power do not exist between the involved information producing and processing levels, the feasibility and operationality of data reporting systems, besides the legal context, highly depend on the common definition of mutual interests and benefits. Those are not necessary defined in terms of financial rewards but mostly refer to a 'plus-valued' data feedback to data producers; data that might enable field institutions for instance to locate gaps in their treatment offers and to possibly improve quality standards. It should be stressed that this negotiation process is fairly supported by at least two factors : the awareness of all involved actors that there exists at least one common objective, that is the long term improvement of drug treatment services as well as a common constraint : the reciprocal dependence whether in terms of financial founding or updated data income.

Long term oriented agreements have to be compliant enough to allow eventual amendments aiming to promote or to maintain active involvement of data providers.

Surprisingly this data feedback to field institutions, although it often represents a formal requirement of the latter, may be as well one of the main impediments to the set up of PADCTRSs. Especially in a long term perspective, the delivered data, if accurately processed, might be used for purposes as for instance quality and effectiveness assessment of treatment agencies involved in a given network. Even if this particular aspect may be less visible to the actors at a first stage, it will most likely emerge if the given reporting system offers the opportunity to index treatment demanders (cases, not episodes) during a long time period.

An intra and inter institutional PADCTRS such as it is currently applied in the G.-D. of

Luxembourg allows to follow up addicts not only during a specific reporting period or within a given type of health care institutions but provides updated data on all institutional contacts a specific person might have established over several years (since 1994). This anonymised follow up provides reliable information on drug careers as well as on the impact, influence or effectiveness of undergone treatments.

This information could possibly be used to pressure field institutions and might finally interfere in the founding process. Thus, institutions that do provide patient related data put themselves in a somehow awkward position by being exposed to possible quality controls or criticism which have thoroughly been avoided until then for there were no reliable evaluation criteria.

The most effective solution, but undoubtedly not the easiest one, is to openly discuss these matters from the very beginning and to figure out other quality assessment criteria to be taken into account. (Abstinence and number of post treatment institutional contacts are indeed not always and not the only indicators of the therapeutic effectiveness of whatever treatment or intervention.

Data management level has to be fully aware of the complexity of its status and objectives. In addition to the ongoing negotiation process with data providers, data management actors face another responsibility which is defined in terms of political impact.

The interest of policy makers generally focuses on prevalence data which is considered to be a quality indicator regarding political strategies towards demand reduction. Public opinion often exclusively refer to prevalence estimations to approve governmental programmes in the field of drugs and drug addiction. Since in most of the countries there exists a kind of scientific monopoly regarding reliable national prevalence data, the final estimation outcome strongly depends on the quality and coverage of collected data as well as on the methodological framework the given data management actors have decided or are obliged to work in. The set-up of a high standard information network including national wide PADCTRSs or even merely the improvement of a yet existing reporting system will not only have immediate consequences on the prevalence figure but will also cause major political impact even if the genuine number of drug addicts has actually not increased. The final outcome will be considered but not necessarily the way that had lead to it.

PADCTRS Applied at the European Level

Table 8. Preliminary Remarks

Preliminary remarks:

1. The following countries have been participating in the present study : **Austria, Belgium, Denmark, France, Germany, Greece, Ireland, Italy, Luxembourg, the Netherlands, Portugal, Spain, Sweden, United Kingdom.**

   National PADCTRS are presented in an alphabetical order except for Austria, France, Ireland and Spain which do not dispose of any standardised PADCTRS at the present time.

2. Paragraphs printed in *italics* have been selected from the original documents provided by the respective national focal points.

3. Paragraphs printed in **bold** refer to the descriptor list.

4. The figure at the end of the present analyses presents an overall picture of national PADCTRS with reference to the main descriptor categories:

   *****: guaranteed
   ****: guaranteed but possible improvements
   ***: medium development level
   **: low development level
   *: only very specific and limited applications
   (): no information given

Table 9. Overall descriptor analysis of national PADCTRSs

Country	B	D	DK	E	GR	I	LU	NL	SW	UK
Descriptors **Year**	1992	1980	1996	1987	1994	1992	1994	1988	1993	1992
A. Double / Multiple counting (inter institutional)	***	**	*****	*****	****	***	*****	****	*****	*****
B. Hard matching	***	*	****	**	****	***	****	****	****	****
Soft matching	*	*	****	****	()	***	****	()	****	*****
C. Checking procedures	*	*	*****	****	NO	NO	*****	()	*****	*****
D. Coverage of PADCTRSs										
Treatment demand level (Health sector)	****	***	***	****	***	NO	***	****	****	****
Non sanitary institution level	0%	0%	0%	0%	0%	***	****	*	****	****
E. Operational level of PADCTRS (nat./reg./local)	***	****	*****	***	*****	*****	*****	*****	*****	*****
F. Data protection										
PADCTRS specific code	YES	YES[3]	NO	YES	YES	YES	YES	YES	NO	YES
Identificative weight of final PADCTRS code	***		**	***	***	****	*****	*****	***	*****
Other identificative variables on the protocol	YES	YES	NO	NO	NO	not applicable	NO	NO	NO	NO
G. Encoding procedures and encoding flow	***	****	****	*****	****	***	*****	****	****	****
H. Encoding device (algorithm based transcription)	NO	NO	YES	NO	not available	NO	YES	YES	not available	YES
I. Availability of input data (attributor)	****	****	****	****	****	****	****	****	****	****
J. Confidentiality and psychological impact	****	*****	***	****	****	not applicable	*****	****	***	****
K. Transmission procedures	***[3]	****[3]	***[2]	****[3]	****[2]	not applicable[3]	*****[2]	****[3]	not applicable[3]	****[3]

[1] As already stated, the Italian Focal Point has only aggregated data income of patients addressing to treatment centres. The only personal information they collect is on people indicated by police forces because of personal drug use to Local Administrative Offices which establish links with public and private facilities. For this purpose, they use a PADCTRS specific code, which precisely is described in this figure.

