European Monitoring Centre
for Drugs and Drug Addiction

12th Annual Expert Meeting on the Treatment Demand Indicator -TDI-

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Final Minutes

20-21 September 2012

EMCDDA - Lisbon

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Summary

- The 12th TDI expert meeting took place on the 20-21 September 2012 at the EMCDDA premises in Lisbon
- The TDI Protocol ver 3.0 was printed and launched to the press on 20th of September
- The meeting was structured in three plenary sessions and five parallel sessions
- The three plenary sessions focused on:
  - State of progress of the indicator and TDI implementation
  - Opioids misuse and trends among people entering drug treatment
  - Issues related to TDI: psychiatric co-morbidity, cannabis treatment demands, opioid treatment and TD data dissemination
- The five parallel workshops focused on:
  - heroin trends
  - new trends in treatment demand
  - methodological issues and client's profile
  - misuse of opioids other than heroin
  - heroin and other TDI trends.

Next Steps for 2012-2013

- The TDI protocol version 3.0 will be implemented at national level; the countries will provide data according to the new Protocol in September 2014. In September 2013 data should still be provided according to the TDI Protocol; ver 2.0
- The new FONTE template for data submission to the EMCDDA will be finalised by May 2013, when it will be presented to the National Focal Points meeting in May 2013. The NFPs can adopt the template in May 2013 and in November 2013 within the full package of the reporting guidelines
- During next year's meeting parallel thematic work-shops will also be organised; countries will have the opportunity to present and discuss their analysis using TDI data with the other experts
- The TDI experts can already start planning next years' presentations
- **Next meeting: September 2012 *(exact date to be confirmed*)**

PART I -

State of Progress of the Treatment Demand Indicator and use of data

1. Welcome and introduction by the EMCDDA Director, Wolfgang Götz

The EMCDDA's Director welcomed the participants. He thanked everybody for the large participation, welcomed the new TDI experts and the experts from candidate and potential candidate countries who were present at the meeting. He highlighted the progress made within the TDI project and in particular the publication of the TDI ver. 3.0, and its launch to the press which happened on the first day of the meeting.

W. Götz stressed the relevance of the TDI as fundamental instrument for the EMCDDA and for the drug information in general. The indicator has substantially improved over the past years, contributing to the improvement of the knowledge in the drug field in Europe. He also underlined the progress and improvement made in data provision and quality, which has enhanced the analytical capacity of the indicator.

The future projects should focus on trends analysis, particularly regarding drug injection. Considering the peculiar moment of economic crisis, he concluded highlighting the need to maximise the use of the TDI information, making highest use of available resources and increasing the data utilization for analysis and dissemination.

2. State of progress of TDI and related projects

The TDI state of implementation was presented, with an overview of 2010 data reported, used for the 2012 Annual Report. The main issues regarding data quality were also discussed and the on-going internal projects related to the TDI presented (*Linda Montanari, Julian Vicente- EMCDDA*).

In general an improvement of data quality and further use of TDI data in the current year was shown. In 2012 the detailed data quality assessment conducted in 2008 will be repeated. The first results showed data quality improvement in several quality criteria (*Sandrine Sleimann- EMCDDA*).

The TDI data were presented describing the current profile and patterns of drug clients in Europe. In the last years the number of primary cannabis clients increased; the number of heroin clients has decreased, and treatment demands for other drugs remained quite stable. Relevant country differences in drug use patterns and geographical groups of countries were seen (*Bruno Guarita, EMCDDA*).

The TDI is one of the 5 epidemiological indicators, included in a more general EMCDDA treatment monitoring strategy. The strategy has the objective to coordinate the data collection and analysis on drug treatment at European level. A meeting on definition of data collection instruments on treatment facilities was held the day before the TDI meeting, with the participation of most of the TDI experts. On the basis of the conclusions of the meeting it was decided to carry out a facilities survey, with the objective to quantify and describe the existing facilities providing drug treatment in Europe (*Dagmar Hedrich-EMCDDA*).

TDI is currently being extended to the candidate and potential candidate countries. The activities currently on-going in those countries were briefly presented. The IPA project aims to establish and implement the TDI, as TDI is often the starting point for establishing a national drug monitoring system (*Sandrine Sleimann-EMCDDA*).

The progresses on the PDU revision were presented, with particular attention to the areas close and interesting for the TDI data collection. Joint analysis using TDI and PDU data will be carried out in the next period; a specific project has ben launched on analysing trend in drug injection (*Danica Thanki - EMCDDA*).

Progress on the behavioural DRID indicators and corresponding guidance modules was presented. The new version of the DRID behavioural indicators will be implemented in 2013. DRID behavioural data coming through TDI and DRID reporting will be consolidated at EMCDDA. The DRID toolkit guidance modules are available in unedited final versions and will be published in 2013. An evaluation of DRID is also planned for that year (*Lucas Wiessing –EMCDDA*).

2.1 TDI implementation

The feasibility assessment conducted in the countries has shown that countries will be generally able to provide data according to the new TDI Protocol in September 2014. For some countries the adaptation will imply changes in the national monitoring system and some time for their implementation. The most difficult aspects concern the new variables and the limited human and financial resources currently available (*Linda Montanari-EMCDDA*).

The results of the project concerning the mapping and assessment of the national instruments used to collect TDI data were presented. They show an already high level of harmonisation of the national tools compared to the EMCDDA TDI Protocol, regarding variables and methodology. The full assessment report is available in the TDI web page (*Filomena Gomes-Portugal*):

Most control double counting when individuals data are recorded. An assessment on the level and quality of control of double counting was presented. The level of control on double counting is quite high and allows excluding a large proportion of individuals reported twice in the monitoring system. However some overlap still exists, especially in the countries where the regions have a high level of autonomy. The need to have better and detailed information on control of double counting was underlined; therefore the new template for reporting TDI data will include a larger section on methodological information. This will allow collecting more detailed and up-dated information on several methodological aspects, including double counting (*Bruno Guarita-EMCDDA*).

