European Monitoring Centre
for Drugs and Drug Addiction

TDI Methodological information on 30 European countries

Methods and Definitions
of TDI data reported to the EMCDDA in 2014

June 2016

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Austria

Sources: FONTE Reports, 2014 National Report, National TDI expert

1. The National monitoring system: description

In Austria two national registries are used to report information on people entering drug treatment to the EMCDDA: DOKLI – (einheitliches Dokumentationssystem der Klientinnen und Klienten der Drogenhilfe) and eSuchtmittel. The DOKLI registry includes data on all the country from any type of specialised drug treatment ; it is based on aggregated data. The eSuchtmittel registry is a central registry for substitution treatment (OST), where each treatment has to be registered by the medical officer who controls the prescription of the substitution medication.

2. Coverage:

The data coverage is national and quite extensive. Data cover all existing types of centres providing drug treatment. The DOKLI report data from outpatient (121) and inpatient (21) treatment centres. The level of coverage is high: the DOKLI system report data from 91% outpatient and 81% inpatient centres; only a few outpatient or inpatient centres are not covered by TDI, mainly due to technical incompatibility of their documentation system. The level of data overage of the clients is unknown.

The eSuchtmittel report data from all types of treatment centres at national level providing data on all clients starting an OST.

3. Double counting control

In DOKLI there is control on double counting with an identifier at centre level; in Vienna the overlap between treatment centres is controlled for double counting. Around 20% of the clients are treated in 2 or more centres in Vienna. As in the rural areas the density of treatment centres is low the double counting might also be below 20%.

In the eSuchtmittel system each person has to be identified via the population registry before a new entry in the substitution treatment database can be done. There is an automatic control in case the person is already in the registry; therefore no double counting is possible.

4. Harmonisation with EMCDDA guidelines: definitions

(case definition, treatment episode, start and end of treatment, type of treatment centre)

In DOKLI definitions are all exactly the same as in the TDI protocol 3.0. In eSuchtmittel the person is reported when the starting date of a treatment was in the reporting year. A case is a person; the treatment episode is the time between start and termination of treatment. In 2013 the first treatment episode of the year has been reported rather than the last one, as under the TDI protocol ver 2.0..

5. Limitations

Data limitations are related to the existence of two different registries in Austria: one for all types of drug treatment other than OST (DOKLI) and one for the OST clients (eSuchtmittel); for people with

opioids related problems there is an estimated overlap between the two systems of 57% of clients in outpatient centres and 54% in inpatients centres.

Some data on the profile and patterns of drug use of the clients are not recorded in the monitoring systems. In particular:

- in the OST register only data on age and gender of the clients are recorded
- in the DOKLI register around 21% of clients is not reported a primary drug. This is mainly because the DOKLI register allows to record clients entering treatment for legal problems without indicating their primary drug (most probably the majority of them are cannabis users); and for around 18% of opioid clients the specific opioids used are not reported (e.g. heroin, methadone misused, etc).

In terms of definitions in 2013 the first treatment episode of the year has been reported rather than the last one, as it was under the TDI protocol ver 2.0. This has led to changes in the time series, and comparisons with previous years cannot easily be made.

Limitations are finally related to trends data; changes in the monitoring system occurred in 2006 and 2014; in 2006 Austria has implemented the EMCDDA TDI Protocol and in 2014 the revised TDI Protocol ver.3.0, with the adoption of the revised case definition, which is now harmonised with the definition reported in the TDI ver 3.0

6. Bibliographic reference

a) DOKLI: Busch, M., Grabenhofer-Eggerth, A., Kellner, K., Kerschbaum, J., Klein, C., Türscherl, E. (2014). Epidemiologiebericht Drogen 2014. Wien.Gesundheit Österreich GmbH

b) eSuchtmittel: Busch et al. (2014) Epidemiologiebericht Drogen 2014

Belgium

Sources: FONTE Reports, 2014 National Report, National TDI expert

1. The National monitoring system: description

In Belgium the Treatment Demand Indicator (Belgian Treatment Demand Indicator Register) was officially approved by the Inter-ministerial conference on Public Health in 2006 (Conférence interministérielle Santé publique 2006), adopted in 2010 and launched in 2011. It is used in the specialised drug treatment centres and based on the TDI Protocol version 2.0 (Conférence interministérielle Santé publique 2006). The TDI version 3.0 has been adopted in 2013 (Conférence interministérielle Santé publique 2013) and has been implemented from 2015.

Data at national level is gathered and managed by the Scientific Institute of Public Health (WIV-ISP). Two systems have been developed in Belgium: 1) A registration module, which is a secured online form accessible by treatment centres through their eID. The centres can encode the individual clients' data in the system via the electronic form. Data are anonymized automatically by a trusted third party (eHealth). 2) A repository module, which is a secured mailbox that can be used to send complete, structured files containing a complete set of data. A specific part of this file containing identification data will be automatically anonymized by the trusted third party during the transfer of the file.

2. Coverage:

The data coverage is national and quite extensive. Data cover 68% of outpatient and 45% of inpatient treatment centres existing in the country (there are respectively 65 and 143 centres) and 100% (9) low threshold agencies. Data from general practitioners and prison are not part of the registration. General practitioners may play an important role in the treatment of drug users, however information is lacking. No data are available on the total number of clients in the TDI system, and no tool exist to estimates the level of coverage of the number of cases in the country.

3. Double counting control

Control on double counting is carried out at the level of the treatment centre and at national level. The control consists in performing a specific data checking in case a person is appearing twice in the central database. However as the coverage is not 100%, the control of double counting is not complete.

4. Harmonisation with EMCDDA guidelines: definitions

(case definition, treatment episode, start and end of treatment, type of treatment centre)

The Belgian Treatment Demand Indicator Register followed the TDI Protocol 2.0 until 2014 and started from 2015 with the TDI protocol 3.0. The last episode in the year is registered within protocol 2.0 and the first in the TDI version 3.0. A treatment episode is defined as the period between the start of the treatment for a drug or alcohol use problem and the end of the activities in the context of the prescribed treatment program. The other definitions (treatment start and end, type of treatment centre) are in line with the EMCDDA TDI Protocol version 3.0.

5. Limitations

Data limitations are related to lack of data on drug treatment in prison and among general practitioners, which may play an important role in drug treatment at national level.

Furthermore it has to be considered that there are differences between the Belgian monitoring system and the EMCDDA protocol concerning case definition. The complete matching with the TDI V3.0 will only be effective in 2016 concerning data referring to the year of treatment 2015.

Regarding trends, limitations are reported regarding the description of long time trends, as no trend data are available before 2011 and cautions should be paid when analysing data from 2011 to 2014 as the data coverage has increased with the inclusion of some hospitals and big specialized drug treatment centres; this explains the increase in the total number of cases reported.

6. Bibliographic reference

Conférence interministérielle Santé publique (3-5-2006). Enregistrement des demandes de traitement via le Treatment Demand Indicator.

Conférence interministérielle Santé publique (30-9-2013). Protocole d'accord des ministres qui ont la santé publique dans leurs compétences concernant l'enregistrement des demandes de traitement en matière de drogues et d'alcool via l'opérationnalisation du Treatment Demand Indicator européen.

Bulgaria

Sources: FONTE Reports, 2014 National Report, National TDI expert

1. The National monitoring system: description

In Bulgaria data on drug treatment clients are collected through the National Monitoring System for Drug Related Treatment Demand (I-MIS). The monitoring system gathers data from specialised drug treatment centres at national level. Individual data are collected by the drug treatment units and transmitted to the National Focal Point (NFP) either as individual cases or aggregated data. In 2011 a new form for registering clients demanding treatment was introduced, with the provision of aggregated data to the NFP – for those who strongly do not prefer to use the Internet based questionnaire for individual data.

2. Coverage:

The data coverage is national and extensive (more than 70% of units and 80% of cases). Data cover outpatient and inpatient treatment centres and treatment units in prison. The treatment demand monitoring system in 2013 covers around 70% of outpatient (32 out of 44) and inpatient (22 out of 32) treatment units and 12 out of 13 treatment units in prison. General practitioners and low threshold services do not provide drug treatment in Bulgaria.

Outpatient units include substitution treatment programs and centres with methadone, buprenorphine and substitol (slowly released morphine), outpatient treatment programs and centres, group psychiatric practices, etc. and inpatient centres include state hospitals, centres for mental health, psychiatric clinics and units. Finally treatment units in prison include two specialized hospitals for prisoners and medical services in all the prisons in Bulgaria.

Regarding clients, data cover 80% of the almost 3000 drug clients registered in the country.

3. Double counting control

In Bulgaria double counting is controlled at national level for outpatient and inpatient centres and at the level of treatment unit for prison, where data are aggregated to guarantee anonymity; therefore duplications may exist for some clients who may have entered other types of treatment centres. Furthermore since 2011 a new instrument was introduced for registering persons demanding treatment. For a part of the clients data are then sent in aggregated form. For all treatment centres the control on whether a client has been treated before the current year the recorded episode is based on self-reporting.

4. Harmonisation with EMCDDA guidelines: definitions

(case definition, treatment episode, start and end of treatment, type of treatment centre)

The definitions used in the Bulgarian treatment demand system are in line with the TDI Protocol ver 3.0 which was implemented in 2013.

5. Limitations

Limitations are related to the existence of two ways to gather data, based either on individual or aggregated data. For aggregated data in particular the level of missing data is high for some combinations of variables (e.g. primary drug and sex); that information cannot be recuperated as the client cannot be tracked back after the aggregation.

Furthermore cautions should be paid when interpreting trends data, as changes have occurred along the years both in the registration system and in the organisation of treatment services, with inclusion and withdrawal of some units over the years.

Finally it has to be considered that pharmacological treatment is insufficient in Bulgaria and distribution is uneven across the country, which sometimes makes treatment scarcely accessible; therefore the purpose of the TDI in providing information on the high risk drug use may be incomplete.

6. Bibliographic reference

Annual National Report on Drug related problems - Bulgaria 2014; TDI monitoring system, National Focal Point on Drugs and Drug Addictions.

Croatia

Sources: FONTE Reports, 2014 National Report, National TDI expert

1. The National monitoring system: description

In Croatia data on drug treatment clients are collected from public and private centres and from units managed by NGOs. Data are collected on individual clients through the National Register of Treated Abusers, established in 1978. Treatment facilities included in the register contain health facilities, hospitals, therapeutic communes and NGOs. Data are collected by the Croatian Institute of Public Health since 1997;they are then transmitted to the National Focal Point (NFP).