[2] The Swedish Focal Point (SFP) does not use a PADCTRS code. The SFP does not have access to personal identity numbers due to personal integrity requirements, but only to aggregated data. From time to time the SFP uses information from the Patient Register (PAR) which is described in this figure.

[3] Personal institution related intake number that allows no multiple counting control.

7.3 Reliability of Data collected by Treatment Demand Reporting Systems

On the basis of 1,784 subjects' treatment data, which were collected using the Pompidou Protocol by Belgium, Finland, Greece and -Luxemburg in 1996 a reliability check has been done. The following tables are taken from:

Kokkevi, A. (1997a). *REITOX Sub-Task 3.1. To Improve the Reliability of Data Collected by Treatment Demand Reporting Systems. Final Report.* Greek REITOX Focal Point, University Mental Health Research Institute, Athens, Greece

Table 10. Missing Values on the Pompidou Protocol for 2nd semester 1996 data in each of the 4 countries Belgium,. Finland, Greece and Luxembourg

Number of Treatment demands	Belgium N=689	Finland N=670	Greece N=186	Luxembourg N=239
Treatment Centre	0.0	/	0.0	0.0
Date of Treatment Demand	9.6	2.4	0.0	0.0°
Ever previously Treated at any Treatment Centre	3.6	4.4	5.9	3.4
Source of Referral	/	63.7	0.0	/
Sex	1.0	0.6	1.1	0.0
Age	2.2	1.0	0.0	0.0
Date of Birth	5.9	/	0.0	0.0
Current Living Status	9.4	1.9	3.2	8.9
Nationality/Ethnicity	1.3	0.4/97.8	1.1	0.0
Employment status	3.0	2.4	3.2	0.4
Highest Educational Level	15.7	10.7	1.6	1.1
Primary Drug	0.9	0.0	0.0	0.0
Route of Administration Primary Drug	6.1	2.5	0.0	0.0
Frequency of Use Primary Drug	16.3	9.8	0.0	0.3
Age at 1st Use Primary Drug	18.0	15.0	0.0	1.6
Secondary Drug (1)	0.9	15.7	19.4	0.0

Currently Injecting	0.7	25.8	0.0	0.0
Ever Injected	6.9	7.6	0.5	0.0

Table 11. Inconsistencies on the Pompidou Protocol for 2nd semester 1996 data in each of the four countries Finland, Greece and Luxembourg (not available for Belgium)

Number of Treatment demands	Finland N=670	Greece N=186	Luxembourg N=239
Previous Treatment: 6a vs. 6b	-	0.0	0.0
Age: 9a vs. 9b	-	0.5	0.0
Current Living Status: 10a vs. 10b	1.3	1.6	0.0
Employment Status & Educational Level: 13 vs. 14a	-	0.0	0.0
Primary Drug & Route of Administration: 15a vs. 15b	0.0	0.0	0.0
Secondary Drug (1) vs. Route of Administration: 16a vs. 16b	0.0	0.0	0.0
Secondary Drug (2) vs. Route of Administration: 17a vs. 17b	0.0	0.0	0.0
Age, Age at 1st Use & Duration of Use of Primary Drug: 9a vs. 15d vs. 15e	5.1	3.2 (0.0)[1]	0.24
Age, Age at 1st Use & Age 1st Used Any Drug: 9a vs. 15d vs. 18age	1.8	0.0	0.0
Route of Administration & Currently Injecting or Ever Injected: 15b vs. 19a & 20a	2.1	6.5	0.24
Route of Administration & Currently Injecting or Ever Injected: 16b vs. 19a & 20a	2.6	0.0	0.34
Route of Administration & Currently Injecting or Ever Injected: 17b vs. 19a & 20a	1.7	1.1	0.07
Ever Injected & Age 1st Use: 20a vs. 20b	8.4	1.1	0.0

[1] The real inconsistency is the number in the parenthesis, after excluding cases where item g15d was coded incorrectly (months instead of years).

7.4 The National Translation Rules for the CIT - Examples (UK and NL)

7.4.1 The Netherlands

(Only Items which require a translation are itemised in the „English“-column)

	Core-Items (EMCDDA)	Monitoring-System (national language)	Monitoring-System (English)
1	**Treatment Centre Type**	**Soort instelling**	
2	**Date of Treatment Month**	**Maand van hulpverlening**	
3	**Date of Treatment Year**	**Jaar van hulpverlening**	
4	**Ever Previously Treated**	**Ooit eerder hulp ontvangen**	
	• Never	• nee	•
	• Previously treated	• ja	•
	• Not known	• onbekend	•
5	**Source of Referral**	**Aanmelding via**	**Entered by**
	• Self referred	• cliënt zelf	•
	• Family / Friends	• directe omgeving	•
	• Other drug treatment centre	• verslavingszorg	•
	• GP	• algemene gezondheidszorg	• Health Care
	• Hospital / other medical source	• algemene gezondheidszorg	• Health Care
	• Social services	• gemeenschaps- voorzieningen	•
	• Court / probation / police	• justitie	• Justice
	• Other	• anderszins	•
	• Not known	• onbekend	•
6	**Gender**	**Geslacht**	
	• male	• man	•
	• female	• vrouw	•
	• not known	• onbekend	•

	Core-Items (EMCDDA)	Monitoring-System (national language)	Monitoring-System (English)
7	**Age of Person at Start of Treatment**	**Leeftijd tijdens start hulp-verlening**	
8	**Year of Birth**	**Geboortejaar**	
9	**Living Status**	**Leefsituatie**	**Living condition**
	• alone	• alleenstaand	• single
	• with parents	• met ouder(s)	• with parent(s)
	• alone with child	• met kind(eren)	• with child(ren)
	• with partner (alone)	• met partner	• with partner
	• with partner and child	• met partner en kind(eren)	• with partner and child(ren)
	• with friends	• met ander(en)	• with other(s)
	• other	• met ander(en)	• with other(s)
	• not known	• onbekend	•
10	**Nationality**	**Nationaliteit**	
	• National of this country	• Nederlands	•
	• National of EU-Member-States	• land van de EU	•
	• National of other countries	• land buiten de EU	•
	• Not known	• onbekend	•
11	**Employment**	**Bron van inkomsten**	**Source of income**
	• Regular Employment	• regulier werk	• wages or independent
	• Pupil / Student	• studiefinanciering	• scholarships
	• Economically inactive (Pensioners, Housewifes, -men / Invalidity)	• AOW/pensioen • geen eigen inkomen uitkering	• pensions/no income • social benefits
	• Unemployed	• AOW/pensioen • geen eigen inkomen uitkering	• pensions/no income • social benefits
	• Other	• anders	•
	• Not known	• onbekend	•

