KEY FIGURES ADDICTION CARE 2004

NATIONAL ALCOHOL AND DRUGS INFORMATION SYSTEM (LADIS)

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CONTENTS

INTRODUCTION

IVZ has been publishing its annual *'Key Figures Addiction Care'* since 1988. This publication highlights trends and developments in demands for assistance and the assistance system in addiction care. The figures in this publication are derived from the National Alcohol and Drugs Information System (LADIS). This registration system has been in existence since 1986 and has been anonymously monitoring unique clients since 1994. The Stichting Informatievoorziening Zorg (IVZ; Foundation for the provision of information on the care of drug addicts) [1] has been designated by the Minister of Health, Welfare and Sport as the manager of the LADIS within the framework of the implementation of the Registration Regulations for Addiction Care. IVZ is also responsible for publishing data from this system. The regulation obligates institutions for (outpatient) addiction care to provide annual anonymous individual client data about the nature and extent of the use of care. IVZ also provides the national link of the Client Monitoring System (CVS) of the Probation and After-Care Service, in which addiction care registers its probation data. This creates a coherent picture of the care system and care consumption within (outpatient) addiction care.

New systems for data collection have been set up with some regularity. Not infrequently, it has been suggested that other databases can be discontinued. Addiction care is also continuously confronted with changes in this field and the extra organisational burden that results. To meet this administrative pressure, therefore, a link between a number of systems in mental health care (GGZ) has been introduced. By doing so, institutions need provide data to this central system only once. The central system then supplies all source files. This trend is expected to continue in care in the coming years, thereby further reducing the administrative work pressure.

Organisations frequently regard the registration of activities within the framework of addiction care as a heavy burden in their daily activities. Institutions may not be fully aware that the transparency resulting from the provision of registration data may also serve other purposes. In a national and international connection, trend figures are largely indicative of the detailed development and financing of the care. This fact however is still insufficiently persuasive for the parties in the field. Insight into the development of treatment demand and the assistance system in such a sensitive policy area as alcohol, drugs and gambling addiction is necessary for proper policy development in this field.

The LADIS annually demonstrates in numerous publications and through contributions to national policy documents such as the National Drug Monitor (NDM) and municipal monitors that the content of such systems can thoroughly shape image and policy. These contributions have resulted in an increased public profile and recognition of the LADIS among numerous parties. Recently, IVZ also intensified its collaboration with the Trimbos Institute and the RIVM to even further improve the utilisation and distribution of the registered data.

New forms of publications, including frequent topical bulletins and a CD-ROM on 10 years of unique client coding in addiction care should contribute toward motivating employees in addiction care to continue to register and deliver their basic materials with precision.
We would like to take this opportunity to thank these employees. Without their efforts, the registration could not exist.

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Director IVZ

[1] See http://www.sivz.nl

DATA PROVISION 2004

During 2004 and early 2005, IVZ compiled the figures for the entire registration year 2004. The majority of the institutions can provide data on a regular basis (quarterly), but there are also institutions that incidentally/constantly have problems in delivering the required data. This is usually the result of changes within the organisation and problems linked to the designs and input of new registration systems.

IVZ endeavours to provide optimal support for the problems that are often technical in nature. IVZ also conducts checks on the submitted data. Logical checks can rectify simple administrative errors, such as 'the married pre-schooler' or 'the missing registration data, while contact data had been sent in'. Through this close cooperation with the registration employees, adequate delivery to the LADIS can usually be realised within the deadlines. To illustrate, the schedule for submission is included as an example below. (Figure 1)

Through organisational mergers and demergers, however, there are also problems that unfortunately result in the omission of institutions in the LADIS database. This year, for example, the information on South Limburg was not delivered due to the transition and division of the CAD Limburg into the Mondriaan Zorggroep and the GGZ group North and Central Limburg. This is a major loss for the regional figures, certainly given the importance of the region with respect to the countries around us and the specific related drug problem.
This has been solved quantitatively by utilising the extrapolated regional figures from 2002 (the latest reliable registration year). The result is a full-fledged national picture, but a current picture cannot be provided for South Limburg as yet.
The data from the methadone distributions significantly improved and became more comprehensive after the installation of new software at a number of methadone stations. Thanks to the improvement of the various client databases linked to this, good information is now available from various methadone stations in Brabant, Limburg, Gelderland and Overijssel.

In most areas, a good qualitative level of data delivery has been attained with some effort, but hard work is needed in a number of areas to acquire a better quality of data in 2005. Continuous monitoring of data remains a necessity.
Various quality checks take place after the institutions deliver the data. The institutions receive a quality report with the opportunity to improve the file, if necessary.

Figure 1 Diagram of data delivery

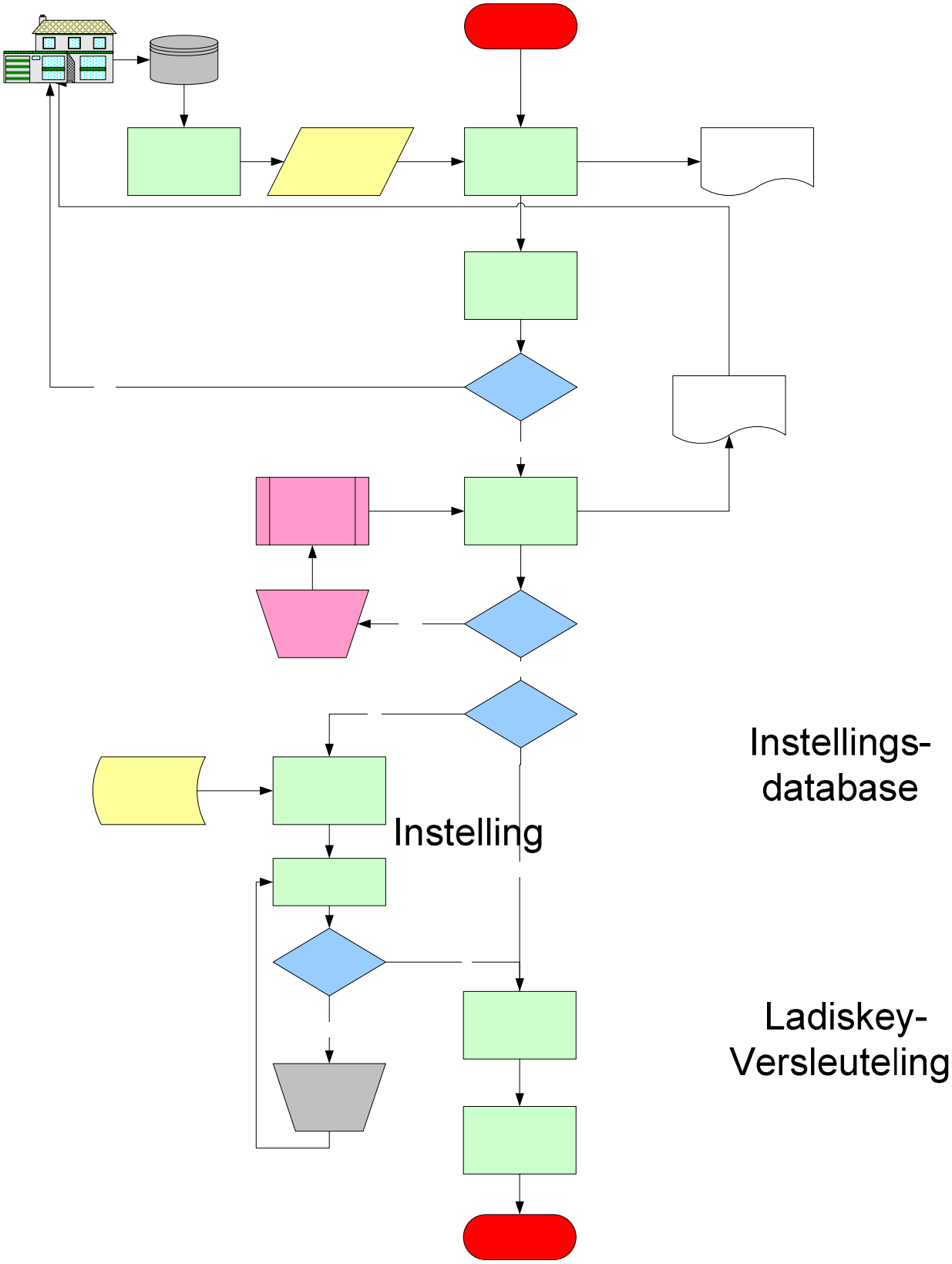


Diagram of the data delivery and monitoring procedure at IVZ. After the first checks, the files are merged with files from CVS (Probation).

Further checks are also made during processing and reporting. Ultimately, after a second encryption, this provides a database from which the key figures and other reports are prepared.

The new 'LADIS Specifications 2005' will apply starting in 2005. Client applications at the institutions had to be revised for this as well. The data model for the LADIS delivery has been greatly simplified. The new specifications can be found on the IVZ website[1], or can be requested from the IVZ administration.

[1] http://www.sivz.nl/content/_files/ladis_specs_2005.pdf

KEY FIGURES ADDICTION CARE 2004

1. Characteristics of the assistance system and the demands for assistance
2. Problems
3. Characteristics of individuals who demand assistance
4. Special characteristics of problems and care

1. CHARACTERISTICS OF THE ASSISTANCE SYSTEM AND THE DEMANDS FOR ASSISTANCE

1.1 Assistance system

Figure 1 Organisation of (outpatient) addiction care and treatment and work areas in the Netherlands

This map depicts the institutional boundaries as of 31 December 2004. The municipal medical and health service (Amsterdam), Stichting de Regenboog (Amsterdam), Stichting Triton (Den Helder) and the Stichting HKPD (Vlissingen) are not mentioned separately within the Amsterdam, North Holland North and Zeeland work areas.
In 2004, a number of developments took place within the institutional boundaries:

- As of 1 January 2004, Novadic and Kentron merged into one institution, thereby covering the entire province of Brabant.
- As of 1 January 2004, CAD Limburg has been divided into two parts, northern and southern Limburg. The northern part has been absorbed in the GGZ group North and Central Limburg, and the southern part has become part of the Mondriaan Zorggroep.
- As of 31 May 2004, the Dr. Kuno van Dijkstichting, AVG Groningen and CAD Drenthe have merged into the Stichting Verslavingszorg Noord-Nederland (VNN).

