KEY FIGURES
ADDICTION CARE 2010

NATIONAL ALCOHOL AND DRUGS INFORMATION SYSTEM

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Contents

LADIS **Introduction**

LADIS and quality policy

This is the 25th edition of the Addiction Care Key Figures.
In order to be able and continue to fulfill the role of source of information about treatment demand in relation to addiction problems, IVZ needs to constantly improve its quality image.
A number of important elements include:

1. Complementing and improving the participation;
2. Improving incoming (data input) information from institutions and improving technical processing and quality control;
3. Improving bilateral contacts with the institutions and feedback;
4. Improving the interpretation of incoming data;
5. Data Security and Data Protection.

Ad 1) Complementing and improving the participation

In LADIS we try to give a complete overview of all persons who knock on “some door” in the Netherlands with a request for assistance related to the problematic use of substances. In this context “some door” means all addiction care institutions and GGZ institutions which offer specific treatment or assistance to these persons.
In general terms, LADIS generates an overview of everyone who actually calls on the addiction care institutions. This includes both outpatient and inpatient facilities. Due to the changed financing systems and the innovation of the mostly automated systems at the institutions, significant improvements have been made over the last couple of years. The quality of registering request for assistance, the people who seek help and their specific problem has clearly improved. However, the importance of tendency developments which are largely based on the LADIS data can still be improved. An important addition and improvement are the data which can be retrieved from the National Database for Registration of Substances (Landelijke Centrale Middelen Registratie (LCMR)). The policy information will be further extended in the years ahead. The LCMR also provides insight in the group of patients who receive substitute drugs within Penitentiary Institutions and who are not seen by addiction care institutions.

In order to obtain a comprehensive overview of help requests and addiction care provisions, the data of the addiction rehabilitation since 1994 have, if possible, been linked to the individual client level. This link has, despite the positive cooperation of the persons involved, turned out to be more difficult due to the method of registration in case of rehabilitation. For LADIS data about primary and, if available, secondary problems are essential. However, this is not, or not completely, recorded within addiction rehabilitation in the current CVS / CBO system. The CVS has now been “frozen” as a system and the new IRIS system will again fully meet the LADIS criteria. This means, since 2007, an increasing number of unlinkable rehabilitation data and, therefore, a lower number of discharged prisoners undergoing rehabilitation with LADIS data. Hopefully the data will be fully compatible with LADIS again next year.

There are also missing data. The Netherlands faces an increase of internet treatments / care provision. These projects are offered by several institutions. The care provision is anonymous in first instance and is not registered (at least not according to LADIS criteria). Care insurers and other financers are still looking for solutions to formalize internet treatments to the largest possible extent. If internet treatment is financed, data required for registration in institutional systems can be included and registered as specific internet treatment in LADIS. LADIS is prepared for the registration of identifiable internet treatments.

A second missing link are the private care providers and private hospitals which have come into existence here and there. These private hospitals are mostly aimed at a specific target group and in many cases the treatments are not or not entirely covered by the insurance. IVZ is talking to a number of these hospitals about the supply of data to LADIS. In principle, they seem to be willing to cooperate, although some of them are not recording any or very few (LADIS) data about the persons requesting help. In the coming months further action will be undertaken in this respect. For now, it is about a very limited number of people requesting help which do not largely affect the trend-related developments as presented in LADIS.

Ad 2) Improving incoming (data input) information from institutions and improving technical processing and quality control

Recording data and registering activities is often seen as synonymous to administrative burden. On the other hand, we can say that recording requests for assistance and treatments does not only serve a direct patient/therapist interest, but can also be seen as a requirement and justification for financing and policy, but also for qualitative and content-specific research of the (addiction) care. Every therapist realizes that his or her interventions mean something if you look at the overall care offer in an institution. In addition, the institution must be aware of its place and role in the care system. Many of the people requesting help do not exclusively use local institutions, but also look for care elsewhere. Sometimes people requesting help, and this happens quite often in the addiction sector, seek help and assistance from several institutions. This means that people requesting help are registered in different places in the care provision circuit. Therefore, to gain insight in the actual quantity of the problems of people requesting care and the offer of care account has to be taken with the correction for double counts. This is part of an extensive quality policy implemented by IVZ. LADIS corrects double counts at all levels.
All this requires continuous testing and improvement of the data input from IVZ. Some improvements which have recently been implemented are listed below.

- To reduce the administrative burden, the technical delivery of data to LADIS by the institutions has been reduced to maximum one hour per period, by means of embedding the LADIS input in the most important institutional application.
- By linking diagnose codes, which are required for invoicing of the care insurers, with the primary and secondary problems as defined in LADIS, a strongly improved profile of the persons requesting help becomes visible. In doing so the most up-to-date problem recorded by the institution/therapist is considered representative without losing sight of the history of the persons requesting help. All this results in an increasing insight in the client and the problems occurring with the total group of people seeking help.
- In order to make sure the national database runs as smoothly as possible for research and policy, strict criteria are imposed on the information recorded in the system about requests for assistance and the person seeking help. LADIS stores all data based on unique codes which cannot be traced back to the original person. Under the heading “Data security and data protection” we will tell you more about this. The data are tested on integrity, reliability and are compared with previous deliveries and published figures from the institution in question by means of a specific structure process. In addition, the data of the addiction rehabilitation are added, as well as data about the provision of substitutes (heroin/methadone). Furthermore, in close cooperation with the institutions the completeness and correctness of the provided data are verified.

As from 2007, in the event that people seeking assistance are presented without sufficient identifying information or if elementary information such as gender, date of birth or primary and secondary problem are missing and if actual contacts have not been registered people seeking assistance are not included in the LADIS Core Figures. It is always tried, in cooperation with the institution, to realize a presentation that is as complete as possible.

In these Key Figures a clear break with previous years can be seen in the 10-year series. In 2010 the institutional information system significantly improved with regard to the input to LADIS. Whenever possible, institutions redelivered data from 2007 onwards which reveal certain corrections, as explained above, in previously publishes quantities in Key Figures. Where relevant, this is explicitly mentioned with the figures. The trend-like effects are very limited. Recalculations of years before 2007 is too much of an administrative burden for the institutions and also unnecessary in view of the limited trend effects (see appendix II).

The demands for the delivery of data in the context of the European obligations of the Netherlands and the EMCDDA (TDI) are becoming more and more stringent. LADIS data can still meet these TDI requirements. Adding the actual contact criterion was already necessary for the TDI. The LADIS requirements are gradually being adjusted to the European requirements.

Ad 3) Improving bilateral contacts with the institutions and feedback

In 2010 IVZ increased the bilateral contacts with institutions and strongly intensified the consultation with suppliers of applications for the institutions (USER and Psygis). The purpose was to reduce the administrative pressure in cooperation with the institutions and the application providers and to increase the quality of the data whenever possible. In addition, IVZ took the initiative to make the data of institutions of the past 10 years available for the institutions as benchmarking tool via the domain LADIS online. Every institution can retrieve its own data about main groups to be selected by them and compare it with the total national data. Besides tables and overview, also graphic displays are offered which make it possible to gain insight in the similarities and deviations from the national pattern.
The data allow the institutions to analyze the own data of the institution in a secured domain. For the participating institutions IVZ is always prepared to help out and, where appropriate, implement any further processes. LADIS online will be further expanded in 2011 as a reporting tool for institutions.

Ad 4) Improving the interpretation of incoming data

If all processes and controls have been implemented, LADIS will become available for analysis and research. LADIS is a source of information for lots of people and organizations.
Besides major data for the National Drug Monitor, LADIS also provides data for lots of other studies. Studies about addiction and addiction care are often interlaced with data from LADIS. In addition, IVZ also supplies the data to the European Drug Monitoring Centre in Lisbon, in the context of the international agreements of the Government. European studies on drug policy and drug care are based on the uniform data from the 27 affiliated countries.
IVZ also analyses the data. In the form of bulletins thematic analyses are made. The following bulletins were published in 2010 and 2011:

- Youths in addiction care 2004-2008 (February 2010)
- Ageing of Methadone users 1999-2009 (September 2010)
- Key figures 2009 (September 2010)
- Older people in addiction care 2000-2009 (October 2010)
- GHB treatment demand in the Netherlands (February 2011)

- 15 years of Cannabis treatment demand in the Netherlands (April 2011)
- Key figures 2010 (June 2011)

In order to continuously improve the quality of these analyses the concepts are often presented to different experts in the IVZ network. In doing so, we try to avoid our “blinkers” and possible “pitfalls” of data collection and interpretation. We also try to provide readable analyses for a broader audience about different topics.
In the years ahead IVZ hopes to expand the research by intensifying the active cooperation with research institutes. Proposals to this end, in the form of an academic workplace, have already been presented to the government. Because the LADIS database is one of the oldest registrations (25 years in 2011) and since 1994 (start of the unique client coding) more than 275,000 people with a request for assistance and an addiction problem are registered in the database, research can also be conducted by means of secondary analyses such as cohort studies and offer insight in careers in addiction care.

Ad 5) Data Security and Data Protection

Data security means more to IVZ than just knocking the door. Security of information is defined and implemented by IVZ according to its defined Information Security Policy. This policy has been set up in accordance with the applicable NEN 7510-7512 standard. IVZ instructs an external expert to conduct an audit to test all internal and external processes in terms of integral security. The data itself are delivered via ZorgTTP and are provided with a pseudonym per person by ZorgTTP. These pseudonyms make it impossible to reduce the data to the identifiable individual. ZorgTTP is also under constant supervision of authorities and clients and is regularly audited. In order to further increase the continuity and security IVZ outsourced all data storage to secured data centers in 2009 and 2010.

IVZ appreciates everyone at the institutions who made the effort to provide the content of this 25th edition.

A.W. Ouwehand
Chairman of the Board of Directors

1. Entire addiction care

1.1 Highlights

- Ageing in addiction care continues.
- Cannabis treatment demand keeps increasing.
- The treatment demand by younger people (<25 years) in addiction care is cannabis problems related in over 50% of the cases.
- The GHB related treatment demand is increasing, but the number is still limited.
- In the past 15 years about 275,000 unique people have been seeking assistance in addiction care.
- Over one-third of the people seeking assistance is experiencing problems with more than one substance.

1.2 In brief

Table 1: **Overview of entire addiction care 2010**

Demography		
	Number of people seeking assistance	76.295
	Male : Female	77 : 23
	Average age	41.1
	Share of 25-	11.6%
	Share of 55+	15.5%
	Share of native Dutch	79.2%
	Number per 100,000 inhabitants	460
Problems		
	Single : Multiple	63 : 37
	First application ever	21.5%
	Number of contacts	1.858.000
	Average number of contacts/client	24

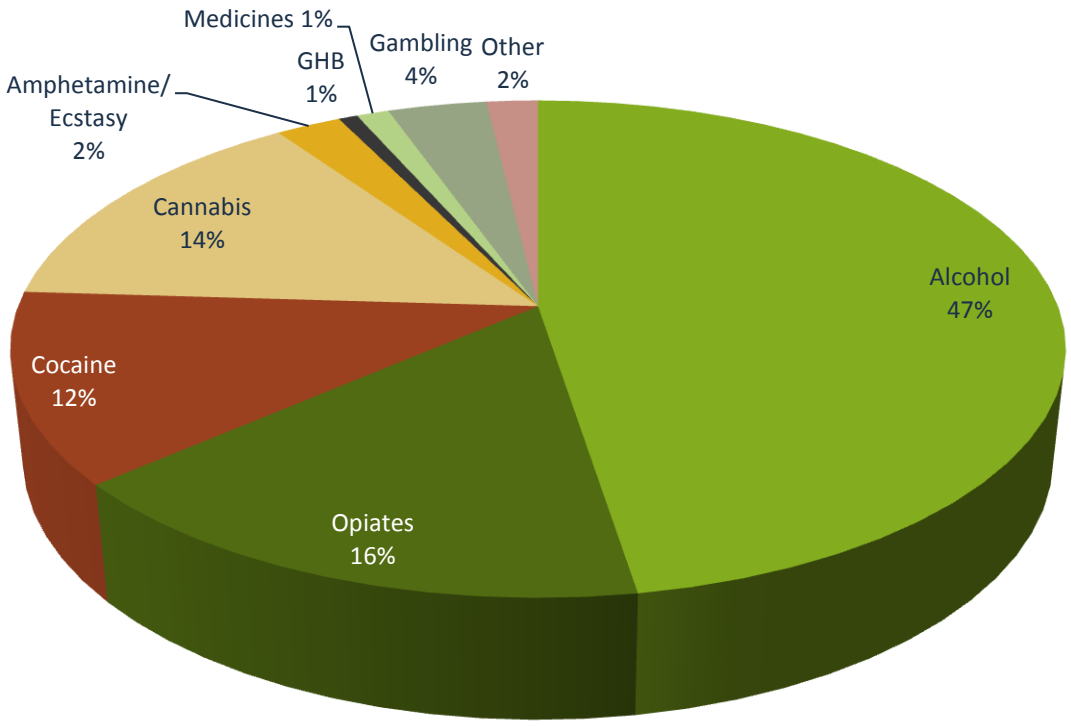
1.3 People by primary problem

- In 2010, over 76,000 people sought assistance in the addiction care sector.
- The group requiring alcohol treatment is by far the largest, representing almost half of the total.
- Although opiate addicts still comprise the second largest Group, their number has decreased since the beginning of this century.
- Cocaine lost its third place due to the increased demand for cannabis use related assistance.
- The treatment demand from amphetamine and ecstasy users and gamblers remains fairly stable.

Table 2: **Persons and contacts by primary problem**

Primary problem	Number of pers in 2010	Share of problem	Change comp. to 2009	Number of contacts (x1000)	Share of contacts
Alcohol	36.203	47%	-3%	819	44%
Opiates	12.313	16%	2%	455	24%
Cocaine	9.437	12%	-10%	268	14%
Cannabis	10.971	14%	7%	185	10%
Amphetamine Ecstasy	1.805	2%	-3%	41	2%
GHB	524	1%	51%	15	1%
Medicines	893	1%	7%	21	1%
Gambling	2.733	4%	2%	31	2%
Other[1]	1.416	2%	24%	23	1%
TOTAL	**76.295**	**100**	**-1%**	**1.858**	**100%**

Figure 1: **Treatment demand, distribution by primary problem 2010 (N=76.295)**



[1] The composition of this Group is specified in Chapter 10

Figure 2: **Development of the treatment demand by share of primary problem 2001, 2005 and 2010**

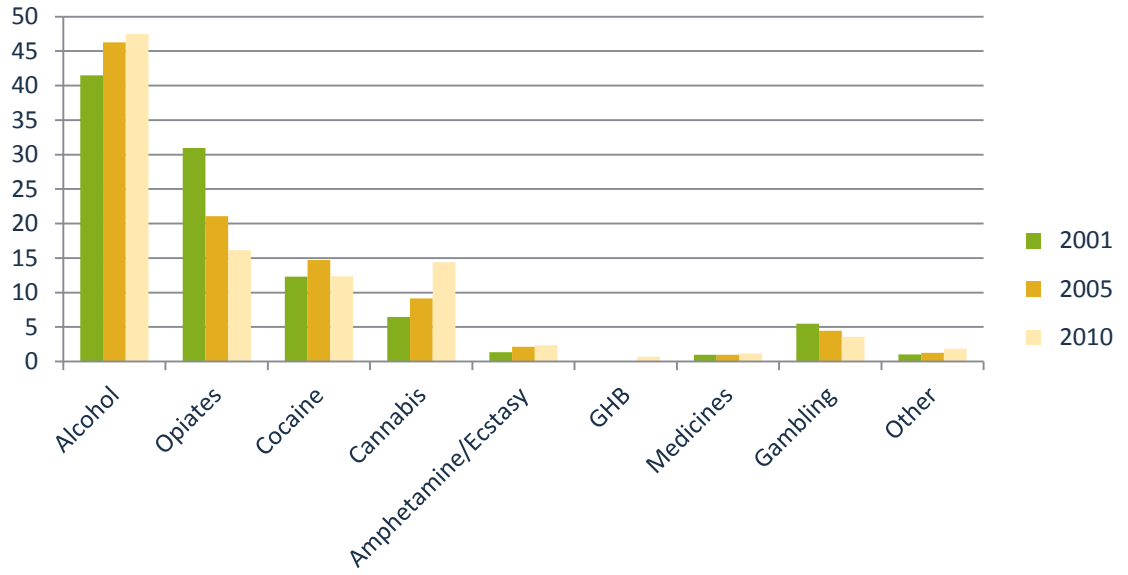
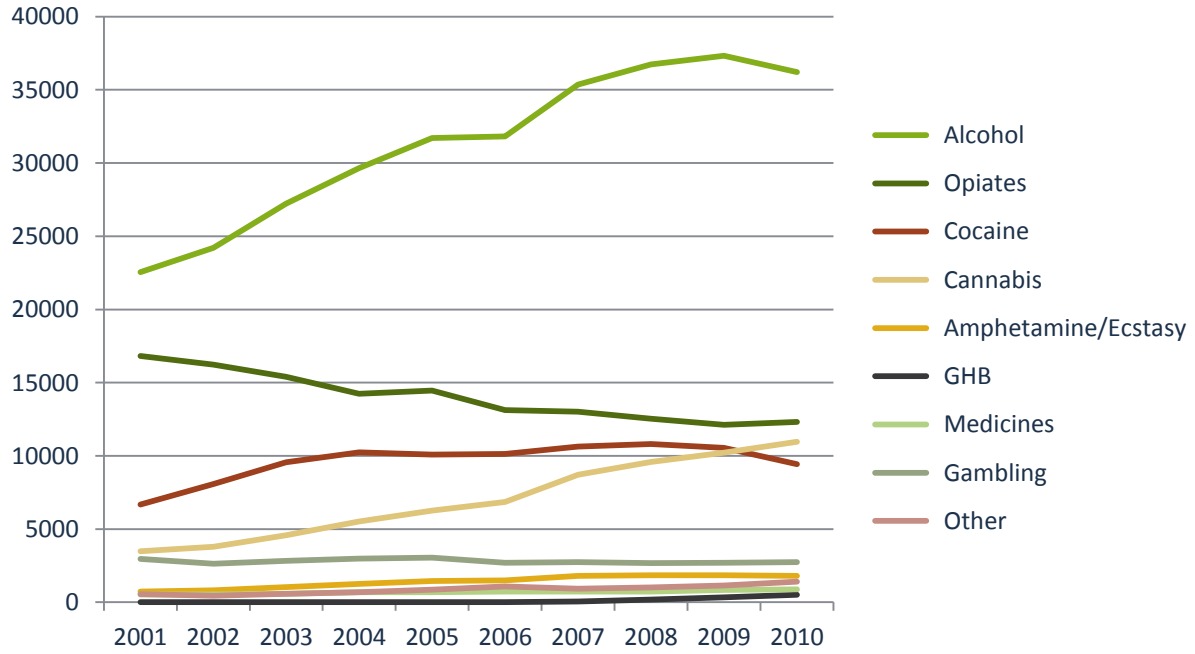


Figure 3 shows that alcohol related treatment demand has increased by almost 50% over the past 10 years of addiction care. In the same period the percentage of opioid related demands for assistance have dropped from 31% to 16% of the total demand for assistance. The share of cannabis in addiction care was doubled from 7% in 2001 to 14% in 2010.

1.4 Trend in primary problems 2001-2010

Figure 3 shows the treatment demand for the various primary problems over the past 10 years.

Figure 3: **Number of people seeking assistance by primary problem 2001-2010**



It is known that the group of opiate (heroine in particular) related people demanding treatment has been decreasing over the past few years. Cocaine as well showed a slightly decreasing trend after 2007 as well. Hard drugs are losing ground in addiction care. Cannabis, however, is increasing considerably with regard to demand for assistance. The group GHB and medicines, although smaller in number and therefore a bit less visible, have increased relatively strongly. As these groups are increasingly gaining attention, these Keyfigures report about GHB (Chapter 7) and medicines (Chapter 8) separately. In the previous editions both substances were discussed in the category Other.

1.5 Primary problem in the population

The Nationale Drugmonitor includes figures about the use of alcohol and drugs in the population. Based on this, a percentage can be calculated on the reach of addiction care.

Table 3: **Primary problem by extent in population, problematic use and % in treatment**

Primary problem		Extent of (problematic) use within the population[2]	% in treatment 2010
Alcohol		1.200.000	3%
	Abuse	395.600	9%
	Dependency	82.400	44%
Opiates		17.300-18.100[3]	68%-71%
Cocaine		55.000	17%
Cannabis		408.000	3%
	Abuse	40.200	27%
	Dependency	29.300	37%
Amphetamine/ Ecstasy		22.000	8%
GHB		Unknown	-
Medicines		Unknown	-
	Benzodiazepine use[4]	1.400.000	-
Gambling		40.000[5]	7%

It is clear that the “glasses” used to look at the problems determine the extent of the care provided. Based on the criterion of independence this is 44% with regard to alcohol problems and 37% in the event of cannabis dependency.
There are considerable differences between the types of drugs. There are no numbers for GHB and medicines available regarding the problematic use in the population.

1.6 Number of unique persons in treatment as from 1996

With the aid of the unique key (see introduction) it can be determined with a reasonable certainty whether someone has been treated in addiction care previously. In this way, it is also possible to calculate how many unique persons have turned to addiction care for assistance over the past 15 years. In the period 1996-2010 about 275,000 different persons have turned to addiction care for assistance. Table 4 shows the number of unique persons subdivided into primary problems.

[2] Nationale Drug Monitor, Jaarbericht 2009, Trimbos Instituut; 2009 Utrecht
[3] Number of problematische harddruggebruikers in Nederland, Trimbos Instituut; 2010 Utrecht
[4] Stichting Farmaceutische Kengetallen, Farmacie in cijfers, Pharmaceutisch Weekblad, Jaargang 145 Nr 42
[5] De Bruin et al, 2006. Verslingerd aan meer dan een spel. Een onderzoek naar de aard en omvang van kansspelproblematiek in Nederland. Den Haag: WODC.

Table 4: **Number of unique persons in addiction care according to primary problems 1996-2010**

Primary problem	Number of unique persons
Alcohol	150.000
Opiates	40.000
Cocaine	42.000
Cannabis	42.000
Amphetamine and Ecstasy	9.000
GHB	700
Medicines	5.000
Gambling	23.000

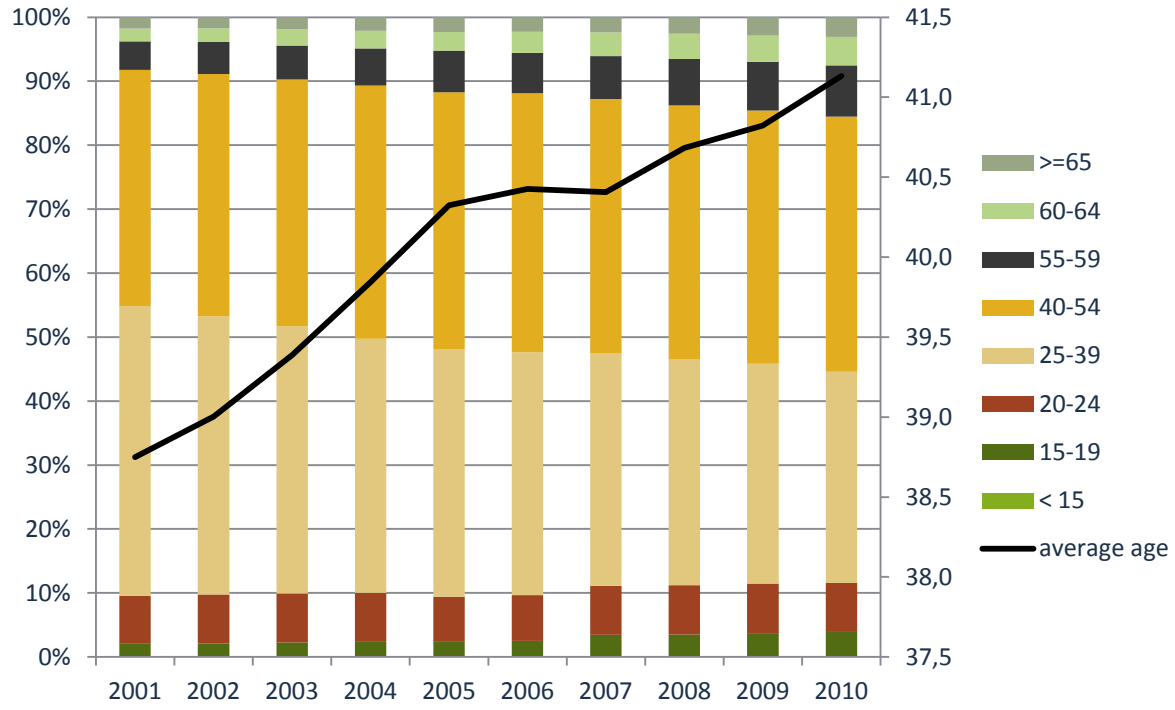
The Total is not equal toe the sum of the various problems as in this period of time 50,000 persons with more than one problem have contacted an institution to ask for assistance.
In the near future, IVZ will encourage more retrospective cohort studies among the total population of the people seeking assistance in the past 15 years.

1.7 Demography

1.7.1 Young and old

The Dutch population is ageing . And the number of elderly people in addiction care is increasing. The average age in addiction care has been increasing for years. The ageing of the group of people seeking assistance in addiction, however, is developing more rapidly than in the general population. This is caused by the increase in the proportion of elderly in the Group with an alcohol and opiates related demand for assistance. See also sections 2.4 and 3.4.

