European Monitoring Centre
for Drugs and Drug Addiction

Current state of the DRID bio-behavioural data collection
Discussion on possible ways forward

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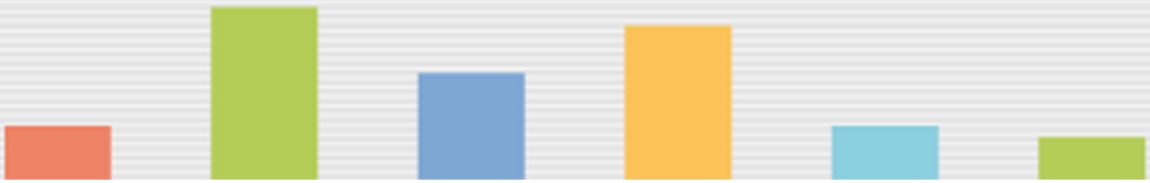
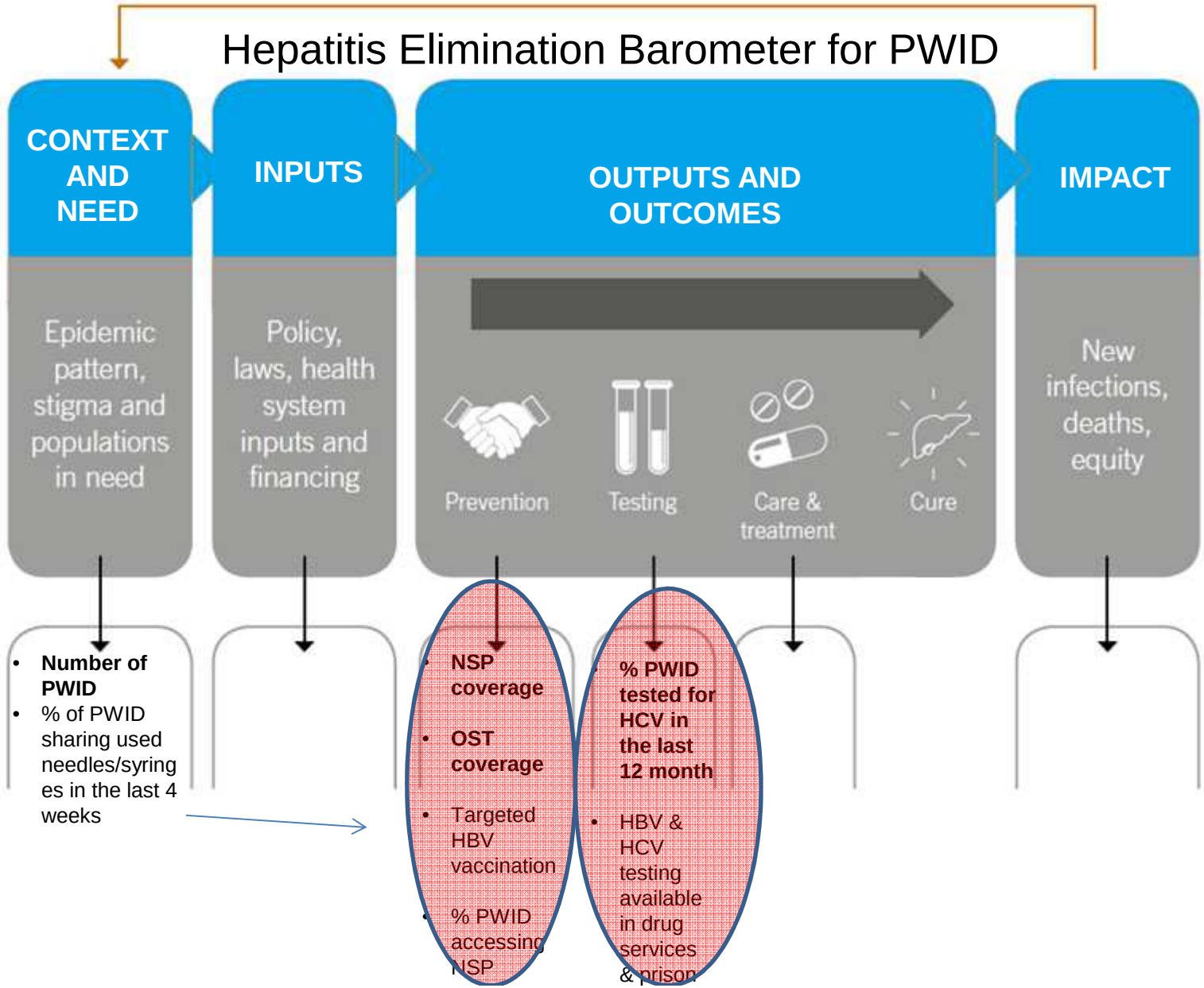
Session 6: – Behavioural data: Why and how to improve completeness and quality of the core data