A pilot data collection for testing the new template for data reporting form countries to the EMCDDA was conducted in some volunteer countries (Czech Republic, Spain, Estonia, France, Poland, The Netherlands, United Kingdom). The template was built to respond to the changes occurred in the TDI Protocol ver 3.0. The pilot exercise showed that minor changes should be introduced; the methodological section should be expanded and should include more detailed information. That information should then be only up-dated when necessary; not every year as it is now the case. The final template will be presented for discussion and adoption to the National Focal Points in May 2013. The data, as agreed with experts and NFPs, will be submitted according to the new TDI Protocol ver. 3.0 in September 2014 (*André Noor –EMCDDA)*

A project on assessing the key indicators expert meetings was presented. The objective is to improve the format, effectiveness and usefulness of the expert meetings. Interviews were conducted with some experts and a general assessment of all the indicators meetings will be presented. Alan Lodwick is in charge of conducting the assessment and participated at the all meeting (*Alan Lodwick – United Kingdom*).

An evaluation questionnaire was distributed to the experts. Only 13 experts filled in the form. The general evaluation was extremely positive, both in terms of content and organisation. The plenary sessions on analysis (TDI trends and opioids other than heroin) were considered particularly interesting; the methodological sessions were useful for the practical work on the national TDI

implementation. The organisation of the work-shops was highly appreciated since it allowed a large and active participation of all the experts present at the meeting. Improvements can be done in the shortening of presentations of the plenary sessions and some logistic aspects of the parallel work-shops. In conclusion the general evaluation of the meeting was positive. More detailed feedback on the external meeting evaluation will be provided by Alan Lodwick on all the key indicators meeting (*Linda Montanari- EMCDDA*)

3. Making use of TDI data

3.1 Misuse of opioids, including heroin and pharmaceutical opioids

Data from Europe and US were presented and showed that heroin treatment demand is decreasing, partly replaced by other opioids, including pharmaceuticals opioids which are indeed on increase.

Data from US (*Michael Calla-ONDCP*) show a large increase of misuse of pharmaceutical opioids, resulting from analysis on different data sources.

In Europe there are indications of an increase of use of opioids other than heroin (fentanyl, buprenorphine, etc.); those data are however limited to few countries. An analysis on TDI and drug related deaths data has confirmed that increase in some restricted countries (*Isabelle Giraudon – EMCDDA*). Reasons for that increase seem to be related to several factors, including a shortage in heroin provision, for which a trend-spotting meeting was organised in 2011 and results presented during the meeting (*Jane Mounteney – EMCDDA)*.

An analysis of TDI data for clients entering treatment for primary heroin use in the last 10 years has shown a decrease in heroin treatment demand. This decrease is clearer in the Westerns countries compared to Eastern countries, where the heroin epidemic appeared later. The clients are increasingly older and the age at first use is also increasing. Heroin injecting is reported to have strongly decreased. A specific project on injecting trends wil be conducted in 2012-13 (*Gregorio Barrio, Ana Sarasa- Carlos III Institute – Madrid).*

3.2 Other TDI related issues

Psychiatric comorbidity is an important health problem among drug users and should be better investigated. A presentation on data from patients suffering from psychiatric comorbidity in Barcelona was provided underlining the complexity of the problem, both in terms of diagnosis, analysis and treatment (*Marta Torrens, Hospital del Mar – Barcelona).*

Another important issue regarding the TDI data concerns the increase in the last years of the number people entering treatment for primary cannabis use in most countries. A specific analysis conducted in Germany has shown that there are several reasons for the increase in cannabis treatment demands; those relate to trends in the referrals from the Criminal Justice system, higher prevalence of problem cannabis users, and other factors still unclear (*Martin Steppan, IFT-Germany*).

The results from a research on a European project on access and quality of Opioid Substitution Treatment were presented. The project provided relevant information on the needs of clients in substitution treatment and possible indications on necessary changes to be adopted to improve the

treatment. It also shows the importance of disposing of qualitative information to better understand and interpret TDI data (*Heino Stöver, Frankfurt University – Germany*)

A software application for disseminating and visualize TDI data was presented. The VIewit project is implemented in England and Wales; it shows TDI data on a geographical basis. Its utilities and potentialities for data description at European level and data dissemination have demonstrated to be very useful. Other countries may want to use similar software at national level (*Michael Donmall, Manchester University*).

PART II – Parallel work-shops

4. Session 1 – Heroin trends

Chair/Rapporteur: Tim Pfeiffer- Germany
Discussants: Etienne Maffli- Switzerland; Martta Forsell- Finland

The first parallel workshop concerned heroin trends, with 5 presentations provided by United Kingdom, Luxembourg, the Netherlands, Poland, United Kingdom, Cyprus.

In United Kingdom the NTA (National Treatment Agency) data 2010/11 for England show a decrease in the number of opiate users new to treatment. This was largely due to the "sharp decrease in the number of newly presenting opiates users aged 18-24, from 11,309 in 2005-06 to 5,532 in 2010-11*".* The latest prevalence estimates also suggest a decline of opiate users. These figures give rise to claims of an ageing opiate using population. From the triangulation of information from different sources (prevalence estimates, surveys, treatment demand), a general decrease of heroin use in England is confirmed. However PDU estimates show a decrease in some areas and increase in others, and differences reported between age groups of users. Even if a considerable decrease of the younger age groups is observed, the fact that the population in treatment is ageing keeps the treatment numbers high. But the number of cases presenting to treatment for primary heroin use is falling both among new and repeated treatments. The latest unpublished figures show a continuation of all presented trends with a decrease of heroin treatment demands. However it is necessary to be vigilant and consider that new groups of users can emerge; in fact changes in prevalence may be cyclical and not linear (*Andrew Jones-Unite Kingdom*).