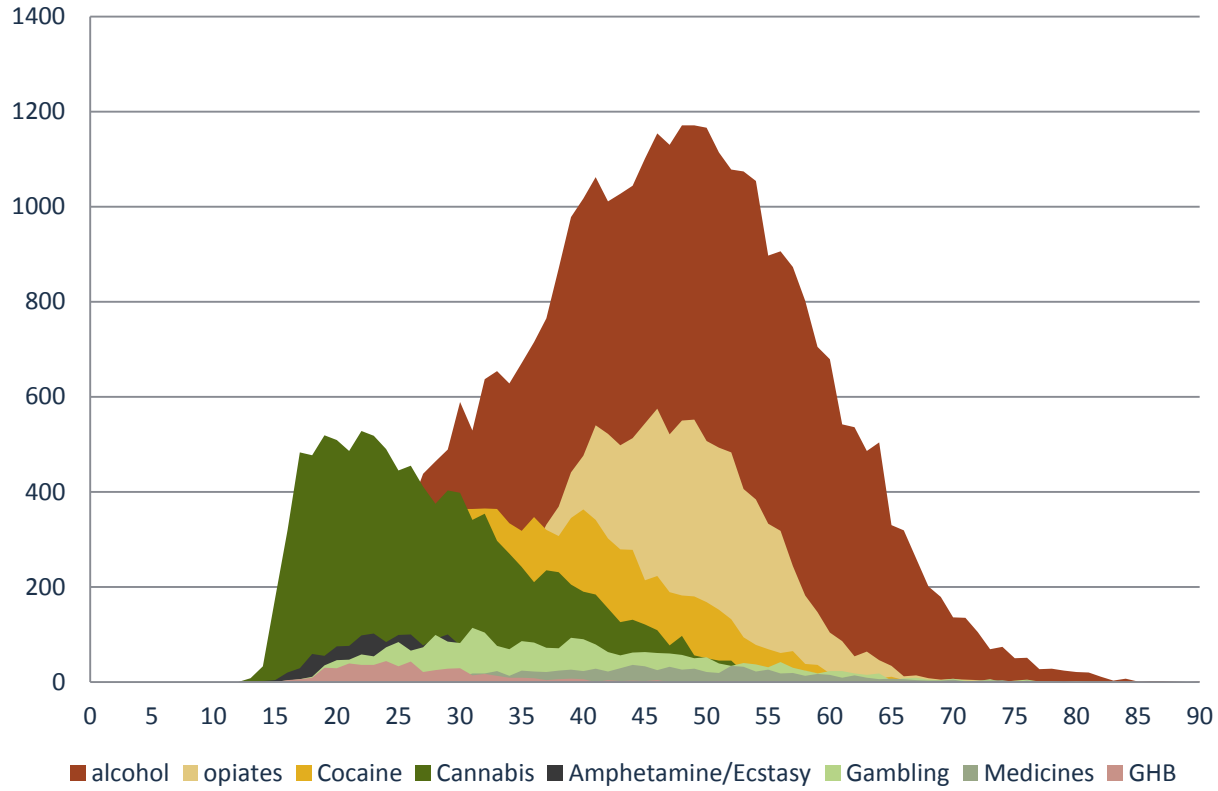
Figure 4: **Treatment demand by age category 2001-2010**



By far the largest group of people turning to addiction care for assistance is between 25 to 55 years old. The proportion of younger people (<25 years of age) has been reasonably stable over the past 10 years, whereas the proportion of elderly people is increasing. In 2010, one in six people seeking assistance is older than 55 years.

1.7.2 Age distribution by primary problem

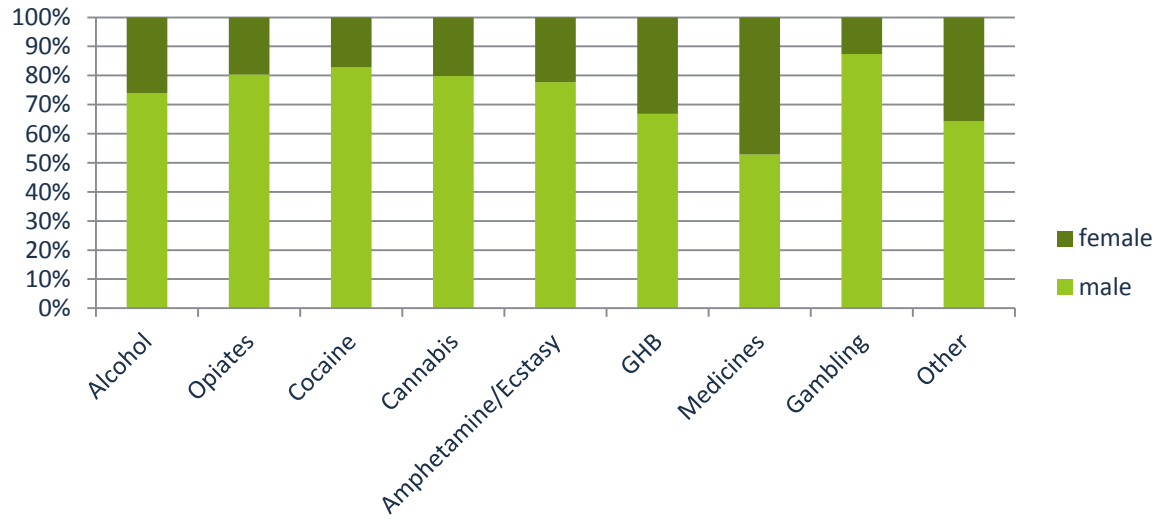
Figure 5: **Age distribution by primary problem 2010 (N=76.295)**



The age distribution in Figure 5 clearly shows the differences between the problem categories. For alcohol and opiates, the older group is over represented. Cannabis, GHB and the amphetamine and ecstasy Group include relatively more young people. In younger people up to 25 years, cannabis is the problem in more than half of the cases. Gambling and medicines related problems occur equally in all ages. Although this age distribution has developed for each problem over time, this will be discussed in the individual chapter.

1.7.3 Gender

Figure 6: **Gender by primary problem 2010 (N=76.295)**



The distribution male – female has been reasonably stable in addiction care for years. Men suffer from addiction problems more often than women. About 20% of all demands for assistance come from women. Subdivided into specific problem there are difference according to gender.
Gambling is mainly a problem for men, whereas medicines addiction occurs in women relatively frequently. These difference can also be observed in the treatment demand in addiction care.

1.7.4 Cultural origin

Persons of about 100 different nationalities and backgrounds can be found in addiction care each year. Almost 80% of all people seeking assistance are, however, Dutch natives. This is in accordance with the percentage of Dutch natives in the general population. The Group of western ethnic minorities under represented in addiction care, whereas the Group of non-western ethnic minorities slightly over represented in addiction care.

Table 5: **Cultural origin**[6]

	LADIS	Population 2010[7]
Native/Dutch	79%	80%
Western ethnic minority	4%	9%
Non-western ethnic minority	17%	11%

The subdivision according tot cultural origin for the various addiction problem are shown in Figure 7.

Figure 7: **Origin by primary problem 2010 (N=76.295)**

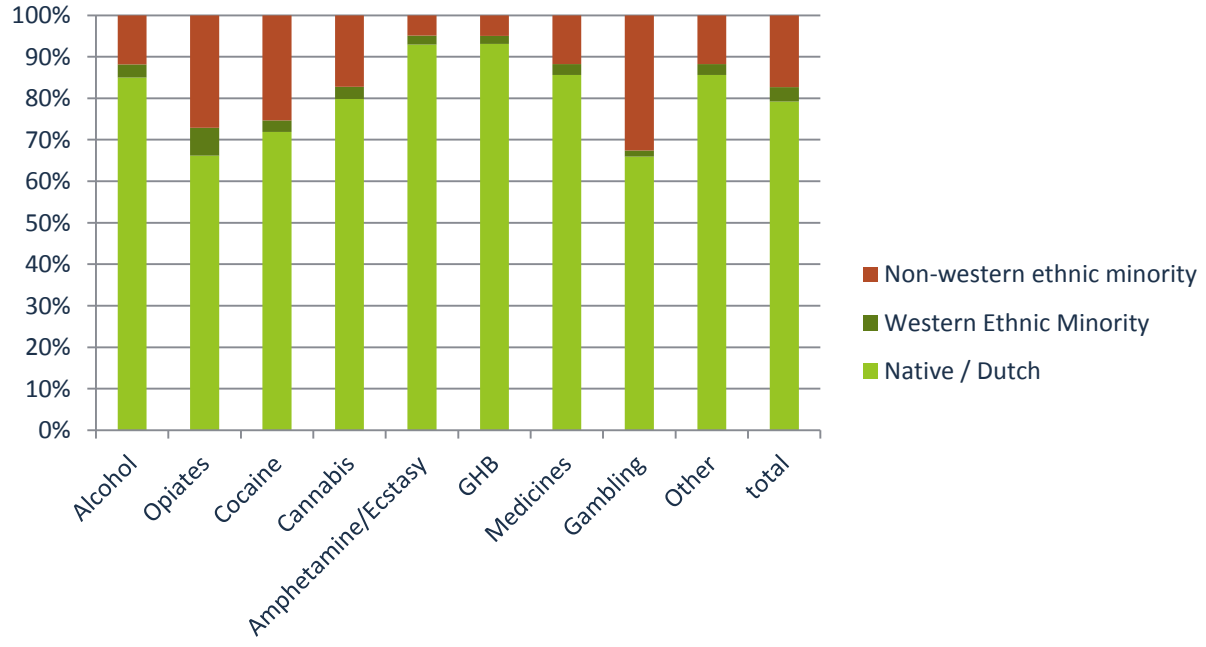


Figure 7 shows that the non-western ethnic minorities group is over represented with regard to demand for assistance with opiate, cocaine, gambling and, to a lesser extent, cannabis related demands for assistance. This Group is under represented with regard to amphetamine and alcohol related demands for assistance.

[6] According to the CBS definition. The determination is base don country of origin, parents' country of origin and nationality
[7] CBS 2010

1.8 Regional spread

Figure 8 shows the regional spread with regard to the number of people seeking assistance in addiction care per 100,000 inhabitants. The various chapters present the number of people seeking addiction care by substance per 100,000 inhabitants.

Figure 8: **Number of people seeking assistance addiction care per 100,000 inhabitants 2001 and 2010**

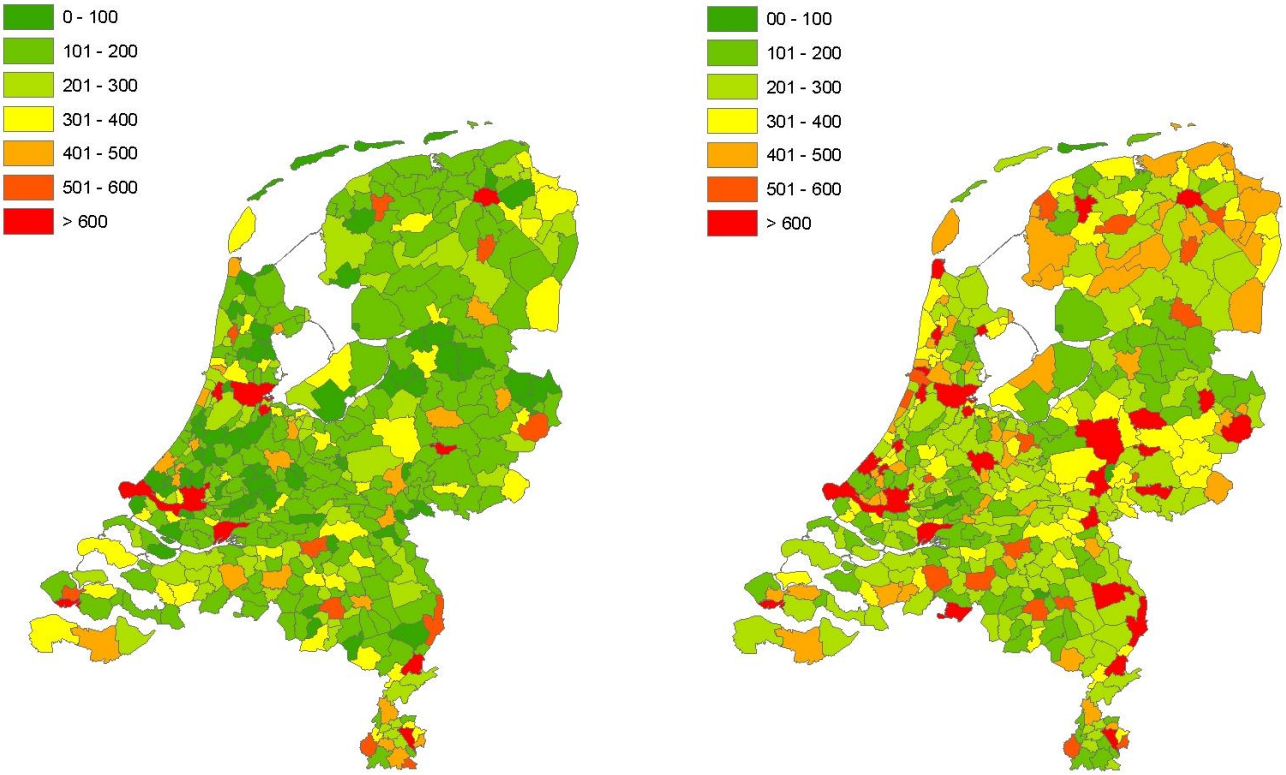


Figure 8 shows that the demand for assistance has increased over the past 10 years. The number of people seeking assistance per 100,000 people has increased from 340/100,000 in 2001 to 460/100,000 in 2010.

1.9 Multiple problems

40% of all people seeking assistance in addiction care have multiple problems (also referred to as poly drug use). This means that there if problematic use of at least two substances or use of substances in conjunction with problematic gambling.

Figure 9: **Secondary problems (%) by main problem 2 010 (N=76.295)**

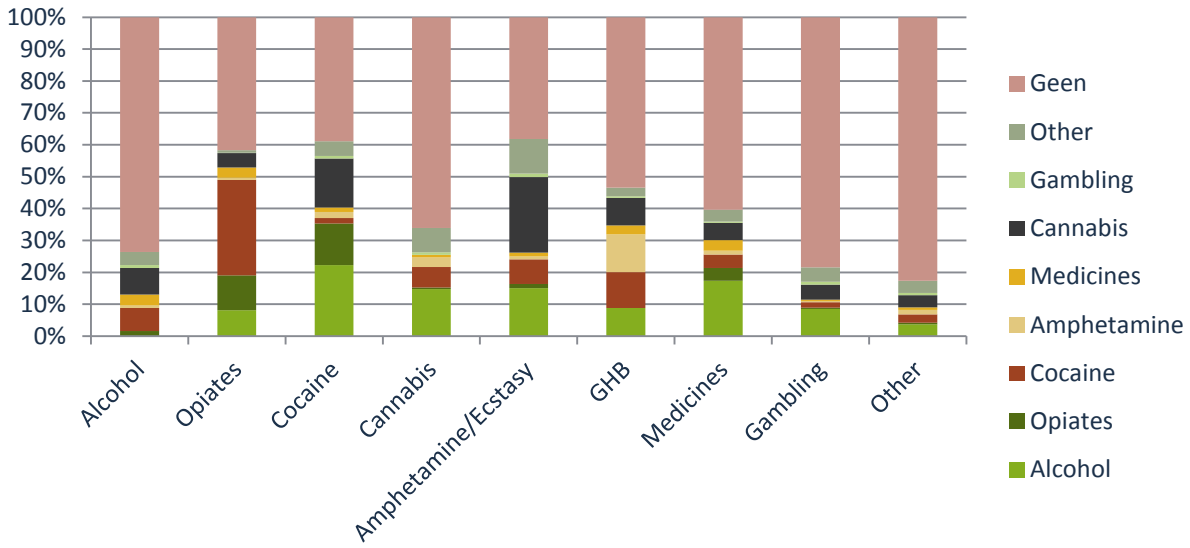


Table 6 shows the figures for Figure 9. It shows for each primary problem what part of the people seeking assistance also have a secondary problem. The main percentages are marked in **red**.

Table 6: **Secondary problems (%) by main problems 2 010 (N=76.295)**

	Primary problem								
Secondary ↓	Alcohol	Opiates	Cocaine	Cannabis	Amphetamine and Ecstasy	GHB	Medicines	Gambling	Other
Alcohol	0	9	**23**	**15**	**15**	9	**19**	9	4
Opiates	2	**12**	**14**	1	1	0	4	0	1
Cocaine	8	**34**	2	7	8	**11**	4	2	3
Amphetamine	1	1	2	3	1	**12**	1	0	2
Medicines	4	4	1	1	1	3	4	0	1
Cannabis	**9**	5	**16**	0	**24**	9	6	5	4
Gambling	1	0	1	1	1	1	0	1	1
Other	4	1	5	8	11	3	4	5	5
None	**71**	**34**	**35**	**65**	**38**	**53**	**58**	**76**	**79**

Hard drugs problems in particular are often multiple problems. Two-third of the classic hard drugs users (opiates and cocaine) seeking assistance indicate that they have other problems as well. The most frequently occurring secondary problem is cannabis. Cannabis is often used in conjunction with alcohol, cocaine and amphetamine and ecstasy as primary problems.
Moreover, alcohol as a secondary problem frequently occurs in people seeking assistance in relation to cocaine, cannabis, amphetamine and ecstasy and medicines.
People using GHB often use amphetamine and cocaine as well.
The combination of opiates and cocaine (in the form of crack) occurs frequently.
Please note that for opiates, cocaine, gambling and other addictions the same category, in an other form or as another substance, may also occur as a secondary problem.

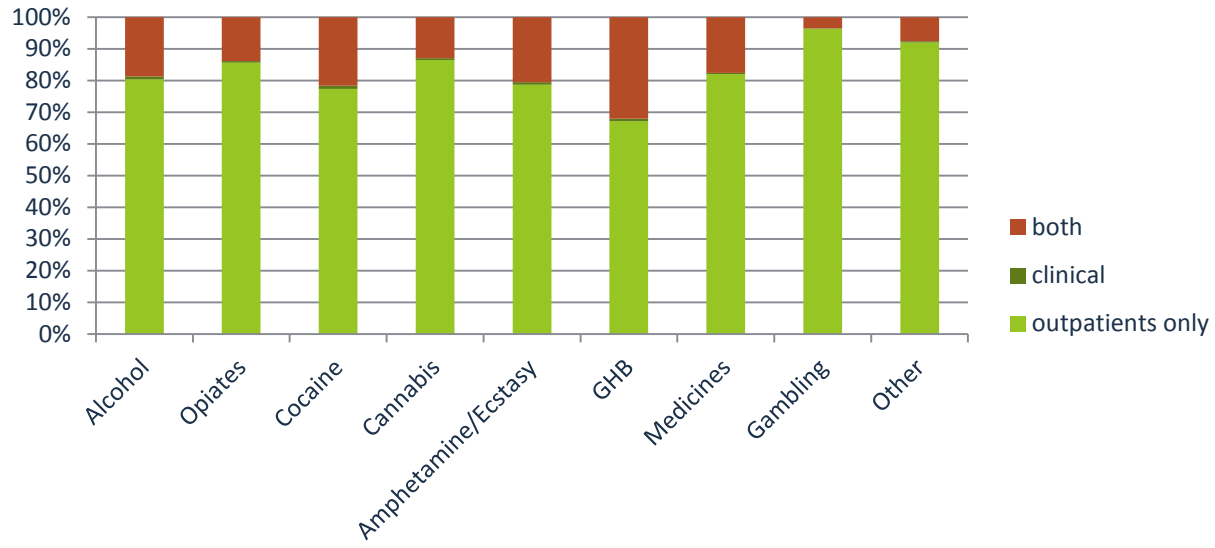
1.10 Type of assistance

Table 7: **Type of assistance 2010 (N=76.295)**

	Number of persons	%
Outpatients only	49.692	65%
Clinical only	460	<1%
Clinical and outpatient (overlap)	10.102	13%
Not specified	16.041	21%
TOTAL	76.295	100%

In 2010 10,000 persons with at least one clinical admission were registered in addiction care.
A clinical admission almost always implies a registration as an outpatient as this is the usual route to a clinical admission. This is shown in Table 7. Less than 1% has a clinical admission without having been registered as an outpatient.

Figure 10: **Type of assistance by primary problem 2010 (N=60.254)**

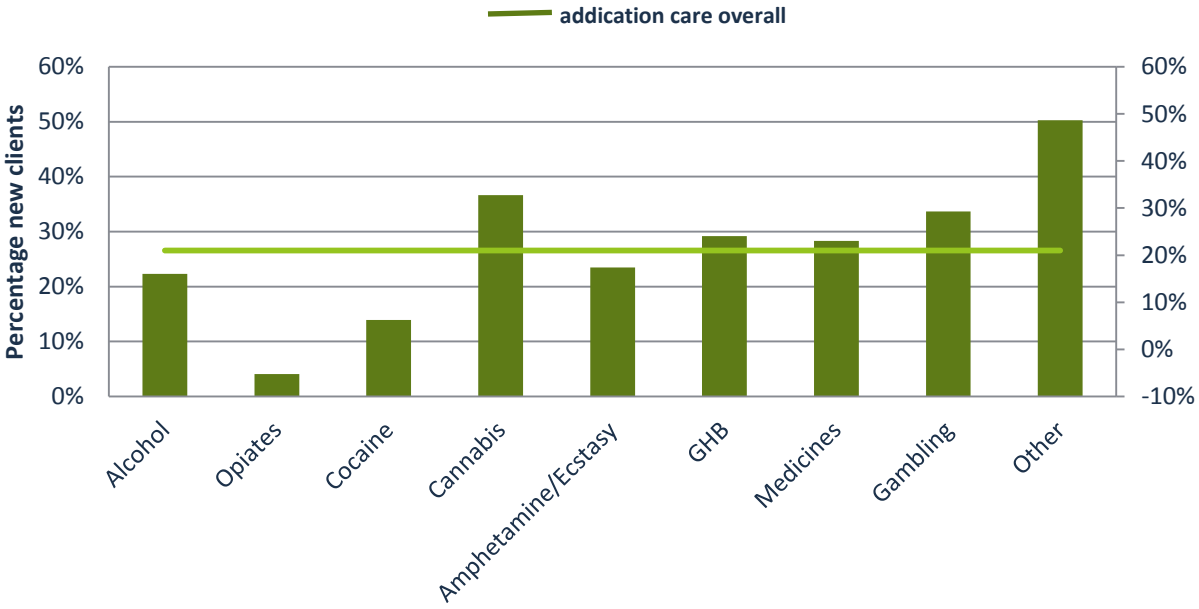


Although alcohol and cocaine as primary problem are associated with the highest number of admissions, the number of clinical admissions in connection with GHB and amphetamine is relatively high. People seeking assistance in relation to gambling are hardly ever being treated in addiction care.

1.11 New clients

Approximately 20% of the clients have never been treated before. This percentage differs by primary problem.

Figure 11: **Share of new clients by problem 2010**

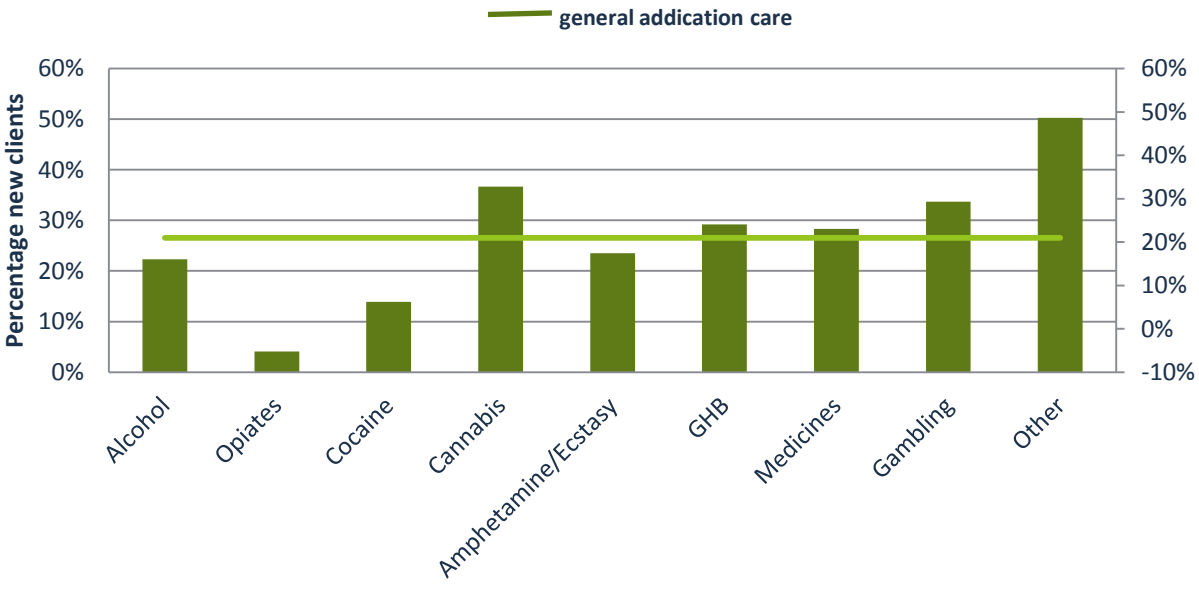


No new people are included in the Opiates Group. In 2008, no more than half of the people seeking assistance with regard to GHB related problems was new. Meanwhile, this percentage has dropped to less than 30%. The category Other has relatively the most newcomers (50%). Prominent groups are people seeking assistance for eating disorders and those with internet addiction related problems (see Chapter 10). The g amount ?of people with gambling as their primary problem includes a relatively high number of new people seeking assistance.

1.12 Career within addiction care

Of all 76,295 people seeking assistance their First registration in addition care has been recorded. For 25% of all registered unique persons their history in addiction care goes back to more than 10 years ago.

Figure 12: **First registration ever in addiction care by primary problem**

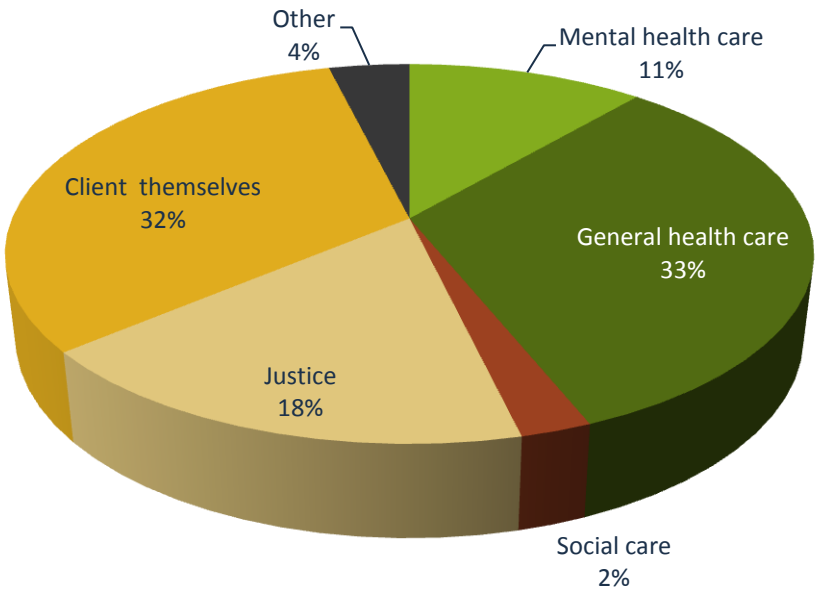


In the category Other the demand for assistance for eating disorders and internet are responsible for the relatively large number of newcomers. Both the hard drugs and the alcohol addictions have a chronic character. Most of the people seeking assistance for these problems have been in care before.

