# Evaluation of the Focal Points of the European Information Network on Drugs and Drug Addiction (REITOX)

**CT.01.RTX.02**

**Draft Final Report**

***Volume 2***
***Focal Point Profiles***

*Submitted by*

ECONOMISTI ASSOCIATI
Bologna - Italia

November 2001

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**Austrian Focal Point**

***ÖBIG***

**Short Profile**

## Institutional Background.

Since 1995 the Austrian Focal Point has been located within the Austrian Health Institute (ÖBIG), an NGO funded by the Ministry of Health and responsible for carrying out research work and planning, training and information activities in the field of public health. ÖBIG, a relatively small research institute, had no previous experience in the drug field and it can be estimated that even now research on illicit drugs accounts for some 8% of total ÖBIG activities.

The FP has no formal legal basis for its operations. It was simply appointed as a FP through a contract with the Ministry of Health. The contract has then been routinely extended on an annual basis to ensure national co-financing of activities. The total level of national funding is set on an annual basis depending on a pre-defined total number of projects. The FP responsibilities were made known to all relevant stakeholders through an official presentation letter. No other official steps were undertaken to legally empower the FP, as this would be considered not totally appropriate in Austria where regions enjoy a large degree of autonomy in the drug field. The FP itself by far prefers relying on its partners' willingness to cooperate. The FP must work within the framework of very tough regulations on privacy and data protection and this sometimes can hinder smooth development of activities. The FP is nowadays well renowned among all the major stakeholders in the drug field.

## Organisation.

Since 2001, ÖBIG has been divided into nine working areas. The FP is *de facto* a part of the ÖBIG's working area on drugs whose head acts as head of the FP. Together with EMCDDA-related responsibilities the same unit is also responsible for keeping relations with other international organisations (the UNDCP, the Council of Europe). These activities are reportedly carried out under a different budget line.

At present the FP is composed of a staff of five, of which one support personnel. Three researchers belong to the same drugs department and all scientific personnel contribute to the FP only a part of their working time. The FP can also rely on the informal collaboration of a number of other in-house experts. Available scientific expertise includes two sociologists, an epidemiologist, a regional planner and an ecologist. Some half of the personnel is senior and all have a good command of English. There has been no turnover in staff so far, and the head of the Focal Point has been in the post since beginning of activities. Most staff is also involved in scientific publications.

FP operations are supervised by an advisory board composed of representatives of the Ministry of Health, the Austrian representatives in the EMCDDA MB and in the SC and representatives of the Provincial Drug Co-ordination and of the Federal Drug Co-ordination offices (all in all some eight members). The advisory board meets on average every three months to discuss about FP activities and related outputs.

**Operational.**

*Overview.* A closely-knit and dedicated FP based on a combination of centralisation of activities for data processing and analysis – nothing is contracted out[1] – and extensive networking for data collection. This is compounded by a good level of scientific expertise. External inputs are provided on a routine basis only for quality control. Main weaknesses are related to structural difficulties in implementing certain indicators and to an uneven availability of data at the regional level. The FP manages the early warning system in strict coordination with the Federal Drug Coordination Office.

*Specific Areas*

- *National Report.* The report generally provides an exhaustive overview of the drug situation in Austria and is based on high methodological standards in both quantitative and qualitative terms. It mainly suffers from uneven geographical coverage of data, which, in turn, reflects the different availability of resources to implement drug information systems at the regional level. A German version of the report is made available to the public. Work is entirely carried out by internal staff.

- *Key Indicators* Progress is in comparative terms fairly advanced. The most problematic area is represented by demand for treatment, where no national data collection system is in place, as this would require voluntary contributions from hundreds of practitioners, which the FP alone cannot manage. The first general population survey is under preparation. Privacy and data protection considerations hinder the development of all those techniques requiring drug-user identification, starting from treatment demand. This may represent an obstacle also for cohort-based studies on drug-related deaths and drug-related infectious diseases. A common national methodology for the monitoring of drug-related deaths allows the FP to attain fairly high standards as regards this indicator. For each epidemiological indicator a specific working group was set up involving all national partners at both scientific and political level. No external expert hired with EMCDDA funds or recourse to external consulting.

- *Demand Reduction.* Very good contributions in both quantitative and qualitative terms fully meeting EMCDDA expectations. The system is founded on extensive networking involving on a permanent basis all the Regional Governments plus another twenty NGOs. Since in Austria these activities are carried out at the regional level and there was no previous national collection information system, the FP report has become the reference document in this area in the Country. No external expert hired or recourse to external consulting

- *Early Warning.* Managed by the FP in strict co-ordination with the Federal Drug Coordination Office that oversees the whole system and is responsible for final political decisions. An interlinking forum ensures information exchange with the Provincial Drug Coordinators. Good network based on both institutional contributions and information directly collected in the field through various sources. Some ten NGOs have also been involved.

- *Dissemination and PR.* The Austrian FP has devoted a substantial effort to dissemination and PR activities so far. Centre publications are regularly distributed. Since 1999, a paper on progress reached on the five epidemiological indicators has been presented and delivered in the "Drug Forum", an event involving every year federal and provincial policymakers in the drugs field. Since 1997 the Focal Point has been publishing the newsletter "DrugNet Austria", also as a tool to improve national networking.

- *Policy analysis.* No major difficulties to cope with this new area of activities.

- *Networking.* Fairly developed and considered a strategic priority. When ÖBIG was appointed as Focal Point, it started from scratch building up its own network of partners. In order to avoid duplications and competitions it tried to make use of existing networks. Now it can relies on two well-structured networks – the Provincial Conference of Drug Co-ordinators and the Addiction Prevention Unit Co-ordinators – as well as on some umbrella organisations grouping specialised drug services. Moreover, the membership in

[1] In fact, one consultant was hired for a capture-recapture study but this is not strictly considered a FP core task.

the Drug Forum and frequent contacts with the Federal Drug Co-ordination ensure networking and co-operation at the federal level.

- *Quality Control.* Peer reviews also involving contributions from external experts are carried out on a regular basis for the National Report and the key indicators (even ten times per year). As to the rest, quality control is mainly ensured by the Advisory Board with some kind of formalised procedures (minutes of meetings).

*Main Problems in Relations with the Centre.*

- Limited information available on the Centre's activities;
- Poorly structured and formalised information flows;
- Poor availability of documentation centre services;
- Limited utility and user-friendliness of the REITOX website.

**Financial**

The Austrian FP receives co-financing from the Austrian Government through cash contributions. This co-financing exceeds minimum contractual arrangements. Funds are credited to OBIG headquarters that keeps a share for overheads and capital investments (depreciation). A separate accounting is kept of direct EMCDDA-related costs.

Actual costs exceed minimum contractual arrangements by some 29% and are fully covered by State contributions. Staff salaries account for 54% of overall costs; overheads (inclusive of depreciation) account for as high as 35%, while travel and printing and translation services respectively account for 3% and 8%. These figures do not include additional € 180,000 that are spent on parallel EMCDDA-related pilot projects such as that on the implementation of treatment demand, which are considered outside REITOX financing.

Work on the National Report accounts for 32% of REITOX direct costs. Harmonised indicators cover another 28% followed by activities on demand reduction (17%). PR and dissemination activities account for another 10% of direct costs, while Focal Point co-ordination absorbs another 8%. The early warning system is given the remaining 5% as much of the related costs are borne by the Federal Drug Coordination.

EMCDDA financing is something of a constraint in operational terms as the FP is run on a project basis. The FP would like to have additional part time expertise in the field of epidemiology and policy evaluation and this would come at an estimated cost of some € 40-50,000.

**Overall Assessment.**

The FP is a stable organisation with a good deal of scientific expertise generally capable of delivering good outputs. Networking has been dealt with as a strategic priority in both political and operational terms and this has allowed the FP to develop demand reduction as a field of excellence. Unlike other research institutes policy issues and PR activities do not seem a major problem, although some additional human resources would be required in the first case. The FP is working very hard on the key harmonised indicators, but significant structural problems are still to be solved as far as demand treatment is concerned. Substantial support from Government also in financial terms.

*FINAL SUMMARY SWOT MATRIX*

| **Strengths** | **Weaknesses** |
|---|---|
| • well-structured and efficient networking<br>• high scientific expertise<br>• strong implementation capabilities<br>• good project management skills<br>• good PR capabilities<br>• good command of English | • uneven geographical coverage of data<br>• no documentation centre also to support network<br>• no full time professional staff |
| **Opportunities** | **Threats** |
| • strong support from Government<br>• good relations with representatives in the Management board and Scientific Committee<br>• involved in the enlargement process | • treatment demand data collection system on a voluntary basis<br>• problems with current data protection legislation |

**Belgian Focal Point**

*Section d'Epidémiologie de l'Institut Scientifique de la Santé Publique*

**Short Profile**

## Institutional Background.

Since its establishment, the Belgian FP has been located within the Epidemiology Unit of the Scientific Institute for Public Health (hereinafter, ISP). ISP is a State (Federal) scientific organisation, under the responsibility of the Ministry of Social Affairs, Public Health and the Environment (hereinafter, Ministry of Health). Since 1995 the ISP has been jointly co-financed by the Federal Budget and by the two major Belgian Communities, i.e. the French and the Flemish.

FP operations suffer from the complex Belgian institutional context. The powers and responsibilities of the FP are not clearly defined in any normative act. Therefore, the data collection process is totally based on voluntary agreement with data providers at the regional level. Moreover, the new Belgian law on private life protection somehow hinders the data collection process. So far the FP has enjoyed little political support from the Federal Government. Some frictions between the Ministries of Health and Justice have also reportedly represented an obstacle to smooth implementation of FP activities.

The FP will soon undergo a substantial restructuring. Two major institutional developments are foreseen in the near future, which are likely to provide the FP with a more clearly defined role in a clearer and stronger institutional framework, namely:

- The creation of a *"Drug Cel"*, with the participation of representatives of the various Ministries of Justice, Health, Home Affairs, Finance and under the coordination of the Federal Ministry of Health. The Cel will have responsibility for coordinating all the drug-related activities in the Country. It is due to start its activities in January 2002. The Drug Cel will have the power of giving well-defined tasks to the Belgian Monitoring Centre (*see next bullet*).
- The Focal Point itself will be turned into a "Belgian Monitoring Centre on Drugs and Drug Addiction".

Belgian stakeholders are not very familiar with the FP because they mainly keep relations with drug-related organisations at the regional level where the bulk of activities in the drug field concentrates. The FP is mainly known among scientific specialists.

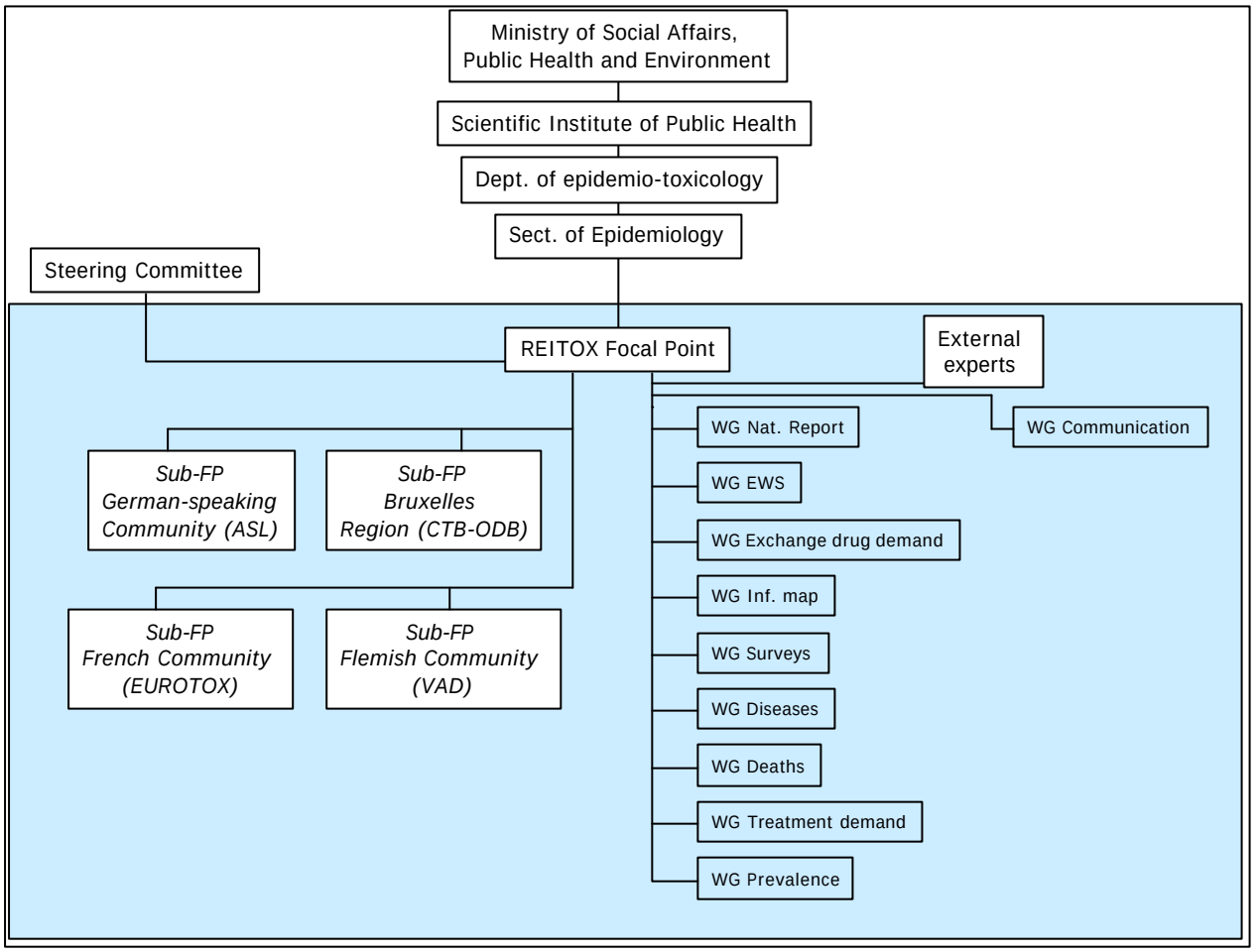
## Organisation.

The structure of the Belgian FP mirrors the architecture of the Belgian State, where competencies on Health are both at the local (Communities, Regions) and at the National (Federal) level. An *ad hoc structure* – the BIRN, Belgian Information REITOX Network - was therefore created. It is composed of the FP and of the so called four regional sub-Focal Points, each for every Belgian Region/Community, that have coordination responsibilities for local actions against drugs, namely:

- VAD, an umbrella organization (1982) for the Flemish Region.
- EUROTOX, an umbrella organization (1990) for the French Community.
- CTB/ODB Brussels, an independent organization (1993) for the Region of Brussels.
- ASL, an independent organisation (1997) for the German-speaking community.

The mandate of the Sub-Focal Points is to "*gather the information requested by the EMCDDA as exhaustively as possible, within the limits set by the law on privacy, and transfer this information to the Focal Point*" It must be noted that the Belgian FP keeps relations with the EMCDDA and carries out the report drafting activities, but is not entitled to have direct access to drug-related data in the country, which remains a Sub Focal Point responsibility. The FP organizational structure is reported in the figure 1 below.

**Fig. 1 FP Organizational Structure**




The FP has a professional staff of five representing some 1-2% of the total ISP staff: three full-time and one part-time professional, plus 1 part-time administrative assistant. On top of that the FP can also rely on the assistance provided on a voluntary basis by of some external specialists and on trainees. Expertise presently available includes epidemiologists a chemist, an anthropologist and a nutritionist. Staff turnover is very high and the current personnel's experience in the drug field was acquired only while working for the FP. The need for a more experienced staff with a longer period of permanence in the post is deeply felt. Language also represents an important problem in the FP because a trilingual staff (French, Dutch and English) would be ideally required, but this is not always easily available (only 2 out of 5 staff members are currently trilingual). The four regional organizations have different resources in terms of staff, ranging from the one full time equivalent staff of ASL[2] for the German Community to the 24 full time staff of VAD in the Flanders. The total person-time effort for EMCDDA-related activities and the related burden on available staff is also very dissimilar. It goes from a 0.1 full time staff of ASL (10%) to the 311 working days of VAD (4.7%).

The overall coordination of the data collection activity is highly demanding, and in some cases appears as very problematic and scarcely effective. First, the Sub-Focal Points data gathering and processing systems are fairly different and mainly reflect their local communities' information needs rather than the FP's. Then there are serious problems with geographical overlapping[3] and possible double counting of individuals. In practice, it happens that VAD, EUROTOX and CTB/ODB have concurrent geographical competencies, and

[2] i.e. 3 employees sharing among them one full time job

[3] It is the case for instance for data gathering in Brussels. Brussels is the capital city of the federal Belgium, but is the capital of the Flemish Region, and the capital of the Region of Brussels, as well. Moreover, it hosts several bodies of the French Community.

must find ways of coordinating their efforts[4]. Data exchange is also made difficult by software and data formatting. Each of the Sub-Focal Points adopts different standards, and none of them corresponds to the standards adopted by the hospitals. It may frequently happen that data gathered from the hospitals need to be converted twice: a first time from the hospital to the Sub-Focal Point, and a second one from the recipient Sub Focal Point to the possible further Sub-Focal Point with concurrent competencies. All of these double data records are flagged, and a mechanism is put in place to avoid the double counting problem, i.e. that data related to the same provider would be passed twice to the National FP. The whole process is time consuming and potentially risky in terms of final data quality. Data sets risk being corrupted during each conversion, and the possibility of double counting cannot be really ruled out.

Final data processing by the federal FP is also problematic and time consuming. All the Sub-Focal Points store the information on "their" databases, and only aggregated data are transmitted to the National FP in the format of standard tables. The FP processes the information received from the Sub-Focal Points with "traditional", manual methods. The FP does not have direct access to the data collected by the Sub-Focal Points, and possess no database on its own.

**Operational.**

*Overview* . The Belgium FP's political mandate is mainly oriented to fulfil EMCDDA's requirements. The national (federal) policy orientation is not a strong factor in shaping FP activities and the perceived Government's interest in what the FP does is not very high also because in Belgium drug-related issues are mainly dealt with at the regional level. FP activities are structured on the basis of ten working groups[5] for each specific REITOX activity. These are composed of internal staff, Sub-Focal Points staff and external experts collaborating with the Focal Point on a voluntary basis.

*Specific Areas*

- *National Report.* The report is prepared by both the FP and the Sub-Focal Points and reflects the inhomogeneous availability of data and their quality. The FP relies for its comments on final tables only often containing outdated information due to the lengthy and complex data collection and validation process. Collaborations are requested to external experts on specific matters. Once a draft has been prepared, a peer-review like mechanism is launched, with request for comments by the Members of the different specific working groups. The document is published in the FP website.

- *Key Indicators.* FP contributions in this area have suffered from the complexity of the information collection system involving a wide range of information providers located at different level (federal, communities, regions, provinces, cities). This is especially the case for drug prevalence where not enough financial means have been found yet to carry out a general population survey. Treatment demand is probably the indicator showing the best progresses towards agreed standards. The current problems with drug-related deaths (special mortality register) and problematic drug use are deemed bound to improve with the establishment of a unique police force which should make access to data simpler. However all EMCDDA methodologies based on cohort studies are difficult to implement under the new Belgian law on privacy protection.

- *Demand Reduction*. The quality and the number of contributions in this area have suffered from the underdeveloped data collection network and the related difficulties in acceding to information sources throughout the country. Consequently the FP progress in this area can be considered as still limited.

[4] As an example, we mention the data gathering process from hospitals. Every single hospital is free to accept to participate to the data collection program proposed by one (or more) of the three Sub-Focal Points, on the basis of a direct agreement. The Sub-Focal Point that receives data sets from a hospital, forward them to the other Sub-Focal Point who has concurrent competency on the same hospital/territory.

