# Adequacy in Drug Abuse Treatment and Care in Europe (ADAT)

# Part II: Treatment and Support Needs of Drug Addicts

## Country Reports and Assessment Procedures

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# Content

# 1. Introduction

There is adequate professional treatment and care of drug abusers if, amongst other things, the services - both individual and the entire care system as a whole - best meet the needs of the service recipients.

As service recipients of the care system in the broader sense we mean in particular the drug abusers themselves, and indeed regardless as to whether they are currently making use of the services offered. However, people close to drug abusers, specialists working in addiction care, allocators, as well as the neighbourhood of treatment and care facilities, are also in the broader sense clientele of the addiction care system.

In order to be able to determine and assess the adequacy of treatment modalities, establishments and care systems as defined above, it is necessary to specify what we mean by needs:

- With *drug abusers* it can be distinguished between their *subjective need* (from their view) for social, material and therapeutic support in order to free themselves from the drug addiction and/or in order to be able to live, as well as an *objective treatment need* which can be determined on the basis of systematic investigations of the extent and type of drug abuse amongst the population and amongst the drug consumers[1].
- With *relatives and friends of drug abusers* the *subjective need for support* is of interest (what sort of support do they require for themselves as well as for the drug abuser close to them in order to be able to live with him/her and /or to be able to support him/her?).
- With regard to the *local community* in the vicinity of addiction care facilities, of interest is the extent to which they are restricted in their ability to fulfil their *private and/or business needs* (e.g., security in the district) as a result of the presence of the establishments.
- With *professionals* employed in the treatment and care of drug abusers, of interest is their *satisfaction at work*.

[1] Such information can in particular be derived from epidemiological studies, the monitoring of client data as well as investigations on the causes, course and consequences of psychoactive substance abuse.

Different procedures need to be implemented depending upon which service recipients and which needs are to be taken as the starting point, the level at which the suitability of services and needs (adequacy) is intended to be assessed[2], as well as the time-scale of the investigation. (see 4.1).

Thus, *satisfaction surveys* generally serve to provide a retrospective assessment of the adequacy of the service for the subjective needs of the clientele and are implemented in the evaluation of individual establishments. The investigation of the *treatment needs of individual clients* serves as a basis for drawing up individually suited treatment plans and is intended to ensure the adequacy of the treatment in particular cases. Or, at the level of the care system *the need for treatment and care places* can be assessed using epidemiological studies. Such surveys are often used for comparisons when allocating existing resources (including funds, people, buildings and knowledge) for the treatment and care of drug abusers. Differences between the services and needs thus provide an indication of the inadequacy (under- or over-provision and/or inadequate provision) of the care system.

The aim of ADAT is to present an overview of the procedures implemented for assessing the adequacy of the services for the needs of the various demand groups at the level of the individual clients, individual establishments, and the entire care system, to make available instruments and, where there are none available, to provide check lists. On the other hand it is not the aim to discuss different methodological research approaches. For this we refer to (WHO - UNDCP - EMCDDA 1999a).

For this purpose the ADAT principal investigators were asked to describe the procedures and instruments used in investigating the needs and/or the degree to which the needs are fulfilled in the various demand groups in their countries, and if possible to make them available, as well as to report about studies and projects which are of particular interest in assessing the adequacy[3]. In concrete terms the principal investigators were asked the following questions:

[2] It can be investigated as to what extent a service meets the needs of an individual client (individual level), to what extent the service of an establishment meets the needs of all their clients as a whole and/ or their target groups (institutional level), or to what extent the care system as a whole is able to meet the needs of the drug abusers as a whole (system level).

[3] In concrete terms, these were studies on qualitative support and treatment needs of clients and potential clients, studies on the identification of unmet needs of hidden populations, as well as studies on new development trends concerning drug abuse, as identified in the ADAT concept paper.

- Which general needs from the various groups are known and form the basis of the adequacy assessments?
- Which procedures and instruments are used to assess the extent to which these needs are met?
- How are unmet needs specific to target groups and locations assessed? Which needs specific to target groups are known?
- How are unmet needs from hidden populations[4] determined? Which needs are known?
- How are new development trends (new forms of drug use, regional shifts, etc.) recognised in order to be able to react early to new needs? Which trends are known?

In the following country reports current projects, procedures and discussions in the field of needs assessment as well as concerning the suitability of needs and services are presented. Following the reports is a summary of the European approaches in the assessment of met and unmet needs in addiction treatment and care (3.1), as well as of met and unmet needs of drug abusers in Europe as based on the country reports (3.2).

The Materials section (4) documents existing and recommended assessment procedures and instruments. It is intended to provide interested readers with an overview of possible approaches as well as information on available instruments and other useful references.

[4] i.e., drug addicts who do not make use of specific treatment and care facilities.

# 2. Country Reports

The following reports illustrate how different countries examine the extent to which care systems are able to meet the needs particularly of drug abusers, but also other demand groups, as well as which needs are considered to be relevant. The aim is to provide both a selection of concrete approaches as well as an insight into the significance attached to the needs of drug addicts in evaluating the adequacy of the drug care system in Europe.

The individual country reports do not follow any unified scheme. This would do justice to neither the very different developments nor the emphasis of the individual reports‘ contents. Instead, it is intended to give expression to national projects and discussions which are of particular interest.

## 2.1. The Czech Republic[5]

### 2.1.1. Current Developments in the Assessment of Needs and Services

#### Clients' needs and their satisfaction with treatment and care

In the Czech Republic clients or their relatives are usually[6] asked about their satisfaction with the service received as well as about other issues. So far, however, each service provider asks such questions individually. The first *structured questionnaire* is now in preparation. The instrument will be based on existing sources (such as EuropASI[7] and various satisfaction questionnaires). Its use will be recommended to all service providers. A periodic assessment is planned for the year 2000.

In *low-threshold services* users are asked about their needs and satisfaction with services, mostly within the framework of consultations by member of the staff. Structured questionnaires are barely used. Clients are asked about the fre-

5 Based on text prepared by Josef Radimecky, Executive Secretary of the National Drug Commission, Prague, The Czech Republic, 1999.

6 Mostly in NGOs, in state facilities it is rather unusual.

7 EuropASI is used as a diagnostic tool. The questionnaires are inspired by "Client Satisfaction Questionnaire" (CSQ-8 - C.C. Atkinson 1991) and by "Evaluation of Psychoactive Substance Use Disorder Treatment - Workbook 6", © World Health Organisation 1998.

quency of use of the different services, about satisfied and unsatisfied needs within the programme, about safety in the programme, trust towards the staff as well as suggestions for change.

Facilities providing *residential treatment and/or after-care* discuss the satisfaction of their clients within the framework of house meetings held approximately once every two or three months. Additionally, a few facilities use *structured questionnaires*. The assessment is then conducted anonymously by an external supervisor. These questionnaires include questions on the client's relationship to individual staff members, suggestions on how the programme could be improved and whether they would recommend our programme to their friends.

Until quite recently[8] no *self-help groups* or organised *interest groups* of drug addicts and relatives existed in the Czech Republic which could be interviewed on unmet needs and on their satisfaction with the services offered. Moreover, up to now there have been no results from studies[9] on the *hidden population*, neither on their specific needs nor on their number.

### Satisfaction of staff

The *assessment of staff satisfaction* is mostly conducted by an external supervisor within the framework of team supervision. However, because there is a great lack of qualified supervisors, a lot of programmes do not have an external supervisor. Many professionals suffer from burn-out syndromes, especially in low-threshold services and in street work. Only a few facilities use *structured questionnaires* which examine staff satisfaction. These contain questions concerned with their satisfaction with their own work, with their function in the programme, with the services offered, its weaknesses, questions on suggestions for quality improvement, on problems and mutual support within the staff, as well as on specific difficulties in their work.

### Assessment of the type and number of services

One possibility in order to be able to recognise unmet needs is to compare an identified treatment and care need with the available services. A questionnaire was constructed in 1999 in order to assess the type of services offered in the Czech Republic, their capacity, target groups and the co-operation between services. The outcome will be a *programme map* reflecting the current situation in the field of drug demand reduction in the Czech Republic. Furthermore, the questionnaire will serve as a basis for the *"Address Book"* of service providers for

[8] In June 2000 a civic association named "Parents anonymous" and another one named "Parents" have been established.

[9] In the autumn of 1999 a study on the needs of the hidden population was initiated by Dr. Bavel Bém with collaborators.

drug users[10]. It includes information on the kinds of services, on geographical locations, target groups, acceptance and intake procedures, philosophy and procedures of treatment and care, on accommodation, privacy of clients, medical care, costs as well as on staff, service evaluation and supervision.

### Access to Services

By the time of this report there will be 44 low-threshold centres operating in the Czech Republic which serve as referral agencies for drug addicts and use a variety of ways to inform their potential clientele about their services. Furthermore, some private out-patient ambulatories are operating as referral agencies. However, there are no research activities focusing on unsuccessful or problematic referrals owing to lack of suitable places. Problematic admission procedures and reasons for exclusion from treatment facilities are solved case by case. Regional deficiencies in provision have not yet been investigated either. The funding system is based on applications for grants at national and/or local/regional level. It does not depend on the actual needs of the programme.

## 2.1.2. Study on Unmet Support and Treatment Needs in the City of Ústí nad Labem

The purpose of the study was the assessment of material and human resources in the City of Ústí nad Labem as well as the needs of clients of social services, including clients of drug services. The project was realised as a *model project for the planning of social services* for one region/ large city with approx. 100,000 inhabitants[11], and was carried out between June 1997 and June 1998 with the Phare[12] financial and expert support. It is the only study[13] oriented to *qualitative support and treatment needs of (potential) clients* as well as to the identification of unmet *needs of hidden populations* to have been realised in the Czech Republic until now.

[10] The address book was distributed for the first time to relevant institutions in September 2000. It was inspired by the British drug treatment services address book developed by SCODA.

[11] The project resulted in the Model Manual of Social Services Development, which had been inspired by the British model for services planning (care plan for the community) and includes about 100 pages entirely on drug services.

[12] The Phare project Technical Assistance to Drug Demand Reduction assists Central and Eastern European Countries with the elaboration, development and implementation of appropriate policies, strategies and actions in the crucial field of drug demand reduction (http://www.fad.phare.org).

[13] In 2000 Dr. L. Csémy carried out a study on the accessibility of services for drug abusers, which could not be included in this report.

## Assessment Procedure

The intention was to carry out an investigation and comparison of existing services in order to provide a basis for the planning of further treatment services. As a first step a *Drug Focus Group* was established, including representatives of social and health care service providers, representatives of the city and local institutions (police, university, Employment Office Agency, hospital, Social Affairs Office). Subsequently, the following steps were carried out by the group:

- Social analysis of the city of Ústí nad Labem
- Creation of a map of current services of prevention and treatment in the city[14]
- SWOT analysis[15] of the prevention and treatment system in the city
- Description of clients; definition of clients' needs for primary prevention, treatment and resocialisation programmes
- Definition of services which can meet these needs
- Definition of facilities which can provide the needed services
- Description of various ways of co-ordination/ collaboration between facilities

## Definition of needs

The needs of (potential) clients were defined by members of the focus group based on their experiences in working with drug addicts[16].

The needs of the following target groups had been assessed: children and youth not using drugs; parents, teachers and adults involved in leisure-time activities for children; drug users attending various services; and the hidden population of drug users (defined as drug users who do not make use of any kind of low-threshold and/or outreach programmes or any other treatment programmes for drug users).

The following needs of drug users and non-users (potential users, their relatives, and adult people) had been formulated: housing, eating, friendship, relationships, love, etc. (non-specific needs) as well as specific information, clean syringes and needles, drugs or substitution, detoxification, treatment, etc. (specific needs).

[14] Services for drug abusers in this area include one low-threshold centre with a syringe and needle exchange programme, one parents group, one after-care group with the possibility to participate in a requalification programme, one detoxification unit with the capacity for four clients, one psychiatric ambulatory (short-term in-patient treatment), and one therapeutic community (four places reserved for the clients of the city) and the possibility of referring clients to other programmes in the Czech Republic. In preparation is a Methadone Maintenance Treatment Programme with 50 places starting in January 2000.

[15] Analysis of Strengths, Weaknesses, Opportunities, and Threats.

[16] The members of the focus group are working in various services/professions (outreach, low-threshold, detoxification, therapeutic communities, counsellors, social workers, psychotherapists, psychiatrists, educationalists and administrators).

## Recommendations

For the field of drug addiction *the following facilities were recommended*: Outreach programme; low-threshold centre; methadone maintenance programmes; detoxification unit; out-patient facility; short-term in-patient facility; therapeutic community; after-care programmes; sheltered work places; sheltered housing; and social flats.

For *planning and control* the following measures were recommended: a system of services funding; a system of co-operation between various facilities within a focus group; service planning; and service evaluation.

## Continuation of the project

Within the framework of the project a questionnaire was developed which is now being distributed once a year to all kinds of social services to assess information on existing services in the city (not only facilities for drug abusers). The local authority uses this information for the planning of treatment and care in the city, to keep "The Local Services Address Book" up-to-date, and to create a "Community Care Plan". The questionnaire contains the following information: address of facility, contact person, target group, type of services provided, capacity of services, conditions of admission, composition of team by professions, working methods with clients, number of clients in the last year (after target groups, age, diagnosis, etc.), costs per client, duration of treatment/ care per client, types of co-operation with related facilities, recommendations, and needs of the facility in the framework of city services.

## 2.2. Denmark[17]

### 2.2.1. Current Developments in the Area of Service Improvement and the Assessment of Needs

Since the 1994 Government White Paper on Drug Policy in Denmark ("Regeringens Redegørelse") a number of measures have been undertaken *to improve services for the drug dependent* in the country, strongly stimulated by the Danish Ministry of Social Affairs and its special section for persons deprived of resources.

In continuation of the increased focus on drug addicts, the Parliament issued separate *grants for service improvements*, rising from 24.9 mio dkr. (approx.3 mio Euro) in 1995 to 108.9 mio dkr. in 1998 (in addition to 18.8 mio and 22.6 mio dkr. for central initiatives in the respective years). For 1999 and 2000 the grants for support to counties and communes were set at 90 mio dkr./yr. and approximately 22 mio dkr. was set aside each year for central initiatives, including research and evaluation. The grants to counties and communes were for a major part was allocated to increased in-patient treatment.

During the years in question Denmark saw a continued *rise in drug related deaths*[18]. A steep increase in 1994 gave rise both to efforts to locate the causes of the increase and to a *scrutiny of the services available*. At the same time efforts were undertaken to better estimate the total number of addicts in need of treatment, and regulations on methadone were tightened up.

In order to *relate the level of services to the estimated needs* an inquiry was set up to ask counties and communes about their estimates of persons in need of offers of treatment or social assistance in connection with drug problems (see 2.2.2). The initial estimates indicated that some 12,500 addicts would be in need of such treatment. This estimate was later (1999) revised by the National Board of

[17] Based on text prepared by Jørgen Jepsen, Centre for Alcohol and Drug Research, University of Aarhus, Denmark, 1999.

[18] From 123 in 1989 to 210 in 1993, then rising sharply to a level of around 270 in 1994 to 275 in 1997, then tapering off slightly to 250 in 1998 and 260 in 1999 (figures from the National Chief of Police). Haaastrup, in Sundhedsstyrelsen, 1999, estimates the total number of deaths at 350 since 1994, (based upon a somewhat broader definition of death among addicts). It has been alleged that the Danish mortality rate is the second highest in Europe (based primarily upon EMCDDA publications). But the basis for comparisons on a European level is weak.

Health to 14,000 based upon death statistics from two sources[19] (out of a total Danish population of just over 5 million).

A sizeable portion of drug addicts (around 5000 or more) are undergoing *methadone treatment*, but for many there may be little offered by the service beyond the methadone itself. And in some counties the waiting time for admission to methadone treatment is extremely long - in 1999 it was more than a year in at least one county (Fyn). Recently, however, the waiting time has been significantly reduced in most counties.

The information available is poor in terms of locating or estimating needs in *hidden populations.* The legitimisation for not going more closely into this is the assumption that most persons in need will be in contact with the social service system in one way or another owing to the efficient Danish registration system. However, it had been found (Pedersen, Sälan & Kringsholm, 1996), that 74% of 125 drug abusers in Greater Copenhagen, who died in the period 1991-1993, were not in treatment at the time of their death, while 4 persons received "social treatment" only, 26 methadone only and 2 received both modalities. Up to one year before their death, 62% had received either one or both types of treatment. Poisoning was the most frequent cause of death. Of these 50% were due to methadone. Of those in treatment, 63% died from poisoning as compared to 85% of the rest[20]. Also, other studies of addicts found dead note that a fairly large proportion of them (25-30%) were not known by the treatment system at all (although some of them were probably known by other parts of the welfare system[21]).

The *needs of parents and relatives* are promoted by parents groups (NGOs), who are also represented in the Danish Narcotics Council, a committee which advises the Government. This also goes for the Users' Union (Brugerforeningen, Copenhagen).

The *needs of local communities* have been much discussed in the public and political discourse, and major police campaigns have been undertaken to control open drug scenes and problematic environments (see for example Jepsen, 1996 and Jepsen & Laursen, 1998). In one of the most problematic central areas of Copenhagen, Vesterbro, a programme of urban renewal is currently changing the drug scene.

[19] Annual Police Reports and mortality tables of the health sector. A calculation based upon a capture-recapture model led Haastrup (Sundhedsstyrelsen, 1999 b), p.16) to an estimate of the total population of addicts at 14,000, whereas the Agerschou committee ("Narkofølgegruppen", 1997) a couple of years earlier had estimated it at 12,500.

[20] The death-rate among persons not in treatment has been estimated as being 2-3 times as high as among those in treatment.

[21] In a study of 55 addicts' deaths by poisoning in Fyn county 1993-94, Lis Sahl Andersen (1996) found that 60% were not known in the drug treatment system. GPs knew about their drug abuse in 67% of the cases, the social services in 58% of the cases knew about it.

Along with the funds for service improvements, the central initiatives have involved *grants for research and evaluation*. A 3-4 year programme of evaluation of in-patient treatment has just been completed by the Centre for Alcohol and Drug Research, University of Aarhus (Pedersen, 2000), which is now launching a follow-up study and a study of after-care and methadone treatment. A new study, "The every-day life of drug addicts - the drug scene, the assistance and the control" will look at the extent to which the needs of users at "street level" are being met. Finally, the Centre for Alcohol and Drug Research will make a pilot study to form the basis for DANRIS, a registration of treatment systems and their operations in relation to client characteristics.

### 2.2.2. Evaluating the Impact of State Grants on the Improvement in Services for Drug Abusers[22]

In pursuance of the above mentioned Government Paper on Drug Policy (16 March 1994) and subsequent parliamentary decisions, an *improvement in services for drug (ab)users* was decided upon and monetary support for counties and municipalities was granted from the state budget, beginning in 1996 and increasing over the subsequent years.

In order to ascertain whether the increased grants to the counties and communes were actually used for the purpose for which they were given[23] the (semi-) political *Agerschou committee* was established. Its secretariat asked counties and communes for their estimates of "persons in need of offers of treatment or social assistance" in connection with drug problems. The idea was to make sure that the system was developed to accommodate realistic needs.

The reports of the follow-up-committee were based upon *investigations of needs and investments* as reported by counties and communes in 1996, 1997 and early 1998. For these purposes two sets of questionnaires (see annex II) had been issued to all the counties and municipalities in 1995 and 1997 (for a summary of the results see annex I).

In the first section counties and municipalities were asked *to estimate the number of drug abusers in need of offers of social assistance*. They had to estimate the absolute number of drug addicts in need as well as the proportion of drug addicts in need per 1000 inhabitants in the relevant area. Estimates of counties and municipalities could be compared. The "need of offers of social assistance" was defined as both the need of treatment of the addiction as such and the need of

22 Excerpt from the reports of the "Agerschou Committee", see "Narkofölgegruppen", 1997. 1998 a & b).
23 Technically they were granted as an increase in the general funds from Parliament to counties and communes, the so-called "bloktilskud".

broader social assistance. However, the estimates are uncertain as is the definition of "in need of assistance". To some extent the estimates are also different owing to the different roles and responsibilities of counties and municipalities.

In a second step the counties and municipalities were asked for *information on the extent to which the needs are being met*:

An important tool in securing the integration of treatment offers[24] with other offers of social support is the *"plan of action"* (PA) for the individual drug addict. Such plans are supposed to be worked out in co-operation with the drug abuser, and contain an overview of the concrete course of treatment in the narrow sense as well as other offers of social support, which are to be included in the measures (e.g. housing, job activation, vocational rehabilitation, etc.). In some instances the PA also includes methadone prescription[25]. The contribution to the development of PAs have been the joint responsibility of the counties and the communes. Consequently, *the number of PAs to which they have contributed* can be seen as an indicator of the extent to which treatment needs are being fulfilled.

In order to gain information on the *integration of methadone services into social assistance programmes* a qualitative inquiry with open questions has been conducted.

The social welfare authorities in the relevant administrative units[26] reported the *number of "contacts" to persons with drug abuse problems* (as well as the estimated number of persons in need of social assistance in the respective catchment areas), the number of those "in contact", who have had one or another *offer of in-patient or out-patient assistance* (with or without connection to the methadone programme), the *number of annual referrals to in-patient or out-patient treatment* (for parts of the country) and the number of persons referred to different kind of in-patient institutions[27].

*Treatment capacity* has been defined by the *numbers of personnel involved* in the treatment sector and by the *number of institutional treatment slots*. The number of treatment slots available includes the total number of institutions being studied as well as the *number of treatment slots for which the individual county or commune has funds*, computed on an annual basis. Referral practices may be based either upon the unit having a certain number of reservations for one or more institutions or upon "referral according to need". The latter measure may be based upon the number of addicts estimated to be in need of treatment, but it may also be defined simply by the amount of funds set aside for such treatment in

[24] methadone in particular

[25] Since 1997 the counties are exclusively responsible for the prescription of methadone, while the municipalities/ communes are responsible for the "social-psychological support".

[26] Counties and communes with independent responsibility.

[27] Institutions with "enterprise arrangements" with counties or municipalities as well as institutions run by the counties themselves or under general agreements with the counties.

the individual budget year. Also, the number of "slots" in in-patient institutions is fairly simple to compute, but the number of "slots" in a variety of out-patient offers is hard to define.

In terms of services for *"special groups" of addicts*, the counties have been asked for the number of (special) treatment slots for long-term methadone treatment, for young abusers of hashish or multiple drug users, for pregnant abusers or abusers with young children, for dual diagnosis abusers and for addicts with HIV/AIDS.

*Waiting lists and waiting time* provide an approximation of the balance between needs (as known) and their fulfilment. However, the Agerschou Committee found it difficult to utilise the waiting lists and the waiting time as indicators of the degree of sufficiency of the treatment system. There is evidence[28] that waiting lists have not so much been a consequence of a lack of institutional space but a lack of funds allocated for such treatment in the budgets of counties and municipalities. Nevertheless, the committee states that no more than 14 days should elapse before the implementation of a treatment offer, but in the meantime other measures should be available. Acute treatment needs should be served immediately.

Outside the treatment system several *other assistance and care services* are available specifically for drug addicts. The *number of slots available* in housing arrangements, in day-care centres (low threshold) and in half-way houses have been assessed. Finally, the *number of addicts* who are not involved in any form of treatment or after-care but are rendered various forms of social assistance, and the number of addicts in treatment or after-care who additionally receive housing support, are in "activation" or receive support in their own home, have been assessed[29].

The reported results (see annex I) point to considerable increases in investment and in the coverage of needs, increased utilisation of private treatment institutions, and to an increased number of treatment slots. Therefore, the follow-up committee recommended the continuation of state funds allocated on a general basis (not earmarked) for counties and communes, but with a continued annual or bi-annual follow-up. To some extent the reports also raise questions about the completeness of the information received and the uncertainty of the definitions of need - including the balance between in- and out-patient treatment.

[28] Socialministeriet, 1996, 1997. Available information on later developments point to an increasing preference for out-patient treatment instead of expensive in-patient treatment which has meant that the problem of waiting lists for in-patient treatment has been "solved" (diminished).

[29] Persons in methadone treatment or using other services of the health sector such as psychiatric services, hospitals, ambulance services, etc. are excluded.

## 2.2.3. Considering Adequacy in Treatment and Care

In estimating the sufficiency of the system on a national basis it might be noted that some counties accept addicts into (methadone) treatment quite rapidly (little or no waiting time), but then offer little in the way of psycho-social treatment, while others do not accept addicts before they can offer them adequate services. To what extent "need" is served under such different systems is to some extent a matter of semantics.

Moreover, studies at the Centre for Alcohol and Drug Research indicate that on the average 34% of addicts accepted into *in-patient treatment* complete the treatment as planned. Of those who do, 40-60% are drug free one year after discharge, i.e., a total "success rate" of around 20% (Pedersen et al. 1999). These findings have led some municipalities to move from the heavy reliance on in-patient treatment, in particular under the Minnesota or 12-step-model, to building up municipal services on an out-patient basis, based upon drug free treatment on the same model and - to a lesser extent - on other models. Thus a wider variety of treatment efforts is developing in several municipalities in Denmark. The same money will - by preference being given to *out-patient services* - go much further. It is also a matter of definition as to whether one or the other system is considered more "adequate" than the other.

The *"Effectiveness" of treatment systems* may be evaluated by 1) the proportion of clients who complete the treatment as planned and, among those who do, by 2) the proportion which is drug free within and after the first year following discharge (in addition to the time spent in treatment), as well as by how long they stay drug free or for how long they have drug free periods after their release. If we take this type of "combined effectiveness" of a municipal system to be around 20% - pretty much across the different in-patient treatment modalities - there is little ground for enthusiasm.

However, some systems (communes, counties) reach 50% of their clientele in need, while others reach maybe 25%. For two cities with pretty much the same size of population in need of treatment, the one which reaches 50% (or more) by energetic work is more "effective" in absolute terms, even if the other city has a "cure rate" of 30% instead of the standard 20% quoted above (See Dahl, Pedersen & Heckscher, 1999). Thus effectiveness and the "fulfilment of needs" is a complex entity.

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## 2.3. Germany[30]

### 2.3.1. Analyses of Needs as a Precondition for Planning and Control

The necessity of a systematic analysis of the treatment system[31] is being increasing recognised in the Federal Republic of Germany. Nevertheless, even today there are hardly any systematic research efforts. According to the draft report "On the future of addiction treatment" in Germany by the Deutsche Hauptstelle gegen die Suchtgefahren (DHS), there still continues to be a research deficit.

Of particular relevance is the field of epidemiology, including needs determination, the recording and observation of consumer trends, and treatment research. Evaluation research for assessing the success of individual forms of intervention and care could contribute to a further development of the service content and foster better deployment in accordance with needs.

Within the framework of the previous research funding, extremely few projects were supported within the field of therapy or treatment research[32]. Given the enormous financial expenditure in the addiction care system it is amazing just how few resources are available for quality control and evaluation. This has also been decisive in concentrating the emphasis of research funding for the year 2001 within the field of so-called treatment-relevant addiction research networks[33]. According to the DHS, a particular need for research can be ascertained "(...) where far-reaching decisions are having to be met without there being any sufficient basis of knowledge currently available to validate these decisions". Such decisions are made both at the micro-level of patient-oriented "case management" as well as at the macro-level of the quality network and management, particularly at the treatment interface.

To sum up it can be ascertained that, for systematic evaluation in the field of addiction treatment, there is an inadequate infrastructure for this type of research and no adequate or systematic form of funding. In the existing main areas of research, corresponding projects were mostly either not funded or not commissioned. The existing university structures in the field of addiction research only contribute to a limited extent to research of the health system.

[30] Based on text prepared by Prof. Michael Krausz, University Hospital Eppendorf, Hamburg, Germany, 2000.
[31] This applies just as equally to therapy evaluation and treatment monitoring as it does to the development of systematic treatment system research.
[32] In particular this applies to the focus on addiction by the Federal Ministry of Education and Research.
[33] This will be in the assessment phase at the end of 2000.

## 2.3.2. Studies on treatment-relevant questions

Although there has not been any systematic research, there have been individual studies as well as unsystematic analyses within the framework of individual projects:

### Homeless Study

In this study the true prevalence of selected physical and psychological illness were surveyed with a representative sample of homeless persons. Based on a preliminary study, in the main project a random sample of 301 homeless men was established corresponding to the distribution found. 265 homeless persons were interviewed and physically examined. 73.4 percent of the men had at least one psychiatric illness at the time of the examination (lifetime prevalence: 93.2 percent). 58.4 percent were alcoholic (lifetime prevalence: 72.7 percent). With alcohol abusers there was an increased frequency of fine resting tremors, gastro-oesophageal reflex illnesses, liver damage, cardiac murmurs, cerebral seizures, chronic obstructive lung illnesses, skin diseases and poor dental findings. Hypotension was established for 24.4 percent of the homeless and was untreated for 89 percent at the time. The prevalence rates of hepatitis antibodies were high in comparison to the general population. The high rate of psychological and physical illnesses and the very low frequency of treatment show that an improvement of the medical provision in specific low-threshold services is of the utmost urgency.

### Comorbidity amongst heroin addicts

Within the framework of a 5-year progress study on comorbidity amongst opiate addicts, 350 clients staying in various Hamburg drug addiction care units were examined. Over two-thirds of the study participants are men, who at the time of the survey had an average age of 29 years. The majority are undergoing methadone substitution treatment (42%), around a quarter are in in-patient long-term therapy and a further 17% are in in-patient withdrawal. The clients have been consuming heroin for an average of 9 years.

With 55% of the opiate addicts (at least) one other psychological disorder was established according to ICD-10 (lifetime prevalence). Not taken into consideration were the F6 personality disorders. The 6-month prevalence is 37%, the two-week prevalence is 23%. The prevailing disorders for a total of 43% of the opiate addicts belong in the group of neurotic, stress and somatic forms (F4), and for 32% of the clients in the area of affective disorders (F3). Disorders from the group of schizophrenic, schizotypical and delusion disorders occur more rarely (5%). 5% of the opiate addicts also suffer from eating disorders (F5). These are partly multiple diagnoses; on average there are 1.3 diagnoses per patient. Women are

more severely affected by comorbidity. For the opiate addicts most of the disorders appear for the first time between the ages of 18 and 21. Thus, according to existing information the (lifetime-) prevalence rates are double to three times as high as in the general population of the Federal Republic of Germany. This emphasises the enormous importance of integrating specific diagnostic and/or explorative procedures in addiction therapy. Psychological disorders or impairments which could have a negative influence on the course of treatment need to be taken into greater consideration in addition therapy.

### 2.3.3. Quality assurance system of the pension funding institutions in addiction treatment

The Peer Review procedure was developed within the framework of the state pension authority‘s quality assurance programme in order to analyse the process quality of in-patient rehabilitation measures (Koch et al. 2001, Suchttherapie - currently being printed). Here, the quality of the rehabilitation process documented in each anonymous discharge report is assessed by specially trained professional colleagues ("peers”) from other rehabilitation clinics using a checklist of quality-relevant process characteristics. The checklist for somatic indications developed by the Hochrhein Institute was adapted for indications of psychosomatic and addiction illnesses by the Department for Medical Psychology at the Hamburg-Eppendorf University Hospital. The checklist valid here and the explanatory manual[34] are based on 67 characteristics and are divided into six areas: Anamnesis, Diagnosis, Therapeutic aims and planning, Progress and epicrises, Social-medical appraisal and Further measures/after-care.

In the first phase of the routinisation, 51 senior doctors from establishments for the indication areas of psychosomatic and addiction illnesses, together with social-medicine experts from the pension funding institutions, were trained to screen the process quality with the doctors’ establishments being included in the investigation. After completing the peers‘ training, a total of 1271 assessments were performed. These included a partial random sample of 245 evaluations which were gained from multiple assessments of identical reports and exclusively used for the theoretical test control of the procedure. The average processing time of a peer per discharge report was 33.4 minutes. This indicates that the procedure is practicable. In order to test the assessment reliability as well as to examine any possible systematic differences between the peers (severe and/or mild), five control reports were selected from both indication areas which were then assessed by all the peers in the respective indication group. As a

[34] See ADAT Part III, Professionalism.

measure of the assessment reliability the Finn coefficient was used. The corresponding coefficients for the summarising assessments of the entire rehab process are average for both indication fields with a value of 0.53. For the summarising assessments of the six subsections of the checklist the coefficients fluctuate between 0.45 and 0.66. Thus the between 0.45 and 0.66. Thus the interrater reliability of the summarising assessments can be described as satisfactory both for the summarising assessments of the subsections as well as for the summarising assessments of the entire rehab process. In the overall summarising assessment for the field of Psychosomatics, based on the 410 items of information which were evaluated here, 24.9% of the documented rehab processes were assessed as having no deficiencies, 44.6% as having slight deficiencies, 23.2% as having clear deficiencies and 7.3% as having serious deficiencies. The distribution of the assessment categories for the field of addiction illnesses (basis: 597 assessments) resulted in: 19.8% with no deficiencies, 46.6% with slight deficiencies, 25.6% with clear deficiencies and 8.0% with serious deficiencies.

Analysis of the assessments of the fields showed that in some areas there is considerable potential for development in current rehab practice. The most frequent problem areas - measured in terms of the percentage frequency of clearer and more serious deficiencies - are found in the areas Diagnosis with 28.9% (psychosomatics) and 33.1% (addiction illnesses), Therapeutic aims and planning (psychosomatics: 25.5%, addiction illnesses: 29.2%) and Social-medical appraisal (addiction illnesses: 25.8%).

A detailed report of the findings was produced for each clinic from which they can ascertain the areas and characteristics in their own clinics where there are problems and/or strengths in terms of process quality. In addition, the clinics receive the mean distribution of the findings of all clinics for their reference indication so that they are better able to estimate their position compared to other clinics in their indication field.

