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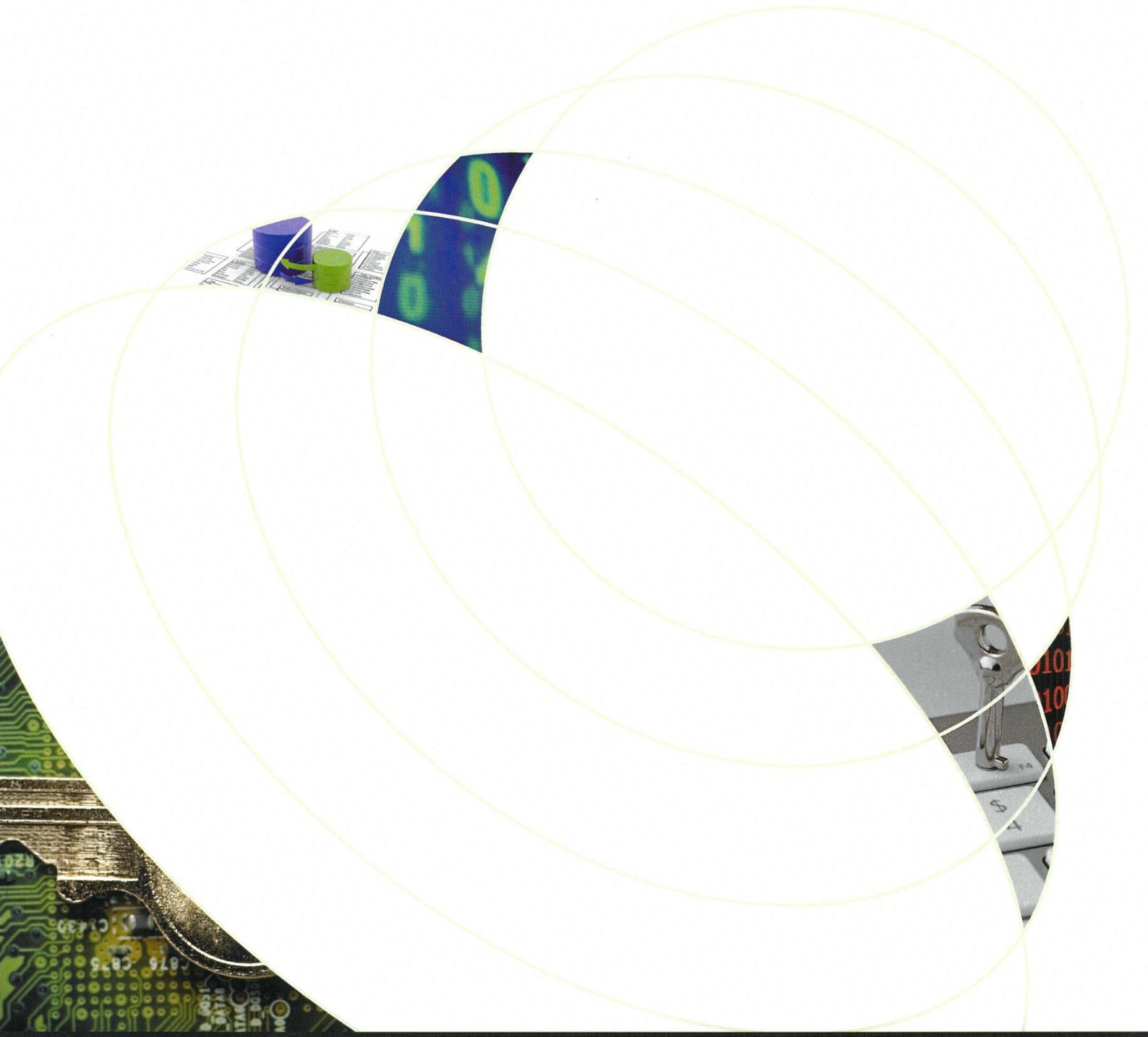

Key Figures Addiction Care 2015

National Alcohol and Drugs Information System

KEY FIGURES
ADDICTION CARE 2015

LADIS
NATIONAL ALCOHOL AND DRUGS INFORMATION SYSTEM

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Table of Contents

Introduction 7

1. Addiction care as a whole 10
1.1 Highlights 10
1.2 In brief 10
1.3 People by primary problem 11
1.4 Trend in primary problems, 2006-2015 13
1.5 Number of unique people treated since 1994 13
1.6 Demographics 14
1.6.1 Young and old 14
1.6.2 Age distribution by primary problem 14
1.6.3 Gender 15
1.6.4 Cultural origin 16
1.7 Regional spread 17
1.8 Multiple problems 18
1.9 Type of treatment 19
1.10 Throughput 20
1.11 Treatment history 22
1.12 Contacts 24

2 Alcohol 27
2.1 Highlights 27
2.2 In brief 27
2.3 Trends and development of treatment demand 27
2.4 Young and old 28
2.5 Regional spread 29
2.6 New and known 30
2.7 Treatment history 30
2.8 Secondary problems 32
2.9 Use as an additional substance 32

3 Opiates 33
3.1 Highlights 33
3.2 In brief 33
3.3 Trends and development of treatment demand 33
3.4 Young and old 34
3.5 Regional spread 35
3.6 New and known 36

3.7 Treatment history 36
3.8 Secondary problems 37
3.9 Use as an additional substance 38
3.10 Intravenous use 38
3.11 Methadone 39

4 Cocaine 40
4.1 Highlights 40
4.2 In brief 40
4.3 Trends and development of treatment demand 40
4.4 Young and old 41
4.5 Regional spread 42
4.6 New and known 43
4.7 Treatment history 43
4.8 Secondary problems 44
4.9 Use as an additional substance 45

5 Cannabis 46
5.1 Highlights 46
5.2 In brief 46
5.3 Trends and development of treatment demand 46
5.4 Young and old 47
5.5 Regional spread 48
5.6 New and known 49
5.7 Treatment history 49
5.8 Secondary problems 50
5.9 Use as an additional substance 51
5.10 Type of cannabis 51

6 Amphetamine 52
6.1 Highlights 52
6.2 In brief 52
6.3 Trends and development of treatment demand 52
6.4 Young and old 53
6.5 Regional spread 55
6.6 New and known 56
6.7 Treatment history 56
6.8 Secondary problems 57
6.9 Use as an additional substance 58

7 Ecstasy 59
7.1 Highlights 59
7.2 In brief 59
7.3 Trends and development of treatment demand 59
7.4 Young and old 60
7.5 Regional spread 61
7.6 New and known 62
7.7 Treatment history 62
7.8 Secondary problems 63
7.9 Use as an additional substance 64

8 GHB 65
8.1 Highlights 65
8.2 In brief 65
8.3 Trends and development of treatment demand 65
8.4 Young and old 66
8.5 Regional spread 67
8.6 New and known 68
8.7 Treatment history 68
8.8 Secondary problems 69
8.9 Use as an additional substance 70

9 Medicines 71
9.1 Highlights 71
9.2 In brief 71
9.3 Trends and development of treatment demand 71
9.4 Young and old 72
9.5 Regional spread 73
9.6 New and known 73
9.7 Treatment history 74
9.8 Secondary problems 75
9.9 Use as an additional substance 75

10 Gambling 76
10.1 Highlights 76
10.2 In brief 76
10.3 Trends and development of treatment demand 76
10.4 Young and old 77
10.5 Regional spread 78
10.6 New and known 79

10.7 Treatment history 79
10.8 Secondary problems 80
10.9 Gambling as a secondary problem 81

11 Other 82
11.1 Highlights 82
11.2 In brief 82
11.3 Internet gaming 83
11.3.1 In brief 83
11.4 Nicotine 84
11.4.1 In brief 84

12 Rehabilitation 85
12.1 Highlights 85
12.2 In brief 85
12.3 People by primary problem 86

Annex I: Participating institutions 88

Annex II: LADIS compared to previous editions 89

Annex III: Definition of an episode in LADIS 90

Annex IV: Dictionary Dutch – English 91

Colophon 93

Introduction

You have before you the 30th edition of the Key figures in Addiction Care. These figures contain up-to-date insights into the development of treatment demand and care provision in the addiction care sector in the year 2015.
As the words indicate, “key” figures are shown and regularly raise questions for further examination of the figures presented. We shall be pleased to consider with you if and how we might provide such additional insight.

The demand for treatment has decreased by about 7% compared to 2014.
This decline continues the trend of decline in the demand for treatment that began in 2011. This decline, which mainly took place in 2015 for alcohol, cocaine and gambling, was not observed at the same rate for all substances; the drug ecstasy even showed an increase.

IVZ and LADIS

IVZ has been collecting data for 30 years on the treatment demand and care provision in Dutch addiction care. As a result, a unique data collection has been created. As well as producing annual key figures, IVZ regularly publishes themed bulletins providing in-depth insights into current issues.
A strong point is that information concerning the same people can be gathered from multiple sources. Because of the unique manner of identification, data encryption and the use of pseudonyms, individuals can be followed even though the data is not traceable to them.
IVZ has paid considerable attention to protecting the privacy of individuals and improving it in connection with relevant recent developments in legislation and technical capabilities.

Additionally, IVZ is constantly engaged in improving the quality of the LADIS database. The better the quality of the data collected, the greater the value of what is presented and the more extensive its usefulness for policy and research. Therefore, we give continuous attention to:

- New and improved insights based on the data collected
- Improving data submission and quality control
- Improving feedback to institutions
- Enlarging coverage of participation in LADIS

New and improved insights based on the data collected

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

IVZ also prepares thematic analyses of the data collected. Over the past few years, the following bulletins have been published:

- 25 years of LADIS (December 2011), a publication on the occasion of the symposium emphasising the value of LADIS from various aspects;
- GHB treatment demand in the Netherlands (May 2013);
- Key Figures 2014 (August 2015);
- Recidivism in GHB treatment demand (September 2014).
- Bulletin on developments in alcohol treatment (December 2015).

These analyses are achieved in collaboration with various experts from the IVZ network, such as Trimbos and the contributing institutions. Since the LADIS database is one of the oldest registrations (30 years in 2016) and since there have been more than 350,000 individuals with a treatment demand related to an addiction problem in the database since 1994 (the start of unique client coding), investigations using secondary analyses, such as cohort studies, are also possible.

Improvement of data submission and quality control

Registration of data and registration of activities are often regarded as synonymous with administrative burdening. IVZ is continuously trying to make the registration of data as simple as possible.
In 2013, an important step was taken to reduce the administrative burden and improve the quality of the supply. This makes it easier to supply the recorded data within the institution from the EPD. LADIS stores all data on the basis of unique characteristics that are no longer traceable to the original person. The data is tested for quality and reliability, among other things, by comparison with earlier submissions from the relevant institution.
In consultation with the institutions, the completeness and accuracy of the data supplied are reviewed. If data on those requesting treatment is supplied without sufficiently identifying particulars or elementary data is missing such as gender, date of birth or primary and secondary problems, these data is not included in the LADIS Key figures.
One complication in delivering data was the Basic Mental Health Care[1]. Due to the different ways in which this is arranged within institutions, a number of institutions had discrepancies in delivery. Where possible, they were resolved together with the relevant institutions. We would like to express our appreciation for the cooperation from the institutions and for the major effort with which everyone concerned ultimately provided data. Also, a special word of thanks for the responsible staff within the institutions.

The demand for data delivery within the framework of the European obligations of the Netherlands to the EMCDDA (TDI) is modified on a regular basis. IVZ commits itself to make sure LADIS continues to comply with these TDI requirements permanently. To do so, LADIS regularly updates the data in consultation with the Ministry of Health, Welfare and Sport and the institutions.

Improvement of feedback reports to institutions

It is important for the quality of data collections that those reporting data have insight into the results of the data supplied. IVZ therefore also provides feedback in a number of ways. Firstly, in a transparent report including a justification of the data submitted. Institutions can then check quickly whether the content of LADIS matches their own insights. Meanwhile, the LADIS dashboard is operational as well. Using the dashboard, institutions can compare the data submitted by them with national figures, and identify differences with national trends or trends from the institution's past. In cooperation with the institutions, IVZ is gradually expanding this feature with new relevant information, such as recidivist and throughput data.

Enhancing the coverage of participation in LADIS

In LADIS, the IVZ is trying to provide a full overview of all people in the Netherlands who "somewhere" come knocking at our door with treatment demand related to problematic use of substances. "Somewhere" in this context means all addiction care institutions and GGZ institutions that offer specific treatment or supervision to these people.
LADIS provides an insight into these clients, both the ambulatory and the intramural, who actually call on addiction care institutions.

[1] Since 2014, primary mental healthcare and part of the secondary mental health services together form the generalist basic mental health care. People with mild to moderate, non-complex psychiatric and addiction problems and people with stable chronic problems are treated here.

In order to obtain as full a picture as possible of the supply of and demand for addiction care, data on addiction rehabilitation have since 1994 also been linked in, where possible, at the individual client level. This linkage has proved increasingly more difficult in recent years due to the way rehabilitation is registered. This means that, for 2015, the lack of this information has affected trends to such an extent that it has been decided to present rehabilitation as a separate group and not link it with addiction care data.

Data is also missing. In the Netherlands, internet treatment/care provision has increased. These projects are offered by various institutions. This care provision is in first instance anonymous and is not registered (at least, not according to LADIS criteria). LADIS is adapted to registration of identifiable internet treatments.

Another partially missing link were the private care providers and private clinics. These generally concentrate on a specific target group within addiction care. IVZ meanwhile made arrangements with several clinics about supplying data to LADIS. Most of these institutions have meanwhile also supplied data that have been included in this year's key figures.
These private clinics generally involve a limited number of people requesting treatment. The trend-based developments, as presented in LADIS, have little or no influence.
Often missing are also the users' data, which for other, often psychological problems are handled in other institutions in mental health care. There is an increasing supply within this area focused on addiction problems. Meanwhile, the first institution, Dimence, has supplied data to LADIS. It has contributed to the key figures since 2013.

Effective security and protection of privacy for the data submitted.
Data protection is a very important point of attention for IVZ. IVZ ensures data protection in accordance with the established security policy and the NEN 7510-7512 standard. IVZ has external experts undertake an audit frequently to test all internal and external processes against the standard.
The data for LADIS are supplied through ZorgTTP, ZorgTTP assigning a pseudonym to each person by encrypting the identifying data. This approach guarantees that the individual can no longer be traced. ZorgTTP also complies with strict safety requirements and is audited for this regularly. For more information see www.zorgttp.nl.

Finally, a word of thanks to all those who have contributed to the compilation of these key figures, at the participating institutions in the field of addiction care, at research institutions and at IVZ.

Jan Weber
Director IVZ

1. Addiction care as a whole[2]

1.1 Highlights

- The number of persons in addiction care decreased by 7% in 2015 compared to 2014.
- Treatment demand for alcohol, cannabis, opiates and cocaine is responsible for 87% of the total treatment demand.
- The decrease is mainly caused by the decrease in these groups.
- The number of people requesting treatment for GHB and ecstasy is relatively small but contrary to the overall trend, the number of people requesting treatment is increasing.
- The average number of hospital stay days per person is declining.

1.2 In brief

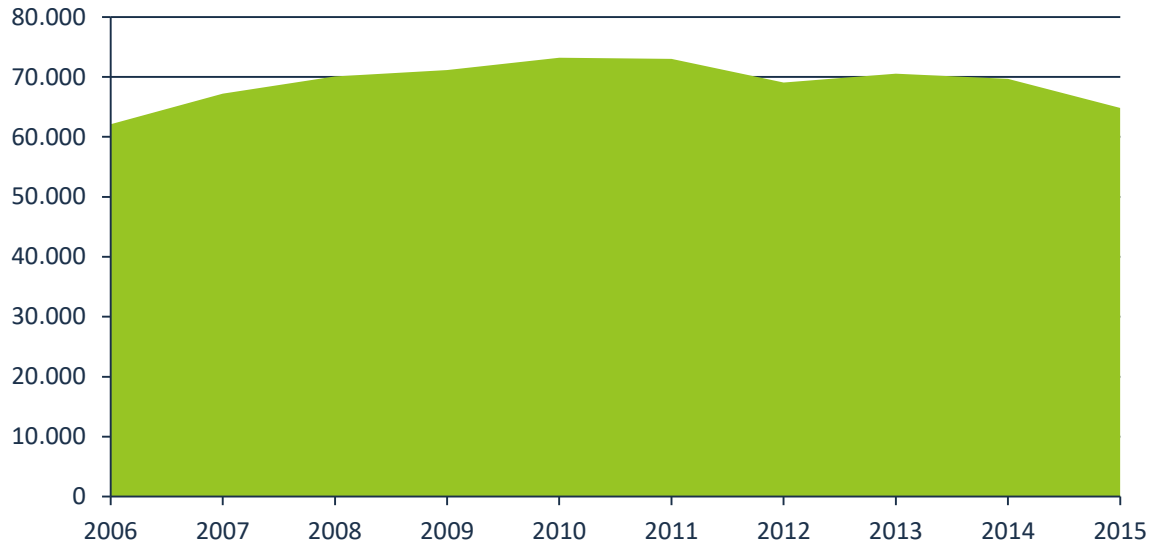
table 1 **Overview of addiction care as a whole in 2015[3]**

Demographics		
	Number of clients	64,821
	Male : Female	76:24
	Average age	42
	Proportion 25-	13%
	Proportion 55+	19%
	Proportion of Dutch natives	80%
	Number per 100,000 inhabitants	384
Problems		
	Single: Multiple	58:42
	First registration ever	21%
	Number of contacts	2,109,000

In 2015, 65,000 unique persons were treated in addiction care. More than three quarters are male. The average age is just under 42 years.
One in eight clients is younger than 25 years old. One in five clients is over 55 years old.
For one in five clients registered in 2015 it was their first registration in addiction care.
The number of clients that underwent treatment in 2015 decreased by 7% compared with 2014 (see Figure 1: .

[2] The source of the Key Figures Addiction Care is the National Alcohol and Drugs Information System (LADIS). Almost all addiction care institutions submit their data. Annex I shows an overview of the list with participating institutions.
[3] Unless stated otherwise, the presented figures concern addiction care exclusive of addiction rehabilitation. This also applies to the trend figures.

Figure 1: Treatment demand in addiction care: Number of unique clients, 2006 - 2015



There has been a declining trend in the number of clients in addiction care since 2011. This decline continued in 2015. This does not mean that there have been fewer people in the Netherlands with an addiction problem. Other factors may play a role, such as cutbacks in mental health care and the introduction of a personal contribution starting 1 January 2012. Municipal transition processes may also play a role. Furthermore, there may be a visible effect from the introduction of the generalist basic mental health care on 1 January 2014. The extent to which these factors play a role in the decline in treatment demand in addiction care cannot be established based on the LADIS figures.

1.3 People by primary problem

table 2 **People and contacts by primary problem, 2015**

Primary problem	Number of people in 2015	Proportion of problem	Change compared to 2014
Alcohol	29,374	45%	-8%
Opiates	9,093	14%	-6%
Cocaine	7,295	11%	-10%
Cannabis	10,816	17%	-6%
Amphetamine	1,794	3%	-1%
Ecstasy	122	0%	18%
GHB	837	1%	4%
Medicines	839	1%	-2%
Gambling	2,186	3%	-10%
Other	2,465	4%	-3%
Total	**64,821**	**100%**	**-7%**

- In 2015 the number of **clients** dropped by 7% compared to 2014.
- **Alcohol** is the most frequently occurring problem. Almost half of treatment demand in addiction care concerns alcohol. Compared to 2014, there is a decrease of 8%.
- The number of clients for **cannabis** decreased by 6% in 2015.
- The years of decline in treatment demand for **opiates** continues. There was a 6% decline in 2015.
- Treatment demand for **cocaine** also decreased by 10% in 2015.
- The number of people requesting treatment for **GHB** and **ecstasy** is relatively small but contrary to the overall trend there has been a limited increase in the number of people requesting treatment.
- Treatment demand for **gambling** decreased by 10% in 2015.

- The category **Other** includes treatment demand for Internet gaming, nicotine addiction, eating disorders and sex addiction. This category has been increasing as a **percentage** of the total treatment demand in addiction care (3% decline in number compared to a 7% decline in the total treatment demand).

Figure 2 shows the distribution of treatment demand by problem in 2015.

Figure 2: Treatment demand distribution by primary problem in 2015 (N=64,821)

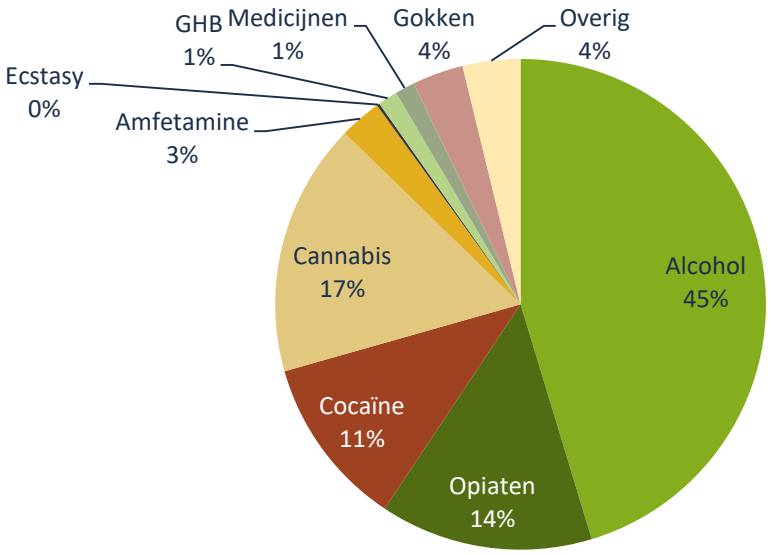


Figure 3: Development of treatment demand by percentage (%) of primary problem 2006, 2010 and 2015

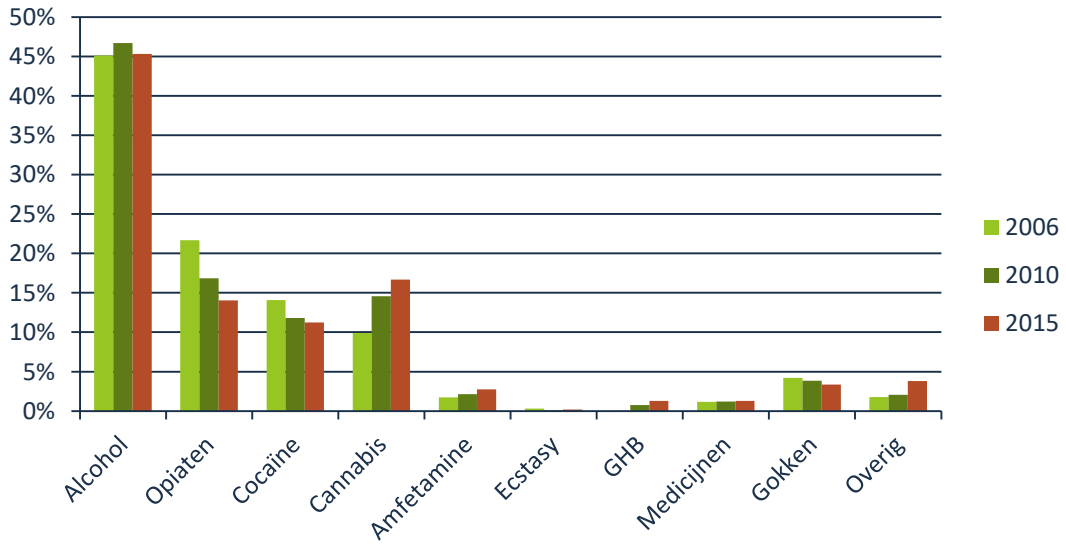


Figure 3 shows the development of treatment demand by proportion in addiction care.
The proportion of opiates and cocaine has decreased over the past 10 years. The proportion of cannabis use related treatment demand has increased over the same period. The proportion of gambling is decreasing whereas the proportion of the group of other addictions (particularly nicotine addiction, eating disorders, internet gaming, and sex addiction) is increasing.

1.4 Trend in primary problems, 2006-2015

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

Figure 4: Number of clients by primary problem 2006-2015

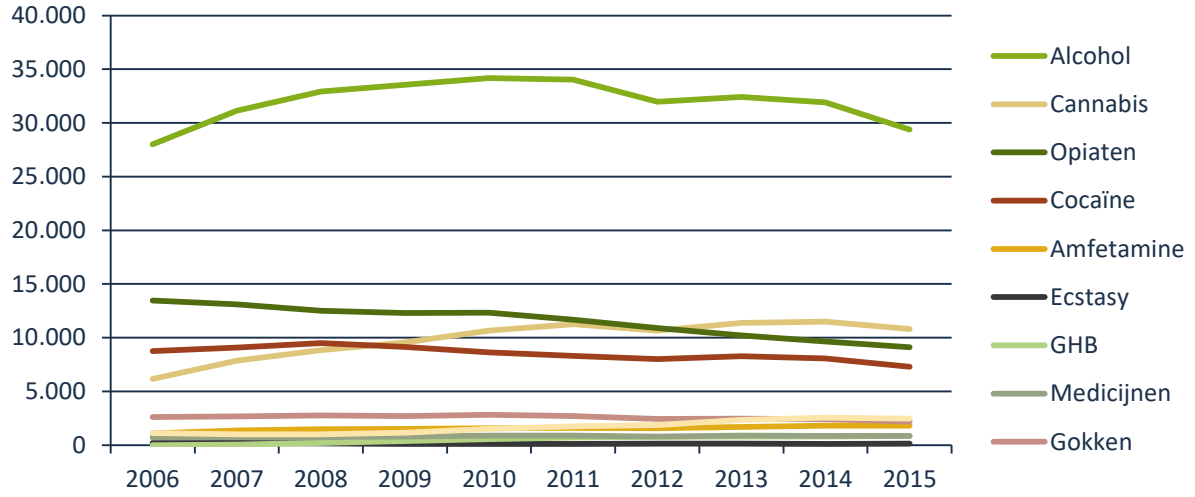


Table 2 shows that total treatment demand in addiction care decreased by 7% in 2015 compared to 2014. Figure 4 shows that this decline is mainly caused by the decline among the large groups: in 2015, taken together, alcohol, cannabis, opiates and cocaine accounted for almost 90% of the treatment demand in addiction care.

1.5 Number of unique people treated since 1994

Using the anonymised key, which is created to the source during registration and a second encryption via ZorgTTP, an independent party (Trusted Third Party), it can be determined with 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 treatment over the past 21 years. In the period 1994-2015 more than 400,000 unique people have turned to addiction care for treatment. Table 3 shows the number of unique people, subdivided by primary problem. The numbers have been rounded up/down.

table 3 **Number of unique people in addiction care by primary problem 1994-2015**

Primary problem	Number of unique people
Alcohol	212,000
Opiates	49,000
Cocaine	56,000
Cannabis	68,000
Amphetamine	11,000
Ecstasy	2,700
GHB	2,300
Medicines	7,200
Gambling	34,000
Other	16,000
TOTAL[4]	395,000

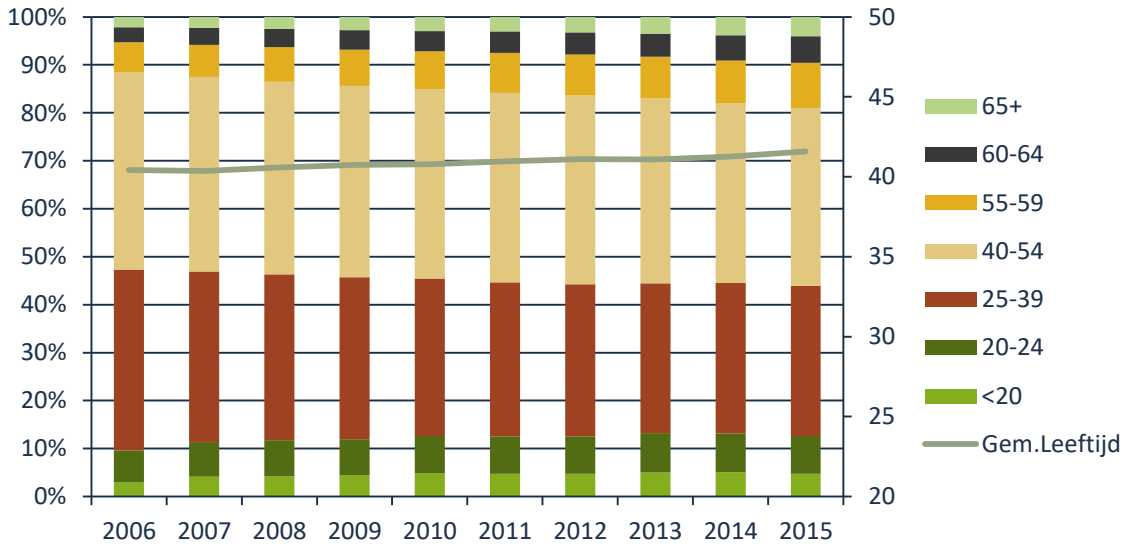
[4] The total number of these unique people does not equal the sum of the various problems. Approximately 65,000 people have approached an institution for treatment several times and for different problems.

1.6 Demographics

1.6.1 Young and old

The Dutch population is ageing. And the number of older people in addiction care is increasing. In 2015, the average age of people requesting treatment in addiction care increased to 41.6 years. This is caused, in particular, by the increase in the proportion of older people in the group with an alcohol and opiates related treatment demand. See also sections 2.4 and 3.4.

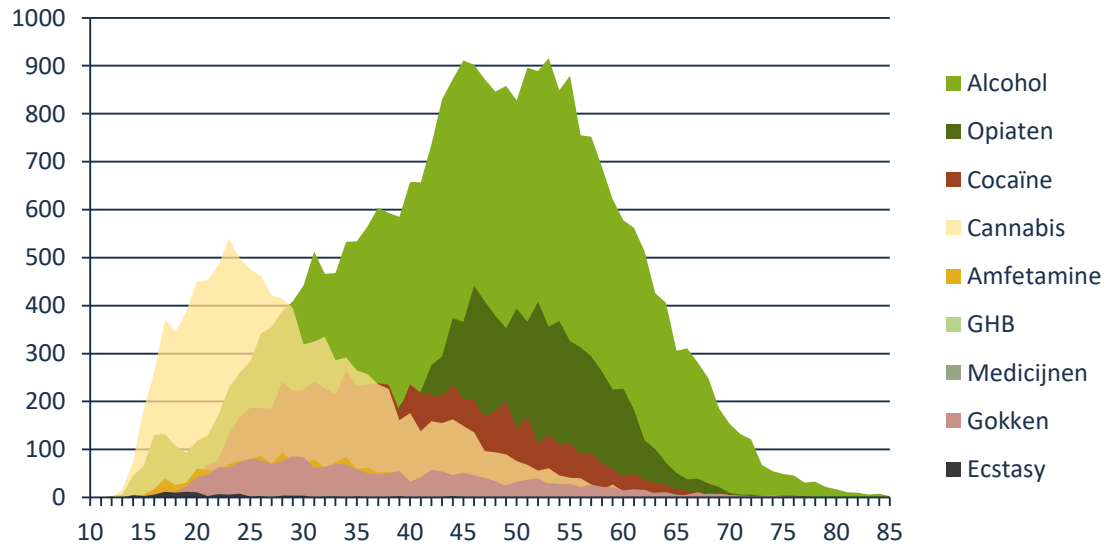
Figure 5: Treatment demand by age category, 2006-2015



By far the largest group of people who turn to addiction care are between 25 and 55 years years of age. The share of this age category is, however, decreasing. The percentage of young people (<25 years) increased between 2006 and 2010, remained the same between 2011 and 2014 and declined in 2015. The percentage of people 55 years and older continues to rise. In 2015, nearly one in five people requesting treatment in addiction care was older than 55 years.