	Core-Items (EMCDDA)	Monitoring-System (national language)	Monitoring-System (English)
12	**Highest Educational Level Completed**	**Opleidingsniveau afgerond**	**Finished education**
	• never went to school / never completed primary school	• geen	• none
	• primary school	• lager onderwijs	• lower
	• secondary school	• voortgezet onderwijs	•
	• tertiary education	• tertiair onderwijs	•
	• not known	• onbekend	•
13	**Primary Drug**	**Primaire problematiek**	**Primary problem**
	• **Opiates (total)** ▫ Heroin ▫ Methadone ▫ other Opiates	• Opiaten (totaal) ▫ heroïne ▫ methadon ▫ overige opiaten	• ▫ ▫ ▫
	• **Cocaine (total)** ▫ Cocaine ▫ Crack	• Cocaine (totaal) ▫ cocaine ▫ crack	• ▫ ▫
	• **Stimulants (total)** ▫ Amphetamines ▫ MDMA and other derivates ▫ other stimulants	• Stimulerende middelen (totaal) ▫ amfetaminen ▫ ecstacy ▫ overige stimulerende middelen	• ▫ ▫ **ecstacy** ▫
	• **Hypnotics and Sedatives (total)** ▫ Barbiturates ▫ Benzodiacepines ▫ Others	• Medicijnen (totaal) ▫ barbituraten ▫ benzodiazepinen ▫ overige medicijnen	• ▫ ▫ ▫
	• **Hallucinogens (total)** ▫ LSD ▫ Others	• Hallucinaten (totaal) ▫ LSD ▫ overige hallucinaten	• ▫ ▫
	• **Volatile Inhalants**	• **Vluchtige middelen**	• **Volatile substances**
	• **Cannabis (total)**	• **Cannabis (totaal)**	•
	• **Other Substances (total)**	• **Overige middelen (totaal)**	•

	Core-Items (EMCDDA)	Monitoring-System (national language)	Monitoring-System (English)
14	**Route of Administrationation (primary drug)**	**Wijze van gebruik**	**Methods of drug use**
	• Inject	• spuiten	• intravenous
	• Smoke / Inhale	• roken	• smoking
	• Eat / Drink	• slikken/drinken	• swallowing/drinking
	• Sniff	• snuiven	• snorting
	• Others	• anders	• other
	• Not known	• onbekend	•
15	**Frequency of Use Primary Drug**	**Frequentie gebruik**	
	• Not used in past month / occasional	• niet meer van toepassing/onregelmatig	•
	• Once per week or less	• wekelijks	•
	• 2 - 6 days per week	• meer malen per weerk	•
	• Daily	• dagelijks	•
	• Not known	• onbekend	•
16	**Age at First Use of Primary Drug**		
17	**Current Secondary Drugs**	Primaire problematiek	
	• **Opiates (total)** ▫ Heroin ▫ Methadone ▫ other Opiates	• Opiaten (totaal) ▫ **heroine** ▫ **cocaine** ▫ **overige opiatem**	• ▫ ▫ ▫
	• **Cocaine (total)** ▫ Cocaine ▫ Crack	• Cocaine (totaal) ▫ **cocaine** ▫ **crack**	• ▫ ▫
	• **Stimulants (total)** ▫ Amphetamines ▫ MDMA and other derivates ▫ other stimulants	• Stimulerende middelen ▫ **amfetaminen** ▫ **ecstacy** ▫	• ▫ ▫ **ecstacy** ▫
	• **Hypnotics and Sedatives (total)** ▫ Barbiturates ▫ Benzodiacepines ▫ Others	• Medicijnen (totaal) ▫ **barbituraten** ▫ **benzodiazepinen** ▫ **overige medicijnen**	• ▫ ▫ ▫

	Core-Items (EMCDDA)	Monitoring-System (national language)	Monitoring-System (English)
	• **Hallucinogens (total)** ▫ LSD ▫ Others	• Hallucinaten (totaal) ▫ **LSD** ▫ **overige hallucinaten**	• ▫ ▫
	• **Volatile Inhalants**	• **Vluchtige middelen**	• **Volatile substances**
	• **Cannabis (total)**	• **Cannabis (totaal)**	•
	• **Alcohol as secondary drug (total)**	•	•
	• **Other Substances (total)**	• **Overige middelen (totaal)**	•
18	**Ever / Currently (last 30 days) injected**	**Spuiten**	
	• Ever injected, but not currently	• ooit gespoten	•
	• Currently injected	• spuit nog	•
	• Never injected	• nooit gespoten	•
	• Not known	• onbekend	•

7.4.2 United Kingdom

	Core Items (EMCDDA)	UK Monitoring System (DMD)
1	**Treatment centre type**	**Agency type** General practice: Private General practice: NHS funded Police Surgeon Community based drug service: statutory Community based drug service: non-statutory Hospital in-patient treatment: statutory Hospital in-patient treatment: private Hospital in-patient treatment: non-statutory Hospital out-patient treatment: statutory Hospital out-patient treatment: private Drug Dependency Unit in-patient Drug Dependency Unit out-patient Residential rehabilitation: statutory Residential rehabilitation: private Residential rehabilitation: non-statutory Day care service: statutory Day care service: private Day care service: non-statutory NHS Psychiatric in-patient NHS Psychiatric out-patient Hospital drug clinic: statutory Hospital drug clinic: private Accident and emergency wards Private in-patient facility Private out-patient facility Nursing services Needle/syringe exchange service Outreach work (detached) Police station Young offenders institution Probation Prison medical service Social Services Other
2	**Date of treatment month**	**Date of contact**
3	**Date of treatment year**	**Date of contact**
4	Ever previously treated never previously treated	* Not collected * (proxy)[1] (proxy)[1]