1.13 Method of registration

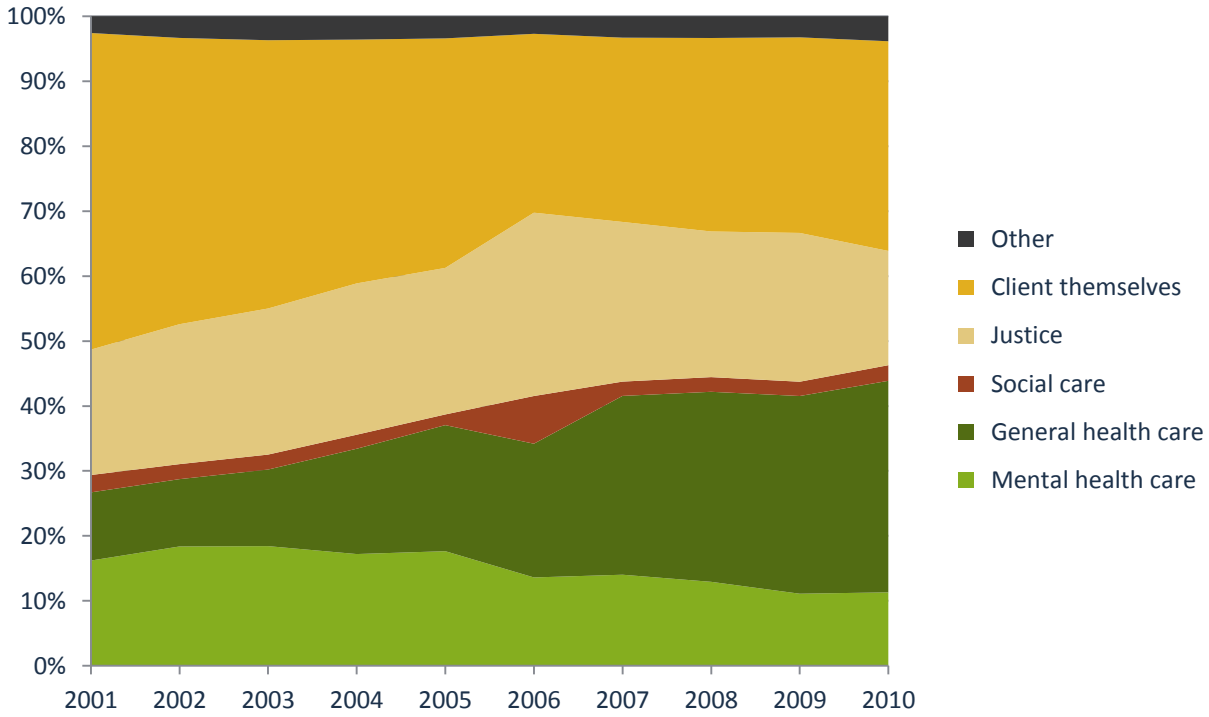
Many clients register themselves when they are seeking addiction care. Many others are referred by general healthcare and Justice. Figure 13 shows the distribution.

Figure 13: **Type of referral 2010 (N=56.375)**



The way in which someone presents in addiction care has changed over the past 10 years. The trend can be seen in Figure 14.

Figure 14: **Type of referral 2001-2010**



Registration through general healthcare showed the most prominent increase over this period. Over the past five years, the client has become once again the person who approaches addiction care himself. Application through Justice has been decreasing over the same period of time. This can partly be explained by the reduced quality of the registration by the probation office (see section 1.14 below).

1.14 Rehabilitation

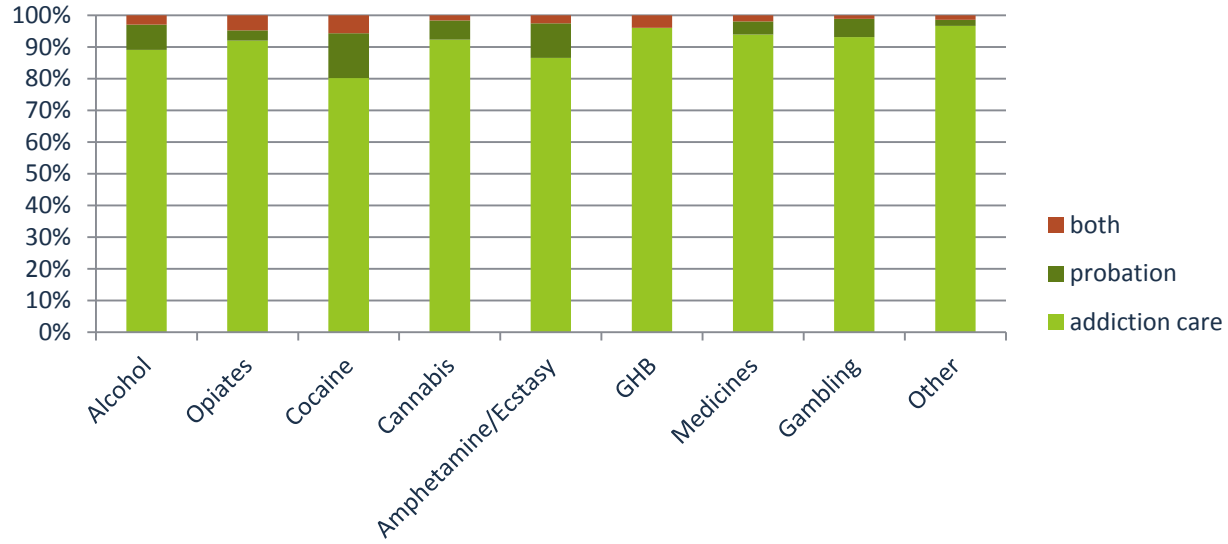
As stated before the information required by LADIS about the primary and, if applicable, secondary problems within addiction rehabilitation in the current CVS /CBO system is increasingly often not registered or not fully registered. This means that as from 2006 the number of unlinkable rehabilitation data has been increasing and therefore a lower number of people seeking assistance originates from addiction rehabilitation. The figures presented are therefore an underestimation of the actual number of people seeking assistance from rehabilitation with an addiction problem.

In 2010, about 15% of all people seeking assistance in addiction care were confronted with addiction rehabilitation. In 2009 this percentage was 20%.
Almost half of the people seeking assistance from rehabilitation have, besides this registration in the registration year 2010, another registration in which rehabilitation has not been involved.

Table 8: **Probation and addiction care 2010 (N=76.295)**

	Number of persons	%
Addiction care only	65.968	86%
Probation only	5.523	7%
Probation and Addiction care (overlap)	4.804	7%
TOTAL	76.295	**100%**

Figure 15: **Probation and addiction care by problem 2010 (N=76.295)**

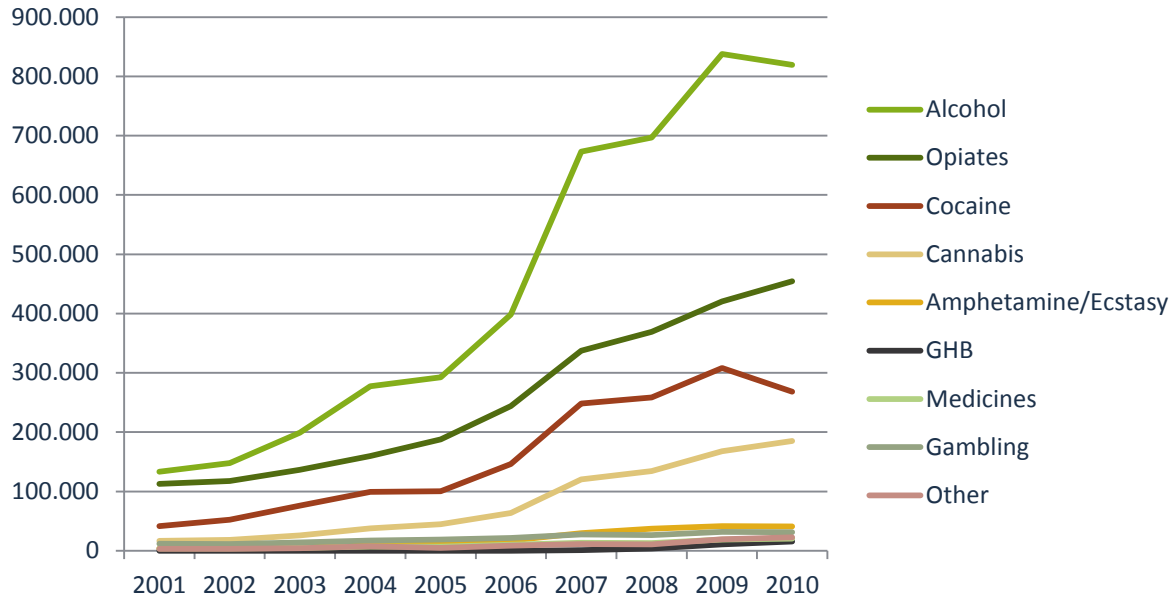


Ad regards the distribution of substance specific problems, a relatively large proportion of the cocaine users seeking assistance originates from addiction rehabilitation. The same applies to the amphetamine users seeking assistance, although in absolute numbers this is obviously a much smaller group.

1.15 Contacts

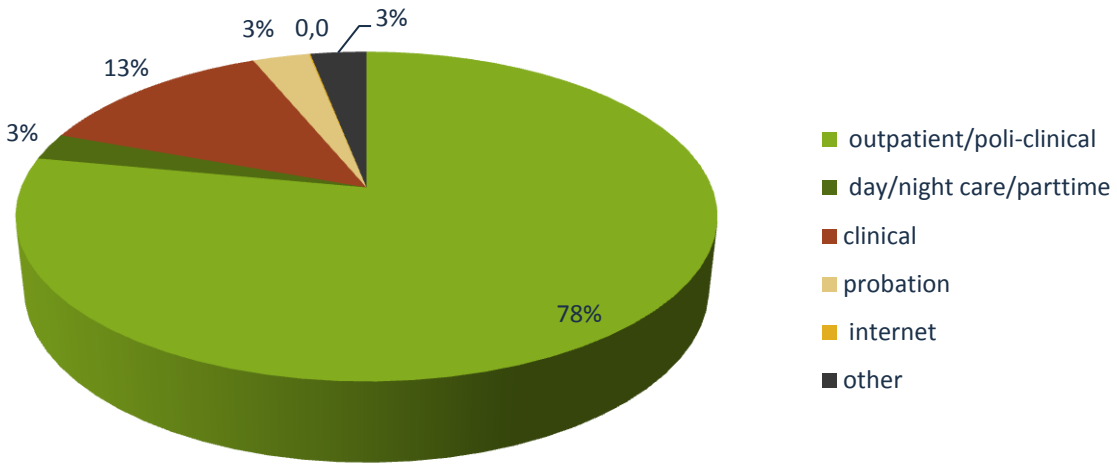
Registration of contacts is a labor-intensive activity. Nevertheless, health care institutions, insurers and government find these contacts of great importance. Proper contact registration may provide insight into the efforts made in addiction care for the very diverse problems.

Figure 16: **Number of contacts by primary problem 2001-2010**



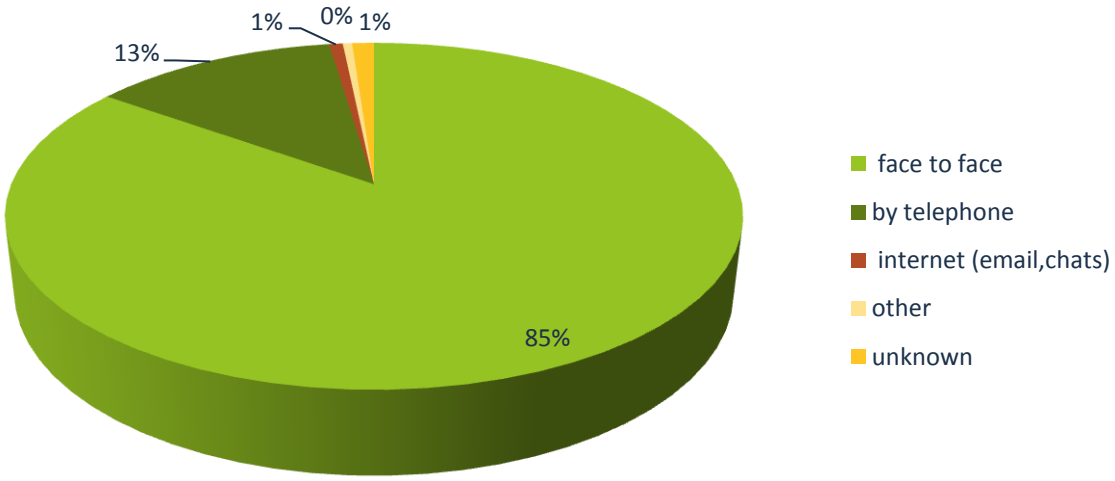
In 2010, a total of approximately 1,8 million contacts were registered within addiction care. Figure 16 shows a considerable increase as from 2001. This can largely be explained by an improvement of the registration of contacts.
Most of these are contacts in the context of requests for assistance with alcohol and opiates.

Figure 17: **Assistance setting 2010 (N=1.858.000)**



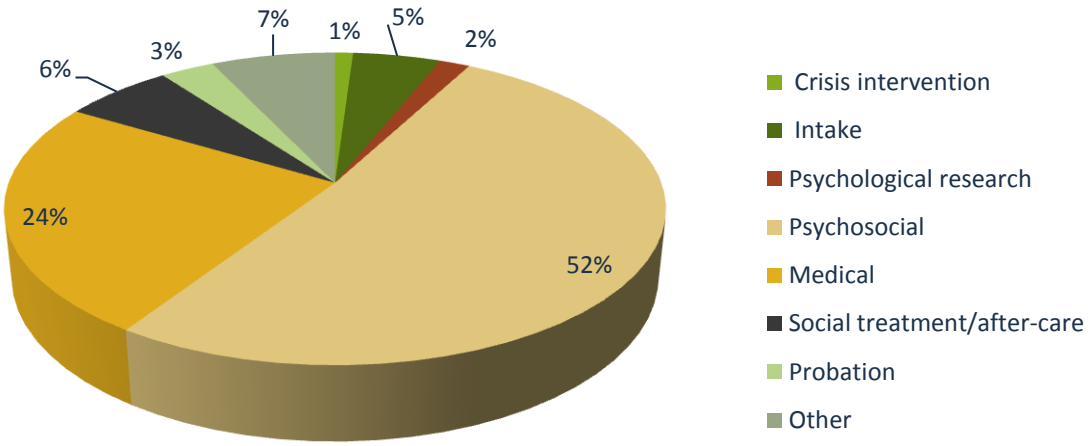
Most contacts between addiction care and clients take place in an outpatient setting. Almost 80% of the 1.8 million contacts in an outpatient setting. The second large group constitutes the clinical setting (13%). Contacts with people seeking assistance via the internet take place in less than 1% of the contact. For the time being, anonymous internet contacts cannot be included in LADIS.

Figure 18: **Method of contact 2010**



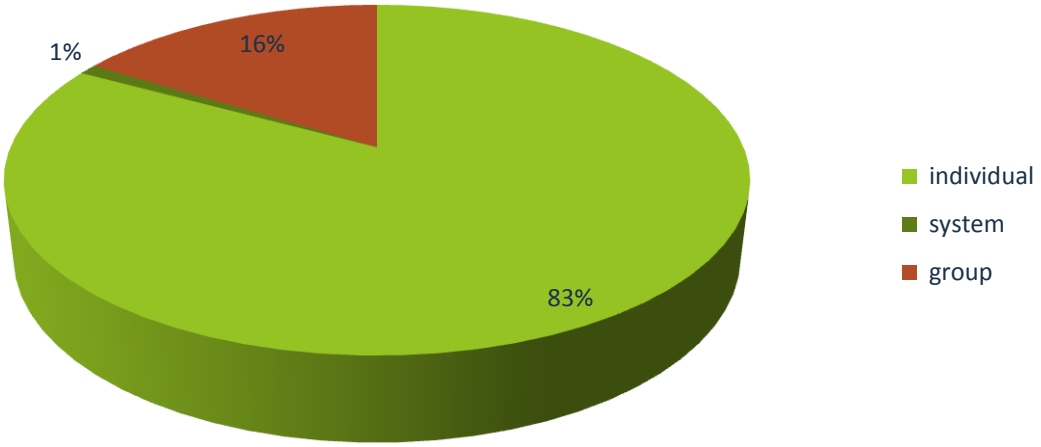
Face to face contacts are the most numerous (85%).
Slightly more than 10% of the contacts are by telephone. Contacts via the Internet (e-mail/chat) are, as yet, minimal. There may be under registration.

Figure 19: **Nature of contact 2010**



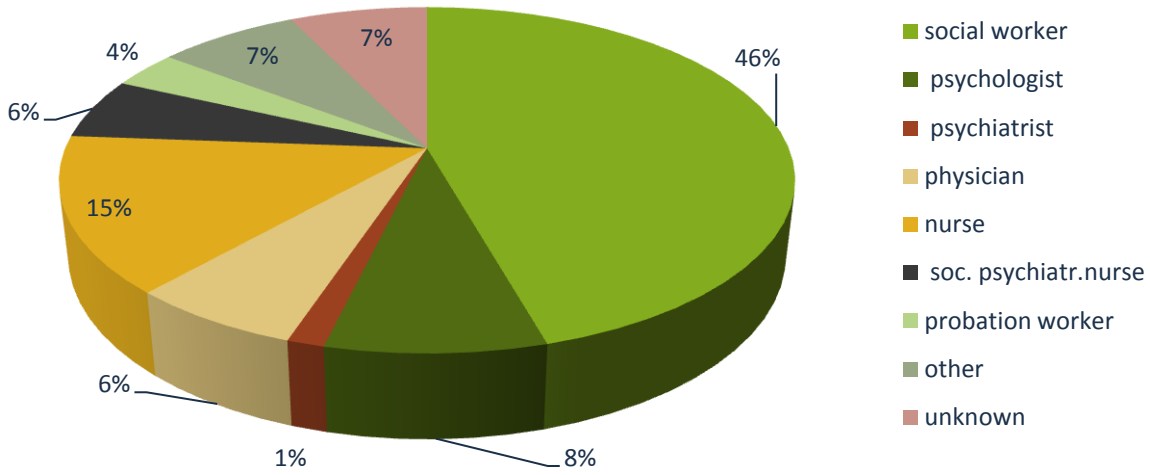
Most contacts are of a psychosocial or medical nature. This includes both treatment and counseling. Social counseling or after-care and rehabilitation occur in nearly 1 in 10 contacts. The number of crisis interventions accounts for only 1% of all contacts.

Figure 20: **Contact type 2010**



By far the majority of the contacts concern personal contact with clients (83%), followed by group contacts (16%) and contacts together with relatives or other persons from the client's circle 1%.

Figure 21: **Contacts by discipline 2010**



Social workers provide the majority of the contacts with clients. In addition, many clients have contact with medical disciplines (physician, nurse, psychologist) and with probation officers.

2 Alcohol

2.1 Highlights

- Alcohol treatment demand stabilized following many years of growth.
- The increase in the elderly group (over 55) continues.
- Proportion of youth is slightly dropping.
- 75% have been treated previously.

2.2 In brief

Table 9: **Overview of the requests for assistance related to alcohol addiction 2010**

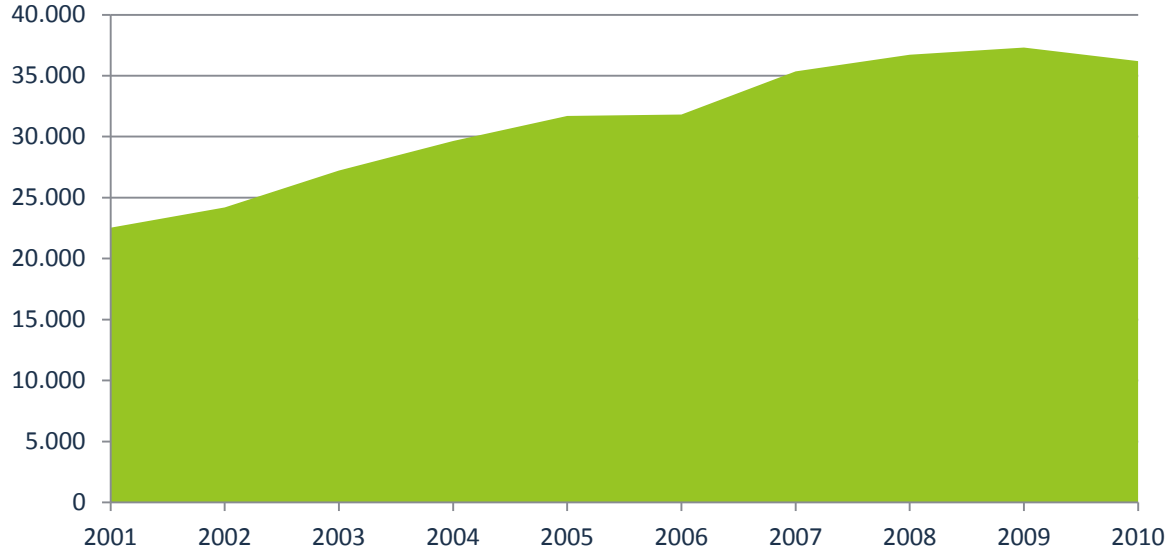
Demography		
	Number of people seeking assistance	36.203
	Male : Female	**74 : 26**
	Average age	45,9
	Share of 25-	4.7%
	Share of 55+	24.8%
	% Dutch	85.0%
	Number per 100,000 inhabitants	218
Problems		
	Proportion in addiction care	47%
	Single : Multiple	74 : 26
	First application ever	22%
	Average number of contacts/client	23

Alcohol remains responsible for the largest group of people requesting assistance from the addiction care sector. From the total of 76,000 people requesting assistance in 2010 over 36.000 do so for an alcohol-related problem.
Approximately 25% of this group are women. This percentage has remained constant for many years. The average age of the group of alcohol addicts seeking assistance has increased over the past few years and is now 46 years. Ten years ago this was below 44 years. In the youth group, alcohol is rarely the problem leading to people's requesting help from addiction care[2]. In 2010, 400 people under 20 years registered a request for alcohol treatment.

2.3 Trends and development in treatment demand

The demand for alcohol-related treatment has always formed the largest group in addiction care. Since 2001, this problem has required more attention (and capacity) in addiction care.
Over the past five years this share has been stable; in 2010 it was 47% of all people seeking assistance. The number has increased from 22,000 in 2001 to over 36,000 in 2010 (see also Table 9 and Figure 22). The development of this population over the last 10 years can be seen in Figure 22. This shows that the past 10 years have shown a 50% increase which has stabilized over the past few years.

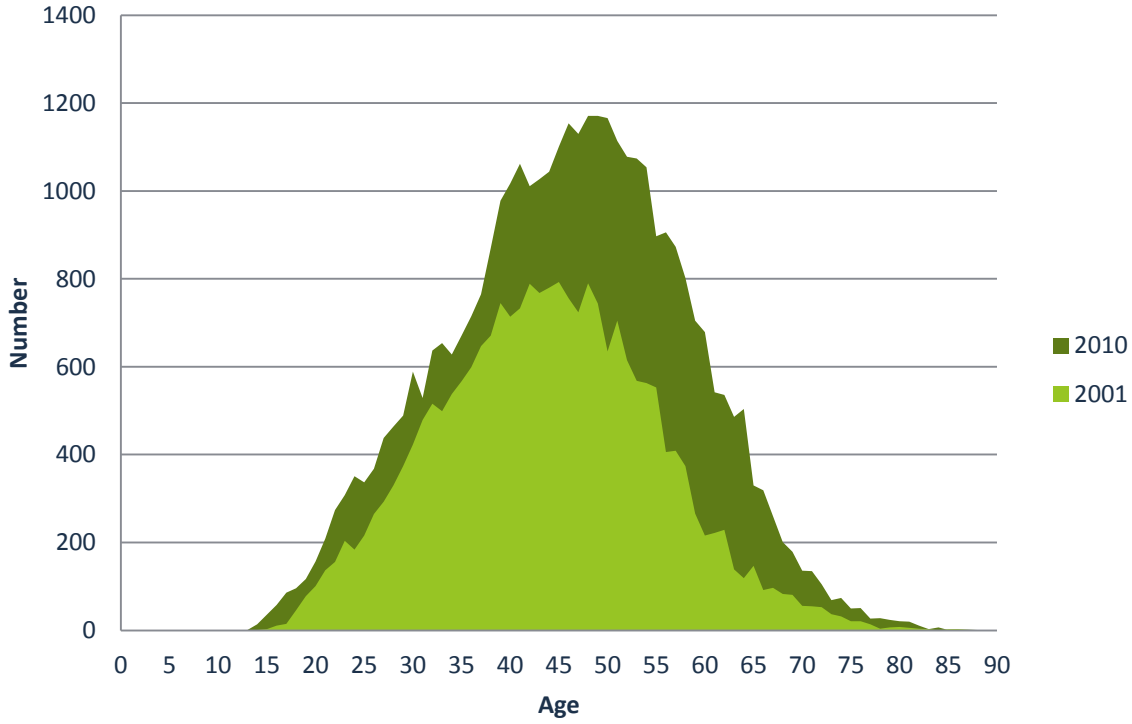
Figure 22: **Alcohol: Number of people requesting assistance 2001-2010**



2.4 Young and old

In recent years, the proportion of alcohol clients in the 55+ age group has clearly increased[8]. The proportion of youth. The proportion of youth in the total group of alcohol addict seeking assistance remains relatively stable. In 2010 there even was a minor decrease in this age group. The largest number of clients is in the 40-54 age group.

