KEY FIGURES

ADDICTION CARE 2011

LADIS

NATIONAL ALCOHOL AND DRUGS INFORMATION SYSTEM

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Table of Contents

Introduction

You have before you the 26th edition of the Core Figures in Addiction Care. As in previous years, various views are presented here on the development of care provision in the addiction care sector. As the words indicate, key figures are shown that beg further enquiry into the views put forward. Should that be so in your case, we would welcome your reaction and shall be pleased to consider with you further how such additional insight might be provided.

Compared to last year, a number of new views have been added. A separate chapter is therefore devoted to the substances amphetamine and ecstasy. In addition, an account is given of the trend in the number of episodes where clients have recourse to addiction care. IVZ is particularly concerned with the quality of the data presented. IVZ continuously aims for improvement, by amongst other things responding to developments in the sector and the demand for relevant information. We are at all times busy updating insights, also in cooperation with partners. A number of fine examples of this were presented to the symposium at the 25th anniversary of LADIS on 1 December 2011. See also the information on our website www.sivz.nl for this.

To improve insight and quality, IVZ is continuously working on:

- Presenting new and improved insights based on the collected data;
- Improving data providing and quality control;
- Improving feedback to institutions;
- Enlarging coverage of participation in LADIS;
- Effective security and protection of privacy for data provided.

New and improved insights based on the data collected

Data are used from LADIS for various projects, in addition to important data for the National Drug Monitor (NDM). In addition, IVZ provides the European Drug Observation Centre in Lisbon with information on international arrangements made by the government. European studies on drug policy and drug care provision are based on the uniform data from the 27 member countries.

IVZ also itself prepares data analyses. Thematic analyses are made in the form of bulletins. The following were published in 2011 and 2012:

- GHB requests for assistance in the Netherlands (February 2011);
- 15 years of cannabis use related requests for assistance in the Netherlands (April 2011);
- Key figures 2010 (June 2011);
- 25 years of LADIS (December 2011), a publication on the occasion of the symposium emphasizing the value of LADIS from various aspects;
- Alcohol and older people in addiction care in the Netherlands (2001-2010); April 2012.

These analyses are made in cooperation with various experts from the IVZ network. IVZ will cooperate more closely with research institutions in the future. Since the LADIS database is one of the oldest records (25 years old in 2011) and more than 310,000 people seeking assistance with an addiction problem have now been included in the database since 1994 (the commencement of unique client coding), research is also possible with the aid of secondary analyses, such as cohort studies.

Improvement in data provision and quality control

Registration data and listing activities are often regarded as synonymous with administrative burdening. On the other hand, registration requests for assistance and treatments not only serves a direct patient/carer interest but also where demand and justification support funding and policy and substantial quality research of the care and addiction problem is important. This requires ongoing testing and improvement by IVZ of the data input. To make the quality of the total national database as effective as possible, strict criteria are imposed on the information stored in the system regarding demands for assistance and the people seeking assistance. LADIS saves all data on the basis of unique codings no longer traceable to the original person. Data are tested for integrity and reliability and are compared to earlier submissions and statistical publications from the institution concerned. In addition, addiction reclassification data are added, together with data on the provision of replacement substances (heroin, methadone). In consultation with the institution, a look is also taken to the completeness and accuracy of the data supplied. If data on those seeking assistance is supplied without sufficient identifying particulars or elementary data are missing such as sex, date of birth or primary and secondary problems, applicants are not included in the LADIS Core figures. An attempt is always made in consultation with the institution to achieve as full a supply as possible.

The requirements for data provision within the framework of the Netherlands' European obligations towards EMCDDA (TDI) are becoming ever more stringent and continues to develop. LADIS meets these TDI requirements. The LADIS submissions are increasingly adjusted to European requirements and communication takes place with institutions and ICT suppliers.

Improvements in feedback to institutions

It is important for the quality of data collections that reporters have a feeling for what they supply. IVZ therefore also ensures feedback in a number of forms. Firstly, in justification for what is supplied. Institutions can then check faster whether the content of LADIS reasonably matches their own insights. Another development concerns the LADIS online dashboard. Here, institutions can reflect the data supplied by them against the entirety of submissions and reporting differences. IVZ is in the process of gradually further extending this dashboard function, with new insights relevant to institutions. A new version is expected on-line in September 2012.

Enhancing coverage for participation in LADIS

In LADIS, we are trying to provide a full overview of all people who "somewhere" come knocking at our door with treatment demand related to problematic use of substances. "Somewhere" in this connection means all addiction care institutions and GGZ establishments that offer specific treatment or supervision for such people. LADIS provides an insight into applicants, both from the out-patient and the intramural aspect, who actually call on addiction care institutions. In order to obtain as full a picture as possible of the supply of and demand for care for addiction, data on addiction rehabilitation have since 1994 also been linked in, where possible at individual client level. Despite positive support by all concerned, this link has proved ever-more difficult in recent years through the method of rehabilitation registration. The new IRIS system is able to make LADIS submissions to specification but the primary problem is very poorly registered. This means that, for 2011, the lack of this information has so affected trends that it has been decided to present rehabilitation as a separate group and not link it with addiction care data.

Data are also missing. In the Netherlands, internet treatment/care provision has increased. These projects are offered by various institutions. Care provision is in first instance anonymous and is not registered (at least, not according to LADIS criteria). A search is made with care insurers and other backers for solutions towards making internet treatment also formally possible. If internet treatment is funded, data required for registration in the institutional systems can be included and registered in LADIS as a specific internet process. LADIS is adapted to registration identifiable internet treatments.

Another missing link are the private care providers and private clinics. These approach a specific target group and in many cases treatment is not or not fully refunded by insurance. IVZ is discussing the supply of data to LADIS with a number of these clinics. Willingness has been shown in principle to participate. Unfortunately, for many clinics the effort and expense of implementing computerised supply to LADIS is at present a serious obstacle. Insofar as IVZ has been able to ascertain, the number of those seeking assistance is so small that development trends as presented in LADIS are not greatly affected.

A last missing category are the users who are treated for other, often mental, problems in other institutions within the GGZ. More is continuously being offered within this area aimed at the problem of addiction. Discussion is in progress with the authorities and institutions as to whether this specific provision should perhaps be included in the LADIS domain.

Good security and privacy protection for data provided

Data protection is a very important point of attention for IVZ. IVZ undertakes this in accordance with established security policy and the NEN 75107512 standard. IVZ has external experts undertake an audit yearly to test all internal and external processes against the standard. Data are supplied through ZorgTTP, ZorgTTP applying a pseudonym to each person. This approach guarantees that the individual can no longer be traced. ZorgTTP also meets strict safety requirements and is audited for this yearly.

Finally, a word of thanks to all those who have contributed to the compilation of this publication, in the area of addiction care, amongst the research institutions and within IVZ.

Jan Weber
Acting Director

1. Addiction care as a whole [1]

1.1 Highlights

- Number of people in addiction care slightly reduced.
- Alcohol use related treatment demand stabilizes.
- Opiates and cocaine use related treatment demand continues to decrease.
- Cannabis and GHB use related treatment demand keeps increasing.
- Opiates use related treatment demand reduced by 50% over the past 10 years.
- Cannabis use related treatment tripled during the same period of time.

1.2 In brief

Tabel 1: **Overview of addiction care as a whole 2011**

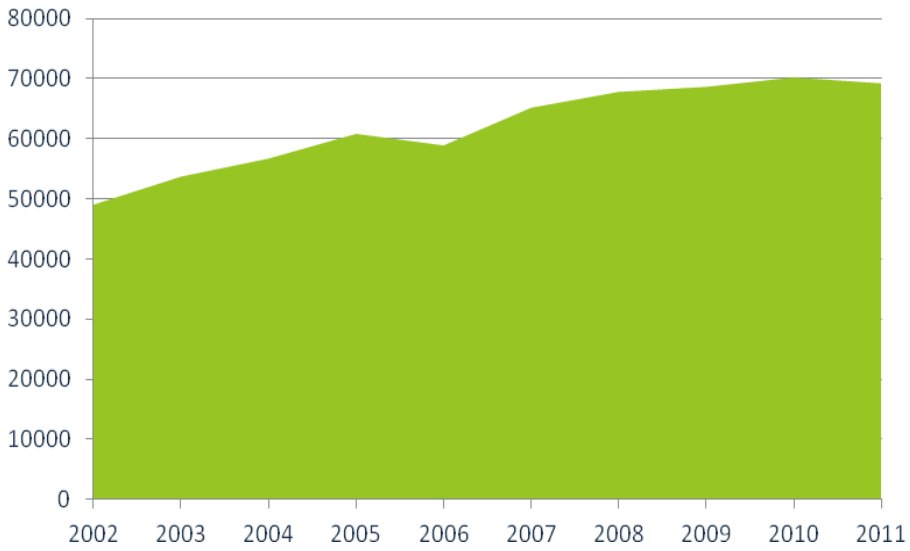
Demography		
	Number of people seeking assistance	69.312
	Male : Female	75:25
	Average age	41.0
	Share of 25-	12.6%
	Share of 55+	16.0%
	Percentage of native Dutch clients	80%
	Number per 100,000 inhabitants	416
Problems		
	Single : Multiple	64:36
	First registration ever	24.7%
	Number of contacts	1.950,000
	Average number of contacts/client	28

In 2011 almost 70,000 unique people have been treated in addiction care.
Seventy-five percent of them are male. The average age is 41 years. One in six clients is older than 55. In one of four clients in 2011 it's their first registration in addiction care.

After several years of increase, the number of clients has slightly dropped in 2011, see Figure 1.

[1] Unless stated otherwise, the presented figures concern addiction care exclusive of addiction rehabilitation. This also applies to the trend figures. As a result, the figures deviate from the Key Figures 2010. See also Chapter 2.

Figuur 1: **Hulpvraag verslavingszorg: Aantal unieke cliënten 2002 - 2011**



1.3 People by primary problem

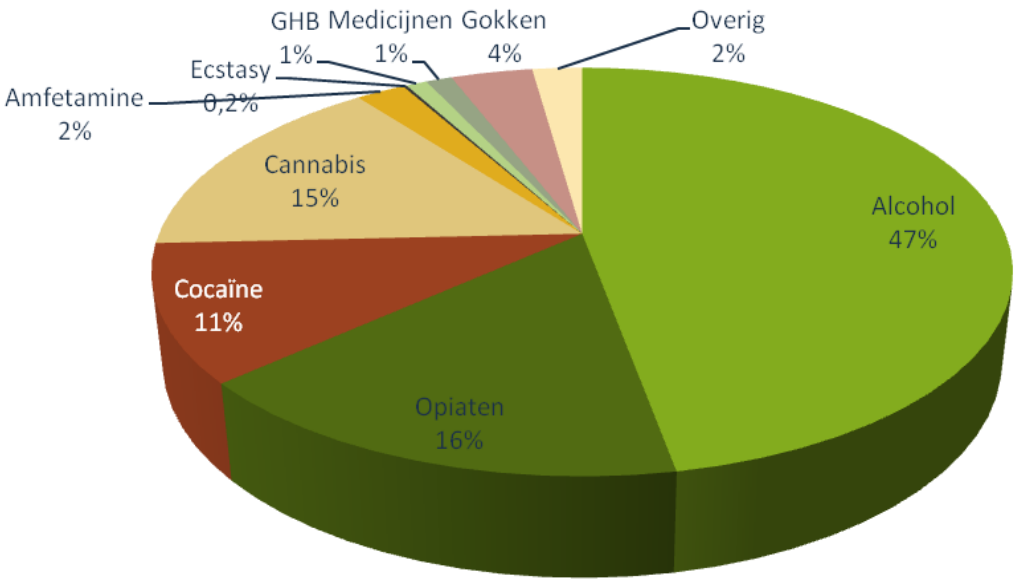
Tabel 2: **Personen en contacten naar primaire problematiek**

Primary problems	Number of people in 2011	Share of Problems	Change compared to 2010	Number of contacts (x1,000)	Share of Contacts
Alcohol	32.635	47,1	-1%	865	44%
Opiates	11.315	16,3	-6%	460	24%
Cocaine	7.517	10,8	-7%	252	13%
Cannabis	10.632	15,3	+4%	218	11%
Amphetamine	1.533	2,2	+2%	447	2%
Ecstasy	112	0,2	+24%	2.7	0%
GHB	659	1,0	+21%	22	1%
Medicines	810	1,2	-5%	22	1%
Gambling	2.545	3,7	-5%	36	2%
Other	1.554	2,2	+15%	27	1%
Total	**69.312**	**100**	**-1.4%**	**1.950**	**100%**

Alcohol is the most frequently occurring problem. Almost half of the treatment demand in addiction care is alcohol use related. Compared to 2010, there is a slight reduction treatment demand. Notwithstanding the continuing decrease, Opiates are still the second largest group.
Cannabis takes third place. The increasing trends in recent years has continued in 2011. Treatment demand for cocaine decreases. Treatment demand for amphetamine use related problems is still increasing, but less compared to earlier years. In 2011, treatment demand for ecstasy and GHB use related problems has increased most in percentage. But, especially with regard to ecstasy, these are small numbers.

Figure 2 shows the distribution of treatment demand by problems in 2011.

Figuur 2: **Hulpvraagverdeling naar primaire problematiek 2011 (N=69.312)**



Figuur 3: **Ontwikkeling hulpvraag naar aandeel (%) primaire problematiek 2002, 2006 en 2011**

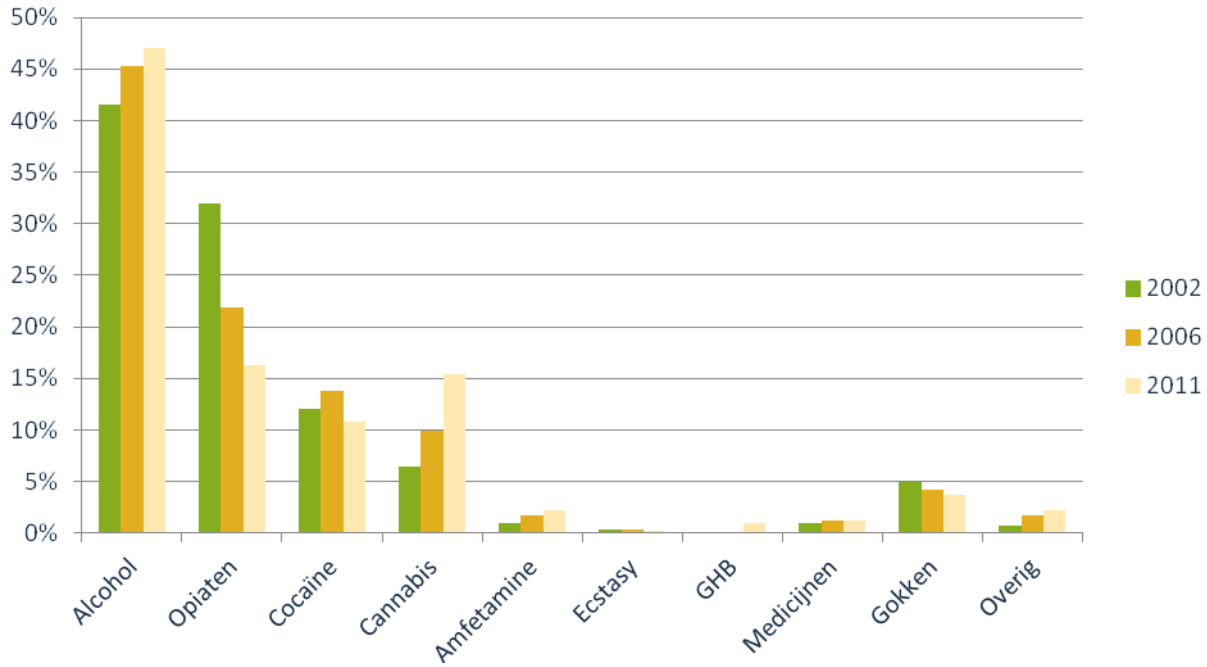
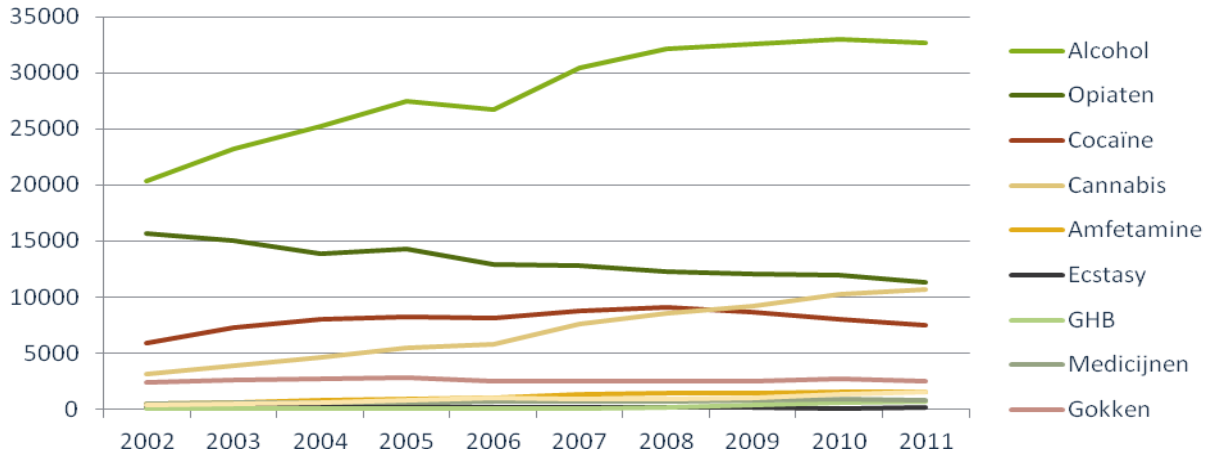


Figure 3 shows the development of treatment demand by share in addiction care.
Over the past 10 years, treatment demand for opiate use related problems has decreased by 50%. The share of cannabis use related treatment demand has doubled over the same period.

1.4 Trend in primary problems 2002-2011

Figure 4 shows the trends the treatment demand for the various primary problems over the past 10 years in absolute figures.

Figuur 4: **Aantal hulpvragers naar primaire problematiek 2002-2011**



Treatment demand for alcohol use related problems has increased considerably over the past 10 years. In 2011, treatment demand has slightly dropped again for the first time (see Chapter 3). It is known that treatment demand for opiate use related problems has been dropping for years. This trend has continued in 2011 (see Chapter 4). Cocaine use related problems have decreased since 2007 (see Chapter 5). Treatment demand for the classic hard drugs is decreasing. Treatment demand for cannabis (Chapter 6) and GHB (Chapter 9) is increasing relatively considerably.

1.5 Primary problems in the population

Tabel 3: **Primary problems by incidence in the population and % under treatment**

Primary problems		Incidence in the population aged 15-64 years[2]	% treated in 2011
Alcohol	Recent use	76%	-
	Abuse	395,600	8%
	Dependency	82,400	40%
Opiates	Problematic use	18,000	63%
Cocaine	Recent use	55,000	
Cannabis	Recent use	7%	
	Abuse	40,200	26%
	Dependency	29,300	36%
Amphetamine	Recent use	0.2%	-
Ecstasy	Recent use	0.4%	-
GHB	Recent use	0.2%	-
Medicines	Recent use	Unknown	-
-Benzodiazepines	Recent use	1,400,000[3]	-
-Narcotics and sedatives	Abuse	35,000	2%
	Dependency	22,000[4]	4%
Gambling	Problem players	20,300[5]	13%

[2] Nationale Drug Monitor, Jaarbericht 2011, Trimbos Instituut; 2012: Utrecht
[3] Stichting Farmaceutische Kengetallen, Data en Feiten 2011, augustus 2011
[4] NEMISIS-2, De Graaf et al., Trimbos Instituut; 2010: Utrecht
[5] Bieleman, B., et al. Gambling in Kaart. Tweede meting aard and omvang kansspelen in Nederland; 2011: Groningen.

It is clear that the “glasses” used to look at the problems determine the extent of the care provided. Based on the dependency criterion, the extent of care for alcohol use related problems is 40%, whereas this is 36% for cannabis use related problems.
There are considerable differences between the types of drugs. For GHB, ecstasy and medicines no recent figures for problematic use in the population are known.

1.6 Number of unique people treated since 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 people have turned to addiction care for assistance over the past 18 years. In the period 1994-2011 more than 300,000 different people have turned to addiction care for assistance.
Table 4 shows the number of unique people, subdivided by primary problem.

Tabel 4: **Number of unique people in addiction care by primary problem 1994-2011**

Primary problems	Number of unique people
Alcohol	175,000
Opiates	44,000
Cocaine	46,000
Cannabis	50,000
Amphetamine	8,500
Ecstasy	2,500
GHB	1,000
Medicines	6,000
Gambling	30,000
Other	11,000

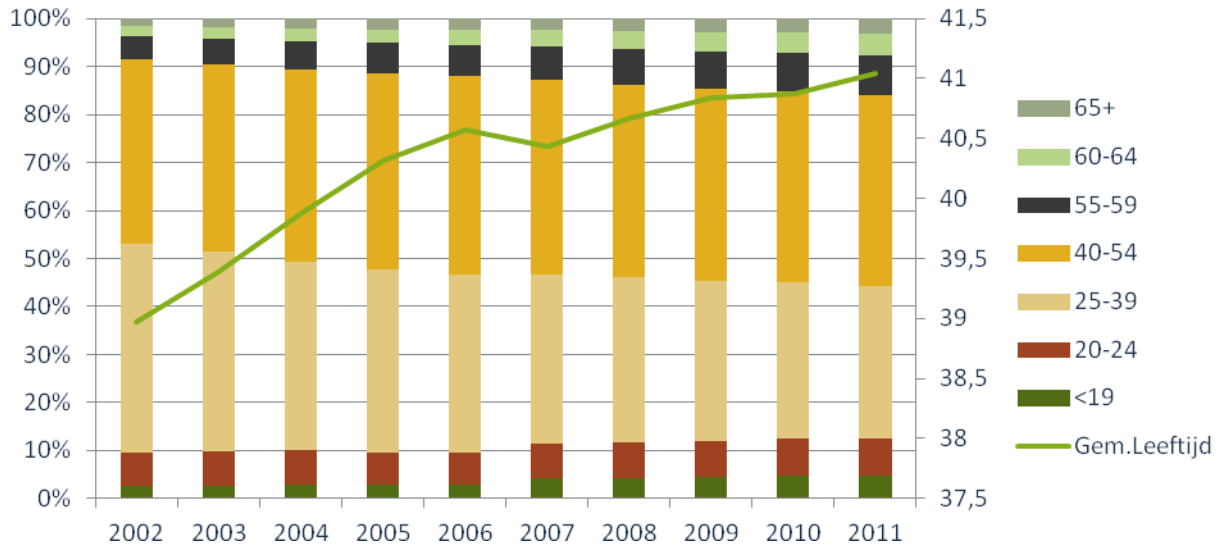
The total number of unique people is not equal to the sum of the various problems as 60,000 people have turned to an institution for assistance several times and for different problems.

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. In 2011 this was 41 years. The ageing of the clients in addiction care, however, is developing more rapidly than in the general population. This is caused, in particular, by the increase in the percentage of elderly in the group with an alcohol and opiates related demand for assistance. See also sections 2.4 and 3.4.

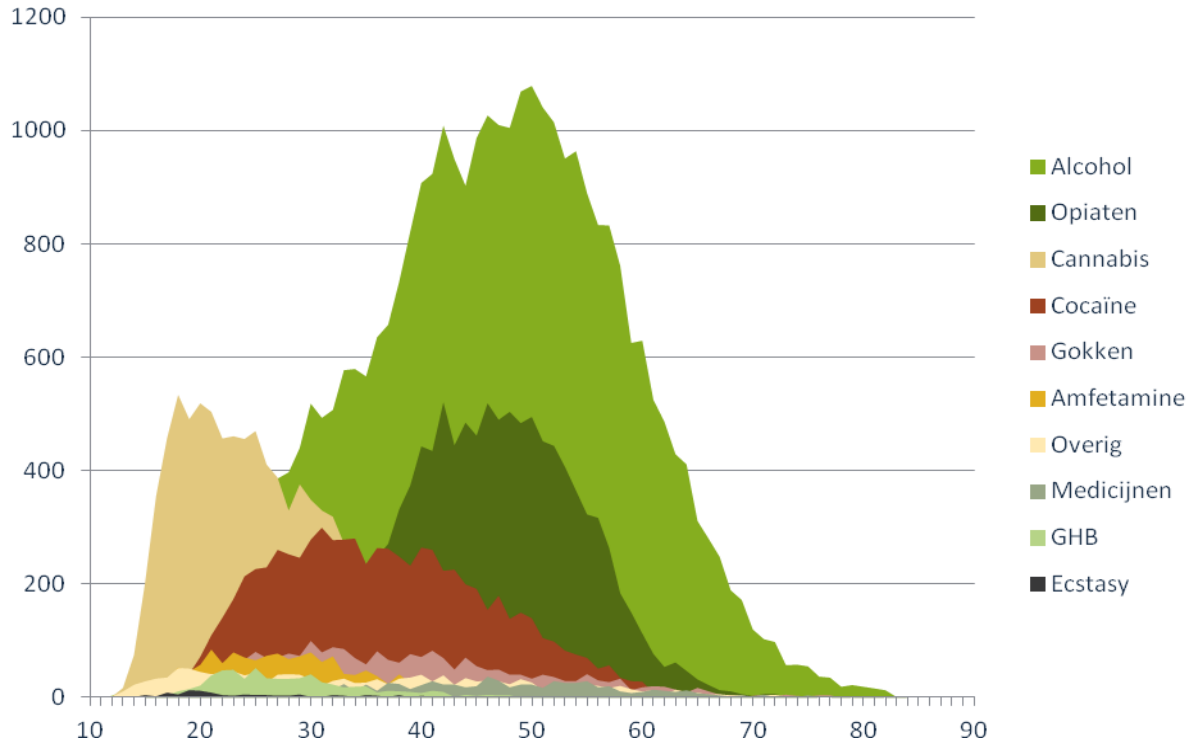
Figuur 5: **Hulpvraag naar leeftijdscategorie 2002-2011**



By far the largest group of people who turn to addiction care are aged between 25 and 55 years. The share of this age category is, however, decreasing. The share of adolescents (<25 years) has increased slightly over the past 10 years. The share of elderly people is increasing more rapidly. In 2011, one in six clients is over 55 years old.

1.7.2 Age distribution by primary problem

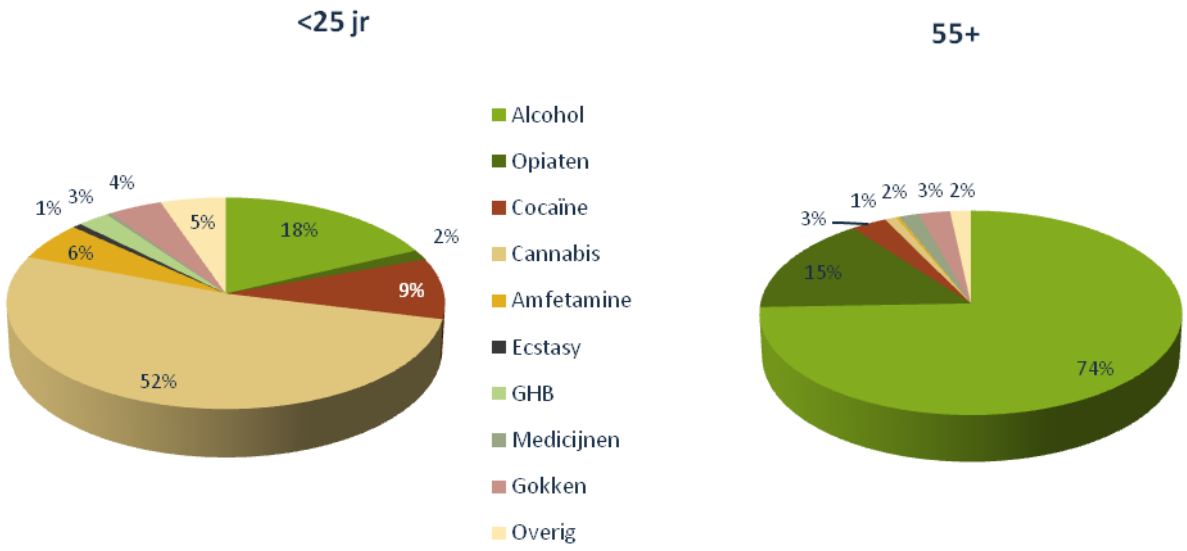
Figuur 6: **Leeftijdsverdeling naar primaire problematiek 2011 (N=69.312)**



The age distribution in Figure 6 clearly shows the differences between the problem categories. Alcohol, opiates and cannabis are the largest groups in addiction care.

For alcohol and opiates, the older group is over represented. The cannabis, GHB and amphetamine and ecstasy group includes relatively more adolescents.
Figure 7 shows the distribution of primary problems for adolescents (<25 years) and older people (55+).

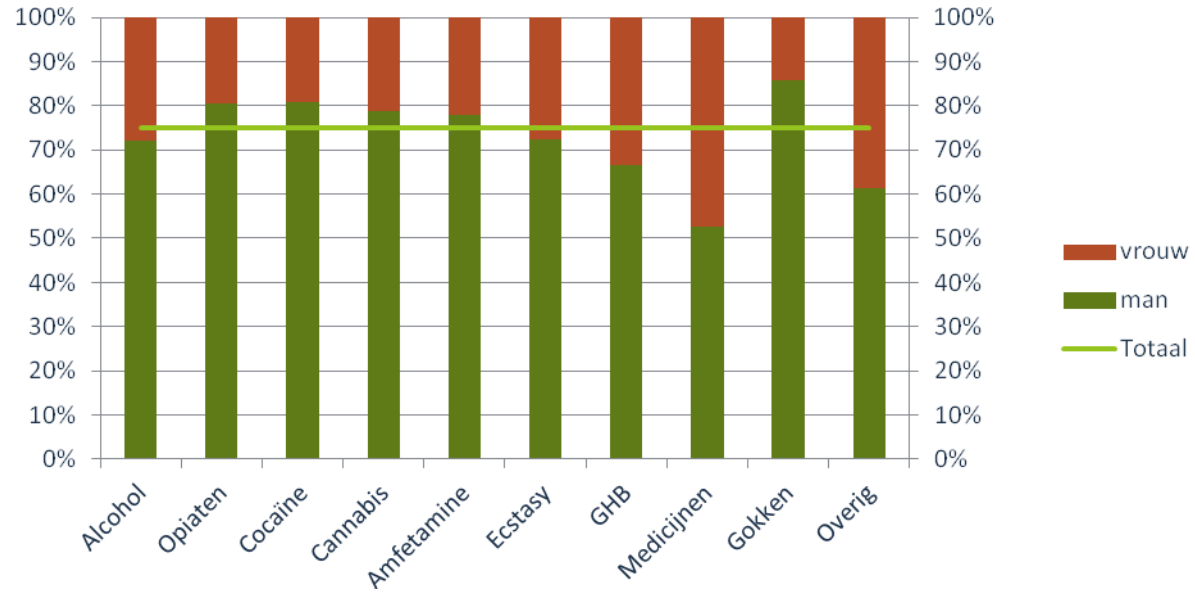
Figuur 7: **Verdeling primaire problematiek 2011 voor jongeren (<25 jaar) en ouderen (55+) in 2011**



In adolescents > 25 years, cannabis is the problem in more than fifty percent of the cases. Gambling problems occur equally in all ages. Alcohol is the main problem in older people (55+) in 75% of the cases.
The development of this age distribution by primary problem over time, will be discussed in the individual chapters.

1.7.3 Gender

Figuur 8: **Geslacht naar primaire problematiek 2011 (N=69.312)**



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 differences can also be observed in treatment demand in addiction care.

1.7.4 Cultural origin

People of about 100 different nationalities and backgrounds are registered 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 is under represented in addiction care, whereas the group of non-western ethnic minorities is slightly over represented in addiction care.

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

	LADIS	Population 2011[7]
Native Dutch	80%	80%
Western ethnic minority	7%	9%
Non-western ethnic minority	13%	11%

Figure 9 shows the subdivision according to cultural origin for the various addiction problems.

Figuur 9: **Herkomst naar primaire problematiek 2011 (N=68.114)**

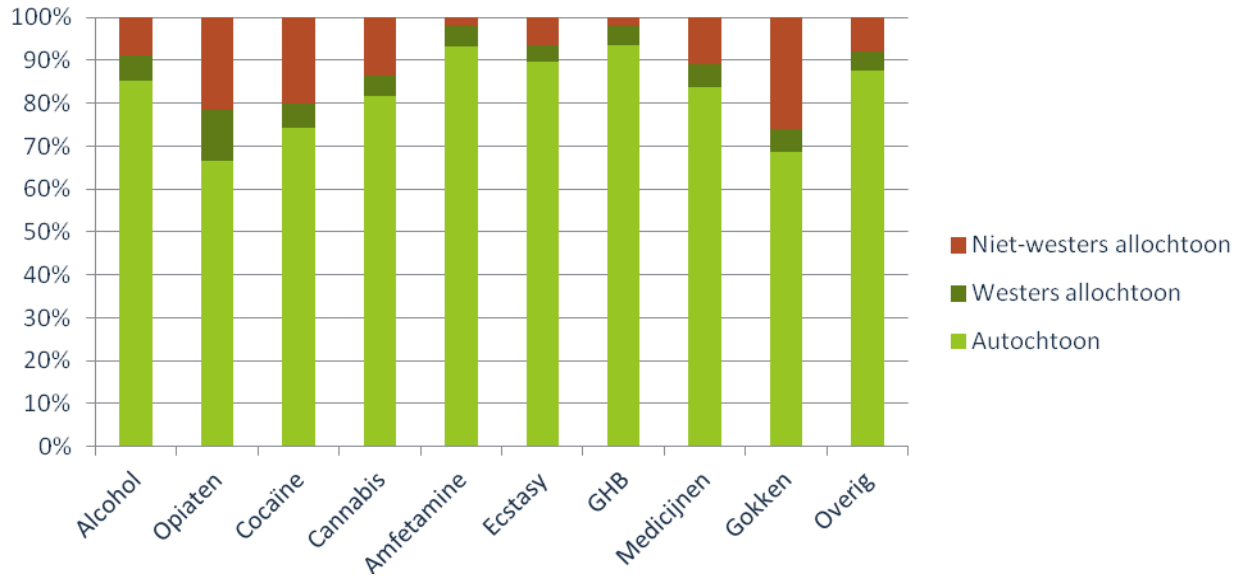


Figure 9 shows that the non-western ethnic minorities group is over represented with regard to demand for assistance with opiates, cocaine, and gambling related demands for assistance. This group is under represented with regard to amphetamine and alcohol use related demands for assistance.
Western ethnic minorities have relatively considerable treatment demand in relation to opiates use.

[6] According to the CBS definition, based on country of origin, parents'country of origin and nationality
[7] CBS 2011

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.