1.2 Demands for assistance

The LADIS was originally designed as a registration system for outpatient addiction care. Through a large number of mergers between institutions for addiction care, both outpatient and clinical data are available in a number of cases. The following types of care are registered in the LADIS: (outpatient) addiction care, probation and after-care, intramural and outpatient.
The table below depicts the share of these types of care within the LADIS by percent of the total for the period 2002-2004.

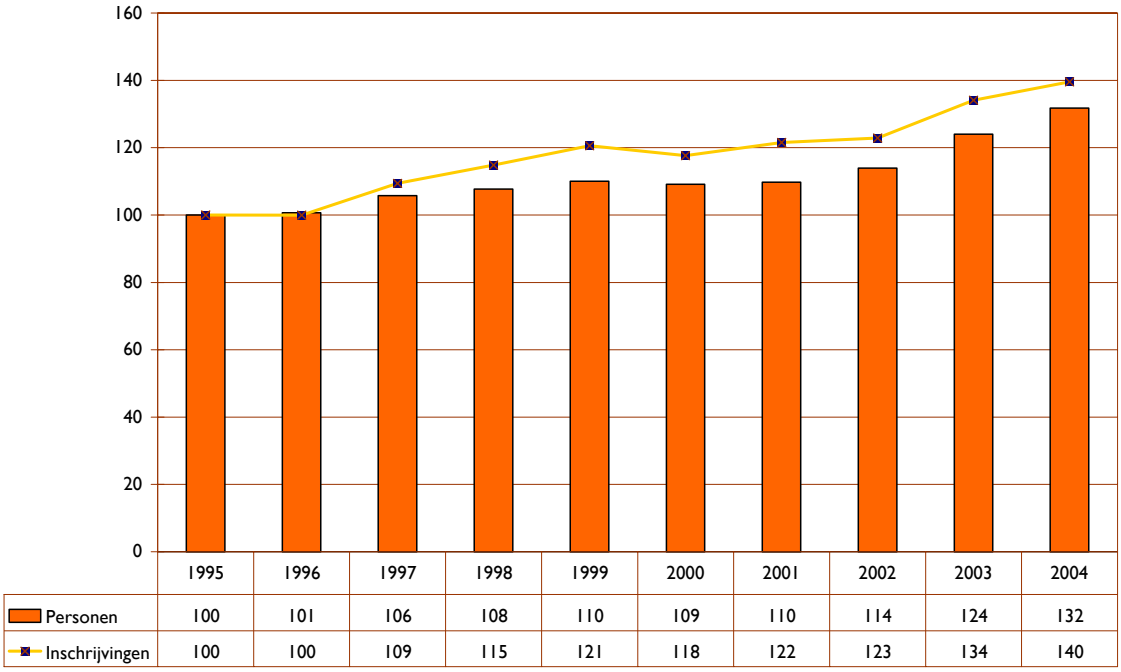
Table 1 Individuals by type of care 2002-2004

Type of care	2002	2003	2004
(Outpatient) addiction care	66%	49%	40%
Clinical	5%	6%	4%
Outpatient	13%	30%	40%
Probation[1]	16%	16%	16%
Total	**100%**	**100%**	**100%**

Source: LADIS 2004, IVZ, Houten

While the number of people in outpatient care declined during the past two years, there has been a proportional increase in the percentage of clients receiving outpatient care.

Figure 2 Individuals and registrations 1995-2004 (index figure 1995 = 100)



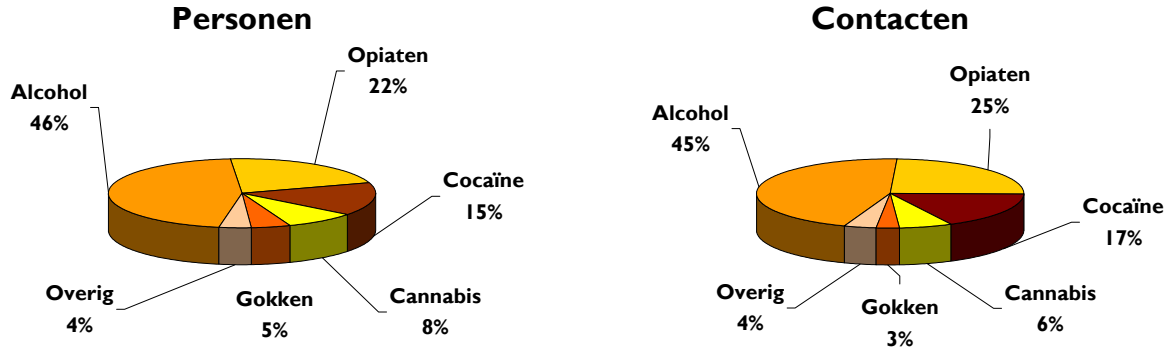
	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Personen	100	101	106	108	110	109	110	114	124	132
Inschrijvingen	100	100	109	115	121	118	122	123	134	140

Source: LADIS 2004, IVZ Houten

[1] Data on addiction probation are not provided to the LADIS directly via the addiction care institutions. Data on individual probation clients with addiction problems are provided via the Client Monitoring System (CVS) of the Stichting Reclassering Nederland.

After a number of years of reasonable stability, the years after 2001 have seen a sharper increase in the number of care demands and accompanying registrations [1].

Figure 3 Demands for assistance 2004 by individuals and contacts



Alcohol	Drugs	Other		Alcohol	Drugs	Other
46%	45%	9%		45%	48%	7%

Source: LADIS 2004, IVZ, Houten

- The percentage distribution by problem has remained virtually the same for individuals and number of clients.
- Cocaine is the most striking riser in share of contacts (from 4% in 1994 to 17% in 2004) and share of individuals (from 5% in 1994 to 15% in 2004).

Contacts

The contacts of addiction care institutions can be divided into type or kind of contact. These contacts distributed by problem are described in Table 2.

Table 2 Contacts by primary problem and nature

Contacts	Alcohol	Opiates	Cocaine	Cannabis	Gambling	Other	Total
Total contacts	286,852	154,800	108,319	39,228	17,426	26,014	632,639
Percentage							
Individual contact Public Health	80%	88%	73%	79%	75%	82%	81%
Individual contact Justice	9%	9%	22%	13%	9%	9%	11%
Group contacts	10%	3%	5%	7%	15%	4%	7%
Once-only contacts	1%	1%	0%	0%	1%	5%	1%

Source: LADIS 2004, IVZ, Houten

- The number of Justice contacts increased somewhat this year to 11% from 9% in 2003. Cocaine users continue to stand out among these contacts.
- This increase applies for all types of primary problems except gambling.
- The number of once-only contacts declined further in 2004, from 2% to 1%.
- Group contacts are still an appropriate form of assistance for 1 out of 10 alcohol addicts. This picture has been stable for years (approx. 10%). There has been a visible decline in the number of group contacts for all other problems.

[1] The last significant expansion of the LADIS took place in mid-2000. As a result, a possible registration artefact should have already been evident in 2001. Therefore, the increase in demand for assistance in the most recent years does not appear to be caused by a registration artefact.

2. PROBLEMS

2.1 Coverage of addiction care

A further impression of the scope of (outpatient) addiction care can be acquired from the most recent data taken from the National Drug Monitor (NDM 2004).

Table 3 Problems by scope and use

Extent of use in the population		Estimate dating from	Clients in treatment in (outpatient) addiction care	
			In %	Number
Alcohol	1,175,000 [1]	2003	3%	29,518
Opiates	between 22,000 and 42,000	2001	between 33 and 63%	13,929
Cocaine	55,000	2001	18%	9,999
Cannabis	40,000	2001	1%	5,456
Gambling	70,000	1998	4%	3,056
Other				2,564

Sources: NDM 2004, LADIS 2004 and Profile of gambling clients

Note. The use figure in the table for cannabis and cocaine regards figures on CURRENT use among the population. These may not be confused with the use figures for alcohol, opiates and the gambling group. Research-based figures for these groups indicate PROBLEMATIC use in the population. Recent figures on problematic use of cannabis and cocaine in the Dutch population are not available.

- The latest figures from the NDM show that the average estimate of opiate users comes to around 32,000 with a range of 22,000 to 42,000. This range has increased compared with previous estimates. No new estimates are known.
- For alcohol and cannabis, the number of demands for assistance remains strikingly low, while estimates show that 10% of the Dutch population between 16 and 69 years of age are problem drinkers. Demands for assistance in relation to estimated use are also relatively low for cannabis. Demands for assistance have been increasing, however (see also Table 5).

Table 4 Scope of total demands for assistance 1994 – 2004

Period	Total number of demands for assistance
1994	48,158
…	…
2002	55,783
2003	60,707
2004	64,522
1994-2004	19,016

- Compared to 2003, the total number of individuals who appealed to addiction care rose by 6%. The Dutch population increased by 0.4% during that same period.
- The number of individuals who register for assistance in addiction care per year has risen by 31% since 1994.

[1] According to a report by Dijck & Knibbe, *De prevalentie van probleemdrinken in Nederland (The prevalence of problem drinking in the Netherlands),* there was a 10.3% increase in the number of problem drinkers in the Dutch population in 2003.

Table 5 Volume and development of demands for assistance 2003 -2004

Primary problem	Number of individuals in 2004	Change compared to 2003	Share in 2004
Alcohol	29,518	+ 10 %	46 %
Opiates	13,929	- 8 %	22 %
Cocaine	9,999	+ 8 %	15 %
Cannabis	5,456	+22 %	8 %
Gambling	3,056	+ 8 %	5 %
Other	2,564	+21 %	4 %
Total	64,522	**+6 %**	**100%**

Source: LADIS 2004, IVZ, Houten

- The demand for assistance from opiate users declined again in 2004. On the other hand, there has been a continuous increase in the use of other substances.
- It is also striking that demand for assistance for gambling addiction has shown an increase for the second consecutive year after years of decline: this year an increase of 8% compared with 7% in 2003.
- After cannabis, demand for assistance in connection with cocaine use has been a sharply increasing group among problematic drug users. This trend has been observed since 1994.
- Demand for assistance from cannabis users compared with estimated use in the Netherlands is relatively low, but has continued to increase sharply in percentage terms during the past few years.

