



**Classifications of drug treatment and social reintegration
and their availability in EU Member States plus Norway
FINAL REPORT**

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Introductory notes

Classifications of drug treatment and social rehabilitation/reintegration and their availability in EMCDDA member states

This introductory note outlines the sort of considerations made prior to the collection and analysis of data on treatment availability. This was collected through NFPs and various other sources.

Due to great variation and diversity across EMCDDA member states in both the terminology used and the syntax of those terms, some preliminary exercises are necessary in order to assure that similar data are collected from the countries. A perfect harmonisation of data from member states is not possible in view of the current nature and diversity of country data. Consequently comparisons between countries will be made with great caution.

Although this perfect harmonisation of data is unachievable, some initial considerations are crucial in order to ensure that the data collected is as similar as possible in its nature and coverage. In other words, we must define as clearly and simply as possible what kind of data we want in order to assure, if not complete comparability, then similarity in the data collected.

The overall context

The very idea of classifying and measuring drug treatment and social rehabilitation availability originates from the third strategy target of the EU drug action plan 2000-2004, which states: *'to increase substantially the number of successfully treated addicts'*. In various settings and forums (Reitox work groups, meetings on instituting the EU action plan) it has become clear however that this is by no means an easy task and also that there is no direct way of shedding light on this objective. Instead, the 'evaluation' of this objective can only be made by looking at related issues, such as measuring availability of treatment, presenting findings from scientific evaluations on treatment outcomes, sketching expenditures on treatment facilities, and so on.

Defining drug treatment

The initial step is to define what we mean by treatment of drug addiction¹. Our definition of drug addiction treatment is as follows:

- *Formalised treatment in a physical setting in the community with specific medical and/or psychosocial techniques aiming at reducing or abstaining from illegal drug use thereby improving the general health of the client.*

This definition leaves out the following types of intervention: a) methadone busses as it's not in a physical setting (this is instead considered as outreach work), b) needle exchange in any given setting as this has no psycho-social or medical component, c) drug-free wings and substitution treatment in prisons as the intervention is penal not civil, d) telephone help-lines as the aid provided does not take place in a physical setting, e) self-help groups as these are not a formalised intervention, and lastly, f) treatment exclusively for alcoholics as alcohol is not considered an illicit drug.

This definition includes amongst others the following types of intervention: a) any kind of substitution treatment in an outpatient or inpatient setting regardless of admission criteria, b) drug-free treatment in any sort of setting, c) pharmacological treatment with non-substituting

¹ Except cases where the term 'abuse' is explicitly used we shall generally use the term 'addiction'.

substances (for instance, Clonidine or Naltrexone), and lastly, d) general practitioners providing psycho-social support and/or carrying out substitution treatment.

Classifying drug treatment

For each member state an attempt will be made to identify a more or less common classification of drug treatment facilities. These will vary greatly but - as stated earlier – some ‘pre-definitions’ are necessary in order to achieve some sort of similarity in the data collection process. Hence, the following concepts will be used as guidelines for classifying drug treatment facilities and their treatment activities;

- Drug-free or substitution treatment?
- Treatment setting (inpatient, outpatient, general practitioner, semi-residential etc.)
- Treatment modality (Minnesota, Christian/religious, Social-educational, Phoenix House, Behaviouristic/cognitive, Psycho-analytical, etc.)
- Ownership of treatment facilities (municipalities, state, private, NGO, church)

Regarding the first distinction, the objective of substitution treatment can be divided into:

- Detoxification (which can again be broken down into short-term and long-term)
- Maintenance (by default time-unlimited)

Regarding the second distinction on treatment setting, we define inpatient treatment as; *treatment in which the patient spends the night in the treatment centre*. This also means that semi-residential treatment - where the client spends the night in the treatment centre without receiving therapy in the daytime - is considered inpatient treatment. Conversely, outpatient treatment is treatment where the patient does not spend the night at the treatment centre. However, it still has to fulfil the requirements of our treatment definition which rules out counselling and advisory services as well as needle exchange programmes. A treatment slot is defined as *a bed in an inpatient setting*. In an outpatient setting this issue gets more tricky, varies between treatment centres and therefore depends on the specific treatment centre.

Lastly, the substances used in substitution treatment are:

- Methadone
- Buprenorphine
- LAAM
- Heroin
- Slow-release morphine

In addition to this, but outside the categories above, pharmacological treatment with non-substituting substances such as Naltrexone and Clonidine will be covered.

Drug treatment shall, as a point of departure, cover all interventions targeted against the consumption of any illicit drug - be it cannabis, amphetamines, cocaine, heroin or others. However, substitution treatment is only meant for opiate addicts and hence information on this can be said to cover only a part (albeit the majority) of the total problem drug-using treated population.

Another factor that has to be borne in mind is that much of the treatment of drug addiction takes place in treatment centres/units which also treat other kinds of addictions (such as alcohol or licit drugs). To the extent that data allows it, a distinction will be made between substance addiction treatment (which includes alcohol and licit drugs) and drug treatment (which includes all illicit drugs from cannabis to heroin). In the cases where data does not

allow a distinction to be made, treatment efforts will be classified as substance addiction treatment.

In February 2002 an expert meeting held on the EMCDDA premises aimed at classifying and identifying main concepts drug treatment. The outcomes of the meeting will not be elaborated here but will serve in a future analysis of drug treatment and its availability in the European Union and Norway.

Operationalising drug treatment

The final goal of the operationalisation is to provide the framework so that as precise a 'snapshot' as possible can be taken on the basis of the existing empirical material. The operationalisation does not aim to come up with a framework that can provide the basis for a cross-country analysis, but aims to provide a country snapshot that can be compared over time. This does not however mean that no initial attempts will be made to define what sort of information will be gathered from the member states. Cross-country analysis cannot be carried out but we must ensure that a similar picture is being obtained in each country.

In order to ensure that similar information is collected from all member states a template was developed. The template is effectively a check list with a number of items that should be covered. The items in the check list are the result of a selection process from three main sources:

- Guidelines for the national reports (thereby increasing the likelihood of the information actually being available),
- Treatment Demand Indicator (especially the concept under TDI protocol item 1, treatment-centre type), and lastly,
- Case study literature in selected member states (thereby ensuring applicability of the chosen items).

It would have been a more simple solution to take the items from the guidelines for national reports. However it transpired that some crucial elements were not covered satisfactorily by these and therefore the items were slightly altered or supplemented. Similarly, the TDI could not simply be adopted due to the fact that it also covers treatment units in prisons and low threshold services which belong to other core data programmes.

The items in the check list consist of the items under 'Classifying drug treatment' (see above) plus an extra sub-chapter called 'National Context' which deals with matters regarding commonly used central terms in the classification of drug treatment facilities, national legislative issues on drugs (including substitution treatment), national drug plan, admission criteria and coordination between services (NB. to the extent the information is available).

Aside from analysing and mapping treatment availability in itself, comparison and referral to other previously collected data must also be carried out. In particular, comparison with two programmes (or rather key indicators) must be made; namely with the prevalence of problem drug use and the Treatment Demand Indicator. Firstly, comparison with the prevalence of problem drug use must be carried out in order to shed light on how many drug users are being reached by the treatment services. Secondly, comparison must be made with the Treatment Demand Indicator in order to shed light on the supply/availability and demand/request situations.

In terms of empirical material, a 'treatment inventory' has been created for each of the EMCDDA member states. Ideally, a treatment inventory would contain standardised information from each treatment unit in the country with both quantitative figures on treatment slots and capacity, as well as qualitative data on description of services - preferably using the

terminology listed above (treatment setting, treatment modality and so on). However, it is rarely the case that such an inventory exists and for each country a tailor-made solution has to be found on the basis of the existing empirical material.

Defining social (rehabilitation and) reintegration

Unlike treatment, social rehabilitation and reintegration do not need a psycho-social or medical component. For instance 'subsidised vacancies' is a way of rehabilitating/reintegrating (former) drug users although it has no psycho-social or medical component. Our country studies so far have shown that the term 'rehabilitation' is used ambiguously across Europe - from low threshold refugees to normal treatment to actual reinsertion into society. For this reason we shall use the term 'reintegration' as this has proved to be used much more consistently across Europe and is less likely to cause confusion.

We shall define social reintegration the following way:

- *Any integrative efforts made in the community as a last step in a treatment process*

This implies that first contact between the drug addict and treatment/reintegration services is not considered as social reintegration since it is not the last step in a treatment process. The term *social* stems from the EU action plan but it now seems evident that the majority of EMCDDA member states do not use the term. Reintegration and social reintegration will be used synonymously. Also, self-help groups (like Narcotics Anonymous - or NA) will be included as an example of a social rehabilitation intervention. By definition, data on client contact is unavailable from NA but information was sought regarding the number of NA contact centres. Lastly, note that the definition above of social reintegration includes interventions targeted at former drug abusing prisoners since the intervention takes place in the community.

Classifying reintegration

As with 'treatment' it is necessary to produce some 'pre-definitions' in order to ensure some sort of similarity in the data collection process of social reintegration. The following concepts will be used as guidelines for classifying *reintegration settings*:

- Outpatient
- Inpatient (including semi-residential)

And the following concepts shall be used as guidelines for classifying the *type of social reintegration intervention*:

- Education (for instance, vocational training)
- Housing
- Employment (for instance, subsidised employment)

Two things have to be kept in mind regarding the points above. Firstly, they are only guidelines since the actual classification varies considerably between countries (and also within them); and secondly, that they reflect an ideal situation in which information broken down into above-mentioned items exists at all. In summary, the points listed above are the items that will be searched for in each member state, but in case the data is unavailable, an item will be left uncovered.

Operationalising social reintegration

Similarly to treatment, the goal of operationalisation is to provide a framework so that a precise 'snapshot' can be taken on the basis of the existing empirical material. Again similarly to treatment, a check list has been developed with items from the Guidelines for the national report plus some additional literature studies.

The items in the check list consist of the items under 'Classifying social reintegration' plus an extra sub-chapter called 'National Context' which deals with matters regarding central terms used, national drug plan, accessibility and admission criteria. Data on social reintegration is not foreseen to be compared with data from any other core data programme or key indicator.

Classification of and concepts in drug treatment facilities in Belgium

National context

As one of three EU member states with a federal constitution, Belgium's activities in the field of treatment and the monitoring of it takes place at regional level. Therefore the Belgian National Focal Point depends on the reporting of four so-called 'Sub-Focal Points', namely one each from the Flemish-speaking community, the French-speaking community, Brussels and the German-speaking community. Despite an apparent 'regionalisation' of treatment interventions there are similarities and types of intervention that are present in each of the Communities. So, although the data is collected at regional level some parallels can be drawn at a national level.

Current classification in Belgium

We will first examine the concepts and terms used in each of the communities and then identify common concepts and terms that can be applied to the whole country across communities and regions.

Flemish speaking institutions

The concept and terms used in the Flemish Community are based on a recently released inventory of treatment facilities for alcohol and drug addiction named 'Referral guide' (*'Doorverwijs gids'*)² issued by the Flemish Sub-Focal Point. The inventory uses the following concepts and breakdowns to describe treatment interventions:

- Outpatient treatment (*'ambulante hulpverlening'*)
 - Medical and Social Reception Centres (*'Medisch-Sociale OpvangCentra'* - MSOC)
 - Outpatient treatment facilities (*'ambulante Opvang/dagcentra/dagbehandeling'*)
 - Mental Health Care Centres (*'Centra voor Geestelijke Gezondheidszorg'*)

- Inpatient treatment (*'residentiële hulpverlening'*)
 - Activities for homeless (*'thuislozenwerking'*)
 - Crisis intervention centres (*'crisisinterventiecentra'*)
 - Psychiatric wards of general hospitals (*'psychiatrische afdeling van algemeen ziekenhuizen'*)
 - Detoxification wards of psychiatric hospitals (*'ontwenningsafdeling van psychiatrische ziekenhuizen/ontwenningskliniek'*)
 - Short therapeutic programmes (*'kortdurende therapeutische programma'*)
 - Therapeutic Communities (*'Therapeutische Gemeenschappen'*)
 - Housing (*'beschut wonen'*)

² The Referral Guide includes only those centres which are members of the umbrella organisation VAD (*Vereniging for Alcohol- and Other Drug problems*, Brussels). These are almost all of the centres in Flanders with a specific focus on alcohol and other drug-related problems.

However, as the breakdown of the inpatient treatment facilities is not completely compatible with our pre-definitions of treatment (and social reintegration) we shall regroup and rename these categories as follows:

- Outpatient treatment (covering social reception facilities, outpatient treatment facilities and mental health care centres)
- Short-term inpatient treatment (covering activities for the homeless, crisis intervention centres, short therapeutic programmes, psychiatric wards in general hospitals and detoxification wards in psychiatric hospitals/detoxification clinics)
- Long-term inpatient treatment (covering therapeutic communities)

Housing will be regarded as a reintegration intervention and consequently dealt with in a separate paper.

French and German-speaking institutions

The inventory 'A qui s'adresser?' supposedly lists all treatment centres ('centres de cure') in Wallonie, Brussels and the German-speaking community. The treatment centres are divided into the following sub-categories:

- Reception and information centres ('services d'information et d'accueil')
- Reception centres in the community ('centres d'accueil en milieu ouvert')
- Counselling centres ('centres de consultations')
- Crisis centres ('centres de crise')
- Crisis centres in hospital settings ('centres de crise en milieu hospitalier')
- Outpatient treatment centres ('centres de jour')
- Therapeutic Communities ('centres résidentiels')
- Short-term treatment centres ('centres de séjour court')
- Hospitals ('Hôpitaux')

In order to ensure comparability with treatment services in the Flemish community we shall use the same categories and put the following type of interventions into each of them:

- Outpatient treatment (covering reception and information centres, reception centres in the community, counselling centres, and outpatient treatment centres)
- Short-term inpatient treatment (covering crisis centres – including those in hospital settings - short-term treatment centres and hospitals).
- Long-term inpatient treatment (covering Therapeutic Communities).

Availability of drug treatment facilities in Belgium

National context

As mentioned in the paper on treatment classification, Belgium has a federal structure and consequently there is no drug policy on demand reduction at a national level. Generally speaking the demand reduction interventions - and hence also treatment - are set up by the Communities or Regions.

Current availability of drug treatment in Belgium

There is no information available on the number of treatment slots in the two treatment inventories, 'Doorverwijs gids' and 'A qui s'adresser?', so only the number of units can be provided. The two inventories provide information on what types of addiction treatment centres are addressed (alcohol, drugs, legal drugs, gambling). It is therefore possible to exclude treatment centres which do not address drug addiction (although many will also address other types of addiction).

Table 1: Availability of drug and addiction treatment facilities in Belgium

Setting	Drug treatment facilities	Addiction treatment facilities [^]	Total
Outpatient treatment	21	60	81
Short-term inpatient treatment	9	21	30
Long-term inpatient treatment (Therapeutic Communities)	7	7	14
Total	37	88	<u>125</u>

[^] covers treatment of drug addiction plus treatment of at least one other kind of addiction.

What does not appear in the table above is the rather fine network of substitution treatment services offered via General Practitioners. There is no exact information on how many General Practitioners are involved in substitution treatment but the figure of between 400 and 500 has been suggested by more than one source. The bulk of these General Practitioners is to be found in Brussels and the French community. Some General Practitioners in the Flemish community are involved in substitution treatment but the bulk of this takes place through specialised centres.

It must also be noted with regard to the table above that the German-speaking community have agreements with Germany and Luxembourg to ensure that German-speaking Belgian drug addicts can be treated in their mother-tongue.

Prevalence of problem drug use, treatment demand and treatment availability

The latest estimate (1997) of the number of 15-64 year old intravenous drug users in Belgium is 23200-28400. As we possess no data on the number of treatment slots it is not possible to make a comparison between treatment availability and drug addicts. There is no reporting of

waiting lists in Belgium and outpatient substitution treatment (always methadone) in particular is readily available. The latest scientific estimate on the number of subjects in substitution treatment dates back to 1996 when it was believed to be around 7000. Although there are no newer scientific estimates it is widely believed that the number has grown notably in the last few years. Figures from INCB (the International Narcotics Control Board) suggest that this might be correct. In 1999 there was a total consumption of 155 kg of methadone in Belgium. If we assume that an average dose is 50mg a day (or in other words 18.25g a year) then there were around 8500 subjects in substitution treatment in Belgium in 1999.

In 1999 there was a total of 10273 treatment demands in Belgium according to data collected through the Treatment Demand Indicator. This number does not include treatment admissions at General Practitioners which (especially for Wallonie) are believed to be many in number.

Classification of and concepts in (social) reintegration in Belgium

In the two main inventories for Belgium ('*A qui s'adresser?*' and '*Doorverwijsgids*') there is unit level information about interventions including some that could be considered to be reintegration. Unfortunately the information is not presented in a structured, systematic and standardised way and instead space is allotted to 'open-ended' and qualitative descriptions of the interventions. The terms used to describe reintegration interventions in the Flemish Community span from *Nazorg* (aftercare) and *resocialisatie* (re-socialisation) over *herintegratie* and *reintegratie* (both re-integration) to *sociale werkplaats* ('social workplaces'). In the French Community and Brussels a great number of concepts are used, some of which are seemingly interchangeable. Examples of concepts and terms are; *Réseau de familles d'accueil pour toxicomanes* (family networks for drug addicts), *Centre d'accueil pour toxicomanes et parents de toxicomanes* (Reception centres for drug addicts and parents), *Groupes 'parents-solidarité'* (parents support groups), *Centre de post-cure pour toxicomanes* (after care treatment centres for drug addicts), *reinsertion* (reintegration), *Travailler avec les familles* (work with families) and *Centre thérapeutique de post-cure* (therapeutic after care centre). As these terms are not in any way defined or uniform it is not possible to carry out a reliable categorisation of the reintegration efforts taking place in Belgium.

Another important issue which complicates matters further, is that reintegration is generally seen as an integral part of treatment and consequently not considered a separate kind of intervention. Thus, a separate mapping exercise for reintegration is virtually impossible.

A last point that has to be mentioned is that much reintegration seemingly takes place in penal settings. As our task here is to draw an overview of reintegration efforts carried out in the community, much of the Belgian reintegration effort is not even therefore covered by this exercise.

Availability of (social) reintegration facilities in Belgium

Although, as mentioned in the paper on classification of reintegration facilities in Belgium, it is not possible to give a comprehensive and quantitative overview of reintegration activities in Belgium, it must be mentioned that quite a few treatment centres do report activities that could be interpreted as being reintegration (that is, using one of the terms mentioned in the classification paper). Another thing that seems clear is that there are numerous reintegration activities taking place after prison in Belgium. Especially in Wallonie/the French-speaking part of Belgium there are many treatment facilities reporting activities both inside prisons and immediately after prisoners have been released. Again, the data does not allow a reliable and comprehensive overview to be drawn.

Summary

- The main bulk of drug treatment takes place in outpatient settings, seemingly, very often using methadone.
- Most treatment facilities are not especially earmarked for drugs but for addiction in general.
- There are big differences in terms and concepts used in the Regions due both to language differences and federal structure.

Sources

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Classification of and concepts in drug treatment facilities in Denmark

National context

After legislative alteration in 1995 (which came into force on 1st of January 1996) the counties took over responsibility for the treatment and recovery of drug addicts. The counties have each since founded one or more treatment units providing predominantly methadone treatment (LAAM-treatment has taken - and is taking - place in one county and one municipality). Besides this there are also a number of drug-free in-patient treatment centres that have emerged, particularly during the 1990s. These are normally privately run and owned, although they depend entirely on counties sending drug addicts there and financing treatment. In other words, there is a quite clear distinction in Denmark between substitution treatment and drug-free treatment.

From a legislative point of view, in-patient drug-free treatment facilities in Denmark are based on at least one of the following laws;

- Law on social services § 51, 85, 91 and 93 (*'Loven om social service'*)
- Penal Code § 49, second paragraph (*'Straffeloven'* - allowing treatment as alternative to prison)
- Law on social welfare § 66 and 68 (*'Bistandsloven'*)

The most relevant legislative (although not strictly speaking legal) paper regarding substitution treatment is the 'Circular on prescription of addictive medicinal products (*'Cirkulære om ordination af afhængighedsskabende lægemidler'*), which is the legal basis for the county-run specialised methadone treatment units.

Finally, the law on hospitals § 16 (*'Sygehusloven'*) covers treatment of alcohol addiction. Since some treatment centres deal with both substance and alcohol addiction this law applies to them. All treatment facilities in Denmark are based on at least one of the above-mentioned laws.

Current classification and concepts of treatment facilities in Denmark

The following classification is based on terms and concepts used in the 'The county-organisations overview of drug treatment offers' (*'Amtsrådsforeningens oversigt over tilbud til stofmisbrugere'*). This treatment inventory includes information on 32 drug-free in-patient treatment centres (many also offering outpatient services). At the time of data-collection this inventory is believed to give an almost complete overview of inpatient treatment facilities in Denmark. The concepts used for classifying the treatment setting are the following (reintegration is dealt with in a separate paper):

- Detoxification (*'Afgiftning/nedtrapning'*)
- Pre-care (*'indslusning'* – normally outpatient preparation before in-patient treatment)
- In-patient (*'Døgnbehandling'*)

Some treatment units do not specify what their treatment slots are targeted at but simply report a total number of treatment slots (no break down into outpatient, inpatient or the like) which can then be used according to the definite treatment demand. The term 'pre-care' (*'indslusning'*) covers an outpatient phase between detoxification and in-patient treatment. The idea of this phase is for the treatment unit to differentiate the motivated from the unmotivated, thereby hopefully reducing drop-out rates and consequently increasing a positive spirit in the unit.

Regarding treatment approach (*'Behandlingsindhold'*) the terms used for classifying and describing the interventions are the following:

- Minnesota-model (also known as '12 steps' or 'NA-philosophy')
- Social-educational (*'Socialpædagogisk'*)
- Christian
- Other or non-specified

Other terms such as 'NLP' (Neuro-linguistic programming) and 'Phoenix house' are also used but there's only one treatment unit of each kind and therefore they will be put under 'other or non specified'. Each treatment unit has elaborated in detail as to what their treatment approach is all about. However, there is no overall generic definition of the concepts and terms above.