Figuur 10: **Aantal hulpvragers verslavingszorg per 100.000 inwoners 2002 en 2011**

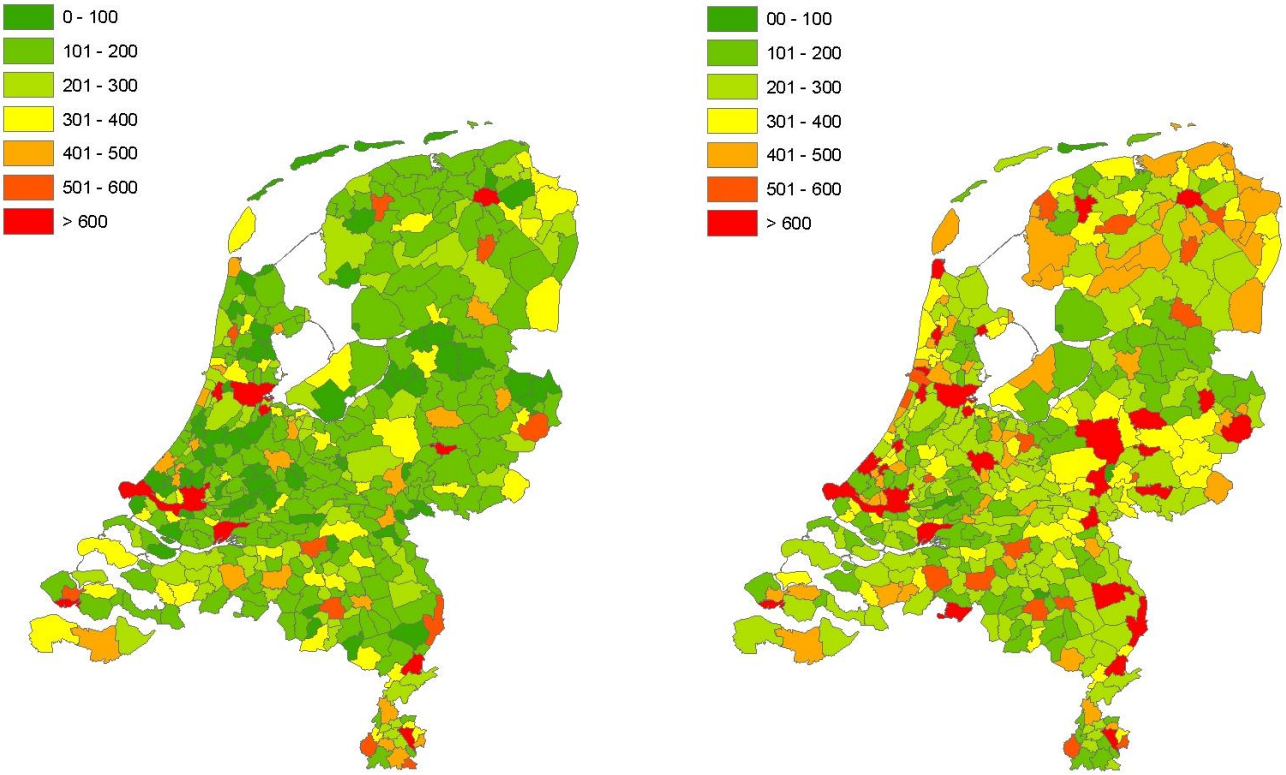


Figure 8 shows that the number of people seeking assistance has increased over the past 10 years . Their number has increased from 305/100,000 inhabitants in 2002 to 416/100,000 inhabitants in 2011.

1.9 Multiple problems

Of those seeking assistance in addiction care, 36% are facing multiple problems (also often referred to as poly-drug use). In other words, problematic use of at least two substances or use of substances combined with a gambling problem.

Figuur 11: **Secundaire problematiek (%) naar hoofdproblematiek 2010 (N=64.299)**

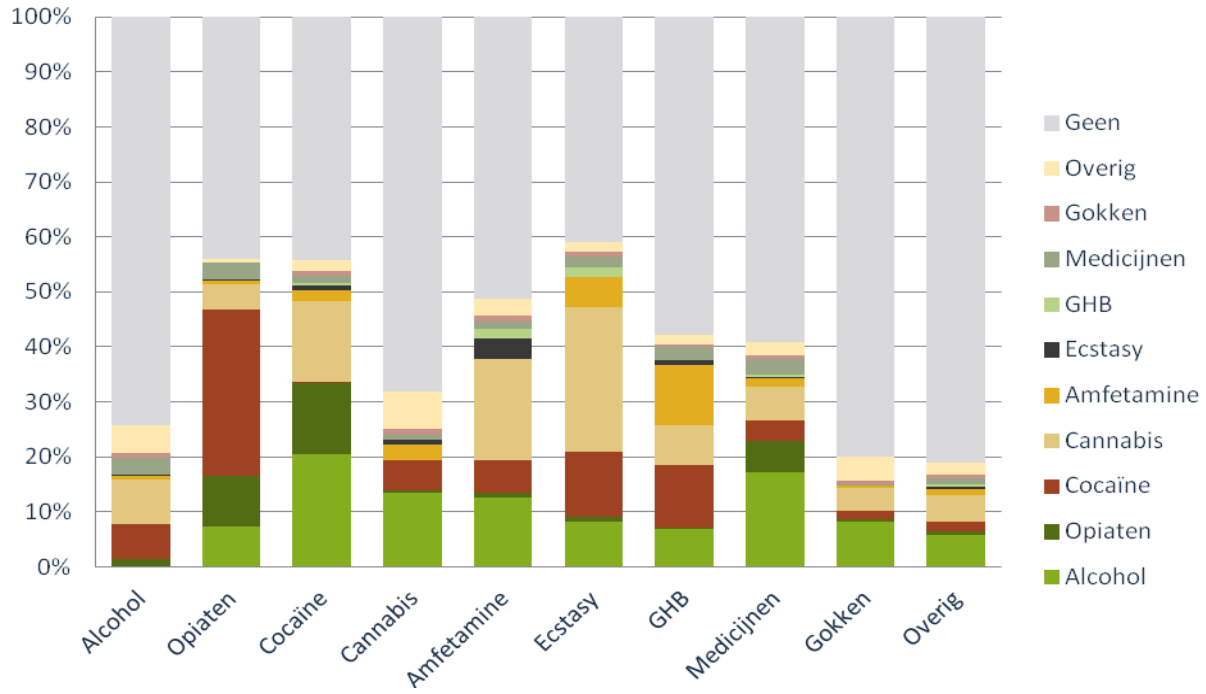


Table 6 shows the figures for Figure 11. The percentage of people seeking assistance who also have a secondary problem is indicated by primary problem.

Tabel 6: **Secondary probems (%) by main primary problem 2011 (N=64,299)**

	Primary problems									
Secondary ↓	**Alcohol**	**Opiates**	**Cocaine**	**Cannabis**	**Amphetamine**	**Ecstasy**	**GHB**	**Medicines**	**Gambling**	**Other**
Alcohol	0%	7%	20%	13%	13%	8%	7%	17%	8%	6%
Opiates	1%	9%	13%	0%	1%	1%	0%	6%	0%	1%
Cocaine	6%	30%	0%	5%	6%	12%	11%	4%	2%	2%
Cannabis	8%	5%	15%	0%	18%	26%	7%	6%	4%	5%
Amphetamine	1%	1%	2%	3%	0%	5%	11%	1%	0%	1%
Ecstasy	0%	0%	1%	1%	4%	0%	1%	0%	0%	0%
GHB	0%	0%	0%	0%	2%	2%	0%	0%	0%	1%
Medicines	3%	3%	1%	1%	1%	2%	2%	3%	0%	1%
Gambling	1%	0%	1%	1%	1%	1%	0%	1%	1%	0%
Other	5%	1%	2%	7%	3%	2%	2%	2%	4%	2%
None	**74%**	**44%**	**44%**	**68%**	**51%**	**41%**	**58%**	**59%**	**80%**	**81%**

Two-thirds of traditional hard-drug clients (opiates and cocaine) also indicate having other problems. The most common secondary problem is cannabis. Cannabis frequently occurs in combination with alcohol, cocaine and amphetamine and ecstasy as primary problem.

In addition, alcohol use related problems often occur as a secondary problem. Demands for assistance concern cocaine, cannabis, amphetamines and medicines. With GHB, amphetamines and cocaine are the most common secondary problems. The combination of opiate use and cocaine (crack) use related treatment demand also frequently arises. Please note that for opiates, cocaine, medicines, gambling and other, the same category may occur as both a primary and a secondary problem.

1.10 Type of assistance

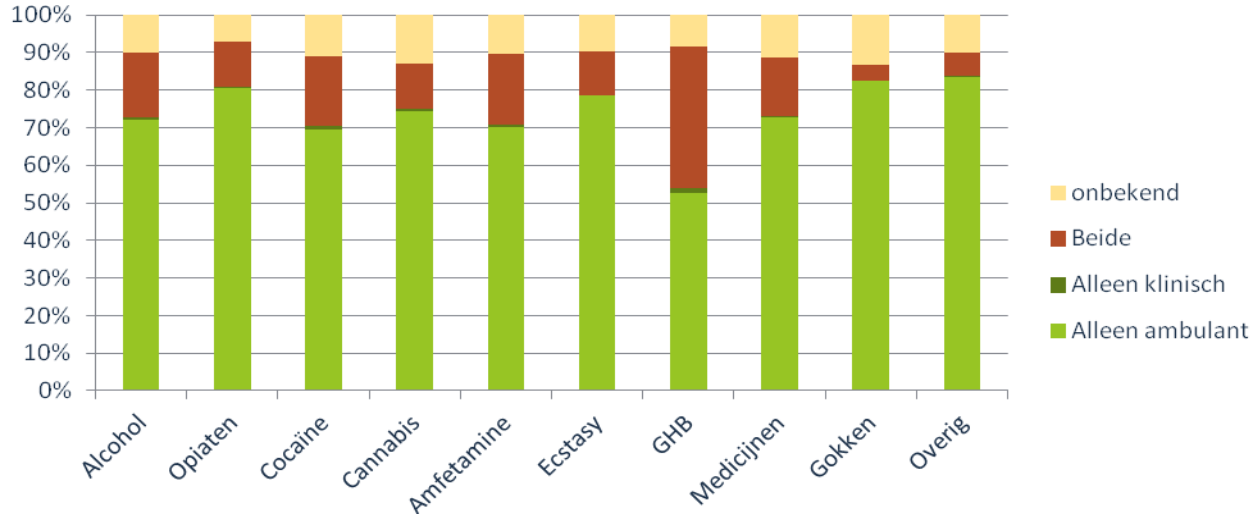
Tabel 7: **Type of assistance 2011 (N=69,312)**

	Number of people	%
Outpatients only	51,301	74%
In-patient only	440	<1%
Outpatients and in-patient (overlap)	10,496	15%
Unknown	7,075	10%
TOTAL	**69,312**	**100%**

In 2011, 11,000 people turned to addiction care, with a minimum of one in-patient admission. Less than 1% have an in-patient admission without outpatient registration. An in-patient admission nearly always also means outpatient registration because this is the suitable route within institutions towards in-patient admission.

The Highlights by type of care differs per primary problem. This is shown in Figure 12.

Figuur 12: **Zorgsoort naar primaire problematiek 2011 (N=60.254)**

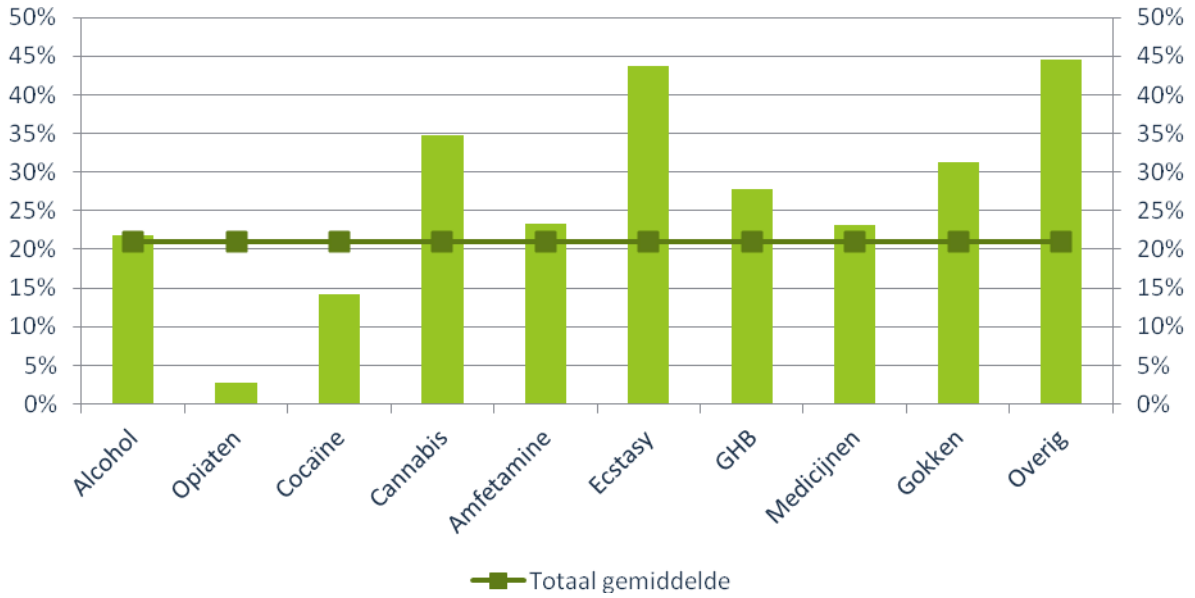


Although alcohol and cocaine account absolutely for the largest number of in-patient admissions as primary demand for assistance, in-patient admissions for GHB and amphetamines and ecstasy are relatively many. Those seeking assistance for gambling are nearly always treated in-patiently within addiction care.

1.11 New clients

Approximately 20% of the clients have never been treated before. This percentage differs by primary problem (see Figure 13).

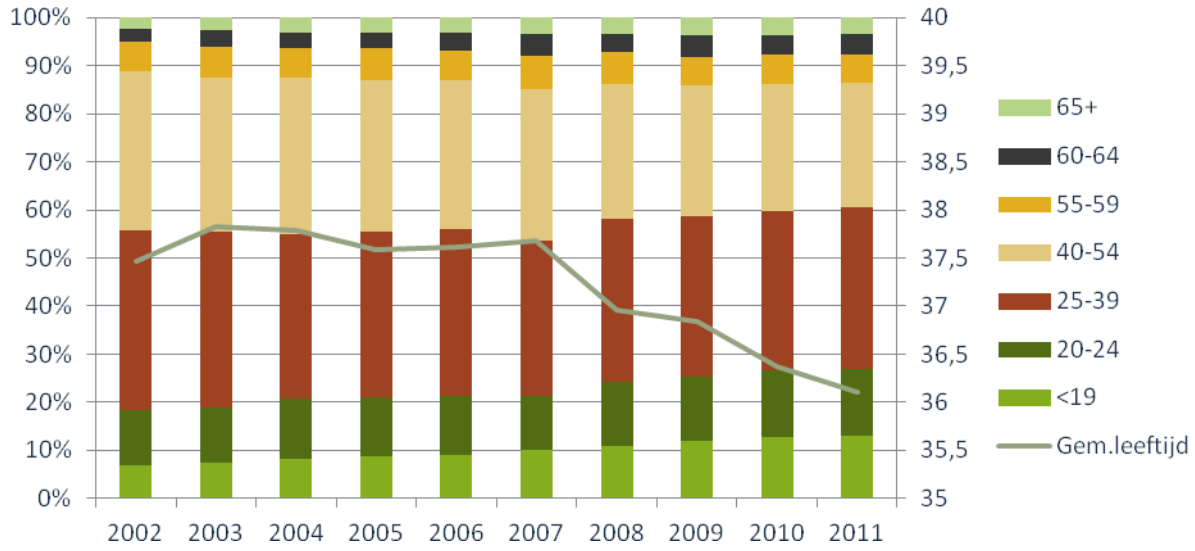
Figuur 13: **Aandeel nieuwe hulpvragers naar problematiek 2011 (N=69,312)**



No new clients 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%. Relatively most newcomers (45%) can be found in the categories ecstasy and other. Important groups in the last-mentioned category include the clients with eating disorders and internet addiction (see Chapter 12). There are relatively many new clients in the cannabis and the gambling groups.

The newcomers' ages are considerably below the ages of all other clients.

Figuur 14: **Leeftijd nieuwe hulpvragers 2002-2011**

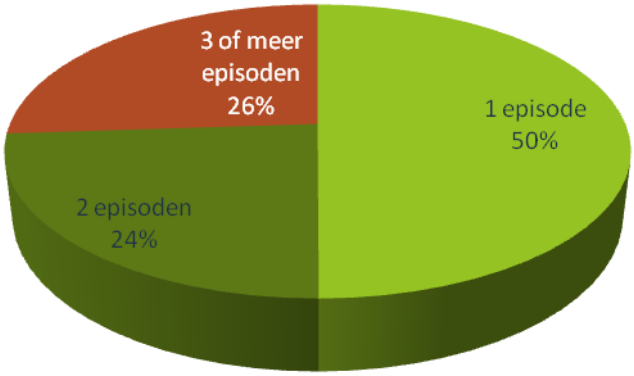


1.12 Case history

By using the LADIS code, clients can be followed through the years and over and beyond institutions. National figures can thereby be presented for unique people in addiction care. The number of episodes for which a person has been in care can also be calculated for each individual client.
An episode means the period during which a person is receiving treatment in addiction care for a consecutive period of time. An episode may consist of several registrations at several institutions, either overlapping or occurring briefly after each other.
How precisely an episode is defined can be seen in Annex III. The difference between a new client (see 1.11 above) and a client with a previous episode is that the latter can already have been first registered years ago; an episode or first episode may concern several registration years.

Figure 14 shows the distribution of the number of episodes during which a person has been in care for those seeking assistance in 2011.

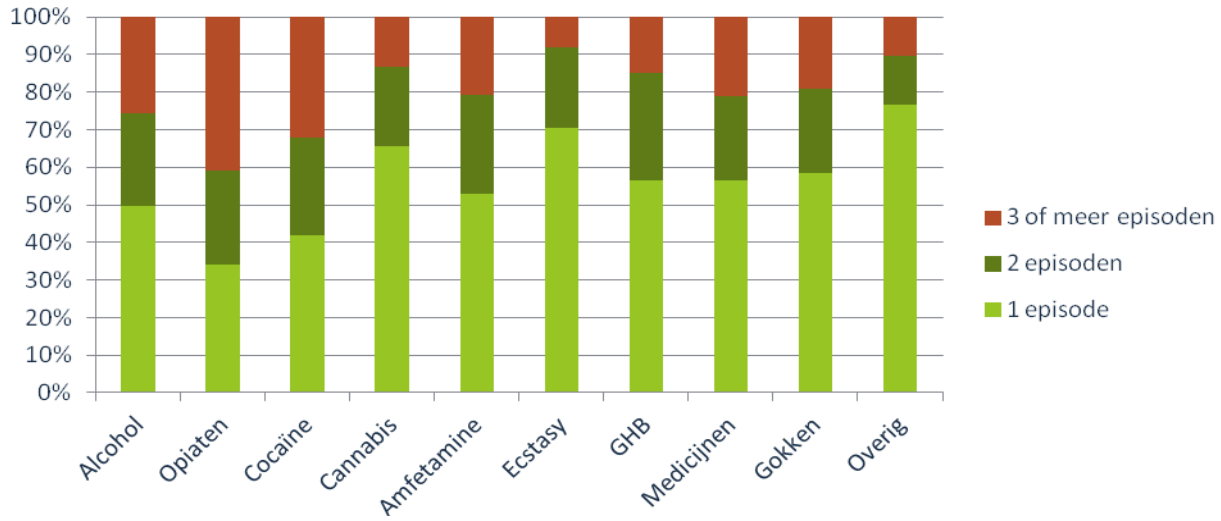
Figuur 15: **Aantal episoden in de verslavingszorg (N=69,312)**



Half the number of people are in the first episode. A quarter of the people have three or more episodes in addiction care.

The number of episodes in the case history of clients from 2011 differs according to primary problem. This Highlights is shown in Figure 15.

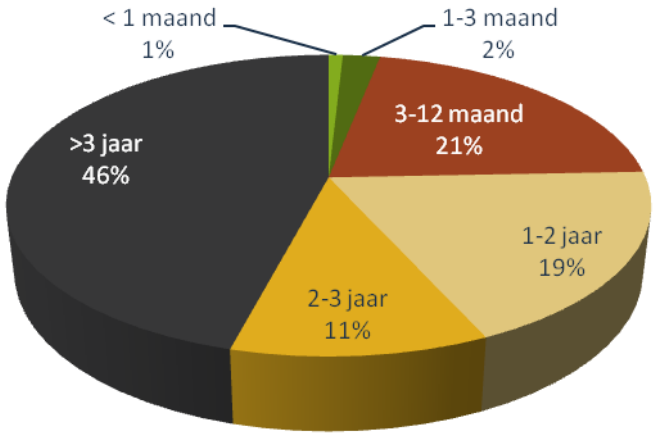
Figuur 16: **Aantal episoden in de verslavingszorg naar primaire problematiek (N=69.312)**



Those seeking assistance for cocaine and opiates more frequently account for several episodes. The case history for these groups is more extensive. In the event of treatment demand for cannabis, ecstasy and the "others" category (especially eating problems), the majority is limited to one episode.
Not only the number of episodes but also the period of treatment per episode has an important bearing on the extent to which a call is made on addiction care. It should be noted that the total duration of an episode is always a "state of affairs". For newcomers, the duration of an episode is by definition relatively short. Possible registrations in subsequent years are also included in the total duration of treatment for clients from earlier reporting years.

Figure 16 shows how the average total duration of treatment for all episodes (as from 1994) breaks down for clients in 2011.

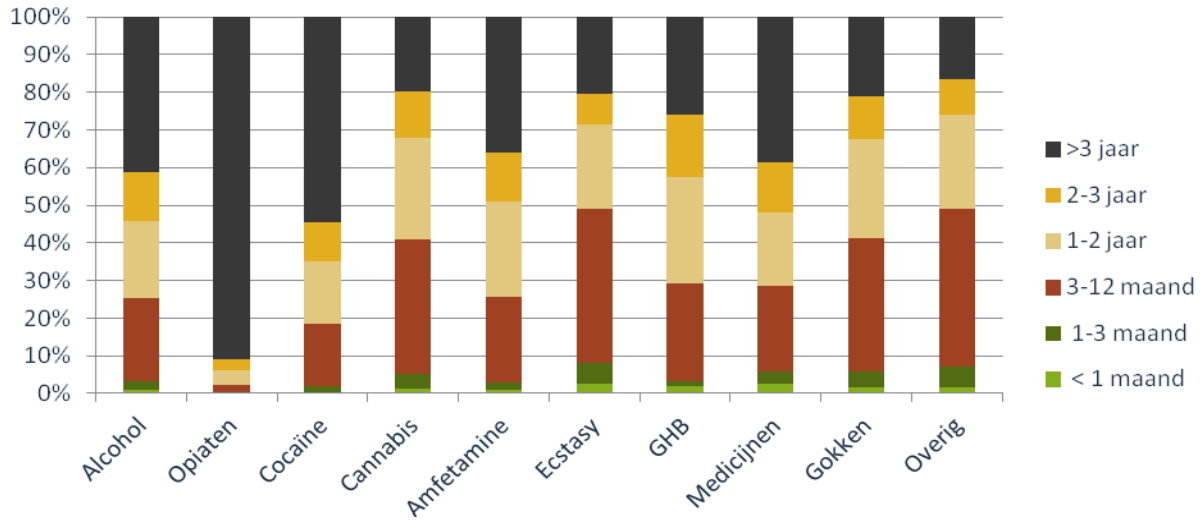
Figuur 17: **Totale behandelduur (1994-2011) van alle episodes in de verslavingszorg (N=69.312)**



About a quarter of all registered clients have been in care for less than 1 year altogether. Nearly half have been treated in addiction care for more than 3 years since 1994. These are mainly clients requesting assistance for opiates, cocaine and alcohol.

Figure 17 shows a Highlights of the total duration of treatment by primary problem. This also includes past treatments for other problems than the primary problem for which the client was registered in 2011.

Figuur 18: **Totale behandelduur (1994-2011) van alle episodes in de verslavingszorg naar primaire problematiek (N=69.312)**



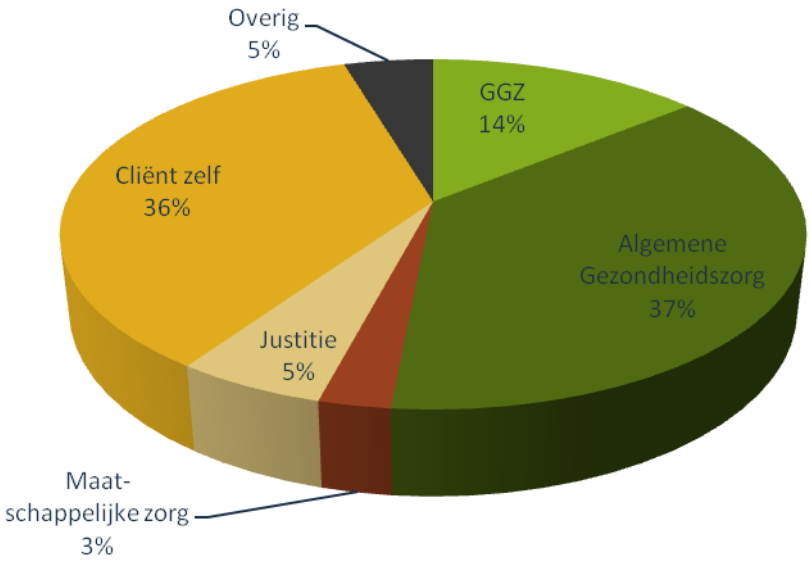
People seeking assistance for opiates have been in care the longest. 90% have a treatment history in excess of 3 years in care. This is explained by methadone treatment. This substitute treatment is not generally directed at achieving abstinence. But those seeking assistance for cocaine and alcohol use related problems often have a long career in addiction care. The total duration of treatment for more than half exceeds 3 years. For alcohol, the percentage is 40%.

The trend in the past 10 years in total episode duration for the individual problems will be described in chapters 3 to 11.

1.13 Method of registration

Many clients register with addiction care themselves. Many others are referred by general healthcare. Figure 18 shows the distribution.

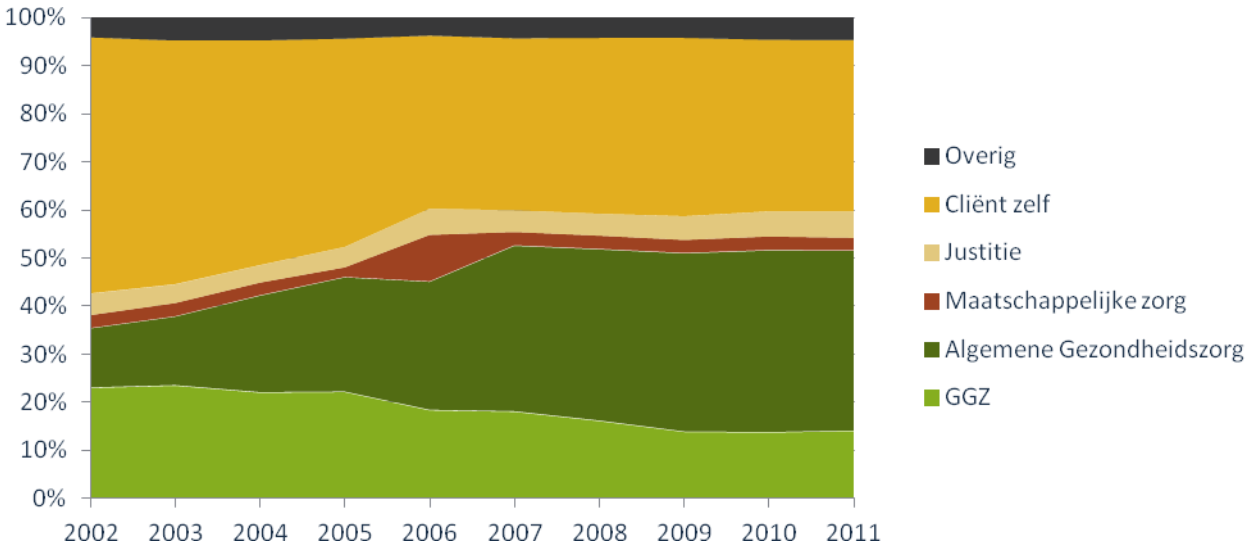
Figuur 19: **Wijze van aanmelding 2011 (N=49.159)**



Between 2002 and 2007 registration by the client himself/herself gradually occurred less often. After that, this number of people has remained stable. At the same time, the share of registrations through general healthcare will increase, whereas this percentage through the GGZ will drop in the short term

The distribution has continued to be stable over the past 5 years (Figure 19).

Figuur 20: **Wijze van aanmelding 2002-2011**



1.14 Secondary clients

Apart from addiction care assistance is also provided to those around the client. Assistance is provided to parents, partners and children of people with addiction problems. These people are also referred to as secondary clients.

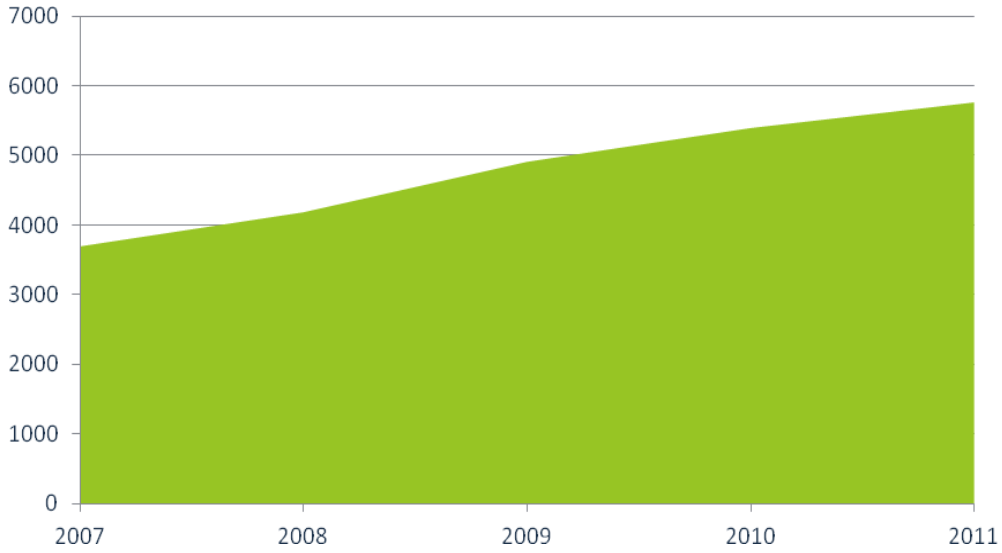
Tabel 8: **Secondary clients 2011**

Demography	
Number of people seeking assistance	5758
Male : Female	38:62
Average age	44.4
Share of 25-	13%
Share of 55+	24%
Percentage of native Dutch clients	96%
Average number of contacts/client	4

Most secondary clients are female and the percentage of ethnic minorities in this specific group is clearly under represented. Less than 4% of the secondary clients are ethnic minorities, whereas this percentage is 20% for the number of people seeking assistance.

Over the past few years, the number of secondary clients in addiction care has increased.
In 2007 this was 3500 people, whereas it has increased to just under 6000 in 2011.

Figuur 21: **Aantal nevenclienten 2007-2011**

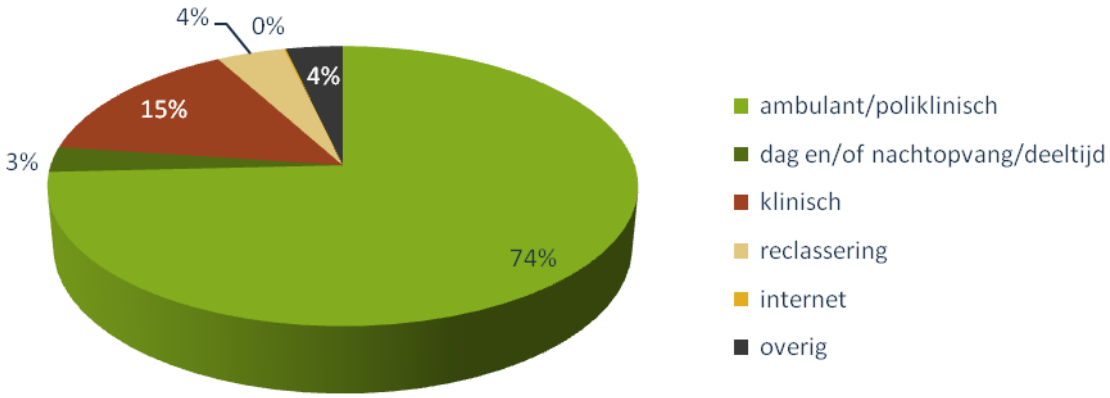


1.15 Contacts

Registration of contacts is a labour-intensive activity. Nonetheless, care institutions, insurers and the government attach particular importance to these contacts. Good contact registration can provide an insight into the efforts made in addiction care for the very diverse problems.

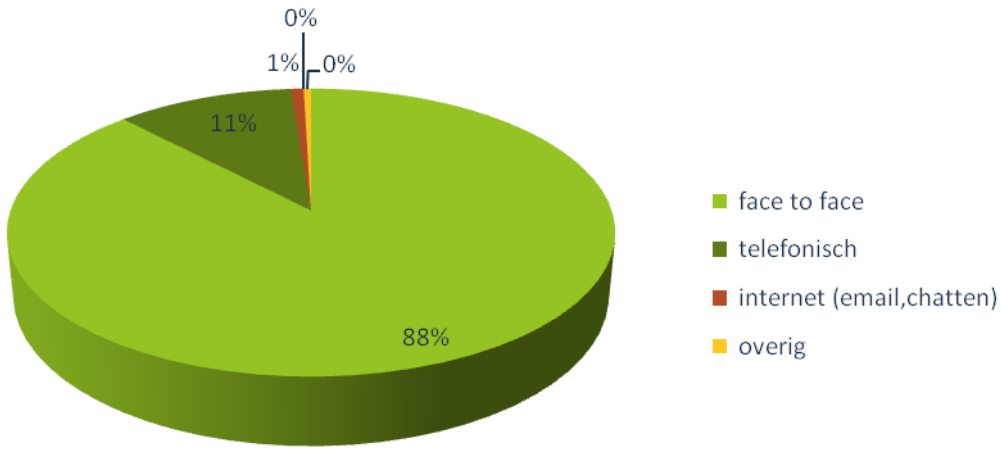
Altogether, nearly two million contacts were registered in addiction care in 2011. The majority of these contacts are those connected with alcohol and opiate use related treatment demand.

Figuur 22: **Setting van de hulp 2011 (N=1.948.000)**



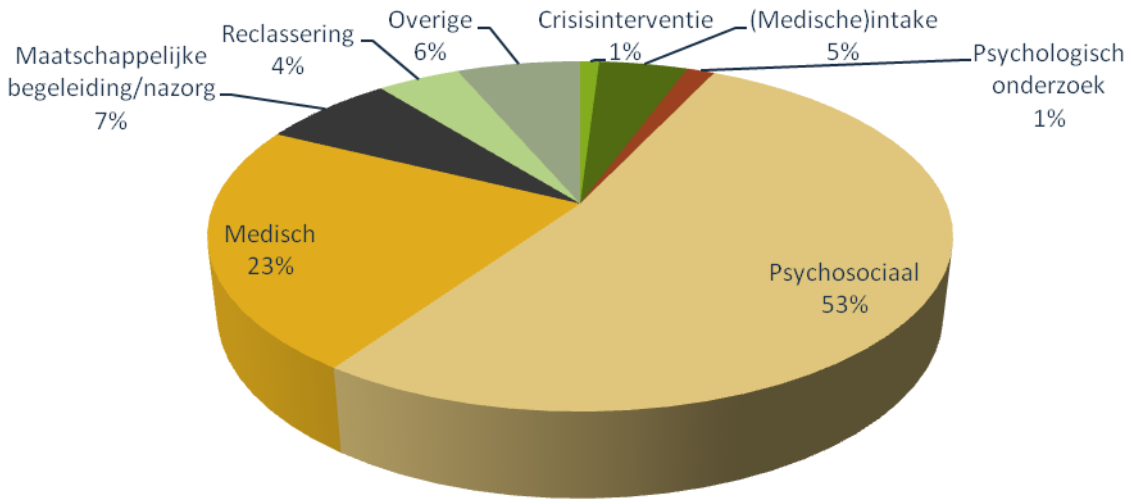
Most contacts with people seeking assistance in addiction care are made in an outpatient setting. Of the two million contacts, nearly 75% occur in an outpatient setting. The in-patient setting is the second largest group (15%). Contacts with people seeking assistance on the Internet account for fewer than 1%. Anonymous internet contacts cannot be included in LADIS for the time being.

