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Treatment demand indicator Standard protocol 2.0

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Abbreviations

CCAD	Comité de concertation alcool et autres drogues de la Communauté française de Belgique (Consultative Committee on Alcohol and other Drugs, French Community of Belgium), Brussels, Belgium
CEEC	Central and Eastern European Country
CTB–ODB	Concertation Toxicomanies Bruxelles–Overleg Druggebruik Brussel, Brussels, Belgium
DSM	Diagnostic and Statistical Manual
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction, Lisbon, Portugal
GP	General Practitioner
ICD	International Classification of Diseases
IFT	Institut für Therapieforschung (Institute for Therapy Research), Munich, Germany
ISCED	International Standard Classification of Education
IVV	Informatievoorziening Verslavingszorg (Organisation Information Systems on Addiction Care and Treatment), Utrecht, The Netherlands; holder of LADIS, IVZ sub-unit
IVZ	Informatievoorziening Zorg (Organisation Care Information Systems), Utrecht, The Netherlands
LADIS	Landeslijke Alcohol en Drugs Informatiesysteem, Utrecht, The Netherlands; national system for collecting data on drug users in treatment
LBI	Ludwig Boltzmann Institut für Suchtforschung (Ludwig Boltzmann Institute on Addiction Research), Vienna, Austria
NFP	National focal point; institutions and national departments forming the EMCDDA's Reitox network
OFDT	Observatoire Français des Drogues et des Toxicomanies (French Monitoring Centre for Drugs and Drug Addiction), Paris, France
PG	Council of Europe co-operation group to combat drug abuse and illicit trafficking (Pompidou Group)
Reitox	Réseau européen d'information sur les drogues et les toxicomanies (European information network on drugs and drug addiction), network of EMCDDA national and European Commission focal points
SPTT	Serviço de Prevenção e Tratamento da Toxicodependência (Prevention and Treatment of Drug Addiction Service), Lisbon, Portugal
Stakes	Sosiaali ja terveystalouden tutkimus ja kehittämiskeskus (National Research and Development Centre for Social Welfare and Health), Helsinki, Finland
TDI	Treatment Demand Indicator

Preface

The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) was set up in 1993 to provide the European Union Member States, the European Parliament and the European Commission with reliable and comparable information on drugs and related subjects. While much work had already been undertaken in this field before the Centre was established, comparability of the methods and instruments used for collecting data on drugs, drug users and demand-reduction activities was limited.

Since the EMCDDA became operational in 1995, it and its national partners – particularly the national focal points (NFPs) of the Reitox network – have made significant advances to overcome these limitations in several areas of research and data collection. This work has made considerable progress during the past few years, especially in the field of treatment monitoring. Building on the extensive activities undertaken by the Council of Europe co-operation group to combat drug abuse and illicit trafficking (Pompidou Group – PG) and a broad range of national expertise from the EU Member States, projects have been carried out to develop a European standard protocol for monitoring the treatment of drug users.

This paper is the first version of this Treatment Demand Indicator (TDI) Protocol produced for a wider audience. It will form the basis for a process of harmonisation between the EMCDDA and the Reitox national focal points to increase the comparability of the treatment-related data flowing from the Member States into the EMCDDA's data pool and from there into the Centre's reports.

The criteria used for selecting the items included in the TDI were:

- information needs;
- availability in a considerable number of Member States;
- reliability; and
- comparability.

Experts from nearly all 15 EU Member States have already been involved in this work and they will be even more deeply implicated in the coming phases of harmonisation and implementation at national level. The Pompidou Group took the lead in initiating the new TDI which is now the common standard for both the PG and the EMCDDA and will gradually replace the earlier Pompidou Group Definitive Protocol (see Introduction, below). To make the transition to the TDI easier, rules governing how to adapt data to the new protocol have been included in the TDI itself.

The new protocol also bridges the gap between the PG Multi-City Study – begun in the 1980s as a collaborative exercise among several major European cities which faced increasing drug problems to develop common methods to assess these problems – and the national level, where data collection for the EMCDDA's purposes really takes place. In this way, synergy between the Monitoring Centre and the Pompidou Group will be increased and both organisations will benefit from each other's knowledge in, for example, the area of prevalence estimation.

The TDI lies at the heart of the harmonisation of data-collection and data-processing activities that form part of the EMCDDA's 1998–2000 work programme. The data-collection process and the new experiences associated with the TDI will be comprehensively evaluated and – if necessary – changes and additions will be made to the protocol. Because drug use and users – as well as drug treatment itself – are constantly changing, this evaluation phase will not be the final one. If required, the protocol will be reconsidered and revised every five years. This five-year period is long enough to allow a routine method of data collection to be

developed while also being short enough to avoid significant delays before changes in reality are also reflected in the TDI Protocol.

In an effort to keep this paper concise and easy to use, only the most important parts of the protocol have been included, such as the list of items and basic definitions. A more complete technical annex is available separately at <http://www.emcdda.org>.

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1. Introduction

Treatment monitoring for epidemiological purposes

Treatment-monitoring systems are one of the major information sources for drug epidemiology and demand reduction. These systems provide valuable information on the extent and characteristics of drug use as well as on measures taken to deal with the phenomenon. This information can be collected with limited financial effort within the framework of treatment services, as data on treated persons are readily available and are already collected for treatment purposes. In addition, this information is generally of high quality, as experts such as social workers and therapists complete the relevant questionnaires. Data on treated drug users are already available in many EU Member States, as well as in some of the Central and Eastern European Countries (CEECs). Some treatment-monitoring systems have been in existence for more than 15 years and cover anywhere between 40% and nearly 100% of specialised national outpatient centres.

The Pompidou Group–EMCDDA Treatment Demand Indicator Protocol (hereafter referred to as the TDI Protocol) plays an important role among the Centre's five key epidemiological indicators which provide a broad, comparative description of the state of, and trends in, drug use in Europe. These five indicators reflect both the prevalence of drug use and its health consequences as defined by the EMCDDA and its partners (Hartnoll, 1998). The five indicators are:

- national prevalence estimates of problem drug use;
- population surveys;
- drug-related infectious diseases;
- drug-related deaths and mortality among drug users; and
- demand for treatment.

Implementing these key indicators at European level will improve comparability and data quality by allowing national definitions, methodologies, the coverage of information sources and procedures for data processing to be analysed. It should, however, be borne in mind that the implementation will take time and the comparability of indicators will thus increase only gradually.

Developing a European standard for documenting treatment demand

The Pompidou Group's Definitive Protocol as the first European standard

The first pan-European protocol for treatment-reporting systems was the Pompidou Group's Definitive Protocol. The aim of this protocol was to provide drug professionals and researchers with a standardised methodology for collecting and reporting core data on drug users in contact with treatment services (Stauffacher and Kokkevi, 1999). As a result, it became easier to compare data from different treatment services, cities and countries. The main steps involved in producing the final version of the Definitive Protocol included a pilot study carried out in 1991 in Dublin and London, a developmental project in which 11 cities participated, and several expert-group meetings which agreed standard definitions, a core data set for a model questionnaire and data-collection procedures. The protocol was finalised in 1994 (Hartnoll, 1994).

