



European Monitoring Centre
for Drugs and Drug Addiction

EMCDDA MANUALS

Treatment demand indicator (TDI) Standard protocol 3.0

Guidelines for reporting data on people entering drug treatment
in European countries





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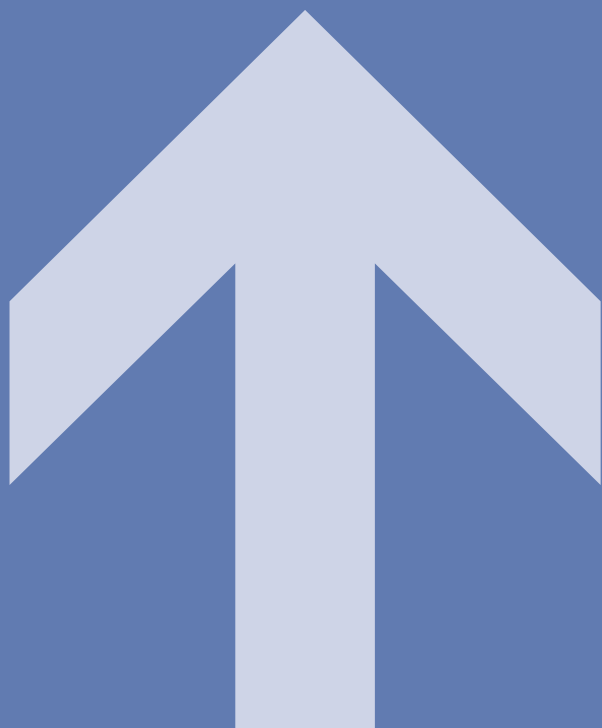
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Preface

Understanding the nature and scale of the drugs problem is critical for effective policymaking and action. As such, the EMCDDA uses a variety of monitoring methods and tools that offer countries a 'common language' with which to interpret the drugs phenomenon. Among these instruments are the five key epidemiological indicators, one of which is the Treatment demand indicator (TDI).

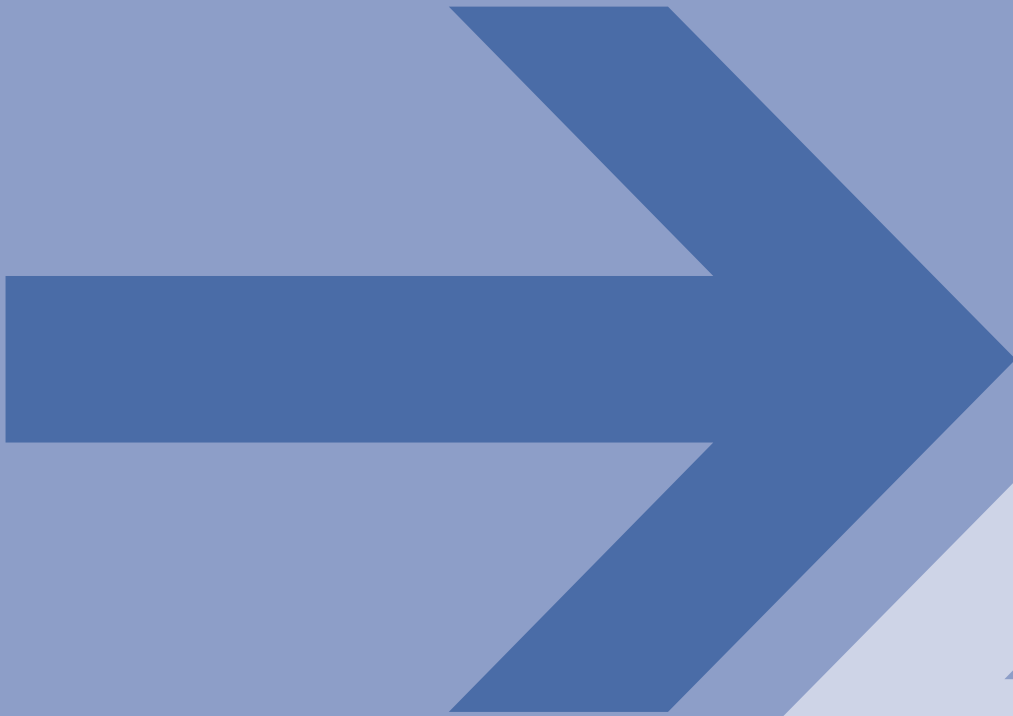
The purpose of the TDI, which was established in 2000 following the work of the Council of Europe cooperation group to combat drug use and illicit trafficking (the Pompidou Group), is to gather comparable and reliable information on the number and characteristics of drug users presenting for treatment in EU Member States. It provides a measure of treatment demand, indicates trends in the extent of problem drug use and provides profiles of problem drug users, while also identifying patterns in the use and uptake of treatment facilities.

This manual presents a revised edition of the TDI protocol (version 2.0). After 10 years of data collection at the European level using this protocol, modification is now required so the TDI can better reflect the changes that have occurred over this period not only in the situation of drug use, but also in the treatment system and national and international information systems.

The revised protocol (version 3.0) represents a significant step forward for the indicator, and has been made possible thanks to the coordinated effort and commitment, for over 2 years, of the national TDI experts and national focal points together with the EMCDDA.

Wolfgang Götz

Director, EMCDDA



CHAPTER ONE



Chapter 1

Introduction

History

The history of the Treatment demand indicator (TDI) can be traced back to almost 20 years ago, when a first harmonised data collection form was defined. The aim of the protocol was to provide professionals and researchers with a common European methodology for collecting and reporting core data on the profile of drug users in contact with treatment services.

The core data set was built on the national experiences of data collection in the drug treatment system, often already existing before the establishment of the TDI. In the countries where a national data collection system did not exist, the TDI was frequently adopted as a minimum data set for a more extended national monitoring system of drug users in treatment (European Addiction Research, 1999).

The first actor who defined a common protocol for collecting data on people entering drug treatment was the Pompidou Group (PG), who coordinated studies at city level (in Dublin and London in 1991) and a developmental project in 11 cities and the creation of a European expert group which met several times to discuss and agree the methodological guidelines. The PG protocol was published in 1994 (Hartnoll, 1994; Stauffacher and Kokkevi, 1999) and was first implemented at city level and then at country level in west European countries; in a second phase, it was implemented in central and east European countries.

In 1994, the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) was established, and it assumed responsibility for collecting European treatment demand data.

The EMCDDA/Pompidou Group Treatment demand indicator 2.0 (Simon et al., 2000) was published based on a revision of the first Pompidou Group protocol. It was preceded by a feasibility assessment concerning methodology and data collection (Origer, 1996) and by an evaluation of national experiences of data reporting using the TDI (Simon and Pfeiffer, 1999).

Since 2000, the EMCDDA has been implementing the data reporting from the EU Member States and adopted formal agreements with the Member States to stimulate and facilitate data collection and reporting from national to European level.

The five EMCDDA key epidemiological indicators, including the TDI, were formally adopted by the EMCDDA Management Board (EMCDDA Management Board, 2001) and by the Council of the

European Union in 2001 (CORDROGUE 67 Council of the European Union, 2001). In those formal documents, 'the EU Member States (...) are encouraged to ensure the availability of information on the five key epidemiological indicators and to identify and address possible problems in the production and dissemination of this information; the Council urges the Member States to give priority to the production and dissemination of information on the five key epidemiological indicators in a comparable form; (...) to provide the EMCDDA with information on the five key epidemiological indicators according to the EMCDDA guidelines (...); finally, the Council invites the Member States and the Commission, in close cooperation with the EMCDDA, to examine the best ways and means, in particular of a financial nature, to support the implementation of the five epidemiological indicators (...)'.

Since 2001, the data collection and reporting have been implemented and improved in most of the EU Member States, and TDI data are now routinely used in the EMCDDA's analyses of the drug situation in Europe (see <http://www.emcdda.europa.eu/themes/key-indicators/tdi>, 2011).

Objective, purpose and methodological implications

Why the TDI: what is its objective?

The objective of the Treatment demand indicator is to collect information in a harmonised and comparable way across all Member States on the number and profile of people entering drug treatment (clients) during each calendar year.

Although the name of the indicator is the 'Treatment demand indicator', it collects information on people entering treatment. This name will be maintained since the TDI is widely recognised as the instrument for collecting and reporting data on people entering treatment for their drug use inside and outside Europe, as an *indirect indicator* of the unobserved level of people that are potentially in need of drug treatment.

The TDI protocol prescribes which clients should be reported at European level, and the minimum common set of items each national monitoring system should be able to record and report to the EMCDDA for each client.

Each national drug treatment monitoring system may include more items than those defined in the EMCDDA TDI protocol, according to national and local information needs. Also, the categories of the items collected at national level may be different from those requested in the TDI protocol, as far as it is possible to conduct a reliable conversion to the TDI categories (see below 'Hierarchy of data needs: from clinical data to information of European policy relevance').

What is the collected information for: what is its purpose?

The primary purpose of the information collected by the TDI indicator is to gain insights into the characteristics, risk behaviours and drug use patterns of people with drug problems in the community, and to help to estimate trends in the extent (prevalence and incidence) and patterns of problem drug use; ideally, in combination with other drug indicators. This purpose is fundamental, since it determines the inclusion/exclusion criteria for the case definition of the TDI: the cases (drug clients) who should be reported to the EMCDDA should reflect as much as possible the characteristics of problem drug users in the community.

This can best be achieved by recording the information soon after the user contacts the services, usually at the moment of admission/entry into treatment, after the professional assessment of the client's characteristics. For the purpose of the indicator, the information collected on the client should reflect as much as possible his/her drug use patterns before contact with drug treatment; the treatment interventions on the client carried out before the registration should have no or limited influence on the recorded information (e.g. a person who enters treatment because he/she is injecting heroin could be recorded as not using heroin and not injecting if data collection and reporting is done when the client is already receiving some therapeutic intervention). Reporting the first treatment admission in the year generally will help to fulfil the indicator's purpose. In addition, the information collected by the TDI indicator can help (together with other indicators and sources of information) to assess some parameters of drug treatment itself (provision, uptake, coverage). These aspects are being developed at present in the framework of a drug treatment monitoring strategy.