Figuur 23: **Wijze van contact 2011**



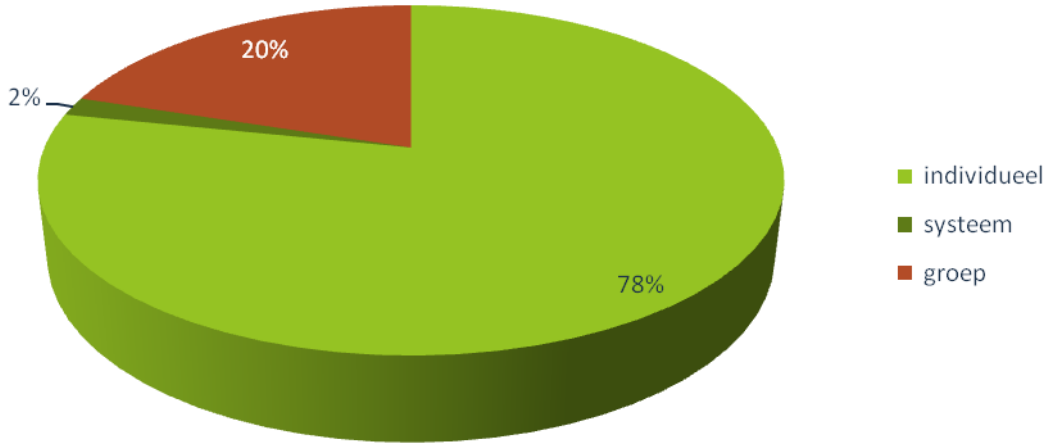
Face-to-face contacts are by far the most frequent (88%).
About 10% of the contacts are by telephone.

Figuur 24: **Aard van contact 2011**



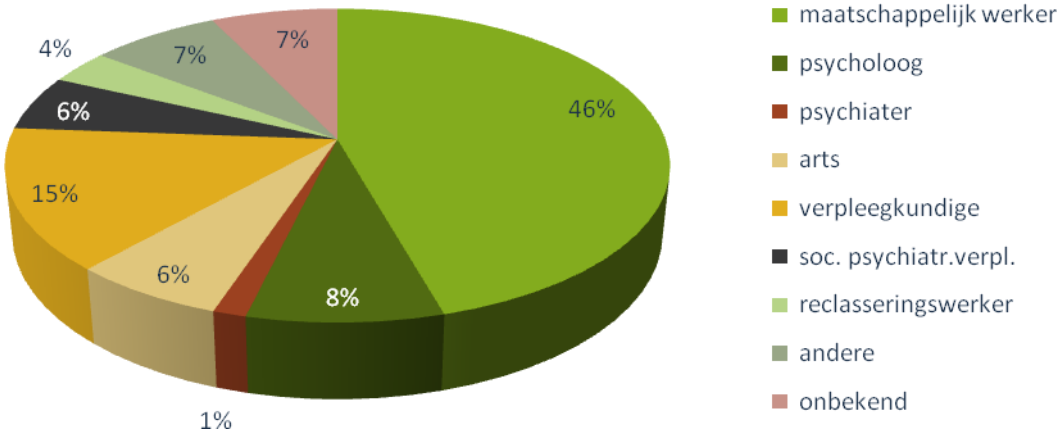
The majority of contacts are psychosocial or medical by nature. This applies both to treatment and to supervision. Social supervision or aftercare and rehabilitation occur in nearly 1 out of 10 contacts. The number of crisis interventions is 1% of all contacts.

Figuur 25: **Soort contact in 2011**



The largest percentage of contacts are individual contacts with the client (78%), followed by group contacts (20%). These are contacts together with people in the same situation. The percentage of group contacts has risen compared to 2010. System contacts, contacts together with family members or other people in the client's environment constitute 2%. Although the percentage is small, this percentage has increased compared to 2010.

Figuur 26: **Contacten naar discipline in 2011**



Social workers account for the largest percentage of contacts with people seeking assistance. In addition, many people seeking assistance have contact with medical disciplines (doctor, nurse, psychologist) and rehabilitation workers.

2 Rehabilitation

2.1 Highlights

- Alcohol is the most frequently occurring problem.
- Approx. 40% also have contacts in regular addiction care.
- Registration in addiction care rehabilitation is incomplete.

As stated earlier, the data required for LADIS on primary and, if present, secondary problems, in addiction rehabilitation are more often than not unregistered or not fully registered. The number of records with missing data has increased since 2007 and the number of reported people seeking assistance originating in addiction rehabilitation is therefore lower. In 2011, the number of people for whom the primary problem is unknown had risen so much that the figures had been separated from those from addiction care. The trends towards primary problems are too strongly influenced by the increase in the number of incomplete data in 2011. Since many people in rehabilitation contact also have contact in ordinary addiction care, a good picture of this group can nonetheless be provided.

2.2 In brief

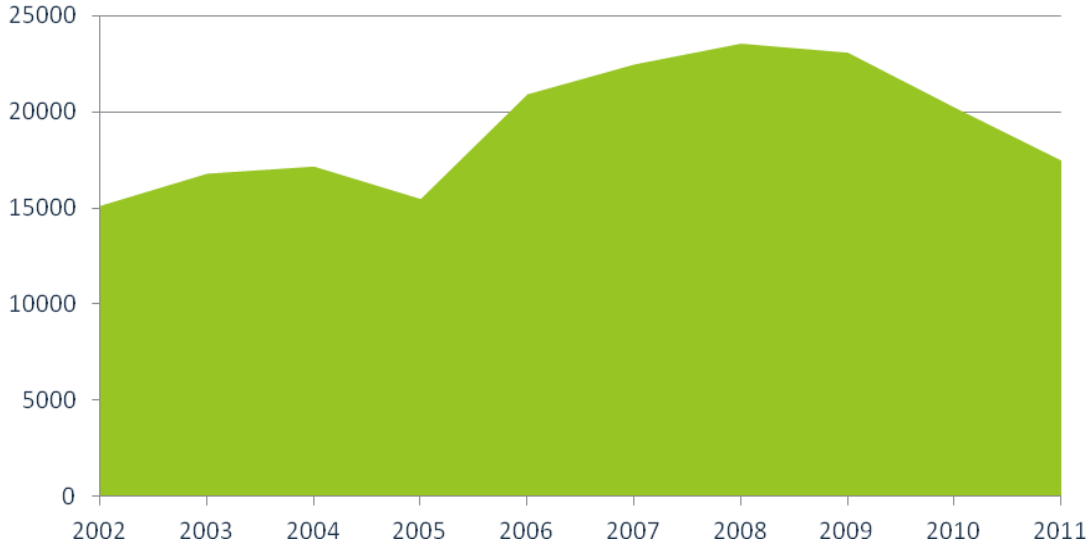
Tabel 9: **Rehabilitation overview 2011**

Demography		
	Percentage of people seeking assistance	17.453
	Male: female	92:8
	Average age	35.7
	Number 25-	19.0%
	Number 55+	5.0%
	Percentage of native Dutch clients	68%
Problems		
	Single: multiple	64:36
	First registration ever	2%
	Number of contacts	196098
	Average number of contacts/client	11

In 2011, nearly 17,500 unique people originated from addiction rehabilitation.
Approx. 40% (n=6,623) also have contacts in general addiction care in the same year. Only fewer than 10% are female and the average age is at 35.7, nearly 6 years below the average age for addiction care. The group of ethnic clients in addiction rehabilitation is under-represented compared to ordinary addiction care and compared to the general population.

There has been a steady fall since 2008 in the number of registered clients in addiction rehabilitation. This fall is probably largely attributable to the changes that have been made in the registration system. The old registration system was phased out and a new system implemented early in 2009. It is to be hoped that this will again improve records in the coming years.

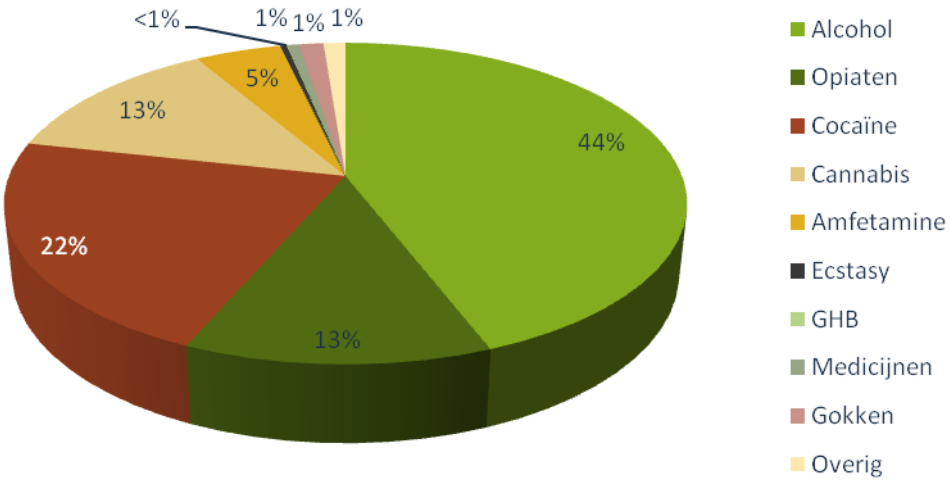
Figuur 27: **Hulpvraag verslavingsreclassering: aantal unieke cliënten 2002 - 2011**



2.3 People by primary problem

Figure 27 shows the distribution of the group where the primary problems are known. Alcohol is the most frequently occurring primary problem at 44%, followed by cocaine at 22%.

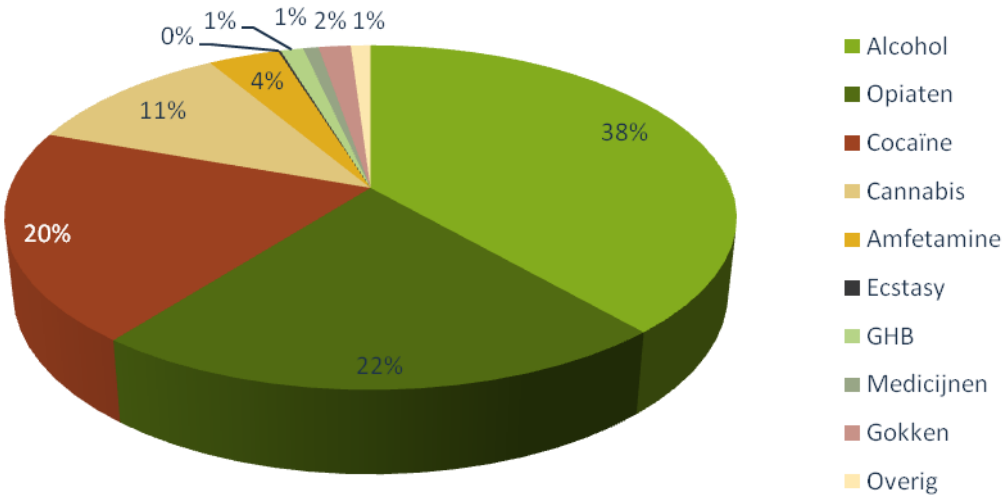
Figuur 28: **Primaire problematiek verslavingsreclassering 2011 (N=2530)**



The percentages in Figure 27 should be approached with some caution because there may be a bias in selection. However, there is no reason for assuming that the Highlights of the primary problems for the group of those where this is not registered is quite different from this distribution. This is confirmed by the distribution of primary problems for the group also known within ordinary addiction care (N=6,623).

This distribution (see Figure 28) does not differ substantially from Figure 27. The most noteworthy difference is a lower percentage of alcohol and a higher percentage of opiates as primary problems.

Figuur 29: **Primaire problematiek groep overlap verslavingszorg en verslavingsreclassering 2011 (N=6.623)**



3 Alcohol

3.1 Highlights

- The increase in the number of elderly (55+) is continuing.
- The number of adolescents (<25 years) is limited, but is slightly increasing.

3.2 In brief

Tabel 10: **Average treatment demand for alcohol use related problems in 2011**

Demography	
Number of people seeking assistance	32635
Male : Female	**72:28**
Average age	46
Share of 25-	5%
Share of 55+	25%
Percentage of native Dutch clients	85%
Number per 100,000 inhabitants	196
Problems	
Percentage in addiction care	47%
Single : Multiple	74:26
Use as an secondary problem	5479
First registration ever	22%
Average number of contacts/client	39

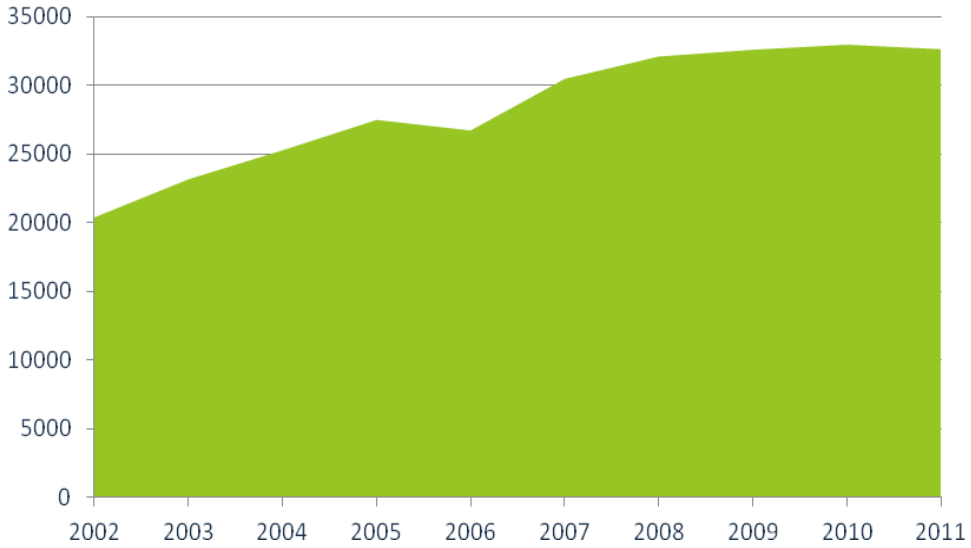
Alcohol remains responsible for the largest group of people seeking assistance from the addiction care sector. From the total of 70,000 people seeking assistance in 2011 over 32.000 do so for an alcohol-related problem.
Approximately 30% of this group are women. This percentage has remained stable for 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 < 44 years. Alcohol problems that lead to treatment demand do not often occur in the adolescents group. The percentage of adolescents under 25 is 4.8%. In the age group under 20, 530 adolescents registered with an alcohol use related treatment demand in 2011, compared to 450 in 2010. This means that there is an increase.

3.3 Trends and development of the treatment demand

Alcohol use related treatment demand has always constituted the largest group in addiction care.
As from 2002 this problem has been given more attention (and capacity). Over the past five years this share has been stable, about 47% of all clients in 2011. Their number has increased from 20,000 in 2002 to over 32,000 in 2011 (see also Table 10 and Figure 29).
Figure 29 shows the development of this population over the past 10 years. The table shows that the past 10 years have shown a 50% increase which has stabilized over the past few years.

Note:
These figures do not include the figures of emergency treatment in hospitals for binge drinkers. It may be advisable to investigate whether the people/adolescents in this group register in regular addiction care.

Figuur 30: **Alcohol - Aantal hulpvragers 2002-2011**



3.4 Young and old

In recent years, the percentage of clients with alcohol related problems in the 55+ age group has clearly increased[8]. The increase with regard to the adolescents in this group is minor. The largest number of clients is in the 40-54 age group. See Figure 30.

Figuur 31: **Alcohol – Leeftijdscategorieën 2002-2011**

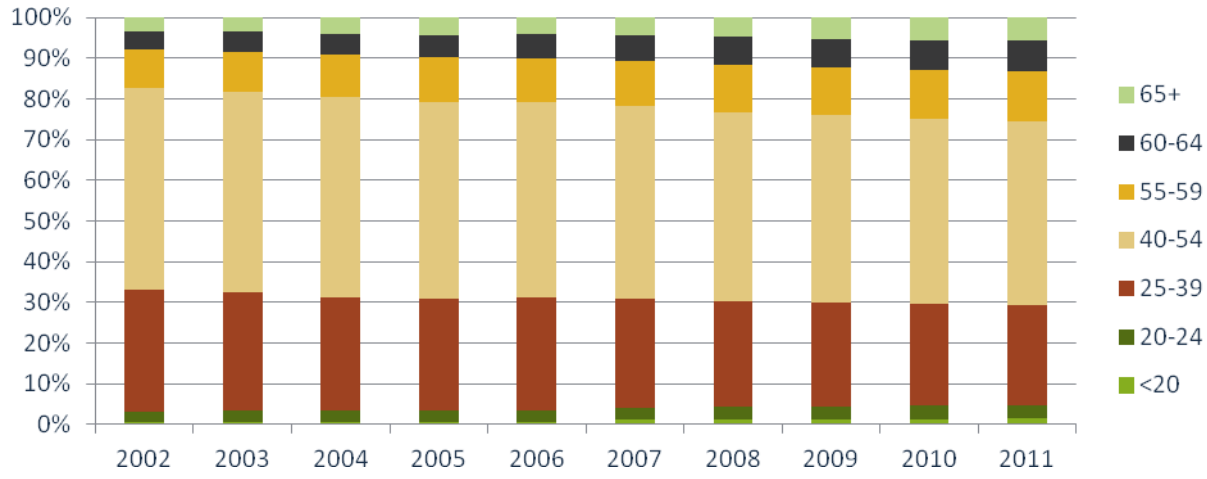
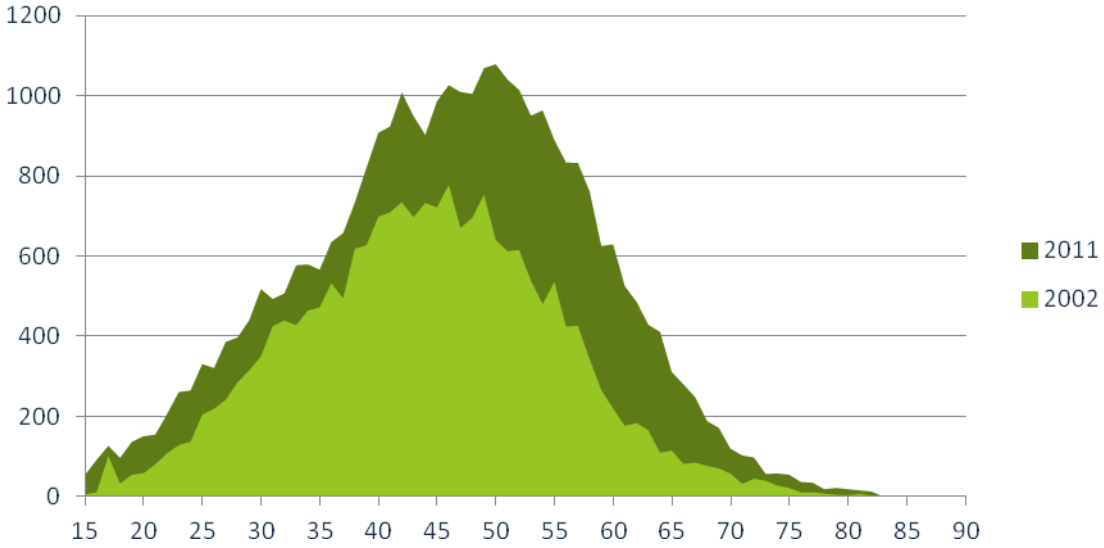


Figure 31 shows that treatment demand for alcohol use related problems has increased over the past 10 years, in all age categories, but in the 50 to 65 years age group in particular.
It is anticipated that the increase in treatment demand for alcohol use related problems in this group will continue to increase. This increase will partly concern new clients, but also the large group of people aged 50-55 whereas part of them will continue to be treated in addiction care.

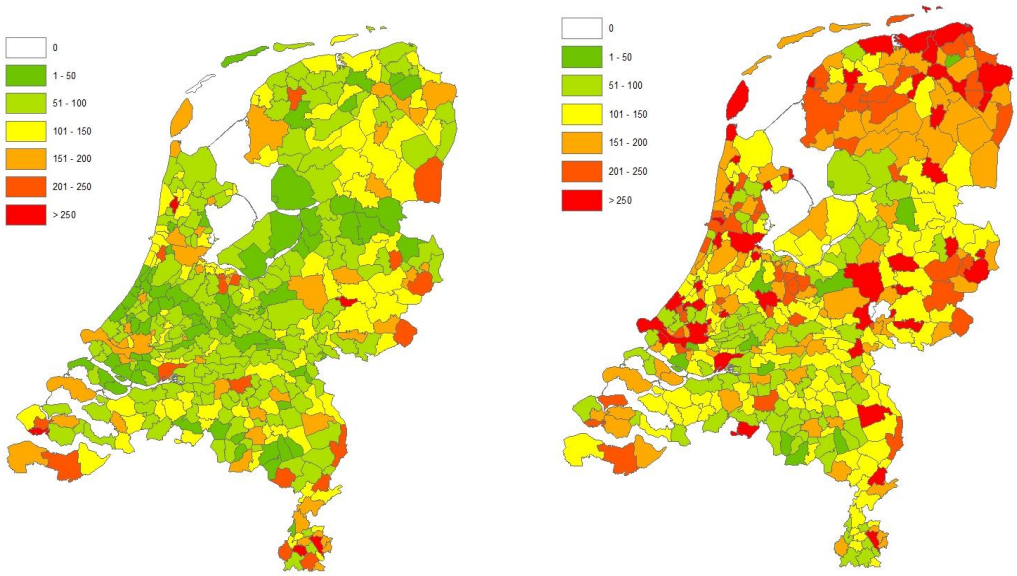
[8] Alcohol and ouderen in de verslavingszorg in Nederland (2001-2010), Trimbos-instituut, Nederlands Kenniscentrum Ouderenpsychiatrie en IVZ, april 2012;

Figuur 32: **Alcohol - Age distribution 2002 versus 2011**



3.5 Regional spread

Figuur 33: **Number of clients for alcohol use related problems per 100,000 inhabitants 2002 and 2011**

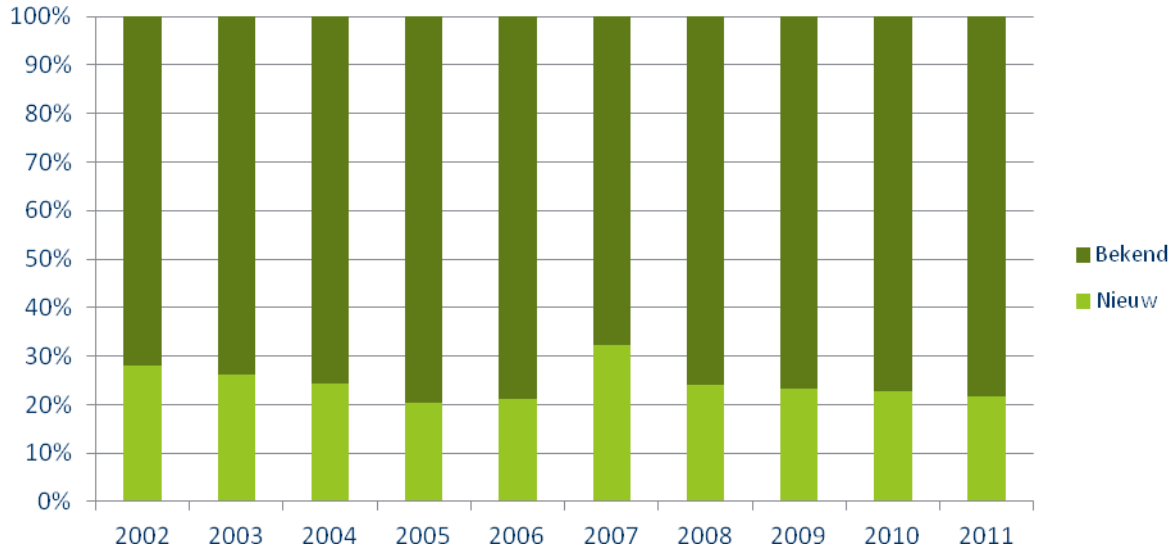


In 2011, the national average of treatment demand for alcohol use related problems was 196/100,000 whereas this was 127/100,000 inhabitants in 2002.

3.6 New and known

In recent years, about 20% of the new clients (over 7,000 in 2011) registered in addiction care with alcohol use related problems. This means that almost 80% of the people with an alcohol use related treatment demand were already known to addiction care before 2011.

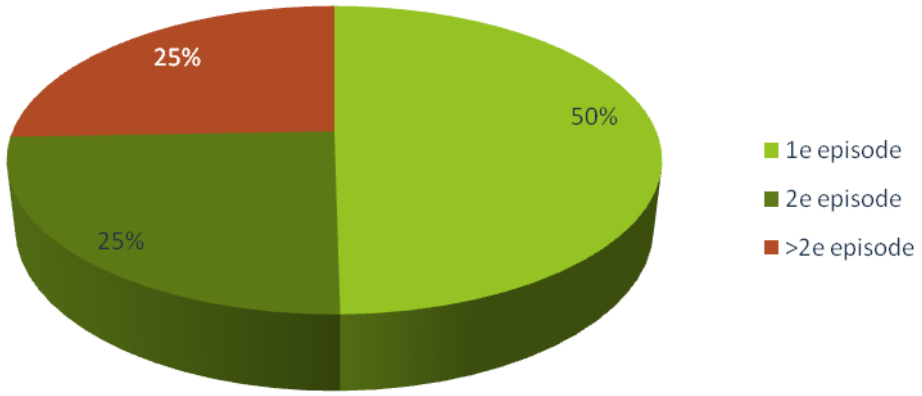
Figuur 34: **Alcohol - Trend nieuwe en bekende hulpvragers 2002-2011**



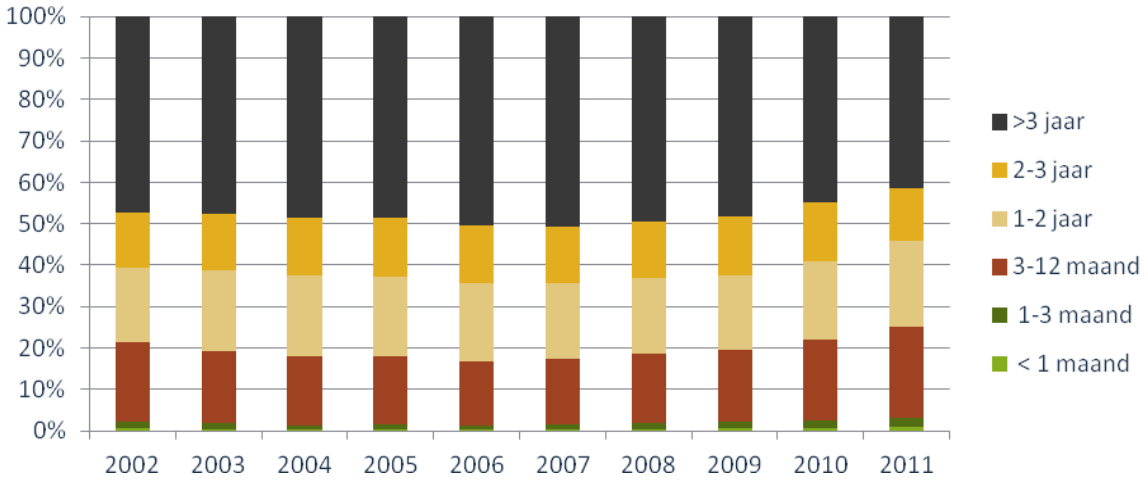
3.7 Treatment history

By using the LADIS key, it is possible to follow clients throughout the years and throughout institutions. As a result, the number of episodes and the duration of these episodes can be calculated. An episode is defined as a consecutive period of contacts with addiction care. Therefore, the episode may cover several registration years. The exact definition of an episode can be found in Appendix III.
Figure 34 shows the distribution of the number of episodes in 2011.

Figuur 35: **Alcohol - Aantal episoden in de verslavingszorg 2011**



Figuur 36: **Alcohol - Totale duur alle episoden in 2002-2011**



Not just the number of episodes, but also the duration of the episodes says something about the extent to which someone seeks assistance. The total duration of all episodes can be calculated for each client.

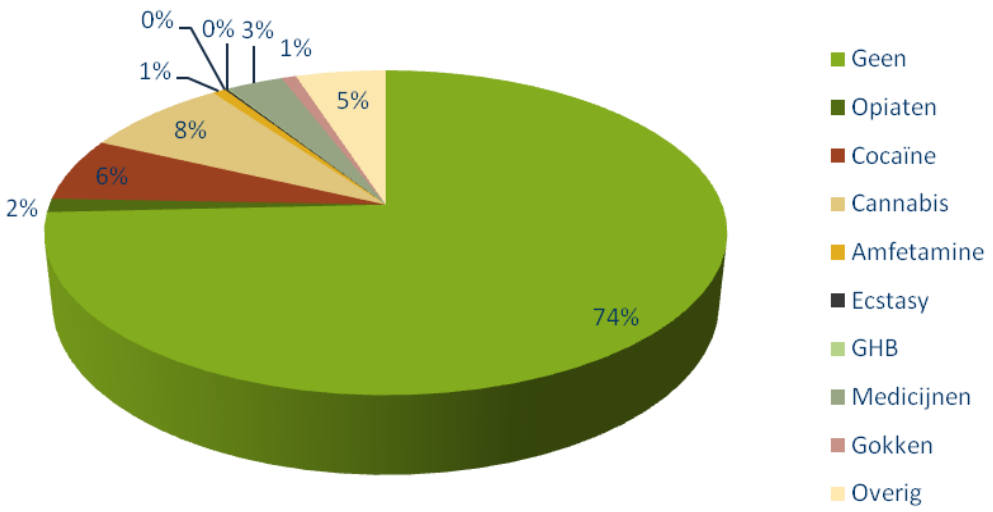
Figure 35 shows that in 2011 for more than 60% of the clients the total duration exceeded 3 years. The percentage of people with a total treatment duration of less than a year has increased since 2007. It should be noted that the people who have registered for the first time in 2011 have also been included in the calculation of the average total episode duration. For clients from earlier years any registrations in subsequent years have been added. Figure 35 therefore provides some information about the care consumption of all clients inclusive of the newcomers.

3.8 Secondary problems

In about 25% of the cases, alcohol use related problems are associated with problematic use of other drugs or with gambling. Compared to other primary substances, this is a relatively minor percentage (see Figure 36). 75% of the clients with alcohol use related problems do not have problems with other substances.

It is striking that in 10% of the population with alcohol use related treatment demand use hard drugs (opiates, cocaine and amphetamine), which is referred to as secondary problems.

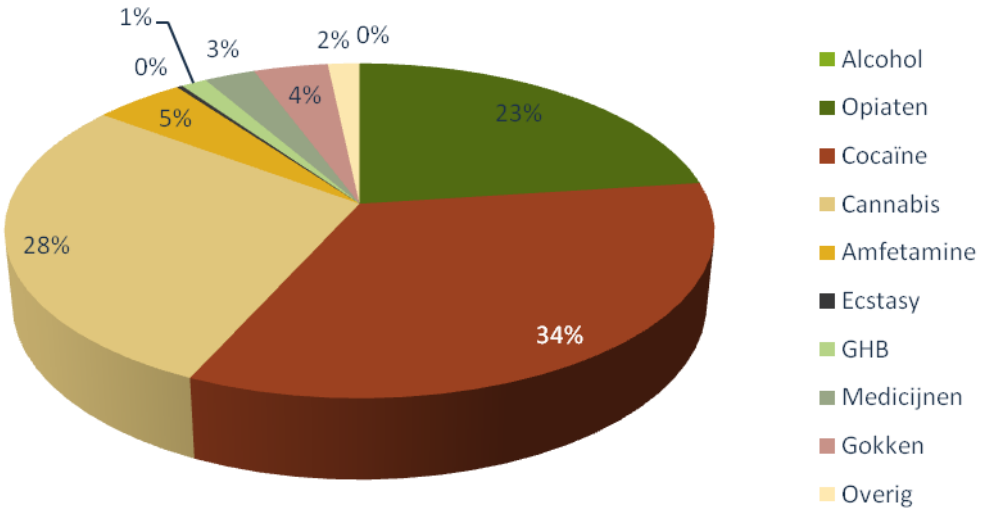
Figuur 37: **Alcohol - Secundaire problematiek 2011 (N=32.635)**



3.9 Use as an secondary problem

Problems related to alcohol use also occur as secondary or tertiary problems.
Alcohol is registered as an secondary problem in 5479 clients. Figure 37 shows the distribution of this.

Figuur 38: **Alcohol – Gebruik als bijmiddel 2011 (N=5.479)**



Alcohol as an secondary problem often occurs in addition to cocaine, cannabis and opiates related problems.

4 Opiates

4.1 Highlights

- The decrease in number of clients with opiates related problems continues to decrease.
- The group with an opiate use related treatment demand is getting older: The number of people aged 55 or older increases to 15%.
- Few new clients, but also little outflow of clients.

4.2 In brief

Tabel 11: **Overview of treatment demand for opiate use related problems in 2011**

Demography		
	Number of people seeking assistance	11.315
	Male : Female	80:20
	Average age	45.5
	Share of 25-	1.2%
	Share of 55+	15.0%
	Percentage of native Dutch clients	66.5%
	Number per 100,000 inhabitants	68
Problems		
	Percentage in addiction care	16%
	Intravenous use never : ever	60:40
	Intravenous use previous years/month	11.0% / 8.6%[9]
	Single : Multiple	44:56
	Use as an secondary problem	3.148
	First registration ever	2.8%
	Average number of contacts/client (excl. methadone)	189
	Average number of uses/methadone client	

4.3 Trends and development of the treatment demand

The opiates group within addiction care is a relatively stable group of clients in number.
Around 95% of those seeking 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 study conducted by the Trimbos-instituut[10] 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 2002, this was a significant drop (from between 25,700 and 39.000 problematic opiate users).
Over 11,000 have been registered with opiate use related problems.

[9] Total N=4889
[10] Number of problematic hard drug users in the Netherlands, Trimbos Instituut; 2011 Utrecht

Figuur 39: **Opiaten – Aantal hulpvragers 2002-2011**

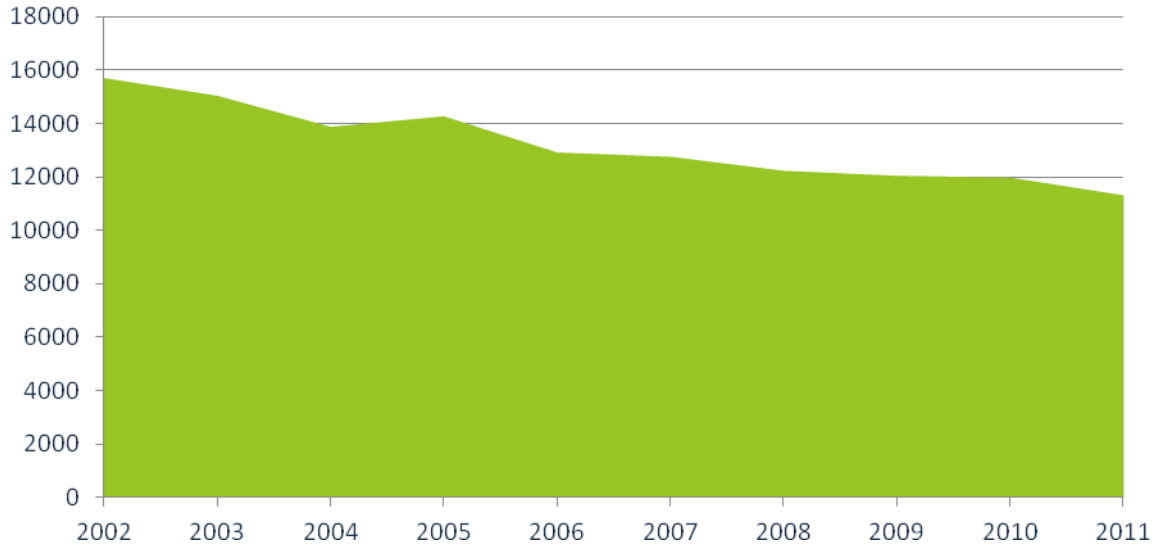


Figure 39 clearly shows a decreasing trend over the past 10 years with regard to treatment demand for opiate use.

