EMCDDA treatment strategy

Related documents

EMCDDA internal documents regarding the cross-unit project on treatment

Decision of the Director of the EMCDDA on the creation of the cross-unit project 'Treatment'. DEC/DIR/2010/13, 6 July 2010

Decision of the Director of the EMCDDA on the cross-unit projects 'Treatment' and 'Prison'. DEC/DIR/2012/06, 14 February 2012

Reports

EMCDDA Treatment Working Group, EMCDDA Treatment Data Collection Strategy. (25 May 2010)

Cross-unit project on Treatment - Progress report September 2010 – May 2012. (May 2012)

Consultant report: 'Assessment of National Estimates of the Number of People in Drug Treatment. Development of a Generic Mapping System and Revision of National Estimates', by Trutz Haase, Jonathan Pratschke and Feline Engling. (July 2012)

Meeting report: 'European exchange on similarities and differences in treatment systems in Europe and consequences for treatment monitoring'. EMCDDA Lisbon, 18 January 2012. Available at: www.emcdda. europa.eu/html.cfm/index118406EN.html

Meeting report: 'Treatment facility surveys: which perspectives for data collection at European level?'. EMCDDA Lisbon, 19 September 2012. Available at: www.emcdda.europa.eu/html.cfm/index192068EN.html

Documents not available through the public website can be requested.

Contact: info@emcdda.europa.eu

This report makes reference to the following EMCDDA data collection tools:

ST24 – Standard Table on Access to treatment

SQ27 Part 1 – Structured Questionnaire on Treatment Programmes

SQ27 Part 2 – Structured Questionnaire on Treatment Quality Assurance

TDI – Treatment Demand Indicator

PDU – Problem Drug Use Indicator

Acronyms used:

TDI: Treatment demand indicator

PDU: Problem drug use indicator

HSR: Health and social responses

BPP: Best practice portal

OST: Opioid substitution treatment

NFP: National focal point

CUP: Cross-unit project

Contents

1.   Introduction

1.1 New challenges in monitoring drug treatment

When the illicit drug use epidemic started in Europe in the 1970s and 1980s, treatment was mainly provided at specialist residential long-term facilities to clients who were predominantly heroin users. Since then, service provision has diversified and the profile of clients, in particular their drug use patterns, have changed. Outpatient treatment provision increased considerably during the 1990s, and a range of new specialised facilities, providers and approaches, including outreach, and low-threshold agencies, was established.

A major expansion of drug treatment provision was documented in Europe since the mid-1990s. It was accompanied by the involvement of office-based doctors and national health systems in the care of opioid users. The involvement of a more diverse range of treatment providers has improved availability and access to treatment for people with drug use-related health problems. In a broader and at the same time more integrated national response, wider health service resources are employed to respond to a range of health and social needs of people who use drugs. Typical drug treatment trajectories involve the use of several providers and services consecutively or in parallel.

While treatment systems are under increasing pressure to respond in a timely and flexible manner to client needs, changing drug use patterns and polydrug use, and to provide ongoing care for chronic cases, health budgets are shrinking. As the evidence base for treatment continues to grow, up-to-date information on effective treatments must be available and easily accessible. This brings new demands on policymakers who need to determine the capacity and performance of national treatment systems and respond to questions such as 'How many people are in drug treatment?', 'Does the

treatment system meet the demand?', 'What treatments are offered?' and 'Are they effective?' These questions are not only relevant for national policymaking but also at European level.

Health policymakers and service planners need reliable information from across an increasingly broad range of service providers to correctly assess the capacity of the treatment response, determine access barriers and support investment decisions.

Routine monitoring of drug treatment entrants (TDI key indicator) is well established in Europe and now covers the majority of specialist drug treatment centres for illicit drug users. Further information can be gleaned from databases on clients receiving opioid substitution treatment, as far as medications are registered in order to prevent double-prescription and diversion of the medications. Data on drug treatment carried out by non-specialist providers may not be as easily accessible to policymakers as those from specialist treatment centres or prescription-registry data. To plan national treatment capacities adequately, policymakers need reliable information and estimates, based on the combination of available data from different sources.

1.2 First steps: the 2007 'Treatment working group'

Recognising the need to make EMCDDA treatment data collection fit for the future, the agency set up in 2007 an internal working group to facilitate collaboration and exchange between staff working in the field of treatment. The group was composed of representatives from the TDI and PDU key indicators, the epidemiology, health and social responses work areas as well as best practice. Operational until September 2009, the informal group discussed the general directions to take when integrating epidemiological and response data collection on treatment. The final report presented in September

2009 ([1]) contains a brief historical overview of data collection on drug treatment in Europe, a description of the EMCDDA's conceptual framework for treatment data collection and of the tools used.

It finishes by listing a variety of projects already underway or planned within different units and work areas (see box below), underlining the need for a common strategy in data collection and analysis.