In Luxembourg the demand for heroin treatment is going down. A specific analysis on women heroin patients showed that, when compared to men, women demanding treatment for heroin use are younger and start injecting heroin earlier in their age. They have more contacts with law enforcement and prison; they are less treated in opioid substitution and share more needles with other drug users. These findings raise some questions: is women's addiction more complex and problematic than men's addiction? Are women problems over-reported? Is treatment offer adequate and targeting women? Are there methodological issues (sample size, etc.) to be considered when looking at treatment demand among women? (*Sofia Lopes Costa –Luxembourg*)

In the Netherlands experts are wondering whether treatment demand for opioid use seems to be a disappearing problem. On the long term with ongoing observed trends the treatment demand for opioids is declining since 2000, the heroin use in general population is stable and the incident numbers are low and decreasing; also no new groups of heroin users were recently reported. The generation of those entering treatment is aging and will eventually disappear. However it has to be considered that the number of elderly clients is rapidly growing: this implies that there will probably

be less people in need for heroin treatment, but they would need more intensive care (*Wil Kuijpers/Jeroen Wisselink- The Netherlands*).

In Poland TDI data are coming from a limited number of treatment facilities, as the monitoring system is still in its pilot phase. In order to formalize the new TDI system the Polish parliament adopted a national law, foreseeing the obligation of collecting data on drug treatment. The law must be followed by an ordinance which is ready but not yet adopted by the Ministry of Health. The limited and variable coverage, especially when looking at different years, has a significant impact on data analysis. Time series are also rather short and only data from the period 2008-2010 can be analyzed. The main findings from the analysis show that the time-lag between first use, regular use and treatment demand is over 10 years. There is a high rate of injection; the HIV rate is going down, while the trend for HCV is not clear as well as the trend in opioid substitution treatment (*Marta Struzik-Poland*).

In Cyprus heroin is going down as primary drug for entering treatment, among first treatments in particular; the relative figure is decreasing while the absolute numbers remain relatively stable; this is confirmed in the PDU estimates. Foreigner drug users are playing a crucial role among the heroin treatment demand and a significant proportion is registered in centres offering substitution treatment. Heroin injecting and sharing is dropping, particularly among Cyprus nationals (*Ioanna Yasemi- Cyprus*).

Discussion and methodological conclusions:

- A decrease in heroin use and heroin treatment demand has been reported in several EU countries
- The decrease is confirmed in most countries and seems related to a real decrease in use, with no new generations of heroin users appearing
- It is always necessary to perform a careful analysis of TDI data, distinguishing between first clients and all clients and between absolute numbers and percentages
- When analysing the heroin trends is also necessary to look at specific groups and client's characteristics, like gender and age, since there may be relevant differences by users' groups
- The trend in treatment provision and accessibility to opioid substitution treatment is a key factor for the analysis of heroin trends in treatment demand
- Data triangulation with other data sources or indicators is always beneficial and helps interpreting the trends

5. Session 2 – New trends in TDI

Chair: Dragica Katalinic – Croatia
Discussants: Suzi Lyons – Ireland; Anastasios Fotiou – Greece
Rapporteur: Christine Marchand-Agius

The second parallel workshop concerned new trends in TDI, with 4 presentations provided by Hungary, Romania, The Netherlands, Slovenia.

In Hungary In the past two years new trends could be observed in the market and consumption of illicit and non controlled psychoactive substances. A significant drop in the availability of heroin in

seizures data since the second half of 2010 was observed, together with an increase of the availability of mephedrone and other cathinones. Changes could be observed in the drug treatment and care system. Qualitative (Horváth et al. 2011; Rácz et al. 2011; Csák et al. 2012a) and quantitative (Csák et al. 2012b) studies describe changes in the patterns of use of clients of drug treatment and of needle and syringe programmes. These studies show a drop of treatment and care demand related to heroin use and an increase in demand related to amphetamines and cathinones. In TDI data a similar shift of primary drugs among people starting treatment can be observed. The proportion of clients with primary heroin use among all patients starting treatment dropped from 27% (2009) to 16% (2011). While the proportion of amphetamines and other stimulant susers increased from 9% and 0% (2009) to 15% and 9% (2011) there has been a drop in heroin use since 2009, within both previously treated and first treated clients. But there was an increase in amphetamine treatment and other stimulants within previously treated clients. Within first treated clients, amphetamine use remained stable, heroin declined and other stimulants increased. There was an increase in IDU's reporting methadone (to 4%). When data were compared to other data sources the following findings were described: seizure data show that heroin seizures began to disappear and synthetic cannabinoids and new amphetamines ruled the market in the 3rd quarter of 2010; GPS (ESPAD study) shows that there was a lifetime prevalence of 6% mephedrone; qualitative studies conducted by the syringe distribution centre with the highest turnover in the country reported an increase in cathinone users. The national needle exchange program reported a decline in heroin IDU's and an increase in other drugs IDUs; mortality rates reported a decline in mortality rates related to heroin use. In conclusion a decline in heroin related treatment demand was reported and a correspondent increase in amphetamine and other stimulants related treatments (*Anna Péterfi – Hungary*).