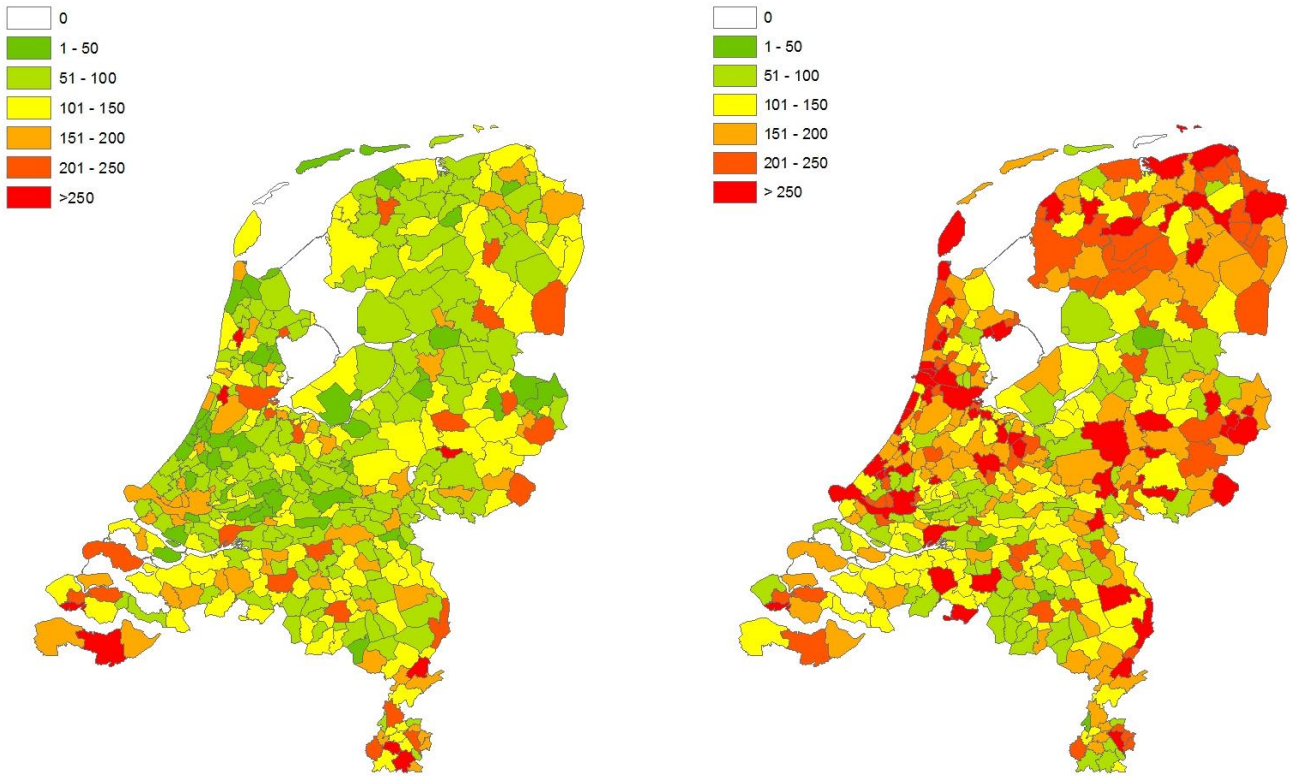
Figure 23: **Alcohol – Age distribution 2001 versus 2010**



[8] Alcohol and the elderly in addiction care in the Netherlands (1998-2007), Trimbos-institute, Nederlands Kenniscentrum Ouderenpsychiatrie and IVZ, June 2009

2.5 Regional spread

Figure 24: **Number of people seeking assistance for alcohol problems per 100,000 people 2001 and 2010**

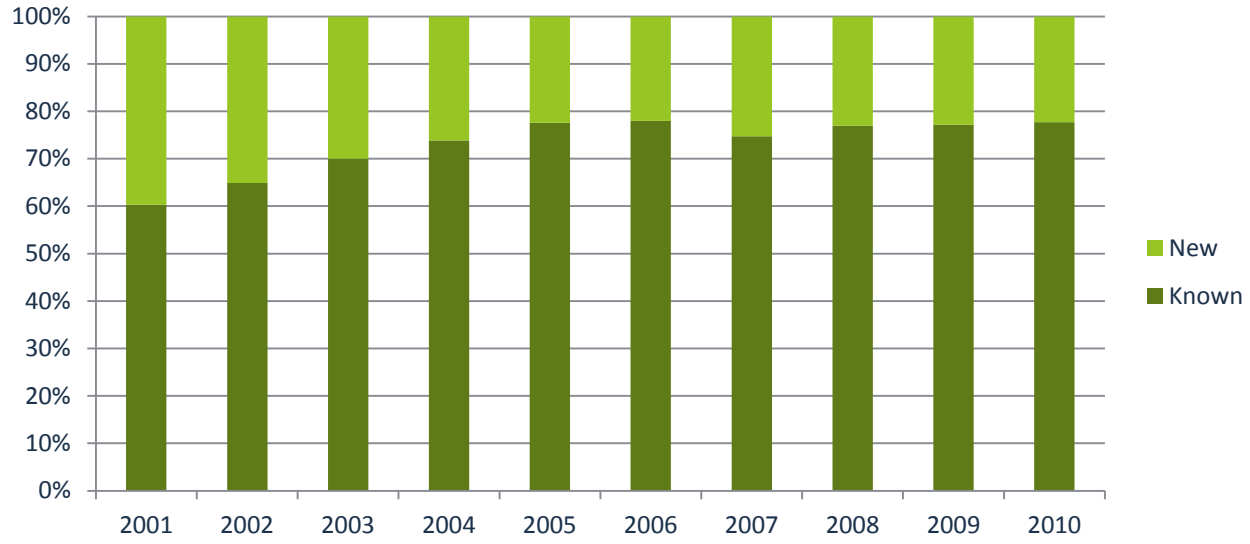


In 2010, the national average of the demand for assistance for alcohol is 218/100,000 inhabitants. In 2001 this was 141/100,000.

2.6 New and known

In recent years, approximately 20% of the clients (over 8,000 in 2010) registering at addiction care with alcohol problems were new clients. From this, we can deduce that nearly 80% of the people who approached addiction care with alcohol problems were previously registered.

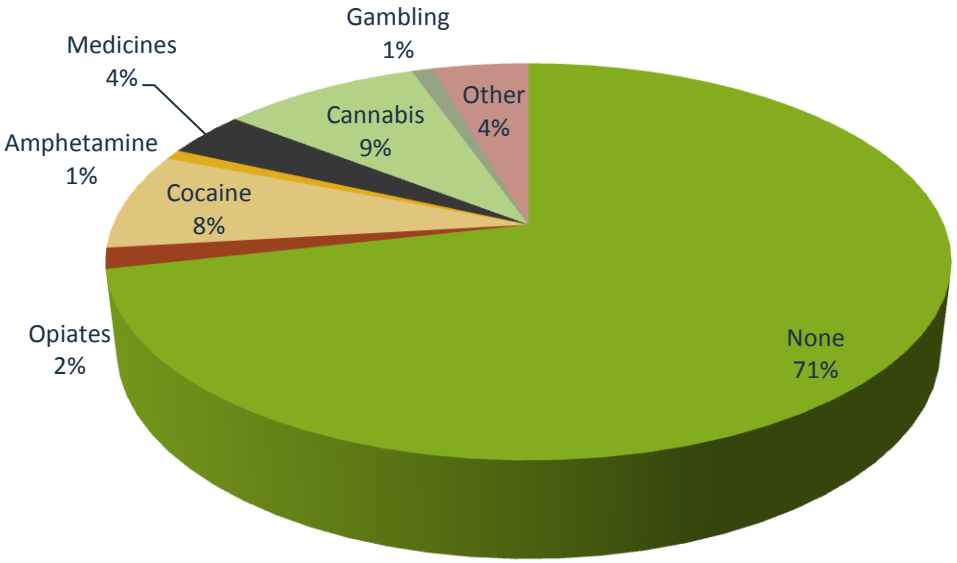
Figure 25: **Alcohol - Trend for new and old clients 2001-2010**



2.7 Secondary problems

In more than 30% of the cases, alcohol problems are associated with the problematic use of other drugs or gambling.In relation to other primary drugs, this is a relatively small percentage (see Figure 26). Three quarters of the alcohol clients have no problems with other drugs.
It is striking that in over 10% of the population requiring assistance with alcohol, hard drug use (opiates, cocaine and amphetamine) is involved as a secondary problem.

Figure 26: **Alcohol - Secondary problems 2010 (N=33.418)**



3 Opiates

3.1 Highlights

- The drop in number of people seeking assistance with opiate problems is stagnating.
- The group with an opiate use related treatment demand is getting older: the number of people over 55 has increased to 1700.
- Little new inflow, but also little client outflow.
- No new groups among the minor new inflow.

3.2 In brief

Figure 27: **Overview of the 2010 demand for opiate assistance**

Demography	
Number of people seeking assistance	12.313
Male : Female	80 : 20
Average age	45.1
Share of 25-	1.1%
Share of 55+	13.6%
% Dutch	66.2%
Number per 100,000 inhabitants	74
Problems	
Proportion in addiction care	16.1%
Proportion intravenous use	8%
Single : Multiple	42 : 58
First application ever	4.1%
Average number of contacts/client (excl. methadone)	37
Average number of intakes / methadone client	228

3.3 Trends and development in treatment demand

The opiates group within addiction care is a relatively stable group of clients in number.
Around 95% of those requesting assistance are "old acquaintances". The number of newcomers is limited and there is little outflow. Addiction care for this group of clients consists mainly of "maintenance care". This means that treatment is focused on “harm-reduction” rather than abstinence.
In a recent Trimbos Institute study, the number of problematic opiate users in the Netherlands was estimated to be 17,700 - within a range of 17,300 and 18,100. Compared to 2001, this was a significant drop (from between 25,700 and 39.000 problematic opiate users).
Nearly 12,500 people with opiate problems are registered in LADIS.

Figure 28: **Opiates – Number of people seeking assistance 2001-2010**

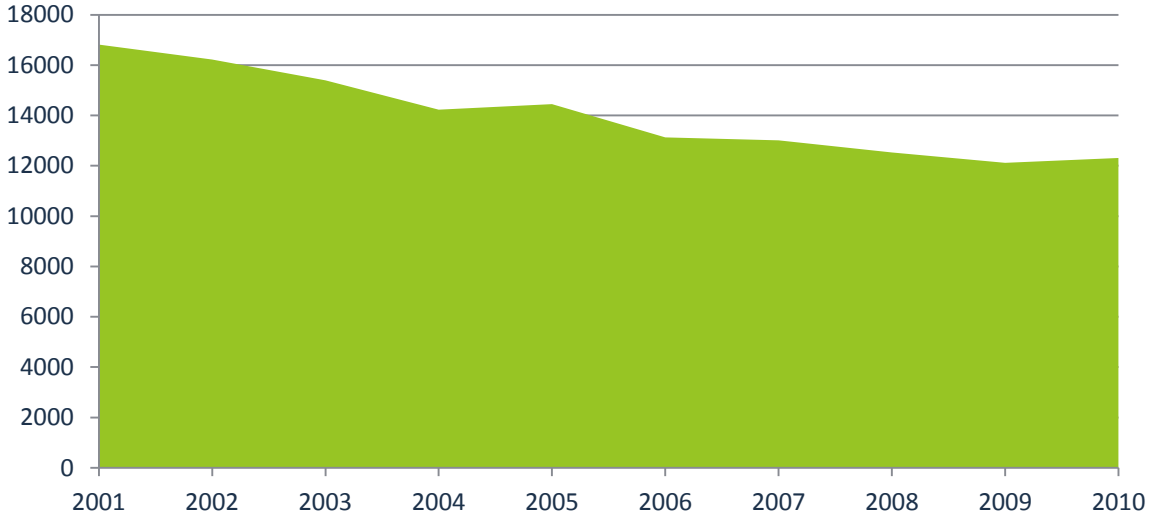
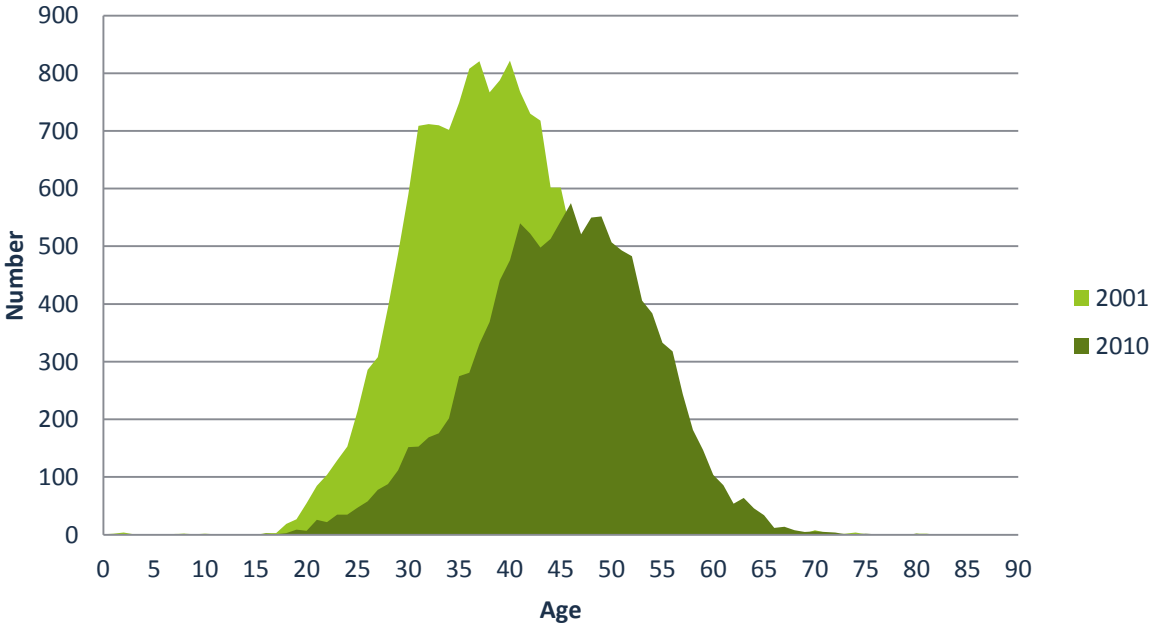


Figure 28 shows a clearly decreasing trend over the past 10 years with regard to demand for assistance with regard to opiate use. This decrease appears to tend to come to a halt as from 2006. In 2010, a minor increase by 193 persons was registered compared to 2009. Further analysis shows, however, that this can be explained from an incomplete delivery by an Institution for the year 2009. The trend is still dropping compared to 2008 and the years before 2008.

3.4 Young and old

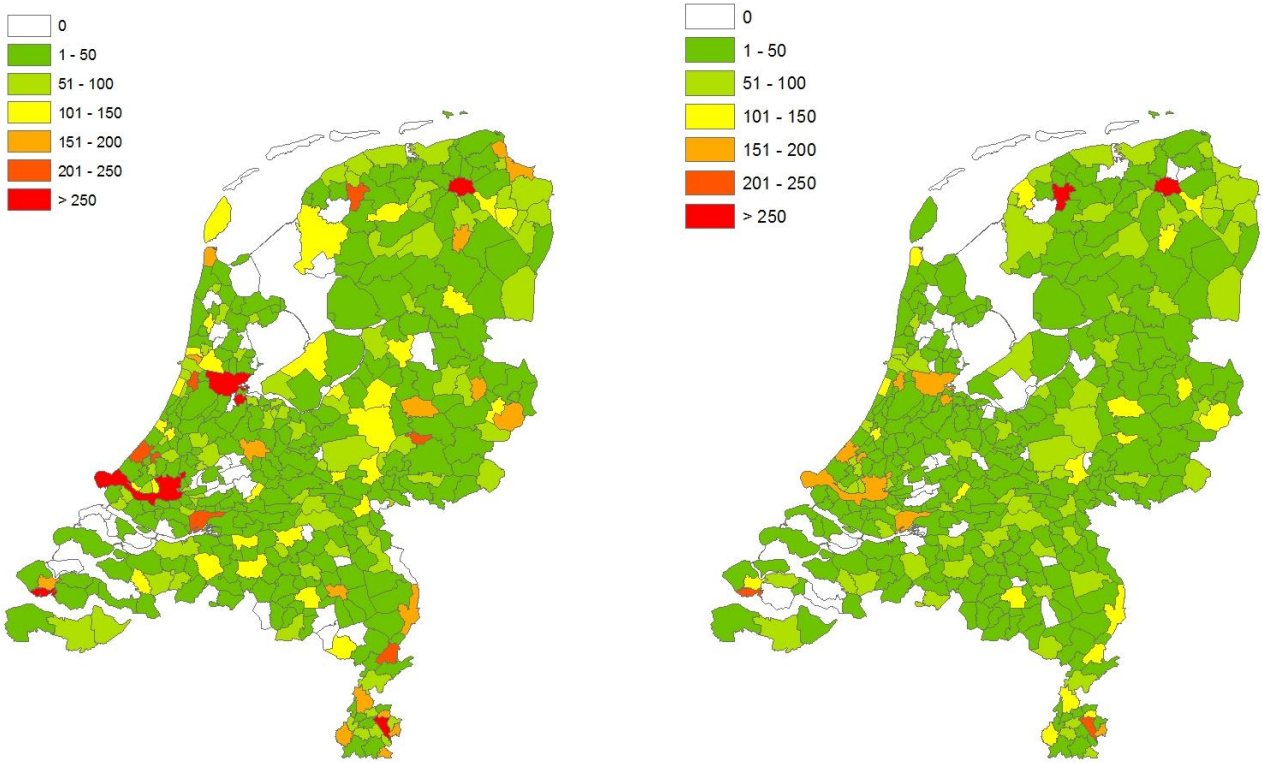
The opiate aid-requesting population is ageing and the proportion of 55 + is increasing both in number and percentage. This largely concerns a group of people in chronic care, for whom this is expected to remain the case. For this reason, the group of opiate clients in addiction care will get progressively "greyer." In Figure 29, this development of age-shift is clearly seen compared to the year 2001.

Figure 29: **Opiates – Age distribution 2001 versus 2010**



3.5 Regional spread

Figure 30: **Number of people seeking assistance for opiate related problems by 100,000 inhabitants in 2001 and 2010**

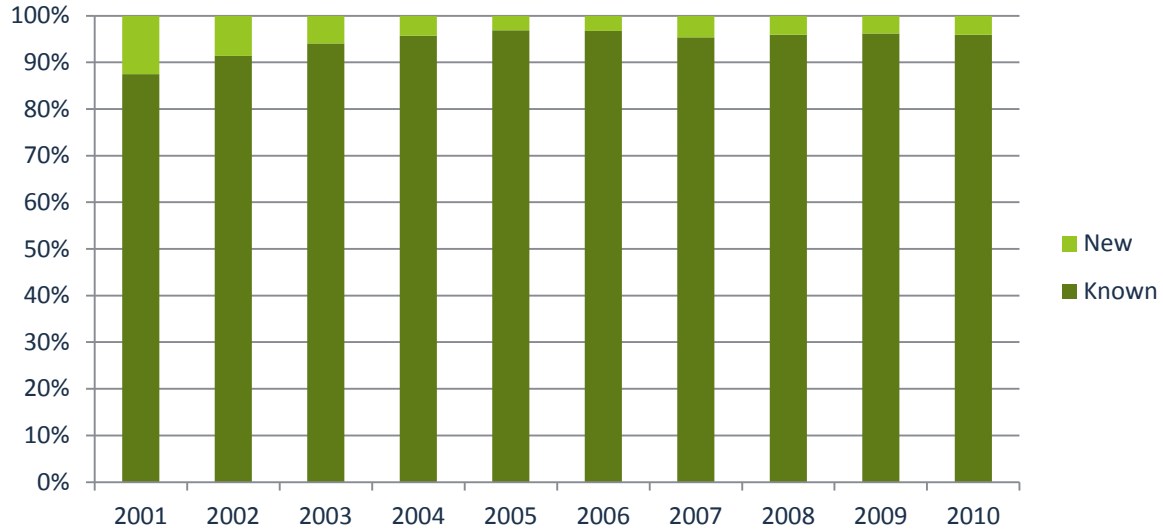


In 2010, the national average with regard to demand for assistance with opiate related problems was 74/100,000 inhabitants. This was 105/100,000 inhabitants in 2001.

3.6 New and known

The vast majority of clients are "old acquaintances." In the Netherlands, there is hardly any new growth in the opiate problem; the vast majority of clients were already in care (the so-called "revolving door clients"). Figure 30 also clearly shows the downward trend in opiate treatment demand. In 2009, 414 new persons were registered.

Figure 31: **Opiates – New and existing clients trend 2001-2010**

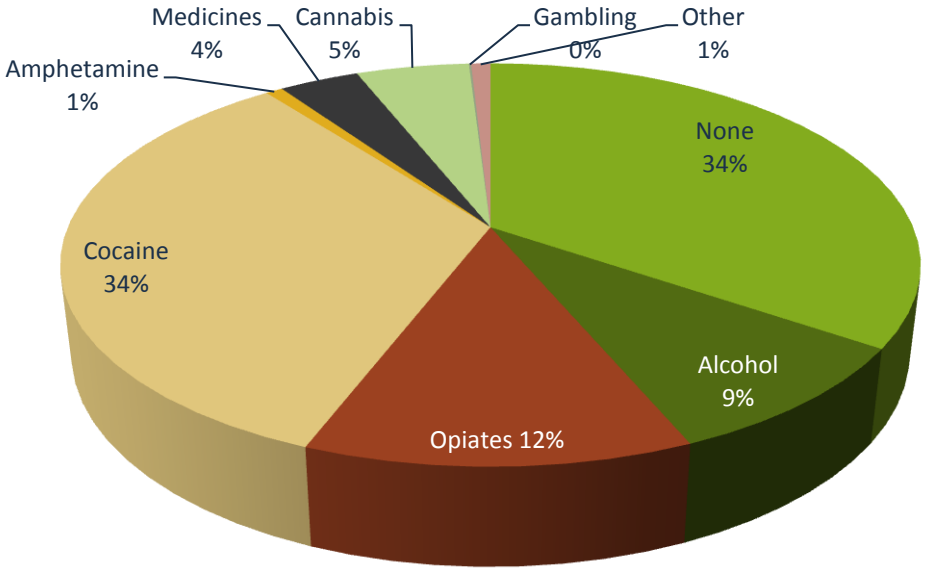


For the group of 4% newcomers it has been established whether this includes new groups, for example from the former eastern block countries. This is not the case. There are no striking differences in characteristics between the newcomers and the group that is already known.

3.7 Secondary problems

Many opiate users have a secondary problem apart from problems with the primary substance. Only one third does not have any problems related to other substances.
The secondary problems many involve cocaine and other opiates.

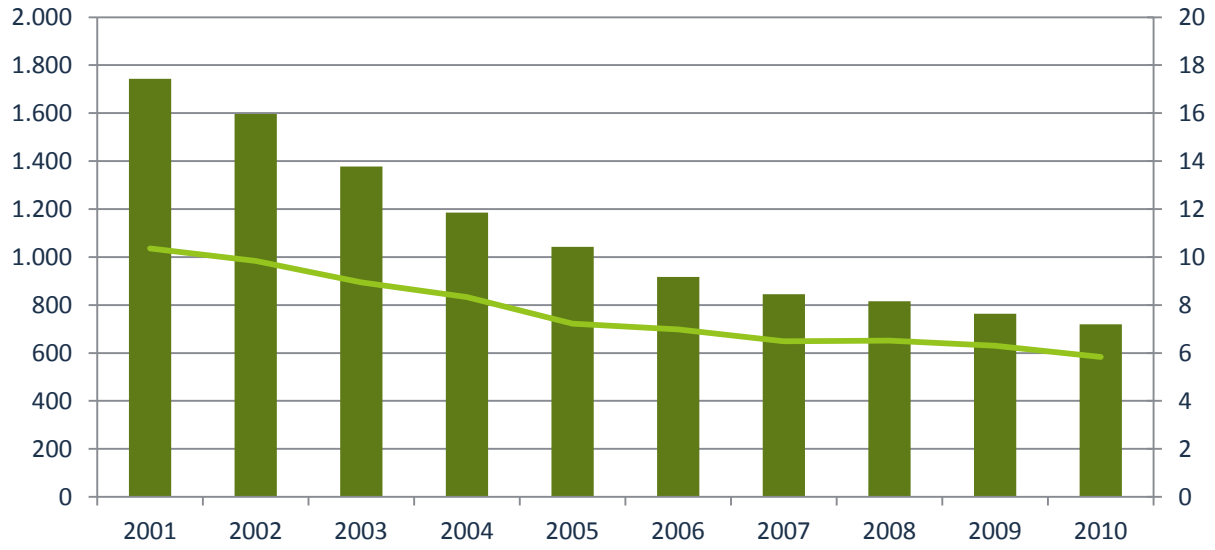
Figure 32: **Opiates - Secondary problems 2010**



3.8 Intravenous use

In the Netherlands, intravenous opiate use is still decreasing. In the last 10 years, the number of needle-users in treatment has decreased by half. During this period, the percentage declined from over 10% to below 6%.

Figure 33: **Number and proportion (%) intravenous opiate users 2001-2010**



3.9 Methadone

The majority, over 80% of the opiate addicts in treatment, are also enrolled in a methadone program and/or heroin project. The increase as from 2007 is explained by improved methadone registration at a number of facilities.

Table 10: **Methadone contacts**

Years	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Clients	11.597	11.399	9.924	10.199	10.416	9.192	8.187	8.494	9.793	10.085
Intakes x 000	2.561	2.577	2.195	2.303	2.403	2.201	1.875	1.869	2.295	2.304
Intakes/ client	221	226	221	226	231	239	229	220	234	228

3.10 Figures from the National Database for Registration of Substances (Landelijke Centrale Middelen Registratie (LCMR))

The LCMR is an information system about opiate addiction. It contains data about persons who receive replacement therapy in the context of their opiate addiction. The system was developed by order of the ministries of Public Health, Justice and Internal Affairs and Kingdom Relations (BZK). The LCMR is intended for care providers working in the addict care chain. The system offers safe, reliable and quick information exchange between care providers. It provides them with information about the client and about a number of relevant related matters. They will know whether the customer is (has been) in treatment, at which institution(s) and in which period. They will also know who was/is the treating physician and which opiate replacement therapy and in which dose was provided. The data are used anonymously to prepare certain policy information.
In this paragraph a number of key figures will be presented which are an addition to the figures collected in the LADIS system.
The most important difference is that the LCMR is not restricted to addiction care, but also collects data of the medical services, which form part of the 46 penitentiary facilities (prisons and houses of detention) in the Netherlands. These are mainly occupied with the care for imprisoned addicts.

