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Original article

Treatment of substance-related problems in Switzerland: implementing a new harmonised monitoring system

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Summary

Objectives: In the past, five different monitoring systems were used in the various areas of the care supply for substance-related problems in Switzerland, without any real coordination between them. In 1999, a project aiming at the harmonisation of these five monitoring systems was launched by federal agencies. A further aim was to ensure compatibility with the Treatment Demand Indicator (TDI) adopted as European standard.

Methods: The different steps of the conceptualisation process and their rationales are described. They involve a first phase of consultation among all key players, a second phase of preliminary realisation according to the target criteria, a third phase of probation by the application of a pilot survey, and a last phase of consolidation and adjustments before the official implementation.

Results: A comprehensive and flexible monitoring system was settled for all fields of the addiction care in Switzerland. It consists of a fully standardised pool of core items to be shared by the five treatment sectors as well as optional items intended for specific needs. The practical aspects of the implementation, like data protection, organisation of data collection, and valorisation of the results are presented. The first experiences in the different treatment sectors are also reported.

Conclusion: The implementation of "act-*info*" is still an ongoing process that began in 2003. Since 2005, the new monitoring system is well implemented in three out of five treatment sectors, whereas its introduction proves more challenging in the two remaining sectors. Perspectives of improvement regarding coverage and data quality are proposed.

Keywords: **Substance abuse treatment – Monitoring system – Data protection.**

From a total population of 7.4 million residents, it is estimated that around 300,000 people have alcohol-related problems in Switzerland while there are an estimated 30,000 with illicit drug-related problems [1]. Collecting data on the profile of the clients of the care supply represents an important source of information on the prevalence and the nature of serious addictive problems. This information is relevant in planning measures to dam the emerging problems and also to assess their efficiency. Several countries throughout the world have implemented such reporting systems and they are considered as an important component of public health monitoring [2–4].

The Swiss addiction care supply

The Swiss addiction care supply is characterised by its highly decentralised structure. Typically, the outpatient services (ambulant facilities) and inpatient centres (residential facilities) are set up and embedded locally. With a few exceptions, the inpatient centres are specialised either in alcohol- or drug-related problems. They are mostly organised as therapeutic communities, offering different therapeutic approaches and vocational activities. There are approximately 80 of such centres (20 in the alcohol sector and about 60 in the drug sector, excluding detoxification units, homes and residential aftercare places). In the outpatient sector, the offer is much more mixed than in the residential one, varying between specialised units and multifunctional services, treating not only substance abuse disorders. The number of outpatient facilities is estimated to be about 250. Several outpatient services offer methadone substitution programs and more than 20 participate in heroin-assisted treatment programs. Beside these facilities, a number of practitioners are allowed to prescribe methadone or other opiate substitutes. A growing number of inpatient centres for drug-related problems accepts clients already involved in methadone substitution or provide themselves parallel substitution treatment.

The five existing monitoring systems before harmonisation

The first systematic collection of data concerning the treatment of persons with substance-related problems in Switzerland dates back to 1941 and was applied in the former "welfare houses for drunkards". In the mid-fifties, outpatient services were added to these official statistics, and annual figures were published by federal agencies until the early eighties. Due to general budget restrictions in the federal administration, this primary monitoring system, limited to the alcohol care field, was abruptly stopped after the 1981 report. A partial revival took place in 1984 on the private initiative of an association of inpatient alcohol treatment centres in the German-speaking part of the country (SAKRAM). This system was soon adopted by an analogous corporation in the French-speaking part (CIRSA) and represents the first sector of monitoring activities in the addiction care supply. At about the same time (1983), a research network was initiated across some inpatient centres for drug-related problems and was gradually expanded to a national documentation system (FOS) that constitutes, since 1989, the second monitoring system in the addiction care field. The dramatic rise in drug-related problems and the rapid spread of the AIDS virus among drug users at the end of the eighties led the government to introduce a series of measures. A concomitant measure was a return to the promotion of monitoring efforts in the addiction care field, especially in the outpatient sector, since no system existed there at that time. A pilot project was started in 1988 and was followed six years later by the implementation of a third monitoring system intended for the outpatient services for both drug- and alcohol-related problems (SAMBAD). This monitoring system was built and carried out by federal agencies, while the existing systems in the inpatient area were now also financially supported and promoted. A further project supported by the government was the implementation of experimental heroin assisted treatments in 1994 [5] that was later extended as an integrated part of the overall treatment supply. These heroin-assisted treatments (HeGeBe) are now accompanied by obligatory follow-up measures, representing the fourth body of monitoring activities in the Swiss addiction care field [6]. Finally, national statistics on methadone substitution programs based on the registration data provided for approval procedures on the cantonal level were established between 1999 and 2000 and represent the fifth monitoring system implemented. Table 1 summarises the monitoring activities in the Swiss addiction care field before harmonisation process.