Table 6 Turnover 2004 addiction care by primary problem

	Number of individuals				
Primary problem	Registered as of 1-1-2004[1]	New in 2004	Treated in 2004	Discharged in 2004	Registered as of 31-12-2004
Alcohol	18,263	11,255	29,518	9,224	20,294
Opiates	12,146	1,783	13,929	1,646	12,283
Cocaine	6,760	3,239	9,999	2,739	7,260
Cannabis	2,857	2,599	5,456	1,876	3,580
Gambling	1,797	1,259	3,056	1,065	1,991
Other	1,428	1,136	2,564	769	1,795
Total	**43,251**	**21,271**	**64,522**	**17,319**	**47,203**

Source: LADIS 2004, IVZ, Houten

- 58% of the newly registered individuals in 2004 had not previously been in treatment at an institution for addiction care. See also Table 10.
- In 2004, 27% of the clients who were in treatment were discharged again.

[1] Compared with the 'Key Figures 2003' publication there may be small deviations in the presented figures due to corrections.

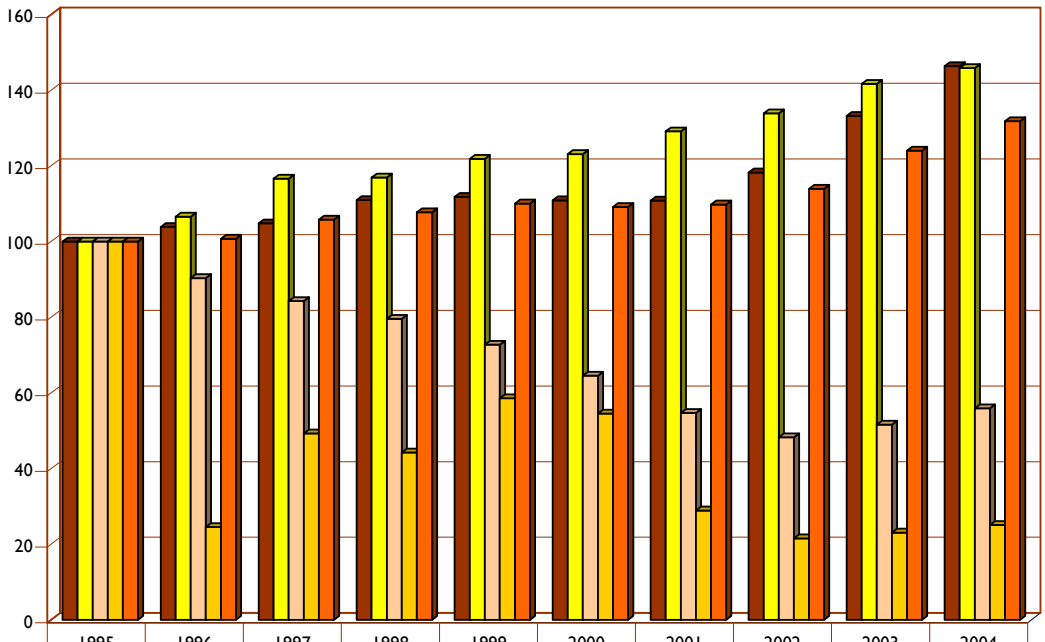
Table 7 Primary problem by individuals and contacts (index = 1994)

Primary problem	Individuals in 2004 (1994 = 100)	Contacts in 2004 (1994 = 100)
Alcohol	147	163
Opiates	99	88
Cocaine	405	545
Cannabis	280	296
Gambling	50	47
Other	57	79

Source: LADIS 2004, IVZ, Houten

- With an index figure of 405, the number of individuals with cocaine use as a primary problem has more than quadrupled since 1994. The number of contacts has increased by a factor of 5.5.
- The attention that the assistance system has devoted to cannabis clients also continues to grow. The rising trend of the past years persists.
- Since many opiate clients are in a methadone programme, the number of contacts from this group appears to be on the low side. Methadone distribution is discussed further in chapter 4.3.

Figure 4 Primary problem by demand for assistance 1995-2004

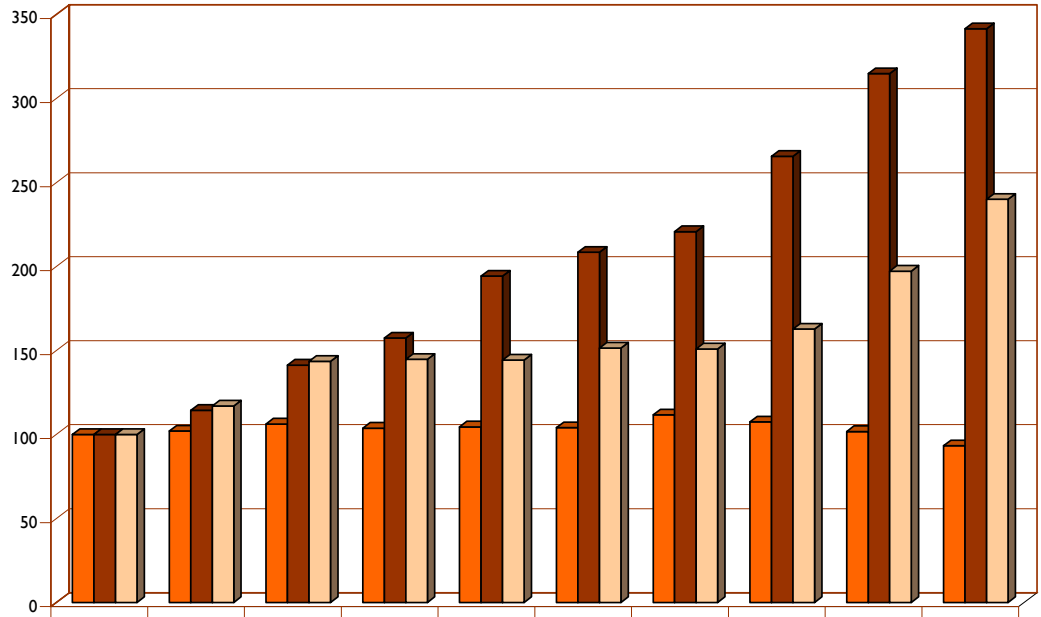


	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Alcohol	100	104	105	111	112	111	111	118	133	146
Drugs	100	107	117	117	122	123	129	134	142	146
Gokken	100	90	84	80	73	65	55	48	52	56
Overig	100	24	49	44	59	54	29	22	23	25
Totaal	100	101	106	108	110	109	110	114	124	132

Source: LADIS 2004, IVZ, Houten

Demand for assistance itemised by type of drugs as primary problem provides the following picture.

Figure 5 Primary problem of drug use (index = 1995)



	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Opiaten	100	102	106	104	104	104	112	107	102	93
Cocaïne	100	114	141	157	194	208	221	266	315	341
Cannabis	100	117	144	145	144	151	151	163	197	240

The following features emerge from figures 4 and 5:

- Since 2000 the number of demands for assistance in addiction care has increased sharply by nearly 21%.
- During the past 3 years, the number of opiate users has declined to below its 1995 level.
- After many years of a declining trend for gambling clients, an increase has been observed for the second successive year, with an 8% increase in 2004.
- Cocaine and cannabis traditionally remain strong risers.
- In 2003, a sharp increase was observed in the demand for assistance for alcohol problems. This trend continued in 2004. In all probability, the first effect of the Alcohol Care Plan of Action, initiated in 2002, will be visible.

A classification according to the CBS standard has been used to give insight into the distribution of the demand for assistance related to the size of the population of municipalities in the Netherlands.

Table 8 Primary problem by size of municipality

No. of inhab. in community	Dutch population	Alcohol	Opiates	Cocaine	Cannabis	Gambling	Other	Total
Unknown	0%	3%	6%	5%	2%	4%	3%	4%
< 10,000	4%	2%	1%	1%	2%	1%	3%	2%
10,000 – 20,000	15%	9%	4%	5%	7%	6%	9%	7%
20,000 – 50,000	33%	24%	17%	16%	21%	21%	29%	21%
50,000 – 100,000	17%	21%	19%	17%	22%	21%	19%	20%
> 100,000	31%	41%	53%	55%	46%	46%	37%	46%

Sources: CBS 2004; LADIS 2004, IVZ, Houten

Demand for assistance for addiction problems is high in the major cities, particularly for opiates and cocaine.

Table 9 represents demand for assistance expressed in a figure per 10,000 inhabitants in the Netherlands.

Table 9 Primary problem in individuals per 10,000 inhabitants

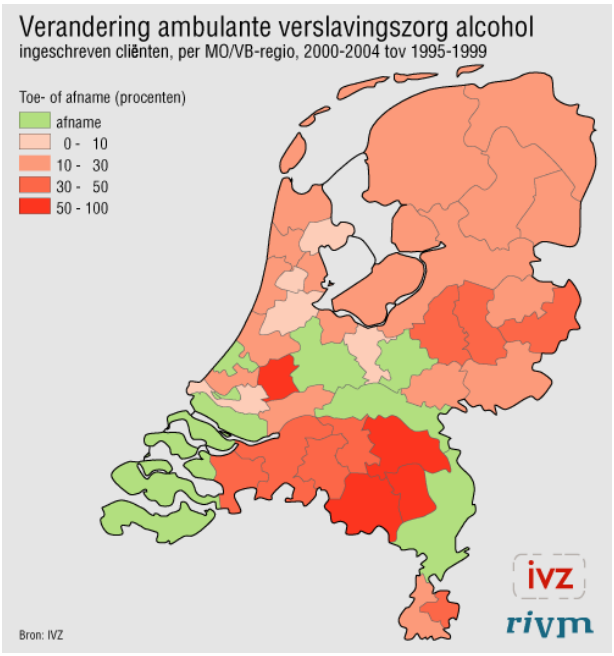
Primary problem	1998	1999	2000	2001	2002	2003	2004
Alcohol	14.3	14.3	14.1	14.0	14.8	16.6	18.2
Opiates	9.9	9.9	9.8	10.4	10.0	9.4	8.6
Cocaine	2.9	3.6	3.8	4.0	4.8	5.7	6.2
Cannabis	2.1	2.1	2.2	2.1	2.3	2.7	3.4
Gambling	2.8	2.5	2.2	1.9	1.6	1.7	1.9
Other	1.7	1.8	1.5	1.1	1.1	1.3	1.6
Total	33.7	34,2	33.7	33.6	34.6	37.5	39.5

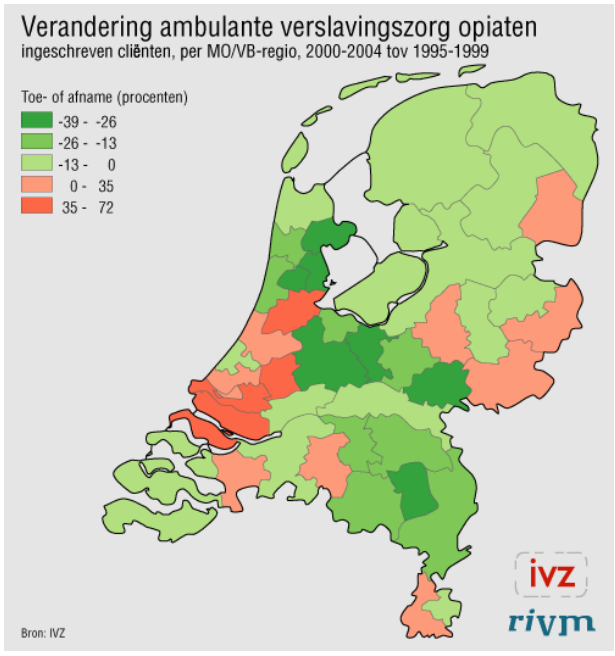
Source: LADIS 2004, IVZ, Houten

- This table also shows that alcohol, cannabis and cocaine are increasing and that gambling addiction is back to its 2001 level.
- The trend for opiates starting in 2002 also continued in 2004 and declined further to 8.6 clients per 10,000 inhabitants.