Since then, the PG Definitive Protocol has been implemented in an increasing number of Western and Eastern European cities. More than 20 cities are currently using it and many national systems are either entirely (Greece and Ireland) or at least partly (Belgium, the

Czech Republic and Denmark) based on it. In 1997, 23 cities provided treatment-demand data that were compiled and analysed in a final project report (Stauffacher, 1999).

The Pompidou Group has also helped to develop treatment-reporting systems in several Central and Eastern European cities. As part of a new PG project, these systems will now be expanded to national level. Another new project currently under way is developing a treatment-discharge form that can be linked to existing treatment-demand information.

Previous studies and EMCDDA projects

Three broad factors have contributed to the development of the present PG–EMCDDA TDI Protocol over recent years:

- the developmental work undertaken by the PG;
- national experiences; and
- a series of projects run by the EMCDDA (see also Simon et al., 1999).

In addition to the Definitive Protocol, another major contribution from the Pompidou Group has been a quality control performed on several items of the TDI Protocol to identify missing values and inconsistencies between items (Kokkevi, 1997).

Some national treatment-reporting systems (for example, those of Germany, the Netherlands and Spain) were developed independently of the Definitive Protocol and already had a lengthy history of use when it came into use. (Simon, Hoch and Holz, 1999; Ouwehand and van Alem, 1999; Alvarez-Requejo et al., 1999; Donmall, 1999). The TDI Protocol could not, therefore, simply be a copy of the earlier PG protocol. However, the Definitive Protocol was used as a point of reference and formed the basis for discussions and for developing the TDI. Experiences from national or semi-national systems in different European countries were also taken into account.

On this basis, the EMCDDA, in close co-operation with experts from all 15 EU Member States, defined the first common set of items deemed necessary, useful and sufficient to describe:

- the characteristics of persons treated for drug problems in the EU; and
- recent developments in the field (Simon and Tauscher, 1997).

Special studies dealt with the definitions and methodological aspects of these items at European as well as at national level. Worthy of particular mention is a study into ways to avoid double counting of single cases while simultaneously respecting the client's privacy and the requirements of data protection (Origer, 1996). A feasibility study by Simon and Pfeiffer (1998) presented an overview of the state of development of treatment monitoring in the EU Member States and defined the basis for harmonising this indicator. The common PG–EMCDDA core item list was then finalised in 1999 by experts from both organisations (Pfeiffer and Simon, 1999).

Additional details focusing on methodological aspects of the TDI Protocol can be found in the separate technical annex to this paper available at <http://www.emcdda.org>.

2. The Pompidou Group–EMCDDA Treatment Demand Indicator Protocol

Purpose of the TDI Protocol

The purpose of the Treatment Demand Indicator Protocol as a basis for the data-collection processes co-ordinated by the EMCDDA is to provide comparable, reliable and anonymous information on the number and characteristics of people being treated for their drug use in Europe. Information on the numbers and profile of problem drug users and their patterns of use (injection, multiple drug use) can help to identify tendencies in the use of services, to assess resource needs and to plan and evaluate services for drug users. This information also indicates trends in problem drug use and provides fertile ground for more in-depth assessments of the prevalence of such use (Hartnoll, 1998).

The objective of the TDI Protocol is to define the minimum data set (the core item list) which national treatment-monitoring systems should be able to provide on each individual admitted to treatment. Step-by-step national standards will be harmonised on this basis in the coming years, leading to comparable data at European level. This will help to improve and further develop national health systems by taking into account a broader range of experiences. At the same time, the TDI Protocol will help to adapt these systems to cope more adequately with the demands of the growing European context.

The TDI items represent the smallest common denominator in terms of required information and national systems are therefore free to collect any additional information they consider relevant or important. While the protocol items do not necessarily have to be collected in exactly the same form and using exactly the same categories as specified in the TDI core item list, each Member State should be able to draw these data from its national sources and to provide the EMCDDA with this information. Well-defined procedures are therefore required at national level to clarify how this data processing and transfer should take place (see below).

The TDI items have not been constructed as a ready-to-use set. Their main purpose is to form the framework for a certain amount of minimal standardised information. Nevertheless, some of the items may be used as they are when constructing a new treatment-monitoring system or updating or reviewing an existing system. Other TDI items should be adapted to the national context by means of comprehensible definitions for their conversion.

Development of the TDI Protocol: Selecting the items

In addition to the relevance of the items themselves, a key selection criterion was the current or potential availability of key information within existing monitoring systems. In selecting the items, a pragmatic approach was adopted guided by availability. The list may be further developed and expanded in future, but when the process began it proved necessary to limit the number for compatibility with as many countries as possible.

The starting point of the TDI was the existing European list of core items from the Pompidou Group's Definitive Protocol and the different item lists already used by national treatment-monitoring systems. Altogether, more than 50 different items were analysed during this phase of development. After a process of discussion and selection by national experts, EMCDDA representatives and PG experts, a core list of 20 items was drawn up. Those not available in more than 50% of the participating national systems were excluded.

The final list covers three different areas:

- treatment contact details;

- socio-demographic information; and
- drug-related information.

Additional interesting items which are either not currently available in the majority of countries or whose adaptation from the national to the European system is problematic were placed on a 'wish list' which can be found in the technical annex to this protocol. These items are not currently part of the TDI Protocol, but should be considered relevant for future discussions and developments.

The TDI Protocol and national monitoring systems

One of the most important tasks undertaken before the core item list was developed was to clarify and understand how the subjects of the various national monitoring systems were defined and the different methods used to handle subjects within them. This process of clarification and understanding is essential if drug-treatment data are to be successfully interpreted and compared among countries.

Many national monitoring systems use additional information not reflected in the TDI Protocol. However, each country is free to be more complete or more specific, as long as it is able to provide the relevant information for the protocol items. Countries can use as many categories as they wish for a single item, as long as they can be converted to the standard European categories. A reliable method for routinely extracting these core data from national sources will be necessary. Items relevant only for local or national organisational purposes (code of treatment centre, client code, and so on) are not discussed here.

The actual implementation of a national treatment-monitoring system is not discussed here. Technically, such a system could be paper-based, but in this day and age it is more likely to use some form of electronic data processing. In practice, what format the system takes will depend on administrative requirements, the level of technical experience of staff and available funding. In addition, legal restrictions regarding such information still vary in Europe, but should become more uniform in future following the European regulation on data protection (Regulation 95/46/EG) that, by 1998, had become law in all Member States. Currently, only a few countries collect individual instead of aggregated data sets at national or regional level, thereby preventing double counting. Different methods can be used to avoid, or at least reduce, double counting. Based on a country's specific legal situation, a choice has to be made from among the different options listed below (for more on double counting, see Chapter 3, below).

National data collection and transfer to the TDI Protocol

Some TDI Protocol items could only be defined at intermediate level, requiring national data to be converted to this level. In these cases it becomes very clear that the TDI is not a 'ready-to-use' questionnaire, but has to be individually tailored to each country.