Furthermore, the treatment inventory provides information on ownership. Since the ownership terms used are compatible with those used in Norway, they will also be applied here:

- State
- Private (which covers both private foundations and private persons)
- Municipality (which covers both municipalities *'kommuner'* - and counties - *'Amter'*)
- Church (*'kirke'*)
- Hospitals (*'Sygehuse'*)

As mentioned in the foreword, practically all substitution treatment takes place through county-run specialised outpatient treatment units (a few places offering emergency overnight stays). There are three types of substitution substances in use, namely;

- Methadone
- LAAM
- Buprenorphine

Availability of drug treatment facilities in Denmark

National context

The 1994 'Government drug-policy statement paper' (*'Regeringens narkotikapolitiske redegørelse'*) is the most recent general Danish drug-policy paper. It is intended partly to summarise the state of the drug situation and partly to present the government's position on drug issues.

Amongst other issues, the paper states that treatment should be upgraded and based on the principle of differentiated requirements and goals. It states that demand reduction interventions should reach as many - and as broad a spectrum of - drug addicts as possible. This implies that there should be no overall generic admission criteria to Danish treatment facilities. The paper furthermore calls for a balance between prevention and treatment and for the increased use of alternatives to punishment (such as prison). Lastly, the paper emphasises the need for transversal collaboration at a central level and sketches the roles of various coordination committees.

Current availability of drug-free treatment in Denmark

The following data on drug-free treatment availability originates from the treatment inventory 'The county-organisations overview of drug treatment offers' (*'Amtsrådsforeningens oversigt*

over tilbud til stofmisbrugere'). The data on the number of subjects in substitution treatment comes from the 1999 Danish national report with additional data collected directly from the Danish NFP. In both cases the data dates from the 1st of January 1999. The data on both treatment setting and treatment approach can be combined in one table as shown below.

Table 1: Availability of drug-free treatment facilities in Denmark (by number of treatment slots)

Treatment approach Treatment setting	Minnesota-model	'Social-educational'	Christian	Other or non specified	Total
Detoxification	6	22	-	4	32
Pre-care	-	45	-	-	45
In-patient	489	116	18	56	679
Non specified	54	7	-	-	61
<i>Total</i>	<i>549</i>	<i>190</i>	<i>18</i>	<i>60</i>	<i>817</i>

As can be seen in the above table, two-thirds of the total number of drug-free treatment slots in Denmark are to be found in Minnesota-model treatment centres. The same trend can be seen with the division of *in-patient* drug-free treatment slots where some 72% of the slots are in Minnesota-institutions.

Regarding ownership, treatment units and treatment slots are divided as follows:

Table 2: Division of treatment units and treatment slots by ownership

Owner	Number of treatment units	Number of treatment slots	Treatment slots as percentage of total
State	1	75	7,9%
Municipality	4	88	9,3%
Foundation/Private/NGO	25	757	79,9%
Church	2	28	3,0%
Hospital	-	-	-
<i>Total</i>	<i>32</i>	<i>948</i>	<i>100,1%</i>

As seen above, the bulk of drug-free in-patient treatment slots in Denmark are privately owned and run. However, they clearly only exist as a result of the counties sending their drug addicts for treatment in the centres.

Current availability of substitution treatment in Denmark

Methadone treatment, both for detoxification and maintenance, dates from 1970 and was - until 1998 - the only substitution substance in use. In 1998, however, two trials were launched on LAAM and buprenorphine. LAAM was trialled in the municipality of Copenhagen and the county of Funen (Fyn), whereas buprenorphine was trialled in Copenhagen only. There are no restrictions on how many subjects are able to receive substitution treatment and therefore there should be no discrepancy between the demand for and the supply of substitution

treatment. There are no reports of waiting lists or lack of the means to receive clients. The data on clients in substitution treatment dates from 1st of May 1999.

Table 3: Number of subjects in substitution treatment in Denmark

<i>Substitution substance</i>	<i>Number of subjects</i>	<i>Percentage of total</i>
Methadone	4298	93,5%
LAAM	200	4,3%
Buprenorphine	100	2,2%
Total	4598	100,0%

It can be seen that the main bulk of substitution treatment slots are in methadone treatment. According to what is publicly known as the 'methadone circular' (correctly and officially known as the 'Circular on prescription of addictive drugs') methadone treatment should always be complementary to psycho-therapeutic help. However, there is currently no data to shed light on the extent of this phenomenon.

Prevalence of problem drug use, treatment demand and treatment availability

According to the latest figures from Denmark there are some 12.500 to 15.000 problem drug users compared to a rough total of 5.500 treatment slots. This suggests that some 35% - 45% of the total drug using population is in contact with treatment services.

As regards Treatment Demand (from the TDI) and treatment availability, the latest figures show that there was a total of 3429 treatment demands in 1999, 1026 of these being first treatment demands. The most obvious explanation for this apparent discrepancy is that the TDI does not have full coverage. It should, on the other hand, be mentioned that the Danish TDI is presumed to have roughly 90-95% coverage.

However, a very prudent interpretation of these figures is that overall there seems to be a good balance between treatment demand and treatment supply/provision. However, on the basis of the current available figures, are further breakdown of, for instance, treatment demand for drug-free treatment and the availability of drug-free treatment cannot be made.

Although in-patient drug-free treatment units mushroomed in Denmark during the 1990s after the aforementioned drug-policy paper, the vast majority of overall treatment slots are still in substitution treatment. Again, almost all of these are to be found in methadone treatment. *Of a total of around 5500 treatment slots, some 4300 are in methadone substitution treatment* (most often maintenance – rarely detoxification) which accounts for roughly 80% of all treatment slots.

Evaluations of treatment services (and possible success rates)

From 1st of January 1996 to 1st of January 1999, the Centre for Alcohol and Drug Research was awarded money by the Ministry of Social Affairs, in order to evaluate the treatment services of seven of the largest drug-free in-patient treatment centres. The evaluation included a follow-up study tracing drug-addicts who had left treatment services a year earlier. The evaluation concluded that results and outcome were ambiguous. Only a few of the drug addicts who had entered treatment were found to be 'clean' one year after having left. However, the vast majority of drug addicts had improved their frequency and patterns of use, while not staying totally 'clean' (alcohol consumption was considered to constitute relapse). Another study conducted by the Centre for Alcohol and Drug Research of clients in

methadone treatment showed that these clients halved their heroin intake, injection frequency and illegal activities, compared with a non-treated control group.

By the first of May 2000 the launch of DANRIS ('Danish Rehabilitation- and Informations System') had taken place. DANRIS covers and collects information on a regular basis from 40 drug-free in-patient institutions on retention rates, outcomes, time in treatment etc. DANRIS is intended to be used as a way of carrying out nation-wide treatment evaluations.

Classification of and concepts in (social) reintegration in Denmark

Current classification of social reintegration in Denmark

Firstly, the term *social* reintegration has not been observed in the Danish literature studied. Also, the term 'reintegration' is normally used to describe the last phases of a treatment process. Lack of clarity sets in when a distinction has to be made between treatment in halfway-houses and reintegration. Some Minnesota-model treatment units use halfway-houses as the last phase of a treatment process (and should consequently be categorised as reintegration), whereas others take the word 'halfway' more literally and have a reintegration phase after the midpoint (which is then in between primary treatment and reintegration). In order to overcome these difficulties a distinction in Danish reintegration has to be made between in-patient and outpatient reintegration.

- Halfway houses and in-patient reintegration ('*halvvejshus*' og '*semi-døgn*')
- Outpatient reintegration ('*efterbehandling/efterværn*')

The Minnesota-model treatment units all offer follow-up treatment in their halfway houses. But whereas some do this in an outpatient setting others do it in an in-patient setting. Furthermore, some have halfway-houses as the last step in a treatment process whereas others have in-patient treatment in halfway-houses followed by reintegration in an outpatient setting. For this reason, a distinction has been made between in-patient reintegration and outpatient treatment. Subjects in halfway-houses have been put into the boxes corresponding to the setting in which reintegration takes place.

Current concepts in reintegration in Denmark only allow a breakdown of setting (in- or outpatient) and do not allow breakdown by education, housing and employment.

Availability of reintegration facilities in Denmark

National context

The 1994 'Government drug-policy statement paper' ('*Regeringens narkotikapolitiske redegørelse*') does not refer explicitly to reintegration but does however state that treatment services should be available to as wide a range of drug addicts as possible.

Current availability of drug-related (social) reintegration facilities in Denmark

The availability of reintegration facilities in Denmark is shown below:

Table 4: availability of reintegration facilities in Denmark (number of treatment slots)

Reintegration approach	Minnesota-model	'Social-educational'	Christian	Total
Reintegration setting				
Halfway and in-patient reintegration	73	12	10	95
Outpatient reintegration	26	10	-	36
Total	99	22	10	131

It must be added that some reintegration units (either detached or attached to ordinary treatment units) report that there is no real maximum for how many subjects can be included, especially in outpatient reintegration.

Moreover, the role of NA (and AA) in reintegration in Denmark is very important due to the large extent of Minnesota-treatment. However, NA-units are by their very nature not possible to trace let alone quantify.

Summary

- The majority of drug treatment slots in Denmark are in methadone treatment (around 80%).
- The main bulk of in-patient treatment slots are in Minnesota-institutions (around 67%).
- Most of the drug-free in-patient treatment slots are run and owned privately (around 80%).
- Treatment services reach some 35-45% of the total problem drug-using population (a quite high figure).
- There seems to be a good balance overall between treatment demand and treatment availability.
- Evaluation findings of treatment services on a national level should be available from the beginning of 2003.

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Classification of and concepts in drug treatment facilities in Germany

National context

Similarly to Austria, the term 'Sucht' is a key term in German drug terminology. The term does not simply mean dependent or addicted but implies a somewhat 'haunted' state of the afflicted. The term 'Sucht' can be used for denoting addiction of any drug including licit medicines and alcohol. Although the term 'Sucht' is still widely used, it has developed negative connotations over the last years and therefore a new and increasingly used term has emerged as an alternative – 'Substanz-bezogenen probleme' ('substance-related problems'). 'Substanzbezogene Probleme', apart from being considered as less stigmatising than 'Sucht', has the advantage, it is argued, that it not only refers to the addiction itself but to related problems too.

The conceptualisation of drug-treatment facilities is particularly difficult to carry out in Germany due mainly to three circumstances. Firstly, the size of the country and population is a barrier to the development of harmonised terminology. Secondly, the federal structure, with its extensive regional powers, hinders the emergence of a countrywide concept of drug-treatment interventions. Thirdly, the existence and importance of various insurance systems, each with their concepts and terminology, presents an obstacle for the standardisation of terms.

However, there are some features of the German drug-treatment system that are valid generally and that are outlined here according to the structure of a typical treatment process, i.e., first contact with counselling centres, followed by detoxification, then inpatient treatment and lastly aftercare ('Nachsorge'), mainly through self-help groups.

Counselling centres ('Beratungsstelle') are run by welfare organisations and are financed at regional or local level, that is, 'Länder', 'Kommune' or 'Bezirk' (roughly translated as region, county, municipality) or through some kind of co-financing arrangement between them. After counselling, the patient undergoes a detoxification process which usually takes place in psychiatric wards of hospitals. As detoxification is considered to be medical rehabilitation, it falls under the responsibility of the health insurance. It is paid for by public health insurance in around 90% of cases and private in the remaining 10%.

After detoxification, an application is usually sent to pension funds ('Rentenversicherung') for financing the inpatient treatment and rehabilitation. The legal basis for this is the 'Social law book' ('Social Gesetz Buch') which has a section on social insurance ('Sozialversicherung') entitled 'Social book V for health insurance and Social book VI for pension funds', which guarantees social rehabilitation. The idea is that once the treated patient is socially rehabilitated he/she is ready to return to the labour market.

Aftercare in the alcohol field most often takes place through self-help groups which may or may not receive funding from region, county or municipality. The counselling centres often play an active role in setting up self-help groups.

Current classification in Germany

As is the case in many other countries, much of the drug addiction treatment takes place in centres/institutions which deal with addiction in general, although there are also treatment units for drug treatment only. The addiction treatment available is broken down into the three following categories:

- Detoxification unit and/or detoxification unit with motivational work ('*Entzug mit Motivationsanteilen*')
- Counselling centres ('*Beratungsstelle*'), partly connected with,
- Outpatient treatment centres ('*Ambulante Therapieeinrichtungen*')
- Inpatient treatment centres ('*Vollstationäre Fachkliniken*') for medical rehabilitation

Substitution treatment is sub-divided into the following categories:

- Methadone
- Levomethadone
- Buprenorphine
- Dihydrocodeine

Availability of drug treatment facilities in Germany

National context

Other than the current drug treatment presented in the following sub-chapter, a new treatment intervention is foreseen in the near future – a 'heroin-based treatment pilot project'. The launch of this intervention, which has been some time in the planning, is now expected to in spring 2002 in Hamburg, Hanover, Cologne, Bonn, Frankfurt, Karlsruhe and Munich. It is estimated that around 1120 patients will participate in the project.

Current availability of drug treatment in Germany

An overview of German drug treatment has been produced at central national level, in the Ministry of Health, and is entitled: '*Zusammenstellung der Länderkurzberichte über die Situation im Suchtbereich - 1999.*' When the units and slots are counted according to the categories mentioned earlier, the following picture emerges for Germany for 1999:

Table 1: Availability of drug treatment facilities in Germany (in units)

	Substance addiction [^]	Drug addiction only	Total
Detoxification unit	133	74	207
Counselling centres	656	295	951
Outpatient treatment centres	288	116	404
Inpatient treatment centres	n.a.	n.a.	n.a
Total	1077	485	<u>1562</u>

[^] The units listed here provide treatment for the addiction of substances including illicit drugs. Treatment units dealing only with other addictions such as alcohol or gambling are not listed.

The availability of treatment slots is shown below.

Table 2: Availability of drug treatment facilities in Germany (in slots)

	Substance addiction [^]	Drug addiction only	<i>Total</i>
Detoxification	4972	1644	6616
Inpatient treatment	9707	4894	14601
<i>(sub)total</i>	14679	6538	<u>21217</u>
Counselling	n.a.	n.a.	n.a.
Outpatient treatment	n.a.	n.a.	n.a.

[^] The slots listed here provide treatment for addiction to substances including illicit drugs. Treatment slots available exclusively for other addictions such as alcohol or gambling are not listed.

Other than the interventions described above, one other intervention exists – the so-called 'transitional housing' ('Übergangs- oder Wohnheime'). The purpose of this intervention is to keep a client in contact with the treatment system after detoxification and while waiting to enter a proper treatment programme. In 1999, there were 114 of such transitional housing units with 1739 slots – these slots were targeted towards addicts in general.

All of the treatment units listed above should deal with drug addiction although many of them treat other kinds of addiction too. However, the data available do not allow direct comparison between the availability of inpatient and outpatient treatment as data on the former is available only in slots and on the latter only in units. However, other figures from the DHS yearbook indicate that between 250000 and 275000 addicts (no breakdown available for illicit problem drug users only) are in contact with the counselling centres and 10000 with outpatient treatment centres.

For substitution treatment, data according to the breakdown into substitution substances set out above are only available for the year 2000 and are presented below.

Table 3: Availability of substitution treatment in Germany (in slots)

	Number of patients	In percentages
Methadone	32100	69.3
Levomethadone	10000	21.6
Buprenorphine	500	1.1
Dihydrocodeine	3700	8.0
Total	46300	100

In 1999, according to the publication 'Zusammenstellung der Länderkurzberichte über die Situation im Suchtbereich – 1999', there were 33553 patients in substitution treatment, of

which 1106 received their treatment through specialised centres and the remaining 32447, through general practitioners. These figures reveal that as much as 97% of the patients in substitution treatment in 1999 were treated by general practitioners.

As can be seen by the three tables above, the main bulk of drug treatment in Germany is in outpatient settings. The tables also show that the offer is quite extensive with around 1350 outpatient treatment units. Unfortunately, it is not possible to give a well-based estimation of the substitution/drug-free ratio in outpatient treatment.

Prevalence of problem drug use, treatment demand and treatment availability

There were estimated to be between 80000 and 152000 problem drug users in Germany in 1999. No comparison can be made between problem drug use and drug-free treatment slots as there are no figures available for the latter. However, when problem drug users are compared with subjects in substitution treatment, the result is a relatively high coverage rate of between 30 and 58%.

The German Treatment Demand Indicator only covers about 40% of the treatment institutions it aims to cover. As there are no data on drug-free treatment slots, a comparison of the two is not possible. It should however be mentioned, that in the German literature and web sites studied there are no references to waiting lists.

Evaluations of treatment services (and possible success rates)

An article by Karin Welsch in the DHS yearbook concludes that 36% of opiate addicts in inpatient treatment conclude their treatment successfully.

Classification of and concepts in (social) reintegration in Germany

In most of the German literature studied, including the national report, the term rehabilitation is used synonymously with treatment. This is not compatible with the definition of rehabilitation/reintegration used here as this is seen as the last step in a treatment process. However, the publication *'Zusammenstellung der Länderkurzberichte über die Situation im Suchtbereich - 1999'* provides information on the availability of so-called 'protected housing' ('Betreutes Wohnen'). Protected housing facilities are intended as an intervention in the last phase of a complete treatment process aiming at integrating the (former) user into society.

Availability of (social) reintegration facilities in Germany

National context

The central drug paper at federal level, 'Addiction and Drug Report 2000', is a paper that both sums up the latest trends in the drugs field and formulates goals for future policies. The drug paper explicitly mentions the need to reintegrate addicts through work and employment and states that 'work is a preventive factor'. It mentions no quantitative goals but stresses the need to further improve and expand this type of service.

The German national report states that reintegration is 'no longer the last link in the chain of treatment but has to be offered in each phase of the treatment process'. This is unfortunately not in line with the definition used here but does, however, reveal a tendency to 'individualise' interventions so that for instance relatively well-functioning drug addicts do not have to go through an entire treatment process but can pass directly to the reintegration phase.

Current availability of drug-related (social) reintegration facilities in Germany

Based on 'Zusammenstellung der Länderkurzberichte über die Situation im Suchtbereich - 1999' we observe the following picture for Germany for 1999 in the field of reintegration:

Table 4: Availability of social reintegration facilities in Germany (in units)

	Substance addiction	Drug addiction
Housing	268	107
Total	375	

And in terms of treatment slots:

Table 5: Availability of social reintegration facilities in Germany (in slots)

	Substance addiction	Drug addiction
Housing	3810	1961
Total	5771	

The reintegration slots are either semi-residential or inpatient as the patients (or former substance users) spend the night there but whereas some actively participate in sessions through self-help groups others just live in those settings for awhile without undergoing any actual treatment.

Evaluations and evaluation findings

A reintegration programme in Frankfurt entitled 'training in relapse prevention' aimed at improving the (former) drug users' abilities to solve problems and to communicate. The methods used in the training programme included role-playing, video recordings and analysis and modification of behaviour. An internal evaluation study showed improved communication skills as well as fewer psychological problems in stressful situations.

Summary

- The main bulk of drug treatment in Germany is substitution treatment through general practitioners.
- Alternatives to methadone treatment are being explored.
- (Social) reintegration facilities are quite extensive and with quite a few available slots.

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Bundesverband für stationäre Suchtkrankenhilfe ('buss') at:
<http://www.suchthilfe.de/kliniken/bundesuebersicht.htm>

Deutsche Hauptstelle gegen die Suchtgefahren at: www.dhs.de

Fachverband Sucht ('FVS') at: www.sucht.de

Classification of and concepts in drug treatment facilities in Greece

National context

In both the national report and other studied literature, the terms primary, secondary and tertiary prevention are widely used. Although this is unusual in a European context, the names when described in further detail apply to what in other countries would be termed prevention, treatment and harm reduction.

Although there is no Greek national drug action plan specifying total abstinence as the ultimate goal of treatment (and of other demand reduction measures), this is explicitly mentioned in national reports as the ultimate goal of all interventions, except harm reduction (or in other words low-threshold services).

Current classification of and concepts in drug treatment facilities in Greece

The following presentation is based primarily on the treatment inventory written and compiled by the Greek REITOX Focal Point.

The three main providers of drug treatment are OKANA, KETHEA and 18 ANO (although there are also psychiatric wards in hospitals offering drug treatment services). OKANA is a state-financed private institution working both directly with treatment (and prevention) and the collection of data on treatment, whereas KETHEA is an NGO running therapeutic communities. 18 ANO is the drug dependency unit at the public psychiatric hospital of Attica. Treatment in Greece is generally termed 'Therapeutic Services' ('Θεραπευτικών Υπηρεσιών') and takes place in both in-patient and outpatient settings. Whereas KETHEA normally describe their therapeutic services as a 'therapeutic self-help community model' OKANA 18 ANO use a very wide range of terms to describe their treatment approach.

The most commonly used models for describing *therapeutic services* are the following:

- In-patient therapeutic communities (sometimes named 'Drug-free residential treatment')
- Outpatient therapeutic communities
- Outpatient treatment centres

The term 'Preparation for integration into therapeutic community' is used quite often to describe the phase before entering treatment in a therapeutic community. However, a wide range of terms is used for describing other measures before entering actual treatment. Unfortunately the terms vary substantially and are very hard to categorise uniformly.

The only distinction regarding substitution treatment made in Greece is between;

- Long-term detoxification, and,
- Maintenance.

In both cases the substitution substance is methadone. There is no other substitution drug being prescribed although substitution treatment may be assisted with antagonists (like Naltrexone), antidepressants (like Amitriptyline) or benzodiazepines (like Diazepam). The long-term detoxification programmes were originally intended to last approximately three years. However, in 2000 increased waiting lists forced OKANA to shorten them to a planned 1½ year duration. Maintenance is a relatively new phenomenon in Greece with the maintenance unit being inaugurated in Athens during 2000.

Availability of drug treatment facilities in Greece

National context

Perhaps the most central law in Greece dates back to 1993 and paved the way for the establishment of the Greek Organisation Against Drugs (OKANA) as well as for substitution treatment. Although an independent and private sector organisation with executive powers, OKANA is under the auspices of the Ministry of Health and acts in accordance with ministerial policies. It carries out treatment projects and furthermore is responsible for coordinating Greek drug policies.