2. Coverage:

The data coverage is national and extensive (around 90% of existing units and 96% of registered clients). Data cover 22 out of 23 outpatient treatment centres, 5 out of 8 low threshold agencies and 30 inpatient units. Data on number of existing inpatient units is unknown. The number of clients registered in the TDI register is around 35 000; around 96% of them are recorded in the TDI. Drug treatment is also provided in prison, but data are not collected yet, even if negotiations for the exchange of data and information relating to drug addiction treatment in prison system started in 2010. General Practitioners (GP) provide drug treatment but data on clients are not available. Outpatient centres include services for mental health protection, addiction prevention and outpatient treatment of public health institutes. Inpatient centres include psychiatric hospitals, clinical teaching, special and general hospitals. Low threshold agencies include therapeutic communities where persons stay for few months or years.

3. Double counting control

Double counting is controlled at treatment centre, regional and national level. There might be overlap between treatment centres as clients move from one centre to another; checking on double counting is done through a unique identification number assigned to every person.

4. Harmonisation with EMCDDA guidelines: definitions

(case definition, treatment episode, start and end of treatment, type of treatment centre)

The definitions used in Croatia are in line with the TDI Protocol ver 3.0 which was implemented in 2013 at national level

5. Limitations

Data limitations relate to lack of TDI data from prison and general practitioners. . No data are provided on some variables: injection, polydrug use, HCV and HV testing and needles sharing.

6. Bibliographic reference

None

Cyprus

Sources: FONTE Reports, 2014 National Report, National TDI expert

1. The National monitoring system: description

In Cyprus there is national treatment demand monitoring system which collects individual data from the specialised drug treatment centres and transmit them to the National Focal Point (NFP).

2. Coverage:

The data coverage is national and extensive. Data cover all existing outpatient and inpatient treatment centres and the treatment services provided in prison. The treatment demand monitoring system in 2013 covered around 85% of treatment units (20 in total) providing drug treatment in the country. In particular it covered 14 out of 16 outpatient centres and 3 out of 4 inpatient centres. 2 existing outpatient centres did not submit the data, and in 1 therapeutic community data collection was not in line with the TDI ver.3.0. In Cyprus one treatment unit with a dedicated physical space for drug users in prison is usually available, but it was not operational in 2013 or 2014. Drug treatment is provided by General Practitioners (GP), but the number of GPs offering drug treatment is unknown, and they do not participate in the data collection.

Outpatient units include public and private centres and NGOs. Inpatient units include therapeutic communities, private clinics and units in hospitals.

3. Double counting control

In Cyprus the control on double counting is performed at national level as data collection is centralised in a national database including individual data at the National Focal Point.

4. Harmonisation with EMCDDA guidelines: definitions

(case definition, treatment episode, start and end of treatment, type of treatment centre)

The definitions used in the Cypriot treatment demand system are in line with the TDI Protocol ver 3.0 which was implemented in 2013.

5. Limitations

Trends in TDI data in Cyprus should be viewed with caution, as part of the observed increase is related to increased treatment availability and improved data reporting and coverage.

6. Bibliographic reference

Cyprus NFP, 2014, 2015

Denmark

Sources: FONTE Reports, 2014 National Report, National TDI expert

1. The National monitoring system: description

The Danish treatment demand monitoring system -“SMDB Stofmisbrugsdatabasen”- collects individual data from drug patients admitted to outpatient and inpatient treatment centres. The monitoring system has been in place since 1996 when the Danish Health and Medicines Authority (then National Board of Health) started recording data on drug users admitted to treatment. From 2006 to 2008 the monitoring system went through several changes, including the transition f the responsibility for data collection to the municipalities, which are also responsible for drug treatment in Denmark.

Currently the National Board of Social Services is responsible for the central data collection and the management of the national drug abuse database, which was launched in June 2011. The drug abuse database is the joint reporting portal for all relevant authorities, including:

- the State Serum Institute's register on drug abusers in treatment (SIB), the National Board of Social Service's VBGS registry, which provide data on clients in substitution treatment;

- DanRIS-"ambulant" outpatient as well as the Centre for Alcohol providing data on outpatient centres

- Drug Research's register DanRIS-"døgn", providing data on inpatient clients.

The merge of the registers contained in the drug abuse database has required major technical changes – both on the establishment of the drug abuse database itself and in the technical solutions to put in place the new common reporting platform.

2. Coverage:

The data coverage is national and quite extensive. Data are collected from 90 out of 100 outpatient centres and 40 out of 45 inpatient centres (around 90% of all centres) and on around 90% of registered clients. No data are provided on clients entering drug treatment in prison, low threshold agencies and general practitioners. Before the merging of the monitoring systems, the Danish Health and Medicines Authority also recorded persons admitted to methadone treatment under the Danish Prison and Probation Service and number of persons without a civil registration number.

3. Double counting control

Double counting is controlled at national level through the national drug abuse database.

4. Harmonisation with EMCDDA guidelines: definitions

(case definition, treatment episode, start and end of treatment, type of treatment centre)

In the Danish monitoring system the definitions are in line with the TDI Protocol ver.2.0: the case definition refers to the last episode during the year, as in the TDI ver.2.0, but cases are counted only once during the year (as in the TDI ver.3.0). The other definitions, with the exception of referral sources, are in line with the TDI Protocol ver. 2.0. No data have been collected yet on the variables introduced with the revised protocol.

5. Limitations

The main limitations of the Danish system are related to the lack of recent data: the last available data refer to 2011. Furthermore the data based on the TDI protocol ver.3.0 have not been provided yet, but the implementation was foreseen for 2014 and the first data should be provided to the EMCDDA in autumn 2015.

6. Bibliographic reference

www.socialstyrelsen.dk

Czech Republic

Sources: FONTE Reports, 2014 National Report, National TDI expert

1. The National monitoring system: description

The Czech Drug Information System collects data on clients entering drug treatment in Czech Republic. Individual data are reported from treatment centres to regional hygiene services than to the Hygienic Station of the Capital Prague (Drug Epidemiology Headquarters); from there data are sent to the National Focal Point. In 2014 preparation of transition to the on-line electronical system of data collection started, the electronical register is held by the Institute for Health Information and Statistics. It combines Treatment demand register of In/out-patient care data (Hygienic Station of the Capital Prague) and Register of Substitution treatment which was held by the Institute for Health Information and Statistics.

2. Coverage:

The data coverage is national and quite extensive. Data cover several types of centres providing drug treatment (254 treatment centres); in particular it covers 68 % of outpatient units, and 81,5 % of inpatient treatment centres and 86,8 % of low threshold agencies. Data are not collected in treatment units in prison and among general practitioners which represent a substantial part of treatment provision, especially OST in Czech Republic. As OST register is a part of TDI register since 2015, data should be available also from GPs who provide OST.

Data on clients registered in the TDI system are not available and it is not possible to estimate the level of clients' coverage

The different types of treatment centres collecting TDI data include the following facilities:

- Outpatient treatment centres include centres that provide outpatient care in a medical treatment facility (hospital, clinic, etc.) or in a non-medical facility, such as psychosocial treatment centre, for a condition or course of treatment, which does not require admission to a hospital
- Inpatients centres include acute standard, acute intensive, follow-up and long-term. Inpatient care must be provided in a medical facility of a healthcare provider with 24-hour operating hours, hospitals - intensive treatment units in substance abuse (detoxification units), drug inpatient treatment units and others. Inpatient non-medical care is provided in therapeutic communities
- Low threshold agencies are centres aiming to prevent and reduce health-related harm associated with drug dependence. They include contact (drop-in) centres and outreach programs.

3. Double counting control

The control on double counting is performed at treatment centre, regional and national level. Double-counting control is provided based on the specific code of client; the treatment centres check their database, which is available at regional and national level. Identical records of clients are searched and, in case of duplications, those with a later date of treatment demand are excluded.

4. Harmonisation with EMCDDA guidelines: definitions

(case definition, treatment episode, start and end of treatment, type of treatment centre)

Case definition and definition of treatment start are in line with the EMCDDA definitions. In 2014 the definition of the end of the treatment was not clearly stated. Since 2015 the end of treatment will be reported within the register including limited number of other variables. If an episod will not be terminated by treatment centre, it will send a reminder after 6 months from the start of treatment. Treatment centre will choose either continuation of episode or termination of treatment.

5. Limitations

Data limitations in the Czech Drug Information System are related to the fact that General practitioners providing a relevant part of drug treatment in the country are not included in the monitoring system.

Some limitations are also related to the lack of full harmonisation with the EMCDDA standards.

6. Bibliographic reference

None

Estonia

Sources: FONTE Report, 2014 National Report

1. The National monitoring system: description

The national monitoring system in Estonia is called "National Drug Treatment Database"(NDTD). It is coordinated by the National Institute for Health Development. All treatment units are obliged to send individual data to NDTD through an internet program to the national level.

Coverage:

Data are reported from 1 inpatient and 8 outpatient treatment centres and from 1 treatment unit in prison. General practitioners and low threshold agencies do not provide drug treatment in Estonia.

TDI monitoring coverage is high for all types of treatment centres and for clients. Data is reported from 88% of outpatient and 100% of inpatient centres and from 75% of prison healthcare units. Data covers 97% of the clients entering treatment.

All treatment centres that do not provide hospitalization and residential services are monitored as outpatient centres.

> Inpatient treatment centre is a healthcare facility where patient is hospitalized and provided residential services. In Estonia there is only one inpatient treatment centre providing in and outpatient psychiatric treatment for all types of addictions (alcohol, drugs, and other addictions).
>
> Treatment units in prison are healthcare units that provide all kinds of healthcare services including drug addiction treatment (incl OST). Drug treatment patients are not accommodated in prison healthcare units during the drug treatment.

2. Double counting control

Double counting is not fully controlled at national level, as there is not a unique individual code. The server uses mathematical algorithm which generates from the ID-code (entered in the treatment center) a new code. But as this code is generated with this 5% error, it is not possible to use this code to get the ID back. Therefore this is not unique and double counting is possible because one person can have several codes or different persons can have the same code.

3. Harmonisation with EMCDDA guidelines: definitions

(case definition, treatment episode, start and end of treatment, type of treatment centre)

A case is defined as a person who starts a treatment in calendar year. If person stops treatment falls out of treatment and for a while in that year starts again it is considered as a new case. A treatment episode starts from the beginning of the treatment to its end. The start of treatment begins with signing the treatment contract. The end of the treatment is defined as end in case of: falling out the treatment, stopping by patients own wish, marked as treated and not needing the treatment

anymore, death, going living abroad and losing the contact because it, falling into prison or getting out of prison

4. Limitations

The Estonian treatment monitoring system covers virtually all drug treatment system in the country, which is quite limited.

Limitations are also related to the harmonisation with the European guidelines, as the definition of case and of treatment episode are fully in line with the EMCDDA Guidelines. No time is indicated for the end of treatment in case of treatment drop.