A good example might be 'school education'. Each country has its own particular education system and the TDI has therefore used the categories 'primary school', 'secondary school' and 'higher level of education'. Each country must adapt these categories to its national educational system before data on drug users can be transferred to the TDI items. The International Standard Classification of Education (ISCED) should be used to do this. The ISCED is also a good example of how already existing standards may help to implement certain TDI items at national level and process them into information that is comparable at international level.

Examples of further items and real questionnaires can be found in, for example, the national systems of Germany and the Netherlands and in the PG Definitive Protocol (see technical annex).

One of the most important tasks in implementing the TDI is to test the availability of all the requested information. Each country must therefore define its national equivalences, or its rules for converting national data into TDI items. These rules clarify how data are transferred from the national reporting system and/or other sources to the TDI-based report which is then passed on to the EMCDDA. These rules also allow a more fundamental interpretation of the core information and help to develop a common understanding of the items among different countries.

It is essential that treatment-related data are interpreted in the context in which they are collected. As already mentioned, differences in definitions still exist (for example, of part-time work or 'stable' versus 'unstable' living status), and these differences must continue to be taken into account.

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

Figure 1. Data collection and flow of information from national to European level

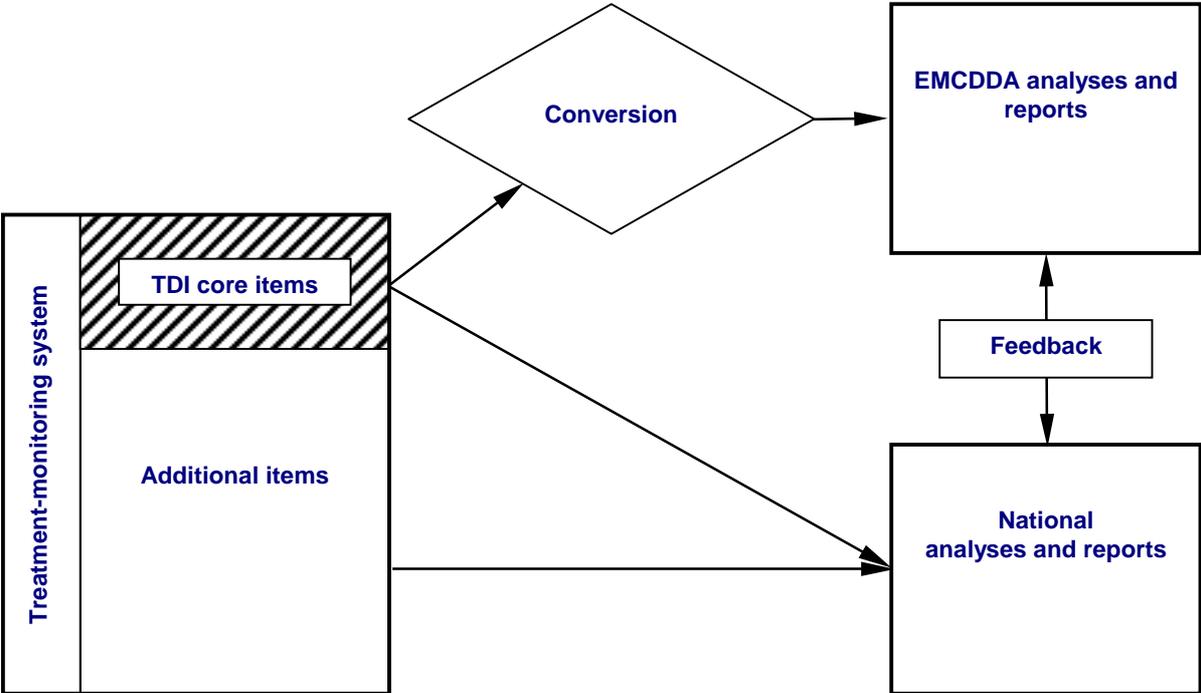


Figure 1 illustrates how TDI items are embedded in a national data-collection process. The usefulness of these items is not limited to the EMCDDA’s purposes, and they can also be used for analyses and reports at national level. The ‘conversion’ box indicates that although information can be collected in a non-standard format, it will require further processing according to clear rules before data can be passed to the EMCDDA.

In many countries, TDI items will form only a small part of the total information collected. Taking into account that the majority of TDI variables ask for the most basic information relevant for national purposes, the implementation of these items should not cause major problems. Feedback between the EMCDDA and national systems completes the picture and ensures permanent evaluation and improvement of methods and interpretation.

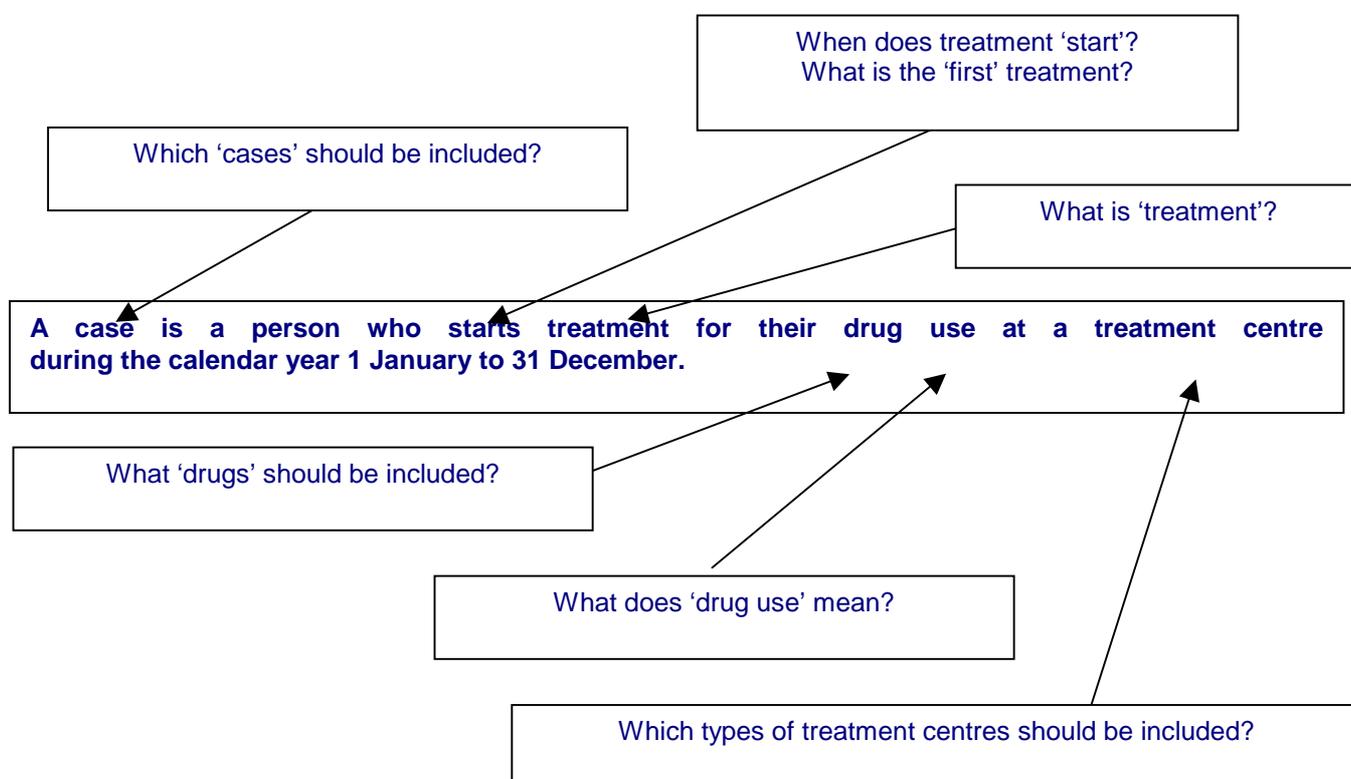
3. Definitions and methodological guidelines