By and large the Peer Review procedure in the field of psychosomatic and addiction illnesses has proven to be practicable and reliable in terms of measurement technique. Most of the peers regard the method positively and have begun to implement the assessment criteria in practice in their own clinics. The analysis of the process quality has, as expected, shown that there is still clear potential for further development in current rehab practice. This concerns above all rehabilitation-specific responsibilities such as the grouping of individual complaints or the inclusion of patients in the rehab process. Through the feedback of the findings to the clinics and the acceptance of the procedure by the peers in their simultaneous function as head or senior doctors, a rapid transfer of the knowledge into practice in terms of the possibilities for optimisation is probable.

## 2.3.4. Documentation Systems and Monitoring as Systematic Evaluation Documentation

### 2.3.4.1. German Documentation Systems

The following first of all deals with the most relevant and wide-spread German documentation systems in the field of addiction. The presentation is made on the basis of information provided by the respective funding institutions themselves. The EuropASI[35] is then presented. Since this system is a standard at European level (at least for research questions), all suggestions which go beyond the previous "basis documentation" should refer to this standard. This is followed by the documentation standards of the Deutsche Gesellschaft für Suchtforschung (DGS) [German Society for Addiction Research]. Finally, the documentation systems are compared with each other and their limitations shown.

#### EBIS-A

The PC version of EBIS-ambulant, EBIS-A, (establishment-related information system for out-patient addiction care establishments) has been in operation since 1989. Approximately 600 facilities are currently working with EBIS-A[36]. The funding institution is the EBIS-Arbeitsgemeinschaft[37].

The documentation system contains data on the respective establishments such as, for example, the type and services of the employee structure as well as data on the clientele in the fields of anamneses, social demography, treatment needs, diagnostics, etc. In addition, individual questions can be integrated.

The intention is that, through EBIS, the psycho-social treatment facilities are provided with information which can be used as a basis for their own planning, controlling, evaluation and improvement of work. The system is funded by the Federal Ministry for Health and is free for the participating establishments. The annual pooling of data must be performed by the establishments. The central evaluation is performed according to the following criteria:

- Clientele (e.g., problem situation, social and material starting situation)
- Therapy programmes (e.g., termination quotas or catamnesis results).

[35] European version of the Addiction Severity Index.

[36] The closer linking of EBIS within a European information network for drug consumption and drug therapy has in recent years led to the DHS and the Institut für Therapieforschung (IFT) becoming established as national centres within the framework of the European Drug Observation Centre (Lisbon).

[37] This is composed of representatives of the Deutsche Caritasverband e.V., Freiburg, the Deutsche Hauptstelle gegen die Suchtgefahren e.V., Hamm, the Gesamtverband für Suchtkrankenhilfe im Diakonischen Werk der Evangelischen Kirchen in Deutschland e.V., Kassel, as well as the Institut für Therapieforschung IFT, Working Group Epidemiology, Munich.

- Therapeutic establishments and services (e.g., emphasis or employee structure)
- Treatment at national level (e.g., treatment density or changes in the clientele)

EBIS claims to be *epidemiological*, i.e., through the regular and unified collection of information and evaluation, trends in the field of addiction and drugs are supposed to be detectable. Depending upon the situation, the national evaluation level can be a city, a district, a federal state, a charitable organisation or the entire Federal Republic of Germany. The evaluation is based on personal information from individual clients and combines together the data from the individual establishments. This aggregated data is used to analyse and improve the work of the establishments as a whole as well as of higher authorities. The evaluation does not claim to be relevant for therapeutic work with clients.

### SEDOS[38]

The documentation system SEDOS was established by SEDOS-AG[39] as a combination and further development of the previous DOSY and EBIS-stationär [in-patient] systems and has been in operation since the beginning of 1994. Approximately 150 in-patient establishments (psychiatric clinics, addiction clinics, therapeutic organisations, complementary facilities and the after-care field) work with this documentation system.

SEDOS is an establishment-related documentation system. The client data is compressed into aggregate data, and thus in its final form is not available for more individual therapeutic work. The emphasis is on the analysis and improvement of the work of the establishments as a whole as well as the higher co-ordinating authorities.

Using different survey questionnaires, SEDOS collects data on various fields: socio-demography, anamneses, diagnostics, progress and completion of therapy. In addition, 1-4 annual catamneses (follow-up questionnaires) have been possible since January 1995. The annual catamneses are conceived as written patient surveys. Once a year data on the respective establishments are collected. These establishment questionnaires include, for example, questions on the type of the treatment establishment, the therapeutic emphasis, the catchment area and the services.

The SEDOS system is funded by the Federal Ministry of Health and is free for the participating establishments. It is used to receive information as the basis for

[38] In-patient establishment-related documentation system in addiction care.

[39] Members: Deutscher Caritasverband e.V., Referat Gefährdetenhilfe, Freiburg; Deutsche Hauptstelle gegen die Suchtgefahren e.V., Hamm; Gesamtverband der Suchtkrankenhilfe im Diakonischen Werk der Evangelischen Kirchen in Deutschland e.V., Kassel; Bundesverband für stationäre Suchtkrankenhilfe e.V., Kassel (formally Verband der Fachkrankenhäuser für Suchtkranke e.V.); IFT, Institut für Therapieforschung, Munich; Fachverband Sucht e.V., Bonn.

individual planning, controlling, evaluation and improvement of the work of the psycho-social treatment establishments. The Institute for Therapy Research in Munich is the central evaluation authority. The information is evaluated for different levels:

- Treatment of a patient (e.g., problem situation or progress of therapy)
- Therapy programmes (e.g., termination quota or catamnesis results)
- Therapeutic establishments (e.g. emphasis or employee structure, quality assurance)
- National levels (e.g., treatment density or changes in the clientele).

### DESTAS[40]

The DEzentrale STAtistik System was developed during the 1980s by the Verbund des Deutschen Paritätischen Wohlfahrtsverbandes (DPWV) and the Fachverbands Drogen und Rauschmittel e.V. (FDR) as part of the project "Standardisation of data collection and evaluation". The system is conceived as a service for computer-aided statistics for out-patient, in-patient and clinical fields of work. DESTAS ambulant [out-patient] is orientated to the DHS standards (cf. back).

DESTAS consists of a survey instrument (index cards or questionnaires) and a computer-aided evaluation programme. The "DESTAS ambulant" basic data standard collects client-related basic data for the fields of social demography, anamneses, addiction diagnostics, courses of treatment as well as facility-related work. The system provides free space in order to extend individual question areas. DESTAS is not publicly financed (in contrast to EBIS/SEDOS) and is therefore not available free of charge to the establishments. Programmes and services are offered for a small fee.

The aim is to achieve comparability of evaluation findings of the member establishments at state and federal level. The data remains in the establishments. It can be evaluated using an appropriate evaluation programme at the level of the individual establishment for the purposes of the establishment‘s statistics. Only the accumulated evaluation results are passed on to the organisations. Thus, comparisons between several establishments are only possible to a limited extent on the basis of aggregate data. There is the possibility, however, of carrying out a summarising and/or central assessment for funding organisations with several facilities.

DESTAS is the most wide-spread documentation system in the field of illegal drugs. According to the FDR, this statistics system is used by more than 100 counselling centres, therapeutic facilities with more than 1000 places and by

[40] DEcentral Statistics System; out-patient.

many (withdrawal) clinics. Evaluations of data made on the basis of DESTAS (previously called Infomaster) are available at funding institution level. It is not known of any summarising epidemiological work at regional or federal level. As a result of the procedures explained here the possibilities for this are extremely limited.

### EuropASI (European Addiction Severity Index)

EuropASI is a documentation system which is based on the American Addiction Severity Index and is divided into the fields of general information, physical and psychological condition, social situation, family background, drug and alcohol use. For each question area the current level of problems and the importance of treatment are ascertained using a rating scale by the client and the interviewer (see also 4.2.4.2).

In a series of points the ASI clearly goes beyond a basis documentation as previously understood. In particular this applies to areas concerned with an inventory of the client‘s situation in different dimensions. The ASI is a possible starting point for the debate on standards in addiction care regarding different areas of "social diagnostics". Of the documentation systems presented in this chapter, only the EuropASI realises an assessment of the patient during the interview. Furthermore, it includes comprehensive data/areas which, particularly for extended monitoring services, are expected to become standard at European level. Thus questions on characteristics which go beyond the standards of the Deutsche Gesellschaft für Suchtforschung (DGS) ought to be oriented to the ASI.

### "Documentation standards 2" for the Treatment of Addicts

Parallel to the development of individual documentation procedures, there has been an increase in the effort to standardise and agree upon variables and characteristics in the main fields. The first version of the "Standards for the implementation of catamneses with addicts" was published in the mid-1980s by the DGS. A second version which was revised and extended at the end of the 1980s, the "Documentation Standards 2", considers standards for the entire field of therapy documentation for the treatment of addicts. Moreover, the DGS formulated standards for the collection of data during the course of therapy. The Documentation Standards 2 is conceived as a reference work which offers advice and suggestions when planning studies.

The aim is to achieve a standardised documentation of the main characteristics of the clients, the measures, the therapeutic facilities and other structural conditions, thereby simultaneously creating a uniform standard for scientific investigations and so guaranteeing comparability. For therapeutic work, the collected data

from anamneses is intended to have an indicative function. A standardisation of document standards at European level is being striven for.

Various national documentation systems are oriented to these documentation standards, for example the EBIS, SEDOS and DESTAS systems described previously. Any considerations for expanded versions of the documentation systems in the field of addiction should be based on these standards to ensure comparability in the main fields and support for the national and European evaluation through the more differentiated regional evaluation. Since these documentation standards include aspects which go beyond the basis documentation to include documentation on therapeutic intervention and courses of therapy, any expansion of the basis documentation to include these aspects, which are relevant with regard to quality assurance, should take into consideration the suggestions made by these standards. Linked to various associations and organisations, the documentation standards are used and further developed by a variety of national and international scientists and practitioners.

### 2.3.4.2. Comparison of the Documentation Systems

The documentation systems referred to have a limited *joint basis* regarding the ascertained characteristics. In addition, the joint characteristics are not documented in a unified way[41]. This means that even a combination (blanket coverage) of these - independent - survey instruments could only provide reliable intervention and planning data to a limited extent.

*Structural deviations* exist mostly in the construction of the individual documentation systems. Whilst the survey instruments do not display any structural differences as regards the in-patient and the out-patient systems, the structure of the EuropASI deviates quite severely here. These deviations affect the inclusion of the individual categories /variables in terms of time, in this respect the last 30 days before admission, as well as the assessment of the treatment needs by the clients themselves.

*Deviations in terms of content* affect the addiction diagnoses. The EBIS-A, SEDOS and DESTAS systems assume that diagnoses are in accordance with the ICD-10 classification. The EuropASI surveys the addiction problem according to its own descriptive system. Here, a substance classification is used whereby, for each substance, the age of first use, the total number of years of use (from approx. 3 x per week), as well as the use during the last 30 days and the way and means of taking it are recorded.

[41] All the named systems use the following categories/variables: serial No., gender, date of birth/age, nationality, admission status, start/end of counselling/care, marital status, school qualifications/current position in school/studies, vocational training, income, debts, previous convictions, addiction substance diagnosis, main diagnosis, previous out-patient/in-patient treatment.

## The limits of the documentation systems

The existing systems for basis documentation have until now not met the requirements of a documentation which can serve as a basis for regional planning data whilst enabling various aspects of client and establishment-related developments to be monitored.

Monitoring refers to procedural methods for the systematic observation and assessment of various processes (such as drug consumption, the health situation or the constant linking of clients to the care system) using scientifically developed indicators. The objectives of monitoring within the fields of addiction and drugs are:

- to evaluate the epidemiological development of various aspects of addiction,
- to examine the development of the scope and effectiveness of addiction care facilities,
- to observe the effectiveness of individual interventions in terms of the course of the addiction,
- to compare different facilities in order to further develop the forms of intervention.

Despite the various efforts, until now there has not been a unified documentation or agreed document standard across Germany:

With DESTAS the data remains in the establishments and are only passed on in aggregate form. This considerably limits the possibilities for further processing and for gaining knowledge. It is not known of any joint regional evaluation experiments. Thus, although DESTA can be used in terms of the variables, it is unsuitable for qualitatively sophisticated research or for a monitoring system.

EBIS is now extensively used and, in contrast to DESTAS, retains the data from the establishments for central evaluation (anonymous client data). This is mostly due to the fact that EBIS has taken over the service for producing the establishments‘ statistics.

The EBIS annual statistics, which report on demands on the counselling and treatment centres linked to the system, have been published since 1980. It currently includes information from around 500 facilities (approx. 35% of German establishments). New facilities have been continuously ”fed” into the system since 1980. Changes in demands made by drug clients can also therefore reflect changes in the composition of those establishments providing reports.

EBIS considers the linked establishments to be representative for the total number of establishments. However, in terms of the regions and the funding institutions this is not the case. There is a severe regional distortion of the catchment area with a over-representation of the south. In particular, the city states show

fewer participation numbers. Furthermore, almost 90% of the establishments are currently under the sponsorship of religious charitable organisations. Consequently this leads to failings in the field of illegal drugs[42].

Moreover, it is concerned with very different types of counselling and treatment centres. The lack of differentiation between alcohol and special drug counselling centres, and between low- and high-threshold facilities, has led to very different utilisation behaviour, so that the interpretation of the data must be regarded as having very little value in terms of their epidemiological meaningfulness. Apart from such differentiated distortion effects, the possibility that one and the same client can appear several times is problematic and limits the possibilities for gaining knowledge. For more precise epidemiological data and more differentiated evaluation procedures, the systems lack anonymous labelling of the data for individual clients which would exclude doubling in various establishments, make it possible to observe course changes in the composition of the clients in the establishments, and enable course models for the use of the establishments to be analysed.

These distortions are by no means unusual for institution-connected statistics. They also do not fundamentally detract from their epidemiological meaningfulness. Thus it is perfectly possible to balance such distortions using projections and weightings. This requires, however, a detailed explanation of the collected data and a much more in-depth analysis of the participating facilities. This applies even more so as it is precisely the drugs field which is poorly developed within the EBIS and thus highly subject to selective influences. The high aggregation level of the information in the EBIS annual statistics as well as the lack of differentiated information prevent any possible improvement of the epidemiological meaningfulness of the EBIS data in terms of figures.

The databases collated today do not allow any systematic evaluation of the client-related data of an establishment in its development, and only to a limited extent enable a check and/or comparison of the various fields of the care system. Where there is systematic documentation, different systems are used which are incompatible. Where combined systems are used, they are not available as source data for independent regional evaluations. As a result of the limited epidemiological meaningfulness, the existing systems are unsuitable as a starting point for regional planning. The information which can be gained on their basis is too crude. Statements on the exact target groups of specific care services and their effectiveness which go beyond the elementary aspects have not been possible until now. Significant information, such as, for example, details about the addiction substance anamneses and on the health situation, are either insufficiently documented or not at all.

[42] For instance, the 1993 statements on drug addicts treated as in-patients are based on data from less than 500 clients for the whole of Germany.

The collection of data for the planning and evaluation of addiction care treatment in its broadest sense is a necessary basis for the effective development of the care system. To achieve this, specific research projects based on systematic treatment and health system research as well as continually standardised documentation and quality assurance are necessary. In the Federal Republic of Germany both are only still in their infancy and are inadequate. The developments of recent years, however, provide hope for the setting up of the corresponding areas of specialisation and research funding.

### Possibilities for the deployment of computers

The greatest contribution in recent years is without doubt the fact that, as a result of the spread of PCs in the 1980s, data has been centrally collected in order to gain an overview of the clientele being treated and their development tendencies. The computer systems used, however, are simply database systems which, beyond maintaining the patient source data, are unable to perform any other functions. With EBIS and DESTAS the data is collated on index cards and fed into the computer at a different point in time to the contact with the client.

The purpose of computer deployment in the future will be in directly supporting the work of the carer/advisor in the creation of specific services. The development is moving in the direction of computer-aided file management for the entire course of care. This creates an abundance of information in the care working process which provides the cornerstones of a "basic documentation". Other fields in which the deployment of computers is foreseeable concern documentation with respect to quality assurance, the evaluation of individual measures and changes in the accounting system. Accounting will become more differentiated and require the use of corresponding computer equipment, which is why flexible systems are required. Thus, development in terms of the necessary systems is going in another direction than provided for by EBIS or DESTAS.

## 2.4. Greece[43]

In a wide sense, understanding the needs of treatment and support related to drug abuse existing in a given population includes different levels of research: *Epidemiological studies* aim to assess rates of drug abuse in the population, to show diachronic, quantitative and qualitative changes in patterns of use and abuse, and, consequently, give necessary information to those who design the support system at local and national level. *Continuous clients' monitoring* represents one of the ways treatment agencies map their clients' needs. This kind of activity is necessary in order to adjust the offered services to the evolving needs of support. *Studies focused on special groups of clients or subjects* (i.e. female drug addicts, adolescents, prisoners, relatives, professionals working in key-areas, etc.) offer an even more specific assessment of support needs.

### 2.4.1. Epidemiological studies

One of the main aims of the Greek scientific community working in the drug abuse field has been to assess the extent of illegal drug use and abuse in the population. The first epidemiological survey to assess the diffusion of drug use in Greece was carried out in 1984. After this, two national surveys have been carried out twice in the last decade, in 1993 and in 1998, both in the general and in the school population. They have been implemented by the Department of Psychiatry and the University Mental Health Research Institute of the Athens University (Kokkevi & Stefanis 1994), with grants (in 1998) from the Greek Organisation Combating Drugs (OKANA). The methodology of all three surveys was the same, enabling the comparison of results and the evaluation of trends. From all findings, it would be useful to stress here that in the general population, reported lifetime use of any illicit drug was three times more in 1998 than in 1984 (respectively, 12.2% and 4%) in the total sample of 12-64 year-olds. In the school population, the comparison between 1998 and 1993 showed that lifetime prevalence of any illicit drug use had more than doubled, from 4.8% to 11.4%.

[43] Based on report by Valeria Pomini, Psychologist - Psychotherapist at Athens University Medical School, Department of Psychiatry, "Eginition" Hospital - "ATHENA" Programme, Greece, 2000.

## 2.4.2. Clients Studies

During the last decade, the interest of the treatment services has been focusing on the characteristics of their clients, recording changes in patterns of use and trying to better understand their needs.

### Treatment demand reporting system

Substitute treatment centres and other out-patient centres of OKANA[44], the Out-patient Drug-free Clinic for Alcohol and Drug Addiction "ATHENA"[45], and other treatment centres in Greece have been collaborating since 1995 with the Greek Reitox Focal Point in the continuous *monitoring of clients demanding treatment*. The 'First Treatment Demand Form' (developed by the Group Pompidou) is filled out at first contact with each client and sent to the Greek Reitox Focal Point, which is in charge of data collection, analysis and dissemination of results at national and European level. General and specific findings are periodically (once a year) given back to the collaborating centres, which have the possibility to up-date their knowledge of their clients' profile, as well as to compare their clients with the population of all clients. Consequently, each treatment centre receives both a specific and a general view of the clients' population, with the possibility to adjust its activities, approach, methodology, etc., on the basis of the new findings in order to better understand and respond to clients' needs. Additionally, a global view of characteristics and patterns of substance abuse of the people demanding treatment at a nation-wide level enables administrators in theory to improve the adequacy of the treatment network in the country.

Because two drug-free treatment services networks, KETHEA and the Psychiatric Hospital of Athens, have withdrawn from the system since 1995, the sample cannot be considered to be totally representative of all individuals asking for treatment in Greece[46].

During 1998, a total of 1,151 individuals demanded treatment at the treatment centres participating in the treatment demand reporting system (Greek Reitox Focal Point 1999). The following *socio-demographic characteristics* could be observed: males outnumber females by 5:1. The 75% approximately are residents of the two main cities in Greece (Athens and Thessaloniki). The average age is 30 years. 2/3 have not completed their secondary education. Over half are unemployed, while only 25% have regular employment. 65% of users are living with their parents. Over half are requesting treatment for the first time. *Drug use*

[44] OKANA is the Greek governmental institution co-ordinating the action against drug use and abuse.
[45] The Athens University Department of Psychiatry, the Psychiatric Hospital of Thessaloniki.
[46] In fact, findings in 1998 are mainly influenced by the high presence of clients in substitute treatment (43% of all clients), because two new substitute treatment programmes started to operate in Athens and in Thessaloniki during 1999. Clients of these programmes are usually older, with a greater history of drug abuse and major social problems.

*patterns*: half of users abuse at least three substances. Heroin is the main substance of abuse. The average age when first using of heroin is 21 years, for cannabis 17 years and for pills 21 years. Injecting is the main method of administrating heroin, but there is an increasing trend for sniffing and smoking. *Risk behaviour*: over 70% of users are currently injecting. 1/3 of users share syringes, with a higher proportion for women than for men. *Infectious diseases*: about 1/3 of the users report that they have never been tested for hepatitis and HIV. Among those tested, 2/3 report having been infected with hepatitis. Few of those tested report having been infected with HIV (3%).

### The Annual Report of KETHEA

In addition, the socio-demographic characteristics and patterns of use of clients contacting KETHEA's counselling centres are systematically collected through the 'First Treatment Demand Form' (Group Pompidou) when the clients are admitted in each one of the nine counselling centres of KETHEA[47]. During 1997, 1,598 individuals contacted KETHEA's Counselling Centres. 86.3% of them were males and 17.3% females. The mean age was 27 years. Almost all clients were Greeks (98.3%), residents in urban centres (98.5%), living with their parental families (72.3%), unemployed or part-time employed (71.2%). The average age of dropping out of school was 15.2 years, while the educational background was 32.0% primary school, 36.8% secondary school, 26.5% high school and 4.5% university. Heroin was the main substance of use in 76.3% of cases, i.v. use 65.5%, daily use 59.4%. The average age of onset of the main substance use was 20 years, and the average duration of main substance use 6.1 years. The average age of onset of use of any illegal substance use was 15.7 years, the substance of use being cannabis in 56.5% of cases (KETHEA 1999).

## 2.4.3. Studies focused on specific groups and issues

### Study on the Dance Scene

The study "New Life Styles and New Consumption: Nightlife and Synthetic Drugs" was carried out by the Greek Reitox Focal Point in Athens during 1998 and 1999, within the framework of a European research project co-ordinated by IREFREA, with the participation of nine European cities. The study aimed to assess new patterns of drug use and abuse among young people, specially in nightlife. The study was a combination of qualitative and quantitative research. In the first stage, 24 key informants strictly related to the dance scene provided the

[47] Therapy Centre for Dependent Individuals.

necessary information through semi-structured interviews as part of the organisation of the quantitative study. In the second stage, a sample of 305 filled in a self-rate questionnaire on recreational attitudes and behaviour, drug use - paying special attention to the use of "ecstasy" - and beliefs regarding dangers related to drug use.

The results of this study have been compared with the results of a national epidemiological study on the general and school population[48] carried out in the same period (Greek Reitox Focal Point 1999). Findings showed that the "dance scene" study group was composed mainly of males whose alcohol and tobacco consumption was double that of the school and general population, while the use of cannabis, ecstasy and cocaine appeared to be significantly more frequent. The "dance scene" group represented a higher educational level but lower stability in employment. An interesting finding with regard to the "dance scene" group risk behaviours showed that individuals belonging to this group were more aware of dangers related to drug use, especially to the use of ecstasy. Most of these individuals declared that they do not mix ecstasy with other substances, such as alcohol or cannabis, being aware of the possible damage it could cause. In conclusion, the use of synthetic drugs, this being mainly ecstasy, seemed to be mostly connected to a particular context within the Athenian dance scene, the so-called "house" and "trance" scene, while the young people who prefer rock and Greek music bars usually prefer the use of cannabis.

### The "Early Warning System"

Within the framework of the European Union Joint Action/1997, a warning system for new synthetic drugs has been developed in collaboration with the EMCDDA and the Europol. Since 1998, a network of treatment centres and other institutions has been created under the co-ordination of the Greek Reitox Focal Point to monitor new synthetic drugs as well as new patterns of use of already known drugs (see 4.2.7.2).

### Low-threshold services contacting the hidden population

*OKANA's Help Centre* has been working since 1996 in the heart of Athens's down-town, in an area where social problems related to drug use are much evident. The Help Centre has been designed to respond to the needs of drug addicts who do not want or do not know how to contact a treatment centre, as well as to give immediate help in case of emergency. The Help Centre offers medical care, social support, counselling and information to drug addicts who are not involved in any treatment programme through a group of street workers. Further-

[48] Specifically two groups, 17-19-year-olds from the school population and 18-24-year-olds from the general population, have been compared to the group of the "dance scene" study (mean age 21 years).

more, the Help Centre provides needles and condoms, immediate medical assistance in emergencies, SOS hot-line, legal support, motivational interviews, general health care, dental care, meals distribution, laundry facilities, etc. The Help Centre contacts users who usually do not come into contact with treatment centres. It thus provides *information on the characteristics of the hidden population*. Several questionnaires have been created to monitor users' characteristics: a Registration Form; a General Health Form; a Dental Health Form; and a Social Care and Street Contact Registration Form. During 1998 the OKANA's Help Centre contacted 2,202 drug addicts and distributed 46,660 needles, exchanging them with used needles. Sixteen users have been trained as street workers, while five of them started a therapeutic programme (KETHEA 1999, p.65) [49].

*The Multiple Intervention Centre of KETHEA*[50] is a therapeutic programme especially designed to meet the needs of drug addicts who lack any kind of social support (KETHEA 1999). This group usually includes people who are homeless, with legal problems, a prostitution history, absence of financial resources, etc. The Centre offers its services regardless of the client's motivation to enter treatment. The Centre provides a variety of facilities, such as street work, prison counselling and support programme, a drop-in centre where drug users can find psychological support, hot meals, clothing, a dental clinic, self-help groups, etc. In 1998, 1,237 persons visited the drop-in centre and 262 persons visited the dental clinic. Through the street work programme, the centre came into contact with 407 users.

### The diffusion of blood-borne viruses and risk behaviours in prisons

A research project has been developed since 1997 in the Greek prisons by OKANA, in collaboration with the Ministry of Justice, the Athens University Medical School Epidemiological Centre and the French Regional Observatory of Health (Malliori et al. 1998). 544 drug users were contacted in prisons. 68.9% had injected, 35% of them while in prison. Among i.v. heroin users, 0.27% were HIV positive, and 80.6% had been infected with hepatitis C, 62.7% with hepatitis B, and 3.3% with hepatitis D. 92% of users injecting heroin while in prison shared needles. This seems to be the main risk behaviour among drug users in prison.

## 2.4.4. Clients and Staff Satisfaction

During the last two years KETHEA has paid particular attention to the evaluation of its service as a means for its continuous improvement (KETHEA 1999). The

[49] Several publications on other findings are currently being printed.
[50] Therapy Centre for Dependent Individuals.

Continuous Quality Improvement Effort consists of two levels of evaluation: the internal evaluation involves staff members, clients and family members, the external evaluation is conducted by an International Committee of three experts. A tool of instruments has been created for the assessment of client's and staff's satisfaction. KETHEA's evaluation activities are currently in progress and the instruments are not yet available for external use. An English version will be published by KETHEA in the future.

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## 2.5. Italy[51]

### Questionnaire on Client Satisfaction

In Italy, the only assessment instrument existing in the sector of support and treatment needs is a questionnaire on client satisfaction approved by the Emilia Romagna region in October 1997 and disseminated in the public services of this region in the autumn of 1998. It is a self-reported questionnaire comprising 22 items, each with a yes- or no-answer on a scale from 1 to 6. The items refer to three areas:

- Service organisation: opening hours, confidentiality, organisation of space and information
- The client's relationship with professionals, through a number of statements which refer to the following subject areas: agreement with the professional; whether or not the client's requests has been fulfilled; waiting time for reservations and services; the time dedicated to the client by the professional; the professional's respect as perceived by the client; the client's trust towards the professionals; the client's perception of the professionals' effort to solve his problems.
- The client's overall judgement of the service: whether the service may be of actual help to drug users and abusers; whether the service may be of actual help in overcoming dependency; whether the service offers personalised alternatives; whether the client is generally satisfied about his relationship with the service.

Although the use of the questionnaire is intended to be mandatory for each patient in all public facilities in the Regione Emilia Romagna, there is information that its use has been very poor up to now. No studies have been performed on the use of the questionnaire or on the reported data.

[51] Based on text by Maurizio Coletti, Centre for Addiction Research (Centro per la Ricerca dei Comportamenti Additivi), Rome, Italy, 2000.

# 2.6. The Netherlands[52]

## 2.6.1. Dutch Registration Systems

In the Netherlands the needs and functioning of drug abuse treatment and care are being studied at regional as well as national level: almost all institutions for out-patient addiction treatment and care are connected to the National Alcohol and Drugs Information System *LADIS*. Another registration system is the national Patient Registration of Intramural Mental Health Care (*PIGG*). At regional level there are, for example, the Central Methadone Registration (*CMR*) for Amsterdam and surroundings, the drugs monitor for Amsterdam and surroundings (*Antenne*), and the Rotterdam Drugs Information System (*RODIS*).

In recent years, more insight into addiction treatment and care has been achieved through the growing importance of LADIS and through links between registration systems. By using regional Drugs Monitoring Systems (*DMS*) researchers can describe not only trends in drugs use, but also the problems and support needs of drug users. Currently the Ministry of Health, Welfare and Sports (1999) is developing a National Drug monitor (*NDM*). Several standardised methods are combined in order to get reliable information on the scale and nature of drug use among the population and groups at risk, both at regional and national levels (Bureau NDM 1999). Results of existing monitors such as the alcohol and drugs monitor in Dutch cities (*Stedenmonitor*) will also be used by the NDM (Mensink & Spruit, 99). On the basis of these registration systems a diversity of studies on development trends and needs are being carried out:

### Antenne

The goal of this drugs monitor ("Antenne") used in Amsterdam and surroundings is to signalise and interpret new trends and developments in legal and illicit drugs use and gambling among youth in Amsterdam, and to update and improve drug prevention (Korf et al. 1998). The population under study are visitors of trendy clubs and raves, insider experts from the trend-setting social world (clubs, raves), groups at risk (problem areas, molested youths, etc.), and people who enquire about information and advice (telephone help line). The methods used are (1) bivariate and multivariate statistical analysis of data from the site survey, (2) interviews with a panel of insider experts on trends in drug use (twice a year), and (3) analysis of data from the telephone help line and pill testing service of the Jellinek Centre's department for prevention (see 4.2.7.1).

[52] Based on text prepared by Monique Nieuwenhuijs and Wim van den Brink, The Amsterdam Institute for Addiction Research, The Netherlands, 2000.

### Regional Drug Monitoring System

The purpose of the Drugs Monitor (DMS) is to give continual actual quantitative and qualitative information on phenomena and developments in drug use on a regional level (Lempens et al. 1999). Together with the knowledge gained from other existing registration systems, it creates a basis for policy and development of care which is closely connected to the specific regional aspects and needs. Yearly publications appear of DMS surveys in the regions of Rotterdam, Utrecht and Heerlen. The information is gained from three sources: key informants or experts on the actual situation in the specific area, respondents of the target group in question and the community fieldworker.

### Central Methadone Registration

The purpose of the CMR is to register adequately the supply of methadone from assistance institutions and detention centres (Central Methadone Registration 1998). The general conclusions of previous analysis are as follows: (1) The number of clients receiving methadone treatment keeps decreasing, since 1989 this has dropped by 25%. At the same time there is constancy in the number of methadone treatments given. A smaller group of clients that grows older very fast uses care more intensively. (2) The number of criminal opiate addicts has dropped by 25% in the last seven years. (3) In the case of clients from Eastern Europe and refugees these groups stayed respectively small, while the number of West Europeans and North Africans in treatment dropped. (4) More clients were referred to general practitioners. (5) Less new clients were registered compared to 1997.

### National Alcohol and Drugs Information System (LADIS)

The population observed through LADIS includes all clients that have received out-patient addiction care and treatment in the Netherlands. By means of the registration and output programme ADDICTIS, the IVV[53] receives every quarter year standardised data about demographic variables, care and treatment variables, and variables concerning results of care and treatment from all the Institutions for Out-patient Addiction Care and Treatment located in the Netherlands. Statistical analyses are then performed on these data (Ouwehand et al. 1999).

[53] The Organisation Information Systems on Addiction Care and Treatment (Informatievoorziening Verslavingszorg)

## 2.6.2. Studies on qualitative support and treatment needs[54]

### Opiate Addicts in and outside of treatment

In a clinical field investigation Eland-Goossensen (1997) compared opiate addicts in three types of treatment and outside of treatment in terms of the nature, severity and extent of drug use as well as medical, legal, psychosocial and psychiatric problems. 91 respondents were interviewed in an outpatient methadone programme, 72 respondents in a clinical detoxification centre, 77 respondents in a drug free therapeutic community and 83 respondents outside of treatment. The three research groups in treatment were consecutive samples and the addicts in the community had been approached by means of snowball sampling with nominee selection. The following instruments were used: the Addiction Severity Index (ASI), the Composite International Diagnostic Interview (CIDI), and a qualitative interview about help-seeking and barriers in the process of asking for professional help.

A very profound difference which was found between the four groups was that opiate addicts applying for help in a detox or Therapeutic Community programme experienced more social and psychological problems. Psychopathology prevalence was given for the four groups in terms of DSM-III-R diagnoses. Furthermore, opinions of drug users about their drug using career were described (qualitatively), and factors identified that were related to the decision to ask for professional help.

### Evaluation of care by clients of Dutch addiction care programmes

The study by Jongerius et al. (1994) reports on the evaluation of care by clients of Dutch addiction care programmes. Clients and ex-clients of 16 institutions for addiction treatment have been included (N=2000). A satisfaction questionnaire was developed for this purpose.

### The practice of methadone dispensation in the Netherlands

Methadone maintenance programmes play a key role in the national medical experiment for the treatment of heroine addicts with heroin. The practice of methadone dispensation (high and low dosages) in maintenance programmes was assessed from the perspective of the medical experiment with heroin (Korf, Nabben, Letting & Bouma 1998a). The population under study were medical doctors, nurses and methadone patients in Amsterdam and Utrecht. The sample of pa-

[54] Partly obtained from Buro Beta, 94-98.

tients refers to patients in methadone programmes that provided candidates for the experiment.