Admission criteria have been established for substitution programmes and are as follows; being an injecting heroin addict; older than 22 years; minimum of 2 years drug addiction; and at least one failed treatment attempt. While not classified as high threshold services, these admission criteria might at least be considered rather high.

Current availability of drug treatment in Greece

There are three main participants in the field of drug treatment in Greece, namely KETHEA, OKANA and 18 ANO. KETHEA runs seven different treatment units of which some are divided into a number of sub-programmes. Originally KETHEA ran only in-patient therapeutic communities but with time there has been expansion to other areas. They now also run outpatient therapeutic communities and rehabilitation projects. Lastly, the drug dependency unit '18 ANO' at the psychiatric hospital of Attica runs five different treatment programmes.

OKANA runs the substitution treatment units in the country plus some other outpatient treatment facilities. In terms of substitution treatment, there are four such units in Greece and one methadone maintenance unit. All are run by OKANA, two of them in Thessaloniki and two in Athens. Although substitution treatment with methadone was started in Greece in 1993 it was not until July 2000 that the first methadone *maintenance* unit was opened. Until then methadone had been used only for long-term detoxification lasting for as long as up to three years. The treatment inventory was updated in June 2000 and methadone maintenance dates back to July 2000 so it can be said that the 'snapshot' is from July 2000.

Table 1: Drug treatment slots in Greece

Treatment setting	Number of treatment units/ programmes	Number of treatment slots
In-patient therapeutic communities	8	326
Outpatient therapeutic communities	3	105
Outpatient treatment centres [^]	9	No data*
Long-term detoxification	4	650
Methadone maintenance	1	100
<i>Total</i>	25	<i>No data*</i>

[^]includes one so-called day-clinic

* Many outpatient treatment units report 'No limit' in treatment slots thereby rendering exact quantification impossible.

As can be seen by the above table there are around three times more in-patient treatment slots in Therapeutic Communities settings than outpatient. However, an overall comparison

between treatment slots in in-patient and outpatient settings cannot be made as there is no data on the number of treatment slots in outpatient treatment centres. It does seem that the political priority of putting emphasis on long-term in-patient abstinence-oriented treatment has been largely carried out. Other than the 326 in-patient treatment slots there are 650 substitution treatment slots which are aimed at abstinence.

The number of treatment slots specified in the table are the official planned allocations. However, due to massive demand, more patients have been put into the treatment slots. In fact, there were 966 subjects in substitution treatment in January 1999 (maintenance treatment had not yet been launched). Despite these extra individuals being admitted to treatment they have still been unable to keep up with a massive and increasing demand for substitution treatment and waiting lists have grown steadily. In 1999 (according to the 2000 Greek national report) there were *more than 4000 addicts on waiting lists*. Evidently, there is an imbalance between treatment demand and treatment supply in substitution treatment.

Prevalence of problem drug use, treatment demand and treatment availability

There is no scientifically based, estimated number of problem drug users for Greece. Consequently, comparison between the extent of problem drug use and treatment availability is impossible. Regarding treatment demand, the current TDI collects data from 12 treatment units (only half of the registered treatment units) which again makes it impossible to draw conclusions. From the 12 treatment units, 1093 treatment demands were reported in 1999 of which 605 were first treatments.

Evaluations of treatment services (and possible success rates)

The Therapeutic Community "ITHAKE" was the first systematic attempt in specialised therapy for drug users in Greece. Through different therapeutic measures (i.e. therapeutic community, psychoanalytic and behaviouristic models, psychodrama, educational activities) drug users pursue and comprehend the factors that led them to drug use. The average duration of the therapeutic programme at the Therapeutic Community is 12 months and the capacity is 70 treatment slots/persons. Evaluation results showed that the main percentage of those who attend the Therapeutic Community for more than 60 days (60-70%) were referred to the Social Rehabilitation Centre. Almost 1/3 finalised successfully the programme in the Therapeutic Community.

Classification and concepts of social reintegration in Greece

National context

Unlike many other countries the term *social* reintegration is used with great frequency in the Greek literature studied. The term 'social' generally implies that there are active attempts to integrate the former drug addict by finding a stable occupation and/or re-establishment of relations with family and friends.

Current classification of social reintegration in Greece

The most common concepts used in the studied literature for describing *social reintegration interventions* were the following:

- Social reintegration centres (normally a semi-residential setting as the client stays in a hostel at night but does not receive treatment)
- Vocational training centres
- Social reintegration unit (used for subjects in or after substitution treatment)
- Subsidised employment (a labour market grant for helping former drug users enter the labour market)

Availability of social reintegration facilities in Greece

Current availability of social reintegration in Greece

In 2000 there were three main providers of social reintegration services in Greece.

Firstly, KETHEA ran their own social reintegration services. These were carried out from various physical settings and had a total treatment capacity of 130 treatment slots. However, due to great demand there was an average of 147 subjects occupying these 130 slots. Such social reintegration primarily took place in a 'semi-in-patient' setting with former drug users living in a hostel without receiving either medical or psycho-social treatment there. Clients stay in hostels until they are settled and/or have found a job.

Secondly, OKANA ran three social reintegration units. One was named the 'Vocational Training Centre' and opened in April 2000 with a capacity of 90 slots. A second social reintegration unit was opened in September 2000 with 50 treatment slots for subjects having completed substitution treatment or attending methadone maintenance. The third social reintegration unit of OKANA opened in 1999 in Western Greece with 30 slots for former drug users who have completed treatment in the outpatient therapeutic programme "GEFIRA".

Lastly, the Ministry of Labour launched a reintegration project which aimed to reintegrate ex-addicts in the labour market by subsidising vacancies. 300 such posts were earmarked for employment in the private sector and 120 for self-employment.

Moreover, NA (Narcotics Anonymous) is represented with 15 different groups in 5 cities across Greece. Obviously however there is no data on how many subjects NA have had contact with. Furthermore there are two other reintegration services from the "Drug Dependency Unit "18 ANO" and the Therapeutic Programme "ARGO", which state that they have 'no limit' of treatment slots.

In summary, *there were 720 counted and dedicated social reintegration slots by September 2000* plus an unknown number in other services (plus NA). However, most of these slots were launched during 2000 and had not really become established. Demand did not appear to meet supply as, for instance, the KETHEA service reported that it exceeded its capacity for the fourth consecutive year. OKANA plans to launch two additional social reintegration programmes (one in Athens and one in Thessaloniki) in the near future.

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Classification of and concepts in drug treatment facilities in Spain

National context

The central Spanish drug policy paper is the Spanish National Drug Strategy '*Estrategia Nacional sobre Drogas*' (which is a Royal decree approved by the Spanish government). Regarding treatment it states that by 2003 there will be a network to offer resources and guarantee full cover for drug addiction. It furthermore states that this network will consist of three different types of programme, namely drug-free programmes, harm reduction programmes (which includes substitution treatment) and lastly programmes targeted at special sections of the population. We will not make any attempt to assess the drug strategy but will instead take a closer look at the terms used to describe treatment interventions in Spain.

Current classification in Spain

The closest we come to a treatment inventory for Spain is issued by *Plan Nacional sobre Drogas* and is called '*Memoria*'. For this classification exercise we will use the 1999 '*Memoria*' which, amongst other things, lists the drug-related activities and programmes carried out in the Spanish regions ('*Comunidades Autónomas*'). The terminology is - with a few exceptions - quite standardised and the most commonly used definitions and concepts are the following:

- Drug-free treatment
 - Outpatient treatment centres ('*Centros ambulatorios de asistencia*')
 - Day therapy centres ('*Centros de día terapéutico*')
 - Detoxification hospital units ('*Unidades hospitalarias de desintoxicación*')
 - Therapeutic Communities ('*Comunidades terapéuticas*')

- Substitution treatment
 - Health centres ('*Centros de salud*')
 - Mental health centres ('*Centros de salud mental*')
 - Specialised drug centres ('*Centros de tratamiento específico de drogodependencias*')
 - Pharmacies ('*Oficinas de Farmacia*')
 - General hospitals ('*Hospital General*')
 - LAAM (this was only launched as a pilot project)

These categories are however too numerous considering our aim of trying to apply similar terminology across EU countries. We shall therefore put some categories into one term only and order them as follows:

- Drug-free treatment
 - Outpatient treatment (covering outpatient treatment centres and day therapy centres)
 - Inpatient treatment (covering therapeutic communities)
 - Detoxification units (covering detoxification hospital units)

- Substitution treatment
 - Specialised drug centres (covering health centres, mental health centres, specialised drug centres, general hospitals and LAAM).
 - Pharmacies

Availability of drug treatment facilities in Spain

National context

Regarding drug treatment facilities the Spanish National Drug Strategy states that by 2003 there will be 'full specialised outpatient care for those affected by the problem of drug addiction'. It also states that a system of quality indicators will be in place in order to assess the treatment programme.

Current availability of drug treatment in Spain

The publication '*Memoria*' by *Plan Nacional sobre Drogas* provides data on the availability of drug treatment in each of the Spanish regions ('*Comunidades Autónomas*'). For each region there is information on the number of units in various intervention areas but only in a few cases on the numbers of treatment slots. The quality of the available data allows us to arrive at the following overview:

Table 1: Availability of drug-free treatment facilities in Spain

Treatment setting	Treatment units	Treatment slots [^]
Outpatient treatment	490	No data
Inpatient treatment	101	2697+
Detoxification	56	216+
<i>Total</i>	647	----

[^] = some services provide no information on the number of slots and the figures above are consequently represent a minimum.

Unfortunately many outpatient treatment centres provide no information on treatment slots (there are figures regarding users who have been in contact with services but not on the availability of treatment slots).

Table 2: Availability of substitution treatment facilities in Spain

Delivery settings	Treatment units
Specialised drug centres	625
Pharmacies	575
<i>Total</i>	1200

There is no information available on the total number of substitution treatment slots, but there is information on how many people have been in substitution treatment over the course of a year. In 1999 there were 72 236 people receiving methadone treatment in Spain and 206 receiving LAAM (which has now been abolished due to a European-wide market suspension of LAAM).

Virtually all outpatient treatment centres, with or without substitution treatment, are publicly owned. The picture is slightly more complex with regard to drug-free inpatient treatment and this is reflected in the following table:

Table 3: Ownership of drug-free inpatient treatment facilities (TC's) in Spain

Ownership	Treatment units	Treatment slots [^]
Public	26	801
Private	75	1896+
<i>Total</i>	101	2697+

[^] = some services provide no information on the number of slots and the figures above consequently represent a minimum.

As can be seen above, some two-thirds or three-quarters of drug-free inpatient treatment takes place in settings which are privately owned and run. The vast majority of them are however dependent on public funding (the authorities' payment when they send/refer drug addicts for treatment).

Prevalence of problem drug use, treatment demand and treatment availability

There are estimated to be between 83 972 and 177 756 drug addicts in Spain. Furthermore, we know that there were 6 101 people in treatment in Therapeutic Communities and that 77 199 people have been in contact with drug-free outpatient centres during the course of 1999. What we do not know however is the exact number of double-counts (or in other words, how many were first counted at one treatment centre and later at a second treatment centre). However, we do know that it is high as many drug addicts first establish contacts with the drug-free outpatient centres and are later referred for either methadone treatment or to Therapeutic Communities. In summary we know that at least 77 199 drug addicts have been in contact with drug services in the course of 1999; this implies that *between 43 and 92 % of all drug addicts in Spain have been in contact with drug treatment services during 1999.*

Evaluations of treatment services (and possible success rates)

One study from Barcelona showed using Cox-regression that drug addicts not taking methadone had a much higher mortality rate than those taking methadone.

Summary

- The main bulk of drug treatment in Spain is outpatient methadone treatment.
- Spain seems to reach a relatively high proportion of its problem drug use population.
- Outpatient treatment services are almost all public whereas Therapeutic Communities are most often owned and run privately.

Classification of and concepts in (social) reintegration in Spain

National context

Social reintegration (*'Integración Social'*) is mentioned in the *'Estrategia Nacional Sobre Drogas'* although there is no specific definition of the difference between treatment and social (re)integration. Part of the reason for this might be that the strategy mentions the establishment of a complete treatment system. This might imply both treatment as well as social reintegration. The strategy paper states that the system allowing treatment for all who would need it should be ready by 2003. It furthermore states that ongoing evaluation of services is a means to ensure the quality of the aid provided at the treatment centres.

Current classification of social reintegration in Spain

The concepts and terms used to describe interventions in the field of social reintegration in the publication *'Memoria'* (where they use the term *'incorporación social'*) from Plan Nacional Sobre Drogas are as follows:

- Therapeutic Communities with reintegration activities (*'centros terapéuticos con actividades de reinserción'*)
- Therapeutic Communities with reintegration programmes (*'centros residenciales con programas reinserción'*)
- Housing (*'apoyo residencial'*)
- Employment (*'integración laboral'*)
- Education (*'formación'*)

Availability of (social) reintegration facilities in Spain

Unfortunately the treatment and social reintegration inventory from Spain (*'Memoria'*) does not give sufficient information to determine exactly the number of units that provide such services, let alone the number of treatment slots. What does remain clear is that social reintegration is an intervention which is mentioned explicitly in drug plans and which exists in all Spanish regions.

Evaluations and evaluation findings

An EDDRA-entry from Barcelona named 'Individual Social Reintegration Allowance' found that not only did the participants actually improve their skills, but they also felt that the training programme had increased their chances of employment.

Sources

National Report from Spain (especially chapter 9.4 on after-care and re-integration, chapter 9.3 on Treatment services, chapter 3.1 on Treatment Demand Indicator and chapter 8.1 on Strategies in demand reduction at national level).

Memoria 1999. Plan Nacional Sobre Drogas. Ministerio del Interior.

EDDRA-entry: ' Pilot Programme for Individual Social Reintegration Allowance'.

Estrategia Nacional Sobre Drogas 2000 - 2008.

Presentation by Teresa Brugal representing Spain at a conference on mortality at EMCDDA premises 2001.

Classification and concepts in drug treatment facilities in France

National context

One important point on the classification of drug treatment in France is that the term *prevention* is often used for interventions that would normally be classified as secondary or even tertiary prevention (in other words, treatment and harm reduction). The difficulty for our classification however is that these units also offer what could be considered primary prevention (such as handing out leaflets and brochures about drug abuse as well as organising professional training). The secondary prevention centres provide what is normally named 'receipt and guidance' (*accueil et orientation*) and the tertiary prevention services are normally called 'harm reduction' (*Réduction des risques*). In this overview, secondary prevention centres/treatment units will be covered.

Current classification and availability of drug treatment facilities in France

The drug treatment facilities include the structures financed by the General Health Department for fighting drugs. Since a decree of June 29, 1992, all specialised state-financed structures have been given the generic name Specialised Drug Addiction Treatment Centres (CSST) - for both inpatient and outpatient centres. Since the decree, these structures have been responsible for jointly providing medical-social and socio-educational treatment.

Specialised centres can be run by private associations or by public institutions (public hospitals).

Three key types of treatment centres can be defined:

- Outpatient treatment centres
- Reception areas
- Inpatient treatment centres

Regarding substitution treatment there are two substitution substances that are widely used, namely:

- Buprenorphine
- Methadone

Availability of drug treatment facilities in France

National context

The central policy paper in the drugs field is the three-year work plan named 'Fight against drugs and prevention of addictions' (*Plan triennal de lutte contre la drogue et de prévention des dépendances*), which was produced and released by the central French drug body MILDT (*Mission Inter-ministérielle de Lutte contre la Drogue et la Toxicomanie*). Despite the title which emphasises prevention, this work plan also addresses treatment issues and stresses the importance of a more equal distribution of treatment facilities alongside the need for further attention to social and professional monitoring during treatment.

MILDT is the French drug coordination body and coordinates drug efforts horizontally between ministries as well as vertical coordination with regional and local levels. The three year work plan foresees a project manager (*Chef de Projet*) in each region to deal with drug coordination. This 'regional project manager' works within DASS (*Direction Départementale des Affaires Sanitaires et Sociales*) and covers both treatment and prevention issues.

Current availability of drug treatment in France

The following information on availability of drug treatment in France has been collected through the French National Focal Point with data having been collected in the course of 2001. The information provided is broken down according to our earlier established categories and shows the following:

Table 1: Availability of drug treatment facilities in France (in treatment units)

Types of intervention (<i>secteur d'activité</i>)	Number of treatment units
Outpatient treatment centres	201
Reception areas	85
Inpatient treatment centres	46
Total	332

It is important to note that the data in the table above is for treatment units and that it is presently impossible to say anything about the number of treatment slots under each of the categories. The 85 so-called 'reception areas' are run by outpatient treatment centres but are detached units with specific tasks which is why they have been counted separately.

Regarding substitution treatment, the figures are provided by the French focal point (and are to be published in the OFDT report 'Drugs and addiction, indicators and trends, 2001'). The figures presented below are estimates and are calculated using sales figures of methadone and buprenorphine divided by the estimated average daily prescribed doses of these treatments. The 'snapshot' below of subjects in substitution treatment was made **in March 2001**.

Table 2: Number of subjects in substitution treatment

Substitution substance	Number of subjects	Percentage
Buprenorphine	74000	88%
Methadone	10000	12%
Total	84000	100%

As can be seen above, unlike any other country in the European Union; the bulk of substitution treatment in France takes place using buprenorphine. Substitution treatment has increased rapidly since its launch in 1995-1996 but must be expected to slow down slightly as the coverage seems to be rather extensive – especially if compared to other countries. Buprenorphine substitution treatment is mostly provided by general practitioners but also by

specialised centres. Methadone treatment has to be implemented in a specialised centre. General practitioners can only prescribe methadone to patients who have already started their treatment in the specialised centres.

Prevalence of problem drug use, treatment demand and treatment availability

The estimated number of problem drug users (opiates or cocaine users) in France is believed to be between 150 000 and 180 000. Due to the nature and quality of data the only comparison that can be made is with substitution treatment. Comparing 84 000 in substitution treatment with an estimated problem drug using population of 142 000 to 176 000, the conclusion is that roughly *between 47 and 59% of problem drug users are reached by substitution treatment services* (this is through general practitioners in 85% of cases).

From the TDI, we know that there were 17 124 treatment demands³ in November 1999 in the specialised centres and that 5 858 of these were first treatment demands. For the whole year, specialised centres declared around 64 000 treatment demands⁴. However, as there is no information on availability of treatment measured in terms of slots, no comparison - however prudent - of this data can be carried out.

Evaluation of treatment services (and possible success rates)

The evaluation of public policies is one of the priorities defined in the guidelines of the inter-ministerial plan. In order to implement this MILDT has commissioned the French OFDT to make an active contribution to the task. However, findings are now presented in the French national report on this issue.

Classification, concepts and typology of (social) rehabilitation in France

Note that the term *social* rehabilitation is not used in the studied French literature. As with drug treatment facilities, social reintegration facilities are financed by the General Health Department on the Fight against Drugs (they are part of same system, not a separate one).

The concepts used for describing social reintegration interventions/facilities are as follows:

- Therapeutic apartments (*'Appartement thérapeutique'*)
- Transitional or emergency housing (*'structures d'hébergements de transition ou d'urgence'*)
- Host families (*'familles d'accueil'*)

Therapeutic apartments are designed to help drug users regain their independence. Currently, they are reserved for individuals who are experiencing serious health and social difficulties. These apartments may also be used as emergency or transitional housing, where treatment can be provided by enabling users to have a "break," stabilise detoxification or substitute treatment, or wait for a more stable housing environment. This housing is also available to drug users who have recently left prison, or for those who have been given an alternative to incarceration.

The *transitional or emergency housing* consists of a short stay of one to four weeks according to the medical and social needs of the person. A socio-educational and/or medical

³ Definition of cases in the French system of data collection on treatment demand includes all people in treatment during the month or the year and not only new cases of treatment.

⁴ which includes a certain proportion of double counting

accompaniment is also envisaged. This type of housing is especially useful for people suffering from a significant marginalisation – such as those leaving prison or those where alternatives to prison have been used.

Reintegration through *Host families* is an intervention that dates back to the late 1970s. The target group of these interventions varies (single, with children, separated, in substitution treatment, on trial, etc.) and so too does the duration of stay (from a weekend up to 9 months).

Availability of (social) reintegration facilities in France

In 1999 there were the following social reintegration facilities available in France:

Table: Number of social rehabilitation units in France

Type of social rehabilitation intervention	Number of reintegration units	Number of reintegration slots
Therapeutic apartments	86	422
Transitional or emergency housing	18	134
Host families	20	116
Total	124	672

Since 1999 reintegration has been subject to increasing political attention and the French Directorate-General of Health now believes that there are around 1250 reintegration slots in France (no information is available on the breakdown of these slots).

Summary

- The main bulk of treatment availability is buprenorphine outpatient treatment.
- Substitution treatment coverage seems to be quite high.

Sources

French national report (especially chapter 9.3 on treatment services, chapter 3.1 on Treatment Demand Indicator, chapter 9.4 on after-care and reintegration, and chapter 8.1 on strategies in demand reduction at national level).

Drogues et dependences, Indicateurs et tendances, OFDT, à paraître en décembre 2001.

Plan Triennal de lutte contra la drogue et de prevention des dependance 1999 - 2000 – 2001. Released by MILDT, June 1999.

Unpublished Excel-sheet from France on Treatment Demand Indicator.

Morel, A., Hervé F. and Fontaine, B.: *Soigner les toxicomanes*. Released 1997, Paris. ISBN 2 10 003262 3.

'Measuring the roles, structures and cooperation of drug demand reduction services: Results of a preliminary study'. Unpublished EMCDDA-report prepared by RAND Europe, 2000.

Classification of and concepts in drug treatment facilities in Ireland

National context

The central Irish drug policy paper is actually two; namely one paper outlining the state of the art regarding drugs and another one setting objectives and key performance indicators. The National Drug Strategy operates with four pillars, namely; Supply reduction, Prevention, Treatment and Research. There are two objectives under treatment which can be said to be complementary. The first objective is the ultimate aim of leading a drug-free lifestyle and the other aim is to minimise risk for those who continue to engage in drug-taking. There is no further explanation of what treatment implies and no breakdown of treatment activities in the drug policy paper.