4.4 Young and old

The group of opiate related clients is ageing and the percentage of people aged 55 and older is increasing both in number and in percentage. This group of clients now includes 1700 people aged 55 or older, including 100 people > 65.
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.". De group of clients with opiate use related problems in addiction care will therefore age increasingly further over the next few years. Figure 40 clearly shows the shift in age development compared to the year.

Figuur 40: **Opiaten – Leeftijdscategorieën 2002-2011**

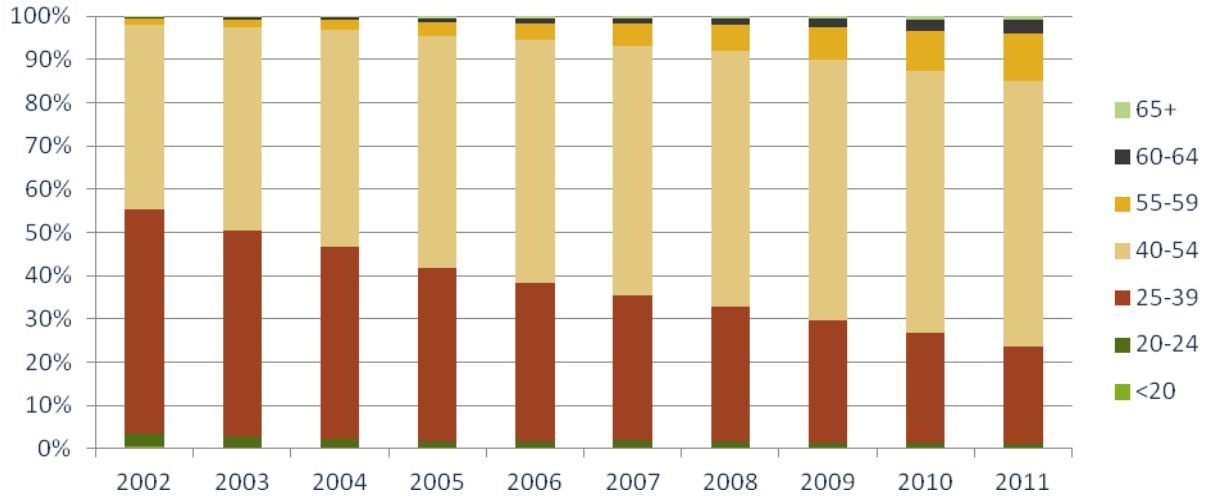
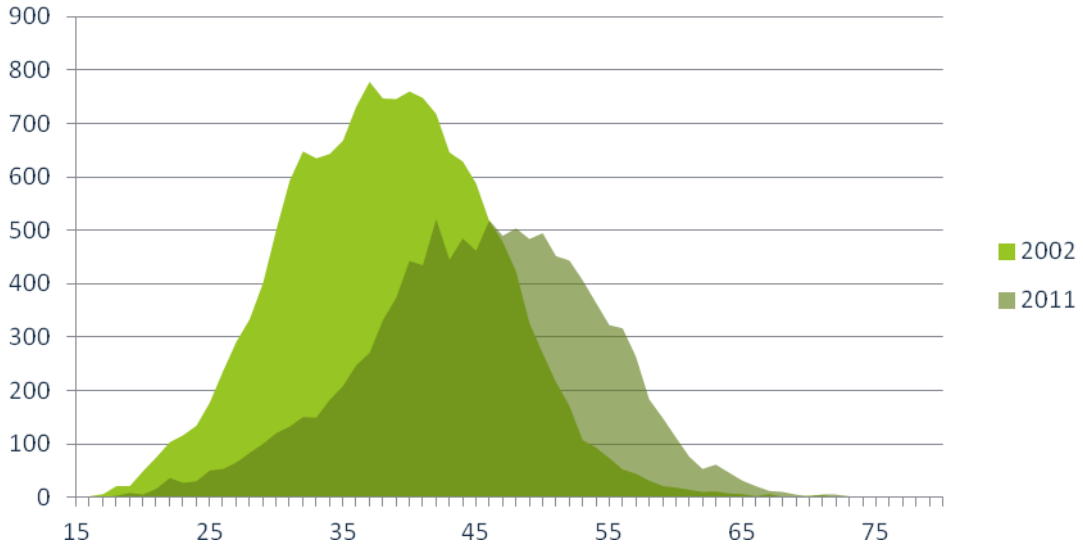


Figure 41 shows this picture even more clearly.

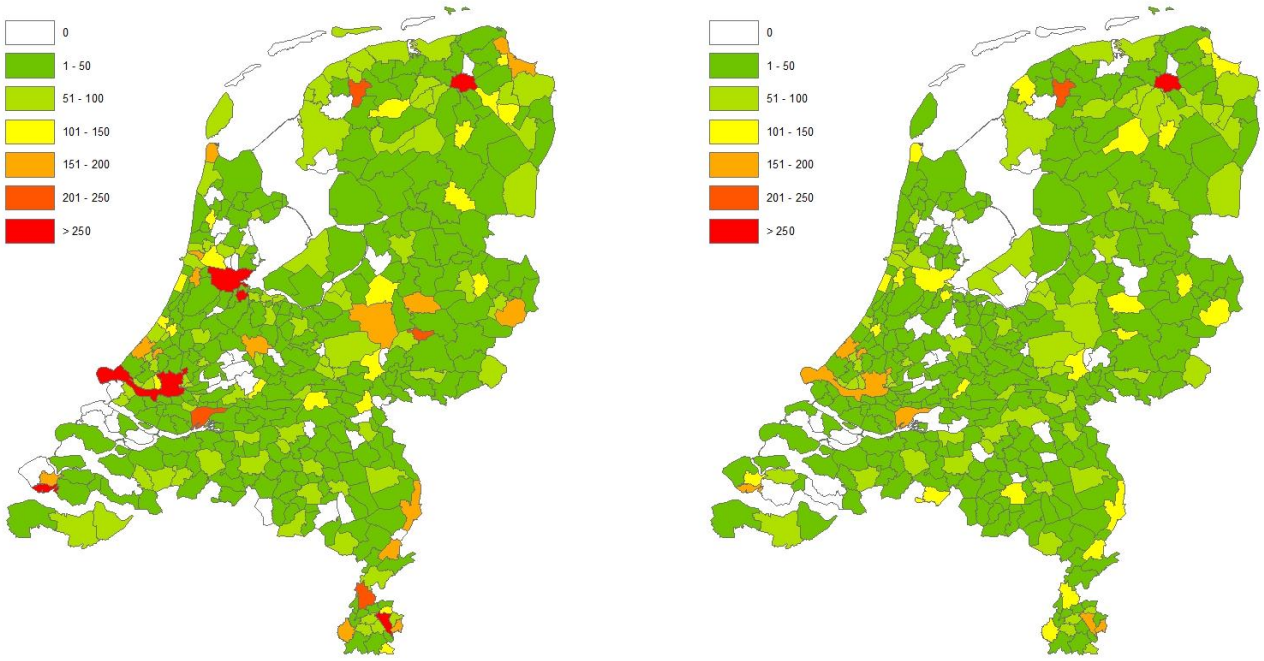
Figuur 41: **Opiaten - Leeftijdsverdeling 2002 versus 2011**



It is clearly visible that compared to ten years ago the group has become considerably smaller and older. Notwithstanding this decrease, the number of people aged 55+ in this group will increase considerably over the next few years.

4.5 Regional spread

Figuur 42: **Aantal hulpvragers opiatenproblematiek per 100.000 inwoners 2002 en 2011**

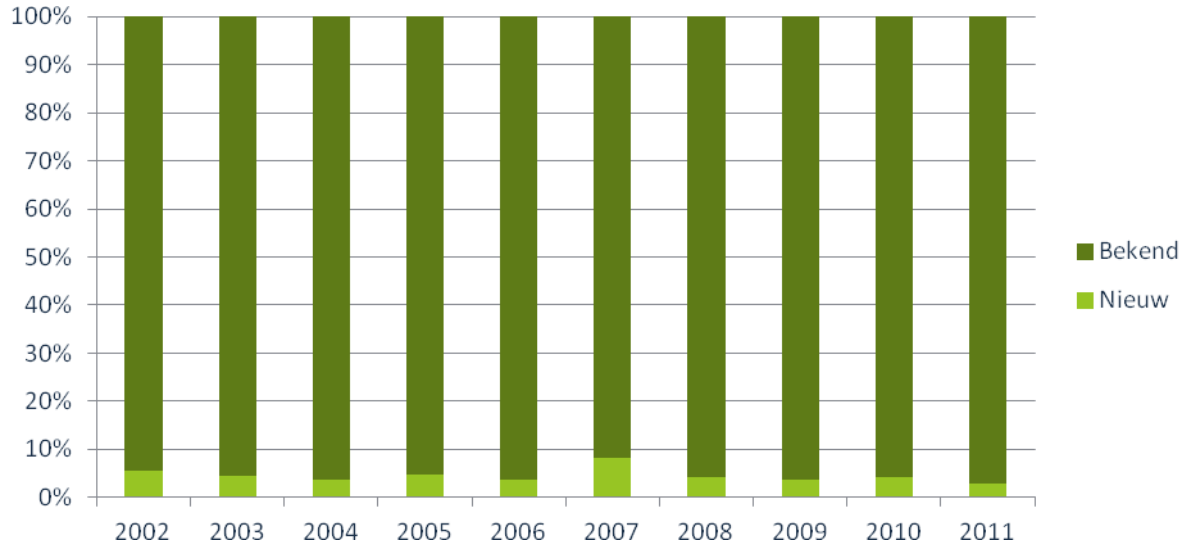


In 2011, the national average with regard to demand for assistance with opiate related problems was 68/100,000 inhabitants, compared to 98/100,000 inhabitants in 2002.

4.6 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.

Figuur 43: **Opiaten - Trend nieuwe en bekende hulpvragers 2002-2011**

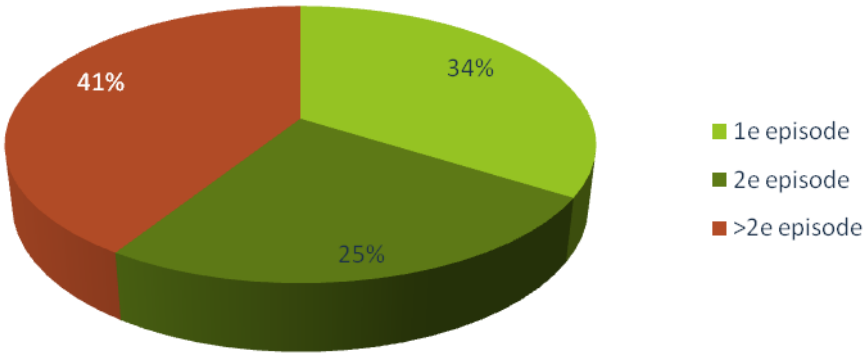


For the group of 4% newcomers it has been established whether this includes new groups, for example from the former eastern block countries. This is not the case. There are no striking differences in characteristics between the newcomers and the group that is already known.

4.7 Treatment history

Most clients in the group of clients with opiates use related problems are chronic clients. This seems to be inconsistent with the picture in Figure 44, which shows that one third of the clients with opiates related problems are 'just' in their first period of care.

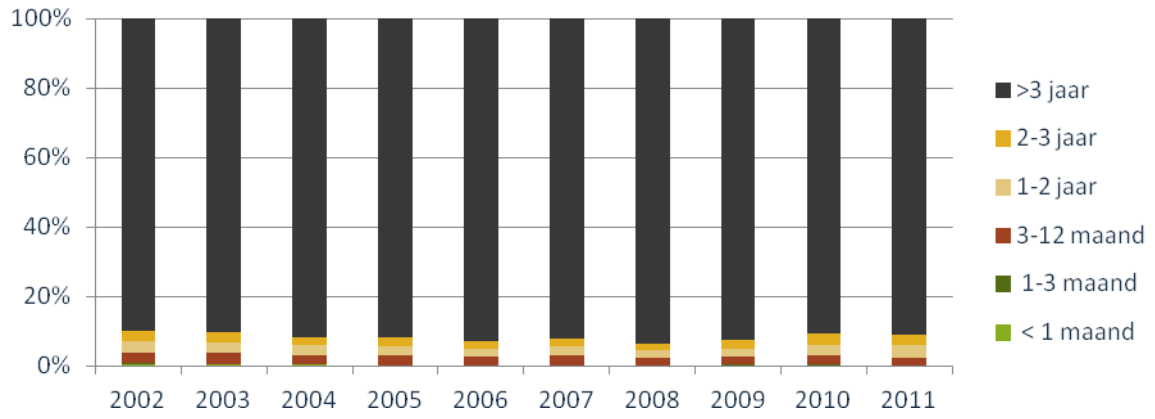
Figuur 44: **Opiaten – Aantal episoden in de verslavingszorg 2011**



An episode may include several registrations and several registration years. The definition of an episode is described in Appendix III.

However, when the duration of the episodes is considered, this confirms the use of the term chronic.

Figuur 45: **Opiaten- Totale duur alle episoden in 2002-2011**

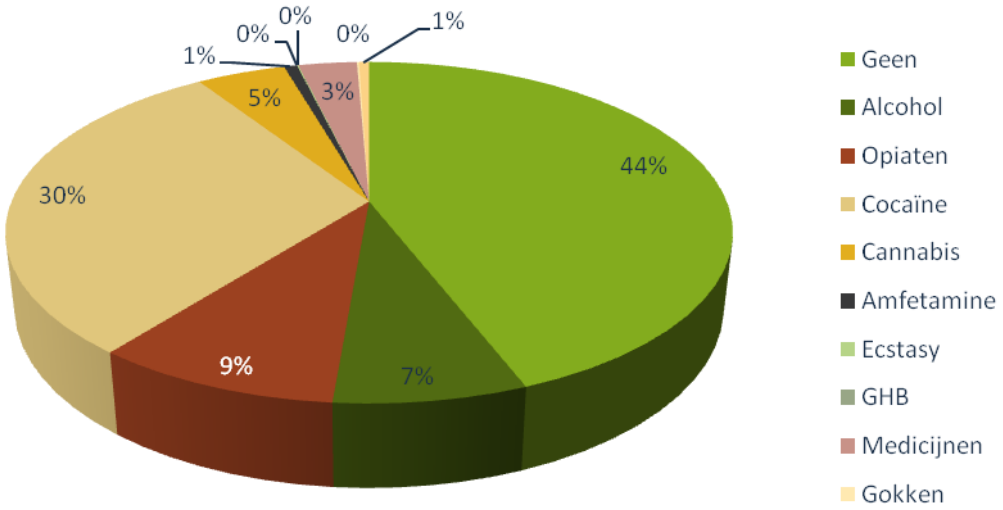


90% van de clients have a total treatment history of more than 3 years in addiction care. This is the same ten years ago.
The average total of all episodes was more than 12 years in 2011. For the group with 'just' 1 episode (see Figure 44) this also concerns a very long consecutive episode, i.e. chronic care.

4.8 Secondary problems

Many opiate users have a secondary problem apart from problems with the primary substance. 44% does not have any problems related to other substances.
The secondary many involve the use of cocaine and other opiates.

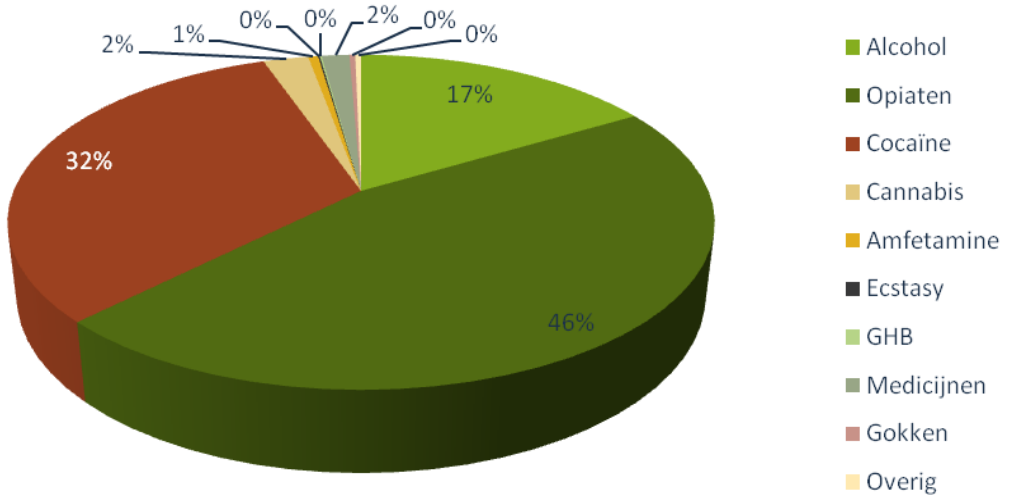
Figuur 46: **Opiaten - Secundaire problematiek 2011**



4.9 Use as an secondary problem

Apart from opiates as primary problem these substances also occur as secondary or tertiary problems. Contrary to for example alcohol, opiates can be both a primary and a secondary problem. Figure 47 shows the distribution of this.

Figuur 47: **Opiaten – Gebruik als bijmiddel 2011 (N=3.148)**

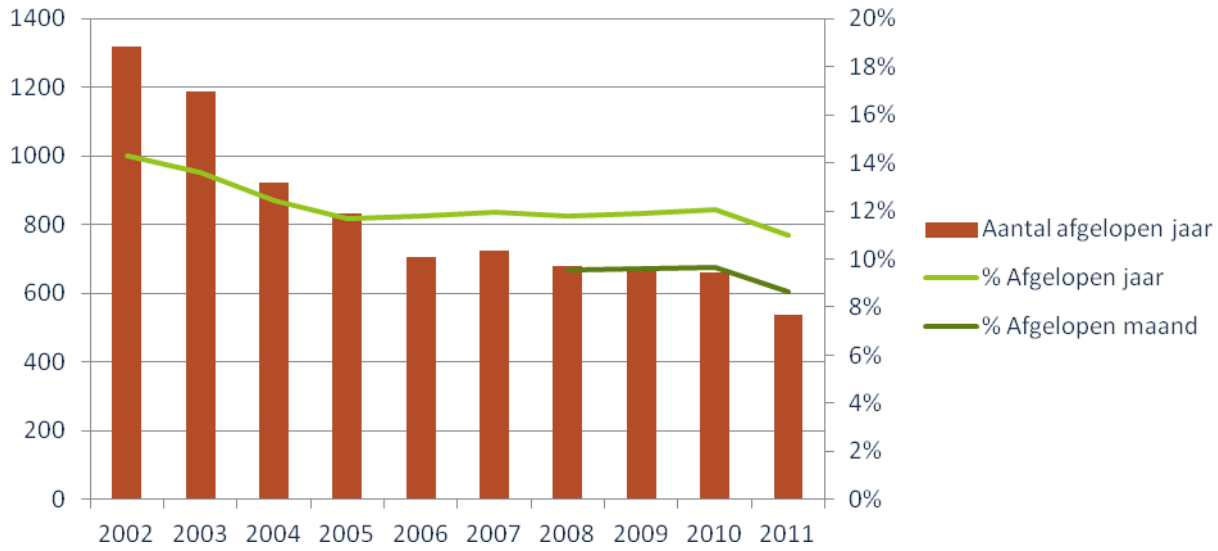


Opiates are registered as an secondary problem in 3148 clients. Particularly where several forms of opiates are used, these are registered both as a primary and as an secondary problem (about 46%).

4.10 Intravenous use

In the Netherlands, intravenous opiate use is still decreasing. In the last 10 years, the number of needle-users treated has decreased by more than half. During this period, the percentage dropped to below 9%.

Figuur 48: **Aantal en aandeel (%) intraveneus opiaatgebruikers 2002-2011**



4.11 Methadone

The majority, over 80% of the opiate addicts treated, are also enrolled in a methadone program and/or heroin project.
Table 11 shows the development of the number of clients and the number of methadone contacts from 2002-2011.

Tabel 12: **Methadone contacts**

Years	2002	2002	2003	2004	2005	2006	2007	2008	2009	2011
Clients	11.399	9.924	10.199	10.416	9.192	8.187	8.494	9.793	10.085	8.851[11]
Intakes X1. 000	2.646	2.406	2.362	2.457	2.232	2.062	1.896	2.270	1.861	1.964
Intakes/ client	232	242	232	236	243	252	223	237	230	222

4.12 Figures from the National Database for Registration of Substances (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). In 2011, VWS decided to stop financing the LCMR.
However, the data up to and including 2011 have been collected. As from 2012, there will no longer be a complete picture of the provision of opiate substituting substances in the Netherlands. Addiction care data will continue to be collected through the LADIS, but, for the time being, the data from the justice institutions will no longer be available.

This section shows a number of key figures from 2011, that will complement the figures collected in the LADIS.

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.

[11] In 2011, 1 institution was unable to provide the methadone data. According to the institution involved, they estimate the number of methadone clients at approximately 1000.

4.12.1 Use of opiate substituting substances

Figuur 49: **Aantal innames per maand 2011**

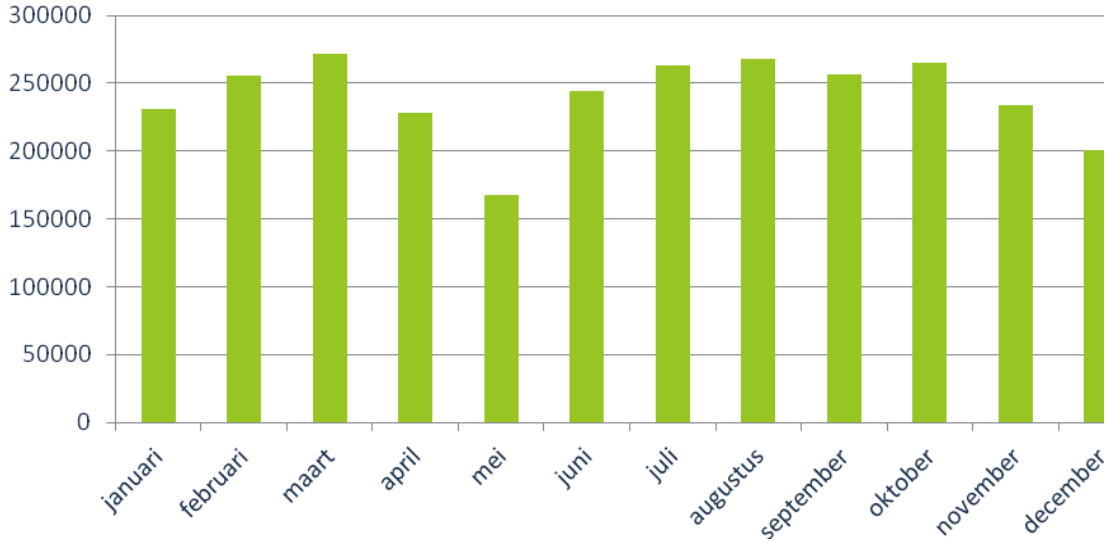
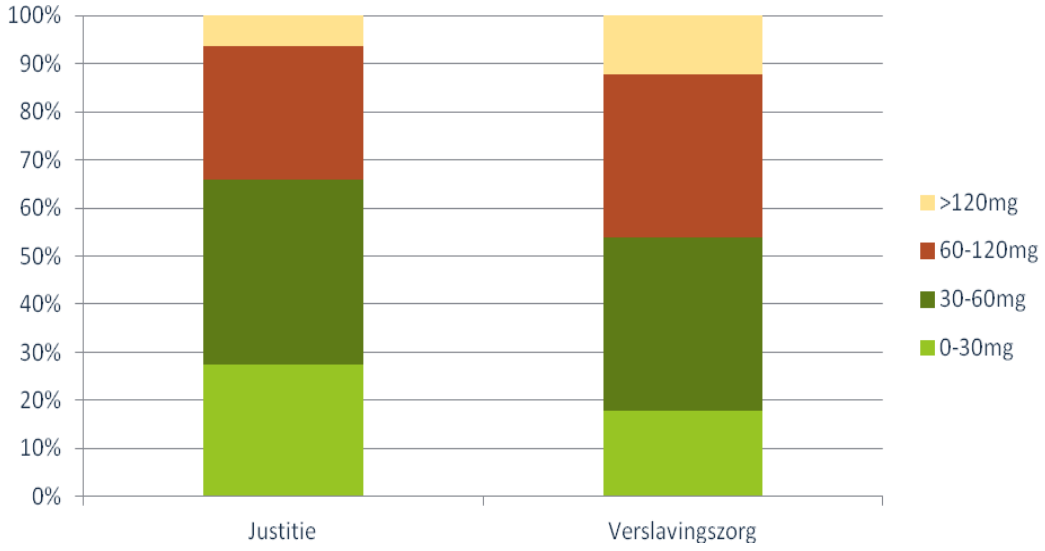


Figure 49 shows that more than 200,000 registered doses are delivered to the LCMR every month and that this is quite a constant flow. In total, about 3 million doses have been registered at the LCMR in 2010.

4.12.2 Dosages

The dose level is projected in figure 50, 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.

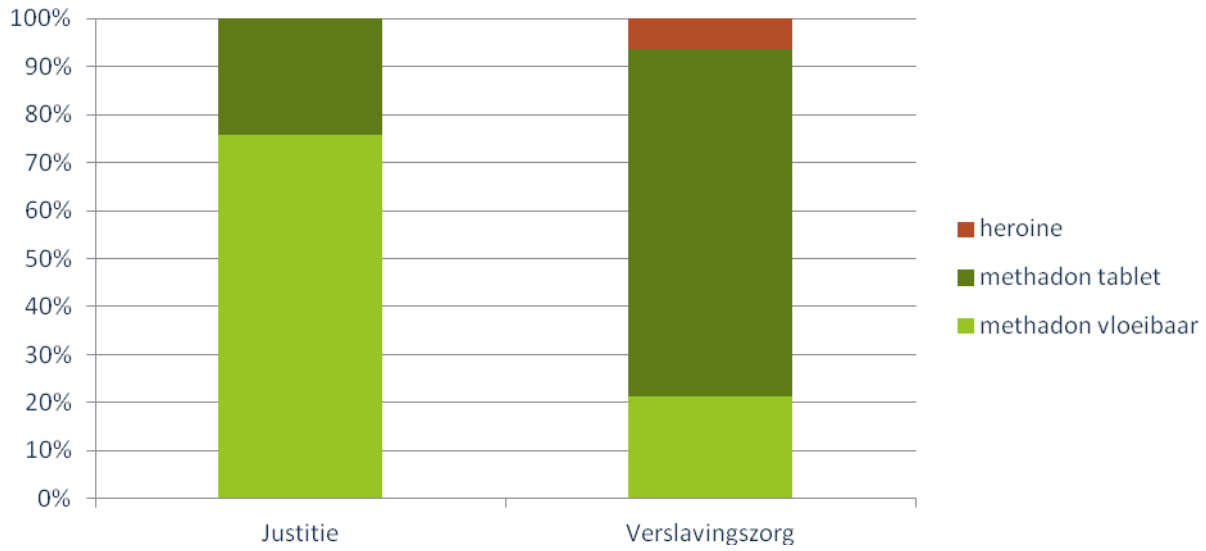
Figuur 50: **Verdeling aantal milligrammen Justitie / Verslavingszorg (N=2.886.754 doseringen)**



4.12.3 Pills or liquid

Figure 51 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.

Figuur 51: **Soort verstrekking (N=2.886.754 doseringen)**



The unique LADIS keys are generated by means of ZorgTTP (Trusted Third Party).

Through ZorgTTP the LADIS data with regard to methadone can be compared to the LCMR data. ZorgTTP can link the LCMR domain with a pseudonym to the LADIS data. This 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 clients who go to the pharmacist with a prescription.

5 Cocaine

5.1 Highlights

- Decrease in the demand for cocaine treatment continues.
- The percentage of adolescents <25 years continues to decrease.
- The average age of the cocaine clients increases.
- Most new clients use crack.

5.2 In brief

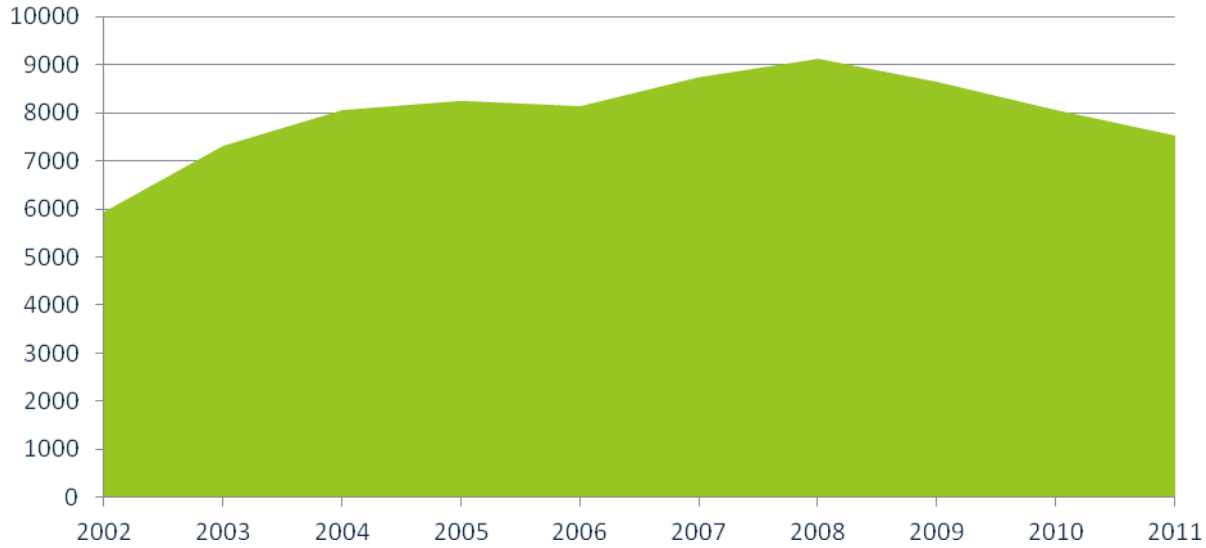
Tabel 13: **Overview of treatment demand for cocaine use related problems in 2011**

Demography		
	Number of people seeking assistance	7517
	Male : Female	81:19
	Average age	35.6
	Share of 25-	11%
	Share of 55+	4%
	Percentage of native Dutch clients	74.3%
	Number per 100,000 inhabitants	45
Problems		
	Percentage in addiction care	11%
	Crack	49:51
	Single : Multiple	44:56
	Use as an secondary problem	7.310
	First registration ever	14.2%
	Average number of contacts/client	70

5.3 Trends and development of the 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. Like in the group of opiates, the percentage of chronic clients is increasing.
The treatment demand of newcomers is mostly related to the use of crack.

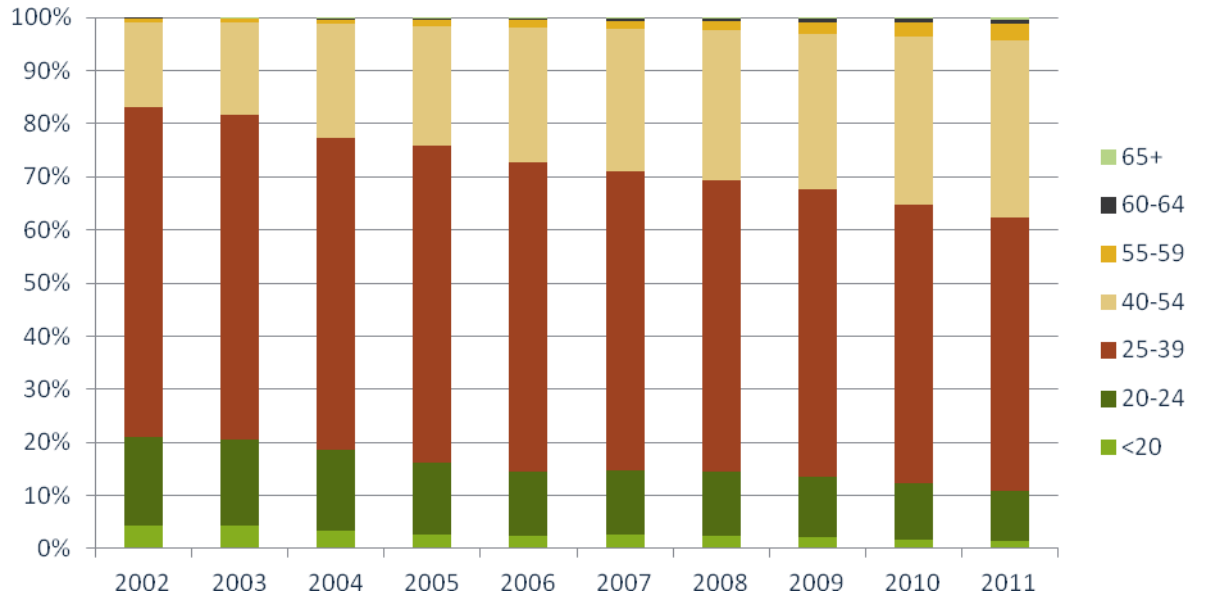
Figuur 52: **Cocaïne – Aantal hulpvragers 2002-2011**



5.4 Young and old

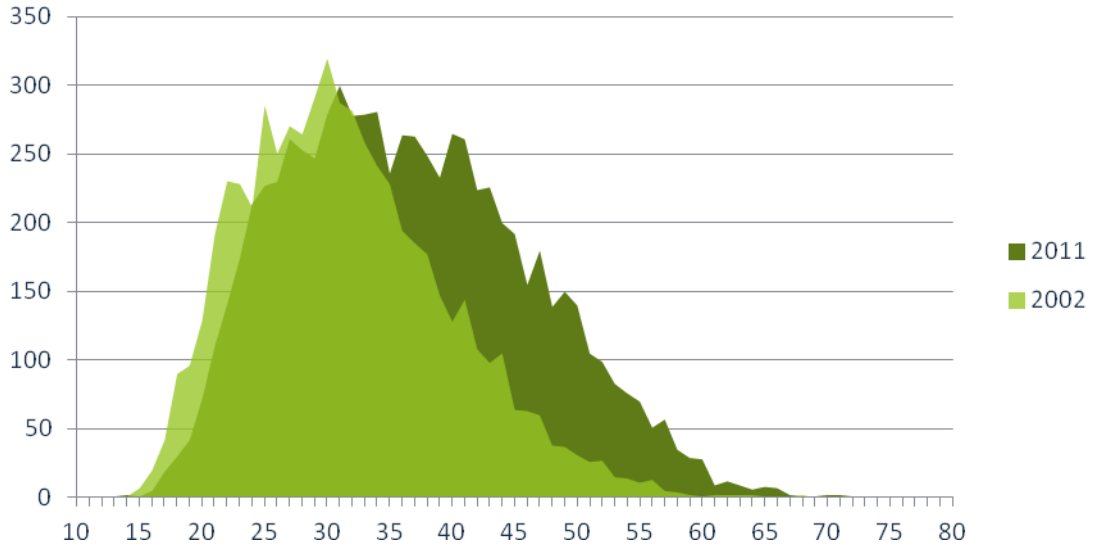
The largest group still consists of people aged 25-39. However, the percentage 40-54 year old has increased over the past 10 years, from 16% in 2002 to 33% in 2011. Both the percentage and the number of adolescents (<25 years) with cocaine use related problems is gradually decreasing.

Figuur 53: **Cocaïne – Leeftijdscategorieën 2002-2011**



As is the case with opiates, ageing is clearly visible when comparing the age distribution of 10 years ago with that of 2011.