[5] FP working groups: National report; Early Warning System; Exchange on drug demand reduction actions; Information map; Surveys of drug use, behaviour and attitudes in general population; Drug-related infectious diseases; Drug-related deaths; Drug treatment demand indicator; Prevalence estimates of problematic drug use; Communication

- *Early Warning.* FP's performance in this area has generally met expectations, although the data collection system has not reached full possible effectiveness because of structural legal constraints. However mainly due to staff commitment the FP has scored more than acceptably especially when compared with other FPs facing similar difficulties.

- *Policy Analysis*. A point generally deemed as week. The FP seems to avoid entering into policy considerations.

- *Dissemination and PR.* The FP dissemination activities have been mainly targeted to the Belgian scientific community. The Sub Focal Points are also heavily involved in this process.

- *Networking*. Networking is based on a two-tier structure: between the FP and the Sub-Focal Points and between the latter and direct data providers. As a result there are very limited contacts between the FP and primary data sources (mainly with Universities and scientific institutions). As a consequence, both the FP and the EMCDDA are hardly known among drug practitioners and policymakers, who are mainly in contact with the Sub-Focal Points. To this it must be added that the Sub Focal Points networking strategies mainly reflect local or regional factors.

- *Quality Control.* Quality control is mainly based on peer-review for the National Report and on steering committees for all other institutional activities. Steering Committees are made up of the national Members of the EMCDDA Management Board and of the Scientific Committee, Sub-Focal Points' representatives, members from both the central and the local health administrations and two University professors. These quality control mechanisms are poorly formalized and structured both in terms of time available for a real feedback and in terms of quality of the inputs received.

*Main problems in Relations with the Centre.*

- Cases of misuse of data provided by the FP and of publication of unreliable information in the annual reports.

- Delay in receiving requested documents from the Centre.

- Delay in the provision of guidelines and information on demand reduction area.

- Limited functionality of the REITOX website.

- Insufficient information on the Centre's strategic planning.

**Financial.**

The Belgian Focal Point is presently co-financed by both the local Communities (i.e. the French and the Flemish ones) and the National Government mainly through cash contributions linked to an annual contract. A reform of the financing system is presently under way. Local communities financing is expected to end in 2002, and will be fully replaced by funds provided by the Federal Ministry of Health. In 2000 some 39.5 % of the EMCDDA financing for REITOX activities went to the Sub-Focal Points that are also co-financed by Community/Regional authorities. The FP operates based on its own budget and has a separate accounting of costs.

Actual costs exceed contractual arrangements by some 57%. Salaries for internal staff account for 64% of costs; external consulting services (the Sub Focal points) for another 12%, travel for 3%, printing and translations for 3% and the participation in meetings (1%); 17 % of other costs are related to equipment, running costs, and overheads.

27% of total direct costs are related to the key indicators; 19% for the national report; 17% for the early warning System and 18% for Focal Point Co-ordination and PR and dissemination activities. Demand reduction accounts for a 6% direct costs, while the remaining 12% is spent in other projects (incidence, legislation, publications).

**Overall Assessment.**

The FP is located within a Federal Scientific Institution below the Ministry of Health. It can rely on good skills in epidemiology, while lacks expertise in social sciences and qualitative analysis. For the implementation of its institutional activities an *ad hoc* structure (BIRN) was established, mirroring the federal nature of Belgium. Four independent regional Sub-Focal Points keep direct contacts with data providers; with little or no direct contacts with the national FP. Considerable efforts have therefore to be devoted to data collection, transmission and processing harmonization. And several obstacles also of political nature hinder any rationalization of activities. This clearly represents a major burden on the FP performance and overall quality of outputs. However, the FP has managed to involve in its activities several external experts on a voluntary basis and has put in place a vast consultation process.

## FINAL SUMMARY SWOT MATRIX

| **Strengths** | **Weaknesses** |
|---|---|
| • Scientific support from Ministry of Health<br>• Capacity to involve external experts on voluntary basis<br>• Better coordination among Sub-Focal Points in recent years | • Young staff, high turnover<br>• Some institutional activities performed by volunteers<br>• Scarce motivation of staff, due to lack of professional perspective<br>• Scarce specific previous experience on drugs of the FP's staff<br>• Lack of trilingual staff<br>• Complex and time consuming data collection activity<br>• Insufficient coordination among the Sub-Focal Points<br>• No data sharing mechanisms<br>• Conflicts with Sub-Focal Points |
| **Opportunities** | **Threats** |
| • Envisaged institutional reform in drug field at federal level: Drug Cel, Belgian Observatory<br>• Participation in support projects | • Complex structure of the BIRN<br>• Scarce collaboration between the Ministries of Health and Justice<br>• Absence of political support<br>• Strong sense of ownership of the data on the Sub-Focal Points<br>• Political/local resistances to a rational restructuring of data gathering activities<br>• Poor involvement in the enlargement |

## Danish Focal Point

### *Sundhedsstryelsen (National Board of Health) - NBH*

### Short Profile

### Institutional Background.

The Danish Focal Point has always been located within the National Board of Health (NBH) - an autonomous Government agency depending on the Ministry of Health. In Denmark health services, including drug-related health aspects, are the responsibility of the fourteen Counties. The Central Government is left with co-ordination, supervision, information and scientific documentation responsibilities and the NBH is the technical arm advising Government on medical education, health care planning and education, medical computer science, etc. Among its traditional areas of activity there is also the production of statistics on health. The NBH is mostly Government-funded and has a total staff of over 200 professionals.

Drug abuse together with alcohol abuse and tobacco are dealt with within the National Centre for Health Promotion and Prevention-NCHPP a NBH internal institution grouping several different divisions for a total 50 staff, or so. Health prevention in general and drug prevention in particular have been given various degrees of political priority over the last few years and this was reflected in the NCHPP's staffing. So far drug prevention has ranked rather low compared to other issues in the National Board of Health in general and it can be estimated that no more than 5% of NBH activities is currently related to illegal drugs. However, as far as prevention is concerned drugs score relatively high as respect alcohol or tobacco within the NCHPP agenda. Due to the risks related to the new synthetic substances, the ranking of importance of illicit drugs is likely to become higher in the future.

The NBH was officially appointed as a FP by the Ministry of Health. As such, it has little problems of continuity of functions. At any rate its responsibilities and powers have never been clearly defined in any normative act. Unclear whether this has had any impact in operational terms. In principle some kind of official right to ask Counties for information on their initiatives would have been welcome. In practice, the FP itself has doubts about the real expedience of such a provision in the present institutional context. The FP has not faced yet any serious problem with protection of personal data or privacy laws. However, similar constraints are likely to appear in implementing the five key indicators, for instance in estimating drug-related infectious diseases. The NBH is well known among all main actors in the policy field and, in particular within the scientific community.

### Organisation.

The Head of the FP is one of the directors of the NCHPP. The role of interacting with the EMCDDA has been *de facto* played by a senior NCHPP staff who co-ordinates all FP activities. The FP comes therefore to be a small unit within the NCHPP staffed with two operatives and one secretary who operate on a part time basis for the FP as they also have other tasks. This core expertise is supplemented, as far as statistical data are concerned, by additional man-time provided by another professional in the NBH health statistics department. All in all at present no more than four people take directly part to FP activities. Core team professionals contribute as high as over 75% of total man-time, the other NHB professional a rough 15% and support staff the remaining 10%. Other NHP staff on an informal basis also provides additional support, but this cannot be considered as real man-time work.

Expertise available in the FP core staff is mainly related to social sciences (sociology and anthropology). The related department provides additional expertise in statistics. All operatives have a certain degree of seniority and have been active in the drug field for some five years. The same staff are also involved in tasks of a more strictly national nature, such as filling in questionnaires for other international organisations, answering to Government and Parliament requests, directly working in the demand reduction area and contributing to

National reports and publications. In such conditions a certain degree of overlapping between FP and non FP-related activities seems hardly avoidable.

**Operational.**

*Overview.* The FP is located in a Government Agency where illegal drugs have not been given a particularly high priority. It suffers from non-negligible staff and resources constraints. However current personnel are highly professional and committed, thus compensating these structural weaknesses including the complex institutional framework around demand reduction. FP activities are characterised by a notable recourse to in-house staff and institutional co-operation only, with very limited access to external consulting resources.

*Specific Areas*

- *National Report.* The report is of a fairly good quality and quite accurate from a methodological point of view with some minor weaknesses in comparability of data and policy aspects. Work is entirely carried out by internal staff with very limited recourse to external consulting services and external institutional experts. Some parts of the report are drafted in co-operation with the relevant Ministries. The professional editing and some innovative solutions are due to the personal commitment of the staff involved that has heavily invested in this document also as an internal communication and visibility tool. As a matter of fact, the same report is already translated into Danish and circulated. Adherence to the Centre guidelines and requirements has reportedly substantially improved the quality of the pre-existent National report. Some problems in ensuring even geographical coverage in the demand reduction area.

- *Key Indicators.* The progress on the key indicators is on average fairly advanced and Denmark can be considered among those Countries closer to achieve the desired technical standards. Some technical aspects are assessed as more problematic in-house than from a broader Centre's perspective, especially as far as general population surveys are concerned. The FP can rely on its consolidated expertise in the field. The only problematic aspect seems to be drug-related infectious diseases, not only because guidelines are still in the process of being refined, but because privacy considerations may substantially hinder data collection and processing. External experts either on an informal or an institutional basis appointed for all indicators. No reliance on consulting services.

- *Demand Reduction.* This has traditionally been one of the FP weakest points due to a combination of factors: limited in-house resources, difficult relations with practitioners in the field, a complex institutional framework and a lack of an evaluation culture in the Country. At any rate, past efforts are beginning to pay off results and the first signs of improvement have recently appeared. No reliance on external consulting services.

- *Early Warning.* Another problem area. Despite initial political interest the task was found difficult to manage in a health-oriented institution because of its perceived police-like nature. Nevertheless some initiatives ("regional hearings" and establishing an ecstasy data base) have been put in place to collect information in the field. Modest results achieved so far also depend on poor communication and lack of mutual understanding with the Centre and consequent lack of motivation. Expert involved on an institutional basis.

- *Policy Analysis.* Acceptable as far as basic features are concerned. More in-depth analysis will probably require recourse to additional external expertise.

- *Dissemination and PR.* One of the few FP that already paid attention to these aspects in the past.

*Networking.* Fairly developed if also available staff resources and institutional constraints are taken into consideration. The FP keeps permanent relations with a dozen Universities ensuring constant inflow of scientific expertise and some 60 government agencies in the various fields, including the sometimes time-consuming fourteen Counties consulted on an ad hoc basis. NGOs are a bit less covered and some ten of them are consulted on a more sporadic basis. All in all the network of contacts exceeds 150 different bodies.

No problem in communication, on the contrary an intranet has already been planned with alcohol-and drug consultants in the counties.

*Quality Control.* Quality control mainly consists in National Report proofreading and approval by NBH Drug Advisory Committee composed of representatives from Ministries and other Scientific Institutions. However no formalised procedure in place based on written reports.

*Main Problems in Relations with the Centre.*

- limited information about award of contracts and related results;
- poor communication and lack of mutual understanding in the EWS;
- limited user-friendliness and utility of the REITOX website.

**Financial.**

Denmark complies with co-financing requirements through in-kind contributions by paying FP staff salaries and contributing overheads and rent costs. The FP only partly has a separate budget to cover operating expenses. It directly manages EMCDDA financial contributions. Separate accounts are kept for FP-related costs, but not for salaries.

Actual costs exceed contractual arrangements by a tiny 4%. Staff salaries account for some 51% and overheads for as high as 38% of total costs. However these include rent costs for some 30 sq.mt operational space in a prime real estate market area in downtown Copenhagen. Travel costs and organisation of meetings and conferences respectively account for 6% and 4% of total costs. A tiny 1% is allocated to external consulting services.

Work on the key indicators accounts for 33% of total direct costs. The national report together with overall FP coordination accounts for another 34% of direct costs (roughly split in 24% and 10%), while demand reduction accounts for 20% and the early warning system for the remaining 13%.

It is unclear how EMCDDA financing represents a constraint in operational terms. Although apparently well-funded the NBH presently commits limited resources to drug issues and on the contrary some piggybacking on EMCDDA funding to carry out in synergy tasks of a more national nature appears likely. However, the present system has already reached its limits and additional requirements would need additional staff resources for at least one full man year possibly split into several different kinds of expertise.

**Overall Assessment.**

The FP has managed to cope with its tasks quite effectively mainly due to the high professionalism of its staff and the consolidated expertise in collecting and analysing statistical data within the NBH that has compensated so far inadequate staffing and other structural weaknesses. While the performance on the national report and the key harmonised indicators can be considered as fairly effective, other areas show some sign of operational over-stretching. No resources are available for voluntary tasks, involvement in support projects or participation to assistance to the enlargement. If REITOX activities are to be substantially widened in the future, the FP needs substantial strengthening and additional expertise.

## FINAL SUMMARY SWOT MATRIX

| **Strengths** | **Weaknesses** |
|---|---|
| • good institutional networking<br>• support from scientific institutions<br>• good scientific expertise<br>• good reporting skills<br>• good project management skills<br>• good PR and communication capabilities<br>• command of English | • limited staff resources<br>• uneven data collection in demand reduction<br>• informal quality control procedures<br>• problems in ensuring even geographical coverage in demand reduction<br>• poor mirroring of Centre's functions in EWS<br>• lack of experience in policy analysis |
| **Opportunities** | **Threats** |
| • continuity of activities<br>• good standards reached with most key indicators<br>• good overall financing of the drug system<br>• close links with representative in the Management board<br>• vast scientific community available | • not entirely clear definition of tasks at the national level<br>• limited familiarity with evaluation culture in the Country<br>• communication problems with some areas in the Centre<br>• poor involvement in the Centre support activities<br>• poor involvement in the enlargement |

**Dutch Focal Point**

*Trimbos Institut*

**Short Profile**

## Institutional Background.

The Netherlands has opted for the double focal point system. The Official (or Policy) Focal Point is the Ministry of Health Welfare and Sports (VWS). But as early as in 1993 after a brief informal consultation process, the Ministry entrusted a NGO, the Netherlands Institute on Alcohol and Drugs (NIAD), with the operational responsibilities for carrying out Focal Point activities (operational focal point) on a contractual basis. In 1996 NIAD merged with another NGO, the Netherlands Centre for Mental Health (NcGv), thus creating a new NGO, namely the *Trimbos-instituut-netherlands - Institute of mental health and Addiction* [6] (hereinafter, Trimbos), which inherited from NIAD its FP competencies. In 1999 the Dutch Government established the National Drug Monitor- NDM and attached it to Trimbos. Primary target of NDM is the collection of data on drugs from all the relevant national agencies and bodies, in order to prepare a National Report on Drugs and Drugs addiction aimed at national policy makers and the national public. NDM is supported by a National Working Group[7] on Epidemiology composed of representatives of monitoring projects and independent experts whereas the Ministries of Health and Justice are observers. More recently, the Focal Point was integrated with NDM, thus creating a single Unit, named NDM-FP, which became *de facto* the national body where all the information gathered on drugs should converge.

The Dutch Law does not contain a general provision empowering Trimbos to ask for information. Collaboration from data providers is obtained on a voluntary basis, with the only exception of data on treatment, where compulsory information to Trimbos is actually envisaged in the law. A debate on whether such a general piece of legislation on the mandatory nature of data provision would be beneficial to the FP activity is still on going between Trimbos and the Ministry. Pros and cons are being weighted, but a solution based on informal, voluntary agreement seems still the preferred one. So far problems in obtaining data have been experienced only with the Ministry of Justice and have been solved by the Ministry of Health acting as an intermediary. The situation is expected to become easier with the direct involvement of the Ministry of Justice in the NDM. In fact the Ministry so far has enjoyed the simple status of observer.

The FP does not face major privacy or data protection problems, but those common[8] to all scientific institutions in the Netherlands. It is well renowned among stakeholders, even if to a lower extent among drug-practitioners in the field.

## Organisation.

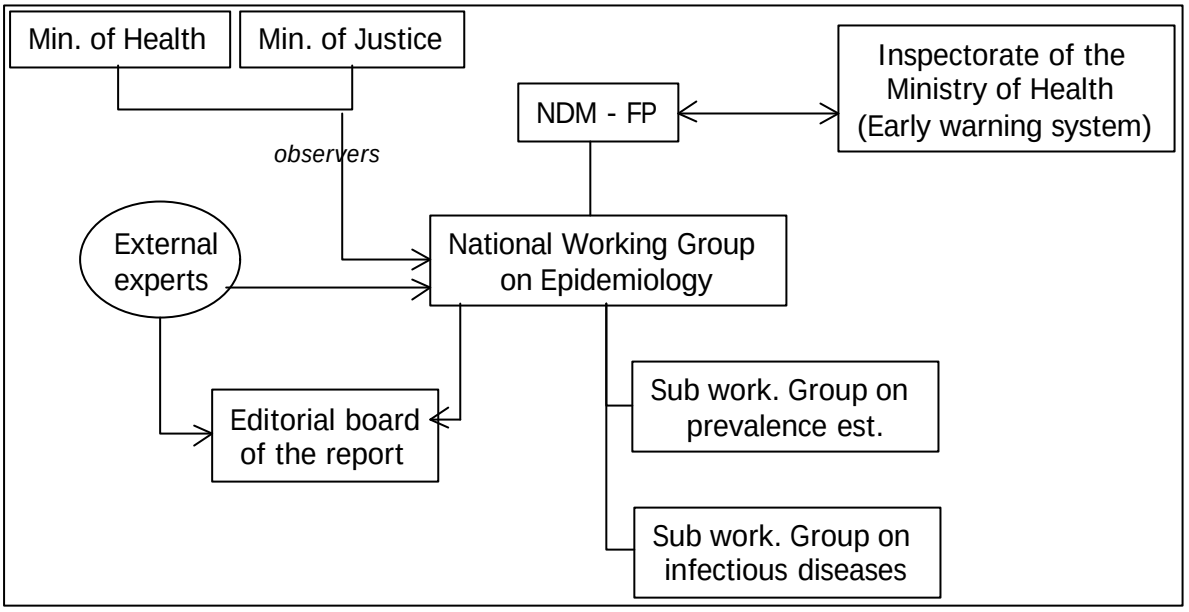
Trimbos is presently undergoing an organisation restructuring. Till 2001 the FP/NPM has been considered as a special unit running horizontally across Trimbos, which is structured along five technical departments (prevention, addiction and substance use, mental health, care and rehabilitation, organisation and policy) and three support sections (information and documentation, communication, human resources administration and finance). Present staff are allocated to the NDM / FP Unit, irrespective of whether they work for FP specific

[6] Trimbos is "an independent national centre of expertise that, on scientific grounds, it provides services in the field of mental health care, substance use and the care of addicts. Its main client is the Ministry of Health Welfare and Sport, which contributes to its yearly budget for an approximate 50%. In terms of staff, about a 50% of the activities of Trimbos are related to the drug field.

[7] One of the tasks of the working group is to provide technical and scientific assistance in the implementation of the five key indicators; furthermore, specific sub-working groups have been nominated to give specialised support on individual key indicators.

[8] The owners of sensitive data are bound by law to distribute them only after having processed them, in order to make it impossible to deduce personal information. As any other "data customer" Trimbos receives from its data providers data sets that have been previously processed.

activities or for NDM/FP common activities. The new organisation of Trimbos is based on "programs" and each of the envisaged 12-13 new units will be in charge of a specific programme, like in the present case the NDM-FP. The following table summarises the organisation of the NDM-FP Unit and the involvement of the main national stakeholders in its institutional activities. It must be noted how the early warning system is managed by the Inspectorate of the Ministry of Health, which although a part of the NDM, is external to Trimbos.




Some five technical staff work for the NDM/FP, of which two on a full-time basis. The other three professionals contribute on average some 20% of their total working time. Some more two support staff, a documentation expert and a secretary contribute to FP activities some 50% of their total working-time.