How the TDI purpose is achieved

Drug treatment centres usually collect a considerable amount of information on their clients. This information is collected by professionals primarily to facilitate the therapeutic process, but also for administrative and management reasons at the local level, and for epidemiological purposes at the local, national or international levels. Some of the collected information will not be made available outside the treatment centre, some will be passed on to regional or national bodies and, finally, a limited part of the information will be collated at European level, following the procedures and definitions of the EMCDDA TDI protocol.

Drug treatment centres represent a fundamental information source to gain insight into drug use and problem drug use, since problem drug use is difficult to quantify and describe. Problem drug use has a relatively low prevalence in most EU Member States and is often socially stigmatised and, therefore, difficult to capture.

However, it should be borne in mind that not all problem drug users are in contact with treatment centres. Some users may not be in contact with any service (e.g. some socially integrated cocaine or cannabis users, some very marginalised heroin users) or they could be in contact with services that, for different reasons, may not collect information from their clients, or do not report it to national monitoring systems (e.g. private psychiatrists, web-based programmes or, in some countries, general practitioners or low-threshold agencies).

Therefore, conclusions on problem drug use in the community based on data collected by the TDI should be drawn with caution, in particular when changes are small and/or based on limited numbers of clients. In addition, the availability of services, changes in service provision and the coverage of the reporting system must all be taken into account. Furthermore, interpretation of TDI information will benefit considerably from cross-validation with other indicators (e.g. drug-related deaths, law enforcement indicators) and ad-hoc studies (e.g. qualitative studies on street samples, studies and reports from other drug services not covered).

Despite all these caveats, in many EU countries the TDI reports information from a considerable number of problem drug users (in some cases over 50 % of the overall estimated number of PDUs). This makes the indicator a strong and often the main, source of information on the population of problem drug users. In countries where a significant share of the PDU population is captured by the TDI reporting and the use and risk patterns of those not reported do not diverge substantially from those who are reported, the basic findings of the indicator can be considered robust, in particular if observations are consistent over time. Where it is known that subgroups of problem drug users exist with use and risk patterns that diverge dramatically from the patterns observed in the TDI indicator, local and targeted studies may be necessary to capture their behaviour. Furthermore, if service availability and treatment policies remain without fundamental changes during a period of time, trends observed in the TDI can signal important developments in problem drug use (e.g. changes in injection behaviour, expansion of crack use, etc.).

Finally, the data obtained through the TDI indicator are an essential component of different methodologies to estimate the prevalence of problem drug use, usually based on the combination of databases generated by different services using different computation methods.

What additional challenges has the TDI faced in recent years?

In the last 10–15 years, opioid substitution treatment has expanded dramatically in many EU countries, although not in all of them. The treatment population in these countries includes

a growing proportion of clients who entered treatment for heroin problems and have remained in opioid substitution treatment (OST) for a long period of time. Therefore, there are a considerable number of clients in continuous, long-term substitution treatment, who do not re-enter treatment again. Cocaine, amphetamine or cannabis clients are less affected by this situation, but some of them can be also in other forms of long-term treatment.

It has become therefore increasingly necessary to estimate the number of those people and the module on 'Treatment prevalence' was conceived and tested in the past to assess the number and basic characteristics of this group of clients. This information will be collected in a separate voluntary module and is still in a developmental phase in the framework of a new strategy for data collection on treatment, which will include treatment availability, organisation and quality (the EMCDDA treatment monitoring strategy will be finalised by the end of 2012). Several countries are not currently able to compute the information that will be included in this module, as it requires a tracking system that allows the status of each client as 'being in treatment or not' to be determined, whereas the TDI itself is only designed to count treatment entries. At the same time, clients in continuous treatment (most of whom are opioid users) are in a special situation, as many of them are no longer using illegal opioids, though they may be using other drugs. Interpretation of this information regarding estimation of prevalence and patterns of problem drug use is particularly complex. But even considering the relevance of this new challenge, the core objectives of the TDI remain the same, and mainly concern the assessment of the number and characteristics of people with problems related to their drug use who enter drug treatment services during the calendar year.

TDI implementation

TDI data are collated at national level, often following a long process from treatment centre to regional level and from regional to national level. Then data are transmitted to the national focal points (NFP), which are the national agencies nominated by each government as the bodies responsible for providing the most up-to-date available information on drugs and drug addiction. National TDI data are then sent in aggregate form to the EMCDDA, according to the data reporting forms agreed by NFPs and the EMCDDA.

From the late 1990s until 2011, the provision of treatment demand data to the EMCDDA has been implemented in most European countries. In 2000, the 15 countries that were Members of the European Union reported TDI to the EMCDDA, but data completion and data quality

was variable. Since then, data reporting has been progressively extended and data quality significantly improved.

In 2010, the EMCDDA received data from 29 countries (27 EU Member States plus Turkey and Croatia) and since 2011, Norway will also send its data to the EMCDDA. The data were reported on the basis of TDI Protocol 2.0 and collected using the 'Fonte' (!) online tool.

The data reported up to 2011 mainly cover outpatient and inpatient treatment centres. In the 10 years since its implementation, it has proved difficult in most countries to collect information from other types of treatment centres.

Most countries send almost all data required by the EMCDDA, but some limitations still remain regarding specific variables, which may change according to country. Data are still collected on other types of treatment centres, and efforts will be made to extend the data collection, where possible, to other services where drug users represent a relevant group of the clients.

The level of harmonisation is sufficiently good to enable comparability across countries, even though caution should be made in data interpretation, due to country differences in the drug treatment systems and variability in implementing some TDI definitions.

In 2009, a specific system to assess the quality of the EMCDDA Key indicators data, including TDI, was approved by the European Member States and applied on the basis of data reported for the year 2006. The system has shown substantial progress in TDI implementation and data comparability, even if some areas still need further improvement.

In 2006, a separate module of the TDI was field tested to report data on people 'in continuous treatment'. The data collection has been maintained as a pilot data collection during several years. It is now included in the current version of the TDI protocol, as a separate module to be further developed and finalised.

The TDI has also been increasingly utilised over the last 10 years as an example and benchmark for countries and international organisations outside Europe, through presentations and training activities; in some cases, the instruments have been adopted as the main tool for collecting drug treatment data. This particularly concerns countries in the process of joining the European Union, the EU bordering countries and other international organisations (e.g. CICAD).

(!) Fonte is the name of the online tool used by the EMCDDA to collect data from European countries.

Regular collaboration has been maintained with global organisations working in the drugs area (UNODC and WHO). A joint publication on data collection on drug treatment demand was launched in 2006 as part of the UNODC toolkit series (UNODC, 2006).

Even though much progress has been made, some limitations in data quality still exist and improvement should be made in drug demand data collection and reporting, especially from a European perspective.

General principles of TDI protocol 3.0

The TDI protocol 3.0 is based on some general principles, which should guide the data reporting from the countries to the EMCDDA and data analysis at European level. The EMCDDA and the European experts agreed on the following principles as the basis for implementing the TDI protocol 3.0.

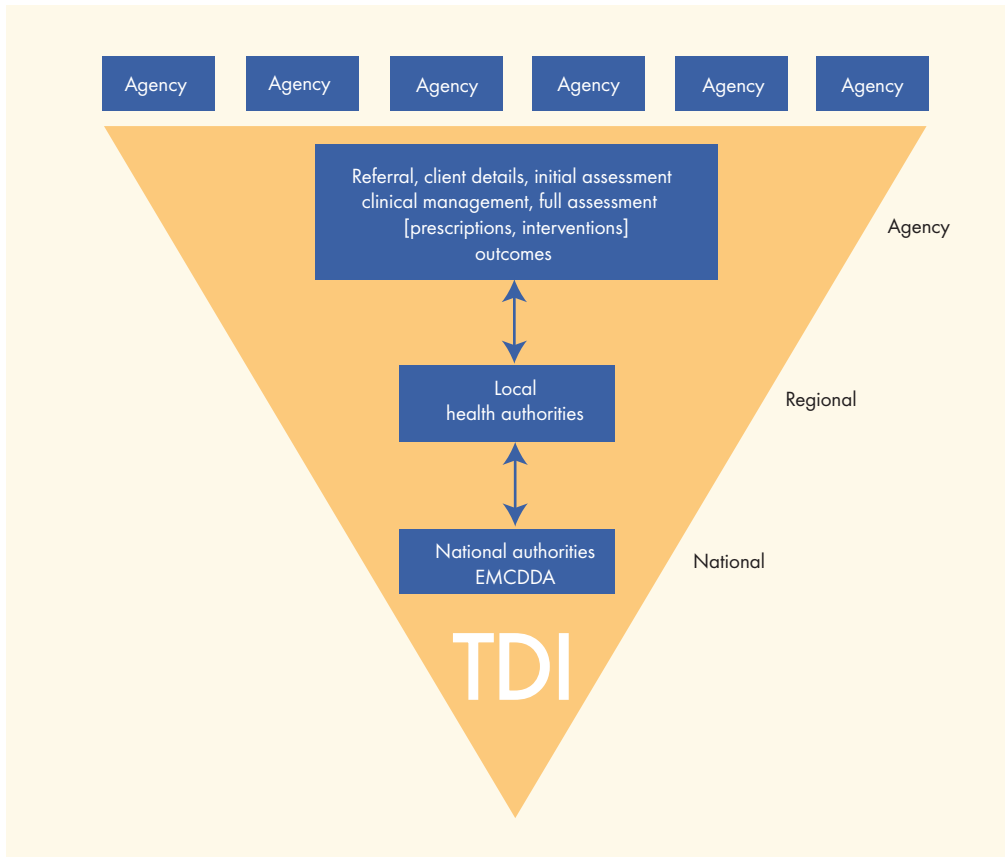
Monitoring versus research/ad-hoc studies

Data monitoring differs from research and ad-hoc studies. Monitoring implies data collection of a limited set of information in a regular and systematic fashion, allowing the identification of changes over time. The need for more specific information is better addressed through ad-hoc projects and research. The TDI can only explore basic information and guide the exploration of further investigations based on general findings (e.g. social exclusion, patterns of drug use, outcome evaluation). Research projects can be based on questions emerging from the TDI, but will be built in different places and in a different format and only by those experts interested in a more in-depth analysis.