Although daily dosages of methadone in the Netherlands are still relatively low, in recent years there has been a rather steady increase. Both patients and professionals report that patients play an increasingly important role in deciding the daily methadone dosage. Imprisonment appears to be the most dominant reason to lower the daily dosage of methadone or to leave the programme temporarily.

To some extent, the inclusion of a ‘high dose’ of methadone as part of the criteria for the heroin experiment conflicts with the interests of methadone patients. From the patients’ perspective, the two main reasons are: a ‘high dose’ of methadone blocks the ‘kick’ of heroin and it is associated with the ‘junkie-image’. Preference for heroin-on-prescription is stronger among those who appreciate the kick of heroin. These patients tend to have a more negative attitude towards ‘high doses' of methadone.

## 2.6.3. Studies on Size and Needs of the Hidden Population

### Methodological Procedures

In the Netherlands considerable importance is given to the research of hidden populations of drug addicts, whereby attention should in particular be drawn to the substantial methodological discussion which has taken place (see also 4.2.3 and 4.3.4).

An invited *European Expert Group Meeting* was held in Rotterdam that focused *on research methods for hidden populations using illicit drugs* (Goor et al. 1994). Experts from most European Community member states participated and contributed state-of-the-art presentations on various research methodologies. Attention was paid to the more quantitatively oriented research methods, such as surveys using questionnaires, interviews, and routine statistics from treatment and criminal justice, as well as to more ethnographically oriented research methodologies. Recommendations were formulated for the near future: research methodology needs to meet all the classical methodological criteria, such as clear definitions, tests on reliability and validity, and clear sampling procedures. Interfacing methods is the key phrase. More quantitatively oriented methods, such as interviewing a random sample from a household survey, seem unsuitable for research on illicit drugs, except perhaps for the use of cannabis. A multiple factorial problem, such as illicit drug use and related problems, should be approached in a multidisciplinary way; i.e., the integration of different research methodologies.

Comparability between individual research projects in different countries requires not only technical adjustments of the data, but also a "framework for communication". Data always need to be interpreted in terms of cultural context. A similar framework should enhance studies with respect to comparison of drug policies and their consequences in various cities or countries.

Korf (1995) outlines the general features of *snowball methodologies* (including drug abusers in and outside of treatment) and focuses more closely on their application in drug research. A four-stage model is presented and explained in six field studies. Furthermore a panel study which tests the self-report reliability of heroin users is described.

Van den Brink (1999) describes and criticises the following *methods to bring hidden populations into view* and ready for research: case finding, capture-recapture, multiplier methods (mortality multiplier method) and nomination methods (snowball sampling of chain referral). It concludes that best estimations result from evaluation of results of different methods used at the same time.

Buster et al. (1999) estimate the size of the population of problematic opiate users in Amsterdam and the coverage of the population by health services, and they describe the characteristics of the registered and the hidden population. The *capture-recapture method* is performed with half-year samples of problematic opiate users who were in contact with the police, hospitals and low-threshold treatment in 1997. The total estimated number of problematic opiate users in Amsterdam is 4,556 and the coverage of problematic opiate users by health services is estimated to be 57%. The problems and pitfalls of the capture-recapture method are evaluated.

### Needs of drug using immigrants outside treatment and care

The Netherlands Institute of Mental Health and Addiction, Utrecht, is currently carrying out a study on the *needs of drug using immigrants outside treatment and care*. The study aims to achieve greater insight into the reasons why drug using immigrants (Turkish, Moroccan, Surinam) make little use of drug treatment and care programmes. The problems and obstacles they meet, specific needs and individual differences are under investigation (ZON/NWO 99).

## 2.6.4. Quality Management

The importance of the quality management and research of the Jellinek Centre and its leading role in the Netherlands should be emphasised here. This was recognised in 1996 when the Jellinek received the Dutch Quality Award. Since

1994 it has been working in a structural and systematic manner to improve the quality of the organisation and the services it provides.

The *quality management* focuses on the formulation and realisation of concrete objectives and is based on several important elements, i.e. the EFQM[55]/INK[56] model, annual planning system, trend research, evidence-based treatment, ISO-certification and protocollisation, evaluation of outcomes, tailor-made treatment, results and international activities. The Jellinek Centre Application Report for the Dutch Quality Award (Nabitz & Walburg 98) details the quality management 1994-1996. Needs, satisfaction of clients and staff, professional standards, protocols and training, effectiveness and costs, all being a part of quality management, are studied and described in the report. It forms the basis of further development in the quality of care.

The *Client Satisfaction Monitor* developed by the NcGv[57] and Jellinek measures both general and specific themes of care and provides information on the satisfaction of the clients of different programmes, i.e. out-patient, clinical and social care programmes. An adaptation of the Satisfaction Monitor is available for the satisfaction of prisoners as well.

With respect to *staff satisfaction*, the Basic Personnel Questionnaire Amsterdam (BASAM) developed by the University of Amsterdam describes social and psychological aspects and the consequences of personnel management in organisations. It consists of 21 scales and the rating scale runs from very negative (1) to very positive (5). This questionnaire is systematically used by the Jellinek Centre and gives information on the 21 dimensions of people's job satisfaction. Since the BASAM is also used in other Dutch organisations, it is possible to compare the results between organisations.

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# 2.7. Poland[58]

## 2.7.1. Studies on qualitative support and treatment needs

There are very few studies investigating support and treatment needs of drug addicts in Poland. A couple of studies from recent years were conducted mostly in connection with formulating or implementing relevant programmes in local communities:

### Prevention and Management of Drug Abuse in Poland

Within the framework of a comprehensive action-research project on drug prevention in two local communities, a series of interviews with local addicts was carried out to collect information to be applied in the formulation of the programme of action and in the evaluation of the project (Moskalewicz, Sieroslawski, Swiatkiewicz, Zamecki & Zielinski 1999). The interviews were focused on history of drug use, current life situation, health status, expectations with regard to different forms of assistance. Snowball sampling was applied to identify and to interview several dozen addicts, most of them in contact with local health or/and social welfare agencies. Face-to-face in-depth interviews lasting on average for two hours were carried out by experienced interviewers. The majority of local addicts was covered.

In both communities, a need for social assistance including employment opportunities was expressed as an important element of would-be recovery. Attitudes towards treatment differed largely. In one community the addicts were sceptical with regard to treatment, with particular reservations regarding long-term residential rehabilitation. In another one conventional detoxification was also rejected. Instead, a clear demand for methadone maintenance in combination with psycho-therapy prevailed. Findings from this study indicate existing variation in needs of different groups of addicts and suggest the necessity of undertaking needs assessment studies to identify and to respect local specificity.

[58] Based on text prepared by Katarzyna Przymuszewska, Boguslaw Habrat and Jacek Moskalewicz, Institute of Psychiatry and Neurology, Warsaw, Poland, 2000.

### First Threshold of Treatment

Based on personal observation rather than on systematic research, Brzezinska (1999) describes the *needs of clients of a detoxification centre* in a middle-size urban centre (Olsztyn). Medical treatment seems to be of secondary importance for clients. They need more care and attention in general, a more individual approach, counselling, support, recognition of achievements. Freedom of choice with regard to treatment constitutes a significant value. Brzezinska postulates a continuous dialogue with clients, individualisation of therapy and freedom of choice since pressure and compulsion give birth to numerous side-effects.

## 2.7.2. Studies on Hidden Populations

As Polish drug legislation and policy have been relatively liberal, including depenalisation of drug possession in 1985, the hidden population has always been considered to be rather small. The first studies to *estimate the number of injecting addicts* including the hidden population were carried out in the 1990s, applying the capture-recapture method (Moskalewicz & Sieroslawski 1995) and benchmark assessment (Sieroslawski 1999). According to these studies the total number of injecting drug users could have increased from 20-40 thousand to 36-60 thousand during the 1990s, while the recorded number of addicts lies between one fourth to one third of their total population.

In order to develop a local drug prevention strategy, Sieroslawski (1999) carried out *a study to assess the needs of drug addicts in a large urban centre* (Poznan). Forty-seven addicts were recruited in a snowball sampling procedure (32 male, 15 female, aged 18-45) and then interviewed (face-to-face interview). The results showed that the respondents are not willing to undertake treatment, either because they do not feel addicted or consider themselves too dependent, as incurable cases. Those who had previous experience with treatment are rather critical, especially with regard to conventional residential detoxification and rehabilitation. Inefficiency of treatment was emphasised. Lack of understanding and respect from personnel was regarded as a factor that reduces their demand for treatment. Only a counselling centre run by Monar (NGO) got positive assessment, despite small rooms and an insufficient number of personnel. The study recommends the further development and diversification of out-patient treatment, harm reduction strategies including methadone maintenance, and collaboration among local institutions and NGOs.

## 2.7.3. Comprehensive Adequacy Assessment through Experts

In recent years, three large documents dealing with the assessment of the current system of drug treatment were developed by teams of experts:

### Report on the current status of drug treatment in Poland

A report on the current status of drug treatment in Poland (Institute of Psychiatry and Neurology, 1996) was needed in the context of a public debate on new drug legislation which was adopted in 1997. The report[59] was drafted by a team of experts from the Institute of Psychiatry and Neurology, consisting of four physicians (including two directly involved in drug treatment) and two sociologists.

The team analysed a number of documents: annual reports from regional consultants on psychiatry; research data and health statistics; data provided by the largest NGO, Monar; data provided by the Society for Prevention of Drug Abuse (NGO); data provided by the Bureau for Drug Addiction (the state agency to coordinate drug demand reduction activities); reports from supervision visits in individual treatment centres; and data provided by prison administration. Experiences of the drug treatment system were summarised, and the following recommendations were formulated:

- The current system of treatment, which offers conventional detoxification and long-lasting, drug-free residential rehabilitation, is inefficient and does not meet the needs of drug dependent persons.
- Out-patient treatment and intermediate forms should be developed, including day wards, hostels, and temporary housing schemes.
- Methadone maintenance programmes should be expanded.
- Harm reduction strategies have to be made more available and promoted.
- Vocational training and employment opportunities for drug addicts should be offered.
- A system of training for drug treatment personnel needs to be established.
- A database on all treatment and rehabilitation centres and their programmes should be established and systematically up-dated.

### The National Programme for Mental Health

In 1999 the polish government adopted the National Programme for Mental Health[60] which recommends *minimum standards for a network of mental health services, including drug services*. The national programme was drafted by a team of experts from the Institute of Psychiatry and Neurology. Useful comments were

[59] The preparation of the report was initiated by Professor Stanislaw Puzynski, National Consultant on Psychiatry and Director of the Institute of Psychiatry and Neurology.
[60] Narodowy Programme Ochrony Zdrowia Psychicznego.

given by relevant experts from the World Health Organisation Regional Office for Europe. The purpose was to harmonise mental health policy with general health policies and *to set appropriate priorities and standards*. With regard to drug treatment the following standards and recommendations were formulated:

- Out-patient clinics operating every day - not less than two per region[61]
- Counselling centres for family support - not less than one per region
- Hospital wards for drug treatment - 0.3 beds per 10,000 inhabitants
- Crisis intervention centre - not less than one per region
- Detoxification units - different norms to be established for each region
- Rehabilitation centres - different norms to be established for each region
- Hostels - not less than 20 beds per region
- Improvement of collaboration among different treatment and rehabilitation services
- Securing continuity of treatment and rehabilitation
- Priority for treatment in client's community of residence
- Stress on quality of living in psychiatric settings
- Increasing number of non-medical staff (psychologists, social workers)
- Establishment of a system of staff training
- Improvement of collaboration between specialised drug treatment and general practitioners
- Improvement of collaboration between specialised drug treatment and social welfare agencies
- Development of substitution programmes
- Development of a system of certification of drug services
- Monitoring quality of services including treatment and rehabilitation
- Establishment of an ombudsman for clients/patients.

### National Programme for Counteracting Drug Abuse for 1999-2001

Twenty five experts participated in drafting the National Programme for Counter-Acting Drug Abuse[62], including representatives of the Ministry of Health and Social Welfare, Ministry of Education, Ministry of Labour, Ministry of Finances, Ministry of Foreign Affairs, Customs, Immigration Office, Police Headquarters as well as from the Institute of Psychiatry and Neurology.

The preparation was co-ordinated by the Bureau for Drug Addiction of the Ministry of Health and Social Welfare. It consisted of a series of meetings, during which drafts of the programme were discussed. In addition, written comments were provided for each draft by representatives of all institutions concerned. The following questions were discussed*: assessment of the current situation; national policies and strategies; operational programmes in different sectors; resources,*

[61] Poland is divided into 16 regions with a population ranging from one to three million inhabitants.
[62] Narodowy Programme Przeciwdzialania Narkomanii na Lata 1999-2001.

*finances and management*. A number of recommendations were formulated with regard to drug treatment:

- Development of programmes for those who are not covered by the current drug treatment system
- Development of out-patient services with special focus on attracting under-aged users and on clients using cannabis, amphetamines and hallucinogens
- Introduction and expansion of harm reduction approaches, including substitution programmes (to cover up to 500 clients), syringe exchange and distribution of condoms
- Working out a comprehensive system of care for addicts with AIDS
- Development of readaptation strategies for those who complete treatment and rehabilitation including provision of hostels and temporary housing.

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# 2.8. Spain[63]

## 2.8.1. Focusing on Health Needs of Opiate Users

In Spain, much of the literature on support needs of drug users has been concentrated on *health needs*, rather than psychological or social needs. The great extension of HIV infection among intravenous heroin users may be responsible for these biases in research, but a limited experience of researchers in the collection and analysis of data regarding the psycho-social consequences of drug abuse should be also taken into account. A stronger emphasis of research on psycho- social needs would probably contribute to increasing our knowledge of needs, especially among some large populations, which are still unmet, such as the support needs of drug addicts in methadone maintenance programmes.

The research on support needs of drug users in Spain has been concentrated on the *health problems encountered by opiate users*. For many years, injection was considered to be the main route of administration of heroin, but recently smoking/inhaling heroin has become more common than injecting this drug in many areas of Spain, and particularly in the South West (de la Fuente et al. 1997).

The wide use of injection among heroin users and the fact that many intravenous drug users share their injection equipment has contributed to a very *high prevalence of AIDS* (and probably HIV infection) among drug users in Spain. HIV infection also contributes to or is associated with an increase in the prevalence of other medical conditions such as viral hepatitis (Soriano et al. 1999) and tuberculosis (Godoy et al. 1999). Despite the strong evidence of the association between intravenous drug use and infectious diseases, *harm reduction interventions* such as needle exchange and methadone maintenance programmes were not widely available before the mid 1990s. Changes in the route used for administering heroin will probably reduce, but not suppress health risks associated with drug abuse, as non-injecting drug users still show high rates of infection (Santana Rodríguez et al. 1998).

63 Based on text prepared by Josep M. Suelves, Departament de Sanitat i Seguretat Social (Department of Health and Social Security), Barcelona, Spain, 1999.

## 2.8.2. Unmet needs of high-risk drug users and "new" patterns of use

The extension of treatment and harm reduction interventions has been more limited in the case of *opiate abusers in prison*. Currently, drug-free and methadone treatment programmes are widely available in Spanish prisons, but there is only one prison in which needle exchange is available. Drug users admitted into prisons show a high prevalence of HIV infection and tuberculosis (Martín et al. 1998). More emphasis should be put in the co-ordination between community and prison health and social resources to improve treatment outcomes (Marco et al. 1998).

Pregnancy is widely considered an indication for methadone maintenance in Spain, but the improvement of health, psychosocial and educational support for *pregnant drug users* could improve the health status of the new born (Martínez-Frías 1999).

Recently the Barcelona College of Physicians has begun offering treatment to *doctors who are drug abusers* (Bosch 1998). Doctors have easy access to psychoactive drugs, and drug abuse may represent an important risk for both drug-abusing doctors and their patients.

Many cocaine users only take this drug for recreational purposes, and do not display any severe complications derived from this habit (Barrio 1997). Recent unpublished data from the Spanish State Information System on Drug Abuse (SEIT) show, at least in some Spanish cities, a *sharp increase in cocaine-related emergency room episodes and mortality, as well as in treatment demand*. The prevention and treatment of cocaine-related problems have not received strong attention in Spain.

As in other European countries, there is a strong public concern on the use of *"new" designer drugs* such as ecstasy. Findings from a study of the presence of these substances among drug-related emergency episodes in Spanish hospitals seem to show that the negative impact of the use of ecstasy and other designer drugs may be relatively limited (Rodríguez Arenas et al. 1997).

## 2.8.3. Empirical Studies on Health Needs

### Studies on risk-behaviour and prevalence of hepatitis viruses, HIV and tuberculosis

The purpose of a study carried out by Martín et al. (1998) was to identify *predictors of HIV-infection in injecting drug users upon incarceration*. The population

being assessed consisted of 639 injecting drug users or ex-drug using prisoners admitted to a provincial prison in North-western Spain between 1991 and 1995. Each prisoner was interviewed by health personnel and tested for HIV infection. The data was statistically analysed based on logistic regression. The prevalence of HIV-infection was 46.9%. No decrease in the annual prevalence of HIV-infection was observed. However, for those incarcerated for the first time the prevalence fell from 38% in 1991 to 19% in 1995.

Soriano et al. (1999) investigated the *impact of chronic viral liver disease (CVLD) on the morbidity and mortality of HIV-positive drug users* attending a reference centre for AIDS in Madrid. During a 4.5 year-period a retrospective analysis of the causes of hospital admission was conducted. Decompensated liver disease or complications directly related to it were diagnosed in 143 (8.6%) of 1670 hospital admissions, corresponding to 105 different individuals. The hepatitis C virus, alone or in combination with other hepatotropic viruses, was involved in 93 (88.6%) of these patients. Death directly associated with CVLD occurred in 25 individuals, representing the 5th largest cause of death in hospital for HIV-infected patients. CVLD represents an important cause of hospital admission and death in HIV-infected drug users. HIV infection seems to be highly prevalent among intravenous drug users in Spain, but HIV seroprevalence and intravenous use of drugs vary considerably across the country.

Santana Rodríguez et al. (1998) *compared the prevalence of serological markers of hepatitis B, D, C virus and HIV between injecting and non-injecting drug users* and identified risk factors for HCV and HIV in this population. 385 consecutive patients (122 injecting and 263 non-injecting drug users) admitted to a Drug Dependency Treatment Unit in Gran Canaria between 1993 to 1994 were assessed. Serological markers were determined by ELISA and immunoblot methods. Univariate and multivariate (logistic regression) analysis were performed to compare injecting and non-injecting drug users. Compared to the non-injecting drug users, injecting drug users presented a higher prevalence of antiHBc and antiHIV. There was no significant difference in RPR positivity. Delta infection was only detected in injection drug users, and the prevalence was low. However, drug users have an elevated prevalence of HCV, HBV and HIV infection, even if drugs are only inhaled[64].

Godoy et al. (1998) report on a study carried out in order to determine *incidence and risk factors of the association of AIDS and tuberculosis in Spain*. AIDS cases[65] over 12 years old, diagnosed in Spain in 1994, were included in the study. Cases with tuberculosis were compared with the remaining reported AIDS

[64] Results may have been different in other areas of Spain where the treatment demand for cocaine abuse is lower, intravenous drug use higher and drug-related infectious diseases more prevalent than in the Canary Islands.

[65] 1993 European AIDS case definition.

cases on the register, according to sex, age, transmission category and prison record. A multiple logistic regression was performed to assess the independent effect of each variable. Multivariate analysis revealed that tuberculosis in AIDS patients appear with higher frequency in males (ORa=1.4), the 13-29 age group (Ora=1.3) and the 30-39 age group (Ora=1.1), injecting drug users (Ora=2.1), and those patients with a prison record (ORa=2.1).

*Predictors for adherence to tuberculosis treatment in a supervised therapy programme for prisoners* before and after release were studied by Marco et al. (1998). Included in the study were tuberculosis patients from a Barcelona penitentiary centre who were released from prison in 1995. After their release patients were referred to methadone maintenance centres and other social resources. Incentives and enablers were used to improve compliance. The outcome of the patient's adherence was classified for those who completed treatment, defaulted, died or transferred out. Overall adherence was 89%, 97% among those who completed treatment in prison, and 79% among those who completed treatment outside prison. Ninety-five percent of IV drug users in a methadone maintenance programme completed the treatment. Homeless or alcoholic ex-prisoners completed the treatment only if they were admitted to socio-sanitary centres.

The Spanish Group for the Study of the Route of Heroin Administration carried out a study to measure the current *prevalence of different routes of heroin administration among users* and to describe the *most frequent patterns in the evolution of the main route* from the time of first use to the present and their implications for the control of the HIV epidemic (de la Fuente et al. 1997). The population being assessed consisted of 909 regular heroin users[66], half of them recruited in treatment centres and the other half out of treatment. The study was based on face-to-face interviews using a structured questionnaire. Measurements included socio-demographic characteristics, and current and historical behaviours related to the route of administration. Before 1980, injection was the first main route of heroin administration for most users in Barcelona and Madrid; in Seville smoking already predominated, although 40% of users began by injecting. Sniffing subsequently became predominant in Barcelona, while smoking became the predominant first route in Madrid and Seville. The prevalence of injection as the main route of administration during the last 30 days was 77.3% in Barcelona, 24.3% in Madrid and 23.9% in Seville; smoking predominated in the latter two cities. Some 73% of those who stopped injecting in their last change of route stated that the results of their HIV test or fear of becoming infected had been important in making this decision.

[66] From Madrid, Barcelona, and Seville.

## Patterns of cocaine use and the consumption of designer drugs, hallucinogens and amphetamines

Barrio et al. (1997) investigated the *history and patterns of cocaine use* in a group of cocaine users who do not use heroin. The population being assessed consisted of a non-probabilistic sample of 381 cocaine users from 35 Spanish cities who did not use heroin and had not received treatment for drug dependence. Persons interviewed predominantly took cocaine sporadically, during the weekend, in moderate amounts, and by intranasal route. Only 18.1% of users had taken cocaine more than 3 times a week in any period and only 10.8% had used a main route other than the intranasal route.

The Spanish Group for the Study on the Route of Administration of Drugs carried out a study in order to describe the *prevalence and patterns of use of crack and cocaine hydrochloride among heroin users* in Spain and to explore if the expansion of heroin smoking is accompanied by a similar phenomenon for cocaine (Barrio et al. 1998). 909 heroin users (452 in treatment and 457 out of treatment) had been interviewed (face-to-face interviews using a structured questionnaire) in three cities with different prevalences of heroin use by smoking[67]. Last month prevalence of crack use was 62.3% in Seville, 19.4% in Madrid, and 7.7% in Barcelona. The proportion of users who began taking cocaine by smoking has increased progressively since the 1970s, with the earliest increase in Seville.

The Working Group on the Study of Emergencies due to Psychostimulants analysed the *characteristics of hospital emergencies related to the use of psychostimulants* (designer drugs, hallucinogens, and amphetamines) in 15 Spanish hospitals in Madrid, Valencia and Gran Canaria[68] during 1994 (Rodríguez et al. 1997). 73 emergencies related to the use of designer drugs, hallucinogens or amphetamines were recorded (100 times lower than because of opiates or cocaine). In most cases the use of other substances was also mentioned. Acute psychopathological reactions predominated. Three patients were admitted and five were derived to other hospitals; the remaining patients improved and were discharged.

## Risk for congenital defects due to drug use during pregnancy

In the framework of a Spanish collaborative study of congenital malformations the possible risk of illicit drug abuse during pregnancy was analysed for different selected congenital defects (Martínez-Frías 1999). Mothers addicted to illicit drugs were included in the study as well as matched controls. A case-control study was conducted using different models of logistic regression analysis. The

[67] High in Seville, intermediate in Madrid, and low in Barcelona.

[68] Sampled hospitals cover areas with a relatively high prevalence of psychostimulant use. Results in other areas of Spain could be different.

proportion of mothers addicted to illicit drugs shows an increasing trend over time. These mothers are younger than those who are not illicit drug users, and have an overall risk for congenital defects of 1.84 (p=0.007). After controlling for confounding variables (age, cultural level, alcohol intake, smoking and vitamins/minerals intake), an increased risk was observed for neural tube defects, choanal atresia, esophageal atresia, gastroschisis, anal atresia, and postaxial polidactyly.

## 2.8.4. Studies on Size of the Hidden Population

Several studies have been conducted using capture-recapture techniques (Domingo-Salvany, 1997) to estimate the prevalence of opiate abuse in metropolitan areas of Spain. Using a combination of existing lists of heroin users, Domingo-Salvany et al. estimated the prevalence of opiate addiction in the city of Barcelona (Domingo-Salvany et al, 1995) and its metropolitan area (Domingo-Salvany et al, 1998). Capture-recapture has also been used in combination with other statistical models to estimate the prevalence of opiate addiction in small areas such as neighborhoods in the city of Barcelona (Brugal et al, 1999).

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# 2.9. Sweden[69]

## 2.9.1. The Swedish Perspective on the Needs of Drug Abusers

In Sweden, there are not many studies on the support system and the general treatment needs of drug using individuals, and the few existing studies are all produced within the administrative apparatus of the government, more specifically the National Board of Health and Welfare.

To understand *the topic of clients needs* in the general case, and the unmet needs of potential clients in the special case, it is necessary to remember that to some extent this question *is not really on the Swedish agenda* at all. The reason for this is that it is taken for granted that the basic need of the drug abuser is to get treatment, and presence of coercive treatment is to secure the provision of that basic need. An important part of this context is that the drug abuser is not considered to be a reliable source for obtaining information of what the drug abuser needs in order to stop taking drugs - which is the only legitimate reason for any need that the drug abuser might articulate[70].

More recently there has been a discussion on whether or not the person with drug problems should have *the right to choose the type of treatment* that is offered by the social service system. This used to be the case, but has changed through a modification of the Social Service Act. Connected with this discussion is the restraint on treatment availability that is connected with a relative shortage of economical resources for drug treatment, i.e. now and then it is argued by workers that drug users, for economical reasons, are denied the type of treatment they are asking for.

When it comes to the question of unmet needs of *hidden populations,* it is very hard to find anything at all. There is some anecdotal information of this kind available in relation to a syringe exchange programme in Malmö, where clients can remain anonymous (the only programme of its kind in Sweden), but to this date there are no publications on this topic from this source.

69 Based on text prepared by Anders Bergmark, University of Stockholm, Department of Social Work, Sweden, 1999.

70 Swedish drug policy, with its objective of a drug-free society, is hard to combine with interventions that are intended to reduce the sufferings of the drug abusers rather than making them stop taking drugs altogether, and hence only certain types of needs are perceived as acceptable.

The same lack is also present for the *expert forums*. In the alcohol field there is a national expert group that has dealt with the Swedish treatment system, and there are some vague plans for a similar group to be set up for drug treatment in the years to come. Recently the government has initiated a ”drug commission” with the objective of analysing both the general developments of the drug problem and the measurements taken to deal with it (i.e. including treatment interventions). However, this commission is a political grouping rather than an expert one (experts are only used to provide specific data, but not to participate in the analysis) and it has not yet published anything.

## 2.9.2. Reports on Aspects of Adequacy in the System of Treatment and Care

The two documents presented in the following[71] address questions of treatment needs and the character of support interventions:

### Report on the effects of offensive drug treatment in Sweden

This report of the National Board of Health and Welfare (1993) is a summing-up of a rather extensive special effort in the drug treatment field initiated in 1984, the ”offensive drug treatment programme[72]” (offensive should be understood in its military sense, i.e. on the move forwards). The report does not explicitly identify any needs but it touches upon this subject matter in the sense that it is trying to evaluate to what extent the *out- and inpatient resources for drug treatment* increased as an effect of the programme.

Another possible indication of the needs is the *identification of certain subgroups of clients*[73]. The identified groups are: young drug abusers, female drug abusers, immigrants with drug problems, drug abusers with psychiatric disorders, and HIV-infected drug abusers. Specific needs are identified only for female drug abusers (more resources with reference to a higher degree of physical and psychological vulnerability), immigrants (more intense outreach work owing to their tendency not to contact the social service agencies in these kind of matters), and drug abusers with psychiatric disorders (development of new treatment interventions). However, these needs have not been assessed in any more qualified sense of the word. As a product from an

[71] The search for documents has been restricted to the last decade, and hence any document before 1990 has not been considered for inclusion here. However, the presentation of the selected documents does not mean, that they de facto contain relevant data on treatment and support needs - it is only an ambition that has been identified.

[72] Offensiv Narkomanvård

73 Although it is not clear in all cases if this type of indication takes its point of departure in the needs of these specific clients.

organisation within the state bureaucracy, rather than a scientific one, there is no discussion of how the presented state of affairs has been established.

The report concludes as follows:

- It cannot be decided whether or not the official goal of establishing contact with all drug abusers has been reached.
- The goal of testing all drug abusers for HIV-infection has been reached. It is estimated that 90-95 percent of all injecting drug abusers have been tested.
- It is concluded that all drug abusers that are interacting with the social service agencies should also be offered treatment and care.
- The effects of the different treatment alternatives within the drug treatment sector are, by and large, totally unknown.

### A balanced system for the treatment of substance abusers

Another report from the National Board of Health and Welfare (without year) aims to estimate to what extent the *relative balance between in-patient and out-patient treatment* is in tune with the needs of the substance abusers in Swedish society. However, there is no assessment of such needs, or any discussion of how such needs can be operationalised for empirical studies. The report contains some information on the methodological procedures applied:

- A charting of the out-patient resources in all of the municipalities of Sweden.
- A listing of the inputs and expenditures on different types of treatment interventions in a sample of 50 municipalities.
- Social service agency records in three municipalities were scanned for information concerning the type and amount of treatment that had been distributed to ”heavy substance abusers” in 1992 and in 1996.
- Structured interviews with senior officials within the substance abuse sector in three municipalities, aiming at a description of working methods and organisational aspects of the substance abuse treatment in these communities.

The report concludes that there has not been any general reduction of the treatment resources for substance abuse treatment and no obvious decline in the amount of inpatient treatment for ”heavy substance abusers”. Although these conclusions are reasonably supported by data, they are, by and large, unrelated to the issue that was stated as the main objective for the study, i.e. to analyse and judge to what extent the supply of out-patient treatment can be regarded as ”balanced” with respect to the supply of in-patient treatment. Such a judgement must involve a more elaborated perspective on treatment needs than what de facto is presented in the report.

Another serious drawback with respect to the identification of treatment and support needs is the *absence of more specific information on the needs of drug abusers and drug abuse treatment*. As often is the case in the Swedish context, there are no indications for how interventions for drug problems can be distinguished from interventions for alcohol problems (see Bergmark 1998).

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# 2.10. Switzerland[74]

## 2.10.1. Current Development Trends: Consumers, Substances, Forms of Consumption

The surveying of treatment needs cannot be considered separately from the current developments concerning trend substances and forms of consumption. For this reason a brief overview will be made of the developments in Switzerland:

According to information supplied by the Swiss Federal Statistical Office for the year 1999, there still continues to be an increase in the number of persons between the ages of 15 and 39 who have experience of illegal drugs, in particular soft ones. The largest proportion of this growth is made up of 20 to 24-year-old men (Federal Statistical Office 1999).

The number of consumers of hard drugs appears to have stabilised in the 90s. Official estimates assume that between 25,000 and 40,000 persons consume at least once a week cocaine, heroin or other opiates. A more or less close contact exists with about 23,000 to 25,000 persons[75]. However, the hidden population should not be overlooked: Estermann (2000) estimates this to include another 20,000 to 30,000 persons who are neither registered by the police nor require medical treatment.

*Ecstasy* is mostly attractive to younger people. According to a survey conducted in 1998[76], around 5 percent of the 15 to 30-year-old persons in Switzerland have corresponding experience of consumption. The majority of the ecstasy consumers (65%) swallow their pills at rave parties; the proportion of those who also consume the drug at home, however, has doubled in recent years. Usually ecstasy is consumed or sold together with cannabis derivatives or amphetamines. On the basis of the statistically recorded ecstasy seizures during the past nine years, however, it can be observed that the number of seizures has clearly declined since 1998 (15% in comparison to 1997), whereby this development appears to be sustained (Federal Office for Police, 1999). There are various indications that, at the time of the public discussions on party drugs and the first police

[74] Based on text prepared by Ulrich Simmel, Schweizerische Koordinationsstelle für stationäre Therapieangebote im Drogenbereich (KOSTE), Bern, Switzerland, 2000.

[75] In all of Switzerland there are approx. 2,000 persons in withdrawal and rehabilitation treatment, almost 19,000 in substitution treatment with methadone, around 1,000 in heroin-supported treatment; in addition there are clients in out-patient counselling centres as well as persons who are being treated by services not recorded by official statistics.

[76] Conducted by the Schweizerische Fachstelle für Alkohol- und andere Drogenprobleme.

operations in the raver scene during the mid-1990s, the attractiveness of these drugs began to wane, particularly for young people (Estermann, 2000).

Recently, services close to the scene have been increasingly reporting that neither the consumers themselves nor even the employees know which substances in which doses are currently on the market and being consumed. The *substances and substance combinations* which are offered and consumed appear to change from day to day.

## 2.10.2. Statistics, Monitoring, Evaluations, Registration Procedures[77]

### Clarifying needs and evaluation

Epidemiological, medical, social, police and legal aspects of the drug problem are the subject of extensive research work and various systematic data collections. In addition, diverse activities and programmes are being systematically evaluated. Numerous evaluations ranging from system to project level provide, amongst other things, indications of the adequacy of the treatment services and substantially contribute to a development of services which meet needs[78]. At federal level interventions are evaluated almost without exception. The government's so-called "Drug Measures Packet" (MaPaDro), which is under the overall management of the Swiss Federal Office of Public Health (BAG), is also evaluated along with the individual projects which are supported within the framework of the MaPaDro. These evaluations are valuable indicators of the effectiveness and the efficiency of the individual interventions and services, and can be used at different levels.

In Switzerland the operation of addiction care services is generally subject to approval mostly from the cantons (and mostly requiring public money for the later operation). Although formal and legal preconditions vary considerably from canton to canton, it has recently become practice that, when requesting approval for new addiction care projects, the services and authorities approached must be provided with a relevant needs declaration.