Finally the treatment monitoring system was implemented in 2008 and trend analysis is not possible before.

5. Bibliographic reference

None

Finland

Sources: FONTE Reports, 2014 National Report, National TDI expert

1. The National monitoring system: description

In Finland the National Institute for Health and Welfare collects data on drug treatment patients, but there is no official register of drug treatment centres. Anonymous, individual data are collected in the National Focal Point (NFP). The collection of drug treatment information is voluntary for the care centres in Finland. However the NFP has a register of drug treatment centres that fill in an annual questionnaire based on the TDI Protocol. In 2013 over 100 drug treatment units were informed about the survey. New internet based data collection tool was introduced in 2012 and a revised questionnaire in 2014. The Finish drug treatment reporting system is currently being reformed in order to enhance data coverage and quality.

2. Coverage:

As the monitoring system is voluntary the level of data coverage in Finland is unknown. Two studies were carried out in 2004 and 2009 to give an overall estimate of data coverage (number of clients and units providing specialized drug treatment). According to the survey the data coverage was 32%, which may have decreased since then. In 2013 data were reported overall on 1089 clients entering treatment in 39 outpatient centres, 26 inpatient centres and 1 treatment unit in prison.

General practitioners in Finland may provide drug treatment, but actually they only provide treatment to a marginal share of the total treatment population. However privately organized general practitioners are important providers of primary health care for drug users. In that case they are considered as public health care centres and their clients are reported under outpatient centres.

Low threshold centres in Finland do not provide structured drug treatment; they mainly offer services that mostly do not require any identification (e.g. needle exchange, information, communicable diseases testing and vaccinations, etc.). Therefore they are not registered in the treatment demand monitoring system.

Regarding the inclusion criteria of type of treatment centres comprised under the different categories the following centres are included in each setting:

-Outpatient centres include A-Clinics, youth clinics, substitution treatment clinics, health and social counselling centres for intravenous drug users, day activities centres, psychiatry outpatient clinics for clients suffering from substance abuse, health care centres, outpatient mother and child clinics for clients suffering from substance abuse.

-Inpatient centres include detoxification centres, rehabilitation units, psychiatry inpatient hospitals for clients suffering from substance abuse, mother and child homes for clients suffering from substance abuse.

-treatment in prisons is not very clearly defined. The prisons are asked to report the clients officially part of the prison system entering a drug treatment with some professionally planned treatment steps. Under treatment units in prison all treatment units in prison, covering ‘open prisons’ and parole offices, should be included in the monitoring system. In fact only official prisons are included.

3. Double counting control

In Finland double counting is controlled at treatment centre and at national level. At national level continuous treatments are separated from treatment entrants. The control on previous treatment is performed through a direct question in the questionnaire, asking whether a client has been treated before in any treatment centre in Finland. However it is speculated that sometimes the question is answered too narrowly and only previous treatment in the same centre may be considered. More internal checks can be carried out in 2014.

4. Harmonisation with EMCDDA guidelines: definitions

(case definition, treatment episode, start and end of treatment, type of treatment centre)

The definitions used are mostly in line with the TDI Protocol ver. 3.0 which was partially implemented in 2013 (not all definitions are in line with the TDI Protocol ver.3.0 and data are collected on most, but not all, new variables).

According to the current case definition of the Finnish monitoring system, it is not possible to identify a client who is entering a treatment centre as continuation of a previous treatment episode in another treatment centre; in that case there might be a duplication of clients. Also there is no control on definition of end of treatment in Finland; the data collection on treatment end will be implemented in 2014. Some new variables introduced with the TDI 3.0 were not included in the data collection in 2013.

5. Limitations

Limitations of the treatment monitoring system in Finland are mainly related to the voluntary nature of the monitoring system and the absence of a formal registry of drug clients. This does not allow knowing the level of data coverage and thus the representativeness of the reported data. However validations studies have been conducted to estimate data coverage and recent efforts are being done to reform the treatment monitoring system in order to improve coverage and data quality.

6. Bibliographic reference

Forsell, Martta & Nurmi, Tuula (2014). Päihdehuollon huumeasiakkaat. Tilastoraportti 21/2014. THL.

France

Sources: FONTE Reports, 2014 National Report, National TDI expert

1. The National monitoring system: description

In France a system for recording treatment demands in compliance with the European protocol (Common Data Collection on Addictions and Treatments or "RECAP") was introduced in 2005 in specialised centres dealing with drug users. The centre reorganised in 2010 under the name "National Treatment and Prevention Centres for Addiction (CSAPAs), include all institutions providing support for people with any type of additions, either due to misuse of illegal drug or legal (mainly alcohol) problems, or with a non-substance addiction. For the EMCDDA's purposes only persons with misuse of illegal drugs or psychotropic medicines are included. Data are collected on individual clients and on a continuous basis, with the aim to track clients' characteristics and patterns on drug use along the treatment journey.

RECAP makes it possible to obtain individual data collected on a continuous basis concerning all patients coming forward to seek aid from the CSAPAs.

In addition to RECAP, a multi-centre study on structures treating drug users is conducted every year during the October month. The survey - OPPIDUM- includes more detailed questions on every substances used in the last 30 days by drug users attending a panel of drug treatment facilities. This survey aims more specifically to monitor use and misuse of psychotropic medicines, including OST.

In addition to RECAP, two others surveys are regularly conducted among drug users attending drug treatment facilities. The Ena Caarud survey takes place every two years in the low threshold centers called Caarud in France. It includes all drug users seen in these centers during a week. This survey helps to monitor the characteristics of the more problematic drug users which cannot be included in the RECAP data collection. Another survey, Oppidum, conducted every year during the October month among drug users attending a panel of treatment facilities. It aims more specifically to monitor use and misuse of psychotropic medicines, including OST and asks detailed questions on all drug used in the last 30 days.

The approach of these two surveys differs from the TDI methodology and has different objectives and tools.

2. Coverage:

The data coverage is national and extensive on specialised treatment centres. In 2013, data cover 65% of the 379 outpatient treatment centres, 38% of the 45 inpatient treatment centres and 9 out of 16 treatment units in prison. All specialised addiction centres may provide treatment for both alcohol, and illicit drugs; however a proportion of CSAPAs still provide treatment only for alcohol users and are therefore not included in the data collection. The real coverage for outpatient treatment centers is therefore higher once those centers providing none or very few cases to TDI are excluded.

A second important component of drug treatment in France is the general health care, which include hospitals and general practitioners who provide a substantial part of treatment for opioid users. Those facilities are not included in the RECAP system.

3. Double counting control

The control on double counting is carried out at treatment centre level. The checking on previous treatment is performed with a question to the client. As several clients are referred to inpatient through the outpatient networks, there might be some duplication in the reporting of outpatient and inpatient clients.

4. Harmonisation with EMCDDA guidelines: definitions

(case definition, treatment episode, start and end of treatment, type of treatment centre)

The definitions used in the French monitoring system are in line with the EMCDDA guidelines; in particular the case definition is the same as in the TDI ver.3.0. Also the definitions of start and end of treatment and treatment episode are the same as in the TDI 3.0.

5. Limitations

Data limitations are mainly related to the lack of data reporting from the general health care, in particular the general practitioners, who provide a substantial part of drug treatment for opioid users in France. It has however to be considered that many opioid users in treatment with the general practitioners are stabilised in treatment and would not be included in the TDI system, as it is conceived now, only collecting data on persons entering drug treatment. Studies have been carried out to estimate the part of drug clients who should be included in the system and are not included in the system.

Furthermore as the RECAP system was introduced in 2005, during the first two years of implementation a rather low participation in data collection was reported.

Finally due to changes in the reporting system and data coverage, trends data including 2005-2006 data should be interpreted with caution.

6. Bibliographic reference

http://www.ofdt.fr/ofdtdev/live/donneesnat/recap.html

Germany

Sources: FONTE Reports, 2014 National Report, National TDI expert

1. The National monitoring system: description

In Germany treatment demand data are collected by drug treatment organisations which all use the standards of the German Core Data Set (Deutscher Kerndatensatz zur Dokumentation in der Suchthilfe; KDS) on the Documentation of Addiction Treatment (Deutsche Suchthilfestatistik, DSHS); they are then sent in an aggregated form to the National Focal Point (NFP). The monitoring system also provides extensive data on drug treatment facilities in Germany. The "Treatment Demand Indicator (TDI)" of the EMCDDA is integrated in the Core Data Set. Germany is currently working for the implementation of the TDI Protocol ver.3.0.

2. Coverage:

The data coverage is national. Data cover around 72% (837/1.427) of the outpatient centres, 62% (206/424) of the inpatient centres, 49% (17/64) of the existing treatment units in prison and 34% (35/219) of low threshold agencies. The number of treatment units covered is based on an estimation in which treatment units reporting their data within another treatment unit ("covered reporting") are taken into account.

The level of data coverage for the clients is estimated to be 60-70% for outpatient and inpatient units and 40% for treatment in prison and low threshold agencies. The exact data on the total number of clients registered is not available.

Around 3000 general practitioners, who have followed a specific training on addiction care, provide drug treatment in Germany, particularly substitution treatment; however data from those doctors are not reported in the German Core Data Set.

3. Double counting control

The control on double counting in the German Core Data Set is carried out at treatment centre level, which does not allow controlling for double counting between facilities. As data are sent to the NFP in an aggregated form it is not possible to perform any other type of control on double reporting.

4. Harmonisation with EMCDDA guidelines: definitions

(case definition, treatment episode, start and end of treatment, type of treatment centre)

The definitions of the German treatment demand monitoring system are in line with the TDI protocol ver. 2.0, but not yet with the TDI Protocol ver 3.0, which will be implemented in 2017. When end of treatment is caused by a drop-out, the end is defined when the client has no contact with the centre for a maximum of 60 days.

5. Limitations

The main limitation of the German Core Data set is due to the fact that data are sent from the regions to the national level in an aggregated form, which makes impossible to control for double counting and to perform detailed control at the level of individuals. Furthermore not all requested information is reported by all treatment centres; some treatment centres are covering all requested variables and some not, with variations according to the centre on the variables covered. In this regard, caution should be paid when looking at trend data before 2010 as since 2010 all facilities have been included in the German monitoring system, regardless of completeness of the data they provide.

Furthermore the German system is solely based on the International Classification of Diseases (ICD-10), which makes substance-based analysis difficult. The German monitoring system only reports to the EMCDDA information on the 9 broad drugs categories as indicated in the TDI; no information is provided on detailed substances (e.g. heroin, crack cocaine, etc.)