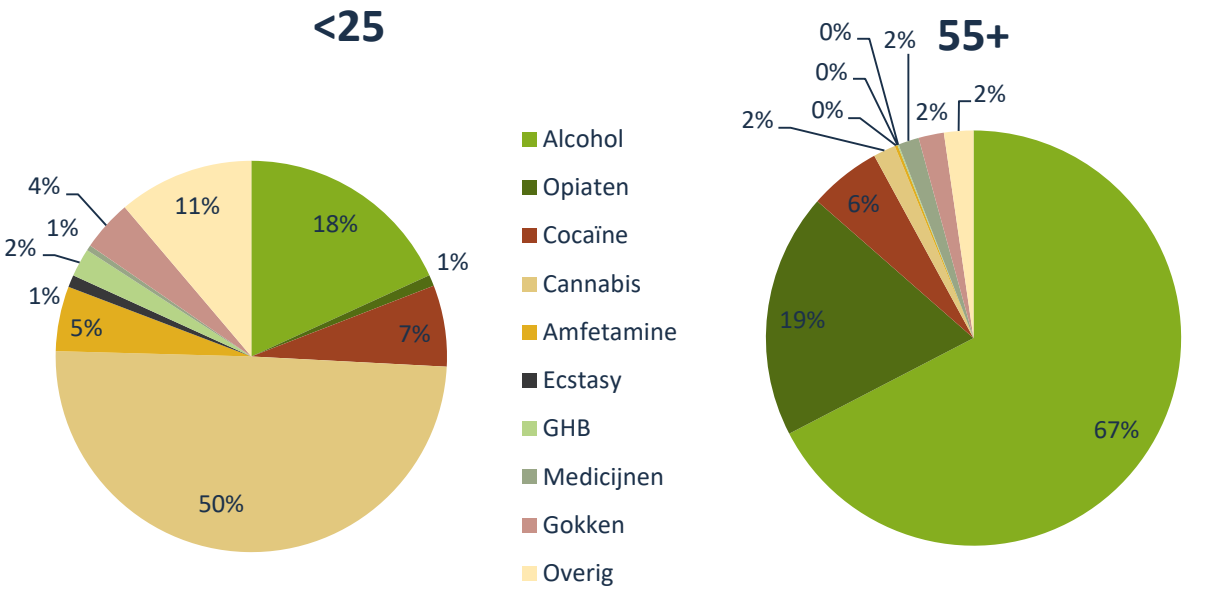
1.6.2 Age distribution by primary problem

Figure 6: Age distribution by primary problem 2015 (N=64,821)



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 overrepresented. The cannabis, GHB, amphetamine and ecstasy group includes relatively more younger people.
Figure 7 shows the distribution of primary problems for young people (<25 years) and older people (55+), respectively.

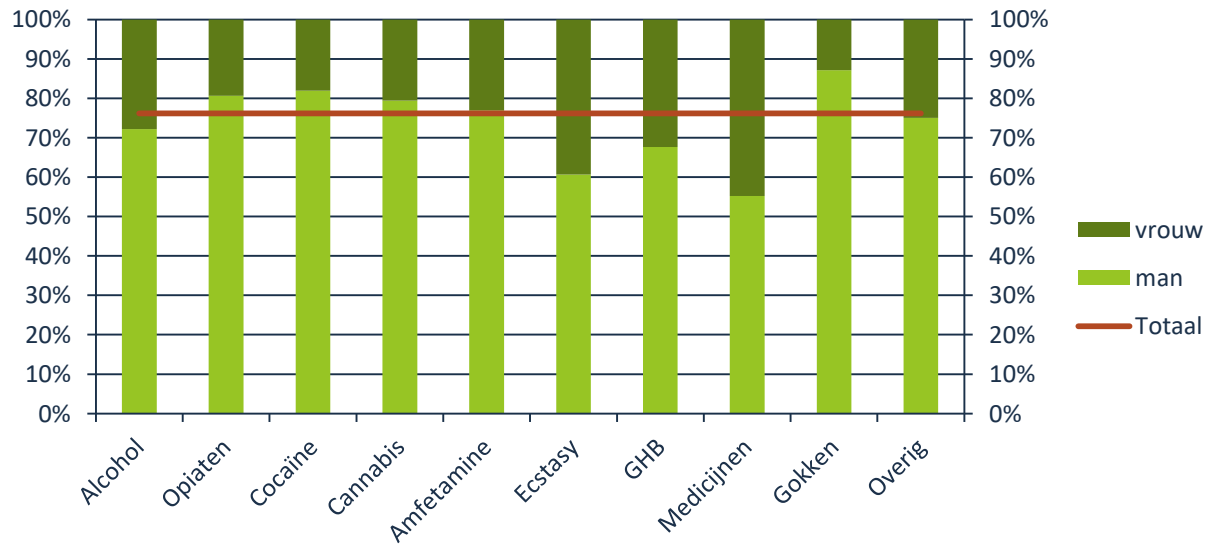
Figure 7: Distribution of the primary problem for young people (<25 years) and older people (55+) in 2015



In young people up to 25 years, cannabis is the reason for the demand for treatment in more than half of the cases. Alcohol is by far the most common reason for the demand for treatment in older people (55 years and older), with approximately two-thirds of the cases. The percentage of opiates among older people is increasing the most as compared to young people.

1.6.3 Gender

Figure 8: Gender by to primary problem 2015 (N=64,821)



During the past 10 years, the male-female ratio has remained constant among people requesting treatment in addiction care. 1 in 4 clients is female.
Subdivided according to problem there are differences by gender. Gambling is mainly a problem for men, whereas medicines addiction, ecstasy addiction and GHB addiction occur in women relatively frequently.

1.6.4 Cultural origin

Almost 80% of all clients are Dutch natives. This is in accordance with the percentage of Dutch natives in the general population. The cultural backgrounds of clients in the addiction care sector are not essentially different from those in the population of the Netherlands.

table 4 **Cultural origin**[5]

	LADIS	Population 20156
Native Dutch	79.6%	78.3%
Western ethnic minority	6.9%	9.6%
Non-Western ethnic minority	13.5%	12.1%

Figure 9 shows the subdivision by cultural origin for the various problems.

Figure 9: Origin by primary problem 2015 (N=64,821)

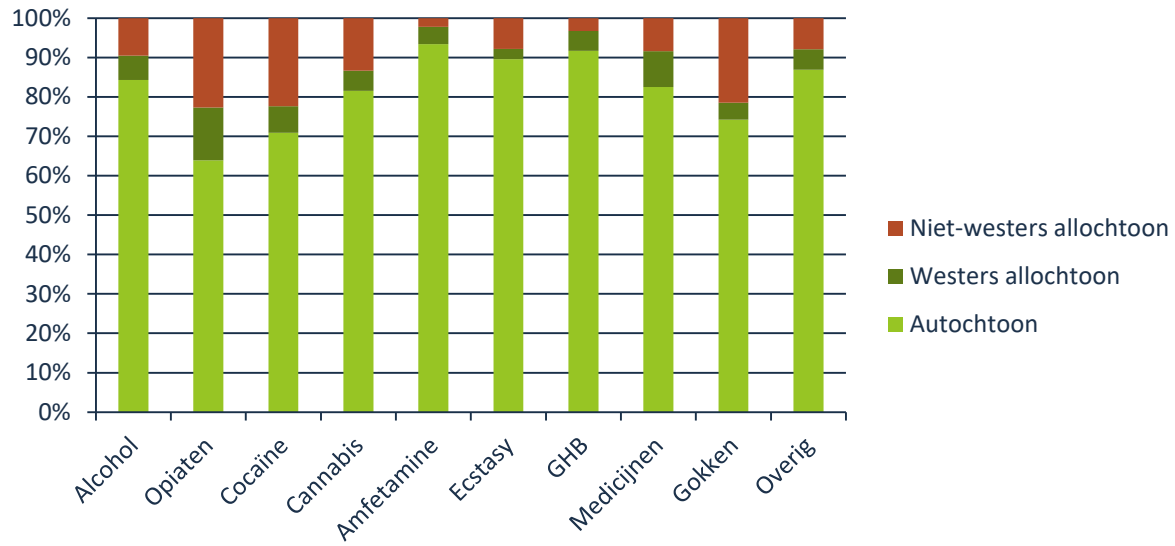


Figure 9 shows that the non-western ethnic minorities group is over-represented with regard to treatment demand with opiates, cocaine, and gambling related demands for treatment, compared to other problems. Treatment demands for GHB, ecstasy and amphetamine use related problems relatively often concern Dutch natives.

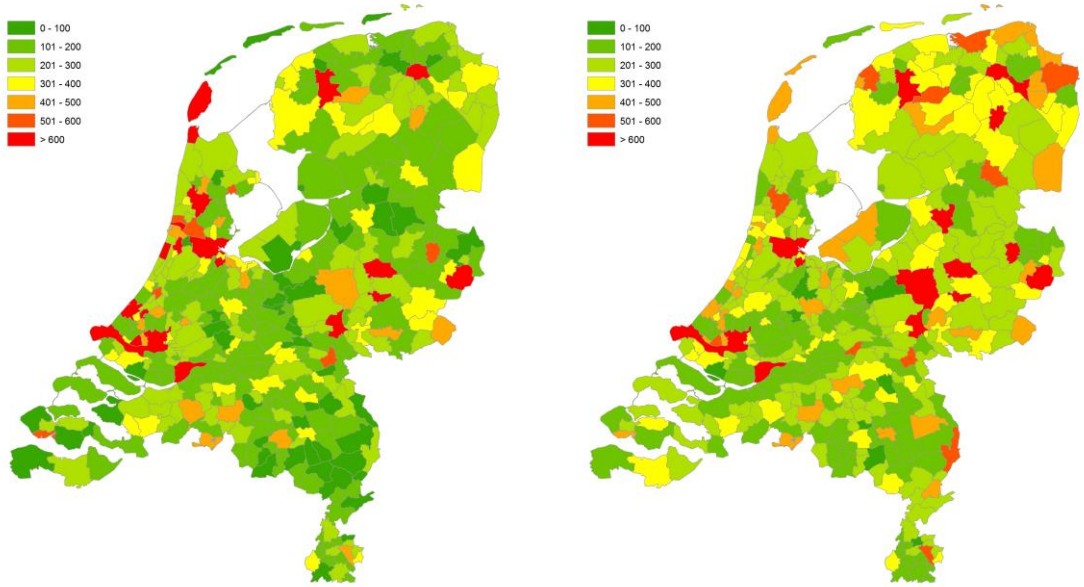
Western ethnic minorities have relatively considerable treatment demand in relation to opiates use.

[5] According to the CBS definition, based on country of origin, parents' country of origin and nationality.
[6] CBS Statline; Population by month; age, gender, origin, generation 2015.

1.7 Regional spread

Figure 10 shows the regional spread with regard to the number of clients in addiction care per 100,000 inhabitants. The various chapters present the number of people requesting addiction care by substance per 100,000 inhabitants.

Figure 10: Number of clients in addiction care per 100,000 inhabitants, 2006 and 2015



The number has increased slightly from 380/100,000 inhabitants in 2006 to 384/100,000 inhabitants in 2015.

1.8 Multiple problems

Of those requesting treatment in addiction care, 42% are facing multiple problems. In other words, problematic use of at least two substances or use of substances combined with a gambling problem. Multiple problems are found relatively often in combination with drugs problems. Single problems are found relatively often with alcohol, other addictions and gambling in particular.

Figure 11: Secondary problems (%) by primary problem, 2015 (N=64,821)

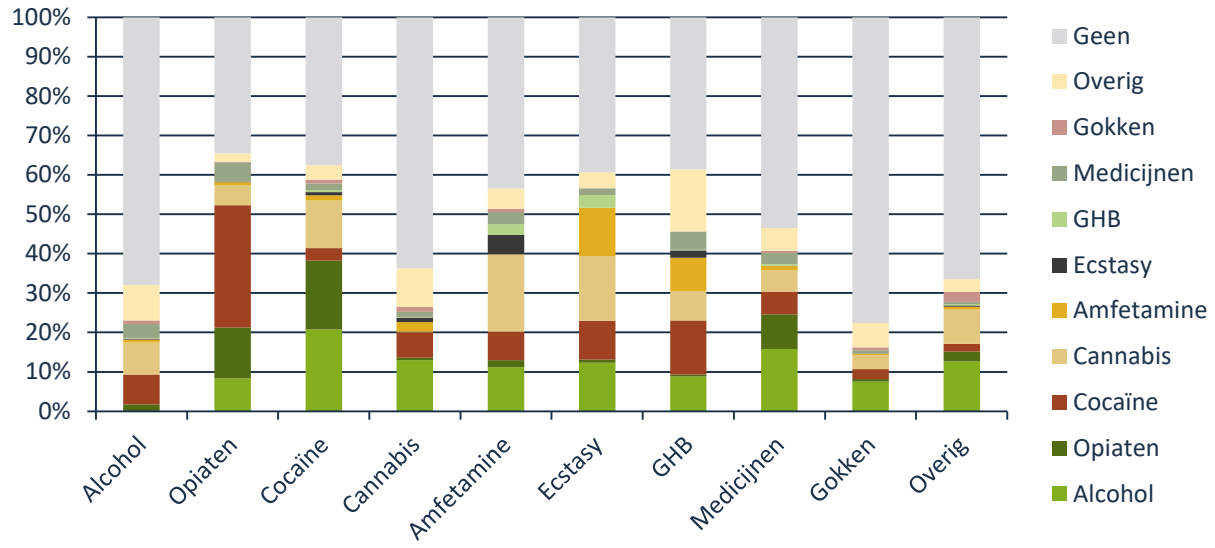


Table 5 shows the percentages for figure 11. The percentage of clients who also have secondary problems is indicated by primary problem.

table 5 **Secondary problems (%) by primary problem, 2015 (N=64,821)** [7]

	Primary problem									
Secondary ↓	**Alcohol**	**Opiates**	**Cocaine**	**Cannabis**	**Amphetamine**	**Ecstasy**	**GHB**	**Medicines**	**Gambling**	**Other**
Alcohol	0%	8%	21%	13%	11%	12%	9%	16%	8%	13%
Opiates	2%	13%	17%	1%	2%	1%	0%	9%	1%	3%
Cocaine	8%	31%	3%	6%	7%	10%	14%	6%	3%	2%
Cannabis	8%	5%	12%	0%	20%	16%	7%	5%	4%	9%
Amphetamine	1%	1%	1%	2%	0%	12%	8%	1%	0%	1%
Ecstasy	0%	0%	1%	1%	5%	0%	2%	0%	0%	0%
GHB	0%	0%	0%	0%	3%	3%	0%	0%	0%	0%
Medicines	4%	5%	2%	1%	3%	2%	5%	3%	1%	1%
Gambling	1%	0%	1%	1%	1%	0%	0%	1%	1%	2%
Other	9%	2%	4%	10%	5%	4%	16%	6%	6%	3%
Total	32%	65%	62%	36%	57%	61%	61%	46%	22%	34%
No sec. probl.	68%	35%	38%	64%	43%	39%	39%	54%	78%	66%

More than 60% of traditional hard-drug clients (opiates and cocaine) also present with other problems. The same applies for ecstasy, GHB and to a slightly lesser extent amphetamine.
The most common secondary problem is cannabis. Cannabis as a secondary problem frequently occurs in combination with alcohol, cocaine and amphetamine and ecstasy as the primary problem.

[7] It should be noted that for opiates, cocaine, cannabis, medicines, gambling and the category Other, the same problems can occur as primary or secondary problems. For example, primary crack-related problems and secondary snorted cocaine-related problems are reported as primary and secondary cocaine-related problems.

In addition, alcohol use related problems often occur as a secondary problem. Demands for treatment concern cocaine, cannabis, amphetamine and medicines. With GHB, amphetamine and cocaine are the most common additional substances. The combination of opiate use and cocaine (crack) use related treatment demand also frequently occurs.

1.9 Type of treatment

Figure 12 shows the trend by type of treatmenttreatment.

Figure 12: Type of treatment 2006- 2015

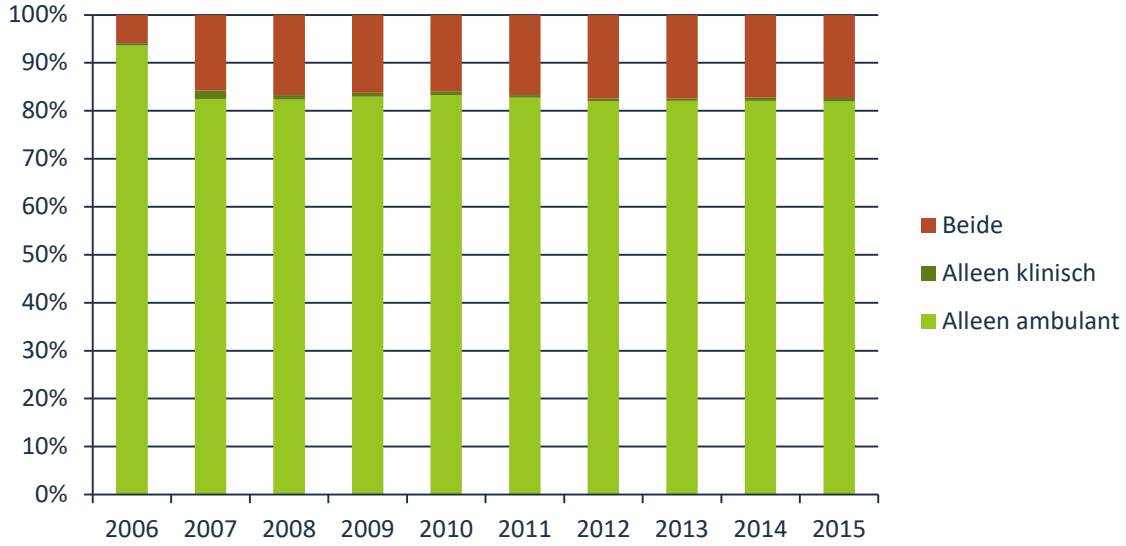
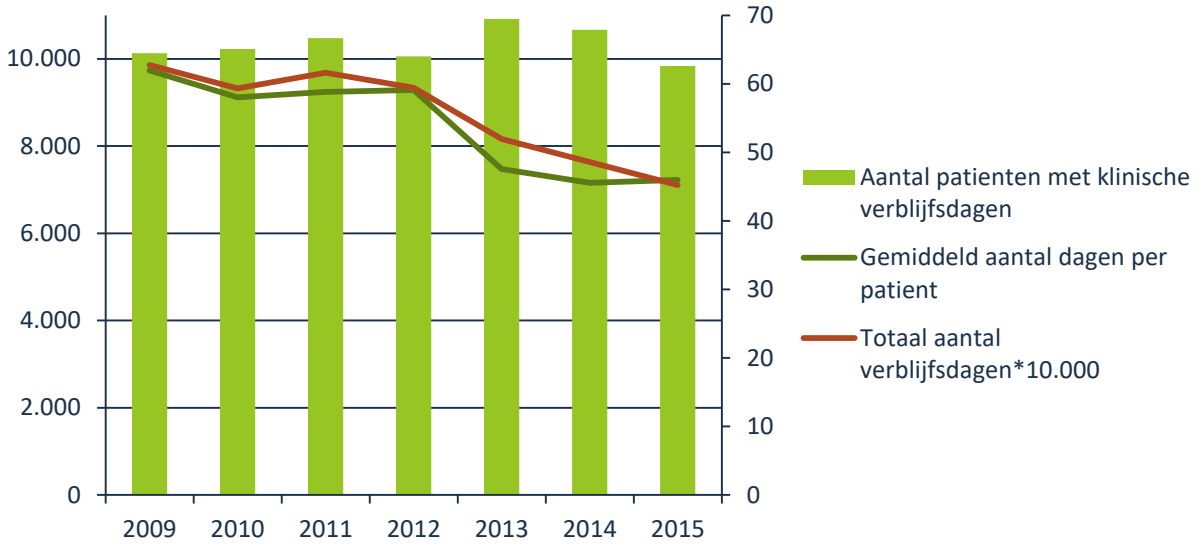


Figure 12 shows that more than 80% of the clients are only treated on an outpatient basis. This percentage has remained fairly constant since 2007.
If we look at the number of inpatient treatment days, the number has declined in the past years. Both the total volume and the average number of inpatient treatment daysper patient have declined.

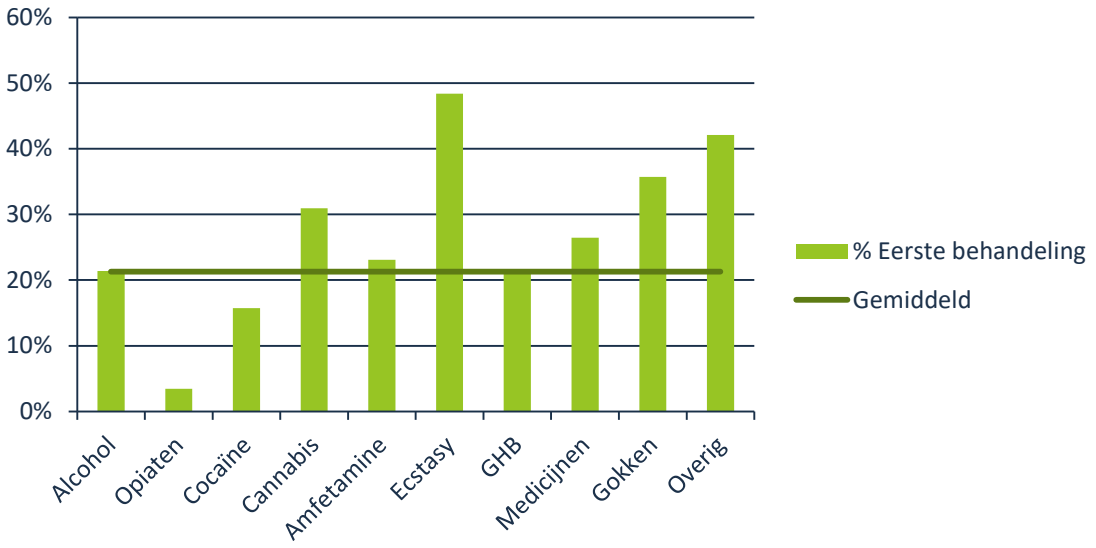
Figure 13: Inpatient treatment days2009- 2015



1.10 Throughput

In 2015, one in five clients has never been treated in addiction care before.
Here, too, there are major differences between the problems (see figure 14).

Figure 14: Proportion of new clients by problem in 2015 (N=64,821)



In the opiates group, there is hardly any new influx. Ecstasy (48%) and the category Others (42%) have most of the newcomers.
Important groups in the category Others are the people requesting treatment for nicotine and internet addiction (see chapter 12). There are also relatively many new clients with cannabis and gambling problems as their primary problem.

The average age of the newcomers is 36.3 years, which is lower than the average age of all people requesting treatment: 41.67 years (see also figure 5). With the exception of a slight increase in 2015 compared to 2014, the average age of the people who were being treated for the first time has decreased over the past 10 years (see figure 15).

Figure 15: Age of new clients 2006-2015

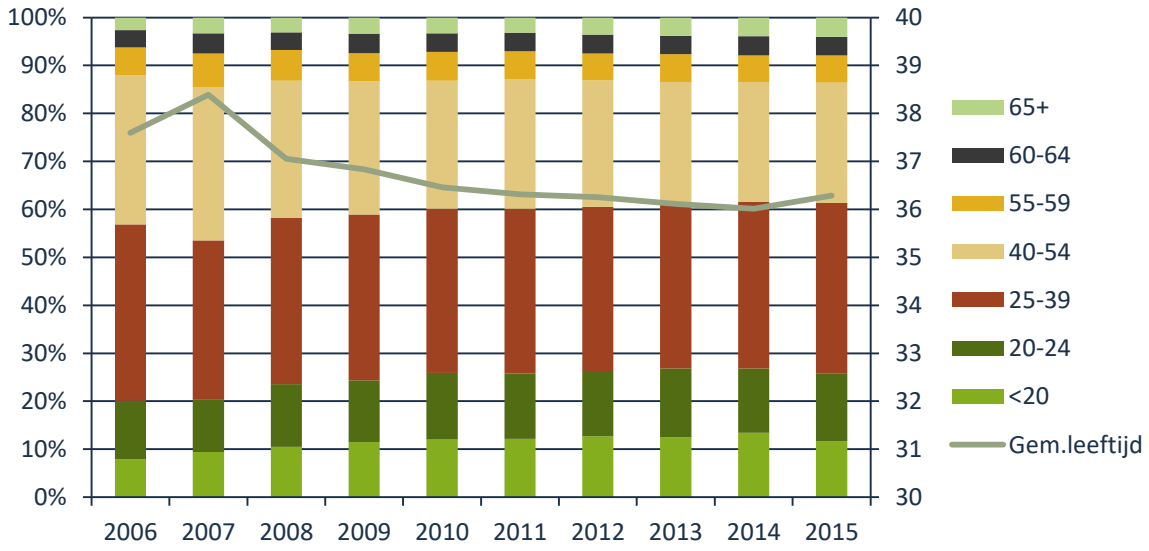
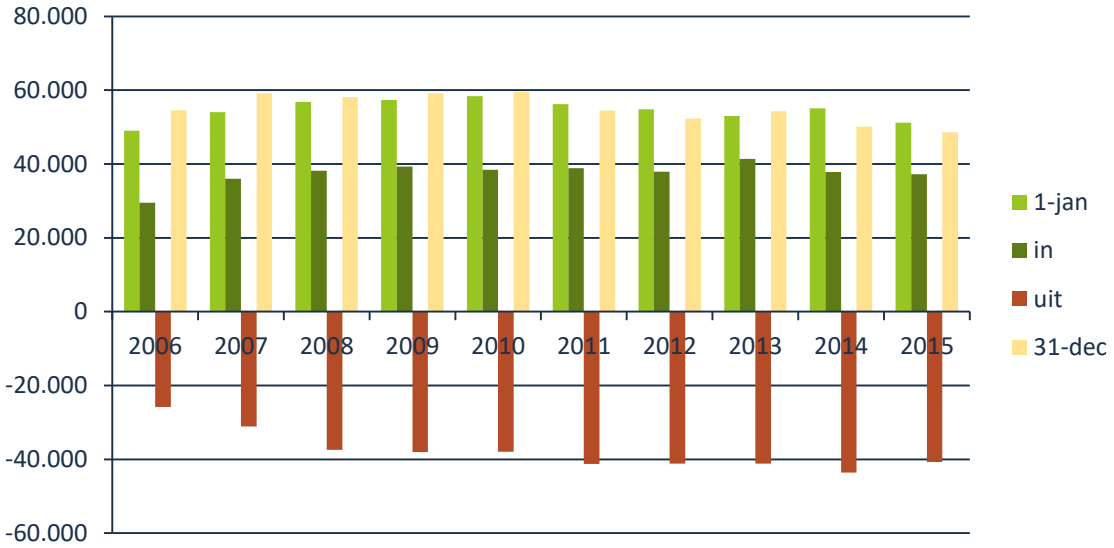


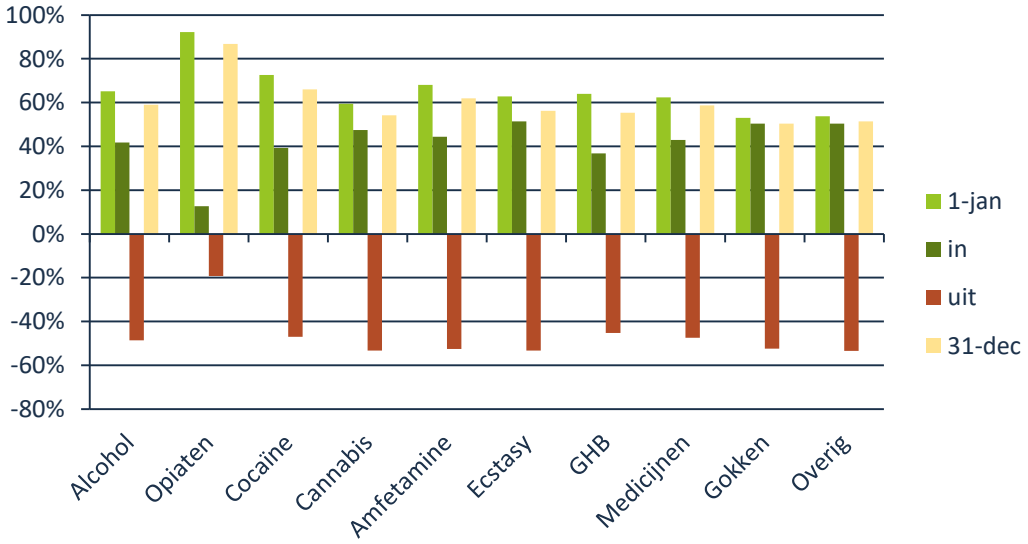
Figure 16 shows the annual number of clients on 1 January, the number of clients added (they may be new clients or clients with a relapse), the number of clients deregistered in the year in question, and the number on 31 December.[8] This gives an impression of the throughput.

Figure 16: Throughput in addiction care, 2006-2015



The pattern of throughput differs for the various problems. Figure 17 shows these differences in 2015. This is expressed as the percentage of the total number of unique clients registered for this problem in the registration year.

Figure 17: Throughput by primary problem in 2015 (as a % of the total number of unique persons in 2015)



As is known, the throughput of clients with opiates related problems is low. Both on 1 January and on 31 December, more than 90% of those requesting treatment for opiates related problems from 2015 were registered. With regard to treatment demand for ecstasy, gambling and the category Other, more than 50% of the total number of persons for the year were newly registered. At the same time, the same proportion were also deregistered. This shows that throughput is relatively high.

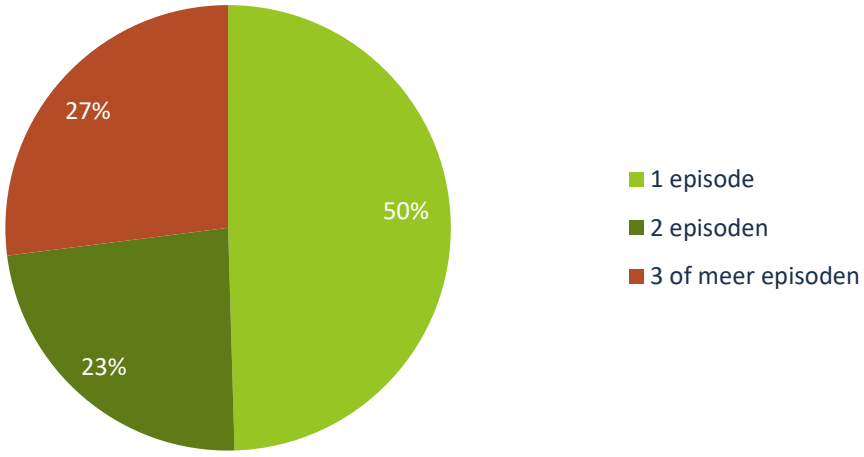
[8] The difference between 31 December and the following 1 January is the result of an administrative backlog at the time the data were supplied to LADIS.

1.11 Treatment history

By using the LADIS key, it is possible to follow clients throughout the years and throughout 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 can consist of more than one registration at several institutions that overlap or occur shortly after each other.
The exact definition of an episode can be found in Annex III. The difference between a new client (see 1.11 above) and a client with a first episode is that the first treatment is still continuing during a first episode. The start may have occurred in a previous year; a (first) episode may relate to several registration years.

Figure 18 shows the distribution of the number of episodes during which a person has been in care for those requesting treatment in 2015.

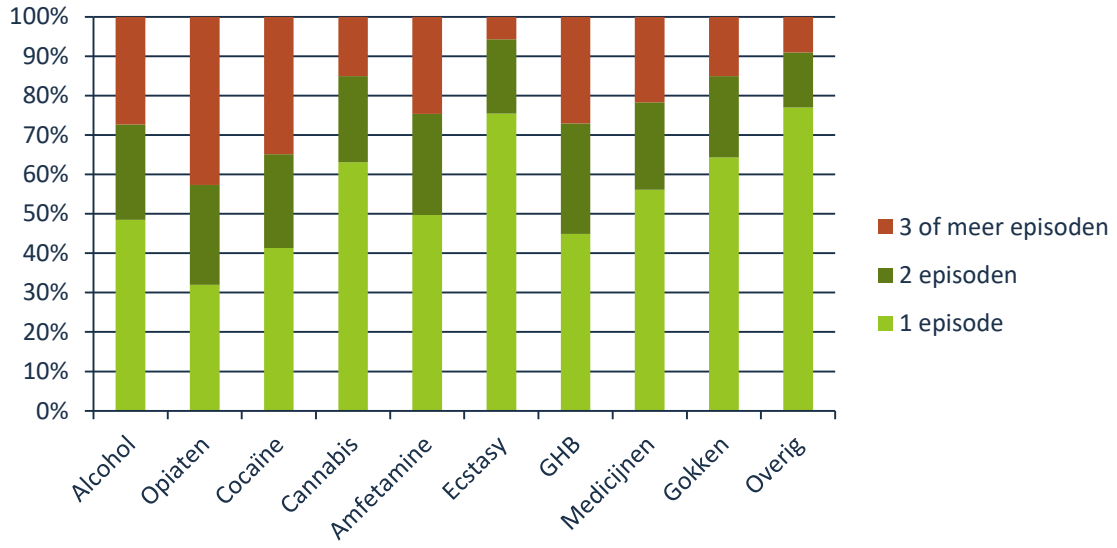
Figure 18: Number of episodes in addiction care 1994-2015 (N=64,821)



About half of the people from 2015 are in the first episode. Twenty-five percent of the people have three or more episodes in addiction care.

The number of episodes in the case history of clients from 2015 differs by primary problem. This distribution is shown in figure 19.