Case definitions

This chapter defines central terms and provides guidelines for data collection, data processing and data transfer from national to European level. In order to maintain and increase comparability between the TDI and the Definitive Protocols, formulations taken from the earlier protocol have been used wherever possible (Hartnoll, 1994).

Given that the definition of a case may itself include several terms requiring further clarification, it is difficult to place the methodological aspects and definitions into a logical order. Figure 2 shows which definitions of the different aspects of the central case definition can be found in this text.

Figure 2. Definitions of key terms



Based on the core sentence of the case definition – ‘a case is a person who starts treatment for their drug use at a treatment centre during the calendar year 1 January to 31 December’ – Figure 2 highlights several issues that need further clarification. The following sections address these points and provide definitions applicable to the TDI. Additional remarks and comments are designed to give the reader a more detailed understanding of the strengths and limitations of the respective definitions.

Which ‘cases’ should be included?

Definition

For the purposes of reporting treatment demand, a case is a person who starts treatment for their drug use at a treatment centre during the calendar year 1 January to 31 December.

Methodological considerations

If a person starts treatment more than once during the same year at the same or at any other centre, then only the last treatment in that year is counted. If a person continues a treatment started in a preceding year, he or she is not counted again. This highlights the need to avoid the same person being counted repeatedly (‘double counting’). The problem of double counting and basic strategies for avoiding it are discussed later in this chapter.

Figure 3 provides an overview of which cases should be included and which should not (modified illustration taken from Stauffacher, 1999).

Figure 3. Treatment-demand cases compatible with TDI and Definitive Protocol methodology

Client	Treatment episode	Treatment centre	Preceding year	Current year	Following year
A	A1	1
A	A2	2		
A	A3	2		—————	
A	A4	3	
B	B1	1		
B	B2	1		
C	C1	1		—————	—————

According to the case definition given above, only treatment episodes A3 and C1 would be reported for the current year.

- *Client A:* Episode A1 began in the preceding year and will therefore not be registered in the current year. Episode A2 would have been registered only if no further treatment in the same year had taken place. Even if A3 is not the only treatment episode started during the current year, it will be reported since it is the latest episode in that year and therefore provides the most current data on the client. Episode A4 began before episode A3 and, as it does not provide the most recent data, will therefore not be reported.
- *Client B:* Episode B1 will not be reported because the client did not start the treatment during the reporting year. It is an ‘old’ case and not a new treatment. Episode B2 does not take place during the reporting year, and is therefore not registered.
- *Client C:* Episode C1 is registered because the treatment started during the reporting year. The fact that the treatment did not finish during the current year does not affect the registration procedure.

Directly linked to the case definition is the question of when a treatment is considered finished and when a subsequent treatment should be registered.

It is important not only to collect information on first treatment demands, but also to describe persons in subsequent treatments due to possible differences in drug use or personal characteristics between these two groups. Most national systems adhere to this concept.

In general, the end of treatment is defined on the basis of either intensity and quality of contact, or of administrative rules (for example, if the treatment lasts for more than six months, a new episode is automatically registered). Until now, a common standard did not exist. Each national system should try to provide a definition as clear and operational as possible for specifying the end of an individual treatment, describing under what conditions a person demanding treatment is registered as a new case. As long as a common definition does not exist, the total number of cases counted nationally will be heavily influenced by these rules. A clear description of the national rules can help to estimate the bias produced and thus increase comparability.

In order to optimise comparability between countries, it is necessary to use similar definitions for the beginning and end of treatment episodes. The most difficult aspect involved is defining the end-point of a single treatment occurrence. Among the various alternative approaches are:

- treatment seen as an ongoing, lifelong process in which the person is treated by the same unit over several years and therefore only the first treatment is documented; or
- each treatment episode finished after a pre-defined period of time and a new treatment episode automatically registered.

These two approaches will inevitably produce divergent results when data are collected and reviewed.

This problem of different approaches producing different results is closely linked to that of double counting. An unclear definition of the beginning and end of a single treatment episode also creates recording problems when a client re-registers within the same reporting year.

What is 'treatment'?

Definition

Drug treatment is any activity that directly targets individuals who have problems with their drug use and which aims to improve the psychological, medical or social state of those who seek help for their drug problems. This activity often takes place at specialised facilities for drug users, but may also occur in the context of in general services offering medical and/or psychological help to people with drug problems.

Methodological considerations

The above is a broad definition that includes:

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

However, the definition excludes:

- contacts with general services involving requests for social assistance only;
- contacts in which drug use is not the primary reason for seeking help;
- imprisonment *per se* (although it includes admissions to drug-treatment programmes in

prison or to treatment as an alternative to prison);

- interventions solely concerned with the physical complications of drug misuse (such as overdoses or infections treated in hospital);
- contacts by telephone or letter only; and
- contact with the family only.

This definition is deliberately broad in order to include as wide a range of drug users as possible. It is primarily based on epidemiology and medical considerations do not play an important role in this context.

A demand for drug treatment reflects several factors that affect the individuals treated. It also, however, reflects the characteristics of the treatment offered: there must be a drug user, a treatment offer and a demand for this offer.

The above considerations make clear that the type of treatment offered (whether high-threshold drug-free programmes or methadone maintenance only) and registered influences the total number of drug users in treatment and possibly also the type of drug users treated (for example, a new offer attracting older, non-treated drug users). As a result, the data should be as complete as possible, and should ideally include all types of treatment offered within a country.

Which types of treatment centre should be included?

Definition

A treatment centre is any agency that provides treatment as defined above to people with drug problems. Treatment centres can be based within structures that are medical or non-medical, governmental or non-governmental, public or private, specialised or non-specialised. They include in-patient detoxification units, outpatient clinics, drug substitution programmes (maintenance or shorter-term), therapeutic communities, counselling and advice centres, street agencies, crisis centres, drug-treatment programmes in prisons and special services for drug users within general health or social-care facilities.