The full-time staff is composed of a senior psychopharmacologist/epidemiologist who has been in the post since beginning of the activities and of a social scientist in the post for three years. Additional technical expertise is provided by highly senior professionals in the field of neurosciences and drug-prevention plus a database manager/social scientist responsible for EDDRA functions. All in all key personnel have benefited from a mid-to-long permanence in the post and within Trimbos. They all have an intense scientific activity that also includes an average of 1 to- 5 publications per year. However, Trimbos has suffered from three key staff involved in the key epidemiological indicators leaving their post in recent months. Neither the NDM/FP Unit, nor Trimbos presently have criminologists or policy analysts among staff. This is considered a problem in the light of the new activities foreseen by the EMCDDA.

**Operational.**

*Overview.* The Dutch FP has a complex institutional structure. The merging of the national and Centre—related functions into the same unit and the peculiar relation with the early warning system may have created from time to time problems in communication with the Centre. However the level of scientific expertise available is on average fairly high, and in the field of epidemiology even of excellence. The FP operates in a favourable context enjoying high political support and significant political interest in its activities.

*Specific areas*

- *National Report* The NDM-FP Unit writes two different reports: the National Report targeted to policy makers and the national audience and the National Report for EMCDDA with some differences in the analyses and tables. There is little interference between the two documents and the report for the Centre generally complies with agreed structure and received guidelines. Contributions in epidemiology often are of an excellent quality. On the other hand the analysis is much weaker when it comes to policy considerations due to lack of in-house skills.

- *Key Indicators* The Netherlands can be considered as one of the most advanced Countries. Some technical problems exist for cohort-based drug-related death studies and for drug-related infectious diseases where however standards have not been fully defined yet. However, the quality of some indicators may decrease in the future. For instance, due to possible budgetary constraints, the funding of the organizations collecting data on problematic drug use in three urban areas, only (so called city monitors) cannot be guaranteed. After a National Research Council review has found that HIV prevalence remains stable over time, it is expected that the frequency of local drug-related disease surveys will be brought down to one in each region every five years. However, NDM-FP together with the Ministry of Health has already taken other initiatives to improve data collection on infectious diseases.

- *Demand Reduction.* Good contribution in both quantitative and qualitative terms to the EDDRA database. Also other related activities can be deemed of a fairly good level. All this in spite of the fact that only a few treatment services only took part to the EDDRA training and therefore can contribute to the EDDRA database.

- *Early Warning System.* The Dutch Government has built one of the largest (and costly) non-police based early warning system in Europe with extensive pill-testing activities. This reflects a high political priority given to the issue. In fact, the Netherlands was among the originators of the idea of implementing such system at the EU level through a joint action. The network is managed outside the FP by the New Drug Assessment and Monitoring Centre – CAM, which provides the Focal Point with the necessary information to fulfil its REITOX tasks. A staff member of the NDM-FP participates in the CAM, and close co-operation is reportedly in place between the co-ordinators of the CAM and of the NFP/NDM.

- *P*olicy *Analysis.* So far it has not been considered as a FP task and therefore in comparative terms it is one the FP weakest areas also due to lack of in-house skills.

- *PR and Dissemination.* Priority has been given to products conceived for a domestic audience. At any rate Trimbos has a communication office and could cope with these tasks if seriously required.

- *Quality control.* There are a number of formalised procedures in place based mainly on peer-reviews and Steering Committee. The Editorial Board acts as Steering Committee of all the report-related activities. The National working group on Epidemiology (and its two sub-groups) acts as peer-reviewer of the reports. The Inspectorate of the Ministry of Health acts as peer-reviewer of the Early Warning System-related and of the pill-testing activities. Independent experts are asked on *ad-hoc* basis to review activities directly linked to their field of specialisation.

- *Networking.* Highly developed and effective at the institutional level even if problems are still experienced with quality of data coming from the Ministry of Justice. Universities, scientific institutions and NGOs extensively involved in the FP activities together with several individual experts. On paper demand reduction seems underdeveloped but this does not have an impact on quality of contributions.

**Financial.**

No conclusive statement can be made on this subject. Although the NDM-FP keeps a separate accounting of its costs, the merging of the National and EMCDDA-related activities into the same unit makes it difficult to make a clear distinction. The NDM-FP receives a € 480,000 contribution from the Dutch Government to carry out all its activities plus the EMCDDA co-financing. Roughly speaking half of the total effort is estimated related to EMCDDA activities. This would bring total income to exceed maximum contractual requirements by as high as 45%. The picture is further complicated by EMCDDA contributing also financing through support projects.

However, a financial breakdown was made available for total costs exceeding contractual requirements by over 90%. These include salaries for staff (inclusive of overheads) accounting for some 85% of total costs, printing and translations and travel costs accounting for another 6% each and the remaining part substantially

covered by external consultants (3%). FP coordination and support staff respectively account for some 37% and 11% of these costs, while the National Report accounts for another 33%, the harmonised indicators for another 11% and demand reduction for 5%. The Early Warning System is apparently reported at no cost even if a few person-days are spent on related activities.

**Overall Assessment.**

A highly professional FP with a good level of scientific expertise. Its contributions have been on average of a very good quality. There is a notable lack of expertise in policy and crime-related aspects but this is easily acknowledged by the FP itself. Also communication and PR activities have been given little priority. Some problems in communication with the Ministry of Justice and with the EMCDDA should be easily solved in the future. The institutional framework of the FP and the related accounting mechanism make its cost structure difficult and somewhat obscure to understand from outside. At any rate the basic requirements for provision of financial information for this evaluation exercise could not be fully met. The FP seems unable to cope with new requirements in policy analysis and criminology only if additional funding for diversified expertise is added. The political FP has been involved in the FP activities through a constant consultation process and has never substantially interfered in operational activities.

*FINAL SUMMARY SWOT MATRIX*

| **Strengths** | **Weaknesses** |
|---|---|
| • Good institutional networking<br>• Good scientific expertise<br>• Good project management skills<br>• Adequate quality control mechanisms<br>• Very good EWS network<br>• Good reporting and editing skills<br>• Advanced level of epidemiological indicators<br>• No language barrier | ▪ Recent lack of key expertise for some epidemiological indicators<br>• Absence of in-house expertise on judicial and policy areas<br>• Poor involvement in PR and dissemination activities<br>• Inadequate financial reporting mechanisms for Centre requirements<br>• Some problems in communication with the EWS |
| **Opportunities** | **Threats** |
| • Strong political support from Government<br>• Excellent relations with the Member of the Management Board<br>• Involvement in support projects<br>• Involvement in the enlargement<br>• Development of monitoring system in the field of criminal justice and law enforcement | • Quality of raw data at risk in problematic drug use and infectious diseases<br>• Problems in data quality and data reporting systems with Ministry of Justice<br>• Preliminary indications of possible future financial constraints<br>• Problems of co-ordination among Ministries involved in drug-field |

**Finnish Focal Point**

***Sosialii ja terveysalan tutkimus ja kehittämiskeskus***
***(National Research and Development Centre for Welfare and Health) - STAKES***

**Short Profile**

## Institutional Background.

After a very short period with the Ministry of Health and Social Services, since 1996 the Finnish FP has been located within STAKES a Governmental research institute contracted by the Ministry itself. STAKES tool over the previous Ministry-based FP staff. The establishment of a monitoring centre within STAKES has gone in parallel with the growing perception of illegal drug abuse in Finland. Until the early nineties the problem was hardly known and there was no real monitoring system or scientific tradition to speak of. STAKES is mainly involved in research and development on social and health services. At present no more than 3% of total STAKES activities are related to illegal drugs. At the national level the drug issue is not yet really comparable to the importance given to other addictive behaviours such as alcohol and tobacco.

STAKES is a mainly Government-funded research institution with a staff of some 400 professionals. Its financing depends on framework contracts agreed on an annual basis with the Ministry and specifying areas of activities and expected targets. For a number of reasons the institute has undergone growing financial pressure over the last few years and the resources available for project initiatives have reportedly decreased. A system of internal contracts among the various divisions and groups has been put in place and staff has also been encouraged to seek external sources of funding.

Although STAKES was officially appointed as the Finnish FP in a Ministry decree, its powers and responsibilities have been based on voluntary and bilateral networking relations. Also because of the lack of any consolidated tradition in the drug field, during its early years of life it was not unusual for the Finnish FP to have to pay consultant services to other Government agencies for starting up new data-collection activities. Since then the situation has improved noticeably and earlier this year STAKES was reportedly given by the law new powers in the field of social and health care statistics. Also privacy and data protection considerations have somehow delayed development of activities. STAKES had to reach an agreement with the privacy ombudsman on data encryption before starting work on demand for treatment and the same process is expected for all cohort-based studies in the drug field. STAKES as focal point is reportedly slightly better known among policy makers and drug practitioners than within the scientific community.

## Organisation.

There are four divisions in STAKES: StakesInformation, Health and Social Services, Promotion of Well-being and Health, and Administration. Various groups in the divisions are involved in the activities of focal point. Co-ordination of FP activities has been located with a project officer within the Statistics group under the division of StakesInformation. Since 1999 following the increase in FP activities additional expertise has been requested from other STAKES divisions, namely from the groups for alcohol and drug prevention and for the alcohol and drug research under the division of Promotion of Well-being and Health. Each year specific REITOX-related internal contracts are agreed with these divisions and groups as a basis for allocation of activities and workloads.

The FP is therefore presently composed of the FP co-ordinator plus one support staff and three professionals from two divisions. Additional specialist staff provides minor contributions totalling some one and half man-month. All in all, FP original “core team” accounts for some 40% of total man-time and support staff for another 14%. Expert staff from different divisions accounts for the remaining 45%, or so of man-time resources. These personnel work as temporary staff for Stakes and are not on a full-time basis for the FP.

Expertise available in the FP core staff includes social sciences (sociology), statistics and health sciences. Minor contributions are expected by a computer expert. All personnel have a certain degree of seniority and have been active in the drug field for many years. Only the statistician is a junior in drug field. Most staff is involved in scientific publications. Core FP staff is also involved in tasks of a more strictly national nature, such as filling in questionnaires for other international organisations, answering to Government and Parliament requests, and contributing to National reports and publications. However these activities are reportedly kept separate from FP activities also because of the internal contract system.

**Operational.**

*Overview.* The FP is located in a Country where illegal drugs have only recently become a matter of real social and political concern. As such it suffers from the historically underdeveloped status of the internal drug monitoring system and from a more general lack of tradition in this kind of studies. This compounds with a general situation of financial constraints, which creates a strong need for prioritising areas of activities. The FP has focused on those REITOX tasks, where the need of data is more acute and that are considered more relevant from a national point of view and has deliberately postponed other topics.

*Specific Areas*

- *National Report.* In 1998 the Finnish FP could produce its first national report in line with the Centre's requirements. Since then it has mainly concentrated in updating relevant parts only. The report reflects the lack of information sources in some specific areas and difficulties in ensuring an overall geographical coverage and usually presents only general data. Lack of basic information is reportedly one of the main reasons why the section on key issues has sometimes been totally neglected. The complex budgeting and contractual procedures also hinder the national reporting process. It usually happens that when internal contracts should be discussed in national budgetary framework, details on the Centre's contract are not available and this makes it impossible to plan an adequate allocation of resources and coverage of topics.

- *Key Indicators.* One of the areas where prioritisation of needs has been stronger. The FP focused on building from scratch a treatment demand monitoring system that has now reached 50% of units and on problematic drug abuse through pilot capture-recapture studies. Given the complexity of the task it comes to little surprise that in the first of these areas results are still far from desired standards[9], while progress in the second one can be better appreciated. The FP has not invested in general population surveys because surveys are expensive and there already is a national tradition in such exercises. However, even if existing surveys are of a fairly advanced quality in some cases any further progress towards reaching full Centre standards could jeopardise a 30-year comparability of national data. No major problems with use of information available in general registers: e.g. the quality of drug-related deaths reporting codes is even deemed better than in other EU countries but work on cohorts has yet to start. A pilot drug-related infectious diseases study has just been launched after problems of privacy problems were solved. External experts on a contractual basis appointed for problematic drug use and treatment demand and on an institutional basis for drug-related deaths and drug-related infectious diseases. Limited reliance on external consulting services.

- *Demand Reduction.* Specialists in the field have not easily accepted the EDDRA database concept. Internal databases have been established for different purposes concerning limited areas of activities that have used other classification criteria than EDDRA. Consequently data on EDDRA projects are collected separately, which often means additional difficulties in receiving proper answers in line with EDDRA guidelines. Limited communication and information exchange in this area also reflects the FP's budgetary constraints and prioritisation of issues in a national perspective. No external expert appointed. No reliance on external consulting services.

9 The system had to be created form scratch: It currently receives information from over 100 centres (roughly 50% of the total), whose main task is treatment. Their own information systems are mainly based on paper documents or using several different programmes in processing information for their own administrative purposes.

- *Early Warning.* It is difficult to see the need for an early warning system on new synthetic drugs in a Country that has reportedly never experienced such occurrences. Therefore it is given a limited political priority. The related activities have been implemented at the minimum possible level in collaboration with a drug laboratory network. Problems of confidentiality and of relations with the judiciary will arise if any in-the-field information system were put in place. Better linkage with early trends of substance abuse in general would make the initiative more acceptable and interesting.

- *Policy Analysis.* Very limited involvement so far in the EMCDDA projects.

- *Dissemination and PR.* Carried out as a collateral activity. The Centre in Lisbon reportedly takes care of EU Drug Report delivery to journalists and the media.

*Networking.* Developed and time-consuming in some areas. Limited in others. The FP has to keep direct relations with the hundreds of institutions providing drug treatment. Different governmental and non-governmental organisations and research centres are contacted at the national level, but there is a need to further extend the network to the Regional Universities. However, in general scientific expertise available in this field is rather limited. After initial difficulties, relations with other Government agencies have become more flexible. Central NGOs are regularly consulted. The network on demand reduction is developed in quantity terms, but some difficulties in getting the system interested and motivated and in providing usable feed-back are still there. The network for the early warning in practice does not exist yet.

*Quality Control.* No formalised procedures in place. Peer review by colleagues and comments from the scientific committee are routinely used. Only data from the general surveys, coming from another institution, undergo a formalised internal audit process.

*Main Problems in Relations with the Centre.*

- limited domestic appeal of the early warning system as defined by the EU Joint Action on New Synthetic Drugs;

- limited knowledge about the Centre's activities also due to FP limited resources and different prioritisation of activities;

- most of the information included in the national report seems to remain underused by the EMCDDA.

**Financial.**

Finland complies with co-financing requirements by including FP responsibilities in its framework annual contract with STAKES. Funds are credited to STAKES headquarters. After overheads are deducted from total financing, what remains is left to the FP co-ordinator for internal and external contracting activities. As a result the Finnish FP has one of the most accurate and transparent accounting system within the REITOX network and can provide the Centre with very detailed financial information.

Actual costs exceed contractual arrangements by some 5%. Staff salaries account for some 52% and together with overheads (38%) account for the bulk of total costs. Overheads include some 100 sq. mt. rents. Travel costs and external consultants account for another 4% of total costs each, while the remaining 2% is spent on printing and translation and the organization of meetings and conferences.

Given Finland's peculiar situation, it comes to no surprise that work on the key indicators accounts for as high as 60% of total direct costs, and that the bulk of it is concentrated on treatment demand. Other significant resources are spent on capture-recapture studies on problematic drug use. Demand reduction and the national report are allocated a 14.5% of direct costs each, (roughly split in 24% and 10%), while another 5% each is spent on FP co-ordination and PR and dissemination activities. Consequently the early warning system is allocated a tiny 1% of total costs.

Finland is one the few countries where EMCDDA financing represents a major source of funds and therefore a constraint in operational terms. Important parts of the national monitoring system exist thanks to the Centre's financial support, and its discontinuation would result in a possible drought of related information sources. The FP is presently surviving with a minimum level of resources. Any additional task would require additional financial resources in the system.

**Overall Assessment.**

A FP with several structural difficulties to cope with, due to the rather underdeveloped nature of the drug information system in the Country. Financial constraints are much more severe than elsewhere. A substantial part of the monitoring system was developed thanks to EMCDDA financing. Work has been concentrated on where lack of information was perceived as most important from the national point of view. Other areas have been purposefully neglected. This obviously includes support projects or participation to the enlargement process. All this together with a rather detached and passive attitude from the FP itself contributes to make relations with the Centre sometimes uneasy. Unlikely to be able to cope with new requirements unless substantially strengthened in the future.

## FINAL SUMMARY SWOT MATRIX

| **Strengths** | **Weaknesses** |
|---|---|
| • good institutional networking<br>• efficient use of existing information systems<br>• adequate scientific expertise<br>• straight project management mechanisms<br>• adequate staff | • informal quality control procedures<br>• problems in ensuring even geographical coverage<br>• poor mirroring of Centre's functions in EWS<br>• poor reporting as translations are needed<br>• limited PR and communication activities |
| **Opportunities** | **Threats** |
| • progresses reached with some key indicators<br>• close links with representative in the Management board | • annual contract mechanism<br>• unclear political support<br>• poor overall financing of the drug information system<br>• prioritisation on national issues followed by passive attitude in communicating with the Centre<br>• limited scientific community available in the Country<br>• limited involvement in the Centre support activities<br>• limited involvement in the enlargement |

**French Focal Point**

***Observatoire Français des Drogues et des Toxicomanies (OFDT)***

**Short Profile**

## Institutional Background.

Since 1996[10] the *Observatoire Français des drogues et des toxicomanies - OFDT* has been entrusted with the coordination of all drug monitoring activities in France and has acted as the REITOX French FP[11]. Since end 1998 its areas of activity have included licit drugs as well (i.e. alcohol, tobacco, medicines). Starting from 2000 the OFDT is also responsible for the evaluation of drug policies in France. The French approach to drug policy is based on a two-tier system where monitoring and evaluation are kept separate from policy implementation. While the first are OFDT's specific responsibility, it is the *Mission interministérielle de lutte contre la drogue et la toxicomanie – MILDT* which since 1996 has been made responsible for the overall coordination of the different activities against drugs and drug-addiction in France. The MILDT is directly attached to the Prime Minister office. It is the MILDT, which directly manages the diffusion to the media of the information produced by the OFDT, and follows communication strategies, timing of publications and even their style and formatting. OFDT is directly responsible for the diffusion to policymakers and professionals in the field. The OFDT apparently does not directly provide information to any international organisation, but the EMCDDA.

The OFDT is an independent body incorporated according to the French Law as a *Groupement d'intérêt public - GIP*. It is not under any direct hierarchical Government control. At any rate, it is funded by the MILDT and is subject to the financial control of the French Court of Auditors and its management board is composed of representatives of several Ministries and national French institutions[12]. The *OFDT* has no problem of continuity of activities and can rely on a large staff in Paris. It also has a vast network of regional correspondents in all *Départements*. For historical reasons, the OFDT experiences little problems in ensuring an even geographical coverage of data. Its functions have been defined in a Governmental act, even if there is no mandatory obligation to provide information enshrined in the law. And the FP feels the need for no such a piece of legislation. Nowadays, the data collection process is partly hindered by privacy considerations, as no drug registers are used in France and drug users are given a strong protection of their privacy. However, the OFDT has managed its way through these difficulties. The FP is widely known among drug practitioners and policymakers. Not the same can be said within the Scientific Community, as responsibility for funding research grants in the drug field still lies with the MILDT. Things are expected to change when the OFDT is given this mission reportedly from 2002.

## Organisation.

The OFDT is steered by a Management Board [13] responsible for its overall strategy and business planning.

[10] For a certain period of time FP-related activities were carried out by *Toxibase*.

[11] The process leading to the creation of the OFDT was not simple. It reportedly took about 12 years to move from the initial idea of creating an independent body responsible for monitoring drugs issues (March 1983) to the actual implementation (October 1995). It was the establishment of EMCDDA strongly supported by the French Government to win internal resistances.