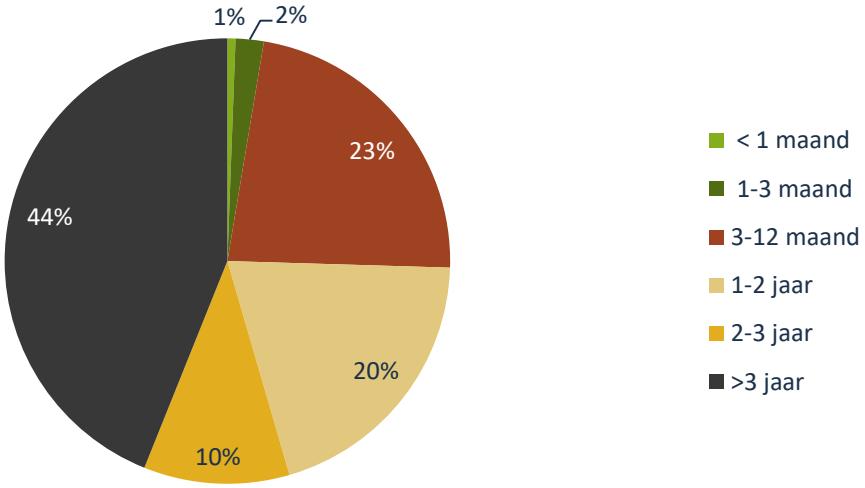
Figure 19: Number of episodes in addiction care by primary problem 1994-2015 (N=64,821)



Those requesting treatment for cocaine, opiates and GHB related problems 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 category Others, the majority is limited to one episode.
Not only the number of episodes but also the period of treatment of each episode has an important bearing on the extent to which a call is made on addiction care. It should be noted that the total episode duration is always a 'state of affairs'. By definition, newcomers have a relatively short episode duration. The total treatment duration for clients who were registered in previous registration years is also included in the calculations.

Figure 20 shows how the average total duration of treatment for all episodes (as from 1994) is distributed for clients in 2015.

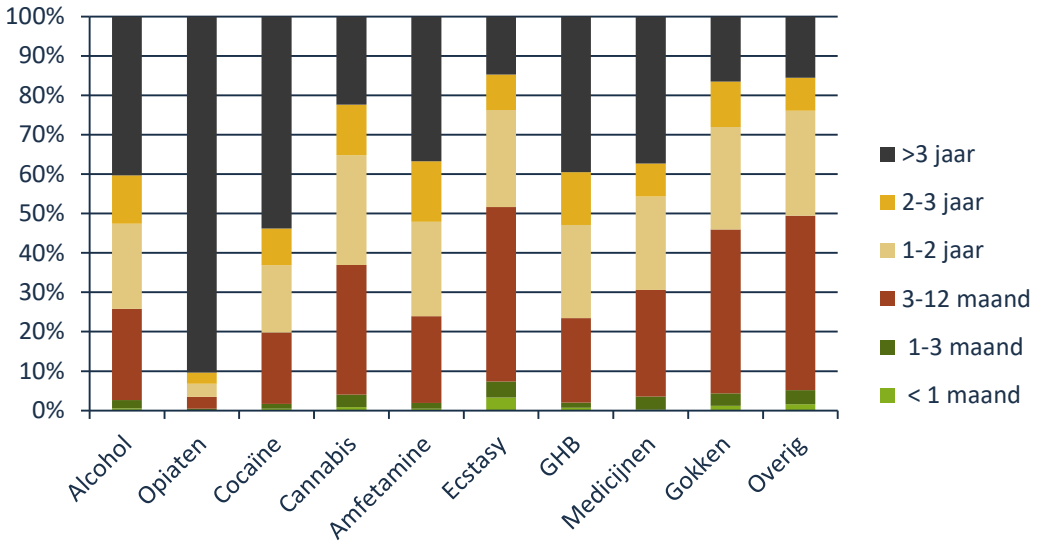
Figure 20: Total treatment duration (1994-2015) of all episodes in addiction care (N=64,821)



About twenty-five percent of all registered clients have been in care for less than 1 year altogether. More than 40% percent have been treated in addiction care for more than 3 years since 1994. A distribution of the total treatment duration by primary problem is shown in figure 21.

This also includes treatments in the past for problems other than the primary problem for which the person was registered in 2015.

Figure 21: Total treatment duration (1995-2015) for all episodes in addiction care by primary problem (N=64,821)

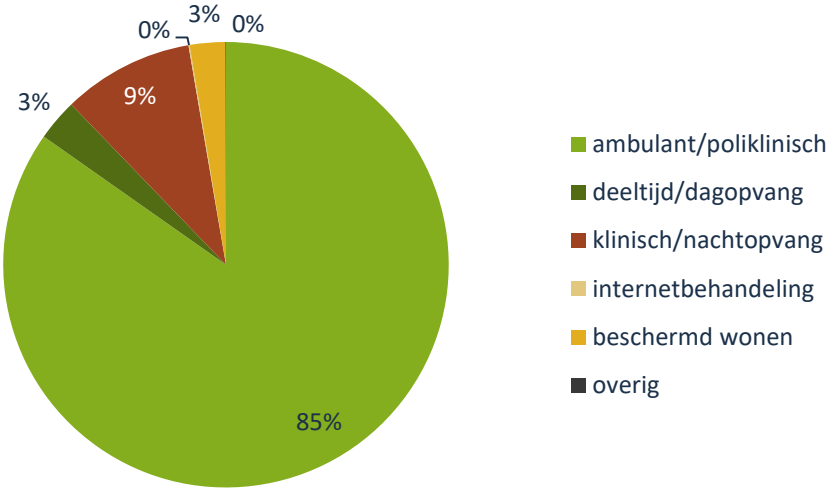


Clients requesting treatment for opiate use related problems have the longest treatment history. 90% have a treatment history in excess of 3 years in care. This is explained by methadone treatment. This substitute treatment is not generally aimed at achieving abstinence.
But those requesting treatment for cocaine, alcohol and GHB use related problems often also have a long career in addiction care.

1.12 Contacts[9]

In 2015 a total of about 2 million contacts were registered within addiction care. These are contacts related to registration in addiction care. Most of these contacts are contacts within the framework of alcohol and opiates related treatment demand.

Figure 22: Setting of treatment in 2015 (N=2,109,000)

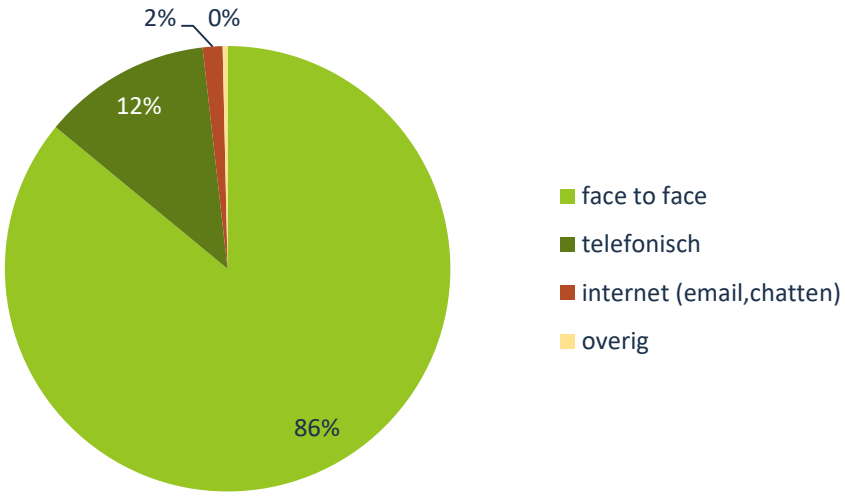


Most contacts with clients in addiction care take place in an outpatient setting.
Of the two million contacts, nearly 80% take place in an outpatient setting.

[9] The methadone contacts are not considered here. Data on methadone distributions can be found in section 3.11.

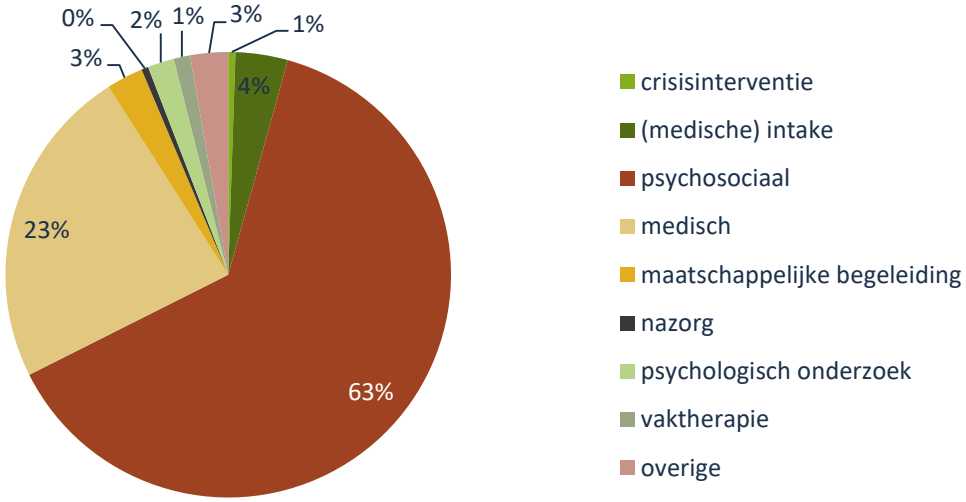
The clinical setting is the second largest group (13%). Contacts with clients via the Internet account for less than 1%. Anonymous internet contacts are not included in LADIS.

Figure 23: Method of contact 2015 (N=2,109,000)



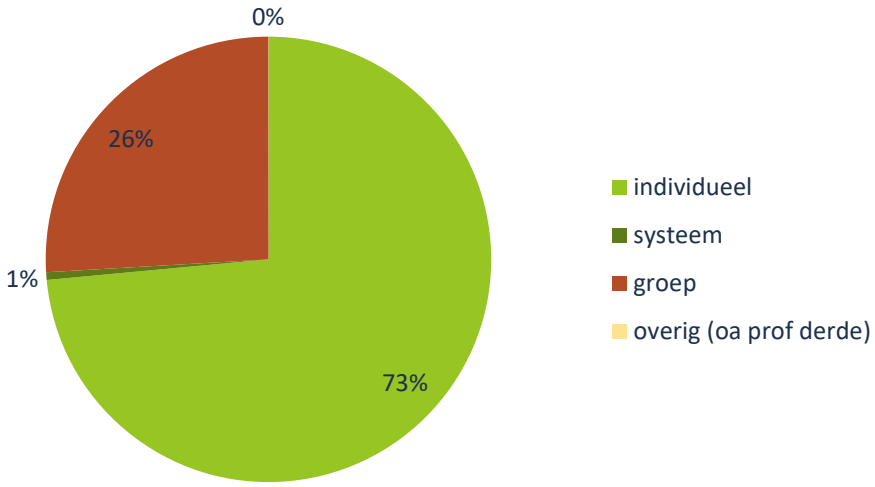
Face-to-face contacts are by far the most frequent (86%). 12% of the contacts are by telephone.

Figure 24: Nature of contact 2015 (N=2,109,000)



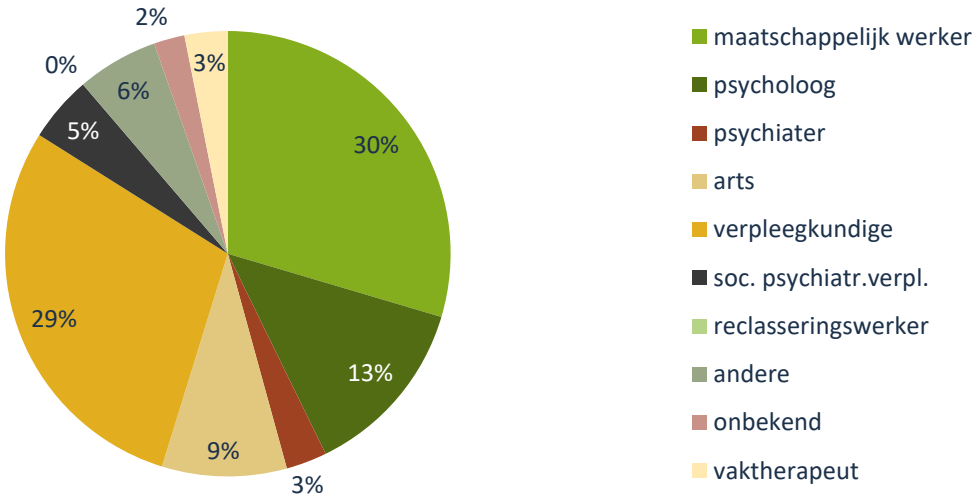
Most of the contacts are psychosocial in nature. 23% are medical. This applies both to treatment and to counselling. Social counselling, occupational therapy or follow-up care comprise 5% of the total. The number of crisis interventions is less than 1% of all contacts.

Figure 25: Type of contact 2015 (N=2,109,000)



Three-quarters of the contacts involve an individual contact with the client (73%), followed by group contacts (26%). This concerns contacts together with others sharing the same problem. The proportion of group contacts increased in comparison with 2014.
System contacts, contacts together with family members or with others from the person's environment constitute 1% of the total contacts.

Figure 26: Contacts by discipline, 2015 (N=2,109,000)



Social workers account for the largest percentage of contacts with clients (36%), followed by (community psychiatric) nurse (30%) and psychologist (13%).

2 Alcohol

2.1 Highlights

- Treatment demand for alcohol decreased by 8% in 2015 compared to 2014.
- This decrease is 20% among young people under the age of 25 years and 4% among people 55 years and older.

2.2 In brief

table 6 **Overview of treatment demand for alcohol use related problems in 2015**

Demographics		
	Number of clients	29,374
	Male : Female	72 : 28
	Average age	46
	Proportion 25-	5%
	Proportion 55+	28%
	Proportion of Dutch natives	84%
	Number per 100,000 inhabitants	174
Problems		
	Proportion in addiction care	45%
	Single : Multiple	68 : 32
	Use as an additional substance	5,900
	First registration ever	21%

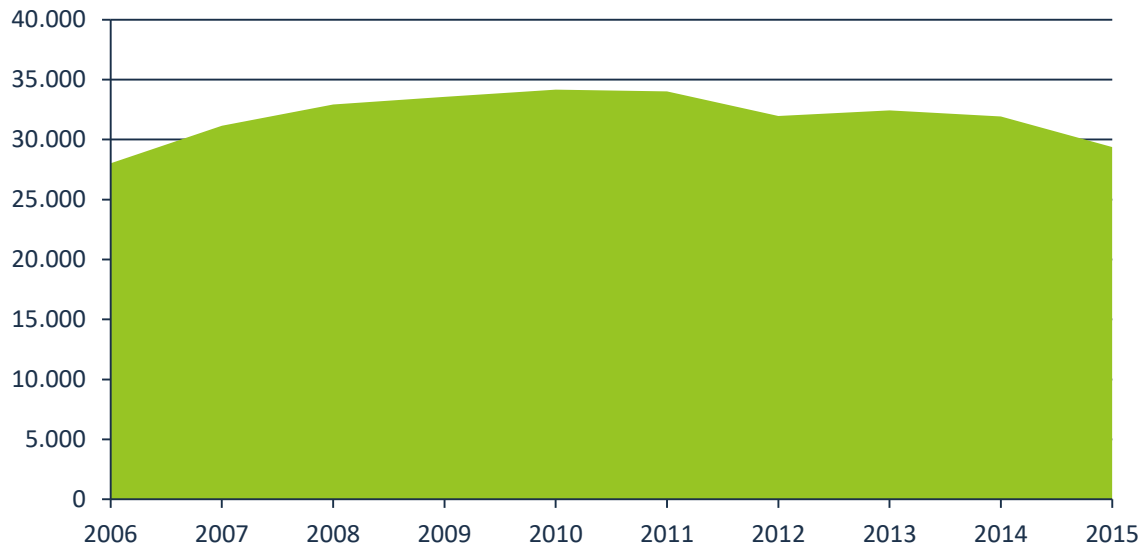
Alcohol continues to be responsible for the largest group of clients in addiction care. Of the total of 65,000 clients in 2015, nearly 30,000 request treatment for a primary alcohol treatment demand. This is 8% less than in 2014.
Approximately 30% of this group are women. The average age of the group of alcohol addicts requesting treatment has increased over the past few years and is now over 46 years.
Alcohol problems leading to a request for treatment are only found to a relatively limited extent among the group of younger people. The percentage of younger people under the age of 25 is 5%. Compared to 2014, the treatment demand for this age category declined by 20%.
The percentage of older people (55 years of age and older) with an alcohol use related treatment demand was 28% in 2015. The decline in the number of people requiring treatment in this age category is relatively smaller.

2.3 Trends and development of treatment demand[10]

The alcohol-related treatment demand has always formed the largest group. The percentage is about 45% of all clients in 2015. The number increased from 28,000 in 2006 to over 34,000 in 2010, and decreased again in 2015 to almost 29,000 people requesting treatment (see figure 27).

[10] See also the bulletin Alcoholhulpvraag in Nederland; Belangrijkste ontwikkelingen van de hulpvraag voor alcoholproblematiek in de verslavingszorg 2005-2014 [Alcohol treatment demand in the Netherlands: The most significant developments in treatment demand for alcohol-related problems in addiction care 2005-2014], which can be downloaded via www.ladis.eu.

Figure 27: Alcohol - Number of clients 2006-2015



2.4 Young and old

In recent years, the percentage of those 55 and older among people requesting treatment for alcohol addiction has increased. Among young people (<25 years) in the total group of people requesting treatment for alcohol addiction, the percentage declined for the first time in 2015. The largest group of people requesting treatment is formed by the group of 40-54 year-olds (see figure 18).

Figure 28: Alcohol – Age categories, 2006-2015

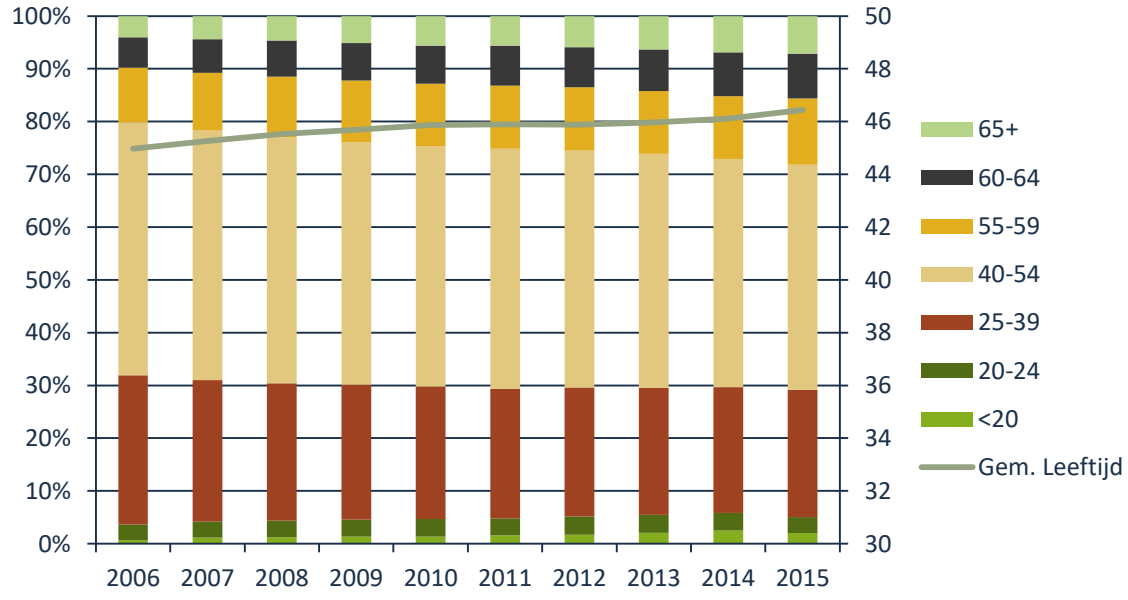
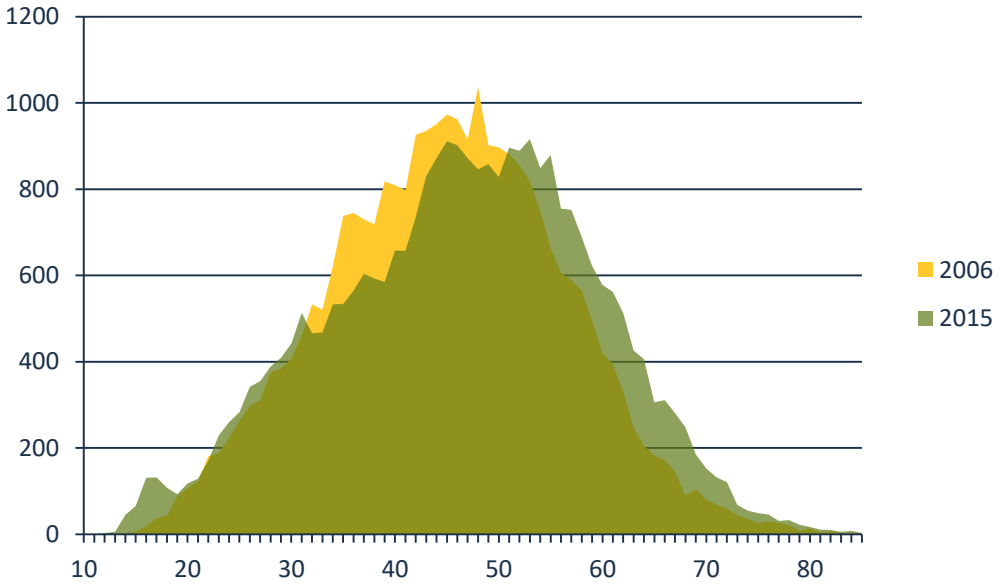


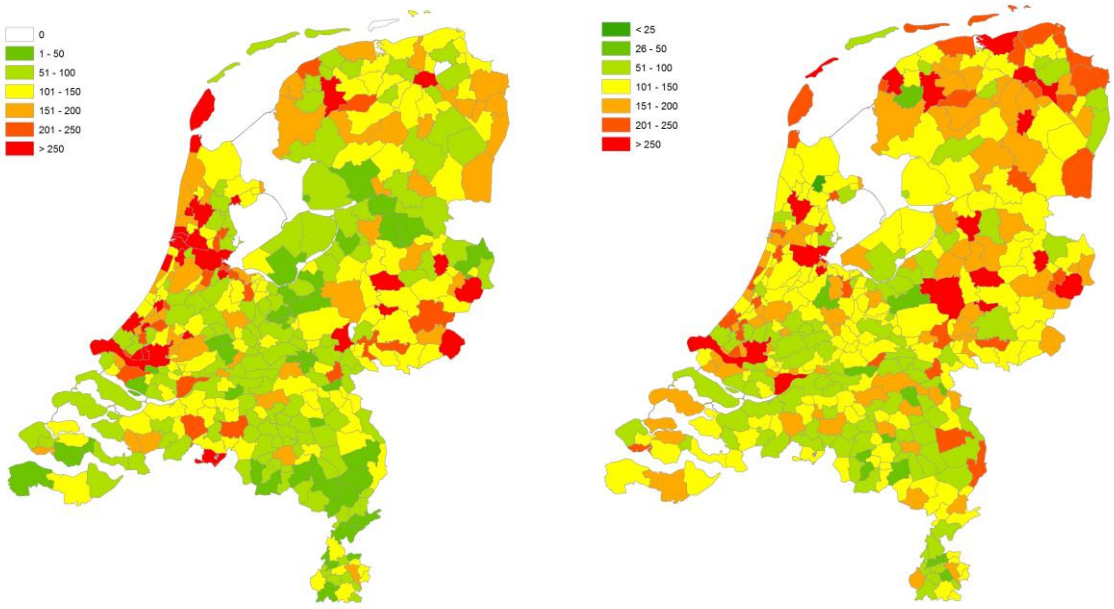
Figure 29 shows that compared with 10 years ago, alcohol related treatment demand mainly increased in the group of young people and older people. The age group of 30-50 years showed a decline.

Figure 29: Alcohol - Age distribution 2006 versus 2015



2.5 Regional spread

Figure 30: Number of clients for alcohol use related problems per 100,000 inhabitants, 2006 and 2015

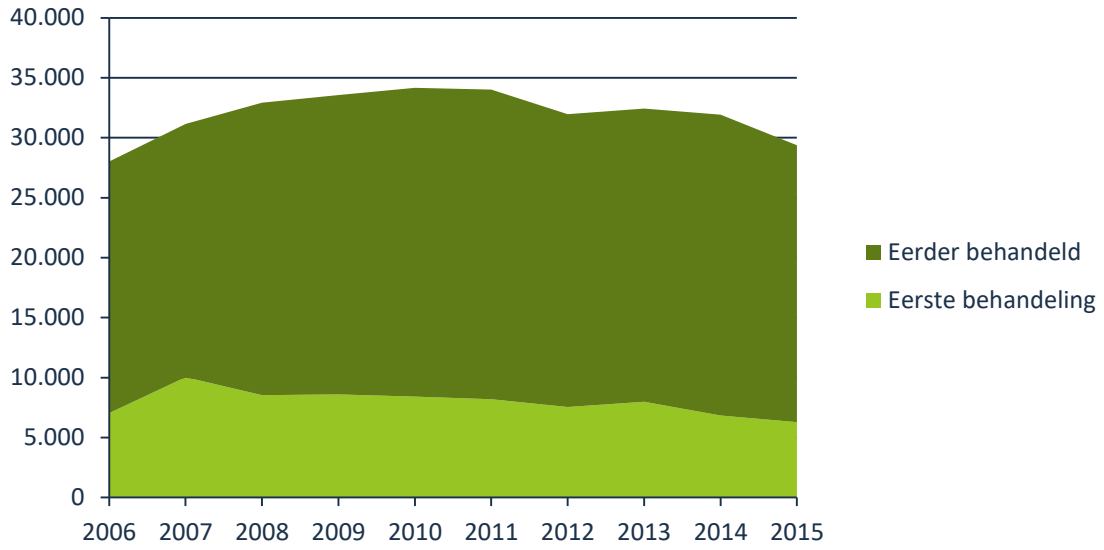


The national average treatment demand for alcohol use related problems in 2015 was 174/100,000 inhabitants. In 2006 this was slightly lower at 172/100,000 inhabitants. The northern provinces have relatively more people requesting treatment for alcohol-related problems than 10 years ago.

2.6 New and known

The number of new people requesting treatment for alcohol related problems as well as the overall treatment demand for alcohol related problems has declined in recent years. The decline among the group of new people requesting treatment is relatively slightly larger than the decline among the group of people requesting treatment who are returning to addiction care. The percentage of newcomers declined to 21% in 2015 compared to 25% in 2006.

Figure 31: Alcohol - Trend of new and known clients, 2006-2015



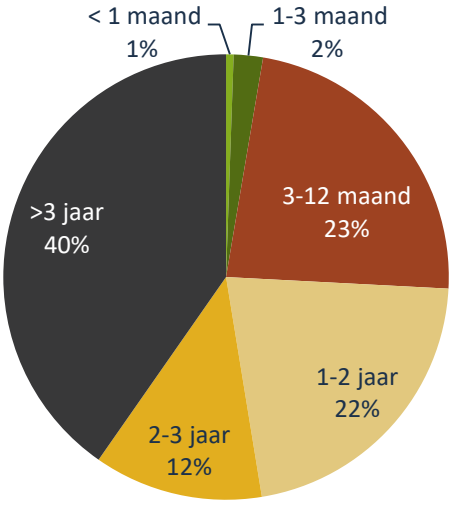
2.7 Treatment history

By using the LADIS key, it is possible to follow clients throughout the years and throughout institutions. This has made it possible since 1994 to calculate the number of episodes that someone was in care and the total duration of the episodes since 1994 (see Annex III for a definition). Figure 32 shows the distribution of the number of episodes in 2015.

Figure 32: Alcohol - Number of episodes in addiction care 1994-2015 (N=30,758)

More than half of the people requesting treatment for alcohol-related problems have more than 1 episode in care.

Figure 33: Alcohol - Total duration of all episodes in 1994-2015



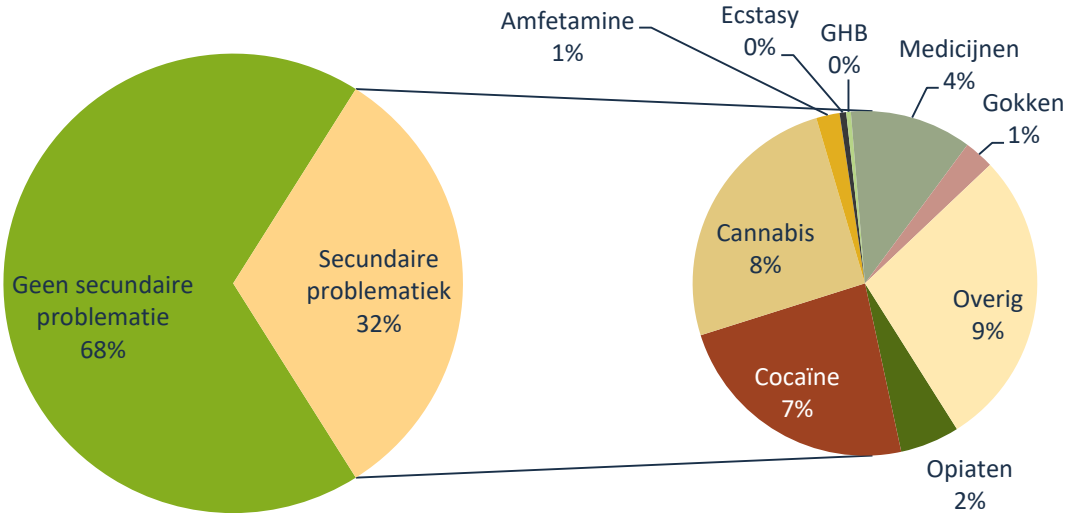
Not just the number of episodes, but also the duration of the episodes says something about the extent to which someone seeks treatment. The total duration of all episodes as from 1994 can be calculated for each client.

Figure 32: shows that in 2015 for more than 40% 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 2015 have also been included in the calculation of the average total episode duration. This also applies to clients from earlier reporting years. Any registrations in subsequent years have been included in the calculation of the total treatment duration. Figure 33 therefore provides some information about the care consumption of all clients inclusive of the newcomers.

2.8 Secondary problems

In approximately one-third of these 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 34). Two-thirds of the clients with alcohol use related problems do not have problems with other substances.
About 10% of the population with alcohol use related primary treatment demand use hard drugs (mainly opiates, cocaine and amphetamine) as a secondary problem.

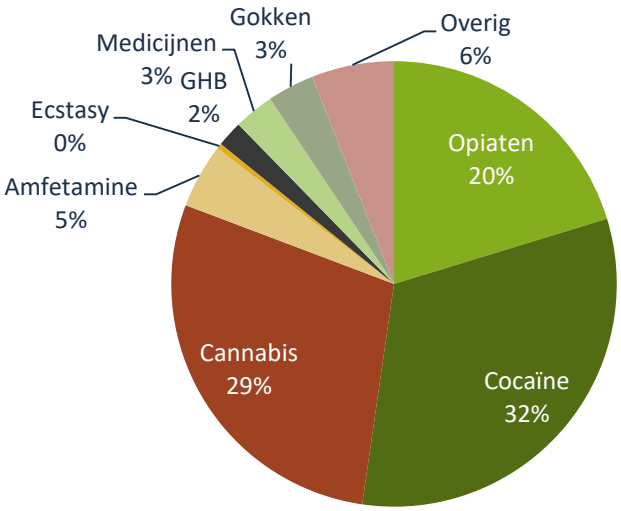
Figure 34: Alcohol - Secondary problem, 2015 (N=30,758)



2.9 Use as an additional substance

Problems related to alcohol use also occur as secondary or tertiary problems. Alcohol is registered as an additional substance in 5,900 clients.
Figure 35 shows the distribution by primary problem where alcohol is an additional substance.

Figure 35: Alcohol – Use as an additional substance 2015 (N=5,558)



Alcohol as an additional substance often occurs in addition to cocaine, cannabis and opiates use related problems.

3 Opiates

3.1 Highlights

- Number of clients requesting treatment for opiate use related problems continues to decline.
- 97% of the clients requesting treatment for opiate use related problems from 2015 had previous treatment or are still in treatment.
- Intravenous use is declining; 6% of the people requesting treatment have injected during the past month.