In Romania new psychoactive substances became manifest in 2008 and as a result of a new adopted legislation. One of the effects of the legislation was the reduction in the number of shops selling these substances (only 10 shops were still selling). A survey found that 42.5% of consumers used daily and they predominantly inject or smoke the substances. 55.9 % of respondents use other 'legal' products and use for an average of 13 months before seeking treatment. The average age of users was 18 years; 67% were male, 21% had medium to high education and 12.5% were employed. These substances were most used by high school and university students. The ESPAD survey reported 5.3% use of these substances in 2011. For TDI they found a difficulty with polydrug use due to difficulty in identifying new drugs. They have also had a shift in persons coming forward for opiates to persons coming due to legal drugs. Regarding the duration of drug use frequency, it was found that on average people came for treatment for legal drugs after 1-1.5 year of use. The average age of using legal highs were 15-19 years. Since most users came to treatment after one year, this had an effect on the average age overall. Meanwhile 50% of legal high users had low level of education, which is similar to opiate users *(Aurora Lefter and Bogdan Gheorghe-Romania).*

In The Netherlands the number of GHB treatment demands is below 1,000, but due to media attention, it was decided to look in more detail at the data for GHB. GHB is known as a party drug, but according to data from the General Population Surveys the use has been transferred to bigger groups; the substance is also predominantly found in rural areas. The reported increase in GHB use is related to accidents and an increase in awareness on how to make it yourself. GHB was found to be fairly addictive and detoxification and relapse are quite hard. 2007 was the first year when GHB was reported in treatment demand data, but with less than 100 persons reporting it as their primary drug. Now this has increased to almost 700 persons, which however represents less than 1% of the population. GHB users are to a higher extent than other drug users females, with a mean age of 28.5 (low age compared to the remaining treatment population) with most being 20-30 years old, and many using other drugs at the same time. 27.7% of GHB clients were first treated clients; this means that most GHB clients have been already in treatment before; they were using mainly amphetamines, switching later to GHB. The GHB clients in continuous treatment have risen, implying some difficulty in treating people with problems related to this substance, whilst the first treated clients have flattened out. With increases in incidences, prevalence and treatment

demand, new legislations were implemented. Treatment involved prevention on the streets but treatment protocols are still being developed. There is more awareness in youths about the dangers and the substance, which may therefore be losing some of its appeal, where it starts to be seen less as a club drug and see it more as an addictive substance *(Wil Kuijpers, Jeroen Wisselink-The Netherlands).*

In Slovenia in 2009 the highest number of all treatments since the establishment of a monitoring system was reported, since all treatment centres reported data. After 2009 the figures declined due to the drop of one large centre. The main findings from the data show that:

- there is a growing gap between oldest users and youngest users;
- the number of heroin users was highest in 2009 but has been decreasing since, whilst cocaine and cannabis remain stable;
- the mean age of users has remained stable over time;
- low threshold programmes reported a decline in heroin users but an increase of clients using other substances;
- both HBSC and ESPAD studies reported an increase in cannabis use, which is however not reflected in TDI;
- the overdose data reported a large decline in heroin related overdoses in 2007 and a large increase in amphetamine related overdoses in 2010 to 2011.

There is a need to evaluate treatment programs and confront TDI data with results frpom other sources (e.g. general population surveys) *(Romana Stokelj-Slovenia).*

Discussion and methodological conclusions

- Clients entering treatment for new psychoactive substances have recently increased; the increase was also reported in PDU and crime indicators; considering that it takes some time for people to go for treatment, it is possible that there will be some more increase in the next period.

- The increase was quite fast and it happened in a similar ways in all the countries participating at the workshop.

- In most countries these substance users are treated with other substance users. In the UK they have a separate clinic (club treatment centres), but the numbers are small. In Hungary there are no treatment programmes tailored specifically to new psychoactive substance users. According to a qualitative study conducted among service providers, treatment demand develops rapidly among cathinones' users, However motivation for remaining in treatment is a relevant problem for these clients. Reintegration programmes reported differing needs on behalf of young cathinone users;

- It is important to monitor the impact in the legislation, the trend in those substances use and possible switch of users from new psychoactive substance to other substances;

- from a methodological point of view it is necessary to raise the issue of definitions, since many substances may not find a place in the TDI; there is also need for more sociological studies on social perception of those substances.

6. Session 3 – Methodological issues and client's profile

Chair and rapporteur: Erik Iversen – Norway
Discussants: Valstimil Necas – Czech republic; Ernestas Jasaitis – Lithuania

The third parallel workshop concerned methodological issues and clients' profile. 5 presentations were provided by Belgium, Sweden, Latvia, France, Italy.

In Belgium new methods to avoid double counting have been introduced recently. The avoidance of "double counting" is a continuous concern in the monitoring of the persons in treatment for a substance related disorder. Therefore, the Belgian TDI registration moved in 2011 from an anonymous registration towards a registration based on the use of the client's coded national identification number (NIN). In 2011, clinicians of 69 Belgian treatment programs recorded the TDI variables and, if available, the NIN of the client. Records are registered into a database after the coding of the NIN by a Trusted Third Party. The coded NIN and the TDI variables are afterwards forwarded to the Belgian Focal Point for analysis. The results show that in 82.15% of the records is the NIN used as identification code of the client. It is estimated that the registration of the NIN will allow to avoid a double counting of 7.3%. The introduction of the NIN allows to adjust the Belgian TDI estimates for a substantial proportion of double counts. Critical factors in the implementation and use of the NIN, as well as future epidemiological opportunities will be addressed (*Jerome Antoine – Belgium*).

In Sweden the 90 treatment-centres administered by the University of Linnaeus and all the institutions of the National Board of Institutional Care use the DOK-system for documentation of treatment, the Intake-Questionnaire including the TDI-variables to make it easy to deliver data also with the help of an interactive data-program. The most exciting development during the latest years has been the construction of special questionnaires/data applications for different target groups including one for people under 25 years of age. In the Swedish database all data are together; in addition there is a special treatment facilities for youngsters in our three largest cities - Stockholm, Gothenburg and Malmoe. TDI will be the common denominator for the new Swedish quality register in health care. More treatment units are no longer specialized, but work with different forms of dependence disorders. Swedish law will still prevent effective control for double counting. TDI integrated data for young persons in a new documentation system (DOK-YP) (*Bert Gren – Sweden*).