Current classification in Ireland

According to the treatment inventory '*Directory of Alcohol, drugs and related services in the Republic of Ireland*' the treatment interventions can be divided into the following *treatment facilities*:

- Inpatient
- Outpatient

Although the inventory also includes a glossary there is no further information on what these categories actually cover.

Availability of drug treatment facilities in Ireland

National context

The aforementioned Irish drug policy paper '*Ireland's National Drugs Strategy 2001 - 2008*' breaks down the two treatment objectives into seven key performance indicators. Regarding availability of treatment the objective is to increase treatment places (what we normally call slots) to 6000 by the end of 2001 and 6500 places by the end of 2002. Another more qualitative key performance indicator regarding treatment availability, is to ensure immediate access for drug abusers to professional assessment and counselling followed by the commencement of treatment.

Current availability of drug treatment in Ireland

The treatment inventory '*Directory of Alcohol, drugs and related services in the Republic of Ireland*' gives information at unit level about the kinds of addiction addressed and about the settings (although the inventory denotes them as treatment facilities) in which they take place. Almost all treatment units report treatment in more than one setting, e.g. both outpatient and inpatient. Based on the treatment inventory we can see the following overview for Ireland in 2000:

Table 1: Availability of drug treatment facilities in Ireland

Treatment setting/facilities	Addiction treatment units [^]	Drug treatment only units
Inpatient	27	2
Outpatient	50	8
<i>Sub-total</i>	<i>77</i>	<i>10</i>
<i>Minus double-counts</i>	<i>14</i>	<i>1</i>
Total	63	9

[^] which includes drug treatment.

As can be seen, all 64 treatment units report having counselling services and almost all report having advisory services as well.

In addition to the treatment units above, General Practitioners play an important role in Irish treatment provision as they carry out the delivery of substitution treatment services. In order to be acknowledged as carrying out substitution treatment, General Practitioners must undergo specialised training. The number of General Practitioners involved in substitution treatment has risen from 58 in 1996 to 97 in 1998, and by 2000 the number had grown to 158.

Substitution treatment in Ireland means methadone treatment and those receiving it are registered in the Central Methadone Treatment List. By the end of 2000, 5032 people were receiving methadone treatment in Ireland.

Prevalence of problem drug use, treatment demand and treatment availability

According to the most recent estimate in 1996 there were between 10655 and 14804 problem opiate users. This number obviously does not count all problem drug users in Ireland, but the majority of Irish problem drug users are in Dublin and they are believed to be predominantly opiate users. If we compare that with the 5032 in methadone treatment we see that between 34 and 59% of the problem drug users are in methadone treatment. In addition there is an unknown number in drug-free treatment (be it outpatient or inpatient).

The total number of treatment demands collected through the Treatment Demand Indicator in 1999 was 4277. This however is not comparable with treatment availability due to the lack of data on availability of treatment slots.

Evaluations of treatment services (and possible success rates)

Aiséirí is a drug free centre which provides a 30 day inpatient programme and a 2 year aftercare system for people who are dependent on alcohol and/or drugs. An evaluation showed that as many as 60% of clients were abstinent after completion of the 30 day inpatient programme. The evaluation also found that three-quarters of those who agreed to be interviewed (122 - a 58% response rate) reported improvements in the quality of their life.

Classification of and concepts in (social) reintegration in Ireland

The aforementioned treatment inventory '*Directory of Alcohol, drugs and related services in the Republic of Ireland*' also has data about (social) reintegration which, combined with information from the National Report, gives us the following types of reintegration:

- Halfway house
- After Care
- Employment programmes

The inventory also includes a glossary which defines after care as 'Ongoing supportive programme'. There is no further information on what these categories actually cover.

Availability of (social) reintegration facilities in Ireland

National context

The aforementioned central Irish drug policy paper also covers (social) reintegration. One key performance indicator on social reintegration states that each Health Board Area must have a rehabilitation option as part of a planned programme of progression for each drug abuser by the end of 2002. The other key performance indicator states that stable drug abusers must be provided with training and employment and that these measures must be increased by 30% by the end of 2004.

Current availability of drug-related (social) reintegration facilities in Ireland

Based on the earlier mentioned treatment inventory and the Irish National Report we can see the following overview of (social) reintegration facilities in Ireland:

Table 2: Availability of (social) reintegration facilities in Ireland

Type of reintegration	Addiction reintegration units	Drug reintegration units
Halfway house	4	0
After Care	53	9
Employment	0	2
Minus double counts	3	0
Total	54	11

Note that the units listed above are not additional to the ones listed in the overview of treatment availability but are simply those treatment centres that report carrying out reintegration activities (the exception being the two employment programmes).

One of two employment programmes has been set up by the Eastern Health Board (Dublin) and is called '*Soilse*'. This aims to reintegrate (former) drug users through employment, vocational training and education. The other employment programme is run by the state training agency, FAS, which aims to reintegrate long-term unemployed - a number of slots are reserved for (former) drug users.

Summary

- The bulk of drug treatment in Ireland takes place in outpatient settings and most of this is substitution treatment.
- Most drug treatment in Ireland takes place in institutions carrying out treatment of general addiction.

Sources

National Report on Drug Issues - Ireland 2000. (Unpublished internal report) Written by Rosalyn Moran, Mary O'Brien, Lucy Dillon and Eimear Farrell. Issued by the Drug Misuse Research Division in 2000.

EDDRA entry named '*Aiséirí - Irish for New life hope freedom*' found at: <http://www.reitox.emcdda.org:8008/eddra/>

'Directory of Alcohol, drugs and related services in the Republic of Ireland'. Compiled by Sally Edwards. Published by the Health Promotion Unit, Dublin, 2000.

'Building on Experience - National Drugs Strategy 2001 - 2008'. Issued by the Department of Tourism, Sport and Recreation, 2001.

'Ireland's National Drugs Strategy 2001 - 2008'. Issued by Government of Ireland, 2001.

Classification of and concepts in drug treatment facilities in Italy

National context

The Italian drug treatment system is a rather systematic arrangement with two well-defined parallel sub-systems.

Firstly there are the so-called 'SerT's' (*'Servizio Tossicodipendenze'*) and secondly there are the Therapeutic Communities (*'Enti Ausiliari'*).

The *SerT's* are public drug treatment units carrying out mainly *outpatient treatment* and are a part of the 'national health system' (NHS) (*'Sistema sanitario Nazionale'*). The financing of the NHS is a responsibility of the Regions, which take equal care of the actual management of the units. Almost all interventions carried out at SerT's are outpatient. They are not necessarily treatment and can also be reintegration interventions. Unfortunately the data does not distinguish between treatment and rehabilitative interventions, which makes it impossible to split the data from the two intervention areas.

A last central characteristic of the SerT's is that they are the main provider of substitution treatment. In order to be allowed to prescribe substitution substances, General Practitioners must agree to use specific prescription modules which are available from their Professional College (*"Ordine dei Medici"*). They must also adopt specific practices for handling drugs to avoid, for instance, thefts or diversion. General Practitioners have been allowed to prescribe substitution substances for the last few years and GP involvement is apparently still very low.

There are also the so-called 'Reintegration structures' (*'Strutture riabilitative'*) often also called Therapeutic Communities (*'Comunità Terapeutiche'*). These Communities/Structures are mostly *private* and most of them are non-profit organisations. They carry out in-patient treatment although there are also semi-residential and outpatient services. Generally speaking, referral to Therapeutic Communities is made by the SerT's which thereby 'authorise' the Local NHS Unit to pay the fees for the duration of the client's stay in the Therapeutic Community. This is, however, only a rule of thumb - Italy's biggest Therapeutic Community, San Patrignano, (which is also one of the world's biggest) does not charge the SerT's but instead finances its activities through sponsorship and the sale of goods produced there. They also obtain some funds by working against AIDS.

Despite its name 'Reintegration structures' does not only refer to units reintegrating former drug users into society; in fact this is a mere fraction. Instead it generally applies to the whole range of in-patient intervention. Similarly to the SerT's, it is not possible to distinguish between treatment and reintegration. Consequently there will not be a separate classification of reintegration efforts or a separate paper on social reintegration.

Current classification in Italy

In view of the above, the first overall distinction that has to be made in Italian drug treatment is between:

- Public treatment services (in the SerT)
- Private treatment services (in the 'Rehabilitative structures')

The *settings* in the private treatment services are sub-divided into:

- In-patient ('*Residenziale*')
- Semi-residential
- Outpatient ('*Ambulatorio*')

The interventions carried out in both public and private services can be broken down into the following *types of treatment* ('*tipologia di trattamento*'):

- Psycho-social treatment, sub-divided into,
 - Psychological support
 - Psychotherapy
 - 'Social service intervention' ('*Interventi di servizio sociale*')
- Pharmacological, sub-divided into,
 - Methadone on short-term basis
 - Methadone on medium-term basis
 - Methadone on long-term basis
 - Naltrexone
 - Clonidine
 - Other non-substituting medicinal product (or in other words, other antagonist)

Please note the term 'pharmacological' which covers both substitution substances and non-substitution substances such as Naltrexone (an antagonist) and Clonidine (for the adrenaline system - it reduces abstinence syndromes).

Availability of drug treatment facilities in Italy

National context

Italian drug policies are the result of enforcement of various Italian drug laws, of which the most central is the 1990 national law DRP n. 309/1990. This, amongst other things, sets out the objectives for drug services. These objectives were revised in 1999 by the law 45/99 which, for instance, states the importance of having services evenly spread, geographically.

Regarding admissions criteria, SerT's are intended to be open institutions that must not discriminate in accepting potential clients. When clients contact SerT's they are required to undertake a health check, including checks for any infectious diseases. A multi-disciplinary assessment is then carried out and on that basis the client will be allocated to the appropriate treatment.

Current availability of drug treatment in Italy

The following snapshot covers data as at 31st of March 1999. Data was provided by Italian National Focal Point through its national report and was collected via a census carried out by the Central Directorate for Documentation of the Ministry of the Interior.

The following table refers to the division of treatment facilities in the private sector by *setting*:

Table 1: Availability of private drug treatment in Italy

	Number of units	Number of treatment slots
In-patient	857	19044
Semi-residential	252	5015
Outpatient	266	No info.
<i>Total</i>	<i>1375</i>	<i>26059+</i>

Aside from this information on the availability of treatment, there is also information on how many clients were actually in contact with these treatment services during 1999. 19426 clients had contact with these services and, of these, 73,3% were in drug-free treatment (14246 clients). The remaining 26,7 percent received some kind of pharmacological support spanning short-term, mid-term and long-term methadone treatment over Naltrexone to other non-substitution substances. The biggest single group was short-term methadone treatment which applied to 38% of those receiving pharmacological treatment or 15% of the whole treated population.

There is unfortunately no information on the number of treatment slots in public drug services. The following figures on treatment in SerT's apply to the percentage of clients actually in treatment during 1999. The overview is based on data from the Ministry of Health publication 'Activity report for the drug sector 1999' ('Rilevazione attività nel settore tossicodipendenze anno 1999').

The division of the 123255 clients in treatment during 1999 was as follows:

Table 2: People in public outpatient treatment facilities in Italy during 1999 (by percentage)

Type of treatment	Psycho-social or Pharmacological	'Break-down'
Psycho-social treatment, sub-divided into	30	
- Psychological support		10
- Psychotherapy		4
- 'Social service intervention'		16
Pharmacological, sub-divided into	70	
- Methadone on short-term basis (<30 days)		10
- Methadone on medium-term basis (30d. - 6m.)		13
- Methadone on long-term basis (>6 months)		31
- Naltrexone		5
- Clonidine		3
- Other pharmacies non-substituting		8
<i>Total</i>	<i>100</i>	<i>100</i>

The figures above are slightly simplistic as many clients do in fact receive pharmacological treatment alongside psycho-social treatment. Clients are classified according to the presence

of pharmacological treatment or not. If there is no pharmacological treatment they are classified under psycho-social treatment. While this allows a quite precise counting of clients in treatment by intervention type, it makes it impossible to calculate how many clients receive both psycho-social support and substitution treatment. Bearing these circumstances in mind, the above table shows that the main bulk of outpatient public treatment in Italy is in pharmacological treatment and that the main bulk within pharmacological treatment is methadone, especially on a long-term basis.

According to the table 54 percent received some form of methadone treatment which is equivalent to around 66550 individuals. If non-substitution substances are included there were 70 per cent - equivalent to around 86350 - in some kind of pharmacological treatment.

Other than the previously mentioned treatment centres there are also hospitals that carry out detoxification. However, the number of drug addicts in a hospital setting is generally believed to be low.

Prevalence of problem drug use, treatment demand and treatment availability

The estimated number of problem drug users in Italy is believed to be between 277000 and 326000. If that number is compared with the total number in treatment in the course of a year, (a total of 142651 subjects) this suggests that *roughly 44 to 51% of the drug abusing population was in contact with treatment services.*

Comparing treatment demand with treatment availability is only possible for the private treatment services, and must nevertheless be done with great caution. There were a total of 26059 in-patient or semi-residential treatment slots in the private sector plus an unknown number of slots in the 266 outpatient treatment centres. These numbers must be compared with the 19426 clients that were in contact with these services, suggesting that there was no shortage of potential treatment slots ('potential' because this number says nothing about the number of drug addicts in SerT's who wanted to go to private treatment centres but couldn't because of lack of means). Unfortunately there is no information on waiting lists or other data that sheds light on whether the means of the SerT's was sufficient to meet treatment demand.

Evaluations of treatment services (and possible success rates)

One of the biggest ever treatment outcome studies has been launched as a joint project between the Ministry of Health, Turin University and the agency on Public Health of the Lazio Region. The study is called VEdETTE (*'Valutazione dell'Efficacia dei Trattamenti per la Tossicodipendenza da Eroina'*) and its first research findings are due in autumn 2001.

Another large-scale survey was on the quality of services delivered by SerT's. This study, coordinated by Regione Emilia-Romagna, was aimed at evaluating treatment outcomes according to the following criteria, amongst others: retention rates, quality of life and criminal behaviour.

According to the Italian national report, various evaluation and customer satisfaction surveys have been carried out during the last few years. The national report states that a common finding of these studies has been the importance of regular and specific information sharing and staff team development. Also studies find the need for regular training to develop both the motivation to change and to ensure that service provision utilises the most effective treatment methodologies.

Classification of and concepts in social reintegration in Italy

Unfortunately the data from Italy does not allow for a split between social reintegration and treatment - please see the paper on treatment classification in Italy.

Availability of social reintegration facilities in Italy

Unfortunately the data from Italy does not allow for a split between social reintegration and treatment - please see the paper on treatment availability in Italy.

Summary

- The main bulk of treatment in Italy is in outpatient treatment
- The main bulk in outpatient treatment is in substitution treatment
- Services appear to reach a relatively high proportion of drug addicts
- There does not appear to be a shortage of treatment facilities

Sources

The State of the Drug Problem in Italy (1999). Issued by Osservatorio Italiano delle Droghe e delle Tossicodipendenze in 2000.

'Relazione annuale al parlamento sullo stato delle tossicodipendenze in Italia anno 1999'. Issued by the 'Presidency of the Council of Ministers' (*'Presidenza del consiglio dei Ministri'*) and 'Department of Social Affairs' (*'Dipartimento per gli affari sociali'*).

'Rilevazione attività nel settore tossicodipendenze anno 1999'. Issued by the office on drug and pharmacological dependency (*'Ufficio dipendenze da farmaci e sostanze d'abuso e AIDS'*) under the Ministry of Health. Rome, November 2000.

Unpublished Excel spreadsheet from Italy on Treatment Demand Indicators.

Classification of and concepts in drug treatment facilities in Luxembourg

Not surprisingly, Luxembourg being a small country does not have a very wide spectrum of treatment variation.

The closest publication to a national drug treatment inventory is 'Aid and prevention structures for drug addicts' (*'Structure de prévention et d'aides aux toxicomanes / Einrichtungen im bereich forschung, prävention und suchtkrankenhilfe'*) which is issued by the Grand Duchy of Luxembourg. In this publication, treatment interventions are broken down into the following sub-categories:

- Outpatient treatment (*'Centre de consultation / Beratungsstellen'*), and,
- In-patient treatment (*'Structures stationnaires / Stationäre einrichtungen'*)

There are two substances that are widely used for substitution treatment, namely;

- Methadone, and,
- Mephenon (methadone in a non-soluble pill form)

Availability of drug treatment facilities in Luxembourg

Current availability

Being a small country, Luxembourg, possesses only a few drug treatment units.

According to the aforementioned treatment inventory, there are *five outpatient treatment centres* of which three are run by the state-funded Foundation for Youth and Drugs Aid (*'Fondation Jugend an Drogenhëllef'*) also known as JDH. Of these three units, two focus on 'social assistance' and preparation for time in therapeutic communities, while the third is a substitution treatment unit, with or without psychological consultation.

Additionally, the NGO 'Aid for drug addiction youth and family support' (*'Hëllef fir drogenofhängeg Jugendlech an hir Familjen'*) runs the Centre Emmanuel consultation centre. Centre Emmanuel offers outpatient treatment not only to drug addicts but also to their relatives. The centre cooperates closely with the Italian treatment community '*Comunità Emmanuel'* to which clients can be transferred after a given period in outpatient treatment.

The final provider of outpatient services is Médecins Sans Frontières, whose services are not exclusively for drug addicts. Interventions cover both psycho-social support as well as training.

There is no further information on the number of treatment slots in outpatient units mentioned above.

There are *three in-patient treatment units* in Luxembourg, or more accurately, one in-patient detoxification unit and two therapeutic communities. *Centre Hospitalier Neuropsychiatrique* (CHNP) provides in-patient detoxification with possible referral to follow-up either in the national substitution treatment programme or in a drug-free programme. The therapeutic community *Syrdall Schloss* (sometimes referred to as *Manternach*) and *Wessekaer* offer long-

term in-patient drug-free treatment. There is no further information on the number of treatment slots in the in-patient units mentioned above.

Substitution treatment takes place in two major ways. Either through the national methadone programme (which is normally maintenance-based) or through general practitioners prescribing Mephenon®. According to the latest data collected through the national report and directly from focal point there were the following numbers of drug users in substitution treatment as at June 2001;

- 170 receiving methadone
- 700 (estimated) receiving Mephenon.

Prevalence of problem drug use, treatment demand and treatment availability

According to the latest prevalence estimates there are between 1900 and 2220 problem drug users in Luxembourg. The latest TDI-figures date from 1999 when there were 985 treatment demands (there is no information on first treatments for Luxembourg). The TDI in Luxembourg does not cover general practitioners, suggesting that there is a relatively large group of drug addicts being reached in one way or another (as the 700 Mephenon®- treated addicts are to be added to the 985). However, as always, the numbers themselves have to be interpreted with care, and consequently comparisons have to be made with equal prudence.

Evaluations of treatment services (and possible success rates)

The metropolitan methadone prescription programme has jointly been set up by the Ministry of Health and the 'Jugend- an Drogenhelfer'. The care provided in the substitution programme is long-term, 54% of the persons participated for more than 2 years in the programme. Two evaluations have been carried out, the first in 1990 and the second in 1992; both show a significant impact on the infection and mortality rate as well as on drug related crime figures.

Classification of and concepts in social reintegration in Luxembourg

National context

The four year Luxembourg drug action plan running from 2000 to 2004 (*'Plan d'action 2000-2004 en matière de drogues et de toxicomanies'*) refers for the first time to reintegration of drug addicts, (*'Structures post-thérapeutiques / Réinsertion socioprofessionnelle'*). Rehabilitation/reintegration measures did exist prior to the action plan but most are of relatively recent origin and the overall reintegration offers so far are few. Rehabilitation/reintegration activities are supervised by the Ministry of Health.

Current classification of social reintegration in Luxembourg

There are only a few rehabilitation/reintegration activities in Luxembourg. Those that exist fall into two of the categories that have been defined beforehand, namely:

- Education
- Housing

Availability of social reintegration facilities in Luxembourg

Presently there is only one reintegration project in Luxembourg (the term social has not occurred in studied literature). However, there are two more on the way.

The oldest of these three date back to 1995 and is normally denoted as the national after-care centre (*nachsorgehaus Neudorf/Maison de réinsertion Neudorf*). The population at this centre is mainly composed of patients who have successfully finished a therapeutic programme at the *Syrdall Schloss* therapeutic community. The after-care centre has six treatment slots and offers a place to stay plus psycho-social support for six to twelve months. The after-care centre is thought to be an integral part of the socio-professional reintegration strategy, but this strategy is yet to be implemented.

More recently, another housing project was set up in September 2000 with implementation envisaged for 2001. The project is financed by JDH (*Fondation Jugend- an DrogenHëllef*) and will offer accommodation facilities for up to ten former drug users.

There is no structured strategy for education and training but some professional training is taking place via in-patient drug agencies. However, the *Mondorf Group* is planning to establish a job opportunity network for former or current drug addicts.

Sources

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Classification of and concepts in drug treatment facilities in the Netherlands

National context

Generally speaking, most substance addiction treatment in the Netherlands is not sub-divided into units that are specialised in either drug treatment or alcohol treatment (and/or licit drugs). The overall and generic term used to denote substance addiction treatment in general is the commonly used term '*Verlavingszorg*', which means 'addiction care'.

Current classification in the Netherlands

According to the treatment inventory '*Adresgids Verlavingszorg 2000 - 2001*' interventions can be sub-divided into:

- Outpatient aid/treatment ('*Ambulante hulpverlening*')
- Semi-residential aid/treatment ('*semimurale hulpverlening*'), and,
- Inpatient aid/treatment ('*Intramurale hulpverlening*')

Availability of drug treatment facilities in the Netherlands

National context

A document named '*Drugs Policy in the Netherlands*' issued by the Ministry of Health, Welfare and Sport provides a historical overview of drugs in the Netherlands as well as a state of the art of the drugs field (from 1997). The paper states that the Netherlands spends more than 136 million Euros a year on facilities for addicts and that one of the aims of Dutch drug policy is to reach as many addicts as possible and to limit their risk behaviour. Implicitly the drug policy paper states that there should be no admission criteria (or in other words free admission criteria) to treatment services.

The Netherlands is one of the few countries in the EU, that has possessed since April 2001 the legal right to carry out coercive treatment and actually does do so. As these however are in a penal setting (detention or prisons) and not in the community they are not in line with our definition of treatment and will consequently not be covered here.