3.2 In brief

table 7 **Average treatment demand for opiate use related problems in 2015**

Demographics	
Number of clients	9,093
Male : Female	81 : 19
Average age	48
Proportion 25-	<1%
Proportion 55+	26%
Proportion of Dutch natives	64%
Number per 100,000 inhabitants	54
Problems	
Proportion in addiction care	14%
Intravenous use never : ever	63:37
Intravenous use in past year/month	8.1% / 6.0%
Single : Multiple	35 : 65
Use as an additional substance	3,924
First registration ever	3%
Average methadone dosage/methadone client/day	75mg

3.3 Trends and development of treatment demand

Treatment demand for opiate use related problems has decreased over the past 10 years.
Over 9,000 people have been registered with opiate use related problems in 2015. In 2006 these were 13,500 people.
About 97% of the clients are ‘old acquaintances’. The number of newcomers is limited, and there is relatively little outflow. Addiction care for this group mainly consists of ‘care’.
That means that treatment is focused on ‘harm reduction’ rather than abstinence.

Figure 36: Opiates – Number of clients, 2006-2015

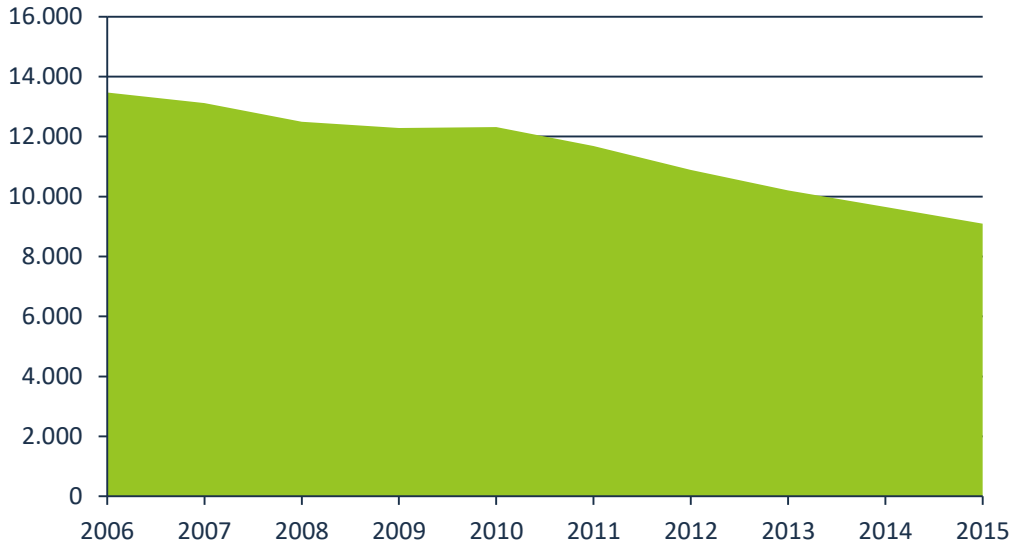


Figure 36 clearly shows a decreasing trend with regard to treatment demand for opiate use over the past 10 years.

3.4 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 proportion. This group of clients now includes 2,300 people aged 55 or older, including 220 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 age progressively over the next few years. **Fout! Verwijzingsbron niet gevonden.**clearly shows the shift in age development compared to the year 2006.

Figure 37: Opiates – Age categories 2006-2015

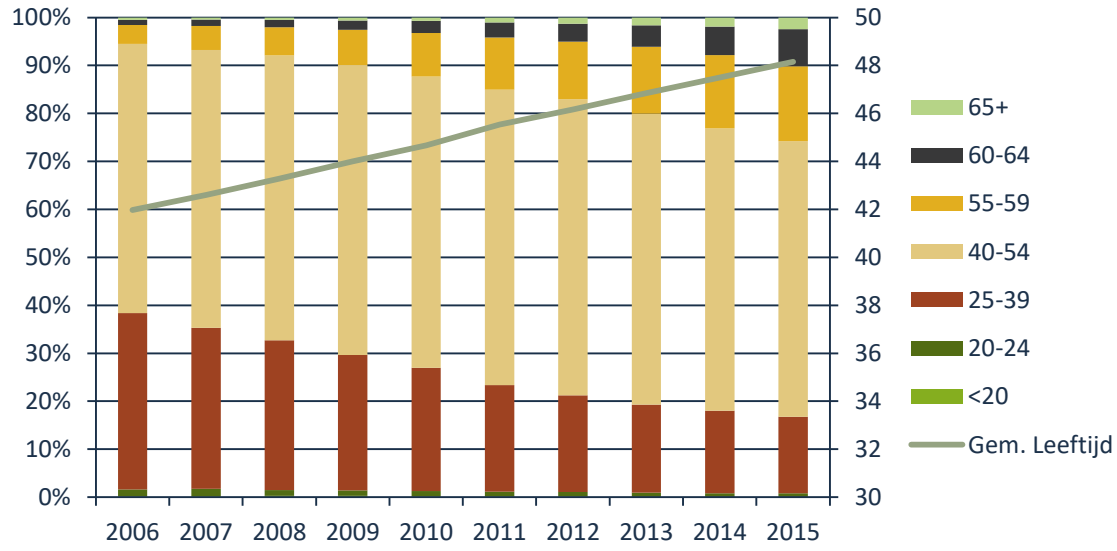
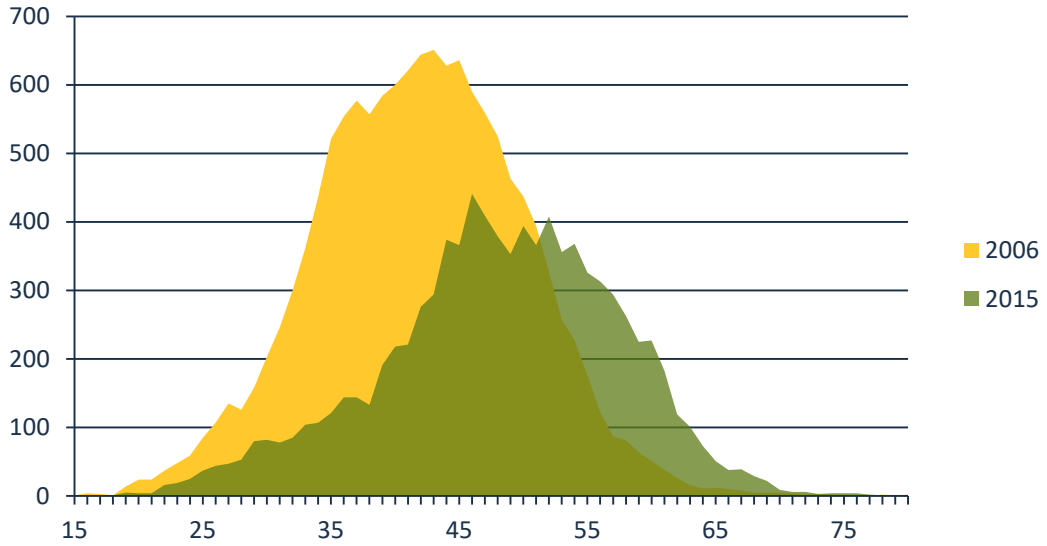


Figure 38 shows this picture even more clearly.

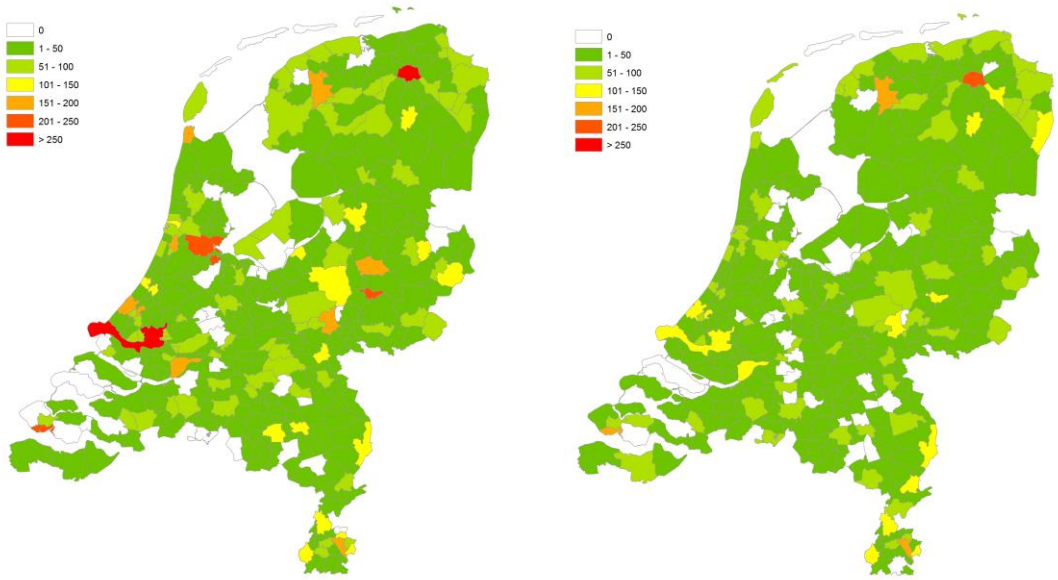
Figure 38: Opiates - Age distribution 2006 versus 2015



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 and older in this group will continue to increase over the next few years.

3.5 Regional spread

Figure 39: Number of clients with opiates use related problems per 100,000 inhabitants, 2006 and 2015

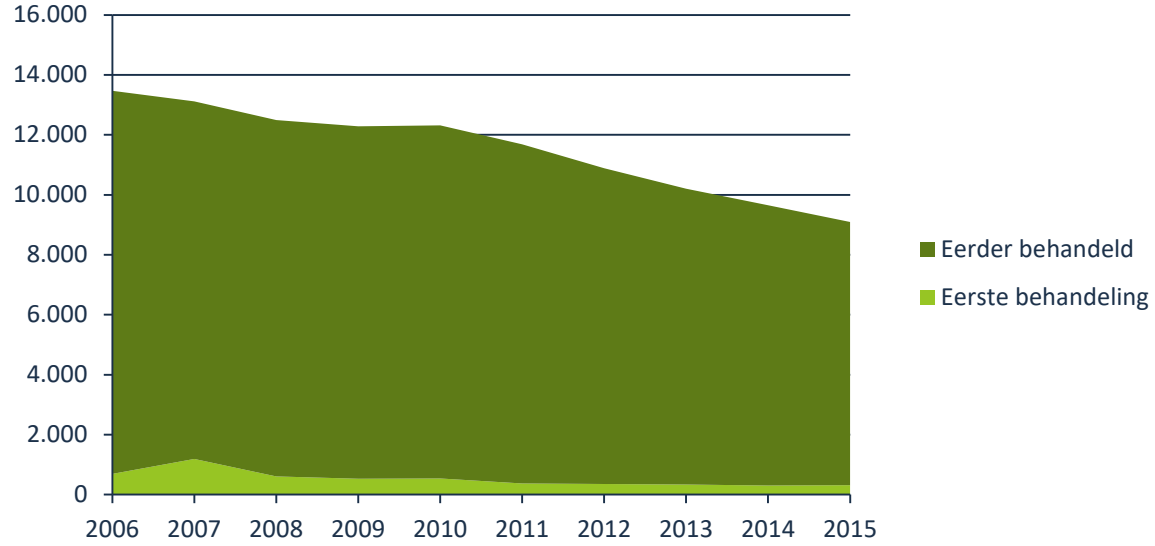


The national average of treatment demand for opiate use related problems was 54/100,000 inhabitants in 2015. In 2006 this was 88/100,000 inhabitants.

3.6 New and known

The vast majority of clients are 'old acquaintances'. In the Netherlands, there are hardly any new clients with opiate use related problems. In 2015 it involves 3% of all clients requesting treatment for opiate use related problems for the first time in addiction care.

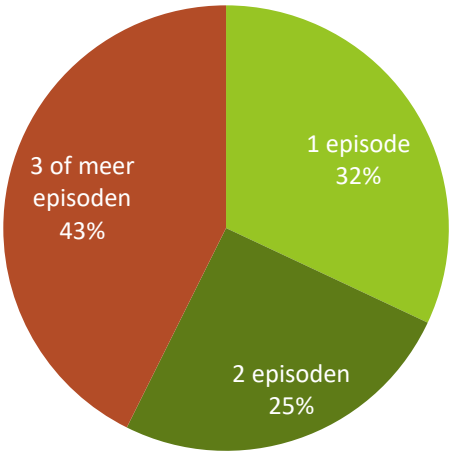
Figure 40: Opiates - Trend of new and known clients, 2006-2015



3.7 Treatment history

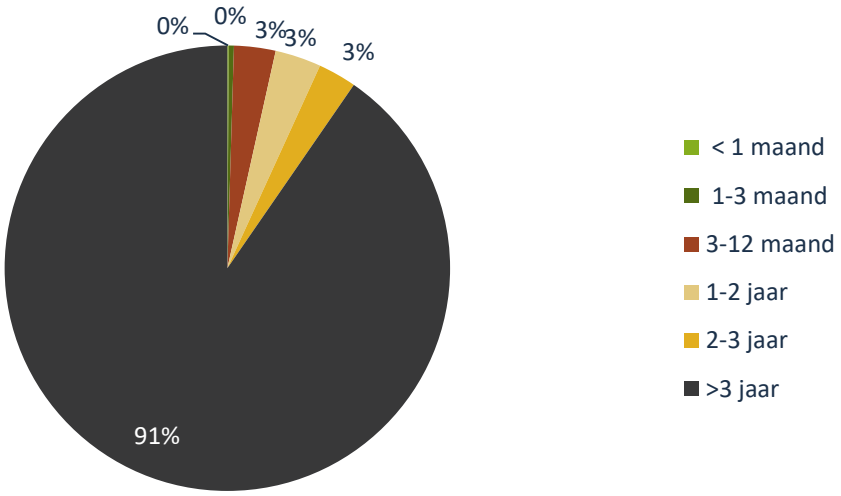
Most clients with opiates use related problems are chronic clients. Figure 41 shows that a third of the people requesting treatment for opiate use related problems are 'only' in the first episode in care.

Figure 41: Opiates – Number of episodes in addiction care 1994-2015



An episode may include several registrations and several registration years. The definition of an episode is described in Annex III.
However, when the duration of the episodes is considered (see figure 42), the group of clients with an opiate addiction chronically request treatment from addiction care.

Figure 42: Opiates - Total duration of all episodes 1994-2015

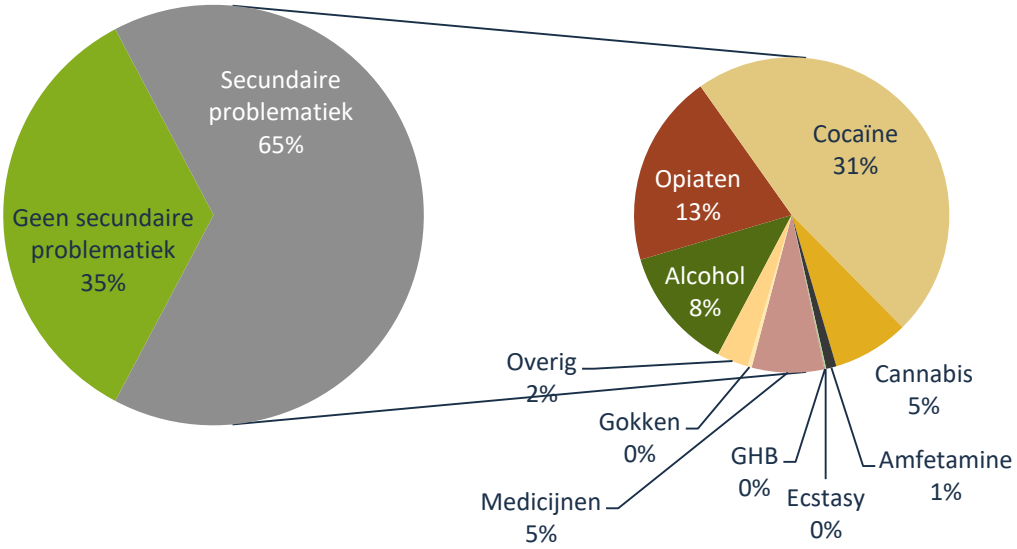


Over 90% of the clients have a total treatment history of more than 3 years in addiction care. This has not changed over the past ten years.
In 2015 the average total of all episodes was 14 years. This therefore concerns an extremely long-term continuous episode, or in other words chronic care, also for the group with 'only' one episode (see figure 42).

3.8 Secondary problems

Many opiate users have a secondary problem apart from problems related to the primary substance. Two-thirds of this group have problems with other drugs. The secondary problem mainly consists of cocaine and other opiates (for example, the combination of heroin and methadone) and alcohol.

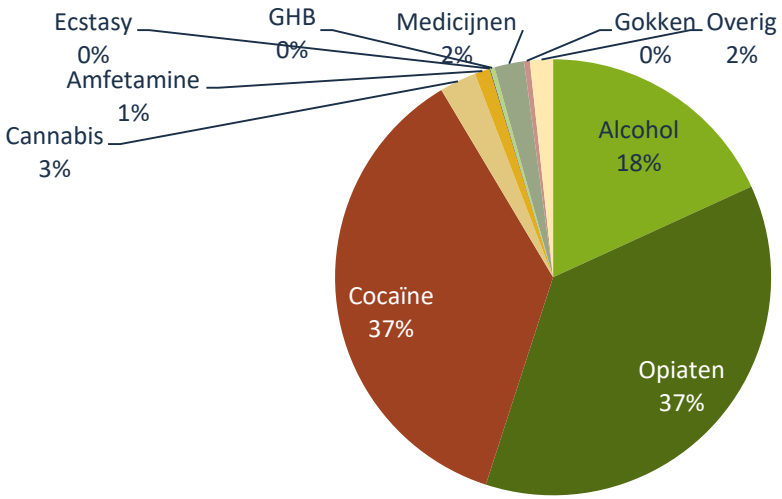
Figure 43: Opiates - Secondary problem, 2015



3.9 Use as an additional substance

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 44: shows the distribution by primary problem where opiates is an additional substance.

Figure 44: Opiates – Use as an additional substance, 2015 (N=3,924)

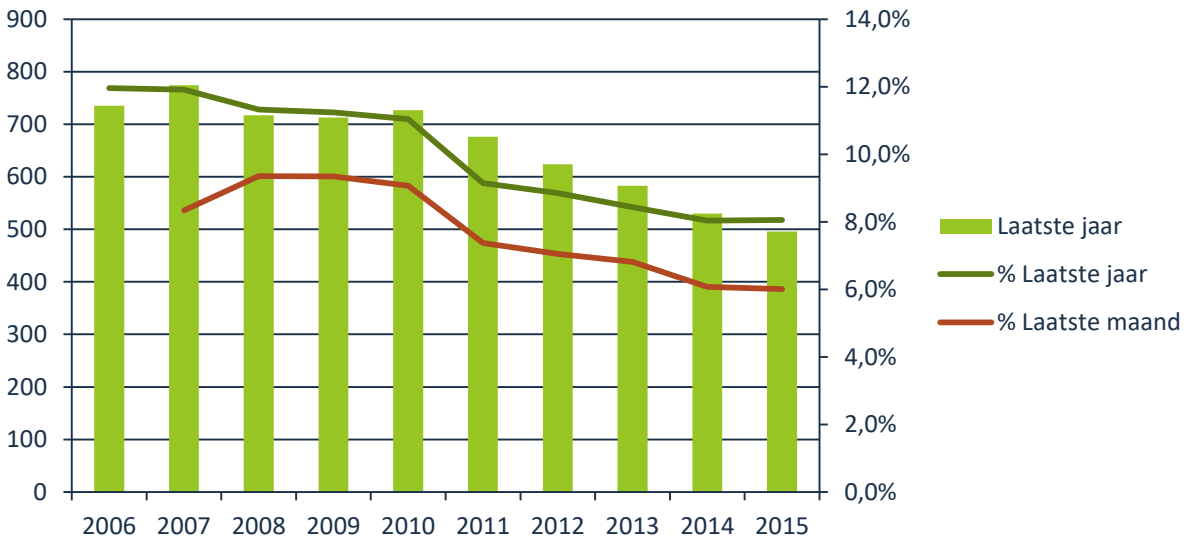


Opiates are registered as an additional substance in 3,924 clients. Particularly where several forms of opiates are used, these are registered both as a primary and as an additional substance (about 37%). Opiates also frequently occur as an additional substance with cocaine (in the form of crack) as the primary problem.

3.10 Intravenous use

In the Netherlands, intravenous opiate use is still decreasing. In the last 10 years, the number of recent intravenous users (during the past year) has decreased from over 700 to just under 500. In 2015, the percentage of current intravenous users (during the past month) is 6%.

Figure 45: Number and proportion (%) of intravenous opiate users, 2006-2015



3.11 Methadone

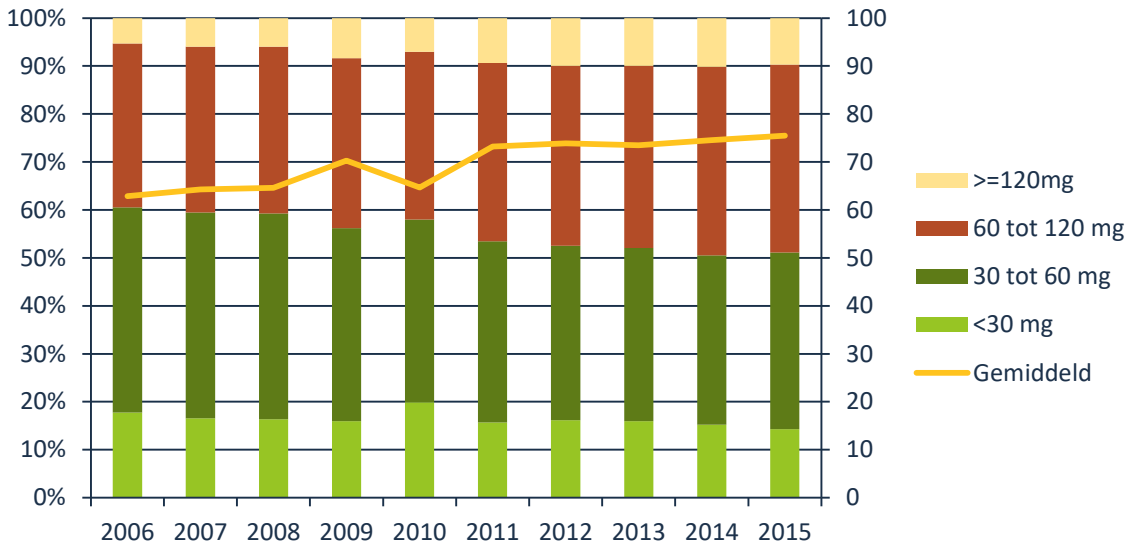
The majority of the opiate addicts treated in addiction care are also enrolled in a methadone program and/or a heroin project.
Table 8 shows the development of the number of clients and the number of methadone contacts from 2006-2015.

table 8 **Methadone use related contacts, figures 2005-2014**

Years	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015[11]
Number of clients in a methadone program	9,818	8,968	8,592	9,918	10,147	10,017	9,148	8,292	7,421	5,214
Intakes X 1,000	2,350	2,024	1,844	2,021	2,153	2,101	2,309	2,093	1,723	1,267
Intakes/ client	239	226	215	204	212	210	252	252	232	243

Figure 46 shows that the number of doses above 60 mg has increased over the past 10 years.
The average dose has increased from about 60 mg in 2006 to about 75 mg per daily dose in 2015.

Figure 46: Average dose of methadone 2006-2015



[11] Some of the data on methadone was not provided in 2015. Methadone data was not provided by several institutions. The actual number of people is higher than reported here.

4 Cocaine

4.1 Highlights

- The decline of cocaine related treatment demand since 2008 is continuing.
- In 2015 the number of clients with cocaine use related problems dropped by 10% compared to 2014.
- The average age of the clients with cocaine use related problems increased to 39 years.
- The percentage of young people with a treatment demand for cocaine is declining.
- Cocaine is the drug that is most common as a secondary problem.

4.2 In brief

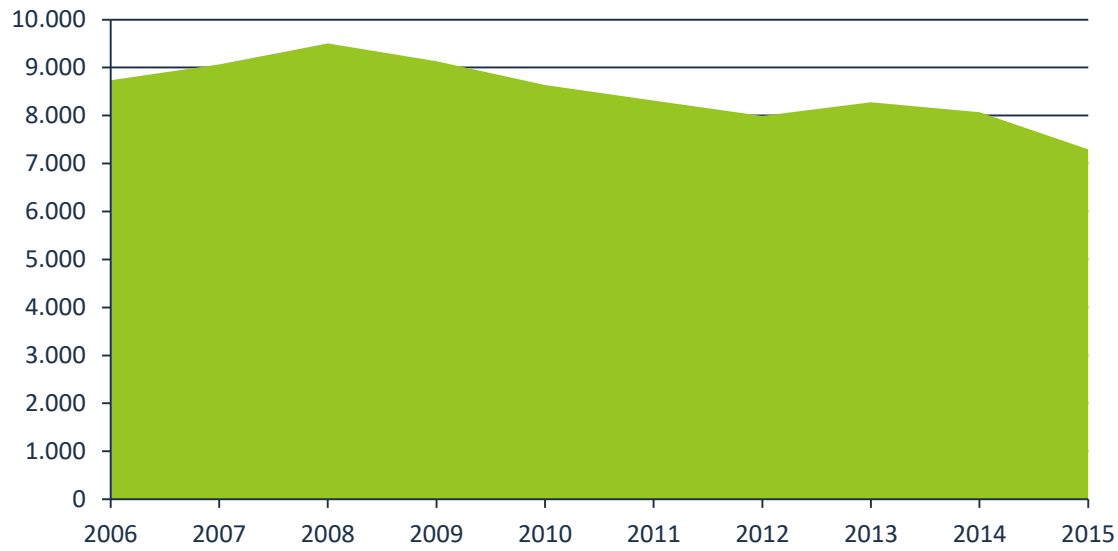
table 9 **Overview of cocaine related treatment demand, 2015**

Demographics	
Number of clients	7,295
Male : Female	82 : 18
Average age	39
Proportion 25-	8%
Proportion 55+	9%
Proportion of Dutch natives	71%
Number per 100,000 inhabitants	43
Problems	
Proportion in addiction care	11%
Crack: Snorted cocaine	47 : 53
Single : Multiple	38 : 62
Use as an additional substance	7,453
First registration ever	16%

4.3 Trends and development of treatment demand

After a sharp increase in treatment demand for cocaine related problems between the late nineties and 2008, the past few years have shown a decline. The percentage of people who come for treatment to addiction care for the first time has also declined among the treatment demand for cocaine.
Among the group of newcomers, the demand for treatment mainly concerns snorted cocaine.

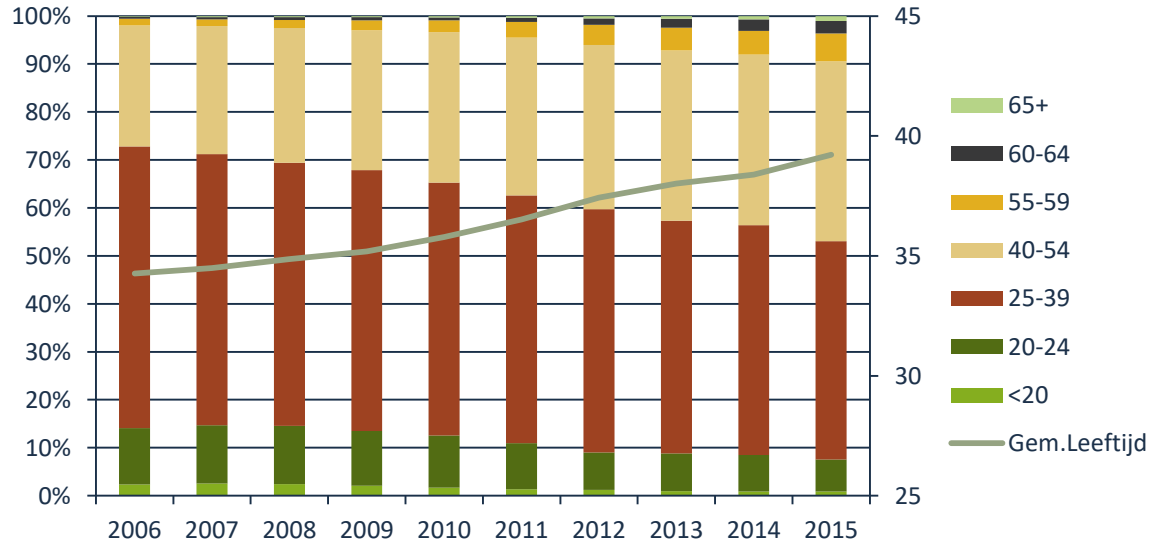
Figure 47: Cocaine – Number of clients, 2006-2015



4.4 Young and old

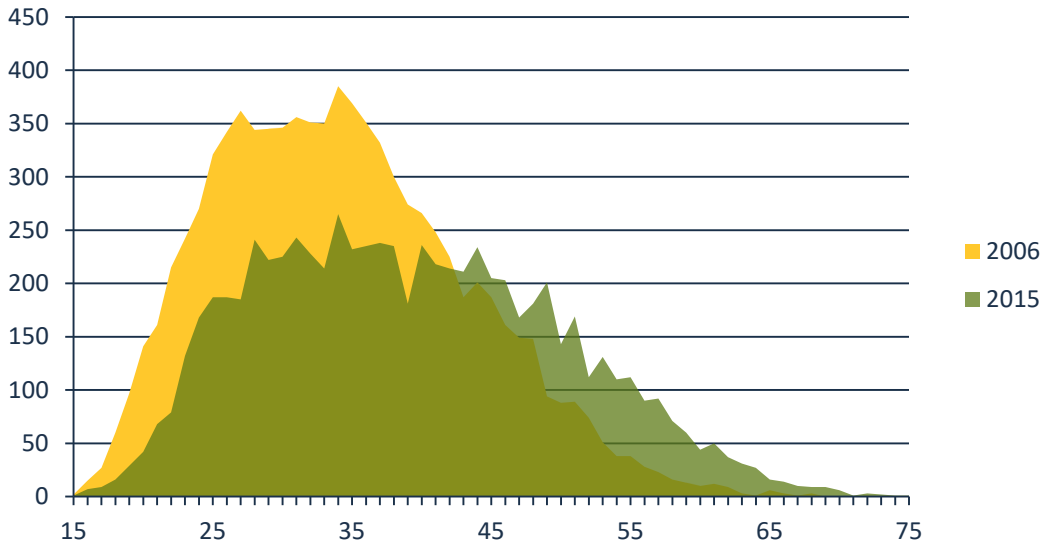
The largest group is still formed by the 25-39 age category. The percentage of people 55 years and older in this group increased from 2% in 2006 to over 9% in 2015. Both the percentage and the number of young people (under 25 years old) with cocaine problems is steadily decreasing. However, over the past 10 years, the percentage in this age group decreased from 14% in 2006 to less than 8% in 2015.

Figure 48: Cocaine – Age categories, 2006-2015



As is the case with opiates, ageing is clearly visible in Figure 49: when comparing the age distribution of 10 years ago with that of 2015.

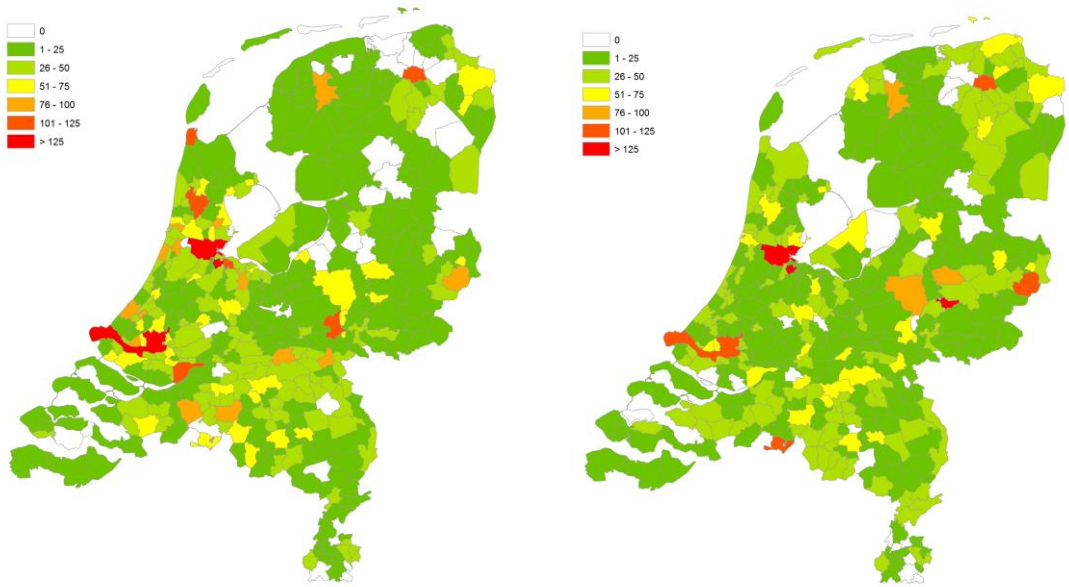
Figure 49: Cocaine - Age distribution 2006 versus 2015



The ageing of this group is partly caused by the group of problematic crack users who are in long-term care.