Project area	Action
PDU (problem drug use indicator)	Improve knowledge of treatment need; revision of the indicator with focus on the number of people in need of (helping) interventions (which includes drug treatment, but is wider) as the main purpose of the indicator
TDI (treatment demand indicator)	Complement TDI data on number of clients entering treatment by other data sources (e.g. clients who remain in treatment from previous years); assess level of TDI implementation at national level; and adequacy of national monitoring systems to reporting on new types and patterns of drug use; finalise TDI revision
HSR (health and social responses)	Improve data on access to treatment (ST24) by elaborating guidance on estimation methodology; prepare country overviews of institutional framework, availability, coverage of treatment using National reports, SQ27 and additional sources; improve data on harm reduction service delivery as part of the treatment response; improve data on treatment of different target groups including prisoners
BPP (best practice portal)	Explore feasibility and development of EU consensus on guidelines and standards in drug treatment; make results of reviews of treatment effectiveness available online; collate national treatment guidelines online (SQ27)

1.3 Terms of reference of the cross-unit project on treatment

Following the treatment working group's assessment of the background situation and exploration of general directions, it is now the task of a formal 'Cross-unit project (CUP) on treatment' set up by the Director in July 2010, to develop a concrete strategy. This is described in the project's mandate as follows:

'…This CUP will further develop and implement a strategy of data collection and analyses on treatment and related areas. This strategy should encourage the adoption of common concepts and ensure maximum analytical value is derived from the different reporting tools existing in this area. The CUP should ensure coordination between activities in different units and produce synergies as well as a more uniform EMCDDA approach. The CUP should

also further develop the analyses of treatment related data and facilitate the conceptualisation of new products and analysis'([2]).

The initial decision was later amended by DEC/DIR/2012/06 of 14 February 2012, which specified that the cross-unit project should provide structured input to defining the mid- and long-term objectives of the EMCDDA, as well as develop draft protocols and other tools in the treatment area, notably with a view to preparing the EMCDDA's three-year (2012–15) work programme and yearly work programmes.

Members of the Treatment-CUP represent all areas where treatment data collection plays a role, from availability and access to treatment, to the PDU and TDI epidemiological key indicators as well as best practice, effectiveness and quality. The cross-unit

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([1]) Treatment Working Group: Proposal for a future EMCDDA Treatment Data Collection Strategy. Version 13:07/09/2009.

([2]) DEC/DIR/2010/13 of 6 July 2010, amended by DEC/DIR/2012/06 of 14 February 2012.

project is designed as a time-limited platform for exchange; it does not have a budget or any aim beyond the coordination of all elements in order to develop the best possible strategy and operational plan. Its activities are based on input from its members and its achievements determined by the efforts its members invest in managing their common task.

Since the inception meeting in September 2010 until November 2012, the Treatment-CUP met eighteen times. Chapter 2 describes how linkages and consistency between datasets were assessed and datasets on treatment integrated. The proposal for a new treatment data collection strategy is presented in Chapter 3 of this document.

2.   Activities

2.1 Definition of treatment

Work in the Treatment-CUP started by identifying the aspects of epidemiological, response- and best practice-related data collection that are relevant for a coherent treatment data collection strategy. Due to the advanced timetable of the TDI revision (which had to be finalised in November 2011), the group prioritised the discussion of issues related to this revision, in order to support and provide input to it. In this context, the discussion about the term 'treatment' in the TDI case definition was of particular importance, as the Treatment-CUP decided to come to a definition to be applied across all data collection tools.

The consequences of changing from a 'broad' definition of treatment as in the original TDI protocol to a more 'narrow' definition proposed by external consultants were analysed by the group. It was underlined that a main purpose of the TDI is to contribute to establishing PDU prevalence estimations and their trends, and to know the characteristics and profiles of PDUs — and that a definition must aim at including the widest range of drug users possible. The use of TDI data for other purposes, e.g. contributing to the estimates of overall level of treatment provision, was also underlined. It was noted as of importance that the coverage of TDI has significantly improved since it became a European standard in 2001 and that it now covers a considerable proportion of specialist in/outpatient treatment facilities in most countries. Furthermore, it was argued that interventions such as harm reduction services should be considered as part of the treatment response, as they promote health and facilitate access to more intensive forms of drug treatment. A comparison of national treatment definitions used in the TDI was made.

The group concluded that the original, broad and inclusive definition should be kept, but that some improvements and clarifications should be made. Furthermore, the definition was to be harmonised

between TDI and ST24. As TDI-based monitoring is not expected to be implemented in all settings where drug treatment takes place, keeping a broad definition implies that other, and indirect, data sources and estimations must be used to determine overall treatment provision and coverage.

The definition adopted in the framework of the TDI revision process and included in the TDI Protocol version 3.0 is as follows:

'Drug treatment is defined as an activity (activities) that directly targets people who have problems with their drug use and aims at achieving defined aims with regard to the alleviation and/or elimination of these problems, provided by experienced or accredited professionals, in the framework of recognised medical, psychological or social assistance practice.'

The following interventions are included:

*   interventions where the primary goal is detoxification
*   interventions where the primary goal is abstinence
*   substitution treatment
*   specialised/structured longer-term drug programmes
*   interventions aimed at reducing drug-related harm if they are organised in the framework of planned programmes
*   psychotherapy/counselling
*   structured treatment with a strong social component
*   medically assisted treatment
*   non-medical interventions incorporated in planned programmes
*   specific treatment in custodial settings towards drug users.