3.10.1 Use of opiate substituting substances

Figure 34: **Number of uses per month in 2010**

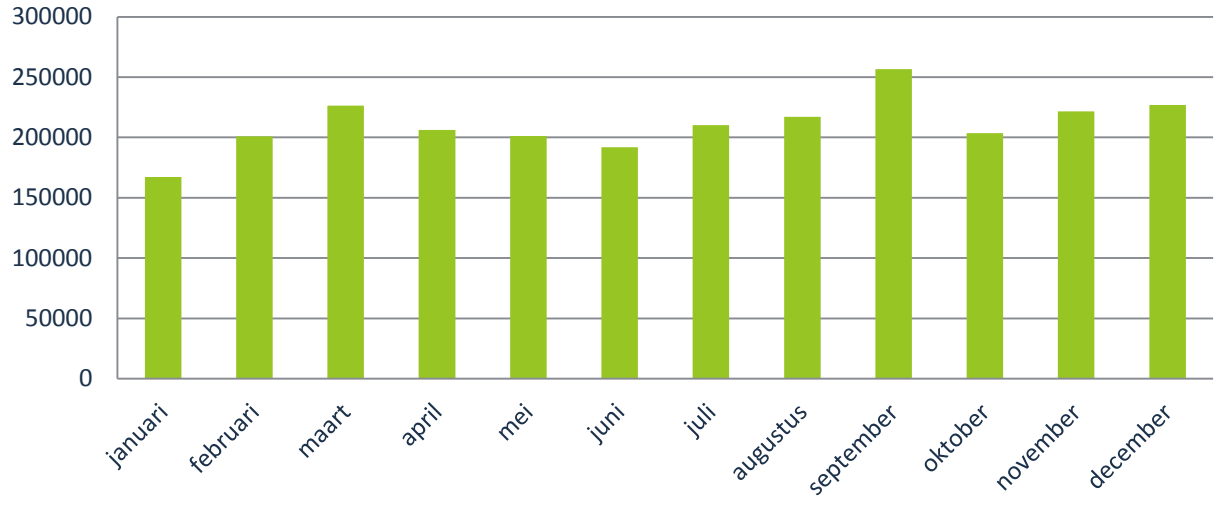
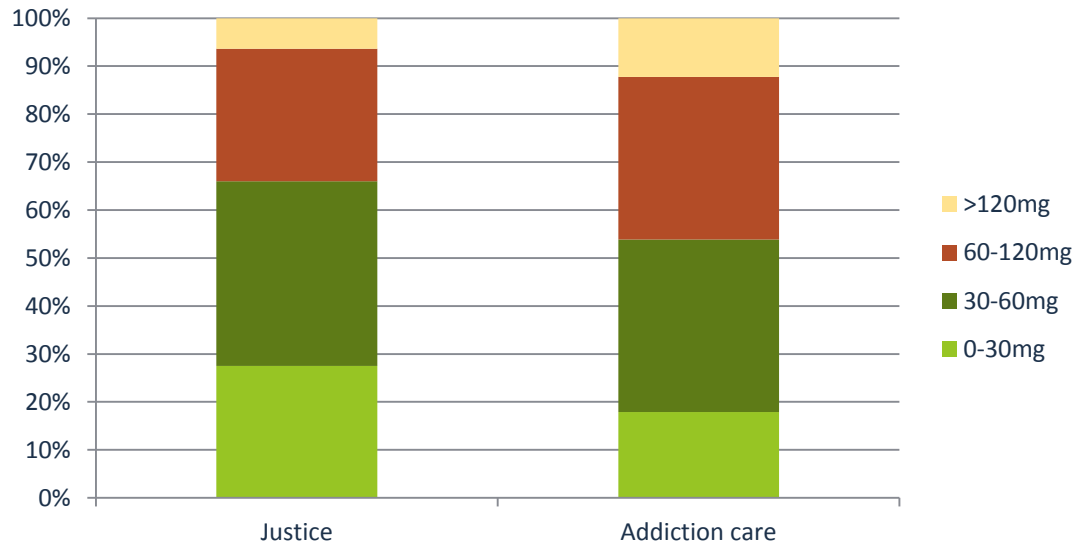


Figure 34 shows that more than 200,000 registered doses are delivered to the LCMR every month and that this is quite a constant flow. In total, about 2.5 million doses have been registered at the LCMR in 2010.

3.10.2 Dosages

The dose level is projected in figure 35, where a distinction is made between the provision within the Justice system and within outpatient addiction care (including GGD Amsterdam).
It shows that within the Justice system lower doses are given on average as compared to outpatient care. The number of high-dose therapies in Justice is significantly lower.

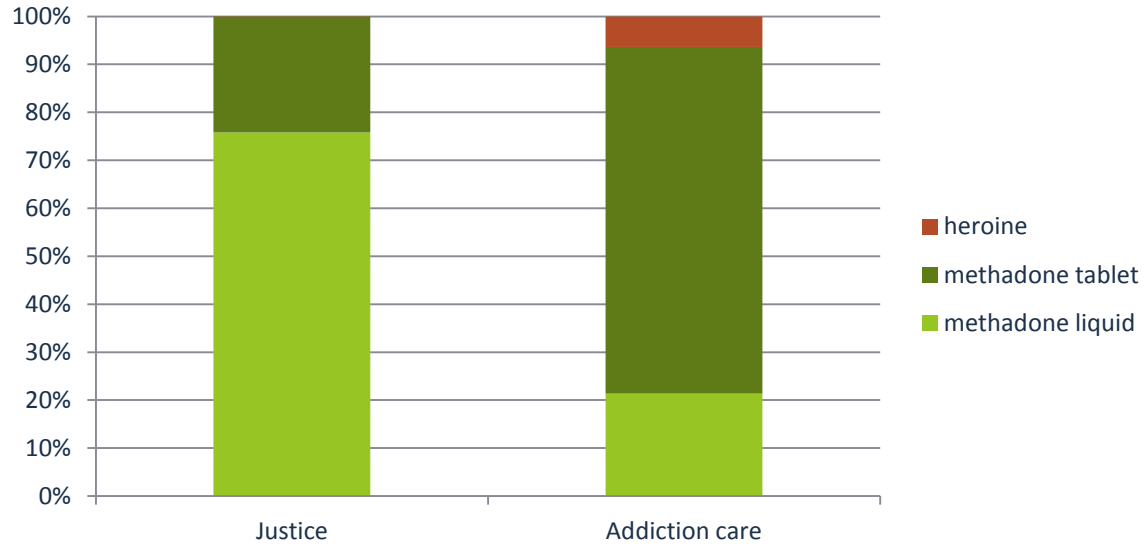
Figure 35: **Distinction in mg Justice / Addiction care**



3.10.3 Pills or liquid

Figure 36 shows that there is a large difference in the type of prescription. Within the Justice system more fluid methadone is prescribed, while in outpatient care a switch is seen more to methadone tablets. The heroin prescriptions are also visible; it is known, though, that not all heroin stations provide data to the LCMR. Some progress can be made in this respect.

Figure 36: **Type of prescription**



The LADIS keys are generated by means of ZorgTTP (Trusted Third Party).
Through ZorgTTP the LADIS data with regard to methadone can be improved with the LCMR data. ZorgTTP can link the LCMR domain with a pseudonym to the LADIS data. A comparison between LADIS figures and LCMR figures shows that about 850 unique persons are well-known within the LCMR, but do not appear in LADIS. This also include the persons requesting help who go to the pharmacist with a prescription. Large part thereof is in the metropolitan area but the phenomenon seems to occur across the Netherlands and in all institutions.
The question arises whether these may be care avoiders or double identities. It has previously become obvious that double identities occur in the care and justice domain.
A further study of this group will take place in 2011.

4 Cocaine

4.1 Highlights

- Decrease in the demand for cocaine treatment continues.
- 85% had been previously treated.
- Percentage of youth <25 years with a cocaine related demand for assistance dropped below 10%.
- Increasing average age of the people seeking assistance with regard to cocaine use.

4.2 In brief

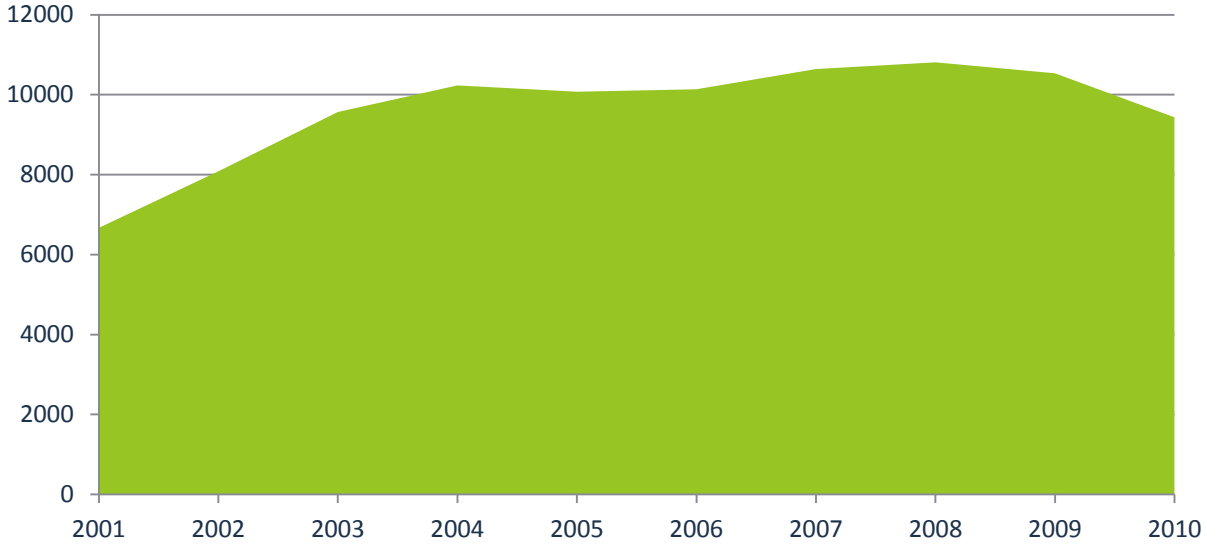
Table 11: **Overview of cocaine treatment demand 2010**

Demography		
	Number of people seeking assistance	9437
	Male : Female	83 : 17
	Average age	36.6
	Share of 25-	9.7%
	Share of 55+	3.8%
	% Dutch	71.9%
	Number per 100,000 inhabitants	57
Problems		
	Proportion in addiction care	12.4%
	Crack : Snortable coke	55 : 46
	Single : Multiple	39 : 61
	First application ever	14%
	Average number of contacts/client	28

4.3 Trends and development in treatment demand

After a sharp increase in requests for assistance between the late nineties and 2004, a certain amount of stabilization appears in the volume of cocaine-related treatment demand. As from 2004 this concerns about 10,000 people seeking assistance. In 2010 a slight decrease has been observed.
Just as with opiates, the number of returning clients is increasing. Here, too, the concept of "maintenance care" or "revolving door clients" would appear to be applicable.

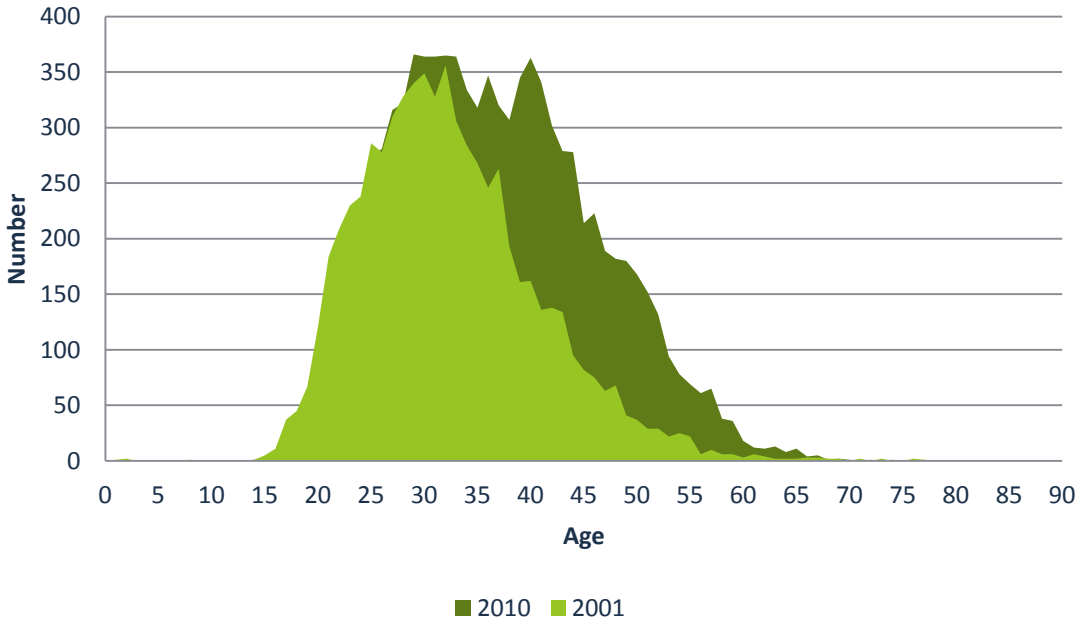
Figure 37: **Cocaine – Number of people requesting assistance 2001-2010**



4.4 Young and old

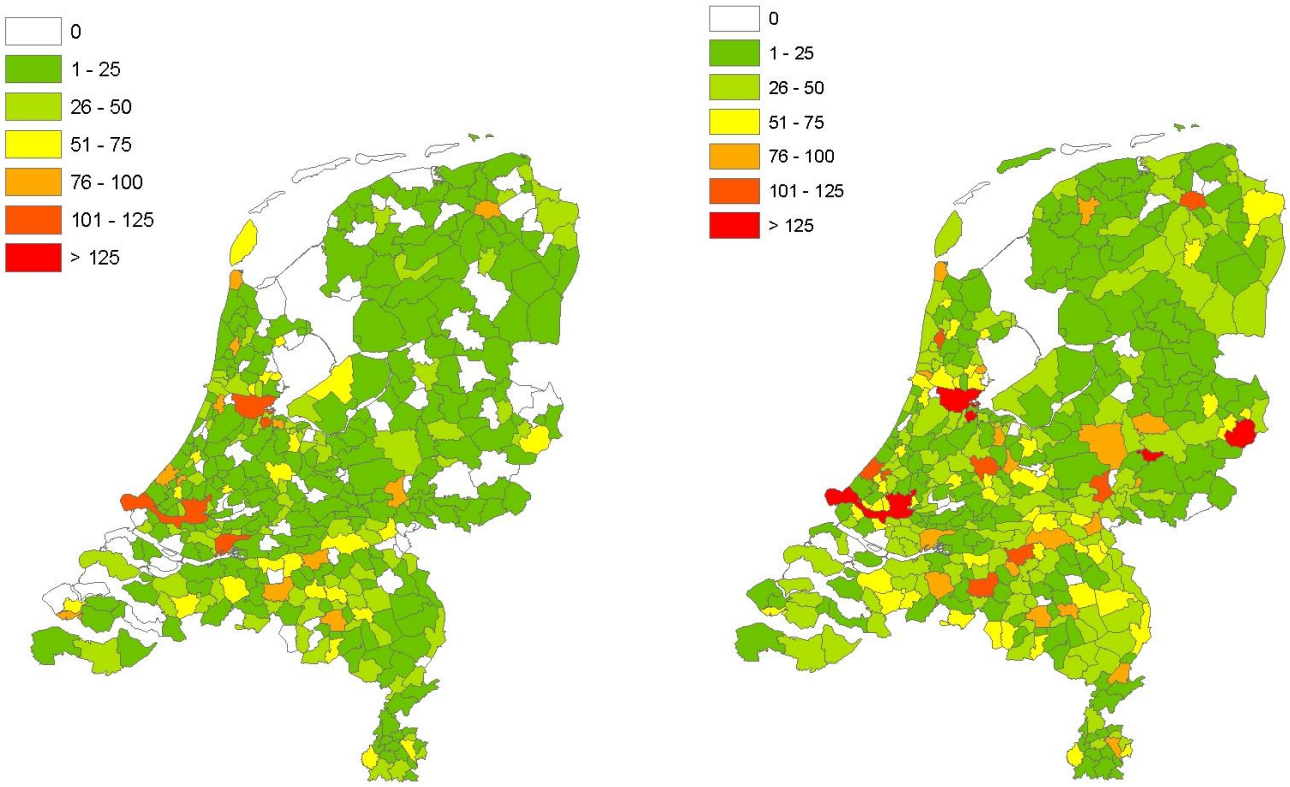
The shift towards older age groups is also reflected in cocaine use in the last 10 years.

Figure 38: **Cocaine – Age distribution of 2001 versus 2010**



4.5 Regional spread

Figure 39: **Number of people seeking assistance for cocaine related problems by 100,000 inhabitants 2001 and 2010**

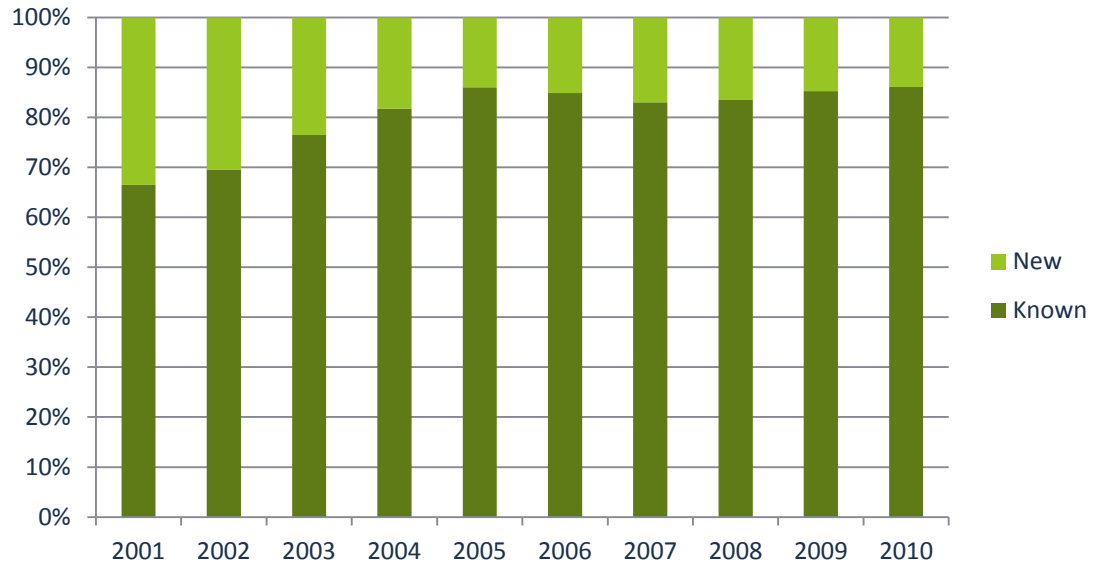


In 2010, the national average demand for assistance for cocaine is 57/100,000 inhabitants, compared to 42/100,000 in 2001.

4.6 New and existing

Just as with other primary substances, there is a growing group of cocaine clients who repeatedly require assistance resources for their problem.

Figure 40: **Cocaine - New and existing clients trend 2001-2010**

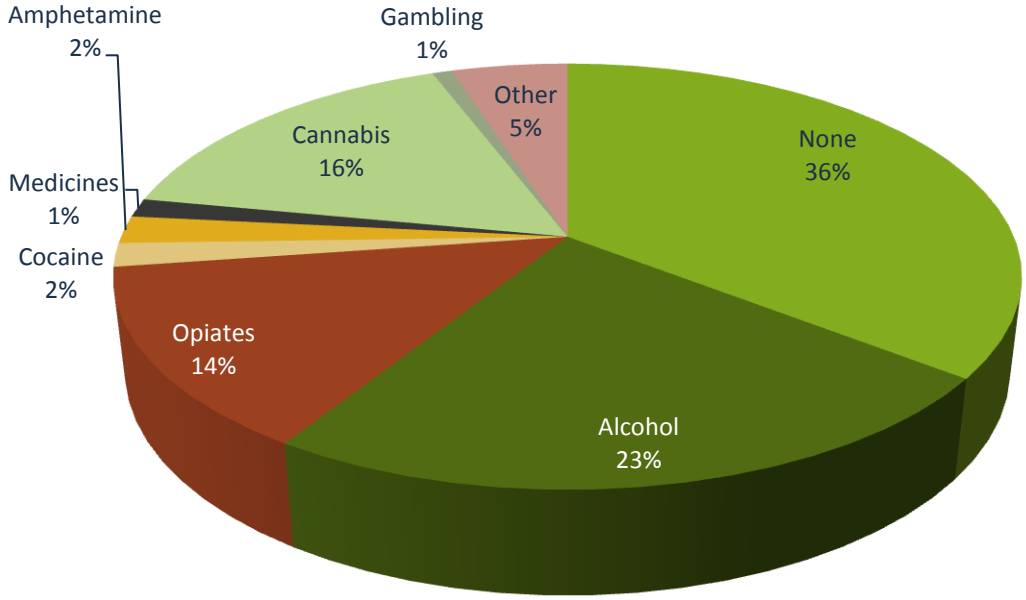


The total group of cocaine clients is now mostly clients who have previously asked for assistance. In 2010, approximately 1,300 new clients register a request for assistance for their use of cocaine..

4.7 Secondary problems

Two thirds of those seeking assistance with cocaine exhibit other problems .

Figure 41: **Cocaine - Secondary problems 2010**



Alcohol is the most frequently occurring secondary problem in the group of people seeking assistance with cocaine related problems, followed by cannabis and opiates.

5 Cannabis

5.1 Highlights

- Treatment demand for cannabis related problems increasingly approach addiction care.
- Demand for assistance increased from 3500 in 2001 to 11,000 in 2010
- The most frequently occurring demand for assistance after alcohol and opiates.
- Relatively large proportion of newcomers in addiction care.

5.2 In brief

Table 12: **Overview of cannabis people seeking assistance 2010**

Demography		
	Number of people seeking assistance	10.971
	Male : Female	80 : 20
	Average age	28.4
	Share of 25-	41.4%
	Share of 55+	1.1%
	% Dutch	79.8%
	Number per 100,000 inhabitants	66
Problems		
	Proportion in addiction care	14.4%
	Single : Multiple	66 : 34
	First application ever	37%
	Average number of contacts/client	17

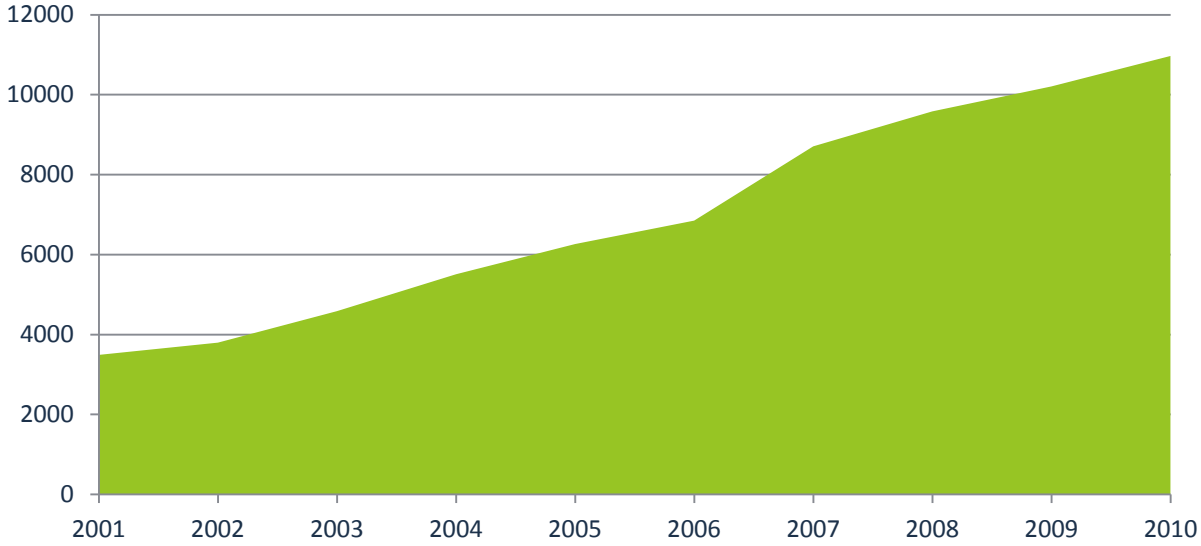
The average age of those people requesting help for cannabis use is 28, which is relatively low. Multiple problems occur in about one-third of the cases. Relative to other substances, there are fewer contacts necessary for the provision of care to those requesting help for cannabis use.

5.3 Trends and development in treatment demand

The demand for cannabis treatment has tripled in 10 years time. IVZ outlined this in a recently published bulletin.[9]

[9] 15 jaar Cannabishulpvraag in Nederland; Belangrijkste ontwikkelingen van de hulpvraag voor cannabisproblematiek in de verslavingszorg 1995-2009, Houten, April 2011

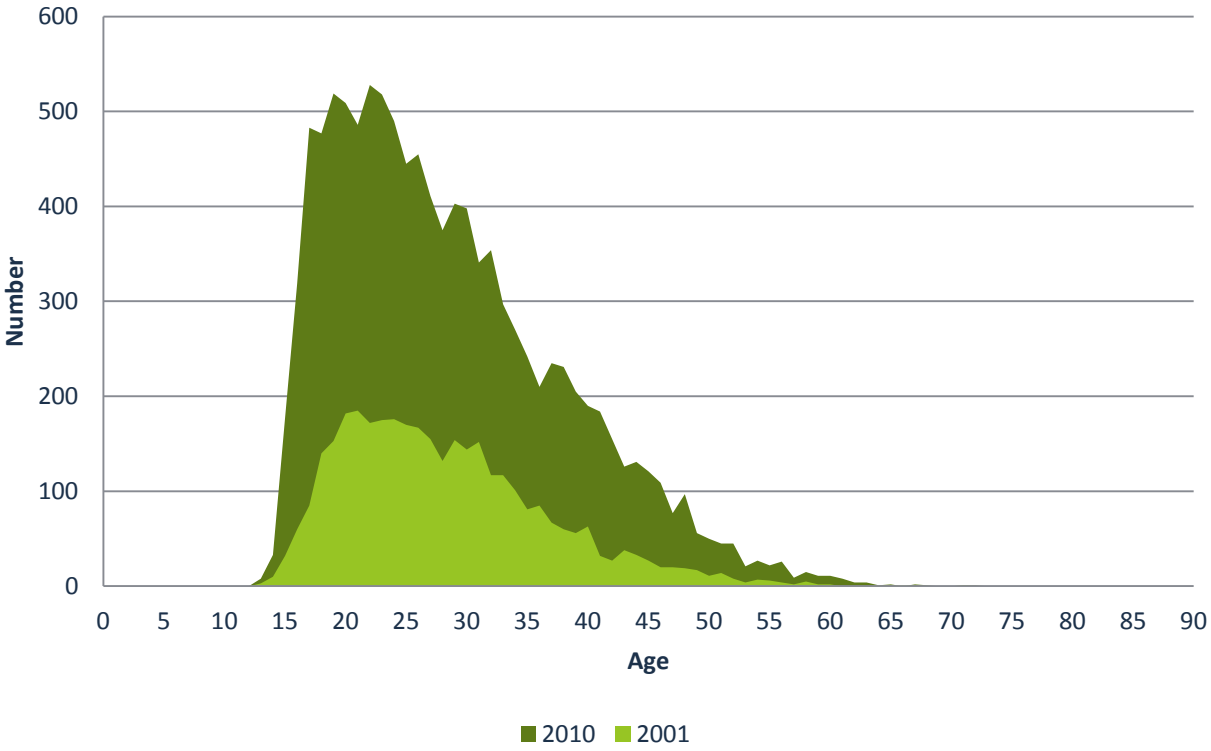
Figure 42: **Cannabis – Number of people requesting assistance 2001-2010**



In 2001 the number of people presenting with a cannabis related demand for assistance was 3500, compared to 11,000 in 2010.