Methodological considerations

Although treatment centres are often staffed by qualified professionals, 'treatment' in this context also includes services provided by those who are assumed to have appropriate therapeutic skills but who lack formal qualifications. Treatment centres do not include hospital emergency rooms or general health or social-care facilities which drug misusers contact primarily for help with problems other than drugs (see above for additional comments concerning the definition of 'treatment').

As many treatment providers as possible in each country should be recruited to participate in the reporting system. Factors that will influence the selection of centres include their willingness to participate and practical constraints such as available resources. However, it is very important that careful attention be paid to the distribution of the treatment centres included and how representative they are in terms of the types of treatment they offer, their geographical distribution and their catchment (referral) areas. If comprehensive coverage cannot be achieved, the aim should be to include a cross-section of the major treatment modalities found.

A clear definition of the types of participating treatment centres is essential if comparability of data between countries is to increase. Because several projects in both Europe and the United States have not yet produced a more complete and useful categorisation of treatment centres, a rather simple one is used here. This simple classification is a compromise which will be used as a working standard until more elaborate ones are available.

Five basic types of treatment centres are distinguishable and should be covered as thoroughly as possible by national sources. These are:

- outpatient services;
- inpatient/residential services;
- low-threshold services;
- treatment offered by general practitioners (GPs); and
- treatment units in prisons.

Special treatment services are offered in prisons and by general practitioners. Both are important, but usually only limited information on them is available. Efforts should be made to include GPs in areas where they play an important role in treating drug misusers (for example, by prescribing methadone). Including general practitioners in routine treatment-monitoring systems may, however, create practical problems (for example, large number of GPs, small number of cases per GP). It may, therefore, only be possible to collect very basic data on clients, for example through a methadone registration system.

The definition of 'treatment centre' also raises issues of coverage concerning interventions such as needle exchanges or outreach projects. Programmes exclusively concerned with making syringes available or disseminating information should generally not be considered as treatment centres. They may be included, however, if these activities are part of a wider range of services offered, such as counselling, health care and other programmes to help people with drug problems. There may also be practical problems in collecting data, as these projects attempt to make themselves as acceptable as possible to clients who may be suspicious of agencies that offer assistance. It is thus difficult for them to record statistical data systematically and they may be reluctant to participate in a reporting system. The best compromise may be to collect only very basic data from these projects.

When does treatment 'start'?

Definition

Treatment in a given treatment centre starts as soon as a client begins a more or less formalised face-to-face contact with the centre that fulfils the criteria for treatment as defined above.

Methodological considerations

Operationally speaking, a person should be registered after his or her second direct (face-to-face) contact with the therapist or treatment facility. This procedure is intended to ensure more complete and reliable data, as the first contact often provides insufficient opportunity for data collection. Another possible solution might be to collect the most basic data (gender, age, and so on) at the first meeting and to gather more extensive information during a later session.

Only those treatments where direct contact has taken place at least once are considered 'started'. Mere requests for treatment have to be excluded.

As mentioned before, this definition excludes:

- contacts over the telephone only; and
- relatives requesting treatment on behalf of a drug addict.

The total number of persons who only appeared at the treatment centre once should also be recorded. The minimum data set for this group, to be collected if at all possible, includes information on age, gender and the primary drug used.

For the sake of comparability of results between countries, it is vital to reach a common understanding as to when a treated person should be counted.

What is the 'first' treatment?

Definition

The 'first' treatment is defined as the very first time during his or her life that a person starts treatment for drug problems (as defined above) at any treatment centre.

Methodological considerations

The very first time a person seeks treatment because of his or her drug use and the problems arising from it can be used to calculate treated incidence. Treated incidence is the number of new drug-treatment cases during a certain period of time. In this situation, however, multiple counting of a person due to treatment (and registration) by several units during the same time period does not occur.

This information is based on a central register of treated drug addicts, the availability of which may vary depending on a country's legal and technical situation. Only cases involving people who are not yet included in this register are defined as 'first treatments'.

In those countries in which a register does not exist, the treatment organisation can perform an internal check (within the same treatment centre) to see if there have been prior treatments. However, the most popular method of monitoring prior treatment remains simply asking the drug user if he or she has ever been in treatment before.

For a definition of 'subsequent treatment', see the definition of a case, above.

What 'drugs' should be included?

Definition

The main categories used for recording drugs in the TDI Protocol can be found in Table 1.

Table 1. Drugs included in the TDI Protocol

Groups of substances	Substances
Alcohol	only as a secondary drug
Opiates	heroin methadone other opiates (e.g., codeine)
Cocaine	cocaine crack
Stimulants	amphetamines MDMA and other derivatives other stimulants
Hypnotics and sedatives	barbiturates benzodiazepines others
Hallucinogens	LSD others
Volatile inhalants	
Cannabis	

Groups of substances	Substances
Other substances	unspecified pharmaceuticals

Methodological considerations

Exclusions include:

- tobacco as a primary drug;
- alcohol as a primary drug; and
- use of any of the above drugs for *bona fide* medical treatment of organic or psychiatric conditions other than drug dependence or drug misuse.

Where relevant (for example, in some CEECs), a distinction should be made between home-made opium or poppy preparations (such as ‘poppy tea’), imported heroin and synthetic opiates.

Methadone and other substitute opiates are treated as special cases. A specific item has been introduced in the TDI core item list to clarify if a person is using drugs such as methadone within the context of a *bona fide* treatment programme such as methadone maintenance or detoxification. Whether these substances are classified as either the main or secondary drug depends on the client’s pattern of consumption. When classifying a substance as either the main or secondary drug, no distinction is made between those substances used for substitution treatment and other illegal drugs.

For users of ‘speedball’ (a mixture of heroin and cocaine), heroin should be recorded as the main drug and cocaine as a secondary drug. If the exact substance is not known (such as amphetamines or MDMA and derivatives) the generic category (for example, ‘stimulants (total)’) should be recorded.

In most countries, specific information on the psychotropic substances typically used is available. In the case of ecstasy, however, detailed information is not always obtainable.

If a centre treats both drug and alcohol problems, it is especially important to include only persons with a primary drug problem.

What does ‘drug use’ mean?

Definition

Drug use includes all possible ways to incorporate drugs into the body. Only information regarding the person using drugs is relevant.

Methodological considerations

Exclusions include:

- persons in contact with treatment centres on behalf of a drug user, but who are not a drug user themselves; and
- persons with problems due to their personal relationship to a drug user, but who are not drug users themselves.

When a person asks for treatment for their personal drug use it is assumed that this drug use has caused a problem for him or her. Assessment can be based on the personal judgement of the person involved or of other persons in his or her social environment.

The medical system, which also covers the field of psychotherapy, defines the client’s problem through an explicit diagnosis made by a therapist. International standards – such as

International Classification of Diseases 10 (ICD 10) or Diagnostic and Statistical Manual IV (DSM IV) – are being increasingly used in this procedure. These need not, however, always be the same as the definitions used by the social-care system. While many of those people applying for treatment might well ‘qualify’ for diagnoses concerning drug addiction in practice, a certain bias may result from varying procedures used in different countries and systems. For the TDI Protocol, the most important aspect is ensuring a clear and comprehensible case definition at national level that specifies which data should be collected and registered by the treatment-monitoring system.