Excluded are:

*   sporadic interventions not included in a planned

programme

- contacts in which drug use is not the main reason for seeking help
- contacts with general services involving requests for social assistance only
- contacts only by telephone or letter
- contact with the family or other persons who are not the drug users him/herself only
- imprisonment per se
- treatment by Internet only
- providing needle exchange only.

2.2 Assessment of linkages and consistency between datasets

In this initial phase, Treatment-CUP work concentrated on the main sources of information on availability and access to drug treatment: TDI routine monitoring databases (using results of the 'Zoomerang survey' 2009 ([3])), results of the TDI 'treatment prevalence' project, as well as the estimates of the total number of people in treatment and data on the number of OST clients (both from ST24). Furthermore, information from the treatment chapter of the national reports was considered. Members of the Treatment-CUP took stock and familiarised themselves with all treatment-related data collection instruments, tools, and datasets and discussed their inter-linkages.

2.2.1 National TDI databases

Characteristics of national TDI database structures were analysed in the framework of the TDI revision process, in particular the level of access of NFP staff to case data, in order to determine the potential options of joint analyses at European level, using a common script. The answers provided by 28 countries (Latvia and Romania missing) to the Zoomerang Survey for the TDI Review conducted during 2009 were analysed in order to determine where and how the TDI data are processed within each country, which type of database or statistical package is used, where case data are stored and how TDI tables are generated. However, no

complete picture could be achieved. It would be necessary to establish the flow of the data, along with the storage and transmission formats, to completely understand the data storage within a country. For example, data may start off in Excel files at the treatment agencies, then be collated at a regional centre into a database, then collated again at national level. The national level data may then be used to generate the TDI submission. However, equally, full or partial aggregation could occur at any point in the chain. It was concluded that establishing a fuller understanding on the data flow, aggregation, data structure and format for each country on the basis of the Zoomerang Survey would be useful and that specific information gaps could then be addressed country-by-country via e-mail. An overview of conceptual and operational overlaps of TDI- and ST24-data for the target group of opioid users was produced and presented at the TDI meeting 2010.

2.2.2 OST registries

The interlinkage and data flow between national TDI and OST databases was assessed to determine the level of double-counting, and to help to improve the knowledge about the national coverage of TDI monitoring. Based on information collected through ST24 (2008), information on OST registries from all but 4 countries where such treatment is available (not from BE, FR, LT, FI) was analysed. In general, OST is registered in a single database, but in nine countries two databases exist and in the Netherlands even three. Structurally, TDI and OST are 'under the same roof' in 11 countries and in several others, there is some type of data flow. However, in 5 countries, no connection or data flow between TDI and OST registries exists.

It was concluded that availability of information about the relationship between TDI databases and OST registries is sufficient, but in several countries there were gaps in knowledge about the variables collected in OST registries. Further in-depth analysis of available information is needed to refine questions about contents and structure of OST registries

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([3]) Available upon request.

to make them useful, e.g. extraction of data for European analyses. However, it should be further explored if and how easily OST registry information on client characteristics or treatment implementation (dosages, duration) can be exploited for EMCDDA purposes.

2.2.3 Online treatment facility inventories

Internet sites which list information about facilities that offer drug treatment services and in particular contain contact details of treatment centres can potentially be used for assessing treatment reporting coverage. Following this idea, information about such inventories was compiled for each country (4). Classifying the inventories according to the dimensions of 'complexity' and 'comprehensiveness' (high/low), a 'main' inventory was identified for each country and analysed in more depth. 'Specificity' emerged as a third dimension: whether the inventory covers a range of service providers active in the wider fields of addiction or general health care, or whether it covers only agencies specialised in delivering treatment services related to illicit drugs. The idea of using the assistance of managers of these facility databases for conducting national treatment facility surveys was briefly discussed and could be explored in the context of developing a methodology for those surveys.

2.3 Integration of datasets

2.3.1 Estimating the total number of people in treatment

In response to changing national and European information needs on drug treatment, in 2008 the EMCDDA standardised the format to report the total number of clients receiving treatment (ST24), which should bring together all information sources and/or estimates available at national level. Information submitted by the National focal points (NFPs) was used to produce a first preliminary European estimate, according to which at least 1 million Europeans received drug treatment in a given year (5). An in-depth assessment of the information revealed considerable variations in quality and completeness and showed in particular that reported client numbers were in most cases likely to be substantial underestimates.

In the course of this quality assessment, the information on the total number of clients in treatment was compared to treatment data available through TDI and OST databases, and a treatment ratio per 100 000 general population was calculated. These comparative analyses provided a means of identifying flaws in data reporting. Additionally, comments from NFPs in the methods sections in ST24 provided further insight into the completeness of the estimates. In many cases, the information was partial, as data were limited to subgroups of treated clients or to specific providers (e.g. treatment entrants only, clients in opioid substitution only, clients in specialist outpatient treatment facilities only, etc).

In order to further assess the completeness of the estimates, the next step aimed at the identification of reporting gaps and involved the mapping of the information submitted through various sources. This exercise illustrated very clearly that data on client numbers reported under different treatment provider categories did not always reflect where the treatment actually took place, but simply where client data were collected — which in turn was determined by technical aspects of national monitoring systems, shaped by administrative accountability or funding streams.