[12] Namely, The Ministry for Work and Solidarity; The Ministry for Health; The Ministry for Urban Life; The Ministry of Justice; The Ministry of Defence; The Ministry of Home Affairs; The Ministry of External Affairs; The Ministry of Finance; The Ministry for Youth and Sport; The Ministry of National Education; The Ministry of Research; The Inter-ministerial mission for the fight against drugs and drug-dependency (MILDT); The National Federation of Regional Observatories on Health; The National Network of documentation on Medicine-addiction.

[13] Apart from the "owners", Members of the Management Board are also the State Controller, the Commissary of the Government, and the President of the Scientific Committee, the Chief Accountant and the OFDT Director.

Its day-to-day activities are closely supervised by a strong and influential Scientific Board, which is structured along four working commissions closely mirroring the OFDT departments (named *pôles*). Within the Scientific Board, an *ad hoc* editorial board oversees the OFDT main report « *Tendances* » (Trends).

Within the OFDT there is no specific unit responsible for FP activities that are scattered across all departments. The head of the OFDT acts as the head of the FP. At present there are five line departments ("evaluation of public policies"; "recent trends"; "indicators" and "surveys on the general population", plus a horizontal one "valorisation of the information") and three support departments (secretariat, human resources and finance and logistics and equipment) employing a total staff of 25. A dozen researchers are deemed to be directly involved in FP activities for a total time contribution ranging from 10% to 50% and roughly averaging some 25% of their total available person-time[14], plus another six support staff. Some half of personnel is fully fluent in English and this can create some kind of linguistic barrier with the Centre.

There is a wide range of expertise available within the OFDT ranging from demography to sociology and statistics. Most staff is relatively young and has been in the post for a couple of years. This reflects both the overall increase in personnel that has passed from six people in 1996 to the current 25 and the OFDT average staff turnover. There is a strong bias towards evaluation as some one third of FP-related personnel are economists trained in evaluation. The FP has no particular complaint about present level of staff. A major program of evaluation of the French Drug Strategy has just started in 2000 will imply substantial recourse to tendering for consulting services.

**Operational.**

*Overview.* The FP is located in an independent organisation responsible for the evaluation and monitoring of the drug phenomenon and related policies in France. It has no great leverage on the basic features of the data collection process carried out by other administrations. EMCDDA-related activities are relatively marginal for the FP in both financial (less than 3%) and to some extent organisational terms (priority is given to domestic issues). Because of its independent and external role the OFDT has given a great importance to the role played by the scientific board that closely supervises all its activities. This makes the French FP very strong from a methodological point of view.

*Specific Areas*

- *National Report.* The report for the EMCDDA has substantially improved over time both in its contents and in its adherence to the Centre's guidelines and reporting requirements. Nowadays disagreements focus on a few technicalities hindering comparability of presented data at the European level. Work is carried out by various internal staff with involvement of external consultants. A number of Universities and other research centres are at any rate routinely consulted. The National Report is considered as a secondary task whose usefulness is not always clear. The domestic report *"Drogues et toxicomanies – Indicateurs et tendances »* issued on a biannual basis is used as a reference basis and this can have a impact on the quality of the report. Presented data are deemed by the FP itself as better than the underlying analysis, a view not necessarily shared by the EMCDDA.

- *Key Indicators.* The situation is highly varied. While surveys and estimates of prevalence in the general population do not pose any major problem all other areas are a bit more problematic, as full compliance with EMCDDA protocols would imply substantial changes in the working and data collection procedures of several institutions in France. This is the case for treatment demand and availability of mortality data in drug users cohorts. Data on drug-related deaths from existing three different sources are not necessarily consistent. Lack of progress in drug-related infectious diseases is mainly attributed to unclear protocols, although France is relatively advanced in this area. No external experts appointed for co-

[14] It is extremely difficult to assess the human resources efforts devoted by OFDT to its activities as a Focal Point, and any attempt in this direction has to be taken as a proxy, only. However estimates made in collaboration with the OFDT leads to an approximate 3.25 - 3.9 full-time resources devoted to REITOX related activities.

ordinating work on any indicator or reliance on external consulting services. Indirect support is obtained from Universities and other individual experts.

- *Demand Reduction.* Although contributions to the EDRRA database have generally met expectations and targets this is the most problematic area of co-operation with the Centre, as acknowledged by both parties. The FP collects information on demand reduction indirectly from other mainly institutional sources and this may hinder quick communication and feedback with the Centre. This compounds with the fact that the OFDT has its own database, APPRE that is based on slightly different methodology. Demand reduction is also one of the few areas where reporting to the Centre still has some weaknesses.

- *Early Warning.* Very strong although quite costly. The OFDT has recently put in place and directly manages a vast national system for the identification of synthetic drugs (SINTES). The system routinely checks samples of synthetic drugs seized by the Police and the Custom Administration, and collected by ground operators in different environments, like discos, private parties, etc. Results are entered into a database with restricted access, while an abstract of the descriptions of the substances analysed is available to the large public via the OFDT website. The system presents innovative aspects and had to solve some legal issues related to the collection of illicit drugs by ground operators before becoming operational. A solution was found with the agreement of the national Judiciary Authorities. No external expert appointed. Substantial recourse to subcontracted studies.

- *Policy Analysis.* Another strong point. Since September 2000, the OFDT has been made responsible for the evaluation of the French three-years national action programme on drugs. This is considered as a pilot experience within REITOX. Results and the lessons learnt are deemed important for the EMCDDA in the light of its new work plan.

- *Dissemination and PR.* Never professionally involved in these activities so far, although quantitative outputs are fairly good. All information is routinely made available in the website managed by MILDT in collaboration with four further partners, among them the OFDT.

*Networking.* Mainly based on institutional relations with other administrations. Data collection is based on two main sources: surveys directly managed by the OFDT and administrative data provided by national and regional administrations. The OFDT has direct relations with a number of treatment centres and has built a network involving some 75 NGOs for the early warning (SINTES see above).

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*Quality Control.* Highly sophisticated and formalised[15]. Methodologies are based on extensive recourse to both steering committees and peer-reviews. Accreditation is also used for all areas but still problematic key indicators.

*Main Problems in Relations with the Centre.*

- limited usefulness of drafting a comprehensive national report on an annual basis;

- limited user-friendliness and utility of the REITOX website;

- neglect of the Centre documentation functions.

[15] The Scientific Committee validates the structure of the publication *"Drogues et toxicomanies – Indicateurs et tendances"* proposed by OFDT. After the internal process of writing, each chapter is sent for scientific validation to experts, even external to the Observatory. After possible integration of comments received, it follows an internal global reading to ensure overall coherence of the publication. Finally, the publication has to be validated by the whole Scientific Committee. As per the further publications of OFDT (blue series), a strict peer-review process is adopted. Every publication is sent for review to two external experts. In any case of conflicting advice, a third expert is consulted.

**Financial.**

The OFDT has a separate budget and is directly credited financial contribution from the EMCDDA. However, it keeps no separate accounting of its FP-related costs. It seems that France complies with co-financing requirements through in-kind contributions by indirectly paying FP staff salaries and contributing overheads and figurative rent costs. No exact calculation is possible of the latter while staff salaries alone cover some 150% of member state contribution.

Declared actual costs exceed contractual arrangements by some 44%. However this is mainly due to studies on the early warning system contracted out for a similar amount. Staff salaries account for some 51% of total estimated costs, subcontracted studies for another 29% while printing and translation and overheads (without rent) respectively account for 9% and 8%. It is worth noting that the French FP claims no travel costs. However the organisation of the meeting and conferences accounts for some 2% of total costs.

The French FP was not able to provide total direct costs according to the template received for this evaluation exercise. Data were provided based on the financial report used for the Centre and as such are of little use for this evaluation exercise. No indication was given of costs for focal point co-ordination. However work on the key indicators and the early warning system accounts each for 36% of total direct costs. The national report accounts for another 14% of direct costs, while demand reduction for 10%. Practically no resources are devoted to information and PR activities. EMCDDA financing is not a serious constraint in operational terms. It accounts for some 3% of the OFDT total budget.

**Overall Assessment.**

The FP is a stable and improving organisation very well staffed and well funded. It faces no main difficulties in delivering expected outputs, but partly in the demand reduction area. Quality control and methodological accuracy of data are among its strong points. Also the early warning system is well developed. Being an independent organisation entrusted with monitoring and evaluation and relying on external sources of data the FP is not very well placed to induce improvements in key indicators facing structural obstacles. In prospective terms it seems bound to play a major role as far as policy evaluation is concerned, while it has been so far relatively detached from any serious involvement in communication and PR activity. Only limited considerations about costs and co-financing are possible with the presently limited available financial information.

## FINAL SUMMARY SWOT MATRIX

| **Strengths** | **Weaknesses** |
|---|---|
| • Good institutional networking<br>• strong involvement of the scientific community<br>• good quality control<br>• even geographical coverage<br>• diversified sources of information<br>• large staff resources<br>• good project management skills<br>• good capability of achieving targets | • poor mirroring of Centre functions<br>• difficulties in the demand reduction area<br>• some linguistic barrier within staff<br>• limited professional involvement in PR activities |
| **Opportunities** | **Threats** |
| • continuity of activities<br>• strong political support from Member State<br>• no institutional constraint to data collection<br>• good overall financing of the drug system<br>• close links with representative in the Management board<br>• clear definition of tasks at the national level<br>• involvement in the Enlargement | • structural problems with key indicators<br>• growing divergences between domestic and EMCDDA missions<br>• poor involvement in the Centre support activities (but now leading a major DG Sanco –financed initiative)<br>• inadequate financial reporting system to EMCCDA |

## German Focal Point

***Institut für Therapieforschung - IFT***
***Bundeszentrale für gesundheitliche Aufklärung - BZgA***
***Deutsche Hauptstelle gegen die Suchtgefahren - DHS***

**Short Profile**

### Institutional Background.

Since its establishment the German Focal Point has consisted of a network of three different organisations that already used to co-operate together before being appointed as FP:

- The *Institut für Therapieforschung* (IFT, Institute for Therapy Research): a research institute mainly responsible for epidemiology-related issues and also in charge of FP overall co-ordination as well as of relations with the EMCDDA (on average accounting for some 75% of activities).
- *Bundeszentrale für gesundheitliche Aufklärung* (BZgA, Federal Centre for Health Education): a federal agency under the hierarchical control of the Federal Ministry of Health and mainly responsible for primary prevention (on average accounting for some 20% of activities);
- *Deutsche Hauptstelle gegen die Suchtgefahren* (DHS, German Council of Addiction Problems): an umbrella NGO grouping over 20 welfare organisations. The DHS is responsible for treatment-related (on average accounting for the remaining 5% of activities).

The Focal Point lacks a clear legal basis for its operations. In an attempt to better formalise its structure in 1999 the *Deutsche Referenzstelle für die Europäische Beobachtungsstelle für Drogen und Drogensucht* (DBDD- German Reference Point to the EMCDDA) was created with the aim of improving the exchange of data concerning drug situation in Germany and the relations with the EMCDDA.

All in all these three organisations can rely on some 170 staff and a wide network of branches all over the Country. The FP operates based on a yearly contract with the Federal Government and enjoys therefore little assurance of continuation of activities. The current legislation on privacy and data protection somewhat hinders the data collection process, especially as far as police-related data are concerned. The FP is widely renowned among policymakers and to a lesser extent in the scientific community. It is relatively poorly known among drug practitioners.

### Organisation.

An IFT head of research department plays the role of the head of the FP. Relations between the three organizations are kept on a contractual basis and personnel from all the three institutions act as FP core staff. In particular, both the DHS Director and the Head of the FCHE Drug Prevention Unit work for the FP, thus ensuring high-level staff coordination of activities. All three organisations are involved in the information gathering process, although data processing and analysis is mainly carried out by IFT that also co-ordinates report drafting activities. Relations with other drug-related international organisation (Pompidou Group, UNDCP) are also kept by IFT although on an individual collaboration basis with the Ministry of Health that is formally responsible for the assignment.

Some eight staff, of which one support personnel, contribute to FP activities on a part time basis. Available expertise mainly includes psychologists and social workers who have different degrees of familiarity with quantitative analysis techniques. Scientific personnel are evenly split between senior and junior researchers. Most staff also has a heavy involvement in scientific publications reflecting a prevailing research-oriented culture.

The national REITOX report is also published nationally as an overview on the drug situation in the country.

**Operational.**

*Overview.* EMCDDA-related tasks are relatively marginal for a FP that is mainly focused on national priorities, such as the national report on drug situation or the maintaining of national databases[16]. It has a strong research-oriented approach and follows highly scientific standards. . The production process is partly shaped by the institutional context, often requiring lengthy consensus building process at the regional level.

*Specific Areas*

- *National Report.* The report for the EMCDDA is on average of good quality and in compliance with the Centre's guidelines and methodologically sound. Problems with homogeneity of data do exist and are mainly due to the German institutional context. There are huge geographical variations in the availability and quality of data. Work is mainly carried out by internal staff with the support of external experts on both an institutional and contractual basis and local health authorities. Activities are based on a well-structured work plan.

- *Key Indicators.* Progress is on average fairly advanced in this field. Minor difficulties are experienced with treatment demand because of privacy considerations and in getting disaggregated data from the regions. As regard drug-related deaths, the Focal Point can rely on the police information system, organised on federal basis and using standardised tools. Only the development of an indicator on drug-related infectious diseases appears really problematic because of major legal restraints to the use of a cohort-based methodology. Work on the key indicators is organised in workgroups including the personnel of the three organisations, external experts involved on an institutional basis, the federal partners, the Länder partners, the Scientific Committee member and the Management Board member.

- *Demand Reduction.* On average good contributions in both quality and quantity terms, although possibly not of the same level as in epidemiology. This is the only task not directly managed by the IFT, but by the BZgA. Works are carried out only by internal staff. Data collection is structured through a national NGO umbrella organisation and contributions from the Laender .

- *Early Warning.* Data collection from in-the-field sources has never started because Police keeps information secret for a long period of time and civilians are not allowed to test pills on a routine basis. Only feedback activities to Centre inputs implemented to some extent. No external expert involved.

- *Policy Analysis.* Never seriously involved so far and apparently not very interested in getting involved in the future. A weak area where the FP apparently lacks expertise. The subject is neither part of the REITOX contracts nor is it reportedly accepted or supported by the national government.

- *Dissemination and PR.* Another weak area deserving future strengthening. National Report is mainly distributed to the FP partners and most important policy-makers and scientists. But little systematic PR activity has taken place yet.

- *Networking.* Fairly developed. The three organisation of the German FP can rely on a wide and well-structured network of NGOs, research centres, federal and local administrations. Information sharing as well as participation to the Focal Points' events (meetings, seminars…) and the related prestige are used as rewarding mechanisms. A newsletter is delivered to national partners. However, current available resources are deemed insufficient to perform adequate networking activities. The DHS can provide data on treatment related issues through its wide network grouping 1000 counselling centres, 4500 self-help groups, over 160 special clinics and other institutions involved in the field of drug treatment. Good relations with the law enforcement agencies.

[16] The IFT runs the main data collecting systems at federal level on treatment of drug addiction (the EBIS system and the SEDOS system); it carries out on continuing basis the Representative Survey on the Use and Abuse of Alcohol, Medicines, Tobacco products and Illegal Drugs. The BZgA conducts another continuing survey on drug-consumer at federal level, the Drug Affinity Study.

- *Quality Control.* Biannual steering committee meetings. Peer review and internal audit usually carried out as part of the National Report revision process.

*Main Problems in Relations with the Centre.*

- insufficient information on Centre's strategic planning;
- unclear information requests concerning policy analysis;
- little information on award of contracts;
- insufficient utility and user-friendliness of the REITOX Website
- little provision of services to the FP such as documentation research or access to data bases

**Financial.**

The German FP receives co-financing from the German Government through cash contributions. Funds are credited to the relevant institutions, but the FP keeps a separate accounting of costs. The FP also received some additional € 73,000 from the Centre because of involvement in support projects. The EMCDDA will stop REITOX support generally at the end of 2001.

Actual costs practically coincide with contractual arrangements. Staff salaries account for 63% of costs, 15% is for overheads (including office rent and equipment), 9% for the organization of meetings and conferences (as a part of its consensus building work with the regions the German FP organizes some 15/20 workshops per year and fully reimburses travel expenses to participants) another 6% for printing and translations. What remains is composed of a 3% of total costs for the website maintenance and Internet costs, 3% for travel 1% for library and documentation.

Work on the five harmonised indicators account for some 31% of costs, but maintenance of major national databases is not included in this figure. Another 28% of resources are spent for the annual report. Overall FP co-ordination accounts for some 13% of costs while another 10% is spent on PR and information dissemination activities. Demand reduction accounts for another 12% of costs, while the joint action covers as low as 6% of available resources.

EMCDDA financing cannot be considered as a serious constraint in operational terms for the various institutions involved, but it is for the FP that is run a project basis. Even today current human resources are considered insufficient to cope with the present needs, as two more full-time personnel would be needed in PR and IT. Involvement in additional areas of activities is estimated to require additional € 50,000 on a yearly basis.

**Overall Assessment.**

The FP is a stable organisation with a great deal of scientific expertise especially in the field of epidemiology. It can generally deliver good quality outputs. It mainly resents of the difficulties related to the German federal institutional context that often causes uneven geographical coverage of data and information. Legal constraints make any early data collection activity in the joint action hardly possible. As research-oriented institutions usually are, the FP is relatively weak in policy analysis and in PR activities

## FINAL SUMMARY SWOT MATRIX

| **Strengths** | **Weaknesses** |
|---|---|
| • good institutional networking<br>• high scientific expertise<br>• strong implementation capabilities<br>• good project management skills<br>• international partnership<br>• command of English | • uneven geographical coverage of data<br>• insufficient resources for public relation activities<br>• legal problems in implementing cohort-based methodologies<br>• underdeveloped in policy analysis |
| **Opportunities** | **Threats** |
| • good overall financing of the drug system<br>• good relations with representatives in the Management Board and the Scientific boards<br>• involvement in the enlargement process<br>• strong institutional support<br>• staff long standing in post<br>• independence from political control<br>• extensively involved in the enlargement process<br>• often leader in REITOX support projects | • focus on national priorities;<br>• lengthy consensus building process at the regional level<br>• short-term contractual arrangement with national authorities<br>• some differences of tasks between European and local level<br>• time constraints in defining strategic plan<br>• some constraints in data collection<br>• legal obstacles to implementing the joint action<br>• high workload of healthcare institutions collecting database<br>• co-ordination of the three-organization activity |

**Greek Focal Point**

***University Mental Health Research Institute - UMHRI***

**Short Profile**

**Institutional Background.**

Since its establishment the Greek FP has been located within the University Mental Health Research Institute (UMHRI) as the National Centre of Documentation and Information on Drug. The FP strictly collaborates with the O.KA.NA. (Greek Organisation Against Drugs), a Governmental Organisation under the supervision of the Ministry of Health with the role of inter-ministerial co-ordinating body for demand reduction in Greece.

The FP operates on the basis of a three-year contract with the Ministry of Health and enjoys therefore a certain assurance of continuation of activities in the mid-run. Its responsibilities were clearly defined in a Governmental Decree. However, at present, the FP because of privacy and personal data protection regulations does not have access to all sources of data on treatment demand and to raw police data. The FP is currently working together with O.KA.NA to solve the problem. The Focal Point is widely renowned among policymakers, drug practitioners and, to a lower extent, the Scientific Community.

**Organisation.**

The Focal Point is located within the UMHRI's department dealing with drug-related issues in the field of epidemiology and prevention and is responsible for carrying out assignments in drug field at the international and at national level.

In particular, at the national level the FP unit is in charge of drafting the Greek National Report, with a different structure from the report for the EMCDDA and the annual Greek Bibliography on Drug. Moreover, the unit has been recently given new assignments in the field of alcohol. At the international level it is involved, among others, in the provision of information to international organisations such as the UNDCP, the Pompidou Group, at the EU level it is a member of the Group HBSC-WHO (Health Behaviour in School Aged Children – World health Organisation) and of the Group ESPAD (European School Survey Project on Alcohol and other Drugs).