	Core Items (EMCDDA)	UK Monitoring System (DMD)
	not known	
5	**Source of referral**	**Referral from**
	• self referred	• self
	• family/friends	• family / friend
	• other drug treatment centre	• Regional Drug Service(Doctor, nurse specialist, psychologist, Social worker, Probation officer, other) • Community Drug Team/Project (CPN/Nurse, Social worker, Probation officer, Counsellor/drug worker, psychologist, health promotion/education officer, health visitor, doctor, volunteer, other) • Other Drug Agency (statutory drug agency, non-statutory/voluntary drug agency, therapeutic community)
	• GP	• GP
	• hospital/other medical source	• Accident & emergency • psychiatric department • hospital out-patient • maternity/ante-natal clinic • other hospital department • psychologist • CPN • health visitor • other nurse • health centre • alcohol treatment unit,
	• social services	• social services
	• court/probation/police	• court • probation • police
	• other	• solicitor • prison officer • employer • job centre • school • community health council • other
	• not known	• Not known

6	**Gender**	**male/female**
	• male	• male
	• female	• female

	Core Items (EMCDDA)	UK Monitoring System (DMD)
	• Not known	
7	**Age of person at start of treatment**	**Age at date of contact** (from date seen and date of birth)
8	**Year of birth**	**date of birth**
9	**Living status** • alone • with parents • alone with child • with partner (alone) • with partner and child • with friends • other • Not known	**Living with** • alone • with parents • *(children recorded elsewhere)* • with partner • *(children recorded elsewhere)* **** Not collected **** • with drug user(s) • with non-drug user(s) • with partner • with parent and partner • with parent(s)/drug user(s) • with partner/drug user(s) • with parent(s)/non-drug user(s) • with partner(s)/drug user(s) • with other family member /non-drug user(s) • with other family member /drug user(s) • with strangers/non-drug user(s) • with strangers/drug user(s) • Not known
10	**Nationality** • national of this country • national of EU member states • national of other countries • Not known	**** Not collected ****
11	**Employment** • regular employment • pupil / student • Economically inactive • unemployed • other • Not known	**Employment status** • employed • student • retired • housewife • in prison • unemployed • invalidity • prostitute • not known
12	**Highest education**	**** Not collected ****

	Core Items (EMCDDA)	UK Monitoring System (DMD)
	level completed • never went to school/ never completed primary school • primary school • secondary school • tertiary education • Not known	
13	**Primary drug**	**Main drug**
	• opiates (total)	• Opiates unspecified
	• heroin	• Heroin unspecified (inject) • Heroin illicit (smoke) Heroin diamorphine
	• methadone	• Methadone unspecified • Methadone mixt(dtf) • Methadone linctus • Methadone 5mg tabs • Methadone 10mg tabs • Methadone suppositories • Methadone (Physeptone) amps
	• other opiates	• Morphine • Opium • Dihydrocodeine (DF118) • Dextromoromide (Palfium) • Dipianone (Diconal) • Pethidine • Hydromorphone • Oxymorphone • Hydrocodone • Oxycodone • Levorphanol • Phenazocine • Piritramide • Codeine tabs • Dextropropoxyphene (Distalgesic) • Pentazocine (Fortral) • Buprenorphine (Temgesic) • Codeine unspecified • Opiate containing compounds • Nalbuphine • Alphaprodine • Anileridine • Ethoheptazine • Fentanyl • Phenoperidine

Core Items (EMCDDA)	UK Monitoring System (DMD)
	• Opiate mixture unspecified
• other opiates (continued)	• Codeine linctus • Gees linctus • Collis-brown • Phensedyl • Actifed • Kaolinmorphine • Other opiates
• cocaine (total)	•
• cocaine	• cocaine unspecifiedified • cocaine hydrochloride powder
• crack	• cocaine smokeable • cocaine hydrochloride smokeable • cocaine hydrochloride aerosol
• stimulants (total)	• Stimulants unspecified
• amphetamines	• Amphetamines unspecified • Amphetamine (illicit) • Amphetamine (pharmaceutical) • Methadrine • Dexadrine • Dexamphetamine syrup • dexamphetamine smokeable • Methamphetamine amps • Drinamyl
• MDMA and derivatives	• MDMA • MDA
• other stimulants	• Appetite suppressants unspecified • Diethylproprion (Tenuate, Dospan etc.) • Phenmetrazine (Preludin) • Fenfluoramine (Ponderax) • Mazindol (Teronac) • Phenteramine (Duromine etc.) • Methylphenidate (Ritalin) • Pemoline • Prolintane • Fencamfamin (Reactivan) • Caffeine(pro-plus) • Other stimulants unpecified
• Hypnotics and sedatives	• Sedatives unspecified
• barbiturates	• Barbiturates unspecified • Amylobarb (Tuinal) • Pentobarb (Nembutal) • Quinalbarb (Seconal) • Phenobarb (Luminal)

Core Items (EMCDDA)	UK Monitoring System (DMD)
	• Butobarb (Soneryl) • Heptabarb (Medomin) • Cyclobarb (Phanodorm) • Hexobarb (Evidorm) • Barbitone unbranded • Methylphenobarbitone
• benzodiazepines	• Benzos unspecified • Diazepam (Valium) • Chlordiaz (Librium) • Nitrazepam (Mogadon) • Lorazepam (Ativan) • Clobezam (Fris) • Chlorazepate (tranx) • Ketazolam (anxon) • Medazepam (Nobrium) • Oxazepam (Serenid) • Flurazepam (Dalmane) • Temazepam • Triazolam (Halcion) • Lormetazepam (Noctamid) • Prazepam (Centrax) • Bromazepam (Lexotan) • Flunitrazepam • Chlormezanone (Trancopal) • Loprazolam • Alprazolam
• others	• Anti-histamines unspecified • Hydroxyzine • Cyclizine (Valloid) • Promethazine • Non-barb,non-benzo,hypotic sedative unspecified • Methaqualone (Mandrax) • Chlormethiazole (Heminevrin) • Meprobamate etc • Zopiclone • Propranolol(Inderal) • Chloral derivatives • Glutethimide • Mephenesin • Methylpentylynol (Oblivon d) • Methylprylone (Noludar) • Oxyprenolol hydrochloride (Trasicor) • Other sedatives
• hallucinogens (total)	• Hallucinogens unspecified