DRID annual expert meeting - 24-25 September 2018



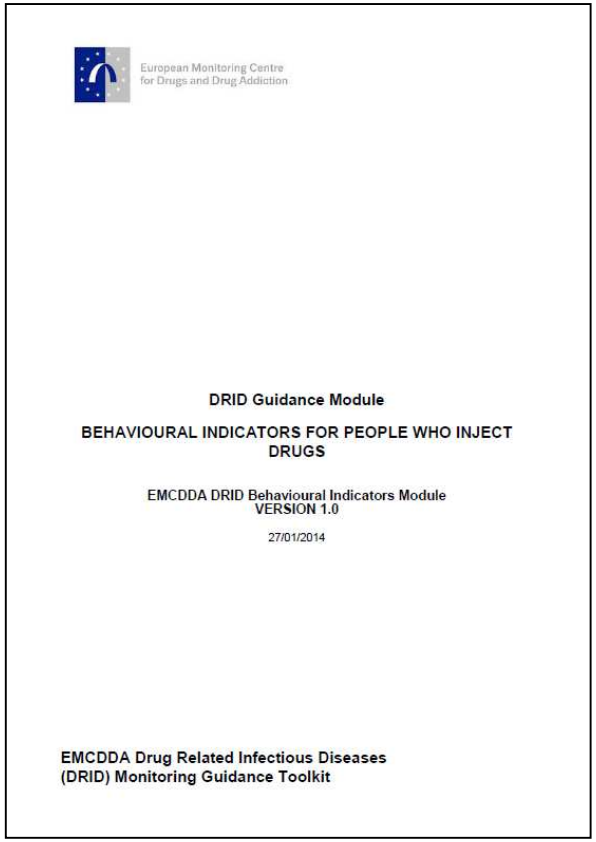
Why are behavioural data important?

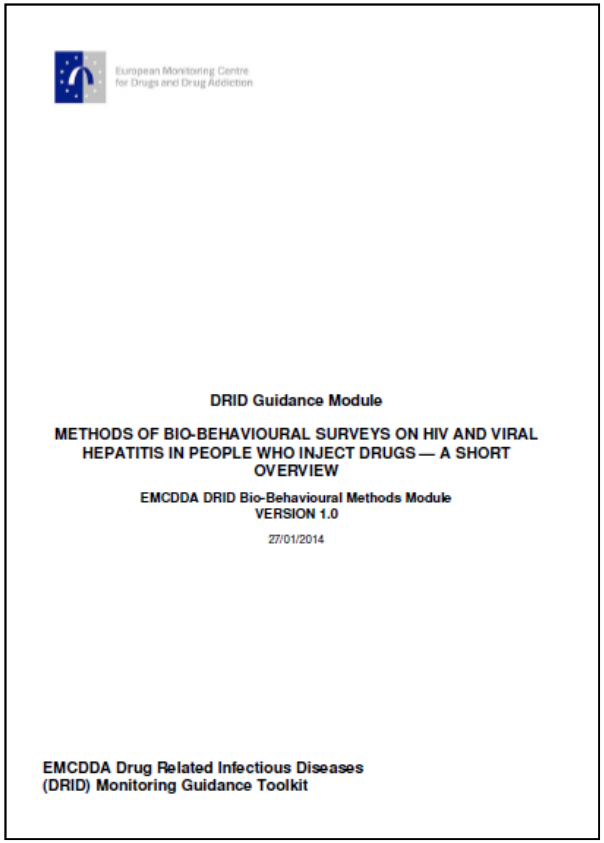


Why behavioural data are important?