6. Bibliographic reference

Braun, B., Brand, H. & Künzel, J. (2015). Deutsche Suchthilfestatistik 2014. Alle Bundeslaender. Tabellenband fuer ambulante Beratungsstellen. Bezugsgruppe: Zugaenge/Beender ohne Einmalkontakte. IFT Institut fuer Therapieforschung, Muenchen.

Greece

Sources: FONTE Report, 2014 National Report, National TDI expert

1. The National monitoring system: description

The drug-related treatment demand monitoring system of the Greek national focal point collects individual data on treatment entries recorded annually in the treatment services in Greece. The system is fully compatible with EMCDDA's Standard Protocol 3.0. Information is collected on the socio-demographic characteristics and the behavioural patterns of individuals who demand and enter treatment for drug-related problems. Data are either sent to the focal point in paper forms or submitted electronically during an ad-hoc meeting with the agencies in the focal point's premises. TDI data collection is also linked to the DRID register.

2. Coverage

Data are reported from outpatient (87) and inpatient (11) treatment centres and from low threshold agencies (2). Data on prison (2 prisons) started to be collected on a pilot basis only from 2015 onwards. General practitioners or private clinics' data are not collected, nor is there any reliable information about the number and the characteristics of the individuals who approach this type of services for drug-related problems.

TDI monitoring coverage at the level of both units and clients in Greece is generally estimated above 90%. The 2014 data in particular were reported on 77% of outpatient and 79% inpatient centres and on 29% low threshold agencies (most of the units with no data in 2014 had reached capacity, i.e., reported no entries during that year). Among the units reporting annually their data to the focal point, data cover virtually 100% of clients entering treatment.

Regarding the definitions of type of treatment centres, the facilities included as outpatient centres are drug-free programs; opioid substitution treatment; specialised programs for adolescents; specialised programs in prisons. The facilities included in inpatient centres are residential drug-free programs; therapeutic communities; detoxification programs; specialised programs in prisons. Finally the facilities included in low threshold agencies are emergency units, medical and social facilities.

3. Double counting control

Individual data are collected at the unit level with the use of anonymous forms which include a unique identifier. With the use of the unique identifier cases are checked to eliminate double counts at national level. At the treatment centre level the clients are also requested to answer the following question: "Have you ever been previously treated? (Response options: never previously treated; previously treated; not known). The control of the double counting at national level takes places at the focal point.

4. Harmonisation with EMCDDA guidelines: definitions

(case definition, treatment episode, start and end of treatment, type of treatment centre)

The definitions used in the Greek National registry are the same as in the TDI protocol 3.0

5. Limitations

General practitioners or private clinics' data are not collected, nor is there any reliable information about the number and characteristics of individuals who approach this type of services for drug-related problems. A waiting list of approximately 3.5 years (as of 2014) exists in the Attica region for opioids users who want to start an OST: this might mean that the level of high risk opioid users captured through the TDI might be lower than in other countries where there is no difference between demand and entry into treatment.

6. Bibliographic reference

Greek REITOX Focal Point of the EMCDDA (2013) - University Mental Health Research Institute

The TDI / DRID Data Collection Form: Guidelines for Completion [in Greek].

Hungary

Sources: FONTE Reports, 2014 National Report, National TDI expert

1. The National monitoring system: description

In Hungary treatment demand data are collected through the TDI data collection. Individual data are collected by the treatment centres and provided to the National Centre for Addictions (OAC), who processes the data (data cleaning and controls for double counting). The OAC then forward the data to the National Focal Point (NFP) as raw data. Data analysis was carried out by the NFP.

2. Coverage:

The data collection covers all types of facilities providing drug treatment in Hungary. The data are collected from 53 outpatient units, 20 inpatient units, 6 treatment units in prison and 16 low threshold agencies. The actual number of existing units is not available as the same addiction units may treat both alcohol and illicit drugs and it is not possible to count how many units are only devoted to illicit drugs; therefore it is not possible to estimate the coverage. The reasons for this is related to the fact that in Hungary funding for health or social services (targeting drug users) can be obtained for “addicted people” or for “people with psychiatric disorders”. Although there are a few units who identify themselves as treatment units for drug users, this is never a formal categorisation; therefore only the formal list of all drug and alcohol service providers can be obtained.

The level of coverage is also unknown for the clients: only the number of clients reported to the EMCDDA for the TDI is known.

General practitioners do no provide treatment for clients with drug problems in Hungary. Their role is to refer the patients to the specialized drug treatment facilities. Therefore they are not included in the data collection.

The centres included in the data collection system include the following types of facilities according to the type of units classified in the TDI:

- Outpatient treatment centres include outpatient facilities of hospitals and other public/non-profit institutions providing care/treatment services to clients with addiction problems in general (i.e. alcohol problems as well) or to patients with psychiatric conditions. They also include non-profit/public/private/church operated services, which do not belong to either of the above categories, offering preventive-consulting services to clients entering treatment as an alternative to criminal procedure (QCTI);
- Inpatient units include hospital wards specialized in inpatient addiction/psychiatric treatment and residential drug treatment institutions. The facilities providing treatment for drug users are usually not specialized i.e. drug users are treated within the same hospital ward as clients with other psychiatric conditions or clients with other types of addiction.
- Low threshold agencies in Hungary are centres providing free services on a voluntary basis, mostly anonymously, aimed to reduce harms associated with drug use and to facilitate access to social and health services. They include NGO/church operated services which provide psycho-social interventions to their clients among other low threshold services
- Drug treatment for prisoners is provided by prison services inside the prisons or (in case of preventive consulting services which are also available for prisoners who committed misuse of drugs prior to their imprisonment) by external organisations inside the prison. If the

appropriate health service is not available within the prison system the service is provided by an independent civil institute outside prison; in that case clients are reported under a treatment unit different from prison. Treatment units in prison include outpatient service providers who provide treatment for prisoners either within or outside of prisons

3. Double counting control

The double counting is controlled at central level as individual data are gathered at national level. It has to be considered that in Hungary some health care institutions provide more than one treatment modalities; for example the hospitals might have an inpatient unit and also an outpatient unit and some of the outpatient units also provide treatment in prison setting. Some service providers operate outpatient and low threshold services as well. Therefore the same treatment unit can appear in different treatment centre type statistics. The control on whether a client has been already treated in another treatment centre is based on unique identifier of the client.

1. Harmonisation with EMCDDA guidelines: definitions

(case definition, treatment episode, start and end of treatment, type of treatment centre)

The definitions used in the Hungarian monitoring system are equivalent to those used in the TDI 2.0. The TDI protocol 3.0 is still not implemented and will be implemented in the next period.

2. Limitations

Data limitations are mainly related to specific legislation in place in Hungary, which leads to a high number of cannabis users entering treatment to avoid punishment. Particular cautions should be paid in interpreting the Hungarian TDI data as reflecting the nature of high risk drug use in the country; the large number of cannabis users entering treatment in the country is mainly due to the specific national legislation. According to Hungarian drug law, offenders of minor drug offences have the possibility to undergo treatment or preventive-consulting services as an alternative to criminal proceedings.

Also a limitation is found in the limited information on data coverage: the number of actual units and clients is not reported due to the way of funding treatment, which does not allow to identify specific illicit drug treatment units. According to the funding system treatment is based on wider categories.

3. Bibliographic reference

Treatment demand indicator. Standard Protocol 2.0. OAC and HNFP 2014

Ireland

Sources: FONTE Reports, 2014 National Report, National TDI expert

1. The National monitoring system: description

The National Drug Treatment Reporting System (NDTRS) is a national epidemiological database which provides data on treated problem drug and alcohol use in Ireland. The NDTRS collects data from both public and voluntary drug and alcohol treatment services. For the purposes of the NDTRS, treatment is broadly defined as 'any activity which aims to ameliorate the psychological, medical or social state of individuals who seek help for their substance misuse problems'. The NDTRS is a case based, anonymised database. The NDTRS is co-ordinated by staff at the Health Research Board (HRB) on behalf of the Department of Health.

2. Coverage:

Data coverage in Ireland is national and extensive; data are collected from all types of treatment centres providing drug treatment in the country: outpatient and inpatient centres, in-reach and treatment units in prison, low threshold agencies and General Practitioners. Data are reported on over 70% of existing units for all types of treatment centres: from 75% in low threshold agencies to 82% of the outpatient treatment centres.

The data coverage on the number of clients is unknown, as a registry of the total number of registered clients does not exist. Only the number of clients reported to the TDI system is known.

One study examining the completeness and accuracy of the data from the national monitoring system was conducted in 2003. The study only concerned the methadone clinics in the Dublin area and indicated that 60% of methadone cases were reported in 2001.

The different types of treatment centre include the following units:

- Outpatient centres: counselling services, day care therapeutic units, methadone services and socio-economic training units
- Inpatient centres: detoxification units, therapeutic communities, other specialised residential treatment centres
- General practitioners: specialised doctors trained in opiate substitution
- Low-threshold agencies: centres/programmes providing low-dose methadone or drop-in facilities only
- Treatment units in prison: (a) units specialised in drug treatment with a dedicated physical space inside the prison; and (b) professionals (external or internal to the prison) who provide a package of interventions aiming to treat or reduce drug related problems of drug users in prison

3. Double counting control

Control on double counting is performed at treatment centre level. Potential duplicates at treatment centre level are identified using the clients date of birth, a list of potential duplicates are returned to the centre for checking locally using name/address information

4. Harmonisation with EMCDDA guidelines: definitions

(case definition, treatment episode, start and end of treatment, type of treatment centre)

The definitions in the NDTRS are the same as in the TDI protocol 3.0. Some differences are reported on some variables: living with children, level of education, frequency of use (not recorded the frequencies 4-6 and 2-3 times a week), injecting status (not recorded for the last 12 months), polydrug use (the main drug is recorded for all clients), shared needles (it includes injection equipment and it is only recorded as lifetimes experience and not for last 12 months or last 30 days). All these variables including data on HIV and HCV testing and OST are not collected yet, but will be introduced in the system for 2016.

5. Limitations

Cautions should be paid when interpreting trends data: the data coverage has expanded over the years and the number of units participating in the national monitoring system has progressively increased. In addition the treatment units in prison started to provide data at national level only in 2009.

6. Bibliographic reference

National Drug Treatment Reporting System of the Health Research Board (2011) Trends in treated problem drug use in Ireland 2005 to 2010. Available at www.hrb.ie/publications

Italy

Sources: FONTE Reports, 2014 National Report, National TDI expert

1. The National monitoring system: description

In Italy data on drug treatment demand are collected by the National Information System on Addictions (SIND), which gathers individual data on subjects receiving care from the addiction services of the Regions and Autonomous Provinces. This system has been approved by a decree of the Ministry of health in 2010 and has replaced a previous system based on aggregated data. The information is recorded in six archives - linked through the key identifier - related to: socio-demographic information, contact information, test infectious diseases, drug-related pathologies, health care, and substance use.