	Core Items (EMCDDA)	UK Monitoring System (DMD)
	• LSD	• LSD
	• others	• Mescaline
		• Psilocybin mushrooms
		• Phencyclidine(PCP)
		• Ketamine
	• Volatile inhalants	• Solvents unspecified
		• Glue
		• Butane gas
		• Amyl nitrate
		• Acetone
		• Aerosols
		• Cleaning fluids
	• Cannabis (total)	• Cannabis unspecified
		• Cannabis (herbal)
		• Cannabis (resin)
		• Cannabis oil
	• Other substances (total)	• Tobacco unspecified
		• Cigarettes
		• Alcohol unspecified
		• Beer or cider
		• Wines
		• Spirits
		• Alcohol mixt
		• Other drugs unspecified
		• Minor analgesics
		• major tranx unspecified
		• Chlorpromazine (Largactil)
		• anti-depressants
		• Anti-diarrhoea, anti-emetic
		• Naltrexone
		• Antabuse
		• Clonidine
		• Steroids

14	**Route of administration (primary drug)**	**Route of administration (main drug)**
	• inject	• inject
	• smoke/inhale	• smoke/inhale
	• eat /drink	• oral
	• sniff	• sniff/snort
	• others	• smoke and inject

	Core Items (EMCDDA)	UK Monitoring System (DMD)
		• sniff and smoke • inject and snort • oral and inject • inhale (solvents) • oral and smoke • oral and sniff/snort • per rectum
	• Not known	• Not known
15	**Frequency of use of primary drug**	**Frequency (main drug)**
		• monthly
	• not used in past month / occasional	• occaisional
	• once per week or less	• weekly/weekends/recreational
	• 2 - 6 days per week	**** Not collected ****
	• daily	• daily
	• Not known	• Not known
16	**Age of first use of primary drug**	**Age of first use (main drug)**
17	**Current secondary drugs**	**Drug 2, drug 3, drug 4, drug 5/alcohol**
	• opiates (total)	• Opiates unspecified
	• heroin	• Heroin unspecified (inject) • Heroin illicit (smoke) • Heroin diamorphine
	• methadone	• Methadone unspecified • Methadone mixt(dtf) • Methadone linctus • Methadone 5mg tabs • Methadone 10mg tabs • Methadone suppositories • Methadone (Physeptone) amps
	• other opiates	• Morphine • Opium • Dihydrocodeine (DF118) • Dextromoromide (Palfium) • Dipianone (Diconal) • Pethidine • Hydromorphone • Oxymorphone • Hydrocodone • Oxycodone

Core Items (EMCDDA)	UK Monitoring System (DMD)
	• Levorphanol • Phenazocine • Piritramide • Codeine tabs • Dextropropoxyphene (Distalgesic) • Pentazocine (Fortral) • Buprenorphine (Temgesic) • Codeine unspecified • Opiate containing compounds • Nalbuphine • Alphaprodine • Anileridine • Ethoheptazine • Fentanyl • Phenoperidine • Opiate mixture unspecified
• other opiates (continued)	• Codeine linctus • Gees linctus • Collis-brown • Phensedyl • Actifed • Kaolin+morphine • Other opiates
• cocaine (total)	•
• cocaine • crack	• cocaine unspecifiedified • cocaine hydrochloride powder • cocaine smokeable • cocaine hydrochloride smokeable • cocaine hydrochloride aerosol
• stimulants (total)	• Stimulants unspecified
• amphetamines	• Amphetamines unspecified • Amphetamine (illicit) • Amphetamine (pharmaceutical) • Methadrine • Dexadrine • Dexamphetamine syrup • Dexamphetamine smokeable • Methamphetamine amps • Drinamyl
• MDMA and derivatives	• MDMA • MDA
• other stimulants	• Appetite suppressants unspecified • Diethylproprion (Tenuate, Dospan etc.) • Phenmetrazine (Preludin) • Fenfluoramine (Ponderax)

Core Items (EMCDDA)	UK Monitoring System (DMD)
	• Mazindol (Teronac) • Phenteramine (Duromine etc.) • Methylphenidate (Ritalin) • Pemoline • Prolintane • Fencamfamin (Reactivan) • Caffeine(pro-plus) • Other stimulants unpecified
• Hypnotics and sedatives	• Sedatives unspecified
• barbiturates	• Barbiturates unspecified • Amylobarb (Tuinal) • Pentobarb (Nembutal) • Quinalbarb (Seconal) • Phenobarb (Luminal) • Butobarb (Soneryl) • Heptabarb (Medomin) • Cyclobarb (Phanodorm) • Hexobarb (Evidorm) • Barbitone unbranded • Methylphenobarbitone
• benzodiazepines	• Benzos unspecified • Diazepam (Valium) • Chlordiaz (Librium) • Nitrazepam (Mogadon) • Lorazepam (Ativan) • Clobezam (Fris) • Chlorazepate (tranx) • Ketazolam (anxon) • Medazepam (Nobrium) • Oxazepam (Serenid) • Flurazepam (Dalmane) • Temazepam • Triazolam (Halcion) • Lormetazepam (Noctamid) • Prazepam (Centrax) • Bromazepam (Lexotan) • Flunitrazepam • Chlormezanone (Trancopal) • Loprazolam • Alprazolam
• others	• Anti-histamines unspecified • Hydroxyzine • Cyclizine (Valloid) • Promethazine