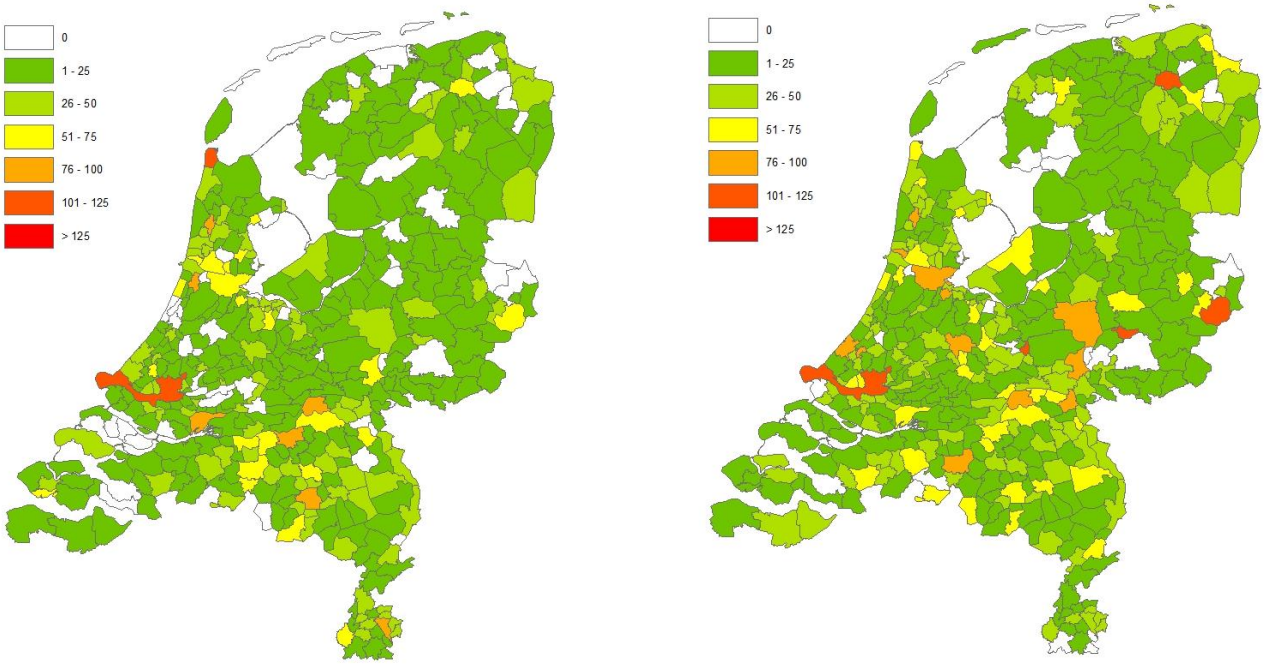
Figuur 54: **Cocaine - Leeftijdsverdeling 2002 versus 2011**



The group of cocaine clients is also ageing. As is the case with opiates, an increase of the group of older clients should be taken into account.

5.5 Regional spread

Figuur 55: **Aantal hulpvragers cocaïneproblematiek per 100.000 inwoners 2002 en 2011**

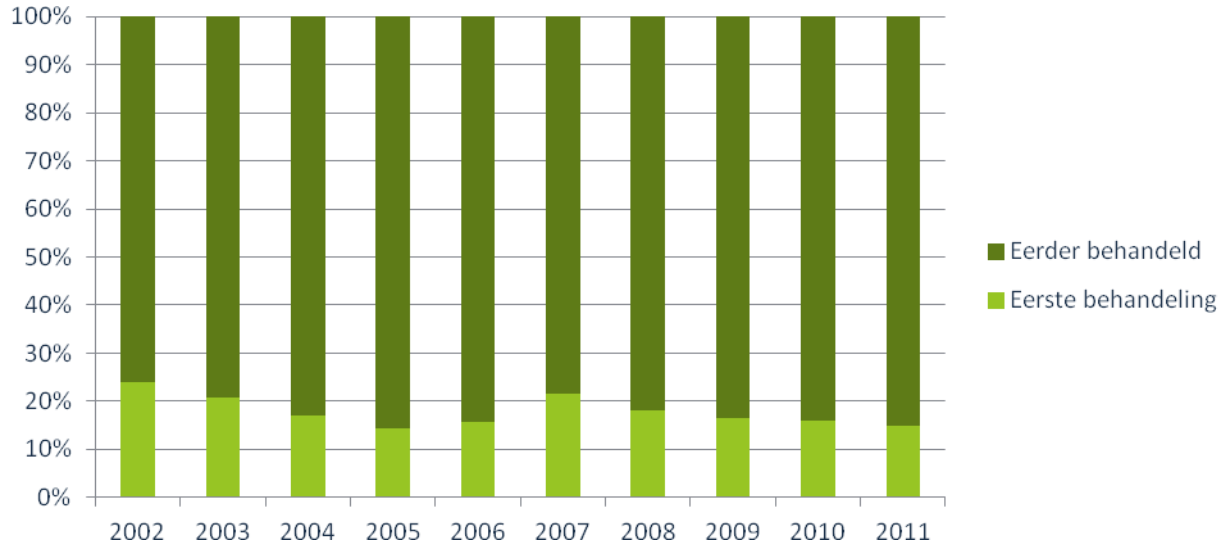


In 2011, the national average demand for assistance for cocaine is 45/100,000 inhabitants, compared to 37/100,000 in 2002.

5.6 New and known

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

Figuur 56: **Cocaïne - Trend nieuwe en bekende hulpvragers 2002-2011**



The total group of cocaine clients is now mostly clients who have previously asked for assistance. The percentage of new clients has dropped over the past few years.
In 2011, approximately 1000 new clients registered with cocaine related problems.
The majority of people in this new group have been registered with crack related problems.

5.7 Treatment history

Just like with opiates cocaine use related treatment demand relatively often concerns several episodes in addiction care. An episode may include several registrations and several registration years. The definition of an episode is described in Appendix III.

Figuur 57: **Cocaïne – Aantal episoden in de verslavingszorg 2011**

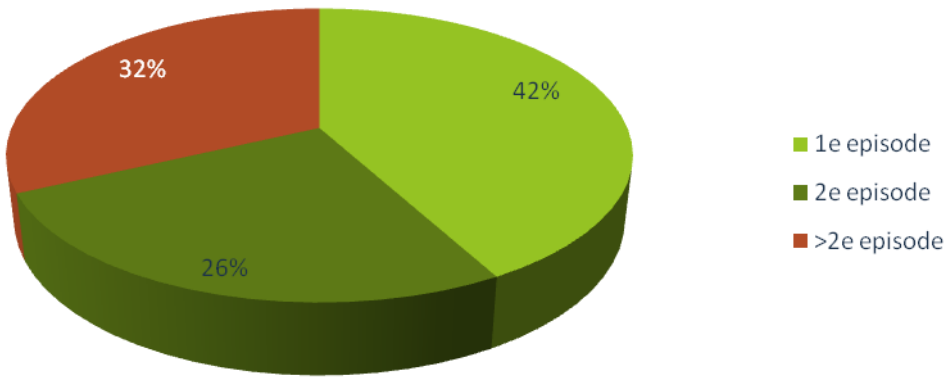
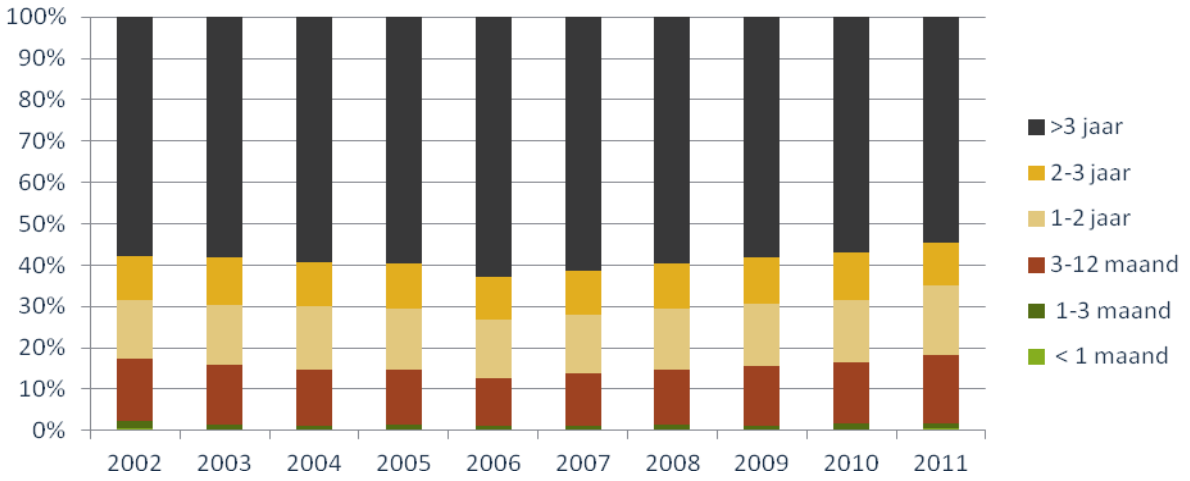


Figure 57 shows that almost 60% have more than 1 episode in addiction care.
Apart from the number of episodes the duration of the episodes is also important.
Please note that the total episode duration is always a 'state of affairs'. By definition, the newcomers have a relatively short episode duration. For the clients from previous reporting years any registrations in subsequent years have been added to the total treatment duration.

Figuur 58: **Cocaïne- Totale duur alle episoden in 2002-2011**

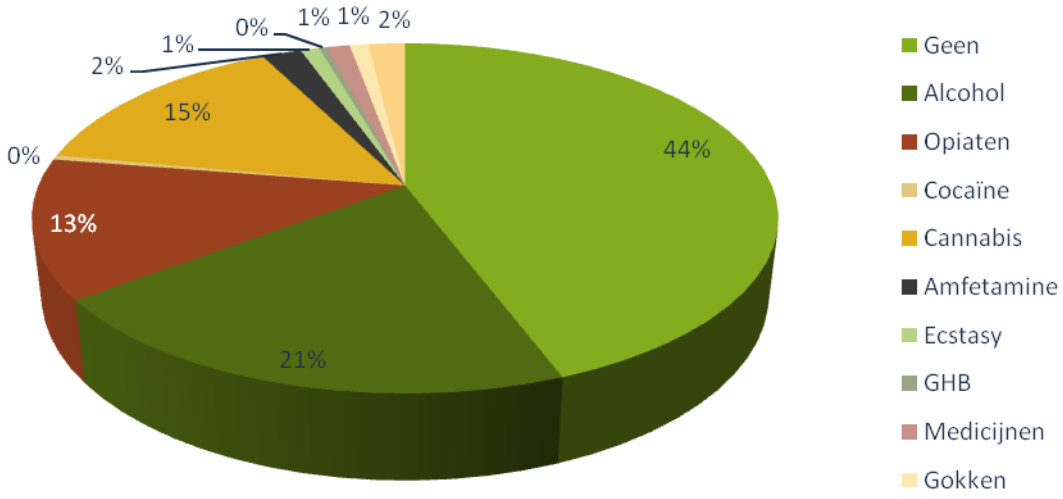


More than 80% van de clients for cocaine use related problems have a total episode duration of more than 1 year in addiction care. More than fifty percent of the clients have a treatment history of more than 3 years in addiction care. This also applies to the group of clients in the reporting year 2002.

5.8 Secondary problems

Two-third of this group has other problems apart from their cocaine use related problems.

Figuur 59: **Cocaïne - Secundaire problematiek 2011**

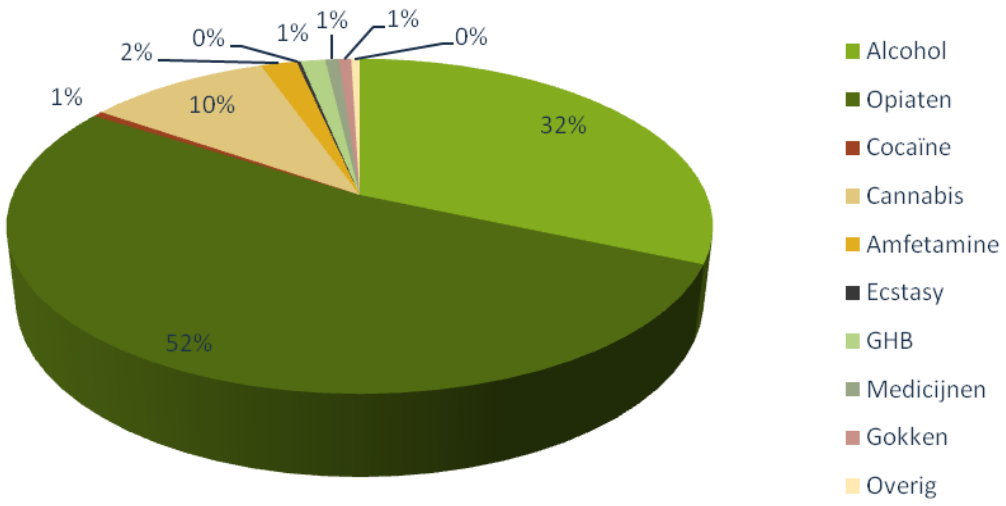


Alcohol is the most frequently occurring secondary problem in cocaine clients. Cannabis use and opiate use also occur frequently.

5.9 Use as an secondary problem

Apart from cocaine as a primary problem, this substance can also be a secondary or a tertiary problem. Contrary to alcohol, cocaine can be both a primary problem and an secondary problem (crack). Figure 60 shows the distribution of this.

Figuur 60: **Cocaïne – Gebruik als bijmiddel 2011 (N=7.310)**



In 7.310 clients, cocaine is registered as an secondary problem, which makes it the most frequently used secondary problem in addiction care. Cocaine as an secondary problems most frequently occurs as a secondary problem to opiate and alcohol use.

6 Cannabis

6.1 Highlights

- Cannabis Treatment demand increases to almost 11,000 in 2011.
- Treatment demand has tripled in ten years' time.
- Cannabis use is the most frequently occurring problem in adolescents.
- Now main treatment demand after alcohol and opiates.
- Relatively many clients registered in addiction care for the first time.

6.2 In brief

Tabel 14: **Overview of treatment demand for cannabis use related problems in 2011**

Demography		
	Number of people seeking assistance	10.632
	Male : Female	79:21
	Average age	25.3
	Share of 25-	43%
	Share of 55+	1%
	Percentage of native Dutch clients	81.6%
	Number per 100,000 inhabitants	196
Problems		
	Percentage in addiction care	15%
	Single : Multiple	68:32
	Use as an secondary problem	6.345
	First registration ever	34.7%
	Average number of contacts/client	28

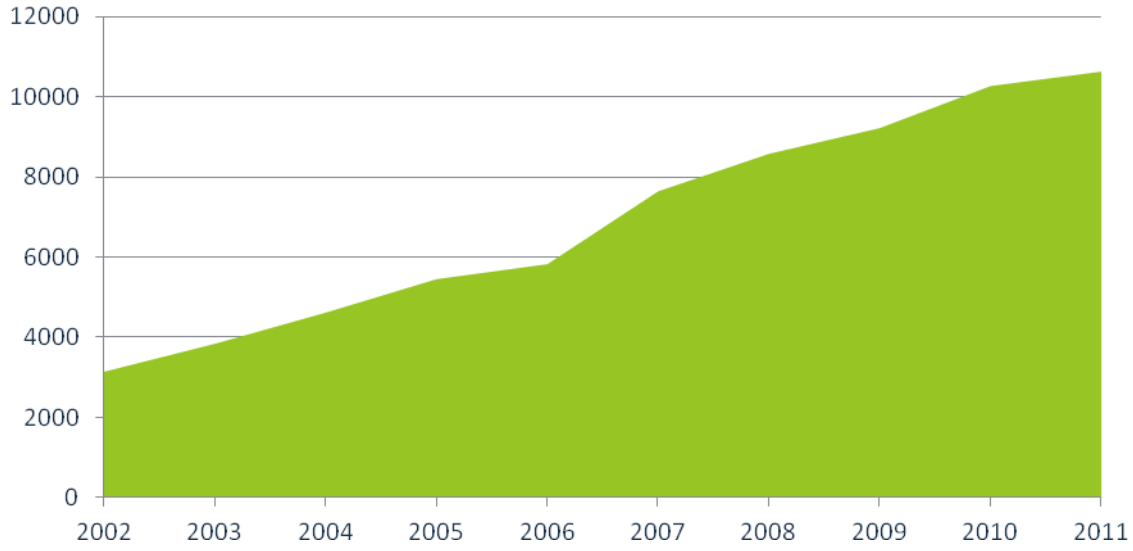
De average age of clients with cannabis use related problems is 25, which is relatively low. Multiple problems occur in approximately one third of these cases. Compared to other substances there are only few care contacts with clients with cannabis use related problems.

6.3 Trends and development of the treatment demand

Treatment demand for cannabis use related problems has tripled in 10 years' time. IVZ has described this development before.[12]

[12] 15 jaar Cannabishulpvraag in Nederland; Belangrijkste ontwikkelingen van de hulpvraag voor cannabisproblematiek in de verslavingszorg 1995-2009, Houten, april 2011

Figuur 61: **Cannabis – Aantal hulpvragers 2002-2011**



In 2002 there were 3500 people with a treatment demand for cannabis use related problems. In 2011. this is almost 11,000.
After alcohol and opiates, treatment demand for cannabis use related problems holds a third position in addiction care.

6.4 Young and old

Cannabis use related problems are by far the most important problems in adolescents. The percentage of adolescents (<25 years), however, does not increase. Over the past ten years, this percentage has fluctuated between 40-45%.

Figuur 62: **Cannabis – Leeftijdscategorieën 2002-2011**

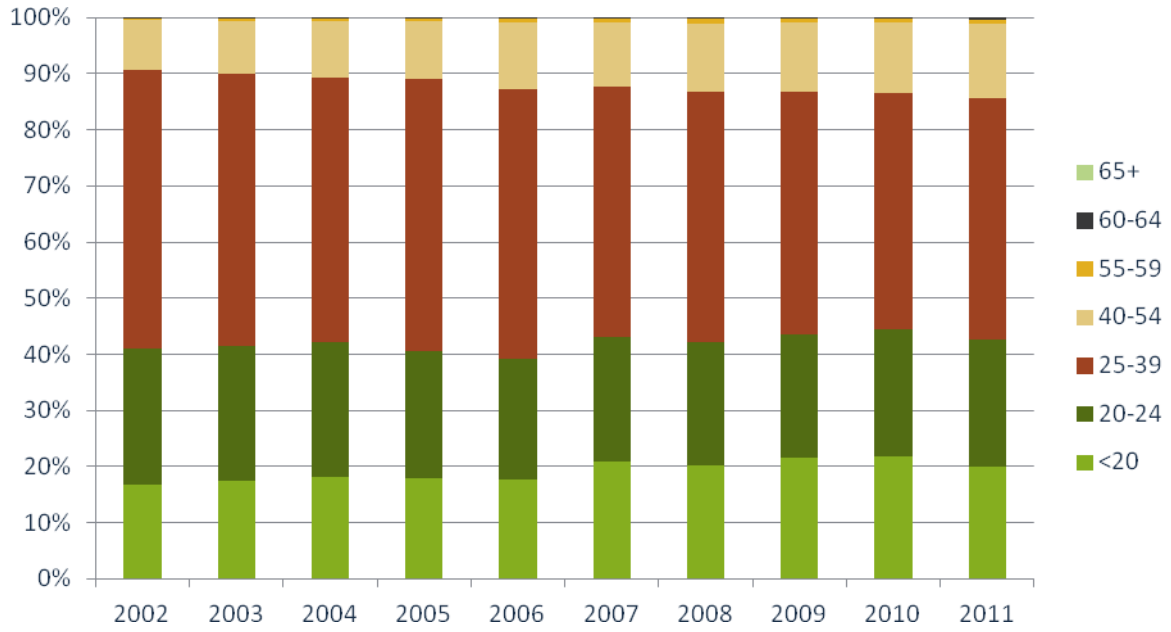
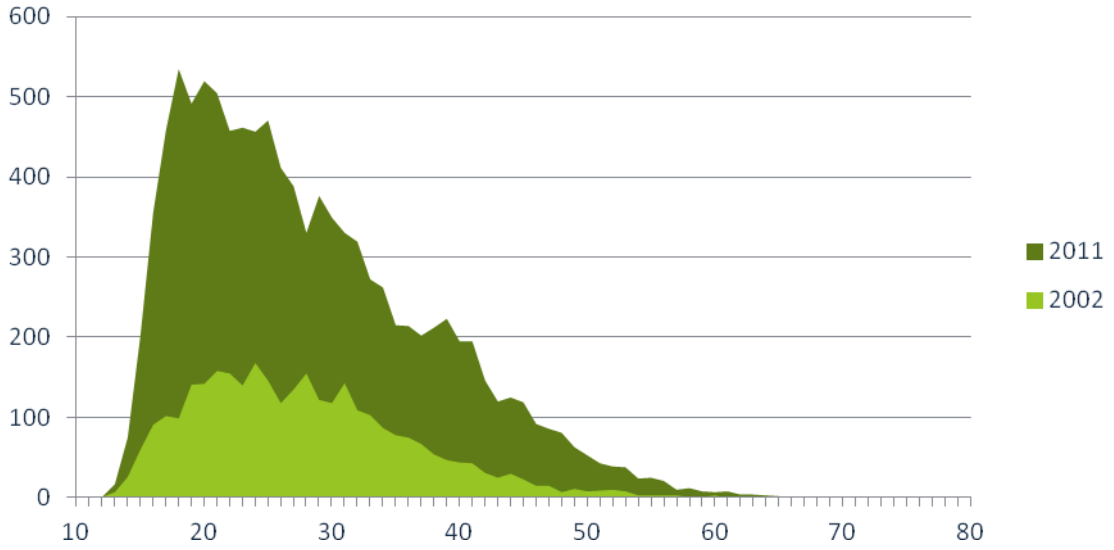


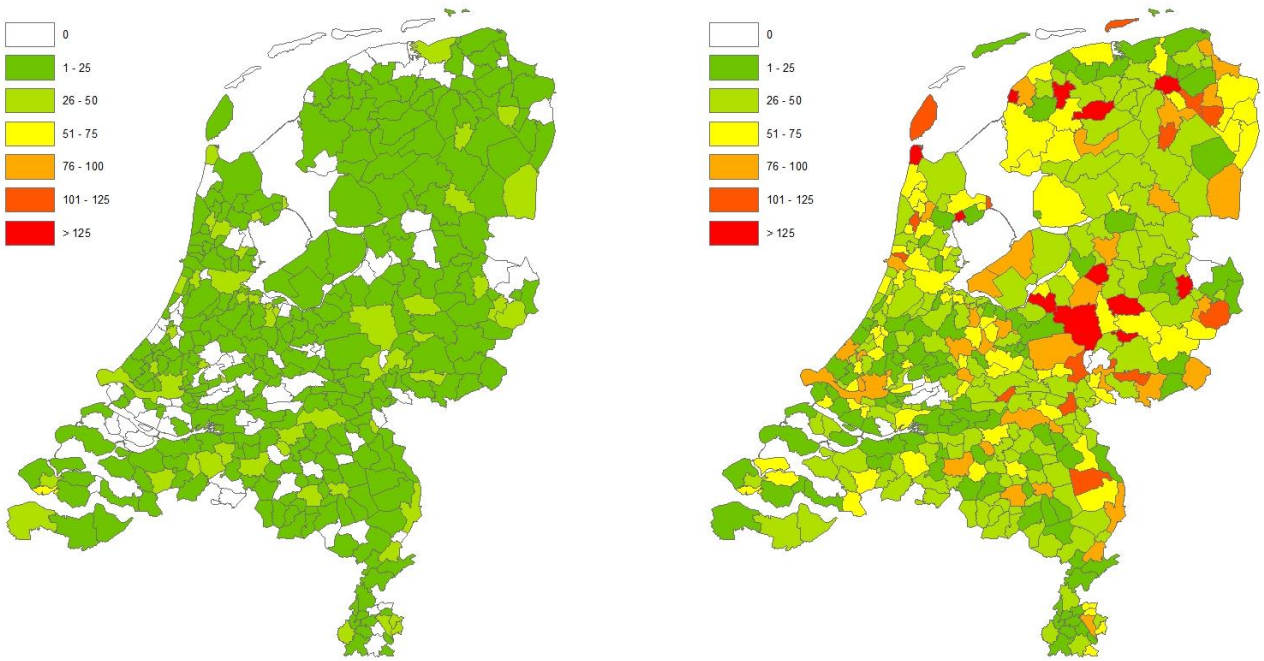
Figure 63 very clearly shows that the increase treatment demand is increasing in all age categories.

Figuur 63: **Cannabis - Leeftijdsverdeling 2002 versus 2011**



6.5 Regional spread

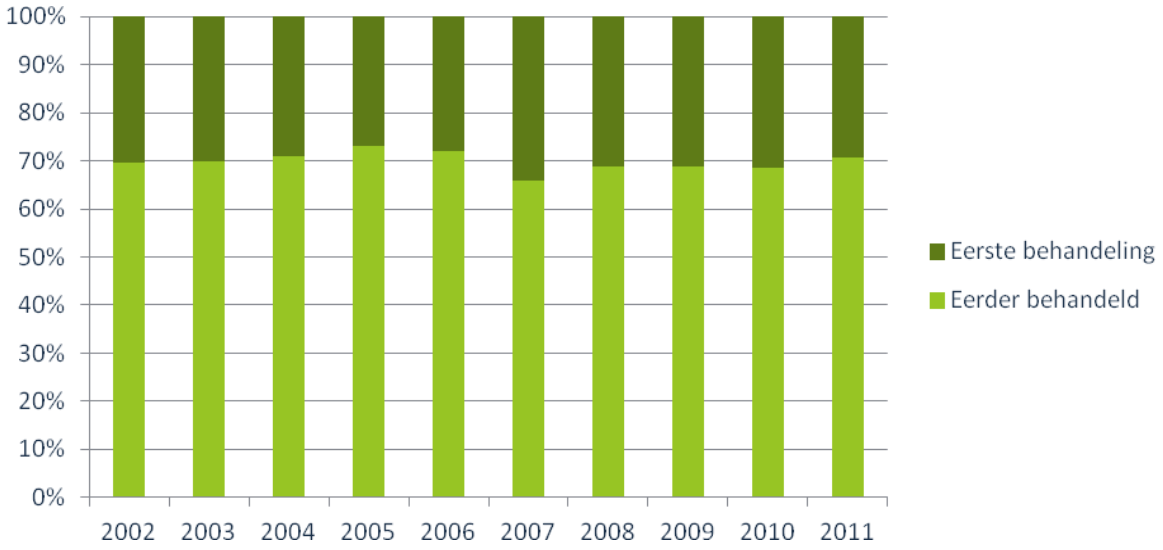
Figuur 64: **Number of clients cannabisProblems per 100,000 inwoners 2002 and 2011**



In 2011, the national average of treatment demand for cannabis use related problems was 64/100,000 inhabitants, compared to 20/100,000 inhabitants in 2001.

6.6 New and known

Figuur 65: **Cannabis - Trend nieuwe en bekende hulpvragers 2002-2011**

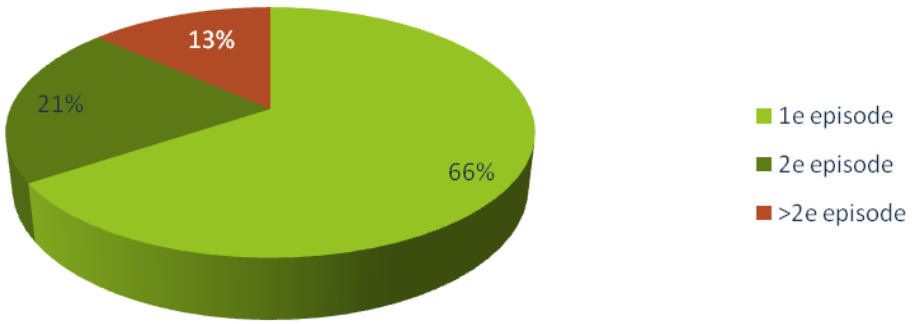


In comparison with other problem areas, cannabis problems exhibit a high percentage of newcomers. In 2011, almost 30% of the people seeking assistance for cannabis related problems were new to addiction care. In 2011, the total percentage of newcomers in addiction care was 20%.

6.7 Treatment history

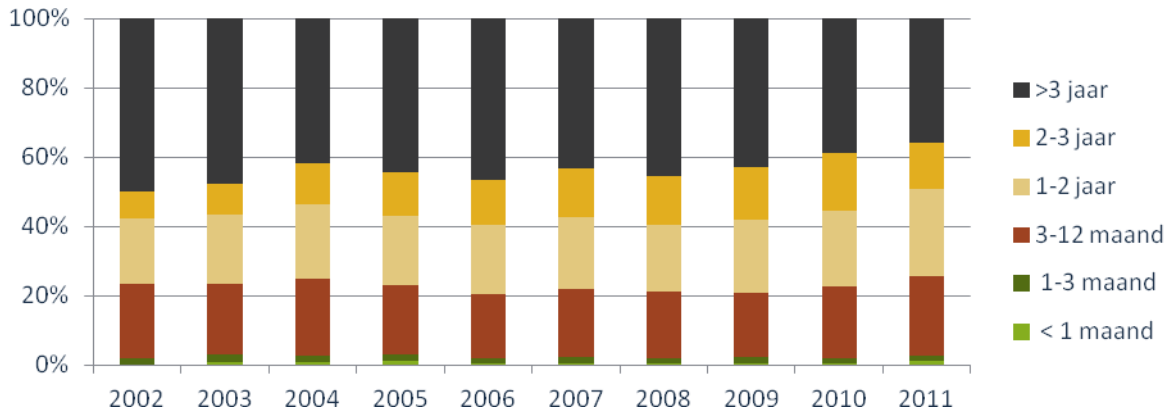
A relatively large percentage of clients with cannabis use related problems are in their first episode in addiction care. An episode may include several registrations and several registration years. The definition of an episode is described in Appendix III.

Figuur 66: **Cannabis – Aantal episoden in de verslavingszorg 2011**



In 2011, 75% of the clients had a total episode duration of less than 1 year in addiction care.
The trend of the total episode duration is shown in Figure 67. It should be noted that the total episode duration is always a 'state of affairs' is. By definition, newcomers have a relatively short episode duration. For clients from earlier years any registrations have been added to the total treatment duration.

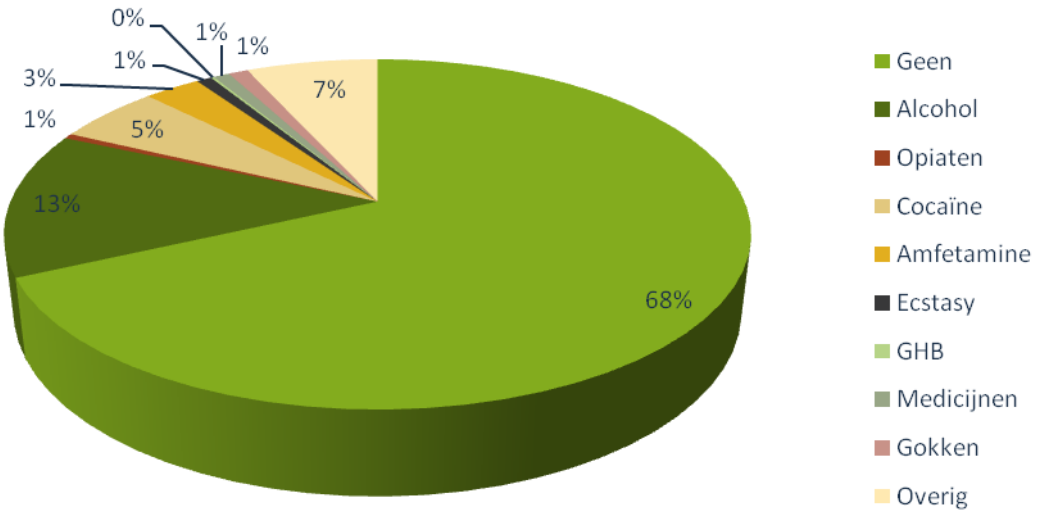
Figuur 67: **Cannabis- Totale duur alle episodes in 2002-2011**



6.8 Secondary problems

In the majority of requests for assistance, cannabis problems stand alone. Approximately one-third of the clients also indicated having problems with other drugs. This often concerns alcohol and cocaine use.
Figure 68 shows the distribution of the secondary problems treatment demand for cannabis.

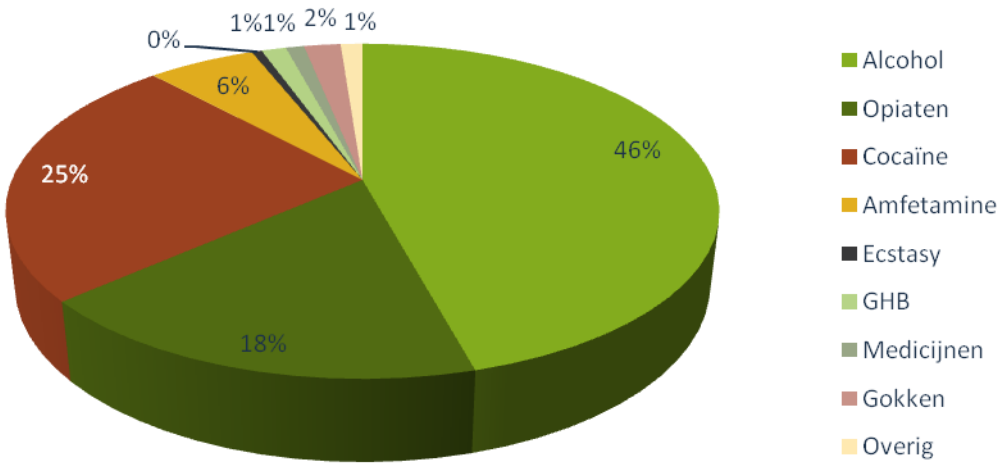
Figuur 68: **Cannabis - Secundaire problemen 2011**



6.9 Use as an secondary problem

Apart from cannabis as a primary problem, this substance is often a secondary or a tertiary problem. Figure 69 shows the distribution of this.

Figuur 69: **Cannabis – Gebruik als bijmiddel 2011 (N=6.345)**



Cocaine is registered as an secondary problem in 6.345 clients. This makes cocaine the most frequently used secondary problem in addiction care. Cannabis as an secondary problem most frequently occurs in connection with primary problems for opiates, cocaine and alcohol.

7 Amphetamine

7.1 Highlights

- The increase in treatment demand for amphetamine use related problems is stabilising.
- Treatment demand mainly concerns the relatively young group of native Dutch inhabitants.

7.2 In brief

Over the past 10 years, treatment demand for amphetamine use related problems has increased. This increase 2002 and 2007. However, the number of clients continues to be relatively limited. In 2011 the number of clients was just over 15, which is low compared to our neighbouring countries in the EU, where amphetamine use is still a relatively major problem.[13]

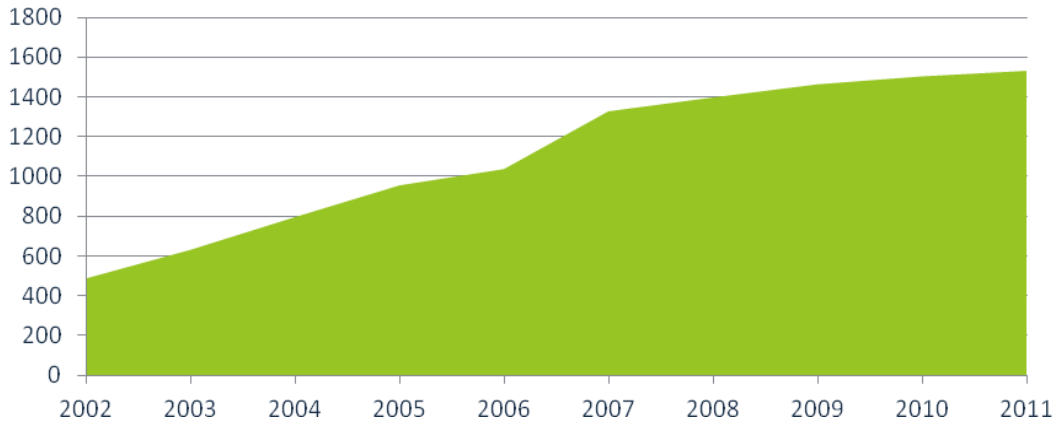
Tabel 15: **Overview treatment demand for amphetamine related problems in 2011**

Demography		
	Number of people seeking assistance	1553
	Male : Female	78:22
	Average age	29.4
	Share of 25-	33.3%
	Share of 55+	1.7%
	Percentage of native Dutch clients	93.2%
	Number per 100,000 inhabitants	9
Problems		
	Percentage in addiction care	2%
	Single : Multiple	51:49
	Use as an secondary problem	1.221
	First registration ever	23.4%
	Average number of contacts/client	44

7.3 Trends and development of the treatment demand

In 2002, 500 people with a treatment demand for amphetamine use related problems were registered in addiction care. Over the years, this has gradually increased to 1300 in 2007. Since then, there has been a slight increase; in 2011, the number of clients is just over 1500.