An accurate but more or less uncoordinated data collection resulted from the successive implementation of these five monitoring systems driven by different interests (e.g. user-oriented and shaped for the own work, or on the opposite, more designed for statistical purposes). The need for harmonisation was recognised by the federal agencies as they found themselves increasingly involved in supporting these different systems. In 1999,

Table 1 Monitoring activities in the Swiss addiction care field before the introduction of act-info

	Statistics of the inpatient treatment of alcohol dependence in Switzerland (SAKRAM/CIRSA)	Research association of residential treatment centres for drug problems (FOS)	Statistics of the ambulatory services for alcohol or drug problems in Switzerland (SAMBAD)	National Methadone Statistics	Statistics on heroin-assisted treatment (HeGeBe)
Monitoring since (excluding pilot surveys)	1984 SAKRAM 1992 CIRSA	1989	1994	1999	2000
Type of treatment facilities	specialized clinics alcohol rehabilitation centres	specialized clinics drug rehabilitation centres	outpatient services for alcohol problems outpatient services for drug problems outpatient services for addiction problems polyvalent or psychiatric services (treating not only addiction problems)	methadone substitution centres general practitioners cantonal doctors pharmacies	heroin prescription centres jail/detention centres
	excluding detoxification units, homes and residential aftercare places	excluding detoxification units, homes and residential aftercare places	excluding centralised methadone programs, heroin prescription programmes and low-threshold services providing only essential care		

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a project aiming at the harmonisation of the five monitoring systems was launched conjointly by the Swiss Federal Office of Public Health and by the Swiss Federal Statistical Office.

Objectives: General aims of the new monitoring system

As for the majority of the treatment monitoring systems implemented in other countries, the new national monitoring system called act-*info* ("The *info*rmation network on *a*ddiction *c*are and *t*herapy in Switzerland") aims at the following key goals [7]:

- providing a national information network by documenting relevant data on the treatment of substance-related problems and other addictive troubles;
- improving the knowledge about the clients of the care supply by assessing their profile at treatment admission and discharge;
- detecting new trends in the characteristics of the clients, their pattern of use and their specific problems and needs;
- collecting information about the structure of the care supply;
- providing standardised assessment and reporting tools for the treatment units allowing an optimal documentation of their work;
- providing a baseline for further research or follow-up studies.

Considering the former monitoring efforts in Switzerland, the new monitoring system aims first to harmonise the instruments of the five monitoring systems collecting data in the treatment facilities for substance-related problems (including non-chemical addictive behaviours) in order to provide a common database. A second aim is to ensure comparability not only between the data collected in the different treatment sectors of the country but also with the standards adopted in the European Union. Finally, it aims to take the specificity of each of the five treatment sectors into account.

Further expected effects of this harmonised monitoring system are the improvement of the adequacy between treatment demand and supply and also indirectly an increase in the quality of the care supply [8, 9].