Avoiding double counting

The term ‘double counting’, in this context, refers to a client being registered more than once in a treatment-monitoring database in a given year. This dual recording may result from the fact that the person collecting the data does not know that the user has already been treated and recorded during the reporting year. A closer look at this issue reveals two basic problems:

- the same client may be treated more than once in a given year in different treatment centres which are not aware of each other; and
- more than one treatment may take place in the same centre. This topic has already been touched on in the section dealing with case definitions above.

These two problems are related and have similar consequences. Nevertheless, differences occur when discussing the difficulties resulting from them and the possible solutions. Double counting causes the total number of treated persons to be overestimated. Theoretically, one individual may be counted several times during the same year, leading to heavily biased data and making reliable calculations or valid assumptions about prevalence or incidence rates impossible.

Assigning unique identifiers to individual client’s data may help avoid this problem. Comparable strategies have already been applied to central AIDS and cancer databases where similar problems have occurred. The establishment of such standardised (national) identifiers based on algorithms (such as AIDS identifier) and stored with the client’s data set in a national treatment database is an adequate way of controlling double counting at national level. However, due to problems with national data-protection laws, it has taken a long time to establish such identifiers and central databases for AIDS or cancer patients. It will take even longer before all EU Member States use such procedures to avoid double counting.

Nevertheless, double counting can be controlled, at least at treatment-centre level, in most cases. The problem of treating the same person in the same centre more than once in a given year is primarily a question of establishing a proper definition of a treatment episode and its beginning and end. This topic has been discussed in the section on case definitions above.

To a certain extent, double counting is controlled within all systems, but methods may vary. In 1998, for example, a nation-wide control on the basis of uniform personal codes was carried out in Denmark, Luxembourg and the Netherlands. This control method ruled out nearly all double-counting incidents that had occurred the previous year. Only those cases with incorrect identifiers might have caused double counting. A limited control at treatment-centre level is carried out in the Flemish Community of Belgium, in France and Germany. In Spain and the UK, double counting can be controlled at regional level. These examples illustrate national differences that are partly due to variations in national laws, but are also due to differences in treatment-monitoring systems and their organisational structure.

Origer (1996) described and analysed the methods used in the different countries to avoid double counting. A short version of his report is included in the technical annex of this

protocol, where an overview of the different methods to define a personal identifier can be found.

Quality control of data throughout the entire process

In discussing international comparisons between treatment data and the purpose of the TDI and other key epidemiological indicators, it should be borne in mind that the outcome of this project and the possibilities for making further use of these data depend heavily on the quality of the information collected.

Only when it is known where the data come from, what information they include and what their limitations and strengths are can the steps to be taken to improve the overall quality of the data and the resulting information be decided. Ongoing studies and evaluation of the work undertaken in the treatment field and of the information collected will facilitate this process. This section provides very brief examples of what may be done to ensure the continual improvement and control of data quality.

First and foremost, feedback and the exchange of experiences and information among all parties involved are of crucial importance. This applies to treatment centres at local level, the intermediate level of processing institutions and the Reitox national focal points as well as the European and national agencies who will make use of the data. Permanent exchange of information needs and ideas for further improvement from different perspectives are also necessary.

Additionally, single projects (such as small validity studies or evaluation of treatment outcome at regional level) may be useful for keeping in touch with developments and/or changes taking place in the field.

Another aspect linked to quality control is the coverage of cases, monitoring systems and treatment centres. National treatment monitoring should attempt to include as many centres and treatment facilities as possible in the system. It is important to keep the sample as representative as possible because under-representation of a certain kind of treatment centre would lead to systematic biases in the data. The sample of treatment centres participating in the national data-collection system should therefore be as representative as possible. While the participation of all such centres in a given country is often impossible for practical and financial reasons, this would be the best solution in terms of completeness and representativeness.

Once good overall coverage of treatment facilities has been achieved, an important secondary aspect is to ensure comprehensive coverage within the treatment centres themselves, which should include as many clients in routine reporting as possible.

To improve data quality on all levels it is necessary to train the relevant professionals in the process of data collection and to explain the purpose of this process. In addition, discussion of ethical issues (see below) and quality checks by database managers or social/medical supervisors will be both helpful and necessary.

At treatment-centre level, data collection should become an essential part of the overall treatment process. This will reduce data loss from the basic level of data collection onwards. Routine reporting to the regional and/or national level and subsequent quality checks will help to uncover problems, gaps or the need for further development. Quality control at regional or national level assumes that basic monitoring has already been carried out at central level. These central-level quality checks include analysing the data for inconsistencies or missing values.

Ensuring optimum comparability at international level requires the establishment of clear and comprehensive rules for converting national data into the information needed for the TDI Protocol. In applying these rules, inconsistencies may be discovered leading to the conclusion that some categories are not suitable for some countries and thereby

encouraging the search for solutions. The definition of national equivalences laid down in the conversion rules will lead to a better understanding of what kind of information is included in the item categories by making them more operational.

In general, the quality of the data collected in each of the EU Member States depends on the work performed at several levels. As a result:

- as many treatment centres as possible should participate in the reporting process and deliver data;
- if certain types of centres are under-represented, possible biases should be estimated and reported;
- data collection at the treatment centre should be complete, thorough, reliable and continuous; and
- data transfer should be prompt and well organised.

The organisation of data collection in each country depends on the national structure, the institutions involved and the technical and financial means available. As details vary greatly from Member State to Member State, a very general request needs to be made that everything possible should be done:

- to make data collection and input as simple as possible;
- to help avoid errors by implementing training, manuals, 'user-friendly' software and other support;
- to offer meaningful output of data analyses;
- to provide feedback where possible; and
- to make all those involved in the process of data collection feel responsible and behave accordingly.

Ethical issues

In treating drug problems, notes are taken on the client's drug use and his or her strengths and weaknesses. Treatment steps are planned on the basis of a formal diagnosis or on an overview of the problems requiring attention. Aims are monitored continuously during treatment and outcome is evaluated at the end. All these procedures, which describe the client as well as the treatment, can be performed in different ways for each client, therapist and treatment centre. Comparability can thus only be achieved by using common data-collection standards.

Comparability is the key to evaluating individual treatment, the type and organisation of treatment and, finally, drug policy. The concept of treatment monitoring, which includes all these activities, can facilitate the development of something like 'evidence-based health interventions'. Continuous feedback on the treatment delivered can help to change and fine-tune treatment services by pinpointing more effective and efficient ways of treating the drug problem. The same is true for all planning and public-health actions at political level. Treatment monitoring is, therefore, not only an administrative activity, but also contributes to the continuous development of the services and assistance offered to drug users. It should, however, be clearly stated that this requires much more detailed information from the treatment services than the TDI Protocol collects for epidemiological purposes. Yet it is an important option which might be integrated into a national monitoring system.