Figuur 70: **Amfetamine - Trend hulpvraag 2002-2011**

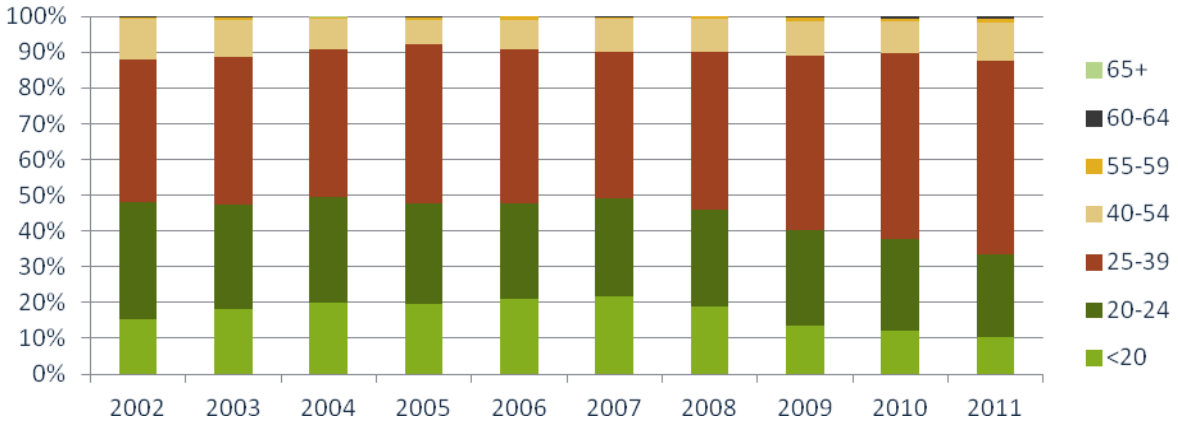


[13] 2011 Annual report on the state of the drugs problem in Europe, EMCDDA, Lisbon, November 2011

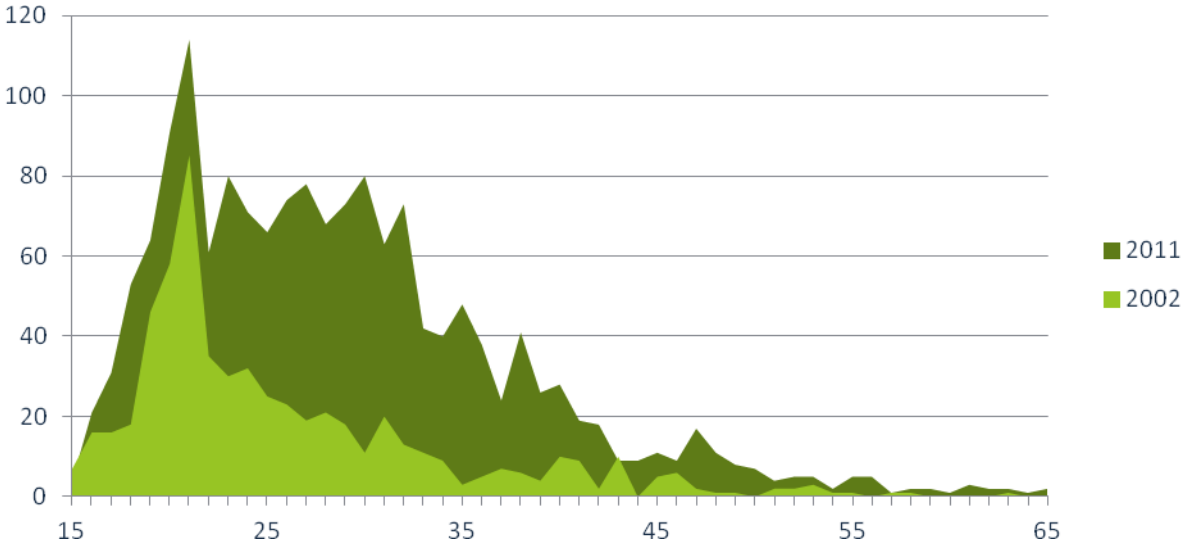
7.4 Young and old

Treatment demand for amphetamine use related problems relatively frequently occurs in younger people, but most clients are between 25 and 39 years old.
Over the past 5 years, the percentage of adolescents (<25 years) has dropped from approximately fifty percent to one-third of the clients, see Figure 71.

Figuur 71: **Amfetamine– Leeftijdscategorieën 2002-2011**



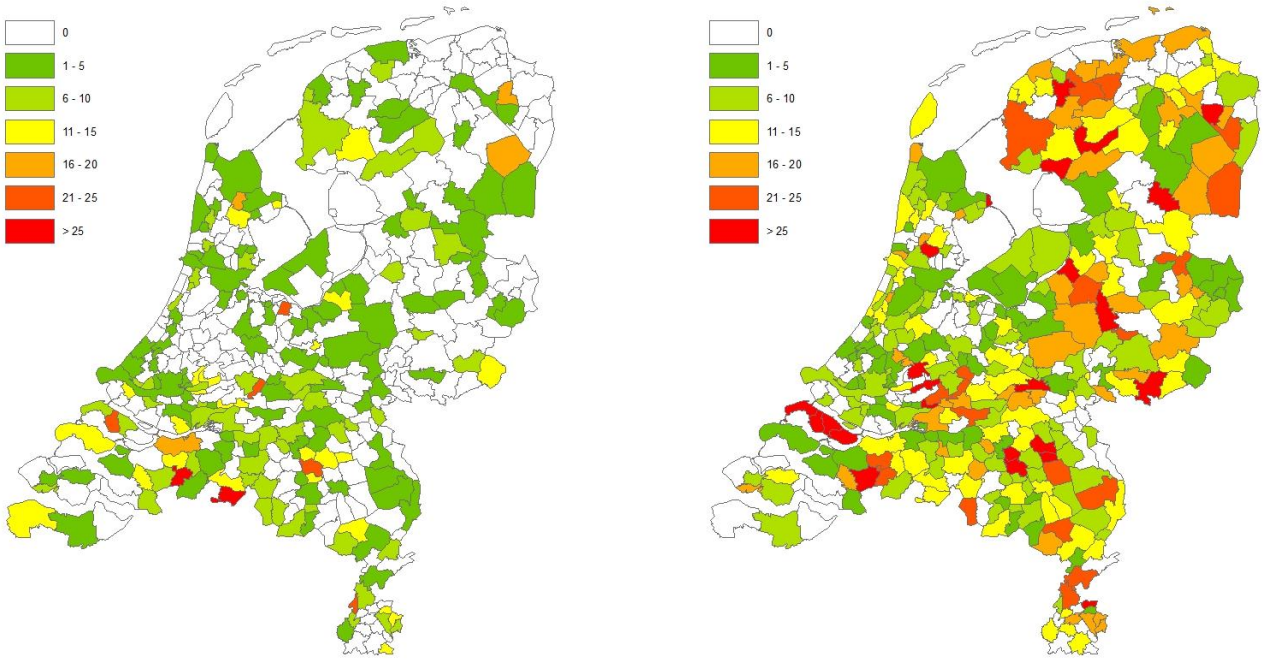
Figuur 72: **Amfetamine - Leeftijdsverdeling 2002 versus 2011**



The increase in amphetamine use related treatment demand concerns all age categories. However, the age group 25-40 has shown most increase.

7.5 Regional spread

Figuur 73: **Aantal hulpvragers amfetamineproblematiek per 100.000 inwoners 2002 en 2011**

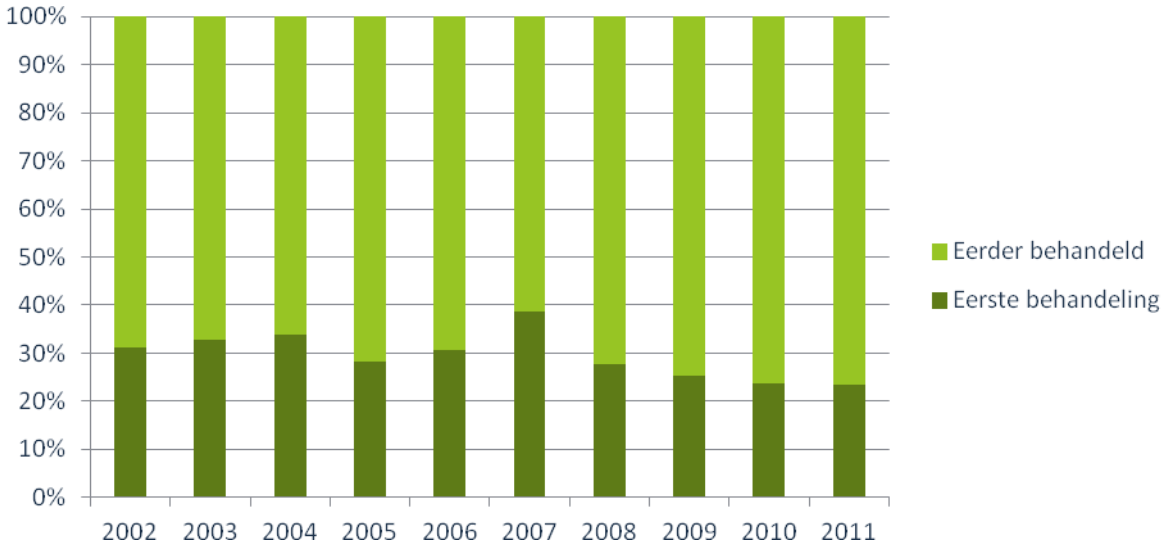


The national average of treatment demand for amphetamine use related problems was 9/100,000 inhabitants in 2011, compared to 3/100,000 inhabitants in 2002.

7.6 New and known

With amphetamine in 2011, 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 percentage of newcomers has.

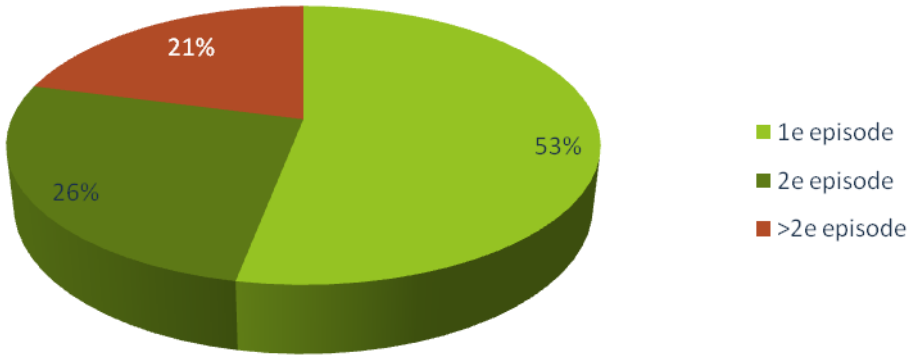
Figuur 74: **Amfetamine - Trend nieuwe en bekende hulpvragers 2002-2011**



7.7 Treatment history

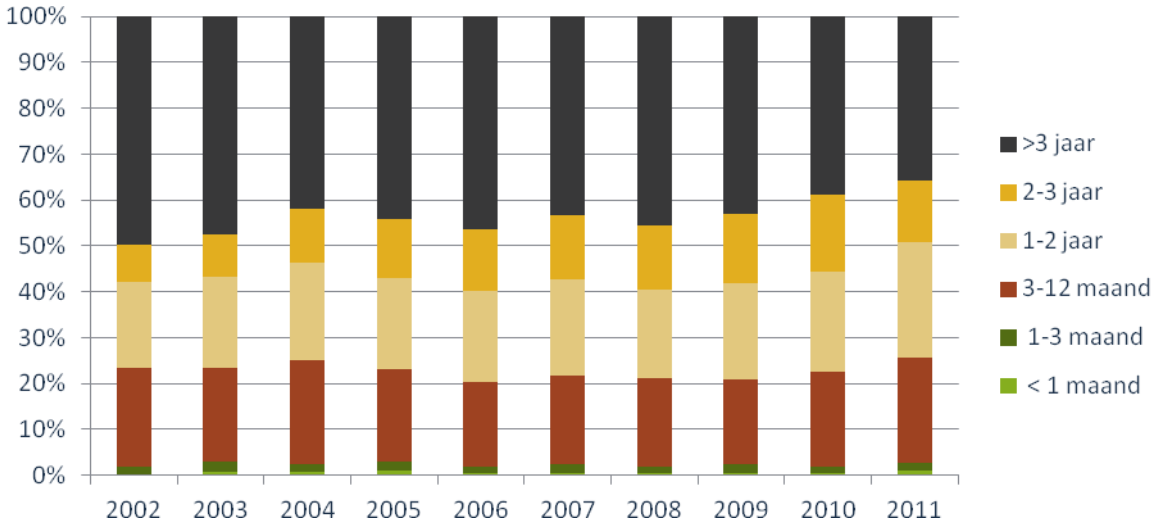
An episode may include several registrations and several registration years. The definition of an episode is described in Appendix III.

Figuur 75: **Amphetamine– Aantal episoden in de verslavingszorg 2011**



More than fifty percent of the clients with amphetamine use related problems are in their first consecutive episode in addiction care. Approximately one in five has two or more episodes in addiction care.

Figuur 76: **Amphetamine- Totale duur alle episodes in 2002-2011**

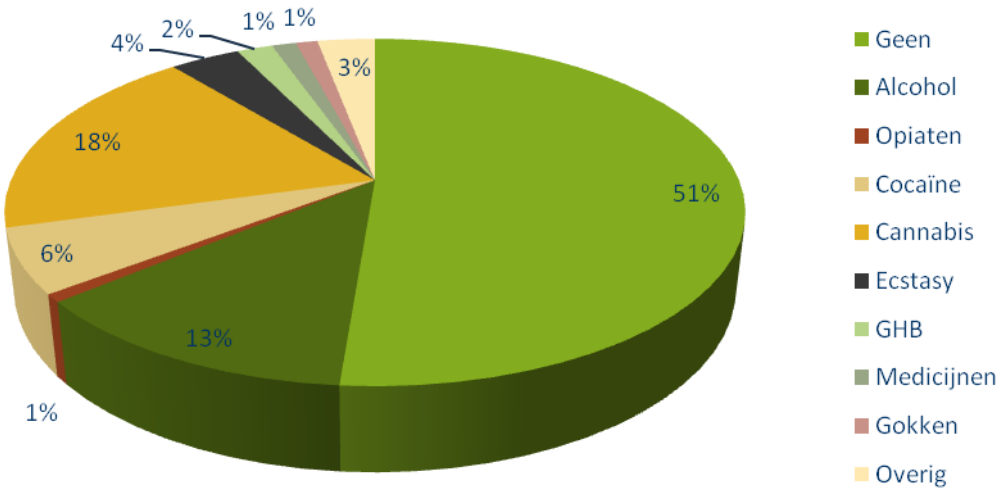


There seems to be a minor decrease in the share of clients with a treatment history > 3 years in addiction care (see Figure 76). At the same time, the share of newcomers in a registration year (see Figure 74) is dropping. Apart from a chronic group there also seems to be a group of amphetamine clients that disappears from addiction care again after one or two episodes.

7.8 Secondary problems

In fifty percent of the cases, there are one or more secondary problems in addition to amphetamine or ecstasy use. Cannabis, alcohol and cocaine are the most frequently occurring problems. GHB is also becoming visible as a secondary problem.

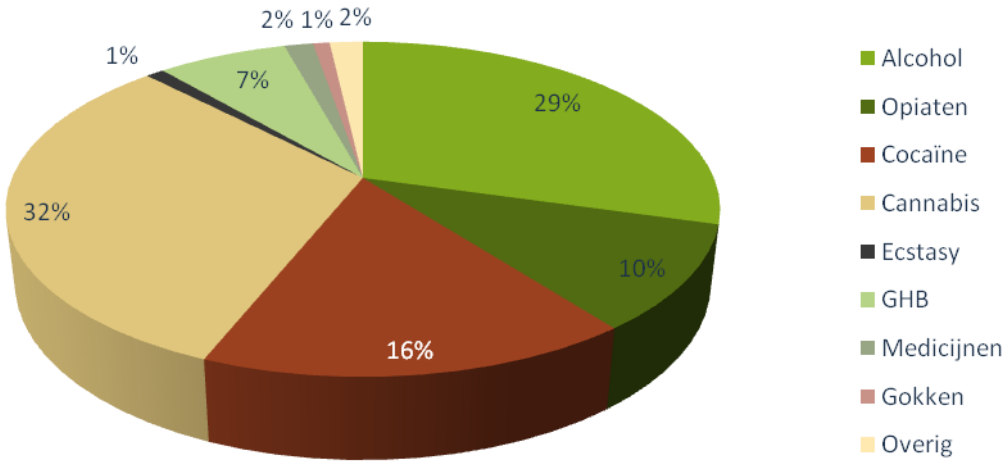
Figuur 77: **Amfetamine - Secundaire problematiek 2011**



7.9 Use as an secondary problem

Apart from amphetamine as a primary problem, this substance is almost as frequently used as a secondary or tertiary substance.
Figure 78 shows the distribution of this.

Figuur 78: **Amfetamine – Gebruik als bijmiddel 2011 (N=1.221)**



Amphetamine is registered as an secondary problem in 1221 clients. Amphetamine as an secondary problem occurs frequently in addition to cannabis and alcohol use.

8 Ecstasy

8.1 Broken down

- Ecstasy is a very small group in addiction care.
- Often as an secondary problem to other problems.

8.2 In brief

By numbers, ecstasy is a "minor" substance in addiction care. The substance appears five times more often as an addition in other primary problems than as a primary problem in itself. The Average age of people seeking assistance for ecstasy use related problems is 25.2 and the ecstasy client is thereby the youngest group on average in addiction care.

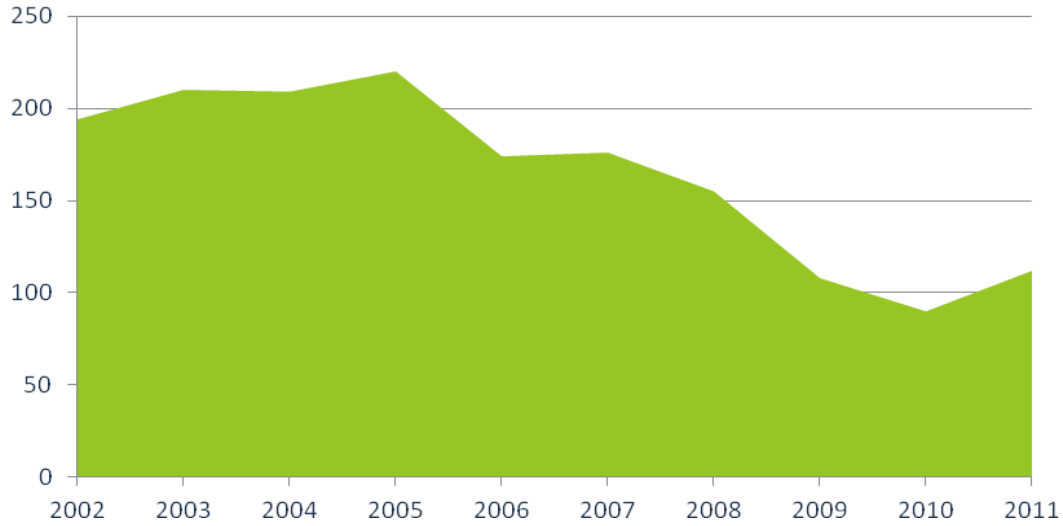
Tabel 16: **Average treatment demand for ecstasy use related problems in 2011**

Demography	
Number of people seeking assistance	112
Male: female	72 : 28
Average age	25.2
Number 25-	56.2%
Number 55+	0%
Percentage of native Dutch clients	89.8%
Number per 100,000 inhabitants	<1
Problems	
Number in addiction care	<1%
Single: multiple	41:59%
Use as secondary problem	558
First registration ever	43.8%
Average number of contacts/client	32

8.3 Trends and development in treatment demand

Ecstasy treatment demand peaked in 2005, about 200 people. After 2005 the number fell to a good 100 in 2011.

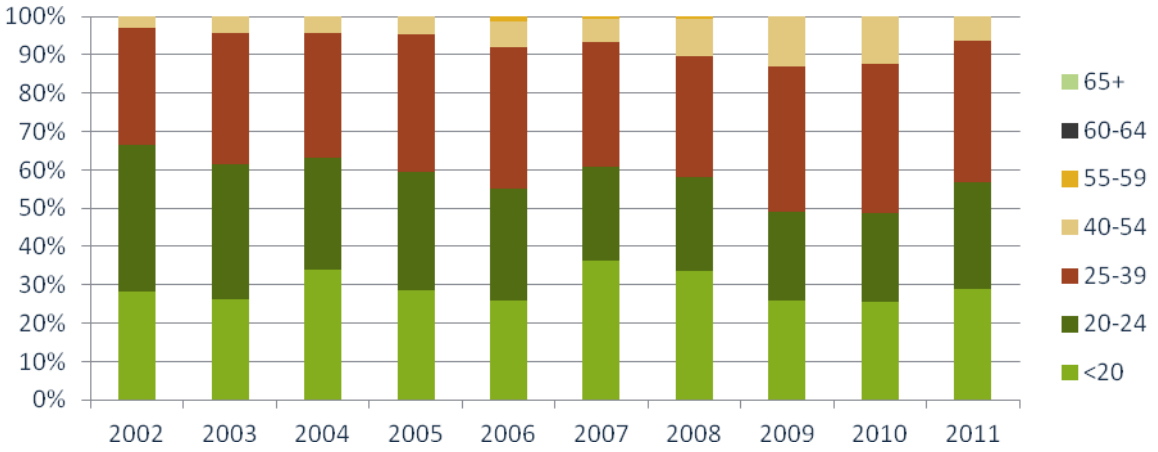
Figuur 79: **Ecstasy - Trend hulpvraag 2002-2011**



8.4 Young and old

With an Average of 25 in 2011, people seeking assistance for ecstasy use related problems are the youngest group in addiction care. The number of young people (age <25) has fluctuated at around 60% over the past 10 years.

Figuur 80: **Ecstasy – Leeftijdscategorieën 2002-2011**



Figuur 81: **Ecstasy - Leeftijdsverdeling 2002 versus 2011**

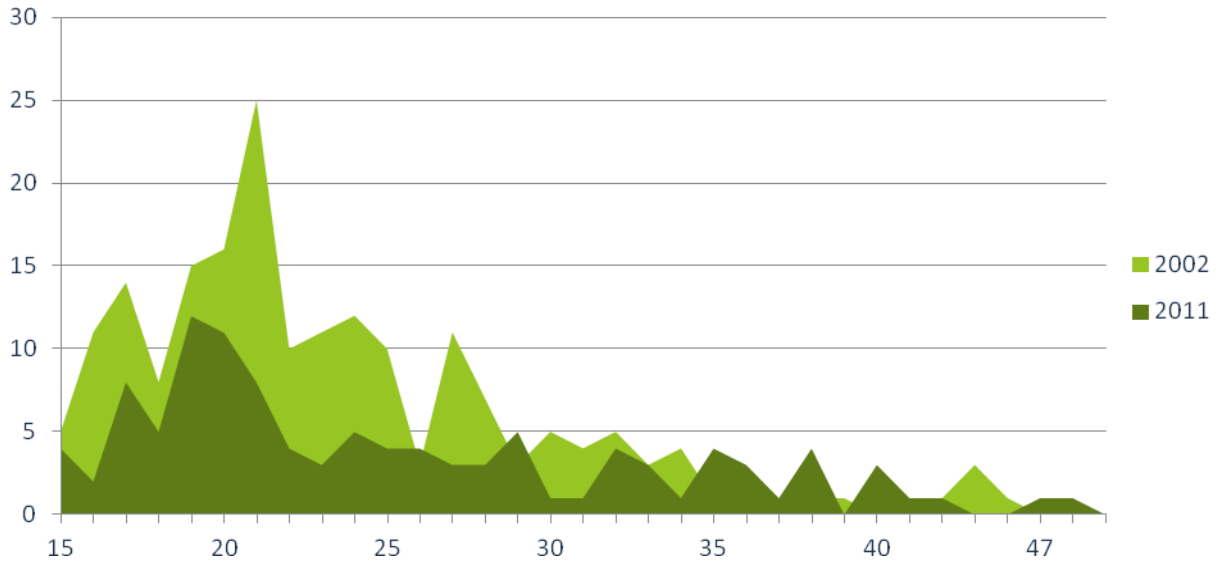
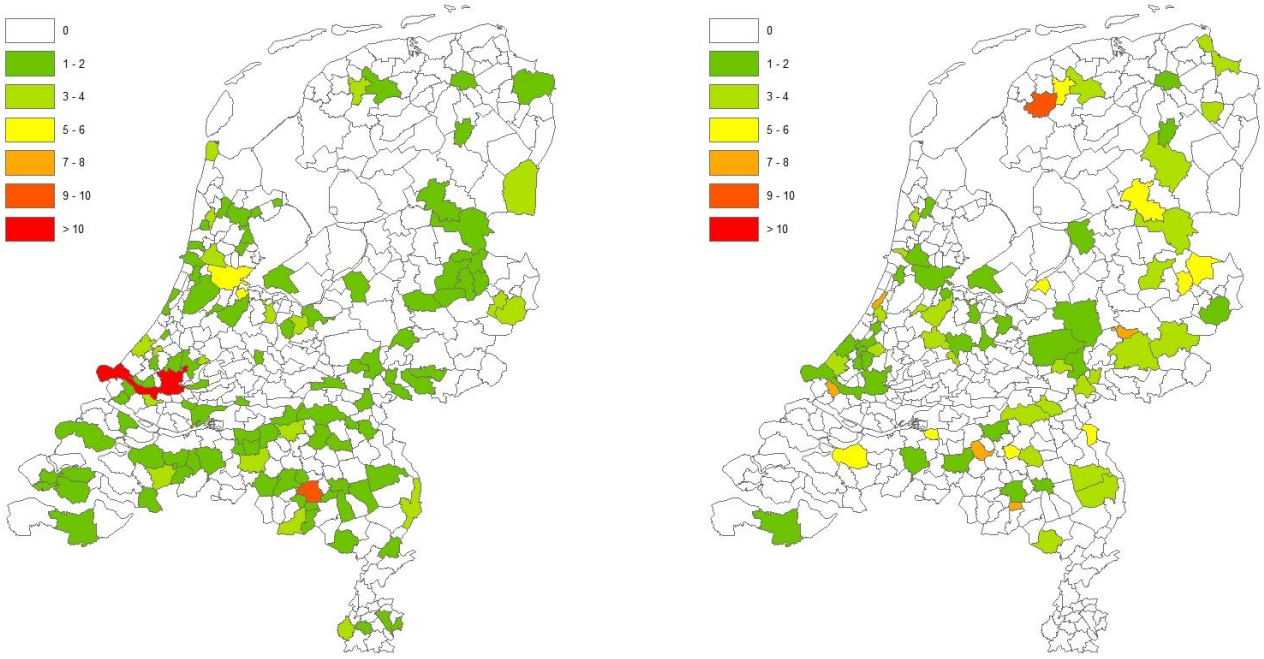


Figure 81 shows that the decrease in people seeking assistance with ecstasy use related problems occurred particularly in the group of under-35s.

8.5 Regional distribution

Figuur 82: **Aantal hulpvragers ecstasyproblematiek per 100.000 inwoners 2002 en 2011**

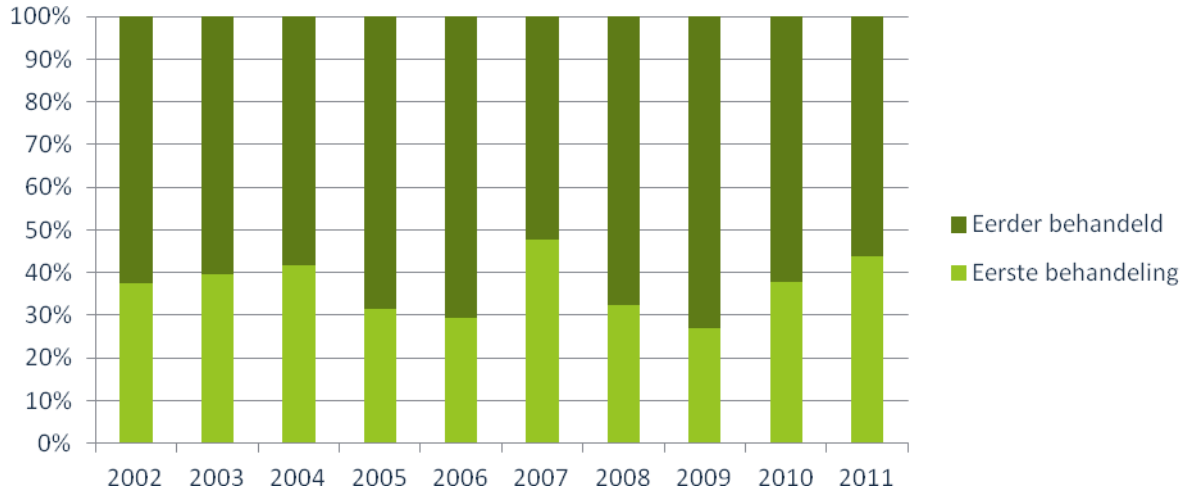


The national average of those seeking assistance for amphetamines and ecstasy use related problems in 2011 was 7/1,000,000 inhabitants. In 2002 this was 12/1,000,000 inhabitants.

8.6 New and known

With regard to ecstasy, many cases in 2011 concerned people who had already been a client in the past. The accrual of really new people seeking assistance is limited. In 2011, 44% of people seeking assistance approached addiction care for the first time. This is slightly higher than in previous years.

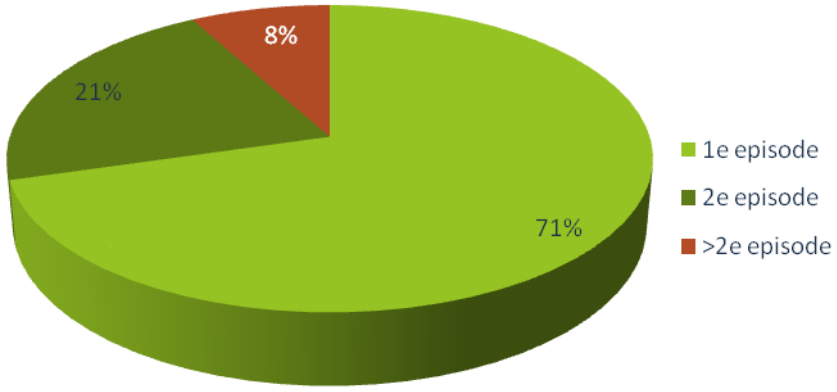
Figuur 83: **Ecstasy - Trend nieuwe en bekende hulpvragers 2002-2011**



8.7 Treatment history

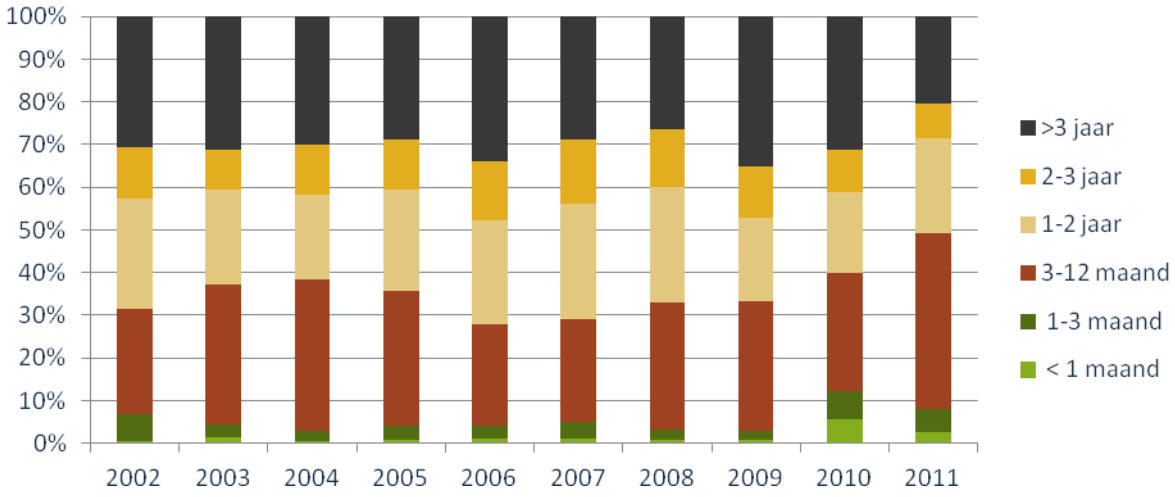
An episode may comprise more than one registration and more than one registration year. The definition of an episode is described in Annex III.
Most people seeking assistance for ecstasy are in their first episode.

Figuur 84: **Ecstasy – Aantal episoden in de verslavingszorg 2011**



The total duration of all episodes amongst people seeking assistance for ecstasy is also low compared to other substances. Half of them have a treatment history in addiction care of less than 1 year.

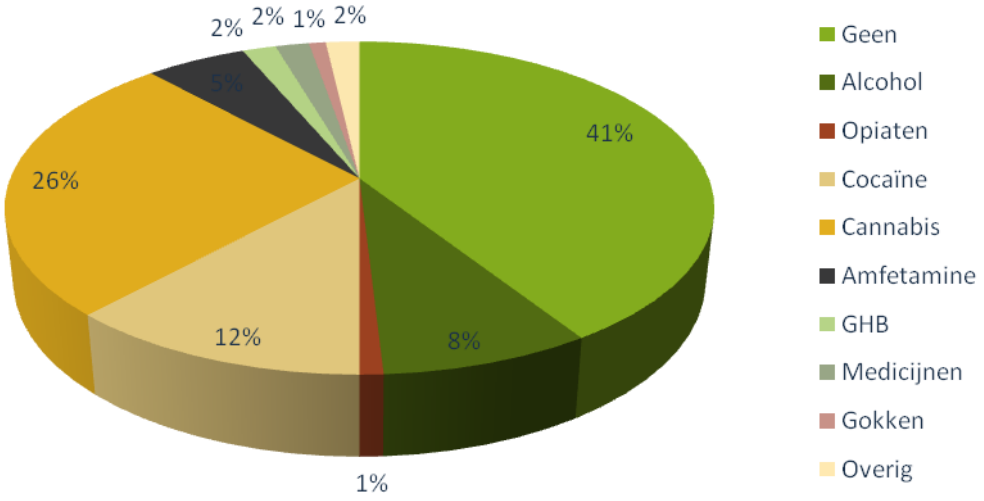
Figuur 85: **Ecstasy- Totale duur alle episoden in 2002-2011**



8.8 Secondary problems

In many cases (approx. 60%), there are secondary problems in addition to ecstasy use. Cannabis, cocaine and alcohol are the most common.