In questions of service planning as a reaction to established or assumed needs, addiction research plays a significant role in providing a basis for decision-making. At national level the Federal Office of Public Health systematically sup-

[77] In the following chapter the national level forms the focus of attention. The numerous statistics, monitoring, studies and evaluations at canton, local and actual project level which are also available go far beyond the scope of this report.

[78] e.g. Nydegger et al. 2000 for the use of low-threshold drug work using the city of Zurich as an example, or the evaluation of drop-in centres in Basel.

ports and funds addiction research. Roughly categorised, the projects in the following fields are supported: aetiology, epidemiology, intervention research (e.g., prevention, and treatment approaches and their comparison, courses) and society-related research (e.g., effect of scenes on the immediate environment, cost of drug consumption, jurisdiction and legislation, drug policies), substance research and evaluation research[79].

Specialised statistics have been operational in the various areas of addiction care for some considerable time:

- SAMBAD (Statistics for out-patient treatment and care in the field of alcohol and drugs ) for out-patient services
- METHADON (national methadone statistics)
- FOS (Forschungsverbund stationäre Suchttherapie) [Research Organisation for In-patient Addiction Therapy]) for in-patient services

These nationally applied statistics as a whole serve in the evaluation of need developments within the addiction system. As an overall view, they serve in quantitative terms more as instruments for service planning, but can certainly also be considered as quality-promoting elements as a part of individual feedback in projects.

The following observations are limited to the field of illegal drugs. For the sake of completeness, we would also like to refer to SAKRAM/CIRSA[80], the statistics for the in-patient therapy services in the field of alcohol. There are still no statistics for low-threshold services. In heroin-supported treatment, although certain data is continually collected, evaluations have occurred until now only within the framework of individual research commissions. The consolidation and further development of the existing data surveys forms, however, the focus of current research efforts (see also chapter: Prof. Standards).

Thus, the "national data situation" regarding the various service segments appears to be a good. Nevertheless, despite manifest, often serious drug problems and accompanying symptoms, many people do not make contact with treatment services, and either do not want to or cannot seek professional counselling. Consequently, it is not possible to draw any direct conclusions from the treatment statistics in terms of the actual frequency of this problem.

[79] According to the BAG, the following have become established as centres of expertise: the Addiction Research Institute (ISF) in Zurich with an emphasis on intervention research, the Schweizerische Fachstelle für Alkohol- und andere Drogenprobleme (SFA) in Lausanne with an emphasis on epidemiological and aetiological research, and the Institute for Social and Preventative Medicine of the University of Lausanne with an emphasis on the global evaluation of the government's packet of measures in the field of illegal drugs and Aids.

[80] Schweizerische Arbeitsgemeinschaft der Kliniken und Rehabilitationszentren für Alkohol- und Medikamentenabhängige/ Conférence des Institutions Romandes Spécialisées en Alcoologie.

### Statistics for out-patient treatment and care in the alcohol and drug field (SAMBAD)

SAMBAD is based on a complete survey. Those questioned include institutions for out-patient care and the treatment of alcohol and drug patients. Recorded, however, are not clients but consultations (therapies, care). Clients who are counselled simultaneously at several locations are correspondingly recorded several times. Since 1994, and from 1995 at monthly intervals, the out-patient counselling centres record, at the beginning and end of the treatment, data on tasks, structures, numbers employed, the health condition and social-demographic characteristics of the clients, implemented measures as well as problems caused by addictive substances, i.e., data about their work in counselling, care and treatment. With SAMBAD several aims are pursued:

- improvements in the amount of information on the consumption of legal and illegal drugs in order to better understand problems and to find suitable alternatives for solutions;
- preparation of principles for specific improvements in the services, whereby existing services are also surveyed along with the demand;
- simplification of the documentation of the individual centres' work;
- stimulation of the professional discussion through the continual observation of counselling practice.

The data is processed by the Federal Statistical Office (BfS) in collaboration with the BAG and the Schweizerische Fachstelle für Alkohol- und andere Drogenprobleme [Swiss Institute for the Prevention of Alcohol and Drug Problems (SFA)] to produce statistics for entire Switzerland which are published by the BfS (Federal Statistical Office 1998).

### National methadone statistics

In 1999, almost 19,000 persons throughout Switzerland were undergoing substitution treatment with methadone. Substitution treatment is subject to the cantons' approval and registration requirements, whereby the modalities differ from each other. Until now the treatments were evaluated at the level of the cantons. At the moment national methadone statistics are being established. The canton data are coded and brought together centrally in the new all-Switzerland statistics in collaboration with canton doctors (approval bodies) and the Federal Office of Public Health. These statistics are in turn intended to flow into the more comprehensive project "act-Info" which is described below. These national methadone statistics create the necessary preconditions for a systematic survey and documentation of the medical and psycho-socially relevant data. For this purpose a questionnaire has been developed which is filled in by the doctors carrying out

the treatment. Corresponding administration software is available for electronically recording data, (Küenzi, 2000). The aims of the methadone statistics are:

- the demographic description of the clients and their consumption habits
- the recording and analysis of the course dates in the medical and psychosocial fields so as to be able to make use of a solid database when decisions need to be made in connection with methadone treatments
- to generate additional knowledge about beneficial and/or restricting factors influencing the methadone treatment.

### Forschungsverbund stationäre Suchttherapie [Research Organisation for Out-patient Addiction Therapy (FOS)]

Since 1995 the *Forschungsverbund stationäre Suchttherapie* has been conducting a continuous annual documentation providing blanket coverage of clients in in-patient treatment in Switzerland. The collected data are processed and published in German and French in the annually appearing "Progress Report with Annual Statistics". The central aims are:

- to collect and make available client data for in-patient therapy
- to contribute to the development of a practice-near evaluation of courses of in-patient therapy
- to contribute to the improvement in the quality of therapeutic services.

### act-Info

The statistics mentioned above form the basis of future confederate addiction care statistics. The aim of act-Info is to harmonise these nationally applied statistics and at the same time to make them compatible with instruments used internationally.

For this reason, since May 1999 the previous statistics have been undergoing an intensive revision process. Representatives from the Federal Office of Public Health and the Federal Statistical Office, from the cantons, research institutes, specialist centres, umbrella and professional organisations, as well as practitioners active in addiction therapy and counselling, have been integrated within the project. The intention is to create modular statistics using a modern information network that, based on internet technology, provides analyses which embrace all professions and are internationally comparable.

The main aims of the act-info project are to simplify data collection, to enable easy and rapid use of the evaluations by the "data providers" themselves, as well as to achieve international compatibility. "Act-Info", the information network on addiction care and therapy in Switzerland, is intended to enter the pilot phase in

the year 2001, and in 2002 definitively integrate and replace the current addiction care statistics mentioned above, FOS, SAMBAD, METHADON and SAKRAM/CIRSA, as well as statistics on heroin-supported treatment (HeGeBe).

## 2.10.3. Inclusion of the Needs of Different Client Groups

Wettach (Wettach et al 1997, 94ff) still came to the conclusion in 1997 that no validated instruments for measuring the *satisfaction of clients* were available. If the emphasis is on the aspect "validate", then this conclusion is probably still accurate today.

There are, however, a series of approaches which both ascertain the satisfaction of the clients as well as illustrate the *complexity of the client relationships*. Addiction work has overcome the strong focus on those undergoing therapy as clients of the facilities and has become much more differentiated in its inclusion of various client categories in making management decisions; an effect which had ceased in the course of the professionalisation of addiction care.

This can be illustrated by the example of an in-patient therapeutic facility (Casa Fidelio) which differentiates between 14 different client groups: those directly affected; fund-raisers and providers; referral authorities; operation; quality management, expert committees; research; institutional networks; approval/recognition authorities; public; prevention; social environment, competition (establishments with the same target groups); building industry (for a detailed list of the clients see 4.4.1). On the basis of this rough categorisation it is clear that surveying the employees of a treatment service as to their satisfaction with all aspects of the contractual relationship must be, along with the satisfaction of those undergoing therapy, an integral part of the quality management system.

In the federal state system in Switzerland, where administrative powers partly extend as far as district level, a *consensual-participative approach* has become established practice *for political projects which include private organisations*. This is not only usual with, for example, drug policy decision-making or legislative plans, but also when establishing treatment needs and/or in the planning and implementation of the resulting projects.

Both *specialist and professional organisations* and *parent/relative organisations* are kept informed at national and regional level about intended plans, are asked for their opinion, and where possible are included in the preparation and implementation.

Other sources of information on the adequacy of addiction care are *surveys of inhabitants, local businesses and police authorities* (e.g., patrol police).

## 2.10.4. Target Groups with Special Treatment Needs

### Drug addicts in the penal system

Whilst the interplay of prevention, repression, survival help and therapy is substantially established outside of prisons under the title of the Four Column Model (cf. Ethics Chapter), corresponding approaches within the prisons continue to be the subject of controversial debate. This is despite the knowledge that many imprisoned drug addicts also consume drugs during imprisonment – mostly under highly problematic conditions with correspondingly negative effects on health. The most important health risks occur in the strongly fluctuating and unknown dosage of substances (degree of purity), in the increased risk of infection from HIV and hepatitis caused by the exchange of used needles, as well as - in almost every respect treated as taboo - through forced homosexual practices (amongst others as a means of payment for drugs). An effective infection prophylactic in the penal system is enormously important in terms of health policy. Corresponding measures have been tested within the framework of several model and pilot projects, e.g., a needle exchange programme in the Hindelbank Women's Penal Institution, a prevention programme in the Realta Men's Penal Institution or a project for heroin-supported treatment in the men's penal institution in Oberschöngrün. (cf. chapter on Prof. Standards).

### Drug addicted parents and their children

Many addiction care services do not have suitable structures to care for parents together with their children. Whilst this does not appear to be necessary for outpatient services, for in-patient admissions together with children there is an urgent need for *infrastructures suitable for children*, *expert advice* concerning possible psychological or physical damage, and *professional child care*.

The correct care and treatment of family systems is in many aspects expensive and cost-intensive, whereby cost-covering *financing of the children's joint residency* is by no means secure, and many in-patient establishments cannot or do not wish to set about procuring additional financial means. There is a need here for cost-effective financing. The funding bodies must be made aware of the importance of professional early treatment and care.

Interested institutions - particularly referral authorities - should be provided with check lists from qualified institutions of *points which need to considered or guaranteed for the correct admission of children* (for instance, which formal precautions must an institution make if one of the parents abruptly leaves, leaving behind the child).

Professionals report on the frequently expressed *fear of parents that the custody of their children will be removed from them*. They therefore conceal their parental role from the care persons or avoid direct contact with professional care structures. With this aspect in mind it needs to be examined as to what proportion of the hidden population consists of mothers and fathers.

### Pregnant drug-addicted women

The most important task is to first of all motivate pregnant women to make contact for (medical) treatment to ensure that they receive the necessary health treatment and pregnancy counselling. It is very much in the interest of health policy that contact is maintained for the purposes of providing infant advice (questions on breast-feeding, general hygiene and nutritional advice, etc.). Here, the extent to which pregnant women belong to the hidden population equally unknown since, for reasons already described above, they avoid contact with professional care services.

### Gender-specific addiction work

The consideration of women-specific needs in addiction care has not only a long tradition in Switzerland but continues to provide current knowledge and information for governing action (e.g. Ernst 2000). In contrast, approaches specific to men can only be described as being almost non-existent. There is obviously a need here to catch up.

### Persons with dual diagnoses[81]

Besides specialised departments in psychiatric hospitals there is also a need for in-patient places outside of psychiatric institutions, whether this is in order to be able to offer increasingly open structures in the course of rehabilitation or for persons capable of living from the beginning in open structures, when given suitable treatment and care. For all service segments which treat dual diagnosis clients, it is considered to be an essential requirement that there is close co-operation with the psychiatrist conducting the treatment as well as agreed and well rehearsed crisis intervention measures.

### Persons with experience of migration

Persons with experience of migration have only recently been made a specific target group. Amongst other things this could be connected to the fact that migrants of the second or third generation are also becoming qualified professionals in addiction care and are therefore correspondingly sensitive to this theme.

[81] Persons who, besides an addiction illness, exhibit at least one other clinical picture diagnosed as psychiatric.

Besides the problem of linguistic communication, these persons and their family environment generally comprehend and deal differently with care "outside of the family". As a consequence, this problem cannot be overcome just by using "interpreting work" but requires culturally-specific "translation work". Depending upon the original culture, it is often above all young women who are prevented by their families from seeking help and support outside of their family system. Particular attention needs to be paid to this situation when conceiving corresponding services.

Within the Federal Office of Public Health a "Migration Service" has been founded that, for example, reappraises drugs and HIV preventative campaigns for specific ethnic groups. Further knowledge is provided by various studies on the theme (e.g., Domenig 2000), whereby on the whole still very few specific research findings have been generated.

### Youth drug consumers and "scene gang members"

With youths the biggest problem is reaching this group. A promising method in registering the needs of this target group is by using anonymous surveys within the framework of general preventative activities and events (questionnaires), and by means of specific interviews with "opinion leaders", e.g., by leaders of youth clubs.

Finally, indications for the suitable organisation of an addiction care system can also be gained from studies on the social functions of a "scene" for the "scene gang members".

## 2.10.5. The Hidden Population

Altogether there are very few studies available in Switzerland which provide research on the hidden population (such as, for example, Kübler & Hausser, 1996 and Estermann, 1996). Little information is available about the *type and extent of consumption amongst socially well integrated groups of people or certain types of professions* (e.g., with so-called "stress jobs" or occupational groups with professional access to substances).

When researching the hidden population the *questions* which stand to the fore are those concerning their characteristics, the socio-demographic differences between the "hidden" and the "registered" populations, or between various groups within the hidden population. Of further interest are the differences between the substances consumed, the type and frequency of the consumption (in particular with respect to health hazards) as well as the general life conditions and the social situation.

Keble & Hawser (1996) have tested various *methods for identifying hidden populations* and have come to the conclusion that the most suitable method of surveying is to use "privileged access interviewers". Here persons who have privileged access to the population under examination are trained as interviewers and are then employed. This could be social workers, "street priests" or even the drug consumers themselves: however, the authors point out the enormous amount of time needed to establish such a network of "privileged access interviewers".

A *general methodical problem* when trying to define the hidden population in epidemiological terms is caused by the permanent fluctuation between occasional consumption, phases of serious addiction, abstinent phases, phases when there is a shift to other things, e.g., legal substances, etc.

## 2.10.6. Referral of Clients to Suitable Treatment Services

In Switzerland the affected persons generally decide first of all for themselves as to whether and when they wish to make contact for treatment and as to the type of treatment. Coercive treatments are not usual and require clear legal preconditions. Exceptions which can be named here include visiting scene and "street" operating care services or the out-patient and in-patient treatments ordered by the judiciary within the framework of legal measures. To be mentioned are also mention the activities of special urban centers for the assessment and repatriation of drug dependents who have been arrested by police and who are examined there and transferred into medical or psychiatric treatment if needed.

The out-patient counselling centres have an important indication function. They are given the sometimes difficult task of referring the clients to the "right" form of treatment. The more transparent the services of the various providers are described, the simpler it ought to be to correctly refer them.

Problematic has proven to be the type of financing for a treatment, which can be considerably different depending on the segment. For instance, part of the services are (at least part) financed through the national health insurance scheme, other services have to be financed by the welfare authorities of the district where the client is resident. Under Swiss law, under certain conditions these welfare payments can be demanded back from those concerned or their relatives, which can have a negative influence on the motivation to make contact for treatment financed in this way.

Another problem whose effect is hard to estimate results from the "service agreements" between the cantons and/or municipalities (responsible for addition

care) and the addiction care services (service providers). The providers must fulfil the negotiated service agreements in order not to risk their financial resources being cut (or the adjustment of the service agreement downwards). Here dangers exist of which there has been very little public discussion, namely artificial increases in quantity and/or treatment contacts which are continued longer than necessary, or the quantitative limitation of referrals for a certain type of treatment which is oriented to budget requirements rather than to expert criteria.

A unified service description for in-patient drug therapies combined with service-related financing is currently being prepared (for a detailed explanation see chapter: Cost-Effectiveness). The suggested differentiated service description according to socialisation and/or work areas has made the therapy services much more transparent, both for persons seeking therapy and for authorities responsible for referrals, by acting as an indication aid (for what sort of clients with what sort of emphasis is the facility suitable?).

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# 3. Summary and Discussion

The contents of the individual country reports vary considerably from each other. On one hand this can be attributed to the different social and social-political developments as well as to different research traditions. On the other hand, this is also a consequence of the concentration on the term "need", which has both an objective as well as a subjective aspect[82], whereby the subject area is very complex. This complexity is, however, a necessary consequence of the intention to have the quality of a service assessed by its users.

In the introduction the various service recipients and/or stake holders of the addiction care systems are named whose needs are intended to be taken into consideration in assessing the adequacy. In the country reports, however, with a few exceptions almost only the needs of drug abusers as well as procedures and instruments for their investigation have been reported. In addition, the objective need tends to stand to the forefront, whilst subjective needs (or needs from the drug abusers point of view) and their fulfilment have only been given partial consideration.

Because of these different social and political developments, needs are defined and weighted differently, which is reflected in the reports. For instance, it is reported from Sweden that the question of needs of drug abusers is not on the Swedish agenda at all. The basic need of the drug abuser is considered to be the need for treatment, and the existence of coercive treatment is to secure the provision of that basic need. In contrast, in Spain objective medical needs form the centre of interest. The needs formulated by the drug abusers themselves play a greater role within the framework of quality management, as is similarly described in the Dutch country report. Finally, national differences exist in the research tradition which likewise contribute to different methodical approaches.

Despite or rather because of their differences, the reports form a suitable basis in order to illustrate a broad spectrum of approaches in the field of needs assessment, as shall be shown in the following overview of European approaches in the assessment of needs. This is followed by a summary of the met and unmet needs of drug abusers in Europe based on the country reports. The following section (Materials) documents possible assessment procedures, available instruments as well as other practical references.

[82] A need " is a state of urgently requiring something, the feeling of the lack of something" (cf. Oxford English Dictionary).

# 3.1. Approaches in the Assessment of Met and Unmet Needs in Addiction Treatment and Care

## 3.1.1. Empirical investigation of the needs from the drug abusers perspective

No systematic investigations are being conducted for the prospective[83] assessment of needs from the drug abusers perspective. Relevant studies are reported, however, by Poland, the Netherlands and Greece:

In Poland several studies on treatment and support needs have been conducted, mostly in connection with the implementation of relevant programmes in local communities. Within a comprehensive action-research project, a series of interviews with local addicts was conducted in order to collect information to be applied in the formulation of the programme of action as well as in its evaluation. The interviews were focused on the history of the drug use, the current life situation, the health status, and on expectations with regard to different forms of assistance. Findings indicate that there is a variation in the needs of different groups of addicts and suggest the necessity of undertaking needs assessment studies in order to identify and respect local specificity.

In the Netherlands qualitative interviews about help-seeking and barriers in the process of asking for professional help were carried out within the framework of a comparative study on drug abusers in and outside of the treatment system[84].

In Greece a study has been conducted on the attitude of users, ex-users and professionals towards the medical prescription of dependency-forming drugs which examines the adequacy of the legal measures in meeting the needs of those affected. Of interest are the different attitudes of users and ex-users as well as the different views of the users themselves.

In conclusion it can be established that the assessment of needs from the drug abusers perspective ('subjective needs') can be combined with the assessment of objective characteristics of drug abusers in and outside of the treatment system, and that attention should be paid to regional as well as group-specific differences.

As an alternative and/or addition to the empirical assessment of the needs of those affected, the needs of drug abusers as well as of their parents and relatives in Denmark, for instance, are taken into consideration by enabling self-help

[83] As distinct from the retrospective investigation of clients' satisfaction with a service received.
[84] See Dutch report, Eland-Goossensen, 1997.

groups of relatives and of drug consumers to be represented on the Danish Narcotics Council (a committee which advises the government). Such an approach is no replacement, however, for empirical studies and precludes the existence of well functioning self-help groups and other interest groups.

Switzerland reports on a consensual-participative approach embodied in the political system for political projects, whereby specialist and professional organisations and parent/relative organisations are traditionally involved in the preparation of drug policy decisions and legislative plans, as well as in the establishment of treatment needs, planning and implementation.

### 3.1.2. Empirical investigation of the needs of drug abusers based on epidemiological data

*Epidemiological studies* aim to assess rates of drug abuse in the population to show quantitative and qualitative changes in patterns of use and abuse. These enable general demands on the care system to be determined. In particular, great importance is attached in the Greek and Spanish country reports to epidemiological research at national and regional level.

Using t*reatment monitoring systems,* selected characteristics of clients who turn to treatment and care facilities can be systematically assessed. Such procedures are reported in some considerable detail by Germany, Switzerland, Greece and the Netherlands. In particular, the Netherlands and Switzerland report various monitoring systems which, beyond the assessment of the client profiles, also enable outcome evaluations to be made, while Germany above all points out the limitations in this regard. In Greece a treatment demand reporting system based on the "First Treatment Demand Form" (Group Pompidou) is co-ordinated by the Greek Focal Point. Participating treatment centres periodically receive both a specific and a general overview of the clients' population, with the possibility of adjusting their activities to respond better to the clients' needs. Frequently, different monitoring systems are implemented for the out-patient, in-patient and substitution treatment. To some extent the same systems are used by services in the fields of illegal and legal substances. The need for a harmonisation of the systems is mentioned on various occasions in order to make better use of it as a planning instrument (in Switzerland the harmonisation project "act-info" is currently under way).

Finally, the needs of drug abusers are being assessed within the framework of *studies on the characteristics of specific target and risk groups*. The Greek report mentions several studies focused on special groups of clients. An extensive study was carried out on the "dance scene" aimed at assessing new patterns of drug use. In Spain specific research is being conducted on high-risk drug users,

especially those in prisons, pregnant drug users, as well as drug-abusing doctors. In Sweden young drug abusers, female drug abusers, immigrants with drug problems, drug abusers with psychiatric disorders and HIV-infected drug abusers have been identified as subgroups with specific needs.

In conclusion it can be established that "objective needs" basically correspond to the characteristics of drug abusers as well as to their number and consumption patterns from which the "needs" are then determined by experts. Epidemiological studies form an important basis for the regional and national planning of the care system. They are only suitable, however, for determining general requirements (for the reasons, see 4.2.2, General Population Surveys). Furthermore, there is a tendency to focus on the need for medical treatment. A similar situation occurs with the monitoring systems, whereby these in addition are limited to the assessment of selected characteristics of *clients wanting treatment*. In contrast, studies on specific target groups enable a more detailed examination to be made of personally related characteristics as well as of the life situation, from which a specific "support need" can be determined.

### 3.1.3. Assessing the satisfaction of clients

In the Netherlands the assessment of client satisfaction is used as an important instrument for quality improvement at the Jellinek centre. On this basis an evaluation of care by clients has been carried out, which included 2000 clients and ex-clients of 16 institutions. In Italy the use of a self-conducted questionnaire on client satisfaction, combined with EuropASI, is (or will be) mandatory for all public services in the Emilia Romagna Regione. In the Czech Republic the satisfaction of clients and their relatives used to be assessed individually and rather informally during counselling sessions and house meetings. In low-threshold services the assessment is combined with a general service evaluation by clients (e.g., frequency of use of certain services). A structured questionnaire has now been developed which is based on EuropASI and client satisfaction questionnaires. Its use is suggested to all treatment and care institutions, and periodical assessments are planned. Greece is currently conducting a satisfaction evaluation within KETHEA. In Germany a variety of scales/ questionnaires have been developed in order to assess client satisfaction within the framework of regional quality assurance projects. No client satisfaction assessments are reported from Denmark, Poland, Spain and Sweden.

In satisfaction assessments it is exclusively enquired about the fulfilment of subjective needs. The are normally conducted retrospectively which is why it is too late for a correction in the case of non-fulfilled needs. Satisfaction assessments should therefore be supplemented with a prospective assessment of the subjec-

tive needs at the level of the individual client as well as of specific groups of drug abusers. Satisfaction assessments are primarily used for for the evaluation of individual institutions; they could be used, however in reference to the entire care system.

## 3.1.4. Comprehensive assessment of service adequacy

### Expert committees

From the Czech Republic, Poland and Sweden are reports on the comprehensive assessment of the treatment systems where the needs of drug abusers are defined by experts, and from this the type and extent of the service determined (service planning) and/ or the adequacy of the service evaluated (adequacy assessment). The experts can make use of sound analyses from numerous sources or general professional experience with drug abusers.

Within the framework of a Czech study on needs planning (2.1.2), the general needs of clients was defined by a group of specialists based on their experience. In Poland an expert team defined the minimal standards in terms of necessary services and the minimum number of treatment and care places. And within the framework of the National Programme for Counter-Acting Drug Abuse, the current situation of the addiction care system was assessed by a large expert committee with the aim of defining political strategies and development objectives for addiction care (services for specific target groups, risk groups, hidden populations). Another report on the current status of drug treatment in Poland was drafted by a team of six experts and was based on a variety of data. Finally, Sweden mentions an administrative report identifying the needs of different subgroups of clients, whereby an empirical basis of the identified needs is not known.

The empirical basis of the expert work varies considerably. The approach is suitable for a rapid and comprehensive, but rather general assessment of the adequacy. It does not allow, however, for a systematic determination of the changes.

### Programme evaluations

An important role for adequacy assessments is also played by comprehensive programme evaluations. In Switzerland the "Governmental Package of Measures to Reduce Drug Problems" is evaluated as a whole just as are projects which are supported within this framework. Evaluations extending from the system to the project level provide, amongst other things, information about the adequacy of

treatment services and substantially contribute to a need-oriented development of these services.

**Indicators for services meeting the needs of drug abusers**

Such a project is only reported by Denmark. In order to be able to assess the extent to which the support services in the counties and municipalities match the needs, the counties and municipalities were first of all asked to assess the number of drug abusers "in need of treatment or social assistance". General indicators for the adequacy of the system were then defined which had to be assessed by the municipalities and regions[85]. Such a procedure enables a rapid as well as regular assessment of the adequacy of the services for the needs (and other quality criteria). However, by these means it can only be examined as to whether the service matches a general need. Unfulfilled needs specific to a place or target group are in this way hardly apparent.

## 3.1.5. Inventory of treatment and care services offered

An inventory of the services is important if the adequacy assessment is not directly made on unmet needs (e.g. waiting lists) but is rather a comparison of needs and services. In the Czech Republic a questionnaire has been constructed to assess the type of services offered, their capacity, target groups and the cooperation between services. The outcome is an institutions map. In the future, this questionnaire will be used as a basis for an "Address Book" of existing services for drug users. In Sweden, besides a comprehensive listing of all out-patient services, the expenditure of districts for various types of treatment as well as a description of methods and organisational aspects has been collated.

If the extent and type of the support needs are to be comprehensively investigated, then the results must be compared with equally detailed service documentation so that inadequate services as well as under- and over-provision can be determined.

## 3.1.6. Detection of new development trends

Client monitoring systems such as described above are only of limited suitability for the early recognition of new trends (in terms of consumer groups, substances, forms of consumption, etc.). This is important, however, in order to recognise new

[85] e.g., number of individual "plans of action"; number of drug addicts in treatment and referred to treatment; treatment capacity (treatment slots and financial resources); treatment slots for special groups of clients; waiting lists and waiting time, etc.

needs early on and to be able to react with preventative and supportive measures.

The Netherlands reports on comprehensive foresighted systems, the so-called regional drug monitors. These serve as a basis for the early development and/or adaptation of prevention, care and treatment services, taking into consideration specific regional aspects. In doing so various information sources and analytic methods are combined. Greece reports on an early warning system for new synthetic drugs, which has been developed in collaboration with the EMCDDA and the Europol. A network of treatment centres and other institutions has been created to monitor new synthetic drugs, as well as new patterns of use for drugs already known. And, based on the Spanish State Information System on Drug Abuse (SEIT), a sharp increase in cocaine-related emergency room episodes, mortality, and demand in treatment could be observed in some Spanish cities.

In order that trends can be recognised before they become a mass phenomenon, it is insufficient just to use information on clients who turn to treatment establishments. This must be combined with other information sources outside of the treatment sector (e.g. key-informants from the social world of trend setters).

### 3.1.7. Assessing the needs of the hidden population

Hidden populations are distinguished in that they do not turn to establishments for addiction care, which is why their needs to do not manifest themselves in surveys. In order to investigate their unmet subjective needs, they must be first of all recognised and subsequently interviewed.

In Greece, information on the characteristics of hidden populations is gained through *low-threshold services*, including street work and users trained as street workers. For this purpose, several questionnaires have been developed to monitor users' characteristics. Similarly, Sweden provides some anecdotal information concerning a syringe exchange programme where clients can remain anonymous.

In Poland a study was carried out on the needs of hidden populations. 47 addicts were recruited in a *snowball sampling procedure* and then interviewed. The results include some interesting information on fears and unmet needs of the hidden population. In the Netherlands the needs of drug abusers in and outside of treatment have been compared in a comprehensive study, whereby the hidden population was also recruited by snowball sampling.

In a Swiss study the surveying of members of hidden populations through interviewers with privileged access to the population of interest (e.g. street workers, drug abusers) proved to be particularly suitable, whereby persons who have

privileged access to the populations being examined are trained as interviewers and then employed. However, considerable time is required for the establishment of such networks.

Poland, Denmark, Spain and the Netherlands also report on studies for assessing the size of the hidden population. Here, the Capture-Recapture technique is particularly significant. It is pointed out, however, that it is important to combine several methods. In Denmark it was investigated, in cases of deaths caused by drugs, how many people at the time of the death were not undergoing treatment and/or were not known by the treatment system. Italy, Sweden and the Czech Republic report that no studies on the hidden populations and their needs are known of.

### 3.1.8. Needs of professionals, relatives of drug addicts, and local communities

The treatment system must not only meet the needs of the drug abusers but also take into consideration the demands of other participants. In the introduction the various beneficiaries of the treatment and care system are named whose needs should be considered in an adequacy assessment. The country reports, however, report almost exclusively on the needs of drug abusers - with only a few exceptions:

The Netherlands reports on the use of a questionnaire (BASAM) to assess the satisfaction of staff. This questionnaire is systematically used by the Jellinek Centre. In the Czech Republic the staff satisfaction is investigated within the framework of external supervision, whereby it is regretted, however, that there is a lack of supervisors. Greece is currently conducting a staff satisfaction evaluation within KETHEA. In Denmark a self-help group consisting of relatives of drug addicts serves on the National Narcotic Council. There are no reports on studies on the needs of professional employees, relatives or local communities.

Admittedly, it is reported by Switzerland that the strong focus on the clients as clients of the establishments has been overcome and that the client categories which are used in the management decisions, in particular within the framework of quality management systems, are much more differentiated. A list of possible clients is also provided (see 4.4.1). However, there are no reports on corresponding studies and instruments. The surveying of residents, local businesses as well as the police force responsible are named as possibilities.

## 3.2. Met and Unmet Needs of Drug Abusers

The country reports report not just on procedures and instruments but also on investigation results: on needs and characteristics of clients, on hidden populations, development trends as well as on the adequacy of the care system.

Because within the framework of ADAT it is primarily the investigative procedures which are of interest, the countries were not asked to report on unified criteria for quantitative results. Of interest, however, are the needs identified in the regions and the indicators which were thereby used, regardless of their quantitative form.

These results can be drawn upon in different ways as a basis for testing the adequacy of the care system and have therefore been included in a systematic form in the check lists in the Materials section. The following is an overview of the results with a list of references showing which results have been included in which material:

### 3.2.1. Needs of Drug Abusers

General needs of drug addicts were - as is shown in the country reports - mostly formulated by professionals and in particular on the basis of epidemiological results, professional experience and "sound minds". Apart from basic needs such as accommodation, nutrition, friendship, relations and love, the need for specific information as well as social, medical and psychological treatment services are named. An overview of the *services demanded in the various counties*[86] *to satisfy these needs* can be found under 4.6.3.2. (Checklist for recommended services).

In addition, on various occasions the *need for free, rapid and simple access* to treatment and care - in particular for clean injection materials and substitution treatment, especially in prisons - are named. To what extent this need is taken into consideration can be assessed as follows:

- Assessment of the accessibility within the framework of *expert forums* (financial aspects as well as specific criteria and procedures for admission; see 4.6.3.3)
- Assessment of the accessibility of facilities on the basis of *the investigation of characteristics of structural quality*[87] (these are considered within the framework of the professional standards in ADAT Part III)

[86] Taken into additional consideration was "Standards of Care" from the WHO (WHO 1993).

[87] The difference between the official and unofficial admission policy is problematic since the latter, which determines actual practice, is hard to assess.

- Finally, the accessibility can be assessed using the *documentation of waiting times and problematic referrals by referral authorities* (see also 4.6.3).

Finally, a *general need for care and attention, for an individual approach, for support and recognition of individual achievements* is formulated. On the one hand the meeting of these needs is assessed using satisfaction questionnaires for clients (see 4.3.1). On the other hand it can be assisted by drawing up an individual treatment plan with the involvement of the client and through periodically defining the position (see 4.3.3 and 4.6.1).

### Needs according to prevalence rates and clients' characteristics

Needs research is primarily concerned with the investigation of prevalences on the basis of which a need can be identified and quantified. Here it can be differentiated between prevalences among the general population, prevalences among drug users in and outside of treatment, prevalences among clients, and prevalences among special groups of clients or the drug-using prison population.

In Germany a survey and physical examination of 265 homeless men showed a high prevalence rate of psychological and physical illnesses as well as a very low frequency of treatment, which indicates the necessity of improving medical provision in low-threshold services. Furthermore, a progressive study on comorbidity with opiate addicts showed that the (lifetime) prevalence rate in terms of psychological disorders is double to three times as high as in the general population in Germany, whereby the women are clearly affected more severely by comorbidity. This underlines the necessity of integrating specific diagnostic procedures in addiction therapy as well as giving greater consideration to psychological disorders in addiction therapy.

Several indicators and procedures are considered within the framework of epidemiological studies (see 4.2) and monitoring systems (see 4.2.4). Recommendations which have been formulated on the basis of research findings are included in ADA part III on professionalism.