In Latvia there is the possibility to link TDI and DRD registries. A research has looked at outcomes of fetal and infant outcomes of substance and alcohol use during pregnancy. A record linkage has been done from 2007 to 2010 in the treatment demand database (PREDA), the health insurance database and the registry of newborns. Unadjusted risk ratio for dying during the first 12 months for children born from women using alcohol and/or drugs is 5.5 times higher as compared with women with no substance use (*Marcis Trapencieris – Latvia*).

In France the new monitoring system was revised and implemented in the last years and applied in the 272 specialised centres. Analysis was carried out on clients' profile, dividing the clients in three groups: cannabis users, opioids, cocaine and other substance users and alcohol users. The three groups have quite different profiles: the first are young, live with family and are often students; the second -opioids and alcohol users - are older (especially the second group), live often alone or with family and are employed. Different characteristics and related trends were analysed according to the different clients' groups. This helps to better understand profile and patterns of drug use, to have comparable results and to minimise data overestimation and underestimation.

In Italy most clients who are in treatment for heroin use, have began using the drug at an earlier age than those undergoing treatment for cocaine or cannabis; they have also been in treatment longer than other clients. The age of first use for heroin or cocaine has increased over the years, while the increase is less noticeable where cannabis is concerned. Over time there has been an evolution in the method of use for heroin, shifting from injecting toward inhalation. There has also been an evolution in first drug use: before the 1990s, the drug of first use was generally the same

primary drug for which clients were being treated. However, after 2000, cannabis becomes progressively the primary drug used by clients (*Bruno Genetti, Silvia Zanone – Italy*).

Discussion and methodological conclusions:

- The use of unique identifier is important for the analysis of TDI data; it allows avoiding double counting;

- to dispose of an individual register also allows to conduct advanced analysis, especially if a record linkage is possible with other individual registries;

- the issue of coverage is always central in the different phases of implementation of a treatment demand monitoring system and should be considered when establishing and implementing a system and when analyzing the data;
- the analysis of client's profile and patterns of drug use according to groups of clients is useful and allows to better understand the clients' characteristics, the trends and to have comparable results; it also help to reduce over and underestimation of the data

7. Session 4 - Misuse of opioids other than heroin

Chair: Grethe Lauritzen – Norway
Discussants: Tanja Bastianic –France; Charlotte Davis – United Kingdom
Rapporteur: Cahrlotte Davis – United Kingdom

The fourth parallel workshop concerned misuse of opioids other than heroin; presentations were provided by Estonia, Czech Republic, Croatia, Finland.

In Estonia illicit fentanyl is the most common substance used by patients entering drug treatment. The fentanyl epidemic in Estonia is the longest reported in Europe. The substance is illegally produced and taken via injection. The phenomenon was probably caused by changes in local drug market (heroin shortage in 2001). Illegally produced fentanyles have continued to be the predominant opiates used in the Estonia. Close to two-third of lethal drug poisonings during the period of 2000-2009 were caused by fentanyles use. HIV prevalence among primary fentanyl injectors is very high (62%), which is significantly higher comparing amphetamine injectors (27%) (Talu et al., 2010). IDUs who injected fentanyl (only or fentanyl +amphetamine) in the past 6 months were more likely to be HIV positive compared to those hwo only inject amphetamines (63% vs. 25%).

In Czech Republic in the last 5 years there was an increase in the misuse of buprenorphine. Most buprenprphine users inject the substance, whilst most PDU in Czech Republic are using pervitin via injection. It is estimated that there are around 6 000 heroin users and 5 000 misusers of buprenorphine, also using via injection and mainly concentrated in the capital area. From 2006 until 2010 the number of PDU using buprenorphine has increased by around 1 000 persons. This is reflected in an increase of clients entering treatment for misuse of buprenorphine. A parallel increase has been seen in the patients in substitution treatment for buprenorphine. Reasons for buprenorphine increase can be related to a decrease in the quality and lower accessibility of heroin. The advantage in using buprenorphine instead of heroin is related to a lower overdose risk and a relative drug safety.

In Croatia drug treatment is provided by outpatient and inpatient treatment centres and by rehabilitation centres. Most clients are heroin users, who have increased substantially since 1996. Some drug users misuse opioids other than heroin. As in the case of heroin, also in that case the

drug is mainly taken intravenously. The opioids used often come from the prescribed therapy; that was prescribed for another patient and often resold in the black market. This problem has been recognised also by an increase of people dying from methadone overdosing and from a large proportion of persons who died for fatal overdose who have never been previously treated. Recommendations should therefore be provided to prevent misuse and harms related to opioids misuse.

In Finland most clients entered treatment for primary use of buprenorphine since many years. Buprenorphine is by far the most commonly used opioid, accounting for at least 69% of all opiate use. Other substances are occasionally reported (heroin and other poppy derivatives -6%, tramadol -4%-, oxycodone -4%-, codeine preparations -4%-, fentanyl -1%-, methadone -1%-, buprenorphine- naloxone -5%-. Of those who reported buprenorphine as their primary problem drug, 86% used buprenorphine mainly intravenously, 75% used it intravenously in the previous month, 54% used it daily. The percentage of clients whose primary problem drugs are opiates has been increasing since 2002. Opioid problem users are more likely to seek treatment than users of other drugs and the number of clients in substitution treatment has multiplied in the past ten years. It is necessary to raise the issue of adequacy and accessibility of treatment and data quality. However in order to better understand this issue several information sources are needed beside the TDI data.

