



European Monitoring Centre
for Drugs and Drug Addiction

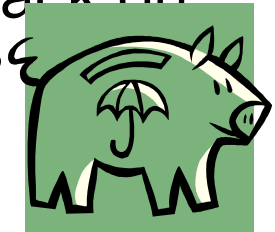
PDU revision – final proposal

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PDU revision

2011: document summarising discussions, ideas, options

Early 2012: online questionnaire collecting feedback on this document, several bilateral consultations
- learning experience, limited space for new developments currently



October 2012: final proposal attempting to take into account all views and feedback

Final revision proposal

- Concepts and definitions, data collection recommendations largely unchanged with the exception of
 - Collection of data on intensive cannabis use
 - Making provision for interested countries to report on other, including new, drugs
- Will be applied in revised guidelines after discussion and consensus



PDU/revised – HRDU

Focus on HIGH RISK DRUG USE

meaning “**drug use that is causing actual harms (negative consequences) to the person (including dependence, but also other health, psychological or social problems) or is placing the person at a high probability/risk of suffering such harms**”.

Definition for measurement: “**High risk drug use is the illicit use of psychoactive substances by high risk pattern (e.g. frequently, in binges) and/or by high risk routes of administration in the last 12 months.**” operationalised by drug



PDU/revised – HRDU

- Principal task: to estimate annual prevalence of high risk drug use, or the sizes of populations with high risk drug use
- Only includes substances which are causing the most harm and are sufficiently prevalent (rare harmful substances are monitored by the EWS)
- Studies should be planned (appropriate data sources and methods sought) with having in mind the utility of estimates to inform policy about treatment need



Three components of the revision proposal

- A. Estimates of prevalence of high-risk drug use
- B. Monitoring of characteristics of high risk drug users and trends
- C. Opioid substitution treatment (OST) clients in the revised indicator



A. Estimates of prevalence of high-risk drug use

- Three core estimates common for all countries:
 - **High risk opioids use**
 - **Injecting drug use**
 - **High risk cannabis use**



- Three elements depending on country situation and data sources:
 - **High risk cocaine use**
 - **High risk amphetamines use**
 - **High risk use of other substances**



- Two elements to understand multiple drug use and poly-drug use
 - **Estimates of overlaps between opioids and stimulants user groups (in national reports)**
 - **OPTIONAL Total PDU (with overlaps accounted for)**



Case definitions – based on what



- Literature review on relation between frequency of use and harm/problems
- Overview of literature on use in recreational settings/controlled use studies
- Characteristics of clients entering drug treatment
- Finally some arbitrary element



High risk opioids use

Case definition at the level of the data source, in the order of preference:

1. Use of opioids including opioid medicines **daily or almost daily** in at least one month of the past year, not according to medical prescription.

OR

2. a **medical diagnosis** according to current DSM or ICD criteria, e.g. “harmful use or abuse or dependence on opioids or opioid use disorder” (diagnosed in the past 12 months)

OR

3. **any other best proxy** of the above which can be collected at the level of the data source for the last year

e.g. if drug treatment data is used, the best available proxy can be “any demand for treatment due to opioids as a primary or secondary drug.”
Or if criminal justice data is used, an example proxy definition can be “registered by police due to possession of opioids, under laws not related to drug trafficking/dealing”.



Injecting drug use

Injecting use of any psychoactive substance(s) not according to medical prescription in the last year.

OPTIONAL: breakdown by injected substances



High risk cocaine use

IF RELEVANT FOR COUNTRY'S DRUG SITUATION AND FEASIBLE

Case definition at the level of the data source, in the order of preference:

1. If **frequency of use** data is available, one or more of these three conditions should be fulfilled:
 - a) Use of cocaine daily or almost daily in at least one month of the past year.
 - b) Use of cocaine weekly or more frequently in the past year for at least six months (alternatively can be measured as 24 days or more in the past year).
 - c) Use of cocaine in binges in the past year (defined as use of cocaine continuously for 48 hours or more).

OR

2. a **medical diagnosis** according to current DSM or ICD criteria: “harmful use or abuse or dependence on cocaine or stimulant use disorder”

OR

3. **any other best proxy** of the above which can be collected at the level of the data source

e.g. if drug treatment data is used, the best available proxy can be “any demand for treatment due to cocaine as a primary or secondary drug”.