Hierarchy of data needs: from clinical data to information of European policy relevance

It is always important to clearly distinguish between the needs for data collection at different levels: local, regional, national and European. The information needs are different, since the level of detail necessary at the different level varies; it starts from detailed information collected for clinical purposes, to information useful to plan and evaluate interventions at treatment centre level, to data for planning treatment centres at local level, to more general information for regional, national and European plans on drugs and for the assessment of long-term results (Donmall, 2003).

Figure 1: The TDI data collection flow – from local to European level



The EMCDDA information needs to provide the minimum common denominator of reporting for all countries. The data collected and/or reported may differ at different levels according to the different needs.

Data reporting versus data collection

Data collection and data reporting are two distinct actions, happening at different levels and for different purposes.

The data reported from each country to the European level is a pre-defined set of outputs obtained from the TDI national treatment databases. Those outputs may commonly be obtained by modifying data extraction routines and can be made without changing the TDI protocol itself and the underlying national, regional, local databases, commonly through modification of the data extraction routines. Adaptations of the reporting form may however require time and some changes to the software in a shared process with the involved partners. The focus of reporting to the EMCDDA under TDI Protocol 3.0 has moved away from the distinction based on the type of treatment centre; this switch should in principle not have implications for data collection at national level.

Individuals versus treatment episode

A treatment demand data reporting system can be based on the number of treatment episodes an individual receives during a certain period of time or on the number of individuals entering drug treatment during a certain period of time. The American drug treatment monitoring system, the Substance Abuse and Mental Health Services Administration (SAMHSA), for example, records the treatment episodes that an individual has initiated during one year.

On the other hand, the TDI Protocol 3.0 is based on reporting information on each individual entering drug treatment during the calendar year, and does not count any person more than once during the time period. If a person has followed more than one treatment episode during a reporting year, only one case is reported.

A treatment episode has been defined as the 'period of service between the beginning of treatment for a drug (...) problem and the termination of services for the prescribed treatment plan' (SAMHSA, 2009), which also implies that 'a client may attend one or more modalities/ interventions (or types) of treatment during the same episode of treatment. A client may also have more than one episode in a year' (Manchester University, 2010). Consequently, the TDI protocol 3.0 defines what is considered a 'treatment episode' for the purpose of TDI reporting in the section on 'case definition' (see below).

This principle has implications at both national and European levels. At national level, methods for controlling and avoiding double counting should be implemented within the country on the drug information system. At European level, it implies that the figures referring to different client groups will sum up to one single total number.

Treatment incidence versus treatment prevalence

The TDI aims to capture the situation of the clients at the moment of their entry into treatment, as the best approximation of the characteristics of problem drug users.

Over the last two decades, the number of clients who remain continuously in treatment over several years, especially in the context of long-term opioid maintenance treatment, has continuously increased in Europe. In 2006, work was started to document this through the development of a module on 'treatment prevalence'.

The module is separate from routine TDI data collection and has no practical implications for the TDI registration of treatment entries. The module is under development and presented in the Annex. It will be finalised in the context of and in collaboration with the EMCDDA Treatment Monitoring Strategy by the end of 2012.

Changes in definition and implications for past data

Changes in some definitions in TDI protocol 3.0 may have some effects on the reported data. Concerning past data, countries are not requested to report new data for previous years. From the analysis already carried out, the impact of the changes on the final results does not seem to be substantial in most countries; however, the effects of the changes will be carefully considered.

CHAPTER
TWO

2

Chapter 2

Guidelines

Definitions

Case definition

A case is a client who starts a drug treatment episode ⁽²⁾ at a treatment centre ⁽³⁾ during the calendar year: 1 January to 31 December for problems created by his/her drug use.

A client should be reported only once during the calendar year: if, for any reason, the client is registered more than once at national level, the duplications should be removed as far as possible according to the existing technical tools at national level for reporting to the EMCDDA. The first treatment episode in the year should be reported.

Purpose

To identify in a reliable way people with drug problems entering treatment and assess their problems, drug use patterns, health and social risks, with the purpose to use the information as an indicator of problem drug use patterns and trends.

Inclusion criteria

- A person who has started a drug treatment (as defined below under the definition of drug treatment) between 1 January and 31 December.
- If a person has started more than once during the reporting year, only the first treatment episode (see below definition of treatment episode) should be reported to the EMCDDA.

Exclusion criteria

- A person who contacts a treatment centre on behalf of a drug user, but who is not a drug user.
- A person with problems due to his/her personal relationship to a drug user, but who is not a drug user him/herself.

⁽²⁾ See below the definition of drug treatment and treatment episode for the purpose of this protocol.

⁽³⁾ See below the definition of treatment centre for the purpose of this protocol.

- A person who has already been reported once in the same centre or in another centre, during the calendar year.
- A person who initiates a treatment activity/procedure in parallel to an ongoing treatment. This may be a component of treatment that has already been reported (in the year or in previous years), such as psychotherapy in parallel to an ongoing opioid substitution treatment, or an additional treatment.
- A person who initiates a treatment activity/procedure as a continuation of an ongoing treatment that has already been reported (in the year or in previous years), such as an inpatient detoxification requested after a two-year substitution treatment.

Methodological considerations

It is recommended that double counting of the same client is avoided whenever possible at different levels and according to existing technical tools at national level: between regions or geographical/jurisdictional areas of the same country; between treatment centres, including treatment centres of a different type and within the same centre. In order to avoid counting the same client more than once during the reporting year, a technically ideal solution would be to have a central national register of drug clients with every client having a unique identifier, which would allow duplicates to be removed when data are reported. But the ideal technical option is not possible in a number of countries for administrative, economic or legal reasons. In those countries, feasible procedures to minimise the eventual double counting of cases should be put in place. The most basic option is that the treatment organisation should perform an internal check (within the same treatment centre) to see if there have been prior treatments. However, in addition to this, it might be necessary to ask the client if he/she has ever been in treatment before, as they could have been treated in other centres in the same period. An additional option in place in some countries is to control double counting at regional level through regional reporting systems and databases. This might avoid most double counts, as the administrative organisation of health and social services in many countries makes it difficult to be in treatment in different regions simultaneously (see also 'Double counting' in Chapter 3).

A graphical presentation is provided in Annex I.

Drug treatment

Drug treatment is defined as an activity/activities which directly targets people who have problems with their drug use and aims to achieve defined objectives with regard to the alleviation and/or elimination of these problems, provided by experienced or accredited professionals, in the framework of recognised medical, psychological or social assistance practice.

This activity often takes place at specialised facilities for drug users, but may also take place in general services offering medical/psychological help to people with drug problems (see also 'Treatment centre').

Purpose

This definition is rather broad, to include a wide range of different users with problems related to their drug use. It has to be recalled that the purpose of the TDI is primarily epidemiological, aiming to collect information on people with significant drug problems.

Inclusion criteria

- Interventions whose primary goal is detoxification
- Interventions whose primary goal is abstinence
- Substitution treatment
- Specialised/structured longer-term drug programmes
- Interventions aimed at reducing drug-related harm if they are organised in the framework of planned programmes
- Psychotherapy/counselling
- Structured treatment with a strong social component
- Medically assisted treatment
- Non-medical interventions inserted in planned programmes
- Specific treatment in custodial settings towards drug users.

Exclusion criteria

- Sporadic interventions not included in a planned programme
- Contacts in which drug use is not the main reason for seeking help
- Contacts with general services involving requests for social assistance only
- Contacts only by telephone or letter
- Contact with the family or other persons who are not the drug users him/herself only
- Imprisonment, per se
- Treatment by Internet only
- Services providing needles exchange only.

Methodological considerations

The data should be as complete as possible; that means that all available data on persons with drug problems entering drug treatment as defined above – inclusion criteria – should be reported.

Start of treatment

Start of treatment is considered as the earliest formalised face-to-face contact(s) between the client and the centre. During this (these) contact(s), it should be possible to identify the client (avoidance of double counting) and to assess the client's characteristics and needs related to their drug problem.

Depending on the type of centre, these requirements should be fulfilled after the first contacts – possibly one to three contacts – between the clients and the therapist (in addition to possible contact with administrative staff).

An indicative criterion of up to three face-to-face contacts is proposed, but countries should have the possibility to apply certain flexibility, according to their reporting practices. In the methodological information, it is important to report when the client is registered to be reported to the EMCDDA data.

If a client starts more than one treatment during the reporting year, only the first treatment episode should be reported to the EMCDDA, as mentioned above.

Purpose

The data reported in the first contacts between the treatment centre and the client aim to obtain recent information on the social profile of the drug client and of his/her patterns of drug use in the period prior to treatment.

Inclusion criteria

- A client who has face-to-face contacts with the treatment centre at an initial stage of treatment (usually between one and three contacts).

Exclusion criteria

- Contacts happening in a late stage of treatment (usually after the third or more contacts between the treatment centres and the client).
- Contacts other than face-to-face contacts (telephone, Internet, etc.).