Discussion and methodological conclusions:

- Problem opioid use is a relevant problem in Europe and the misuse of opioids other than heroin is on increase in several countries, especially in some northern European countries;
- several factors may be related to this phenomenon, including market, social and cultural factors; the expansion of substitution treatment may have also played a role;
- differences in prescription practices and market factors should be better assessed together with TDI data
- a better consideration of data coverage and data quality may help to reach a better understating of the issue of misuse of opioids other than heroin.

8. Session 5 – Heroin and other trends in TDI

Chair: Micahel Donmall – United Kingdom
Discussants: Erik Iversen – Norway; Johan Van Bussel – Belgium
Rapporteur: Janusz Sieroslawski – Poland)

The fifth parallel workshop concerned heroin trends and other trends in TDI; presentations were provided by Greece, Switzerland, Malta and Austria.

In Greece opioids treatment demand increased in numbers, but decreased in proportions; the people is getting older and the previous-treatments now outnumber first-treatments (revolving door). In terms of route of administration sniffing heroin dominates, although injection is now starting hitting back. The drug clients are mainly polydrug users and there is a general increase of misuse of prescription drugs. Daily use among patients shows downward trend and so do current injecting and sharing. The social indicators get worse, but family plays in Greece a key role. Harm reduction interventions have only recently improved their coverage. Cheap and poor quality heroin increases health related risks

In Switzerland different data sources were analyzed in order to better understand the trends in heroin use and problems and prevent premature statements. The sources used were: treatment demand data, general population survey and school survey, mortality register, police data. All data suggest a lowering of the attraction of heroin until 2002 after a peak in heroin consumption reported in the early 90s. Since 2002, no clear trends can be identified regarding incidence. In terms of characteristics of heroin clients and patterns of drug use, injecting is still common among heroin users and an aging cohort of users having started during the peak (around 1990) can be traced. Estimating numbers and not only tendencies seem still challenging in the current Swiss data.

In Malta data from 2009–2010-2011 show that around 65-70 clients * 10 000 adult population (around 2000 clients). Most of them are males and between 10-15% is entering treatment for the first time. Most of them are primary heroin users (77%), even if when first clients are considered the proportion of cocaine and cannabis users is higher. Out of 4% of clients that reported other drugs as their primary drugs, 22% had used cocaine, 22% had used cannabis, 8% had used heroin and a further 24% had used other drugs as their secondary drug. In general there are indications of a decrease in the number of primary heroin users among new clients.

In Austria data on cannabis clients were analyzed and show an increasing trend, which partly may be explained by methodological factors, such as expansion in data coverage and partly by increase of problems related to cannabis use. However when analyzing cannabis treatment demand is important to assess changes in prevalence of cannabis problem use, political influences, increasing awareness of risks related to cannabis use.

Discussion and methodological conclusions:

- The share of opiate users in the three countries (Greece, Switzerland, Malta) presenting data on heroin trends is high among all TDI patients and smaller among first treatments;
- a decreasing trend in heroin use is reported. This is shown by treatment data confirmed by data from various sources;
- when looking at heroin trends it is necessary to assess the change in „opiate" oriented treatment offer, to control for changes in coverage of the reporting system as a key issue when interpreting trends in drug use;
- the analysis of percentage distribution according to main drug should be accompanied by analyses of trend in absolute numbers;
- the use of data from various sources is advantageous for common analyses. The time lag to treatment is greater for newly emerging drugs.

European Monitoring Centre
for Drugs and Drug Addiction

The Treatment Demand Indicator (TDI)

12 th Annual Expert Meeting 2012

20 -21 September 2012 **EMCDDA (Conference Centre)**

AGENDA

Thursday, September 20th

Progress on Treatment Demand Indicator

09.00 - 10.30 **Welcome (*Wolfgang Götz – EMCDDA's director*)**

Introduction (*Julian Vicente)*

Overview of the meeting and the activities carried out in 2012 (*Linda Montanari)*

Overview of the last data from the 2012 Annual Report (*Bruno Guarita*)

Data quality: second Key Indicator assessment *(Sandrine Slieman)*

Treatment Monitoring Strategy *(Dagmar Hedrich)*

10.30 - 11.00 Coffee break

Up-date on EMCDDA projects related to TDI

11.00 - 12.00 Information map of national questionnaires, protocols, codebooks: extent of European harmonisation *(Filomena Gomes)*

Up-date on TDI implementation in the candidate and potential candidate countries (*Sadrine Sleiman*)

PDU revision (*Danica Thanki)*

DRID Toolkit (*Lucas Wiessing*)

TDI Ver 3.0: implementation and state of progress

12.00 - 13.00 State of progress of the TDI: results from survey, feedback from working group meeting and REITOX meeting *(Linda Montanari)*

The control on double counting at national level (*Bruno Garita*)

Pilot data collection: results and discussion *(André Noor)*

Discussion

Information on project on Key Indicators meetings (*Alan Lodwick*)

13.00 - 14.30 Lunch

Parallel sessions: results from national analysis with TDI data to improve understanding of the drug situation and in particular PDU developments

14.30 - 18.00 (Rooms 107, 106, PAL 102)

16.00 - 16.30 Coffee break

18.00 Cocktail at the EMCDDA's patio

European Monitoring Centre
for Drugs and Drug Addiction

Friday, September 21th

09.00 - 10.30 Misuse of opioids in US *(Michael Cala, ONDCP)*

Drug related deaths due to misuse of pharmaceutical opioids in Europe (*Isabelle Giraudon*)

Recent trends in heroin use and heroin injection in Europe: results from the treatment demand indicator (TDI) *(Gregorio Barrio, Ana Sarasa)*