2.2 Regional development of the demand for assistance

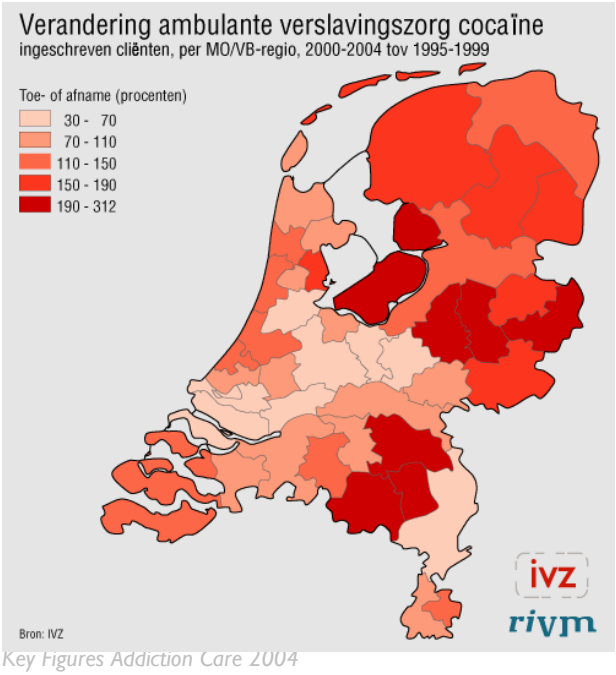
In cooperation with the National Institute for Public Health and the Environment (RIVM), within the framework of the health atlas, a number of geographic charts have been developed to show the relative growth of the demand for assistance. For alcohol, cocaine and opiates, an overview is given of the development of the demand for assistance during the past ten years. The period 1995-1999 is consistently compared with the period 2000-2004. A red colour on the map denotes an increase in the demand for assistance, while a green colour denotes a decline.





Demands for assistance for alcohol dependency provide a mixed picture: increase in demands for assistance in North Brabant, the south of Limburg and the northern half of the Netherlands and a decline in the remaining areas.

The Randstad appears to show a significant increase in demand for assistance in regard of opiate dependency. However, there is a registration artefact caused by the fact that a number of regional institutions started providing data to the LADIS during the past five years.



An increase in demands for assistance for cocaine dependency has been observed in the entire country in the period 2000-2004. Strong growth has been visible in the eastern part of Brabant, Flevoland and the eastern part of the Netherlands.
The existing backlog in absolute numbers of demands for assistance from the provincial areas appears to have shrunk when compared with the major cities.

3. CHARACTERISTICS OF INDIVIDUALS WHO DEMAND ASSISTANCE

3.1 Characteristics of primary problems, sex and type of care

Turnover data give an indication of the availability of assistance. Short duration of treatment, i.e. the period between registration and discharge, provides a rapid turnover in the number of individuals in (outpatient) addiction care. A more rapid turnover offers the opportunity to provide care for a larger number of new individuals. More than 195,000 unique individuals have been treated since 1994.

Table 10 Individuals not previously in treatment

Primary problem	No. of individuals in 1994-2004	No. of individuals in 2004	No. not previously in treatment	% 'not previously' in treatment
Alcohol	96,344	29,518	6,800	23%
Opiates	29,743	13,929	491	4%
Cocaine	21,538	9,999	1,677	17%
Cannabis	16,537	5,456	1,858	34%
Gambling	18,594	3,056	779	25%
Other	12,260	2,564	818	32%
Total	19,016	64,522	12,423	19%

Source: LADIS 2004, IVZ Houten

- The number of gamblers in treatment has increased, but the percentage of new clients faced with this problem declined slightly from 31% to 25%.
- Nearly a quarter of the alcohol group is new. The media increasingly link nuisance behaviour with alcohol use among youth. Further analyses on the relationship between alcohol use and age classification will reveal whether this is indeed the case and whether more youth will appeal for assistance as a result.
- With only 4% new customers, the group of opiate users is now a familiar group within the care system.

Table 11 Individuals by problem and sex 2004 compared with 1994

Primary problem	Number male	Number female	Total no. individuals 2004	Total no. individuals 1994	Index individuals (1994 = 100)
Alcohol	22,061	7,457	29,518	20,085	147
Opiates	11,117	2,812	13,929	14,002	99
Cocaine	8,185	1,814	9,999	2,468	405
Cannabis	4,488	968	5,456	1,951	280
Gambling	2,710	346	3,056	6,126	50
Other	1,649	915	2,564	4,526	57
Total	**50,210**	**14,312**	**64,522**	**49,158**	**131**

Source: LADIS 2004, IVZ, Houten

The proportion of women in assistance has remained virtually unchanged for years, fluctuating around 22%. Internationally, research is currently being performed on this proportion for the various problems. The European Institute for Alcohol and Drugs Monitoring (EMCDDA) has also devoted attention to the differences in sex. IVZ will discuss this in one of the next bulletins.

3.2 Registration method and problems

Individuals register on their own initiative and from various referral institutions for addiction care. The most important sources for registration are indicated below.

Table 12 Individuals by primary problem and registration

	Alcohol	Opiates	Cocaine	Cannabis	Gambling	Other	Total
Number of individuals	29,518	13,929	9,999	5,456	3,056	2,564	64,522
Method of registration							
Own initiative	26%	44%	26%	26%	38%	22%	30%
Justice	17%	16%	29%	17%	11%	17%	18%
Health care	19%	5%	10%	13%	14%	13%	14%
Mental health care	6%	2%	4%	8%	3%	7%	5%
Other	31%	32%	31%	36%	34%	40%	32%

Source: LADIS 2004, IVZ, Houten

- Most individuals in (outpatient) addiction care register without the interaction of a referral institution, particularly among opiate and gambling addicts.
- The largest percentage of the group who are referred via Justice to addiction care (29%) are cocaine-dependent.

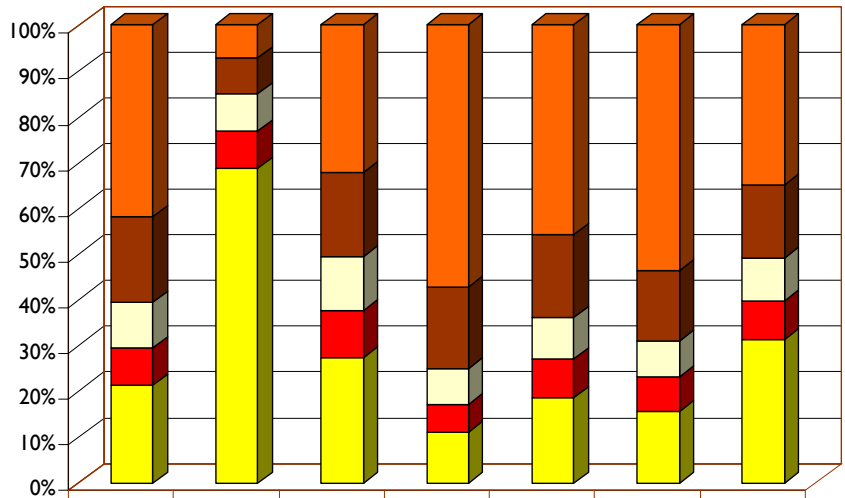
Table 13 Individuals by type of care

Probation and Addiction Care	
Total number of individuals	**64,522**
Exclusively probation clients	7,108
Exclusively addiction care clients	51,642
Both probation and addiction care clients	5,771

Source: LADIS 2004, IVZ, Houten

- Twenty percent of individuals in (outpatient) addiction care have direct involvement with the probation and after-care service.
- An IVZ bulletin published in 2005 provided more detailed information on the probation client in addiction care.

Figure 6 Individuals by primary problem and year of registration

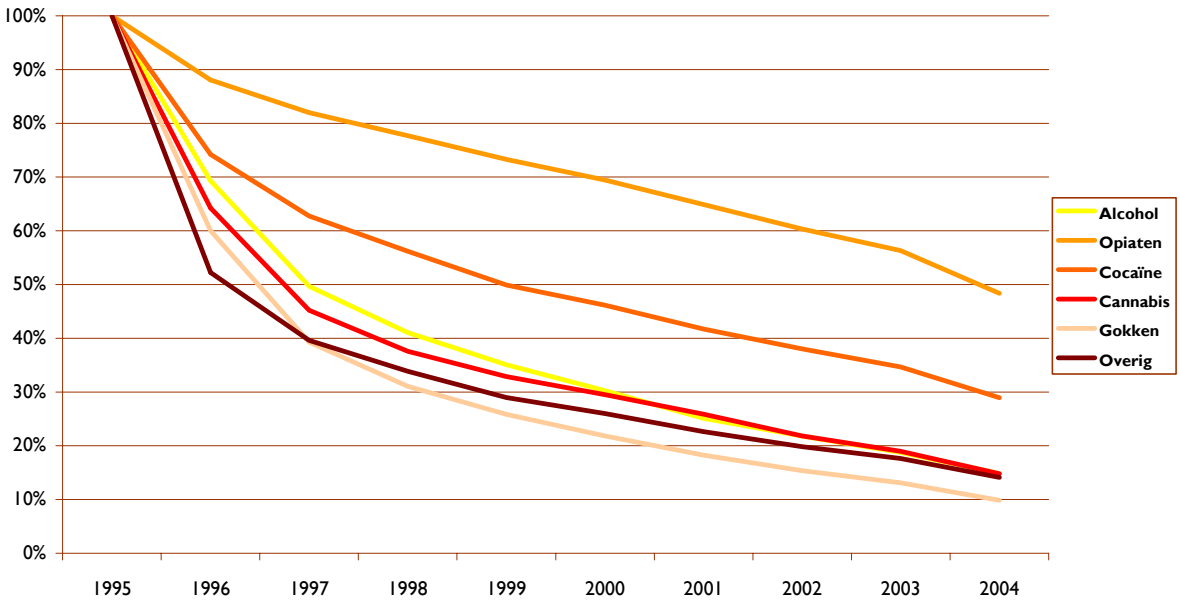


	Alcohol	Opiaten	Cocaïne	Cannabis	Gokken	Overig	totaal
2003-2004	42%	7%	32%	57%	46%	54%	35%
2001-2002	19%	8%	18%	18%	18%	15%	16%
1999-2000	10%	8%	12%	8%	9%	8%	9%
1997-1998	8%	8%	10%	6%	8%	8%	8%
voor 1997	21%	69%	27%	11%	19%	16%	31%

Source: LADIS 2004, IVZ, Houten

- 'Voor 1997' refers to individuals who were registered through 1996. This information has been available since the unique client code was introduced at the LADIS in 1994.
- More than half of the cannabis clients entered care within the past 2 years, while 70% with an opiate problem had been in treatment prior to 1997.