Current availability of drug treatment in the Netherlands

The treatment inventory '*Adresgids Verlavingszorg 2000 - 2001*' provides data on unit level for aspects such as address, opening hours, work areas, activities and target groups. In the cases where the required information is available it is consequently possible to classify whether interventions are targeted at substance addiction in general or specifically drug addiction.

Before we look at the actual availability of treatment, a couple of points have to be made regarding the counting of treatment units and slots.

Firstly, under semi-residential treatment, some treatment units report whether their treatment slots are outpatient or inpatient, whereas others do not specify. Therefore, the information presented in the table will only reflect the number of treatment slots but not detail whether this is in an outpatient or inpatient setting.

Secondly, under inpatient treatment, there is also sometimes information on the number of outpatient treatment slots ('*dagbehandeling*'). In order to maintain a clear distinction between outpatient treatment and inpatient treatment, outpatient treatment slots reported under inpatient treatment facilities have been counted and reported under semi-residential treatment.

Thirdly, some treatment units are registered under more than one kind of setting (for instance, under both semi-residential and inpatient treatment) and consequently a double count control of both treatment units and slots has been carried out.

Lastly, some treatment units have not reported how many slots they have at their disposal. So in order to ensure that these slots appear in our overview, although we do not know exactly how many slots there are, they have been marked with a '+'. A thorough count through the treatment units shows the following:

Table 1: Availability of drug treatment facilities in the Netherlands

Treatment setting	Substance addiction treatment		Drug treatment	
	Treatment units	Treatment slots	Treatment units	Treatment slots
Outpatient treatment	107	n.a.	34	n.a.
Semi-residential treatment	17	420+	5	51+
Inpatient treatment	57	1399+	3	36+
- <i>minus double counts</i>	13	65	1	0
Total	168	1762+'	41	87+'

' = The total is of semi-residential and inpatient treatment only.

As can be seen above, the majority of treatment slots are non-earmarked substance addiction treatment slots. It can also be seen that the majority of treatment units are in an outpatient setting, although unfortunately it is not known how many treatment slots these units have at their disposal (like other countries, outpatient treatment services do not think in terms of treatment slots as they can expand much more easily in case of need, than inpatient treatment facilities can).

It can also be seen that for a relatively small country with a small population, the Netherlands has a relatively fine network of substance addiction treatment services with more than 100 outpatient treatment units and 75 semi-residential or inpatient treatment units.

The latest available figure regarding substitution treatment is from 1997 and states that there were 11767 subjects receiving substitution treatment, either through General Practitioners or specialised centres.

In the field of substitution treatment a heroin trial has been carried out from 1997 to 2001. 625 addicts in six Dutch cities have been enrolled in the trial and the results should be available in December 2001.

Prevalence of problem drug use, treatment demand and treatment availability

There are an estimated 25000 to 29000 problem drug users in the Netherlands. As we do not possess numbers on outpatient treatment slots it is impossible to compare problem drug use with treatment availability. If we instead look at the Treatment Demand Indicator and compare that with problem drug use, we see that 26333 were in contact with treatment services during 1999. This number, if looked at on its own, suggests a treatment coverage rate of close to 100% which is very unlikely. However, there may be some double counts in the TDI figure (though we cannot know for sure how many). The earlier mentioned paper, *Drugs Policy in the Netherlands*, claims that treatment services reach an estimated 75% of all problem drug users, a number that seems high but not unrealistically high.

Evaluations of treatment services (and possible success rates)

Various evaluations of treatment interventions, notably substitution treatment, have been carried out in the last few years in the Netherlands. To our knowledge there has been no nationwide treatment evaluation study but a range of local studies.

One study aimed at measuring the effects of Naltrexone treatment in a specialised outpatient treatment setting. This was intended to gain knowledge on the effect of Naltrexone used first for detoxification and later for maintenance. The patients were urine-tested six months after detoxification and then again one year after detoxification. The evaluation showed that 58% were still abstinent after six months. One year after detoxification 55% were still abstinent. A closer look at the individuals showed that positive outcomes were lower for multi-drug users.

Classification of and concepts in (social) reintegration in the Netherlands

National context

Social rehabilitation is mentioned as an 'essential element' in the drug policy paper issued by the Ministry of Health, Welfare and Sport. Social rehabilitation is mentioned under 'Care' where it is also stated that the aim is to assist drug addicts in their efforts to rehabilitate. Regarding the implementation of this, the drug policy paper states that an extensive network of services has been established in order to achieve these aims.

Current classification of social reintegration in the Netherlands

The earlier mentioned treatment inventory *'Adresgids Verslavingszorg 2000 - 2001'* uses a variety of non-standardised terms to describe social reintegration intervention. However, the two most commonly used are after-care (*'Nazorg'*) and probation (*'reclassering'*) although other terms are used, such as, 'counselling for lodge-finding' (*'woonbegeleiding'*), ('short-stay project') , resocialisation (*'resocialitie'*), counselling (*'begeleiding'*), social recovery (*'maatschappelijk herstel'*), social skills training (*'sociale vaardigheidstraining'*), individual counselling for lodge-finding (*'individuele woonbegeleiding'*) and others. These terms are not defined and it is not clear whether these interventions are necessarily a last step in a treatment process or can be initiated at any convenient time. We shall consider the units that list the following interventions as social reintegration units:

- After care ('*Nazorg*')
- Probation ('*reclassering*')
- Resocialisation ('*resocialitie*')
- Counselling for lodge-finding ('*woonbegeleiding*')
- Individual counselling for lodge-finding ('*individuele woonbegeleiding*'), and,
- Social recovery ('*maatschappelijk herstel*'),

This is because the interventions above are either explicitly reintegration interventions or can be considered as a type of reintegration intervention corresponding to one of our three pre-defined categories, namely; employment, housing, education and training.

Due to the lack of standardised concepts we shall attempt no further breakdown of social reintegration interventions in terms of type of intervention in the Netherlands but merely detail information regarding the setting.

Availability of (social) reintegration facilities in the Netherlands

As a breakdown of the social reintegration facilities is not possible we can only provide an overview of services and centres that claim to provide social reintegration services.

It has to be noted that all of the services and centres listed below can already be found under 'availability of treatment' and are not additional centres.

Table 2: Availability of reintegration facilities in the Netherlands (in units)

Setting of reintegration services	Number of units reporting reintegration service
Outpatient	52
Semi-residential	11
Inpatient	26
- <i>minus double counts</i>	10
Total	79

Although the bulk of social reintegration facilities in the Netherlands are in outpatient settings, (like most other countries) the interesting point is that there are several inpatient or semi-residential units offering reintegration services too. This implies that there is seemingly a wider range of possibilities at the disposal of a (former) drug user who requests reintegration.

Evaluation

The evaluation of an employment project named *'Individual support and placement to obtain a competitive job for (former) addicts'* showed through self-reports that the situation for 60% of the participants had improved. Self-reported answers from the professionals in the employment project showed that cooperation between the stake-holding organisations and the (former) addicts had improved, thus raising the chance of finding employment.

Summary

- The bulk of drug treatment in the Netherlands take place in outpatient settings.
- Substitution treatment delivery is organised both through General Practitioners and specialised centres.
- Dutch treatment services seem to reach a high percentage of the problem drug using population.
- Drug treatment in the Netherlands, both in theory and practice, has a wide range of services spanning heroin substitution treatment, to semi-residential low threshold services and inpatient drug-free treatment.

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Classification and concepts of drug treatment facilities in Norway

National context

A central term in Norwegian treatment terminology is '*Rusmiddelmissbruk*' which literally means 'abuse of inebriants', or in other words, of drugs and/or alcohol. The importance of this term is reflected in the classification and conception of treatment facilities in Norway since only a few interventions are targeted exclusively and explicitly at illicit drug abuse. Much more often interventions are targeted at abuse as such - that is, for drugs and/or alcohol. Consequently it is impossible to speak of a national classification of drug treatment. The following attempt at classifying interventions will start by classifying abuse interventions and leaving out alcohol interventions when they are easily distinguishable from drug interventions.

In terms of legislation there are three central laws in the field of abuse treatment:

- The Social Services Act ('*loven om sosiale tjenester*'),
- The Hospital Act ('*lov om sykehus*'), and, lastly,
- The Psychiatric Health Protection Act ('*Lov om psykisk helsevern*').

All treatment units in Norway are founded on at least one of these laws.

Current classification of drug treatment facilities in Norway

The Norwegian National Focal Point, SIRUS (The National Research Centre on Alcohol and Drugs) has divided treatment interventions into the following categories:

- Psychiatric youth teams ('*psykiatriske ungdomsteam*')
- Inpatient treatment centres ('*institusjoner med døgntilbud*')
- Fraternity houses ('*Kollektiver*')
- Emergency units ('*akuttinstitusjoner*')
- Psychiatric institutions ('*sosialmedisinske/psykiatriske institusjoner*')
- Refuges and reintegration institutions ('*vernehjem og rehabiliteringsinstitusjoner*')

However, as these are not 100% compatible with our European definitions we shall redefine them as follows:

- Outpatient treatment (covering psychiatric youth teams and psychiatric institutions)
- Short-term inpatient treatment (covering emergency units)
- Long-term inpatient treatment (covering inpatient treatment centres and fraternity houses)

Refuges and reintegration institutions will be dealt with in the chapter on reintegration.

Regarding treatment capacity/availability the information is divided into the following three settings:

- Poly-clinical ('*Poliklinisk*')
- Outpatient ('*Dagbehandling*')
- Inpatient ('*Døgnbehandling*')

Although 'Poly-clinical' essentially refers to outpatient treatment, the two categories cannot be merged as their capacities are measured differently (poly-clinical is measured in hours and outpatient treatment is measured in treatment slots).

Substitution treatment is defined in treatment slots and is solely in the form of methadone treatment.

Regarding the 'treatment approach' ('*verdigrunnlag*', which means 'foundation of values', in the country overview and '*innhold*', meaning 'content', in the Oslo overview) there are two general concepts used to classify the treatment centres:

- Neutral ('*livssynsnøytralt*' – that is, no specific or explicit orientation)
- Religious (also covering Lutheran Social Welfare, or '*Diakonalt*', and Christian)

In terms of ownership the following categories are used by the Norwegian National Focal Point:

- State
- County
- Municipality
- Public foundation
- Private

Availability of drug treatment facilities in Norway

National context

The issue of drug treatment slots was first publicly addressed at a political level in a 1989-1992 action plan released by the Ministry of Social Affairs (*Sosialdepartementet*). Its aim, which was fulfilled, was to establish around 400 inpatient specialised drug treatment slots. Since then no more such treatment slots have been established. Drug treatment is also believed to occupy an increasing number of the 'non-earmarked' abuse treatment slots in Norway.

Current availability of treatment facilities in Norway

Much of the drug treatment in Norway is in fact treatment of abuse as such. In some cases however, it is possible to split the treatment units into those that are meant for the treatment of abuse as such and those aimed at the treatment of drug addiction (in some cases however it is not possible). Treatment targeted explicitly and exclusively against alcohol abuse has not been included in any of the following tables.

Applying the categories defined and identified in previous chapters we arrive at the following overview of treatment availability in Norway for the year 1999. We will first look at treatment units *divided by treatment setting*:

Table 1: Availability of treatment facilities in Norway (in number of treatment units)

Treatment setting	Units
Outpatient treatment	57
Short-term inpatient treatment	8
Long-term inpatient treatment	83
<i>Total</i>	<i>148</i>

As mentioned above, poly-clinical capacity is measured in hours and outpatient treatment is measured in treatment slots; a conversion from one to the other is unfortunately not possible. Looking at the breakdown of treatment units by treatment capacity we see the following:

Table 2: Availability of treatment facilities in Norway (estimated)

Treatment capacity	In treatment hours [^]		In treatment slots	
	Abuse as such	Drug treatment	Abuse as such	Drug treatment
Poly-clinical	3000	800	--	--
Outpatient	--	--	200	40
Inpatient	--	--	2400	600
<i>Sub-total</i>	--	--	<i>2600</i>	<i>640</i>
<i>Total</i>	--	--	<i>3240</i>	

[^] treatment hours means hours available a week for treatment

The fact that poly-clinical capacity cannot be converted into treatment slots, slightly distorts the general picture on the balance between outpatient and inpatient treatment. However, it seems evident that inpatient treatment is a significant component in the overall treatment capacity.

The total of 8556 treatment slots in the field of abuse obviously includes all forms of addiction treatment (except those 8% of treatment facilities which did not return the questionnaire).

In the area of substitution treatment, major changes have occurred during the last couple of years. Just a few years ago there were only 50 substitution treatment slots. This number rose to 400 in 1999 and 1100 by the 1st of January 2001. Around three quarters of these slots are believed to be in Oslo. The State decided in 1997 that all those who fulfilled a certain set of criteria (high threshold) for substitution treatment, would receive this treatment. However supply could not meet demand and so some 800 subjects were placed on waiting lists.

With regard to treatment approach, the division of treatment hours (information on treatment availability is only available in a poly-clinical capacity - which again means in treatment hours) looks like this:

Table 3: Availability of treatment facilities in Norway by treatment approach

Treatment approach	In treatment hours [^]		As percentage of total	
	Abuse as such	Drug treatment	Abuse as such	Drug treatment
Religious approach	500	50	13%	1%
Neutral approach	2500	750	66%	20%
<i>Sub-total</i>	<i>3000</i>	<i>800</i>	--	--
Total	3800		--	

As can be seen above, the main bulk of the treatment capacity by treatment approach is in 'neutral abuse treatment'. It is interesting to compare the religious approach with another Scandinavian country, Denmark, where explicit religious treatment is virtually absent.

Regarding ownership, the treatment units and treatment slots are divided as follows:

Table 4: Division of treatment units and treatment capacity by ownership

Owner	Number of treatment units/interventions	Estimated capacity as percentage of total*
State	1	1%
County	73	20%
Municipality	16	11%
Public foundation	3	3%
Private	63	65%
Total	156[^]	100%

[^] = The total here is not 148 (as earlier) since this total includes some reintegration interventions.

*= These figures have been provided by the National Focal Point and are not the result of calculations based on other numbers in this paper.

Problem drug use, treatment demand and treatment availability

According to information provided by the Norwegian Focal Point, there are 9 000-12 000 problem drug (opiates) users in Norway. As treatment services are generally 'non-earmarked' it is hard to comment on the adequacy of treatment facilities, although there do not seem to be signs of insufficiency.

The 1998 annual national report on client mapping ('*klientkartlegging*') includes figures on client profiles when entering treatment. For 1998, 64% of treatment units replied to a request by the client mapping authorities. On the basis of the incoming data the report presents data on client profiles and states that 5 052 clients turned to abuse treatment services after drug abuse (heroin, cannabis or amphetamine). As the total number of registered clients turning to abuse treatment services was 12 597 this suggests that around 40% of the total number of abuse treatment slots were occupied by drug addicts (note that one treatment slot can be

used by more than one drug addict in the course of a year). Applying this percentage to the total number of abuse treatment slots in Norway it can be estimated that some 3 000-4 000 of the abuse treatment slots were in fact used as drug abuse treatment slots.

Based on the findings above, a very prudent interpretation would be that overall there is a balance between the demand for drug-free treatment and treatment availability, but not between demand for substitution treatment and its availability (this is confirmed by the existence of a rather long waiting list).

Classification, concepts and typology of (social) reintegration in Norway

National context

Reintegration (which was in fact called rehabilitation - the term *social* is not used in the studied Norwegian literature) was first referred to in policy papers in a parliament communication ('*melding fra Storting*' number 13 1985-1986). In this paper the rehabilitation of drug addicts was mentioned for the first time stating that it should contribute to the ultimate goal of Norwegian drug policies, namely accomplishing a 'drug free society' (this has now been changed to 'society free of drug abuse').

Current classification of rehabilitation/reintegration in Norway

There are two important concerns to bear in mind regarding the issue of classification of rehabilitation/reintegration in Norway. Firstly, there is no such thing as a standard definition of what rehabilitation/reintegration really means in a Norwegian context; secondly, the term is often used for measures/interventions which in other European countries would be considered low threshold services. The term rehabilitation/reintegration is often used in Norway to mean refuges and drop-in centres as well as for the last phase of a treatment process. Lastly it is also used to refer to what is normally called simply treatment! However bearing in mind that many rehabilitation/reintegration units are not only used in the last phase of a treatment process but also in the first, it is possible to shed light on how many reintegration units exist and what their capacity is in terms of treatment slots.

Availability of (social) rehabilitation/ reintegration in Norway

Current availability of social rehabilitation/reintegration in Norway

Similarly to treatment facilities in Norway, rehabilitation/reintegration efforts are very often targeted against abusers in general and only a few are exclusively for drug abusers. Fortunately, the information available allows a split of the two.

47 units provided reintegration interventions for abusers in 1999 in Norway. These 47 units had a total capacity of 310 treatment slots, of which 250 were for substance abusers in general and 60 were earmarked for drug abusers. There is unfortunately no information as to how many of these treatment slots were in outpatient and inpatient settings.

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Classification of and concepts in drug treatment facilities in Austria

National context

A central term in Austrian drug terminology is '*Sucht*' which does not merely mean dependent or addicted but implies a 'haunted' state. '*Sucht*' can be used for denoting addiction of any drug including licit medicines and alcohol. The concept "*Sucht*" applies to all areas within primary prevention, whereas there is a stronger distinction between "illicit drugs" and other substances (i.e. alcohol) in the field of treatment. There are several treatment/reintegration facilities covering almost exclusively "drug addicts" although an exception to this rule are the so-called counselling centres ("*Suchtberatungsstellen*") which cover illicit drugs as well as alcohol.

One of the most central drug-related laws is the '*Suchtmittelgesetz*' (Narcotic Substances Act) which amongst other things states that substitution substances have to be prescribed by a medical officer, psychiatrist or physician. The law also defines a range of "health-related measures" (medical supervision and treatment, including detoxification and substitution treatment; clinical psychological counselling and care; psychotherapy; social therapeutic counselling and care) available for treatment and care of drug addicts especially in the context of "therapy instead of punishment". The Narcotic Substances Act states that the ministry of health has to announce drug services which are in line with the requirements defined by the law. Recently guidelines were drawn up in this context, focusing especially on aspects of quality assurance and minimum standards for recognition.

Current classification in Austria

There is no such thing as a proper national drug treatment inventory. This is perhaps partly because of the federal system of Austria and consequently its extensive regional autonomy. However, the Austrian national report each year draws a map of the various treatment offers across the country based on information collected from the regional 'Drug co-ordinators' ('*Drogenkoordinatoren*'). The treatment settings/interventions are classified using the following terms:

- Inpatient facilities for long-term treatment ('*Stationäre Einrichtungen für Langzeittherapie*')
- Inpatient facilities for short-term treatment ('*Stationäre Einrichtungen für Kurzzeittherapie*')
- Inpatient detoxification ('*Stationäre Einrichtungen für körperlichen Entzug*')
- Outpatient drug facilities and wards ('*Drogenambulanzen und -ambulatorien*')
- Counselling centres ('*Beratungsstellen*')
- Outpatient counselling centres ('*Ambulantes Beratungsangebot*')

As these concepts are not entirely compatible with the terms and concepts we defined under treatment setting we must re-arrange them as follows:

- Inpatient treatment (covering 'inpatient facilities for long-term treatment', 'inpatient detoxification' and 'inpatient facilities for short-term treatment')
- Outpatient treatment (covering 'outpatient drug facilities and wards', 'counselling centres' and 'outpatient counselling centres').

Availability of drug treatment facilities in Austria

National context

Due to the federal structure of Austria which gives extensive powers to regions especially in health and social matters, there is no national drug plan but a number of regional drug plans. The first dates back to 1991 and originated in Vorarlberg. Since then six regions have followed, including Vienna. The two missing provinces are currently working on their plans which will be available in the course of 2002.

Current availability of drug treatment in Austria

The treatment inventory (which in this case is more like a map) used for making this overview was updated in August 2000.

Table 1: Drug treatment facilities in Austria, 2000 (in units)

Treatment setting	Inpatient or outpatient	'Break-down'
Inpatient treatment	37	
- Inpatient facilities for long-term treatment		11
- Inpatient facilities for short-term treatment		7
- Inpatient detoxification		19
Outpatient treatment	86	
- Outpatient drug facilities and wards		10
- Counselling centres		25
- Outpatient counselling centres		51
<i>Total</i>	123	123

As can be seen above the main bulk of treatment units are outpatient and the majority of these are the so-called counselling centres. The extent to which these centres provide actual treatment or merely work as a centre of referral to other treatment centres, varies considerably.

There were 4893 subjects receiving substitution treatment by 2001, of which around two-thirds received their treatment in Greater Vienna. The monitoring of substitution treatment covers all types of substitution substances. In recent years the number of clients treated by other substances than Methadone - first of all slow release morphine but increasingly buprenorphine - was growing. It can be estimated that a maximum of two thirds of clients in substitution treatment receive Methadone and at least one third are treated with other substitution substances.

Prevalence of problem drug use, treatment demand and treatment availability

According to the latest numbers on prevalence of problem drug use, there are between 15984 and 18731 problem drug users in Austria (defined as either opiate users or poly-drug use including opiates). Through the Treatment Demand Indicator we know that 4232 subjects sought treatment during 1999 but unfortunately this number only covers subjects in substitution treatment - there is no available information on the numbers of subjects in drug-free treatment. If we look only at substitution treatment this treatment intervention reaches

some 23 to 26% of the problem drug using population, which can be regarded as mid-range coverage.

Based on a pilot study carried out in Spring 2000 the Austrian National Focal Point estimates that at least 4000 clients were in outpatient facilities (some overlap with the figures for substitution treatment) and 500 clients were in inpatient treatment facilities in 1999.

There is no information about waiting lists for either drug-free or substitution treatment.

Evaluations of treatment services (and possible success rates)

In order to reach a hitherto ignored target group, namely young drug addicts, a short-term therapy program named *Lukasfeld* was set up in 1995. Treatment content was based on a combination of psycho-analysis and social learning theory. Evaluation of the intervention showed that it had not succeeded in reaching its target group but that the subjects in the treatment programme had positive outcomes. The results indicated significant improvement of frustration tolerance, coping ability and life-skills but also that depressive symptoms remained.

