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Minutes

Meeting • Réunion A comparative analysis of national treatment systems Date 25/26 June 2014

Venue • Lieu Lisbon

Present • Présent(e)(s) See attendance list

Background

This 2-day meeting took place as a follow up to the 2013 EMCDDA activities in the area of treatment data collection and analysis. As a reminder, the EMCDDA adopted in 2013 a systems based approach to collect treatment data from NFPs, which was introduced in 2014 into Standard Table 24 as part of its routine data collection. The adopted systems based approach requests data, in a standardized and comparable form ('treatment system map'), regarding clients and units of all providers composing national treatment systems beyond those covered by national TDI-based monitoring systems. This approach provides greater insight into the extent of treatment availability and diversification at national level and allows to develop estimates of total treatment provision, e.g. the total number of people in drug treatment. However, this approach also comes at a high cost in terms of data quality as the control of client double counting between providers is highly reduced and consequently is likely to produce inflated estimates. In the first instance, work on the systems-based approach will focus on supporting NFPs in improving capacity to develop reliable treatment estimates at national level national and in harmonising data on treatment systems across EU countries.

In this regard, the two day expert meeting brought together experts from 10 Member States to work together with EMCDDA experts towards achieving these objectives by specifically addressing the following points:

Day 1: Development of a methodological toolkit to improve national estimates of the total number of people in drug treatment

Day 2: Identify dimensions and typologies of European treatment systems to carry out a comparative analysis of national drug treatment systems in Europe



Day 1: Development of a methodological toolkit to improve national estimates of the total number of people in drug treatment

Objectives

Identify, with a specified degree of confidence, the magnitude of the overlap between specific categories of service provision in each country.

Identify existing methods to control for double counting

Describe the most practical and effective estimation techniques that National Focal Points have developed to date, or could conceivably apply, to produce more accurate estimates of the number of people in drug treatment.

Methodological toolkit: In this respect, one concrete output from the meeting is to produce a methodological toolkit which compiles identified methods and 'best practices' for reducing overlaps between system categories. Thus, countries with similar treatment systems can apply these methods to adjust their estimates of the total number of people in drug treatment.

1. Wil Kuijpers (Netherlands)

Between 2004 and 2013 there has been a strong decrease in % opiates in terms of clients in treatment while alcohol remains the biggest problem with about 50% of all demands for treatment are for alcohol-related problems. Additionally, costs of all treatments (incl. alcohol which is by far the biggest problem) are exploding with most expenses focussed in specialized care (approx. 4 billion euros for the total mental health care sector, while addiction-related care represents about 500 million euros). There are changes in the healthcare system to reduce the specialised sector and increase the share of primary mental health care and first-line treatment (GPs), self-management and e-health. While cost-efficiency will be improved, challenges to access client data may appear in the future. When presenting the national treatment system map, we notice that currently the number of people only using inpatient is very small (1%), that they combine this in the reporting (e.g. 400 cases, out of total 30.000 using treatment facilities in most recent reporting year). Patients in outpatient treatment are all known (99%). Regarding private clinics, there are 10-15 of them and they don't provide official data. Data from prison is problematic as criminal justice is not reporting due to low interest and technical issues. Finally, the methadone registry was deemed too expensive and was stopped (there is however an alternative data source). Opportunities exist in terms of high interest in combining outcome and financial data in care, with both using unique identifiers. Finally, some mental health institutes also have addiction treatment teams, but data on provision are not available.



All experts have been asked questions below regarding double counting control and methodological information on this topic. Here the answers from the Dutch experts.

What is the level of client overlap (in %) between the different categories of the national treatment system map (e.g. between A and B; B and C; A and I, etc.)?

And are you able to control for the overlaps mentioned in question 1?

Technically they are able but in practice the data is not yet available.

If yes, what methods do you use to control for each or for some of these overlaps?

Unique national identifiers / anonymous

Please mention any additional methodological issues regarding the estimation or count of the total number of people in drug treatment in your country and on methods that would need to be implemented to improve the total estimate or count?

Alcohol treatment clients represent the largest part of the system and data on drug clients are hard to isolate and extract.