Figure 7 Individuals from 1995 by last year of contact with addiction care (1995=100)



Source: LADIS 2004, IVZ, Houten

Opiate and cocaine clients are discharged significantly slower than clients with other problems. 48% of the opiate clients and 29% of the cocaine clients still have contact with (outpatient) addiction care after 10 years. This percentage ranges between a 'mere' 10% and 15% for other forms of addiction-related problems.

The table below indicates the extent to which individuals who were registered for treatment in 2004 (total 64,522) had already registered for another primary problem on one or more occasions since 1994. In this case, the 'none' column means not previously registered for another problem, possibly however for the same problem.

Table 14 Individuals in 2004 by earlier registration of other primary problem

Present primary problem	Previous other problem						
	None	Alcohol	Opiates	Cocaine	Cannabis	Gambling	Other
Alcohol	87%	0%	5%	4%	2%	2%	2%
Opiates	66%	13%	0%	18%	3%	2%	7%
Cocaine	59%	12%	23%	0%	7%	4%	6%
Cannabis	81%	7%	4%	7%	0%	3%	4%
Gambling	86%	7%	3%	3%	2%	0%	2%
Other	73%	12%	8%	8%	5%	2%	0%

Source: LADIS 2004, IVZ, Houten

The majority of the clients have never appealed to assistance for another form of problem. Exceptions are the opiate and cocaine users, some of whom also have a previous history of opiates and cocaine.

3.3 Age developments

The average age of all individuals who registered within a year can be determined in the LADIS. Age developments can be itemised into the various groups. A number of results appear in the following tables and graphs.

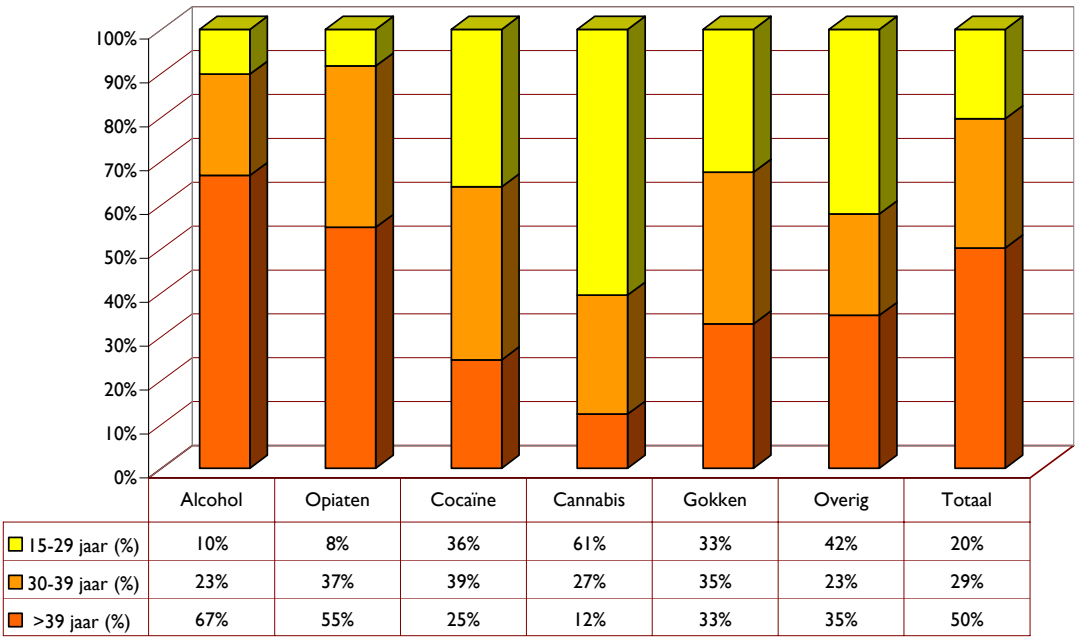
Table 15 Individuals by average age in 2004 compared with 1994

	Average age		
Year	Men	Women	Total
1994	35	38	36
2004	39	42	40

Source: LADIS 2004, IVZ, Houten

Average age increased by approx. 4 years during the past 11 years.

Figure 8 Individuals in 2004 by primary problem and age



	Alcohol	Opiaten	Cocaïne	Cannabis	Gokken	Overig	Totaal
15-29 jaar (%)	10%	8%	36%	61%	33%	42%	20%
30-39 jaar (%)	23%	37%	39%	27%	35%	23%	29%
>39 jaar (%)	67%	55%	25%	12%	33%	35%	50%

Source: LADIS 2004, IVZ, Houten

- It is striking that the gambling problem is uniformly divided among the 3 age groups.
- The increasingly older individual who demands assistance is highly visible among the alcohol and opiates group.
- The largest percentage of cannabis users is under the age of 30. The opposite picture is true for alcohol and opiate clients. These clients primarily come from the age categories above 30 years.

Table 16 Median age by problem

Problem	Alcohol	Opiates	Cocaine	Cannabis	Gambling
Median	43	35	30	25	32

- This table shows the median age by problem. 50% is younger and 50% is older than this age.
- Cannabis is used particularly among youth under the age of 30. The median age of 25 indicates that 50% of the group of users are under 25 years of age.

Figure 9 Individuals with an opiate problem by age 1995-2004

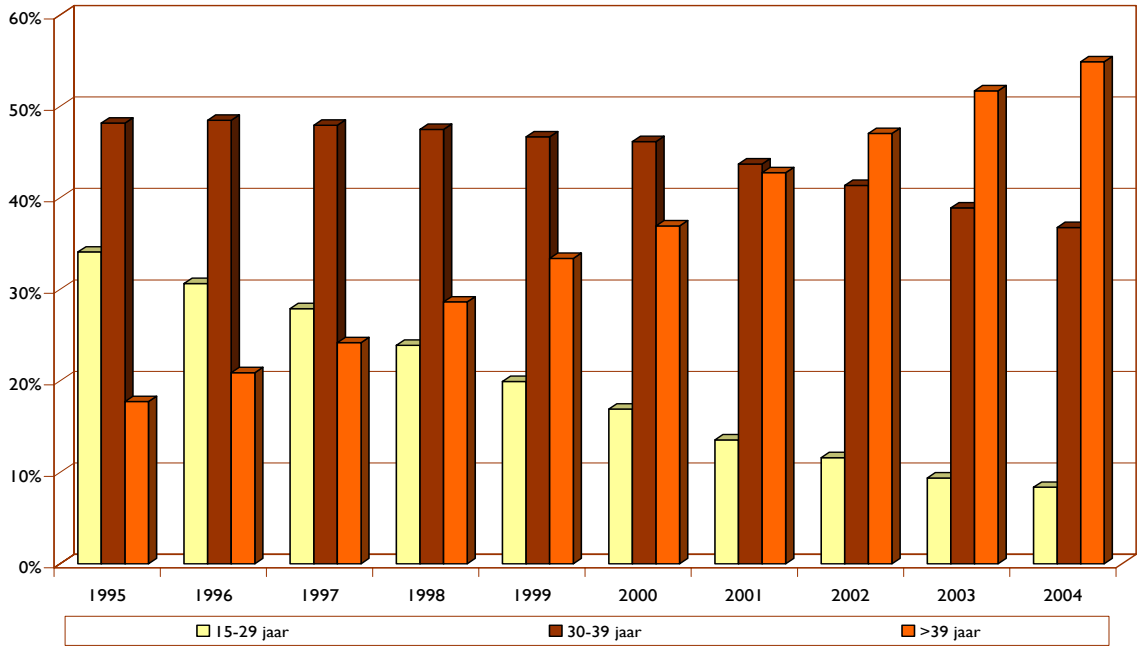
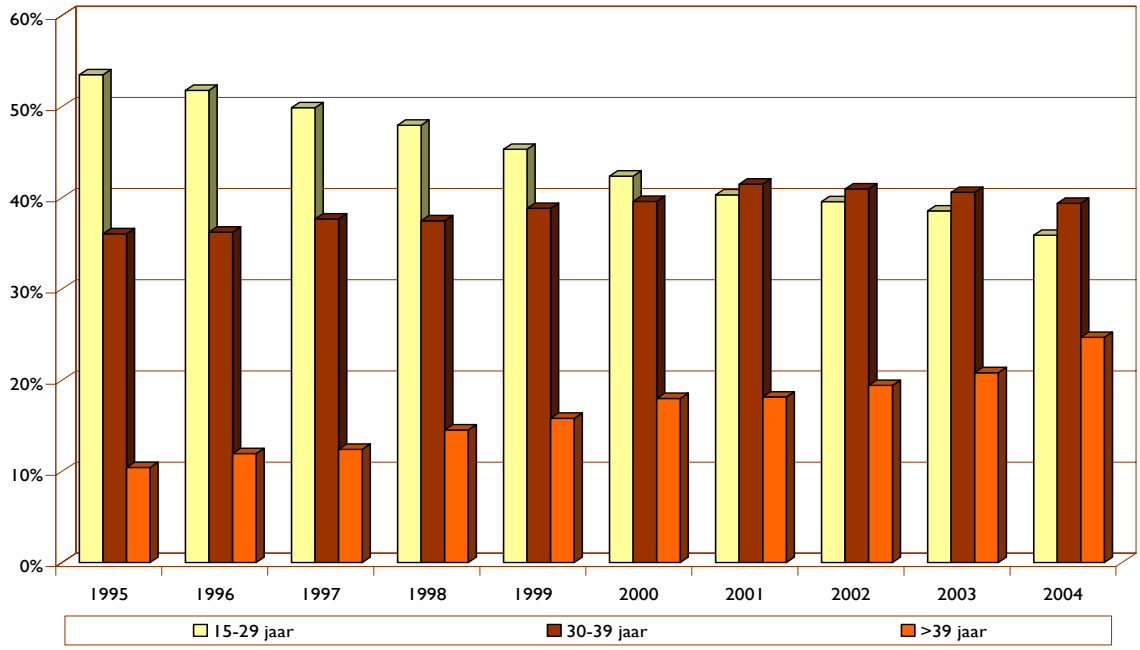


Figure 10 Individuals with a cocaine problem by age 1995-2004



Source: LADIS 2004, IVZ, Houten

- It is striking that a clear shift in age can be seen, particularly among individuals with an opiate and to a lesser degree a cocaine dependency. The number of individuals older than 39 years of age demanding assistance has significantly increased in both cases (see Figures 9 and 10).
- The number of youthful individuals (younger than 30 years of age) demanding assistance has been declining for both the opiate and the cocaine-related demand for assistance.