2. Coverage:

The new system entered into force in 2012 and on the 31/12/2013 all regions except three (Calabria, Molise, and Sardinia) have implemented it. The data cover extensively outpatient centres; it does not cover low threshold agencies and treatment units in prison. Data on most clients entering treatment in inpatient centres are collected through outpatient units, which are the entry door for all clients with drug related problems. Data are not reported for low threshold agencies and treatment units in prison. General practitioners, even if legally entitled, indeed do not provide treatment to drug clients. And all private clinics not certified by the public health services are not part of the monitoring system.

The TDI data collection provide data on 603 out of 644 outpatient units and 58 000 out of 165 000 clients registered in the TDI register; the estimated coverage is 94%.

3. Double counting control

Double counting is controlled at regional level. For each client, the information is recorded by individual record identified by a unique key at the regional level. However it is estimated that the level of overlap between regions is not large due to administrative reasons and may mostly happens in the bordering areas between regions. This key is implemented in anonymous form based on socio-demographic information of the patient. The information system contains two variables: the opening date for the first medical record and, for each treatment provided, the starting date of treatment; through the comparison between these two dates, the patient is classified as never previously treated or previously treated.

4. Harmonisation with EMCDDA guidelines: definitions

(case definition, treatment episode, start and end of treatment, type of treatment centre)

The SIND definitions are mainly harmonised with the TDI protocol 3.0. In particular case definition is the same as in TDI 3.0 and treatment episode is defined as a therapeutic intervention including medically assistance and/or psychosocial treatment; each patient is considered to enter treatment if she/he receives at least two health or social interventions. In case of drop-out from treatment the

end of treatment is defined after 2 months of no contacts with the services. Outpatient units include all outpatient territorial facilities in Italy.

5. Limitations

Data limitations are related to the fact that three regions are not covered by the data collection as well as by the absence of data coverage for the treatment centres (prison and low threshold agencies) providing drug treatment, even if the covered treatment may be considered as the bulk of drug treatment in Italy.

Another limitation is due to the absence of the indication of the primary drug for almost half of the drug clients entering treatment in 2012 and 2013. This makes it impossible to carry out relevant data analysis for Italy at European level.

As the national monitoring system has changed in 2010 (the first data collected through the new system refer to 2012), cautions should be paid when interpreting trends data before 2012, as they may be partly related to the changes in the reporting system. Furthermore before 2005 the total number of clients undergoing treatment was reported to the EMCDDA, and not those starting a new treatment, which makes difficult to do any comparison at European level.

6. Bibliographic reference

Decree of the Ministry of Health - June 11, 2010.

Latvia

Sources: FONTE Reports, 2014 National Report, National TDI expert

1. The National monitoring system: description

In Latvia the national system for data collection on treatment patients is called PREDA - Patient Register Data (Register of persons with certain diseases). It is based on an online data collection system. In Latvia the TDI Protocol v.3.0 was implemented as foreseen by the European guidelines in 2013.

The process for data reporting to the national level and to the EMCDDA is based on several steps: the treatment centres sign an agreement with the National Centre for Disease Prevention and Control to enter individual data, then the treatment centres enter the clients' data into the system PREDA and finally data (after data quality check and correction if necessary) are sent to the National Focal Point, that computes the data and produce TDI tables through Stata and SPSS.

Data quality control is carried out by several persons and in different phases: by the PREDA coordinator regularly on the first data collected from the treatment centres and by the National Focal Point at different stages, with a regular communication with the treatment centres.

2. Coverage:

The data coverage is national and quite extensive. Three data sources used for estimating total number of treatment provision - two databases belonging to the National Health Services (systems called APANS - for out-patient data and SPANS - for in-patient data), that collects data on all people in contact with the treatment system and system PREDA that collects data according to the TDI Protocol v.3.0. Databases are linked by using unique identifier.

Data cover 42 out of 53 outpatient treatment centres (79%) and 8 out of 32 (25%) inpatient treatment centres. Data on other types of treatment centres (treatment units in prison, general practitioners and low threshold agencies) are not included in the PREDA system. However data from outpatient centres might include a small number of cases of drug treatment provided in prisons, as new regulations foresees that methadone can be provided in prison for inmates who have been in methadone treatment before entering prison. Those clients are only recorded as treatment demand data if they are new entries or they start a new treatment episode when they enter treatment.

The level of coverage of clients attending drug treatment is estimated to be 60% (58% for outpatient and 88% for inpatient clients). However since the new data collection system was fully launched on February 2013 and although data providers were instructed to include clients treated also in January and February - there might be some (unknown but probably small) level of underreporting of clients in January-February

3. Double counting control

The control on double counting is carried out at the level of treatment centre and at national level for both outpatient and inpatient centres. The monitoring system is based on individual data collection with a unique identifier for each patient; it is therefore possible to have a virtually full control on duplications.

4. Harmonisation with EMCDDA guidelines: definitions

(case definition, treatment episode, start and end of treatment, type of treatment centre)

In the PREDA system the definitions are all harmonised with the definitions of the TDI protocol 3.0. All the clients entering in contact with the treatment system are registered in the system including alcohol users; for the purpose of the EMCDDA TDI data collection the cases that fit the TDI definition are selected and sent to the EMCDDA. A treatment plan exists which defines what is the start and the end of treatment. Both definitions are in line with the TDI definitions (drop out is defined after six months from no contact with the treatment system).

5. Limitations

The main data limitations in the Latvian treatment demand monitoring system are related to trends data; since the first data collection system was implemented in Latvia in 1997, the treatment monitoring system has gone through several changes over the years. At the earlier stage the treatment related data came from different databases that were merged in one database and monitoring system –PREDA.

Also compared to 2014 data collection (2013 data), previous years' data differed in several aspects: in the way data were reported (e.g. from discharge forms in some years and types of centres), in the definitions (e.g. no use of ISCED to define educational levels were used) and in the data coverage (e.g. for some years data were referring to first clients for outpatient treatment centres and for all and new clients for inpatient treatment centres; also inpatient data were not reported for all years). In 2013 Latvia implemented the TDI Protocol and a harmonised national system for data collection. Data quality has improved, even if there are still some part of the treatment system uncovered (see coverage) and few variables incomplete (secondary drugs and OST).

According to the items included in the TDI 3.0 protocol, no data on secondary drugs are reported, but only the number of polydrug users according to the new TDI definition. Also no data are available on years since first OST, whilst data on clients who have been on OST might be underestimated as not very precise data about buprenorphine treatment are available; for validation of previous methadone treatment valid data has been obtained for 2007-2013.

6. Bibliographic reference

Regulations of the Cabinet of Ministers No. 746 - for system PREDA data collection form.

Lithuania

Sources: FONTE Reports, 2014 National Report, National TDI expert

1. The National monitoring system: description

In Lithuania a monitoring information system of persons who apply to health care institutions for mental and behavioural disorders and use of narcotic and psychotropic substances has been established with an Order of the Minister of Health of the Republic of Lithuania in 2007. However due to technical, financial and legal problems, the computerized monitoring system has only been developed in 2012. Data collection started in 2013 according to the EMCDDA Guidelines TDI Protocol ver.2.0. Health service providers should complete a statistical form and submit data electronically to the State Mental Health Centre, responsible for data analysis and for providing information for national focal point. Finally the National Focal Point provides with the data the EMCDDA.

2. Coverage:

The data coverage in Lithuania is national. Data coverage is estimated to be above 50% of existing outpatient and inpatient treatment centres and of the treatment units in prison. However it has to be considered that in Lithuania the same facility may offer outpatient and inpatient services.

Data are not collected in low threshold agencies and among general practitioners.

Outpatient centres include non-specialized, qualified health care services provided by norms of general practitioners and medical nurses in the outpatient health care facility. Inpatient centres therapeutic communities, private clinics, units in a hospital and centres that offer residential facilities. Treatment units in prison include services that deliver specific services to prisoners because of their drug problem.

3. Double counting control

The control on double counting is national and no duplications between treatment centres are possible through the national computerised monitoring system.

4. Harmonisation with EMCDDA guidelines: definitions

(case definition, treatment episode, start and end of treatment, type of treatment centre)

The basic definitions in the Lithuania monitoring system are in line with the TDI Protocol ver. 3.0. In particular the case definition, the start and end of treatment are harmonised with the TDI ver. 3.0. No information was reported for several requested variables, as at national level information is either not collected or collected in a different way.

5. Limitations

Data limitations are related to the lack of data on the following variables requested in the TDI Protocol ver 3.0: mean ages and lag to treatment, route of administration (see point 4), frequency of use, age at first use, injecting behaviour, years since first injection, polydrug use, secondary drug, HIV and HCV testing, needles exchange and opioid substitution treatment.

Furthermore limitations are related to trends data. The Lithuanian monitoring system has a long history, but before the major change occurred in 2012, data were scarcely comparable with the TDI standards. The Ministerial order lead to changes in the data collection which make information more harmonised with the TDI Protocol ver. 3.0.

6. Bibliographic reference

Order of the Minister of Health of the Republic of Lithuania on the Persons who apply to the individual health care facilities for mental and behavioural disorders who apply to health care institutions for mental and behavioural disorders and use of narcotic and psychotropic substances *(issued on 1'th August 2007 No. V-636*)

Luxembourg

Sources: FONTE Reports, 2014 National Report, National TDI expert

1. The National monitoring system: description

Drug treatment demand data are reported by *Réseau Luxembourgeois d'Information sur les Stupéfiants (RELIS*), a multi-sectorial drug monitoring system covering both, public and private partners. Each treatment centre is requested to fill in an individual paper questionnaire for each client/patient. The data are then collected by the National Focal Point and entered in the national RELIS database.

2. Coverage:

The data cover all treatment centres providing drug treatment in Luxembourg, with the exception of the general practitioners. Data are reported from 1 inpatient and 6 outpatient centres, 2 treatment units in prison, 1 low threshold agency and 4 hospital units treating drug users.

Outpatient treatment centres include specialized counselling services, medical offers in specialized centres as well as OST programs.

Inpatient treatment centres include therapeutic treatment centres and hospital units offering specialized care and overnight stay of variable durations.

Low threshold agencies include specialized facilities offering help and consultations other than classic (abstinence or drug day contact offers, syringes' exchange programmes, and supervised consumption.

Finally treatment units in prison include programs in prison, specifically targeting drug users seeking help, counselling, treatments etc. for their addiction problem.

The clients' coverage is unknown as the total number of clients entering drug treatment is not reported.