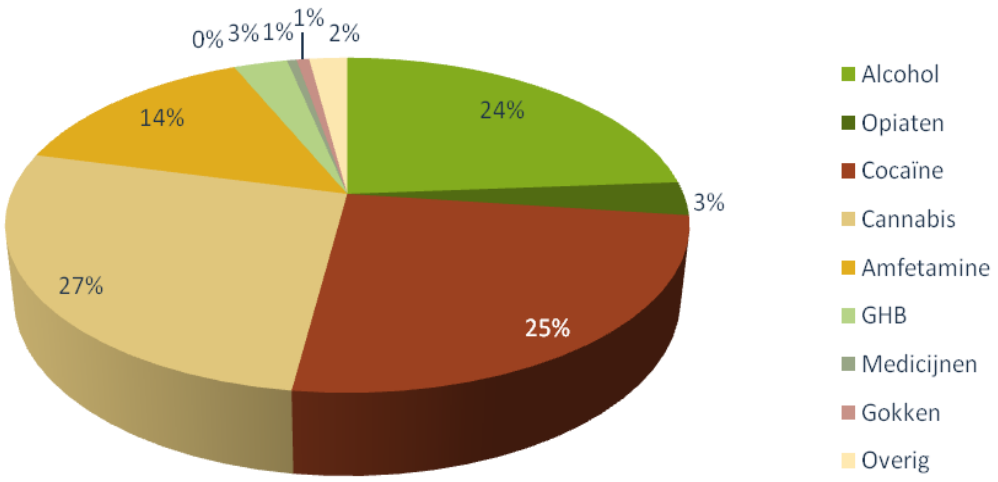
Figuur 86: **Ecstasy - Secundaire problematiek 2011**



8.9 Use as an secondary problem

Ecstasy occurs less often as primary problem than as secondary or tertiary problem. Figure 87 shows the distribution with which problem cannabis occurs as secondary problem.

Figuur 87: **Ecstasy – Gebruik als bijmiddel 2011 (N=558)**



Ecstasy occurs most commonly with cannabis, cocaine and alcohol as secondary problem in addiction care.

9 GHB

9.1 Highlights

- GHB-Treatment demand continues to increase.
- Not just adolescents.
- GHB treatment demand occurs in increasingly more regions.

9.2 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 among policy makers has been reason to start a separate registration.

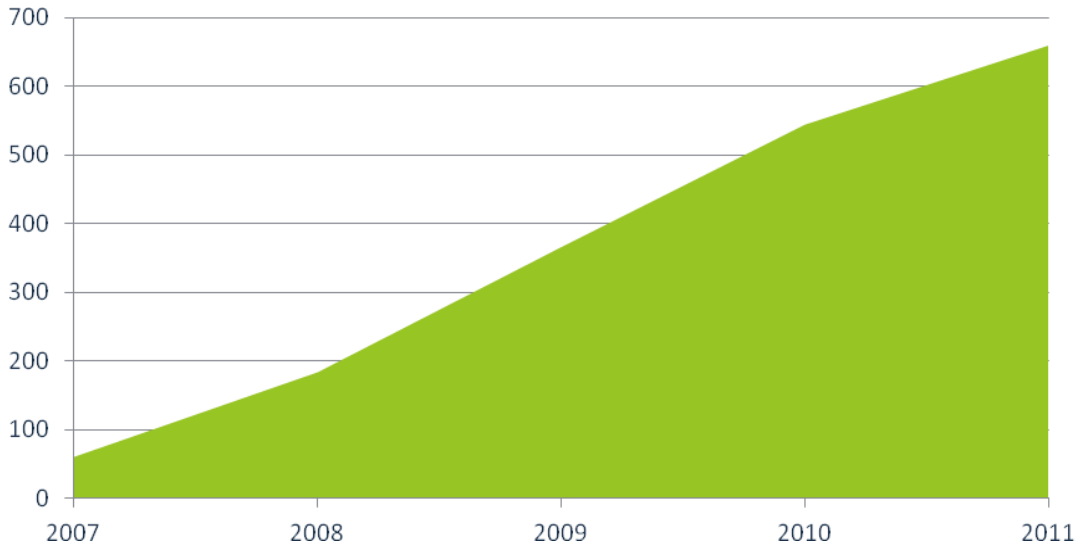
The increase in the number of clients with GHB use related problems has increased in 2011.

Tabel 17: **Overview of treatment demand for GHB use related problems in 2011**

Demography	
Number of people seeking assistance	659
Male : Female	66:34
Average age	28.5
Share of 25-	34%
Share of 55+	<1%
Percentage of native Dutch clients	93.4%
Number per 100,000 inhabitants	4
Problems	
Percentage in addiction care	1%
Single : Multiple	42:58
Use as an secondary problem	178
First registration ever	27.7%
Average number of contacts/client	

9.3 Trends and development of the treatment demand

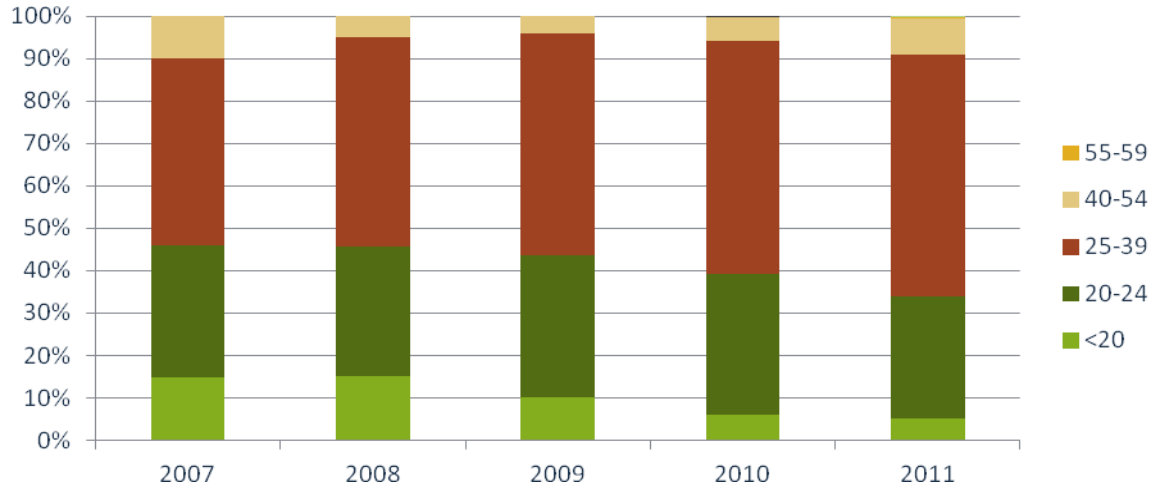
Figuur 88: **GHB - Trend hulpvraag 2002-2011**



Treatment demand for GHB has increased considerably. The percentage of GHB use related treatment is, however, still very limited.

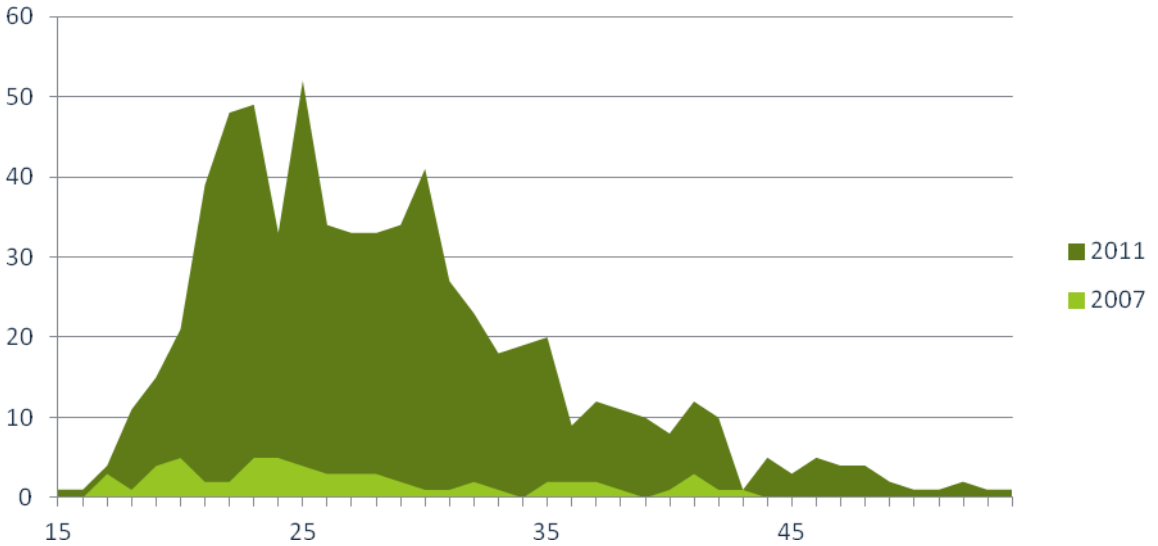
9.4 Young and old

Figuur 89: **GHB – Leeftijdscategorieën 2002-2011**



GHB is not just a problem among adolescents. In 2011, the increase in the age group 25-39 is was the most prominent increase compared to the previous years.

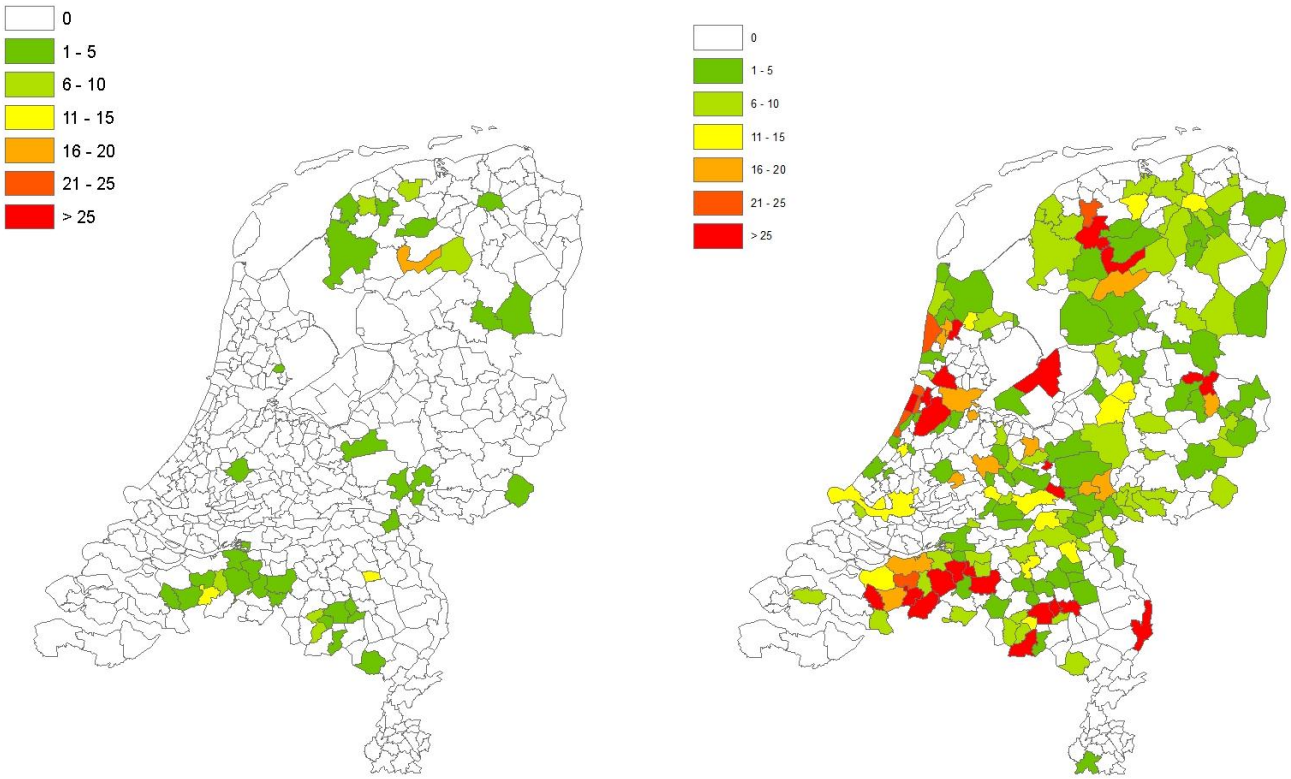
Figuur 90: **GHB - Leeftijdsverdeling 2007 versus 2011**



Most GHB clients are between 20 and 30 years old. In 2007 no clients with GHB use related problems were registered, but in 2011 there were also clients aged > 40, although their number is very limited.

9.5 Regional spread

Figuur 91: **Aantal hulpvragers GHB problematiek per 100.000 inwoners 2007 en 2011**

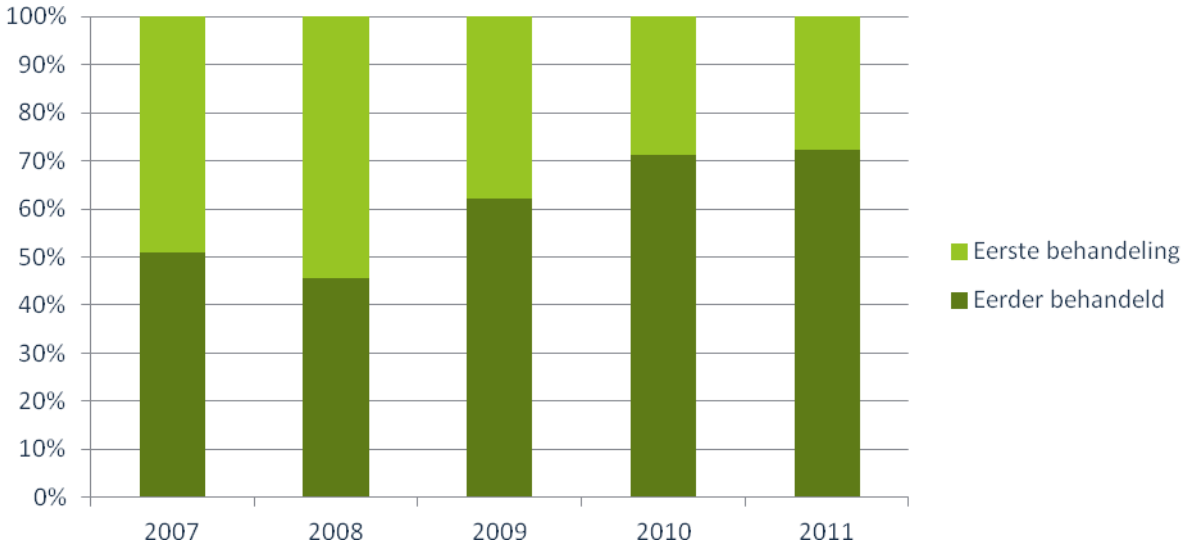


These maps for GHB deviate from the maps showing the regional spread of treatment demand in the other chapters. As GHB has not been registered before 2007, this is used as the map on the left side instead of 2002. In 2011, average treatment demand for GHB was 4 in 100,000 inwoners.

Figure 91 clearly shows that in 2007 GHB use related treatment mainly concentrated in parts of Nor-Brabant and Friesland. In 2011, treatment demand in these regions has increased compared to 2007 and has spread to a lot more regions.

9.6 New and known

Figuur 92: **GHB - Trend nieuwe en bekende hulpvragers 2002-2011**

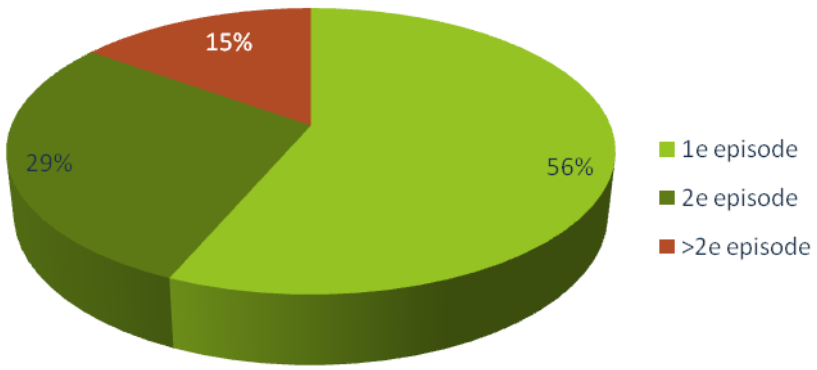


Notwithstanding the increase in GHB related demand for assistance most people seeking assistance have been registered before. The percentage of real newcomers was 28% in 2011.

9.7 Treatment history

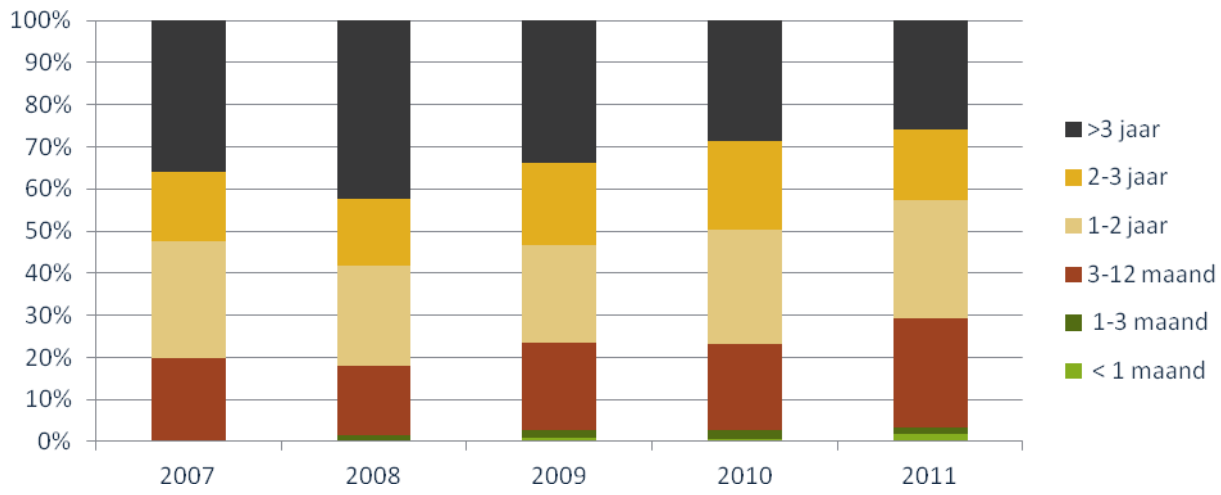
An episode may include several registrations and several registration years. The definition of an episode is described in Appendix III.
Most GHB-clients are in their first episode in addiction care. 45% have been treated at least twice during a consecutive period.

Figuur 93: **GHB – Aantal episoden in de verslavingszorg 2011 (N=659)**



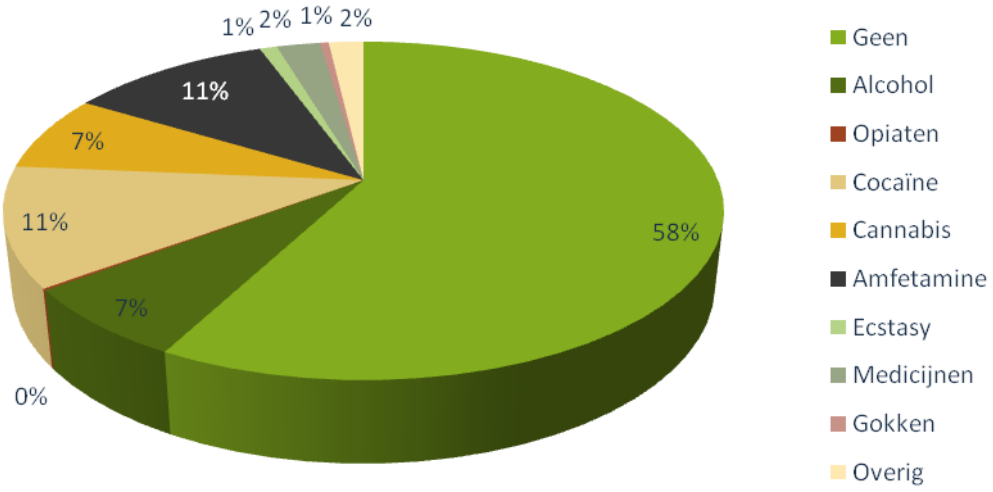
Approximately 25% of the clients registered in 2011 have been registered for more than 3 years (see Figure 94).

Figuur 94: **GHB- Totale duur alle episodes in 2002-2011**



9.8 Secondary problems

Figuur 95: **GHB - Secundaire problematiek 2011 (N=659)**

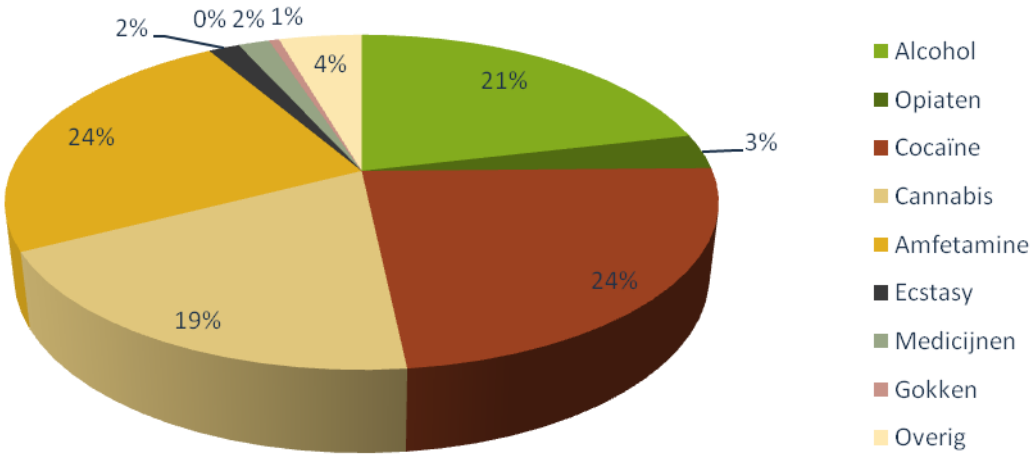


42% of the GHB clients also have secondary problems.
Cocaine and amphetamine use are the most frequently occurring secondary problems.

9.9 Use as an secondary problem

The use of GHB as a secondary substance is still limited. In 2011 GHB was registered as a secondary substance in 178 clients.
Figure 96 shows the distribution of GHB as a secondary substance to the various primary problems.

Figuur 96: **GHB – Gebruik als bijmiddel 2011 (N=178)**



GHB as a secondary substance is most frequently related to amphetamine and cocaine clients.

10 Medicines

10.1 Highlights

- After several years of increase, treatment demand for medicine use related problems has not increased any further.
- Most of the treatment demand concerns problems with the use of benzodiazepines.
- A relatively large percentage of the clients is female.

10.2 In brief

The number of people turning to addiction with medicine use related problems has increased considerately between 2002 and 2010. In 2011 a major change has taken place. The number of clients was 810, which is below the number registered in 2010. This mostly (77%) concerns the benzodiazepines use related problems; benzodiazepine is among the most frequently used medicines in the Netherlands. In 2010, 1.4 million people in the Netherlands used a benzodiazepine [14].
The average age is45 years and the percentage of women is high.

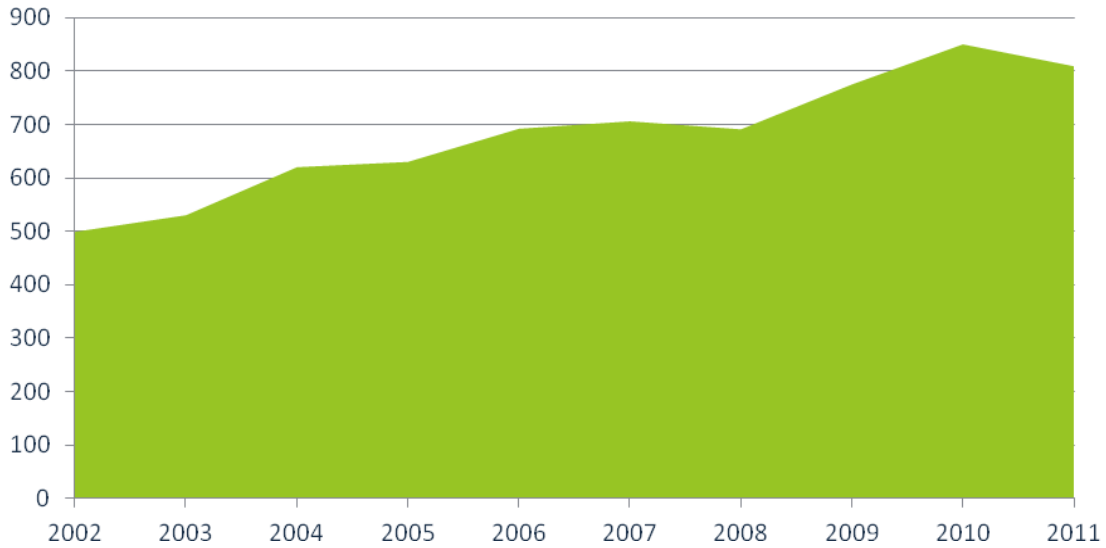
Tabel 18: **Overview of treatment demand for medicine use related problems in 2011**

Demography		
	Number of people seeking assistance	810
	Male : Female	53:47
	Average age	45.3
	Share of 25-	3.7%
	Share of 55+	23.0%
	Percentage of native Dutch clients	84%
	Number per 100,000 inhabitants	5
Problems		
	Percentage in addiction care	1%
	Single : Multiple	41:59
	First registration ever	23.1%
	Average number of contacts/client	51

[14] Stichting Farmaceutische Kengetallen, Daten and Feiten 2011, het years 2010 in cijfers

10.3 Trends and development of the treatment demand

Figuur 97: **Medicijnen - Trend hulpvraag 2002-2011**

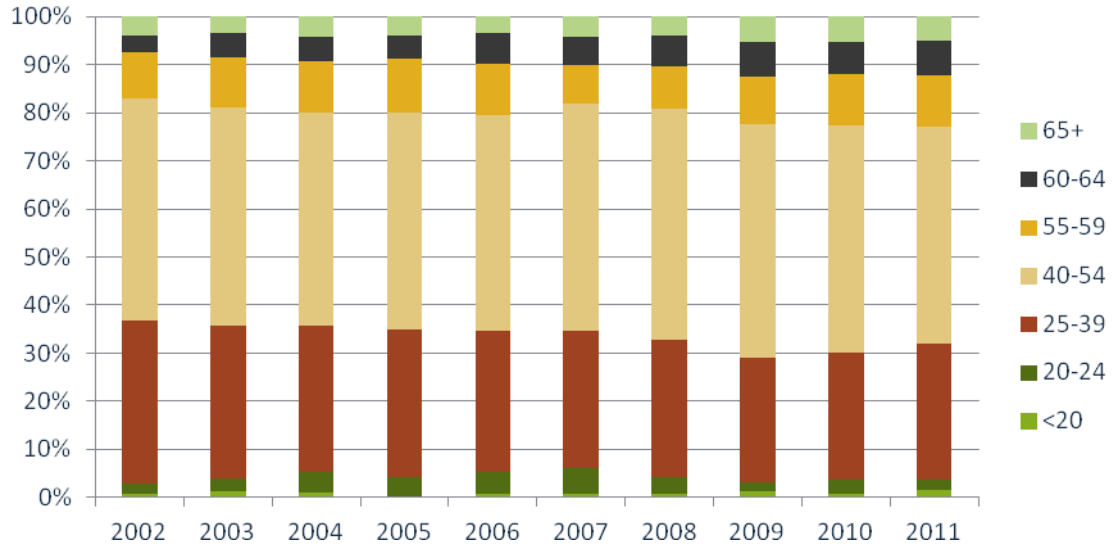


After a long period of increase, treatment demand for medicine use related problems has now decreased.

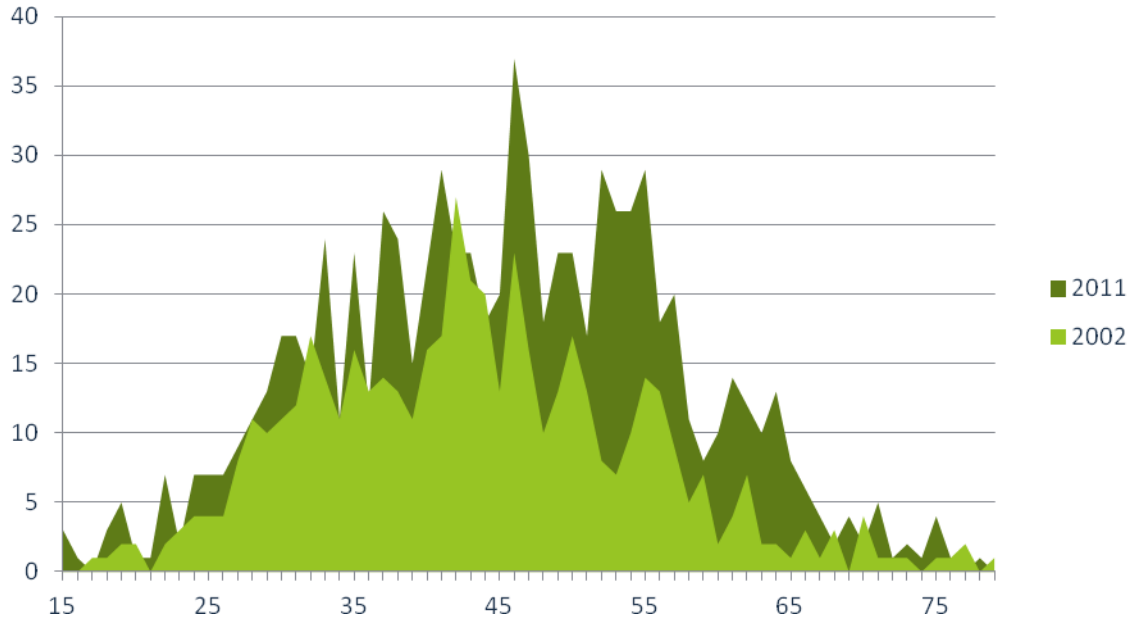
10.4 Young and old

The age of clients registered for medicine use related problems continues to increase. In 2002, 1 in 6 clients was > 55 years. In 2011, this percentage has increased to 1 in 4 clients.

Figuur 98: **Medicijnen – Leeftijdscategorieën 2002-2011**



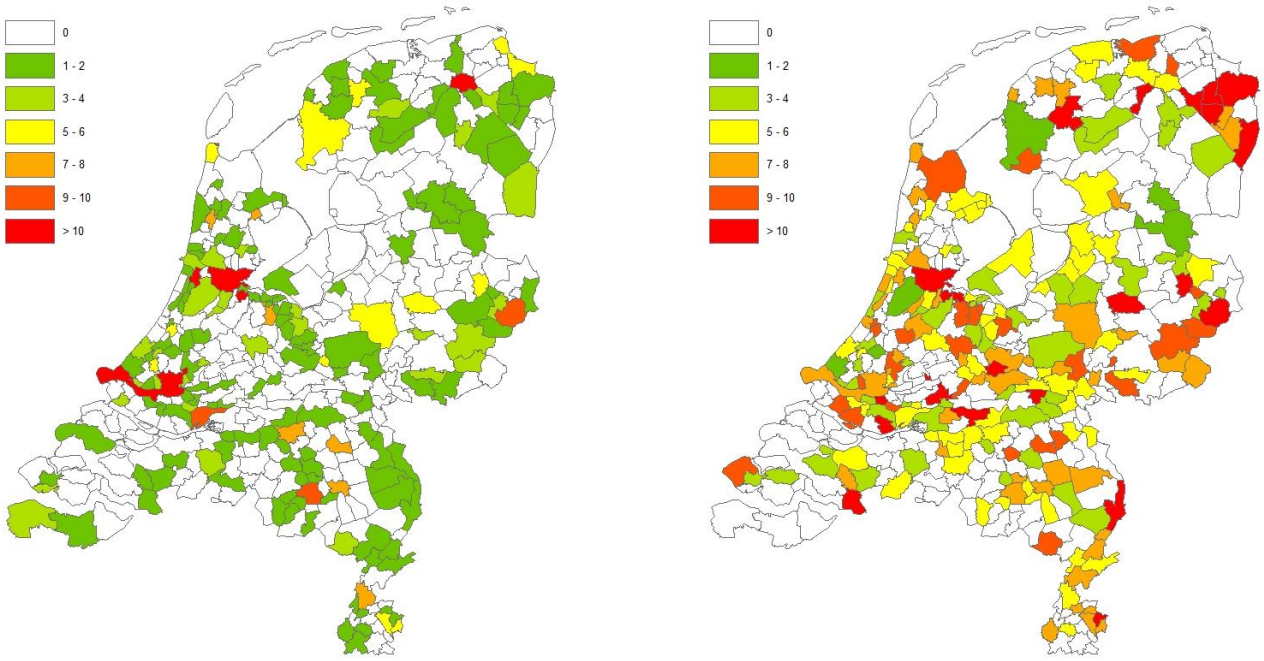
Figuur 99: **Medicijnen - Leeftijdsverdeling 2002 versus 2011**



The increase treatment demand has taken place in all age categories over the past 10 years, mainly in the age group between 40 and 65 years.

10.5 Regional spread

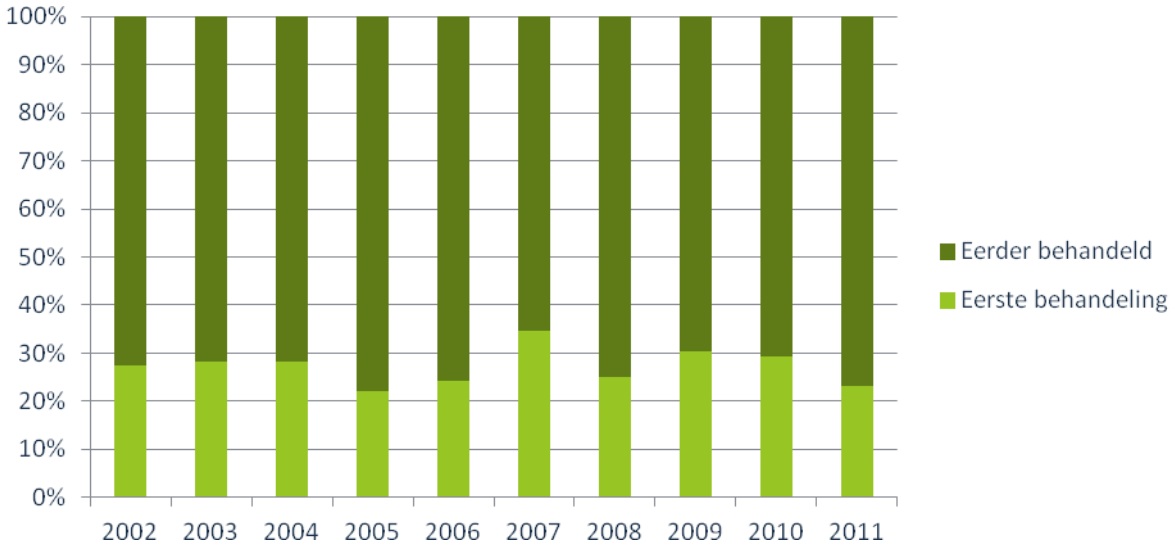
Figuur 100: **Aantal hulpvragers medicijnenproblematiek per 100,000 inwoners 2002 en 2011**



In 2011, the national average treatment demand for medicine use related problems was 5/100,000 inhabitants, compared to 3/100,000 inhabitants in 2002.