High risk amphetamines use

IF RELEVANT FOR COUNTRY'S DRUG SITUATION AND FEASIBLE:

Case definition at the level of the data source, in the order of preference:

1. If **frequency of use** data is available, one or more of these three conditions should be fulfilled:
 - a) Use of amphetamines daily or almost daily in at least one month of the past year.
 - b) Use of amphetamines weekly or more frequently in the past year for at least six months (alternatively can be measured as 24 days or more in the past year).
 - c) Use of amphetamines in binges in the past year (defined as use of amphetamines continuously for 48 hours or more).

OR

2. a **medical diagnosis** according to current DSM or ICD criteria: "harmful use or abuse or dependence on amphetamines/other stimulants or stimulants use disorder"

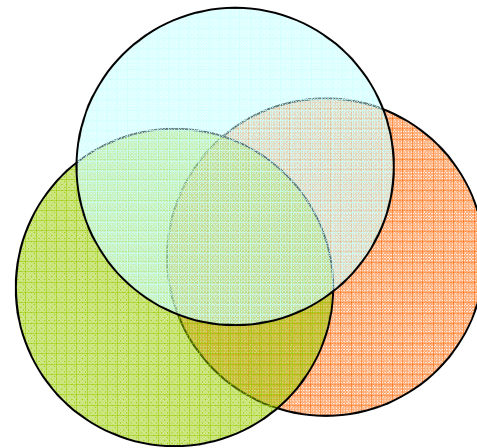
OR

3. **any other best proxy** of the above which can be collected at the level of the data source

For example, if drug treatment data is used, the best available proxy can be "any demand for treatment due to amphetamines as a primary or secondary drug"



Estimates of overlaps between the above-mentioned groups, accounting for multiple drug use and poly-drug use



From model or other studies, to be reported in national reports

**Total of the above-mentioned categories
(after accounting for overlaps within the
model)**

OPTIONAL

If interested to calculate previous PDU - can be
reported



High risk cannabis use

- Synthetic cannabinoids?

Case definition at the level of data source:

1. use of cannabis daily or almost daily in at least one month of the preceding year; in case of general population surveys this will be approximated by use of 20+ days in the month preceding interview,

OR

2. medical diagnosis according to current DSM or ICD criteria, e.g. cannabis abuse/harmful use or dependence or cannabis use disorder in the past year. For the purpose of monitoring this phenomenon at the level of general population surveys, this will be approximated by short psychometric scales (see the respective upcoming guidelines).



High risk use of other substances

OPTIONAL AND ACCORDING TO COUNTRY
SITUATION

Cathinones, GHB, volatiles, ...

Case definitions? Cathinones possibly same as
stimulants. Other drugs?



Monitoring of characteristics of high risk drug users and trends

- Characteristics of users (for example, their age distribution, gender, drugs used, patterns of use, mental/physical health, social and legal problems
 - Use of TDI data and studies in other settings (e.g. national LTS surveys, street population, serosurveillance studies)
- Incidence of high risk drug use
- Options for better understanding of current, possibly new, trends (non-treatment studies, new approaches – wastewater, new ways of data collection)



Opioid substitution treatment (OST) clients in the revised indicator

- Currently in POU, OST clients included to varying extent
- Needs to be understood better (Fonte)
- Importance of OST coverage calculation

- If non-OST data sets used for estimation, non-stable OST clients will naturally be included
- If OST treatment entries are used – the same situation
- If entire OST data set is used – more serious violation of homogeneity assumption, unless basically all OST clients are unstable



Problem and solution

- Problem – philosophical, statistical, coverage
- i.e. how to obtain methodologically “clean” estimates and be able to calculate coverage at the same time
- Part of OST clients included – not to compromise the homogeneity assumption
- Three elements to even more correctly calculate coverage:
 1. OST total
 2. proportion non-stable &
 3. HROU estimate



Discussion



New questions

- “hybrid” overall estimate? Interpretability
 - improvement over the existing situation? Moving towards harmonisation?
- Comparability over time?
- Decisions about data collection at the level of data source?



Next steps

- 5 November – deadline for additional comments
- 9 November – Updated proposal for discussion at the HFP meeting