Methodological considerations

Recording procedures differ between countries. This variable should ensure a certain harmonisation in the recording procedure across the countries and should guarantee that the basic data on the client can be recorded.

The number of contacts with the client which allows the countries (treatment centre, etc.) to report the data into the TDI protocol should be specified in the methodological information.

See also Table 1: Case definition – graphical description, in Annex I.

End of treatment

Treatment is considered to be ended either when there is a formal conclusion (agreed or not) or when the client stops attending the treatment centre or dies.

The reasons for the end of treatment ('treatment end') may be related to dropping out of treatment, death, an explicit decision to abandon the treatment by the client or a termination of the treatment programme established by the centre (see also the module on Treatment prevalence).

Purpose

The TDI protocol focuses on the 'treatment entry' and does not aim to collect data on treatment end. Data collection on treatment end is necessary for two operational reasons:

- Treatment end is directly linked to the TDI case definition and the decision of when a subsequent treatment should be recorded. The assessment on whether a previous treatment is finished is done at the moment of each treatment entry.
- Treatment end information is related to the 'Treatment prevalence' module; it enables the identification of clients who are still in treatment from one year to the next or have concluded a treatment for any reason.

For that reason, the information concerning the end of treatment does not aim to measure the treatment outcome, but only to assess whether a person is still to be reported as a treatment client or not.

Inclusion criteria

Treatment is considered to be ended when:

- a professional has discharged the client;
- a client has explicitly decided to conclude the treatment;
- a centre/professional decides to terminate the treatment for reasons not related to the conclusion of the treatment, but for other reasons, such as not complying with treatment, breaking regulations, etc.;
- the client dies;
- the client has no contact with the treatment centre. It is recommended to consider a treatment finished after six months of no contact between the client and the treatment centre; however, countries vary greatly in the definition of the end of treatment. If countries have a different period for considering a client out of treatment (drop-out), the treatment can be considered ended according to the national rules. Countries should indicate the time for the end of treatment in the methodological specifications.

Exclusion criteria

Treatment is not considered concluded when:

- a client moves in the treatment system from one centre to another centre because he/she is referred in the framework of the same treatment episode (sometimes called 'shared care');

- a client finishes one treatment activity and starts a new treatment activity as part of the same treatment episode;
- a client still has contacts with the treatment centre within a period of six months or earlier (according to the period defined in the national rules as treatment drop-out).

Methodological considerations

The countries should state in the methodological information what the period for considering a client dropped out of treatment is. The rule of six months should be followed as much as possible.

Treatment episode

A treatment episode is defined as the 'period of service between the beginning of treatment for a drug (...) problem and the termination of services for the prescribed treatment plan'.

Drug treatment is a complex process, and often different therapeutic activities/procedures have to be delivered in parallel or consecutively, sometimes for a long period of time (e.g. counselling, psychotherapy, substitution treatment, other pharmacological treatments, outpatient or inpatient detoxification, longer-term residential care ...). 'A client may attend one or more modalities/interventions (or types) of treatment during the same episode of treatment. A client may also have more than one episode in a year' (Manchester University, 2010) (SAMHSA, 2009).

Purpose

To determine when a client is undergoing the same treatment process and therefore to determine whether a client needs or does not need to be notified again for the purpose of the TDI indicator.

Inclusion criteria

- All the activities/procedures delivered to a client to address the drug problem that caused the treatment entry, as far as they are done in an organised/planned way. These activities may be delivered over a long period of time, and in the same premises or in different premises. They can follow an initial established plan or may be modified according to the client's needs and evolution.
- If the process of treatment is formally finished or the client drops out of treatment ⁽⁴⁾, and subsequently the client is admitted again to treatment, a new treatment episode admission is notified.

⁽⁴⁾ See definition of end of treatment.

Exclusion criteria

- A single activity in the framework of a set of planned/organised chain of interventions is not considered as a treatment episode.

Treatment centre/programme

A drug treatment centre/programme is any facility that provides drug treatment, as defined above, to people with drug problems. Treatment centres can be specialised centres, focusing on the treatment of drug users, or included in bigger centres targeting different client groups (e.g. mental health patients, alcohol users, etc.). They can also be based within centres that are medical or non-medical, governmental or non-governmental, public or private.

Purpose

To identify the broad range of facilities where a client is entering drug treatment, regardless of the type of interventions received. As the purpose of the indicator is identification of clients with drug problems, the type of facility is not a determinant factor.

As explained in detail in the methodological considerations below, it is important to underline that for the previous TDI protocol version 2.0, detailed data were reported by type of treatment centre. In the current version of the protocol, the data will be reported in one template.

The type of treatment centre will not be the focus of data reporting. In the reporting forms, there will be few tables where the breakdown by type of treatment centre should be reported.

Centres to be included

The following types of treatment centres are defined in the TDI:

- outpatient treatment centres/programmes;
- inpatient treatment centres/programmes;
- treatment units in prison/programmes;
- general practitioners;
- low-threshold agencies/programmes;
- other types of treatment centres/programmes (please specify which type of centres/programmes).

Definitions of the types of treatment centre

(a) Outpatient treatment centres are defined as treatment facilities where the clients are treated during the day (and do not stay overnight). They include public or private centres/clinics which may open in the evening but where the opening time excludes the night.

(b) Inpatient treatment centres are defined as centres where the clients may stay overnight. They include therapeutic communities, private clinics, units in a hospital and centres that offer residential facilities. Clients should be reported as clients entering inpatient treatment centres when the first contacts between the client and the centre are happening in the inpatient centres and the TDI data are registered in those treatment facilities.

(c) Treatment units in prison are defined as those services that deliver specific services to prisoners because of their drug problem. They can include:

- units specialised in drug treatment with a dedicated physical space inside the prison;
- 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.

(d) General practitioners are medical practitioners who treat acute and chronic illnesses and provides preventive care and health education for all ages and both sexes. They may treat drug users for their drug problems, in some cases in liaison with outpatient or inpatient drug services, and some of them may have a specific training on the treatment of drug users.

(e) Low-threshold agencies are centres/programmes aiming to prevent and reduce health-related harm associated with drug dependence, in particular the incidence of blood-borne viral infections and overdoses, and to encourage active drug users to contact health and social services.

(f) Other types of treatment facilities are all treatment centres that provide drug treatment as defined above. In the case of the use of the category 'other types of treatment facilities', the type of treatment facility that is reporting data should be described and specified in the methodological specifications.

Centres/programmes to be excluded

- Any other type of treatment facilities, when they are not involved in drug treatment as defined above (definition of treatment)
- Centres/programmes for information dissemination only

- Centres/programmes only concerned with needle/syringe exchange only
- Sporadic interventions towards drug users in prison are not included (e.g. information, needle provision and exchange only, etc.) as defined in the exclusion criteria for drug treatment
- Hospital emergency rooms
- General social care facilities, not targeting drug use.

Methodological considerations

Data will be reported to the EMCDDA with a focus on the clients themselves, their characteristics and their patterns of drug use, particularly the primary drug. The treatment centre/programmes, that previously were the basic stratification of the reporting, will only be one of the reported variables. The focus on the clients is related to several reasons:

- The purpose of the indicator is epidemiological and focuses on the number and characteristics of clients entering drug treatment as an indirect indicator of problem drug use.
- 10 years of European data collection show that 80 % of clients reported to the EMCDDA enter treatment in outpatient centres, while the other types of centres (excluding prison) are usually not the point of entry, but are used in subsequent phases of the treatment programme.
- In a number of countries, general practitioners, low-threshold services and other types of treatment source either do not play a substantial role in the provision of drug treatment as defined in the protocol (though they can provide very valuable help to drug users), or it is not possible to collect data from these sources. Consequently, data is available from only a few countries, making it difficult to analyse them at European level.
- Only a few specific analyses are useful by type of treatment centre. It is difficult to make detailed comparison by type of treatment centres, due to national differences in treatment organisation.

Primary drug

The primary drug is defined as the drug that causes the client the most problems at the start of treatment. This is usually based on the request made by the clients and (or) on the diagnosis made by a therapist, commonly using international standard instruments (e.g. ICD-10; DSM-IV ⁽⁵⁾, ASI) or clinical assessment. This item is of central importance and it should be collected for every client.

Purpose

To identify the clients' primary drug problem, assessing their profile and trends over time in drug use patterns. This variable allows information to be kept on the most relevant problems for the drug users from an epidemiological point of view.

Inclusion criteria

- The primary drug is the drug that leads to the most serious problems (health, mental, social problems, etc.) for the client
- The primary drug is the main reason the client has entered treatment
- The primary drug may include any drug misused by the client but not used in accordance with a medical prescription
- The primary drug includes any drug specified in the item list of the primary drugs presented below.

Exclusion criteria

- Alcohol can only be recorded as a secondary drug accompanied by a primary drug (see Secondary drug section)
- Tobacco
- All psychoactive medicines and drugs used exclusively for medical treatment under a medical prescription and according to medical practice.

⁽⁵⁾ It has to be noted that the DSM-IV is under revision and a revised version – DSM-V – should be available in the near future.

Methodological considerations

The decision on the choice of a primary drug should be based on the diagnosis of the professional plus the request of the client.

The criteria to select the primary drug have not changed and are consistent with the criteria for data reporting included in the TDI protocol 2.0. A new variable on polydrug use is now added to provide complementary information, but not as a replacement.

If the exact drug is not known (e.g. amphetamines or MDMA and derivatives), the generic category (e.g. Stimulants other than cocaine) should be recorded.

The category 'Not known' should be used exceptionally.

Secondary drug

Secondary drugs are those drugs used in addition to the primary drug, and are substances that cause problems for the client and/or change the nature of the problem as assessed by the client and the therapist.

Purpose

To identify other drugs that cause problems for the clients.

Inclusion criteria

- All drugs that can cause problems for the health and social condition of the client, but are not identified as the primary drug
- Alcohol.