2. Tanja Bastianic (France):

It is estimated that about 124.000 drug users are in specialised outpatient (incl. Young people centres and prisons) and inpatient treatment in France. This estimate on total number of people in drug treatment is obtained from the annual activity report of the Treatment centres (90% response rate vs 75% response rate for TDI data). It is estimated that 150.000 are in OST, but the overlap between total specialised services' clients and OST clients is not known. Furthermore, Low threshold services are surveyed every 2 years, but there are uncertainties around data quality, which is not used for TDI reporting. Across the treatment system, client overlap is controlled only at the centre level, however, at national level the client overlap is estimated roughly at 5% which is partially confirmed by the NEMO study in Toulouse. Currently a publication is in preparation which presents a study using a single source capture recapture method using TDI data for estimating the total number of drug users in France. It was suggested to add a column on "overlap" to the table in ST 24.

3. Marta Struzik, Anna Strzelecka (Poland)

Three separate drug treatment monitoring systems are established in Poland. One administered by the Institute of Psychiatry and Neurology (inpatient and outpatient treatment), the TDI monitoring system operated by the Reitox National Focal Point (with limited coverage) and the National Bureau for Drug Prevention data base on the number of drug treatment centres and the number of substitution treatment clients.

There are about 30.000 outpatient clients (alcohol not included) – reported to IPiN. Data on outpatient are collated at centre level, and added up at IPiN. There can be double counting within centres and clients could be counted multiple times each year. The reporting is funding-related, so counting could



be based on visits/services. Also, low threshold is excluded from treatment monitoring system. There are no data from GPs which is a large system, but it's assumed that GPs refer clients to specialized treatment. In Poland, about 2000 problem opioid users receive OST. Inpatient treatment takes place in 79 TCs which is provided in the manner of a therapeutic community approach, but in reality, they fulfill conditions of hospital based facilities (and are therefore removed from TC count).

What is the level of client overlap (in %) between the different categories (e.g. between A and B?; B and C?; A and I?, etc.)? List only the ones you know.

Double counting control is only available for the inpatient treatment data and substitution treatment. Overlap exists between inpatient and outpatient treatment data from IPIIN (no information on the level of overlap) and there is no link between drug free treatment data and substitution treatment data. TDI treatment data controls double counting but the coverage is still limited (although increasing).

Are you able to control for the overlaps mentioned in question 1?

It is feasible to control between inpatient treatment data (IPIIN) and TDI data, and between inpatient, TDI and substitution treatment data

If yes, what methods do you use to control for each or for some of these overlaps?

Data collection with unique IDs.

Please mention any additional methodological issues regarding the estimation or count of the total number of people in drug treatment in your country and on methods that would need to be implemented to improve the total estimate or count?

Currently it is not possible to sum up all the different client data in drug treatment due to the different monitoring systems.

4. Suzi Lyons (Ireland)

In Ireland no unique health identifier is yet available, but work on the legislation is ongoing (process started in 2013). NDTRS Ireland is case based; they assume 75%+ reporting coverage; includes GPs, but doesn't include psychiatry hospitals. These have a very 'old' data system there, but they see that drug treatment is decreasing, to negligible numbers (100, est.). Currently includes only prison in-reach but will include prison inpatient from 2014. The total number of clients in outpatient and inpatient is about 7700 and the number of outpatient and inpatient units is 327. Approx. 200 GPs offer drug treatment; 52 reported data in 2012. Only a small proportion specializes in OST, serving multiple clients.

What is the level of client overlap (in %) between the different categories (e.g. between A and B?; B and C?; A and I?, etc.)? List only the ones you know.

As currently there is no unique patient identifier in Ireland, duplication can only be controlled for within a centre, not between centres. Example of information available (outpatient centres): Of the 169



cases known to have started treated but transferred 2012, 47 were transferred to an inpatient (residential unit). Less than 5 were sentenced to prison.

Are you able to control for the overlaps mentioned in question 1?

Currently No

Please mention any methods that would need to be implemented to improve the total estimate or count?

New ICT system is being developed in-house which will improve data and move to a more timely system. New unique identifier should be commenced in 2015. Additionally, there is also data on numbers leaving 'exit' treatment, but not much has been done with them so far. Example of analysis of exit details: By 31/12/2012 of the 7703 cases who entered treatment in 2012, 4,865 cases had exited treatment (63%) (Completed/ dropped out/imprisoned, etc).