Core Items (EMCDDA)	UK Monitoring System (DMD)
	• Non-barb,non-benzo,hypotic sedative unspecified • Methaqualone (Mandrax) • Chlormethiazole (Heminevrin) • Meprobamate etc • Zopiclone • Propranolol(Inderal) • Chloral derivatives • Glutethimide • Mephenesin • Methylpentylynol (Oblivon d) • Methylprylone (Noludar) • Oxyprenolol hydrochloride (Trasicor) • Other sedatives
• hallucinogens (total)	• Hallucinogens unspecified
• LSD	• LSD
• others	• Mescaline • Psilocybin mushrooms • Phencyclidine(PCP) • Ketamine
• Volatile inhalants	• Solvents unspecified • Glue • Butane gas • Amyl nitrate • Acetone • Aerosols • Cleaning fluids
• Cannabis (total)	• Cannabis unspecified • Cannabis (herbal) • Cannabis (resin) • Cannabis oil
• Other substances (total)	• Tobacco unspecified • Cigarettes • Alcohol unspecified
	• Beer or cider • Wines • Spirits • Alcohol mixt • Other drugs unspecified • Minor analgesics • major tranx unspecified • Chlorpromazine (Largactil) • anti-depressants • Anti-diarrhoea, anti-emetic

	Core Items (EMCDDA)	UK Monitoring System (DMD)
		• Naltrexone • Antabuse • Clonidine • Steroids
18	**Ever / currently (last 30 days) injected** • ever but not currently • currently injected • never injected • Not known	**Ever / currently (past 4 weeks) injected** • ever injected • injected past 4 weeks • • Not known

Notes:

[1] 'Proxy' = question not asked but information is retrievable from the system at a Regional level (not National) dependent on how long the system has been in operation.

7.5 Levels of Education (ISCED)

Levels of Education According to the International Standard Classification of Education (ISCED) in the 15 countries of the European Union

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

Remarks:

- ISCED 0 = Early childhood education not included
- Higher education:
  ISCED 5 = Non-university tertiary level of education
  ISCED 6 = Universitary tertiary level of education: first stage
  ISCED 7 = Universitary tertiary level of education: second stage, post-graduate
- For Grand-Duché Luxembourg, Northern Ireland (UK) and Scotland (UK) only less detailed information is available due to the use of another source, i.e. European Commission (1996), and not OESD (1997) as for the other EU countries. No clear references are made to the ISCED levels of education, so here only 'estimates' are presented
- *1-3 years* = Theoretical year(s) of study *within* the type of educational programme / institution (not the theoretical duration of total study career, e.g. from year 1 primary education total year 17 university).
- Information about private education and special education is not available for each country

COUNTRY	ISCED 1 PRIMARY LEVEL OF EDUCATION	ISCED 2/ISCED 3 LOWER/UPPER SECONDARY LEVEL OF EDUCATION	ISCED 5, 6, AND 7 HIGHER EDUCATION
België / Belgique: Vlaamse gemeenschap	**Lager onderwijs**	**1ste graad:** **A, B** (year 2: Beroepsvoorbereidend)	Hoger onderwijs buiten de universiteit: **Korte type, Lange type**
	Buitengewoon onderwijs	**Buitengewoon onderwijs**	**Universiteit**
Communauté française	**Enseignement primaire** **Enseignement spécial**	**Enseignement secondaire:** **Type II: Cycle inférieur** *year 1-2*: Professionel, Technique, Général **Type I: Cycle d`observation** (year 2: Professionel) **Enseignement spécial** **2de graad:** Algemeen, Kunst, Technisch, Beroeps **3de graad:** Algemeen, Kunst, Technisch, Beroeps **Deeltijds** **Buitengewoon onderwijs** **Enseignement secondaire:** **Type II: Cycle inférieur** *year 3-5*: Professionel, Technique, Général **Cycle supérieur:** Professionel, Technique, Général, Année préparatoire **Type I: Cycle d`orientation:** Général, Technique de transition, Technique de qualification, Professionel, Année préparatoire **Enseignement à horaire réduit** **Enseignement spécial**	**Enseignement supérieur non universitaire:** **Type court** **Type long** **Université**

COUNTRY	ISCED 1 PRIMARY LEVEL OF EDUCATION	ISCED 2/ISCED 3 LOWER/UPPER SECONDARY LEVEL OF EDUCATION	ISCED 5, 6, AND 7 HIGHER EDUCATION
Danmark	**Grundskole** *year 1-6* **Special education**	**Grundskole** *year 7-9 or year 7-10* (including year 8-10 Efterskole) **Special education** **(Voksenuddanelse** (part-time)**)** **Individuelle uddannelser:** EGU, FUU **Erhvervsfaglige uddannelser:** Erhvervsududdannelser, social- og sundhed-suddannelser, landbrugs søfartsuddannelser, CCC **Gymnasiale uddannelser** **(Voksenuddanelse** (part-time)**)**	**Korte videregående uddannelser** **Mellemlange videregående uddannelser** **Bacheloruddannelser** **Kandidatuddannelser** **(Voksenuddanelse** (part-time)**)**
Deutschland	**Grundschulen** **Sonderschulen**	**Hauptschulen** **Integrierte Klassen** **Realschulen** **Gesamtschulen** **Gymnasien** *year 1-6* (all: including year 1-2: Orientierungsstufe) **Sonderschulen** **Berufsschulen (Duales System)** **Berufsaufbauschulen** **Fachgymnasien** **Fachoberschulen** **Berufsfachschulen** **Gesamtschulen** **Gymnasien** *year 7-9*	**Fachschulen** **Schulen des Gesundheitswesens** **Fachhochschulen** **Universitäten** **Weiterbildung**
Greece	**Dimotiko**	**Gymnasion**	**Technological education establishments:**