2.3.2 Mapping national treatment systems

The initial 'stock-taking actions' described above led on to a more systems-based approach to treatment data collection. Work in the Treatment-CUP was important to clarify the diversity of data needs and objectives with regard to treatment and how different questions are addressed by the different tools. TDI's basic purpose is to provide a basis for estimation of problem drug use. ST24 aims at determining the capacity and performance of the overall treatment

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(4) Results were also used in the evaluation of the EU-Action Plan, where the availability of online registries at national level was a specific objective.
(5) EMCDDA Annual report and Statistical bulletin 2010 – HSR-10. Please note that a second data collection of ST24 in 2009 resulted in additional countries providing estimates of the total number of treatment clients in treatment. As a result, the overall European estimate increased to 1.1 million in 2011 (EMCDDA Annual report and Statistical bulletin 2011 – HSR-10).

system. SQ27 has the function to explore treatment programme characteristics and quality management. The latter are relatively new information needs, linked to more 'operationalised' national treatment policies and accountability towards national and EU objectives.

At the same time, the group realised that, regardless of the data collection tool, the reach of reporting within the individual national treatment systems is a major determinant of the quality of treatment data. If large proportions of the system are not covered by monitoring or reporting systems, conclusions on capacity and performance are difficult to draw, unless a validated methodology to estimate missing parts is available. To judge the level of reporting coverage, an accurate picture of each national system was needed.

A first systematic attempt of integrating all available treatment datasets for each country (TDI, ST24, SQ27 and National report chapters) was made and a 'map' of each national treatment system was created. It was felt that, once such maps existed, they could support more structured and clear treatment reporting, and replace some of the current descriptive and rather vague elements of the National reports. Furthermore, by linking the different treatment system elements in the maps with information on the number of units and people in contact with health and social treatment services, the maps would provide an overview of capacity and performance of the system. By identifying reporting gaps, proposals for improvement could be elaborated for each country.

The use of national terminology in the labelling of the different treatment providers led to national treatment system maps which appeared at first sight not directly comparable. Additionally, the lack of descriptive documentation of national monitoring systems made it harder to pinpoint information gaps. In order to move forwards to improve the quality of the national 'maps' and the accuracy of the estimates, a more homogenous schematic overview of treatment provision was needed.

In October 2011, a consultant project was launched to support this process by defining generic modalities and types of provision to integrate the available data from all 30 EMCDDA countries (27 Members States, the 2 candidate countries Turkey and Croatia, plus Norway; Project CT.11.IBS.054). The tasks of the consultants were, to identify monitoring and information gaps in each country in a systematic way, to critically assess the quality of the national estimates and to rate their completeness according to specific criteria. This implied the development of a generic mapping system based on the provisional treatment system maps.

After the consultants' presentation and discussion of the proposed approach at an expert meeting in January 2012, experts from eight ([6]) NFPs volunteered to conduct a pilot study of the map in their countries. This study also aimed to better determine the coverage of TDI. The final report is available on request.

2.3.3 Determining the characteristics of the treatment offer

Further needs relate to determining the characteristics of the current treatment offer as well as treatment quality management. Due to the challenges of collecting treatment data from what in many countries are quite large and fragmented systems, the EMCDDA currently employs mainly expert opinion (the relevant tool is SQ27) to obtain information on the characteristics of the treatment offer.

New information and communication technologies have revealed a high potential to increase efficiency and sustainability of health systems; their progressive use plays a major role in the Commissions' vision of health in Europe in 2020 ([7]). The application of ICT tools in the field of drug treatment is likely to grow as it helps to improve and to rationalise processes, make them more transparent, user-friendly and cost-effective.

([6]) Bulgaria, Czech Republic, Germany, Spain, Netherlands, Austria, Poland and Portugal.
([7]) See eHealth initiatives of the European Commission at http://ec.europa.eu/information-society/activities/health/policy/ehtask_force

More robust and reliable data on the characteristics of the treatment offer could be collected if NFPs obtained them in a standardised way directly from drug treatment facilities, using such improved communication channels and tools, e.g. internet-based surveys.

2.3.4 Treatment outcome

The study of the outcome of treatment interventions is an important area of clinical research and the importance of using the results of such research is increasingly recognised by policymakers. The concept of treatment outcome was discussed by the Treatment Working Group (TWG, 2007–09) [8] and results of the discussion were taken into account in the development of the current data collection framework.

The EMCDDA addresses treatment outcome through chapter 5 of the National report, where Member States report research results on treatment outcome, which the EMCDDA then summarises. With the enlarged mandate of the EMCDDA in the area of best practice, a wider assessment of the international research literature takes place and this knowledge is made available through the Best practice portal. Treatment quality assurance mechanisms are monitored through SQ27, part II.

The TWG noted that the collection of data regarding treatment outcome '… would require a substantial expansion of the existing data collection efforts, including post-treatment assessments of outcome variables. Treatment outcome, as presented by the EMCDDA, relies on results from national treatment outcome studies, literature reviews and outcome evaluations of specific interventions (EDDRA) instead. Such information is presented in the Best practice portal and in specific papers and recommendations.'

The report states that 'the EMCDDA is not collecting aggregated data on treatment outcome due to limitations in the existing data collection framework. Also only a few countries are conducting regular treatment outcome evaluations. The Centre will concentrate in the coming years its efforts on the collection and dissemination of findings from efficacy trials and effectiveness studies (e.g. national treatment outcome studies). These findings will be presented on the EMCDDA Best practice portal.'