5. Ioulia Bafi (Greece)

In Greece there is a well-established monitoring system, based on a facility survey through a tool called 'Treatment Questionnaire' (not TDI-based), which aim is to provide an overall profile of the treatment units (structural and functional characteristics). It collects aggregate data on their clients in a standardised way annually at national level. The response rate is above 95% of existing units. There are a total of 103 treatment units in Greece (90 outpatient and 13 inpatient) with a total of 12257 clients (101 out of 103 units). LTAs are excluded as they don't offer treatment according to the national definition but there is a specific questionnaire for them. Data also exclude GPs and private clinics.

What is the level of client overlap (in %) between the different categories (e.g. between A and B?; B and C?; A and I?, etc.)? List only the ones you know.

As the existing data collection system in Greece offers only aggregate data and the Treatment Questionnaire doesn't include a question on multiple service use or referrals, the issue of overlaps cannot be known. However, Treatment demand (TDI) data indicate that the level of overlap does not exceed 8% and treatment outcome data indicate that - annually - a max. of 15% of the clients have left their treatment units (referrals, drop-outs, premature discharges).

Please mention any methods that would need to be implemented to improve the total estimate or count?

The solution in a situation where you have aggregate data and no individual identifiers would be to add a question on 'use of other service' in the same year.

Also it would be necessary to collect individual data, including an item that directly measures prior mobility across services within the calendar year.

6. Miguel Pérez-Lozao - RAIS Foundation, Spain



Spain is composed of 17 Autonomous Communities (AC) or Regions, which have a wide range of political and administrative competences on a great number of issues. Also 2 Autonomous Cities (Ceuta & Melilla) have, to a lesser extent, some competences. These AC are responsible for the provision of drug treatment in their respective territories. All of them have Regional Strategies or Action Plans that define, among other matters, the role and functions of the different drug treatment facilities, as well as the way in which facilities and services are interconnected. All of them have also passed Laws over the last 25 years which deal with drug interventions in different fields: prevention, care, social rehabilitation, etc. Treatment facilities are operated either by personnel depending directly of the Regional Governments or by NGOs (in this case funded by public resources).

Outpatient network:

Specialized drug treatment centres are, usually, operated by public personnel (rarely NGOs). Low-threshold agencies (52 emergency centres, 36 mobile units and 12 supervised drug consumption facilities) can be operated either by public personnel or by NGOs (in most cases). The degree of involvement may vary significantly from one AC to another. Regarding OST, All data are included and reported as outpatient; 65.392 methadone + 2.166 suboxone (Buprenorfine-naloxone)

Inpatient network:

Overall, hospital-based residential drug treatment is operated by public personnel and includes detoxification and specific cocaine programmes (rare). There are also private clinics which provide treatment for these patients. However the Spanish Drug Treatment System does not collect data from them. Therapeutic communities, treatment support flats and social reintegration flats are mainly operated by NGOs (with public funding).

There are a total of 934 treatment units in Spain (615 outpatient and 319 inpatient) with a total of 144484 clients.

What is the level of client overlap (in %) between the different categories (e.g. between A and B?; B and C?; A and I?, etc.)? List only the ones you know.

There are issues about treatment itineraries within different AC (17 AC + 2 A cities). Clients come into the network from different facilities, and go on to different facilities. A very detailed analysis of overlaps between each category of the map is reported in the ppt.

Are you able to control for the overlaps mentioned in question 1?

It is not possible to control for overlaps, but estimates can be calculate. However, resources to do this work are limited.

If yes, what methods do you use to control for each or for some of these overlaps?

Estimation methods are used to control for overlapping – Miguel, could you please expand a bit what these methods are?



Please mention any additional methodological issues regarding the estimation or count of the total number of people in drug treatment in your country and on methods that would need to be implemented to improve the total estimate or count?

Review the data with all the partners, but it would be very resource demanding.

Possibly a common drug information system for the whole country.

Changes in the reporting package (info/data/breakdowns by substance/ by type of centres)?

Information system collecting data on the drug treatment itinerary of every patient?

Control for overlapping would require changes in the AC reporting package (breakdowns by substance, OST, etc.)

There are ideas about a pilot study, and extrapolation could be tested in 2 or 3 volunteering AC (not only for reporting purpose, but for improving knowledge).