3. Double counting control

The control on double counting is carried out at treatment centre and national level through a unique identifier code for each client. Therefore no double counting is possible in Luxembourg

4. Harmonisation with EMCDDA guidelines: definitions

(case definition, treatment episode, start and end of treatment, type of treatment centre)

The basic RELIS definitions are in line with the definitions of the TDI Protocol ver. 3.0, including case definition, start and end of treatment. However no data were reported in 2014 on age at treatment entry, mean ages and lag to treatment, living with children, years since first injection, secondary drug, HIV and HCV testing, needle sharing, OST and years since first OST.

5. Limitations

Limitations of RELIS data are mainly related to the fact that for several years' data on new clients were not reported to the EMCDDA as the figures are small. Another limitation , which temporary and will be solved soon, is the limited implementation of the TDI ver.3.0.

6. Bibliographic reference

None

Malta

Sources: FONTE Reports, 2014 National Report, National TDI expert

1. The National monitoring system: description

In Malta the national treatment demand monitoring system is managed and coordinated by the National Focal Point (NFP). There are five treatment providers, including residential/inpatient treatment, low-threshold services, out-patient/community treatment and treatment for drug users in prison. For example, Caritas offers varies services including all of the above mentioned. Individual data are provided by each service to the NFP in an excel sheet format. When all files are received, the NFP merges all data into one structured file and identifies any double counting of cases.

2. Coverage:

The data coverage is national and complete. Data are delivered by all five treatment providers on outpatient and inpatient services, low threshold agencies and treatment units in prison. Data also cover 100% of registered clients. Only General Practitioners (GP) do not provide data to the national monitoring system; however their role in drug treatment is limited to the provision of health education and preventive care.

3. Double counting control

Double counting is controlled at national level by the Focal Point that manages the national data base on individual treated clients.

4. Harmonisation with EMCDDA guidelines: definitions

(case definition, treatment episode, start and end of treatment, type of treatment centre)

The definitions in the Maltese monitoring system are harmonised with the TDI Protocol 3.0, implemented in Malta in 2013 as foreseen. Those include case definition, end and start of treatment and treatment episode.

5. Limitations

Data limitations only refer the need to improve internal consistency in the data reporting, even if this mainly refer to few variables and to the inclusion of GPs in the monitoring system, even if the GPs' involvement in drug treatment is limited.

6. Bibliographic reference

National Focal Point on Drugs and Drug Addiction, Ministry for the Family and Social Solidarity.

Norway

Sources: FONTE Reports, 2014 National Report, National TDI expert

1. The National monitoring system: description

The Norwegian Patient Register is authorised by the regulation of 2009 to collect personally identifiable information about drug patients. Data are collected with a national register and then aggregated to be sent to the EMCDDA.

2. Coverage:

The data coverage is national and quite extensive. Data cover all existing types of specialised centres, which may provide outpatient and inpatient services; therefore it is not possible to distinguish between these two types of centres. Outpatient and inpatient centres both include units from the specialized health care system for substitution treatment and psychiatric treatment.

In Norway Information on clients' coverage is not known.

Data on drug clients entering treatment in general practitioners, low threshold agencies and treatment units in prison are not recorded. General Practitioners (GP) play an important role in drug treatment in Norway, especially regarding OST. It is estimated that GPs order around 60% of the OST-medication and play an important part in the long-time following up of these patients in co-operation with the specialized substitution treatment. They also have a role in urine-controls of younger drug users, and in early intervention strategies as well as long-time following up

3. Double counting control

In the Norwegian monitoring system double counting is controlled at national level, through the national register.

4. Harmonisation with EMCDDA guidelines: definitions

(case definition, treatment episode, start and end of treatment, type of treatment centre)

In the Norwegian monitoring system some basic definitions are harmonised with the TDI protocol 3.0: in particular case definition, treatment episode and end of treatment.

For the definition of treatment start, currently only treatments started during a calendar year are reported. It is not specified whether they refer to the very first time a client had received treatment, or whether the client had undergone treatment before. The primary drug on admission is recorded using the F-codes in the ICD-10 diagnosis system; therefore it is not possible to collect data on specific substances, but only on large drug categories (e.g. opioids, stimulants, etc.). Most data included in the TDI Protocol ver.3.0 are not included in the Norwegian monitoring system.

5. Limitations

Some limitations are found in the Norwegian monitoring system. The most relevant are related to the limited implementation of the TDI Protocol and the reporting to the EMCDDA on few basic variables. Furthermore some parts of the drug treatment system are not covered; even they play an important role in drug treatment in Norway (e.g. GPs). However it has to be considered that Norway only since 2010 has started its participation in the EMCDDA TDI monitoring system, which may have caused some delay in the full implementation of the European standards.

6. Bibliographic reference

"Guidelines for registering within specialized treatment for substance abusers (TSB)" (IS-1787 - Guidelines) the Directorate of Health 2010

Poland

Sources: FONTE Reports, 2015 National Report, National TDI expert

1. The National monitoring system: description

Information on the number of individuals admitted to drug treatment for drug addiction in Poland is collected by the National Bureau for Drug Prevention (that has also the role of Polish National Focal Point) through a centralised system of electronic or paper based data reporting from the treatment centres. The system has been implemented since 2008. The National Focal Point collects data on clients in treatment in the framework of the treatment demand indicator (TDI), which was a pilot project until the end of 2013. Following an Act of Law and Ordinance of the Minister of Health, it has become obligatory for treatment facilities to collect TDI data since January 2014.

Another relevant source of data on drug patients is the Institute of Psychiatry and Neurology (IPiN) that has been collecting data since many years from residential treatment on people with drug related problems. However the data collected by the IPiN are not in line with the EMCDDA guidelines.

2. Coverage:

The data coverage is national, but limited. It is hard to estimate coverage because we have only National Bureau for Drug Prevention booklet with information about treatment centres in Poland as the reference point (benchmark). There are not all treatment centres in the booklet. We have found in our TDI treatment centres which are not in the booklet e.g. 15 inpatient treatment centres. Data from 2014 are sent from outpatient centres (65) and inpatient (71). Based on the booklet we have in TDI 54 from 107 inpatient treatment centres (+15 inpatient treatment centres there are not in booklet but in TDI) and 65 from 211 outpatient treatment centres on average around 37% of both types of treatment centres are covered. When we take into account 15 inpatient centres which are not in booklet the coverage is higher more than 40%. However we do not know how many treatment centres are neither TDI nor the booklet.

Outpatient treatment centres include counselling centres, day-care centres, ambulatory substitution treatment centres, mental health ambulatory centres. Inpatient centres include detoxification wards, rehabilitation centres, inpatient substitution treatment, psychiatric wards.

Data from prison and general practitioners are not reported in the system, whilst low threshold agencies do not provide drug treatment in Poland.

In Poland Information on clients' coverage is not known.

3. Double counting control

The Polish TDI monitoring system control for double counting at national level, as the system is centralised at the National Focal Point which collects individual data from the specialised drug treatment centres either electronically or on paper. Data are then entered in a central database.

Double counting control is based on individual identifiers of every patient.

4. Harmonisation with EMCDDA guidelines: definitions

(case definition, treatment episode, start and end of treatment, type of treatment centre)

The definitions used in the National Polish Monitoring System are harmonised with the EMCDDA definitions included in the TDI Protocol ver. 3.0; those include the case definition, the start and end of treatment.

5. Limitations

Data in the current monitoring system present several limitations, mainly related to the recent implementation of the new monitoring system by the NFP.

The system has been put in place since some years and the drug treatment centres are gradually entering the monitoring system; therefore the data coverage is limited both concerning treatment centres and clients' coverage: around 37% of treatment centres.

Limitations are relevant when looking at trends data; it is not possible to compare data before and after 2014. Between 2008 and 2013 drug treatment units which reported treatment demand data did so on a voluntary basis. The treatment demand data project was a pilot undertaking. The number of participant units fluctuated between 2010 and 2013. During that period the most treatment units (59) reported data on the number of individuals seeking medical assistance due to drug use in 2012. Considerable changes occurred in 2014 as on 19 January 2014 the Regulation of the Minister of Health of 17 October 2013 came into force. The regulation defined the manner and procedure for the cooperation of drug treatment or rehabilitation units and the National Bureau for Drug Prevention. As a consequence, the National Bureau developed an online computer application for collecting statistical data under the drug treatment demand monitoring system (TDI) which included changes introduced with the TDI Standard Protocol 3.0. At present, the TDI system lists nearly 200 drug treatment units and the number will keep rising. Unfortunately, not all the TDI units report drug treatment demand data. In 2014, the data were reported by 71 inpatient units (including 45 residential centres, 12 wards and 14 detoxification wards) as well as 65 outpatient facilities (52 addiction counselling centres, 4 mental health counselling centres, 7 day-care centres and 2 substitution treatment programs).

In 2014 data started to be reported according to the new monitoring system and follow a different methodology and different definitions. After 2010 it is anyway necessary to be cautious in making any trend analysis with the Polish treatment demand data as the treatment monitoring system is gradually expanding and enrolling every year new treatment centres.

6. Bibliographic reference

None

Portugal

Sources: FONTE Reports, 2014 National Report, National TDI expert

1. The National monitoring system: description

In Portugal data on drug treatment demand from the public outpatient network are collected through the Multidisciplinary Information System (SIM), which was launched in 2010 and has merged the different existing monitoring systems at national level. SIM is an Electronic Clinical Record system in use in all public drug treatment units. According to the Portuguese regulatory framework information is collected on all patients attending public and private treatment centres, including clients both entering and continuing treatment from previous year(s). TDI data are extracted from the monitoring system for the EMCDDA's purpose. In 2013 the TDI Protocol ver.3.0 was implemented at national level.

2. Coverage:

The data coverage is national and extensive; according to the SIM register the coverage is estimated to be over 95% for the clients. Data cover all existing public outpatient centres. As clients have to enter the specialised drug treatment system through the outpatient centres in order to admitted to any other type of treatment centre, the reported actually data cover any other type of centre which is part of the public system (inpatient centres, GPs, low threshold agencies, treatment units in prison).

Outpatient centres include the following types of centres: public addiction centres, private licensed consultation centres, day centres. Inpatient centres include residential drug treatment units in specific detoxification units and therapeutic communities. General practitioners include doctors (generic and family doctors) providing outpatient drug treatment services to drug users among a range of other health services. Low threshold agencies include agencies for drug users without social and familiar support; refuge centres; contact and information points; outreach/street teams. Treatment units in Prisons include drug free wings where inmates are involved in drug treatments aimed at abstinence, and also other interventions, involving psycho-social follow-up and eventually OST.

3. Double counting control

In the SIM system double counting is controlled at national level through the national register.