Methods: Steps of the conceptualisation process

Consultation phase

In the primary period of the development of the project (2000–2001), a broad platform of experts and representatives from the federal and cantonal authorities, professional associations, research institutes, and potential users (therapists from the outpatient and inpatient sectors) was constituted in order to take into account as much opinions and interests as possible. This wide consultation was also launched in order to facilitate the later implementation of the system by involving all potential partners in the first phase of the process. Different expert working groups have been set up for the different aspects of the project (topics to be included in the instruments, scientific prerequisites, political implications and user-related interests). These early deliberations resulted in a great amount of proposals that were sometimes hardly reconcilable. In order to coordinate and synthesize this work, a task force was constituted, whose most difficult challenge was to find an acceptable compromise between the various suggestions and proposals. The aim of the task force consisted in elaborating a first version of the instruments to be tested under real conditions. The leading criteria in this procedure were: 1) public health considerations (e.g. injecting behaviour, early detection of new problems), 2) comparability with the former instruments, 3) practical acceptance (e.g. length, balance between the different treatment fields), 4) item validity, and 5) full compatibility with the European standards.

Preliminary realisation: Options taken by the task force

In order to provide valuable information on key topics across all treatment fields on one hand, and in order to fulfil the specific needs of the different sectors by keeping a good comparability with the data gathered in the past on the other hand, the task force opted for a flexible organisation of the instruments by defining core items for all treatment fields and specific items intended for the single sectors. In order to be compatible with the European standards for treatment reporting systems in the field of illegal drug abuse, the task force decided for including the items of the Treatment Demand Indicator (TDI) [10] into the set of core items common to all sectors.

A crucial condition of the new monitoring system is its acceptance by the field. Indeed, except for the heroin-assisted treatment sector, no treatment field is obliged by the federal authorities to take part in such a survey. Also there is no general pressure to participate on these centres from their funding sources, characterised by a broadly decentralised structure. In this respect, the task force selected topics being of practical relevance for the treatment services or centres, the counsellors or therapists as well as for the political bodies involved. Efforts were also undertaken to produce acceptable instruments in terms of duration and complexity of use.

Unlike the TDI protocol requiring data only at treatment intake, the first version of the instruments elaborated by the task

force consisted of two questionnaires corresponding to the two measurement points already adopted in the former monitoring systems: one at treatment intake and the other at discharge. This enables the monitoring of the kind of treatment termination, the duration of the intervention and the problems remaining at discharge. In addition, this allows a direct comparison of general life conditions like the living status or the labour status at intake and discharge.

Probation: Pilot survey

A pilot survey covering three sectors of the addiction care supply was organised for testing and improving the questionnaires at treatment admission and discharge [11, 12]. The sectors of methadone substitution and heroin prescription were not included in the pilot survey, due to the official function of their monitoring systems (official registration forms), that could hardly be changed temporarily. For this pilot phase performed between 2001 and 2002, the first version of the instrument (as paper forms and as software in the outpatient field) was applied over a period of 2–6 months in 8 outpatient services (for drug- or alcohol-related problems) as well as in 6 inpatient centres for drug-related problems and also in 2 inpatient centres for alcohol-related problems (in 6 additional centres of this last sector, only among samples of clients). The services or centres involved in the pilot survey could not be selected randomly. As the first version of the instruments was available only in German, the services and centres to take part in the pilot phase had to be located in the German-speaking part of Switzerland. In addition, only services willing to participate in the pilot project could be chosen. However, efforts were undertaken to ensure an acceptable representativeness of the pilot sample.

The evaluation included semi-structured qualitative interviews of the person responsible for monitoring activities in each participating service or centre (N = 16). Additionally, counsellors or therapists in the outpatient sector and in the inpatient sector for alcohol-related problems, were asked to fill out evaluation forms with scales to be ticked (N = 39). The evaluation was to be linked up to the former instruments used in the three treatment fields.

The conclusions of the interviews were interesting in several respects. In the outpatient sector, an important part of the comments concerned the software solution which was perceived as much too slow and not very practical. Regarding the content, the first version was perceived as too long and too complicated by the outpatient field and alcohol-related inpatient centres, especially the part devoted to substances. Inconsistently, additional subject areas were also suggested. In the sector of drug-related inpatient centres, the questionnaire was inversely perceived as shorter and as more user-friendly than the former questionnaire. Several comments on single items were also made in terms of their comprehensibility, clearness, and unambiguousness. Compared with the former instruments applied in the three respective sectors, the ratings for the new system showed an acceptable improvement in the drug-related inpatient facilities, but no real improvement in the outpatient sector. The picture was even worse among the alcohol-related inpatient centres.