4.5 Regional spread

Figure 50: Number of clients with cocaine use related problems per 100,000 inhabitants, 2006 and 2015

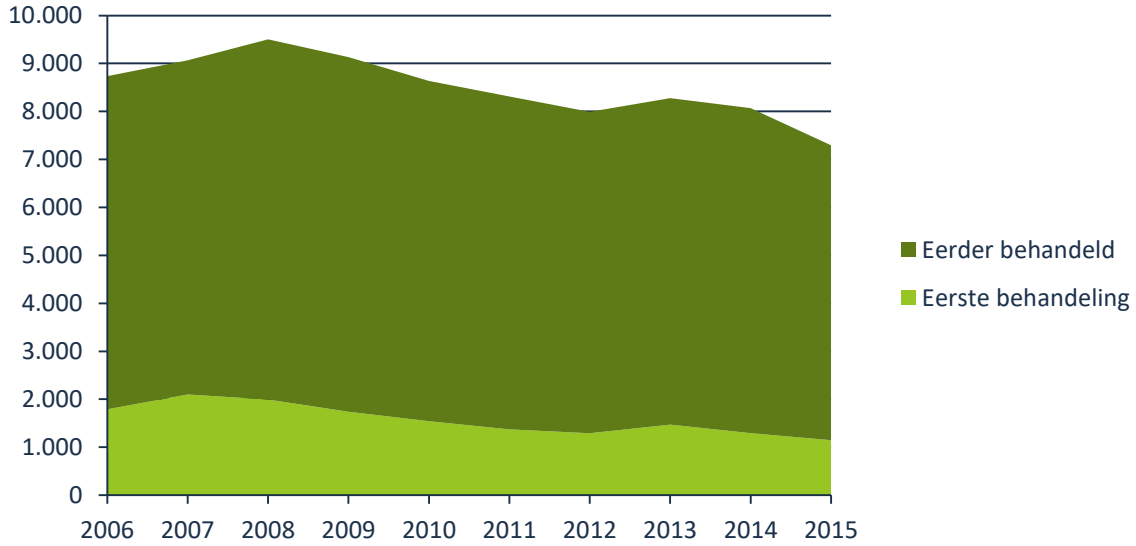


The national average of the demand for treatment for cocaine related problems in 2015 was 43/100,000 inhabitants. In 2006 this was 53/100,000 inhabitants.

4.6 New and known

Just as with other primary substances, there is a growing group of clients with cocaine related problems who repeatedly require treatment within the framework of their problems.

Figure 51: Cocaine - Trend of new and known clients, 2006-2015



The total group of clients with cocaine related problems now mostly (84%) consists of clients who have previously requested treatment. In 2015, over 1,100 new clients registered with cocaine related problems. This largely consists of clients for snorted cocaine and relatively few crack users.

4.7 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 Annex III.

Figure 52: Cocaine – Number of episodes in addiction care 1994-2015

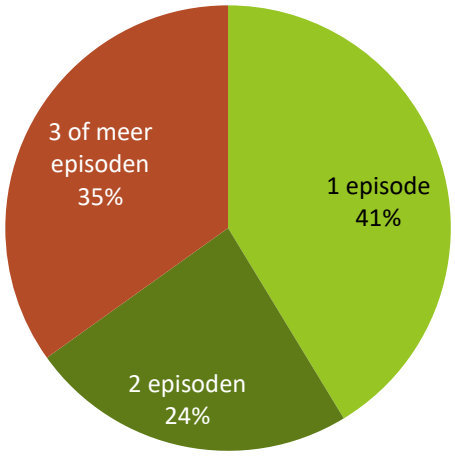
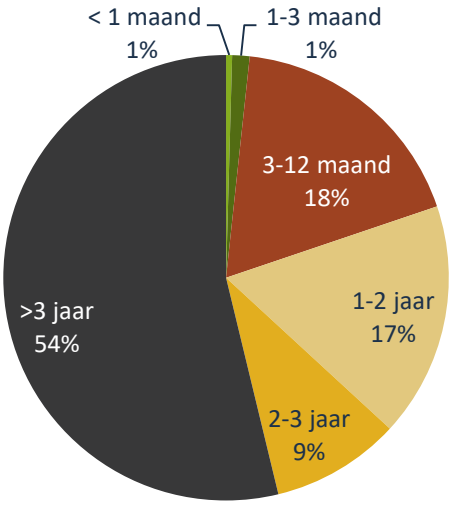


Figure 52: shows that almost 60% have more than 1 episode in addiction care. Apart from the number of episodes, the duration of the episodes is also important. It should be mentioned that the total episode duration is always a ‘state of affairs’.

By definition, newcomers have a relatively short episode duration. This also applies to clients from earlier reporting years. Any registrations in subsequent years have been included in the calculation of the total treatment duration.

Figure 53: Cocaine - Total duration of all episodes 1994-2015

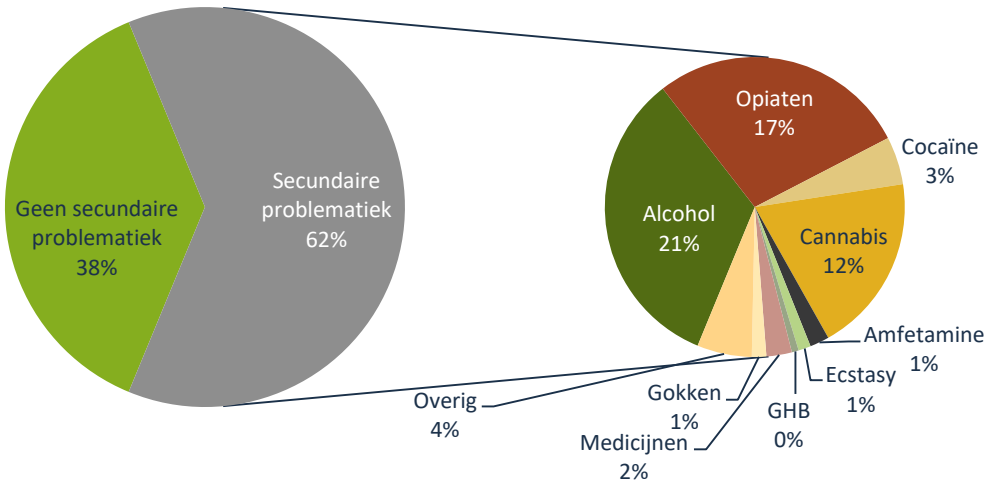


80% of the clients for cocaine use related problems in 2015 have a total episode duration of more than 1 year in addiction care. More than half of the clients have a treatment history of more than 3 years in addiction care.

4.8 Secondary problems

For 62% of the group there is another problem aside from the cocaine problem.

Figure 54: Cocaine - Secondary problem 2015 (n=7,516)

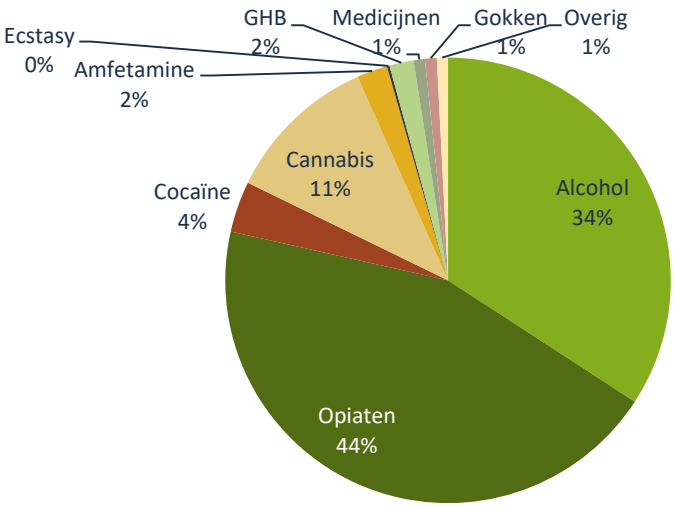


Alcohol is the most frequently occurring secondary problem in clients with cocaine related problems. Cannabis use and opiate use also occur frequently.

4.9 Use as an additional substance

Apart from cocaine as a primary problem, this substance can also be a secondary or a tertiary problem. Contrary to, for example, alcohol, cocaine can be both a primary problem and an additional substance (a combination of snorted and crack cocaine).
Figure 55: shows the distribution by primary problem where cocaine is an additional substance.

Figure 55: Cocaine – Use as an additional substance 2015 (N= 7,453)



Cocaine is registered as an additional substance in about 7,500 clients. This makes cocaine the most frequently used additional substance in addiction care. Cocaine as an additional substance most frequently occurs as a secondary problem to opiate and alcohol use.

5 Cannabis

5.1 Highlights

- After a steep increase from 2001 until 2010, treatment demand has remained about the same since 2011.
- Cannabis is the most common problem among young people.
- After alcohol, cannabis is the most frequently occurring problem in addiction care.
- Among most people requesting treatment, weed as type of cannabis is the primary problem (70%)[12].

5.2 In brief

table 10 **Overview of treatment demand for cannabis use related problems in 2015**

Demographics		
	Number of clients	10,816
	Male : Female	79 : 21
	Average age	30
	Proportion 25-	38%
	Proportion 55+	2%
	Proportion of Dutch natives	82%
	Number per 100,000 inhabitants	64
Problems		
	Proportion in addiction care	17%
	Single : Multiple	64 : 36
	Use as an additional substance	6,215
	First registration ever	31%

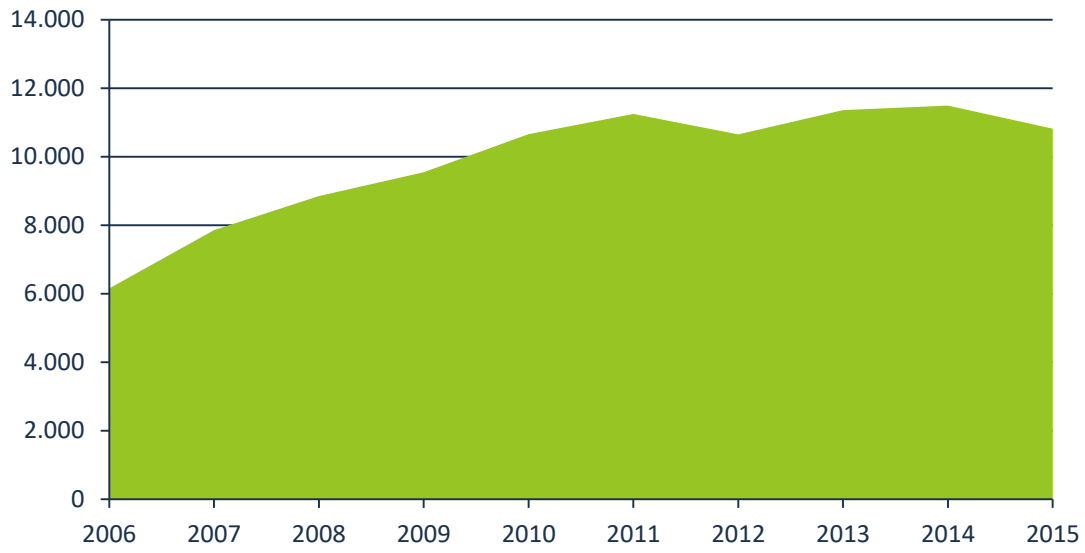
The average age of clients with cannabis use related problems is 30, which is relatively low. Multiple problems occur in approximately one-third of these cases.

5.3 Trends and development of treatment demand

The request for treatment for cannabis problems rose sharply until 2011 but since that time has basically remained unchanged. In 2015, it involved less than 11,000 clients with cannabis as the primary problem (see figure 56).

[12] Based on 33% of the number of people requesting assistance for cannabis related problems. Among 67% of the people requesting treatment, the type of cannabis as the primary problem is unknown. See also section 5.10.

Figure 56: Cannabis – Number of clients, 2006-2015



The treatment demand for cannabis is the largest group of the total treatment demand in addiction care after alcohol, with a share of 17%.

5.4 Young and old

Cannabis use related problems are by far the most important problems among young people. The percentage of young people (<25 years) shows a slight decrease over the past few years: from 45% in 2011 to 38% in 2015. See Figure 57: below.

Figure 57: Cannabis – Age categories, 2006-2015

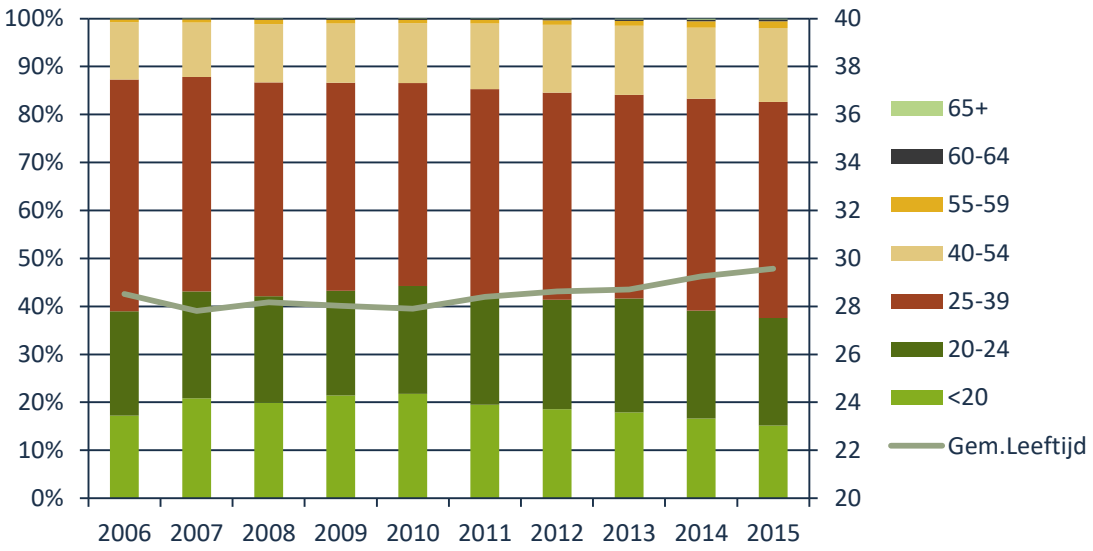
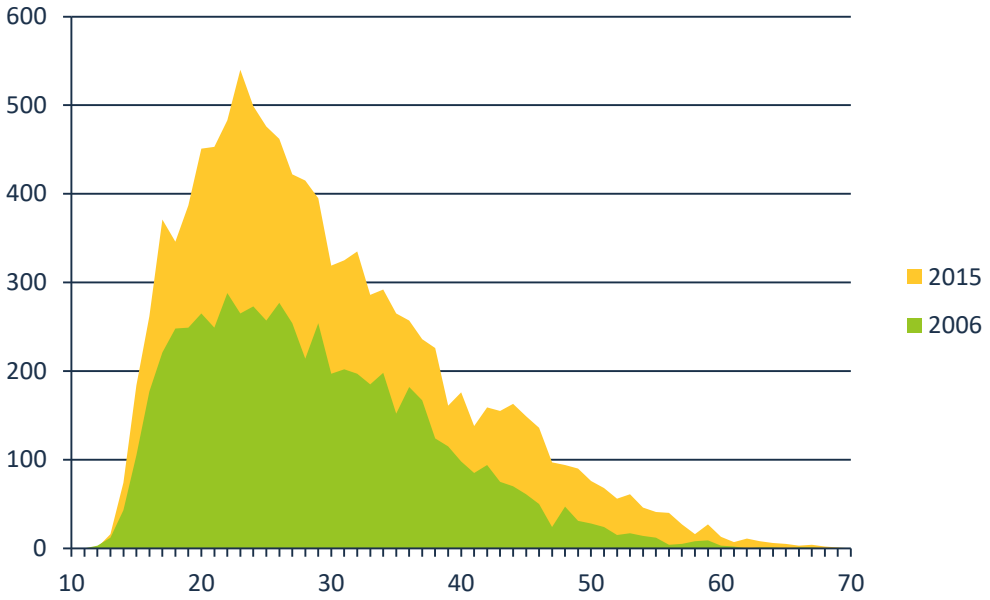


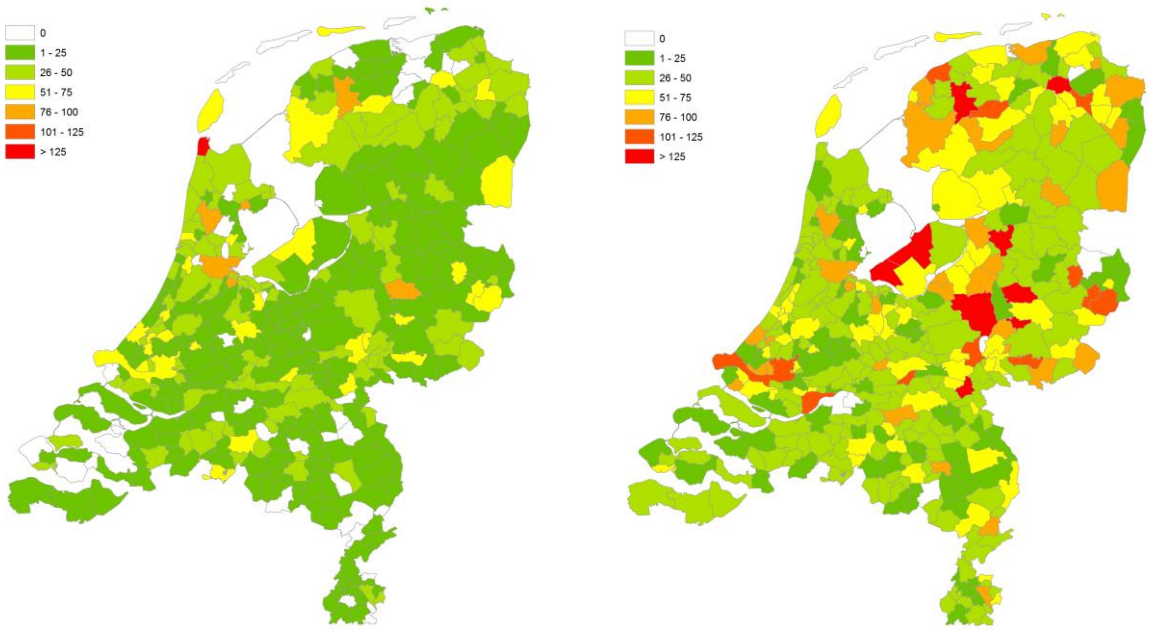
Figure 58: on the next page shows an increase in demand for treatment throughout the age categories.

Figure 58: **Cannabis - Age distribution 2006 versus 2015**



5.5 Regional spread

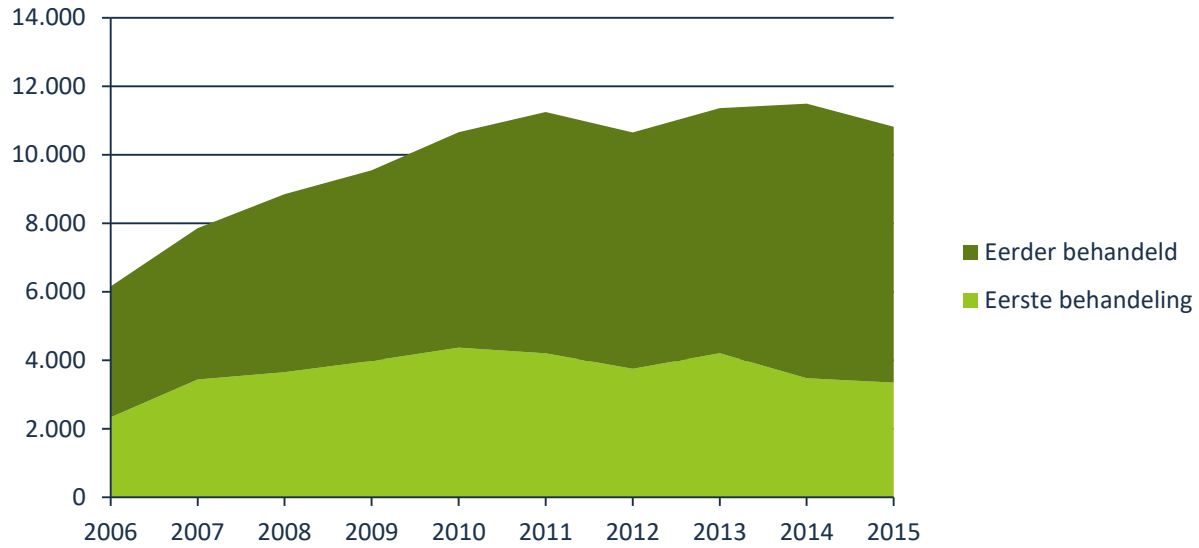
Figure 59: **Number of clients with cannabis use related problems per 100,000 inhabitants, 2006 and 2015**



The national average of those requesting treatment for cannabis use related problems in 2015 was 64/100,000 inhabitants. In 2006 this was 38/100,000 inhabitants. The increase was most visible in Flevoland and in northern and eastern Netherlands.

5.6 New and known

Figure 60: Cannabis - Trend of new and known clients, 2006-2015

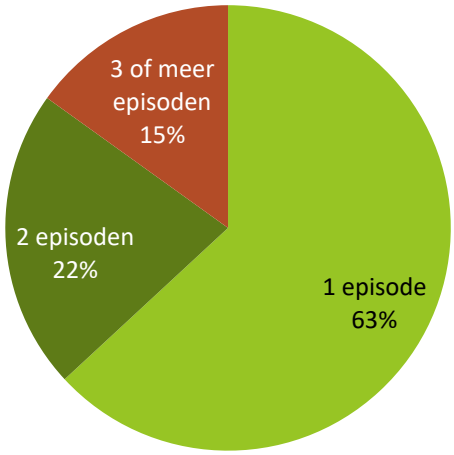


In comparison with other problem areas, cannabis problems exhibit a high percentage of newcomers. In 2015, almost 31% of the clients for cannabis related problems were new to addiction care. In 2015, the total percentage of newcomers in addiction care was 21%.

5.7 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 Annex III.
The proportion of cases with two or more episodes in addiction care is relatively small in comparison with alcohol, opiates and cocaine. Over 60% of all people requesting treatment are in their first episode.

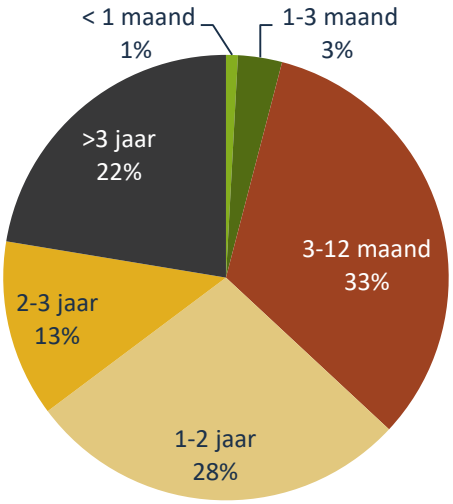
Figure 61: Cannabis – Number of episodes in addiction care 1994-2015



The same applies to the number of episodes and to the total duration of the episodes. The total duration is shorter in comparison with alcohol, opiates and cocaine.
In 2015, almost 40% of the people requesting treatment had a total episode duration of less than 1 year in addiction care, calculated as from 1994.

The distribution of total episode duration is shown in figure 62. It should be mentioned that the total episode duration is always a 'state of affairs'. By definition, newcomers have a relatively short episode duration. This also applies to clients from earlier reporting years. Any registrations in subsequent years have been included in the calculation of the total treatment duration.

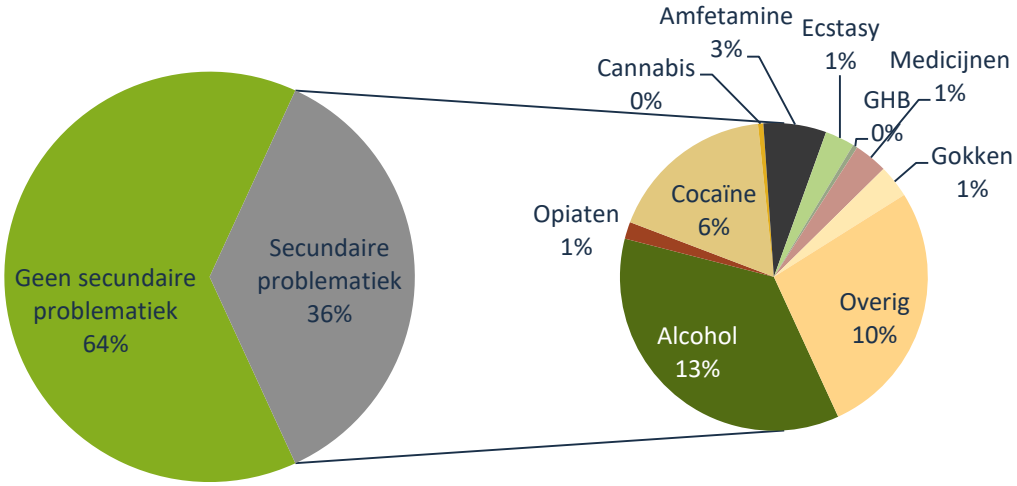
Figure 62: Cannabis - Total duration of all episodes 1994-2015



5.8 Secondary problems

In the majority of the requests for treatment, cannabis problems are the single issue. 36% of all clients with cannabis use related problems have problems related to other substances. This often concerns alcohol or cocaine use. Many other problems are also involved, particularly nicotine.
The distribution of the secondary problem for cannabis is shown in figure 63.

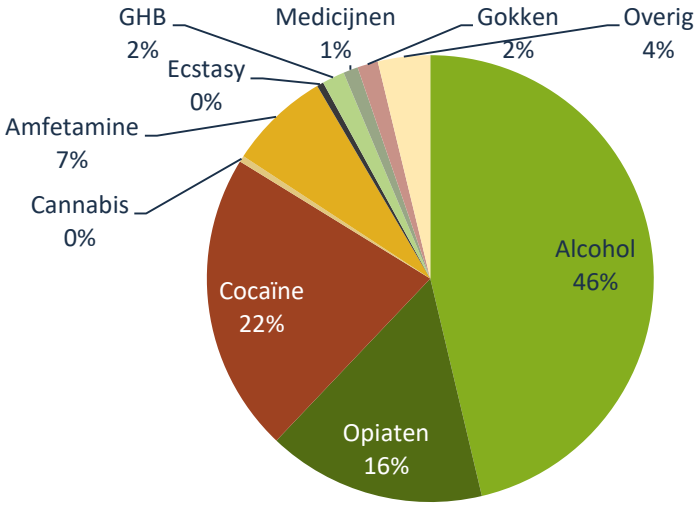
Figure 63: Cannabis - Secondary problems 2015



5.9 Use as an additional substance

Apart from cannabis as a primary problem, this substance is often a secondary or a tertiary problem. Figure 64 shows the distribution by primary problem where cannabis is an additional substance.

Figure 64: Cannabis – Use as an additional substance 2015 (N=6,215)

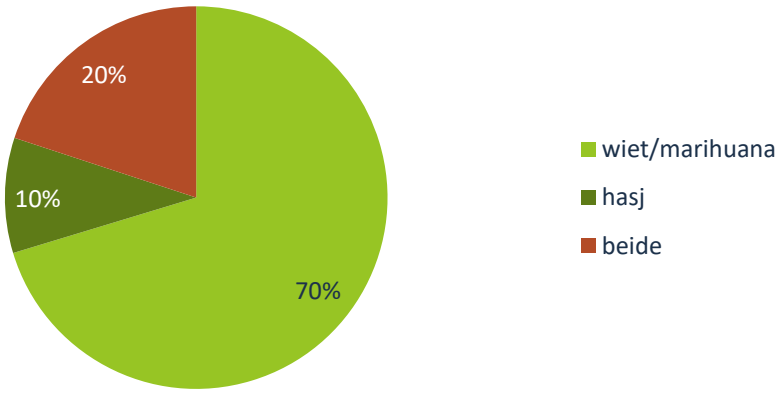


Cannabis is registered as an additional substance in over 6,000 clients. This makes cocaine the most frequently used additional substance. Cannabis as an additional substance most frequently occurs in connection with primary problems for alcohol, cocaine and opiates.

5.10 Type of cannabis

Since 2012, the type of cannabis is questioned for the primary problem cannabis. The figures must be interpreted with caution. This data is not registered for 67% of the people requesting treatment. The group for which it is known can be seen in figure 66.

Figure 65: Cannabis as primary problem by type 2015 (N=3,595)



Of the group for which it is known, weed is given in 70% of the cases as the type of cannabis as primary problem. Hashish is involved in 10% of the people requesting treatment for cannabis related problems. The remaining group of 20% indicate both types as the primary problem.

6 Amphetamine

6.1 Highlights

- Treatment demand for amphetamine rose between 2006 and 2014; in 2015 it remained the same.
- The increase is mainly attributed to clients who were previously in treatment; the influx of newcomers is stable.
- The percentage of young people has declined in the past 10 years; the average age is rising.

6.2 In brief

table 11 **Overview of treatment demand for amphetamine use related problems in 2015**

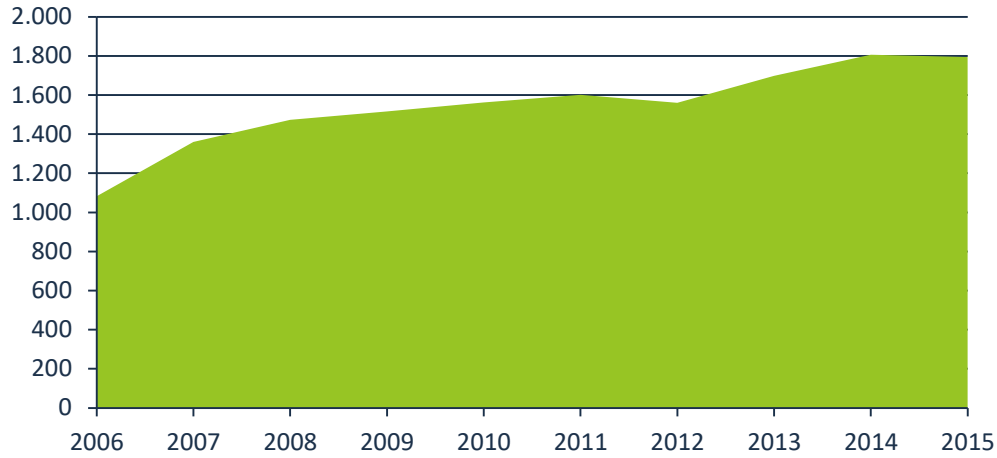
Demographics		
	Number of clients	1,794
	Male : Female	77 : 23
	Average age	31
	Proportion 25-	24%
	Proportion 55+	2%
	Proportion of Dutch natives	93%
	Number per 100,000 inhabitants	11
Problems		
	Proportion in addiction care	3%
	Single : Multiple	43 : 57
	Use as an additional substance	1,032
	First registration ever	23%

In 2015, the number of people requesting treatment has remained virtually the same compared with 2014. This is contrary to the trend of the overall decline of 7% in the entire addiction care.
There are relatively many people requesting treatment who indicate having problems with other drugs in addition to amphetamine. Almost 60% have multiple problems.

6.3 Trends and development of treatment demand

Treatment demand for amphetamine use related problems has increased almost every year over the past 10 years. In 2006 there were 1,100 people with a treatment demand for amphetamine. In 2015 this number increased to about 1,800.

Figure 66: Amphetamine - Trend in treatment demand, 2006-2015



6.4 Young and old

Most clients are between 25 and 39 years old.
Over the past 10 years, the percentage of young people (<25 years) has decreased from almost 50% to 25% of the clients. The average age has increased to 31 years in 2015 (see figure 67).