### Needs of specific target groups

In the reports from Denmark, Greece, Poland, Sweden, Spain and Switzerland, specific target groups are identified. This refers to drug abusers for whom the general service for treatment and care is inadequate as a result of specific needs (as a result of special personality characteristics and/or life situations). An adequate care system should provide specific services for these groups.

The specific target groups and their needs, which have been identified in the ADAT country reports (whereby there is considerable conformity between the reports), are summarised in the table in chapter 4.3.5.

### Findings on the hidden population

The term hidden population refers to persons with a drug consumption problem who, for different reasons, do not (or no longer) turn to specific establishments for addiction care and who have also not approached any general institutions belonging to the social and health services in order to be treated or counselled with regards to their drug problem.

On the one hand the *size of the hidden population in relation to the entire population of drug abusers* can be used as an indicator for the adequacy (range) of the care system[88] (for methodological procedures, see 4.2.3). On the other hand, *specific needs or characteristics of hidden populations* can provide information on the adequacy of the care system: In a Dutch study it was found that opiate addicts applying for help in a detox or therapeutic community programme experienced more social and psychological problems than drug abusers outside the treatment system, while psychopathology prevalence was given for the four groups. A Polish study on drug abusers outside of the treatment system shows that the respondents are not willing to undertake treatment either because they do not feel addicted or consider themselves to be too dependant, i.e., as incurable cases. Those who had previous experience with treatment are rather critical, especially with regard to conventional residential detoxification and rehabilitation. The inefficiency of treatment was emphasised. The lack of understanding and respect from personnel was regarded as a factor that reduces their demand for treatment. In the Swiss report it is assumed that both pregnant drug abusers and addicted parents are increasingly belonging to the hidden population because they fear that, if they do make contact with the care system, the right of care or the parental authority could be withdrawn from them. In addition it reports on consumption by socially well integrated groups of people, on so-called "stress professions", and on occupational groups with professional access to the substances.

If use is not made of the services by drug consumers because they have no need for them (nor for other services), then - from their point of view - there is not any inadequacy. If use is not made of the services because they do not meet the need of drug abusers (here: effectiveness of treatment; understanding and respect from personnel; fear of their parental rights being restricted), then this indicates that there is inadequacy. The *investigation of unmet needs in hidden populations* is dealt with under 4.3.4.

[88] In Poland the total number of injecting drug users could have increased from 20-40 thousand to 36-60 thousand in the 1990s, while the recorded number of addicts constitutes between one fourth to one third of their total population. In Denmark it had been found that 74% of 125 drug abusers in Greater Copenhagen who died in the period 1991-1993 were not in treatment at the time of their death. Up to one year before their deaths 62% had received either social or methadone treatment or both.

### New Development Trends

Very little has been reported about new trends in the substances used, patterns of use and related health consequences. Only in Spain has a sharp increase in cocaine-related emergency room episodes and mortality, as well as in treatment demand, been registered recently, which indicates a *need for prevention and treatment for cocaine-related problems*. However, the majority of cocaine users take cocaine sporadically, during the weekend, in moderate amounts, and by intranasal route. It is reported from Switzerland that the increase in persons who have experienced illegal (in particular soft) drugs is greatest under the 20-24-year-old men. Furthermore, in 1998 approximately 5 per cent of those between the ages of 15 and 30 had experience of consuming ecstasy. The majority (65%) swallow their pills at rave parties; the proportion of those who consume drugs at home has, however, doubled in recent years. Finally, it is reported that the substances offered and consumed and the substance combinations change practically every day, and neither the consumers themselves nor the employees of facilities close to the scene know which substances in which combinations are currently on the market.

These trends have been included in the list of specific target groups (see above) as well as in the checklist for recommended services (see 4.6.3.2).

## 3.2.2. Needs of Professionals and System Adequacy

The *needs of professionals* are hardly mentioned in the country reports. Where they are mentioned, these are concerned with a general need at the level of the care system, mostly as a result of a comprehensive assessment by experts. This need[89] will therefore be more closely dealt with in ADAT part III on professionalism.

Denmark in particular mentions various indicators for directly assessing the adequacy of the services to clients needs (see annex II). However, several indicators were able to be inferred from the other country reports. These concern *range*[90]*, accessibility* and the *capacity of the care system* as well as the *integration of various services* (see 4.6.3).

[89] The need essentially covers opportunities for training and further training, finance systems, collaboration between the establishments, service planning, service evaluation, supervision, expert forums, an information bank for treatment and rehabilitation centres, an ombudsman for clients, quality monitoring, and a system of certification for drug services.

[90] The proportion of drug addicts who can be reached with the existing services, differentiated according to treatment and care modalities.

## 3.2.3. Conclusion

As a result of this overview it can be established that when investigating met and unmet needs - in particular at the level of the care system, but also at institutional and individual level as well - the investigation of objective needs using client characteristics stands to the fore. Little attention is paid to the subjective view of drug consumers. Most widespread are retrospective satisfaction assessments at institutional level. However, even such procedures are not reported by all countries.

That knowledge of the subjective needs of drug abusers can be a prerequisite for adequate treatment and care is shown by the example from the Dutch heroin experiment: It was found that the inclusion criteria for the heroin experiment of a 'high dose' of methadone conflict with the interests of methadone patients; from the patients' perspective the two main reasons are: a 'high dose' of methadone blocks the 'kick' of heroin and it is associated with the 'junkie image'. Preference for heroin on prescription is greater among those who appreciate the kick of heroin. These patients tend to have a more negative attitude towards 'high doses' of methadone[91]. Another example is the regionally different preferences of drug abusers concerning treatment modalities which have been determined in Poland.

If drug abusers are to be taken seriously as clientele of the care system, and if the adequacy of the care system for their subjective needs is to be recognised as a criterion of quality, then there is still some development work to be done in this field. That this is possible is shown by the various examples in the Materials section.

Just as little is reported about the hidden populations and their unmet needs. While estimates are available in various countries as to their number, there are very few studies which enquire about their specific needs – and what is more from the point of view of the drug addicts themselves.

Very little is also reported about procedures which directly concern unmet needs (for example, waiting lists or unsuccessful referrals due to lack of places, specific admission criteria, high-threshold admission procedures or regional underprovision).

The same applies for the needs of other stake holders such as, for example, relatives, local communities and professionals. An adequate care system must also investigate their needs and take account of them.

[91] Korf DJ, Nabben T, Letting D, Bouma H (1998). Methadon dosering in Nederland. Een exploratief onderzoek onder verstrekkers en cliënten naar hoge en lage doseringen methadon. Amsterdam, O+S.Lempens A, Barendregt C, Zuidmulder L, Blanken P (1999). Kenmerken Rotterdamse druggebruikers. Enkele resultaten van de survey 'drugs, huisvesting, schulden en gezondheid'. IVO Bulletin, 2(3): 1-20.

# 4. Assessment Procedures and Instruments

The materials section presented here contains procedures, instruments and checklists which can be deployed for assessing the adequacy of treatment and care services for the needs of drug abusers as well as other demand groups. The materials section is substantially based on studies, procedures and instruments presented in the country reports as well as on documents from European and international organisations and other specialist literature. ADAT wishes to provide primarily an overview. It is not possible to go into any detail here as regards individual methods and discussions of content.

The materials section is divided into six chapters:

- First of all an overview is given of several *basic criteria* on the basis of which the presented procedures can be described and classified.
- This is followed by a chapter on *needs-led service planning,* i.e., on the establishment of objective (and in particular subjective) needs for treatment and care services on the basis of the number and characteristics of drug abusers. The emphasis of most of the country reports is on such procedures, which are also the most developed and have been tested many times. Besides estimation procedures, epidemiological studies and client documentation systems, the identification of new development trends is also a major part of needs-led service planning.
- The third chapter deals with the *identification of unmet needs from the drug abusers' perspective*. This is concerned with the adequacy of the services in meeting needs from the point of view of those who are themselves affected. This includes client satisfaction, the inclusion of those affected (drug abusers and their relatives) in the service planning, individual treatment planning, needs of hidden populations as well as specific target groups.
- In the fourth chapter procedures are discussed including how the *needs of other demand groups* can be included in the assessment and improvement of adequacy.
- The fifth chapter is concerned with the *surveying, description and evaluation of the services*. This is a prerequisite for assessing as to whether there is a balanced relationship between service and need.
- Finally the six chapter is devoted to the *comparison of services and needs* at the level of individual clients, establishments and entire treatment regions.

## 4.1. Criteria for the classification of survey procedures

In order that the following depicted procedures can be described and classified, a list is provided here of some of the main characteristics by which the approaches can be differentiated:

| | |
|---|---|
| Knowledge to be gained from the survey | - Subjective needs(from the perspective of the service recipients)<br>- objective treatment need (quantitative/ qualitative)<br>- Adequacy of the system |
| Demand group | - Drug addicts in general (incl. hidden populations)<br>- clients<br>- Relatives/ people close to the drug addicts<br>- Neighbourhood, community<br>- Professional |
| Information sources | - Subjective assessment (opinion of affected persons and experts)<br>- Empirical assessment |
| Level of the survey | - Individual (client; relative; professional)<br>- Institution<br>- Care system |
| Time period | - Retrospective needs survey<br>- current/ prospective needs survey |
| Frequency of the survey | - Periodic survey<br>- Continual survey<br>- Individual studies |

## 4.2. Needs-led service planning on the basis of epidemiological studies

### 4.2.1. Introduction

The adequacy of the treatment and care services of a treatment region can be estimated on the one hand through the comparison of the service and need, and on the other directly through the specific determination of unmet needs. In this chapter the possibilities for empirical surveys and/or the estimation of the quantitative treatment needs (capacity) at the level of the addiction care system will be presented on the basis of epidemiological procedures.

Epidemiological studies collect data on the extent, type and problematic consequences of drug consumption from which the current needs for definite treatment and care services for various target groups in a definite region can be determined. Needs research therefore refers primarily to the surveying of prevalences on the basis of which a need can be identified and quantified, whereby it can be differentiated between *prevalences among the general population* as well as *prevalences among drug users in and outside of treatment* (prevalences among clients in general, among special groups of clients or among the drug using prison population). Accordingly, also of interest is the prevalence of the consumption of illegal psychoactive substances (in the total population) or the prevalence of definite persons and/or consumption-related characteristics (in the case of clients and drug using prisoners; e.g. prevalence of crack use among heroin users; prevalence of routes of administration; prevalences of AIDS, HIV, hepatitis and tuberculosis among the drug-using population - differentiated according to routes of administration, gender, age, and prison history; (see Spain country report).

Epidemiological studies form an important basis for the regional and national planning of a care system. They are most suitable, however, for the determination of general needs and/or demands. Specific needs and, in particular, needs from the perspective of the drug addicts either cannot be surveyed in this way or only to a limited extent.

At European level, the EMCDDA has made great efforts to improve the comparability of a selected set of five key indicators reflecting both the prevalence of drug use and its problematic consequences. The five key indicators are:

- Surveys of the prevalence of drug use in the general population
- Estimates of the prevalence of problematic patterns of drug use
- Demand for treatment for drug problems
- Drug-related deaths and mortality of drug users
- Drug-related infectious diseases

(see: http://www.emcdda.org/activities/epidem.shtml)

With regard to these five indicators it will be shown in the following section how information on the number and characteristics of drug addicts can be gained by using (1) population surveys, (2) different estimation procedures, (3) treatment monitoring and reporting systems as well as 4) mortality and (5) illness survey systems. Finally it will be shown how (6) new development trends in drugs and drug use, which are not recorded by the conventional indicators, can be determined.

## 4.2.2. Assessing the prevalence of drug use in the general population

Population surveys play an important role at local, regional and national level in estimating the prevalence of legal and illegal drug consumption in the entire population or in definite population groups (e.g. school student surveys).

### General Population Surveys

In population surveys a representative sample of persons are interviewed about one or various themes. In surveys which, amongst other things, have the aim of determining the prevalence of legal and illegal drug consumption, various social-demographic characteristics are also surveyed. This thus enables differentiated analyses to be made of the connections between definite behaviour patterns and these characteristics. Using the data gained in this way, it is very easy to calculate the number of persons who consume illegal drugs. Here, drug consumers are also represented in the random sample who do not make use of any treatment services (and therefore belong to the hidden population).

Nevertheless, the deployment of general population surveys for empirically assessing the treatment need can only be recommended to a limited extent for the following reasons see (WHO 1998a):

- The proportion of consumers of, in particular, hard drugs relative to the total population is so small that enormous random samples would be necessary in order to be able to make a differentiated statement on the prevalence of drug consumption as well as on the problems and needs of drug consumers. Large random samples, however, mean higher costs.

- The willingness of respondents in surveys to provide answers on illegal activities is also likely to be rather small. In population surveys the actual substance consumption and related problems are therefore often underreported by as much as 50% to 60% (see WHO - UNDCP - EMCDDA 1999a, p. 8.).
- Important subgroups of the drug abusing population are difficult to reach in population surveys as they cannot easily be located (e.g. homeless people) or are excluded from the sampling procedure (e.g. incarcerated or institutionalised people).
- Results of population surveys can be biased when response rates are lower for particular subgroups (e.g. young persons, non-language assimilated persons).
- In population surveys new substances may simply not be recorded. New trends in drugs and drug use are only identified with the usual monitoring systems after a time lag and are therefore likewise only included in population surveys after a period of delay.

Some of these shortcomings can be lessened using suitable measures. Within the framework of the EMCDDA Project CT.97.EP.09[92], guidelines and a model questionnaire were developed in order to improve the quality and comparability of general population surveys on drugs in the European Union. The final report and the question module (in various languages) can be downloaded from the EMCDDA homepage:

http://www.emcdda.org/activities/epidem_comparability.shtml

### School Surveys

School surveys are frequently conducted to survey the prevalence of drug consumption amongst youths. The Pompidou Group has developed a manual and a standard questionnaire (address: Groupe Pompidou, Conseil de l'Europe, Bâtiment B, F - 67075 STRASBOURG Cedex, Fax: +33 3 88 41 27 85).

School and general population surveys provide a possibility for estimating the type and extent of the consumption of legal and illegal drugs in the entire population. They are primarily suitable as indicators for the development of the consumption habits in a definite region. Moreover, they form a possible basis for the estimation of the quantitative treatment need. However, the need for treatment and care cannot be automatically inferred just based on the extent of the consumption. General population surveys should therefore be supplemented with other procedures.

[92] European Monitoring Centre for Drugs and Drug Addiction. Co-ordination of an expert working group to develop instruments and guidelines to improve quality and comparability of general population surveys on drugs in the EU. Follow up of EMCDDA project CT.96.EP.08 (CT.97.EP.09, Lisbon, EMCDDA, Sept. 1999.

## 4.2.3. Estimation techniques

In order to estimate the extent of the more severe patterns of drug use at the local and national level, The Rapid Assessment and Response Guide on Injecting Drug Use (RAR) (WHO 1998a) suggests the following estimation techniques:

- case-finding and enumeration
- multiplier techniques
- nomination techniques
- capture-recapture techniques

Whilst with the multiplier and nomination techniques basically all consumers can be considered, i.e., hidden populations as well, case-finding and capture-recapture methods are limited to those drug consumers who are already known to the addiction care, welfare and health authorities or the law. The following explanations essentially follow the Rapid Assessment and Response Guide on Injecting Drug Use (WHO 1998a):

### Case-finding and simple enumeration

Using the techniques of case-finding and simple enumeration, the size of the "visible" population of drug addicts can be estimated. (i.e. clients of treatment and care services, as emergency case in hospitals or by the police). It is possible to draw conclusions as to the size of the overall population (including the hidden population) using this technique.

By listing all the clients of treatment and care establishments (case-finding), the prevalence of known drug abusers during a definite period of time can be determined. In order that the survey is as complete as possible, the cases must be recorded by using a combination of various information sources (case-finding in various services and agencies), whereby various points are of significance:

- *Coverage:* Owing to inefficiencies in the basic reporting systems it is unlikely that the coverage of the known population will be complete.
- *Feasibility:* Information sources and screening strategies may need to be assessed beforehand in order to test if they can (or are willing) to provide the data required by the study.
- *Case Definition*: In order to obtain reliable and comparable data, clear case definition and comparability across agencies are required.
- *Double counting:* When different sources are combined there is a risk of overestimating the number of cases. By assigning "unique identifiers" to the cases in a standardised way across all sources, it is possible to identify the cases and the duplicate cases can be removed.

- *Confidentiality:* It is necessary to ensure that the identities of the drug abusers are not disclosed to others. Therefore the "identifiers" should not allow the identity of the individual drug abuser to be inferred.

### Multiplier techniques

The estimation of the total number of a population using multiplier techniques is based on informed assumptions on the proportion of the cases in the population being examined which undergoes a certain experience during a definite time period (e.g. overdose, death, arrest). The multiplier and the benchmark provide numbers for the events that are known to occur.

*Procedure:*

- Select a benchmark where data is available
- Select a multiplier using data from research studies
- Calculate the number of cases by multiplying the benchmark by the multiplier.

*Example*:

A benchmark might be the total number of deaths in a region which are attributed to drug abuse during the year in question, say 50. The multiplier in this case is the assumed mortality rate of drug abusers, say 1%. Applying the benchmark-multiplier calculation to these figures, the size of the population would be: 50 x 100 = 5,000.

When estimating the entire population multipliers and benchmarks should be used if possible from various data sources. This results in a range of estimates of the total number of drug users which provides an approximation of the actual number.

*Advantage:* Once the necessary statistical data are obtained, the calculation procedure is very simple.

*Disadvantage:* The number of people in need of treatment within specific population sub-groups (e.g. age, gender) cannot be estimated.

### Nomination techniques

With nomination techniques, the estimation of the entire population is based on information which individuals in a sample provide about their acquaintances. Prevalence is estimated by using the benchmark-multiplier approach. In contrast to the multiplier technique, the multiplier with the nomination technique is based on information which can be gained from the informants who are interviewed.

*Example:* A sample of drug abusers is asked whether they or their friends (who are drug abusers too) have had any contact with a drug treatment agency in the

past six months. The ratio ”did have contact” / ”no contact” is compared to the number of persons known to the agencies. The total number can be extrapolated.

### Capture-recapture techniques

One of the most important methods of estimating the size of the drug abusing population is the capture-recapture method. The size of a population is estimated from the number of members of this population who appear in multiple samples taken from the same population.

Capture-recapture refers to a technique developed at the beginning of the twentieth century in biostatistics to estimate the size of wild animal populations. It involves capturing a random sample of animals who are then marked and returned to their habitat. Subsequently a second sample is recaptured and the number of marked animals from the first sample is observed. The ratio of marked animals in the recaptured sample to the recaptured sample size is assumed to be the same as the ratio of the first captured sample to the total population.

When estimating the drug abusing population, existing records from two or more sources are utilised. Possible sources of information are police records for possession of narcotics or court convictions, hospital emergency room admissions or admissions to drug abuse treatment agencies. The overlap of cases between the data sources is then measured.

*Example:* In a given area or region two separate listings of drug abusers are available. The first list (sample 1) consists of overdose cases appearing in hospital emergency rooms and the second list (sample 2) consists of drug-related arrest cases. With two lists there are four possible locations for any given individual: on list 1 and not on list 2, on list 2 and not on list 1, on list 1 and on list 2 and finally on neither list 1 or list 2. The following contingency table presents the range of possible locations.

| | | List 2 (sample 2): Drug related arrest cases | |
|---|---|---|---|
| | | Yes | No |
| List 1 (sample 1): Overdose Cases | Yes | f11 | f12 |
| | No | f21 | f 22 |

The only unknown cell of the table is f22. From the number of cases in the first three cells f22 can be estimated and subsequently the total number of drug abusers (P).

$$F22 = \frac{f12 * f21}{f11} \qquad P = \frac{(f11+f12) * (f11+f21)}{f11}$$

For effective two-sample capture-recapture studies the following points are important:

- The two samples are independent of each other.
- There is an equal likelihood of each member of the population being sampled on each occasion.
- The population is stable during the sampling period.
- Both samples must cover different aspects of drug consumption (e.g. health-related and legal system, etc.).
- The homogeneity and the representativeness of the samples in terms of the population must be considered.
- The direction in which biases might occur must be considered (e.g. if samples are not independent the estimation will over-estimate the true population).
- Both the time period and the graphical area must be limited.
- The definition of the target population must be equivalent in all samples (in relation to geographical area, time period, drug use, etc.).
- Unique identifiers must be attached to each case (e.g. date of birth, mother's birthday and first name, gender, etc.). The larger the number of unique identifiers, the greater the precision in matching.
- The resulting estimate should be compared with other prevalence estimation.

There is no restriction on the number of samples that may be used in the calculation of estimates. The more samples included in the calculation the more precise the estimate. The requirement of independence can be ignored with three or more samples since more sophisticated statistical methods using log-linear modelling are used for the estimation.

### Improving comparability

The EMCDDA Projects CT.97.EP.04[93] and CT.96,EP.07[94] have the aim of improving the comparability of estimations of the extent of the problematic drug

[93] European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). Study to Obtain Comparable National Estimates of Problem Drug Use Prevalence for all EU Member Stages. Lisbon: EMCDDA, October 1999.

consumption at national and local level. The EMCDDA has made available on its homepage the final report of the project, guidelines for using the estimation techniques in the EU as well as a help desk which supports local prevalence estimation studies:

http://www.emcdda.org/activities/epidem_comparability_estimates.shtml

## 4.2.4. Treatment monitoring and reporting systems

Treatment monitoring and reporting systems are one of the major sources of information for epidemiological research among the drug abusing population. These systems systematically and continually survey the number of clients who consult treatment and care facilities, as well as person and consumption-related characteristics. The data is usually collected in similar or different treatment and care establishments mostly at the beginning and completion of the treatment, and is periodically evaluated by a central authority. Ideally, overall evaluations are made as well as evaluations for the individual establishments.

On a *regional/ national level* the findings on the distribution and change of client characteristics, patterns of drug use and the use of services can be used both as a basis for further service planning (e.g. adapting the capacity, creation of specific services for definite target groups) as well as for estimating the adequacy of the treatment system (e.g. suitability of the spectrum of services for the target group making the demands). At *institutional level,* for example, the data allows the establishments to up-date their knowledge of their clients' profile. If the system includes discharge surveys, then it can also be used for an outcome evaluation[95]. The extent to which monitoring systems can also be deployed for *individual treatment planning* as well as for controlling whether the aims has been reached on discharge is dependent upon the respective system and is to some extent aspired to as an aim.

Treatment monitoring systems are limited to the survey of selected characteristics of clients who are willing to be treated, and are therefore mostly suited for identifying a general need. It is important that additional studies on the characteristics and needs for special subgroups are conducted, including outside the treatment system.

In the ADAT country reports (front), existing monitoring systems are in particular described by the Netherlands (2.6.1), Germany (2.3.4) and Switzerland (2.10.2).

[94] European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). Methodological Pilot Study of Local Level Prevalence Estimates. Lisbon: EMCDDA, December 1997.

[95] In particular, the Netherlands reports on various monitoring systems which, beyond providing assessments of the clients' profile, also enable outcome evaluations to be made (cf. LADIS). Germany, however, points out the limitations of this.

In Greece a Treatment Demand Reporting System based on the "First Treatment Demand Form" (Group Pompidou), co-ordinated by the Greek Focal Point, has been established.

A detailed description of the individual systems from Germany, the Netherlands, Spain and Great Britain can be found in the special issue of European Addiction Research on Treatment Monitoring and Reporting Systems (Simon 1999). In the following sections two instruments of international importance will be briefly described:

### 4.2.4.1. Treatment Demand Indicator Protocol (TDI)

Information on drug treatment is collected in almost all European States. The methods of data collection, however, vary considerably. The EMCDDA and the Pompidou Group, in collaboration with experts from the EU member states, have therefore launched various projects in order to develop comparable treatment reporting systems.

The Treatment Demand Indicator Protocol[96] is the latest result of these joint efforts. Its purpose is to provide comparable, reliable and anonymous information on the number and characteristics of people in treatment for drug abuse in Europe. The protocol defines a minimum data set (core item list) which national treatment-monitoring systems should provide on each individual admitted to treatment. The TDI items represent the smallest common denominator in terms of required information and the national systems are free to collect any additional information they deem relevant.

The latest version 2.0 of the Joint EMCDDA-Pompidou Group Treatment Demand Indicator Protocol is the reference document for implementation in the member states. The instrument can be obtained at the following address:

http://www.emcdda.org/activities/epidem_comparability_treatment.shtml.

### 4.2.4.2. European Addiction Severity Index (EuropASI)

The EuropASI is a documentation system based on the US document standard, the Addiction Severity Index (ASI), developed by McLellan. Its objective is a simplification of the documentation in the field of addiction and drugs at European level (in particular in terms of research). An English version was produced a few years ago by a working group of which translations now exist in the most important European languages.

[96] European Monitoring Centre for Drugs and Drug Addiction & Council of Europe (EMCDDA). EMCDDA Scientific Report, Treatment demand indicator, Standard protocol 2.0. Lisbon, EMCDDA, 2000.

The Addiction Severity Index is a semi-structured interview designed to provide important information about aspects of a client's life which may contribute to his/her substance abuse syndrome. It is divided into the following fields: General information (9), Physical condition (16), Employment and income situation (26), Legal problems (23), Family background regarding alcohol and drug use as well as psychological problems, drug and alcohol use (28), Family/social relationships (26) and Psychological state (22)[97].

The diagnosis of the drug consumption is not made here using a medical/psychiatric classification system, but using a frequency-determined questionnaire on drug consumption along a time axis. For each question area, the current degree of problems and the importance of treatment are evaluated by both the client and the interviewer using a rating scale. To assess the need for treatment and the reliability of the information provided by the patient, the EuropASI uses rating scales (severity rating and reliability rating). Furthermore, this questionnaire additionally allows a psychological assessment to be made of the client during the interview.

On the clinical level, using the EuropASI an overview can be gained across the entire span of problems for which a client seeks help. At the same time the information received serves as the basis for the initial treatment plan. At the research level the EuropASI enables, using the description of client populations from different therapy programmes, the selectivity of these programmes to be comprehended. Since there are severity ratings for each of the surveyed fields, the EuropASI is also suited for progress investigations and thus for monitoring the treatment quality of the individual programmes.

The EuropASI can be downloaded in English from the homepage of the Addiction Research Institute, Zurich: http://www.suchtforschung.ch.

The European Addiction Training Institute is offering training seminars for the use of EuropASI (see: http://www.eati.org/easi.htm).

A new version of the widely accepted ***"Documentation standards"*** for the treatment of addicts (see German report, 2.3.4.1) will be available in the book trade in spring 2001 in German and English (for details see Lambertus-Verlag: http://www.lambertus.de/).

[97] The figure given in brackets corresponds to the categories for the various fields for this survey instrument including the rating scale.

## 4.2.4.3. Characteristics, aims and requirements of a monitoring system

In the country reports various aims are named to which monitoring systems should contribute as well as requirements formulated as to what should be expected of good treatment monitoring. After a listing of characteristics, these findings will be summarised below:

**Characteristics of Monitoring systems:**

- *Intervention areas:* There are usually various monitoring systems for outpatient and in-patent services as well as for substitution treatments. No monitoring system is known of for low-threshold outreach services. In addition, the Netherlands has a monitoring system for intramural health care. Attempts to harmonise the various systems are already underway at national and international level.
- *Forms of addiction:* Sometimes only facilities for addicts of illegal drugs are surveyed, sometimes those for alcohol and medicine substance abuse as well.
- *Participation requirements for facilities:* Normally participation in the monitoring systems is voluntary for the establishments. Sometimes there is the possibility of choosing between various systems, or there are regional systems. This situation limits the use of these systems for service planning and evaluation.
- *Recorded unit:* clients (also beyond the institution) or treatment cases (clients who seek counselling at several locations simultaneously are repeatedly recorded)
- *Random samples:* Complete survey or a selection of random samples
- *Information source:* The need for treatment can only be assessed by the professional or, in addition, by the clients (e.g. EuropASI).
- *Time intervals:* Start of treatment; completion of treatment; follow-up survey; periodic recording of basic information concerning the establishments (service)
- *Evaluation level:* client-related, institutional, regional, national evaluations,

**Objectives of treatment monitoring at different levels:**

*Treatment area*

- Assessment of epidemiological developments with regard to various aspects of dependence for clients willing to be treated

- Improvement of the amount of information about consumption and consumers of legal and illegal drugs as the basis for regional service planning (observation of the needs development)
- Observation of the development of the scope (utilisation) of the addiction care establishments
- Comparison of the concepts of different facilities and observation of their effectiveness for the further development of intervention forms (e.g., the development of the drug consumption, the health situation or the linking of clients to the health system); influencing factors which promote or hinder identification
- Stimulation of professional discussion through the continual observation of the counselling and treatment practice

*Treatment and care facilities*

- Simplification of the documentation work of the facilities
- Preparation of principles for a specific improvement of their services through a systematic observation of client-related data; improvement of quality through the practical evaluation of courses of treatment

**Demands made on a treatment monitoring system to reach these objectives:**

- Uniformity or compatibility of the monitoring systems in a planning region which also enables professionally all-embracing and internationally comparable analyses (unified documentation of the same characteristics, e.g., addiction diagnoses)
- Large participation of the treatment and care facilities within a treatment region in a monitoring system to optimise the planning basis.
- Detailed information on the facility (service, aims, target groups) as a prerequisite for differentiated evaluations at regional level
- Anonymous labelling of client data to enable differentiated epidemiological evaluations at regional level (e.g. to analyse course use patterns for the facilities)
- Enabling and supporting differentiated evaluations at institutional level as an element of the quality assurance
- Integration of the electronic recording of the monitoring data in the facility as part of comprehensive computer-aided case management (documentation, file management, quality assurance, accounting)

## 4.2.5. Drug-related deaths and mortality of drug users

The monitoring of drug-related deaths and mortality of drug users can help to identify inadequacies in the existing system of treatment and care. Whereas a decreasing mortality rate is an indication of adequate measures being taken, an increasing mortality rate suggests deficiencies of the treatment system. Detailed information on overall and cause-specific mortality rates among drug users can serve as a basis for possibilities for improving the treatment system.

The EMCDDA differentiates the indicator ”drug-related deaths and mortality of drug users” into two elements: the national population statistics on drug-related deaths, and mortality among drug users.

### National population statistics on drug-related deaths

In most European countries data on drug-related deaths is collected. Various methodical problems prevent, however, the use of this indicator. The main limitation is the lack of consensus regarding the definition of "drug-related death” and the method of classification. In most countries deaths are coded on the basis of the International Classification of Diseases (ICD). As there is no ICD code for ”drug use”, drug-related deaths can be classified among mental disorders or among injury and poisoning. It is therefore very difficult to compare the figures on the extent and patterns of drug-related deaths within Europe (Final report EMCDDA project CT97.EP.03, 7). A further problem is caused by the fact that the data on drug-related deaths stems from different sources (such as, for example, general mortality registers, hospital records, police data, coroners‘ reports, information from GPs). The methods of procedure for data collection, data processing and coding are not uniform and there is often no link between different sources of information.

This therefore suggests the importance of having the collection of mortality data in every country co-ordinated by a central authority and that a standardised methodology and a standardised protocol for surveying drug-related deaths should be developed at national and international level.

EMCDDA has previously concentrated on the development of comparable reporting criteria from the same source (general mortality register), and in this connection has produced the *Drug-Related Deaths (DRD) Standard*, a standard protocol for extracting data on drug-related deaths from registers in the member states of the European Union. In addition, a feasibility study commissioned by the EMCDDA has been conducted to improve the quality and comparability of data on drug-related deaths, and guidelines prepared for reporting data from general mortality registries. The three documents can be downloaded from the homepage of the EMCDDA:

http://emcdda.org/activties/epidem_comparability_deaths.shtml

**Mortality among drug users**

Prospective cohort studies on mortality among drug users can provide information on the risk of dying from any cause in a defined group of drug abusers. In contrast to population statistics, mortality rates can be given which include all possible causes of death and not only those which are directly connected with drug consumption. Indirect causes are, for example, AIDS, suicide or traffic accidents. However, such studies can only provide information about those drug abusers who are included in the cohort. The forming of cohorts is mostly conducted using data from treatment centres. For this reason no statements can be made about the subgroups of drug abusers who do not make use of any services.

An ongoing project launched by the EMCDDA has produced a working protocol for a common methodology for monitoring overall and cause-specific mortality in cohorts of drug users. The final report can be down-loaded from the homepage of the EMCDDA (see address indicated above).

## 4.2.6. Drug-related infectious diseases and other health problems

Drug-related health problems can be divided into the following three categories[98]:

- *Infectious diseases associated with injecting and sexual behaviour* such as HIV-Infection, AIDS, Hepatitis B, Hepatitis C, sexual diseases
- *Problems associated with drug ingestion and route of administration* such as non-fatal and fatal overdoses, physical damage resulting from injections, adverse mental effects connected with drug consumption
- *Health problems and adverse events linked to living conditions and life-style* such as tuberculosis, violence, accidents and other diseases and problems.

Data on the prevalence of these health problems are useful for identifying needs for prophylactic measures, making prognoses concerning health care needs and costs, and for monitoring the impact of preventive interventions. Furthermore, the information can be used for indirect estimates of the incidence, prevalence and trends in drug use over time (see estimation techniques, 4.2.3).

[98] The following descriptions are mainly based on the WHO publication "Rapid Assessment and Response guide on injecting drug use" (WHO 1998a).

Example I: in Germany a survey and physical examination of 265 homeless men showed a high prevalence rate for psychological and physical illnesses as well as a very low treatment frequency, which indicates the necessity for improvements in the medical provision in low-threshold services.

### Sources of information

Information on the prevalence of drug-related health problems can usually be obtained from existing sources. It is advisable to combine information from different sources in order to get more accurate prevalence estimates. Useful sources of information include national and local health information systems, hospital statistics on discharge diagnoses, sentinel surveillance records, prison data, analysis of local records, existing research. Incomplete or missing data can be supplemented by key informant interviews, focus groups, or ad hoc surveys.