The Head of the Focal Point has been recently appointed to the job to replace the former Head who now is O.KA.NA president. However, having acted as deputy head of department since the unit establishment in 1993 she can ensure smooth continuation of activities. REITOX-related tasks are mainly carried out in-house. The FP can rely on 13 internal staff of which 12 full-time and 1 part-time; moreover, it has the support of a consultant mainly working as university professor. Available scientific expertise includes psychologists, statisticians and a sociologist. The FP can rely on six support staff (an information technology technician, a librarian, two administrative staff and two secretaries). Current staff is deemed insufficient in order to cope with the unit's responsibilities and two new personnel are deemed necessary in epidemiology and social sciences.

**Operational.**

*Overview.* The Greek FP is given by O.KA.NA a larger mandate than the mere accomplishment of EMCDDA-related activities. However REITOX-related tasks cover a significant share of the FP activities. A closely-knit unit with very limited recourse to external consulting services. The FP can rely on very strong support from O.KA.NA on implementing activities. When it comes to other Government institutions patterns of co-operation may vary.

*Specific Areas*

- *National Report.* Remarkably improved over the years. The report has recently attained good scientific standards in almost all areas. The report is mainly based on official data, with a small involvement of NGOs or other research institutes. Major shortcomings are related to the different progress achieved in the five key epidemiological indicators. No recourse to consulting services.

- *Key Indicators.* Problematic drug use estimates are made hardly possible by lack of access to raw data because of privacy regulations problems. Notably two major treatment centres refuse the provision of personal and sensitive data as well as the access to the police records on arrests and to the death registers are reportedly very difficult. Harmonisation work on the critical drug-related deaths area is not a FP direct responsibility. Work on mortality was undertaken by O.KA.NA and that on acute deaths has been contracted out by the FP. Fairly advanced progresses in the other areas. External experts involved for drug related deaths, drug mortality and problematic drug use.

- *Demand Reduction.* The largest contributor to the EDDRA database so far due to extensive networking. Qualitative analysis is possibly of a slightly lower level reflecting the relatively short tradition of such studies in Greece. No recourse to external experts.

*Early Warning.* The system was built from scratch and is now fairly developed in both institutional and operational terms. There is no pill testing in Greece. An electronic database was recently implemented on a pilot basis.

- *Policy Analysis.* Progress in this area is relatively advanced. O.KA.NA is using the FP expert who is seconded there. Through this, the FP has better access to policy data.

- *Dissemination and PR.* The Focal Point is significantly involved in dissemination activities. The National Report is distributed to policymakers, drug practitioners, members of the scientific community and journalists. The dissemination of the Centre bulletin is mainly aimed at drug practitioners.

- *Networking.* The FP can rely on a fairly developed network composed of national and local health authorities, universities, research centres and NGOs. Focal Point networking activities mainly involve individual experts, government agencies and NGOs. Participation in meeting and information sharing are considered as rewarding mechanisms. The Focal Point is provided with an up-dated website mainly targeted at professionals.

- *Quality Control.* Quite formalised and developed. Internal and external peer review for the National Report. Regular steering committees with a reporting system on four harmonised indicators. Questionnaires are regularly sent to partners involved in data collection activities and an evaluation committee exists for incoming information on the early warning system.

*Main Problems in Relations with the Centre.*

- EMCDDA exceeding request of information in the National Report

- REITOX website not enough user-friendly and up-dated

**Financial**

The Greek Government complies with co-financing requirements through cash contributions. The FP is not directly credited funds that are channelled to the relevant organisation. The FP budget coincides with that of the department, and therefore includes also other activities. There is no separate accounting of EMCDDA-related costs in terms of person-time and other direct costs, but this is the subject of rough estimates. Some

of the figures made available for this evaluation refers to the Department and as such should be considered as a proxy of FP cost structure. All in all, total financing exceeds contractual arrangements by some 90%.

The bulk of the total budget is spent for staff and consultant (64% of the overall expenditure and inclusive of UMHRI support staff); the external consultant services account 4% for total costs. Overheads are 13% of the budget, but these do not include rents as the operational space is provided for free. Printing and translation account for 7%; travel costs for 4%; equipment for 3%; and library and documentation costs 2%; website and Internet costs to 1%; the statistical software to less then 1%. Also the expenditure for the organisation of meetings and conferences (0,3% of the total budget) is very limited.

Focal Point coordination accounts for some 10% of total direct costs. Other major direct cost items are: the National Report (25%), PR and communication activities (20%), work on the five key indicators (18%), demand reduction (20%) and the early warning system (10%).

**Overall Assessment.**

A stable organization with a great deal of scientific expertise. After starting from scratch it has notably improved its performance over the last few years. It still significantly suffers from certain institutional constraints in the availability of data and the range of sources available. Very active in networking, the FP already has already developed certain PR and communication skills.

**FINAL SUMMARY SWOT MATRIX**

| **Strengths** | **Weaknesses** |
|---|---|
| • good networking<br>• good scientific expertise<br>• strong support from national authorities<br>• contacts with a wide range of organisations operating in drug field at international and EU level<br>• good PR capabilities<br>• command of English | • bias towards official sources<br>• difficulties with implementing two key epidemiological indicators<br>• difficult relations with some information provider |
| **Opportunities** | **Threats** |
| • strong support from Government<br>• good relations with MB representative<br>• clear definition of tasks at the national level<br>• relevant financial support from national authorities<br>• involvement in support projects<br>• involvement in the enlargement | • Greek legislation on data protection<br>• operational overstretching to cover national and international assignments<br>• almost total dependence on O.KA.NA for financing |

**Irish Focal Point**

***Drug Misuse Research Division - Health Research Board - HRB***

**Short Profile**

## Institutional Background.

The National FP is the Drug Misuse Research Division (DMRD) of the Health Research Board (HRB), a semi-public research institute that according to the Irish legislation pursues public objectives and is partly controlled [17]and largely financed by the Government. However, FP is considered as largely independent from political control; this is considered a point of strength especially as far as the relations with in-the-field operators and NGOs are concerned.

The HRB does not directly provide any money to the FP other than bearing overhead costs (see financial below). The FP like other external parties is simply allowed to take part in the competitive tenders launched by the Board for research grants. This does not represent a relevant source of funding for the Division, as the Board tend to allocate funds to external institutions to avoid conflict of interest allegations.

Research on drug-related issues has been traditionally neglected in Ireland. In the last few years, however, more money has become available through the National Advisory Committee on Drugs. The Health Research Board has been active in the drug field since its establishment (1986), and its Drug Misuse Research Division has been appointed as FP since 1995. The funds to set up the Division came from the Department of Health and Children.

Some regulatory problems occur as regards the information gathering process. Contractual obligations for the drug practitioners' to provide their information to the Focal Point have been recently removed and at present there is no Governmental act stating Focal Point's powers and responsibilities. The FP does not face any major problem related to privacy or data protection regulations. It also acts as a data provider for UNDCP and draws up several publications for national purposes. The DRMB is setting up a National Documentation Centre on Drug Misuse.

## Organisation.

The Head of the DRMB acts as the Head of the Focal Point. He has been recently appointed to the job. The Health Research Board has a total staff of 71. At present nine staff work in the Drug Misuse Research Division, of which seven are involved in the Focal Point-related activities: three on a full-time and four on a part-time basis. There has been a high turnover in staff and only one professional has remained in the post for more than three years.

In terms of working efforts, the FP accounts on the overall activities of the Health Research Board for an approximate 7%. Its staff has increased by 150% over the 1995-2001 period. In terms of expertise available, the FP can rely on in-house experts in health economics and social sciences but has no specific resource in epidemiology. External consultants sometimes provide additional competencies, although FP activities are preferably carried out in house.

Two further full-time employees have been sought (mainly to cover the annual "key issues" item of the report), but have not been hired yet because of lack of suitable candidates and budgetary constraints (proposed salaries were not competitive).

[17] In the case of the Health Research Board, the Government has the role to nominate the Management Board, the power to accept/refuse new employees and to negotiate their salaries. As far as its daily management is concerned, the Board is autonomous from the government.

The FP set up five working groups, one for each indicator, operating under the responsibility of a staff member. At the beginning of every year, a work program setting priorities and methodology is approved by the FP. According to the work program, specific tasks are attributed to specific staff members. External experts, on either an informal or institutional basis are sometimes called to chair these events organized by the FP.

**Operational.**

*Overview.* The Focal Point is an academic-type organization; it co-ordinates primary data collection, which is carried out all over the country by different entities (drug treatment clinics, general practitioners, hospitals, police, etc.), and acts as a provider of technical assistance on methodological aspects to these institutions when requested.

*Specific Areas*

- *National Report*. The quality of the report suffers from general the lack of funding for drug research in Ireland and from the existing severe shortages in the availability of data[18]. Also geographical coverage is uneven as data on the Eastern part of the Country where the problem is more acute are often late or partly missing. However, the report has notably improved over the years and is the result of a vast and articulated[19] consultation process involving both internal and external experts.

- *Key Indicators.* Progress achieved varies in the different areas. As regards the prevalence in general population, only fragmented and disaggregated data are available because a survey at national level is not available so far (one is planned for 2002). Also problematic drug use needs substantial strengthening in terms of sources available. Progress is being made on drug-related deaths, although the problem of death identification due to the fact that drug related deaths are often hidden in Ireland. Some progress has also been achieved in the harmonisation of register codes. Work on harmonised indicators is carried out by internal staff. With the support of external experts for problematic drug use and drug-related deaths. Drug-related diseases have been approached only recently.

- *Demand Reduction*. Contributions in this field possibly have not been outstanding in both qualitative and quantitative terms, but at any rate never below average or insufficient. Focal Point keeps direct contacts with people in charge of managing projects and, therefore, directly collects information.

- *Early Warning.* A joint action working group has been formally set up, but there is little activity in the detection of new synthetic drugs, this because of the specific characteristics of the Irish market - when a drug appears on the Irish market, usually it is no longer new and because the only legal source of information is drugs seized by the Judiciary.

- *Policy Analysis*. At present the Focal Point is not really involved in this field.

[18] For instance, Irish Hospitals do not collect drug-related data on accidents and emergencies, thus making the monitoring of these events impossible. A general, nationwide survey on prevalence has never been carried out, because of national budget limitations. An estimate of problematic drug use was made in Dublin in 1996; the next one is planned at the national level for year 2002). Problems are also experienced when collecting timely and complete drug treatment returns (primary data sets) from practitioners, mainly due to scarce availability of data providers. To circumvent the above problems, the FP has undertaken the initiative to consult key health board personnel and the National Advisory Committee of Drugs (NACD) in order to obtain timely and complete returns and ensure prompt reports.

[19] The first step is the organisation of one or more round tables with the relevant key actors (external experts) in order to get contributions to the report. Then, the internal staff prepares a first draft of the report. Special topics not covered by the FP in-house expertise are delegated to external experts. Once the first draft is ready, it is circulated among the authors and given to two external peer reviewers who .are either members of the Scientific Community or, of the EMCDDA Scientific Committee. Finally, when comments are integrated, the final version of the report is drafted.

- *Dissemination and PR.* Contribution to dissemination and PR activities is positive as reflected in the large number of recipients of the Centre's publications (270 for the national report, with a large score among policymakers 48%). A major dissemination project is presently being planned, and expected to be launched in year 2002. It will enable web access to the whole library (including newspapers) of the documentation centre.

*Networking.* Fairly developed and involving all the relevant key actors and including NGOs, research institutions, practitioners and administrative bodies. Problems in data gathering are due to the lack of some relevant sets of data rather than to the inadequacy of the network. Drug is a relatively new phenomenon in Ireland (mainly developed on the Eastern Coast of the Country). The evolution of the network of organisations dealing with drug-related issues broadly coincides with the establishment of the Drug Misuse Research Division.

*Quality Control.* The quality control mechanisms put in place for the National Report are peer review and involvement of external experts in the drafting stage. Involvement of external experts (from the National Advisory Committee on Drugs –NACD-, the Working Group of Drug Related Deaths, the National Disease Surveillance Centre) in the relevant working groups is also expected in the other institutional activities.

**Financial.**

The Irish FP receives co-financing from the Irish Government through cash contributions agreed on an annual basis. Extra funding is received if the Focal Point successfully participates in some open tender for research money launched by the Health Research Board; in case, the amount provided generally represents a marginal part of the FP's incomes. The FP has its own budget and can directly manage funds once token overheads are deducted by the HRB. Therefore it can be said that it receives hardly quantifiable in kind contributions from the mother institutions as far as actual rents and overheads are concerned. It keeps separate accounts of EMCDDA-related costs.

Actual costs exceed EMCDDA contractual arrangements by some 25%. Salaries for staff account for 69% of costs. Consumables and other costs account for another 14%, printing and translations for 7%, travel costs (6%), overheads (3%), and library and documentation (1%). External consulting services account for another 2% of costs.

Work on the five Harmonised Indicators absorbs some 50% of total direct costs, followed by overall focal point co-ordination (inclusive of PR and dissemination activities) accounting for another 29% of direct costs. Report drafting covers the remaining 13% of costs followed by demand reduction 7% and the Early Warning System (1%).

EMCDDA financing can be considered as a serious operation constraint as the FP is not given easy access to other sources of national funding.

**Overall Assessment.**

The FP is stable organisation suffering from the relatively underdeveloped status of research on drugs and from the shortcomings of the national information system on drugs, which are largely outside of its control. It is also subject to serious financial constraints and is not always in a position to offer competitive salaries to attract high profile expertise, especially in certain areas. Nevertheless it has substantially improved its performance over the years and has reached good methodological and scientific standards.

## FINAL SUMMARY SWOT MATRIX

| **Strengths** | **Weaknesses** |
|---|---|
| • good networking<br>• good scientific skills<br>• good project management<br>• English native speakers<br>• very good relations with main key players | • non competitive salaries<br>• difficulties in operating the EWS<br>• uneven geographical coverage of data<br>• lack of available data sources<br>• lack of sufficiently diversified in-house skills<br>• inability to cope with extra demand, due to staff and budget constraints<br>• no involvement in support projects |
| **Opportunities** | **Threats** |
| • small size of the Country, making easier to establish contacts with key actors<br>• independent nature of the FP<br>• standing in the community<br>• no competition from other organisations | • high turnover in personnel<br>• poor funding of national drug information system<br>• extent of State budget contribution is subject to yearly decisions |

**Italian Focal Point**

***Ministry of Labour and** Social Policy **- OIDT***

**Short Profile**

## Institutional Background.

Over the last few years the Italian FP has undergone a notable series of institutional changes and moved from one Government organization to another broadly reflecting the changing responsibilities for the drug problem within the Italian Government. The FP was first located under the hierarchical control of the Ministry of Home Affairs. In 1999 it moved to the Department of Social Affairs under the Presidency of the Council of Ministries where it became a branch of the newly established OIDT (Italian Observatory for Drugs and Drug Addiction). The OIDT was established with the aim of monitoring the drug-situation in Italy and providing technical and scientific support to policymakers at the national, regional and local level. In 2001 because of an already planned Government re-organisation the Department of Social Affairs, and consequently the OIDT was moved under the responsibility of the Ministry of Labour and Social Policy. At any rate while the first change brought about some significant turnover in staff, the second has not had so far any major impact in organizational terms, but for the obvious uncertainties related to the new institutional context.

The role and the responsibilities of the FP as a component of the OIDT were defined in two different Government decrees that at any rate do not contain specific provisions for mandatory data collection. At any rate data collected by the other Ministries have to be provided to the FP by law. Requests for additional data arising from core or additional REITOX tasks are left to a voluntary co-operative approach with the various partners involved. As a Government agency the OIDT has little problems of contractual continuation of activities and can directly rely on funding from the State Budget. Recent developments in the Italian legislation on personal data protection have somewhat slowed down development of activities as complex procedures are now requested to be able to track down individuals in a cohort. Since its recent establishment the OIDT has increasingly become renowned among main drug stakeholders, although the overall degree of political interest in their activities has remained rather low.

## Organisation.

The FP has a very loose and complex structure in organizational terms. FP activities are supervised by two Ministry's civil servants, one of whom acts as the formal head of the FP. The Ministry has no other permanent staff to devote to FP activities. Operational co-ordination is ensured by a consultant who collaborates with the Ministry on a *de facto* permanent basis and who already used to collaborate with the Ministry of Home Affairs and was therefore in a position to ensure a certain degree of continuation of activities. All other FP core staff are external consultants hired on a *de facto* permanent basis, most of whom already collaborated with the Ministry of Home Affairs. Logistical and operational support is provided to the FP by a major Italian NGO that also hosts the FP website. At any rate official communication to the FP is channelled through the Ministry. The NGO is mainly responsible for co-ordinating report drafting activities. The OIDT is also responsible for some aspects of the relations with international organisations such as the UNDCP, the Pompidou Group and the European Union Horizontal Drug Group.

Together with the two civil servants and the FP consultant who are allocated to FP co-ordination responsibilities for a few working person months a year, the FP can rely on some other eight staff, of which two NGO-based support personnel. All six scientific staff are high profile senior experts mainly working for other organizations and contributing only part-time to FP activities. Available expertise includes among others an epidemiologist, a mathematician, a sociologist, and a health specialist. Most staff has a good command of English and an English native speaker is responsible for report drafting activities.

The Ministry produces the annual report on drug situation in Italy drafted for the Parliament with contributions from other Government institutions at national and regional levels but without any direct

involvement of the FP. The report is used as provisional source of data to be validated for the National Report to the Centre.

**Operational.**

*Overview.* The Italian FP is a very loosely structured organization mainly based on contracting out of activities. Despite its being a Government organisation the FP does not appear to enjoy great political and institutional support and is mainly based on commitment from staff. It results in a peculiar mixture of bureaucratic information processed through high scientific standards and the quality of the output is therefore highly variable depending on the different fields.

*Specific Areas*

- *National Report.* The Italian report has remarkably improved over time. In general the analysis is of good quality and methodologically sound. The report suffers from a certain lack of sources of data and mainly relies on official information. The part on demand reduction is comparatively weak. Also because of its loose organisational structure the FP has experienced some serious problems in meeting the Centre deadlines. Work is almost entirely subcontracted.

- *Key Indicators.* Also substantially improved over time. Italy is carrying out its first general population survey having already participated in the ESPAD study in schools in 1995 and 1999. Estimates of problematic drug use appear accurate and methodologically sound. The most problematic area remains treatment demand where the data collection network is insufficient and regional divergences in the quality of data are common. The situation with drug-related deaths and drug-related infectious diseases is relatively advanced. External experts hired on an institutional basis and heavy recourse to consulting services.

- *Demand Reduction.* After a difficult start the FP has started contributing relatively good inputs in both qualitative and quantitative terms. The FP suffers from a poor development of the project evaluation culture in this field in the Country and has heavily invested to promote it and spread the word about EDDRA amongst drug specialists. Analytical contributions have been much weaker.

- *Early Warning.* The information collection system is there on paper but its really becoming operational as an early warning mechanism depends on a legal framework, which is far from clear and apparently of obstacle to divulge information on suspected substances seized in the street.

- *Policy Analysis.* Reasonably good as far as mere description is concerned. Untested and potentially weak if it comes to analysis.

- *Dissemination and PR.* So far carried out on an institutional basis mainly by involving network partners. At the Third National Drugs Conference a Focal Point stand disseminated the Centre's products and developed a mailing list of all those interested in receiving information about them. DrugNet, the Annual Report and some other publications are directly available from the FO web site and an e-mail notification of up-dates and new publications is sent to around 300 organisations. There is, however, no systematic effort to involve the media or to disseminate the Centre products to specific target groups.

- *Networking.* The OIDT relies on a network composed of central, regional and local authorities, universities and research centres. At present FP's networking activities are mainly focused on institutional actors while the involvement of private and non-institutional entities is limited. Data are mainly received in an aggregated form. This is remarkably mirrored in the Focal Point's outputs, which are almost totally based on official information. The problem is clearly perceived by the Focal Point itself. Analytical information on specific topics is provided by universities and external experts on a case-by-case basis.