4. Harmonisation with EMCDDA guidelines: definitions

(case definition, treatment episode, start and end of treatment, type of treatment centre)

In the SIM system the definitions are mostly harmonised with the TDI protocol 3.0. These include case definition and treatment start. The treatment episode is defined as a sequence of contacts directly connected with treatment, between a start date (first appointment) and an end date; the treatment end is defined when there is either a clinical discharge, or a death, or a drop out; in that

last case drop-out is defined as a period of no less than 12 months without contacts with the treatment centre.

5. Limitations

The main limitations are related to the changes in the reporting system that occurred in 2010, when a new reporting system was implemented. Cautious should be paid when looking at trend data before 2010.

6. Bibliographic reference

http://dis.dgs.pt/2013/05/29/sistema-de-informacao-multidisciplinar/

Romania

Sources: FONTE Reports, 2014 National Report, National TDI expert

1. The National monitoring system: description

In Romania the treatment data reporting system is based on the TDI Standard European Protocol ver. 3.0, implemented in 2013, for which data collection has been prepared since 2011. The RMCDDA (Romanian Monitoring Centre for Drug and Drug Addiction) manages the data reporting system: individual data are collected from the treatment centres and then reported to the national monitoring centre. This process is regulated by law.

2. Coverage:

The data coverage is national and extensive. Data cover all existing types of centres providing drug treatment in Romania, which include outpatient and inpatient treatment centres and treatment units in prison. Information on treatment units in prison were provided by outpatient professionals. General Practitioners and Low Threshold Agencies do not provide drug treatment. The extent of data coverage for both units and clients is unknown.

3. Double counting control

In the Romanian monitoring system double counting is controlled at national level through the national register. Controls on previous treatments are also done through the national register.

4. Harmonisation with EMCDDA guidelines: definitions

(case definition, treatment episode, start and end of treatment, type of treatment centre)

The definitions in the Romanian monitoring system are harmonised with those included in the TDI protocol 3.0, including case definition, treatment episode and treatment start and end.

5. Limitations

Data limitations are related to the lack of information on coverage, both on units and clients. Another limitation is due to the lack of recording of primary drug for a relevant proportion (around 20%) of clients; their primary drug is reported as “other”. Furthermore cautious should be paid in trends analysis, especially before 2006 as changes took place in the national monitoring system.

6. Bibliographic reference

RMCDDA: legislation on data reporting

Slovakia

Sources: FONTE Reports, 2014 National Report, National TDI expert

1. The National monitoring system: description

In Slovakia treatment demand data are collected through a national reporting system managed by the National Centre of Health Informatics (Národné centrum zdravotníckych informácií – NCZI), that allow to write the Report on treatment of dependency in drug user ZS (MZ SR) updated in October 2014. Data are forwarded in aggregated form to the National Focal Point (NFP) at The Ministry of Health.

Individual treatment providers send their report in a standardised unified form (paper or electronic) to the National Centre of Health Information (NCHI) quarterly, following methodological guidelines. They are transformed to individual electronic records database. Annually, NCHI processes the data avoiding double counting and provides cleaned data to the NFP, either as anonymised database or in a form of standardised predefined output tables (following the Fonte structure)

Data collection strictly observes the principle of data privacy; only health care providers have the access to personal data and the NCZI has access to individual anonymous data. Those data are then aggregated to be sent to the EMCDDA. Data collection is realised separately from medical facilities and prisons.

2. Coverage:

The data coverage is national and extensive. Data cover all existing types of centres providing drug treatment in Slovakia. In particular data cover around 60% of outpatient and 30% of inpatient treatment centres and all treatment units in prison in the country (40 units). General practitioners and low threshold agencies do not provide treatment in Slovakia.

In the three types of centres reporting data to the national monitoring system the level data coverage for the clients is high: 80%for outpatient clients, 90% for inpatient clients and 95% for clients entering treatment in prison.

Outpatient treatment centres include separate outpatient office at a specialised drug-treatment centre, outpatient room at an inpatient ward of a specialised drug treatment centre, day centre at an inpatient ward of a specialised drug treatment centre, stand-alone outpatient psychiatric service, outpatient room at an inpatient ward of general psychiatric services.

Inpatient treatment centres include inpatient wards at specialised drug treatment centres, inpatient wards for drug treatment, psychiatric inpatient wards.

Treatment units in prison comprise outpatient or inpatient treatment units, based either on general practitioners contracted by Prison Health Care Service, or internal treatment units within- general practitioners; they include stand-alone outpatient psychiatric service provider, day centre psychiatric inpatient ward, outpatient room at an psychiatric inpatient wards unit for voluntary treatment.

3. Double counting control

Double counting control exists at national level. The control on eventual previous treatments already recorded in another part of the system is indicated by the client him/herself and then controlled in

the national database through a unique identifier, checking whether this identifier appears again in the database.

4. Harmonisation with EMCDDA guidelines: definitions

(case definition, treatment episode, start and end of treatment, type of treatment centre)

The national reporting system is harmonised with the TDI protocol and all definitions are in line with the TDI Protocol ver.3.0. End of treatment is defined either when the treatment is concluded (according to ICD-10 criteria or when a client abstains for more than one year, without withdrawal symptoms) or when there is a death or no contact with any treatment centre for more than 30 days. Slight differences with the EMCDDA definitions are reported for some definitions (living conditions, frequency of use).

5. Limitations

Data limitations are related to some discrepancies between categories in the TDI Protocol and in the Slovakian reporting system (see point 4) and to unavailability of data for some new variables introduced in the EMCDDA's data reporting with the TDI 3.0: years since first injection, testing HIV and HCV, OST and years since first OST.

6. Bibliographic reference

NHCI (2014): Report on treatment of dependency in drug user ZS (MZ SR) 4-12 - data outputs for ST34. NHCI data on drug treatment, however in different structure than requested for ST34, is also published online with English summary and identification of statistical tables http://www.nczisk.sk/Publikacie/Edicia_Zdravotnicka_statistika/Pages/2014.aspx
and in print.

Drogová závislosť - liečba užívateľa drog v SR 2014 (PDF, 831 kB)

Slovenia

Sources: FONTE Reports, 2014 National Report, National TDI expert

1. **The National monitoring system: description**

Treatment demand data in Slovenia are collected through the National Drug Treatment database of individual data collected from the national network of the Centres for Prevention and Treatment of Drug Addiction (CPTDA) and from the Centre for Drug Addiction Treatment at the Ljubljana Psychiatric Hospital. In 2013, a new Treatment Demand Questionnaire based on the TDI Protocol 3.0 was introduced in Slovenia. Health care services are part of the main health care programme funded by the National Health Insurance Institute and are obliged to collect data by a national legislation.

2. **Coverage:**

The data coverage is national and quite extensive. Data were submitted by 17 outpatient drug treatment centres (out of 18 CPTDAs). Data are not reported from prison and low threshold agencies as data collection is not implemented in those facilities yet. Hospitals (except the Centre for Drug Addiction Treatment at the Ljubljana Psychiatric Hospital) did not participate in TDI data collection in 2013. One inpatient unit exists in the country but does not provide data yet. Finally General Practitioners (GP) are not involved in drug treatment in Slovenia and are therefore not included in data collection.

3 **Double counting control**

In the Slovenian treatment demand monitoring system double counting is controlled at treatment centre level. A new special personal identifier is being developed, which will help identifying the double counting.

1. **Harmonisation with EMCDDA guidelines: definitions**

(case definition, treatment episode, start and end of treatment, type of treatment centre)

The definitions included in the Slovenian treatment demand monitoring system are harmonised with the definitions of the TDI protocol 3.0, including case definition, start and end of treatment, treatment episode.

2. **Limitations**

Data limitations are related to lack of information on coverage both concerning units and clients and lack of data reporting from hospitals units, treatment units in prison and low threshold agencies. Furthermore, because changes in data coverage and improvement of data quality over the years, cautions should be paid in the trends analysis, especially before 2006.

3. **Bibliographic reference**

National Institute of Public Health: National Drug Treatment Database

Spain

1. The National monitoring system: description

Spain has a National Monitoring System on drugs, which is in place since 1987. The monitoring system included some periodic sources of information and other ad hoc adapted to the specific needs.

The main periodic indicators are: Treatment demand indicator, Drug-Related Deaths and Mortality Indicator, Drug-Related Emergencies Indicator, High-Risk Drug Use and Drug-Related Infectious Diseases Indicator. The main periodic surveys are: General Population Survey, Students Survey, Survey on health and drug use in Prisons and Survey on psychoactive substance use at the workplace.

This information is complemented whit other sources as Early Warning System, information from other Ministries (Ministry of the Interior, Justice…), National Statistical Institute, Non-Governmental Organizations, etc.

The Spanish Observatory on Drugs collaborate whit the different regions (community or city autonomous) to obtain the information.

2. Coverage

The TDI data coverage is national and extensive. Data cover around 90% of the all public outpatient treatment centres in the country. Additionally, 35% of all Spanish prison notified to TDI.

3. Double counting control

The monitoring system is based on regional reporting systems (17 community/2 city autonomous). Double counting is controlled at regional level by means of the use of a specific code for each patient preventing overlap between treatment centres. Although, at national level, controlling for overlapping is not possible, this is very unlikely to happen.

4. Harmonisation with EMCDDA guidelines: definitions. *(Case definition, treatment episode, start and end of treatment, type of treatment centre)*

The definitions included in the Spanish monitoring system are exactly the same as in the TDI Protocol ver. 3.0; those include the case definition, the definition of treatment start and the definition of outpatient treatment centre. The only difference between EMCDDA and Spanish definitions concerns the end of treatment, not in place in the Spanish system.

A case is considered: as a person admitted to treatment for drug abuse or dependence of a psychoactive substance in a public outpatient centre for the first time in a particular year in a region (community or city autonomous).

5. Limitations

The main data limitation in the Spanish treatment demand data from the EMCDDA's perspective is related to the delay of one year in data reporting; this delay may have some impact in the calculation of European trends, especially due to the large size of the country.

The new variables added to the TDI ver. 3.0 have been collected, for the first time, in the year 2014. Data whit new variables will be reported to EMCDDA in 2016.

Other limitations are detected; on the one hand TDI data is including publics outpatient centres only, so a lack of information is possible due to the absence of notification from private drug treatment centres. In any case, they would account for a small share of drug treatment patients in the country. On the other hand, TDI data is only including cases in treatment in the current year (first treatment or previous treatment). Therefore, currently, TDI doesn´t inform about prevalence (all people in treatment). For instance, it is likely that weight represented by opioid users (as prevalence) is greater than it is shown by TDI substances share.