Heroin shortages in Europe? Results from an EMCDDA trendspotter meeting (*Jane Mounteney*)

10.30 - 11.00 Coffee break

11.00 - 12.30 Psychiatric comorbdity in illicit substance users *(Marta Torrens)*

Understanding the increase in cannabis treatment demand. Cross-national Research in Germany, the Netherlands and the United Kingdom *(Martin Steppan)*

European Quality Audit of Opioid Treatement - EQUATOR (*Heino Stöver)*

The Vewit Project *(Michael Donmall)*

12.30 - 14.00 Lunch

14.00 - 16.00 Reporting back form parallel sessions:

Heroin Trends (*Tim Pfeiffer*)

New trends in TDI (*Safet Blakaj*)

Methdological Issues and client's profile (*Erik Iversen*)

Misuse of pharmaceutical opioids (*Grethe Lauritzen*)

Heroin and other trends (*Janusz Sieroslawski*)

Remaining issues and next steps

Conclusion of the meeting

European Monitoring Centre for Drugs and Drug Addiction

Parallel sessions: results from national analysis with TDI data to improve understanding of the drug situation, and in particular PDU developments
14.30 -18.00

Session 1: Heroin trends 1
(14.30 - 16.00 – Room 107)

Chair: Tim Pfeiffer

Presentations

Heroin trends in United Kingdom
(*Andrew Jones*)

Heroin trends in Luxembourg
(*Sofia Lopes Costa*)

Treatment demand for opiates in the Netherlands; a disappearing problem?
(*Wil Kuijpers/Jeroen Wisselink*)

Discussant: Etienne Maffli

Heroin trends Poland
(*Marta Struzik*)

Heroin trends in Cyprus
(*Ioanna Yasemi*)

Discussant:: Martta Forsell

Session 2: New trends in TDI clients
(14.30 - 16.00 –Room 106)

Chair: Dragica Katalinic

Presentations

New trends in Hungary
(*Anna Peterfi*)

Consumption of new substances with psychoactive effects in Romania
(*Aurora Lefter and Bogdan Gheorghe*)

Discussant:Suzi Lyons

GHB treatment demand in the Netherlands: A new heroïne epidemic?
(Wil Kuijpers/Jeroen Wisselink)

Trends of using drugs in Slovenia
(*Romana Stokelj*)

Discussant: Anastasios Fotiou

Session 3: Methodological issues and clients' profile
(14.30 - 16.00 – Room PAL102)

Chair: Erik Iversen

Presentations

The use of national identifier in Belgium
(*Jerome Antoine*)

The use of TDI data for clinical and monitoring purposes in Sweden
(*Bert Gren*)

Linking TDI and DRD registry in Latvia
(*Marcis Trapencieris*)

Discussant: Vlastimil Nečas

Clients' profile by groups in France
(*Tanja Bastianic*)

Epidemiological characteristics of treatment clients: from drug of first use to primary drug in Italy
(*Bruno Genetti*)

Discussant: Ernestas Jasaitis

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Session 4: Misuse of pharmaceutical opioids
(16.30 - 18.00 – Room 107)

Chair: Grethe Lauritzen

Presentations

Misuse of fentanyl in Estonia
(*Ave Talu, Kaire Vaals*)

Misuse of buprenoprhine in Czech Republic
(*Vlastimil Nečas*)

Discussant: Tanja Bastianic

Misuse of pharmaceutical opioids in Croatia
(*Dragica Katalinic*)

Mixed Bag of Everything – Interpreting the Finnish TDI Data for Misuse of Pharmaceutical Opioids
(*Martta Forsell)*

Discussant: Charlotte Davis

Session 5: Heroin and other trends
(16.30 - 18.00 – Room 106)

Chair: Michael Donmall

Presentations

10-year overview of heroin abuse in Greece through the treatment demand -and other indicators
(*Anastasios Fotiou*)

Heroin trends in Switzerland
(*Etienne Maffli*)

Discussant: Erik Iversen

Other trends in Malta
(*Christine Marchand Agius*)

Problematic cannabis use in Austria based on TDI data
(*Alexander Eggerth*)

Discussant: Johan Van Bussel

18.00: cocktail offered in the EMCDDA's patio

European Monitoring Centre
for Drugs and Drug Addiction

Document: REITOX/46

Implementation of the new TDI Protocol

Key Idea

The EMCDDA has finalised the TDI revision process and the NFPs have adopted the TDI Protocol ver 3.0. during the RTX meeting in November 2011. The finalisation of the TDI protocol has followed a 3 years process, coordinated by the EMCDDA and involving the national TDI experts and the NFPs. The TDI protocol will be soon available in the web site, after its media launch in 2012.

Background

According to an agreed time schedule, the countries have started in 2012 the preparatory work for the TDI implementation at national level. To this end the EMCDDA has carried out a consultation survey to assess the feasibility and impact of the TDI implementation at national level.

A pilot exercise was also launched to test the revised reporting form with 9 volunteer countries (CZ, EE, ES, IE, FR, NL, PL, PT, UK). On the 28 of May the 9 countries met to discuss the survey results and the future steps for the pilot exercise.

The results of the survey and the outcomes from the working group meeting are presented below. In Annex the detailed results of the survey are presented.

Results from the survey and the working group meeting

According to the survey most countries will be able to provide data according to the new Protocol and the time schedule agreed with the Focal Points (which will be September 2014). The main challenges will concern the involvement, acceptance and motivation of the TDI Protocol ver 3.0 by the national data providers (treatment centres and professionals from the treatment sector). To this end most countries have already foreseen training and information activities with treatment centres and professionals from the drug field. Some issues were raised concerning political acceptance of the TDI Protocol, which sometimes may involve the adoption of a new regulation or legislation at national level. In many countries the implementation of the TDI, including the revised reporting form, will be linked to technical IT developments in data collection and extraction. Finally most countries will be able to provide data on the new items and to implement the overall changes without substantial difficulties (See Annex for details on the results from the survey).