Consolidation and last adjustments

Starting from the outcome of the pilot survey, an exhaustive revision of the instruments was undertaken during 2002. In this process, the following tasks were seen as essential:

- simplifying the assessment of substance-related information by focussing on the primary substance of abuse;
- reducing the number of core items;
- simplifying the structure of the instruments by building specific variants for the different target groups instead of using the same form everywhere, requiring complicated jumping procedures;
- using unambiguous terms or providing clear definitions and instructions for use;
- enhancing the flexibility of application by providing an extended pool of optional items;
- optimizing the layout of the questionnaire to make it more user-friendly.

Although the technical specifications for a computerised version and some details were still pending, the revised act-*info* was already put into practice in 2003 in one of the five treatment fields (drug-related inpatient treatment). This was possible in this sector since only paper forms were used at this moment. Moreover, there was a high readiness to switch rapidly to the new forms in this field. This early implementation played at least a role of dress rehearsal before the general introduction of the new treatment monitoring system. Consecutively to this preliminary implementation of act-*info*, some last modifications were done before the official introduction of the new monitoring system in the other treatment fields.

Results: Implementation of the new Swiss treatment monitoring system

Instruments

The final act-*info* consists of a pool of more than 300 well-documented items available in the three official languages (German, French, and Italian). They stem from five main sources: 1) the Treatment Demand Indicator (TDI) [13]; 2) the follow-up standards for the evaluation of addiction treatment

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in German speaking countries [14]; 3) the Addiction Severity Index (ASI) [15]; 4) the former instruments used before in the different sectors; and 5) from some standardised screening tests like the AUDIT [16] or the Fagerström-test [17].

Like in the first version, all items for the two measurement points (intake and discharge) are organised according to two distinct levels:

– Core items: The first level is the minimum common body of information that is collected in all sectors of the addiction care supply participating in the monitoring system. This first core of items ensures the comparability between the five different sectors and concurrently their compatibility with the European standard protocol (TDI). Therefore, they are obligatory for all sectors.
– Specific optional items: The second level consists of items that can be applied in one or more sectors, according to the specificity of the different treatment fields. For example, persons seeking help for a relative's problems occur only in the outpatient sector. Items to assess this kind of demand are therefore only needed in this area. Several items of this second level give only further detail on the basic information collected anyway. Once adopted for a specific sector, these secondary items are intended to be used by all services involved. Several items from the general pool remained not used at all by any sector. They still can be used optionally by single services or centres.

Independently of this ongoing monitoring, the treatment services or centres are asked at the end of each year to complete a form with items pertaining to their own functioning.

Table 2 summarises the topics included in the common body (core items) of all variants of the act-*info* instruments.

Several additional topics are included in the different versions designed for the distinct treatment fields. In order to make the use of the instruments more practical and to enhance their reliability, detailed instructions, especially on the meaning of the key terms used in the forms, were formulated and are provided with the instruments. All forms and manuals are available in the three official languages of the country: German, French and Italian. Most of the instruments are available online and can be required from the authors.

Data protection

A basic dilemma in reporting monitoring observations is the choice of the unit considered, either treatment episodes or individuals. For example, the European TDI standard protocol defines as unit only the last treatment initiated in a given reporting year [13]. Avoiding multiple counting presupposes at least the identification of clients being treated in different places or repeatedly in the same service or centre. This raises the question of data protection since this task is only possible if highly sensitive personal data are considered. In order to comply at least with prevailing rules in matter of data protection, a two-level and non-reversible encryption method was adopted to generate an unique code identifier. This method allows the identification of different treatment episodes from a same person without any possibility to return to the original data imputed for this code on the previous level. At the first level (participating treatment services or centres) a primary code is built, starting from four fixed letter positions from the first and last name (at birth) of the client. At the second level (data collecting research institutes), this code is appended to the date of birth and to the gender digit and can then be encrypted for the next level of data flow. For more security, this