3.4 Discharges

An approach for increasing insight into assistance is the turnover of individuals in addiction care and the degree of care that is devoted to them. When an individual is discharged, treatment duration and effort can be determined. In a number of cases, individuals are referred to other (assistance) institutions.

Table 17 Discharges in 2004 by individuals and characteristics

Characteristics		
Number of discharged individuals		17,319
Of whom:	- referred	22%
	- not referred	45%
	- otherwise/unknown	33%
Average age		40
Average number of contacts		22
Average treatment duration in days		338

Source: LADIS 2004, IVZ, Houten

Turnover in addiction care is partly determined by the discharge of individuals. In 2004, 17,319 individuals were discharged; that represents 27% of the total number of individuals who made use of addiction care in 2004. Twenty-two percent of this group were referred to other care.
The average number of contacts rose from 17 in 2003 to 22 in 2004. The demand for care has clearly increased. The number of discharges increased somewhat in 2004 (2003: 16,005), while the number of registrations remained virtually the same (2003: 21,259; 2004: 21,271). The average duration of treatment rose by 35 days compared to 2003.

Table 18 Discharges in 2004 by primary problem and referral

	Alcohol	Opiates	Cocaine	Cannabis	Gambling	Other	Total
Discharged in 2004	9,224	1,646	2,739	1,876	1,065	769	17,319
Referred	24%	15%	19%	23%	23%	22%	22%
Not referred	44%	36%	41%	49%	58%	50%	45%
Otherwise/unknown	32%	49%	40%	28%	19%	28%	33%

Source: LADIS 2004, IVZ, Houten

- Figures on referral are not available for approximately one-third of the discharged clients. This should be clarified by a further analysis.
- 58% of the gamblers are not referred. The question is whether this group successfully completed the process or whether there was no opportunity for referral.

Table 19 Discharges 2004 by primary problem, contacts and treatment duration

Average	Alcohol	Opiates	Cocaine	Cannabis	Gambling	Other	Total
Number of contacts	20	32	27	17	14	20	22
Duration of treatment	310	578	315	227	239	279	338

Source: LADIS 2004, IVZ, Houten

The number of treatment days for the opiate clients (578 days) is much greater than for the other problem groups. In addition to these registered assistance contacts, discharged opiate clients have on average a further 71 methadone contacts with the institutions. They remain the largest group of individuals demanding assistance in terms of treatment duration.

4. Special characteristics of problems and care

A large number of characteristics of individuals and assistance are established in the LADIS. A number of special characteristics are further elucidated in this chapter.

4.1 Characteristics of substance use

In addition to the main division into six categories (alcohol, opiates, cocaine, cannabis, gambling and other drugs), substance use is further detailed. This gives insight into the share of care that is devoted to the group involved. In addition to the totals for the demand for assistance per category, a distinction is also made by sex.

Table 20 Problem by substance use and sex

Substances	Male	%	Female	%	Total	%
Alcohol	22,061	44%	7,457	52%	29,518	46%
Heroin	9,945	20%	2,445	17%	12,390	19%
Morphine	28	-	10	-	38	-
Methadone	906	2%	295	2%	1,201	2%
Other opiates	238	-	62	-	300	-
Cocaine	8,185	16%	1,814	13%	9,999	15%
Amphetamines	724	1%	230	2%	954	1%
Other stimulants	59	-	13	-	72	-
Benzodiazepines	217	-	193	1%	410	1%
Barbiturates	7	-	8	-	15	-
Psychiatric drugs	39	-	24	-	63	-
Other medicines	90	-	74	1%	164	-
Ecstasy	205	-	86	1%	291	-
LSD	10	-	3	-	13	-
Cannabis	4,488	9%	968	7%	5,456	8%
Other hallucinogens	66	-	79	1%	145	-
Volatile substances	7	-	1	-	8	-
Gambling	2,710	5%	346	2%	3,056	5%
Other addiction	225	-	204	1%	429	1%
Total	50,210	100%	14,312	100%	64,522	100%
Male-Female	77.8%		22.2%			

Source: LADIS 2004, IVZ, Houten

For a clear organisation of the table, percentages of less than1 have been omitted.

Compared to 2003, the following developments were observed in 2004:

Male-female ratio

- The male-female ratio in outpatient addiction care remains unchanged.
- Since 1994 nearly a quarter of the group of addicts in addiction care has been female. (The Netherlands: 49.5% - 50.5%, CBS).
- More than half of the women in addiction care have alcohol as their primary problem (52%).
- The picture for men and women does not differ much in any other respect.

Proportion of problems

- The share of the heroin problem is still declining and has declined since 2001 from 29% to 19%.
- In the same period, the share of the cocaine/crack problem increased from 12 to 15%.
- As from 1994 to 2000, the share of the alcohol problem ranged between 37% and 40%. It subsequently rose from 41% in 2001 to 46% in 2004.
- The demand for assistance for amphetamine clients has increased sharply for the second year in a row. While this is a relatively small group, a 35% increase could already be seen last year. There was also a sharp increase of 30% this year (956 individuals).

Most important risers and decliners in 2004 compared to 2003

- The total number of individuals in addiction care increased by 6%.
- The number of gambling addicts rose by 8% this year.
- The group of cocaine clients increased to more than 9999, or an 8% increase.
- The group demanding assistance for alcohol problems increased by 10% to 29,518 individuals.
- The cannabis users group was the second largest riser this year (22%) after amphetamines.
- Opiate use has continued to decline and has now declined by 8%.

4.2 Ethnic minorities and 'native' Dutch in addiction care

The LADIS establishes cultural origin in addition to nationality and country of origin. Based on current data, a division can be made as defined by Statistics Netherlands (CBS): Western ethnic minority, non-Western ethnic minority and 'native' Dutch. A number of tables and graphs that adhere to this division are presented on the following pages. Corrections have also been made for the 'missing values'.
In the LADIS, cultural origin is determined on the basis of the culture within which the individual has been raised, as indicated by the individual himself.

Table 21 Origin of individuals by CBS division

Origin	In %
'Native' Dutch	82%
Western ethnic minority	3%
Non-Western ethnic minority	15%

Source: LADIS 2004, IVZ, Houten

- According to CBS statistics, the Netherlands has approximately 3.1 million people of ethnic minority, representing nearly 20 percent of the total population. The 'native' Dutch – ethnic minority ratio within addiction care largely agrees with the ratio in the Netherlands (Netherlands 2004 'native' Dutch 81%, ethnic minority 19%, source: CBS).
- For the ethnic minorities group, the Western versus non-Western ratio deviates from the national picture. The non-Western ethnic minorities group is overrepresented in addiction care ('native' Dutch 9% Western, 10% non-Western, source: CBS).
- A total of more than 100 nationalities appealed to (outpatient) addiction care.