COUNTRY	ISCED 1 PRIMARY LEVEL OF EDUCATION	ISCED 2/ISCED 3 LOWER/UPPER SECONDARY LEVEL OF EDUCATION	ISCED 5, 6, AND 7 HIGHER EDUCATION
	(primary school)	**TES: Technical and vocational school** **TEL: Technical and vocational lykeion** **EPL: Integrated lykeion** **GEL: General lykeion** **IEK: Institute of vocational training (1 year)** **EPL: Vocational training** **(1 year)**	14 institutions **Universities:** 18 institutions: Technical universities, Medicine school, Dentistry schools, Agricultural schools, Other universitary schools **Post-graduate studies**
España	**Colegios de educación general bàsica (EGB)** *year 1-5*	**Colegios de educación general bàsica (EGB)** *year 6-8* **Institutos de formacion profesional (VTI):** Formacion profesional de primer grado Formacion profesional de secundo grado **Institutos de bachillerato unificado y polivalente (BUP)** **Curso de orientación universitaria (COU):** pruebas de acceso a la universidad	**Universidades:** Escuelas Universitarias Escuelas Técnicas Superiores Facultades
France	**Écoles élémentaire**	**Colléges:** 3e générale, 3e d'insertion, 3e technologique, lycées professionels **Ècoles spécialisées** **Lycées:** BAC général, BAC technologique, BT **Lycées professionels:** BEP ou CAP, BAC professionel	**Grandes écoles** **Écoles spécialisées** **Universités:** UFR-Santé, UFR-Lettres-Arts-Sciences humaines-Sciences-droit-Sciences economiques **IUT, IUP, BTS**
Ireland	**First Level:** National schools	**Junior cycle (Junior certificate):** Vocational schools	**Regional Technical Colleges** (and Dublin Institute of Technology)

COUNTRY	ISCED 1 PRIMARY LEVEL OF EDUCATION	ISCED 2/ISCED 3 LOWER/UPPER SECONDARY LEVEL OF EDUCATION	ISCED 5, 6, AND 7 HIGHER EDUCATION
	Non aided private schools Special schools	Community & comprehensive schools Voluntary secondary schools Private schools Special schools *all: year 1-3* **Junior cycle (Leaving certificate):** Vocational schools, Community & comprehensive schools, Voluntary secondary schools, Private schools, Special schools *all: year 4-6* (including year 4: transition year) Special schools *year 4-5* **Apprenticeship training:** FAS, CERT, TEAGASC **Post-leaving certificate** **Private business schools**	**Universities** (including teacher training) **Private third level**
Italia	**Scuole elementari** **Educazione speciale**	**Scuole medie** **Educazione speciale** **Scuolo magistrali** **Instituti magistrali** **Licei artistici** **Instituti d'arte** **Instituti professionali** **Instituti technici** **Licei classici, scientifici, linguistici**	**Academie** **Università ed instituti universitari:** Corsi di laurea, corsi di diploma universitario, scuole dirette a fini speciali
Grand-Duché Luxembourg	**Enseignement primaire**	(Lower secondary schools general:) **Lycée général** (Lower secondary vocational:)	(Higher non-university:) **BTS** **IST/SERP/IEES**

COUNTRY	ISCED 1 PRIMARY LEVEL OF EDUCATION	ISCED 2/ISCED 3 LOWER/UPPER SECONDARY LEVEL OF EDUCATION	ISCED 5, 6, AND 7 HIGHER EDUCATION
		Lycée technique (Upper secondary schools general:) **Lycée général** (Upper secondary vocational:) **Régiem technique** **Régiem de technicien** **Régiem professionel**	(Higher university:) **Supérieur universitaire:** including continuation of studies abroad
Nederland	**Basisonderwijs:** *year 3-8*	**Voortgezet onderwijs:** VBO, MAVO, HAVO *year 1-3,* VWO *year 1-3* *(all: year 1*: Gemeenschappelijk brugjaar) **VSO** *year 1-3* **Voortgezet onderwijs:** LLW, MBO, HAVO *year 4-5,* VWO *year 4-6* **VSO** *year 4-6*	**Hoger onderwijs:** HBO, WO **Post-doctoraal:** Tweede fase, Post-doctoraal, AIO
Österreich	**Voksschule** **Sonderschule** *year 1-4*	**Hauptschule** **Allgemeinbildende höhere Schulen - Unterstufe** **Sonderschule** *year 5-9* **Polytechnischer Lehrgang Berufsschule und Lehre** **Berufsbildende und Lehrerbildende mittlere Schulen** **Berufsbildende und Lehrerbildende höhere Schulen** **Allgemeinbildende höhere Schulen - Oberstufe** **Oberstufenrealgymnasium**	**Sonstiger nichtuniversitärer Sektor** **Fachhochschulen** **Kunsthochschulen** **Universitäten**
Portugal	**Compulsory basic school: general school: 1st cycle** year 1-4 **2nd cycle** year 5-6	**Compulsory basic school: general school: 3rd cycle** (Certificate of degree) year 7-9	**Polytechnic higher education** (Licenciatura, Masters degree, Doutoramento

COUNTRY	ISCED 1 PRIMARY LEVEL OF EDUCATION	ISCED 2/ISCED 3 LOWER/UPPER SECONDARY LEVEL OF EDUCATION	ISCED 5, 6, AND 7 HIGHER EDUCATION
	Educ o especial	**Educ o especial** **Vocational school courses** **Secondary courses:** **general and technological courses** **Educ o especial**	
Suomi / Finland	**Primary:** **Peruskoulun ala-aste** (comprehen-sive schools, lower stage) *year 1-6*	**Lower secondary:** **Peruskoulun yläaste** (comprehensive schools, upper stage) *year 7-9* **Upper secondary:** **Ammatilliset opplilaitokset** (vocational and professional education) **Lukio** (upper secondary schools)	**Lower tertiary:** Ammattikorkeakoulut (AMK) (polytechnics) **Ylopistot** (universities): Alempi Korkeakoulututkinto (Bachelors) Ylempi Korkeakoulututkinto (Masters) Lisensiaatti (licentiate) Tochtorin tutkinto (doctorate)
Sverige	**Grundskola** *year 1-6* **Utlands, Sär- och Specialskola** (Swedish schools aboad, special schools) **Vuxenutbildning och folkbildning**	**Grundskola** *year 7-9* **Utlands, Sär- och Specialskola** **Vuxenutbildning och folkbildning** **Gymnasieskola:** Nationelle program, Specialkurser **Vuxenutbildning och folkbildning**	**Grundläggande högskoleutbildning:** Program, Fristående kurser **Forskarutbildning:** Licenciat, Doktor
United Kingdom: England and Wales	**Primary schools (including special education)**	**Comprehensive schools (including special education)**	**Further education (FE) sector colleges** *years 3-4*: Sub-degree HND / HNC / NVQ4