Classification of and concepts in (social) reintegration in Austria

The main source for this classification are the maps provided by the National Focal Point in the national report. The terms used on these maps to classify reintegration interventions are as follows (originally in English hence no translation):

- Housing for former drug addicts
- Housing for (current) drug addicts
- Occupation projects for former drug addicts
- Occupation projects for (current) drug addicts

However, as we earlier defined reintegration as the last step in a treatment process and as the concepts suggested earlier are slightly different we shall operate with the following two concepts:

- Housing (covering only housing for former drug addicts)
- Employment (covering only employment for former drug addicts)

Availability of (social) reintegration facilities in Austria

According to the earlier mentioned maps, there are the following number of units carrying out reintegration of former drug addicts in Austria:

Table 2: Availability of reintegration facilities in Austria (in units)

Type of reintegration intervention	Units
Housing	8
Employment	4
Total	12

Other than these, NA plays a role in reintegration efforts in Austria though its extent is not well-known at present.

Evaluations and evaluation findings

Some reintegration programmes in Austria have been evaluated. The Vienna Job exchange provides labour market services aimed at the occupational rehabilitation and reintegration of those with an addictive past (including to alcohol). During 1999, around 1000 clients turned to the Vienna Job exchange and evaluation showed that about one third of these could be referred to a job or training course.

Another employment project (*'Fix und Fertig'*) intended to allocate temporary assignments to both current and former drug addicts. Evaluation showed that with an average of 25 work requests a day, 15 one-day jobs could be provided.

Of evaluated housing projects, the *'Assisted Housing'* project in Vienna provides temporary accommodation accompanied by outpatient psycho-social care. Preliminary results of an internal evaluation showed that the majority of the 12 tenants improved in areas such as employment, debts and drug use.

Sources

Dokumentations- und Berichtswesen der Einrichtungen der Drogenhilfe in Österreich. Written by Elisabeth Türscherl, Martin Busch, Klarissa Guzei and Sabine Haas. Issued in Vienna, April 2001.

EDDRA entry named *'Lukasfeld - short-term therapy for addicts of illegal drugs'* found at: <http://www.reitox.emcdda.org:8008/eddra/>

Report on the Drug Situation 2000 - Austria. Written by Sabine Haas, Martin Busch and Elisabeth Türscherl. Issued by Österreichisches Bundesinstitut für Gesundheitswesen, in Vienna, November 2000.

Unpublished TDI Excel-sheet from Austria with data from 1999.

Classification of and concepts in drug treatment facilities in Portugal

National context

There is no central document establishing what might be considered as national concepts of drug treatment. However, since the main provider of treatment services - the public body and national authority 'Service for the prevention and treatment of drug addiction (*'Serviço de prevenção e tratamento da toxicoddependência'* or SPTT) - is dominant, it sets the agenda of which concepts are used and what they mean.

Current classification in Portugal

The closest we come to a Portuguese treatment inventory is the activities report (*'Relatorio de actividades 2000'*) of SPTT. This gives a systematic and comprehensive overview of the treatment activities carried out but no information about what has been carried out by others, such as private therapeutic communities. It is therefore not a complete inventory in itself but combined with data and information from the Portuguese national report a complete overview should be achievable. Keeping the two main sources in mind, the following division of treatment interventions can be established:

- Outpatient drug treatment centres (*'Centros de Atendimento a Toxicodependentes -CAT'*)
- Detoxification units
- Therapeutic Communities

SPTT runs the outpatient treatment centres itself whereas many of the detoxification units and Therapeutic Communities (almost all of them) are run by others that are either certified or have 'protocols' with the SPTT.

Availability of drug treatment facilities in Portugal

National context

One of the most central Portuguese drug policy papers is the paper named '*30 objectives in the fight against drugs and drug addiction*' (*'30 objetivos na luta contra a droga e a toxicoddependencia'*). This paper lists four objectives in the field of treatment, the first being to finalise the national network of treatment centre and increase the number of drug addicts in treatment by 50% by 2002. The second objective states that detoxification facilities should be increased by 50% in order to meet needs. The third objective is to double substitution treatment capacity and fourthly, to increase the number of Health centres collaborating with SPTT and increase by 300% the number of protocols between SPTT and hospitals as well as other treatment providers. Our aim is not to assess these objectives or their feasibility but they do serve to underline the political attention that has been paid to drug treatment and to the fulfilment of the goals.

Current availability of drug treatment in Portugal

Combining our two main sources - the Portuguese National Report and the Activities Report from SPTT - we obtain the following overview of drug treatment in Portugal (as at 31st of December 1999:

Table 1: Availability of drug-free treatment facilities in Portugal

Treatment setting	Treatment units	Treatment slots
Outpatient treatment centres	51	n.a
Detoxification units	19	162
Therapeutic Communities	122	2806
Total	192	2968[^]

[^] total only includes treatment slots in detoxification units and Therapeutic Communities, not outpatient treatment.

It is notable that - between the lines - drug treatment facilities are clearly separated from other kinds of addiction treatment. A clear distinction between drug treatment and addiction treatment in all units is a rare phenomenon in the European Union.

If we look at the ownership of these treatment services the following picture emerges:

Table 2: Ownership of drug treatment facilities in Portugal (by % of treatment units)

Treatment setting	Public	NGO/private
Outpatient treatment centres	51 (100%)	0
Detoxification units	5 (26%)	14 (74%)
Therapeutic Communities	2 (2%)	120 (98%)
Total	58	134

It can be seen that there is a clear pattern as regards the ownership of treatment facilities - the outpatient treatment centres are publicly run and owned (by SPTT) whereas Therapeutic Communities are run and owned by NGO's/private (who are then either certified or have a protocol with SPTT as mentioned earlier). The only exception to this rule are two of the Therapeutic Communities which are public and run by SPTT. In the third kind of treatment setting - detoxification units - the picture is slightly more blurred with the majority being owned by NGO/private but with a certain representation from public units. It must also be pointed out that the measurement unit is '% of treatment unit' which might give a slightly distorted picture as the private units are generally smaller than the public units. However, a comparison by '% of treatment slots' is not possible due to the missing data on this issue in outpatient settings.

Regarding Therapeutic Communities that are run and/or owned by NGO's or privately these have one of two agreements with public authorities. Either they have 'licence' ('*licenciamento*') which implies that the state acknowledges and accepts their existence, or, they are 'approved' ('*convencionado*'). Being 'approved' implies that not only does the state accept and acknowledge the existence of these units but they also have an agreement about sending clients to these services and paying for them.

Like Therapeutic Communities, detoxification units can either have 'license' or be 'approved'. In late 1999 eight detoxification units had 'licence' and six were 'approved'.

Substitution treatment is provided exclusively through the outpatient treatment centre. With one or two exceptions the outpatient treatment centres all deliver methadone substitution treatment and this is quite often accompanied by psycho-social care. Unfortunately there is no comprehensive record of the existence of substitution treatment accompanied by psycho-social care. Buprenorphine is prescribed from 14 of the outpatient treatment centres.

Portugal used to be the country in the EU where the distribution of LAAM was most widespread. Following a recommendation from the European Medicinal Evaluation Agency (EMEA) in London the use of LAAM was suspended from late April 2001. Until then there were around 5400 subjects in methadone treatment and 600 in treatment with LAAM.

Prevalence of problem drug use, treatment demand and treatment availability

There were an estimated 18450 to 86800 problem drug users in Portugal by 2001. That the 18450 is a very low estimate is supported by the fact that there were 21702 treatment demands in 1999 and these came through only half of the outpatient treatment centres (TDI only collects information from 25 of 50 outpatient treatment centres - no Therapeutic Communities). We cannot compare treatment slots with treatment demand as we have no information on number of treatment slots. However, the Portuguese National Report has information, stating that 677 subjects were on waiting lists by the 31st of December 1999. 28427 requested treatment but only 27750 received it, leaving a small group who were not actually dealt with. This group is however only one third of what it was two years earlier.

Classification of and concepts in (social) reintegration in Portugal

SPTT talks of four kinds of reintegration (*'reinserção'*) which are used to classify the reintegration activities carried out at the outpatient treatment centres (CAT's). The four categories are

- Day centres (*'Centros de dia'*)
- Networking (*'Participacao em Redes'*)
- Job-club (*'Clube de emprego'*)
- 'Life programme' (*'Programma Vida Emprego'*)

Availability of (social) reintegration facilities in Portugal

In the earlier mentioned Portuguese drug policy papers *'30 objectives in the fight against drugs and drug addiction'* objectives and goals for reintegration are also mentioned. The 22nd objective states that the 'Life Programme' (*'Programma Vida Emprego'*) should be strengthened and that its capacities should be increased by 50%. The 23rd objective (one of two on reintegration) states that reintegration in the form of housing should be increased by 100% compared with current capacities. As with treatment, the aim is not here to assess these objectives or their feasibility but instead this underlines the political attention that has been paid to drug treatment and to the assessment of these goals.

Current availability of (social) reintegration facilities in Portugal

The term *social* (reintegration) has been noted in the studied Portuguese literature but most often there is no clear distinction made between social reintegration interventions and simple reintegration interventions. Generally speaking, the term used to denote interventions aiming at reintegrating former drug users into society, is reinsertion ('*reinserção*').

Based on literature studied we see the following overview of reinsertion/reintegration interventions in Portugal as at the end of 1999.

Table 3: Reinsertion/reintegration facilities in Portugal

Type of reinsertion/reintegration	Number of treatment units
Day centres (' <i>Centros de dia</i> ')	12
Networking (' <i>Participacao em Redes</i> ')	24
Job-club (' <i>Clube de emprego</i> ')	19
'Life programme' (' <i>Programma Vida Emprego</i> ')	45
Total	100

Of the 12 day centres, four are run by *Serviço de prevenção e tratamento da toxicoddependência*, five have a so-called 'license' and three are 'approved' (see paper on availability of treatment). Day centres are conceived as units for the first phase of a reinsertion/reintegration process in which the (former) drug user learns and regains the life lived before addiction to drugs.

The Life Programme aims to reintegrate (former) drug users through employment programmes and the creation of companies by (former) drug users themselves.

Summary

- There is a distinct separation between drug treatment and general addiction treatment.
- There is a clear pattern in ownership - outpatient treatment centres are public and Therapeutic Communities are NGO/private
- There is vast treatment availability which does not however entirely meet the treatment demands

Sources

Annual report on the drug phenomena 2000 - Portugal. Issued by Instituto Português de Drogas e Toxicoddependências in 2000.

Unpublished Excel spread sheet from through the Treatment Demand Indicator.

'*Relatorio de actividades 2000 - versão abreviada*'. Issued by SPTT in 2001. Portugal.

'*Relatorio de actividades 1999 - versão abreviada*'. Issued by SPTT in 2000. Portugal.

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'30 objectivos na luta contra a droga e a toxicodependencia - plano de acção nacional de luta contra a droga e a toxicodependencia. Issued by Instituto Português da Droga e da Toxicodependência.

Classification and concepts of drug treatment facilities in Finland

National context

As in Norway, abuse is a concept that in terms of treatment facilities is generally not broken down into drug treatment or alcohol treatment. Normally treatment facilities are directed at all kinds of abuse - that is, of alcohol and illicit as well as licit drugs. Alcohol abuse is much more frequent than drug abuse in Finland. And Finland is characterised by having a larger population of amphetamine problem users than heroin problem users. These three circumstances make the examination of drug treatment a highly complex issue.

Current classification of drug treatment facilities in Finland

The following classification is based on the database found on the Finnish focal point's website. The classification is not "official" but the best available and the definitions will be specified by an unofficial group of experts in the field. The database is not comprehensive but again the best available and allows treatment units to add or specify data on their units. However, this information is based on self-reporting.

The website provides a virtually complete overview of abuse treatment facilities in Finland and provides three search engines, one by region, another by the name of the treatment unit and the third by the theme of "*description of services*" (*'Palvelun mukaan'*). The first distinction made between the services on the website is whether the service is targeted at abuse as such (and hence covers alcohol as well as licit and illicit drugs) or drug abuse (illicit drugs only).

The treatment interventions targeted against abuse as such are broken down into the following sub-categories:

Residential detoxification and inpatient treatment for abusers (which in practice means inpatient or residential treatment for abusers). This is broken further down into two parts: Inpatient treatment (*'Kuntouttava hoito'*) and Detoxification (*'Katkaisuhoito'*) – in Finland the term "reintegration" is in practice limited to after-care services. *Kuntouttava hoito* includes psychosocial or medical (residential) treatment for abusers but not detoxification (or withdrawal) treatment.

Outpatient treatment for abusers (*'Avomuotoinen päihdekuntoutus'*).

Psychiatric services for abusers in the specialised health care system.

Youth services (*'Nuorten päihdehoitopaikat'*), meaning treatment centres for young abusers and those with other problems. This is broken down into two parts;

- Outpatient services for youth (*'Avopäihdehoitopaikat'*)
- Residential services for youth (*'Laitospäihdehoitopaikat'*)

The treatment interventions targeted against drug abuse are broken down into the following sub-categories:

Specialised units for drug abusers (*'Huumehoitoon erikoistuneet yksiköt'*). This is not an official but a practical concept and means treatment units specifically for drug addicts (not alcoholics). It is also split into three parts:

- Outpatient services for drug abusers (*'Avohoitopaikat'*)
- Inpatient services for drug abusers (*'Laitoshoitopaikat'*)
- Needle exchange programmes with health counselling services (*'Terveysneuvontapisteet huumeiden käyttäjille'*)

Detoxification, substitution and maintenance treatment for opiate addicts ('Opioidiriippuvaisten henkilöiden vieroitus-, korvaus- ja ylläpitohoitoa eräillä lääkkeillä tarjoavat hoitoyksiköt'). These are in or outpatient units which carry out substitution and maintenance treatment.

The classifications presented above and previously are however not completely compatible with ours. For instance, inpatient treatment services are broken down according to whether the services are for young or old, and in another example, needle exchange programmes are included above although, according to our definition, this is not a form of treatment. Therefore, we shall rearrange and reclassify the above categories as follows:

- Inpatient treatment (which covers detoxification, inpatient treatment, youth residential services, psychiatric services for abusers in the specialised health care system, and lastly, inpatient services for drug abusers)
- Outpatient treatment (which covers outpatient treatment for abusers, youth outpatient services, and lastly, outpatient services for drug abusers)
- Substitution treatment

Substitution treatment is a category on its own (unlike many other countries) since in Finland it can be in both in and outpatient settings. The distinction between abuse treatment services and drug abuse treatment services will be maintained.

There is also information on the ownership of treatment services. However, this is not standardised and in many cases there are co-ownerships which complicate a quantitative overview.

Availability of drug treatment facilities in Finland

National context

There are essentially two central Finnish drug policy papers, namely the Act on Welfare for Substance Abusers (1986) and the government's 'Decision-in-principle' (1998). Whereas the former places responsibility for organising services for intoxicant abusers (and also for alcoholics) in the municipalities, the latter contains a proposal for a new national drug policy, including a draft proposal for a drug research programme.

Regarding substitution treatment the central paper at national level is a regulation from the Ministry of Social Affairs and Health which dates from 1997. This paper was revised and passed in 2000, launching for the first time (explicitly and officially) maintenance treatment. One special Finnish feature is the 'ombudsman institution for ('intoxicant') abusers' which has existed since 1996 and gives counselling in legal matters for substance addicts.

Drug treatment and the prevention of drug-related harm was discussed at a consensus meeting on treating drug dependence in Finland, organised by the Academy of Finland and the Finnish Medical Society 'Duodecim' in 1999. Based on questions raised at the meeting, in the summer of 2000 the Ministry of Social Affairs and Health appointed a working group on the treatment of drug abusers. This would investigate whether the existing service system could meet

treatment needs, make proposals for developing the service and financial system, and assess the need for amending social welfare and health care legislation. The working group submitted its proposal in June 2001.

Based on the results, another working group was appointed with a tight schedule to propose action to increase the treatment of opioid-dependent clients with medicines. The group submitted its report on 2 October 2001, and included proposals for increasing treatment based on the existing regulations and for new regulations to meet present requirements. In Autumn 2001 the Finnish National Focal Point, Stakes, appointed a working group to develop guidelines for quality control/recommendation for Finnish treatment demand system for substance abusers.

Current availability of treatment facilities in Finland

As stated above, the main bulk of treatment facilities for drug abusers are general treatment facilities intended for all kinds of abusers, although there are some specialised services. Of the abuse treatment units (see below) there are around thirty residential drug treatment units. Unfortunately, figures on treatment slots are either scarce or unavailable.

The following quantification of treatment facilities in Finland is based on an internet-sourced treatment inventory (see sources) which should be the best available information source in Finland (although not a totally comprehensive one) and was **updated on the 7th of November 2001**.

One problem in calculating the number of treatment slots according to services is that each treatment unit typically reports two or three types of treatment. Consequently, one treatment unit with 10 treatment slots might be counted as 30 if they report that the treatment carried out is outpatient treatment, substitution treatment and a specialised service. Because there is no universal definition of how to calculate the treatment slots (although a few centres also mark the slots according to the different departments in the centre, so there is no overlapping concerning the summarised number of slots) the exact number of treatment slots is not summarised at all.

However in 2000 a report on treatment demand in Finland was produced by STAKES, the National Focal Point of Finland. As a result it has been estimated that there are 30 units specialising in problem drug users which have a special drug treatment programme. Of these, 13 provide residential detoxification services for problem users, 18 provide withdrawal treatment, and 18 give drug-free inpatient treatment. Drug treatment periods in detoxification and withdrawal are usually 2–3 weeks, while in drug-free inpatient treatment the duration is 2–3 months or longer. The units are predominantly located in Southern (13) and Western (9) Finland. The province of Oulu, Northern Finland, has five units. Eastern Finland has three units, but, in contrast to the rest of the country, these units mainly concentrate on rehabilitation.

Table: Availability of abuse treatment facilities in Finland (in units)

'Service description'	Number of abuse units	Number of drug abuse units
Inpatient treatment	115	43
Outpatient treatment	138	50
Substitution treatment	--	19
<i>Sub-total</i>	253	112
<i>Correction for double-counts</i>		123
Total		242

There are an estimated 360–440 beds in drug treatment institutions - and around 200 in or outpatient treatment slots (persons in treatment) of substitution and maintenance treatment for opiate addicts (around 100 slots for subjects in buprenorphine treatment and 100 in methadone maintenance treatment). There are six institutions specialising in young substance abusers, with a total of 40 beds. In addition, community homes have three units specialising in drug treatment, with a total of 23 beds.

Regarding ownership, there is no standardised information given. Additionally, there are many examples of shared ownership. However, a qualitative view of the information reveals that about half of all treatment services are owned by the municipalities or towns (*'Kaupunki'*), which is in line with the statement in the Act on Welfare for Substance Abusers. The other half of ownership's is divided between associations, private foundations or are examples of shared ownership's.

Problem drug use, treatment demand and treatment availability

The last national prevalence estimate in 1999 suggested that there are some 10 600 – 13 400 hard drug users in Finland of which between 2 500 and 3300 are believed to be opiate addicts. Given that the average stay in inpatient treatment is three months and the estimation of beds available in inpatient treatment (previous chapter), it means that 1 440–1 760 problem drug users receive institutional care annually. This is a tenth of the estimated number of problem users. However, it is estimated that in all there are about 25 000-30 000 regular users of drugs (mainly cannabis) in Finland, who also may be counted as potential customers of drug treatment services.

According to the TDI standard table for 2000 there were 4 700 people requesting treatment for drug addiction. The coverage of TDI data is almost 40 - 50 % of units and the data was collected over the course of one year. During the same year there were around 4 800 persons visiting needle exchange units. Due to the partiality of this data it is not possible to draw any further conclusion on the relationship between problem drug use, treatment demand and treatment availability other than mentioned in the previous paragraph.

Classification, concepts and typology of (social) reintegration in Finland

National context

Reintegration (the term *social reintegration* is not used in the studied Finnish literature) has according to the Finnish national report received significant attention in Finland during the last few years, not due to an increase in problem drug use but perhaps more because of increased unemployment. This in some cases also leads to a marginalisation process because of problem substance abuse. In combination with the substance abuse problem, the term is normally used to describe the last phase of a treatment process. This general understanding however cannot be tested for all of the units claiming to possess reintegration services.

In Finland the entire treatment system was created primarily for alcoholics and has a long tradition, which does not make clear the difference between the treatment (e.g. rehabilitation) and reintegration (if support housing is concerned). That is the reason why in the treatment chain, many treatment units also supply after-care services which can be included under the concept of reintegration. After leaving these after-care services, ex-patients or ex-clients are taken into the general social and health service systems (e.g. housing, education and employment services mostly run in cooperation with municipal authorities).

Because almost all units claiming to carry out reintegration also carry out other activities, it is impossible to quantitatively differentiate between reintegration and treatment units. However, it is possible qualitatively to describe activities reported in the Finnish national report.

Current classification of reintegration in Finland

Most reintegration services in Finland fall under the three 'standardised' sub-categories of reintegration; namely education, employment and housing. The electronic treatment inventory referred to earlier (see sources) sub-divides housing into housing services (*'Päihdehuollon asumispalvelut'*) and day centres (*'päihdehuollon päiväkeskukset'*)

Availability of (social) reintegration in Finland

National context

There appears to be no national drug plan or other policy paper dealing exclusively and solely with (social) reintegration for drug addicts. However drug addicts are included in the general programmes to reintegrate people who have been excluded from society. Similarly, there are no valid nationwide criteria on accessibility and admission to reintegration services for drug addicts only.

Current availability of social reintegration in Finland

In the field of *education and training*, a broad scale project for young drug addicts named 'Back to the future' was implemented in Greater Helsinki in 1998-1999. Partly funded by the Integra Programme under the EU Social Fund, this project aimed to provide vocational training and upgrade work capacities.

In the field of *employment*, there has been no large scale integration project, though some reintegration units fund their own small-scale projects. The Kalliola Clinics ran a special service in 1999 to assist with finding employment for former addicts, released from prison.