2.4 Other activities

2.4.1 Main results of TDI revision

In parallel to the Treatment-CUP, the revision of the TDI took place. The revised TDI protocol was published in September 2012. The main implications of the revision for the new treatment monitoring strategy will be the following:

- Change in case definition: only cases starting treatment in the country will be introduced; no continuous treatment will be kept inside, the first episode will be recorded and not the last episode (see TDI Protocol version 3.0)

- Addition of items on infectious diseases, polydrug use and opioid substitution treatment (OST);

- the information on opioid substitution treatment should be used not only to check for misuse of opioids by people already in substitution treatment, but also in the framework of the monitoring on OST;

- TDI prevalence: even though it was not included in the TDI protocol, the idea to include TDI prevalence in the data collection was accepted. The Treatment CUP should develop a plan to introduce TDI prevalence in the treatment monitoring strategy.

2.4.2 Treatment quality and practice

The SQ27 part 2 is used to gather information on treatment quality assurance in terms of treatment guidelines, monitoring and evaluation, development, promotion and dissemination of 'best practice' at

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[8] The final report of the Treatment Working Group of May 2010 is available upon request.

country level. Changes towards a new treatment data collection strategy should focus on making available further details on treatment quality assurance, certification, and accreditation.

2.4.3 Terminology

A report summarised the findings of a scoping exercise, providing a 'conceptual map' of selected terms (e.g. treatment coverage, availability, accessibility) relevant to the work of the treatment cross-unit project. Electronic databases were searched. The findings were synthesised into a narrative review which first discussed definitions of 'coverage', 'availability' and 'access' and then identified possible implications for the treatment data collection strategy at the EMCDDA.

3. Data collection framework

3.1 Framework for treatment data collection and analysis (⁹)

A framework for treatment data collection and analysis at EU level must in the first place be relevant and helpful for the countries themselves.
If it advances the countries' ability to obtain objective, reliable and valid information on treatment provision and coverage for national level use, it will not only be beneficial to national and local treatment providers and to clients, but the data will also be useful to those managing European or sub-regional information. The primary goal for the EMCDDA is to develop practical tools for use by national treatment policymakers that can enhance data collection at national level, help to close information gaps and to draw policy conclusions. These tools could be, for example, methodological toolkits or protocols. New developments in information and communication technologies, translated into e-healthcare applications, may open up unprecedented options for improving data collection and monitoring and should be considered in all future discussions about the strategy.

A broad, inclusive definition of drug treatment, reconfirmed in the third revision of the TDI protocol, is the frame of reference for all EMCDDA treatment data collection. The following proposal is based on the analysis of all treatment data collection tools and datasets and a number of specific analyses in 2011 and 2012.

Herewith, the Treatment-CUP proposes a data collection framework that consists of (a) the TDI, plus three additional components: (b) Treatment system 'maps', providing an overview of the treatment system, (c) a methodological toolkit for estimating the number of people in drug treatment and (d) a facility survey to determine characteristics of facilities but also to complement and cross-validate information on clients collected through other sources.

| TDI | + | Treatment system maps | + | Estimation toolkit | + | Facility survey |

Elements (b), (c) and (d) are expected to provide clear benefit for treatment planning at national level, complementing the TDI instrument and data collection process.

At European level, the proposal aims to make offer and utilisation of drug treatment more transparent and to enhance more recent EMCDDA work areas, especially the estimation of overall treatment coverage and treatment quality and best practice information.

3.1.1 Treatment systems maps

A one-page graphical model of the treatment system was drawn up by members of the Treatment-CUP for each country. This included information about the types of in- and outpatient treatment providers in the country, the available information about the number of treatment facilities/units, and of people receiving treatment in the different parts of the system. These initial maps of each national treatment system were subsequently reviewed and consolidated in the context of a consultant study that started in October 2011.

The consultants in charge of project CT.11.IBS.054 developed a generic treatment system map. Treatment data from different sources (incl. TDI, ST24, NR) were entered and quality and

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(⁹) A first draft of this proposal was distributed at the meeting of Heads of national focal points in 23–25 November 2011. The version below has been revised and updated following feedback from NFPs and further discussion in the Treatment-CUP.

+ Treatment system 'maps'

Purpose: To improve knowledge about the total number of drug users in treatment, the treatment reporting coverage and the characteristics of national treatment systems.

Description: The main elements of the national treatment system, i.e. all facilities where drug treatment services are delivered have been mapped. By allocating the data on the number of individual clients treated (or number of treatments provided) that are available through our current reporting tools to the different elements within the national treatment system, these maps make the 'reach' of current treatment reporting visible. The treatment system maps also provide a sampling frame for the facility survey.

Timetable: Draft maps of national treatment systems were developed internally, based on various sources of information (1st half of 2011). They were further improved and analysed under Project CT.11.IBS.054 ([10]). Draft versions of the national treatment maps were made available to the Heads of NFPs. Once agreed with NFPs, all treatment system maps will be fed back to the countries to be finalised during 2013. These maps would later become a component of the National report to the EMCDDA together with ST14 and would undergo regular (annual) updates.

completeness of the data and the overall national treatment estimates were assessed for all 30 countries.