Exclusion criteria

- Tobacco
- Substances that are used by the clients, but do not cause problems to his/her condition
- Medicines used under medical prescription and according to medical practice.

Methodological considerations

The secondary drugs should be substances used and creating problems for the clients. Up to four secondary drugs should be reported to the EMCDDA. However, countries have different recording

procedures and may record a different number of secondary substances. In that case, it is necessary to indicate how many substances are recorded for each client in the methodological information.

Polydrug use problem

Information on polydrug use problem is complementary and additional to the information on the primary drug. Existence of a polydrug use problem should always be assessed after the primary drug is determined, following the guidelines and the specific procedures.

Purpose

The polydrug use problem variable aims to assess whether a client is a problematic user of more than one drug at the same time, in a way that is very difficult to identify clearly one primary drug. This concept should be used in a very restricted approach as in the ICD-10, which defines polydrug use as multiple drug use to be used 'when two or more psychoactive substances are known to be involved, but it is impossible to assess which substance is contributing most to the disorder'. The decision is fundamentally clinical, and it should be used in a restrictive way.

Inclusion criteria

- Clients that present a pattern of use where several substances are causing substantial problems simultaneously to the client and it is very difficult to determine what is the primary drug.
- This information should be collected only after a primary drug has been determined as previously under protocol 2.0, even with the known difficulties in some cases. Existing rules and procedures to select a primary drug should continue to be applied.

Exclusion criteria

- Clients using only one drug
- Clients using more than one drug, but only one causing problems
- Clients using more than one drug that cause problems, but for whom it is possible to identify with some confidence which one is causing more problems.

Methodological considerations

The use of multiple drugs per se does not constitute a polydrug use problem for the purpose of the TDI protocol. A client is defined as a polydrug problem user when more than one drug creates

problems systematically to the client in a way that it is difficult to determine clearly which drug causes more problems.

Rationale of the approach adopted in TDI protocol 3.0

Polydrug use can be conceptualised in different ways, including use of different substances in the same timeframe (e.g. in the last 30 days) but without a relevant pharmacological interaction, or it can imply simultaneous use of several substances mixed together (e.g. heroin and cocaine in the same injection) or within a short period of time. Also, it may imply a regular replacement of a substance by another depending on availability (e.g. opioids and benzodiazepines).

A simple replacement of the 'primary drug' concept might imply a very high risk of fundamental divergences in data collection and reporting by countries, making data not comparable and almost impossible to interpret. Also, there is a considerable risk that current historical series are totally discontinued. Some countries that attempted to implement 'polydrug' data collection found considerable difficulties. Finally, most European and not European countries have been able to identify a primary drug for years, despite the known difficulties. Any modification of this concept has to be done with extreme care as it may imply a fundamental change for all analysis, trends and other methodologies based on TDI data.

An approach where a primary drug is not indicated would imply a high risk of divergence by countries in data reporting and loss of information. Therefore, the approach adopted allows the collection of complementary information on polydrug use problems, while maintaining the concept of primary drug and consistency with existing data and between countries.

This situation is not unique for treatment data. Similar questions have been raised in mortality data. WHO, in its 2002-03 update of ICD-10 classification for drug-related deaths, addressed the same problem and a priority list of drugs to codify the more dangerous drug was established (in case the certifying doctor cannot reach a conclusion).

See EMCDDA DRD protocol 3.2

- <http://www.emcdda.europa.eu/html.cfm/index107404EN.html> (Annex 7, page 64)

Or the WHO list of ICD-10 updates

- <http://www.who.int/classifications/icd/icd10updates/en/index.html>

HIV or HCV testing uptake

HIV and HCV testing uptake represent basic information on the access to care of drug treatment clients (mainly those injecting drugs).

Purpose

The information is useful to cross and complement data with the client's information on injecting behaviour (collected in the TDI on one hand, and from other sources of infectious diseases information – Standard Table 09 – on the other hand). The final aim is to have a more complete and reliable picture on the level of testing of infectious diseases among treatment clients.

Methodological considerations

It is very important to know the injecting status of the client (ever vs never) and data should always be provided, broken down by injecting status and by drug.

The consistency of the information reported through the TDI indicator and information reported in the DRID indicator will be assessed in detail, and in cooperation with countries.

Needle/syringe sharing

There are several patterns of equipment sharing (needle, syringes, filters, drug solutions, lending/borrowing equipment, sharing with partner, with friends, etc.) that represent important risk behaviour. Needles and syringe sharing is one of these risk behaviours.

It is not possible to capture all possible patterns of drug equipment sharing in a European monitoring system. At national or local level, much more detailed information can be collected, in particular where infectious diseases have a high prevalence or there is a risk of increasing prevalence. For that reason, it is only requested to report the information on needles/syringes sharing to the EMCDDA. More detailed information at European level is reported through other instruments (notably Standard Table 09).

Purpose

To collect basic information on important risk behaviour (needles/syringe sharing), which can lead to infectious diseases.

Inclusion criteria

- All clients who have ever injected drugs.

Exclusion criteria

- All clients who have never injected.

Methodological considerations

Information should refer to ever injectors of any drug.

Opioid substitution treatment (OST)

Opioid substitution treatment is a long-term intervention with the use of an agonist substance with the goal of reducing or eliminating the use of an illicit opioid drug, or to reduce harm from a particular method of administration and the attendant dangers for health.

Purpose

To better determine the level of accessibility of substitution treatment. To check whether a client re-entering treatment is/has been already in substitution treatment before. It will also provide information about lifetime OST among those entering treatment for another problematic drug use and time spent since the first OST.

Inclusion criteria

- Clients who have already been treated in year(s) prior to the reporting year.

Exclusion criteria

- Clients who have never been treated before the reporting year.

Methodological specifications

It is important to check if the client is undergoing substitution treatment with a substance and whether he/she is also reported as misusing the same or another substitution substance. This will be useful as validation information and to check the appropriateness of the treatment.

Item list

1. Treatment centre type

1. outpatient treatment centres/programmes
2. inpatient treatment centres/programmes
3. treatment units in prison/programmes
4. general practitioners/programmes
5. low-threshold agencies/programmes
6. other (please specify which type of treatment centre/programme)
99. not known.

Methodological specifications

The six types of treatment centres presented above are the most common types for which clients are identified and data reported; they are also the most common points of entry into the treatment system.

Treatment units in prison represent an important entry point for many drug users who would not appear in treatment otherwise. In addition, the issue of drug and prison currently represents a high priority issue in the European political agenda and deserves specific attention.

For the definition of treatment and the classification of treatment centres that are not included in the three groups presented above, please see the section on definition of drug treatment and treatment centre.

It is noted that in the data reporting form, the breakdown by type of treatment centre will not be central and only a few breakdowns will be reported by type of treatment centre.

2. Year of treatment

/_____/

Methodological specifications

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.

The month of treatment should not be reported to the EMCDDA, but must be recorded at national and treatment centre level in order to avoid the risk of counting the same person twice in the same reporting period.

3. Ever previously treated

1. never previously treated
2. previously treated
99. not known.

Methodological specifications

See also definition of 'first treatment' in the section on definition for client never treated before the reporting year. If a client is entering treatment more than once in the same reporting year, only the first treatment episode should be recorded. Other previous treatments may refer to treatment undergone because of the use of any drug, which might be different from the current primary drug. Double counting should be avoided within the same country as much as possible, according to the possibilities of each country.

4. Source of referral

1. court/probation/police
2. general practitioner
3. other drug treatment centre
4. other health, medical, or social service
5. educational services
6. self-referral, referral from family, friends, etc./no other agency/institution involved

7. others (please specify)

99. not known.

Methodological specifications

The source of referral provides some insight into the pathway by which the client has reached drug treatment. According to the European analysis carried out in the last 10 years, it has been seen that it is relevant to understand what services other than drug services are involved in the referral to treatment. The objective of this variable is to understand the level of involvement of other agencies, health, social services and institutions in referring the client to treatment. Data on source of referral is also important to estimate the extent of treatment which is due to a legal obligation. The 'Source of referral' refers to the source that was most instrumental in referring the client to treatment.

5. Sex

1. male

2. female

99. not known.

Methodological specifications

Basic epidemiological information.

6. Age at treatment start (in years)

Age: /___/___/

99. not known.

Methodological specifications

Basic epidemiological information.

7. Living status (with whom)

1. alone

2. with the family of origin (parents, etc.)

3. with partner/children

4. with friends or other people (with no family relation)
5. in detention
6. in institutions/shelters (not detention)
7. others
99. not known.

Methodological specifications

The primary purpose of the 'with whom' aspect of the living status is to indirectly assess the relational status of the clients. The situation refers to the prevailing situation of the client, if he/she is living in more than one context in the same period. The living status refers to the current situation: It refers to the 30 days before entering treatment.

8. Drug clients with children

1. not having children
2. having children
 - 2.1 not living with children
 - 2.2 living with children
99. not known.

Methodological specifications

The item wants to assess if the clients have children and what is the living condition of drug users and children. Children include all ages of children, both biological and not biological.

9. Living status (where)

1. stable accommodation
2. unstable accommodation and/or homeless
3. in detention
4. others
99. not known.

Methodological specifications

The 'where' aspect of living status stresses the stability of the living situation. Clients in unstable accommodation are clients who have lived in different places (friends' home, street, shelters, etc.), moving from one place to another in the period prior to treatment entry. If a client is living in an institution, he/she should be reported in category 4 'others' and the institution specified. The situation refers to the prevailing situation of the client, if he/she is living in more than one context in the same period. The living status refers to the current situation: it refers to the 30 days before entering treatment.

10. Labour status

1. occasionally employed
2. regularly employed
3. student
4. unemployed/discouraged
5. receiving social benefits/pensioners/house-makers/disabled
6. others
99. not known.