10.6 New and known

Figuur 101: **Medicijnen - trend nieuwe en bekende hulpvragers 2002-2011**

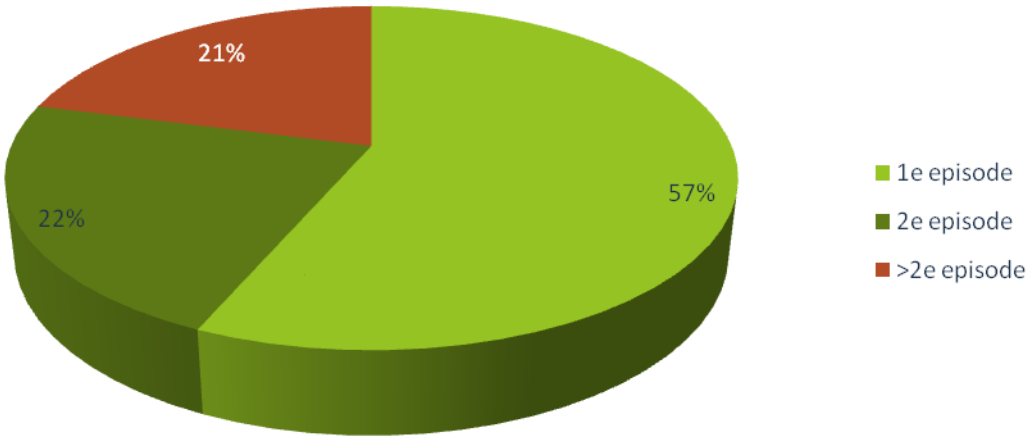


In 2011, almost 200 clients register in addiction care for the first time for medicine use related problems, which is a decrease compared to the past two years.

10.7 Treatment history

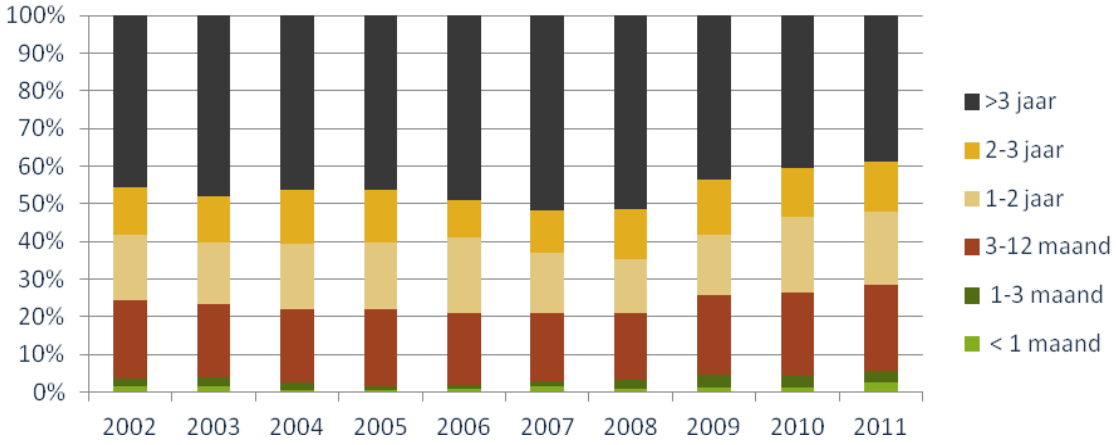
An episode may include several registrations and several registration years. The definition of an episode is described in Appendix III.
Most clients with medicine use related problems are in their first consecutive period in addiction care. 43% of the group registered in 2011 have more episodes.

Figuur 102: **Medicijnen – Aantal episoden in de verslavingszorg 2011 (N=810)**



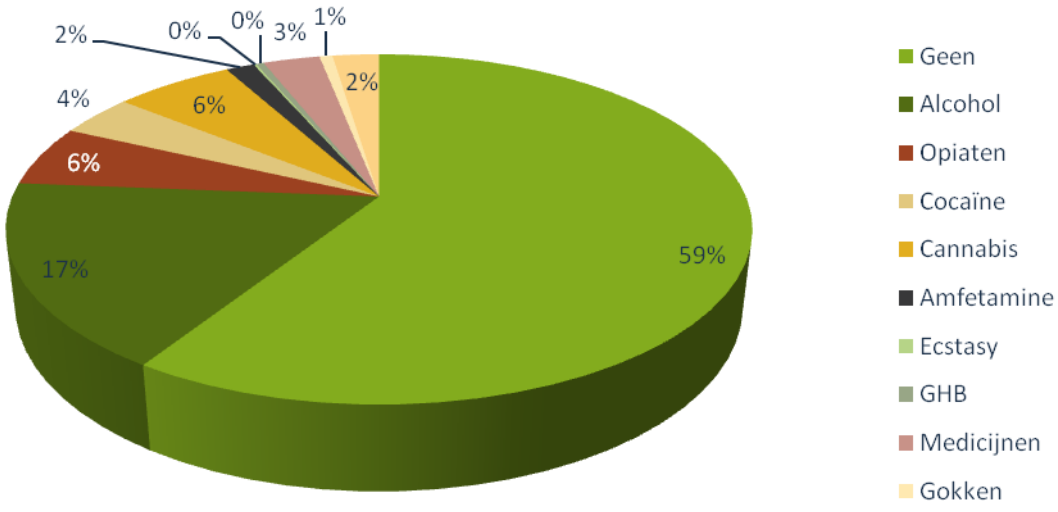
The group registered in addiction care for more than 3 years seems to have become slightly smaller over the past few years. In 2008, this was still fifty percent of the clients. In 2011, this percentage has dropped to less than 40% (see Figure 103).

Figuur 103: **Medicijnen - Totale duur alle episoden in 2002-2011**



10.8 Secondary problems

Figuur 104: **Medicijnen - Secundaire problematiek 2011 (N=810)**



More than 40% of the clients registered for medicine use related problems have other problems as well. Approximately 20% of the clients also have problems with drugs (opiates, cocaine, amphetamine and cannabis). Besides, one in six clients have alcohol as a secondary problem.

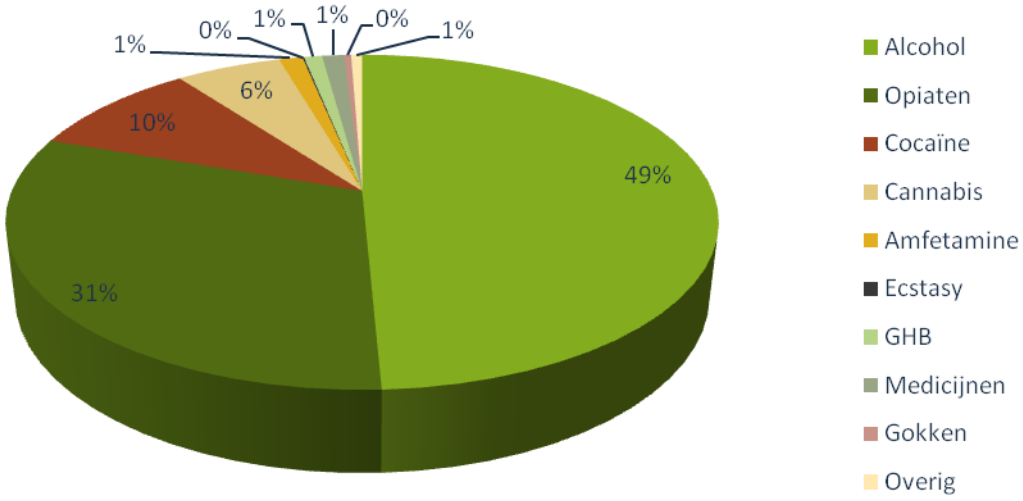
10.9 Use as an secondary problem

The extent of medicine use in addition to other problems is considerable.

In 2011, 2346 clients were registered with medicines as an secondary problem. This is three times the number of people registered with medicines as the primary problem.

Figure 105 shows the distribution of medicine use as an additional problem to the various primary problems.

Figuur 105: **Medicijnen – Gebruik als bijmiddel 2011 (N=2.346)**



Medicines are often used in combination with alcohol, opiates and - to a lesser extent - cocaine. This mainly concerns benzodiazepines.

11 Gambling

11.1 Highlights

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

11.2 In brief

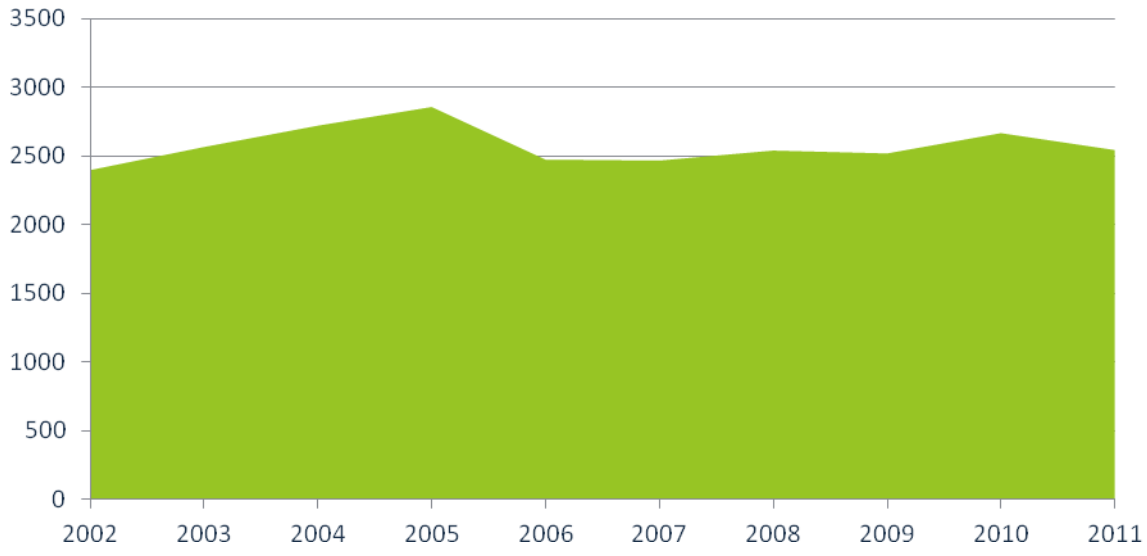
Tabel 19: **Overview of treatment demand for gambling related problems in 2011**

Demography		
	Number of people seeking assistance	2545
	Male : Female	86 : 14
	Average age	37.6
	Share of 25-	15%
	Share of 55+	12%
	Percentage of native Dutch clients	69%
	Number per 100,000 inhabitants	15
Problems		
	Percentage in addiction care	4%
	Single : Multiple	65 :35
	First registration ever	31%
	Average number of contacts/client	17

11.3 Trends and development of the treatment demand

Over the past 10 years requests for assistance with gambling problems have remained more or less stable. Most clients 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.

Figuur 106: **Gokken – Aantal hulpvragers 2002-2011**



11.4 Young and old

Over the past few years, the age distribution of people with a gambling addiction related treatment demand has been stable.
There are less people aged 20-40 years compared to 10 years ago, but it's still the largest group.

Figuur 107: **Gokken – Leeftijdscategorieën 2002-2011**

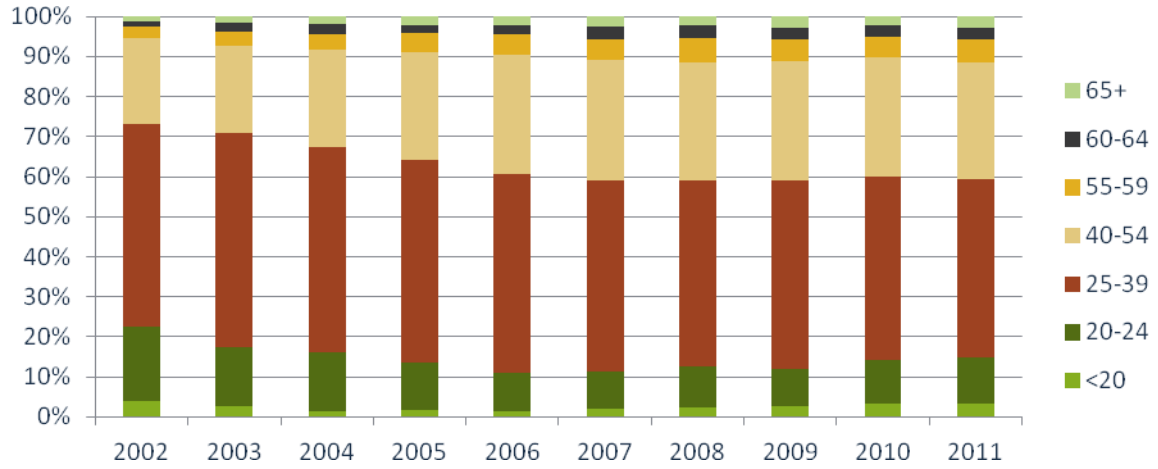
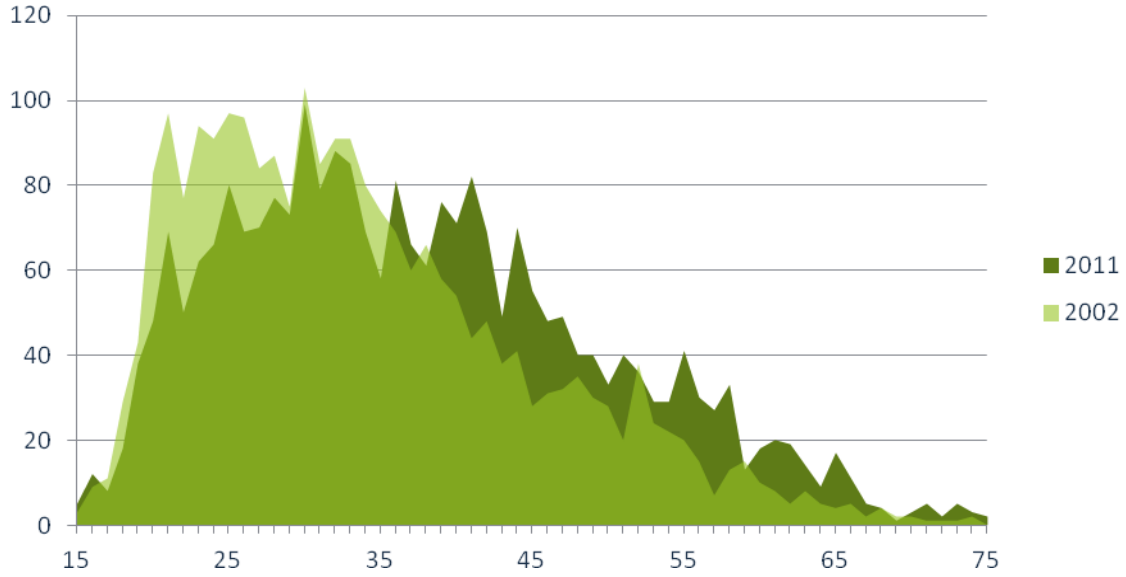


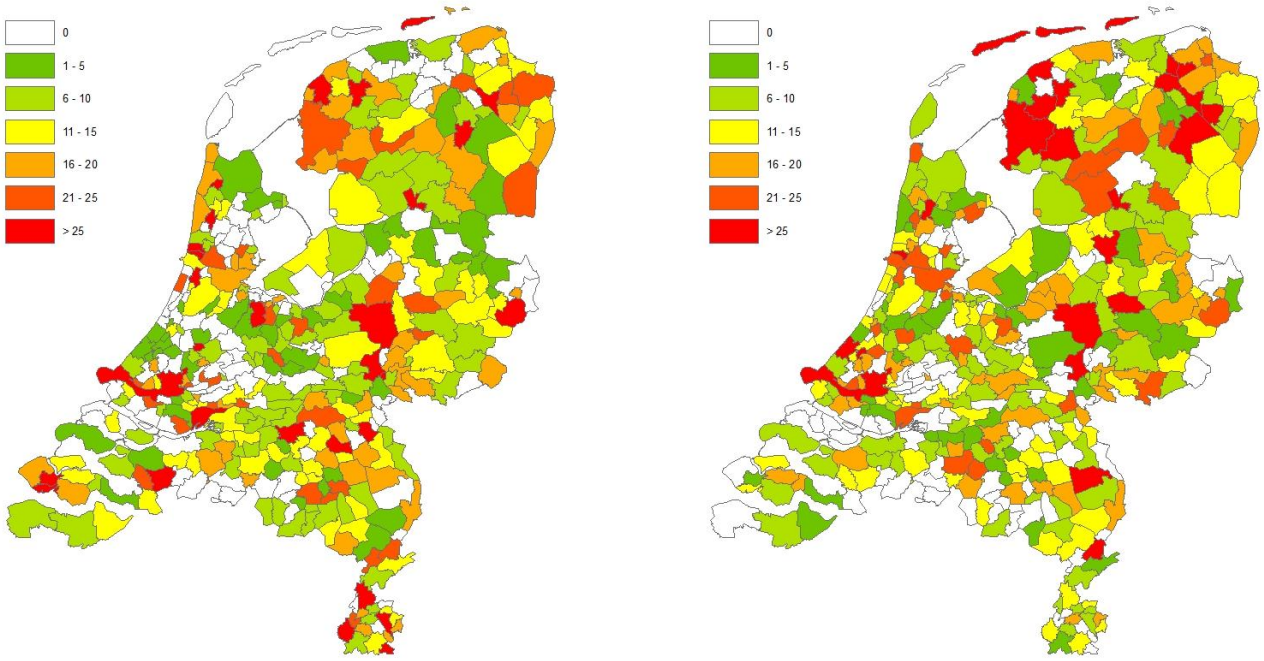
Figure 108 shows that the group of adolescents has become smaller compared to 10 years ago and that the total number has remained more or less stable.

Figuur 108: **Gokken - Leeftijdsverdeling 2002 versus 2011**



11.5 Regional spread

Figuur 109: **Aantal hulpvragers gokproblematiek per 100.000 inwoners 2002 en 2011**

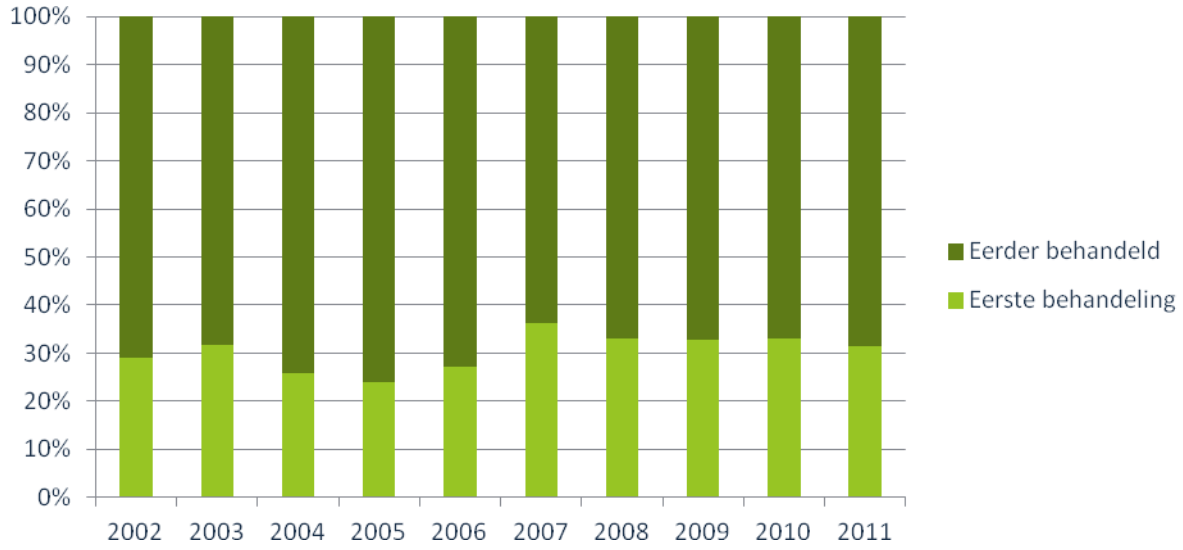


Both in 2002 and 2011 the national average treatment demand for gambling was 15/100,000 inhabitants.

11.6 New and known

The ratio between newcomers and people having requested assistance with gambling problems before has been more or less stable over the past ten years, apart from a number of fluctuations. In 2011, approximately 30% was first registered with addiction care.

Figuur 110: **Gokken - Trend nieuwe en bekende hulpvragers 2002-2011**



11.7 Treatment history

An episode may include several registrations and several registration years. The definition of an episode is described in Appendix III.
In 2011, for 58% of the clients with a treatment demand for gambling related problems it's their first episode in care. One in five clients registered in 2011 has had 2 or more episodes in addiction care.

Figuur 111: **Gokken – Aantal episodes in de verslavingszorg 2011 (N=810)**

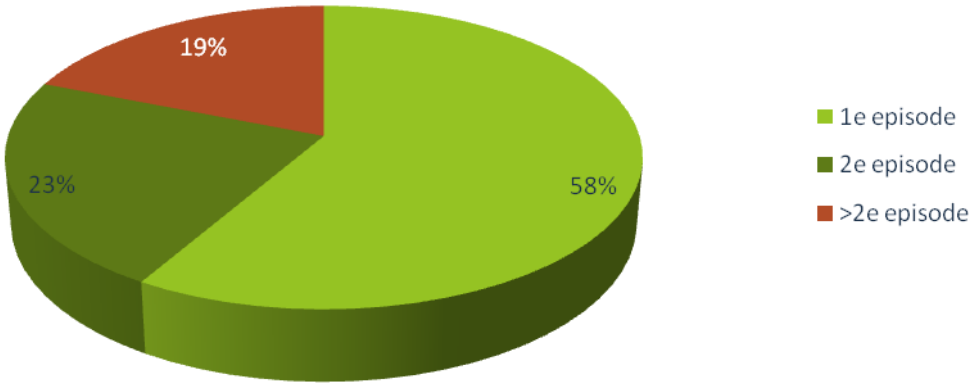
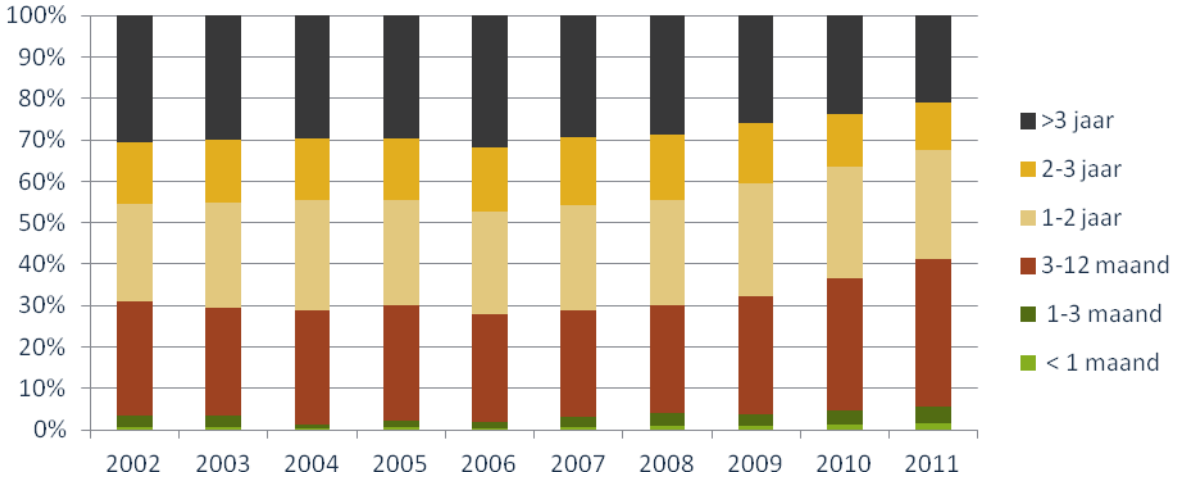


Figure 112 shows the total duration of all episodes. The group of clients registered for gambling is comparable with the group of clients registered for cannabis and for ecstasy related problems with regard to the total duration of all episodes in care. The percentage of clients with a total treatment duration of less than a year was 40% in 2011.

Figuur 112: **Gokken - Totale duur alle episodes in 2002-2011**



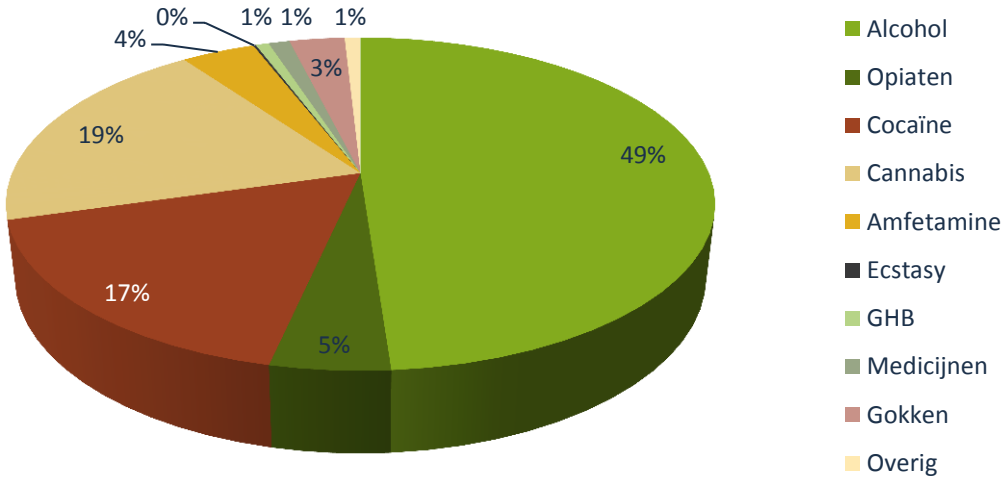
11.8 Secondary problems

In 80% of the cases, people registering with gambling problems have no other problems. More than 80% of the persons presenting with gambling problems do not have any secondary problems. In 8% of cases alcohol abuse also plays a role and 4% of those seeking assistance also use cannabis.

11.9 Gambling and secondary problems

Problematic gambling as a secondary problem to other primary problems occurs as well. In 2011, almost 700 clients had gambling as their second or third problem. Figure 113 shows the distribution of this.

Figuur 113: **Gokken – Gebruik als bijmiddel 2011 (N=696)**



Gambling as a secondary problem occurs most frequently with regard to alcohol, cocaine and cannabis.

12 Other

12.1 Highlights

- Compared to 2010, 10% more ’life-style’ problems (smoking addition, eating disorders).
- Internet gaming problems demand for assistance increases somewhat to 245 people.

12.2 In brief

The group referred to as "other" covers a range of problems giving rise to demand for assistance for addiction care. This concerns both substance and behaviour-related addictions. Figure 114 shows this in main groups. All categories are set out in detail in Table 19.

Internet gaming is discussed further in this chapter because this substance is receiving additional attention in the media and there is particular demand in society for information on this "new" phenomenon. In addition, the largest group within the category "other", eating disorders, is considered further in paragraph 12.4.

Figuur 114: **Hoofdgroepen binnen de categorie overige hulpvragen**

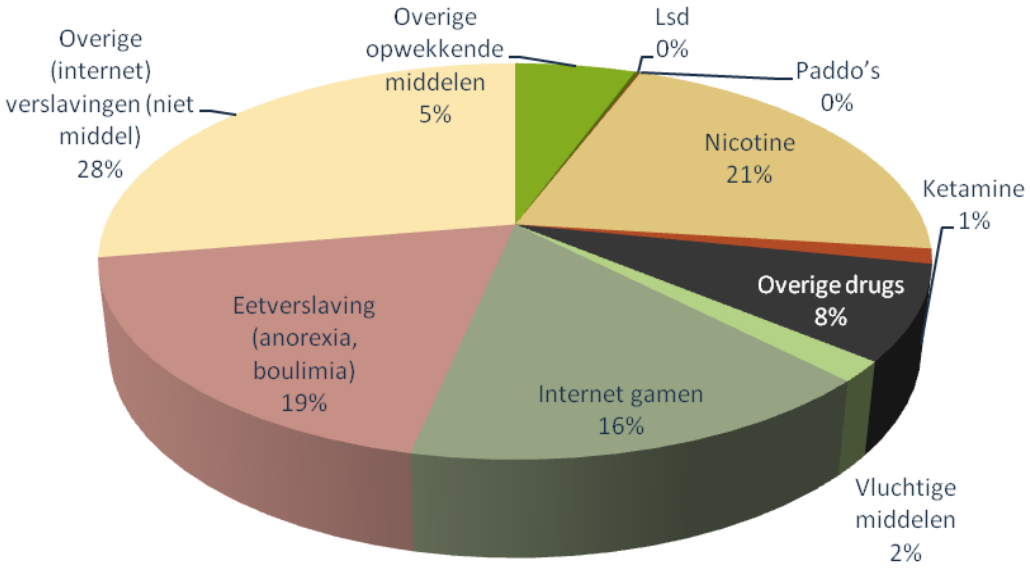


Figure 114 shows that there is also a large group of "other non-substance addiction". This covers internet addictions such as chatting and eroticism. It is quite possible that this category also includes a number of gamers who have wrongly not been registered among the Internet group. This category is relatively new and is not as yet fully registered everywhere.

Tabel 20: **Other demand for assistance 2011**

"Other" category	*N*	*%*
Other stimulants	87	5,6
Lsd	3	0,2
Glue-sniffing	1	0,1
Nicotine	328	21,1
Ketamine	19	1,2
Other drugs	120	7,7
Volatile substances	26	1,7
Internet gaming	245	15,8
Eating disorder (anorexia, bulimia)	295	19,0
Other and internet addictions (not substances)	430	27,7
Total	1554	100

12.3 Internet gaming

The rapid increase in Internet use in various forms is receiving increasing attention. The number of young people spending an unhealthy amount of time gaming online and consequently having problems is also causing concern. These problems have many parallels with other forms of addiction. IVO research shows that 1.5% of young people aged between 13 and 16 can be identified as video game addicts according to the existing criteria for determining addictive behavior. This translates into 12,000 young people.[15]

Reports in addiction care of young people seeking assistance as a result of video gaming addiction is still relatively small. But it is on the increase. In 2010, 182 people requested assistance, in 2011, 245 people were being treated in addiction care for internet gaming problems.

12.3.1 In brief

Tabel 21: **Internet gaming – Overview of people seeking assistance 2011**

Demography		
	Number of people seeking assistance	245
	Male:female	93 :7
	Average age	22.3
	Percentage 25-	76%
	Percentage 55+	1%
	Percentage ethnic clients	93%
	Number per 100,000 inhabitants	<1
Problems		
	Percentage in addiction care	<1%
	Single: multiple	89 : 11
	First registration ever	63%

Demand for assistance for internet gaming is clearly a male problem. These are predominantly young people but certainly not exclusively so.

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

12.4 Eating disorders

Demand for assistance with eating disorders (bulimia, anorexia) has increased in recent years. In 2011 this number decreased to nearly 300.

12.4.1 In brief

Tabel 22: **Eating disorders – Overview of people seeking assistance 2011**

Demography	
Number of people seeking assistance	295
Male:female	7 : 93
Average age	37.6
Percentage 25-	16.3%
Percentage 55+	9.4%
Percentage of native Dutch clients	95.6%
Number per 100,000 inhabitants	<1
Problems	
Percentage in addiction care	<1%
Single: multiple	94 : 6
First registration ever	87%

In 2011, 295 people, mainly women of ethnic origin, requested assistance. There is virtually no question of a multiple problem, as is more frequently the case with other primary substances.

Appendix I: Participating institutions

Arkin
Arta-Lievegoedgroup
Bouman GGZ
Brijder Addiction care (inclusive of Parnassia)
Centrum Maliebaan
Emergis
GGD Amsterdam
IrisZorg
Mondriaan Zorggroep
Novadic-Kentron
Tactus Verslavingszorg
Verslavingszorg Noord Nederland
Vincent van Gogh

Annex II: LADIS compared to previous editions

Each year the Core figures provide the latest trends in addiction care. Differences may occur here against figures shown in previous editions. Administrative adjustments and improved records from previous years are included in the latest figures each year. Three elements are discussed below that were changed in the 2011 Core figures compared to earlier years.

1. Addiction rehabilitation reported separately

An important contribution towards the fullest possible completeness of the demand for assistance picture and the availability of addiction care is obtained by linking the addiction rehabilitation data to individual client level where possible. This linkage has proved increasingly more difficult in recent years due to the way rehabilitation is registered. For LADIS, data on primary and, where present, secondary problems form the nucleus. However, they are not or not fully registered as such under the present system within addiction rehabilitation. This problem already arose to a minor extent in previous years with CVS as the registration system. This system has been replaced by IRIS. Unfortunately, implementing the new registration system has not resulted in the desired improvement. The information for 2011 included so many incomplete data that presenting them with the addiction care figures was no longer justified, because the increase in the number of rejected records excessively affects the trends. Chapter 1 and the chapters for the individual problems (Chapters 3 to 12) are therefore based only on the addiction care figures. This also applies to the trend figures and those of previous years. The rehabilitation figures have also been filtered out with retroactive effect. The rehabilitation figures appear in a separate chapter (Chapter 2).

2. Calculating episodes in addiction care

The episode concept is introduced into the Core figures for the first time. The history of all registrations and contacts is portrayed for each person seeking assistance. Care episodes can be calculated from this. The total number of episodes and the duration of all episodes are reported. The definition of an episode in LADIS is explained in Annex III.

3. Secondary clients

Addiction care also makes provisions for the client's environment. Parents, partners and children are involved in providing assistance. They are also sometimes referred to as secondary clients. A separate paragraph is devoted to this group in Chapter 1.

Annex III: Definition of an episode in LADIS

The term episode is used for the first time in the Core figures. A treatment history with data as from 1994 can be drawn up for each client in addiction care. All registrations and contacts can be shown chronologically and care episodes can be defined. This refers to a period where a person has been treated in addiction care for a consecutive length of time. An episode can consist of more than one institution that overlap or occur shortly after each other.

Two points play a role from an historic perspective when operationalising the definition:

1. Contacts were not effectively registered at all institutions in the past
2. Discharge was not consistent at all institutions.

In the light of this historic practice with registration, the following definition has been adopted:

- The start of an episode is the contact date.
- The end is determined by the discharge date.
- If this is not known, the end of the episode is determined by the date of the last contact + six months.
- The above rule is also applied when the discharge date is later than the last contact date + six months.
- A new registration or a contact without prior discharge within six months following the end of an episode without a discharge date is registered under the previous episode.

An episode is therefore not really a treatment period that runs from the first to the last contact. This would be the most desirable approach but because of the limitations mentioned an administrative basis was adopted for the episode.
The result of this decision is that an episode sometimes takes longer than the actual treatment period where no discharge date exists. The episode has nonetheless been consistently calculated for all registration years and for the various problems.

A look will be taken in consultation with experts from the institutions at whether this definition can be improved within the possibilities for data collection.

Annex IV: Dictionary Dutch – English

Aandeel	Share
Aantal	Number
Afgelopen	Last
Alcohol	Alcohol
Ambulant	Out-patient
Amfetamine	Amphetamine
Arts	Practitioner
Autochtoon	Native Dutch
Behandeling	Treatment
Beide	Both
Bekend	Known
Bijmiddel	Secondary problem
Cannabis	Cannabis
Cliënt(en)	Client(s)
Cocaine	Cocaine
Crisisinterventie	Crisis intervention
Dag- nachtopvang	Day/night care
Ecstacy	Ecstasy
Eerder	Previous
Eetverslaving	Eating disorder
Geen	None
Gemiddelde	Average
Geslacht	Gender
Gezondheidszorg	Health care
GHB	GHB
Gokken	Gambling
Hulpvraag	Treatment demand
Intraveneus	Intravenous
Jaar	Year
Jongeren	Younger people
Justitie	Justice
Klinisch	In-patient
Leeftijd	Age
Maand	Month
Maatschappelijke begeleiding	Social assistance
Man	Male
Medicijnen	Medicines
Methadon	Methadone
Niet-westers allochtoon	Non-Western ethnic minority
Nieuw	New
Onbekend	Unknown
Ontwikkeling	Development
Opiaten	Opiates
Opwekkende middelen	Stimulants
Ouderen	Elderly people
Overig	Other
Primair	Primary
Problematiek	Problem
Reclassering	Rehabilitation

Secundair	Secondary
Totaal	Total
Uniek	Unique
Verpleegkundige	Nurse
Verslavingszorg	Addiction care
Vloeibaar	Liquid
Vluchtige middelen	Fluid substances
Vrouw	Female
Westers Allochtoon	Western ethnic minority

Colophon

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