- *Quality Control*. Quality control ensured through internal and external peer review. Ad hoc working groups established on the five key indicators.

*Main Problems in Relations with the Centre.*

- some conflicts, especially in the past, concerning the accuracy of the information published on Italy
- limited information on contracts awarded;
- limited functionality of the REITOX website;
- limited time available to collect information on key issues;
- impossibility to work on special projects.

**Financial.**

Italy complies with the co-financing by providing partly in cash partly in kind contributions. Civil servants' salaries and rents and overheads at the Ministry are considered in kind contributions, as are salaries, rents and overheads in other public institutions providing services to the FP core tasks. Other items are paid for in cash either for specific projects to develop the core tasks further or as sub-contracts to private institutions. The Ministry as such cannot receive external funding that should be credited to the general State budget. The Centre has therefore been allowed to credit it to the operational NGO that manages them under the direct Ministry control and the supervision of the Court of Auditors. The FP keeps a separate accounting of costs resulting from the financial accounts of all subcontracted activities.

Actual costs borne by the FP substantially exceed contractual arrangements by 118%. At any rate, if library and documentation costs[20] are deducted this percentage decreases to 48%. External consultant services account for some 30% of costs and staff salaries for 22%. Library and documentation services account for another 24% of the budget, travel costs for some 4%, meeting organisation for 7% printing and translation costs for 3% and website and internet costs for another 2%.

Work of the five key epidemiological indicators accounts for 54% of the direct costs. Another 13% is spent on the National Report, 10% for demand reduction and 9% for the early warning system. Focal Point co-ordination cover 6% of the budget; the same amount devoted to dissemination activities.

Given the heavy national financial support, EMCDDA financing cannot be considered a serious constraint in operational terms. The FP is always in a position to draw from relevant expertise in the Country. No major staff shortcoming envisaged.

**Overall Assessment.**

The good scientific expertise available among staff hardly compensates for difficult and complex overall coordination and underdeveloped networking. Several aspects of the legal framework for the joint action are unclear. The FP is also relatively weak in PR activities.

[20] A complex electronic library and documentation system is available in the FP website.

## FINAL SUMMARY SWOT MATRIX

| **Strengths** | **Weaknesses** |
|---|---|
| • high scientific expertise<br>• advanced progress on some key indicators<br>• very open to contributions from outside the Government<br>• good command of English | • overall coordination<br>• underdeveloped networking<br>• uneven geographical quality of data<br>• project management problems<br>• excessive reliance on official sources<br>• weak PR activities |
| **Opportunities** | **Threats** |
| • strong financial support<br>• long continuity in post of some staff<br>• no relevant institutional constraint to data collection<br>• close links with the MB<br>• clear definition of tasks at the national level | • dependence on outsourcing operational support<br>• weak political support<br>• time constraints in highlighting key issues<br>• legal difficulties with the early warning<br>• no involvement in support projects<br>• no involvement in the enlargement<br>• English language command in outsourcing |

**Luxembourgian Focal Point**

***Direction de la Santé – Point Focal OEDT-CRP SANTE***

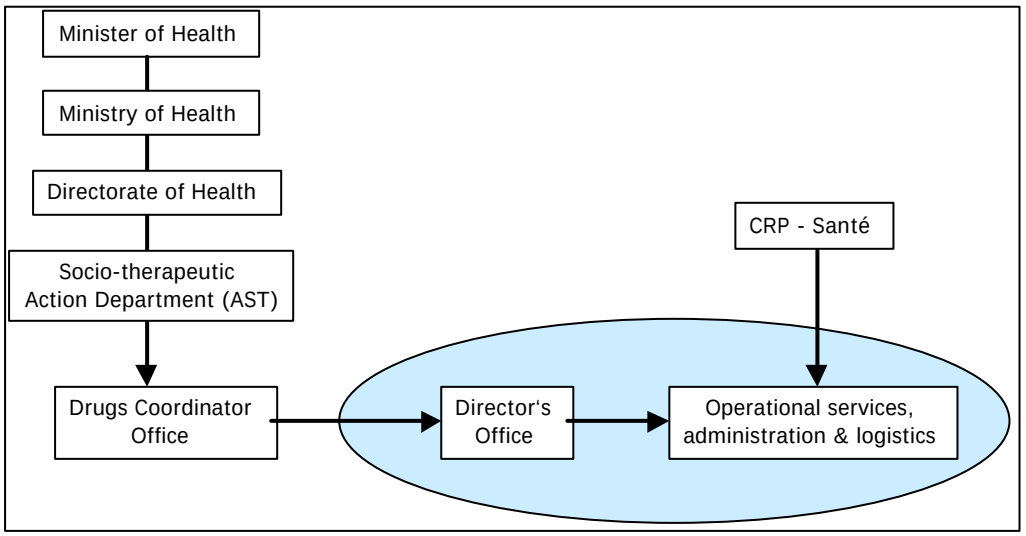
**Short Profile**

## Institutional Background

The Luxembourgian FP has recently undergone a major restructuring. Until 1999, it was located within a department of the Ministry of Health – the Socio-Therapeutic Action Department -AST. In 1999, first AST and consequently the FP were moved inside the Directorate of Health. Then in year 2000 the FP was split between two different organisations: the headquarters are located within the recently established National Drug Coordinator's Office[21] which is still a part of AST, while all the technical, logistical and administrative activities are managed by the Public Health Research Centre (CRP-SANTE). As a scientific research institute in the field of public health CRP Santé is an institution of common welfare (*Etablissement d'utilité publique*), partly financed by the National Administration. The complex and original structure of the Luxembourgian FP is represented in the figure 1 below. This restructuring has also had some impact on the seniority of staff. While the head has remained in the post since beginning of activities other core staff have been active respectively for three years and for six months.

While AST is currently a branch of the Directorate of Health, CRP-Santé carries out its FP-related activities thanks to a convention with the Ministry of Health. Until 2000 its drug-related expertise was mainly loosely connected with toxicology and pharmaceutics. This reflects a more general lack of expertise in the drug field of activities both in the Ministry and in the Country. In the Luxembourgian context no need for a specific piece of legislation defining FP powers and responsibilities is felt after the restructuring process of 2000. All main drug-related institutions already provide information to the RELIS network managed by the FP. Previous problems with data provision were solved through better co-operation and information-sharing with law enforcement agencies and non-specialized field agencies. Furthermore, the modest geographical size of the country allows to keep direct contacts with almost all the information sources. As the main institution in drug-affairs the FP is widely renowned among all stakeholders.

**Fig.1 Organisational Structure of the Luxembourgian FP**




[21] The National Drug Coordinator's Office ensures the overall coordination of illicit drug-related activities. Moreover, it ensures the coordination among the national and the international activities, by representing Luxembourg in the relevant international bodies. In particular the Drug Co-ordinator chairs the national delegation within the *Horizontal Drug Group* (European Council) and is the vice-president of the *Inter-ministerial Committee on Drugs* (Ministries of Justice, Foreign Affairs, Home Affairs, Health, Family and solidarity, National Education; plus the 2 Police Administration,

**Organisation.**

At present the National Drug Coordinator is also the Head of the National Focal Point and his working-time is contractually shared fifty-fifty between the two tasks. This co-existence of functions allows a high degree of centralisation of activities. For instance, despite its double reporting line, the FP is not subject to leading and/or controlling structures such a Management Board or a Steering Committee. The Interministerial Committee, as such, does not play any direct role in the life of the FP.

The FP remained stable in terms of staff for the period 1996-2000 (three part-time plus one full-time professionals), then this year the staff has increased to two full-time plus four part-time. However, apart form the head of the FP, the other part-time employees are support staff. All scientific personnel have a background in psychology. AST is also responsible for providing information to a number of other international organizations ranging from the UNDCP to the Pompidou Group and the Horizontal Group on Drugs at the EU Council. In addition to the EMCDDA-commissioned national drug report, the Luxembourgian FP also publishes another report for a national audience. This national report is conceived to appeal a wider public and has a more accessible language. It has a different structure and includes more information of interest to the national public, such as on national policy, drug legislation, national events and administrative functions.

**Operational.**

*Overview*. FP operations are shaped by the nature of the Country: Luxembourg has a small size and a limited population. This has an impact on the feasibility and cost-effectiveness of certain statistical techniques. On top of that there is limited national scientific expertise available to contribute to FP activities. Also the double role of the head of the FP, who is also the National Co-ordinator of Drug Policy, is an important factor for FP activities.

**Specific Areas**

- *National Reports.* The report for the Centre derives from the National report and this can create some problems in sticking with the Centre guidelines, requested style and structure. The quality has improved over time and data are always disclosed, although information is spread across the document and is not always easily accessible. The FP assesses the quality of data and of the analysis as equally positive, a view not necessarily shared by the Centre that sometimes expects more in terms of cross-linkages between sections. While internal staff carries out the bulk of the work there is some limited recourse to external consulting services.

- *Key Indicators.* A problem area as Luxembourg experiences significant internal data harmonization difficulties. Different protocols are still used by different in-the-field institutions together with the common RELIS protocol. This has an impact on collecting data on drug-related deaths and to some extent drug-related infectious diseases from hospitals and general practitioners. However, the FP has increasingly reached consensus with all institutions on using the RELIS protocol as a basis, to be possibly expanded if deemed necessary by field agencies. This flexible approach allows the FP to have data in the common RELIS format the data providers to gather data in a timely and cost effectively way according to internal needs. The feasibility of a data harmonization project financed by the Ministry of Health is presently under consideration. Luxembourg also has no real drug population survey to speak of. It is considered as very costly and funding has been sought for long. The first exercise should reportedly take place in 2003-2004. Data on demand treatment and problematic drug use are in line with the Centre standards. Ad-hoc working groups for the five key-indicators have been created. They are chaired by a member of the staff and participated by experts who are external to the FP but not

Customs Department, National Youth Service, the Centre for the Prevention of drug dependencies, Institute for Training to Teachers).

necessarily external to the Ministry of Health or to CPR-Santé. Also substantial recourse to external consulting services.

- *Demand Reduction.* Good contributions to the EDDRA database in both quantitative and qualitative terms. Also contributions to other demand-reduction related parts of the Centre activities can be generally deemed as more than adequate. Limited recourse to external experts.

- *Early Warning.* The network is there, but operates mainly on paper, as it is the General Prosecutor's office that has reportedly the power to order more in-depth toxicological analysis on seized substances. Therefore there is a substantial lack of raw substances to be scrutinized and hardly any real contribution to the Centre's activities. External expertise provided on an institutional basis only.

- *Policy Analysis.* So far basic contribution, but the FP seems in a position to fairly easily cope with more requirements.

- *PR and Dissemination.* Significant effort if the Country's size is taken into account. The FP would like to capitalize on more intensive promotion work coming from the Centre.

- *Quality control.* Based on a mixture of steering committee, unstructured peer-review and internal audit, but without any formalised procedures. The National Report is produced by all the FP's staff as a collective task, according to the individual areas of specialisation. The field operators involved in the RELIS network deal with the issue of prevention. An internal collective reading follows, often with the participation of an external expert. A Steering-Committee-like mechanism is involved in activities concerning the problematic drug use, demand treatment, demand reduction, and early warning, where semi-formal groups of independent experts (often working inside the same Ministry) are involved in the quality control process.

- *Networking.* Highly developed to the extent made possible by the Country's size with extensive contacts both at the institutional level and with universities, scientific institutions and NGOs. This depends on the double role covered by the Head of the FP with related pros and cons. While ensuring effectiveness, this makes the system fragile and highly dependent on personal factors. Data collection is based on the RELIS/LINDDA database[22] where all State-funded institutions have an obligation to report information. The FP acts as a service provider to those institutions with no contractual obligation to provide data, supplying them with data-entry and database hosting functions. However, due to security reasons, no on-line access to these databases is granted to the partners; listings and batch functions are provided instead. In return of this free service, the FP has the right to use their databases. Institutional relations are generally good, although problems are experienced from time to time in sharing information with some ministries and general hospitals.

[22] In 1995 the FP created a multi-sector national network (RELIS / LINDDA), based on both private and public bodies. It includes "*in-and-outpatient specialised treatment centres, low threshold facilities, general hospitals as well as law enforcement agencies and national prisons*". In terms of units, 7 of the non-governmental members of RELIS have an "agreement with the state, i.e. are State-subsidised, while the residual 6 ones are not. Following a law of 1998 (ASFT law) all State funded institutions working in the social and therapeutic fields do have to obtain and state controlled quality license granted by competent ministries. The National Drug Coordinator is in charge of the application of the agreement involving drug- and AIDS-related institutions, and this role allows him to require the information to subsequently pass to the Focal Point. When the RELIS network was established, all its Members signed an agreement, undertaking to provide the Ministry with all the requested data sets on drugs. The National Drugs Coordinator is in charge of the application of the agreement, and this role allows him to require the information to subsequently pass to the Focal Point.

*Main Problems in Relations with the Centre.*

- Overtly exceeding information requested in the national report. The whole process should be reconsidered and streamlined. More intensive use of previously provided information (avoid double reporting from FP to the Centre).

- Unclear aspects of the Centre's expectations on drug prevalence in general population and drug-related infectious diseases because of inconsistencies in concepts, timing and financing

- Poor general knowledge about the Centre's activities compounded by a not proactive attitude in asking for information.

**Financial.**

Luxembourg strictly abides to the 50%-50% co-financing requirements and is the only Country that does not ask for a full € 100,000 financing from the Centre. The FP has a separate budget and keeps a separate accounting of its costs. Nevertheless funds are credited to mother organisations. The State contribution comes from both the Cabinet of the Minister of Health that finances 50% of the Head of the Focal Point working-time and the Ministry of Health that funds 50% of the FP's activities under CRP-Santé, by means of an ad-hoc agreement.

Total costs fall short of maximum contractual arrangements by some 11%. Staff salaries account for over 60% of total costs. Other main items () are services for external consultants (9%) and publications (8%). Travel costs and other costs account respectively for 7% and 9% of the total. It must be noted that overheads are as low as 5%, as rents are not included.

Work on the key indicators accounts for 45% of total direct costs. The national report accounts for another 30% of direct costs that includes also a rough 10% of focal point coordination. Demand reduction accounts for another 16% of direct costs and the early warning for the remaining 9%.

EMCDDA financing appears a major constraint in operational terms. The FP extensively relies on Centre financing for its activities and part of the national monitoring system are funded through it. There are instances (general population surveys) of difficulties in raising funds from national sources. The FP would like to increase staff with one more research assistant and more permanent IT expertise. But due to budgetary constraints this is likely to happen only in a two-to –three-year term.

**Overall Assessment.**

The FP highly relies on its complex institutional asset. Its operations are to be substantially affected as soon as the overlapping with the Drug Co-ordinator Office comes to an end, as seems inevitably the case in the long run. However, in terms of data collection procedures, mutual benefits arrangements are solidly established and should resist to any institutional changes. Solid and multi-disciplinary network, including both public bodies and private organisations / volunteer associations has so far compensated for a lack of a certain tradition in the field of drug studies in the Country. Drug research has known a significant development since the establishment-up of the FP, especially in the field of drug monitoring methodologies, drug-related deaths, socio-economic costs and problematic drug prevalence studies. Data produced by the FP are highly considered in the framework of drug legislation amendments and in the conceptualisation of the national action plan on drugs. There are a number of serious institutional obstacles to full compliance with key indicators requirement. While activities mainly related to the health field are easily managed by the FP, actual and prospective difficulties appear when the judiciary is also involved. Financial constraints do not seem a negligible factor.

## FINAL SUMMARY SWOT MATRIX

| **Strengths** | **Weaknesses** |
|---|---|
| • good institutional networking<br>• adequate staff resources<br>• strong relations with the community of experts<br>• implementation in the conceptualisation of the national drug strategy (legislation and national action-plan)<br>• contractual power to the bodies having an agreement with the Members of RELIS | • poor mirroring of Centre's functions (EWS)<br>• reduced budget<br>• compliance with editing requirements<br>• dependency from the Cabinet of the General Attorney for testing the new substances (negative impact on the Early Warning System<br>• multiple reporting of field agencies<br>• poor harmonisation in data collecting procedures<br>• lack of representative general population surveys |
| **Opportunities** | **Threats** |
| • strong political support from Member State<br>• continuity of activities<br>• close links with representative in the Management Board<br>• involvement in support projects and in international technical assistance activities | • excessive dependence on personal factors<br>• lack of formal agreements on FP mission<br>• institutional (national) framework on drugs not yet well defined<br>• poor overall financing of the drug IS<br>• complex institutional asset, double reporting<br>• lack of a multidisciplinary real scientific community in the Country<br>• relatively isolated from the Centre |

**Norwegian Focal Point**

***Statens Institutt for Rusmiddelforskning – SIRUS (National Institute for Alcohol and Drug Research)***

**Short Profile**

## Institutional Background.

Since January 2001 the Norwegian Focal Point has been located within SIRUS an independent and mainly public-funded research institute whose director is directly appointed by the Ministry of Health and Social Affairs. SIRUS itself was established at the beginning of 2001 and resulted from the merging of the previous National Institute for Alcohol and Drug Research – SIFA with the information and documentation centre of the Norwegian Directorate for the Prevention of Alcohol and Drug Problems. SIRUS has replaced another organisation that was originally thought to act as the FP for Norway.

SIFA, whose staff was mostly taken over by SIRUS, had a long tradition in the field of drug-related studies and research and even today drugs account for a rough 50% of SIRUS activities. SIRUS has a total staff of some 26 professionals, including six support personnel. SIRUS was appointed as a FP through a ministerial order, but its responsibilities vis-à-vis other possible sources of information have not been clearly spelled out in any normative act. It is too early to say whether this could represent a serious obstacle for implementation of future activities. Norway has some legislative restrictions as concerns privacy and data protection and it is unclear whether this may represent an obstacle for data collection in line with Centre standards as happens in other Nordic countries. However, now FP staff does not seem inclined to consider this as a serious issue.

## Organisation.

SIRUS is currently structured along three departments strictly resembling a typical University institution: the research department, the library and the administrative department. FP responsibilities will be scattered across the organisation, although core staff will be located within the research department. Although SIRUS reportedly has senior staff with experience in the drug field, FP responsibilities will be covered by hiring new staff. Two posts were created and during the first nine months two professionals were hired, but both left. In September a new head of FP with previous experience on drugs in the Commission services was appointed.

SIRUS is also involved in other activities such as filling in the UNDCP and UNGASS questionnaires and writing the report on Alcohol and Drugs in Norway. Unclear whether and to what extent FP personnel will be associated to these activities to exploit related synergies.

## Operational.

The Norwegian FP has just started its activities and so far the efforts have been concentrated in writing the first national report for the Centre. In spite of high turnover in personnel the FP is confident they can meet the first deadline for delivery. Plans on future activities are based on a staged approach. The focus is on the five harmonised indicators that are considered as the first priority whereas the. establishment of the early warning and the EDDRA networks will follow later.

- *Key Indicators.* The FP can capitalise on some progress already reached in this area. Data on prevalence coming from general population and school surveys already exist and need some fine-tuning. A new national database on treatment demand has been in place in Norway only for four years, and needs further testing and consolidation before being considered as fully reliable. Data on drug-related deaths can be collected from two different sources that have to be made consistent. It does not seem that privacy considerations will seriously hinder study on problematic drug use based on capture-recapture techniques or cohort studies on drug-related deaths or drug-related drug diseases.

- *Demand Reduction.* The FP seems intentioned to follow an approach based on quality of projects rather than on their sheer quantity. Main difficulties are anticipated not so much in establishing the related network, but in the lack of a consolidated project evaluation culture in the Country. An EDDRA internal co-ordinator will be appointed.

- *Early Warning.* The issue of new synthetic drugs is reportedly considered as a matter of great political concern in the Country and this should ease the establishment of the related network.

*Networking.* The FP is committed to keep an open-door approach in the implementation of its activities and plans to include contributions and data from other research institutions and NGOs. At present SIRUS is poorly known among drug-practitioners, while it is well renowned among Government institutions, and to a lower extent, Universities and research centres.