COUNTRY	ISCED 1 PRIMARY LEVEL OF EDUCATION	ISCED 2/ISCED 3 LOWER/UPPER SECONDARY LEVEL OF EDUCATION	ISCED 5, 6, AND 7 HIGHER EDUCATION
	(key stage 1 and key stage 2): First schools, Middle schools *year 1-2*	*years 1-3* (key stage 3) (including Middle schools *year 3-4)* **Grammar and secondary schools** *years 1-3* (key stage 3)	**Higher education (HE) institutions (universities and colleges)**: Sub-degree HND / HNC / NVQ4, First Degree, Masters, Doctorate
Northern Ireland	**Private education**	**Private education**	
	Primary schools	(Lower secondary schools general:) **Grammar schools** **Secondary schools**	**Private education**
Scotland	**Primary schools**	(Lower secondary schools general:) **Secondary schools** **Comprehensive schools (including special education)** *years 4-5* (key stage 4): GCSE / Foundation or intermediate GNVQs / NVQ 1 or 2 **Grammar and secondary schools** *years 4-5* (key stage 4) **Further education (FE) sector colleges** *years 1-2* **School sixth forms** **Adult education centres** all: GCE A level / advanced GNVQ / NVQ3 **Private education** (Upper secondary schools general:) **Secondary schools** **Further education college** **Grammar schools**	**Sub-degree higher education** **First degree / post-graduate higher education** **Further education** **Higher education**

7.6 Abbreviations

18 ANO	Greece treatment service in greater Athens area
ACMD	Advisory Council on the Misuse of Drugs, United Kingdom
ADDIBRU	Belgish monitoring system for specialised centres
ASI	Addiction Severity Index
CAD	Consultation Bureaus for Alcohol and Drugs, sub-units of OAC, Netherlands
CCAD	Comité de Concertation sur l'Alcool et les autres Drogues de la Communauté française de Belgique, Belgish monitoring system (French Community)
CEEC	Central and Eastern European Countries
CIDI	Composite International Diagnostic Interview
CIT	Core Item List for Treatment
CNIL	French National Commission for Informatics and Liberties
CTB-ODB	
DGPNSD	Delegación del Gobierno para el Plan Nacional sobre Drogas, Spain
DMD	Drug Misuse Database, United Kingdom
DMRU	Drug Misuse Research Unit, United Kingdom
DOK	Swedish Monitoring System
DSM	Diagnostic and Statistic Manual
DTRS	Drug Treatment Reporting System, Ireland
EBIS	German out-patient centre-based documentation system
EMCDDA	European Monitoring Centre for Drugs and Drugabuse
GO	General Outpatient Treatment Centre
GP	General Practitioner
GR	General Residential Treatment centre
ICD	International Classification of Deseases
ICPC	International Classification of Primary Care
IFT	Institut für Therapieforschung
IHIS	Institute of Health Information and Statistics, Czech Republic
IKM	Institute for Development of Knowledge about Treatment of Alcohol and Drug Misusers, Sweden
ISCED	International Standard Classification of Education
IUS	Danish drug register
IVV	Organisation Information Systems on Addiction Care and Treatment, holder of LADIS, IVZ sub-unit, Netherlands
IVZ	Organisation Care Information Systems, Netherlands
KE.TH.E.A.	Greece treatment service in greater Athens area
LADIS	Nation-wide system for the collection of data on drug users in treatment, Netherlands
LAN	Local Area Network

LBI	Ludwig Boltzmann Institut, Austria
LFP	Luxembourgish Focal Point
MEDARD	Belgish monitoring system for outpatient mental health services
NADH	National Anti-Drug Headquarters, Czech Republic
NGO	Non-governmental Organisations
NHS	National Health Service
OAC	Institutes on Outpatient Addiction Care and Treatment, Netherlands
OFDT	Observatoire Français des Drogues et des Toxicomanies, France
OS	Other Services
PADCTRS	Procedures to Avoid Double Counting in Drug Treatment Reporting Systems
PDA	Persons Drug Addicted
PSYFILE	Belgish monitoring system for outpatient mental health services
QIS	French social treatment programme for prisoners
REITOX	Reseau Europeen d'Information sur les drogues et les Toxicomanies
RELIS-LINDDA	Luxembourgish Information Network on Drugs and Drug Addiction
RPM-MPG	Belgish monitoring system for inpatient mental health services (minimal psychiatric data)
SCAN	Schedules for Clinical Assessment in Neuropsychiatry
SEDOS	German in-patient centre-based documentation system
SEIT	Spanish State Information System on Drug Abuse
SerTs	Italian Services for addicts
SESI	French Studies and Information Systems Service
SFP	Swedish Focal Point
SiS	National Board of Institutional Care, Sweden
SL	Specialised low Threshold Unit/ Drop-In/ Street Agency
SO	Specialised Outpatient Treatment Centre
SP	Specialised in Prison
S.P.T.T.	Serviço de Prevenção e Tratamento da Toxicodependência, Portuguese health care and specialised treatment service for drug addiction
SR	Specialised Residential treatment
STAKES	Statistics and Registers Unit (National Drug Monitoring Centre) Finland
T/C centre	Treatment/Contact Centre
TRANS-RELIS	Inter-regional reporting system (Luxemburg, France, Germany, Belgium)
TUF	Treatment Unit Form, Kokkevi (1997)
VAD	Belgish monitoring system (Flanders)
VLIS	Belgish monitoring system for specialised centres
WAN	Wide Area Network