In the field of *housing*, there are three different ways that drug addicts in Finland might get support. Firstly, it is possible to ask for financial support as part of general social services. Secondly, there are some specialised housing services for alcoholics and drug addicts. Thirdly, there are a few housing services which are exclusively for former drug addicts. A study in 1998 showed that there were 4 100 subjects in housing services for alcohol and/or drug abuse. A one-day census carried out in 1999 concluded that one out of eight clients in such services were former drug addicts, suggesting that *around 500 drug addicts were in housing services in Finland in 1999*. The housing was provided through either 47 housing services or 15 day centres though it is not possible to obtain data on the division of the 500 drug addicts between these two types of service. Note that day centres are also frequently used as 'pre-treatment' facilities.

The role of NA as a participant in rehabilitating former drug addicts exists in Finland although its role and extension is not very clear. By mid 2000 there were NA groups in 21 different municipalities.

Summary

- Around half of treatment services are owned and run by regional authorities, the other half by private and/or NGOs.
- The main bulk of treatment is in abuse treatment.
- Substitution treatment is limited in terms of coverage and treatment slots.

Sources

National Report from Finland (especially chapter 9.3 on treatment services and chapter 8.1 on strategies in demand reduction at national level).

Treatment inventory found at STAKES website; <http://www.stakes.fi/neuvoa-antavat/hoitopaikat>

Unpublished Excel spreadsheet from Finland on Treatment Demand Indicator.

Classification of and concepts in drug treatment facilities in Sweden

National context

Similarly to Norway, Sweden has a tradition of having substance addiction treatment and alcohol addiction treatments under the same roof. This of course constitutes a problem in the isolation of data on specific drugs treatment. However, there is a solution to this problem as data on the profiles of clients is available and consequently on the use of the given treatment slots. This will be explained more thoroughly later.

Sweden has the explicit goal of achieving a drug-free society and furthermore states the importance of having *'a society in which drug addiction remains a marginal phenomenon and socially unaccepted form of behaviour'*. The way to this goal is mostly through drug-free treatment although substitution treatment does take place on a small scale. The number of substitution treatment slots is a political decision which has been changed a number of times since the implementation of the first substitution treatment programme in Sweden in 1966. The latest change dates back to 13th of October 1999 when the allowed number of substitution treatment slots was raised from 600 to 800.

Current classification in Sweden

No treatment inventory with standardised information from each treatment unit has been found for Sweden. However, one publication has had access to such data and the findings will be reported here. According to *"Insatser och Klienter i Behandlingsenheter inom missbrukarvården - IKB 1999"* treatment interventions can be divided into the following categories regarding *types of treatment units ('behandlingsenhetstyp')*:

- Care in hospital (*'Slutenvårdsavdelning inom sjukhus'*)
- Psychiatric outpatient treatment unit (*'Psykiatrisk öppenvårdsenhet'*)
- Hospital care and outpatient treatment (*'Slutenvårdsavdelning och öppenvårdsenhet'*)
- GP's, psychologists and psycho therapists (*'Privatläkar-, psykolog- eller psykoterapeutmottagning'*)
- Outpatient Treatment Unit for addiction treatment (*'Öppenvårdsenhet för missbruksbehandling'*)
- Inpatient treatment institution or foster home (*'Vårdsinstitution eller familjehem'*)
- Inpatient treatment institution and outpatient treatment unit (*'Vårdsinstitution och öppenvårdsenhet'*)
- Municipal or ideological social counselling (*'Kommunal eller ideel socialbyrå'*)
- Others or combined treatment units (*'Andra, eller övriga kombinerade, enhetstyper'*)

However, as we have the task of ensuring some level of comparison, some of these categories will have to be combined. We shall use categories applied with other countries as follows:

- Outpatient treatment (Psychiatric outpatient treatment unit; Hospital care and outpatient treatment; GP's, psychologists and psycho therapists; Outpatient Treatment Unit for addiction treatment; Municipal or ideological social counselling).
- Inpatient treatment (Care in hospital; Inpatient treatment institution or foster home)
- Miscellaneous (Others or combined treatment units; Inpatient treatment institution and outpatient treatment unit)

The terms used to categorise *ownership* are as follows:

- Private company or private person ('*Privat företag eller privatperson*')
- Ideological organisation or fund ('*Ideell organisation eller stiftelse*')
- Municipality ('*Kommun eller kommundel*')
- Region ('*Landsting eller region*')
- Region and municipality ('*Landsting och kommun*')
- State board on institutional affairs ('*Statens institutionsstyrelse SiS*')
- Other combined ownership ('*Övrigt kombinerat ägerskab*')

As before we shall limit these categories to a smaller number by combining categories in the following way:

- Private (Private company or private person; Ideological organisation or fund)
- Regional/Municipal (Municipality; Region; Region and municipality)
- State (The state board on institutional affairs)
- Combined (Other combined ownership)

Availability of drug treatment facilities in Sweden

National context

The national plan of action states as an objective that '*offensive drug addiction treatment will be further developed*' and that the National Health Board of Health and Welfare (NBHW) will be supporting both external activities as well as conducting projects of its own. The national plan of action does not however elaborate on how to achieve this nor on how to benchmark this achievement.

The NBHW has formulated the admission criteria to substitution treatment as follows: 1. to have at least four years of documented intravenous opiate addiction; 2. to have tried drug-free treatment; 3. to be at least 20 years old, 4. to have medical records showing that there is no advanced multiple substance addiction involved; 5. to have an acceptable free-choice situation (not to be arrested, remanded in custody, sentenced to imprisonment or in jail). Moreover, patients in the substitution treatment programme might be involuntary discharged if they not comply with the rules regarding criminality and drug use. Threats and violence towards staff might also lead to discharge. These admission criteria may be considered as high threshold and show that there is a political wish in Sweden to put emphasis on drug-free treatment and only take substitution treatment as a last resort.

Current availability of drug treatment in Sweden

Data has been collected by sending out a 12-page questionnaire to all of the registered treatment services in Sweden. Some 70% of services replied though not all treatment services filled out all parts of the questionnaire. 627 services replied satisfactorily and these constitute the statistical grounds for the following overview of drug treatment services in Sweden. Please bear in mind that not all treatment units are represented in the following overview and furthermore that the total of services will not reach 627 as criminal justice interventions have been excluded from this overview. The following overview is based on data as at 31st of March 1999.

Table 1: Availability of addiction treatment facilities in Sweden (in absolute numbers)

Treatment setting	Treatment units	Number of drug abusing clients	Number of alcohol and drug abusing clients	Total number of clients
Outpatient treatment	302	2757	4649	7406
Inpatient treatment	192	496	1241	1737
Miscellaneous	89	714	1207	1921
<i>Total</i>	<i>583</i>	<i>3967</i>	<i>7097</i>	<i>11064</i>

Or by percentage:

Table 2: Availability of addiction treatment facilities in Sweden (by percentage)

Treatment setting	Treatment units	Number of drug abusing clients	Number of alcohol and drug abusing clients	Total number of clients
Outpatient treatment	51,8%	69,5%	65,5%	66,9%
Inpatient treatment	32,9%	12,5%	17,5%	15,9%
Miscellaneous	15,3%	18,0%	17,0%	17,3%
<i>Total</i>	<i>100%</i>	<i>100%</i>	<i>100%</i>	<i>100,1%</i>

As can be seen above, the most commonly used treatment setting for drug-related addiction in Sweden is outpatient. Furthermore, there are more addicts of both alcohol and drugs than purely of drugs.

Regarding ownership, the division of units and subjects in treatment is as follows:

Table 3: Ownership of addiction treatment facilities in Sweden (in absolute numbers)

Treatment setting	Treatment units	Number of drug abusing clients	Number of alcohol and drug abusing clients	Total number of clients
Private	199	398	1397	1795
Regional/Municipal	363	3441	5541	8982
State	15	112	145	257
Combined	6	16	14	30
<i>Total</i>	<i>583</i>	<i>3967</i>	<i>7097</i>	<i><u>11064</u></i>

Or by percentage:

Table 4: Ownership of addiction treatment facilities in Sweden (by percentage)

Treatment setting	Treatment units	Number of drug abusing clients	Number of alcohol and drug abusing clients	Total number of clients
Private	34,1%	10,0%	19,7%	16,2%
Regional/Municipal	62,3%	86,7%	78,1%	81,2%
State	2,6%	2,8%	2,0%	2,3%
Combined	1,0%	0,4%	0,2%	0,3%
<i>Total</i>	<i>100%</i>	<i>99,9%</i>	<i>100%</i>	<i>100%</i>

Regarding ownership it appears that the main bulk of treated drug addicts are in public regional/municipal institutions. These institutions seem to be generally larger than private institutions, since the regional institutions' share of units is 62,3% but they treat 81,2% of addicts.

There were 621 subjects in substitution treatment as at 31st of May 2000. These 621 subjects are included above on outpatient treatment.

It has to be borne in mind that the above numbers are figures collected on a census day, and not, an overview of potentially available treatment slots. This impedes a comparison between treatment supply and treatment demand.

Prevalence of problem drug use, treatment demand and treatment availability

According to the latest estimate on problem drug use in Sweden, there were between 17273 and 33144 drug addicts in Sweden in 1998. If this is compared with the 11064 subjects that were in treatment on the 31st of March 1999 we get a rough treatment coverage rate of 33 - 64%.

To have a closer look at opiate users is harder as the main bulk of drug addicts in Sweden are amphetamine users and as the numbers above also include cannabis users. Fortunately the Swedish estimate also reports figures on addicts according to the primary drug. These show that there are between 5433 and 7773 heroin abusers in Sweden. If we compare this to the figure on substitution treatment we see that *from 8 to 11% of Swedish opiate addicts were in substitution treatment* (again, we do not know how many opiate addicts were in drug-free treatment services).

Evaluations of treatment services (and possible success rates)

The *Ulleråker* methadone programme was evaluated in the late 90s. Amongst other things, the evaluation concluded that as many as 90% of participants stayed off heroin while in the substitution treatment programme and that the crime level had fallen below 10%. The evaluation also showed that the mortality rate of the participants fell drastically and that none of the participants were infected with HIV during the programme.

Classification of and concepts in social reintegration in Sweden

Neither in the treatment inventory (*'Insatser och...*) nor in the Swedish national report is there any mention of concepts in social reintegration. Furthermore, it appears that social reintegration is something that is generally considered to be a part of treatment and consequently not dealt with as an intervention of its own.

Availability of social reintegration facilities in Sweden

As under 'Classification of and concepts in social reintegration in Sweden' there is no special mention and/or inventory of social reintegration efforts in any of the studied Swedish literature. There is however one EDDRA entry about a Swedish rehabilitation/reintegration project named *Basta Work Co-operative (Basta Arbetskooperativ)*. The *Basta* project was based on the idea that the role of work is crucial as a means to regain ability to communicate with fellow human beings and for boosting self-esteem. In the first five years of the project it grew from 5 to 80 participants and the revenue from the created work cooperative had grown too. Unfortunately there is no information on the state of the rehabilitated drug users.

Summary

- Sweden has a relatively high treatment coverage rate
- The bulk of treatment activities is in drug-free outpatient treatment
- The coverage of substitution treatment is relatively low

Sources

EDDRA entry named '*Basta Work Co-operative (Basta Arbetskooperativ)*' found at: <http://www.reitox.emcdda.org:8008/eddra/>

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'*National Plan of Action - for prevention of alcohol related harm and drug abuse in Sweden*'. Issued by the Swedish National Institute of Public Health (Folkhälsainstitutet) in 1995.

'*Socialstyrelsens föreskrifter om ändring i föreskrifterna (SOSFS 1990:16) om metadonunderhållsbehandling och förskrivning av opiater på indikation narkomani*' (Changes to the guidelines for the provision and prescription of methadone on the diagnosis drug addiction). Issued by Socialstyrelsen (the board on social affairs) on the 13th of October 1999.

Classification of and concepts in drug treatment facilities in the United Kingdom

National context

One fundamental complicating factor is that the United Kingdom is comprised of four more or less independent 'countries', namely England, Wales, Scotland and Northern Ireland. As a result, not only does legislation vary but so too does the terminology used in each country. Consequently a split of information is necessary.

Current classification in the United Kingdom

England and Wales

Two treatment inventories have been found covering England and Wales. One is called 'Drug problems – where to get help' which covers mostly outpatient but also some in-patient treatment facilities. The other is called 'Residential drug services – a comprehensive guide to rehabilitation in England and Wales'. This inventory covers virtually all in-patient treatment facilities in England and Wales and provides detailed and easily comparable information on in-patient treatment.

This publication uses the term 'regime' for describing the (in-patient) treatment approach and has divided treatment centres into the following sub-categories:

- Christian philosophy
- Christian staff (Christian staff in a non-explicitly Christian treatment programme)
- General house (the philosophical approach varies but group and individual support are always provided)
- Minnesota model (12 step model / Narcotics Anonymous)
- Modified Minnesota model (regimes evolved from Minnesota model)
- Therapeutic community (phased or hierarchical programmes with intensive group therapy)

Various terms are in use regarding outpatient treatment and are not presented in a standardised way. Consequently, we will not break outpatient treatment into sub-categories.

Northern Ireland

The only treatment inventory for Northern Ireland has been found on the website of the 'Eastern Drugs Coordination Team'. The website has divided services into the following sub-categories:

- Acute/Short term Care
- Treatment and reintegration
- Other services relating to drug addicts' needs.
- Drug Forums

Two comments have to be made about the above list, namely that there is no distinction between treatment and reintegration in Northern Ireland. Secondly, that 'other services' includes psychiatric services, housing support, mental health teams and employment initiatives.

Scotland

One treatment inventory for Scotland has been found online with detailed information for all treatment units. However, the information is too detailed and not easily 'classifiable'. There are around 30 different breakdowns of treatment interventions including 'Advice', 'Aftercare', 'Residential', 'One-to-one counselling', 'Complementary therapy', 'Day Care', 'Home visits', 'Group work', 'Detox', 'Family support' etc. It is not clear what kinds of intervention can be grouped together and hence no attempts to do so will be made.

Availability of drug treatment facilities in the United Kingdom

Current availability of drug treatment in the United Kingdom

England and Wales

The two treatment inventories used in this overview date back to 1998 for outpatient treatment and 1999 for in-patient treatment. A closer look at the in-patient treatment inventory and subsequent calculation shows the following picture:

Table 1: Availability of in-patient drug treatment facilities in England and Wales

Regime	Treatment units	Treatment slots [^]
Christian philosophy	9	140
Christian staff	5	92
General house	36	547+
Minnesota model	19	306+
Modified Minnesota model	15	240+
Therapeutic community	23	557+
Total	107	1882+

[^]As some treatment units have not provided any information on the number of treatment slots a + implies that the number stated expresses a minimum number.

Other than the above-mentioned treatment centres there are also around 15 hospitals with special drug treatment units. However, there is no information on how many treatment slots these special units might cover.

Regarding outpatient treatment in England and Wales, there is no information on the number of treatment slots - only on treatment units. A thorough count of treatment services listed in the outpatient treatment inventory (leaving aside those that are in prisons or low-threshold services) shows that there are a total of *451 outpatient treatment centres in England and Wales*.

Substitution treatment is an area about which it is virtually impossible to say anything in relation to the UK. The reason for this is that there is no central register for subjects receiving substitution treatment and, since the main bulk of substitution treatment takes place through general practitioners, it is virtually impossible to collect data from all over the country.

Northern Ireland

Unfortunately, the electronic treatment inventory for Northern Ireland does not provide any information on the number of treatment slots in treatment units or any other additional information on treatment regime, approach or so on. The data only allows the following global overview for treatment services in Northern Ireland.

Table 2: Availability of in-patient drug treatment facilities in Northern Ireland

Type of intervention	Number of treatment units
Acute/Short term Care	7
Treatment and reintegration	29
Other services relating to drug addicts' needs.	23
Drug Forums	5
<i>Total</i>	<i>64</i>

Scotland

As already mentioned, information from Scotland is too detailed and not easily 'classifiable' as there are around 30 different breakdowns of treatment interventions. Hence, we include a simple count of drug-related services here. According to the electronic treatment inventory for Scotland there is a total of *104 drug-related treatment services for drug addicts in Scotland* (covering everything from outpatient treatment and in-patient treatment to reintegration). However, many of these services also cover the areas of prevention, outreach work, alcohol addiction and so on.

Prevalence of problem drug use, treatment demand and treatment availability

Firstly, estimates of the number of problem drug users in the United Kingdom differ from 88900 to 341423. Secondly, the treatment demand indicator for 1999 states that there was a total of 37681 drug-related treatment demands in 1999, but there are no estimations of how many of the total amount of treatment centres are included in the TDI. Thirdly, there are no figures on substitution treatment. Due to the reasons given above it is not possible to draw any sort of conclusion about the relation between prevalence of problem drug use and treatment availability, let alone treatment demand and treatment availability.

Evaluations of treatment services (and possible success rates)

The United Kingdom has launched one of the most ambitious nation-wide studies on treatment outcome in Europe. The National Treatment Outcome Research Study (NTORS) was the first large scale nation-wide follow-up study of drug misuse conducted in the United Kingdom and began in 1995 with the recruitment of over 1000 people who entered drug misuse treatment services (residential and community-based). Various articles have been written and conclusions drawn since the launch of the NTORS project.

One of the findings of NTORS is that in-patient treatment improved consumption patterns, lowered risk behaviour and reduced drug intake. Alongside earlier findings, the NTORS study confirms that time in treatment is predictive of outcome. The critical time in treatment was analysed and the conclusion was drawn that the 'turning point' for longer stay in-patient programmes was 90 days. The study asserted that attempts to increase clients' retention in treatment is crucial to the outcome.

Another NTORS study looked at clients admitted to community-based methadone treatment services and to GP services and measured the treatment outcome six months after admission. The study found that both groups improved significantly in terms of drug-related problems, health and social functioning. Although the GPs in the study could not be said to be representative due to an over-average willingness to both treat drug addicts and to participate in the study, the improvement of the clients in GP treatment proves that clients can be treated just as satisfactorily in GP settings as in specialist drug clinics.

Classification of and concepts in social reintegration in the United Kingdom

National context

The term reintegration ('social' is generally not used in the studied literature) is used differently in the UK than in other countries. The mere title of one of the two treatment inventories reveals this: 'Residential drug services – a comprehensive guide to reintegration in England and Wales'. Reintegration here is used synonymously with residential treatment and not to denote the last phase of a given treatment process. This has the unfortunate consequence that the above-mentioned inventory cannot be used to map (social) reintegration services in the UK.

Current classification of social reintegration in the United Kingdom

In the two treatment inventories there is no systematic breakdown of reintegration into sub-activities or categories. Moreover, there are a number of terms whose meaning is not clear and might or might not cover what could be considered a reintegration activity. The outpatient treatment inventory speaks of a breakdown of '*service classifications*' and uses the following terms: 'Community advice and information service', 'community drug team', 'criminal justice intervention service', 'crisis intervention service', 'dedicated prison service', 'drug dependence unit', 'family service group/centre', 'hostel/supported accommodation', 'needle syringe exchange', 'regional drug service', 'residential reintegration service', 'self-help service group/centre', 'semi-supported accommodation', 'specialised hospital in-patient unit' and finally 'structured day-programme'.

Although these terms are defined and described individually, some of the definitions do not make it clear whether the intervention can be categorised as a reintegration intervention or not. For instance, NA is mentioned as a self-help service, but NA is a place for all current or former drug addicts and hence cannot be said to be uniquely a reintegration service. Based on the descriptions of the terms, none can be said to be reintegration and reintegration only – a classification with the current data from the UK is therefore not possible.

Availability of social reintegration facilities in the United Kingdom

As mentioned in the paper on classification of social reintegration facilities in the UK a classification with the current data is not possible and consequently an overview of availability cannot be carried out either.

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Gossop, M., Marsden, J., Stewart, D., Lehmann, P., and Strang, J. 'Treatment outcome among opiate addicts receiving methadone treatment in drug clinics and general practice settings: Results from the National Treatment Outcome Research Study'. Abstract found at: www.ntors.org.uk. (Furthermore published in Psychology of Addictive Behaviours. Issue 11 (4), 1997. Page 324-337).

'Residential drug services - a comprehensive guide to rehabilitation in England and Wales'. Issued by the Standing Conference On Drug Abuse (SCODA) in 1999.

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Summing up on:

Classifications of drug treatment and social reintegration and their availability in EU Member States plus Norway

As a last step in this report, we will sum up our findings having analysed treatment availability and social reintegration in the EU Member States plus Norway. The summary will be divided into five parts:

- the difficulties encountered when trying to classify and measure availability of drug treatment and social reintegration;
- drug-free treatment;
- an overview of substitution treatment;
- a global picture on both drug-free treatment and substitution treatment for the EU plus Norway; and
- a very first pan-European overview on social reintegration.

Problems and difficulties encountered

Problems and difficulties vary from country to country, but instead of elaborating on each of the countries here, we will focus on common problems.

There is generally a problem with the treatment inventories being both too generic and too detailed at the same time. This seeming contradiction is possible as many inventories for each treatment unit deliver very generic information such as address, or phone and fax numbers but no information on treatment slots, treatment approach and treatment setting. Conversely, it is a common phenomenon that treatment units report a wide series of services, making it impossible to classify them. There is no solution to this issue on the data quality of the treatment inventories. It simply has to be borne in mind that the lack of quality of data sets limitations on what can be done with it and what can be presented and concluded on the basis of the data.

The main bulk of treatment inventories are based on self-reporting which leaves it up to people in the actual treatment units to interpret what is meant by the various concepts. Unavoidably this leads to very different interpretations.

Another general problem has to do with the split between social reintegration and treatment. Frequently there is no clear distinction between these two concepts and even when there is, the problem arises that many services claim to provide both treatment and social reintegration. How should these services be classified? As either treatment or social reintegration or both? The problem here is a lack of clarity regarding the concept of social reintegration which is understood by some as the last phase of a long treatment process (typically drug-free) whereas others use it practically synonymously with treatment. There are even some who use the term to describe what others would call low-threshold services. This overall problem consists of at least three 'sub-problems', namely; what is treatment? what is social reintegration? and what do we do with units that deliver both services?