*Quality Control.* No formalised procedures in place. Unclear whether SIRUS board will play a role in reviewing and supervising FP activities.

**Financial.**

The FP operates fully on national financing and does not receive any contribution from the Centre for its activities. Present estimated budget is as high as € 150,000 and 1.5 man-year staff is allocated for FP activities.

**Overall Assessment.**

The Norwegian FP has just started activities and has already faced some problems of turnover of personnel. Present estimates of staff-time required seem exceedingly optimistic, especially when the FP is fully operational. However, it can rely on considerable expertise both inside SIRUS and in the Country. In present conditions envisaged co-operation and exchange of experiences with other Nordic FPs through cluster meetings or other similar initiatives may prove more difficult than expected, due to existing time or resource constraints in the potential partners.

**Portuguese Focal Point**

***Instituto Portugues da Droga e da Toxicodependencia - IPDT***

**Short Profile**

## Institutional Background.

Since 1999 the Portuguese Focal Point has been the IPDT - a Government organisation directly under the hierarchic control of the Secretary of State responsible for the co-ordination of the Portuguese drug strategy. The FP was first[23] located with *Observatorio Vida-Projecto Vida*, an NGO-type organization linked to Projecto VIDA and then briefly with the *Gabinete de Planeamento e de Coordenacao do Combate a Droga – GPCCD* under the Ministry of Justice. The IPDT resulted from the merging of these two organizations, even if in the process most of the previous *Observatorio Vida* personnel left and this caused a notable loss of FP expertise in the system. Also the demand reduction network experienced some disruption because of these institutional changes.

As a Government Agency, now the IPDT has no problem of contractual continuity of activities and can rely on some 120 staff in Lisbon and a network of regional branches. The FP responsibilities are clearly defined in a Governmental Decree. The data collection process is not severely hindered by privacy and legal problems but suffers from its bureaucratic nature requiring official approval of data and information. As the main actor on Drug Policy in the Country the IPDT is widely known among stakeholders.

## Organisation.

Although the Head of the FP is formally the Head of the IPDT the role of interacting with the EMCDDA is *de facto* played by the head of the *IFDT-Liaison Unit* who is one of the few staff remaining from the previous FP and therefore in a position to ensure some degree of continuity in activities.

The IPDT is managed by a Management Board and is structured along seven departments grouping over a dozen different units. The *Liaison Unit* has now a staff of two plus the head on a part-time basis. It is an *ad hoc* unit specifically entrusted with keeping relations with the EMCDDA and drafting the National Report for the Centre. Another department within IPDT keeps relations with other drug-related international organisations.

A dozen staff are involved in FP activities: the *Liaison Unit*, and part-time contributions from four professionals from other units and another five[24] support personnel. Also a member of the management board is considered a FP operational staff because of his two-week's supervision of FP activities. In terms of internal human resources effort, it can be estimated that the *Liaison Unit* accounts for a 60% of total man-time, other technical unit staff for another 30% and support staff for the remaining 10%.

Expertise available in the core unit includes two senior staff and a junior. Senior staff from other departments provides specific competencies in statistics and epidemiology. To exploit synergies in data collection and analysis until 2000 the FP was also responsible for writing the Internal National Report on Drugs. In fact, *Observatorio Vida* used to write such National Report on Drugs even before being appointed as the monitoring centre in 1994. Although the structures of the two documents diverge, the 60-70% of their contents practically coincide. EDDRA and key issues are not included in the domestic version that is more policy-oriented. Starting from 2001 the responsibility for drafting the two reports has been reportedly entrusted to two different teams.

[23] It can be noted how the nature of the FP has changed over time. In the Centre's early years of life the Portuguese Focal Point had a strong computer-orientation and was heavily staffed with engineers and MIS experts. This depended on the perception of REITOX as a computer system. The Portuguese FP also took part to the first REITOX – IDA project.

[24] An accountant, a legal advisor, documentation, IT, and human resources specialists.

**Operational.**

*Overview.* The FP is located in a Government Institution, which is given a broader political mandate on drugs and is mainly concerned about national priorities and the internal political debate. It also has a strong policy orientation. EMCDDA-related activities are relatively marginal for the FP in both financial and organisational terms. Because of its nature, the IPDT has a strong bias towards official information and is not easily inclined to consider other sources as sufficiently authoritative.

*Specific Areas*

- *National Report.* The report for the EMCDDA has often suffered in its contents and structure from the existence of a similar document drafted for domestic purposes. Work is mainly carried out by various internal staff with the substantial support of external consultants. Plurality of contributions may create problems in homogeneity. The emphasis is more on reliability and soundness of presented data rather than in innovative or comprehensive analysis.

- *Key Indicators.* Work on the prevalence in the general population and problematic drug use has been subcontracted to two Universities. Progress has been lagging behind for some time and only in 2001 the first results on problematic drug use were sent to the Centre. The first general survey has just been carried out and results are to be submitted by the end of the year. Other key indicators are generally deemed acceptable. Some problems exist for drug-related infectious diseases which started later and for which technical standards are not deemed as entirely clear. Significant divergences do exist only as far as reporting codes of drug-related deaths are concerned. However, the FP puts the emphasis on the importance of having guidelines officially approved in order to have them implemented through administrative means. External experts appointed for all indicators either on a contractual or institutional basis.

- *Demand Reduction.* The quality and the number of contributions in this area have suffered from the disruption of the related information collection network due to moving of responsibilities to the IPDT. Until recently there used to be little evaluation culture of demand reduction projects in Portugal and related analytical skills are somewhat lacking also within FP staff who is more operational-oriented. Sources practically cover State-financed initiatives only, deemed to represent the bulk of existing projects. No external expert appointed or reliance on consulting services.

- *Early Warning.* Considered a low priority in a Country that has never significantly experienced the introduction of new synthetic drugs, the related operations are based on a network of official institutions including the Police, the Armed Forces and forensic institutes. No *ad hoc* mechanism put in place to collect information in the field. No external expert appointed to coordinate activities with Centre, but substantial reliance on consulting services.

- *Policy Analysis.* A strong point, as the FP policy orientation and interests often exceed the Centre's needs.

- *Dissemination and PR.* Very limited involvement in information and dissemination activities also because of parallel arrangements with the Centre.

*Networking.* Given the institutional framework available to the IPDT it appears relatively limited. It is mainly based on keeping good relations with other Ministries whose lack of active co-operation may seriously affect operations. Information sharing and participation to the Centre activities used as rewarding mechanisms. NGOs are involved only in the demand reduction area and have institutional relations with IPDT branches at the regional level from which they heavily depend for their financing. Involvement of University institutions or research centres is rather limited and this reportedly reflects a poor development of drug-related studies in the Country. The IPDT itself has tried to foster scientific research in this area through a grant scheme, but so far to little avail. No real problem in communication.

*Quality Control.* Proofreading and comments from staff and the FP own scientific committees are common procedures together with internal scrutiny of subcontracted work. However no formalised procedure in place based on written reports.

*Main Problems in Relations with the Centre.*

- conflicting epidemiological information presented by the Centre and collected from other sources, which is deemed as unreliable or not sufficiently representative. Linked with poor knowledge of results of other Centre contacts in the Country;
- limited user-friendliness and utility of the REITOX website;
- exceeding information requested in the national report and partial duplication of reporting activities in the demand reduction area;
- limited time available to collect information on key issues;
- neglect of documentation activities in the Centre and little provision of related feedback.

**Financial.**

Portugal complies with co-financing requirements through in-kind contributions by paying FP staff salaries and contributing overheads and rent costs. No exact calculation is possible of the latter while staff salaries alone almost entirely cover the member state contribution. Until recently financial regulations channelling EMCDDA cash contributions into the general State Budget represented a disincentive to take part to other Centre's activities.

Actual costs exceed contractual arrangements by some 7.5%. Staff salaries account for some 46% of total estimated costs, consulting services for another 36% while printing and translation and overheads (without rent) respectively account for 10% and 5%. It is worth noting that, due to its proximity to Centre headquarters, the Portuguese FP practically has no travel costs.

Work on the key indicators accounts for 40% of total direct costs, mainly due to heavy recourse to external consultants (two key indicators are subcontracted). The national report accounts for another 20% of direct costs, while demand reduction for 15%. The remaining resources are equally spent for coordination of activities (12%) and the early warning system (12%). Due to parallel arrangements with the EMCDDA, information and PR activities are given a tiny 1.5% of funds.

EMCDDA financing is not a serious constraint in operational terms. The IPDT is well funded by the Portuguese Government and can rely on a much larger budget for its mission. Involvement in the new areas of activities might require additional expertise for instance in early health responses and supply reduction, but these could be easily made available through an internal reallocation of staff or recourse to analysts in other ministries.

**Overall Assessment.**

The FP suffered from a number of organisational reshuffles in the last few years. Now it seems to have reached a certain degree of stability. Heavily staffed and well funded, it shares the features of FP directly attached to Government organisations: lengthy and somewhat bureaucratic procedures, reliance on official information only, priority to policy matters and national considerations. In some areas it suffers from a certain lack of scientific expertise available both in-house and in the Country. On the other hand once a decision is made and is given a political green light it can easily ensure systematic implementation throughout the Country.

## FINAL SUMMARY SWOT MATRIX

| **Strengths** | **Weaknesses** |
|---|---|
| • good institutional networking<br>• large staff resources<br>• strong implementation capabilities<br>• adequate mirroring of centre functions<br>• strong documentation centre<br>• good PR capabilities<br>• command of English | • excessive reliance on official sources<br>• informal quality control procedures<br>• problems in ensuring homogeneity of contributions<br>• better in data provision than analysis<br>• limited attention to editing requirements<br>• impact of bureaucratic procedures on meeting deadlines |
| **Opportunities** | **Threats** |
| • continuity of activities<br>• strong political support from Member State<br>• no institutional constraint to data collection<br>• good overall financing of the drug system<br>• close links with representative in the Management board<br>• close relations with department staff also due to geographical proximity<br>• clear definition of tasks at the national level | • data sometimes not standardised<br>• problems with drug-related mortality codes<br>• limited scientific community available<br>• time constraints in highlighting key issues<br>• limited familiarity with evaluation culture in the Country<br>• low political interest in the early warning system<br>• poor involvement in the Centre support activities and enlargement |

**Spanish Focal Point**

***Plan Nacional Sobre Drogas***

**Short Profile**

## Institutional Background.

Since its establishment the Spanish Focal Point has been located within the *Plan Nacional Sobre Drogas- PND* a Government organisation directly under the hierarchic control of the Ministry of Home Affairs. The PND is an all-encompassing institution entrusted with co-ordinating different aspects of the drug policy from supply-side measures including drug smuggling and money laundering to demand-side measures including health responses. The PND has quite a complex structure. While supply-side activities are mainly managed at the Central level, the demand side is articulated into seventeen different regional plans enjoying a certain degree of political autonomy from the Centre and without any direct hierarchical subordination to it. In fact, the overall system coordination is ensured by a political body the *Conferencia Sectorial* and a technical body the *Comision Interautonomica* grouping representatives from the Central Government and the Regions. The system is built in such a way that patterns of co-operation with NGOs and other players in the drug field are extremely diversified and may substantially vary from region to region.

As a Government Agency, the *PND* has no problem of contractual continuity of activities and can rely on a large staff in Madrid. It also has a vast network of regional correspondents, on which nevertheless it exerts no direct control. Drug monitoring functions have been refined over time. First in 1996 a national monitoring centre was formally established within *PND* then in 1998 and in 2000 the FP responsibilities were better defined in two different Governmental Decrees. Nowadays, the data collection process is not severely hindered by any privacy or legal problems but resents from the large political autonomy given to the Regional Plans and ultimately depends on their willingness to co-operate. In fact, instances of problems in ensuring an even geographical coverage of data and information are relatively frequent. As the main actor in Drug Policy the PND is widely known in the Country. Not the same can be said of its role as a FP; only an inner circle of specialists is familiar with.

## Organisation.

Spain is one of the few cases where national representatives in the Management Board and heads of the focal point have long coincided in the same individuals. Overall responsibility for managing relations with the Centre has been entrusted with the head of the external relations department and his deputy. The department, one of the five line departments the PND is articulated in, is also responsible for drafting reports for other international organizations, but is only partly involved in information gathering and processing. These activities are usually carried out in other parts of the organisation. The related problems of interdepartmental co-ordination have been reportedly solved at the political level through a directive issued by the responsible Secretary of State ensuring FP needs priority within the organisation.

Together with the external relations department that represents its core staff, the Spanish FP can rely on a highly varied set of in-house expertise from the other departments. It can be estimated that over a dozen people significantly contribute to FP activities, plus a couple of support staff. Most of the personnel are also involved in drafting a national report for domestic purposes. Language seems a non-negligible constraint to FP activities. Some two thirds of contributors, often civil servants with a certain degree of seniority, are not fluent in English and this requires a substantial in-house translation effort.

There is a wide range of expertise available within the PND ranging from epidemiology to sociology and legal issues. The staff is usually not involved in research activities, but mainly process information for concrete domestic policy purposes. The FP is not subject to any particular staff constraint even if the Centre's areas of activity are substantially widened. An internal decision would be needed to allocate new resources to these new areas.

**Operational.**

*Overview.* The FP is located in a Government Organisation responsible for the overall co-ordination of all drug policies in the Country and obviously focused on national priorities and the internal political debate. EMCDDA-related activities are relatively marginal for the FP in both financial and organisational terms. However, opposite from other similar organisations the PND regional branches are given a large political autonomy and this makes the data collection and harmonisation process time-consuming and based on willingness to co-operate between Government institutions at the regional and central level.

*Specific Areas*

- *National Report.* The report for the EMCDDA has constantly improved over time and has more and more reflected the Centre's guidelines and expectations. Work is mainly carried out by various internal staff with no involvement of external consultants or other supporting institutions. Only some parts of the section on demand reduction are not deemed to fully reflect the quantity and quality of the work done by the FP in this area. As in other Government Organisations the emphasis is more on reliability and soundness of the presented information rather than in innovative or ambitious analysis or methodological details. Due to institutional constraints in data collection information is not always very recent.

- *Key Indicators.* Progress is on average fairly advanced in this area. Spain already carries out drug general population surveys and good data are already available as far as prevalence estimates and treatment demand are concerned. Also other key indicators are generally deemed acceptable. Some problems exist for drug-related infectious diseases which started later and for which technical standards are not considered as clear enough. Substantial problems do exist only as far as the national system for reporting codes of drug-related deaths is concerned, while there has been a good progress on work with cohorts of drug users. External experts appointed for all indicators on an institutional basis work together with FP staff.

- *Demand Reduction.* The quality and the number of contributions in this area have generally met expectations. The FP is in a position to have easy access to a number of sources throughout the Country. Moreover its direct involvement in financing initiatives and the existence of an evaluation department within the PND makes its life easier. This degree of administrative effectiveness implies a certain inertia and slowness in reaction times. No external expert appointed and very limited reliance on consulting services.

- *Early Warning.* What was put in place is a network of institutional relations with other Ministries and some three scientific institutions. On-site pill testing exercises also experienced as primary sources of information. Communication with the Centre can be improved. No external expert appointed to coordinate activities with the Centre, but some reliance on consulting services.

- *Policy Analysis.* A strong point, as the FP policy orientation and interests often exceed the Centre's needs.

- *Dissemination and PR.* Very limited involvement in information and dissemination activities

*Networking.* Mainly based on institutional relations. By its own nature the PND cooperates with most Spanish Ministries and Government departments. Information sharing and participation to the Centre activities and the related prestige are used as rewarding mechanisms. NGOs are involved in the demand reduction area and in collecting information on problematic drug use and demand treatment. The FP deems that most of the NGOs active in the drug field in Spain have been contacted either directly or through the Regional Plans, but were in no position to provide exact figures. At any rate the PND involvement in providing financing to the system represent a good incentive for NGOs to make themselves available and reachable. Direct involvement of University institutions or research centres is more limited and concerns only the early warning system. No real problem in communication.

*Quality Control.* Proofreading and comments from staff are common procedures together with a steering committee supervising the work done on the five epidemiological indicators. However no formalised procedure in place based on written reports.

*Main Problems in Relations with the Centre.*

- conflicting information presented by the Centre and collected from other sources that were deemed as unreliable or not sufficiently representative used to be a problem has been overcome in latest years. At any rate poor knowledge of Centre contract awards of the related research results persists;
- limited user-friendliness and utility of the REITOX website;
- limited involvement of the FP as such in the strategic planning process.

**Financial.**

No conclusive comment can be made on this subject.

It might seem that Spain easily complies with co-financing requirements through in-kind contributions by paying FP staff salaries and contributing overheads and figurative rent costs. However, based on available information it must be noticed that Spain tends to consider not better-specified transfers to the Regions and costs for drug surveys as components of its National co-financing. On paper without these components co-financing requirements would not be met.

The FP does not have a separate budget and is not directly credited the Centre's financial contributions that go into the State budget. Moreover it does not keep a separate accounting of its costs as a FP and no accountant is included in its staff. Therefore it was in no position to provide an overall estimate of staff salaries or figurative rents.

As a consequence the FP was not able to calculate total actual costs according to the template received for this evaluation exercise. Some data on direct costs were provided, but their sources was the financial report used for the Centre and as such are of little use for this evaluation exercise.

**Overall Assessment.**

The FP is a stable organisation very well staffed and well funded. In the long run it has usually been able to effectively deliver outputs. It shares some of the basic features of FP directly attached to Government institutions: lengthy and somewhat bureaucratic procedures, priority to policy matters, and preference for sound and tested information rather than innovative or horizontal analytical insights. However data do not rely on official sources only but include also NGOs, while contributions from research centres and universities are rather scarce. More importantly due to institutional constraints it suffers from a certain difficulty in ensuring an even geographical coverage. Its own complex structure together with a certain language barrier makes it difficult to give a quick feedback to the Centre and this may have an impact on interacting with some areas of activity such as demand reduction and the early warning. This also contributes to convey the impression of a relatively isolated FP. No considerations about costs and co-financing are possible with the presently limited available financial information.

## FINAL SUMMARY SWOT MATRIX

| **Strengths** | **Weaknesses** |
|---|---|
| • good institutional networking<br>• diversified sources of information<br>• large staff resources<br>• strong implementation capabilities<br>• good project management skills<br>• good capability of achieving targets in the long run | • poor mirroring of Centre functions<br>• difficulties in providing quick feedbacks<br>• informal quality control procedures<br>• institutional problems in ensuring even geographic coverage<br>• limited involvement of the Scientific Community<br>• linguistic barriers<br>• limited involvement in PR activities<br>• lengthy bureaucratic procedures for data collection |
| **Opportunities** | **Threats** |
| • continuity of activities<br>• strong political support from Member State<br>• no institutional constraint to data collection<br>• good overall financing of the drug system<br>• close links with representative in the Management board<br>• clear definition of tasks at the national level<br>• heavy involvement in the Enlargement | • problems with drug-related mortality codes<br>• relatively isolated from department staff<br>• poor involvement in the Centre support activities<br>• inadequate accounting system |

**Swedish Focal Point**

***Folkhälsoinstituet (National Institute of Public Health) - NIPH***

**Short Profile**

**Institutional Background.**

Since its creation the Swedish Focal Point has been located within the NIPH - a Government agency under the Ministry of Health and Social Affairs with a consolidated tradition and a well-established reputation in research and monitoring work in the public health domain. The NIPH has been recently given a new, more clearly defined role. Its aim is to act on a broad strategic scale to improve public health, with a special emphasis on the determinants affecting groups that run the greatest health risks. NIPH activities are being re-oriented in order to fulfil the new functions as a centre of excellence concerning evidence-based methods for public health interventions; to monitor and evaluate the attainment of the national public health goals and report to the Government; to accomplish a supervisory function for the tobacco, alcohol and parts of the illicit drug legislation. The NIPH is currently provided with a staff of 110. The present restructuring is likely to affect also FP organisation and staff.