Methodological specifications

Labour status provides central information about the client's economic and social integration and his or her daily life. The protocol follows Eurostat's standards as much as possible to enable comparison with the statistics for the general population and to avoid overlapping categories (e.g. unemployed and inactive). The categories defined by Eurostat in the official statistics on labour status are the following:

- Employed: people performing of at least one hour of work (for pay, profit or family gain), during the last 30 days;
 - Occasional: when the job is infrequent, irregular or occurring in scattered instances;
 - Regular: when the job is frequent, regular and/or with a written contract;
- Students: people attending a school;

- Unemployed: people who are not working and actively looking for a job; Discouraged: people who are not working and not looking for a job, because they could not find a job;
- Receiving social benefits/Pensioners/House-makers/Disabled: people who are receiving benefits from social security for their pension or invalidity or are housekeepers.

It refers to the 30 days before entering treatment.

11. Highest educational level completed

1. never went to school/never completed primary school (=ISCED 0)
2. primary level of education (=ISCED 1)
3. secondary level of education (=ISCED 2 and ISCED 3)
4. higher education (=ISCED 4 to 6)
99. not known/missing.

Methodological specifications

Education is an important socio-economic data category. A stricter compliance to ISCED ⁽⁶⁾ (International Standard Classification of Education) classification are recommended as well as the adoption of the country-specific conversion rules that are already implemented for providing education statistics at international level.

12. Primary drug ⁽⁷⁾

1. *Opioids (total)*
 - 11 heroin
 - 12 methadone misused
 - 13 buprenorphine misused
 - 14 fentanyl illicit/misused
 - 15 other opioids (please specify)

⁽⁶⁾ It has to be remembered that the ISCED classifications are under revision; eventual implications of the revised version will be taken into account.

⁽⁷⁾ Note that several substances in the list can be produced illicitly (e.g. fentanyl or some amphetamines) or diverted from legitimate sources. For the purpose of this protocol, both sources are included.

2. Cocaine (*total*)
 - 21 powder cocaine (HCl)
 - 22 crack cocaine
 - 23 others (please specify)
3. Stimulants other than cocaine (*total*)
 - 31 amphetamines
 - 32 methamphetamines
 - 33 MDMA and derivatives
 - 34 synthetic cathinones
 - 35 other stimulants (please specify)
4. Hypnotics and sedatives (*total*)
 - 41 barbiturates misused
 - 42 benzodiazepines misused
 - 43 GHB/GBL
 - 44 other hypnotics and sedatives misused (please specify)
5. Hallucinogens (*total*)
 - 51 LSD
 - 52 ketamine
 - 53 other hallucinogens (please specify)
6. Volatile inhalants
7. Cannabis (*total*)
8. Other substances (*total*) (please specify which substance)
99. Not known.

Methodological specifications

'Primary drug' is the drug that causes the most problems for the client, as defined according to the client's request and (or) the professional's assessment.

This item should always be filled in, regardless of whether a client is subsequently considered to have a polydrug use problem (that will be additional information).

Some new drugs are included in the Protocol. They are substances that have appeared in recent years in the drug market, and for which a non-trivial number of people has entered treatment for problems associated with their use. The classification does not follow a scientific classification of the substances according to their chemical principles or psychoactive effects (e.g. cocaine and other stimulants are separated), route of administration, or other scientific categorisations. Rather, a pragmatic classification is adopted, in order to help professionals working at drug treatment centres to record the data.

The substances included are only those which create problems to the client according to the client's request and the professional's assessment.

The grouping of drugs is not only done on the basis of pharmaceutical criteria but also considering the actual experience of drug professionals.

Other opioids include all the opioids not included in the previous categories (e.g. Polish heroin). The insertion of fentanyl among primary drugs includes both the substance produced in the illicit market and the medicinal product used outside the medical practice.

Any specification on the primary substance should be included in the methodological comments.

The following substances are excluded from the primary drug:

- tobacco;
- alcohol (included among the secondary drugs);
- drugs used for medical purposes under a medical prescription.

It refers to the 30 days before entering treatment, with the exception of clients who have been in withdrawal treatment, were drug-free or were in detention prior to treatment intake. In those cases, the reference period refers to the 30 days before withdrawal treatment, drug-free or detention.

13. Usual route of administration of primary drug

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

Methodological specifications

‘Injection of 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; the reduction of injecting behaviour is the aim of many harm reduction programmes. The ‘Usual route of administration’ refers to the route of administration of the primary drug.

‘Smoke/inhale’ refer to the use of the substance via pulmonary routes (via the nose or the trachea); they concern the substance taken in the form of vapour. ‘Sniff’ refers to the nasal route and to the substance in powder form.

It refers to the 30 days before entering treatment, with the exception of clients who have been in withdrawal treatment, were drug-free or were in detention prior to treatment intake. In those cases, the reference period refers to the 30 days before withdrawal treatment, drug-free or detention.

14. Frequency of use of primary drug

1. daily
2. 4–6 days per week
3. 2–3 days per week
4. once a week or less
5. not used in the last 30 days
99. not known.

Methodological specifications

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

It refers to the last 30 days before entering treatment, with the exception of clients who have been in withdrawal treatment, were drug-free or were in detention prior to treatment intake. In those cases, the reference period refers to the 30 days before withdrawal treatment, drug-free or detention.

15. Age at first use of primary drug (in years)

Age: /_____/

99. not known.

Methodological specifications

The negative effects of drug use often increase over time. The duration of drug use can be calculated on the basis of age of first use and age at the start of treatment. Epidemiologically, age of first use is an indicator of age when risk of drug use starting is greatest. Tracking long-term trends may aid in the development of preventive activities.

16. Secondary drugs ⁽⁸⁾

1. Opioids (total)

11 heroin

12 methadone misused

13 buprenorphine misused

14 fentanyl illicit/misused

15 other opioids (please specify)

2. Cocaine (total)

21 powder cocaine (HCl)

22 crack cocaine

23 others (please specify)

⁽⁸⁾ Same criteria regarding the origin of the substance (illicit production or diversion) as with the primary drug.

3. *Stimulants other than cocaine (total)*
 - 31 amphetamines
 - 32 methamphetamines
 - 33 MDMA and derivatives
 - 34 synthetic cathinones
 - 35 other stimulants (please specify)
4. *Hypnotics and sedatives (total)*
 - 41 barbiturates misused
 - 42 benzodiazepines misused
 - 43 GHB/GBL
 - 44 other hypnotics and sedatives misused (please specify)
5. *Hallucinogens (total)*
 - 51 LSD
 - 52 ketamine
 - 53 other hallucinogens (please specify)
6. *Volatile inhalants*
7. *Cannabis (total)*
8. *Alcohol as secondary drug (total)*
9. *Other substances (total) (please specify which substances)*
99. *Not known.*

Methodological specifications

The substances included are only those that create problems to the client according to the client's request and to the professional's assessment.

If a client does not use a secondary drug, this item should be left empty.

Up to four drugs may be reported. In the data reporting form, the maximum number of drugs reported by each individual should be indicated.

For the purpose of reporting to the EMCDDA, the order of filling in secondary drugs will be according to their clinical relevance for the drug problem of the client. Only if this is not possible, the order of filling secondary drugs will be the following (if there is information collected): first substances used by injection, and then according to frequency of use. If none of the above is possible, the order will be that of the list of substances.

The exact criteria used should be explained in the methodological section of the reporting form.

Alcohol is included as a secondary drug.

Tobacco and drugs used for medical purposes and under a medical prescription are excluded.

Other opioids include all the opioids not included in the previous categories, such as Polish heroin.

It refers to the 30 days before entering treatment, with the exception of clients who have been in withdrawal treatment, were drug-free or were in detention prior to treatment intake. In those cases, the reference period refers to the 30 days before withdrawal treatment, drug-free or detention.

17. Polydrug use problem existing

1. yes
2. no
99. not known.

Methodological considerations

‘Polydrug use problem’ refers to when two or more drugs are involved in the drug problem of the client at the same time and it is very difficult to assess which was the primary drug that caused the treatment entry. This concept will be used in a very restricted approach as in the ICD-10 (see Definitions).

This item should always be filled in, even if only one drug is used (or the primary drug can be established with reasonable accuracy among several substances used) and the client is not a polydrug user (in that case, reply No to the question).

However, even in the case of a client for which a primary drug is very difficult to determine, always a primary drug should be chosen, following the indications provided in the guidelines

and the concrete implementation procedures used at national level (e.g. client request, clinical assessment, standard scales of dependence, frequency of use, agreed hierarchy of substances, etc).

It refers to the 30 days before entering treatment, with the exception of clients who have been in withdrawal treatment, were drug-free or were in detention prior to treatment intake. In those cases, the reference period refers to the 30 days before withdrawal treatment, drug-free or detention.

18. Opioid substitution treatment (OST)

1. never been in OST
2. ever been in OST
99. not known.

Methodological specifications

OST is commonly referred to as 'substitution treatment'. A substitution treatment is defined as 'the administration of thoroughly evaluated opioid agonists; this is done by experienced or accredited professionals, in the framework of recognised medical practice, for achieving defined treatment aims'. This treatment is often provided in combination with psychosocial assistance. This variable will help to better determine the level of accessibility of substitution treatment and provide information about lifetime opioid substitution treatments among those entering treatment for another problematic substance use.

Only clients who have been previously treated should be included.

19. Age at first opioid substitution treatment (OST) (in years)

1. Age at first OST: /_____/
99. Not known.

Methodological specifications

This variable in combination with data on age at first primary drug, age at first injection will contribute to provide information about lifetime opioid substitution treatments among those entering treatment for a problematic substance use other than opioids. The item should be filled in only by people who have been in OST before the current treatment entry.