The value of the data depends on how accurately they reflect the true frequency of the problem in the population. The surveillance of disease and other adverse events is usually far from ideal in the general population, and it is even worse with marginal and hidden populations such as people who inject drugs. It is therefore important to know how the data is produced:

- Who reports cases and events (e.g. special clinics, health centres, hospitals, private doctors), and who does not report?
- What is the estimated proportion of non-reporting and under-reporting?
- Who is identified? Are some people more likely to be identified (e.g. diagnosed) than others?
- How are cases and events identified (e.g. by self-report, laboratory tests, clinical signs)?

### Common problems

- *Non-identification of cases:* the disease or event may not be recorded because there is no system for recording or surveying it.
- *Incomplete identification of cases:* the disease or event may not be recorded because the person does not come into contact with health care or other services.
- *Poor compliance with recording:* those who are meant to record the data may not do so or may do so incompletely.
- *Diagnostic inaccuracy:* this is affected by the skills and diligence of those who record the data. There may be variations in the criteria accepted in defining a diagnosis, or in the use and availability of investigative tests.

- *Time lags:* it may be some time between the recording of the data and its notification to some central body for statistical analysis and reporting.

### Assessment grids

The Rapid Assessment and Response Guide provides assessment grids which cover all the above mentioned health problems. The grids are meant to be used as a guide and adapted to the local situation with regard to the kind of heath consequences experienced and the source of data available:

http://www.who.int/substance_abuse/docs/idu_rar.pdf (p. 178ff.)

### Improving comparability

The EMCDDA launched a project on the fifth epidemiological key indicator "drug-related infectious diseases" with the objective of developing indicators to allow more reliable and comparable monitoring of hepatitis B/C and HIV in injecting drug users. Currently available data, collected by the centre, are based on different types of estimates from various sources and as such are difficult to compare. Routine sources for monitoring purposes, such as infectious-disease notifications, have broad coverage but are of poor quality. High-quality sources such as studies, on the other hand, lack national coverage and are difficult to continue over time. The main options for improving surveillance are:

- to improve the collection of existing data by developing a range of sources or 'infection indicators'
- to develop sentinel surveillance by repeated community-wide surveys,
- to collect data routinely available in (public health) laboratories.

The EMCDDA has developed draft guidelines for the national Focal Points based on the first option:

http://www.emcdda.org/multimedia/Project_reports/epicompdis_dgl.pdf

Options two and three will be developed further through specific proposals aimed at obtaining more substantial funding than is currently available. The aim is to develop all three options in the mid-term future.

## 4.2.7. Systems for the detection of new trends

Existing information systems have proven to be very inefficient in the identification of new substances, new consumption models as well as the new generations of consumers. They usually register the occurrence of new drug trends with a large time lag. The lack of such early-warning information hampers the devel-

opment of adequate prevention, public health or legislative responses. It is therefore an important objective at regional, national and international level that the sensitivity of the drug information systems is increased.

Various factors hinder the detection of new trends:

- *Problem of access:* New drug-use trends often occur in groups which are difficult to achieve access to or within circles which do not display the characteristics of the ”typical” drug user.
- *Problem of focus:* It is difficult to collect information on new drug trend phenomena which at this point in time are not yet defined.
- *Problem of extent:* When taking new drug trends into consideration, at least at the beginning only small numbers of individuals are likely to be engaging in the activity, and detection is therefore a challenge simply because of issues of scale. The probability of identifying drug trends increases, however, with the increasing degree of spread of corresponding use patterns.
- *Problem of spread:* New trends tend to start in a number of small geographical locations and, as such, may be missed if data is only considered on a national level.
- *Problem of foreseeability:* By definition it requires repeated surveys over the course of time in order to detect new trends. This therefore raises questions as to the point at which a trend can be spoken of and at which point is it appropriate and advisable to report a specific drug-use behaviour.
- *Substance-specific factors:* Some substance-specific factors are likely to impede the detection of new drug trends: 1.) A newly developed substance or a substance that has previously not been used for its psychoactive properties becomes popular, 2.) a new preparation of a substance becomes available or a substance that has a previous history of use but has ceased to be commonly used becomes popular again, 3.) a substance is used in a new way (route of administration).

The EMCDDA commissioned in 1997 a feasibility study to examine methods for detecting, tracking and understanding emerging trends in drug use ((EMCDDA) 1999a). Within the framework of this study two case studies were conducted which reviewed the relative performance of information sources in respect to the emergence of ecstasy use in the late 1980s and the growth in heroin smoking in the late 1970s and 1980s. Three main conclusions can be drawn from these case studies:

- *Cultural monitoring:* New indicators need to be developed that are based on cultural monitoring (specialist youth press, television reports, music, fashion, Internet etc.). Drug use is generally located within specific sub-cultural groups

whose members may share affiliations for particular styles of fashion, music or language. Evidence of new drug trends may be found and the trends themselves better understood by monitoring such cultural areas. This requires not only the identification of potential information sources, but also the development of appropriate methodological procedures for collecting the information.

- *Key informants:* The monitoring of key informant groups enables a quicker and more flexible collection of data concerning new drug trends. The methods enable more differentiated insight into both the nature of the new drug-use pattern and the respective environment in which it is being practised.
- *Forum:* A forum is required that allows the data from a range of sources to be considered in context by appropriate experts, and on an ongoing basis so that policy and service responses to new patterns of drug use become more timely and effective. Conceptually, this requires viewing information on drug consumption patterns as an ongoing process in which data from different sources is compared and evaluated. The aim is to identify not only what is currently known but also what other information is required. By using a range of different information sources the weaknesses in individual sources can be compensated for.

Previous experiences show that certain developments in several countries had a signalising function in view of similar developments that then occurred in other countries after a time lag. As part of the continuing globalisation the international exchange of data is of enormous importance. It should therefore be a priority to improve the comparability of reporting systems between countries.

In the following sections two innovative drug information systems, Antenna Drugs and Gambling, Amsterdam, and the Greek Early Warning System, will be presented as examples. Antenna Drugs and Gambling is concerned with an innovative methodological procedure, developed by the Jellinek Institute for improved analysis of new drug trends at regional level, which has been successfully implemented in drug research in Amsterdam since 1993. The Greek early warning system operates at national level and draws upon its information through a network of key informants.

## 4.2.7.1. Antenna Drugs and Gambling (Amsterdam)

The Antenna Project is distinguished by its multi-methodological research design whose aim is to continually investigate new trends and patterns in the field of legal and illegal drug consumption and gambling amongst youths and (young) adults in Amsterdam. The cornerstone of this approach is the qualitative component: a panel study among lay and professional experts. Qualitative findings from the panel study are validated and further explored by quantitative methods.

*Goals of the Antenna Project:*

- Signalise and interpret new trends and developments in consumption of illicit drugs use and gambling among youth in Amsterdam
- Update and improve drug prevention

*Population studied:*

- Visitors of trendy clubs and raves
- Insider experts from the social world of trend-setters (clubs, raves) and of groups at risk (problem areas, molested youth, etc.)
- people who call for information and advice (telephone help line)

*Sources of data:*

*1.) Survey of school students:*

A random sample (n=1000) of students from secondary schools of the same type are surveyed with the same standardised survey instrument in repeated annual cycles. The average age of the respondents students is 17 years.

*2.) Survey of high-risk groups:*

Every year a survey in one selected "high-risk population" is conducted. In the last six years the target groups aimed at have been clients of youth club establishments, visitors of Coffee Shops and the young public visiting clubs and discotheques. The target persons were surveyed by means of a standardised questionnaire.

*3.) Panel study:*

The panel study serves as an information system in which data is constantly being gathered on drugs, drug use, and networks of users, covering a specific geographical area and a specific time period. The panel study has three main objectives:

- *Early identification*: monitoring current developments in the interest of policy, prevention and care. The panel method enables data on new trends in drug use to be collected faster and more flexibly.
- *Orientation to context and practice:* Mapping out trends to improve drug prevention and education among the youth. The panel method is better suited to acquiring in-depth information on the nature of both current and new drug use, and on the contexts in which they take place.
- *Prompt updating of questionnaires applied in surveys:* The panel study makes it possible for surveys to respond promptly and adequately to new developments.

The panel consists of 25 to 30 key informants who are recruited from diverse sources such as: networks of drug-using groups, persons in touch with certain groups of users (e.g. dealers), staff of raves, dance clubs or discos, outreach workers, active ravers, police, hairdressers etc. The members of the panel are questioned twice a year with a semi-standardised interview on drug trends and associated (sub) cultural trends (e.g., music, fashion). Moreover, the research team also makes use of print media, underground publications and the Internet as other sensors in detecting drug-related trends. Observations are then analysed as "trends" when various panel members, independently from each other, report on the same phenomenon. The panel is usually first to discover the new trends, which can then be later recorded numerically and confirmed using the questionnaires with the school students or the high-risk groups.

*4.) Data Collection*:

Data obtained within the framework of the work of the Jellinek Foundation (telephone help line, pill testing service) are evaluated.

*Data interpretation:*

The Antenna Interpretation Committee interprets the data and formulates policy recommendations for the implementation of prevention activities and adjustment of municipal policies. There is a close connection between the instrument, its results and professionals involved in prevention activities. The Antenna Project has been conducted since 1993. The observations made within the project are documented in a twice-yearly report.

*Further information / copyright / address*

The instruments which are used for surveying the school students and the high-risk groups can be received from the contact address given below, but are only obtainable in Dutch. However, the more complex research methodology of the panel study makes it rather difficult to convey the content of the instruments used. Dirk J. Korf is available as a consultant, however, for any questions concerned with conducting the panel study.

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## 4.2.7.2. The Greek Early Warning System

Network agencies of key informants:

- *Treatment services:* Therapeutic programmes, street work programmes, telephone help-lines and programmes for imprisoned drug dependent individuals.
- *Prevention Centers:* 14 centers situated in tourist Greek islands and in big urban areas of the country.
- *Law enforcement authorities:* The Central Anti-Drug Co-ordinating Unit constituted of the Ministries of Public Order, Merchant Marine and Finance.
- *Toxicological Laboratories:* The services of The General Chemical State Laboratory and the Forensic Medicine Laboratories of the Universities of Athens, Thessaloniki and Patra.
- *Other agencies* related to the demand reduction field.

Operation of the Early Warning System:

1. *The Questionnaires:* Three questionnaires addressed to different sources of information (treatment services, police forces and toxicological laboratories) were constructed in co-operation with the representatives of the respective agents. The treatment services questionnaire is also used for the collection of the data from the Prevention Centres, but one of the questions was changed so as to be suitable for the type of information received from these agents. Additionally, the target group from which the professionals of the Centres collect this information is the young drug users.
2. *The method of the data collection:* The information concerning the new synthetic drugs and new patterns of use of already known drugs are recorded into tables so as to be available to the collaborators of the network. Additionally, a monthly report is transmitted by the agents to the Greek Focal Point stating the overall amount of relevant information during the past month or the absence of any new data, so that a regular contact between the Focal Point and the collaborators of the network is secured.
3. *The type of information:* The information on new synthetic drugs and new patterns of use is up to now mainly obtained from the treatment services, which means that it is based on the views of users and is undocumented. For that reason, the assessment of this information is considered to be necessary.
4. *The evaluation of the collected data:* A committee consisting of experts in the field of drugs, who also participate in the Early Warning System Network, regularly evaluate the obtained data so that the information reaching the

EMCDDA and the rest of the collaborators of the Network is validly assessed as new data for Greece.

5. *The exchange of information:* The collaborators of the Network do not only supply information to the Focal Point but they also obtain information from it. In case that the EMCDDA disseminates information on new synthetic drugs to the national Focal Points, the Greek Focal Point transmits the report to the Network agents and asks for additional information, if available, so as to transmit it back to the EMCDDA.

6. *The Early Warning System database:* An EWS electronic database will be operating in the website of the Greek REITOX Focal Point. This decision is based on the fact that most of the collaborators have the necessary electronic equipment in order to use the database and to insert data.

*Further information / copyright / address*

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## 4.3. Identification of unmet needs from the drug abusers' perspective

The identification of the needs on the basis of epidemiological data must be supplemented with the identification of the needs from the perspective of the drug abusers themselves. This can occur retrospectively and at the level of individual clients and facilities in the form of satisfaction surveys, prospectively and at higher level through the involvement of users' and carers' organisations in the evaluation of adequacy and the service planning (case management), as well as through studies to identify unmet needs for specific target groups, in particular hidden populations.

### 4.3.1. Evaluation of client satisfaction

The continuous assessment of client satisfaction can help institutions to ensure the adequacy of their services in respect to the needs of their clients. It can lead to identifying improvements to existing services and the development of new services to meet client requirements. The satisfaction of the clients is generally retrospective, being identified in relation to a definite institution. The most commonly used instruments are self-administered questionnaires.

Various studies have shown that satisfaction with treatment and positive treatment outcomes are interrelated, whereby it should be considered that evidence of positive client satisfaction is not, in itself, sufficient to establish the effectiveness of treatment[99]. Since instruments for the identification of satisfaction do not have any criterion-related validity measures, the relationship between treatment outcome and satisfaction are mostly selected as a measure of validity.

In the following sections four instruments are presented:

- Jellinek: Patient Satisfaction Monitor
- Client Satisfaction with Drug Abuse Treatment (KLIBS)
- The Client Satisfaction Questionnaire (CSQ)
- Verona Service Satisfaction Scale (VSSS)

The "Jellinek Patient Satisfaction Monitor" and "KLIBS" were selected because theses very comprehensive instruments are specially conceived for the field of addiction and can be implemented both for the assessment of out-patients as well as in-patient services. Both the CSQ and the VSSS are methodically vali-

[99] See WHO, UNDCP, EMCDDA. (1999). *Evaluation of Psychoactive Substance Use Disorder Treatment, Workbook 6*, Client Satisfaction Evaluations.

dated, proven instruments which have been developed for the evaluation of mental health services. Whilst with the CSQ only the satisfaction with clinical aspects of the treatment can be measured, the VSSS is suitable for the assessment of the satisfaction with services with various treatment options (hospitalisation, day-care, rehabilitation, psychotherapy, home help, etc.).

The dimensions which are used for the assessment of client satisfaction in the individual instruments vary considerably. In order to have criteria for the completeness of the individual instruments, the used dimensions have been summarised to form the following main categories[100]:

- *Information / consultation:* i.e. information about services that are offered, information on the objectives of the treatment, information about the possibilities of aftercare/future assistance, consultation about type of assistance wanted
- *Client centredness of service*: i.e. opening hours, waiting time (time gap between application and first appointment, speedy provision of help), willingness of provider to meet needs of the clients, accessibility of services
- *Physical environment:* i.e. satisfaction with premises of the services, homeliness, catering, privacy
- *Competence of staff:* i.e. technical skills, interpersonal skills, trust in staff, respectful treatment by staff, co-operation between service providers, confidentiality, respect of clients' rights
- *Satisfaction with various treatment components:* i.e. therapeutic treatment (therapeutic relationship, inclusion of clients' needs, being overtaxed in the therapy, infringements), care consistency of the care team, constancy of the care worker, dealing with conflicts), counselling, medical treatment, withdrawal treatment, work, recreational activities
- *Effectiveness:* i.e. efficacy of treatment/assistance, changes in terms of drug use, physical and mental condition, relationship to people who are close and to life situations
- *Overall satisfaction:* i.e. general aspects of satisfaction with the services received, report mark (indicator of the general satisfaction assessment)

In order to make it easier to compare the individual instruments, the most important characteristics of the four instruments are listed here in tabular form.

[100] The Dimension "Suggestions for improvements" is missing in the described instruments. Therefore potential knowledge as to how services could be improved is not ascertained. In its country report the Czech Republic suggests, amongst others, the following opens questions on this dimension: What is missing in this programme? What should be changed in the programme? What advice would you give the staff?

| Instrument | Target population | Dimensions | Items | Validity | Languages |
|---|---|---|---|---|---|
| Jellinek: Patient Satisfaction Monitor | Persons with lifestyle dependency and addiction problems who are clients of Jellinek's:<br>clinical programmes<br>outpatient programmes and<br>social care programmes. | Information / consultation<br>client centredness of service<br>competence of staff<br>satisfaction with various treatment components<br>effectiveness<br>overall satisfaction | General part: 51 | + | Dutch, partly translated into English |
| Client Satisfaction with Drug Abuse Treatment (KLIBS) | Persons in drug abuse treatment in<br>in-patient programmes and<br>out-patient programmes | Physical environment<br>competence of staff<br>satisfaction with various treatment components<br>overall satisfaction<br>information / consultation | 97 | (+) | German |
| Client Satisfaction Questionnaire (CSQ) | Clients of social, psychiatric, mental health and health care services in:<br>in-patient programmes and<br>out-patient programmes | Overall satisfaction | 8, 18 or 31 | + | English, Spanish, Dutch, French and German |
| Verona Service Satisfaction Scale (VSSS) | Clients of community based mental health services with various treatment options:<br>hospitalisatio<br>day-care<br>rehabilitation<br>psychotherapy<br>home help | Information / consultation<br>competence of staff<br>satisfaction with various treatment components<br>effectiveness<br>overall satisfaction | 32, 54 or 82 | + | Italian, English, Danish, Dutch, French, German, Greek and Spanish |

The instruments are described in more detail in the following sections. The main categories described above will not be used, however, but rather the dimensions given by the authors to ensure that the information content is as high as possible.

For further satisfaction instruments see also the EMCDDA Instumentbank: http://eib.emcdda.org/eib/databases_eib.shtml.

## 4.3.1.1. Jellinek: Patient Satisfaction Monitor

### General information:

The Jellinek Centre is a specialised institution in the Netherlands for prevention, care, and treatment of persons with lifestyle, dependency, and addiction problems. The Patient Satisfaction Monitor measures both general and specific themes of care and treatment and provides information on the satisfaction of the clients of different programmes. The instrument consists of three parts:

- General part, to be completed by every person who has been in contact with the institution
- Setting specific part: i.e. inpatient or outpatient
- Programme-specific part

### Target populations:

Clients of the clinical programmes, of the out-patient programmes and of the social care programmes of the Jellinek Centre.

### Dimensions:

General part:

- Treatment at intake (i.e. feeling of being welcome, of being taken seriously)
- Information/consultation about treatment possibilities (i.e. information about services that are offered, consultation about type of assistance wanted)
- Waiting times (i.e. time gap between application and first appointment, speedy provision of help)
- Information/consultations during assistance/treatment (i.e. involvement in the choice of social worker, information about the objectives of treatment)
- Treatment/assistance (i.e. competence of social worker, attention given to the client's problems concerning addictive substances)
- Treatment during assistance (i.e. trust in staff, respectful treatment by staff)
- Completion of treatment (i.e. preparation for the completion of assistance/treatment, information about the possibilities for aftercare/future assistance)
- Effect (i.e. control over problems, efficacy of treatment/assistance)
- Improvements (i.e. improvement regarding physical health, social position, drug use, problems with family)
- Report mark (0 – 10") (indicator of the general satisfaction assessment)

Additional part for outpatients:

- Medical care
- Group sessions

Additional part for inpatients:

- Medical care
- Group sessions
- Procedures and regulations in the clinic
- Leisure time

Additional part for social rehabilitation setting

- Privacy
- Accessibility
- Life circumstances
- Environment

**Type of questions:**

The questionnaire is compiled of statements and ratings of agreement (six categories from "agree totally" to "disagree totally").

**Number of items:**

General part: 51
Additional part for outpatients: 16
Additional part for inpatients: 16
Additional part for social rehabilitation setting: 16

**Validity:**

A positive relationship between customer satisfaction and perceived treatment outcome was not able to be proved (cf. Aarsse, 1997).

Aarsse, H.R. (1997). What is the relationship between treatment outcome and satisfaction with alcohol treatment programs? Paper presented at the 14th International ISQua Conference on Quality in Health Care, Chicago.

**Studies employing the instrument:**

Van den Brink, W.: Patient satisfaction in mental health care: Determinants and temporal relationship with process and outcome (the study started in 2000 and will continue until 2001).

**Languages:**

The general part is available in Dutch and English. The setting-specific part and the programme-specific part are only available in Dutch.

**Supplementary information:**

The questionnaires were given to the clients at the following times:

- Detoxification programmes: after finishing programme
- Clinics, inpatients: after six weeks
- Out-patient programmes: after third treatment session

Furthermore, a method has been developed to assess the satisfaction of the referral and the social net of the client. The implementation of this total approach is planned but not yet started.

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**Comment:**

This very well prepared instrument has been in use since 1996 and, besides Jellinek, is also used by other institutions in the addiction field. With the exception of the dimension "physical environment", all relevant dimensions are given.

## 4.3.1.2. Client Survey on Addiction Treatment (KLIBS)

**General information:**

The KLIBS instrument was developed within the framework of a study on the theme " Quality Assessment in Addiction Treatment" financed by the Swiss Federal Office of Health.

**Target populations:**

Clients from out-patient and in-patient therapy and care programmes for drug addicts.

**Dimensions:**

- Therapeutic treatment (Therapeutic relationship, needs of the clients, treatment progress, being overtaxed in the therapy, infringements, extent of the treatment, assessment of the treatment, independence, regularity of the treatment, treatment expectations,)
- Care (consistency of the care team, consistency of the personal carer, conflict with the carers, dealing with conflicts, satisfaction with the carers)
- Field of work (problems with superiors, support from the superiors, demanding too little, demanding too much)
- Social relationships (conflicts with clients, outside contacts, relationship with client)
- Residency and facilities (catering, living space, time table, leisure facilities, atmosphere, family character, privacy, size of the establishment, rigidity, structuring, client information)
- Medical treatment and modules (methadone substitution module, withdrawal module, counselling module)
- General satisfaction (The items were taken over from CSQ-8).

Within the KLIBS dimensions, scales on specific questions can be formed; for instance the dimension "care" with 14 items includes 5 scales: "consistency of the care team", "constancy of the carer", "conflicts with the carers", "dealing with conflicts" and "satisfaction with the carers", with each having 2 to 4 items.

**Type of questions:**

Combination of self-contained questions with four and six answer categories and statements with six-level categories for agreement ("not true" to "completely true").

**Number of items: 97**

**Validity:**

The instrument was used in 25 in-patient long-term therapy facilities in the German-speaking part of Switzerland to establish the satisfaction of the drug-addicted clients with their addiction treatment (May-June 1999). The data is currently being evaluated and will serve as a basis for the validation of the instruments.

**Studies employing the instrument:**

Wettach, R. H. U., Dobler-Mikola, A. & Uchtenhagen, A. (1997). Development of instruments for establishing the quality of treatment of out-patient and in-patient therapy and care programmes for drug abusers. Research report from the Institut für Suchtforschung No. 39.

Wettach, R.H.U., Frei, A., Dobler-Mikola, A. & Uchtenhagen, A. (2000). Quality in residential therapy: National survey and analysis of selected quality characteristics of residential treatment programmes for drug addicts. Zürich: Institut für Suchtforschung (in press).

**Languages:** The instrument is only available in German

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**Comments:** The KLIBS instrument covers various important dimensions of the client satisfaction in great detail. The satisfaction is ascertained both directly and indirectly through the assessment of the programmed components . With the exception of the dimensions "client centredness of service" and "effectiveness", all relevant dimensions are listed.

## 4.3.1.3. The Client Satisfaction Questionnaire (CSQ)

**General information:**

The CSQ is a standard global measure of client feedback that is applicable to males and females from a variety of clinical populations. The questionnaire was originally developed for the evaluation of mental health services. The Client Satisfaction Questionnaire assesses both general satisfaction and satisfaction with help received, needs fulfilment, access to and acceptability of the service. The CSQ was developed by Larsen, Attkisson, Hargreaves and Nguyen in 1979 at the University of California[101].

**Target populations:**

Clients of social, psychiatric, mental health and health care services.

**Relevant dimensions (CSQ-8):**

- Quality of service
- Needs fulfilment
- Satisfaction with amount of help received
- Effectiveness
- Overall satisfaction

**Type of questions:**

Questions with 4 answer possibilities (with "1" indicating low satisfaction and "4" indicating high satisfaction).

**Number of items:**

The Client Satisfaction Questionnaire is available as either an 8 (CSQ-8), 18 (CSQ-18) or 31 (CSQ--31) item version.

**Validity:**

Several studies show that the instrument is well suited for the measurement of clients' satisfaction (i.e. Larsen, 1979; Nguyen et al., 1983; Zwick, 1982).

**Studies employing the instrument:**

Larsen, 1979; Nguyen et al., 1983; Zwick, 1982, Kurtz, 1990; Nguyen et al., 1990.

**Languages:**

The instruments are available in English, Spanish, Dutch, French and German.

**Copyright / Address:**

The instrument may be used at no cost in non-profit research and evaluation studies. Interested persons may contact Dr. Attkisson directly regarding the appropriateness of using the questionnaire in their particular setting.

[101] Larsen, D. L., Attkisson, C. C., Hargreaves, W. A. & Nguyen, T. D. (1979). Assessment of client/patient satisfaction: development of a general scale. Evaluation and Program Planning 2: 197-207.

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**Comments:**

The instrument is oriented to in-patient settings. Since it was developed for the evaluation of mental health services there is a lack of dimensions which refer to the specific characteristics of drug abuse treatment. In the most frequently used instrument CSQ-8, it is exclusively the general satisfaction with the services which is measured.

## 4.3.1.4. Verona Service Satisfaction Scale (VSSS)

**General information:**

The aim of the Verona Service Satisfaction Scale (VSSS) is to measure satisfaction with mental health services. Three versions of the VSSS-Patients have been developed: VSSS-82 (for analytical studies on satisfaction), VSSS-54 (for research purposes but quick administration) and VSSS-32 (for routine use).

**Target populations:**

Clients of community-based mental health services run by teams constituted by psychiatrists, psychologist, social workers and nurses. The services are assumed to have various treatment options (hospitalisation, day-care, rehabilitation, psychotherapy, home help, out-patient visits, etc.)

**Dimensions:**

- Overall satisfaction (general aspects of satisfaction with psychiatric services)
- Professional skills and behaviours (satisfaction with the professionals' behaviour such as technical skills, interpersonal skills, co-operation between service providers, respect of patients' rights etc.)
- Information (satisfaction with information on services, disorders and therapies)
- Access (satisfaction with service location, physical layout and costs)
- Efficacy (satisfaction with overall efficacy of service and service efficacy on specific aspects such as symptoms, social skills and family relationships)
- Types of Intervention (satisfaction with care, admissions, housing, recreational activities, work, benefits etc.)

- Relative's involvement (satisfaction with help given to closest relative)

**Types of questions:**

Clients are asked to express their overall feeling about their experience of the service in the last year. Satisfaction ratings are on a 5-point Likert scale (1=terrible, 2=mostly satisfactory, 3=mixed, 4=mostly satisfactory, 5=excellent).

**Number of items:**

The VSSS-Patients is available as either an 82, 54 or a 32 item version.

**Validity:**

The instruments are validated. Divers articles are available. A selection:

Ruggeri, M., Dall'Agnola, R., Agostini, C. & Bisoffi, G. (1994). Acceptability, sensitivity and content validity of VECS and VSSS in measuring expectations and satisfaction in psychiatric patients and their relatives, Social Psychiatry and Psychiatric Epidemiology, 29, 265-276.

Ruggeri, M. & Greenfield, T. (1995). The Italian version of the Service Satisfaction Scale (SSS-30) adapted for community-based psychiatric services: development, factor analysis and application. Evaluation and Program Planning. 18/2, 191-202.

Ruggeri, M., Dall'Agnola, R. & Bisoffi, G. (1993). La misurazione delle aspettative e della soddisfazione dei pazienti e dei loro familiari nei confronti dei servizi psichiatrici territoriali: la validazione della VECS e della VSSS. Sensibilità e validità di contenuto. Epidemiologia e Psichiatria Sociale, 2/3, 191-198.

**Studies employing the instrument:**

Phelan, M., Loftus, L. & Ruggeri, M. (1996). Comparison of service satisfaction among psychotic patients in South London and South Verona. Submitted.

Parkman, S., Davies, S., Leese, M., Phelan, M. & Thornicroft, G. (1996). Ethnic differences in satisfaction with mental health services among representative cases of psychosis in South London. Submitted.

**Languages:**

The instrument is available in Italian, English, French, Spanish, Greek, Danish, Dutch, and German

**Supplementary information:**

A version similar to the patient one has been developed for measuring the key relative's satisfaction. It has been translated into English, Greek and Danish. Furthermore, a VSSS-Staff version is only available in Italian.

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**Comments:**

The VSSS is very orientated to mental health services run by teams of psychiatrists, psychologists, social workers and nurses. Since the instrument was developed for the evaluation of mental health services, it would need to be expanded for use in the field of addiction. With the exception of the dimensions "client centredness" and "physical environment", all the dimensions are included in the VSSS.

## 4.3.2. Inclusion of users' and carers' organisations in quality assurance and service planning

Service users' and carers' voices need to be heard at all levels of the process for improving the quality of services and of planning new services. Drug abusers and their relatives should therefore not just be selectively asked about their needs and their satisfaction. Representatives of users' and carers' groups and organisations should also be directly involved in the service planning in order to be able to represent their concerns as equal members of quality management or service planning boards.

Various countries report on such forms of involvement in decisions. It requires – in contrast to empirical procedures – few resources, is quick and is particularly relevant in terms of action. For it to succeed, the following must be observed:

*Support and funding of users' organisations:*

Users' and carers' organisations fulfil an important function as a mouthpiece and as a representative of interests of the drug abusers and their relatives, who on their own are hardly in the position to fight for their concerns. There should therefore be support and funding for existing users' organisations and the formation of new users' organisations:

- Providing *know-how* on the procedure for forming a users' or carers' organisation and on matters such as public relations work, self presentation, administration, sponsorship, etc.
- Users' organisations to represent the interests of rather low-income or underprivileged groups as well as carers' organisations, who likewise do not have any strong financial lobby and are dependent upon *financial support* from the public sector.

*Possibilities for the involvement of users' organisations:*

- Invitation to give their opinion on relevant laws and drafts for new laws.

- Place on boards of experts and governmental advisory committees where they represent the interests of the users and include their perspectives (e.g., when planning new services).
- Involvement in defining quality and setting standards in drug abuse treatment and care
- Selective consultations on definite themes and questions (e.g., assessment of the accessibility of the treatment services). User involvement in aspects of staff training

*Making involvement possible:*

- Organised groups must exist which represent the interests of the drug abusers and their relatives in public and are ready to fight for their concerns (involvement in committees, public relations work, etc.).
- Users' and carers' organisations must be recognised from a large number of those affected as the representative of their interests.
- The committees for co-operation must be so arranged that those affected can enjoy the same right as experts in introducing their concerns.

### 4.3.3. Needs-led treatment planning

At the level of the individual client a prerequisite for appropriate treatment and care is an expert diagnosis and a treatment plan based on this. Questions on addiction diagnoses cannot be gone into further detail within this context. Mentioned here are just the ICD-10, the DSM-IV[102] as well as the Addiction Severity Index described above (4.2.4).

In addition to the diagnosis, the subjective needs of the client must be included in the treatment planning. This is in order to be able to meet the frequently formulated general need for an individual approach in supporting and recognising individual achievements. These days the assessment of clients' needs should be both an integral part of routine clinical practice and a component of service evaluation.

In the field of treatment and care of drug abusers there has been until now a lack of instruments for systematically assessing the needs from the perspective of the individual clients. In community mental health care, however, the importance of a needs-led approach towards the individual care of those with severe mental illness has been widely recognised. One established needs assessment tool in the mental health field is the Camberwell Assessment of Need (CAN). This is an in-

[102] Diagnostic and Statistical Manual of Mental Disorders, edited by the American Psychiatric Association.

strument for assessing a wide spectrum of met and unmet needs from the perspective of the clients, the personnel and the relatives. A further instrument which is currently being developed is the WHODAS II. Besides the standardised survey instruments, there are also methods for individual treatment planning as part of the case management. Two examples are these from the Czech Republic will be presented here.

### 4.3.3.1. Camberwell Assessment of Need (CAN)[103]

The Camberwell Assessment of Need (CAN) is a new instrument which has been designed to assess both met and unmet needs of people with severe mental illness. The CAN is based on the principle that need is a subjective concept and that there will frequently be differing but equally valid perceptions about the presence or absence of a specific need. The CAN therefore records the views of staff and users separately. A priority of the CAN is to identify, rather than describe in detail, serious social and health needs. Specialist assessments can be conducted in specific areas if required, once the need is identified. Three versions of the CAN are available: a clinical version (CAN-C), a research version (CAN-R) and a short version (CANSAS).

**Target population:**

Clients of mental health services with severe mental health problems.

**Dimensions:**

The CAN assesses problems during the last month in 22 domains of health and social needs:

1. Accommodation
2. Food
3. Looking after the home
4. Self-care
5. Daytime activities
6. Physical health
7. Psychotic symptoms
8. Information on condition and treatment
9. Psychological distress
10. Safety to self
11. Safety to others
12. Alcohol
13. Drugs
14. Company
15. Intimate relationships
16. Sexual expression
17. Child care
18. Basic education
19. Telephone
20. Transport
21. Money
22. Benefits

[103] The following description of the CAN is based on the work book from Mike Slade et al. (1999), which includes a manual, questionnaires, score sheets, training programme, case vignettes, worked examples and answers to frequently asked questions. (Slade, M., Thornicroft, G., Loftus, L., Phelan, M. & Wykes, T. (1999). Camberwell Assessment of Need. London: Gaskell.)

### Administration of the CAN:

An assessment using the CAN involves an interviewer asking an interviewee questions about each of the 22 domains. The interviewee may be the client, the carer (e.g. friend or family member) or a member of staff who knows the user sufficiently well. If the client or the carer is being interviewed, administration involves the interviewer going through the CAN, asking about each domain in turn. If a member of staff is the interviewee, this member of staff himself/herself fills in the CAN.

### Description of questions:

Questions are asked about each domain to identify:

- whether a need or problem is present in that domain,
- whether the need is met or unmet
- how much help the user is currently receiving from informal (friends, family) or formal sources, and how much help he or she needs,
- what the client's views about his or her needs are and
- whether users are getting the right type of help for their problems and (in the user interview only) whether they are satisfied with the amount of help that they are receiving).