The generic maps illustrate, in a standardised way, the extent of the treatment networks in the Member States. They also show whether information from the different elements is reported in TDI, is available in other databases or registries, or is missing.

The conclusions of the project revealed that:

- The generic mapping system allows specifically the question as to what constitutes 'treatment' to be avoided, but instead provides the opportunity

to accommodate national definitions through a broader inclusion of treatment facilities, a more detailed reporting structure and exact definition of each type of facility presented in the system. The contribution of the generic mapping system therefore consists in the disaggregation of reporting categories and their universal application across all countries. This facilitates the identification of gaps in data collection and the appropriate adjustment of national figures before calculating aggregate-level estimates.

- Additionally, the generic mapping system allows comparisons to be made between countries, for example in terms of evaluation of treatment provision on a per capita basis, and to draw inferences about the importance of a particular facility type within a national system. As reporting gaps are filled and estimations refined over time, a higher degree of data quality will be achieved that will allow valid comparisons of the extent of drug treatment to feed the national and European-wide debate.

However, the project highlighted a number of issues that need to be addressed at the EMCDDA and NFP level in order to maximise the informative value and justification of our treatment data monitoring.

- Firstly, the project highlighted the difficulty for experts who are 'external' to the field (and have not previously worked with the EMCDDA) to produce an accurate picture of the national treatment system based solely on the different treatment data sources available to the EMCDDA, including the National reports.

- Secondly, the generic mapping system project revealed that countries are faced with significant double counting issues when attempting to monitor treatment provision beyond specialist providers and sometimes even within specialist providers (e.g. overlap between inpatient and outpatient clients). However, it is the purpose of the generic treatment system map to go beyond

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([10]) The draft national maps are included in consultant report: 'Assessment of national estimates of the number of people in drug treatment, available upon request.

specialised drug treatment providers; hence, the parallel use of care facilities can be considered as a (positive) indicator of the level of integration within modern treatment systems, but there is increasing scope for an individual to be counted more than once.

These issues could not be solved as part of the current project, but are now being addressed through a follow-up study (see 3.1.2).

3.1.2 Estimation toolkit

There is little doubt that the analytical value of a systemic over a fragmented approach to drug treatment monitoring is far greater. However, such an approach inevitably leads to an important level of double counting within and between elements/providers as confirmed by the results of the above-mentioned project on treatment system maps.

Multiple service use reflects an increasing level of integration between care providers and is nowadays more a rule than an exception. To determine the number of individual beneficiaries of drug treatment within a national treatment system in a reliable way is therefore a bigger challenge today than it was some decades ago.

A follow-up project to the treatment system maps was launched mid-2012 with the aim of supporting the NFPs in addressing these issues. This project aims at developing methods for improving national estimates of the total number of people in drug treatment in close cooperation with the NFPs.

In some countries, it will be impossible to accurately identify the overlap in service provision because this requires the availability of individual-level patient data across all services and universal user ID codes, e.g through electronic health research (EHR).

+ Methodology toolkit for estimation of number of people in treatment

Purpose: To improve national estimates of the number of people in contact with treatment and thus contribute to an improved European treatment coverage estimate, where applicable ([11]).

Description: Following the development of treatment system maps ([12]), a second phase of work, supported by a consultant study that was launched in Summer 2012 is oriented towards making recommendations for each individual country on how the national estimate of the total number of people in drug treatment reported in ST24 can be improved, if necessary. Based on the results of these projects, a description of relevant and useful methods which can be used to develop new estimates or refine existing ones will be collated. This work will also be integrated with the TDI 'prevalence project'.

Timetable: The call for tender to develop the 'toolkit' was launched in summer 2012 and work started in October. First results are expected during the first half of 2013.

Where user ID codes have not been implemented, specific surveys may have already been carried out, enabling us to quantify multiple service usage.

One approach to be tested in the project could be to identify, with a reasonable degree of confidence, the magnitude of the overlap between specific categories of service in one or more countries where ID-codes exist, and to project the result from these to similar countries. Facility surveys (see below) and the TDI prevalence module will be important components of this project. In this respect, data obtained from the TDI prevalence module will strengthen the quality of the data in the corresponding categories of the national system map.

([11]) Note: In a few countries with comprehensive treatment data collection systems (electronic systems with a central database), data on the total number of individual clients in treatment may already be available and estimation will not be required.
([12]) CT.11.IBS.054

3.1.3 Facility survey

+ **Treatment facility survey**

Purpose: To increase knowledge about the characteristics, treatment service options and quality assurance mechanisms. A census of clients in treatment on a given day could provide additional input to determine performance of the treatment system.

Description: Starting from all existing listings, an inventory of treatment facilities should be drawn up in each country, representing all parts of the treatment system. Each facility should be identified through a unique name and its postcode (geo-tagging for national 'treatment facility locator', see examples for the US [13]). In order to create a pathway for information exchange, it is necessary to obtain an e-mail address. A survey among facilities should be carried out, using an agreed minimum dataset (suggested domains: characteristics of the facility, services provided, quality indicators).