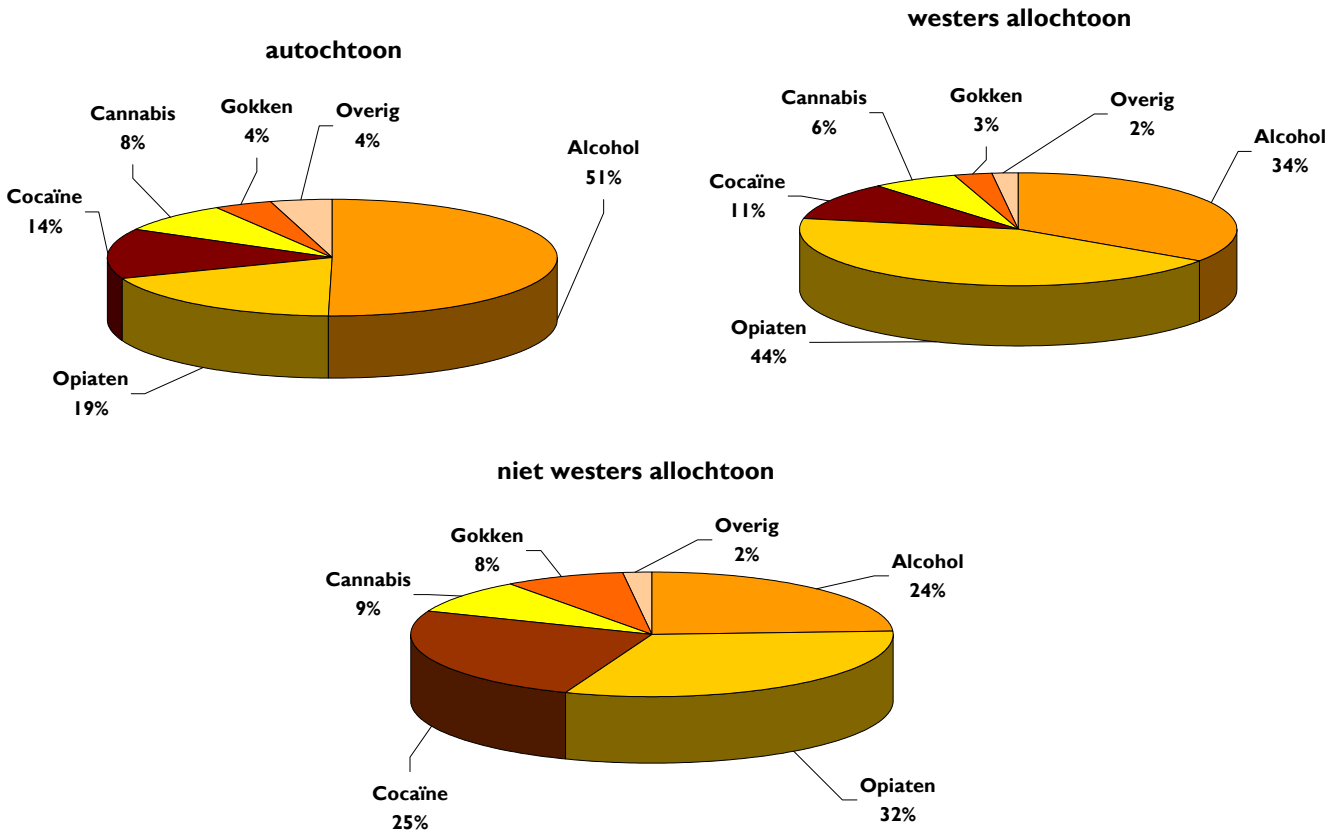
Table 22 Origin by primary problem

Origin	Alcohol	Opiates	Cocaine	Cannabis	Gambling	Other	Total
Number of individuals	29,518	13,929	9,999	5,456	3,056	2,564	64,522
Percentage							
'Native' Dutch	90%	71%	73%	81%	73%	91%	82%
Western ethnic minority	2%	6%	2%	2%	2%	2%	3%
Non-Western ethnic minority	8%	22%	25%	16%	26%	7%	15%

Source: LADIS 2004, IVZ, Houten

- 'Native' Dutch remains the strongest represented group on all fronts.
- Compared with the nationwide ratio, ethnic minorities are overrepresented in opiates, cocaine and gambling.

Figure 11 Division by primary problem within cultural origin



Source: LADIS 2004, IVZ, Houten

- There are major differences in the use of alcohol, opiates and cocaine between ethnic minorities and 'native' Dutch.
- Opiates as primary problem is more common among Western ethnic minorities.
- Alcohol is twice as common among 'native' Dutch than among non-Western ethnic minorities.
- Cocaine use is nearly twice as high among non-Western ethnic minorities.

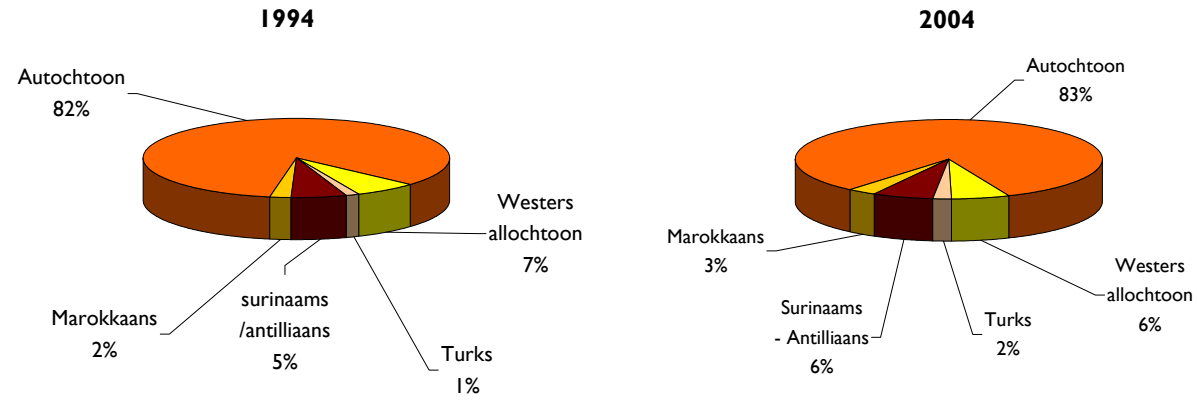
Table 23 Individuals by cultural origin 1994 – 2004

Cultural origin	1994	2004
Native:		
Dutch	39,924	46,452
Western ethnic minority:		
Eastern European	8	429
Southern European	260	465
Other European	1,697	1,203
Other countries	1,181	986
Non-Western ethnic minority:		
Turkish	687	,188
Other Asian	38	706
Surinamese	2,007	2,387
Antillean	692	1,163
Other Latin American	7	161
Moroccan	1,064	1,665
Other African	15	492
Unknown/White	1,578	7,225
Total	**49,158**	**64,522**

- The number of people belonging to ethnic minorities has increased by 42% since 1994.
- The number of 'native' Dutch in the LADIS has increased by 16% since 1994.

Figure 12 Individuals by cultural origin 1994 - 2004

Source: LADIS 2004, IVZ, Houten



4.3 Methadone distribution

An important component of the care for opiate addicts is the distribution of substitution drugs. This section provides a number of indicators and a further elaboration of the average dose of methadone.

Table 24 Indicators of methadone distribution

General characteristics	
Individuals in methadone programmes	12,493
Distributed portions (x 1,000)	2,908
Average dose (in mg)	56

Source: LADIS 2004, IVZ, Houten

- Registration of methadone data has partly improved thanks to the installation of new software at some of the methadone stations. Unfortunately, with the advent of new systems, numerous institutions have still been unable to provide a complete picture of methadone distributions. In 2004, methadone was distributed to 12,493 individuals. Detailed treatment data are available for 9,548 of these individuals.
- The average dose has been stable over the past few years, fluctuating around 56 mg.
- The number of distributed portions remained virtually the same in 2004 compared to 2003: 2.9 million.

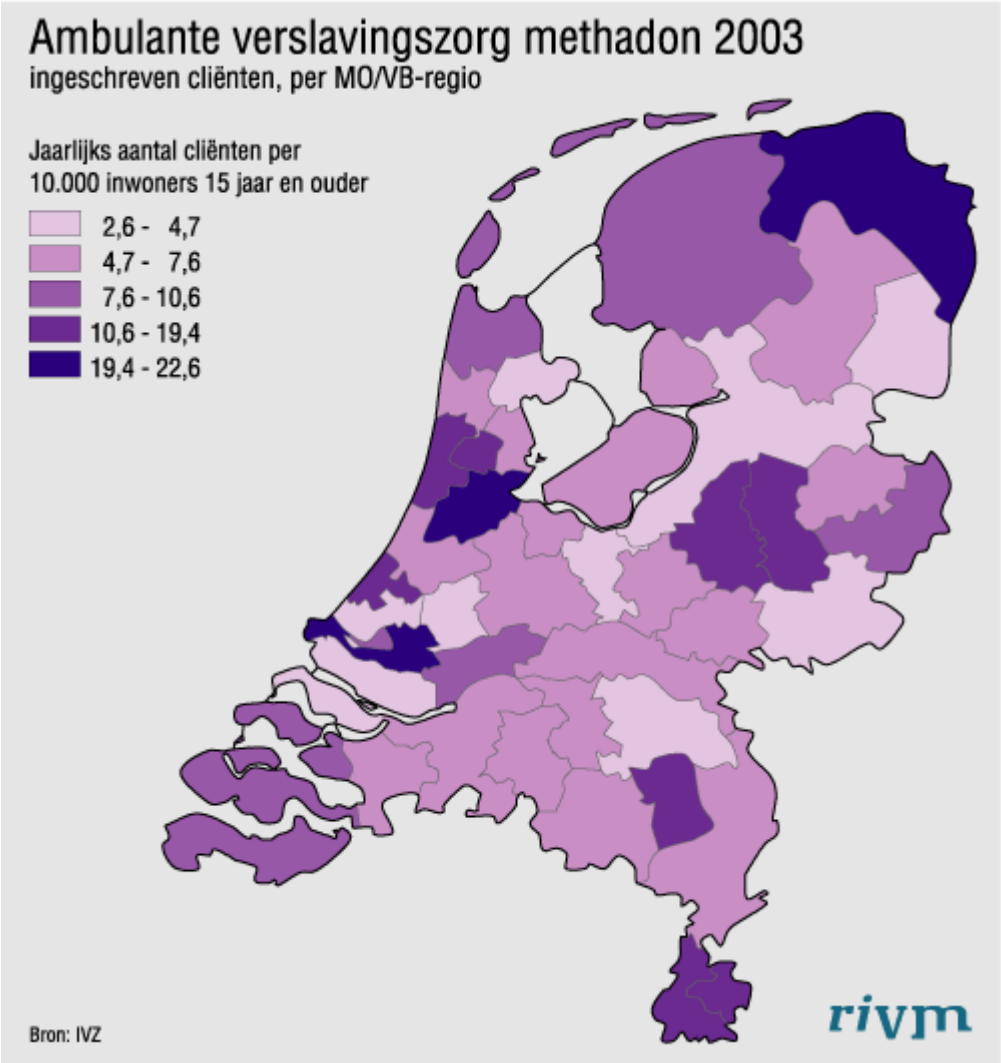
Table 25 Methadone distribution by individuals and average dose

	< 40 mg	40 – 60 mg	60 – 85 mg	≥ 85 mg	Total
Individuals absolute	2847	3013	2673	1015	9548
Individuals in %	30%	32%	28%	11%	100%
Average portion in milligrams	27	48	69	110	56

Source: LADIS 2004, IVZ, Houten

- The distribution of the average dose among the individuals hardly changed compared to previous years.
- Figure 13 depicts the geographical distribution of methadone clients in 2003. This chart is based on a study conducted by IVZ in the course of 2004 on assignment from the Ministry of Health, Welfare and Sport. Given the stable picture of methadone distribution in the Netherlands, it is expected that 2004 will not differ much from 2003.

Figure 13 Geographic spread of methadone distribution 2003



4.4 Other special characteristics of substance use

There are scores of facets in the problematic use of stimulants. The method of use and the combination of various substances are important themes. Particular attention is devoted to this in the following tables.

Table 26 Method of drug use by primary opiate users 1994 - 2004

	1994	2004
Injecting	16%	11%
Smoking	72%	73%
Snorting	4%	3%
Swallowing	2%	5%
Other	6%	8%
Total	**100%**	**100%**

Source: LADIS 2004, IVZ, Houten

- Ratios remain stable, but the numbers decline further in absolute numbers. For example, for injecting the number has decreased from 1961 (in 1994) to 1216 (in 2004).
- The number of problematic users who inject is low compared with the rest of Europe. For countries with higher numbers of clients who inject, the number of deaths is also higher than in the Netherlands (EMCDDA, 2004).