The intention is not to develop a central database of individual treatment at European level. All data are collected, analysed and retained by the respective countries, with strict adherence to accepted ethical standards, and only aggregated statistical data are pooled and analysed for comparative purposes at European level to obtain a standard. Individual

data sets, however, might occasionally be needed here, as in other fields of research, for specific studies.

Within countries, it is vital that reporting systems follow clearly stated guidelines on confidentiality and protecting the rights of clients, staff and of the treatment centres themselves. These guidelines should adhere to the accepted codes that govern data protection, privacy and research in the various Member States. Access to the raw data must be restricted to authorised staff only. Use of the data and procedures governing publishing results should be discussed by those involved (service providers, managers, policy-makers, researchers and so on) and be agreed upon in advance.

The TDI Protocol core item list

Treatment contact details

1. Treatment-centre type

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

A clear definition of the types of treatment centres involved is essential if comparability of treatment data among countries is to be increased. At present, the data are collected from different types of treatment centres and thus the samples of drug users covered differ accordingly. To improve the comparability of treatment data among countries, all basic types of treatment centres should be distinguished and reported separately.

Data from general practitioners are important, especially if these GPs play a significant role in substitution treatment. In most countries, however, coverage of this statistical field is very limited.

2. Date of treatment – month

3. Date of treatment – year

Recording the starting date of treatment is essential for creating trend analyses over time and for separating time periods (treatment episodes) for reporting. This enables a dynamic analysis of the treatment data to be made.

4. Ever previously treated

1. never
2. previously treated
0. not known

This item allows the incidence of cases and client flow through treatment services to be estimated.

The category 'never' refers to a client who has never received treatment for drug misuse at any centre anywhere. He or she is thus making a first-ever treatment demand. 'Previously treated' refers to a client who has received treatment for his or her drug misuse at some point in the past, either from the current treatment centre or from another treatment centre.

5. Source of referral

1. self-referred
2. family/friends
3. other drug-treatment centre
4. general practitioner
5. hospital/other medical source
6. social services
7. court/probation/police

8. other
0. not known

The source of referral provides some insight into the client's motivation for treatment as well as the structure of, and co-operation among, different professional drug-service agencies or private initiatives. Data on the source of referral permit an estimation of double counting that would be impossible on a personal level. It reduces the total number of cases registered in systems A and B by the number of common clients.

This category refers to the most important source for this client.

Socio-demographic information

6. Gender

1. male
2. female
0. not known

Basic epidemiological information.

7. Age

8. Year of birth

Basic epidemiological information necessary for analysing cohort-specific and historic effects in drug problems.

In some countries, a client is given a unique code to avoid double counting of persons treated twice in the same year. This code is usually based on calculations using the date of birth (at the very most, only day and month are used to calculate this code).

These items can be used alternately.

9. Living status (with whom)

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

Living status refers to the current situation (30 days prior to the start of treatment) of the person demanding treatment. If the situation has changed within these 30 days, the living status immediately prior to treatment contact should be entered.

The primary purpose of the 'with whom' aspect is to assess the social contacts or social integration of the drug user. It does not address the question of quality of accommodation (see item 10).

10. Living status (where)

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

Living status refers to the current situation (30 days prior to the start of treatment) of the person demanding treatment. If the situation has changed within these 30 days, the living status immediately prior to treatment contact should be entered.

The 'where' aspect stresses the stability of the living situation. Because of different cultural, political and administrative contexts in the EU Member States, the categories of this item had to be left vague. It is therefore important to define detailed rules to describe what is included under which category at national level.

11. Nationality

1. national of this country
2. EU national
3. national of another country
0. not known

This item is considered relevant for both national and European figures as drug problems are more prevalent among minorities in several places. As minorities vary greatly in different countries (sometimes it is the nationality, sometimes the ethnic origin and sometimes the language spoken that differs from the majority), only very basic categories are used here.

12. Labour status

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

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

13. Highest educational level completed

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

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

The International Standard Classification of Education should be used to adapt national classifications into the categories listed here (see technical annex).

Drug-related information

14. Primary drug

1. Opiates (total)

11 heroin

12 methadone

13 other opiates

2. Cocaine (total)

21 cocaine

22 crack

3. Stimulants (total)

31 amphetamines

32 MDMA and other derivatives

33 other stimulants

4. Hypnotics and sedatives (total)

41 barbiturates

42 benzodiazepines

43 others

5. Hallucinogens (total)

51 LSD

52 others

6. Volatile inhalants

7. Cannabis (total)

8. Other substances (total)

This item is of central importance. The main drug is defined as the drug that causes the client the most problems. It should be noted that different systems may define this category differently. It can be based on problems as defined by clients (as in the Netherlands and the UK) or on short diagnoses based on the ICD 10 (as in Denmark). As empirical research is still lacking on this matter, it remains unclear if this really provides sufficient comparability between countries.

Alcohol may not be recorded as the primary drug, and clients whose primary drug is alcohol should be excluded from this protocol.

For users of 'speedball', heroin should be recorded as the main drug and cocaine as a secondary drug.

If the exact substance is not known (such as amphetamines or MDMA and its derivatives), the generic category (for example, 'stimulants (total)') should be recorded.

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

15. *Already receiving substitution treatment*

- a) Heroin
 - b) Methadone
 - c) Other opiates
 - d) Other substances
1. yes
 2. no
 0. not known

This item helps to identify misuse of, or addiction to, methadone and other drugs used for (substitution) treatment.

This permits both identification of drug users who are in substitution treatment and correct evaluation of items 14 and 19.

All sub-items should be answered.

16. *Usual route of administration (primary drug)*

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

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

17. *Frequency of use (primary drug)*

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

The frequency of use of the primary drug is an indicator of the severity of the drug use.

This item refers to the 30 days prior to the start of treatment. If the client is drug free or has not used his or her primary drug in the past 30 days, this should be coded as 'not used in past month/used occasionally'.

18. *Age at first use of primary drug*

The negative effects of drug use often increase over time. The duration of drug use can be calculated on the basis of the age of first use and the age at start of treatment. Epidemiologically, age of first use is an indicator of the age at which the risk of starting to

use a specific substance is greatest. Tracking long-term trends may help in developing preventive activities.

19. Other (= secondary) drugs currently used

1. Opiates (total)

11 heroin

12 methadone

13 other opiates

2. Cocaine (total)

21 cocaine

22 crack

3. Stimulants (total)

31 amphetamines

32 MDMA and other derivatives

33 other stimulants

4. Hypnotics and sedatives (total)

41 barbiturates

42 benzodiazepines

43 others

5. Hallucinogens (total)

51 LSD

52 others

6. Volatile inhalants

7. Cannabis (total)

8. Alcohol as a secondary drug (total)

9. Other substances (total)

This item is of central importance. It includes up to four drugs, in addition to the primary drug (see item 14), which cause problems for the client. This information might provide more realistic figures on multiple drug use.

It should be noted that there are important differences in how systems define this category. The category can be based on problems defined by clients (as in the Netherlands and the UK) or on short diagnoses based on the ICD 10 (as in Denmark). As empirical research is still lacking on this matter, it is not clear if this really causes significant incomparability between countries.