CANSAS: Only questions of the type (1) and (2) are asked. The answer categories are: "0=no problem", "1=met need", "2=unmet need"

CAN-C: Questions of the type (1), (2), (3) and (4) and CAN-R: (1), (2), (3) and (5) are asked. The answer categories for CAN-C and CAN-R are: Section (1): "0=no problem", "1=no/moderate problem due to help given", "2=serious problem" and sections (2) and (3): "0=none", "1=low help", "2=moderate help" and "3=high help".

### Necessary time for assessment:

CANSAS: approx.. 5 minutes; CAN-C / Can-R: approx. 15 minutes.

### Validity and Reliability:

The studies of Phelan et al. (1995)[104] and Slade et al. (1996)[105] suggest that the CAN is a valid instrument, which when used under research conditions has adequate reliability.

[104] Phelan, M., Slade, M., Thornicroft, G., Dunn, G., Holloway, F., Wykes, T,. Strathdee, G., Loftus, L., McCrone, P. & Hayward, P. (1995). The Camberwell Assessment of Need: The validity and reliability of an instrument to assess the needs of people with severe mental illness. British Journal of Psychiatry, 167, 589-595.

[105] Slade, M., Phelan, M., Thornicroft, G. & Parkman, S. (1996). The Camberwell Assessment of Need (CAN): Comparison of assessments by staff and patients of the needs of the severely mentally ill. Social Psychiatry and Psychiatric Epidemiology, 31(3), 109-13

**Publications using the instrument:**

Owing to the large number of publications only a small selection can be provided here. A complete list can be obtained from PRiSM (see address below).

Burns, T., Creed, F., Fahy, T., Thompson, S., Tyrer, P., & White, I. (1999). Intensive versus standard case management for severe psychotic illness: A randomised trial. *Lancet, 353*, 2185-2189.

Slade, M. & Thornicroft, G. (1999). User friendly assessment of need. *Nursing Times, 95*, 52-53.

UK 700 Group. (1999). Predictors of quality of life in people with severe mental illness. *British Journal of Psychiatry, 175*, 426-432.

Van Os, J., Gilvarry, C., Bale, R., van Horn, E., Tattan, T., White, I. & Murrey, R. (1999). To what extent does symptomatic improvement result in better outcome in psychotic illness? UK700 Group. *Psychological Medicine, 29*(5), 1183-1195.

**Languages:**

Cross-culturally validated versions of the CAN exist in English, Dutch, Danish, Italian and Spanish. Non-validated translations exist in French, German, Greek, Swedish and Turkish. All versions can be obtained from PRiSM (see address below).

**Comment:**

The CAN can basically also be deployed in the treatment and care of drug abusers. However, several adaptations are conceivable. For instance, the field "drugs" could be expanded whilst questions such "Do you know how to use a telephone?" or "How do you find using the bus, tube or train?" could be left out.

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## 4.3.3.2. Disability Assessment Schedule WHODAS II

Another important instrument that can be used to help identify individual needs is the World Health Organization Disability Assessment Schedule II (WHODAS II). It assesses the activity limitations and participation restrictions experienced by an individual irrespective of medical diagnosis. Results provide a profile of functioning across the domains as well as an overall disability score. Whilst in CAN needs are directly assessed, in WHODAS II these must be determined from the limitations which are established..

WHODAS II is currently under development and not yet available for general release and distribution. Further information on the WHODAS II can be obtained from: http://www.who.int/icidh/whodas/generalinfo.html.

### 4.3.3.3. Individual Treatment Planning

The Czech Republic reports on the following procedure to promote adequate individual treatment planning (see country reports, Cost-Effectiveness):

*Individual Treatment Plan or Client Contract*

Individual treatment plans are a kind of contract which is concluded when a client is admitted to the programme. During treatment the contract is regularly up-dated in consultation with the client. It includes the client's main problems together with the steps defined to change the situation which is unsatisfying to the client. The problem area as well as the steps to be taken are defined by the client supported by his/her personal counsellor (staff member). Such contracts include the following items:

- client data (name, birth, address, education/profession, brief drug career)
- relevant persons (basic information, contacts)
- definition of main client's problem
- the main (long-term) aim which the client wants to reach
- partial (short-term) aims which the client wants to reach
- steps - how to get to the targets set
- date of the next contract revision (up-date)
- signature of client, personal counsellor, supervisor of contract

*Programme effectiveness evaluation protocol:*

The programme effectiveness evaluation protocol is completed by the client, a staff member and/or by the client's relative (mostly parents). It is completed (1) at the admission of the client to the programme, (2) periodically while in treatment/ care, (3) at the completion of the programme (at orderly completion, or when dropping out), and (4) approx. one year after completion of the programme (or after dropping out). The following evaluation scales are used:

- *Client's life satisfaction:* client is unsatisfied; more unsatisfied than satisfied; more satisfied than unsatisfied; client is satisfied, everything is OK.
- *Abstinence:* client uses regularly; tries to be abstinent, uses safely, tries a "controlled use"; client relapses, he/she works with staff; client does not use

- *Relation to the family (parents, significant persons):* negative; more bad than good; more good than bad; regular contact with relatives valued positively by the client
- *Contacts with other users:* client has no other contacts than with DUs; client has mostly contacts with DUs; client has mostly contacts with no users; client has no contacts with DUs
- *Education and/or working position:* client is unemployed and does not study; client is employed or studying, but has serious problems (drop-out is very likely); client is working or studying; client is working or studying, he/she is satisfied with this situation.

Goal attainment is documented according to the following grid:

| Evaluated by | Evaluated area | At admis-sion | At comple-tion | 1 year after completion |
|---|---|---|---|---|
| **CLIENT** | 1.Life satisfaction | 0 - 3 | 0 - 3 | 0 - 3 |
| | 2.Abstinence | 0 - 3 | 0 - 3 | 0 - 3 |
| | 3.Relations | 0 - 3 | 0 - 3 | 0 - 3 |
| | 4.Contact with users | 0 - 3 | 0 - 3 | 0 - 3 |
| | 5.Work/Education | 0 - 3 | 0 - 3 | 0 - 3 |
| **RELATIVES** | 1.Life satisfaction | 0 - 3 | 0 - 3 | 0 - 3 |
| | 2.Abstinence | 0 - 3 | 0 - 3 | 0 - 3 |
| | 3.Relations | 0 - 3 | 0 - 3 | 0 - 3 |
| | 4.Contact with users | 0 - 3 | 0 - 3 | 0 - 3 |
| | 5.Work/Education | 0 - 3 | 0 - 3 | 0 - 3 |
| **STAFF** | 1.Life satisfaction | 0 - 3 | 0 - 3 | 0 - 3 |
| | 2.Abstinence | 0 - 3 | 0 - 3 | 0 - 3 |
| | 3.Relations | 0 - 3 | 0 - 3 | 0 - 3 |
| | 4.Contact with users | 0 - 3 | 0 - 3 | 0 - 3 |
| | 5.Work/Education | 0 - 3 | 0 - 3 | 0 - 3 |

## 4.3.4. Identifying unmet needs within and outside the treatment system

If the adequacy of the entire treatment *system*[106] is to be assessed and improved regarding the needs of the drug abuser, then it is extremely advisable to question drug abusers - in addition to their satisfaction with individual establishments - on unmet needs and obstacles to using services as seen from their perspective. In doing so, in addition to considering general and specific target groups, both current clients, ex-clients and potential clients in a given region should be interviewed. Data thus collected can help to provide an overview of met and unmet needs and gaps in the provision of services from the users' perspective, and provides valuable indications about measures to be taken.

Here, attention should be paid in particular to the needs of hidden populations, i.e., those drug abusers who have not made contact with treatment and care services. Of interest are on the one hand specific characteristics (general life circumstances (type and frequency of the consumption) as well as differences between the "hidden" and the "registered" population, and on the other their subjective unmet needs. Ideally, a combination of qualitative and quantitative research methods should be selected.

### Methods of access to the hidden population

The assessment of the unmet needs of treatment and support for persons outside the treatment system poses several problems: first of all it needs to be defined as to which persons are included in the hidden population, which itself raises a few questions:

- Does this include drug addicts who are not in contact with specialised treatment facilities for addiction care? Should the users of low-threshold facilities be considered as part of the hidden or of part of the known population? Or do only those persons who are neither registered by the police and are not known to general social and medical establishments belong to the hidden population?
- Are persons considered to be "hidden" only if they have never made use of a service, or does it also include those who, for example, have not used a service for at least a year?
- Are only those "hidden" drug consumers who feel a subjective need for treatment and support of interest, or are all consumers of illegal drugs of interest?

[106] Unmet needs at the level of individual facilities can be identified through satisfaction surveys.

A further difficulty is the *accessibility* of this group since contact cannot be made through the care facilities, which also hinders the conducting of a *representative sample*. The following variants can therefore be suggested which to some extent overlap with each other:

- *Snowball sampling*: This term covers various methods which are based on the concept of localising the target person though the mediation of 'initial contact persons' (for a detailed description see below).
- *Privileged access method*: Persons who have privileged access to the population being investigated are trained as interviewers (e.g., street workers, drug consumers). The contacting *and* the questioning is carried out by privileged access interviewers .
- *Appeals in the media* (advertisements in publications, radio or television appeals, flyers, posters)
- *Outcropping*: making contact at known meeting points of drug abusers (Diffusion of questionnaires)
- *"Téléphon vert"* (telephone help lines for drug abusers and carers)
- *Use of networks* which deal with fringe groups,
- Records by the police, in prisons, by social services and during emergency admissions (dependent upon the definition of hidden populations).

These procedures can also in principle be used when surveying the known population, in particular the non-registered users of low-threshold facilities.

These methods do not allow for any representative sampling. When selecting the cases the main decision criterion is the wealth of relevant information. Only with the snowball method described below is a certain amount of randomisation striven for:

### Snowball sampling / chain referral sampling[107]

Snowballing as a method of gaining access to the hidden population of drug users involves asking known drug users to identify and/or introduce the researcher (or outreach workers) to drug using friends and acquaintances, thereby attempting to move from known to unknown drug users and to generate a sample of hidden users. The method is based on the assumption that members of a selected hidden population do not live in complete isolation but have extensive social contacts. The users must inevitably procure the drug from someone else, most commonly a friend, a dealer or other user.

[107] See Eland-Goossensen, M. A., Van de Goor, L. A. M., Vollemans, E. C., Hendriks, V. M. & Garretsen, H. F. L. (1997). Snowball sampling applied to opiate addicts outside the treatment system. Addiction Research, 5/4, 317-330.

The essential features of the procedure is that a random sample of persons are asked to nominate other persons. Through the repeating of this procedure many individuals in a definite population can be contacted in a relatively short period of time. The procedure is divided into the following phases:

a) Preparation

- *Definition of the target population:* Which people are to be studied, in what geographical area and with what objective?
- Division of the whole area to be studied into appropriate smaller areas (neighbourhoods) and charting these in more detail (=*initial mapping*)
- Exploration of potential research sites more thoroughly by means of field observations and other qualitative methods (=*ethographic mapping*)
- Description of the goal population in totality and in subgroups. This enables choosing starting points in separate networks (=*network map*).
- Recruiting and training of research assistants
- Provide rooms where interviews can be conducted without being disturbed (possible use of mobile field stations)

b) Referral procedure

- Select in every starting point one or several key informants; ask them to nominate individuals from the target population who meet the inclusion criteria
- For each nominated person record definite social-demographic information and information concerning their drug consumption. The similarity of socio-demographic characteristics of the sample (interviewed nominees) with the total pool of nominees (not interviewed) is an indication of the representativeness of the sample.
- Select a certain number of the nominated persons by random (e.g., by throwing a dice) .
- Ask a key informant to contact the nominees: It can prove difficult to localise the nominated persons and to persuade them to participate. Paying the earlier respondent for guiding the interviewer to the selected nominee can make it easier to make contact.

c) Interviewing

- The nominated persons are interviewed.
- The referral procedure is then repeated for the next respondent.

The extent to which the findings can be generalised is basically very limited since no random samples are taken. To compensate for this condition the following measures can be taken:

- *Network map:* Describe the social networks on a map and start every snowball chain in a separate network
- *Site sampling:* This is a selection procedure in which the target population is divided with regard to place (location of subject) and time (when subjects are at this location). The number of persons that should be interviewed at each site is determined by assigning weights to the number of people attending every site, the estimated size of the total population and the frequency of exchanges between different sites (mobility).
- *Snowballing with random nominee selection*: Make a random choice out of a set of possible respondents, instead of asking every person who is located by snowballing (e.g. random choice by throwing a dice)
- *Long snowball chains*: Use long snowball chains as a means to approach a larger number of networks. However, longer snowball chains only have a positive influence when not too many look-a-likes (referrals with similarity at a certain characteristic) are nominated.
- *Double nominations* of the same person should be removed.

For detailed information see also: Hartnoll, R., Balsa, C., Griffiths, P., Taylor, C., Hendriks, V. M., Blanken, P., Nolimal, D. & Toussirt, M. (1996). *Handbook on snowball sampling*. Strasbourg: Council of Europe / Pompidou Group.

### Methods for questioning known and hidden target groups

The selection of the interview technique depends on the informants as well as the type of information to be gained:

- *Questioning individual drug abusers* on individual experiences and opinions; here face-to-face in-depth interviews which are not too structured are particularly suitable if conducted by experienced researchers. If, on the other hand, the interviews are conducted by 'privileged access interviewers' (see above), then it is recommended that structured procedures are used.
- When questioning *key informants* and/ or representatives from users' organisations as experts, it is questions about the inadequacy of the existing services which tend to be of most interest. Less structured procedures are also recommended here.

- *Conducting group interviews (focus groups)*[108]*:* The objective behind the scheduling of focus groups is to provide an unstructured forum for both current and potential service consumers to raise and explore the issues which they consider important. The composition of the groups can be specific to target groups (e.g. only young drug users or female drug users) or as heterogeneous as possible, and include around 6 to 10 persons, The recruiting can be made though, for example, local treatment services or privileged access interviewers. To ensure that the persons being questioned appear at the group meeting, it is recommended to provide transportation and to compensate the participants for the time given up. Confidentiality must be ensured. Group meetings should be guided by an experienced moderator.
  By using these procedures a great deal of information can be gained rapidly. In addition, different assessments and needs, e.g., of the users and ex-users, can be discussed, which makes it considerably easier to use the findings in improving adequacy.

### Possible questions

The following subject areas could be helpful when compiling the question catalogue:

- *Ascertaining personal information*: social-demographic data; history of drug use and drug treatment; current life situation; health status (in particular should be considered: region of origin; experience of migration; drug abusers with children)
- *Referrals to known or hidden populations*: Was the respondent undergoing treatment in the last two years in connection with his drug consumption?

*Questions to the hidden population*:

- Why has the respondent not attended an agency/service?
- Which agencies/services are known to the respondent?
- In the case that certain agencies/services have already been made use of at some point in the past: how does the respondent assess the existing agencies/services?
- What could each service do to make the respondent more likely to attend?
- How likely is the respondent to ask a treatment service for help over the next year?
- Which services are currently lacking according to the view of the respondent?
- What are the interviewee's potential sources of help with drug problems?

[108] See Flick, Uwe. (1995). Qualitative Forschung: Theorie, Methoden, Anwendung in Psychologie und Sozialwissenschaften. Reinbek bei Hamburg: Rowohlt Taschenbuch.

*Questions on the users of services* (retrospective satisfaction surveys)

- Which services/agencies were used?
- To what extent were the services received in accordance with their subjective need for support? How can the effectiveness of the treatment be judged?
- What are their suggestions for improvements? What did the client miss in the programme? Which services were missing? What advice would the client give to the personnel?

For important dimensions, see also Client Satisfaction under 4.3.1.

When assessing subjective needs, qualitative research is of particular importance, which is why we refer finally at this point to the homepage QED Qualitative European Drug Research (http://www.qed.org.uk/). The aim of QED is to assist with the general networking of qualitative researchers, to encourage dialogue and the sharing of ideas.

## 4.3.5. Needs of specific target groups

Specific target groups refers to drug abusers for whom the general service for treatment and care is inadequate as a result of special personality characteristics and/or life situations. An adequate care system should provide specific services for these groups.

The following target groups with specific needs were identified by the ADAT group. The overview can be used as a checklist for adequate service delivery:

| **Specific Target Groups** | **Specific Needs** |
|---|---|
| Young drug abusers (under 18) | Special outreach and specific in- and out-patient services |
| Pregnant drug users | Special outreach services and motivation to make contact for medical treatment<br>Access to methadone maintenance treatment<br>Health treatment, pregnancy advice, baby advice (medical, psychosocial and educational support) |
| Drug abusers with children | Possibility for in-patient residential stays together with children<br>The specific need is not explicated any further |
| Children of drug abusing parents | Possibility of in-patient residential stays together with the parents<br>Requirements: infrastructure suitable for children, expert psychological or physical clarification; professional care of the children; professional care of the family system; financing of the children's residence covering costs |

| | |
|---|---|
| ”Dual diagnosis” drug abusers | Development of new treatment interventions<br>Specific departments in the psychiatric hospital as well as in-patient places outside of the psychiatric hospitals |
| Drug abusers with HIV/AIDS and Hepatitis | Comprehensive system of care |
| Drug abusing ethnic minority groups | Intense outreach work owing to their tendency not to contact the social service agencies[109]<br>Enabling linguistic communication<br>Development of culturally suitable forms of treatment |
| Drug abusers in prisons | Survival help, preventative and therapeutic services; ID access to clean injection materials and condoms, drug-free and methadone treatment |
| Female drug abusers | Specific offers of treatment and care which are in accordance with needs specific to women |
| Highly qualified drug abusing professionals (e.g. medical professions, managers, pilots) | Specific treatment services (avoidance of contacts to the drug scene; increased need for confidentiality) |
| Drug abusing sex workers | Specific measures for harm reduction (e.g. distribution of condoms, specific information on safer sex, acceptance of sex work, drop-in facilities at night)<br>Specific offers of treatment due to a higher risk of dropping out; adequate outreach |
| Consumers of cannabis, cocaine, and sythetic drugs with problematic patterns of use | Specific treatment of psychotic reactions |

The Pompidou Group published a document which looks at European good practice programmes that take into account the health and social care of addicted women and their children: Leopold, Renate & Stefan, Elfriede (1997). *Special needs of children of drug misusers*. Final Report. Group Pompidou[110].

The results of a European study on problem drug use by women with focus on community-based interventions was carried out by Dagmar Hedrich, Lisbon. The final report can be downloaded at: http://www.pompidou.coe.int/English/therapie/women/pdw-e001.html.

[109] In the Netherlands it can be stated that drug-using immigrants (Turkish, Moroccan, Surinam) make little use of drug treatment and care programmes. Currently, a study is being carried out in order to gain more insight into the problems and obstacles they meet, their specific needs and individual differences.

[110] The publication can be ordered at: http://book.coe.fr/GB/CAT/LIV/HTM/l1113.htm.

## 4.4. Needs of other customer groups

Both individual services and facilities as well as entire treatment networks must not only meet the needs of drug abusers, the expectations of other customer groups (stake holders) must also be taken into consideration in assessing the adequacy.

The most important customers of treatment and care facilities have been listed in the introduction (1). An exemplary, detailed listing from a Swiss in-patient facility is given below.

Although the importance of considering their expectations and needs has been emphasised many times, there is actually very little material available on this field. These will be briefly presented in the following section:

### 4.4.1. Exemplary list of possible customers of a therapeutic facility

Within the framework of their quality assurance, the in-patient therapeutic facility "Casa Fidelio" (Switzerland) divides up its "customer relations" as follows[111]:

**Operation**

1. *Directly affected* (Clientele 1): Clients, relatives
2. *Funding bodies and providers* (Clientele 2): Well-fare authorities of the districts of origin, penal authorities (with detention centre), insurance (medical insurance, social security)
3. *Referral authorities*: drop-in centres; withdrawal facilities; hospitals; doctors in private practice, low-threshold services; substitution programmes, psychiatric facilities
4. *Operation*: Personnel; administration; external personnel; bank
5. *Quality management*: Quality representative for the institution (internal); external auditor

**Increasing knowledge**

6. *Expert committees*: Specialist and professional organisations; funding organisations; colleges; expert commissions
7. *Research*: Participation in the *Forschungsverbund stationäre Therapie* (research network for residential therapy (FOS)); projects from the Swiss Federal office for Health; own themes: commissions

[111] Slightly modified by Ulich Simmel, Koste, ADAT Principal Investigator for Switzerland.

**Partner institutions**

8. *Institutional network*

9. *Granting/Recognition bodies:* Canton Authority for Districts and social security; Federal Offices for Health and Social Security; co-ordination centre for in-patient therapy

**Public Relations**

10. *Public:* general; district authorities; police; neighbours; politicians

11. *Prevention*: general; regional prevention project; schools/youth groups in the region

12. *Social environment*: Future employer; future place of residence; clubs/leisure

**Competition**

13. Facilities wit the same target groups

**Business**

14. *Building industry*: Partner firms; building clients; architecture clients

## 4.4.2. Needs of professionals

As far as the expectations and needs of professionals are concerned, the following areas are of particular interest:

- Job satisfaction of those professionals who work in the treatment and care of drug abusers
- Surveys of the specialist public for their assessment of individual addiction care facilities

The general expectations of professionals with regard to the treatment network as well as to professional networking and further training, on the other hand, will be considered in the ADAT part III on professionalism.

For the area of job satisfaction the Dutch instrument BASAM will be presented in the following section. The questionnaire is used within the framework of the comprehensive quality management in the Dutch Jellinek Centre[112] and has proved worthwhile in practice. Furthermore, two german instruments for the assessment of burnout-symptoms (CBM) and symptoms for the development of burnout (CBE) will be described briefly.

[112] For monitoring job satisfaction further measures are carried out at the Jellinek Centre, such as job functioning interviews and the monitoring of sick leave as a part of the personnel information system (see: Nabitz U, Walburg J (1998) The Jellinek Centre Application Report for the Dutch Quality Award, Public Sector, 1996. Jellinek, Amsterdam.)

## 4.4.2.1. Basic Personnel Questionnaire Amsterdam (BASAM)

**General information:**

The BASAM has been developed by the University of Amsterdam to measure the social and psychological impact of management, especially with reference to job satisfaction. The questionnaire has separate forms for profit and non-profit organisations. Both forms can be extended using organisation-specific topics.

The aim of the BASAM is to measure the concept "Job Satisfaction", the amount of pleasure a person receives from his job. The questionnaire results in a detailed description of the attitude towards several aspects of the work that have an influence upon management of an organisation. The Non-profit version is somewhat more limited than the Profit version and has been developed especially for the Government and affiliated organisations.

**Target population:** Personnel of profit and non-profit organisations

**Dimensions of people's job satisfaction:**

Using a number of questions the employee's attitude toward the following five main aspects is measured: Properties of the work; Leadership as an element of the group; Satisfaction with pay; Properties of the organisation; Attitude toward physical working conditions. The following scales are included:

Autonomy
Information of own job
Importance of the job
Meaningfulness of the job
Perceived responsibility
Information of the results
Role conflicts
Clarity of roles
Work stress
Social-emotional leadership
Corrective leadership
Stimulating leadership
Support by colleagues
Receiving information
Giving information
Correct judgement
Attitude towards reward system
Functionality of reward system
Accessibility of services
Structuring
Physical jobsetting

**Type of questions:** The assessment is depicted in a horizontal histogram with five categories. The rating scale runs from "very negative=1", through "neutral=3" to "very positive=5".

**Number of items:** Background questions: 9; Assessment of statements about work: 100; Organisation-specific questions: 39

**Reliability and Validity:**

The reliability of the scales of the BASAM can be described (by Cronbach's Alpha) as good; average for some scales. Cronbach's Alpha ranges between 0.60 and 0.92. Using Confirmatory Factor Analysis (CFA) the validity was examined. The scales were on average one dimensional. The structure of the scales within the main aspects was confirmed. Extensive research on the criterion-referenced validity was carried out: these examinations also confirmed the validity of the test.

**Languages:** The instrument is only available in Dutch.

**Copyright / address:**

Ordering:

Swets Test Publishers
Postbus 820
2160 SZ Lisse
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## 4.4.2.2. Checklist of Burnout Characteristics (CBM) and Characteristics for the Emergence of Burnout (CBE)

Burnout represents a risk for all occupations in therapeutic care and can be described as a condition of inner exhaustion. When addiction therapists are not only at risk from burnout but are also frequently impaired by burnout, then this will detract from their quality of life and also the quality of their therapeutic work. This is why burnout prevention represents an important part of quality assurance in the treatment of drug abusers.

A starting point for dealing with the theme of "burnout" at personal and institutional level is provided by the checklists Burnout Characteristics (CBM) and Characteristics for the Emergence of Burnout (CBM). The two instruments provide the basis for detecting the main burnout symptoms as well as for identifying influencing factors which encourage burnout in addiction care. Whilst with the construction of the CBM it was possible to make use of existing burnout questionnaires, the CBE was completely newly developed in order to be able to do justice to the special stress factors within addiction care[113].

[113] Since the CBE is oriented towards the therapy of persons with alcohol problems, slight changes are needed in the case of two statements: "after the 'first drink' following a phase of abstinence things inevitably take a turn for the worse" is changed to "After the first relapse after a phase of abstinence things inevitably take a turn for the worse", and "if the course of therapy runs well, I secretly assume that the client will no

**CBM:** The CBM consists of 26 statements which the employees can assess using a semantic differential with a six-point rating (examples of statements: *"I feel worn out by my work"* or *"worrying about work impairs my sleep"*). The statements are divided into the three scales "Emotional exhaustion", "Reduced personal efficiency" and "De-personalised attitude towards Clients". The reliability of the scales can be described as good. Cronbach's Alpha ranges between 0.68 and 0.91.

**CBE:** The CBE contains 27 statements on possible causes of "burnout" which are also assessed using a semantic differential with a six-point rating (examples of statements: "*I regularly work beyond working hours*" or "*When a client has a relapse, I sometimes think that there is no point to my work*"). The statements are classified under the five scales "Personal characteristics", "Client characteristics", "Myths", "Institutional characteristics and Team characteristics. The CBE was developed on a heuristic basis; there are currently still no reliability calculations available.

**Languages**: The questionnaires are only available in German.

**Copyright / address**

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## 4.4.2.3. Assessing the satisfaction of the specialist public

By conducting surveys of the specialist public (i.e. social and health care specialists from within and outside the system of treatment and care), their satisfaction with the services, and the collaboration with one or more treatment facilities can be measured. Furthermore, it can be ascertained as to how far services meet the current needs in a region according to the questioned professionals. And finally, the specialist public's needs for information can also be identified. The following survey variants can be distinguished:

- *Satisfaction with a definite treatment facility v. satisfaction with a treatment system:* The survey can be conducted as part of the quality assurance of an establishment. Thus the questions will manly refer to the satisfaction with the

longer drink for a period of several months becomes "If the course of therapy runs well, I secretly assume that the client will no longer consume over a period of several months" cf. (Wettach, 1997).

services of this one establishment. It is also possible, however, to measure the satisfaction with several establishments of a treatment system.

- *Survey of current allocators vs. Survey of potential allocators:* On the one hand it is possible to survey only the group of persons which has come into contact with a treatment facility at a professional level, e.g., as allocators of a drug abuser. On the other hand it is also possible, however, to survey all potential allocators of a facility irrespective as to whether there has been any contact. In the following section current and potential allocators will be described as specialist public.

Possible content of a survey:

- Knowledge of services and organisation of the treatment facility /information sources used
- Utilisation of the facility or the treatment system (contact with the facility yes/no, frequency of referrals, reason for contact being ceased, etc.)
- Satisfaction with the services of the facility (competence of the personnel, usefulness of the information received, accessibility of the responsible persons, treatment outcome, etc.)
- Evaluation of the concrete services of the facility (assessment of the importance of the individual programme components)
- General needs regarding services in the field of addiction care (met and unmet)
- Attitude to drug policies

## 4.4.3. Relatives of drug addicts

Relatives and people close to drug abusers are subject to enormous pressures. It is therefore extremely important that their need for support can be met with adequate services. Nothing is reported in the ADAT country reports about systematic surveys of this target group. The following forms can, however, be recommended:

- If relatives themselves approach counselling centres as well as self-help groups, i.e., they themselves are clients of counselling centres, then they can be questioned as to their s*atisfaction* with the support received (see Client Satisfaction, 4.3.1).
- In addition there are the *parent and relative organisations* which can introduce their concerns into the service planning and evaluation (see 4.3.2).

It is additionally recommended that *regional surveys* are conducted on these target groups, whereby various forms are possible: written or oral surveys of relatives; group interviews, surveys of parents / relative organisations. The following questions could be of interest in this respect:

- What sort of support do the relatives of drug abusers require for themselves and for the drug abuser close to them in order to be able to live with him and/or to be able to support him? To what extent are they currently receiving this support?
- What is their assessment of the accessibility of the treatment and care facilities for drug addicts (admission procedures; exclusion of treatment services; financial difficulties; availability of information; regional deficiencies in service provision?)

### 4.4.4. Local communities

Little information is provided by the country reports concerning the specific expectations of local communities as well as the possibilities for these to be measured. It is considered to be fundamentally important, however, that their needs are given greater consideration. The World Health Organization 1998 (p. 31f.) stresses the importance of community involvement in the planning and realisation of preventive interventions. Public health responses must be both community-based and community-oriented. Community participation at the local level must be encouraged, especially the participation of key members such as substance users, those affected by substance use, health, welfare and human rights organisations, community advocacy and policy groups (ibid., 34).

In the Swiss report surveys of inhabitants, local businesses as well as the responsible police authorities are mentioned as possibilities. In the application report made by the Jellinek Centre for the Dutch Quality Award[114], it additionally reports on the conducting of neighbourhood research as well as a survey of the Jellinek Centre's image within the population.

Another possibility for taking into consideration the population's assessment of the adequacy of addition care is the use of EUROBAROMETER, which is an opinion survey on drugs last implemented in the fifteen European Union member states in 1995. The survey includes opinion questions on the following topics: Attitudes towards drugs and drug addicts; Main reasons for taking drugs; Knowledge and accessibility of certain drugs; Priorities in eliminating the drug problem; Opinions regarding the treatment of drug addiction; Opinions regarding urine

[114] Nabitz U, Walburg J (1998) The Jellinek Centre Application Report for the Dutch Quality Award, Public Sector, 1996. Jellinek, Amsterdam.

tests. The renewal of this survey is foreseen in the framework of the Community Action programme for the prevention of drug dependence.

(see: http://europa.eu.int/comm/health/ph/programmes/drugs/eurobar.htm)

## 4.5. Survey and description of the service

As has already been described, an unmet need (and therefore the adequacy of the service) can be assessed by comparing the service and need. In order that the service and the need can be compared, however, the existing service must first be systematically surveyed and described. In a similar way to the treatment monitoring system, most countries have at their disposal more or less differentiated systems to survey the services. With such instruments several aims can be pursued:

- Survey of the service spectrum and capacity, including the geographical distribution as a basis for service planning
- Production of an "address book" of available services, which professionals or clients can refer to
- Supplement to the systematic collection of client data (treatment monitoring systems) as a prerequisite for a differentiated evaluation
- Survey of the characteristics of the structural quality as part of a comprehensive quality assurance

In the next sections the following three instruments will be described: Treatment Unit Form (TUF), Monitoring Area and Phase Unit Description Form (MAP-unit), Modular Instrument for the Description of Addiction Treatment (MIDES):

### 4.5.1. Treatment Unit Form (TUF)

The Treatment Unit Form is a questionnaire to be filled in by drug abuse treatment units. There are two formats of the TUF: TUF-A is designed for structured units/programmes and TUF-B for low-threshold units/programmes. The TUF provides a complete and detailed profile of the structural and functional characteristics of the existing treatment services that facilitates:

- their visibility at national and European level through data that can be presented in reports (e.g. the annual reports submitted to the EMCDDA),
- exchange of information between field workers,
- client / treatment matching purposes by providing an account of clients‘ choices of treatment services

**The current versions of the TUF cover the following areas:**

**TUF-A (9 domains):**

- Identification information
- Treatment unit/programme characteristics
- Treatment planning / approach / goals / services
- Assessment of clients
- Completion of treatment
- Staffing
- Finances
- Evaluation
- Changes in the treatment unit/programme

**TUF-B (6 domains):**

- Identification information
- Low-threshold treatment unit/programme characteristics
- Staffing
- Finances
- Evaluation
- Changes in the treatment unit/programme

**Languages:** the TUF is available in English. The draft version is translated into French, Italian, Spanish and German. No information is yet available on the stage of translation of the final edition of the instrument.

**Further information can be obtained from:**

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## 4.5.2. Monitoring Area and Phase Unit Description Form (MAP-unit)

The MAP system is a concept for structured assessment, treatment planning and evaluation of therapeutic communities, treatment centres and other in-patient facilities. The system consists of four instruments called MAP-unit (description of the unit), MAP-in (client intake form) , MAP-out (client discharge form) and MAP-up (client follow-up form). All instruments provide qualitative as well as quantitative measures. In the following section only MAP-unit will be described.

MAP-unit is a screening of the preconditions for treatment at the unit. It provides a resource profile, a goal profile and a treatment spectrum profile. It can be used in different sectors of care (e.g. social services, drug and alcohol treatment, prison and probation, psychiatric care and somatic care).

**The current version of the MAP-unit covers the following areas:**

- Basic data (framework settings, target groups, etc.)
- Staff – quantity and competence
- Treatment goals of the unit
- Treatment spectrum
- Treatment planning
- Services provided by or through the unit

**Languages:** the MAP-unit is available in English, Dutch/Flemish and Swedish. Italian and French translations are under preparation.

**Further information can be obtained from:**

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Homepage: www.homestead.com/projectmaps (for downloading of forms)

### 4.5.3. Modular Instrument for the Description of Addiction Treatment (MIDES)

MIDES is a questionnaire for conducting pragmatic structural surveys of treatment facilities and services for drug abusers. The instrument is modular in structure. Besides the core variables, which are oriented to the entire treatment spectrum, there are out-patient specific and in-patient specific modules. MIDES was developed for the description of facilities for abusers of illegal drugs. MIDES is not suitable for facilities which are purely for alcohol treatment.