5.4 Young and old

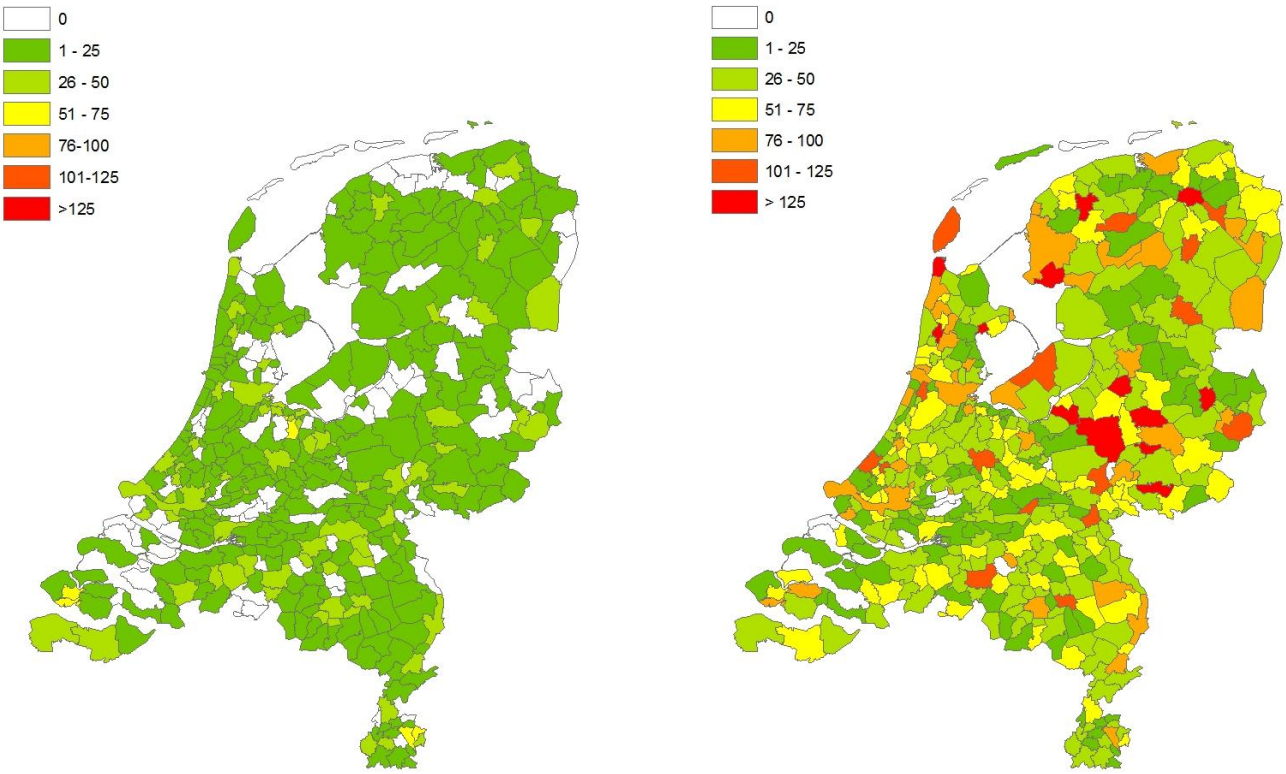
Figure 43: **Cannabis – Age distribution 2001 versus 2010**



Although the demand for care around cannabis is still largely a youth matter, the average age has increased and the over-30 age bracket lands increasingly in assistance with cannabis as the primary problem. The 'age mountain' in Figure 43 for 2010 has also grown for the Group aged over 30 and compared to 2001.

5.5 Regional spread

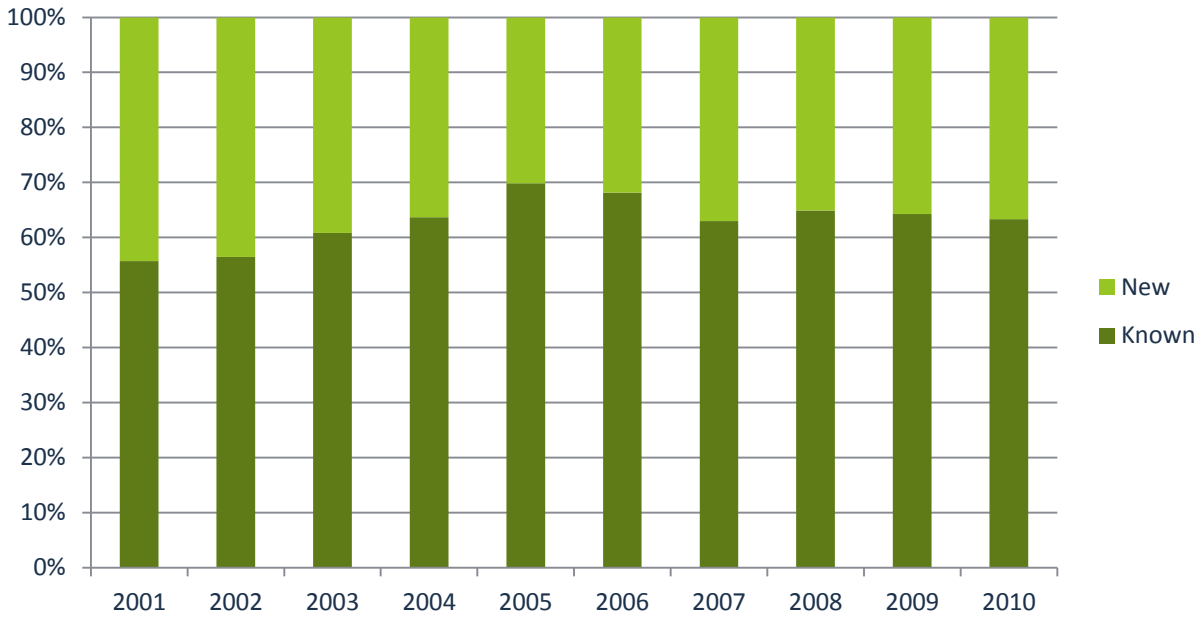
Figure 44: **Number of people seeking assistance for cannabis related problems by 100,000 inhabitants 2001 and 2010**



The national average with regard to demand for assistance for cannabis related problems was 66/100,000 inhabitants in 2010, compared to 22/100,000 in 2001.

5.6 New and known

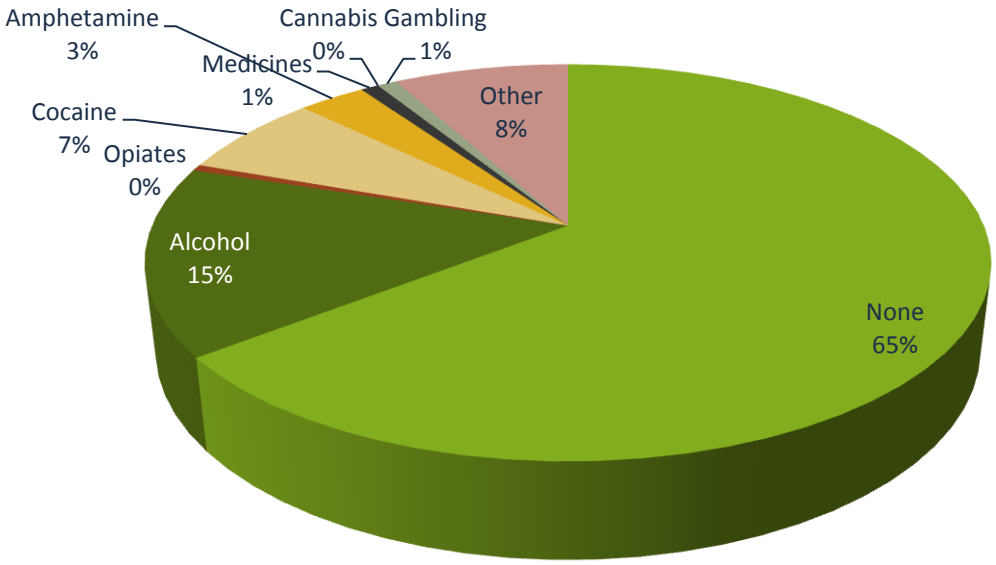
Figure 45: **Cannabis – New and existing clients trend 2001-2010**



In comparison with other problem areas, cannabis problems exhibit a high proportion of newcomers. In 2010, almost 40% of the people seeking assistance for cannabis related problems are new to addiction care. The total percentage of newcomers in addiction care is 20%.

5.7 Secondary problems

Figure 46: **Cannabis - Secondary problems 2010**



In the majority of requests for assistance, cannabis problems stand alone. Approximately one-third of the clients also indicate having problems with other drugs. This is often for alcohol and cocaine use.

6 Amphetamine and Ecstasy

6.1 Highlights

- Since 2007, the number of people seeking assistance for amphetamine use has stabilized.
- The number and proportion of young people seeking assistance for amphetamines decrease.
- More and more of those people seeking assistance for their amphetamine use have been treated previously.
- Amphetamine and ecstasy remain a limited problem in the Netherlands.

6.2 In brief

In the Netherlands, amphetamine and ecstasy are the 'minor' substances in addiction care and has shown a certain stabilization of around 1,800 clients per year since 2007. This is in sharp contrast with neighboring countries in the EU, where amphetamine, relatively speaking, is still a big problem.[10]

Table 13: **Overview of the demand for amphetamine and ecstasy treatment 2010**

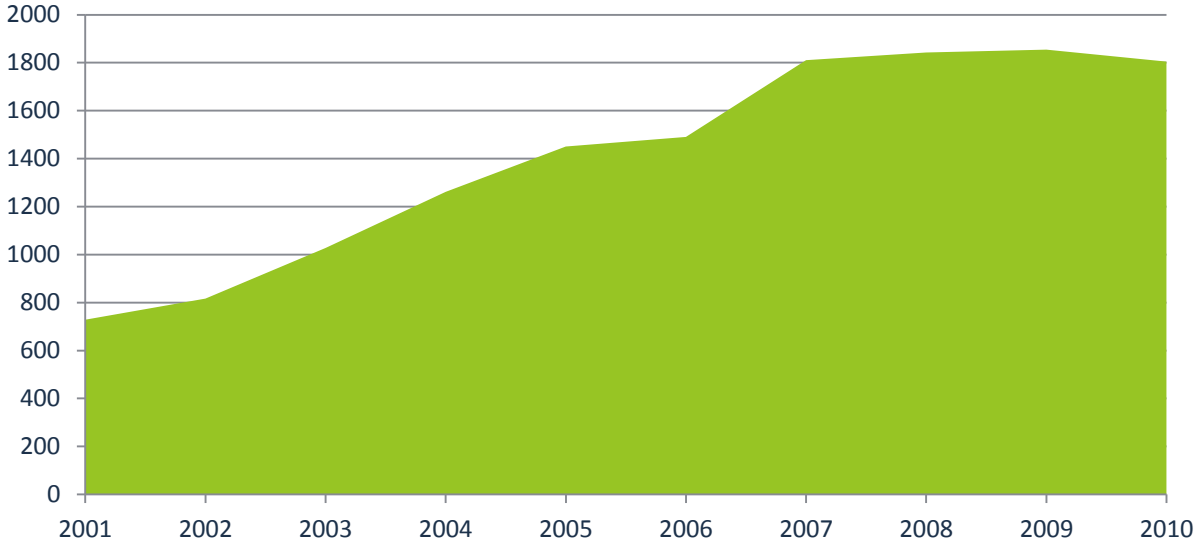
Demography		
	Number of people seeking assistance	1805
	Male : Female	78 : 22
	Average age	29.3
	Share of 25-	42.0%
	Share of 55+	0.9%
	% Dutch	92.9%
	Number per 100,000 inhabitants	11
Problems		
	Proportion in addiction care	2.4%
	Single : Multiple	38 : 62
	First application ever	23.5%
	Average number of contacts/client	23

6.3 Trends and development in treatment demand

In 2001 648 people requesting help for amphetamine use were registered with addiction care. In subsequent years, this grew gradually - to 1.800 in 2007. Since then, a roughly equal number of applicants have registered for assistance with amphetamine problems.

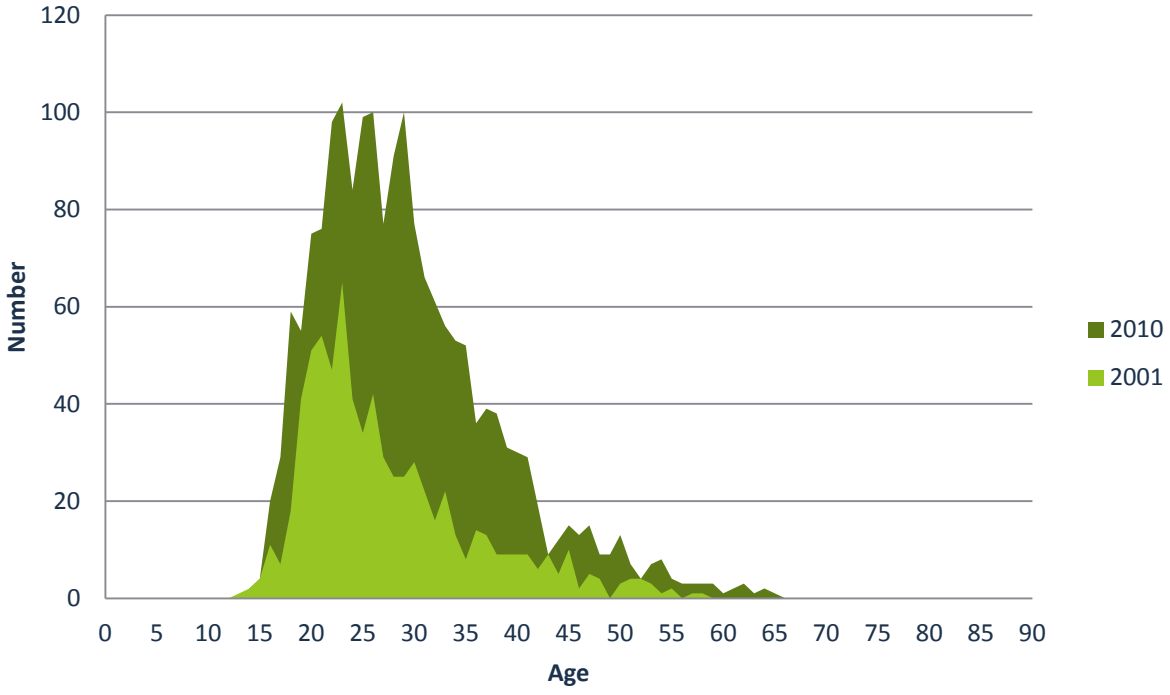
[10] 2010 Annual report on the state of the drugs problem in Europe, EMCDDA, Lisbon, November 2010

Figure 47: **Amphetamine and Ecstasy- Treatment demand trend 2001-2010**



6.4 Young and old

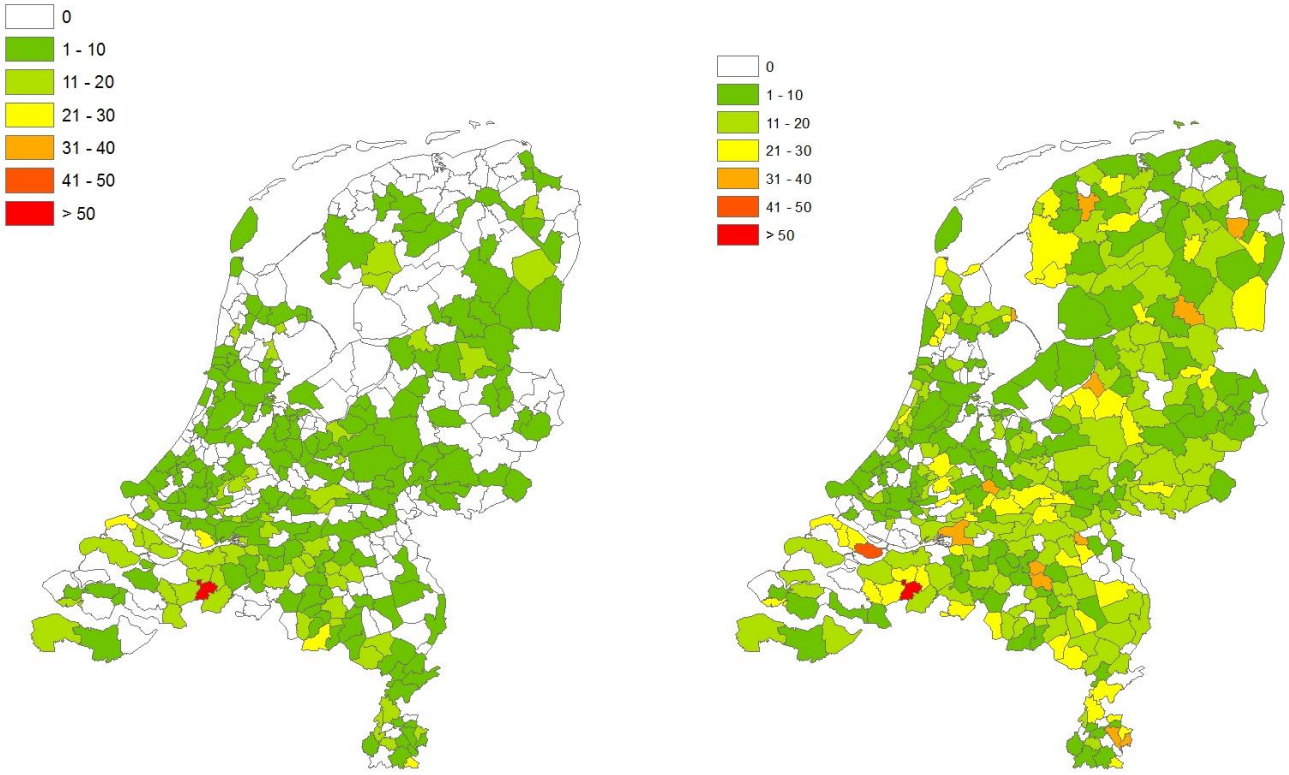
Figure 48: **Amphetamine and Ecstasy - Age distribution 2001 versus 2010**



Amphetamine and Ecstasy can be referred to as a youth related problem, as 42% are below the age of 25.
However, the number proportion of youth has been decreasing over the past few years. It was no less than 49% in 2004.

6.5 Regional spread

Figure 49: **Number of people seeking assistance for amphetamine and ecstasy related problems by 100,000 inhabitants in 2001 and 2010**

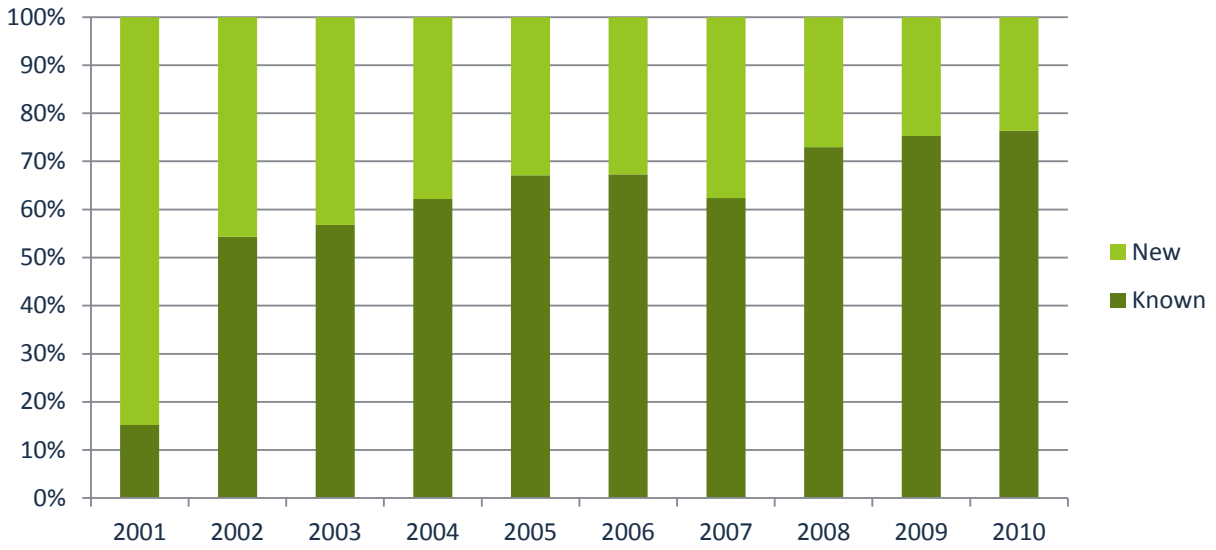


The national average of the demand for assistance for amphetamine and ecstasy for the year 2010 is 11/100,000 inhabitants. In 2001 this figure was 5/100,000 inhabitants.

6.6 New and known

With amphetamine in 2010, too, it's often about people who have previously relied on assistance. The inflow of new clients is limited. Compared to 10 years ago, the proportion of newcomers has dropped considerably.

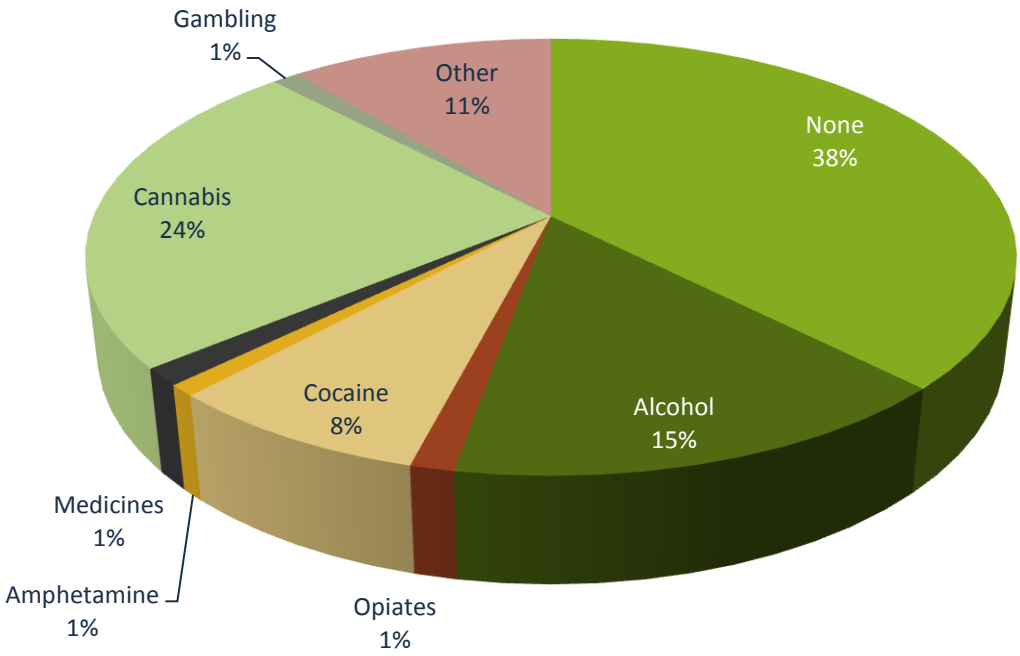
Figure 50: **Amphetamine and Ecstasy - New and existing clients trend 2001-2010**



6.7 Secondary problems

In many cases (about 60%), one or more secondary problems occur along with amphetamine or ecstasy use. Cannabis, alcohol and cocaine are the most common secondary problems.

Figure 51: **Amphetamine - Secondary problems 2010**



7 GHB

7.1 Highlights

- The GHB related demand for assistance is increasing considerably, but the number of people seeking assistance has been limited until now.
- 75% of the people seeking assistance in 2010 has been registered before.

7.2 In brief

GHB problems do not have a long history in addiction care. As from 2007 it has been registered as a separate problem although it occurred occasionally as from the end of the nineties. Before 2007 it was registered in the category Other substances. The increasing concern among some care providers and care organizations and the resulting concern among policy makers has been reason to start a separate registration.

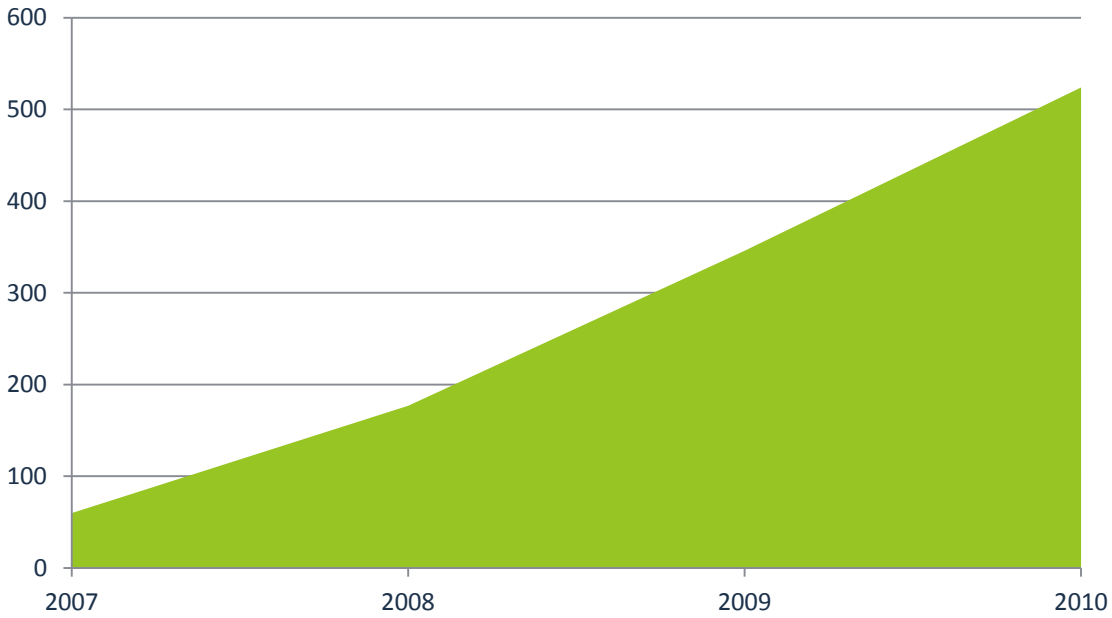
The increase in number of people seeking assistance has been unmistaken over the past few years, although minor compared to other problem areas.