Timetable: Building on the results of an expert meeting on 19 September 2012, which explored the availability of facility surveys in most Member States, an in-depth analysis of the survey instruments and targets, the domains and datasets collected, and the survey mechanisms should be carried out. This should be done in the framework of an EMCDDA project in 2013, drawing on the existing expertise in the NFPs. Relevance of compatibility with international work should also be assessed (e.g. SAMHSA [14] survey). A common minimum dataset should be presented and discussed at an expert meeting in Autumn 2013, provided that funds are available. NFPs will be closely involved in the development and piloting of a survey. In the medium term, the goal would be to survey a representative sample of [health and social] treatment facilities providing treatment to drug users in each country. The treatment system maps should serve as the selection frame for the sample. This survey would replace or complement SQ27.

Over the last years, and more particularly during the current economic downturn, there have been pressing demands from the public and policymakers to be informed about the quality, capacity and performance of national treatment systems. Current monitoring tools in most countries are however limited in their ability to provide crucial information on these aspects to national policy planners. One way of improving this knowledge is to conduct (as a one-off exercise, or once every 4–5 years) a survey among a representative sample of facilities or a full survey of all facilities (in smaller countries).

An expert meeting in September 2012 provided an opportunity for sharing information about ongoing and planned facility surveys at national level between representatives from 22 countries. It also served as a forum for discussion about potential advantages and challenges of a common European core dataset for such surveys. Contributions to the meeting showed that facility surveys are used in many countries to systematically make an inventory of treatment facilities, to document their characteristics and the services they offer. In some countries, such surveys are part of the process of managing treatment licensing and accreditation and allocating funding. Examples of treatment facility surveys were presented, including some very longstanding experiences (EL, DE). The Czech Republic had recently conducted a facility inventory using web-based technology. The use of an electronic survey platform is also planned in Belgium and in the Netherlands. In the UK, the reporting on facility characteristics is routinely linked to funding allocation. New client-based reporting systems using clinical software (case management) are currently being established in Portugal and Romania. While such clinically oriented data collection systems mainly serve the purpose of supporting the organisation and management of treatment, they usually contain a module that allows the documentation of core data regarding the characteristics of facilities where the treatment is delivered.

Coverage of facilities: Basic facility characteristics are always available regarding the subgroup of facilities reporting to the TDI; some facility surveys

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[13] http://findtreatment.samhsa.gov/TreatmentLocator/faces/quickSearch.jspx
[14] The US Substance Abuse and Mental Health Services Administration – survey can be found at http://wwwdasis.samhsa.gov/dasis2/nssats/nssats_2011_q.pdf

were wider. New initiatives target the treatment system as a whole.

Methods used: Some surveys are still paper-based. The use of web-based survey methods seems to provide advantages regarding overall costs. The use of modern information technology including the web as a communication platform and for storage and presentation of data (reports, analyses) could become a new standard.

Data collected: Basic domains and variables in the surveys seemed to overlap, although it was acknowledged that objectives to conduct facility surveys varied between countries.

Conclusions: A common dataset was considered useful for improving comparability within and between countries. To develop a European minimum dataset, domains and variables addressed in national surveys should be compared to develop a minimum list of mandatory data (plus a list of optional variables). Why the European template Treatment Unit Form (TUF) developed in 1997 was not used more widely at the time should also be analysed. Results of current EU health indicator research (ECHIM, EURO-URHIS) and health systems assessments (by WHO) should be taken into account, so that no duplication occurs. A multilingual list of common definitions and terminology would be needed.

3.1.4 Improving the harmonisation of TDI data

An in-depth analysis of TDI data collection forms (questionnaires), guidelines, and codebooks in all European countries was conducted in 2012 and the final report is available on the website. All existing national instruments for collecting information on people entering drug treatment used in the countries have been mapped and assessed in order to see their level of harmonisation with the EMCDDA TDI protocol. The analysis has shown that there is a good level of harmonisation between national and European tools for data collection on people entering treatment.

3.2 Best practice portal — perspectives with regard to treatment

The implementation of the proposed new framework provides the opportunity to gather further information about the coverage of guidelines and adoption of service standards in treatment facilities across Europe, which would contribute to the evidence section in the Best practice portal. Combined with the revision of EDDRA towards examples of implementation practice, the portal would gain relevance for service providers. Furthermore, information about national treatment certification/accreditation systems would provide a basis for building European consensus on indicators of treatment quality in the medium-term.

At the expert meeting on facility surveys (see above), it was suggested that in a medium-term perspective, the establishment of a two-way communication channel (electronic, e-mail list, web-based forum) between the national level and the treatment facilities would be an advantage. This would not only allow the NFP to conduct surveys periodically among all or a selected sub-set of facilities, with reduced cost, but also to proactively distribute new relevant information about treatment (evidence base, best practice, guidance) to treatment facilities across the country.