During the working group meeting on 28 of May the results of the survey were discussed and some issues on TDI implementation were raised. In particular the need to compare data collected through the TDI ver 2.0 and those collected through the TDI ver 3.0 was highlighted; this may especially affect trends and their interpretation.

Double counting represents an important issue and should be further investigated. To this end the meeting participants suggested the EMCDDA to send one page question on the issue of double counting to all countries in the next weeks. Existing information on double counting will be put together and presented to countries.

emcdda.europa.eu

EMCDDA, Reitox Heads of Focal Points
Lisbon, 29 May – 1 June 2011 **46th meeting**

Document: REITOX/46

Implementation of the new TDI Protocol

Finally the template for reporting data according to TDI was discussed during the meeting and some changes were made to improve it. During the pilot exercise countries volunteering filedl in the revised form and sent their data back to the EMCDDA.

Next steps

1. TDI meeting 2012:	presentation and discussion of the results from the feasibility survey; presentation on work carried out on double counting feedback from the pilot exercise on data reporting form with volunteer countries
2. REITOIX meeting November 2012:	presentation of the template for data reporting
3 - 2013:	actual data collection according to TDI ver 3.0
4 - 2014 (September):	data submission to EMCDDA

All documents produced during the auditing and revision process of TDI are available on the TDI restricted area (http://projects.emcdda.europa.eu/alias.cfm/area7.cfm).

Annex: results from the Survey on implementation of TDI ver. 3.0

1) 28 countries replies

2) Possible to deliver data to the EMCDDA according to the TDI Protocol ver.3.0:

22 countries will deliver data in September 2014
3 countries will deliver data in September 2015
2 countries will deliver data in September 2016
1 country will deliver data in September 2018

Comments:

- Needs agreement of all actors involved, in particular professionals of the treatment centres
- Some countries need a formal adoption (Ministerial decree, agreement between regions, Ministries)
- Coverage may be limited in an initial phase in some countries
- There can be some problems with the new variables

3) Main challenges and practical issues related to the implementation of the TDI protocol ver 3.0 (multiple answers)

10 countries
Involvement, acceptance, motivation, training of the stakeholders, treatment centres

9 countries
Technical development of a reporting system/Software adaptation; modification statistical routine

7 countries
Political and legal procedures to implement the new Protocol

6 countries
Adapt, translate the National protocol to the EMCDDA Protocol; define Manual for data collection; having template ready for reporting data

4 countries
Problem with specific variables

3 countries
Funding, Human resources

2 countries
Coverage (non reporting centres, specific type of treatment centres not reporting

1 country
Combination with other revisions - new data collection (DRID, Treatment Prevalence, etc.)

1 country
No Unique identifier

1 country (PT)
Uncertainness at political level (PT)

4) Need for training to ensure implementation of the new protocol.
(multiple answers)

18 countries
will organise specific training at national level for data providers. In some cases they have already a concrete plan. The training will have the objective to instruct the data providers and motivate them. It will be on methodological and definitional issues

6 countries
will organise conferences, meeting and national working groups with relevant stakeholders on

6 countries
do not foresee any specific training since the changes will only concern a data extraction or because of political problems

4 countries
will provide relevant documentation for TDI implementation

5) EMCDDA possible help for TDI implementation
(multiple answers)

11 countries
do not foresee any specific role for the EMCDDA

7 countries
EMCDDA to explain, facilitate the knowledge on the relevance of the TDI data on for the national level; this can be done through letter sent to FP, leaflet, participation in national meetings and training (this include the activities in the framework of the IPA4 project)

6 countries
EMCDDA to provide financial support

3 countries
Translate protocol, define short guidelines

2 countries
Mapping National questionnaires and having them in the TDI web restricted area; include in that area the best national practices in TDI implementation

4 countries
help, advise on case by case need, on bilateral basis

6) New improved EMCDDA "case definition" matching the national case definition:

12 countries
existing national case definition matches EMCDDA case definition"

11 countries
does not match, but no difficulties in extracting data according to it

4 countries
does not match, but possible to extract data according to it with difficulties

1 country
does not match, and not possible to extract data

Comments/Reasons for difficulties:
3 countries no unique identifier/double counting control

2 countries already collect continuous treatments
1 country not possible to estimate overlap between treatment centres in treatment journey
1 country developing a new system
1 country different databases and only one compatible with TDI; need for legislative support to implement the new TDI

7) Possible to collect data on old variables (slightly modified)

15 countries
all of them according to Protocol ver. 3.0

5 countries
all of them but with some difficulties related to deadlines

2 countries: some of them not possible to collect
(end of treatment, education)

2 countries
some with difficulties

1 country
not possible to say, depend on national authorities

Other comments:

- Problems of coverage: not all centres (types of centres) will send information on all data

8) Possible to report the data on new variables according to EMCDDA guidelines

	YES	Partially	NO	Comments
Polydrug use problem	27	1		To be piloted (1 country)
Living conditions: having children	22	3	3	
Living conditions: living with children	25	3		
DRID: HIV testing	22	6		To see (1 country)
DRID: HCV testing	20	8		To see (1 country)
OST	24	3	1	To be piloted (1 country)
Age at first OST	21	3	4	Not known (1 country)
Age at first injection	24	2	2	
Needle/syringe sharing	23	4	1	

9) Possible to implement other changes

22 countries possible

6 countries partially possible

0 countries where it is not possible

10) Further comments

OS managed by GPs, so client's profile totally different
Political, legislative, organisational issues
Need for time
Possible problem of coverage
Financial and human resources issues