**The MIDES questionnaire covers the following areas:**

*A) Structural conditions*

- Basic data on the treatment unit/programme
- Finance
- Networking
- Organisation, Administration

*B) Concept: theoretical background and service*

- Information on the concept
- Aims and service
- Regulations and controls

*C) Team*

- Professional background
- Personnel fluctuation
- Personnel supervision

*D) Clientele*

- Client selection
- Intake and discharge
- Diagnoses
- Joint responsibility of the clients

The data collected with MIDES is used for combined evaluations e.g., in combination with client data or with data on process quality. The main research questions refer to the connection between concept, objectives and the concrete service of the facilities on the one hand, and client characteristics, proportion of terminations and treatment successes on the other. In addition, the data forms the basis for a manual published at regular intervals in Switzerland in which all the in-patient therapy services in the field of drugs are listed according to the same criteria.

**Languages:** MIDES is only available in German.

**Further information can be obtained from:**

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Further instruments can be found in the *Evaluation Instruments Bank* (EIB) at EMCDDA: http://eib.emcdda.org/eib/databases_eib.shtml

## 4.6. Comparison of the service and need

In order to assess the adequacy of the existing treatment and care services with the ascertained need, both in quantitative as well as in qualitative terms, and in order to be able to identify approaches for further planning, the findings of both areas must be compared with each other and evaluated. This comparison must be conducted at the level of the individual clients, individual institutions as well as the level of the entire service of a treatment region.

### 4.6.1. Individually appropriate treatment and care of clients

Whether or not a treatment meets the individual needs of a client can be assessed using the following criteria:

- Suitable referral
- Individual treatment planning
- Suitable aftercare

Under the concept "Client – Service Matching", characteristics of clients and facilities are searched for which, in a suitable combination, positively influence the success of the treatment. No findings were presented on this theme in the ADAT country reports. The development of empirically supported criteria for the matching of client and facility characteristics is, however, currently under way[115] and, in terms of needs-led - and therefore more effective - treatment and care, is highly significant.

Such criteria should be included in the description of treatment and care facilities used by referral authorities, as well as in the admission criteria of establishments. The referral authorities must be corresponding informed and trained. The same also fundamentally applies for adequate aftercare.

In the next stage adequate treatment can be improved by individual treatment planning (see 4.3.3). This presupposes that there has been an expert diagnosis as well as an assessment of subjective needs. The agreement on aims and the care planning are worked out in collaboration between the professionals and the clients. The attainment of the individual aims must be documented and periodically checked.

[115] See Dutch report in ADAT part IV on effectiveness and cost-effectiveness.

## 4.6.2. Adequacy of facilities' services for the needs of identified target groups

A facility can initially assess the adequacy of its service for the subjective needs of its clientele by using systematic *satisfaction surveys* (see 4.3.1).

A further possibility is provided by the *Peer Review procedures for analysing the process quality of in-patient rehabilitation measures* which was developed within the framework of the quality assurance programme of the German nation health insurance scheme (see German country report). The quality of the rehabilitation process documented in the discharge report is assessed by specially trained professional colleagues from other rehabilitation clinics using a checklist of quality-relevant process characteristics. The checklist contains 67 characteristics and is divided into the areas Anamnesis, Diagnosis, Therapeutic aims and planning, Course and epicrises, Social-medical Appraisal as well as Further Measures/Aftercare. The discharge reports are evaluated for the individual characteristics by classifying them into the categories "no deficiencies", "slight deficiencies" and "serious deficiencies", as well as an additional category "not applicable". For each of the named areas a summarising assessment is also conducted for which there are four categories available ("no deficiencies", "slight deficiencies", "clear deficiencies" and "serious deficiencies"). Finally, a summarising assessment of the entire Rehab process is made which also uses these four assessment categories, whereby the respective discharge report, together with the individual weekly therapy plans, form the basis of the assessment.

The extent to which both the identified target group as well as the treatment aims are reached can be examined by collecting suitable intake, discharge and follow-up data within the framework of *treatment monitoring systems* (cf. 4.2.4).The effectiveness should also be take examined[116]

The *adequacy of the capacity* can be assessed using the following indicators:

- *Waiting period*: Number of days from the initial enquiry until admission; difference in days between the desired and the actual admission; number of rejections owing to lack of places (no instruments are named; see Annex II).
- *Degree of utilisation*: Over- and under-capacity can be established based on the degree of utilisation (number of clients per full-time employee and year, differentiated according to the treatment modality; normative guidelines on quantitative personnel-clientele ratios exist e.g. in Italy; cf. Professionalism)
- *Job satisfaction of employees* (cf. 4.4.2.1)

[116] Service adequacy may be evaluated by 1) the proportion of clients who complete the treatment as planned and 2) among those who do, which proportion is drug free within and after the first year after discharge (in addition to the time spent in treatment) and for how long they stay drug free or for how long they have drug free periods after release ( 'combined effectiveness').

## 4.6.3. Adequacy of services for needs at the level of entire treatment regions

When comparing services and needs at the level of a treatment region, the following aspects must in particular be assessed:

- Scope of the care system
- Capacity of the care system
- Adequacy of the service spectrum and the organisation structure (accessibility, networking and client-orientation of the services)[117]

The assessment of the adequacy in terms of needs can be assessed on the one hand by comparing services and needs, and on the other by using indicators which are applied for unmet needs.

The following section provides a list summarising the data which needs to be considered, as well as additional indicators for unmet needs. Finally, possibilities for conducting this comparison are provided:

### Indicators for the range of the care system

- Total number of drug abusers in relation to the general population (see 4.2.2 and 4.2.3)
- Number of drug abusers in contact with different treatment and care services in relation to the total number of drug abusers; or size of the hidden population in relation to the total number of drug abusers (see 4.2.2, 4.2.3, 4.2.4 and Annex II); in order that this ratio can also be used as an indicator, the hidden population must be uniformly defined (see 4.3.4).
- Mean duration of the drug consumption until the first enquiry about treatment (see Treatment Monitoring Systems, 4.2.4)
- Number of drug-related deaths and mortality of drug users (in relation to the general population; regional trends; see 4.2.5)
- Prevalence of drug-related infectious diseases (see 4.2.6)

### Indicators for the capacity of the care system

- Number of treatment slots at disposal to the region in question (differentiated according to type of services and specific target groups; see 4.2.5 and Annex II)

[117] The effectiveness of the care system also ought to be assessed. Information on this is provided in the chapters on Professional Standards and Cost-Effectiveness.

- Waiting period for a suitable treatment slot: lack of corresponding instruments; suitable would be uniform documentation of the waiting periods and reasons for waiting by the referral bodies; possible indicators are contained in the Danish instrument (see Annex II):
  - Number of persons on the waiting list for in- and for out-patient treatment
  - Number of days it takes on average from the appearance/ application of a drug abuser until the implementation of a treatment offer (differentiated according to in-patient, out-patient and methadone treatment)
  - Number of days passing, on average, from the appearance/ application of a drug abuser until the first clarifying interview
  - Types of activities implemented during the time from the appearance/ application until the implementation of a treatment offer[118]
- Depending on the form of finance: existing resources for financing treatment and care in the treatment region.

**Adequacy of the service spectrum and organisation structure**

- Assessing the service spectrum using service description forms (see 4.5)
- Surveying users' and carers' organisations for unmet needs (see 4.3.2)
- Identifying unmet needs within and outside the treatment system (4.3.4)
- Surveys of other client groups (professionals, relatives, local communities; see 4.4)
- Identifying new development trends (see 4.2.7)

[118] Clarification/ anamnesis, the working out of a plan of action, temporary measures, etc.

### 4.6.3.2. Checklist for recommended services for the treatment and care of substance abusers

In order to identify unmet needs and to define measures for improving the adequacy of the system of drug abuse treatment and care, the supply of services and the need for treatment and care within a given region need to be contrasted. For this purpose, the above-mentioned data must be collected, listed and compared.

The following checklist should help to *locate the need for action* in the field of drug abuse treatment and care, excluding prevention measures as well as primary health and social care. It needs to be pointed out, however, that good care for drug abusers is possible only within the framework of a comprehensive and functioning system of primary health care and social services.

The checklist is essentially based on the ADAT country reports as well as the WHO Standards of Care (WHO 1993) and translates the identified needs of drug abusers and their relatives into corresponding services. The list is based on the assumption that the affected population has different needs and that a wide *palette of services* is therefore required. Their needs can be dependent upon the previous course of their drug addiction, their previous contact with the care system, their psychological and physical health condition, and their social and cultural background (ethnic minorities, women, parents). It is not the intention of the checklist, however, that all the services listed below must be provided in an institutional setting exclusively for drug abusers, but rather that the services themselves must be targeted towards the specific support and treatment needs of drug addicts.

The ADAT expert group rated the services listed below as to whether they are

- *necessary (N),*
- *recommended (R)*, or
- *optional (O)* for an adequate system of drug abuse treatment and care.

However, location-specific needs may lead to the need for additional services that are not included in the checklist.

Finally, the order of the services listed does not say anything about their importance or about the sequence of the interventions.

# Checklist for Services

| Out-patient Services | | |
|---|---|---|
| Low-threshold Services (social and medical care) | - Low-threshold contact centres<br>- Emergency overnight accommodation<br>- Cheap or free distribution of needles, syringes, condoms<br>- Low-threshold basic medical treatment<br>- Medical emergency services (e.g. in case of overdose, attempted suicide)<br>- Vaccination programmes (Hepatitis) | N |
| | - Street corner work<br>- Outreach for specific subgroups (i.e. ethnic minority groups, pregnant women, young drug abusers, abusers in situation of crisis)<br>- Education for safe injection<br>- Securing safe and hygienic conditions for consumption (e.g. injection rooms) | R |
| | - Day activity programmes<br>- Low-treshold day labouring projects<br>- Accompanied accommodation for drug abusers | O |
| Counselling | - Individual counselling | N |
| Setting | - Couple counselling<br>- Family counselling<br>- Counselling of parents and relatives | R |
| Content | - Information, clarification, motivation work<br>- Further referral (inpatient and outpatient services)<br>- Aftercare<br>- Professional rehabilitation or reorientation<br>- Help with the job or training problems<br>- Help with accommodation problems<br>- Financial advice/administration, clearing debts<br>- Legal advice<br>- Help with establishing self-help groups | R |
| Target groups | - Specialized offers for young people, ethnic minority groups, pregnant women, women in general, sex workers, drug addicted parents, drug abusers with AIDS/ HIV, and "Dual diagnosis" drug abusers | R |
| | - Specialized programmes for consumers of cannabis, cocaine, and synthetic drugs with problematic patterns of use | O |
| Substitution treatment | - Diversified substitution treatment with obligation for accompanying care | N |
| | - Low-threshold, diversified short and long-term substitution treatment without the clients obligation for accompanying care | O |

| | | |
|---|---|---|
| Detoxification | - out-patient detoxification followed by pharmacological relapse prevention | O |
| Psycho-therapeutic services | - Variety of psycho-therapeutic services (e.g. individual psy-cho-therapy, group therapy, couple therapy, family therapy, crisis intervention) | N |
| Aftercare/ Reintegration | - Accompanying counselling | N |
| | - Possibility of gaining school-leaving qualification<br>- Vocational training/apprenticeship within protective frame-work<br>- Further education within protected framework<br>- Protected jobs<br>- Accompanied living for persons in the rehabilitation phase (e.g. external group accommodation, half-way houses)<br>- Relapse prevention | R |

| **In-patient Services** | | |
|---|---|---|
| Counselling | - Information, clarification, motivation work<br>- Further referral (in-patient and out-patient services)<br>- Organisation of aftercare<br>- Professional rehabilitation or Reorientation<br>- Help with organisation of accommodation after in-patient treatment<br>- Help with organisation of work: searching for work<br>- Financial advice/administration, clearing debts<br>- Legal advice | N |
| Detoxification | - Medication-supported withdrawal | N |
| | - Rapid withdrawal (with or without anaesthetic)<br>- Non medicated withdrawal | O |
| Therapy<br>(duration and ap-proaches) | - crisis intervention<br>- Short-term therapy<br>- Medium-term therapy<br>- Long-term therapy | N |
| | - Variety of psycho-therapeutical approaches (e.g. individual, group, couple, or family therapy) | N |
| | - Experiential Education and Adventure-Based Learning<br>- Work therapy (method-integrated therapeutic work) | O |
| Special programmes for subgroups of clients | - Young drug abusers<br>- Drug abusers with severe mental disorders (Dual diagnosis) | N |
| | - Ethnic minority groups<br>- Female drug abusers (esp. pregnant women/ women with children)<br>- Children of drug abusing parents (possibility for joint resi-dency for parents and children) | R |
| | - Terminal care for drug abusers with AIDS or other severe so-matic illnesses)<br>- Highly qualified drug abusing professionals | O |

| | | |
|---|---|---|
| Activities, Work, Education (during in-patient treatment) | - Leasure activities<br>- Working activities<br>- Possibility for gaining school-leaving qualification<br>- Vocational training/ apprenticeship<br>- Further education opportunities | R |

| **Services in the Penal System** | | |
|---|---|---|
| | - Substitution treatment<br>- Easy access to condoms<br>- Counselling services<br>- Treatment for drug related medical problems | N |
| | - Easy access to clean syringes and needles/ exchange services<br>- Abstinence treatment<br>- Drug-free prison units | R |

| **Self-help Groups, Comlaint and Advocacy Office** | | |
|---|---|---|
| | - Support for self-help groups for drug abusers and patient organisations<br>- Support for organisations and self-help groups for relatives and people close to drug abusers<br>- Accessibility of an independent person/ office for drug consumers and their relatives to register complaints ("ombudsman"); Possibility for inspections of facilities on demand | N |

### 4.6.3.3. Interviewing experts on their assessment of the adequacy in meeting needs

Professionals from various working areas and those affected by problems receive, through their professional work/ being affected, specific insights into the quality and deficits of the treatment service which could otherwise not be ascertained or would require enormous expenditure. The conducting of various forms of expert surveys provides an important addition to the assessment of unmet needs (of clients and other customer groups) as well as to comprehensively assessing the adequacy. Here, it is concerned with collecting not just facts and knowledge gained from experience but also the opinions of professionals and those affected, who can equally be considered to be experts.

Expert surveys as a means of assessing needs are, however, not without controversy because their affiliation to a definite professional group/ being affected can lead to subjectively tainted assessments. Nevertheless, the surveying of experts is indispensable. Important, however, is to have a balanced and broad selection of interviewees in order to be able to offset this disadvantage. The following section provides a list of possible approaches, experts and questions:

### Methods for interviewing experts

- *Conducting a group discussion (focus groups):* Here the surveying of experts is conducted in the form of a group discussion. The advantages lie on the one hand in the limited survey expenditure, while on the other hand different assessments can be discussed together, which makes it easier to use the findings and increases the relevance of the action. What needs to be considered when planning and conducting focus groups is listed in the Rapid Assessment and Response Guide:
  http://www.who.int/substance_abuse/docs/idu_rar.pdf (p. 92ff.)
- *Conducting a Delphi study:* Here the survey is conducted by written means. By conducting several rounds different perceptions and assessments can be discussed and made more precise.
- *Conducting semi-structured interviews using guiding questions* with individual experts (for selection and questions see below)
- *Written questionnaire for individual experts* (for the selection and questions see below); as example see (Fleischmann and Krischker 1997): questionnaire with 29 individual questions on treatment needs of addicts).

### Selection of experts

Fundamentally, the selection of experts must be dependent upon the questions being set, and the number of respondents must be dependent upon the method of surveying. A wider survey is, however, desirable. The following list is intended to act as a checklist:

- Professionals from as wide a spectrum of facilities for psycho-social and medical addiction care as is possible (representatives from low-threshold, out-patient and in-patient fields); balanced consideration of the various occupational groups (social workers, psychologists, doctors, nursing professions; as well as, depending upon the regional importance, ex-users working in addiction care and other occupational groups)
- Representatives from users‘ and carers‘ organisations (current and former drug abusers and relatives of drug abusers)
- Members of other occupational groups which are confronted with drug addicts outside addiction care (representatives from the police, justice, prisons; family doctors, emergency services, pharmacists, social services, youth offices)
- Ombudsmen offices, appeal bodies, etc.

### Guiding questions

*Identification of unmet needs* – in addition to the described alternatives for data collection the following questions can be posed:

- For which services are there waiting periods? Are these deemed to be problematic?
- Are there specific admission criteria and procedures which are identified as being problematic? Why? (high-threshold; selectivity)
- Are all regions equally provided for or are there regions with under-/over provision? Is this deemed to be problematic?
- Does the form of financing the treatment and care limit the admission to suitable services for clients willing to be treated?
- Is the inter-personal contact between professionals and clients in general adequate? If no, which difficulties frequently occur? Complaints?
- Is there a lack of services for definite target groups? (in terms of consumed substances, types of addiction, age, gender, cultural origin, parenthood, psychological and physical health, imprisonment, homelessness or other special life- or risk situations)
- Is there a lack of specific treatment and care procedures (outreach work, crisis interventions, etc)?
- Where have structural deficits been determined (e.g. co-ordination inside and outside the care system, financial deficits; public relations, etc.)?
- Are the occupational training and further education services for professionals adequate and suitable (access to general and specialist professional expertise inside and outsider of the addiction care system)?
- Are there important needs for other customer groups which are impaired by the current services for addiction care?

To assess the findings and to *develop measures to improve adequacy*, the following questions can be posed (see also WHO 1998a):

- What are the most important deficits concerning treatment adequate for needs? (summary of the findings; with the assessment it needs to be taken into consideration that individual indicators alone can never assess adequacy but that various aspects must always be considered).
- What are the most important development aims in improving the adequacy for meeting needs?
- With which measures can these aims be attained? (adapting existing services; development of new strategies)

- In order that priorities can be set, each measure must be assessed according to the following criteria: relevance, feasibility, resources needed, expected efficacy and obstacles.

## References

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WHO - UNDCP - EMCDDA (1999a). Workbook 3. Needs Assessments. Evaluation of Psychoactive Substance Use Disorder Treatment. WHO, World Health Organization (WHO), United Nations International Drug Control Programme (UNDCP), European Monitoring Center on Drugs and Drug Addiction (EMCDDA). 3.

# Annex I: Results of a survey on needs and investments in drug abuse treament and care in Denmark

**Study conducted by the Agerschou-comittee in 1996, 1997 and early 1998[119] (see 2.2.2)**

Reponse rates:

Counties: all 13 counties plus 5 municipalities with competencies on county level replied. The average response rate on questions of a quantitative nature is 81% (range: 53-100). Municipalities: 240 out of 275 relevant communes replied, in total 87% of all communes (range 82-100%). The non-repliers are minor communes not likely to influence the overall results markedly.

Variables:

**I. Estimates of the number of drug abusers in need of assistance**

a) Estimates of the counties: a total of 13.395 persons (1997) or 2.5 per mille of total population (distributed also per county) (range: 7.2 p.m. in the municipality of Copenhagen, 0.7 in Bornholm county (lowest) and 1.4 p.m. in Frederiksborg county (second lowest)

b) Estimates of the (239) municipalites (1997), including persons below 18: In total 10.992 persons or 2.3 p.m. of the respective populations (whereof 950 persons below 18)

Municipal estimates were made for 1995, 1996 and 1997. The estimates rose over this periode from 1.8 pm (95) to 1.9 (96) and 2.3 p.m. (97). In 1998 the Committee made an estimate as an average of the estimates of counties and munidcipalities at 12.500 persons in need of assistance, but in 1999 the National Board of Health on the basis of a different type of calculation made a new estimate of 14.000 (based upon calculations from death ratios) (Sundhedsstyrelsen, 1999).

**II. Information on the extent to which the needs are being met**

**2. Number of "Plans of action" to which the counties and the communes have contributed:**

*Information from the counties*: During 1997 20% of the estimated number of drug addicts in Bornholms County had PAs while the corresponding figure for the county of Nordjylland (northern Jutland) was 91%. The figures show great variation - the second lowest ratio was 29% and a number of counties and

119 The results of the surveys have been published in 1996 and 1998 by the Agerschou Committee through the Danish Ministry of Social Welfare.

communes estimated around 30%. The total estimate for the whole country was 50%.

*Information from the municipalities*: 228 communes (out of the total of 275) reported they had contributed to the preparation of PAs for a total of 5.025 addicts, corresponding to 47% of the estimated number of drug addicts in the commune in question (52% in 5 communes with independent responsibility for treatment decisions).

The regional variations include a low rate of 16% (Viborg county) up to 75% (the municipality of Frederiksberg). Estimates vary again between counties and communes.

**3. Information on the integration of methadone services into social assistance programs (qualitative inquiry/open questions).**

Some of the answers point to organizational measures, others to specific, directed offers, e.g.:

a) "Addiction centres" which take care of treatment referrals and in addition provide offers of education, social contacts, follow up etc.

b) coordination of low-threshold services and other municipal offers

c) networkers

d) short-term residential treatment facilities outside the local environment for stabilization of persons in methadone treatment

e) mutual referrals and exchange of experience among the authorities involved

f) current evaluation of concrete courses of treatment as well as general methadone services

**4. Social assistance**

(1) Contacts with the social welfare system: In 1997 the social welfare authorities in the relevant administrative units (counties, communes with independent responsibility) reported "contacts" with a total of 7.687 persons with drug abuse problems, corresponding to 66 % of the estimated number of persons in need of social assistance in the respective catchment areas. Of these 52% were reported to be in long-term methadone treatment (i.e. for more than 3 months).

(2) 85% of those "in contact" have had one or another offer of in-patient or out-patient assistance, with or without connection to the methadone programme. In 1997 it was shown that in 8 counties /responsible communes, 90% of drug addicts in contact with the welfare system had received offers of assistance other than methadone treatment. The reports from the relevant

units show great variations in the proportion of addicts "in contact" not being referred to one or another type of treatment - from 1-2% (Frederiksberg) to 35-38% in two rural communes.

(3) Referrals to in-patient or out-patient treatment (for parts of the country): From 1996 to 1997 the number of annual referrals for treatment rose by 66%, whereof referrals for in-patient treatment rose by 144%, whereas the number of referrals for ambulatory treatment ("outpatient") rose only by 47%.

(4) Types of treatment referred to - figrues for 1997: During the year a total of 5.103 persons were referred for out-patient ("ambulatory") treatment and 2.210 for in-patient treatment. The in-patient referrals concerned different types of institutions:

Out of the 2.210 persons above, 1.621 (or 75%) were *refered to in-patient institutions* with "entreprise-arrangements" with counties or municipalites, i.e. the bying of individual treatment slots in - mostly - private institutions. 25% (1161 persons) were referred to institutions run by the counties them-selves or under general agreements with the counties (144 to social-pedagogic units or private foster placements). The *out-patient referrals* (5.103) were mainly to programmes of the last-mentioned kind (sect. 96.2 under the Social Assistance Act) (4.277 or 84%) and 173 (4%) to entreprise-arrangements[120].

The relationship between referrals to in patient as vs. out-patient treatment varies considerably between counties/communes. Thus in Frederiksberg municipality and in Aarhus county, only 13/14% of the referrals concerned in-patient referrals, while Copenhagen County referred 51% and Fredericia municipality 50% for in-patient treatment.

## 5. Treatment Capacity

By using figures from the major communes with direct responsibility for treatment referrals for at national estimate it was estimated in 1997 that a total of 692 full-time positions were filled, whereof 238 were employed by the municipality of Copenhagen.

For 1997, based upon the information from the counties and the communes with independent referral compentence, it was computed that the total number of ambulatory (out-patient) treatment slots available in the country was 3.215 and the total number of in-patient slots was 542. The proportion of treatment slots in relation to the number of addicts in need of assistance was estimated at betgween 5% and 27%. The proportion of treatment slots in in-patient facilities was in two municipalities estimated at 13% (Fredericia) and 11% (Odense) and in relation to ambulatory treatment slots the proportion in

[120] Note: the annual number of referrals may be involving a smaller number of persons. Some might have moved from ambulatory to in-patient treatment - or vice versa - and back again.

Fredericia was 58% and in Frederiksberg municipality at 57% - the highest in the country[121].

## 6. Services for "Special groups" of addicts

(1) Available information indicates that most treatment slots exist for *persons in long-term methadone treatment*. In 1997 the estimate was at 2.039 slots, whereof 1.300 in Copenhagen. In later years these estimates have risen considerably. At the end of 1999 the National Board of Health estimated that out of a total of some 14.000 addicts in need of treatment some 5000 were involved in methadone programs.

(2) For *young abusers of hashish - or poly drug users* - a total of 789 treatments slots were deemed available, whereof 568 in Copenhagen (1997).

(3) 5 counties or communes reported to have available special treatment slots for *pregnant abusers or abusers with young children* - a total of 152, where of 85 in the municipality of Copenhagen.

(4) As for *dual diagnosis abusers*, 6 counties/communes reported a total of 98 treatment slots, whereof 50 in Copenhagen municipality.

(5) Treatment slots for *addicts with HIV/AIDS* were reported available in 3 counties/communes, a total of 82 slots, whereof 75 in Copenhagen municipality.

## 7. Waiting lists and waiting time

4 counties and 1 municipality reported a waiting list of a total of 162 persons for ambulatory treatment and 11 persons were reported on waiting lists for in-patient treatment in one county and one commune. *The waiting time* for those on the lists varied between 20 days and 355 days for an out-patient service offer and up to 30 days for in-patient treatment. Among those counties/communes not maintaining waiting lists it was reported that it might take 0-30 days for an out-patient treatment to be established and 1-90 days for in-patient treatment to be implemented. From the first appearance of the ad-dict until the first "clarifying" interviews, waiting time was estimated at 0-25 days - mostly however, one week or less. However, this information appears incomplete and several of the estimates very optimistic.

## 8. Offers of assistance and care

Outside the treatment system and the services for addicts as such, a few other offers are avialable specifically for drug addicts. Thus in 1997 in the counties/communes reporting, 54 slots were available in housing arrangements and 105 in day-care centers (low threshold), while 55 slots were to be

121 The figures and proportions must, however, be taken with some reservation as to the basis for the computations.

found in so-called half-way houses. The figures do not include slots that have been reserved but are not currently utilized and also private instituti-onsare not counted.

## 9. Municipal offers of assistance outside the abuse treatment sector

In 1997 a total of 648 addicts who were not involved in any form of treatment or after-care were rendered various forms of social assistance (16% of those in need in some - but not all - of the relevant municipalities). In addition, of those involved in treatment or after-care, 313 or 3% received housing support, 1.194 (22%) were in "activation" and 203 (3%) received support in their own home[122].

References:

Amtsrådsforeningen (1996): Status på amternes indsats i forhold til lovgivning på stofmisbrugsområdet (The current situation on the measures by Danish counties in relation to new legislation in the drug abuse field (Dec. 1996)

Sundhedsstyrelsen (1998): Alkohol- og Narkotikamisbruget 1997

[122] The information does neither include information on methadone treatment nor on other aspects of the health sector, including psychiatric services, hospitals, ambulance services etc.

# Annex II: Questionnaire to Danish Counties (Social Welfare Section) on Social Assistance Offers in the drug abuse field[123]

### Definitions of terms and concepts in the questionnaire:

*Drug Abuse*: Dependence upon narcotics and psychopharmaca which lead to harm or problems for the individual and/or his or hers environment and which the person needs assistance to stop. The questionnaire includes drug abuse as well as poly-abuse, whereas alcohol abuse only is not included per se. Alcohol may, howeve, play a role in poly-abuse.

*Plan of action ("handleplan")*: Is worked out in cooperation with the individual drug abuser, and contains an overview of the concrete course of treatment as well as other offers of social support such as housing, activation etc. which are to be included in the measures.

*Treatment ("behandling"):* Out-patient ("ambulant") offers of assistance and in-patient treatment aiming at reducing the individual´s abuse/abuse-harm or bring them to complete cessation

*After-care ("efterbehandling"):* May include a phase of de-institutionalization/stabilization from the treatment phase. The measures in this phase may be in both county- and municipal (regie) and may include e.g. methadone treatment, activation/vocational rehabilitation or "protected occupation", measures of care such as support in own home, housing offers, participation in day-care centre/self-help groups etc.

*Long-term methadone treatment:* Prescription of methadone for more than three months.

### Questions (for 1997 only):

1. Number of persons in need of *social services (offers of assistance)*

1.1. Number of persons in the county with drug abuse and in need of social assistance (estimate), whereof:

1.1.a) Number of persons below age 18 (estimate)

2. Cooperation and coordination of the measures:

2.1. Total number of persons with drug abuse problems who during the year have been in contact with the county administration (services), whereof:

[123] Excerpt from "instructions".

2.1.a) Number of drug abusers in long-term methadone treatment

2.1.b) Number of drug abusers who - with or without methadone treatment - have received another offer of treatment (out-patient/in-patient)

2.1.c. Number of drug abusers for whom the contact to the county has not led to referral to a treatment offer

2.2. Number of persons who, *in the course of the year*, have had a plan of action worked out

2.2.a) Which measures, - not counting action plans - has the county taken during the year to ensure that methadone treatment is being integrated with social service offers ? (describe briefly)

2.3. Has the county during 1997 entered into new or revised agreements and/ or distribution of tasks with municipalities within the county? (yes/no - brief description)

3. The social treatment service:

3.1. Number of persons who during the year have been referred to in-patient treatment for drug abuse, whereof:

3.1.a) to institutions regulated by sect. 96.2 of the Social Assistance Act (SSA; ”Bistandsloven”) (i.e. run by the county or with a broad service agreement with the county)

3.1.b) to single slots in institutions without general agreement with county or municipality under section 96.4 of the SAA

3.1.c) Social-pedagogical institutions etc. and private foster placements under SAA sect.66

3.2. Number of persons who during the year have been referred to out-patient/day-time treatment for drug abuse, whereof to:

3.2.a) institutions under the SAA sect. 96.2 (see under 3.1.a)

3.2.b) single slots in institutions without general agreement with county or municipality (SAA sect 96.4)

3.2.c) Social-pedagogical institutions etc. or private foster placements under SAA sect. 66

4. Social service capacity

4.1. Number of staff, computed as full-time employed in institutions under SAA sect. 96.2.

4.2. Number of *in-patient treatment* slots at the disposal of the county, whereof in

4.2.a) institutions under SAA sect.96.2

4.2.b) Single slots in institutions without general agreement with county or municipality (under SAA sect. 96.4)

4.3. Number of out-patient (day care) slots at the disposal of the county whereof in

4.3.a) institutions under SAA sect. 96.2

4.3.b) single slots in institutions without general agreement with county of municipality (SAA sect. 96.4)

4.4. Number of slots in half-way houses, de-institutionalization-housing etc. under SAA sect.96.2

4.5. Number of treatment/ after-care slots for special groups at the disposal of the county whereof for

4.5.a) young hashish- or poly-drug abusers

4.5.b) pregnant drug abusers and drug abusers with children

4.5.c.)”dual diagnosis” drug abusers

4.5.d) drug abusers with HIV/AIDS

4.5.e) immigrants or refugees with drug abuse

4.5. f) persons with long-term methadone prescription

4.6. Does the country have specifif treatment-/ after-care offers directed at young drug abusers (below 18); if yes,

4.6.a) please describe briefly the county´s measures for young drug abusers (below j19)

4.6.b) Number of treatment slots directed specifically at young drug abusers below 18 at the disposal of the county.

4.7. Is there as of Jan. 1st, 1998 a waiting list for drug abuse treatment in the county? If yes, please state:

4.7.a.)how many persons are on the waiting list for in-patient treatment

4.7.b) How many persons are on the waiting list for out-patient treatment

4.8. Howmany days, on average, does it take from the appearance (application?) of a drug abuser until an offer of treatment can be implemented?

4.8.a) in-patient

4.8.b) Out-patient

4.9. How many of the number of days stated under 4.8. will pass, on average, from the appearance (application) of a d.a. until the first clarifying interview will take place (days)?

4.10. Which (types of) activities, services etc. are implemented during the time from the appearance (application) of a drug abuser until the implementation of a treatment offer? (clarification/ anamnesis, the working out of a plan of action, temporary measures etc.)

4.10.a) Which measures have been taken by the county during 1997 to cut down the time from a d.a. appears (applies) until a decided course of treatment is implemented?

5. Care and support - offers

5.a) Does the county dispose of slots directed specifically at drug abusers in institutions under SAA sect.105 (shelters etc.)? If yes:

5.1.a) Number of drug abusers in housing arrangements under sect. 105

5.1.b) Number of slots for drug abusers in day-care centres and the like under SAA sect. 105? (at new year 1995/96, new figures 1995/96, new year 1996/97, new figures 1996/97. 1997/98)

**Questionnaire for Municipalities (Communes):**

1. Number of drug abusers in need of social assistance

1. Number of persons in the commune with problems of drug abuse and in need of social service (estimate)

1.1.a) whereof numbert of persons below 18 (estimate)

2. Social services

2.1. Number of persons with drug problems for whom the commune has contributed to making action plans during the year?

2.2. Does the commune dispose of specific treatment/ after-care slots specifically directed at young drug abusers below 18? If yes, please state:

2.2.a) what measures has the commune established for young drug abusers under 18 (describe briefly)

2.2.b) Number of treatment slots specifially directed at young drug abusers below 18 at the disposal of the commune

3. Offers of care and assistance

3.1. Number of persons who during the year, as part of treatment/ after care for drug abuse

3.1.a) lived in municipal housing arrangements

a1) whereof in half-way houses, de-institutionalization-houses etc.

3.1.b) participated in activation, job training or vocational rehabilitation

b.1) whereof in activation specifically designed for drug abusers

3.1.c) received support in own home, assistance arrangements pursuant to sect. f 68b etc.

3.2. Number of drug abusers who during the year - without being in treatment/ after-care -

3.2.a) received services as mentioned under 3.1.

3.2.b) received other types of social assistance, e.g. under SAA sect. 105

3.3. Number of persons who at the end of the year, as part of treament/ after-care for drug abuse, attend day-care centres, clubs or other offers of care or activation etc.