Alcohol may be included as a secondary drug.

For users of 'speedball', heroin should be recorded as the main drug and cocaine as a secondary drug.

If the exact substance is not known (for example, amphetamines or MDMA and its derivatives), the generic category (such as 'stimulants (total)') should be recorded.

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

20. Ever injected/currently (last 30 days) injecting

1. ever injected, but not currently
2. currently injecting
3. never injected
0. not known

Here, injection behaviour with regard to all drugs must be taken into account, regardless of whether the substances are primary or secondary drugs.

This item and item number 16 identify the injection of drugs other than the main drug and thus give a good indication of risk behaviour. This is of particular importance with regard to the transmission of infectious diseases (hepatitis, HIV) as well as other diseases and injuries and issues of harm reduction.

Injection for medical purposes (such as for diabetes) should be excluded. 'Currently injecting' refers to whether a client has injected any drug at least once in the past 30 days.

The reference point for the 30-day period of use is the start of treatment, in other words the first face-to-face session.

4. Migration from the Pompidou Group Protocol to the TDI Protocol

For those countries which have thus far been using the Pompidou Group Definitive Protocol or their own system based on it, detailed rules for converting items to the TDI Protocol are given in Table 2 below. In some cases, a direct translation of items is not possible and national experts will have to adjust the existing system to fulfil the requirements of the new protocol.

It should be borne in mind that these conversion rules work in one direction only: from the PG Definitive Protocol to the TDI Protocol.

Table 2: Conversion rules from the PG Definitive Protocol to the TDI Protocol

	PG Definitive Protocol item code	⇒	TDI Protocol item code
(2)	Treatment centre TYPE 21, 22, 23, 25, 32, 35, 37 11, 12, 14, 31, 34, 36 24 33 41	1.	Treatment-centre type 1. outpatient treatment centres 2. in-patient treatment centres 3. low-threshold/drop-in/street agencies 4. general practitioners 5. treatment units in prison
(4)	Date of demand for treatment DATEMNTNTH	2.	Date of treatment – month
(4)	Date of demand for treatment DATEYEAR	3.	Date of treatment – year
(6a)	Ever previously treated TREATED 1. never 2. previously treated 9. not known	4.	Ever previously treated 1. never 2. previously treated 0. not known
(7b)	Source of referral REFERRAL <i>A split between the first two possibilities as they can be found on the model form is necessary.</i> 3. other drug-treatment centre 4. general practitioner 5. hospital/other medical source 6. social services 7. court/probation/police 8. other 9. not known	5.	Source of referral 1. self-referred 2. family/friends 3. other drug-treatment centre 4. general practitioner 5. hospital/other medical source 6. social services 7. court/probation/police 8. other 0. not known

(8)	Gender GENDER 1. male 2. female 9. not known	6.	Gender 1. male 2. female 0. not known
(9a)	Age AGE	7.	Age
(9b)	Date of birth YEARBORN	8.	Year of birth
(10a)	Living status LIVING <i>This item cannot be transferred directly. Additional information on children is needed.</i>	9.	Living status (with whom) 1. alone 2. with parents 3. alone with child 4. with partner (alone) 5. with partner and child(ren) 6. with friends 7. other 0. not known
(10a)	Living status LIVING <i>This item cannot be transferred directly. Additional information concerning PG codes 1–4 is needed.</i>	10.	Living status (where) 1. stable accommodation 2. unstable accommodation 3. institutions (prison, clinic) 0. not known
(12a)	Nationality NATIONAL 1. national of this country <i>Other codes have to be combined with the variable NATION to extract codes 2 and 3 for the TDI</i>	11.	Nationality 1. national of this country 2. EU national 3. national of another country 0. not known
(13)	Employment EMPLOY 1. regular employment <i>Other codes cannot be transferred directly.</i>	12.	Labour status 1. regular employment 2. pupil/student 3. economically inactive (pensioners, housewives/-men, invalids) 4. unemployed 5. other 0. not known
(14a)	Highest educational level reached EDLEVEL <i>This item cannot be transferred directly, because the highest level reached and the highest level completed may differ.</i>	13.	Highest educational level completed 1. never went to school/never completed primary school 2. primary level of education 3. secondary level of education 4. higher level of education 0. not known

<p>(15a)</p>	<p>Primary drug PRIMDRUG</p> <p>111, 164 161, 144 all other opiate-type drugs, 820</p> <p>210, 211, 213, 820 212</p> <p>220–228 240, 410 200, 230–233, 288</p> <p>311 320–328 300, 310, 312-318, 330, 331, 388,</p> <p>411 400, 414, 418, 420, 421, 422, 428, 488 500–588 600–688 700 800, 830, 840, 888</p>	<p>14.</p>	<p>Primary drug</p> <p>1. Opiates (total) 11 heroin 12 methadone 13 other opiates</p> <p>2. Cocaine (total) 21 cocaine 22 crack</p> <p>3. Stimulants (total) 31 amphetamines 32 MDMA and other derivatives 33 other stimulants</p> <p>4. Hypnotics and sedatives (total) 41 barbiturates 42 benzodiazepines 43 others</p> <p>5. Hallucinogens (total) 51 LSD 52 others</p> <p>6. Volatile inhalants</p> <p>7. Cannabis (total)</p> <p>8. Alcohol (only as a secondary drug)</p> <p>9. Other substances (total)</p>
<p>(15a)</p>	<p>Primary drug PRIMDRUG</p> <p>164 161 160, 162, 163, 168, 188</p>	<p>15.</p>	<p>Already receiving substitution treatment</p> <p>a) Heroin b) Methadone c) Other opiates d) Other substances</p> <p>1. yes 2. no 0. not known</p>
<p>(15b)</p>	<p>Route of administration (primary drug) PRIMRTE</p> <p>1. inject 2. smoke 3. eat/drink 4. sniff</p> <p>9. not known</p>	<p>16.</p>	<p>Usual route of administration (primary drug)</p> <p>1. inject 2. smoke /inhale 3. eat/drink 4. sniff 5. others 0. not known</p>

(15c)	Frequency of use of primary drug PRIMFREQ 4. not used in past month 1. used once per week or less 2. used 2–6 days per week 3. used daily 9. not known	17.	Frequency of use (primary drug) 1. not used in past month 2. used once per week or less 3. used 2–6 days per week 4. used daily 0. not known
(15d)	Age at first use of primary drug PRIMAGE	18.	Age at first use of primary drug
(16a)	Secondary drug (1) SECDRUG (1) see (15a)	19.	Other (= secondary) drugs currently used see 14.
(17a)	Secondary drug (2) SECDRUG (2) see (15a)	20.	Ever injected/currently (last 30 days) injecting 1. ever injected, but not currently 2. currently injecting 3. never injected 0. not known
(19a)	Currently injecting CURRINJ		
(20a)	Ever injected INJECTED (19a)≠1 AND (20a)=1 (19a)=1 (20a)=2 (19a)=9 OR (20a)=9		

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