Table 14: **Overview of the demand for GHB treatment in 2010**

Demography		
	Number of people seeking assistance	524
	Male : Female	31 : 69
	Average age	28
	Share of 25-	36%
	Share of 55+	<1%
	% Dutch	93%
	Number per 100,000 inhabitants	3
Problems		
	Proportion in addiction care	<1%
	Single : Multiple	53 : 47
	First application ever	29%
	Average number of contacts/client	29

7.3 Trends and developments in treatment demand

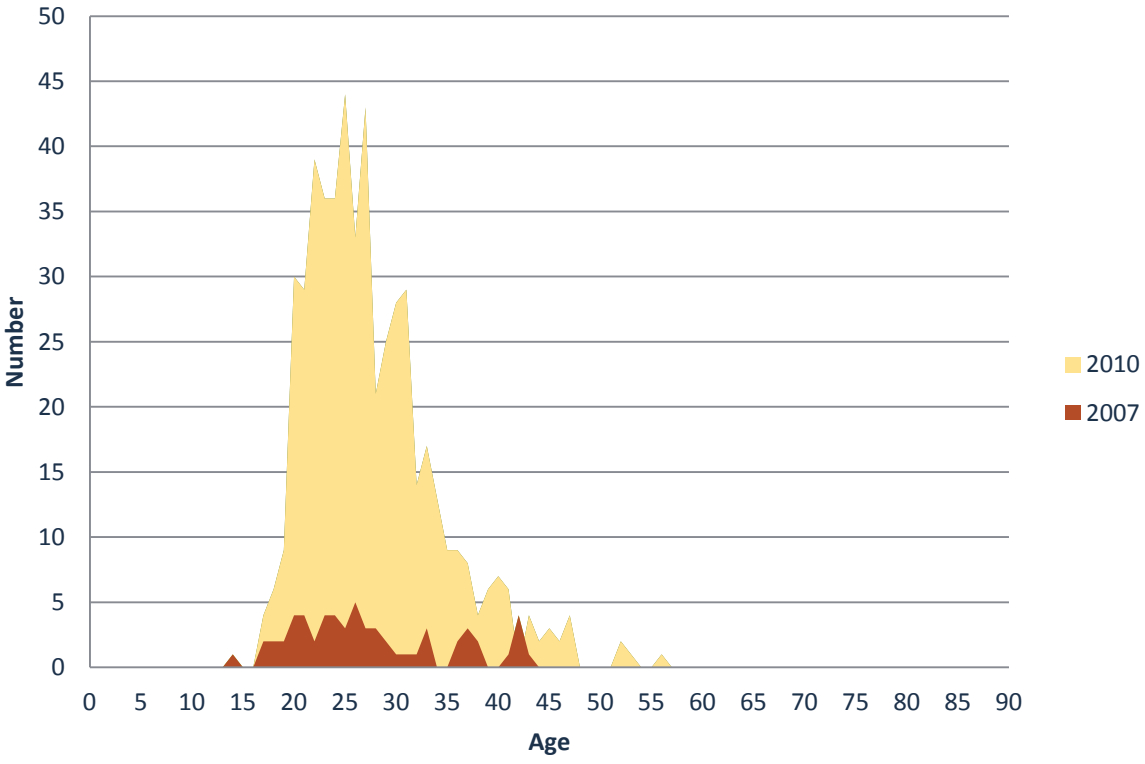
Figure 52: **GHB - Treatment demand trend 2001-2010**



The demand for assistance for GHB has increased considerably, although the proportion in addiction care is still very limited.

7.4 Young and old

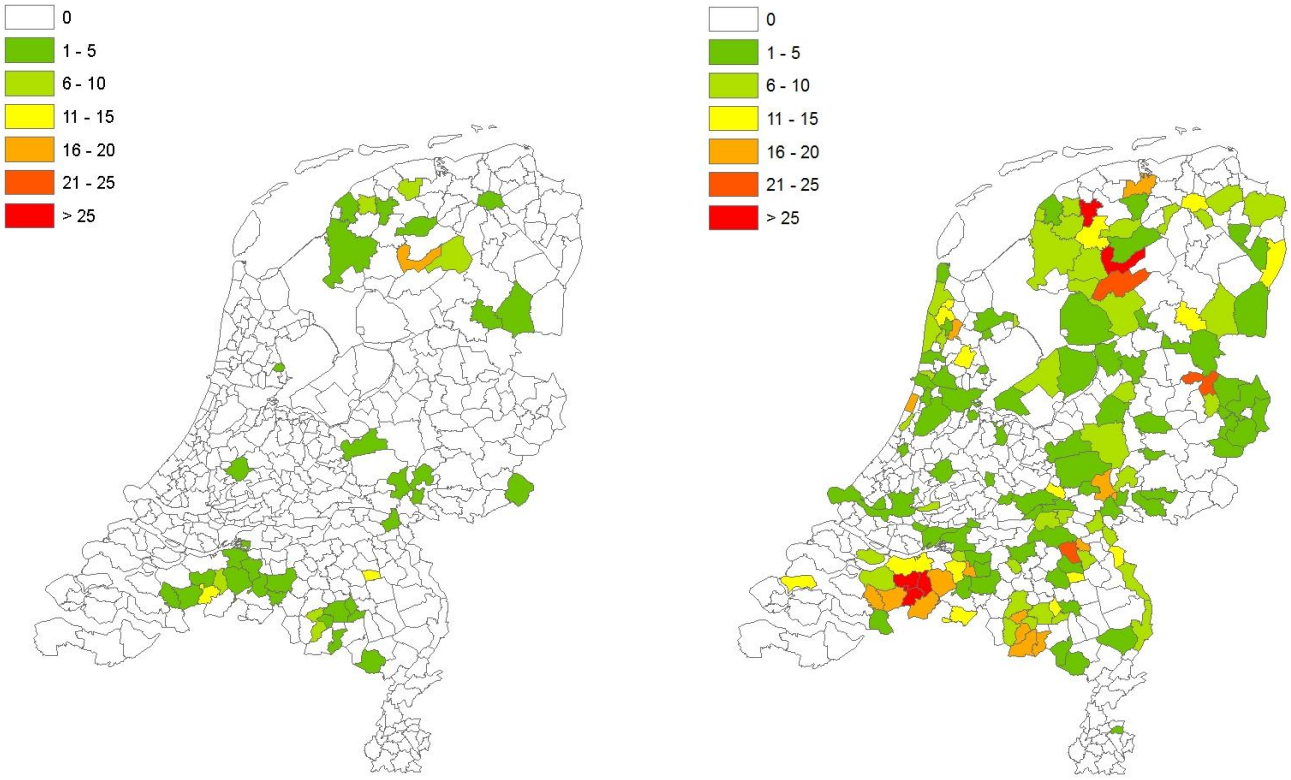
Figure 53: **GHB - Age distribution 2007 versus 2010**



Most people seeking assistance for GHB related problems are aged between 20 and 30.

7.5 Regional spread

Figure 54: **Number of people seeking assistance for GHB related problems by 100,000 inhabitants 2007 and 2010**

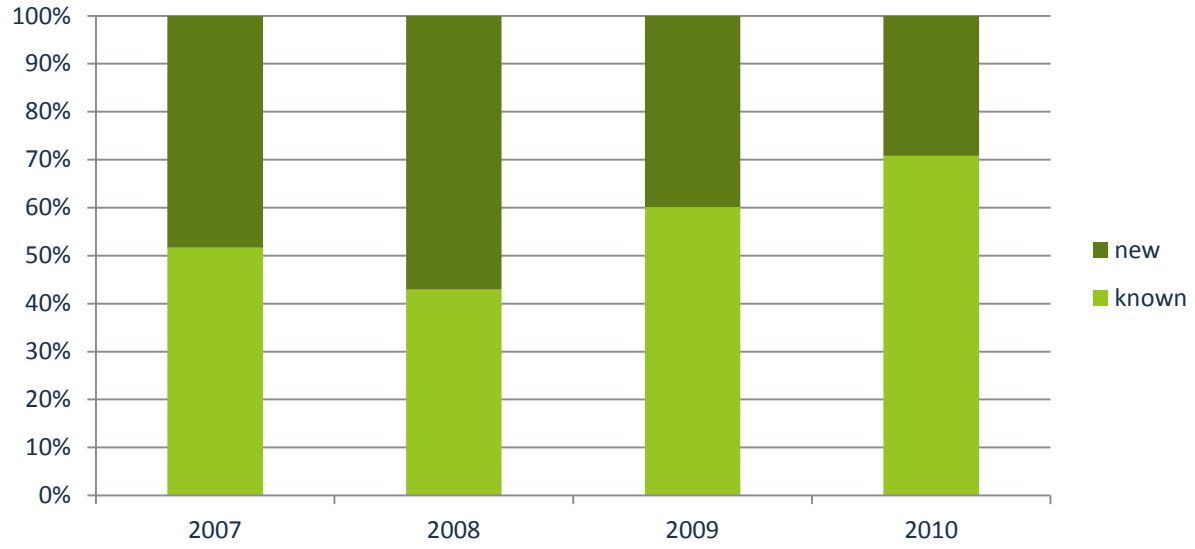


These maps for GHB vary from the maps for the regional spread in demand for assistance in the other chapters. As GHB has been registered as from 2007 this one was used as the left map rather than 2001.

GHB related problems show increased region relatedness. At present, most people demanding assistance for GHB related assistance originate from Noord-Brabant and the Northern and Eastern regions of the Netherlands. The coming years will show whether GHB related demand for assistance will also increase in the other regions of the Netherlands.

7.6 New and known

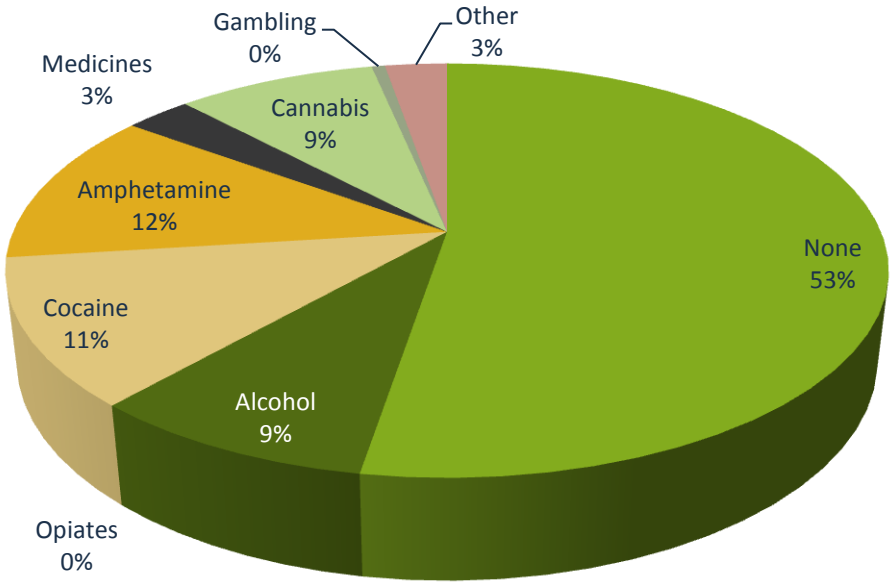
Figure 55: **GHB - New and existing clients trend 2001-2010**



Notwithstanding the increase in GHB related demand for assistance most people seeking assistance have been registered before. The proportion of real newcomers was 28% in 2010.

7.7 Secondary problems

Figure 56: **GHB - Secondary problems 2010**



Almost half of the people seeking GHB related assistance have a secondary problem as well. Alcohol, cocaine, amphetamine and cannabis are the most frequently occurring secondary problems.

8 Medicines

8.1 Highlights

- The demand for medicines related assistance has increased to almost 900 persons over the past ten years.
- Most of the demand for assistance concerns problems with the use of benzodiazepines.
- A relatively large proportion of the people seeking assistance is female.

8.2 In brief

The number of people turning to addiction care with a medicines related problem has increased considerably over the past two years. However, this number is still relatively limited. Most problems are related to the use of benzodiazepines, which are the most frequently used medicines in the Netherlands. In 2010 1.4 million people in the Netherlands used a benzodiazepine[11].

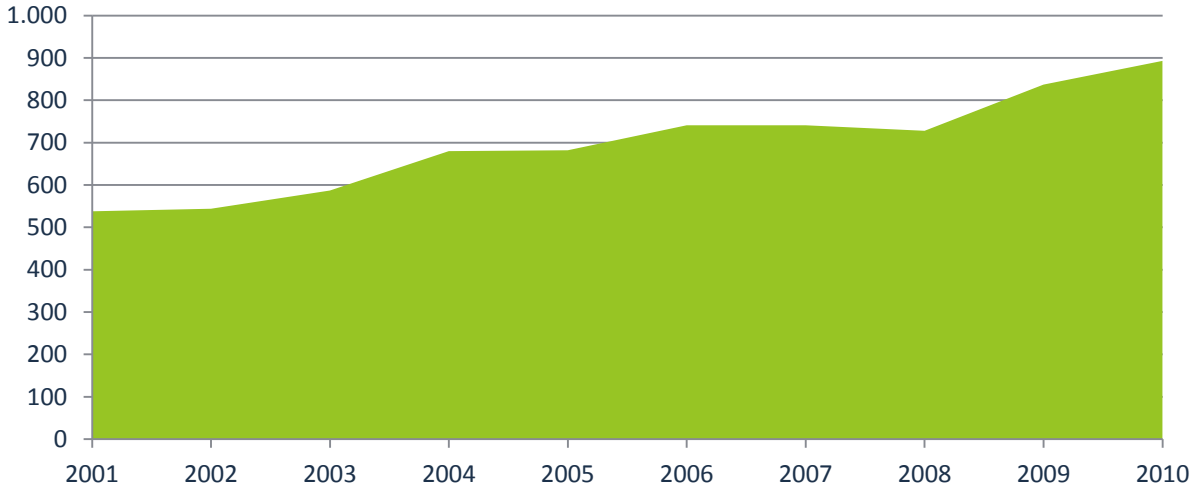
Table 15: **Overview medicines related demand for assistance in 2010**

Demography	
Number of people seeking assistance	893
Male : Female	53 : 47
Average age	46
Share of 25-	3%
Share of 55+	24%
% Dutch	84%
Number per 100,000 inhabitants	5
Problems	
Proportion in addiction care	1%
Single : Multiple	54 : 46
First application ever	28%
Average number of contacts/client	11

[11] Stichting Farmaceutische Kengetallen, Farmacie in cijfers, Pharmaceutisch Weekblad, Jaargang 145 Nr 42

8.3 Trends and developments in treatment demand

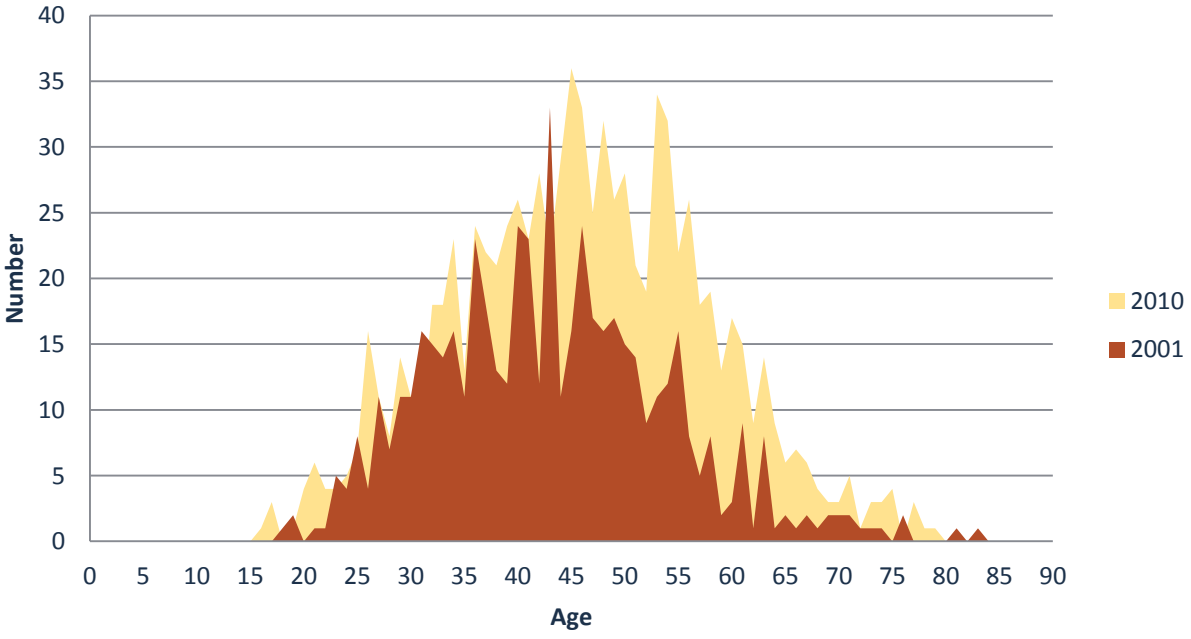
Figure 57: **Medicines - Treatment demand trend 2001-2010**



A possible explanation for the increasing demand for assistance may be the increased attention in healthcare and care provision for the use of benzodiazepines. As benzodiazepines were often used too long and were prescribed too easily, the minister of VWS has limited the refund of these sleeping medicines and tranquillizers in 2009. All kinds of initiatives have been taken in and outside of addiction care to reduce (problematic) use of benzodiazepines.

8.4 Young and old

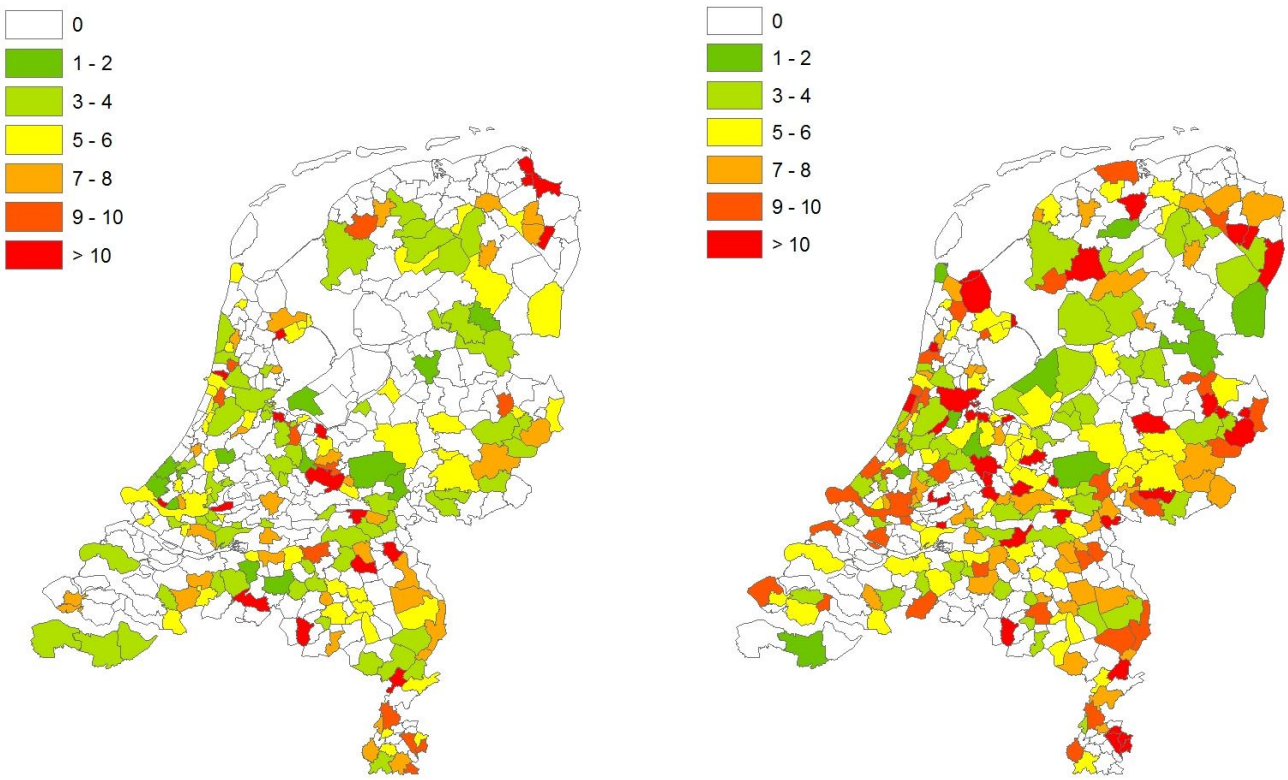
Figure 58: **Medicines - Age distribution 2001 versus 2010**



The increase in demand for assistance has taken place in all age categories over the past 10 years, mainly in the age Group between 40 and 55.

8.5 Regional spread

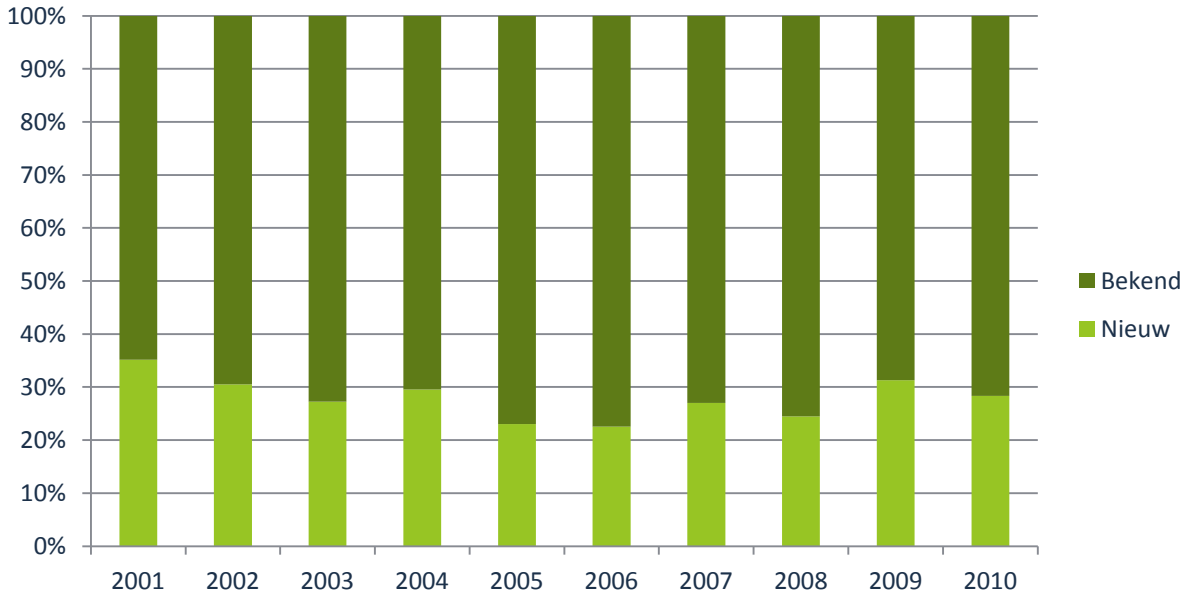
Figure 59: **Number of people seeking assistance for medicines related problems by 100,000 inhabitants 2001 and 2010**



The national average of the demand for assistance for medicine use related problems for the year 2010 was 5/100,000 inhabitants. In 2001 this figure was 3/100,000 inhabitants.

8.6 New and known

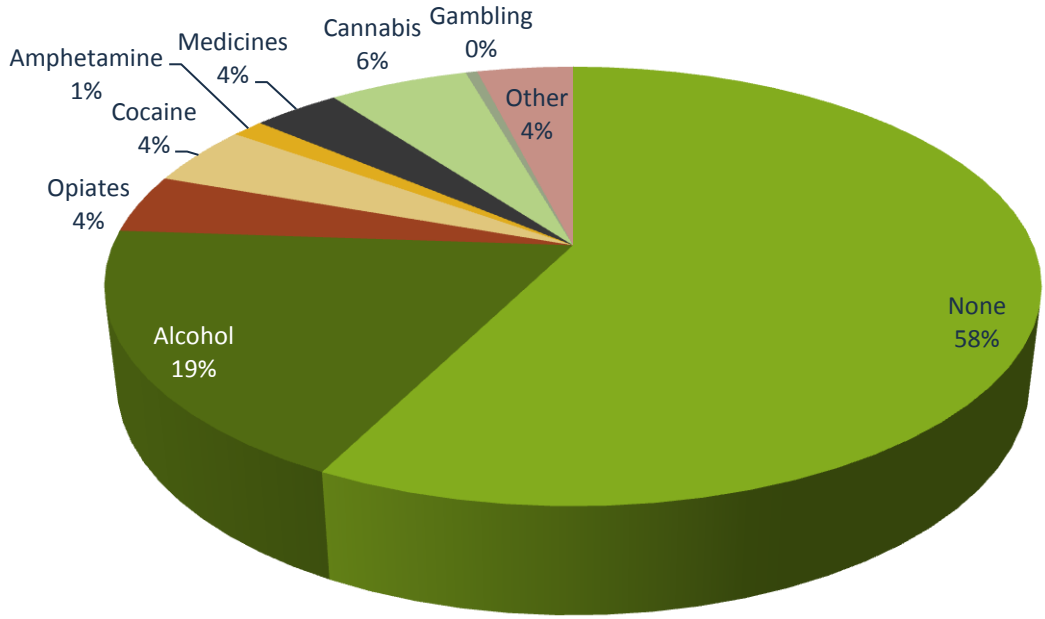
Figure 60: **Medicines - New and existing clients trend 2001-2010**



The proportion of new clients has dropped between 2001 and 2006 and has subsequently shown a minor increase. In 2010, 28% of the people seeking assistance for medicine use related problems were newcomers in addiction care.

8.7 Secondary problems

Figure 61: ***Medicines - Secondary problems 2010***



About 15% of the clients indicate that they have a secondary drugs problem in addition to medicine use (opiates, cocaine, amphetamine and cannabis). Besides, one in five of these people have alcohol use as their secondary problem.

9 Gambling

9.1 Highlights

- The number of gamblers seeking assistance has been at about the same level for years.
- New group of internet gamblers.

