



## An overview of the treatment demand key indicator (TDI)

### Summary

The treatment demand indicator (TDI) is one of five key epidemiological indicators which contribute to the overall EMCDDA aim of providing objective, reliable and comparable information at a European level concerning drugs, drug addiction and their consequences (EU action plan on drugs 2000–04). This information is intended to provide the Community and Member States with, 'a better understanding of the drugs problem and the development of an optimal response to it through a measurable and sustainable improvement in the knowledge base and knowledge infrastructure' (EU drugs strategy, 2005–12).

To achieve this objective, the Centre is required to collect, analyse, compare and disseminate information at EU level, to: 'ensure improved comparability, objectivity and reliability of data by establishing indicators and common criteria of a non-binding nature, compliance with which may be recommended by the Centre, with a view to greater uniformity of the measurement methods used by the Member States and the Community' EMCDDA/7/01.



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### **About this document**

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The information contained in this document may be cited provided there is a clear indication of the source.

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## Introduction to the indicator

The treatment demand indicator (TDI) is one of five key epidemiological indicators which contribute to the overall EMCDDA aim of providing objective, reliable and comparable information at a European level concerning drugs, drug addiction and their consequences (EU action plan on drugs 2000–04). This information is intended to provide the Community and Member States with, ‘a better understanding of the drugs problem and the development of an optimal response to it through a measurable and sustainable improvement in the knowledge base and knowledge infrastructure’ (EU drugs strategy, 2005–12).

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## **The five key epidemiological indicators**

These were first described in the European Union action plan on drugs 2000–04, as:

1. Extent and pattern of drug use in the general population
2. Prevalence of problem drug use
3. Demand for treatment by drug users
4. Drug-related deaths and mortality of drug users
5. Drug-related infectious diseases (HIV, hepatitis)

The third of these has become known as the treatment demand indicator (TDI).

## **TDI core definition**

Routine, anonymous case-reporting of standardised core data on problem drug users presenting for treatment, collected nationally and aggregated at a European level.

The treatment demand indicator (TDI) consists of recommendations regarding method, definitions and items to be collected about problem drug users presenting to drug treatment facilities. These data are collected and collated nationally, and delivered annually to the EMCDDA, who then process and report on the numbers and characteristics of clients presenting to drug treatment facilities at European level.

## Purpose of TDI

The purpose is to obtain comparable, reliable information on the number and characteristics of problem drug users presenting for treatment in the EU Member States. Such information on the number and profile of treated problem drug users and their patterns of use can help in:

- providing a measure of treatment demand
- providing an indicator of trends in problem drug use
- assessing the minimum need for resources
- offering a perspective on the availability of treatment facilities
- identifying patterns in the use and uptake of treatment facilities
- planning and evaluating services for drug users
- estimating prevalence, when used alongside other datasets.

Much drug use, being illicit or illegal, is hidden from view. Information on the number of people seeking treatment for a drug problem provides insight into general trends in problem drug use and offers a perspective on the organisation and uptake of treatment.

TDI is designed to satisfy European requirements. It is envisaged that each country/ Member State will have more specific, and frequently additional national requirements for which local or national systems will be/have been developed.

## Methodology

### TDI core method

The TDI provides a uniform structure for reporting on the number and the characteristics of clients referred to specific drug treatment facilities. TDI collects information on clients at, or close to, their point of entry into treatment facilities for problems with one or more drugs. A core dataset of 20 items are collected anonymously about each presenting client concerning their social characteristics, treatment contact details and drug profile. The TDI Measures the yearly uptake of treatment facilities by those entering treatment for their drug use and by those entering treatment for the first time.

### TDI standard protocol 2.0

The TDI protocol is an established European protocol providing detailed guidance on the indicator. The protocol consists of: the Joint Pompidou Group-EMCDDA Treatment Demand Indicator Protocol version 2.0, and a more detailed Technical Annex. The protocol provides system requirements, a classification of treatment centres, definitions of terms (e.g. treatment, coverage, first treatment demand), case definition, a

core item list of 20 variables covering treatment contact, socio-demographic characteristics, drug use profiles and injecting behaviour, guidelines on methods of data collection, coding, analysis and reporting of results, as well as translation rules for existing national systems, procedures for quality control and a consideration of ethical issues.

The EMCDDA protocol built on work by the Pompidou Group of the Council of Europe, and on already existing European reporting systems, in particular from Germany, the Netherlands, Spain and the United Kingdom.

### **TDI key definitions**

**Case definition** — a case is a person who starts treatment for their drug use at a treatment centre during the calendar year 1 January to 31 December. If a person starts treatment more than once during the same year at the same or another centre, then only the last treatment in the year is counted.