Table 2 Core topics of the act-info instruments

Questionnaire at treatment intake (ongoing monitoring)	Questionnaire at treatment termination (ongoing monitoring)
Intervention context: type of treatment; date of intake; own problems or problems of relatives; former interventions related to substance abuse or similar problems; current substitution treatment; primary and secondary sources of referral	Intervention context: date of termination; type of treatment; own problems or problems of relatives; reason of termination; substitution during intervention; substitution after intervention
Socio-demographics: sex; age; level of urbanity of place of residence; marital status; nationality; living context; primary and secondary sources of income; primary and secondary labour status; educational level and current training	Socio-demographics: sex; age; level of urbanity of place of residence; marital status; living context; primary and secondary sources of income; primary and secondary labour status; educational level and current training
Substance use, addictive behaviour: main problem: frequency of use/occurrence, way of administration; age at first use/occurrence, at first regular use/occurrence and at first problematic use/occurrence; secondary problems; substances used or addictive behaviour occurred in the past month; injection habit	Substance use, addictive behaviour: problems at discharge; substances used or addictive behaviour occurred in the past month; injection habit in the past month
Service/center profile (yearly)	
Service type; specialisation; possibility for withdrawal treatment	

system generates two codes (personal key and session key) that will be different for an additional encryption session of the same data. At the level of the central data base hosted by the Swiss Federal Office of Public Health, a corresponding protected key is needed to interpret the respective code pairs as a single code. However, this method presupposes being very exact in collecting the basic information. A single error in generating the four-letters code or in copying the date of birth would result in an erroneous code on the last level, disabling definitively a correct matching. In order to reduce the liability of errors, all kinds of electronic forms used to collect the data have to produce the four-letters code automatically, according to the rules, including for the exceptional cases. Moreover, a single code generator is also available for the units still using paper forms. On the other side, persons of the same gender, being born on the same date and having incidentally the same four-letters code would be considered as an unique person. This risk however seems to be extremely unlikely, according to the simulations performed. A crucial decision for the overall acceptance of the monitoring system is that the central database holds no sensitive data at all (e.g. only the year of birth instead of the full date, only the urbanity level of the place of residence instead of the postal code). It is also no longer possible to retrieve any of the original information of the unique identifier code. From the central database, neither participating clients nor services can be identified.

Organisation of data collection

In order to preserve the links developed in the frame of the former five monitoring systems between the treatment services or centres and the research institutes managing the data collected, the existing general structure of the previous systems was maintained. This structure consists in five distinct sectors (see above) each collecting the data under the lead management of the respective research staff affiliated to specialised research institutes (Swiss Institute for the Prevention of Alcohol and Other Drug Problems, Research Institute for Public Health and Addiction, and the Department of Social and Preventive Medicine, University of Berne). The participating treatment services or centres have to send the data collected during the year to the research institute in charge of the implementation of act-*info* in their treatment field. The research institutes are responsible for data collection and for the elaboration of annual statistics. They are ultimately in charge of selecting and transferring the core data set to the central database hosted by the Swiss Federal Office of Public Health, that coordinates and funds the whole project. The method of collecting data in the services and treatment centres takes different forms, according to the routines implemented in the different sectors (paper forms, electronic forms, online data entry).

Valorisation and dissemination of the results

In order to guarantee an optimal dissemination of the results, various annual standardized reports are produced. First, each participating treatment service or centre receives a confidential report that offers an overview of its own activities. Second, an exhaustive statistical report for each specific treatment field is published. These two types of reports are based on both core and optional items and are elaborated by the research institutes in charge of the implementation of act-*info* in the different sectors. Finally, information on the whole addiction care field are provided by the Swiss Federal Office of Public Health through the publication of an annual report and of fact sheets based on the core items included in the common central database.