The Best practice portal will disseminate quality standards, including on the assessment of treatment outcomes performed by the services and facility surveys will include information on the adoption of such standards.
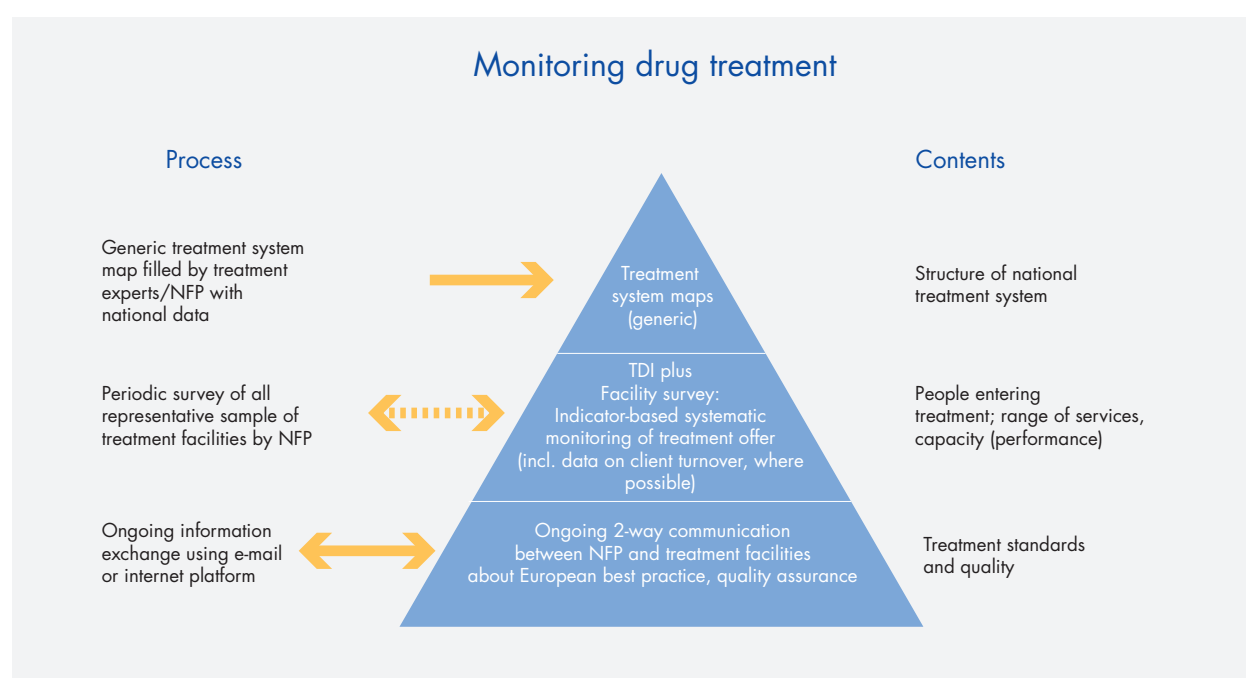
3.3 Update on ongoing PDU revision

The revision of the Problem drug use (PDU) key indicator which started in October 2010 is expected to be concluded by the end of 2012 ([15]). The revision addresses the conceptual framework, case definitions for different substances, and the name of the indicator, which should not induce unwanted labelling. One aspect of the revision which is

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([15]) The revision proposal is outlined in a document entitled 'Principles of PDU indicator revision', available upon request.

important for the EMCDDA treatment data collection strategy is that it is explicitly recommended to construct estimates having in mind their usefulness for approximating 'treatment need', i.e. the principal use of the data generated under the indicator will be, after having obtained an understanding of the prevalence of the phenomenon, to obtain an insight into the number of people who are in need of drug treatment and other interventions such as social services, outreach services, etc.), reflecting the broad definition of 'treatment' as confirmed in the TDI revision. The role of new psychoactive substances will also be taken into account.

3.4 Graphical representation of the treatment strategy

Monitoring drug treatment

Process

Generic treatment system map filled by treatment experts/NFP with national data

Periodic survey of all representative sample of treatment facilities by NFP

Ongoing information exchange using e-mail or internet platform

Treatment system maps (generic)

TDI plus Facility survey: Indicator-based systematic monitoring of treatment offer (incl. data on client turnover, where possible)

Ongoing 2-way communication between NFP and treatment facilities about European best practice, quality assurance

Contents

Structure of national treatment system

People entering treatment; range of services, capacity (performance)

Treatment standards and quality

4.   Implementation steps

The 2013–15 work programme of the EMCDDA foresees the implementation of the new treatment data collection and analysis strategy as a priority intervention with the following expected key results:

• Harmonised and comparable data on treatment systems across EU countries

• Improved capacity to develop treatment estimates at national level

• Implementation of advanced treatment analysis and planning tools

• Targeted dissemination of best practice information and standards.

For 2013, work shall continue in close collaboration with the NFPs to focus on:

– finalisation of the first set of national treatment system maps;

– improvement of methodologies to develop treatment estimates at national level;

– development of a common dataset to improve comparability of facility surveys within and between countries in collaboration with the national experts;

– testing of the common facility survey template through a pilot study.

In 2014 and 2015, when treatment system maps are consolidated and a facility survey mechanism has been established, the following priority interventions of the work programme will be tackled:

• Treatment analysis and planning tools:

– development of a conceptual framework for comparative analyses of drug treatment systems in Europe;

– carrying out of such analyses;

– developing a reporting matrix (policy tool) for treatment planning as a key result.

• Best practice dissemination:

– In parallel to the above activities and in close cooperation with the NFPs options for a tailored and targeted dissemination of best practice information and standards will be analysed.

– The mapping of treatment providers (linked and integrated in the facility survey process) and the establishment of communication channels (ideally electronic) between focal points and treatment providers are important components in this process.

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