7. Domingos Duran, Francisco Bolas (Portugal)

SIM, a multidisciplinary Information System has been introduced since 2009. In 2014 SIM achieved full coverage of all public treatment units as well as SICAD-funded programmes. Regarding double counting, it is not full within the outpatient services, but it's 100% between detoxification and the rest of the treatment system. For therapeutic communities, 100% of clients appear to be referred from outpatient services – but there is currently the option of registering directly, which will be prohibited in the near future. OST = 24.027 (of which 1379 in prison); 2012 data

One of the challenges is that it must be foreseen that, in the future, main drug treatment entry will take place through primary care. However, a referral model of SIM to primary care is under construction through a web-service into which other applications and databases can feed information, e.g. ALERT application that links primary care and hospitals. It should be noted that the treatment facility licensing law from 1999 is to be changed in 2015 in collaboration with the Health Ministry, SICAD and regional authorities.

8. Round of discussion on data collection from general practitioners/primary care

Various methods to collect or obtain data from clients receiving treatment from GPs/primary care have been proposed and which in most cases match the national situations. For example in France, where most OST is prescribed by GPs, data could be obtained from the social security or pharmacies rather than directly from GPs, thereby avoiding burdening GPs with an additional data submission exercise. In Ireland, data recording could be carried out by nurses working in GP practices. In the Netherlands, the health insurance could ask the data from GP practices, but currently not many GPs are involved in drug treatment. It's the same situation in Portugal regarding GP involvement, but there is a general information system for primary care system, called "Assist". This technology is used by GPs during client assessment in primary care; If a lower degree of care need is required, the treatment will be carried out by the GP; if a higher level of treatment is needed, then a referral to specialized care is made. However, it is reported that many intricate information systems are in place and there is a need



to convert these data into the SICAD system on addiction treatment in the future. The idea is to provide a web-service to convert info from other systems into one.

9. TDI prevalence – Linda Montanari (EMCDDA)

An update on the TDI Prevalence project was provided with no objections raised by participating experts. Some comments were made, such as adding HCV treatment to the voluntary items. Also France highlighted the need to have an easier way to enter data. Other countries agreed with the idea to have either an excel file for the first year or an automatic way to input data into FONTE, such as an XML file.

It was also highlighted that the number of core items should be very limited and periodicity may be longer than 1 year (e.g. every 3 years), but some objections to this were advanced and it should be discussed again in September with an implementation plan.

Additional important points were made in respect to maximizing the added value of this information (tdi prevalence) for the European and country level. It was therefore agreed to give the experts some time up to September to provide further comments on guidelines, if any, and to come up in September with a proposal for implementation.

Summary and conclusions Day 1

The increased interest from Member States and the recognized utility to obtain a fuller picture of their treatment system as presented during the meeting is evidence that the approach and the resources invested over the last years by the NFPs and EMCDDA in this project are bearing fruit.

The objective of the meeting was to identify overlaps between the ‘cells’ of the treatment system map and how countries control for these. The presentations by Member States confirmed that overlaps exist in all countries and that there are many. While this has methodological implications in terms of quality and reliability in the total number of people in drug treatment, it should also be considered as a “healthy” aspect of the national treatment system from a client’s perspective. It can reflect multiple usage and diversified access to care.

In many examples presented during the meeting, the magnitude of overlap can be confirmed with some level of security; only in few cases it appears that the country has no knowledge of the magnitude. Examples of how double counting is controlled were presented and in general, the use of unique identifiers appear to be the most efficient way to control for double counting. Other examples, such as estimation techniques, were mentioned but not in detail. It would be important to compile a more detailed description on how controlling of double counting/overlaps was achieved (*see next steps*).



The Spanish expert presented an extensive ‘overlap’ table which presents known and unknown overlaps between all cells of the system map. Participants considered such a table a useful reporting tool for understanding overlaps across the system (*see next steps*).

The presentations also made apparent that some overlaps between providers, such as between low threshold agencies and outpatient services are very difficult to control, while data from prisons and primary care can be hard to access. One idea is to prioritise certain ‘cells’ in terms of improving data quality, e.g, specialised outpatient treatment which is in most countries the most important provider, while prisons may not be so essential. An analysis ‘in pairs’ of the most important cells across countries should be the focus. Gradually and through an iterative process we would improve the data across the map and achieve greater completion in a significant number of countries.