The NIPH is a public-funded institution and its general director is appointed by the Council of Ministers. As such, it has little problems of contractual continuity of activities and can rely on a large staff in Stockholm. Its FP responsibilities have been clearly defined in a Government Ordinance. Laws on protection of personal data and drug-addict right to privacy have partly hindered the data collection process (demand for treatment and cohort studies). The matter is presently under consideration by legal advisors to see whether legislation amendments are required. Because of the nature of its activities, the FP is better known among policy makers and in the scientific community than among drug practitioners directly operating in the field.

**Organisation.**

Although the Head of the FP is formally the Head of the NIPH the role of interacting with the EMCDDA has been *de facto* played by a senior staff within the department for health and addictive behaviours. With the present restructuring a new unit for the "supervision of Alcohol, Narcotics and Tobacco" was created within the newly established "Health Behaviours and Supervision" department. For the time being the unit, led by the same professional, has been given responsibility for FP activities and this has allowed some degree of continuity in activities. However a final decision on how FP activities will be organised in the future has not been taken yet.

The NIPH used to be structured along three different departments. The core of FP activities was with the Health and Addictive Behaviours Department that had a staff of twenty. In year 2000 four of these in-house people substantially contributed to FP work, while two additional man-months work was provided respectively by three more department staff and one support administrator. It must be noted that also other Government institutions contributed to the FP tasks for a total five man-months, or so. This includes, among others, personnel from the Police Intelligence, the Forensic Institute, the National Board for Public Health, the Epidemiological Centre and two major urban treatment centres in Göteborg and Stockholm. The NIPH co-operates with the Ministry of Health also in the provision of information to other international organisations. This task is dealt with more or less by the same individuals, although outside their FP functions. All in all in terms of total Government-related human resources effort, it can be estimated that the NIPH core staff accounts for a 65% of total FP man-time, contributions from other government organisations for another 25% while the remaining 10% is split between NIPH other minor contributions and support staff.

Expertise available among the FP core staff ranged from sociology to epidemiology and medical sciences. Most of these personnel had a long professional experience in the drug field, but one junior sociologist mainly involved in report drafting. To exploit synergies in data collection and analysis the same team was also involved in writing the Internal National Report on Drugs. However, the structure of the two documents substantially differs and no more than some 40-50% of their contents actually coincide.

**Operational.**

*Overview.* The FP is located in a Government Agency that is given a broader political mandate in monitoring and studying addictive substances. In institutional and organisational terms for the NIPH "legal" drugs are even more important than illegal ones. So far the emphasis has been mainly put on the health-related aspects, even though with the present restructuring a more policy-oriented approach can be expected. For whatever does not strictly concern its main field of interest the NIPH extensively relies on external expertise mainly on an institutional basis. And this decentralisation trend seems likely to continue in the future if FP responsibilities extend to other areas.

*Specific Areas*

- *National Report.* The report is of a fairly good quality and quite accurate from a methodological point of view with some minor weaknesses (qualitative research, demand reduction and policy analysis) that the FP itself easily acknowledges. This is reportedly due to lack of time and resources, but also reflects structural weaknesses of the Swedish network and the NIPH own areas of interest. Work is partly carried by various internal staff partly subcontracted to a major Swedish NGO – The Council of Advice on Alcohol and Narcotics-CAN. Plurality of contributions does not create major problems of homogeneity. In general terms, the FP seems more at ease with the provision of objective data than with their analysis which is perceived as something too subjective for an official task.

- *Key Indicators.* The situation appears very varied in the different fields. While work on the prevalence in the general population is fairly advanced and generally meets the Centre's requirements other areas are more problematic. The monitoring of treatment demand faces problems of privacy of data and the system had to be built from scratch. Similar problems also partly hinder the development of studies on drug-related deaths through cohorts and on problematic drug use. On the contrary drug-related deaths recording codes are in line with the Centre standards and the related data are deemed even more accurate than in other Member States. Some problems do also exist for drug-related infectious diseases which started later and for which guidelines are not deemed as clearly defined. External experts appointed on an institutional basis for demand treatment and on an informal basis for drug-related deaths and drug-related infectious diseases.

- *Demand Reduction.* Probably the FP weakest area also reflecting the lack of a direct link with drug practitioners and indirect relations with treatment centres. Nevertheless the FP has managed to provide the Centre with a reasonable number of inputs over time, but it is widely acknowledged that the related network needs enlargement and strengthening together with additional in-house resources before fully meeting the Centre's expectations. No external expert appointed or reliance on consulting services.

- *Early Warning.* Considered a high priority in Sweden that has recently witnessed the appearance of new substances in the market, an active network based on the strict co-operation of official institutions including the Police and forensic institutes has been established. No *ad hoc* mechanism put in place to collect information in the field, but information is shared through a database. External experts appointed both on an informal basis and institutional basis and reliance on services of external laboratories.

- *Policy Analysis.* Good as far as basic features are concerned. More in-depth analysis will probably require recourse to external expertise.

- *Dissemination and PR.* So far neglected. Will possibly become an area of activity after the restructuring.

*Networking.* Networking reflects the fairly centralised nature of Sweden and appears relatively underdeveloped. The FP has permanent relations with a couple of Universities, some seven other Government agencies and CAN, which in turn groups some 15 to 20 NGOs. This has an obvious impact on demand reduction where some more five NGOs and another five Government Agencies are involved on a sporadic basis. Crucial data collection from other administrations is made easier by the NIPH well-established reputation and credibility. No real problem in communication.

*Quality Control.* Quality control mainly consists in National Report proofreading and approval by an ad hoc steering committee composed of representatives from the Ministry, other agencies and Scientific Institutions. However no formalised procedure in place based on written reports.

*Main Problems in Relations with the Centre.*

- limited usefulness of the National Report and EDDRA as they are conceived now;
- limited comparability of data and attention to data quality (drug-related deaths);
- limited user-friendliness and utility of the REITOX website;
- poor knowledge about day-to-day development of the Centre's activities in general.

**Financial.**

Sweden complies with co-financing requirements through in-kind contributions by paying FP staff salaries and contributing overheads and rent costs. The FP is given its separate budget and the EMCDDA financial contributions are directly credited to the NIPH. Separate accounts are kept for FP-related costs.

Actual costs exceed contractual arrangements by over 17%. Staff salaries account for some 51% of total estimated costs and subcontracted consulting services for another 15%. Overheads (including figurative rent costs for about 100 sq. mt operational space) account for another 20% of total cost, travel for 8% and other minor items for the remaining 6%.

Work on the key indicators accounts for 32% of total direct costs, roughly evenly allocated between NIPH and other Government staff. The national report accounts for another 26% of direct costs, while demand reduction for 11%. The remaining resources are spent for coordination of activities (17% including what is done for PR and dissemination) and the early warning system (14%).

EMCDDA financing does not seem a major constraint in operational terms. The NIPH is well funded by the Swedish Government and contributions from other agencies are granted on an institutional basis without major difficulties. Involvement in the new areas of activities could simply require additional external expertise from other Government institutions.

**Overall Assessment.**

The FP is a professional and well-established agency with a good level of in-house scientific expertise. Methodologically sound and usually capable of effective outputs, it reflects the Swedish centralised administrative tradition and mainly operates through a well-knitted network of Government institutions. This inevitably means that it reflects the prevailing views within the Swedish Government. On the other hand areas of activity requiring larger networks are weaker. Comparability and data harmonisation are a key issue for the Swedish FP. Progress on the key indicators mainly depends on structural obstacles and ultimately political willingness rather than on the FP technical skills. The FP sticks to a strict contractual approach and appears relatively detached from what happens in Lisbon. After a long period of stability the present restructuring may have a serious impact on the future smooth continuation of activities.

## FINAL SUMMARY SWOT MATRIX

| **Strengths** | **Weaknesses** |
|---|---|
| • good institutional networking<br>• large staff resources<br>• good scientific expertise<br>• good project management skills<br>• command of English | • underdeveloped network in demand reduction<br>• informal quality control procedures<br>• problems in ensuring even geographical coverage of data due to sparse population<br>• neglect so far of PR activities<br>• more confident in data provision than analysis<br>• some problems with linguistic equivalents |
| **Opportunities** | **Threats** |
| • strong political support from Member State<br>• good overall financing of the drug system<br>• close links with representative in the Management board<br>• strong political interest in the early warning<br>• some involvement in the enlargement<br>• vast scientific community available<br>• clear definition of tasks at the national level | • continuity of activities ?<br>• structural problems with some key indicators<br>• limited scientific community available<br>• time constraints in highlighting key issues<br>• limited familiarity with evaluation culture in the Country<br>• relatively isolated from EMCDDA staff<br>• poor involvement in the Centre support activities |

**UK Focal Point**

***DrugScope***

**Short Profile**

**Institutional Background.**

DrugScope is a NGO incorporated as a limited company, established in 2000, as the result of a merger of the Institute for the Study of Drug Dependence (ISDD, created in 1968) and the Standing Conference on Drug Abuse (SCODA). DrugScope inherited the functions of UK Focal Point from ISDD, which was in charge of the activity since 1995. DrugScope is considered the UK's leading independent centre of expertise on drugs. Its mission is "to inform on policy development and reduce drug-related risk", providing information on drugs, promoting responses to drug problems, undertaking research on local, national and European level, and advising policy-making activities. The organisation is membership-based, grouping about 900 members, both individuals and public and private organisations.

DrugScope was appointed by the UK government as Focal Point through a direct agreement, originally agreed with ISDD and renewed annually. In 2002, this system may cease and a public tender (or a similar sort of competitive arrangement) may be launched to appoint the UK Focal Point. The UK Focal Point is formally nominated by the Department of Health. At the beginning of the Centre's activities, the Department of Health acted as the UK policy Focal Point and nominated ISDD as the operational one. In 2000, an inter-departmental agreement was reached that FP should be tendered during 2002. In early 2001, the Department of Health seemed inclined to 'absorb' FP operational responsibilities. But, after several months of confusion, DrugScope was confirmed as FP for the whole calendar year 2001.

No major privacy or data protection problem has been faced by the FP.

**Organisation.**

DrugScope is structured along six Groups (Resources; International and Policy Research; Policy and Practice; Communications; Information and Customer Services; Welsh Drug and Alcohol Unit), each of them reporting via a Director of Group to the Chief Executive. The FP work is managed by the International and Policy Research Group within which it absorbs roughly 50% of staff time. *DrugScope* does not usually advertise itself as the FP as this is considered of scarce interest to the public. *DrugScope* has an overall staff of 55 full-time employees

Six part-time scientific staff work for the Focal Point, plus another three support staff. The FP in-house expertise mainly includes social sciences (criminology, anthropology, demography) and also chemistry/toxicology. The FP can also rely on further expertise from DrugScope's staff working in its Policy and Practice Group, which has expertise in many areas of demand reduction. External consultants usually provide epidemiological expertise. Given its skills, the FP seems ready to cover new areas of activities, such as availability, petty crime, social exclusion, prevention in schools and in local communities, treatment facilities, etc.

After the merger, the FP underwent a significant turnover in personnel and, aside from the Head of the Focal Point, none of the key-staff has remained in the post for more than two years. Staff turnover in 2001 may have been accelerated by the uncertainty already mentioned over the location of the Focal Point.

**Operational.**

*Overview.* The FP relies largely on established UK sources of epidemiological and demand reduction information, complemented by expertise from elsewhere in DrugScope and from external contractors when needed. It does not consider itself as directly responsible for harmonization of key indicators, which is dealt with at the Government level by civil servants. It does regard itself as being much involved in the EMCDDA's development of new indicators in line with the Action Plan. Delegated (subcontracted) activities

account for 25% of the total in terms of money. The FP has been actively involved in developing the Centre's three-year work programme in the light of the EU Action Plan.

*Specific Areas*

*National Report*.

The way in which the Focal produces the National Report changed between 2000 and 2001. Up to and including year 2000, the work was largely done in-house with some outside assistance, using staff with expertise in information work, public health/epidemiology and demand reduction. The feedback from the Centre was that, although methodologically sound and good in qualitative and quantitative research contributions, the Report could benefit from being longer, more analytical and more detailed. In response, for the work carried out in 2001, the FP adopted a new approach, the bulk of the writing being contracted out to subject specialists (including some in DrugScope).[25]

In any case, the fact that four countries make up the UK – Northern Ireland, Scotland, Wales and England – does to some extent complicate the process of making one UK Report.[26] This manifests itself in two ways:

- data on Scotland, Wales and Northern Ireland may sometimes be missing or structured in different ways, because of some differently structured data gathering systems in different parts of the UK. However, a convergence trend concerning drug data systems is on-going in the UK;
- each of the four parts of the UK has its own national drug strategy, and each administration has to be satisfied with the contents of the UK report. Whilst each national strategy fits within the general UK approach, there are some differences, for example the Welsh strategy covers alcohol and the other three strategies do not. These aspects of devolution in the UK add administrative complexity to the task.

Extracts of the report are generally published by DrugScope for professionals and the national public ('UK drug situation report'), although professionals and the national public are reportedly more interested in more up-to-date information.

*Key Indicators.* The FP mostly limits itself to facilitating the contributions of relevant Government civil servants. On average the UK is fairly advanced. Some problems exist for drug-related infectious diseases, where standards are unclear, and for data on mortality. External experts are appointed on an institutional basis.

*Demand Reduction*. Reasonably good contributions in both qualitative and quantitative terms especially if it is considered that instructions and guidelines are not always deemed as entirely clear by contributors. Slightly weaker in the corresponding parts of the report.

*Early Warning.* Jointly implemented with a UK Joint Action Management Group, ensuring co-ordination with the National Criminal Intelligence Service (Europol Unit) and other interested parties such as the

[25] As of October 2001 this resulted in a report that may more closely correspond to what the EMCDDA wish for but, given its greater length and complexity, it has attracted some comments from the civil servants asked to check it.

[26] The FP working practices were examined and discussed with its national partners and three possible alternatives emerged:

- The Report could be drafted by the FP and its contractors on a UK-wide basis and then checked by the national partners;
- A Report could be produced by each of the national countries and then merged together to form a UK report;
- The UK Report could be drafted by all the partners, according to their specific expertise in order to cover all the territory and all issues.

The first alternative was selected and the national report is accordingly produced from the FP, with the possibility for each of the national partners to integrate it with specific issues.

Forensic Science Service, as well as with government Departments. This Management Group agrees (i) simultaneous reports to the Centre and to Europol, via the FP and NCIS; (ii) any procedural developments required. The Joint Action is considered to work reasonably well in the UK with several notifications have been made.

*Policy Analysis.* Only limited contributions so far but with acceptable results. Future contributions in this field are likely to require the involvement of the four Government agencies. The FP also considers that it would be helpful for the scientific staff of the Centre and FPs collectively to define what assumptions and models are reasonably used in tracking possible linkages between 'policy' (intentions), 'responses' (in practice), and changes in the 'situation' (drug related problems).

*Dissemination and PR.* DrugScope has considerable skills in this field and dedicated human resources. Very good in PR activities and media conferences. Details on dissemination of products not available.

*Networking.* Based on a combination of institutional sources and own contacts. The FP relies either on public institutions or on Members of DrugScope (about 900 over the Country). Other services are usually paid for on an ad hoc basis. . Complexity is added by political devolution in the UK (as mentioned above).

*Quality Control.* The first integral draft of the National Report is sent to external experts for peer reviewing on both scientific and political aspects, whereas policy matters are examined by Government Officers in the four parts of the UK. Once comments and integrations have been finally carried out, the final version of the report is issued. Quality of work on the Joint Action is underpinned by the Joint Action Management Group. Quality of the EDDRA-related work consists of interchange between the FP and the people involved in the projects concerned, until a clear and mutually agreed input is achieved.

*Main problems in relations with the Centre.*

- Data requested for the National Report overtly exceeding needs;
- Lack of focus in request from the EMCDDA as concerns demand reduction

**Financial.**

The UK complies with the co-financing requirements through both cash and in kind contributions (the balance between these two forms of co-financing varying somewhat from year to year). The latter cover civil servants' salaries when such staff are seconded to the Focal Point. However, it was not until October 2001 that government agreed payments for the 2001 contractual period; one payment for the preceding year, 2000, has yet to be agreed. As a result, the Focal Point has been operating without a contract with the EMCDDA during most of 2001 and so without payment by the Centre. The FP keeps separate accounts of its costs and directly manages its budget. EMCCDA funds are directly channelled to DrugScope. As the UK financial year does not correspond to the calendar year this can create some minor problems.

Actual costs fully coincide with the contractual arrangements. Staff salaries account for some 63% of total costs, external consultants for some 7% and overheads for 25% (being fixed at 40% of the staff salary costs). Travel costs are less than 2%.

The national report accounts for some 36% of direct costs, and work on the Harmonised Indicators for another 30%. Focal Point Coordination absorbs another 14%, the Early Warning System (12%) and finally Demand Reduction (9%). Figures on PR and Info dissemination, and Documentation are not analytically reported. For carrying out its activities, the FP strongly relies on the EMCDDA co-financing.

**Overall Assessment.**

The FP is a well-staffed NGO, generally recognised in United Kingdom as the leading structure in this specific sector. Its position within a NGO increases its ability to work with all the organisations involved in drugs related matters. It can rely on a wide range of accessible expertise, while lacking in-house epidemiologists. In prospective terms, it seems to possess all the necessary skills to deal with the future of EMCDDA activities also thanks to a large network, spread over the four nations of the UK, which includes people in many sectors (public administrations, NGOs, practitioners, volunteers). The activities performed by the Organisation as REITOX Focal Point do not seem to be evident to the general public. The FP has the capability to collaborate with the Centre for strategic actions (notably it worked with the Centre management in the definition of the new work programme). Lack of clarity amongst government departments regarding the arrangements to be made for the UK FP, plus arrears in the payment of UK co-financing, have had a negative impact on its recent activities. For the year 2002, the situation is unclear at the time of writing, but some of the options mentioned include UK FP being appointed through a tender, or its functions being taken into government.

**FINAL SUMMARY SWOT MATRIX**

| **Strengths** | **Weaknesses** |
|---|---|
| • Good scientific expertise in-house (criminology, demography, toxicology, demand reduction)<br>• Good institutional networking<br>• Operational Joint Action EWS<br>• Good contribution to EDDRA<br>• Strong PR capabilities<br>• Dynamic and proactive management culture | • Recent high turnover in staff<br>• Lack of in-house epidemiological skills<br>• Quality control procedures need further development<br>• Hands-off approach to the key indicators (although a strong focus on the new EU objectives)<br>• Difficulties in ensuring even geographical data<br>• National report following EMCDDA requirements seen as too complex for UK purposes<br>• Strong dependence from the EMCDDA financing |
| **Opportunities** | **Threats** |
| • Strong relations with MB representative<br>• Active involvement in the Centre's activities<br>• Involvement in support projects<br>• Skills available in future areas of activities<br>• Devolution process taking place in UK<br>• Possibility of public tender for the appointment of the UK FP for the year 2002. | • Unclear political support<br>• Financial constraints<br>• Changing institutional framework on drugs |

## MAIN ABBREVIATIONS AND ACRONYMS

| | |
|---|---|
| AP | Action Plan |
| CU | Coordinating Unit |
| DG | Directorate General |
| DIS | Drug Information Systems |
| EC | European Commission |
| EDDRA | European Database on Demand Reduction Activities |
| EU | European Union |
| EMCDDA | European Monitoring Center for Drugs and Drug Addiction |
| FP | Focal Point |
| JA | Joint Action on New Synthetic Drugs |
| MB | EMCDDA Management Board |
| NGO | Non Governmental Organisation |
| REITOX | European Information Network on Drugs and Drug Addicition |
| SC | EMCDDA Scientific Committee |
| UNDCP | United Nations Drug Control Program |

## SYMBOLS

| | |
|---|---|
| - | Nihil |
| .. | Not Available |
| n.a | Not Applicable |

This report was prepared by a team comprising Alberto Bolognini (project co-ordinator), Marco Lorenzoni, Roberto Raggi and Veronica Magrini. External support in quality control was provided by Roberto Zavatta.