In addition to the primary problem for which they registered with addiction care, the LADIS also establishes the substances that are also experienced as problematic.
This provides insight into the so-called secondary problem.
The table below provides insight into the use of multiple drugs for all individuals who are or were in treatment in 2004.

Table 27 Combinations of primary and secondary problems

		Primary problem						
		Alcohol	Opiates	Cocaine	Cannabis	Gambling	Other	Total
Secondary problem	Alcohol	--	8%	23%	17%	9%	15%	8%
	Opiates	2%	12%	16%	1%	0%	2%	6%
	Cocaine	7%	39%	1%	9%	2%	9%	13%
	Medicines	5%	3%	2%	1%	1%	3%	4%
	Cannabis	7%	5%	16%	--	4%	11%	7%
	Gambling	1%	0%	1%	1%	--	--	1%
	Other drugs	2%	1%	6%	7%	1%	9%	3%
	None	76%	32%	35%	64%	83%	51%	59%
	Total	100%	100%	100%	100%	100%	100%	100%

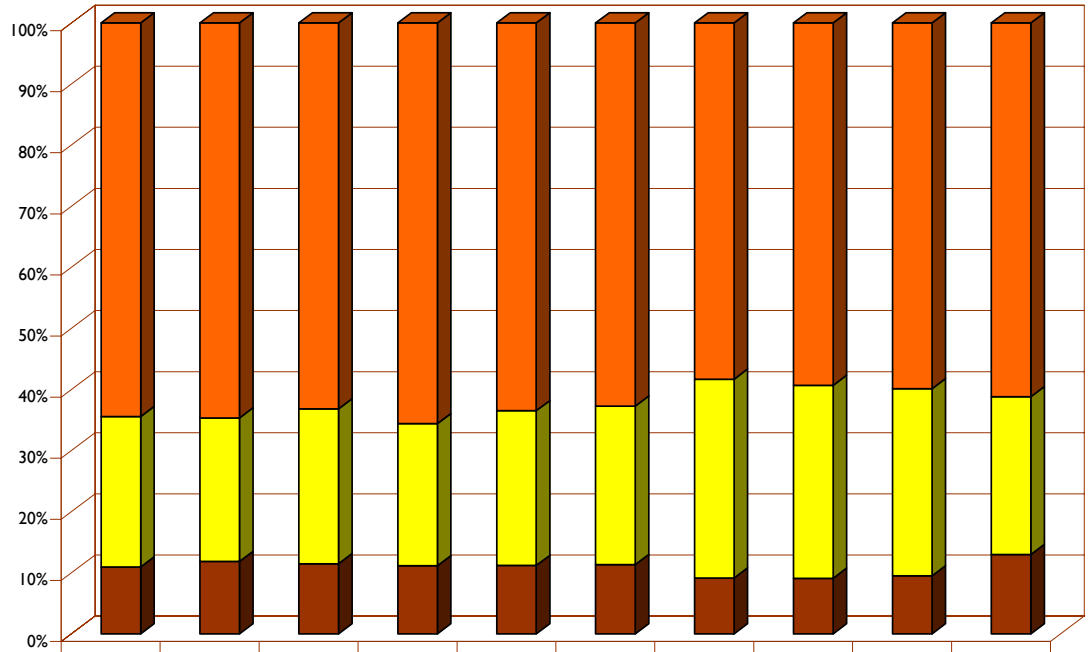
Source: LADIS 2004, IVZ, Houten

- Table 27 shows combinations of substance use: the opiates-opiates combination is included since a client can use various opiates (morphine, methadone, etc.). This also applies to the compiled concept of 'other drugs'.
- Opiate users increasingly use cocaine as a secondary substance (39%).
- The number of individuals in (outpatient) addiction care with a multiple problem declined from 43% (2003) to 41% (2004).
- There are multiple problems particularly among clients who use opiates or cocaine.
- Cocaine is the most common secondary substance (13%).
- Medicines only play a limited role as a secondary substance.

For comparison: figures from the European member states show that 16.8% of the (outpatient) population use one substance and 83.2% use at least two substances (EMCDDA 2002).

In the following graph, the trend in problematic substance use is viewed exclusively among the newly registered clients in the years concerned.

Figure 14 Number of substances per newly registered individual



	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
1 middel	64%	65%	63%	66%	63%	63%	58%	59%	60%	61%
2 middelen	25%	24%	25%	23%	25%	26%	33%	32%	31%	26%
>2 middelen	11%	12%	11%	11%	11%	11%	9%	9%	9%	13%

Source: LADIS 2004, IVZ, Houten

Although the nationwide picture shows a slight decline in multiple problems (a 2% decline compared with 2003), a clear distinction is visible within multiple problems between the use of 2 or more than 2 substances. Simultaneous use of 2 substances declined compared to 2003 (5% decline), while the use of more than 2 substances increased (4% increase). However, a clear rising or declining trend was not visible during the period from 1995 to 2004.

LIST OF TABLES

LIST OF FIGURES

SOURCES

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List of abbreviations

CBS:	Statistics Netherlands
EMCDDA:	European Monitoring Centre for Drugs and Drug Addiction
GGD:	Gemeentelijke Gezondheids Dienst (Municipal Health Services)
GGZ:	Geestelijke Gezondheidszorg (Mental Health Care)
GGZN:	Vereniging GGZ Nederland, brancheorganisatie instellingen Geestelijke Gezondheids- en Verslavingszorg (The Netherlands Mental Health Care Association, trade association for mental health and addiction care institutions)
IVZ:	Stichting Informatievoorziening Zorg (Foundation for the Provision of Information on the Care of Drug Addicts)
LADIS:	Landelijk Alcohol en Drugs Informatie Systeem (National Alcohol and Drugs Information System)
NDM:	Nationale Drugmonitor (National Drug Monitor)
RIVM:	Rijksinstituut voor Volksgezondheid en Milieu (National Institute of Public Health and the Environment)
VWS:	Ministry of Health, Welfare and Sport
ZORGIS:	Zorginformatiesysteem Geestelijke Gezondheidszorg (Information System for Mental Health Care)

APPENDIX I: LADIS QUALITY POLICY AND FUTURE DEVELOPMENTS

A. Quality policy

The LADIS quality policy has the following instruments:

1. LADIS specifications / certification;
2. Periodic check per delivery;
3. Information for benchmarks per institution.

LADIS specifications / certification
The LADIS specifications include a substantive and technical description designed to realise the provision of LADIS data. The LADIS 'specs' translate the data groups reported in the Addiction Policy Registration Scheme. INZ has a separate certification process for applications builders who provide LADIS data. The purpose is to test whether a (new) application provides the data according to the specifications.

Periodic check per delivery
Per LADIS delivery, each institution receives a quality report that monitors a number of commonly used items. Based on these lists, specific problems regarding timeliness, completeness and reliability are discussed with the institution.

Information for benchmarks per institution
When the annual Key Figures are published, each institution receives mirror information that is directly comparable to a number of tables from the Key Figures. With this assistance, institutions can determine the extent to which data are related to their internal figures.

B. Developments in 2005

The LADIS is not a static system, but develops technically and substantively. Attempts are continually made to prevent any breaks in trends in the data that are ultimately presented. Within this framework, a number of issues are on the agenda for 2005.

1. New specifications for the LADIS dataset
   New delivery specifications for the LADIS will be in force as of 1 January 2005. The institutions will work according to these specifications in the course of 2005. The institution software is currently being adjusted by the various suppliers for a smooth transfer to the new dataset.

   The new data set has been greatly simplified compared with the preceding version, thereby linking up better to ZORGIS and European requirements (EMCDDA). The most significant change is the opportunity for non-outpatient addiction care institutions to deliver data to the LADIS. This option ensures that the dataset 'fits' better with the developments in the field toward mental health care institutions.

2. Integration with ZORGIS
   In connection with the above, institutions will be able to combine the deliveries for ZORGIS and LADIS in 2005. After completing the integration, it will be possible to start combined delivery with a press of the button. The requisite technical infrastructure will be realised in the course of 2005.
   Key Figures Addiction Care 2005 will be the first publication to be substantively based on the new specifications and for which data will be compiled via the ZORGIS/LADIS web-based destination module.

3. Improvement in methadone figures
   A third key objective for 2005 is the improvement of data delivery from the methadone programmes. The Key Figures Addiction Care 2004 contain new methadone data that are provided directly from the methadone dispensing machine of the Scarabee company, through a link with the company's Methadone Distribution System (MUS). The data derived from this system are linked to individuals whose data are already input in the LADIS. Through special linking technology, the LADIS can even obtain this data with retroactive effect. This greatly improves the quality of the stored data in the LADIS. The improved quality of the LADIS offers greater reliability in reports and feedback to the institutions and other parties.

APPENDIX II: DEFINITIONS IN KEY FIGURES

Individuals: Key Figures 2004 mainly reports on individuals in addiction care. The number of individuals regards the scope of the group that appeals to (outpatient) addiction care. If a registered client is registered repeatedly, only the *last registration* (with the most current information) will be used in the calendar year concerned. Where clients are mentioned in Key Figures, unique individuals are intended.

Hard drugs: Substances such as heroin, morphine, methadone and cocaine.

Cocaine: Both cocaine and crack fall under this category.

Probation: Work that comes under the Stichting Verslavingsreclassering GGZ Nederland that includes approximately 15 institutions and 50 branches.

The registration of 'native' Dutch/ethnic minority will be adjusted in the LADIS to the CBS division in the coming years. This publication provides a reconstruction, based on the cultural origin item (based on what has been indicated by the individual himself).

'Native' Dutch The 'native' Dutch category includes all individuals who indicate that they are of Dutch origin.

Western ethnic minority: The 'Western' category includes ethnic minorities with Europe (excl. Turkey), North America, Oceania, Indonesia or Japan as origin.

Non-Western ethnic minority: The 'non-Western' category includes ethnic minorities with Turkey, Africa, Latin America or Asia with the exception of Indonesia and Japan as origin.

Cultural origin: In the LADIS, cultural origin is determined, based on the culture within which the client has grown up, as the client has indicated.

Not previously in treatment: All individuals in the LADIS with a registration date in the calendar year and who did not appear in the LADIS in previous years (starting in 1994).

"Other" problems: Amphetamines and other stimulants (excl. cocaine and crack), medicines, ecstasy, LSD and other hallucinogens (excl. cannabis), volatile substances and addictions related to behaviour (or gambling).

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