The meeting also highlighted the importance of the narrative surrounding the data in order to contextualize the treatment system. As the new reporting framework of the National report is being introduced, the workbook on treatment which includes the treatment system map will provide place for this narrative.

“True zeros” and “no info” must be better distinguished within the map.

Alcohol is playing an increasingly greater role in the treatment systems and there is high interest in including alcohol data as part of the treatment systems reported to the EMCDDA.

Next steps

EMCDDA to provide a similar ‘overlap’ table as produced by the Spanish expert and request participants to submit information based on that table:

- the range of overlap (result of estimate)
- which data sources were used
- methodologies/techniques used to control for double counting
- methodologies/techniques used to estimate the overlaps
- Barriers/ difficulties encountered to estimate the overlaps

Taken together, the results will be compiled into a methodological toolbox which will allow other countries with similar treatment systems to apply known techniques to reduce the levels of overlap within the treatment system map.

Timeline: ‘Overlap tables’ to be sent out by the EMCDDA to experts in October 2014.



Day 2: A comparative analysis of national drug treatment systems in Europe

Objectives

- Identify main treatment system typologies in Europe as well as agree on a set of core dimensions that can help characterizing national drug treatment systems across Europe.

Introduction and focus groups – Alessandro Pirona (EMCDDA)

As noted during Day 1, quality, reliability and access to data on drug users in treatment, in other words the monitoring of drug treatment, can be closely related to the systemic characteristics and features of the drug treatment system in a country:

For example, the range of service providers involved may lead to difficulties in accessing data (e.g. GPs in France are the main provider of OST but the access to data is difficult and estimated indirectly through other data sources). Also, systems incorporating alcohol and drugs may pose additional problems in disaggregating data. The level of governance (e.g. central, regional, local, etc.) adds further difficulties (e.g. regional autonomy in Spain or France). The legal frameworks linked to treatment provision may also play an important role. For example, in Portugal the legislation exists to back up monitoring; while other countries rely on voluntary participation. However, it should be born in mind that monitoring in itself is merely a by-product and not the primary goal of a treatment system. It serves a function such as planning services, follow epidemiological trends, assess process and outcomes of service delivery, etc. Subsequently, qualities such as access to treatment, equity, cost-efficiency, etc. can be determined for the overall treatment system.

It is therefore of great interest for a wide range of stakeholders, including European drug monitoring agencies to better understand what dimensions of treatment systems are common or different between Member States, how these can affect system qualities and to what extent each respective national drug treatment system falls within a particular European system typology.

While the ideal objective would be to carry out a comparative analysis of treatment systems across Europe, a more realistic and feasible goal in the short term is a descriptive analysis. Therefore, a number of core dimensions of treatment systems (see below) were identified through small working groups between participants which will help to characterize treatment systems and define a set of 3 to 4 treatment system typologies existing in Europe.



It was discussed that the descriptive analysis of treatment systems could be done as an EMCDDA paper (with all participants as authors) following the format of an existing EMCDDA paper entitled 'Regional strategies across the world' (available at: <http://www.emcdda.europa.eu/publications/emcdda-papers/regional-drug-strategies>).

The structure of the paper, entitled 'Drug treatment systems in Europe' could be as follows: .

Introduction

What are 'treatment systems' WHO, US, Nordic & others

Main treatment system dimensions

Typologies: grouping certain dimensions

Relevance for drug monitoring

Discussion: with regard to the 3 questions/areas (see treatment system qualities as presented by Dr Tuukka Tammi).

Treatment system dimensions

Governance (ownership/in charge of providing treatment):

Centralized (Governmental structures)

Decentralized

Devolution (responsibility to local/regional authorities)

Delegation (responsibility to organizations outside governmental structures but with indirect governmental control)

Privatization (full responsibility to private and non-governmental organizations)

Funding

- Same as above, includes third party payers
- Criteria for entitlement
- Purchasing and purchaser-provider relations

Regulatory framework



Accreditation and standard setting
Enforcement
Legal framework
Qualifications of staff

Diversity and provision

Level of diversity in types of treatment facilities/providers involved
Level of diversity in categories of professionals involved and concentration of decision-making power
Level of integration or fragmentation of services