20. Ever injected or currently injecting any drug

1. never injected
2. ever injected
 - 2.1 injected, but not in the last 12 months
 - 2.2 injected in the last 12 months, but not in the last 30 days
 - 2.3 currently injecting (in the last 30 days)
3. don't want to answer
99. not known.

Methodological specifications

This variable refers to injection behaviour regarding all drugs, not just the primary drug. This item identifies the injection of any drug; it gives a good indication of risk behaviour. This is of particular importance with regard to the transmission of infectious diseases (hepatitis, HIV) as well as other diseases and injuries and issues of harm reduction. Injection for medical purposes should be excluded (diabetes, etc.).

21. Age at first injection (in years)

Age: /_____/

99. not known.

Methodological considerations

This variable should only be filled in for people who have ever injected. If people never injected any drug, it should be left empty.

22. HIV testing

1. never tested
2. ever tested
 - 2.1 tested, but not in the last 12 months
 - 2.2 tested in the last 12 months
3. don't want to answer
99. not known.

Methodological considerations

The item concerns testing activities and can be useful information to be crossed with drug use behaviours (injecting, needle sharing). It is strongly advisable to verify the testing history as far as possible’.

23. HCV testing

1. never tested
2. ever tested
 - 2.1 tested, but not in the last 12 months
 - 2.2 tested in the last 12 months
3. don't want to answer
99. not known.

Methodological considerations

The item concerns testing activities and can be useful information to be crossed with drug use behaviours (injecting, needle sharing).

24. Needle/syringe sharing

1. never shared a needle or syringe
2. ever shared a needle or syringe
 - 2.1 shared but not in the last 12 months
 - 2.2 shared in the last 12 months, but not in the last 30 days
 - 2.3 currently shared (in the last 30 days)
3. don't want to answer
99. not known.

Methodological considerations

Information to be asked only if the client has ever injected. If the clients has never injected, the variable should be left empty.

CHAPTER
THREE

3

Chapter 3

Methodological and ethical issues

Besides the general principles highlighted in the first part of the protocol, it is necessary to explain specific methodological issues that are important for data collection and reporting.

To contextualise the TDI data reported by each country, it is important to have access to methodological information. A space for specifications on methodology used to collect and report data is included in the EMCDDA data reporting form. A dedicated space for comments is included; it will be particularly important to use that space when country data diverge from the EMCDDA guidelines or have specificities which cannot be understood from the quantitative data alone.

Time reference period

The reference period for the whole protocol concerns the current situation of the client in the last 30 days (1 month) before entering treatment. This is the general rule for all the variables included in the protocol, unless it is not applicable by default or differently specified. If not indicated, it means that it is not applicable, but usually this is understandable from the context of each item (e.g. ever injected, age at first OST, etc.). For drug-related aspects and in the case of clients who have been in withdrawal treatment, were drug-free or were in detention prior to treatment intake, the reference period refers to the 30 days before those events (withdrawal, drug-free or detention).

Patterns of drug use: drug of reference

The data on patterns of drug use – age at first use, route of administration, frequency of use – refer to the primary drug. The items ever injected and age at first injection refer to any drug. This is, however, specified in every item.

Coverage

Information on data coverage is required in order to understand the context of TDI data in each country and its level of representativeness.

First, the estimation of the TDI coverage should refer to those centres that are expected to report as part of the TDI reporting system. In addition, an estimate, even an approximate one, should be made of the extent to which the TDI reporting system covers the total treatment services in

the country. This will be influenced by the availability and organisation of the national treatment system and of the referral system, as well as by the drug legislation.

Results from TDI data analyses show that there are both common features and substantial differences among the countries, probably due to national differences in the characteristics of the drug problem, in the treatment systems, and in the reporting systems and their data quality. Some differences are bound to be due to differences concerning which types of treatment facilities and/or client groups the national systems cover. A specific EMCDDA project carried out in 2007–08 (Iversen, 2009) on data coverage highlighted issues to consider when data on treatment demand are collected. A survey in some countries showed the need to have better information on treatment availability and capacity in order to understand the context of TDI data. This information is partly included in the methodological information and partly reported through other EMCDDA tools focused on treatment availability/capacity (Standard Table 24 and Structured Questionnaire 27). The final recommendations of the project highlighted the need to:

- include coverage assessment in more detail in the data quality assurance system for the TDI;
- encourage countries to develop systems for monitoring treatment facilities and treatment capacities;
- encourage countries to design systems with obligatory reporting from outpatient and inpatient drug treatment agencies (centres/units), including capacity data reporting as well as existing TDI data.

Data quality

Data quality is extremely relevant in the utilisation of drug-related data, particularly in a European data set, where information should be as comparable as possible across countries and consistent over time. However, the control of data quality is a complex activity, especially when it involves data from different countries reported in an aggregate form.

Treatment demand data provided by the countries are routinely validated when they are reported to the EMCDDA. Basic validation procedures are implemented regularly on data completeness, consistency, timeliness, problems in the numbers and figures which differ greatly from the general EU picture. Methodological information is also regularly checked to acquire an in-depth knowledge of the information system and the actual implementation of the methodological guidelines in the reported data.

Besides the routine data quality control carried out every year, a specific system to assess the quality of data for all the key indicators was carried out in 2008. The system was applied to the TDI data and includes an assessment of aspects related to two areas of data reporting: process of reporting and data quality. The assessment of data quality was carried out in consultation with the NFPs and the TDI experts.

Concerning the process, the assessment concerned the following aspects: organisation of the reporting system, financial and human resources dedicated to the data collection, legal basis for data collection, data quality assessment, ongoing progress and main obstacles to TDI implementation. In the area of data quality, the evaluation focused on the availability of data at national level and data reporting at European level, harmonisation with the EMCDDA guidelines, timeliness, data coverage and internal data consistency.

The results of that assessment have shown that most countries have made substantial progress in implementing the TDI guidelines in recent years, and the level of data comparability has substantially improved; however, some areas still need improvement, such as data coverage and harmonisation with European standards. Furthermore, the implementation of data quality in the countries may be limited by the scarce availability of financial and human resources.

Double counting

In this context, 'double counting' refers to the fact that a client may be registered more than once in a treatment-monitoring database in a given year. This may be due to several reasons, including lack of communication between treatment centres, absence of a unique system to allow for cross-checking, and others. Double counting causes the total number of treated persons to be overestimated.

Based on the guiding principle that what should be counted are individuals and not episodes, double counting should be avoided as much as possible at any level, from the treatment centre, to local, regional, national or international level. Of course, this rule will be applied considering the level of actual feasibility and limitations at national, regional and local level (technological and methodological instruments, financial and human resources, legal framework, including legal obstacles due to data protection rules).

Several techniques have been implemented in the countries (Origer, 1996), from the most common, such as controlling for double counting in a register through a unique identifier given for

the individuals (usually based on an algorithm which utilises the name and date of birth), to some quite sophisticated techniques, such as the use of digital prints (e.g. the Netherlands).

In an ideal situation, the maximum level of control of double counting implies that the countries have a central register where they record all single individuals, with some form of unique identifier to avoid duplication. This register should fulfil all requirements to guarantee data protection. A second best option is the existence of a regional database that can control double counting to a considerable degree. If a central or regional register does not exist or is not possible to implement for several reasons, including legal, administrative, financial reasons, the treatment organisation should try to implement methods to perform data checking of prior treatments (e.g. electronically and/or asking directly to the client if he/she has ever been in treatment before and/or asking to other treatment centres that may have had previous contacts with the client).

According to the situation updated in 2008, the avoidance of double counting was found to be quite common among the EU countries, with only two countries having no or limited double counting control in place. Out of the 26 countries where such control exists, for nine, it operates at regional or treatment centre level and in 17, at national level.

Ethical issues and data protection

Where treatment of drug problems takes place, notes are taken on drug use and the clients' strengths and weaknesses. Treatment steps are usually planned on the basis of a formal diagnosis or on an overview of problems requiring attention performed by a professional or a team of professionals. Aims are monitored continuously during treatment and the outcome is evaluated at the end. Information is primarily collected for the purpose of improving the care for clients.

Data collection and reporting, beside the clinical purposes, has the scope to obtain basic information on the epidemiological situation to support evidence-based health interventions and support effective and efficient ways of treating drug problems.

For every level of information (e.g. clinical, regional, national, international, etc.), national and international rules of confidentiality and data protection must be considered, as well as rights of clients, staff and treatment centres. This is particularly the case for specific treatment settings, such as treatment in prison, where high attention must be paid to ethical issues (data protection, privacy, human rights), when data are collected and reported.

These guidelines should adhere to the accepted codes that govern data protection, privacy and research in the various countries. Access to the raw data must be restricted to authorised professionals only. Use of the data and procedures governing the publishing of results should be discussed and agreed by those involved (service providers, managers, policymakers, researchers etc.).

The EMCDDA (with TDI protocol 3.0, as it was the case with TDI protocol 2.0) does not wish to develop a central database of individuals entering or being in drug treatment at European level. All data are collected, collated, and retained by the countries, with strict adherence to accepted ethical standards, and only aggregate data are pooled and analysed for comparative purposes on a European level. Individual data sets, however, might occasionally be needed by the EMCDDA, as in other fields of research, for specific studies, but only upon agreement with the countries.