Initial experiences in the treatment fields

The implementation of the harmonised monitoring system is an ongoing process that began in 2003 in the inpatient sector treating drug-related problems. Switching to the new system was relatively easy in the three sectors using in the past only paper forms. Following its introduction through information meetings, the old forms were replaced by the new ones and the move could be realised without significant problems. After the first 18 months of using the new instruments as paper forms, the inpatient sector for drug-related problems introduced an online solution for the interested centres, and now 2/3 of these centres are already reporting online. Having a long tradition in collaborating in research projects and monitoring activities, the acceptance of act-*info* was high in this sector and no change in the coverage (85–95 % of the centres) was observed. With similar pre-conditions, this was also the case in the inpatient sector treating alcohol-related problems and the coverage stood also on its previous level (75 % of the centres). Since data collection is still obligatory in the heroin-assisted treatment programs, full coverage is performed in this sector.

The implementation of the new monitoring system in the outpatient services and in the methadone substitution sector is obviously more challenging, since the differences induced in relation with the new instruments are more salient.

Since the beginning of the monitoring activities (1994), the outpatient sector was provided with a software tool (free of charge), performing not only data entry for statistical purposes but also a variety of useful tasks for the services. This software tool was in principle the key motive behind the participation in the previous monitoring system and was appreciated for the management of administrative and statistical tasks. As the new monitoring system did not provide such a tool but only a data entry application, the acceptance of the new system was not very high after its official launch in 2004 with an

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initial participation by less than 20 % of the services (against 35–45 % in the past). In fact, several outpatient services provisionally abandoned their monitoring activities, waiting for a better alternative to come. According to the general concept, the development of multipurpose tools including the act-*info* forms is left to the free market, but highly promoted by providing act-*info* modules or programming specifications that can be easy implemented in modern software solutions. Participation is now growing rapidly in this field, since multipurpose tools are available recently. Moreover, some services which did not participate in the old monitoring system could be convinced to join the new network because of its overall implementation.

Finally, there were special conditions for the implementation of act-*info* in the field of methadone substitution treatments. First, the primary registering system had only a small number of items and there is some resistance to collect more information. Second, the original items were often embedded in official forms of the individual cantonal administrations. Changing these forms implies complex processes that involve each of the cantonal authorities. As a first step, some of the data collected since 2004 and being already compatible is converted into the new norms to ensure its integration in the general database.

Discussion

The implementation of a harmonised monitoring system for the treatment of substance-related problems in Switzerland intended to replace five different previous systems in an ongoing process that began in 2003 in the inpatient sector treating drug-related problems. Since January 2005, the new reporting system is fully implemented in three out of five sectors. It is already broadly implemented in a further sector (outpatient facilities), whereas the sector of methadone substitution, that collects basic administrative data from cantonal instances, is still dealing with delays regarding the implementation of the new instruments by the cantonal authorities. Nonetheless, considerable efforts are undertaken to include the available data into the common database and to promote the act-*info* standards. Taking the diversity of the treatment approaches and of the modalities of the previous monitoring systems into account, this harmonisation process proves a complex undertaking. In order to comply with the specific needs and interests of the various treatment fields, a flexible frame of functioning was established. The concept consists of a common body of items (core items) that complies with the European standards designed for the documentation of drug-related treatments (Treatment Demand Indicator). This common base is enhanced by a pool of standardised optional items that can be added on for the specific requirements of each treatment field.

To allow the identification of different treatment episodes from a same person without breaking prevailing rules in terms of data protection, a complex method of non-reversible encryption has been adopted.

A general limitation of the monitoring system is its reliability that can hardly be assessed. Numerous social workers or therapists with different styles and motivation are involved in data collection and only both inpatient sectors provide training to the personnel involved. For the other sectors, accurate training of all persons involved is more difficult to organize. A further way to improve reliability can be performed by automatic checks assisting the data entry. So, the online system of data collection in the inpatient sector treating drug-related problems enables the immediate detection of logical errors, so that they can be directly corrected by the centre.