Objectives, planning and policies

Treatment system based on needs assessment or demand-based system
Process or outcome evaluation
Importance of national or regional drug strategies and implementation of objectives
Political commitment
Role of scientific evidence in informing policies and planning of services

Accessibility

Low/High threshold
Importance of coercion
Importance of referral
Cost to users
Users' social power (clients' empowerment, choice, rights, participation, etc)
Geographical availability and accessibility
Equity of access
Equity of financing

Monitoring

Aim of monitoring
Quality of data
Requirement for providers
Linkages to financing
Linkages to policy-making decisions

Main ideology

Harm reduction versus Abstinence oriented



Tuukka Tammi - National Institute for Health and Welfare, Helsinki, Finland

Dr Tammi was invited as a representative of the Nordic group of researchers interested in drug treatment research. His presentation covered an overview on treatment systems research, Nordic examples of recent comparative research on this topic, followed by questions and dimensions to guide the work on the European work on comparative analysis of treatment systems.

Treatment research is a complex and old field of research as treatment systems involve a large number of stakeholders (whose definition and goals of treatment varies) and those that are affected, with many interests leading to constant changes in the treatment systems.

The rationale for studying treatment systems is that although most people with alcohol, drug or gambling problems will improve their situation without treatment, we know very little about what kind of treatment is best for a certain individual. Treatment can also be stigmatising, oppressing, counter-productive however we also know that treatment can improve the situation for individuals, if coordinated and planned well, can also have an effect on public health. However, currently there are no validated methods for measuring the extent, quality and integration of services for substance use disorders, few means to determine whether current services are meeting population needs, little accountability, planning often based on ideology, treatment takes place on the border between morale and science while personal and professional preferences rather than public health considerations.

Common trends in Western societies' treatment systems are a predominant outpatient treatment with increasing self-help, internet and user involvement. Integration (with psychiatry, primary health care, social services) and a pluri-professional approach is also dominant; greater focus on evidence and cost-efficiency; steering through centralisation or decentralisation; purchaser-provider model; substantive local variations in systems and very little monitoring of system effects and comparative research.

One of the examples of comparative research that was presented is based on a study by Stenius et al. between the Swedish (Stockholm) treatment system and the Californian system. The background on the 2 systems were that for Stockholm it is an universal and economically available system in health care and social services, integration with social services, eclectic, well over 100 programs. In California it is public (for those with no insurance) and private specialized systems, 20 programs, AA (twelve-step) domination and abstinence orientation, availability economically somewhat restricted. A 5 year follow up study was carried out with the following hypothesis: In Stockholm the system focuses on social problems and works better for marginalised users, in California the system focuses on drinking (drug use) and is better for socially integrated. The findings revealed that in Sweden, the marginalised groups get more treatment but their situation does not improve as



expected. There were much older clients in Sweden, while they were not visible in the US system. Abstention was emphasised in the US, which bears the question whether it is important for outcomes. Also a greater role of self-help groups such as AA was visible in the US.

Finally, treatment systems ought to be assessed against the 3 following qualities:

Is it available, accessible and equal (on a continuum)?

>important from the PH perspective

Is it voluntary or coercive (on a continuum)?

>strong evidence-base on own motivation

Is it capable of treating more than one problem (addiction, mental problems, social problems, physical problems) (on a continuum)?

>addicts typically have many simultaneous problems

Next steps

EMCDDA to provide a structure following the dimensions agreed during the meeting. Thereafter, participants will fill out the dimensions for their own treatment system in a very simplified way, as the workload has to be minimal for everyone.

EMCDDA to take the lead on the drafting of the paper.

If available, participants should provide references of articles (not National report chapters) relevant for understanding their treatment system (or that of another country) e.g, Boekhout van Solinge about the French system: "U-turn at full speed".



Attendance list

Country	Name
<u>FI</u>	Tuukka Tammi
<u>FR</u>	Tanja Bastianic
<u>GR</u>	Ioulia Bafi
<u>IE</u>	Suzi Lyons
<u>NL</u>	Wil Kuijpers
<u>PL</u>	Marta Struzik
	Anna Strzelecka
<u>PT</u>	Domingos Duran
	Francisco Bolas
<u>SP</u>	Miguel Pérez-Lozao
<u>EMCDDA</u>	Alessandro Pirona
	Andre Noor
	Dagmar Hedrich
	Linda Montanari