Figure 67: Amphetamine – Age categories, 2006-2015

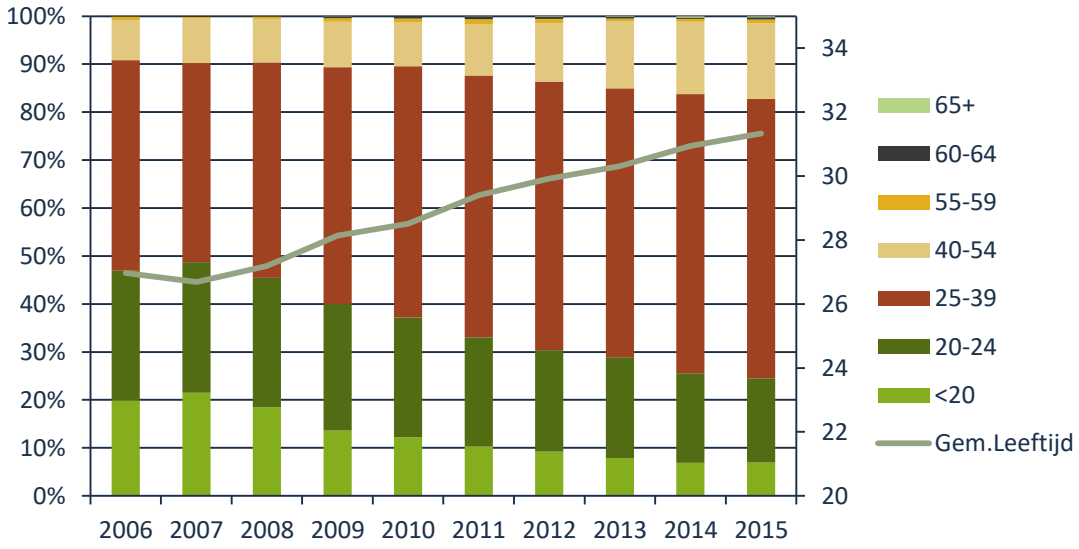
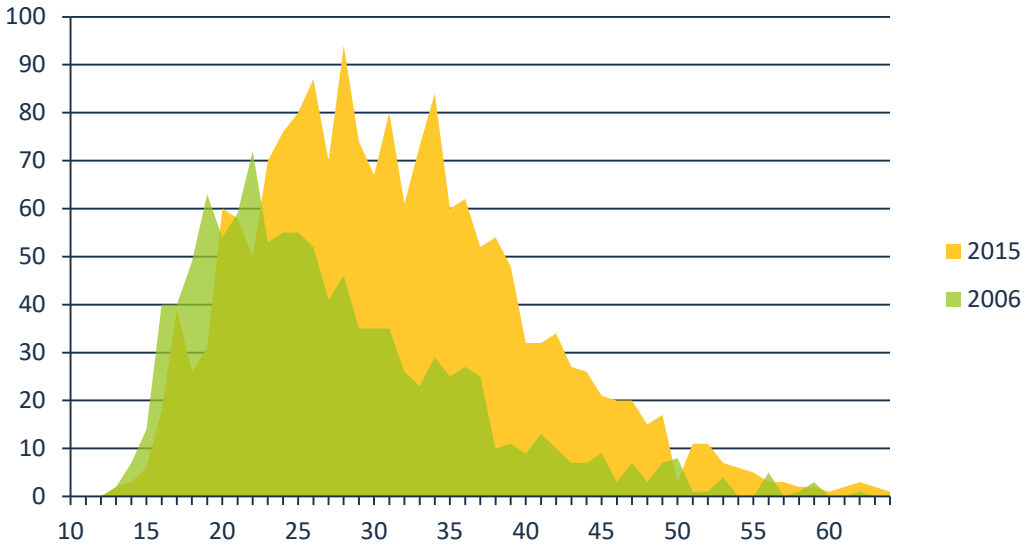


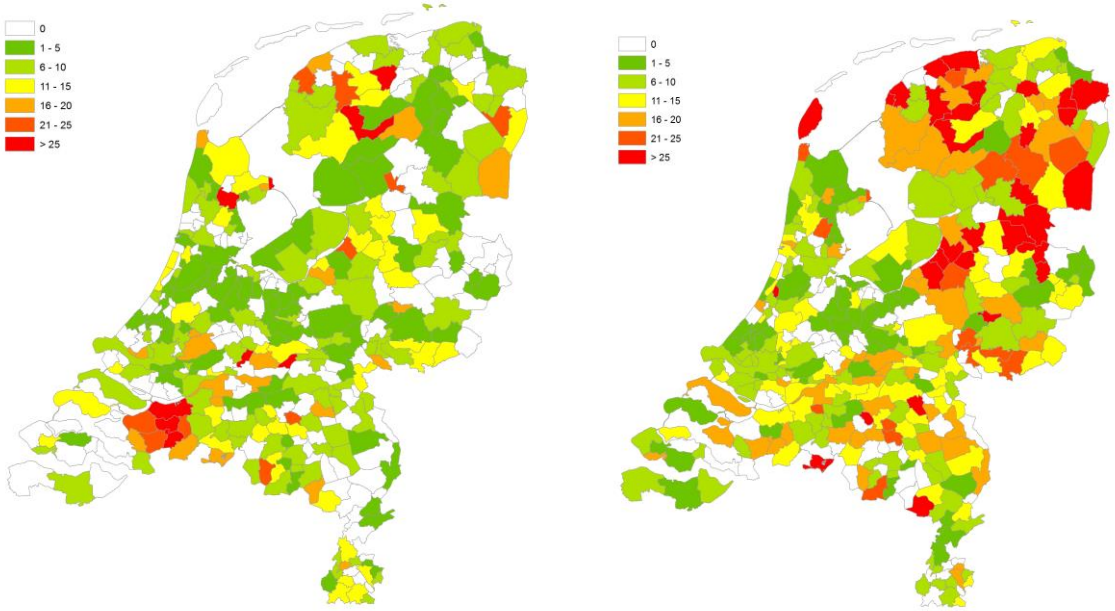
Figure 68: Amphetamine - Age distribution 2006 versus 2015



The increase in amphetamine use related treatment demand compared to 10 years ago has taken place in all age categories, with the exception of the group under the age of 20. There is a decline here. The age group 25-45 has shown the greatest increase.

6.5 Regional spread

Figure 69: Number of clients with amphetamine use related problems per 100,000 inhabitants, 2006 and 2015

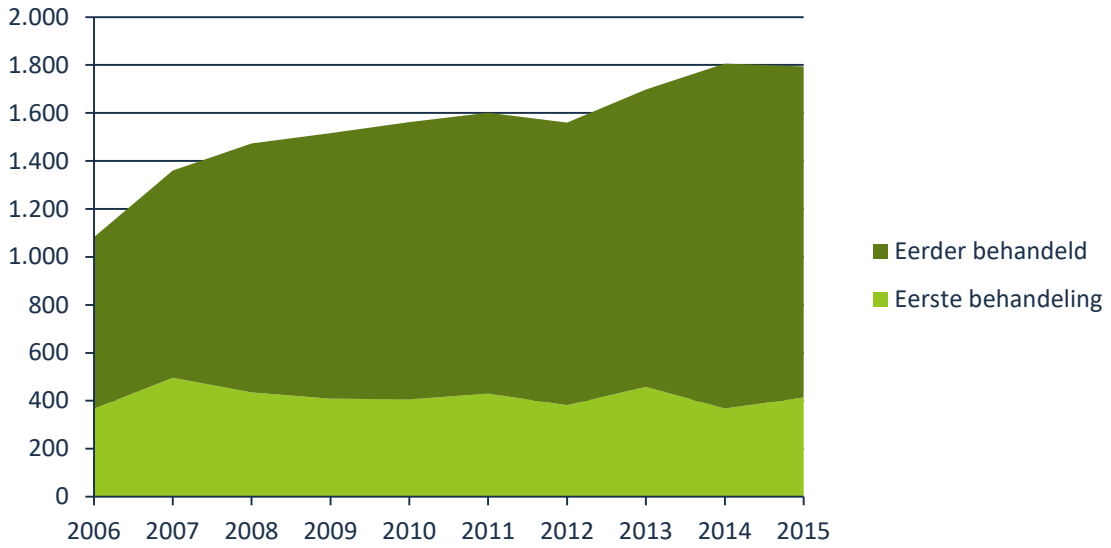


In 2015, the national average of treatment demand for amphetamine related problems was 11/100,000 inhabitants. In 2006 this was 7/100,000 inhabitants. The increase is most visible outside the Randstad, in northern Netherlands, Gelderland and North Brabant. An exception is the West Brabant region where the treatment demand for amphetamine related problems seems to be declining.

6.6 New and known

The percentage of new people requesting treatment declined between 2006 and 2014 from 34% to 20% of the total group with a treatment demand for amphetamine. In 2015 this share increased slightly again to 23%.

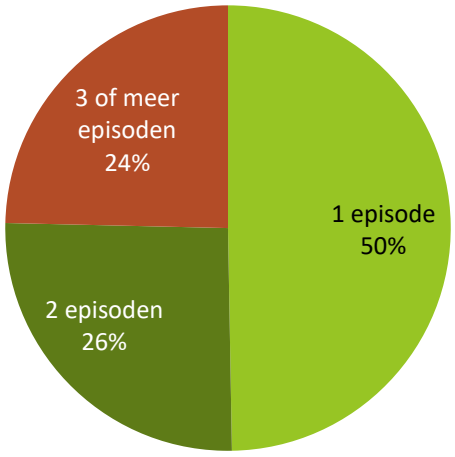
Figure 70: Amphetamine - Trend of new and known clients, 2006-2015



6.7 Treatment history

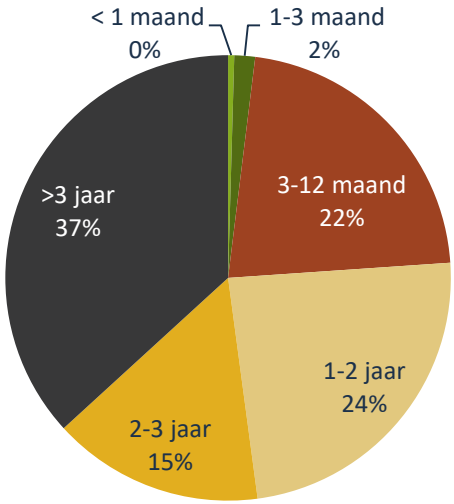
An episode may include several registrations and several registration years. The definition of an episode is described in Annex III.

Figure 71: Amphetamine – Number of episodes in addiction care 1994-2015



Half of the clients with amphetamine use related problems are in their first consecutive episode in addiction care. Approximately one in four has three or more episodes in addiction care.

Figure 72: Amphetamine - Total duration of all episodes 1994-2015

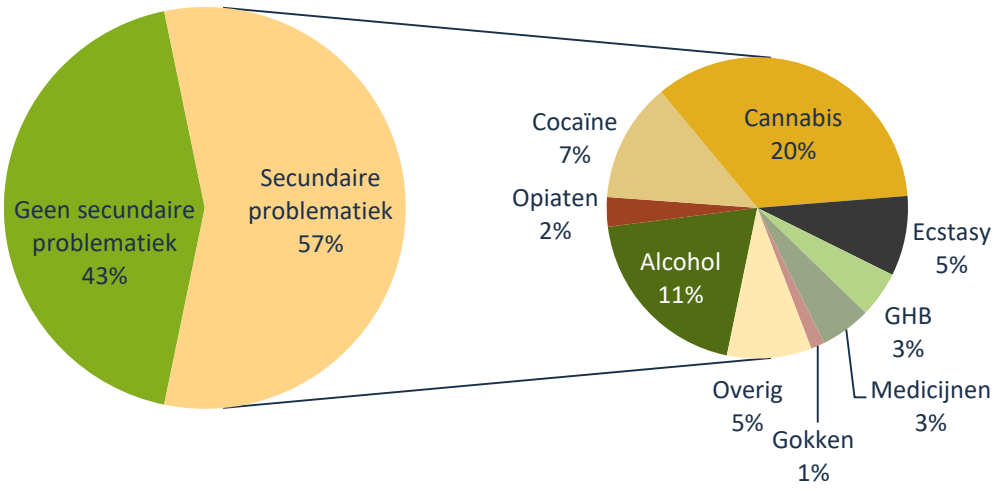


Over 20% of the clients with amphetamine use related problems have a total treatment history of less than one year in addiction care. Over half of them have a total episode duration of more than two years.

6.8 Secondary problems

In almost 60% of the cases, there are one or more secondary problems in addition to amphetamine or ecstasy use. Cannabis and alcohol are the most commonly occurring additional problems, followed by cocaine and ecstasy.

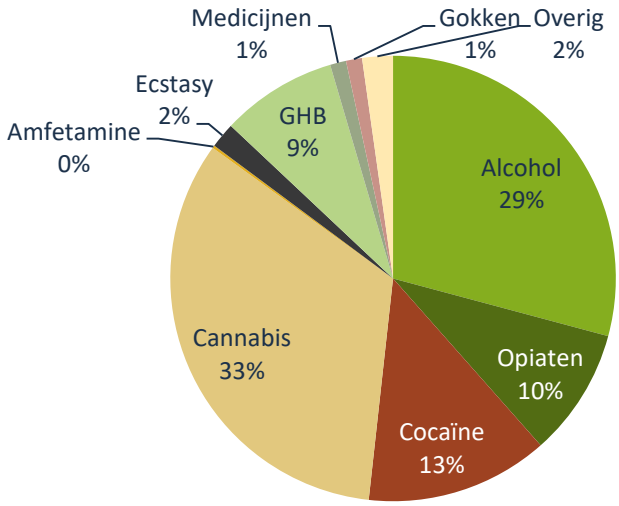
Figure 73: Amphetamine - Secondary problems 2015



6.9 Use as an additional substance

Apart from amphetamine as a primary problem, this substance is almost as frequently used as a secondary or tertiary substance.
Figure 74: shows the distribution by primary problem where amphetamine is an additional substance.

Figure 74: Amphetamine – Use as an additional substance, 2015 (N=1,032)



Amphetamine is registered as an additional substance in about 1,000 clients. Amphetamine as an additional substance occurs frequently in primary cannabis and alcohol use related problems.

7 Ecstasy

7.1 Highlights

- Ecstasy treatment demand is a relatively small group in addiction care with a share of less than 1%.
- Ecstasy is much more common as a secondary substance than as a primary problem.
- Half of the people requesting treatment for ecstasy-related problems in 2015 are new in addiction care.

7.2 In brief

Ecstasy is a very small group in addiction care in the Netherlands. The drug is much more common as a secondary substance with other primary problems than as a primary problem.
The average age of clients for ecstasy use related problems is 24, which makes the group of ecstasy use related clients the youngest group on average in addiction care.

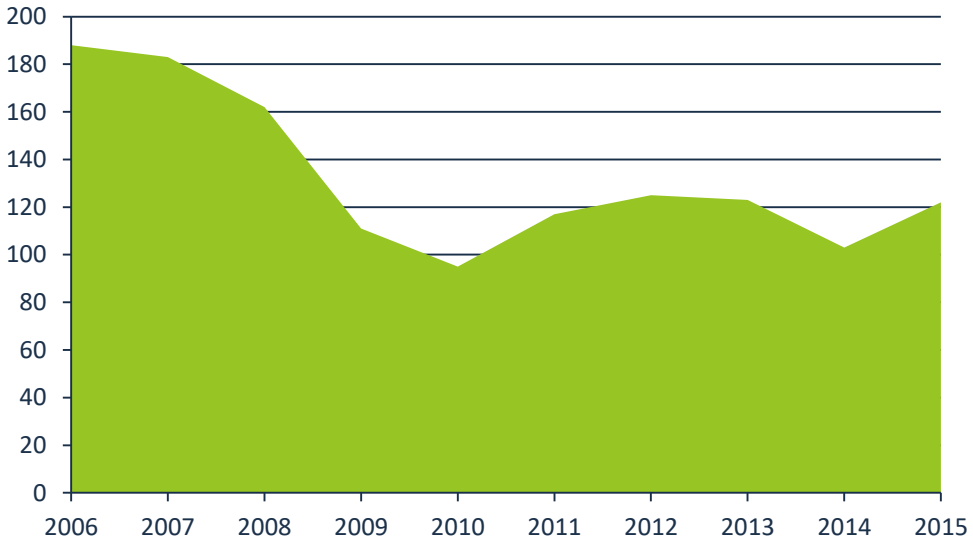
table 12 **Overview of treatment demand for ecstasy use related problems in 2015**

Demographics	
Number of clients	122
Male : Female	61 : 39
Average age	24
Proportion 25-	68%
Proportion 55+	1%
Proportion of Dutch natives	90%
Number per 100,000 inhabitants	1
Problems	
Proportion in addiction care	<1%
Single : Multiple	39 : 61
Use as an additional substance	696
First registration ever	48%

7.3 Trends and development of treatment demand

Treatment demand for ecstasy peaked prior to 2006, and has since decreased to less than 100 clients in 2010. During the last few years, the number of people requesting treatment for ecstasy-related problems was about 120.

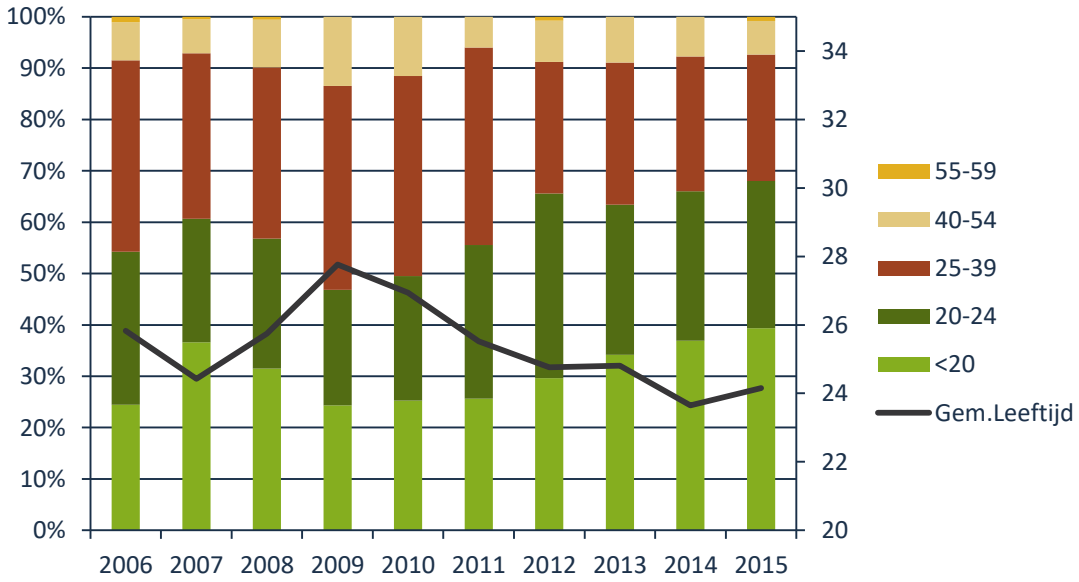
Figure 75: Ecstasy - Trend treatment demand 2006-2015



7.4 Young and old

With an average age of 24 in 2015, clients for ecstasy use related problems are the youngest group in addiction care. Two-thirds of the clients are under 25 years of age.

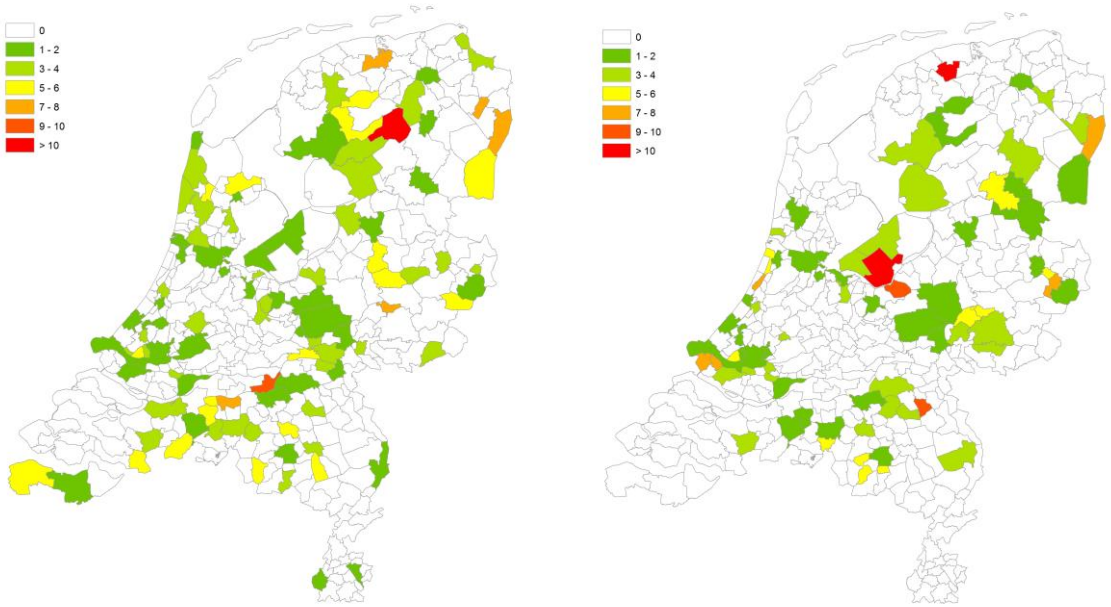
Figure 76: Ecstasy – Age categories, 2006-2015



The numbers in this group are so low that, in contrast to other substances, no age distribution is given for 2006 and 2015.

7.5 Regional spread

Figure 77: Number of clients with ecstasy use related problems per 100,000 inhabitants, 2006 and 2015

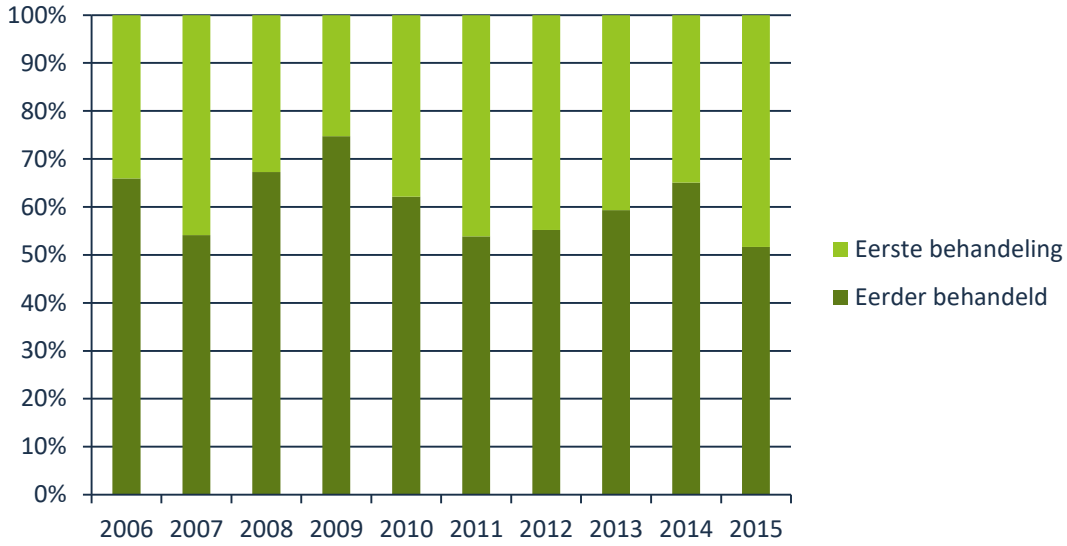


The national average of the treatment demand for ecstasy related problems in 2015 was 7/1,000,000 inhabitants. In 2006 this was 12/100,000 inhabitants. Given the small numbers, Figure 77: should be interpreted with caution.

7.6 New and known

The group of people requesting treatment in relation to ecstasy includes the highest number of newcomers, in relative terms, in addiction care. Almost half of the people requesting treatment in connection with ecstasy related problems in 2015 were entering addiction care for the first time.

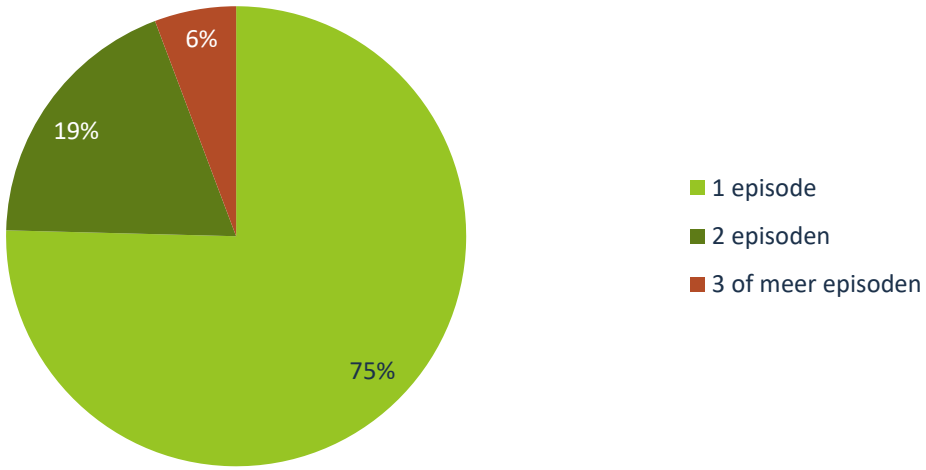
Figure 78: Ecstasy - Trend of new and known clients, 2006-2015



7.7 Treatment history

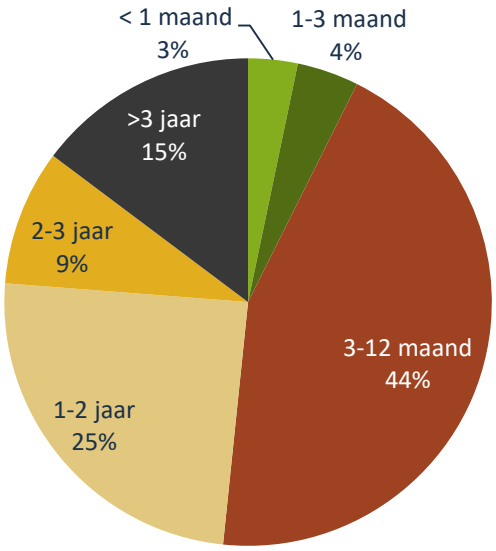
An episode may include several registrations and several registration years. The definition of an episode as used here is described in Annex III.
Three-quarters of the clients for ecstasy are in their first episode in addiction care.

Figure 79: Ecstasy – Number of episodes in addiction care 1994-2015



The total duration of all episodes amongst clients requesting treatment for ecstasy use problems is also low compared to other substances. More than half of them have a treatment history in addiction care with a duration of less than 1 year.

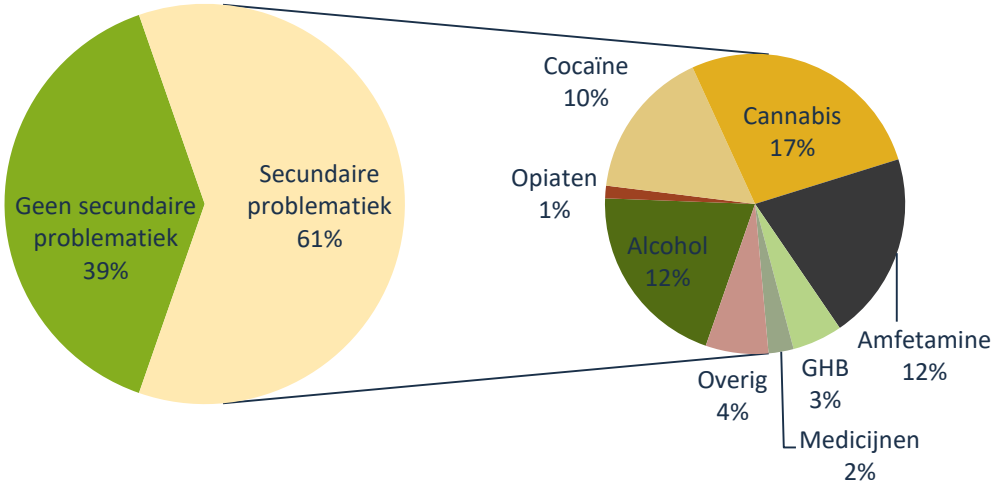
Figure 80: Ecstasy - Total duration of all episodes 1994-2015



7.8 Secondary problems

In over 60% there are secondary problems in addition to ecstasy use. Cannabis, amphetamine, alcohol and cocaine are the most frequently occurring additional problems.

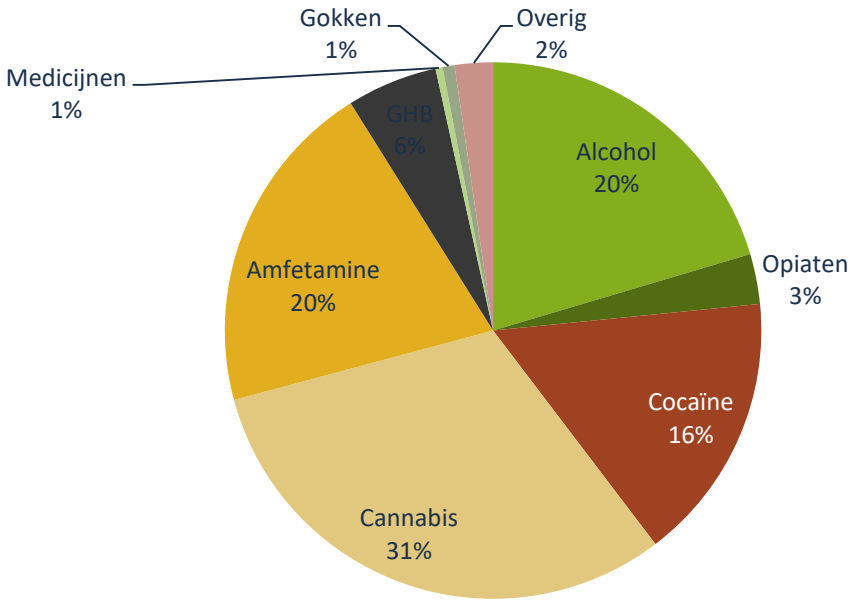
Figure 81: Ecstasy - Secondary problem 2015



7.9 Use as an additional substance

Ecstasy occurs more often as a secondary or tertiary problem than as a primary problem.
In addition to the 122 people requesting treatment with ecstasy as the primary problem there are nearly 700 people requesting treatment in addiction care for ecstasy as a secondary substance. Figure 82: shows the distribution of ecstasy as a secondary substance with which primary problem.

Figure 82: Ecstasy – Use as an additional substance 2015 (N=696)



Ecstasy as an additional substance most frequently occurs as a secondary problem to cannabis, amphetamine and alcohol.

8 GHB

8.1 Highlights

- The number of people requesting treatment for GHB in 2015 rose slightly.
- The strong growth between 2007 and 2012 did not continue.
- GHB treatment demand is mainly concentrated in parts of North Brabant and Friesland.

8.2 In brief

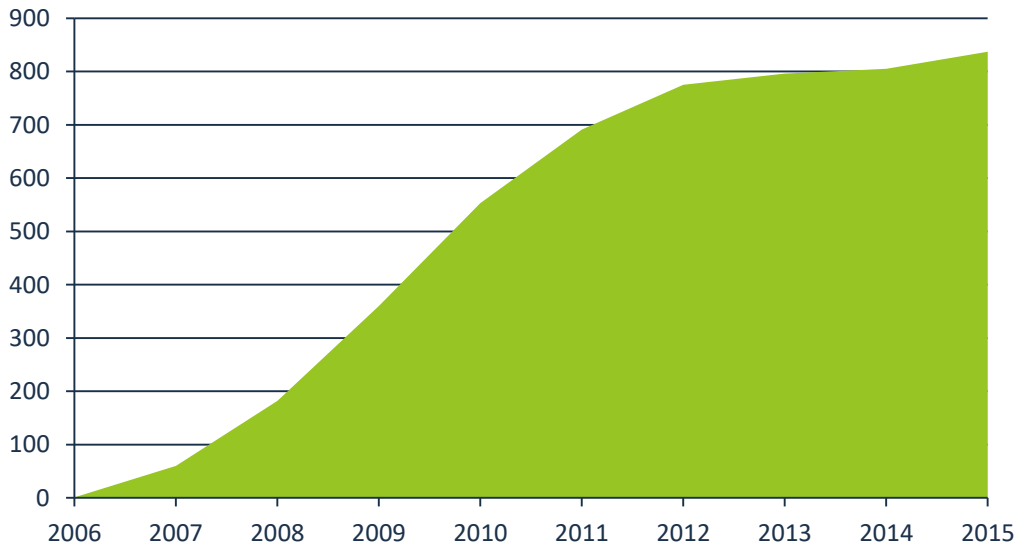
GHB related problems have been registered as a separate problem since 2007, although it was found sporadically since the late 1990s. Before 2007 it was registered in the category Other substances. The previously identified growth in the number of people requesting treatment did not continue in 2015.

table 13 **Overview of treatment demand for GHB use related problems in 2015**

Demographics	
Number of clients	837
Male : Female	68 : 32
Average age	30
Proportion 25-	23%
Proportion 55+	1%
Proportion of Dutch natives	92%
Number per 100,000 inhabitants	5
Problems	
Proportion in addiction care	1%
Single : Multiple	39 : 61
Use as an additional substance	242
First registration ever	22%

8.3 Trends and development of treatment demand[13]

Figure 83: GHB - Trend in treatment demand, 2007-2015

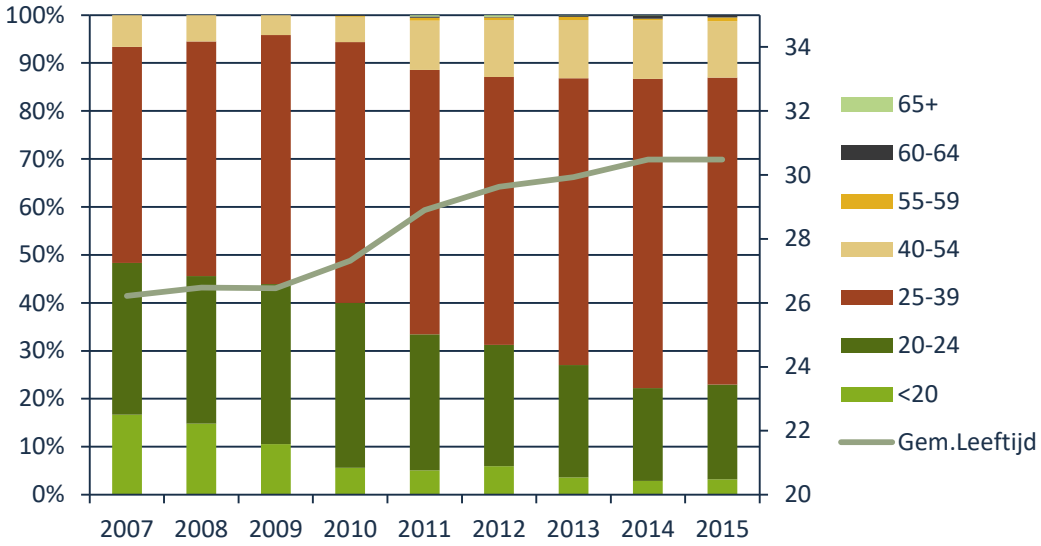


[13] A publication on GHB can be downloaded at www.ladis.eu

Treatment demand for GHB increased sharply between 2007 and 2012 from less than 100 requesting treatment in 2007 to nearly 800 in 2012. Since 2012 growth has slowed down and there is a slight increase to 837 people requesting treatment in 2015. The share in addiction care is still limited at 1%.