6. Bibliographic reference

Spanish Protocol on people admitted to treatment:
http://www.pnsd.msssi.gob.es/Categoria2/observa/seipad/home.htm

Sweden

Sources: FONTE Reports, 2014 National Report, National TDI expert

1. The National monitoring system: description

Treatment demand data in Sweden are collected from different information sources:

(A) the National Patient Registry (PAR) collecting data from specialised outpatient and inpatient treatment services within health and medical sector;

(B) the Prison and Probation service's register based on ASI (Addiction Severity Index) collecting data on one part of the clients with substance use problems sentenced by court;

(C) the DOK system, which covers data from institutions for clients admitted to compulsory treatment.

Data collection is mandatory only for the PAR system, which represents the largest data set on drug clients in Sweden: according to PAR, hospitals and specialised treatment centres are obliged by law to report to the register that is managed by the National Board of Health and Welfare (NBHW). The National Public Health Agency of Sweden (the national focal point) then get the aggregated data from the NBHW and fill in the TDI standard table. In 2014 (data 2013) the three mentioned data sources (A, B, C) have been used to fill in the 2013 TDI data. The data are not pooled together, but reported as separate tables for inpatient, outpatient and prison treatment for most years. Until 2010 a national monitoring system called KIM (Clients in Substance Misuse Treatment) collected epidemiological information at sub-national level from 25% of existing specialised outpatient and inpatient units; the system was directly tailored on the TDI register, but it was dropped in 2011.

2. Coverage:

The information on coverage is limited.

PAR data cover 181 outpatient specialised drug treatment units and 95 hospitals, the DOk covers 11 units for compulsory treatment (LVM) and the Prison and probation service's register covers 47 treatment units in prison. The extent of data coverage for specialised drug treatment is unknown, as information on both number of units existing in the country and total number of patients is not available.

Regarding the second data source (Prison and Probation service's register) data cover 49 out of 50 treatment units in prison and 100% of clients, but only considering those who have been interviewed (818 in 2013).

For the third data source (DOK), all clients accessing all compulsory treatment units are interviewed wen admitted to care, but not all may answer all foreseen questions; therefore the data coverage is in that case virtually complete concerning the number of clients, but information may be lacking.

3. Double counting control

In the Swedish reporting systems there is no control on double counting between the systems, as the parallel systems are run at the same time by different actors and data quality control is not possible at national level, because the coordinating institution does not have access to the raw data.

4. Harmonisation with EMCDDA guidelines: definitions

(case definition, treatment episode, start and end of treatment, type of treatment centre)

The level of harmonisation with the EMCDDA Protocol is limited. The definitions included in the Swedish data sources are mostly not in line with the EMCDDA protocol.

Furthermore a relevant part of information requested by the TDI Protocol is not included in the data reported. In particular the PAR only collects information on primary drug by treatment status and age at treatment entry, but information on single drugs is not available. The system based on ASI

does not report information on secondary drugs, HIV and HCV testing, OST and years since first OST, it also only covers part of the population receiving drug treatment in prison, so the data is not representable for the whole population receiving treatment in prison..

5. Limitations

Data limitations are related to the existence of three different data sources that are not combined and for which it is not possible to estimate the level of overlap and cases duplication. Furthermore information on data coverage is limited. Also data are not harmonised with the EMCDDA guidelines and comparability with other countries' data is therefore difficult.

Limitations are also related to trends data as two major changes in the reporting system occurred in 2000 and 2013; however work has been done in order to obtain data from other sources and get the trend data. In addition in 2011, differently from other years, only data from prison units were reported. Finally between 2000 and 2012 there was an increase of the number of units joining the reporting system; this may have led to a growth of the number of patients mainly due to the improved reporting system.

6. Bibliographic reference

PAR Register: http://www.socialstyrelsen.se/register/halsodataregister/patientregistret

The Netherlands

Sources: FONTE Reports, 2014 National Report, National TDI expert

1. The National monitoring system: description

In the Netherlands, regular addiction care is provided by thirteen institutes, of which seven institutes have merged with an institute for mental health care and one institute has merged with an institute for social relief. The remaining five institutes did not merge, but remained a categorical institute for addiction care and treatment. Thirteen regular institutes and six commercial institutes deliver anonymous data about treatment demand to the National Alcohol and Drugs Information System, the LADIS. LADIS is the most comprehensive information system on treatment demand clients in the Netherlands and contains data from the regular drug treatment services.

Another source of information is the register of the hospital admissions, which provides the number of admissions due to drug related problems during the year; however the definitions are not in line with the EMCDDA guidelines and quantitative data are not delivered through FONTE, but only presented in the National Report.

2. Coverage:

The data coverage is national and extensive. Data cover all regular addiction care provided by the thirteen institutes, with the exception of the five institutes that did not merge. Also some private clinics and addiction units in general and psychiatric hospitals do not participate in the system yet. In 2011 probation services discontinued their participation in LADIS. Low threshold agencies are included under outpatient centres.

Currently LADIS covers 95% of outpatient centres and 75% of inpatient centres. Overall it is estimated that about 5% of total addiction care are not included in LADIS.

The involvement of General Practitioners in the drug treatment is minimal in the country; treatment provided in prison is not recorded anymore since 2008, as the data quality was considered insufficient. There are plans to evaluate these data again at the end of 2015.

3. Double counting control

In LADIS double counting is controlled at national level through a unique identifier for each client recorded in the national database.

4. Harmonisation with EMCDDA guidelines: definitions

(case definition, treatment episode, start and end of treatment, type of treatment centre)

In LADIS the definitions are harmonised with the definitions included in the TDI protocol 3.0; in particular the case definition, the start and end of treatment and the treatment episode. However the data on most of the newly introduced variables are not available with LADIS These variables are not considered as important in the NL and not usefull to collect.

5. Limitations

The Dutch monitoring system is well established since many years and follows high quality standards. The only two limitations refer to the lack of coverage of a small part of the drug treatment system (around 5%) in the country and the not full implementation of the TDI Protocol ver. 3.0 in 2013.

6. Bibliographic reference

LADIS: Dutch Information System on Alcohol and Drugs; Dutch specifications LADIS 2011

Turkey

Sources: FONTE Reports, 2014 National Report, National TDI expert

1. The National monitoring system: description

In Turkey data are gathered by the General Directorate of Health Services under the Ministry of Health through the forms designed for the "Treatment Notification System for Drug Users in Turkey". The database consists of the forms that are manually completed. The identifying details of the patients are kept confidential, as a coding system is used in completing these forms.

2. Coverage:

The data coverage is national and covers 25 out of 26 existing treatment centers, providing inpatient and outpatient services for alcohol and drug problems. Data from outpatient centers are not reported in the TDI. Drug treatment in prison is provided by family doctors, but no specific drug treatment units exist, general practitioners are not entitled to provide drug treatment in the community. Finally there are no low threshold agencies in Turkey and

3. Double counting control

Double counting is controlled in the Turkish monitoring system as data are given an anonymous code which is traceable.

4. Harmonisation with EMCDDA guidelines: definitions

(case definition, treatment episode, start and end of treatment, type of treatment centre)

In the Turkish monitoring system the definitions are not harmonised with the TDI Protocol ver.3.0. However all variables requested by the TDI Protocol ver.3.0 are covered by the data reported.

5. Limitations

Data limitations are related to the low level of harmonisation with the TDI protocol ver. 3.0, particularly regarding definitions. Furthermore double counting is not controlled, as data are collected with an anonymous code with is not traceable. Also data only cover inpatient centres, that however also provide outpatient services.

6. Bibliographic reference

General Directorate of Health Services - TDI Questionnaires

United Kingdom

Sources: FONTE Reports, 2014 National Report, National TDI expert

7. The National monitoring system: description

In the United Kingdom, treatment demand data are reported in aggregated form at national level from four systems: the National Drug Treatment Monitoring System (NDTMS) in England; the Scottish Drug Misuse Database; the Welsh National Database for Substance Misuse and the Northern Ireland Drug Misuse Database. Data from the four systems are combined into UK totals for reporting to the European Monitoring Centre Drugs and Drug Addiction (EMCDDA). The National Focal Point, located within Public Health England, which also houses the NDTMS, receives aggregated data from the four systems. Continuous national data are available from 2003/04. TDI Protocol ver.3.0 was implemented in England and Wales in 2013.

8. Coverage:

The data coverage is national and quite extensive. Due to significant data quality issues, data from Scotland does not cover Greater Glasgow and Clyde or Tayside. For the other geographical areas, data cover all existing types of centres providing drug treatment with the exception of treatment units within prisons. Prison drug treatment reporting is not yet fully integrated with community datasets and, at present, only NI prison treatment data is included in TDI figures. Some GPs in England prescribing without the involvement of specialist agencies do not report to NDTMS, so there is some under reporting of this type of service. Treatment Demand Indicator data is not supplied for services in the UK that are only providing low-threshold interventions.

The level of clients' coverage is also high, and virtually all clients are covered by the data collection. While there is no national treatment register, we are confident that the TDI data coverage is very high given that most treatment is publicly funded and reporting treatment data is a mandatory part of public funding.

9. Double counting control

The double counting is controlled by each of the 4 systems through matching records to see if a client has been treated previously; however, the control is not carried out at UK level.

10. Harmonisation with EMCDDA guidelines: definitions

(case definition, treatment episode, start and end of treatment, type of treatment centre)

The definitions are mostly harmonised with the TDI protocol 3.0. The case definition implemented for TDI in England, Wales and Scotland is fully consistent with the case definition of the TDI Protocol ver.3.0, while the case definition used in Northern Ireland is a very close approximation.

The other definitions are broadly in line with the TDI Protocol ver.3.0 although the classification of treatment centre types do not neatly map to the EMCDDA categories.

In Scotland and Northern Ireland the reporting year is still the UK financial reporting year.

11. Limitations

Data limitations are mainly relate to level of comparability over time trends data. The implementation of protocol 3.0 had a large impact on English and Welsh reporting with many (predominantly heroin) client who would have previously been counted no longer being included in the UK TDI submission. At the same time, the method for controlling for double counting was changed as was the period used. Prior to 2014 the reference period for data reporting was different from European standards (it was from April to March rather than January to December). For these reasons caution should be paid when interpreting trend data. Finally no data are available on clients' educational level.

12. Bibliographic reference

a) England- National Drug Treatment Monitoring System: https://www.ndtms.net/default.aspx
b) Scotland - Scottish Drug Misuse Database- : http://www.isdscotland.org/Health-Topics/Drugs-and-Alcohol-Misuse/Drugs-Misuse/Scottish-Drug-Misuse-Database/
c) Welsh - Welsh National Database for Substance Misuse - http://www.infoandstats.wales.nhs.uk/page.cfm?orgid=869&pid=40979
d) Northern Ireland Drug Misuse Database: http://www.northernireland.gov.uk/index/media-centre/news-departments/news-dhssps/news-dhssps-october-2015/news-dhssps-071015-publication-of-statistics.htm