Turning away from what is related strictly to developing a core data set on availability of treatment and comparing it with data from other indicators and/or core data sets, the main issue concerns comparison with the Treatment Demand Indicator. One initial complicating

factor for comparing these two data sets is that treatment demand does not really count the number of treatment demands but rather the number of contacts. For example, Greece reported 1026 treatment demands for 1999 but at the same time had as many as 4000 drug addicts on waiting lists for substitution treatment: these 4000 addicts are not registered in the Greek Treatment Demand Indicator. Hence the Treatment Demand Indicator covers more what could be denoted as the number of '*client-service contacts*'. This complicates comparison with treatment availability which is normally measured in terms of *treatment slots* that in the course of a period can be occupied by one or more persons.

Nor is the comparison with prevalence of problem drug use an easy task. Firstly, the prevalence of problem drug use is always an estimate which is then compared with data on treatment availability – also an estimate. Furthermore, many prevalence studies try to trace a certain user group, for instance injecting opiate users, whereas the treatment facilities typically accept a wider range of users, for example, users of cocaine and/or amphetamines.

Observations on drug-free treatment

Some methodological notes are necessary before we present a European overview of drug treatment in general. Without entering into detail, here are some basic methodological difficulties that have arisen while trying to map, or obtain an overview, of the availability of drug-free treatment in the European Union and Norway.

Firstly, drug treatment is very often under the same roof as general addiction treatment, that is for alcoholics, gamblers etc. To the extent that data have allowed it, only treatment facilities that also deal with drug treatment are included and those that are exclusively for other kinds of abusers are excluded. On the other hand, there are treatment units dealing exclusively with the treatment of drug addiction which is why the tables that follow have been divided into addiction treatment units and drug treatment units. The addiction treatment units pose an additional problem – how do we count which proportion is for drug addicts? If an abuse treatment unit has, for instance, 100 treatment slots for all kinds of abusers and we have no information on the use or division of them, do we count 100 treatment slots or do we leave them out? In this overview 100 have been counted.

Secondly, what is a treatment unit or a treatment centre and how do we classify them? A straightforward idea is to divide them into outpatient and inpatient treatment but what do we do with those treatment centres/units which have both outpatient and inpatient treatment? In the country profiles they have been included in both and later a manual check of double-counts was carried out. This, however, has the disadvantage that you only count one unit when there in fact are two. In the following tables double-counts are not subtracted, or in other words, treatment centres that have both outpatient and inpatient have been counted in both categories.

Thirdly, the idea behind this exercise of mapping or getting an overview of treatment facilities is consistent with the EU Action plan on drugs (2000–2004). The EMCDDA is contributing to the Action plan at an operational level by compiling a 'snapshot' using 1999 data and later using 2003 data. Much of the empirical material for mapping treatment facilities comes from National Reports of National Focal Points in the Reitox network, but most of it derives from separately collected treatment inventories. The time of publication of these treatment inventories obviously varies largely, in fact as much as almost three years – some data are from 1 January 1999 and others are as recent as 1 November 2001. There is no way to overcome this problem, but it is an important situation to be kept in mind by readers.

Fourthly, some of the treatment units listed below might in some cases provide both drug-free and substitution treatment. Included in the list below are centres that at least provide drug-free treatment. Substitution treatment will be dealt with further on.

With all these precautions, the availability of drug-free treatment appears as follows.

Table 1: Availability of drug-free treatment in the European Union plus Norway (in units)

Country	Outpatient <u>addiction</u> [^] treatment units	Inpatient <u>addiction</u> [^] treatment units	Outpatient <u>drug</u> treatment units	Inpatient <u>drug</u> [#] treatment units	Total of drug-related treatment units*
Belgium	60	28	21	16	125
Denmark	-	-	-	32	32
Germany	944	n.a.	411	n.a.	n.a.
Greece	-	-	16	8	24
Spain	-	-	546	101	647
France	-	-	286	46	332
Ireland	50	27	2	9	88
Italy	-	-	821	1109	1930
Luxembourg	-	-	6	3	9
Netherlands	107	74	34	8	223
Norway	57	91	-	-	148
Austria	-	-	86	37	123
Portugal	-	-	51	141	192
Finland	138	115	50	43	346
Sweden	391	192	-	-	583
UK	n.a.	n.a.	n.a.	149	n.a.

[^]Addiction treatment units are only included here if they also cover treatment of drug addiction.

[#] Detoxification units and treatment in semi-residential settings are included in this category.

* Drug-related refers to both drug treatment and abuse treatment.

▫ Does not include Germany and UK.

~ Does not include Germany.

When the sign ' - ' appears that means that the type of intervention either does not exist (like for instance inpatient addiction treatment in Denmark) or that the data are actually available although not broken down into our categories and are nevertheless included in this table (like for instance Sweden, where data on drug treatment units are not presented but included in figures for addiction treatment). As can be seen in the table above we have obtained a decent overview of treatment units in 14 out of 16 countries (the exceptions being Germany and UK). This table can be used for the 'snapshot' of the situation in the field of drug treatment at the beginning of the EU Action plan and will be compared to the state of the art at the end of the period of the Action plan. However, as the size of units may vary from a few individuals to several hundreds, the data above do not allow us to do cross-country comparison on the availability of treatment. Over time, the country to country comparison can only be done assuming that the average size of units has not changed drastically during the 4–5 year period. The data above also cannot be used for a comparison with prevalence figures of problem drug use and figures on subjects in substitution treatment – for that purpose we need to look at treatment slots.

Table 2: Availability of drug-free treatment in the European Union plus Norway (in slots)

Country	Outpatient <u>addiction</u> [^] treatment slots	Inpatient <u>addiction</u> [^] treatment slots	Outpatient <u>drug</u> treatment slots	Inpatient <u>drug</u> [#] treatment slots	Total of drug-related treatment slots* [@]
Belgium	n.a.	n.a.	n.a.	n.a.	n.a.
Denmark	-	-	-	817	817
Germany	n.a.	9707	n.a.	4894	n.a.
Greece	-	-	n.a.	326	n.a.
Spain	-	-	n.a.	2903	n.a.
France	n.a.	n.a.	n.a.	n.a.	n.a.
Ireland	n.a.	n.a.	n.a.	n.a.	n.a.
Italy	-	-	n.a.	24059	n.a.
Luxembourg	-	-	n.a.	n.a.	n.a.
Netherlands	n.a.	1762	n.a.	87	n.a.
Norway	200	2400	40	600	3240
Austria	n.a.	n.a.	n.a.	n.a.	n.a.
Portugal	-	-	n.a.	2968	n.a.
Finland	n.a.	n.a.	n.a.	440	n.a.
Sweden	n.a.	n.a.	n.a.	n.a.	n.a.
UK	n.a.	n.a.	n.a.	1882~	n.a.

[^]Addiction treatment slots are only included here if they also cover treatment of drug addiction.

[#] Detoxification slots are included in this category.

* Drug-related refers to both drug treatment and abuse treatment.

[▣] Includes treatment in semi-residential settings.

[@] The numbers presented here are all minimum values as we cannot be certain that all treatment slots have been included in treatment inventories.

~ England and Wales only.

What can be seen clearly in this table is that the reliable information we have on the number of drug-free treatment slots in the EU Member States and Norway is extremely scarce. Of 64 boxes that should ideally all be filled in (4 boxes for each of 16 countries) it has only been possible to do so for 28 – leaving 36 blank. The quality of data at national level simply does not allow for such detailed information as number of treatment slots. It is also clear that information on number of treatment slots in outpatient settings is extremely scarce. One obvious reason for this is that the number of patients you are able to treat, and thus the number of treatment slots, is much more flexible and can fluctuate more widely in an outpatient setting than in an inpatient setting (where a treatment slot is simply a bed).

Regarding treatment approach/regime, especially in in-patient settings, it is very hard to 'shoehorn' the countries into a table. Instead the situation in the various countries will be presented briefly. The main bulk of treatment facilities in Denmark are Minnesota-model institutions, while in Norway there is a more or less 50/50 division between religious/Christian in-patient treatment institutions and 'neutral' ones. In the UK the picture is much more unclear, with a relatively even distribution between Christian, Minnesota-models, Therapeutic communities and General Houses. For the remaining countries there is no standardised way of breaking down treatment facilities by treatment regime/approach and consequently this information is not available.

Substitution treatment

As much of substitution treatment in Europe takes place through general practitioners, monitoring substitution treatment units would give an inaccurate picture of the real situation. As information on substitution treatment slots is practically non-existent, information has instead been collected on clients that are actually in substitution treatment. An overview of clients in substitution treatment compared with the prevalence data of problem drug use has already been published in the EMCDDA 2001 *Annual report* and is reproduced here:

Table 3: Substitution treatment amongst problem drug-users

Country	Estimated prevalence of problem drug use (1)	Number in substitution treatment	Coverage (2)
Belgium	20,200	7,000 (1996)	35 (3)
Denmark	12,752-15,248	4,398 (4,298 methadone, 100 buprenorphine) (1 January 1999) (4)	27-34
Germany	80,000-152,000	50,000 (2001) (4)	33-63
Greece	n.a	966 (1 January 2000) (4)	-
Spain	83,972-177,756	72,236 (1999)	41-86
France	142,000-176,000	71,260 (62,900 buprenorphine, 8,360 methadone (December 1999)) (4)	40-50
Ireland	4,694-14,804	5,032 (31 December 2000) (4)	34-100 (5)
Italy	277,000-303,000	80,459 (1999) (4)	27-29
Luxembourg	1,900-2,220	864 (2000) (4)	38-45
Netherlands	25,000-29,000	11,676 (1997)	40-47
Norway	9,000-13,000	1,100 (2001)	8-12
Austria	15,984-18,731	4,232 (1 January 2000) (4)	23-26
Portugal	18,450 - 86,800	6,040 (1 January 2000)	7-33
Finland	1,800 -2,700 (6)	240 (170 buprenorphine, 70 methadone)	9-13
Sweden	1,700-3,350 (6)	621 (31 May 2000) (4)	19-37
UK	88,900 - 341,423 (7)	19,630	6-22

NB: n.a. = Data not available.

(1) Methods for estimating problem drug use vary widely in Member States (EMCDDA, 2001). Estimates of problem drug use are mainly opiate users, except Finland and Sweden, where amphetamine use is significant but excluded from this table.

(2) Estimated proportion of problem drug users in substitution treatment.

(3) Prevalence figure only covers injecting drug users which may result in an overestimated percentage of subjects in substitution treatment.

(4) Information collected through NFP.

(5) A coverage rate of 100% seems implausible which suggests that the prevalence estimate of 4694 (from 1995) may underestimate current prevalence.

(6) Opiate users only.

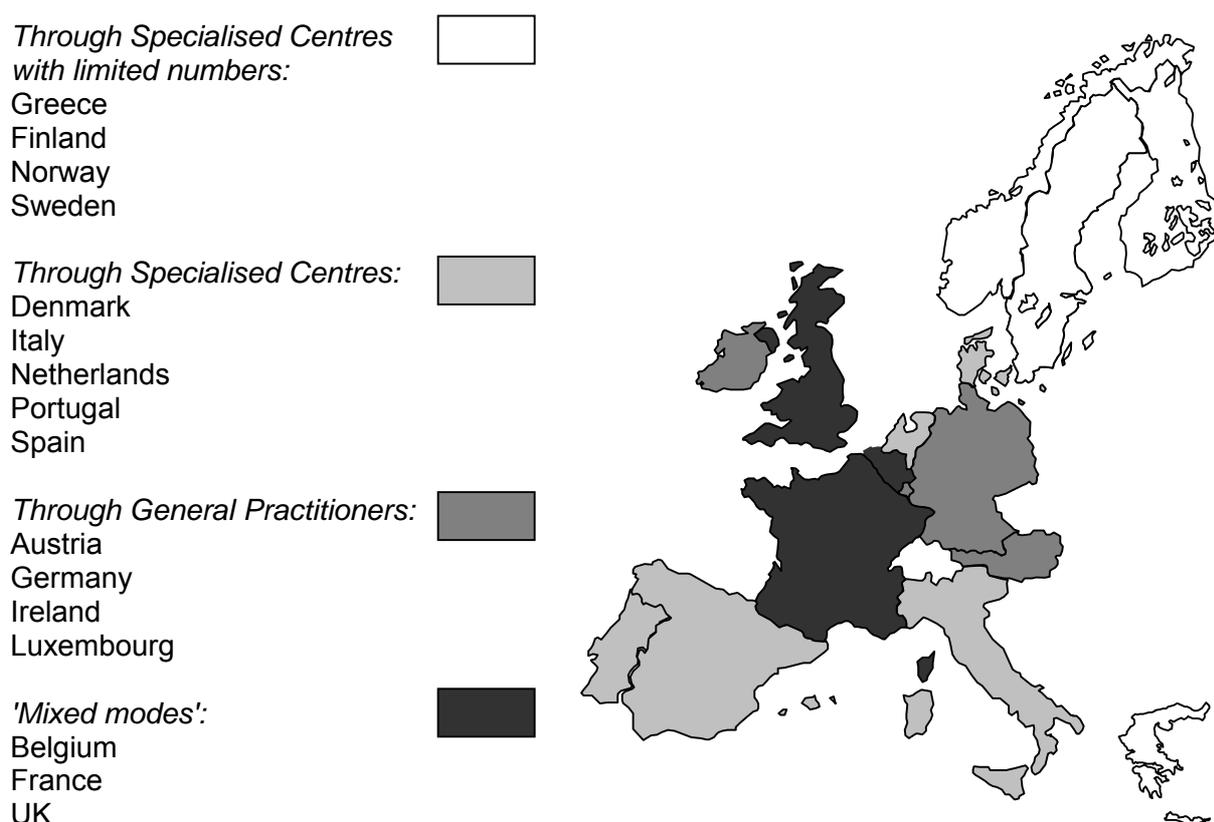
(7) More precise data for UK: prevalence of problem drug use (opiates) = 162,000-244,000; clients in substitution treatment = 35,000; coverage rate = 14-22%.

As can be seen by the table above, the coverage of substitution treatment services vary greatly within the EU Member States and Norway. One major reason for this is of a political nature as some countries have decided to take measures at national level to limit the availability of substitution treatment slots. This is typically done by either deciding how many substitution treatment slots will be made available or by setting high thresholds to enter substitution treatment. In others, and this goes for the majority, there is no decision taken at national level on high thresholds and/or limited number of treatment slots. These two fundamentally different approaches can be denoted as 'supply-driven' and 'demand-driven'

respectively. 'Supply-driven' countries are Finland, Greece, Norway and Sweden where the supply of substitution treatment is decided politically without necessarily reflecting the demand for such interventions. The remaining countries are 'demand-driven' so that the supply to a greater or lesser extent reflects the demand of problem drug users for substitution treatment.

The organisation of the delivery of substitution treatment varies considerably but may tentatively be categorised into four overall 'organisation modes': firstly, countries offering this treatment through general practitioners; secondly, those offering it through specialised centres; thirdly, those who provide it through specialised centres but with a limited number of treatment slots; and lastly, 'mixed modes' in which both general practitioners and specialised centres deliver substitution-treatment services. Expressed graphically it appears like this:

Figure 1: Organisation of delivery of substitution treatment services

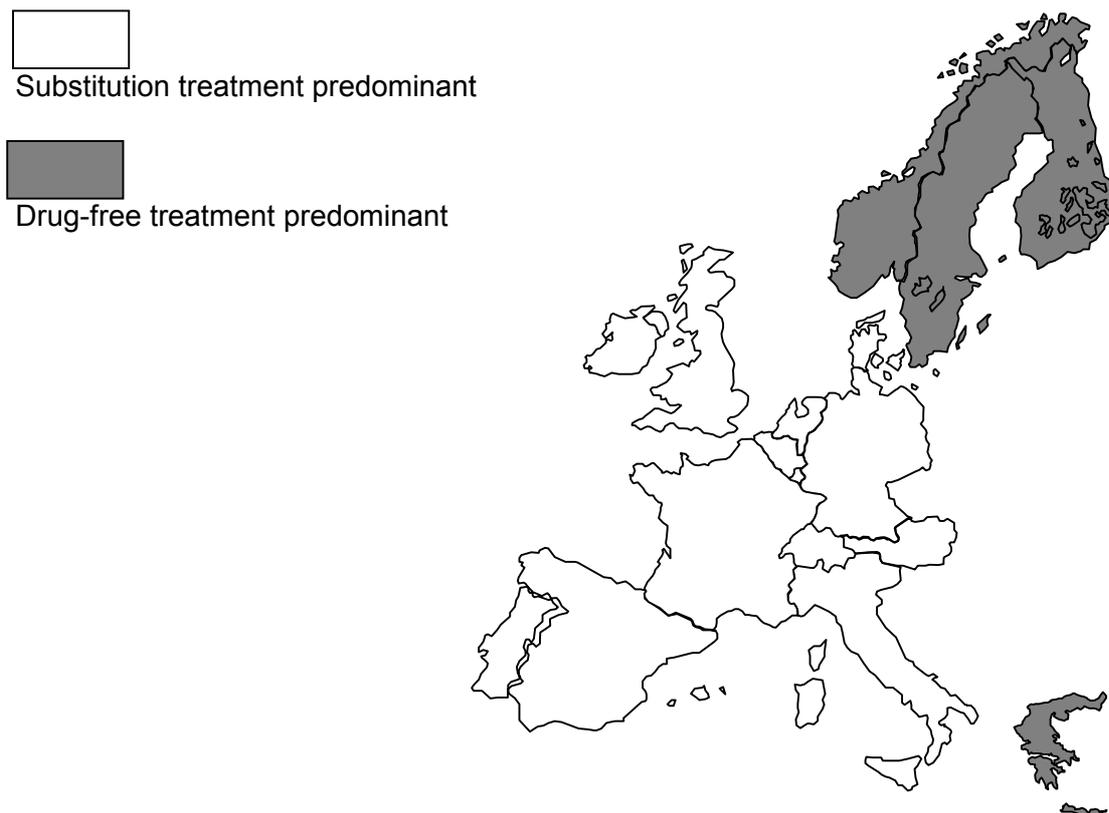


Drug-free treatment vs. substitution treatment

This last step in the exercise of concluding from a European perspective what the differences and similarities are between countries has to be done cautiously. All the problems with data quality and reliability at local and regional level accumulate at national level and of course deteriorate further when raised to European level. The following is not based on hard evidence or quantitative data alone but more on qualitative insights on national features.

Two fundamentally different overall drug treatment modes seem to appear. First there is the most common – substitution treatment – that in terms of numbers absorbs more clients than drug-free treatment. However, there are some exceptions to this, namely in countries where there is resistance to substitution treatment and consequently the emphasis is put on drug-free treatment. Generalised visually the situation appears like this:

Figure 2: Overall Drug Treatment Modes in the EU plus Norway



For both drug treatment modes there seems to be a general tendency for the main bulk of clients to be in outpatient settings. Norway could be the only exception to the rule but it is not possible to say for sure because the Norwegian treatment structure puts alcohol and drug addiction treatment in the same centres.

Regarding ownership of drug treatment services, in Denmark substitution treatment is organised and run at a regional level whereas inpatient treatment centres are almost all privately run. In Greece, the state body OKANA runs outpatient treatment centres whereas the main bulk of inpatient treatment centres are run by the private NGO, KETHEA. In France, the picture is more complex with both private and public sectors running therapeutic communities. Italy is characterised by having on the one hand state-financed and regionally run outpatient treatment centres, and on the other, privately run inpatient treatment centres. In Luxembourg, treatment facilities are run by public bodies. In Finland, almost all treatment centres are publicly run, varying between the municipalities and the state. In Norway, the three general types of ownership are either by private NGOs, Churches or municipalities.

At a European level, we can see two fundamentally different ways of creating treatment services. Firstly there are those that emerged at local level (run by public authorities or private 'grassroots' organisations) and then became part of the national drug treatment system at a later stage – we will call this 'bottom-up creation of treatment services' (for example, in Denmark, Germany, France, Italy, Spain and the United Kingdom). Secondly, there are those that emerged due to decisions taken at national/government level which were then implemented at local level – we will call this 'top-down creation of treatment services' (for example, in Greece, Portugal and Finland).

Social reintegration in the EU and Norway

Based on the country chapters in this report, a comprehensive overview of the availability of social reintegration services gives the following picture:

Table 4: Social reintegration in the EU and Norway[^]

Country	Estimated number of slots
Belgium	n.a.
Denmark	131
Germany	5771
Greece	720
Spain	n.a.
France	672
Ireland	n.a.
Italy	n.a.
Luxembourg	16
Netherlands	n.a.
Norway	n.a.
Austria	n.a.
Portugal	n.a.
Finland	n.a.
Sweden	n.a.
UK	n.a.

NB: n.a. = Data not available.

[^] Please see country chapters for comments on data and its quality for each country.

As can be seen, data on the availability of social reintegration services are even more scarce than on treatment services. However, data are available from a few countries and we will now have a closer look at these one by one.

Denmark reports 131 slots for social reintegration compared with 817 inpatient drug treatment slots. 4,300 individuals are in substitution treatment of which an unknown number will be in need of social reintegration measures sooner or later.

Germany reports as many as 5,771 slots for social reintegration which should be held up against close to 5,000 inpatient drug treatment slots and 10,000 inpatient addiction treatment slots. Moreover, there are roughly 50,000 clients in substitution treatment of which an unknown number will require social reintegration services.

Greece reports 720 slots for social reintegration compared with only 326 inpatient drug treatment slots. This surprisingly high number of social reintegration slots is partly explained by the fact that the 720 slots are not earmarked exclusively for (former) drug users, but also for former prisoners that do not necessarily have a drug problem. Further to these, there are 966 individuals in substitution treatment of which an unknown number will require social reintegration sooner or later.

Unfortunately, the 672 slots for social reintegration in France cannot be compared with treatment data as no information is available on the number of drug treatment slots in France. However, we know that there are around 70,000 clients in substitution treatment in France of which an unknown number will require social reintegration services.

It is the same situation in Luxembourg where no data on number of slots in drug treatment are available. 864 persons were reported to be in substitution treatment.

As can be concluded, it is very difficult to make an assessment of the adequacy of social reintegration services on the basis of the data currently available. If we assume that all treated addicts need social reintegration the data above might suggest a somewhat limited provision of social reintegration services when compared with the availability of treatment.

Further investigation into the availability and structures of social reintegration has been commissioned to an independent researcher and findings will be available in October 2002.