9.2 In brief

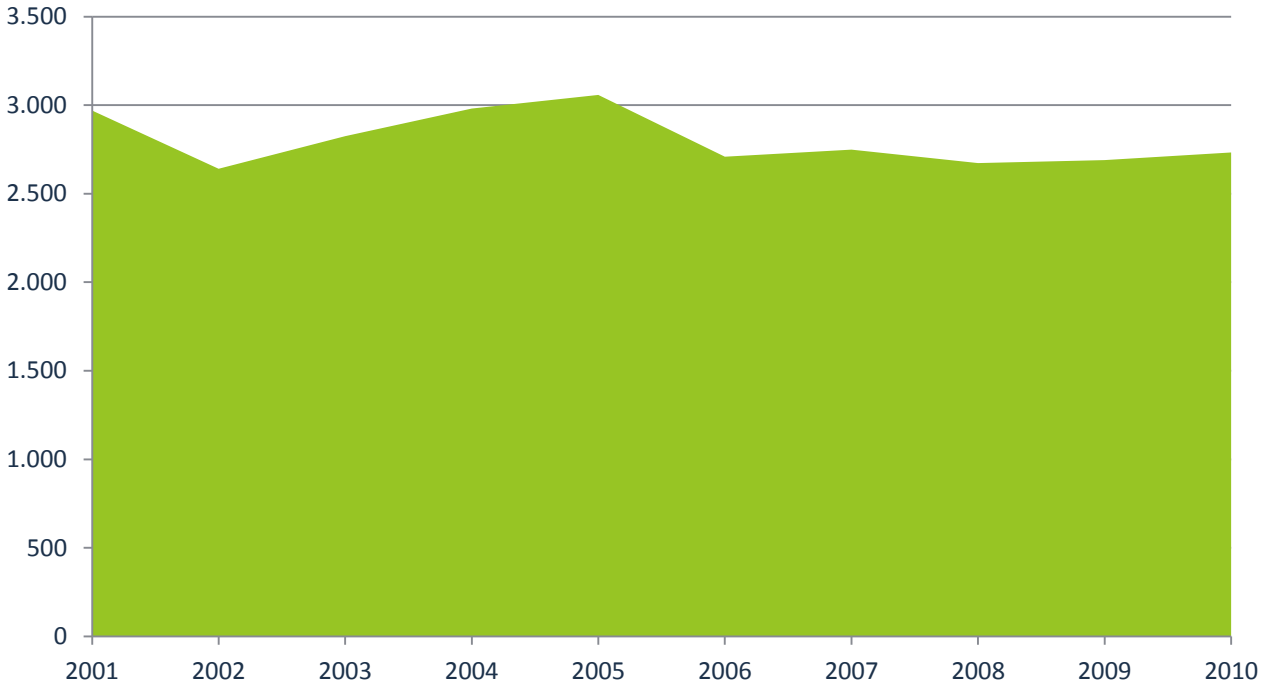
Table 16: **Overview of people requesting help for gambling 2010**

Demography		
	Number of people seeking assistance	2673
	Male : Female	87 : 13
	Average age	38
	Share of 25-	12%
	Share of 55+	6%
	% Dutch	66%
	Number per 100,000 inhabitants	16
Problems		
	Proportion in addiction care	4%
	Single : Multiple	71 : 29
	First application ever	34%
	Average number of contacts/client	11

9.3 Trends and developments in treatment demand

Over the past 10 years requests for assistance with gambling problems have remained more or less stable.
Most of the people seeking assistance with primary gambling related problems are Dutch natives aged around 40.
In the years to come further details will be collected about the nature of the gambling and about the places people go to gamble. This will be done in order to gain more insight into the various types of gambling. As a result of the introduction of gambling on the Internet a new category of gambling has been added. Those seeking assistance with primary gambling problems are mainly native Dutch men around 40 years of age. In the coming years, more detailed data will be collected on these groups - the nature of the problems and the places where they gamble. All this to gain more insight into the varying types of games. The advent of Internet gambling has introduced a new category.

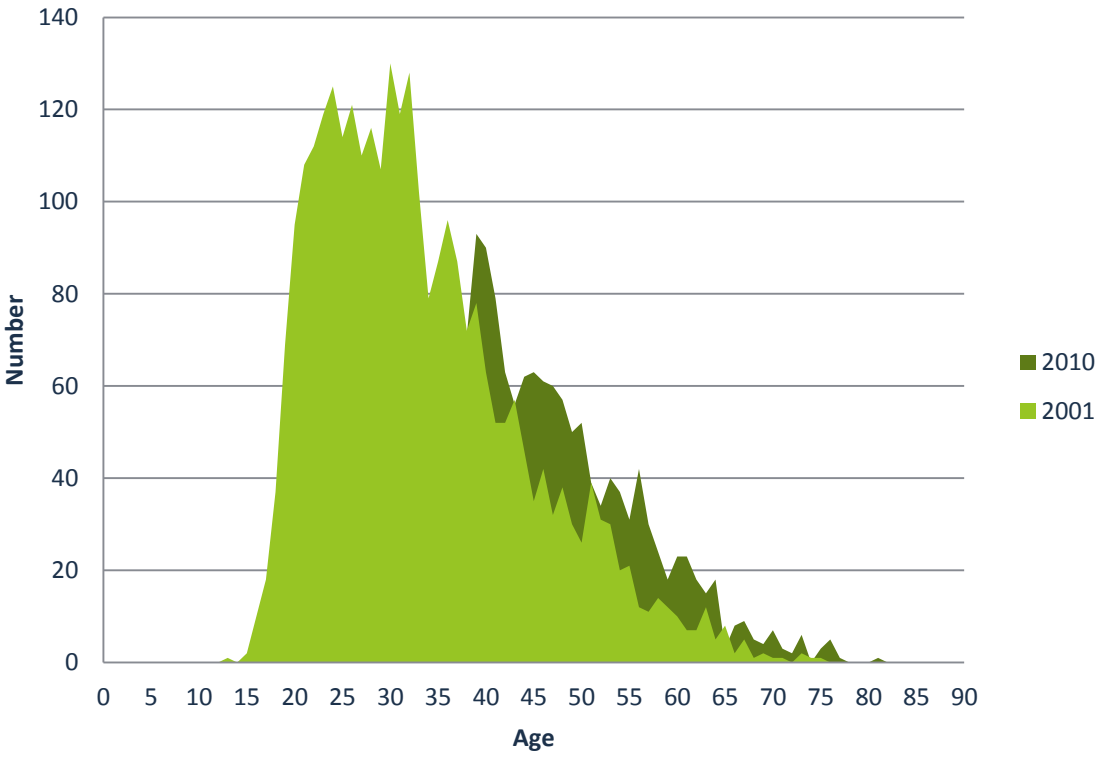
Figure 62: **Gambling – Number of requests for assistance 2001-2010**



9.4 Young and old

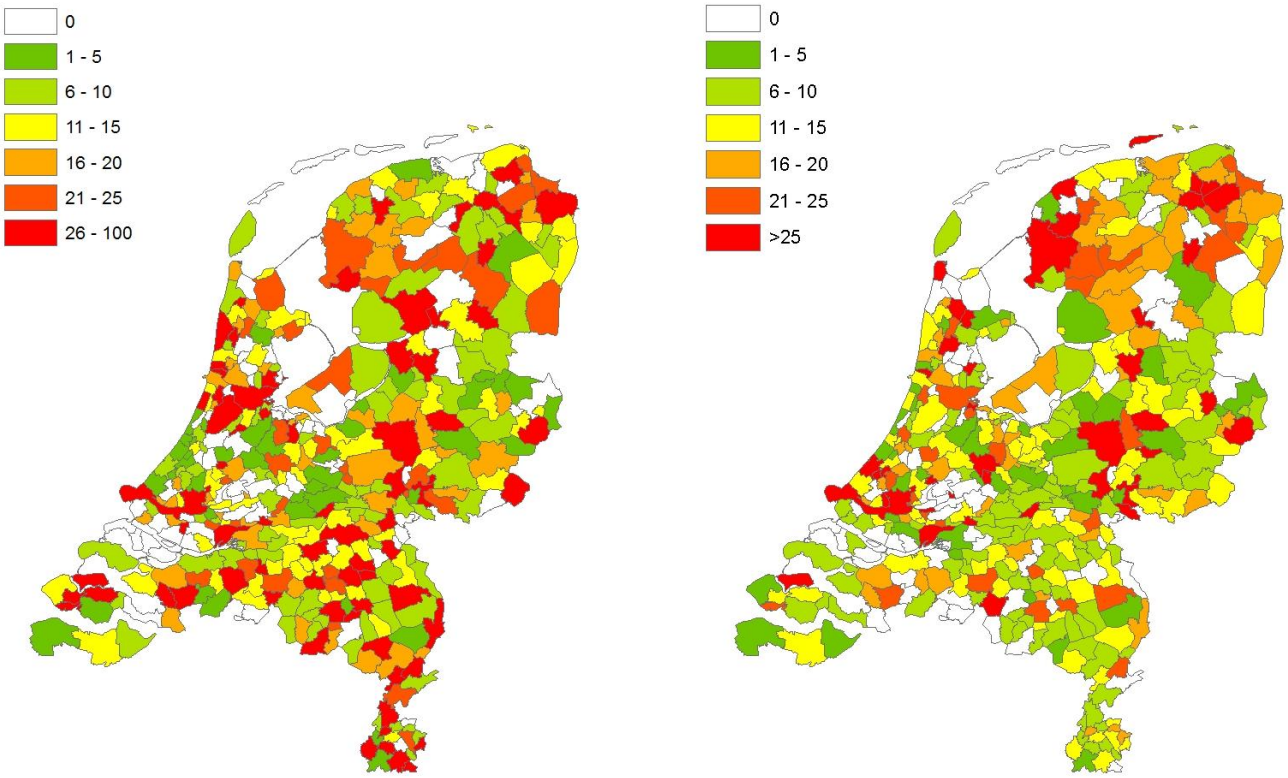
The number of people over 40 getting help with a gambling addiction is steadily increasing. There are fewer (young) adults 20-40 compared with 10 years ago. However it remains the largest group.

Figure 63: **Gambling - Age distribution 2001 versus 2010**



9.5 Regional spread

Figure 64: **Number of people seeking assistance for gambling related problems by 100,000 inhabitants 2001 and 2010**

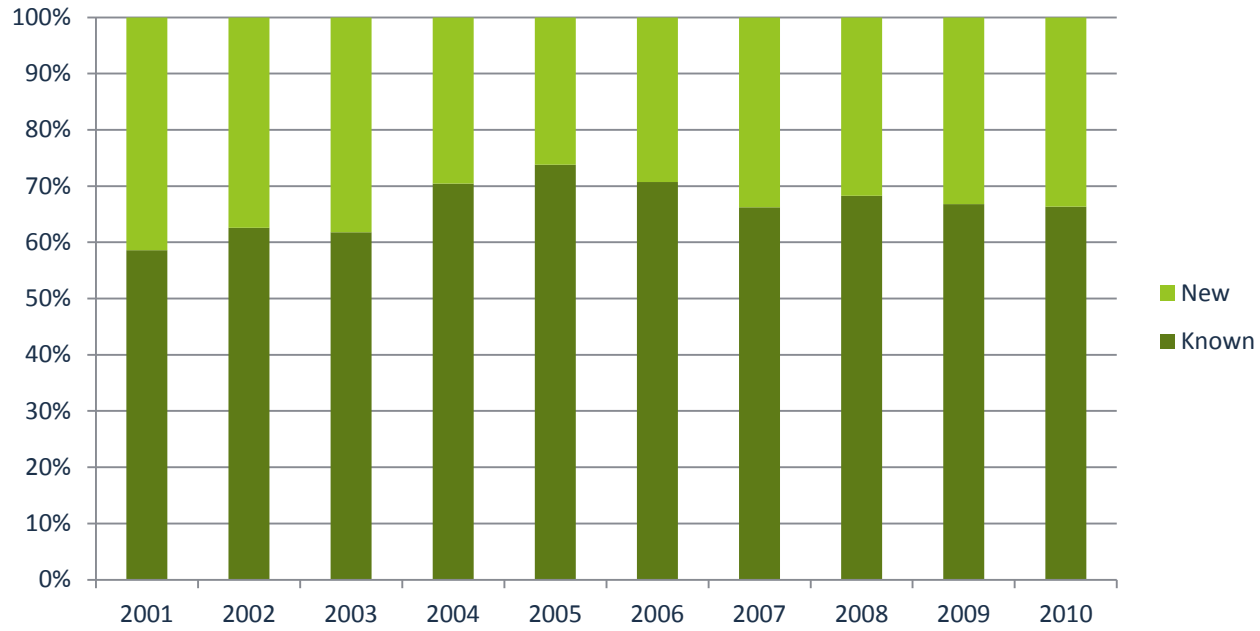


The national average of the demand for assistance for gambling related problems for the year 2010 was 16/100,000 inhabitants. In 2001 this figure was 19/100,000 inhabitants.

9.6 New and known

The ratio between newcomers and people having sought assistance with gambling problems before has been more or less stable over the past ten years, apart from a number of fluctuations.

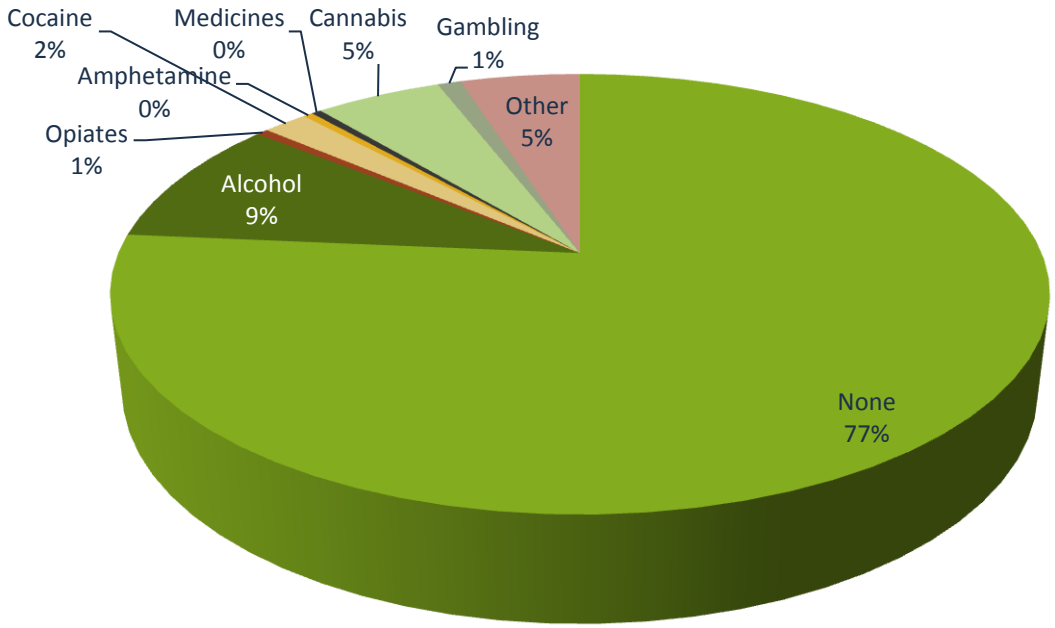
Figure 65: **Gambling - New and existing clients trend 2001-2010**



9.7 Secondary problems

More than 75% of the persons presenting with gambling problems do not have any secondary problems. In 9% of cases alcohol abuse also plays a role and 5% of those requesting assistance also use cannabis.

Figure 66: **Gambling - Secondary problems 2010**



10 Other

10.1 Highlights

- The number of 'life-style' addictions is increasing (smoking addiction, eating disorders).
- The demand for assistance with Internet use related problems is increasing; for the time being this is a small group in addiction care.

10.2 In brief

In the group 'other' there is a range of addictions that leads to requests for assistance. These include both substance and as behavior-related addictions. In Figure 67 these are presented as main groups. In Table 17 all categories are illustrated in more detail.

This chapter outlines Internet gaming as there is additional media attention with regard to this and there is a considerable demand for information in society with regard to this 'new' phenomenon. Besides, the largest group with the category Other, the eating disorders described in subsection 10.4 is further discussed.

Figure 67: **Main groups within the category " other requests for assistance"**

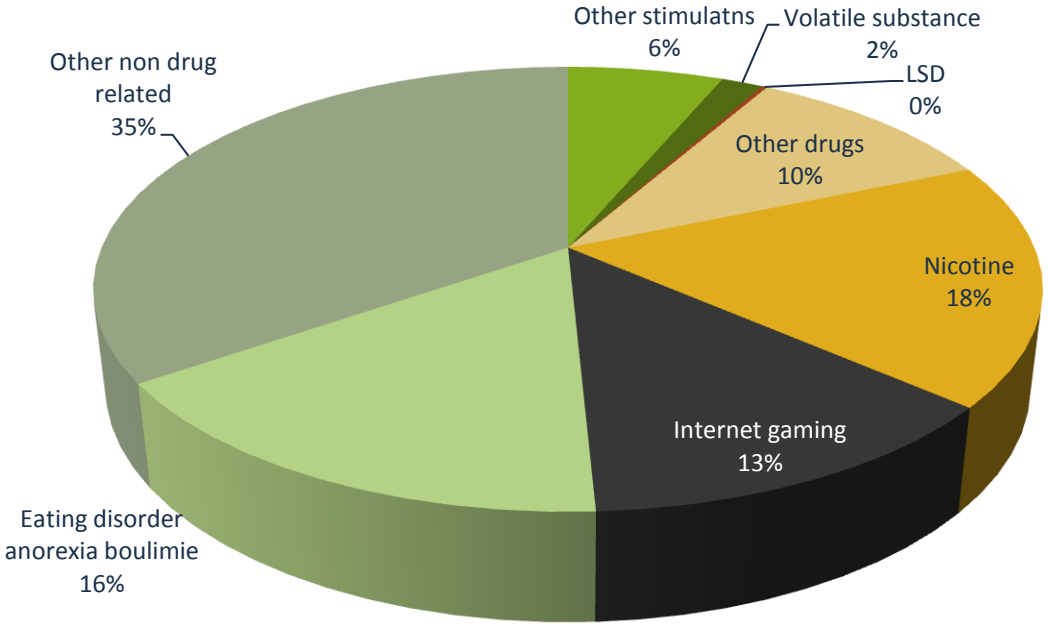


Figure 67 shows that there is a large group of other addictions, including without being limited to internet addictions such as chatting and eroticism. It is very well possible that this category also includes a number of gamers who should have been registered among the internet Group. This category is relatively new and probably not be fully registered everywhere.

Table 17: **Other requests for assistance2010**

Category "Other"	N	%
Other stimulants	90	6%
Volatile substance abuse	24	2%
LSD	3	<1%
Other drugs	147	10%
Nicotine	251	18%
Internet gaming	182	13%
Eating disorder anorexia bulimia	229	16%
Other non drug-related	490	35%
TOTAL	1.416	100%

10.3 Internet gaming

In the past period there has been increasing attention for the relatively rapid increase in Internet use in several forms.
There is increasing concern about the number of young people with an unhealthy gaming habit that leads to problems. These problems have a lot of parallels with other forms of addiction. Recent research conducted by the IVO shows that 1.5 percent of the Young people between 13 and 16 years old can be identified as gaming addicts based on existing criteria for establishing addictive behavior. This can be translated as number of 12,000 young people.[12]
For the time being only few young people have presented with a gaming addiction related demand for assistance, but there is a clear increase. In 2009 the number of people seeking assistance was 128, whereas in 2010 182 persons in addiction are under treatment for Internet gaming related problems.
It is anticipated that as soon as this group knows how to find addiction care and adequate care will be provide the number of people seeking assistance for this addiction will increase in the coming years.

10.3.1 In brief

Table 18: **Internet gaming – Overview of those requesting assistance 2010**

Demography		
	Number of people seeking assistance	182
	Male : Female	91 : 9
	Average age	28
	Share of 25-	54%
	Share of 55+	4%
	% Dutch	92%
	Number per 100,000 inhabitants	1
Problems		
	Proportion in addiction care	<1%
	Single : Multiple	87 : 13
	First application ever	52%

The demand for assistance with Internet gaming problems is clearly a problem for men. Most of them are younger people but certainly not all of them.

[12] Van Rooij, A. J. (2011). Online Video Game Addiction. Exploring a new phenomenon [PhD Thesis].Rotterdam; Erasmus Universiteit Rotterdam

10.4 Eating disorders

People with eating disorders (bulimia and anorexia)have occasionally demanded assistance from addiction over the years.

10.4.1 In brief

Table 19: **Eating disorders – Overview of those requested assistance 2010**

Demography		
	Number of people seeking assistance	229
	Male : Female	7 : 93
	Average age	38
	Share of 25-	14%
	Share of 55+	8%
	% Dutch	94%
	Number per 100,000 inhabitants	1
Problems		
	Proportion in addiction care	<1%
	Single : Multiple	94 : 6
	First application ever	87%

In 2010 229 persons, mostly women, turned to addiction care. There are hardly any multiple problems, which is more often the case with other primary substance use.

Appendix I: Participating institutions

Akin (previously Jellies)
Arta-Lievegoedgroep
Bouman GGZ
Brijder Addiction care (including Parnassia)
Centrum Maliebaan
Emergis
GGD Amsterdam
Iris Zorg
Mondriaan Zorggroep
Novadic-Kentron
Tactus Verslavingzorg
Addiction care Noord Nederland
Vincent van Gogh (previously GGZ Noord and Midden Limburg)

Appendix II Trend figures LADIS compared to previous editions

Each year the Key Figures reflect the latest trends in addiction care, in which differences may occur with regard to the figures presented in the previous editions. Each year administrative corrections and improved delivery performed in previous years are included in the latest figures.
Below three elements are discussed which have an influence on the figures of previous years in the 2010 Key Figures.

1. Delivery by addiction rehabilitation
An important contribution to obtaining a comprehensive overview of requests for assistance and addiction care provisions, is that the data of the addiction rehabilitation, if possible, has been linked to the individual client level. This link has, despite the positive cooperation of the persons involved, turned out to be more difficult due to the method of registration in case of rehabilitation. For LADIS data about primary and, if available, secondary problems are essential. However, this is not, or not completely, recorded within addiction rehabilitation in the current CVS / CBO system. The CVS has now been "frozen" as a system and the new IRIS system will again fully meet the LADIS criteria. This means, since 2007, an increasing number of unlinkable rehabilitation data and, therefore, a lower number of discharged prisoners undergoing rehabilitation with LADIS data.

2. Improved delivery by institutions
Six institutions using the same institutional information system have redelivered data from 2007 onwards, upon which corrections have been carried out in retroaction. Especially contact registration is delivered more completely with this system.

3. Accentuating the definition of a LADIS client
The abovementioned improved delivery ensures that the quality of the client information can be examined even more thoroughly before it is included in LADIS. Since 2007 the criterion applies that when no actual contacts have been registered for two or more years, these clients are not included administratively in the LADIS Key Figures. In the coming years, this criterion will possibly be accentuated further in accordance with the European criteria of the EMCDDA (TDI 3.0 in the making).

The abovementioned elements have some influence on the figures regarding the various problems, especially the figures with regard to alcohol and cannabis. However, as evidenced by Figures 68 and 69, the modifications do not have much impact on the trend.

Figure 68: **Trend figures main primary problems Keyfigures 2009**

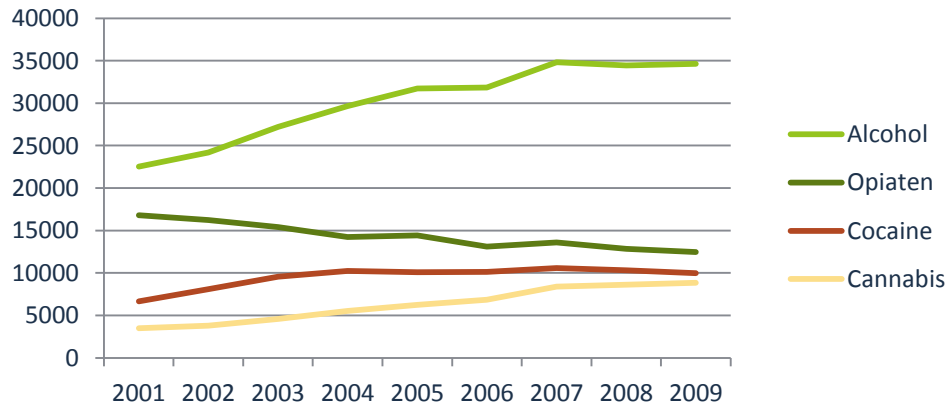


Figure 69: **Trend figures main primary problems Keyfigures 2010**

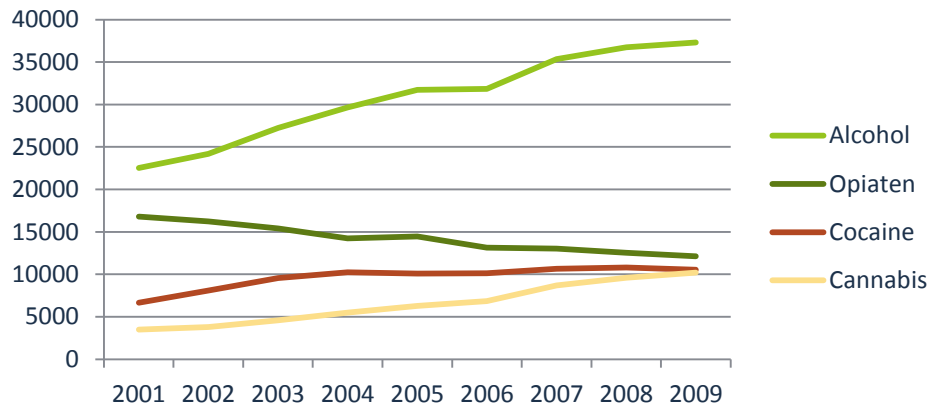


Table 20: **Difference in trend figures main primary problems 2001-2009**

LADIS trends Keyfigures 2009									
	2001	2002	2003	2004	2005	2006	2007	2008	2009
Alcohol	22.547	24.202	27.222	29.648	31.710	31.829	34.826	34.456	34.646
Opiates	16.810	16.221	15.389	14.222	14.429	13.122	13.614	12.835	12.466
Cocaine	6.668	8.089	9.578	10.243	10.091	10.144	10.566	10.311	9.993
Cannabis	3.495	3.800	4.587	5.514	6.265	6.857	8.380	8.617	8.863
Total	54.315	56.773	61.799	65.250	68.555	67.961	73.859	72.352	72.554
LADIS trends Keyfigures 2010									
	2001	2002	2003	2004	2005	2006	2007	2008	2009
Alcohol	22.542	24.205	27.230	29.651	31.709	31.825	35.361	36.729	37.318
Opiates	16.818	16.224	15.398	14.232	14.453	13.131	13.013	12.532	12.120
Cocaine	6.671	8.086	9.570	10.234	10.077	10.138	10.644	10.812	10.538
Cannabis	3.494	3.800	4.588	5.511	6.266	6.853	8.710	9.585	10.209
Total	54.318	56.773	61.800	65.250	68.555	67.961	74.023	76.092	77.059

Colophon

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