Annexes



Annex I

Table 1: Case definition – graphical description





Client	Treatment episode/activity	Treatment centre	Preceding year	Current year	Following year	Specifications	To be reported to the EMCDDA
A	A1	1				Client A is in continuous treatment, starting in the previous year, continuing throughout the current year and into the following year. There are no additional treatments. No treatment is reported for the current year.	
B	B1	1				Client B is in continuous treatment, starting in the previous year, continuing throughout the current year and into the following year. A second treatment occurs during the current year in the same treatment centre. No treatment is reported for the current year.	
B	B2	1				(Note: often B2 will be a treatment activity – e.g. short-term counselling – complementary to the treatment B1 – e.g. long-term OST – carried out in a planned way for the same drug problem that originated the treatment entry.)	
C	C1	1				Client C is in continuous treatment, starting in the previous year, continuing throughout the current year and into the following year. Three further treatments occur during the current year, in the same and two different treatment centres. No treatment is reported for the current year.	
C	C2	1					
C	C3	2					
C	C4	3					

Table 1 (continued)							
Client	Treatment episode/activity	Treatment centre	Preceding year	Current year	Following year	Specifications	To be reported to the EMCDDA
D	D1	1				Client D is in treatment from the previous year, has no treatments starting during the current year, has a treatment starting in the following year, in the same or in a different treatment centre. No treatment is recorded for the current year.	
D	D2	Any					
E	E1	1				Client E enters treatment for the first time ever during the current year. The treatment is reported for the current year as a first-ever treatment.	X
F	F1	1				Client F starts treatment for the first time ever during the current year. The treatment continues into the following year. The treatment is recorded in the current year as a first-ever treatment.	X
G	G1	2				Client G enters treatment for the first time ever during the current year, has subsequent treatments during the current year, within the same and different treatment centres. Only G1, the first treatment in the current year, is reported as a first-ever treatment.	X
G	G2	2					
G	G3	3					
H	H1	1				Client H has a treatment in the previous year that is terminated with an end of treatment. A new treatment commences during the current year, in the same or a different treatment centre, and extends to the following year. The treatment in the current year is reported as previously treated.	
H	H2	Any					X

Table 1 (continued)

Client	Treatment episode/activity	Treatment centre	Preceding year	Current year	Following year	Specifications	To be reported to the EMCDDA
I	I1	2				Client I has a treatment in the previous year that is terminated with an end of treatment. A new treatment commences in the current year in the same treatment centre. A second treatment commences in the current year in a different treatment centre. Treatment I2 is reported on the basis that it is the first treatment during the year. Treatment I2 is reported as previously treated.	
I	I2	2					X
I	I3	3					
J	J1	1				Client J entered treatment in the previous year and that treatment continued into the current year. Subsequently, a further treatment was entered during the current year in the same treatment centre. Provided a formal end of treatment concluded the first treatment, the treatment entered during the current year is reported as previously treated.	
J	J2	1					X
K	K1	1				Client K entered treatment in the previous year and that treatment continued into the current year. Subsequently, a further treatment was entered during the current year in the same treatment centre. Provided 6 months without contact passed between the first and the second treatment, the treatment entered during the current year is reported as previously treated.	
K	K2	1					X

Table 1 (continued)

Client	Treatment episode/activity	Treatment centre	Preceding year	Current year	Following year	Specifications	To be reported to the EMCDDA
L	L1	1				Client K entered treatment in the previous year and that treatment continued into the current year. Subsequently, a further treatment was entered during the current year in a different treatment centre. Provided a formal end of treatment concluded the first treatment, the treatment entered during the current year is reported as previously treated.	
L	L2	2					X
M	M1	1				Client K entered treatment in the previous year and that treatment continued into the current year. Subsequently, a further treatment was entered during the current year in a different treatment centre. Provided 6 months without contact passed between the first and the second treatment, the treatment entered during the current year is reported as previously treated.	
M	M2	2					X

Notes: Cases to be included and excluded from data reporting to the EMCDDA and not necessarily from data collection at national or local level.

To be included: 

To be excluded: 

The cases J, K, L and M can be considered variations of the similar situation, for better illustration. They represent clients that were in treatment at the beginning of the year, then the treatment episode was concluded and a new episode (to be notified) started later in the year. The cases represent the combination of two possibilities; when the treatment episode was terminated formally and when it was a drop-out (in that case, the client should have 6 months without contact with a treatment centre, and when the subsequent episode took place in the same centre and when it took place in another centre).

Annex II

Table 2: Summary table of comparison: items from TDI version 2.0 and TDI version 3.0

Old items	New items
Treatment centre type	Data reporting not anymore focusing on treatment centre type
Date of treatment month	Dropped at EMCDDA level
Date of treatment year	Same
Ever previously treated	For more than one episode, the first treatment episode should be recorded
Source of referral	Minor modifications in categories and order
Gender	Same (word changed)
Age	Same (word changed)
Year of birth	Dropped at EMCDDA level
Living status (with whom)	Clarification of categories to avoid overlap
Living status (where)	Clarification and minor change in one category
Nationality	Dropped at EMCDDA level
Labour status	Harmonisation with Eurostat classification
Highest educational level completed	Same; more detailed reference to the ISCED classification
Primary drug	Same, with addition of a few substances relevant for drug users in the current situation
Already receiving substitution treatment	Similar, but simplified
Usual route of administration	Same
Frequency of use (primary drug)	Clarification of some categories
Age at first use of primary drug	Same
Ever/currently (last 30 days) injected	Specifications of some categories
Other (=secondary) drugs currently used	Same, with addition of a few substances relevant for drug users in the current situation
--	Living status: having children
--	Age at first injection
--	Polydrug use
--	Age at first OST
--	HIV testing
--	HCV testing
--	Needle/syringe sharing



Abbreviations

ASI	Addiction Severity Index
CICAD	Inter-American Drug Abuse Control Commission
DRD	Drug-related deaths
DRID	Drug-related infectious diseases
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders, fourth edition
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
GBL	Gamma-Butyrolactone
GHB	Gamma-Hydroxybutyric acid
HCl	Hydrochloride
HCV	Hepatitis C virus
HIV	Human Immunodeficiency Virus
ICD-10	International Classification of Diseases, 10th revision
IDU	Injection drug user
ISCED	International Standard Classification of Education
MDMA	Methylenedioxymethamphetamine
NFP	national focal point, institutions and national departments which form the Reitox network
OST	Opioid substitution treatment
PDU	Problem drug user
PG	Council of Europe's Pompidou Group
Reitox	Réseau Européen d'Information sur les drogues et les Toxicomanies (European Information Network on Drugs and Drug Addiction)
SAMHSA	Substance Abuse and Mental Health Service Administration
TDI	Treatment demand indicator
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organization



References

Council of the European Union (2001), 'Council resolution on the implementation of the five key epidemiological indicators on drugs, developed by the European Monitoring Centre for Drugs and Drug Addiction', *CORDROGUE 67*, Brussels.

Donmall, M. (2003), *Personal communication*. UNODC meeting to define a toolkit for collecting data on drug treatment demand, UNODC, Vienna, 2–3 December 2003.

EMCDDA (2010), *Annual report 2010: the state of the drugs problem in Europe*, European Monitoring Centre for Drugs and Drug Addiction, Lisbon.

<http://www.emcdda.europa.eu/publications/annual-report/2010>

EMCDDA Management Board (2001), *EMCDDA recommendation on the 5 harmonised key indicators*, European Monitoring Centre for Drugs and Drug Addiction, Lisbon, pp. 1–13.

European Union (2003), 'Council Recommendation of 18 June 2003 on the prevention and reduction of health-related harm associated with drug dependence', *Official Journal of the European Union*, L 165, 3.7.2003.

Hartnoll, R. (1994), *Drug treatment reporting systems and the first Treatment demand indicator. Definitive Protocol*, Council of Europe Publishing, Strasbourg.

Iversen, E. (2009), *Coverage assessment of data collected in the framework of the treatment demand indicator*, Bergen Clinics Foundation, Norway.

<http://www.emcdda.europa.eu/html.cfm/index67086EN.html>

Manchester University, D. N. (2010), *Statistics from the National Drug Treatment Monitoring System (NDTMS) 1 April 2009–31 March 2010*.

<http://www.medicine.manchester.ac.uk/healthmethodology/research/ndec/factsandfigures/NDTMSstatistics/NDTMSannualreport0910.pdf>

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

SAMHSA (2009), *Treatment Episode Data Set (TEDS) Highlights – 2007*, Substance Abuse and Mental Health Services Administration, Rockville, MD.

<http://www.dasis.samhsa.gov/teds07/tedshigh2k7.pdf>

Simon, R. (1999), 'Treatment Monitoring and reporting system', *European Addiction Research*, Vol. 5, N.4; special topic issue.

Simon, R. and Pfeiffer, T. (1999), *Field trial of implementation of a standard protocol to collect information on treatment demand in EU Member States. Final report on behalf of the EMCDDA*, Institut für Therapieforschung, Munich.

Simon, R., Pfeiffer, T., Hartnoll, R., Vicente, J., Luckett, C. and Stauffacher, M. (2000), *The Treatment Demand Indicator (TDI) Standard Protocol 2.0*, European Monitoring Centre for Drugs and Drug Addiction, Lisbon, pp. 2–36.

<http://www.emcdda.europa.eu/html.cfm/index65315EN.html>

Stauffacher, M. and Kokkevi, A. (1999), 'The Pompidou Group Treatment Demand Protocol: The First Pan-European Standard in the Field', *European Addiction Research* 5(4), pp. 191–6.

Treatment demand indicator (TDI) website:

<http://www.emcdda.europa.eu/themes/key-indicators/tdi>

UNODC (2006), *Guidance for the measurement of drug treatment demand. Toolkit Module 8*, United Nations Office on Drugs and Crime, New York.

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The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) is one of the European Union's decentralised agencies. Established in 1993 and based in Lisbon, it is the central source of comprehensive information on drugs and drug addiction in Europe.

The EMCDDA collects, analyses and disseminates factual, objective, reliable and comparable information on drugs and drug addiction. In doing so, it provides its audiences with an evidence-based picture of the drug phenomenon at European level.

The Centre's publications are the prime source of information for a wide range of audiences including policymakers and their advisors; professionals and researchers working in the drugs field; and, more broadly, the media and general public.

The EMCDDA's Manuals are practical handbooks aimed at professionals and grassroot practitioners working in the drugs field.



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