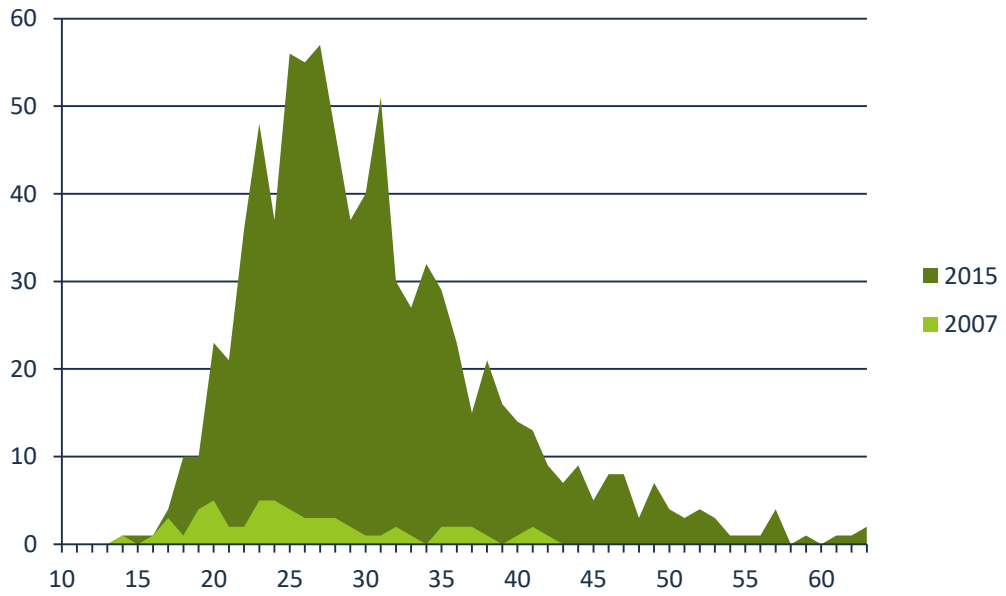
8.4 Young and old

Figure 84: GHB – Age categories, 2007-2015



GHB is not just a problem among young people. The share of young people (<25 years) has decreased slightly over the past 10 years. As a result, the average age has increased to 30 years in 2015.

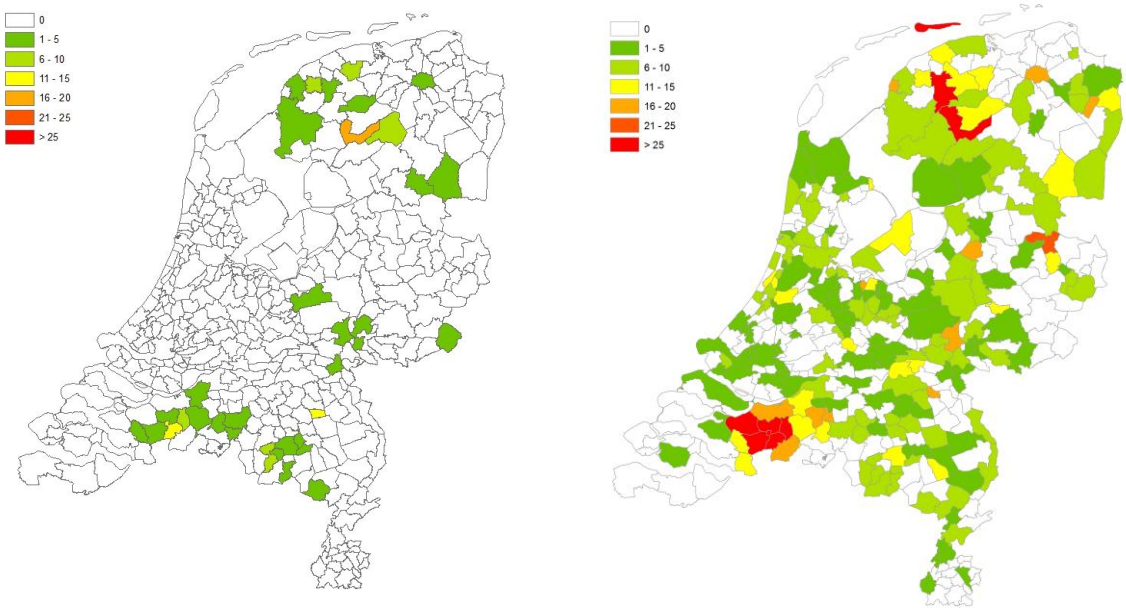
Figure 85: GHB - Age distribution 2007 versus 2015



Compared to 2007, the increase in GHB users requesting treatment has mainly taken place among 20 to 30-year olds, with a peak around 25-year olds.

8.5 Regional spread

Figure 86: Number of clients with GHB use related problems per 100,000 inhabitants 2007 and 2015

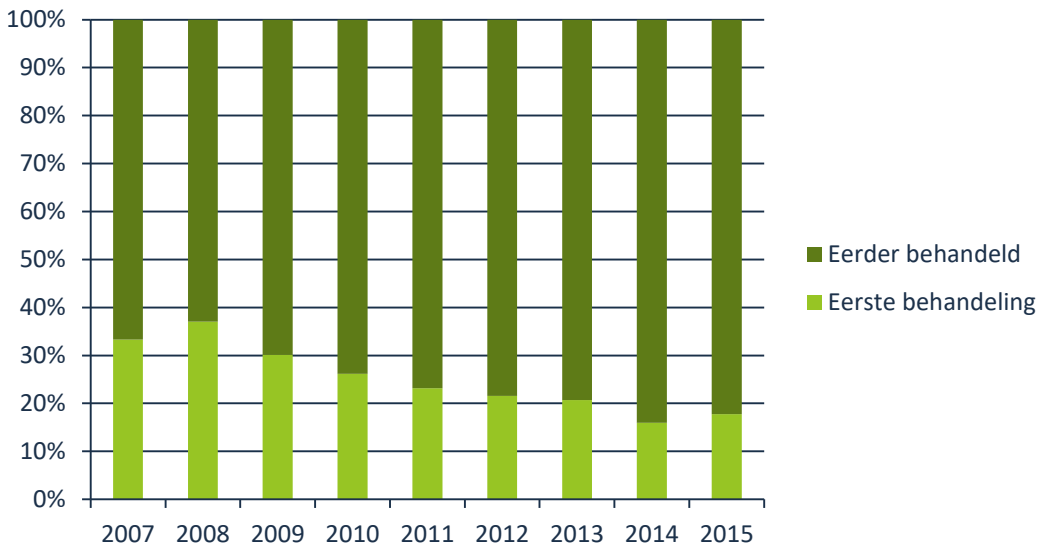


These maps for GHB deviate from the maps showing the regional spread of treatment demand in the other chapters. As GHB has not been registered before 2007, this is used as the map on the left side instead of 2006. In 2015, average treatment demand for GHB in the Netherlands was 5 in 100,000 inhabitants.

Figure 86: clearly shows that in 2007 GHB use related treatment was mainly concentrated in parts of North Brabant and Friesland. In 2015, treatment demand in these regions was still overrepresented and in addition has spread to more regions, mainly outside the Randstad.

8.6 New and known

Figure 87: GHB - Trend of new and known clients, 2007-2015

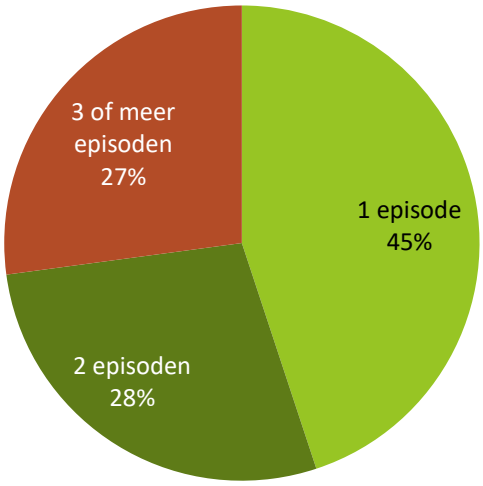


Remarkably, it largely concerns clients who were already registered in a previous registration year. The proportion of real newcomers has been decreasing over the past 10 years.

8.7 Treatment history

An episode may include several registrations and several registration years. The definition of an episode as used here is described in Annex III.
Most GHB clients are in their first episode in addiction care. 45% have been treated at least twice during a consecutive period. This proportion is increasing.
In early 2014, a directive on the treatment of GHB use related problems was published[14].

Figure 88: GHB – Number of episodes in addiction care 2014, (N= 761)

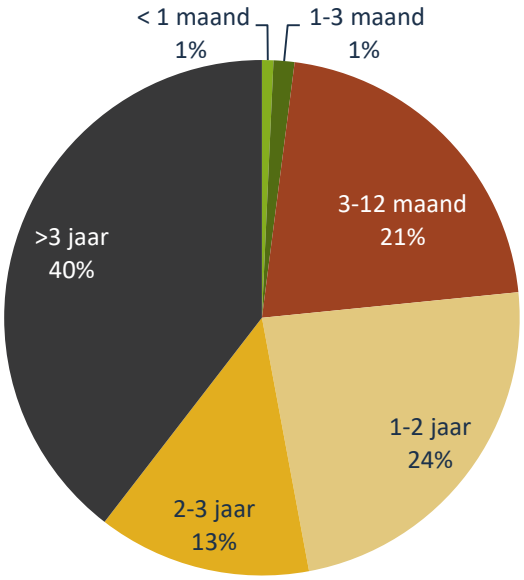


Among the group of GHB users there is also a proportion with a longer history in addiction care.

[14] Kamal R, Dijkstra BAG, van Iwaarden JA, Van Noorden MS, De Jong CAJ. Practice-based recommendations for the detoxification of patients with a disorder in the use of GHB. Results Scores, Amersfoort, 2014.

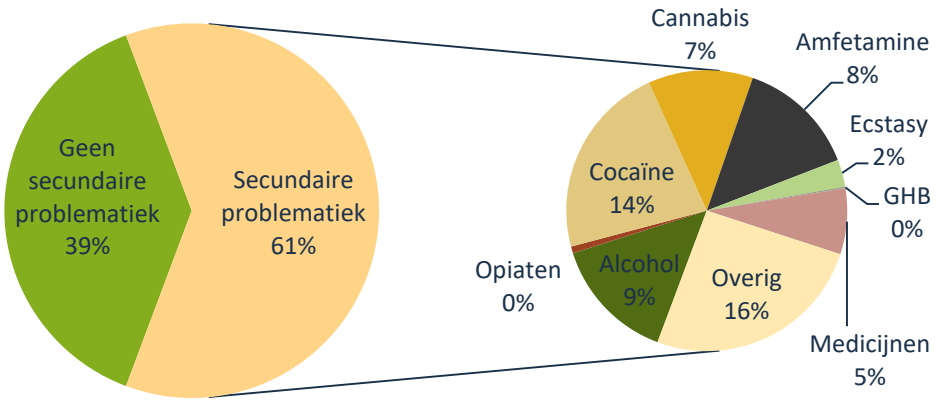
Approximately 40% of the clients registered in 2015 have been registered for more than 3 years (see Figure 89: .

Figure 89: GHB - Total duration of all episodes 1994-2015



8.8 Secondary problems

Figure 90: GHB - Secondary problems, 2015 (N=761)

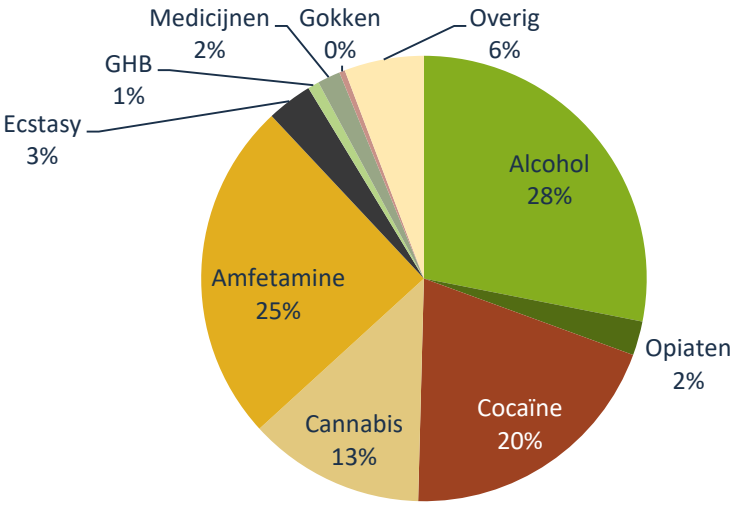


61% of the GHB clients also have secondary problems in addition to GHB.
The category Others (mainly other stimulants) and cocaine are the most common secondary substances. Alcohol, amphetamine and cannabis are also common.

8.9 Use as an additional substance

The extent of the use of GHB as an additional substance has limited visibility in addiction care. In 2015 GHB was registered as a secondary substance in 242 clients.
Figure 91 shows the distribution by primary problem where GHB is an additional substance.

Figure 91: GHB - Use as an additional substance, 2015 (N=242)



GHB as a secondary substance is most frequently related to clients with alcohol or amphetamine clients, followed by cocaine and cannabis.

9 Medicines

9.1 Highlights

- Treatment demand for medicines has remained constant over the past 5 years.
- Largest group requesting treatment has problems with the use of benzodiazepines.
- Compared with other substances, a large share of the people requesting treatment for medicine use problems is female.

9.2 In brief

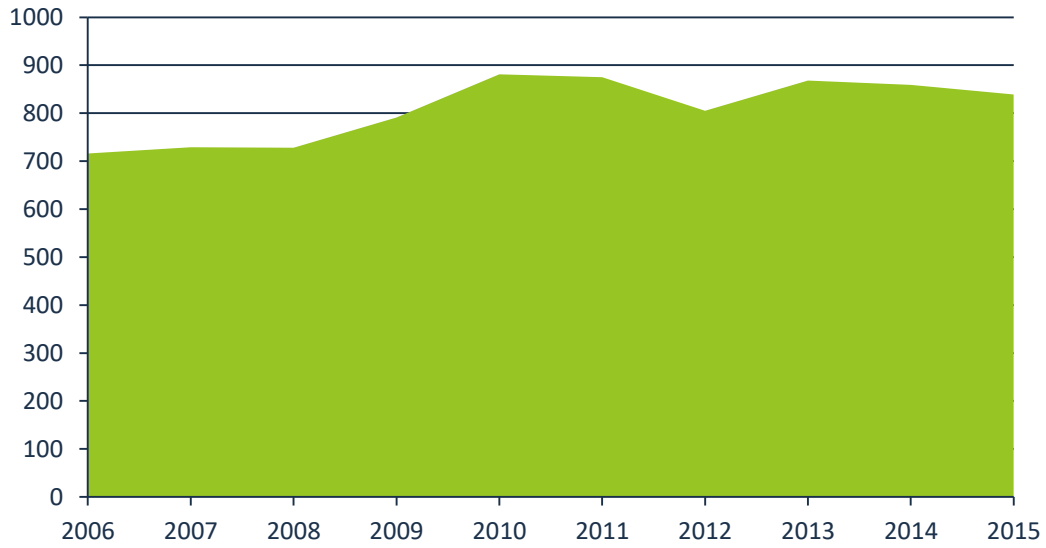
The number of people turning to addiction care with medicine use related problems has increased to almost 900 between 2006 and 2010. Since 2010, treatment demand continues to fluctuate around 850 people. This mainly involves problems with benzodiazepines, which are among the most widely used medicines in the Netherlands. The average age is 45 years and the percentage of women is high compared to other problems.

table 14 **Overview of treatment demand for medicine use related problems 2015**

Demographics		
	Number of clients	839
	Male : Female	55 : 45
	Average age	45
	Proportion 25-	4%
	Proportion 55+	24%
	Proportion of Dutch natives	83%
	Number per 100,000 inhabitants	5
Problems		
	Proportion in addiction care	1%
	Use as an additional substance	3,080
	Single : Multiple	54 : 46
	First registration ever	26%

9.3 Trends and development of treatment demand

Figure 92: Medicines - Trend in treatment demand, 2006-2015



Treatment demand for medicines increased from 700 to more than 800 people between 2006 and 2010. In recent years, the number of people requesting treatment has fluctuated around 850.

9.4 Young and old

The age distribution in treatment demand for medicine use related problems has been reasonably stable over the past ten years.

Figure 93: Medicines – Age categories, 2006-2015

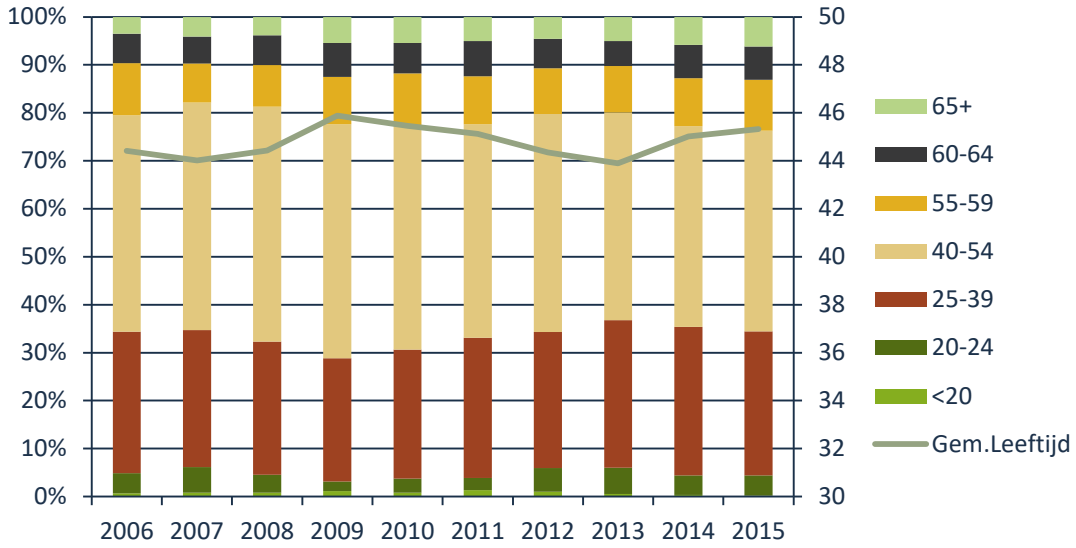
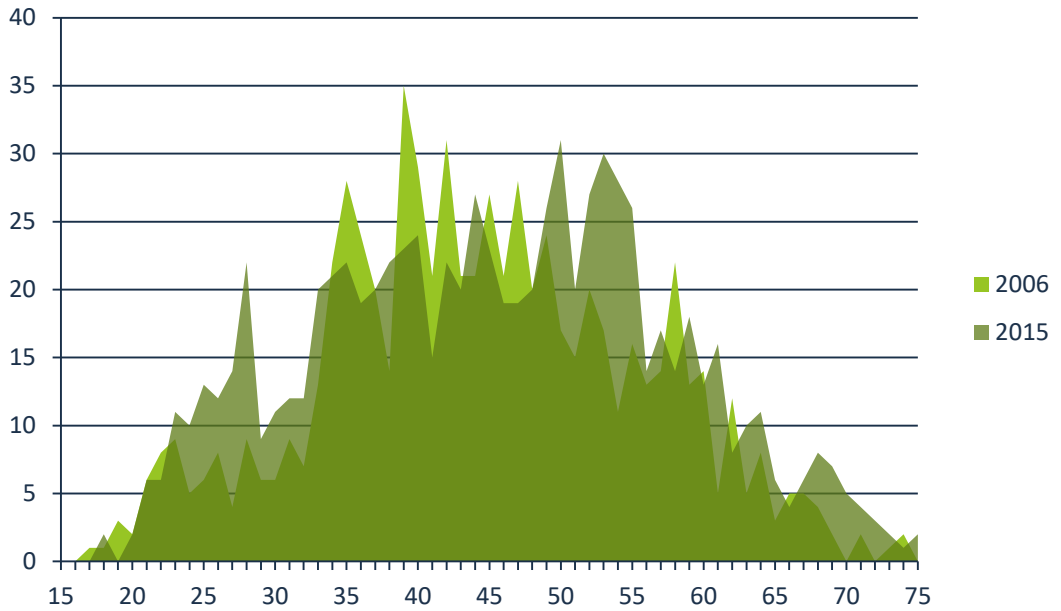


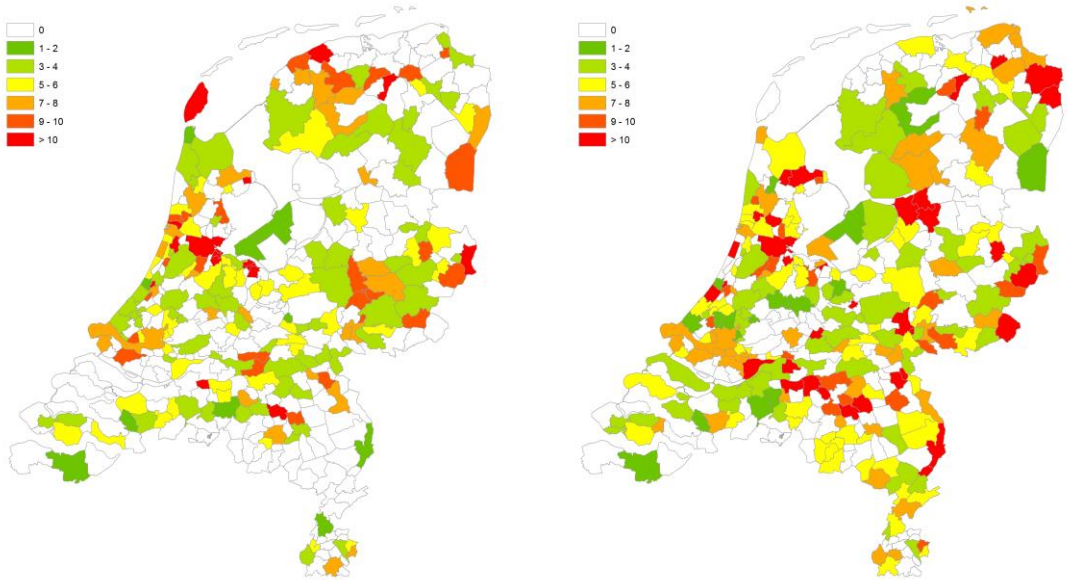
Figure 94: Medicines - Age distribution 2006 versus 2015



Compared to 10 years ago, the percentage of newcomers is not substantially different.

9.5 Regional spread

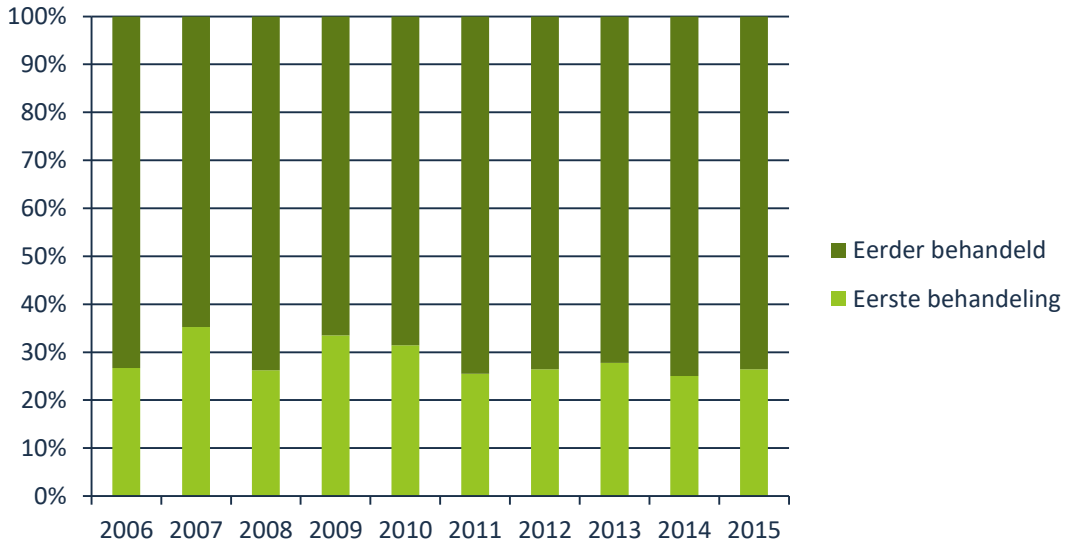
Figure 95: Number of clients with medicine use related problems per 100,000 inhabitants, 2006 and 2015



The national average of treatment demand for medicine use related problems in 2015 was 5/100,000 inhabitants. In 2006 this was 4/100,000 inhabitants.

9.6 New and known

Figure 96: Medicines - Trend new and known clients 2006-2015

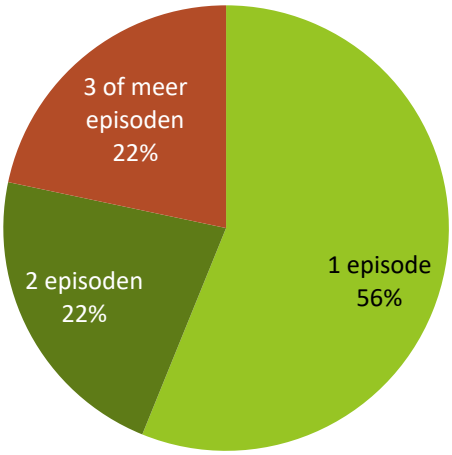


In 2015, around 180 people requesting treatment entered addiction care for the first time for problems resulting from use of medicines. In recent years, the share of newcomers has been about 25%.

9.7 Treatment history

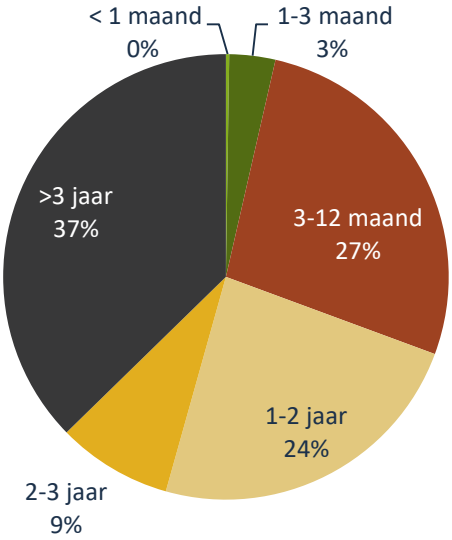
An episode may include several registrations and several registration years. The definition of an episode as used here is described in Annex III.
In 2015, more than 59% of the clients with medicine use related problems are in their first consecutive period in addiction care.

Figure 97: Medicines – Number of episodes in addiction care 1994-2015 (N=748)



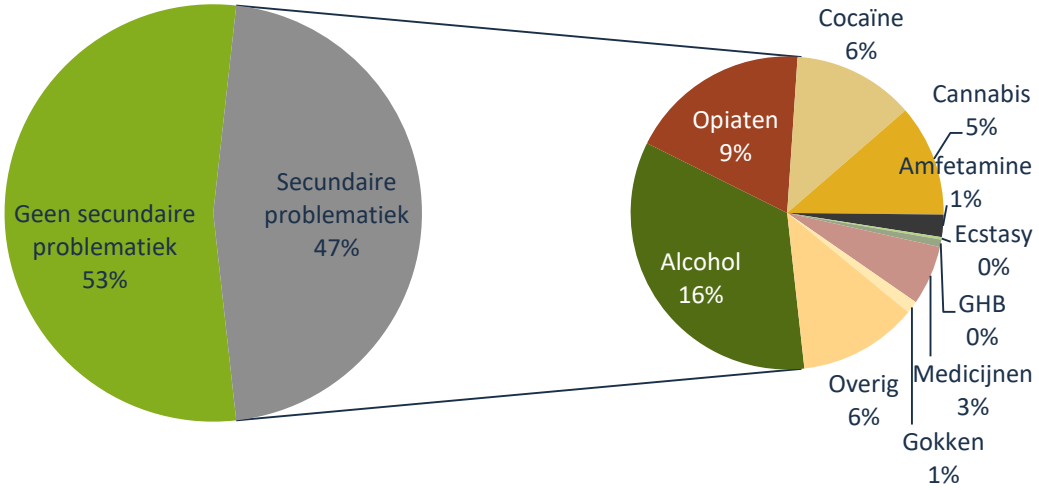
As from 1994, slightly over 25% of the clients have a total episode duration of less than one year.

Figure 98: Medicines - Total duration of all episodes 1994-2015



9.8 Secondary problems

Figure 99: Medicines - Secondary problem, 2015 (N=748)

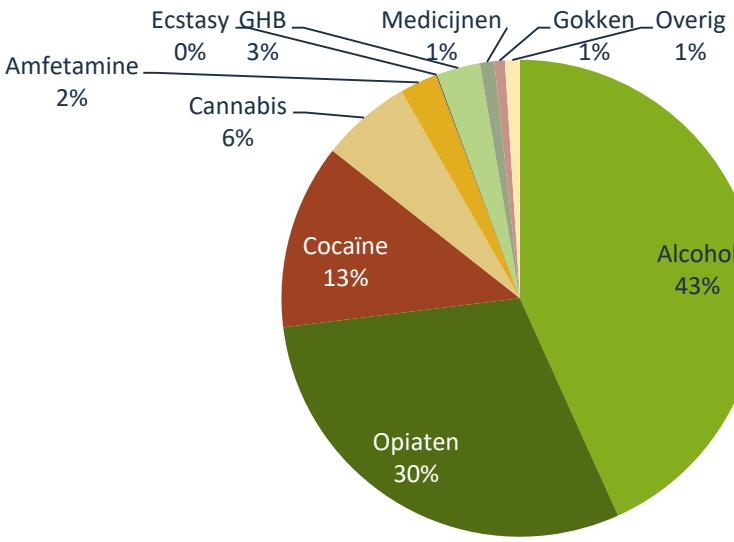


Almost half of the clients registered for medicine use related problems have other problems as well. Alcohol is the most frequently occurring secondary problem, followed by opiates and cocaine.

9.9 Use as an additional substance

In 2015, 2,850 clients were registered with medicines as an additional substance.
Figure 100 shows the distribution by primary problem where medicines is an additional substance.

Figure 100: Medicines – Use as an additional substance, 2015 (N=3,080)



Medicines are most common with alcohol. Medicines are also common as a secondary substance among people requesting treatment for opiate-cocaine related problems. This also mainly concerns benzodiazepines.

10 Gambling

10.1 Highlights

- Treatment demand for gambling decreased by 10% in 2015.
- Gambling related problems mainly occur among men.