**Treatment** — is said to start as soon as a client begins formalised face-to-face contact with a treatment centre.

**First treatment** — the first treatment is defined as the very first time during his or her life that a person starts treatment for drug problems.

**Drug treatment centres** — are defined as:

- outpatient
- inpatient
- low threshold services
- general practitioners
- prison treatment units.

**Primary and secondary drugs** — are defined for each client. Primary drugs are those reported as causing the client the most problems, as defined by the clients themselves or by diagnoses based on ICD-10. Use of the primary drug will usually be the main reason for asking for treatment. Secondary drugs (up to four for each client) are those used in addition to the primary drug.

**Double-counting** — the protocol includes procedures for minimising double-counting whilst respecting confidentiality. The use of the attributor <sup>(1)</sup> is recommended.

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<sup>(1)</sup> The attributor (initials, date of birth and gender) is recommended, or an equivalent method to minimise multiple counts.

## **TDI core item list:**

### *Treatment contact details*

1. Treatment centre type
2. Date of treatment — month
3. Date of treatment — year
4. Ever previously treated
5. Source of referral

### *Socio-demographic information*

6. Gender
7. Age
8. Year of birth
9. Living status (with whom)
10. Living status (where)
11. *Nationality* <sup>(2)</sup>
12. Labour status
13. Highest educational level completed

### *Drug-related information*

14. Primary drug
15. *Already receiving substitution treatment* <sup>(3)</sup>
16. Usual route of administration <sup>(4)</sup>
17. Frequency of use <sup>(4)</sup>
18. Age at first use <sup>(4)</sup>
19. Other drugs currently used <sup>(5)</sup>
20. Ever injected/currently (last 30 days) injecting

Items are fully specified in the protocol, but they do not necessarily have to be collected in exactly the same form, so long as each Member State can draw these data from within their national systems. National systems frequently collect a broad range of additional information considered relevant or important for strategic planning and other purposes.

## **TDI implementation**

Successful implementation relies on organisational ('top-down') commitment, involving political/bureaucratic leadership, and practical ('bottom-up') commitment, involving practitioner level support.

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<sup>(2)</sup> Nationality was included in protocol 2.0 but has since (2004) been dropped from the core item set.

<sup>(3)</sup> Substitution treatment was included in protocol 2.0 but has since been dropped from the core item set.

<sup>(4)</sup> Of primary drug.

<sup>(5)</sup> Up to four secondary drugs.

The treatment demand indicator can be introduced as a new national initiative or. More usually, it will build on pre-existing national structures. Information systems must be relevant to local/ national needs if they are to have value for planning and evaluation of services within a country.

## **TDI organisational structure**

Each Member State has a nominated expert in the field of treatment demand through its national focal points; this expert provides data analyses for the EU project and participates in the annual meeting.

Data are collected at treatment centre level and collated at regional/country level. It is essential to ensure infrastructure provision for data collection at source (this may be via computer or paper based systems). It is also important to provide an adequate skills base and staffing level for the collation, analysis and interpretation of data at Regional/ Country level. An ongoing training/support programme for staff at all levels is vital to ensure good practice and to maintain high quality standards.

## **TDI quality assessment**

Differences in coverage among Member States affects data comparability. To interpret data it is necessary to have a good overview of coverage issues within each country. Data definitions and inclusion/ exclusion criteria may also vary from those recommended in the TDI protocol. There is ongoing work to improve all aspects of data quality and coverage.

Furthermore, changes in policy affect the availability and use of drug treatment services (for example the expansion of methadone programs) and this may influence treatment figures over time. It is essential that treatment-related data be interpreted in the context in which they are collected.

## **TDI ethical issues**

When collecting personal information about persons presenting for treatment, care should be taken to ensure full compliance with national and regional regulations with regard to data protection and ethics. In order to minimise double counting of persons, TDI recommends the use of an attributor (initials, date of birth and gender). However, this is usually considered to be personally identifiable information that may require very specific compliance to regulations concerning use and secure storage.

## **TDI monitoring standards**

Member States are expected to implement the TDI in their country according to the standard protocol 2.0, as fully and completely as possible. It is expected that data collection, quality and analysis issues will be addressed locally and nationally. Final cleaned aggregate data in the form of Excel tables (standard tables 34 and 03) are expected to be uploaded to the EMCDDA via the focal points by the 30 September each

year, following the EMCDDA guidelines for national reporting. The tables allow opportunity for comment on relevant changes from previous years.

The EMCDDA collates the TDI tables and provides country specific feedback on issues of quality and timeliness of return, as well as a wide range of Europe-wide analyses.