Therefore, particular care has to be devoted to the instruments that have to be as unambiguous as possible in their content and as ergonomic as possible in their handling. act-*info* is intended to become a stable monitoring system. Nevertheless, the feedback from the field is important to improve all levels of functioning. The pertinent remarks concerning the instruments are collected and will be considered for a first update. Also the analyses of the first data collected will be an important source for detecting possible problems (lack of precision of the response categories, possible inadequacy of some questions according to the respective treatment field, etc.). Improving these aspects after the first years of application will be an important step to increase both validity and reliability.

A main challenge of the implementation of the new system is its coverage, since the participation remains free for the overwhelming majority of the services. The participation proves to be good enough in three out the four sectors already collecting data with act-*info* (2005: 100 % coverage in the field of heroin-assisted treatment, 95 % or 53 of 56 facilities in the inpatient sector treating drug-related problems, and 75 % or 15 of 20 centres in the inpatient sector treating alcohol-related problems). On the other hand, the sector of the outpatient services had provisionally to deal with a poor starting participation (18 % or 41 out of the 231 existing services in the first year of implementation). However, in view of the still large number of cases surveyed in this sector (more than 3,000 in the first year of implementation), important bias in the results due to participation effects can be seen as unlikely. According to DeVillaer [8], the principal expected causes for resistance to join a reporting system are the increase in administrative work for staff, the little interest for quantitative approaches in the field and the uncertainty of the purpose for which the

data would be used. In this context, participation can only be enhanced if the true benefits in taking part can be influenced favourably. In this respect, efforts could be undertaken on different levels. Promoting the integration of the instruments into the treatment process as a flexible tool for client assessment and treatment planning in order to integrate both therapeutic and research interests [18] is an important topic. Providing or promoting well-designed computer solutions performing various assisting or administrative tasks additionally to data entry represents a further path for enhancing the support given to monitoring activities in the outpatient sector. In addition, delivering prompt and high-quality statistical reports to each participating treatment service or centre offering an overview of their own activities and the related treatment field should also play a crucial role in extending the attractiveness of act-*info*. The main lessons learned from the harmonisation process are summarised in Table 3.

Regarding the costs of such a monitoring system, the question of alternative ways of surveillance addressing the same issues should be considered. A possible alternative would consist in the selection of a representative sample of services or centres involved in the monitoring. However, under the conditions prevailing in Switzerland (small country, decentralised organisation of the addiction care supply, voluntary participation), selecting a sample does not seem being promising since the question of participation would still remain unresolved, and the number of cases would probably become very critical for accurate analyses (e.g. patterns of use among clients having never been treated before). Moreover, monitoring a sample instead of all possible treatment facilities would not result in significant cost savings since only the amount of data to manage would be reduced but not the whole infrastructure needed.

Table 3 Lessons learned from the harmonisation process

- To look for comparability with earlier instruments and international standards seems to be essential for establishing a valuable and informative monitoring system.
- Adopting a flexible and evolutionary system with core items for the shared database and optional items for the specific needs of the different treatment sectors proves being a solution bridging both public health and supply interests.
- Pilot experiences prove to be essential to identify potential difficulties on all levels of application (clear wording of questions and response categories, length of the forms, adequacy of software tools, etc.).
- Providing a high level of data protection is a crucial condition for the acceptance of a database managed by state instances.
- Changes seen as a progress by statisticians may be perceived inversely by the field. So, applying longer forms than the previous ones is likely to trigger resistance.
- Considering the specific interests and needs of the field regarding feedbacks, reports, supports and software options may be a key issue for improving participation.

Conclusion

All in all, the implementation of act-*info* can be seen as an important step for enhancing the availability of comprehensive and comparable data on the profile and the needs of the clients treated in all sectors of the addiction care supply in Switzerland. The existence of such a monitoring system represents a key prerequisite for the development of evidence-based intervention in this field. Facilitating access to the information collected by act-*info* in order to strengthen its relevance to practice remains a central aim of the project.

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