10.2 In brief

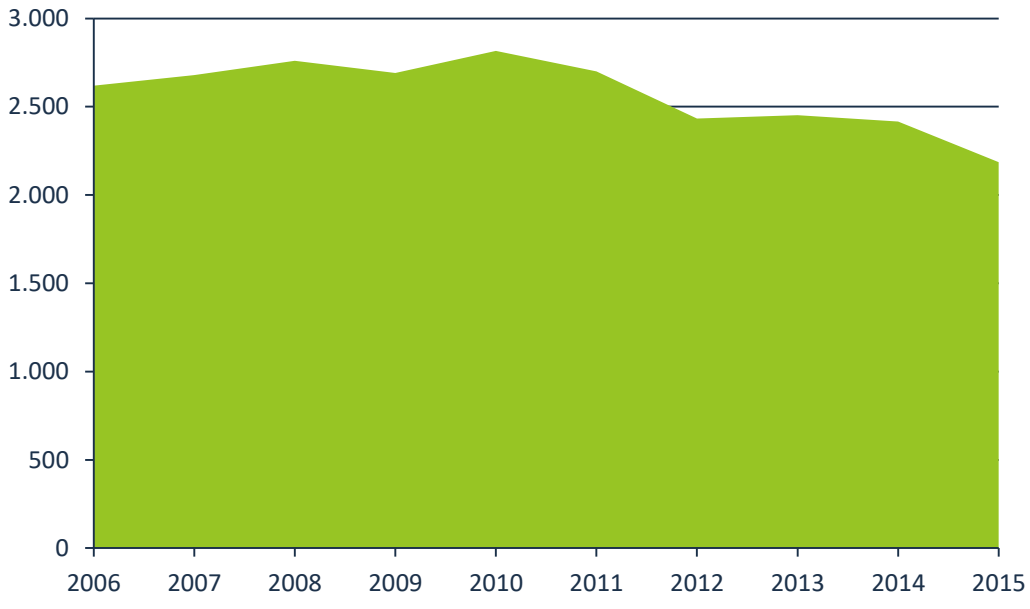
table 15 **Overview of clients with gambling related problems, 2015**

Demographics		
	Number of clients	2,186
	Male : Female	87 : 13
	Average age	37
	Proportion 25-	16%
	Proportion 55+	11%
	Proportion of Dutch natives	74%
	Number per 100,000 inhabitants	13
Problems		
	Proportion in addiction care	3%
	As an additional problem	898
	Single : Multiple	78 : 22
	First registration ever	36%

10.3 Trends and development of treatment demand

Since 2010, the appeal for treatment due to gambling has declined. People requesting treatment with gambling as the primary problem are mainly men around 40 years of age.

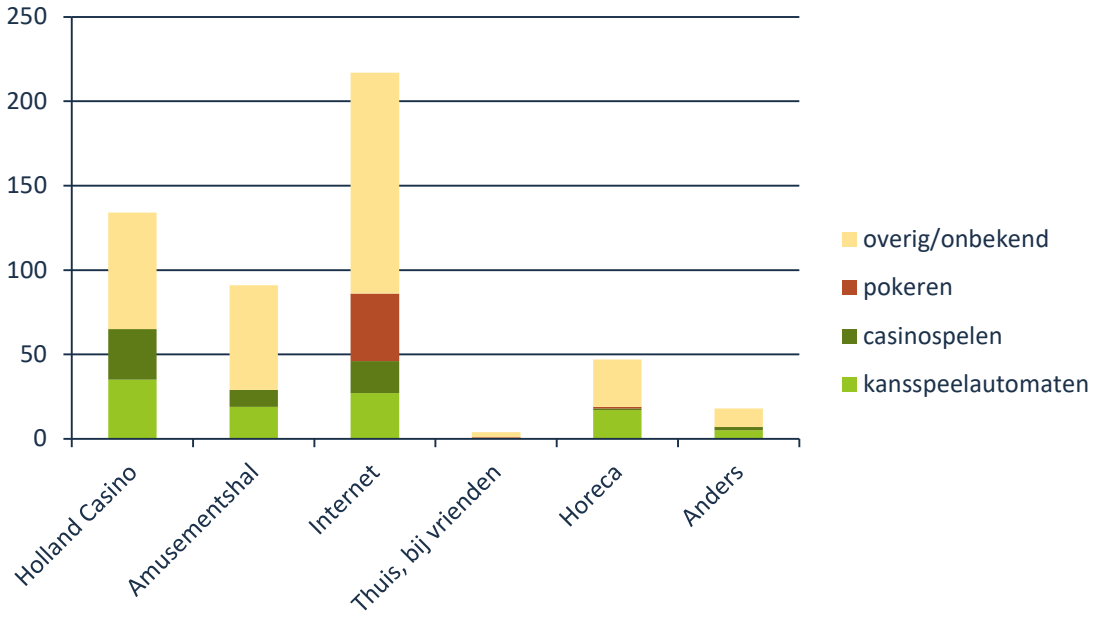
Figure 101: Gambling – Number of clients, 2006-2015



In 2015 there was a 10% decline in the number of people requesting treatment for gambling compared to the previous year. This partly has to do with the overall declining trend in addiction care, but for the treatment demand for gambling this decline is relatively greater.

In 2015, registration for 511 of the clients for gambling included the type of gambling and the location where this mainly occurred. This is shown in Figure 102: .

Figure 102: Type of gambling by location of gambling 2015 (n=511)



10.4 Young and old

Over the past few years, the age distribution of people with a gambling related treatment demand has been stable. The average age, around 37 years, also remained the same through the years.

Figure 103: Gambling – Age categories, 2006-2015

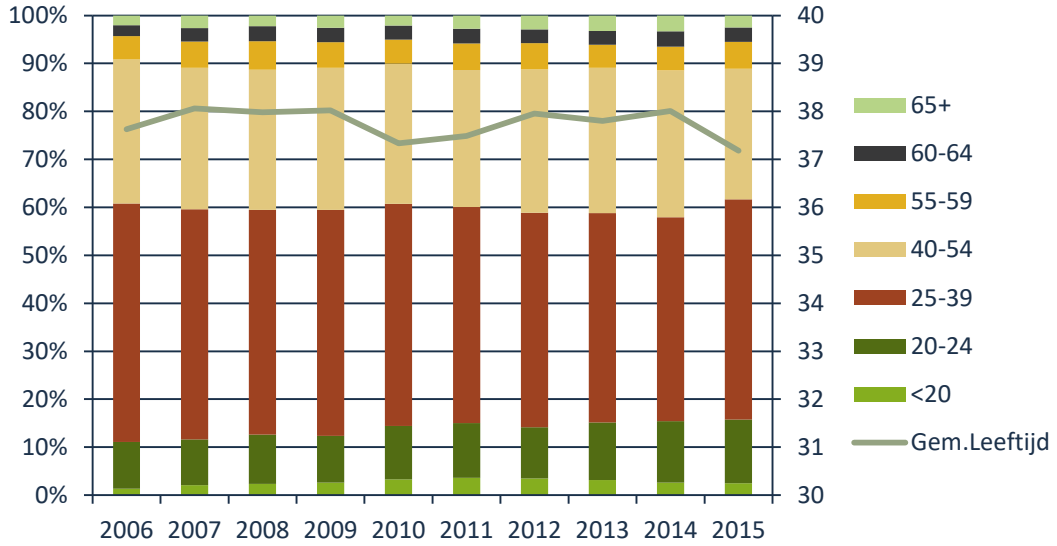
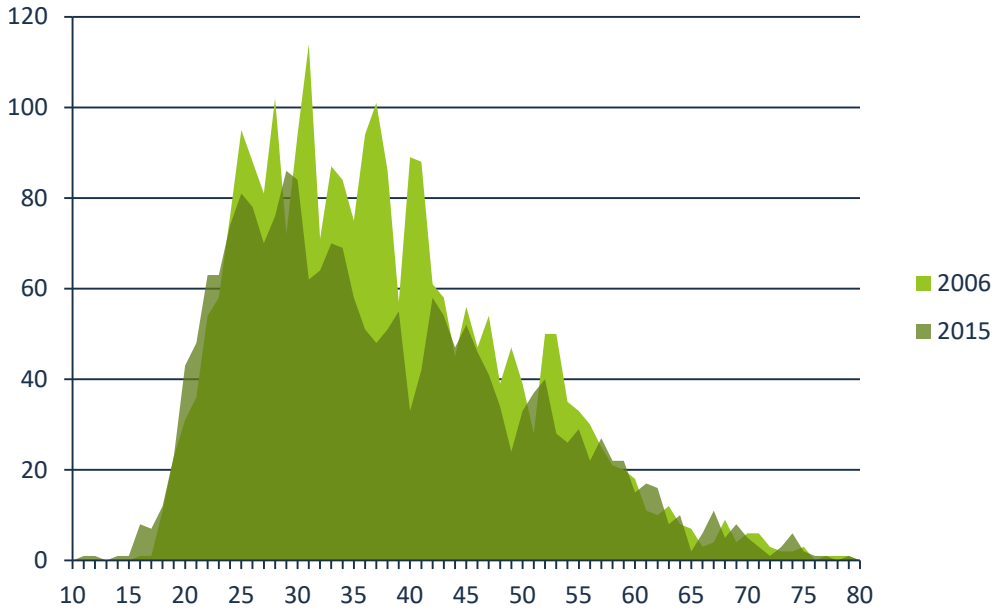


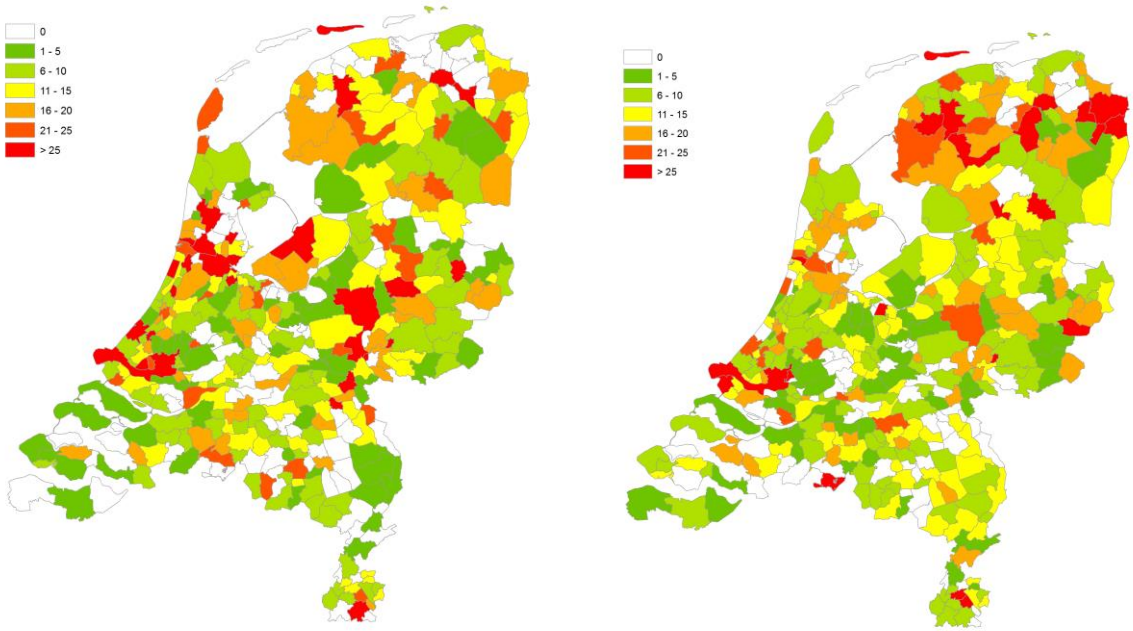
Figure 103 shows that the group of people under 25 years has increased slightly in comparison with ten years ago.

Figure 104: Gambling - Age distribution 2006 versus 2015



10.5 Regional spread

Figure 105: Number of clients with gambling related problems per 100,000 inhabitants, 2006 and 2015

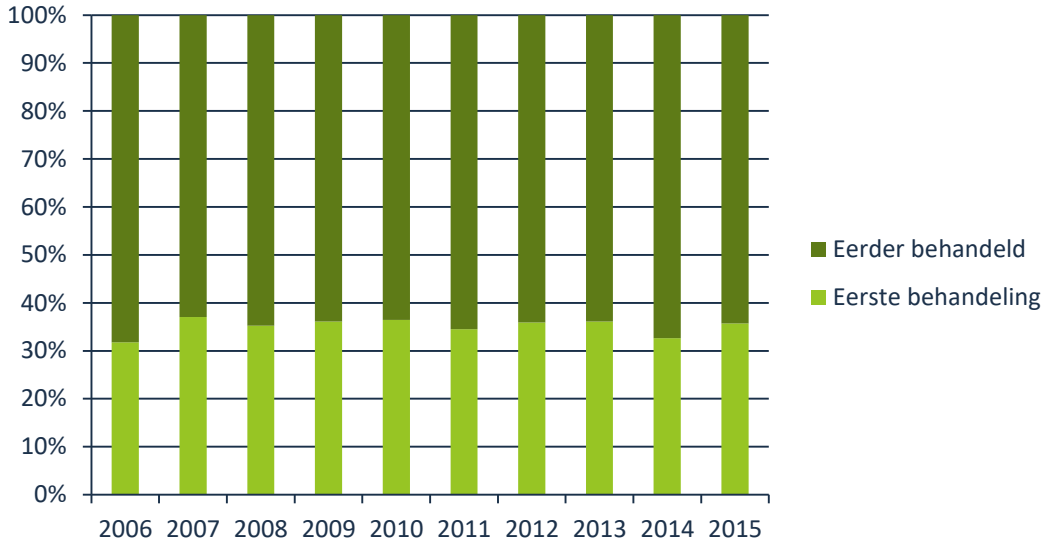


The national average of the gambling related treatment demand was 16/100,000 inhabitants in 2006 and 13/100,000 inhabitants in 2015.

10.6 New and known

The ratio between newcomers and people having requested treatment with gambling problems before has been more or less stable over the past ten years, apart from a number of fluctuations. In 2015, more than one third of the clients with gambling related treatment demand were first registered with addiction care.

Figure 106: Gambling - Trend of new and known clients, 2006-2015



10.7 Treatment history

An episode may include several registrations and several registration years. The definition of an episode as used here is described in Annex III.
In 2015, for two-thirds of the clients with a treatment demand for gambling related problems it is their first episode in care. 18% of the clients in 2015 have had three or more episodes in addiction care.

Figure 107: Gambling – Number of episodes in addiction care 1994-2015

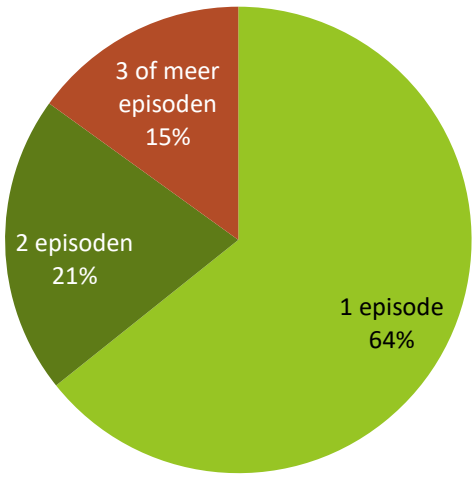
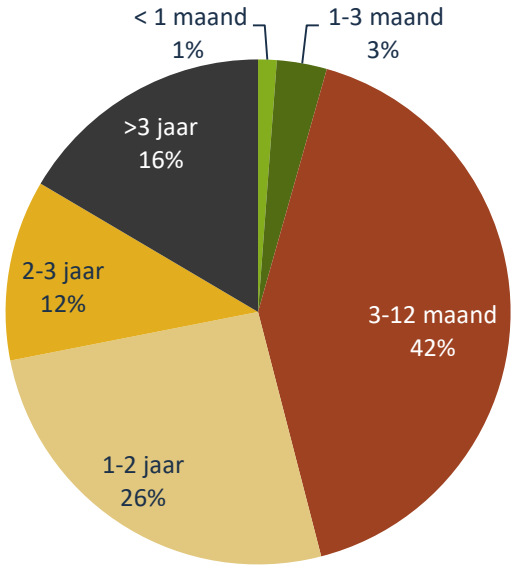


Figure 108: shows the total duration of all episodes. The group of clients registered for gambling is comparable to the group of clients registered for cannabis and for ecstasy related problems with regard

to the total duration of all episodes in care. The percentage of clients with a total treatment duration of less than a year was 46% in 2015.

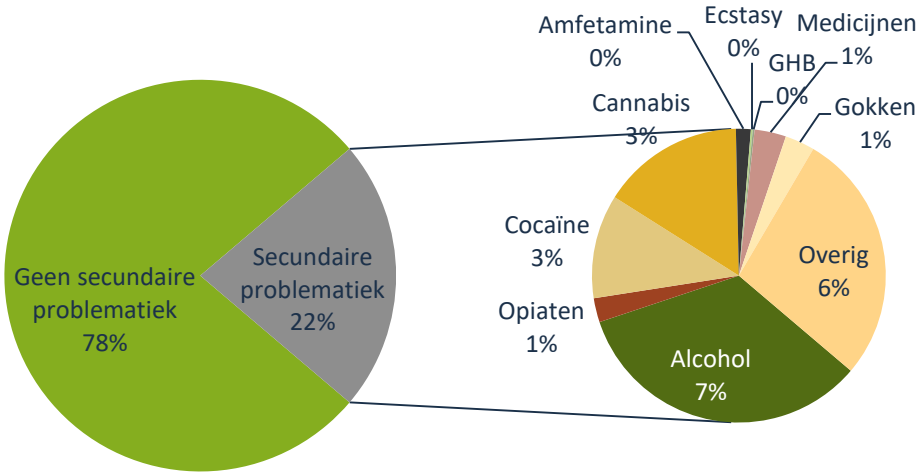
Figure 108: Gambling - Total duration of all episodes 1994-2015



10.8 Secondary problems

In 78% of the cases, people registering with gambling problems do not experience any other problems. In 7% of the cases alcohol abuse also plays a role. The group Other (6%) largely consists of clients with nicotine related problems.

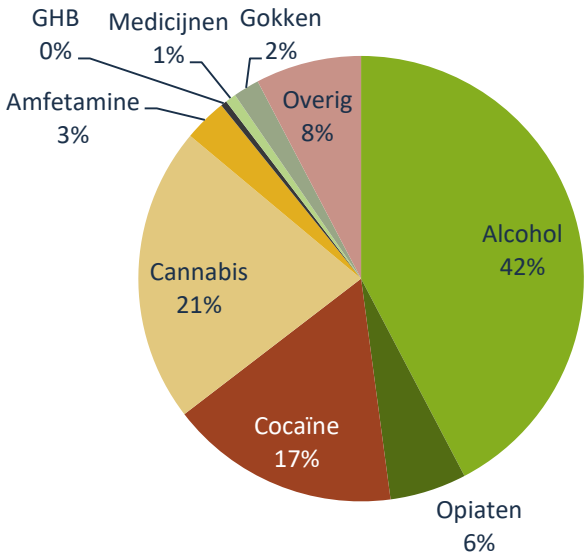
Figure 109: Gambling - Secondary problems (N=2,266)



10.9 Gambling as a secondary problem

Problematic gambling as a secondary problem to other primary problems occurs as well.
In 2015, almost 900 clients were registered with gambling as their second or third problem.
Figure 110: shows the distribution by primary problem where gambling is an additional substance.

Figure 110: Gambling – as a secondary problem, 2015 (n=898)



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

11 Other

11.1 Highlights

- The number of clients with nicotine use related problems is increasing.
- The number of clients with Internet gaming related problems has not changed.

11.2 In brief

The group referred to as 'Other' covers a range of problems giving rise to treatment demand for addiction care. This concerns both substance and behaviour related addictions. Figure 111: shows this in main groups. All categories are set out in detail in table 16 .

Internet gaming is highlighted in section 11.3; nicotine is considered in greater detail in section 11.4.

Figure 111: Main groups within the category other requests for treatment 2015 (n=2,465)

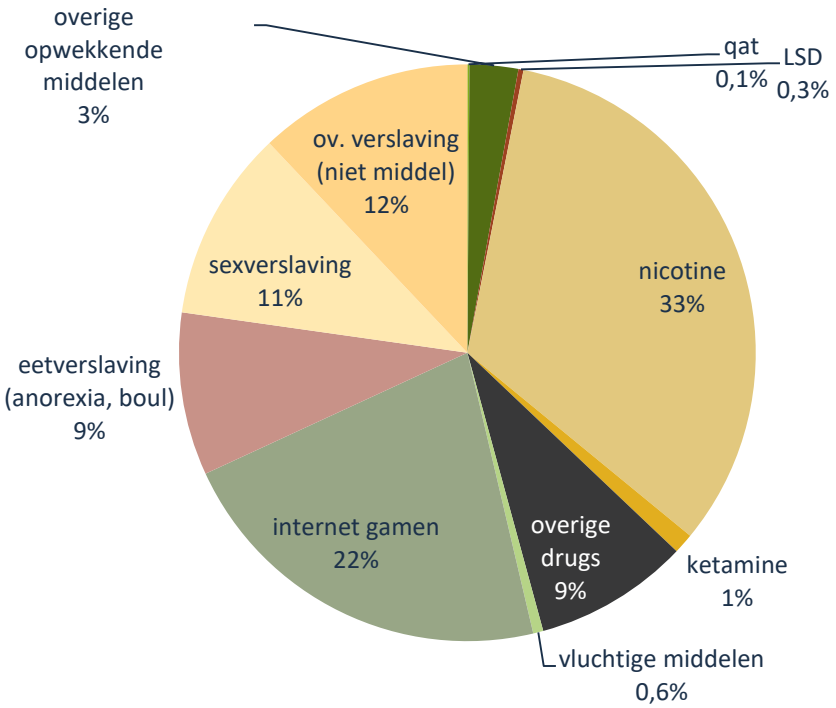


Figure 111: shows that there is also a large group of 'other non-substance addiction'. These include internet addictions such as chatting and possibly people requesting treatment who are not registered under the category of eating disorders, sex addiction or internet gaming. Unfortunately, no other details are known about the categories "other stimulants" and "other drugs".

table 16 **Other treatment demands in 2015**

	N	%
qat	3	0
other stimulants	67	3
LSD	7	3
nicotine	809	33
ketamine	28	1
other drugs	214	9
volatile substances	14	1
internet gaming	537	22
eating disorders (anorexia, boulimia)	225	9
sex addiction	264	11
other addiction (non-substance)	297	12
Total	2,465	100%

11.3 Internet gaming

11.3.1 In brief

table 17 **Internet gaming – Overview of clients, 2015**

Demographics		
	Number of clients	537
	Male : Female	92 : 8
	Average age	21
	Proportion 25-	82%
	Proportion 55+	1%
	Proportion of Dutch natives	89%
	Number per 100,000 inhabitants	3
Problems		
	Single : Multiple	87 : 13
	First registration ever	52%

Treatment demand for internet gaming rose sharply until 2013 and has remained stable since that year with more than 500 clients. In 2015 the number of clients with internet gaming related problems is 537. Treatment demand for internet gaming is clearly a problem in males. These are predominantly young people but certainly not exclusively so. The majority entered addiction care for the first time in 2015. This is therefore mainly a new group.

11.4 Nicotine

11.4.1 In brief

table 18 **Nicotine – Overview of clients, 2015**

Demographics		
	Number of clients	809
	Male : Female	67 : 33
	Average age	40
	Proportion 25-	25%
	Proportion 55+	22%
	Proportion of Dutch natives	84%
Problems		
	Single : Multiple	35 : 65
	First registration ever	43%

In 2015 there has been an increase in the treatment demand for nicotine. One explanation is that among multiple problems, nicotine is increasingly registered as a primary problem. In 2015 the number of clients with nicotine use as their primary problem has increased to over 800, whereas 65% of the clients also have other problems. Alcohol and cannabis are most common as secondary substance.

12 Rehabilitation

12.1 Highlights

- Registration in addiction rehabilitation remains incomplete.
- Addiction rehabilitation had 21,000 people in 2015.
- Alcohol is the most frequently occurring primary problem.

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 clients originating in addiction rehabilitation is therefore lower. In 2015, as in the previous two editions, the figures are presented separately from addiction care. The trends regarding primary problems are too greatly influenced by the increase in the proportion of incomplete data.
Because many people with a rehabilitation contact also have contacts in regular addiction care, it is still possible to form a rough impression of this group.

12.2 In brief

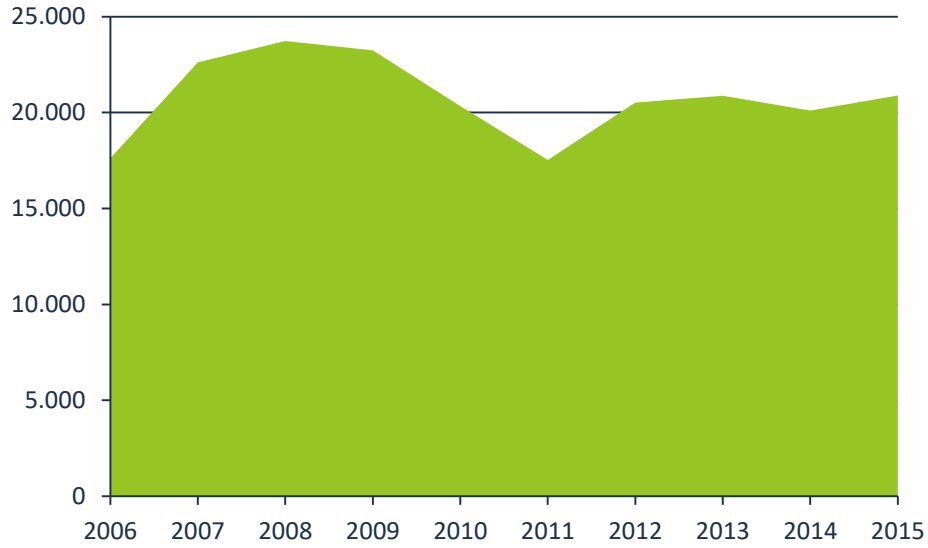
table 19 **Rehabilitation overview, 2015**

Demographics	
Number of clients	20,891
Male : Female	90 : 10
Average age	37
Proportion 25-	17%
Proportion 55+	7%
Proportion of Dutch natives	73%

In 2015, nearly 21,000 unique people originated from addiction rehabilitation.
Approximately 30% (n=5,895) also have contacts in regular addiction care in the same year.
Only 10% are female and the average age is 37, which is about 5 years below the average age for addiction care. The group of native Dutch clients in addiction rehabilitation is under-represented compared to ordinary addiction care and compared to the general population.

Figure 112: shows the number of clients with addiction rehabilitation between 2006 and 2015. The decrease between 2008 and 2011 can probably be largely attributed to the changes that have taken place in the registration system. The old registration system was phased out and a new system was implemented at the start of 2009.

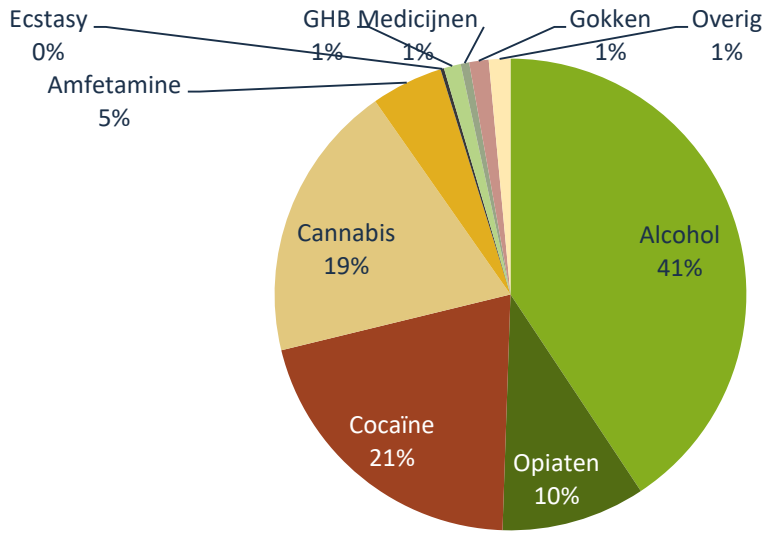
Figure 112: Requests for addiction rehabilitation treatment: number of unique clients, 2006 - 2015



12.3 People by primary problem

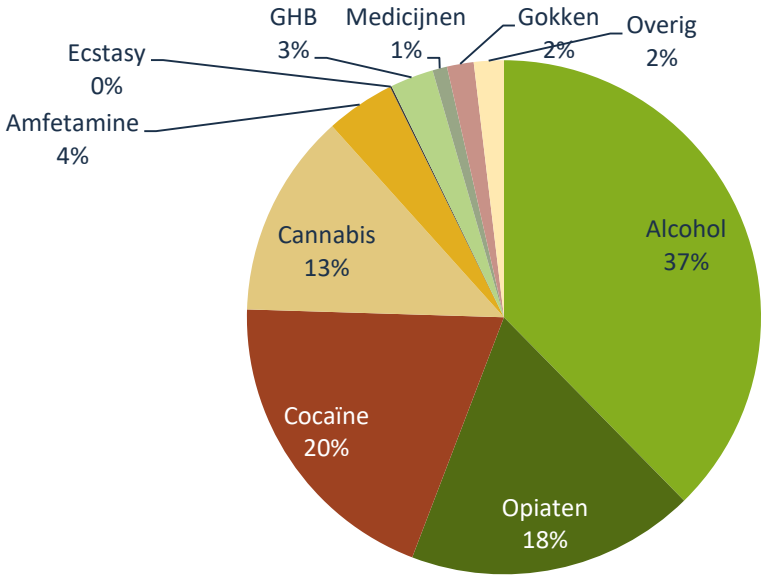
Figure 113: shows the distribution of the group where the primary problems are known. Alcohol is the most frequently occurring primary problem (41%), followed by cocaine and cannabis.

Figure 113: Primary addiction rehabilitation problems in 2015 (N=7,048)



The percentages in figure 113 should be approached with some caution because there may be a bias in selection (66% unknown). The distribution of the problems among the group that also has contacts in regular addiction care is known, however (N=5,895). The most striking difference is a lower percentage for alcohol and a higher percentage for opiates as the primary problem (see figure 114).

Figure 114: Primary problem group overlap between addiction care and addiction rehabilitation in 2015 (N=5,895)



Annex I: Participating institutions

	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Jellinek (Arkin)	■	■	■	■	■	■	■	■	■	■
IrisZorg	■	■	■	■	■	■	■	■	■	■
Emergis	■	■	■	■	■	■	■	■	■	■
Bouman GGZ (Antes)	■	■	■	■	■	■	■	■	■	■
Victas	■	■	■	■	■	■	■	■	■	■
Brijder (Parnassia Groep)	■	■	■	■	■	■	■	■	■	■
GGD Amsterdam[15]	■	■	■	■	■	■	■	■	■	■
Tactus	■	■	■	■	■	■	■	■	■	■
Vincent van Gogh	■	■	■	■	■	■	■	■	■	■
Mondriaan	■	■	■	■	■	■	■	■	■	■
Verslavingzorg Noord Nederland	■	■	■	■	■	■	■	■	■	■
Novadic-Kentron	■	■	■	■	■	■	■	■	■	■
De Hoop	■	■	■	■	■	■	■	■	■	■
De Regenboog	■	■	■	■						
De Wit Consultancy		■	■	■	■	■	■	■	■	
Arta Lievegoed Zorggroep		■	■	■	■	■	■	■	■	■
De Brug			■	■	■	■	■	■	■	■
Rehabilitation in general			■	■	■	■	■	■	■	■
Trubendorffer				■	■	■	■	■	■	■
Momentum GGZ					■	■	■	■	■	■
Amethist								■	■	■
Dimence								■	■	■
Castle Craig				■	■	■	■	■	■	■

[15] GGD Amsterdam provides care for opiate addicts.

Annex II: LADIS compared to previous editions

Each year the Key figures provide the latest trends in addiction care. Differences may occur here compared to figures shown in previous editions. Administrative adjustments and improved records from previous years are included in the latest figures each year.
The most important changes are explained below:

1. Participating institutions

- Castle Craig has submitted data this year, with retrospective effect as from 2009.
- De Wit Consultancy no longer provides addiction care.

2. Improvement pseudonyms

With retrospective effect starting in 2007, encrypted citizen service numbers are accessed via ZorgTTP, thereby greatly improving monitoring for double counting.

Annex III: Definition of an episode in LADIS

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 when a person has been treated in addiction care for a consecutive length of time.
An episode can consist of more than one registration at several institutions 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 light of this historic practice with registration, the following definition has been adopted:

- The start of an episode is a 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 correction on the late administrative discharge.
- 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 for which no discharge date exists. The episode has nonetheless been consistently calculated for all registration years and for the various problems. Ultimately, the vast majority of the episodes end with a discharge date (88%).

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 treatment
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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