- → 1 Indirect measure of NSP coverage, providing information on coverage of individual needs
- → 2 Reaches those who are not in treatment (thus completing the TDI data), e.g. drug users with more chaotic behaviours, homeless users
- → 3 Assess the trends and the possible impact of the interventions (or of their interruption)
- → Rapid (cheap, flexible) assessment of changes
- → in risk related to injection (e.g. changes related to stimulants – sharing, re using..)
- → in needs (quantity and nature of equipment needed..)
- → Early warning system on risk for outbreaks

EMCDDA tools for collection and reporting





Objectives of the DRID reference documents:

to propose a **set of indicators** that allow **comparable**, **reliable** and **policy relevant** data to be collected on behavioural and sociodemographic aspects of the epidemiology of blood-borne infections in IDUs in Europe.

Reference: DRID toolkit 2013-14.
Available from http://www.emcdda.europa.eu/activities/drid

Main focus : risk and protective factors

- → injecting risk behaviour
- → sexual risk behaviour

Risk factors

- → health services access
  - → blood-borne testing uptake
  - → sterile needle/syringe access
  - → drug dependence treatment access (opioid substitution therapy)

Protective factor

- → Socio demographic conditions: gender, age, homelessness or other risk factors for infection that allow the surveillance data to be contextualised

Main focus of behavioural surveillance (risk and protective factors)

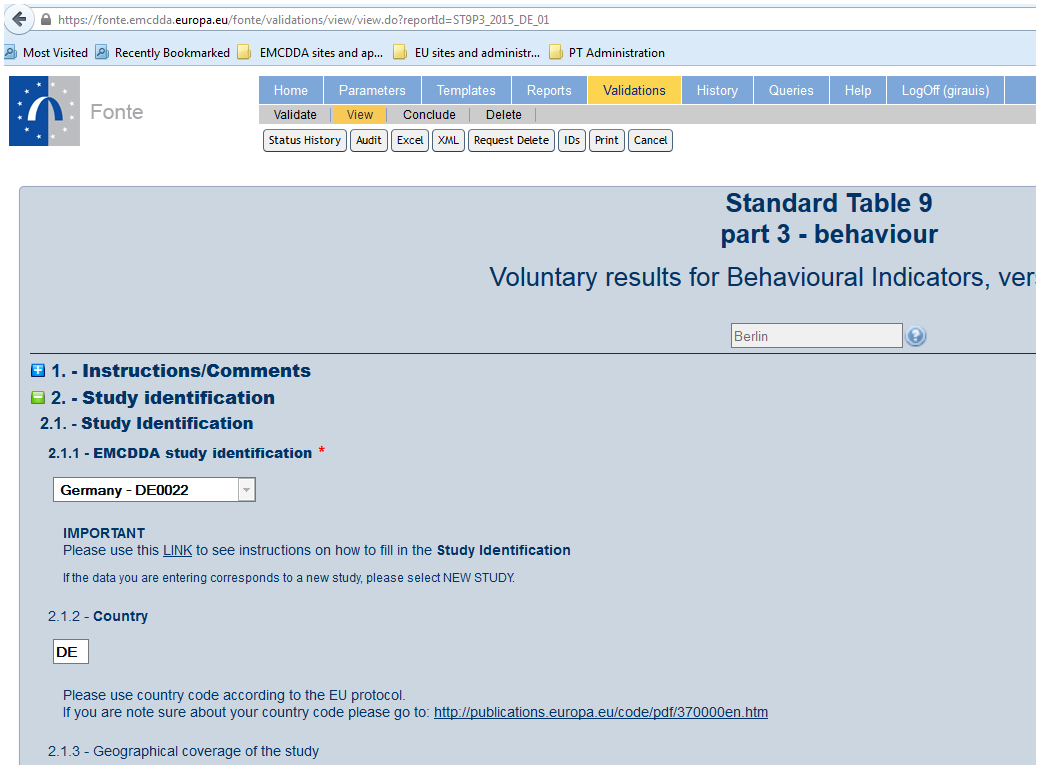
- → injecting risk behaviour
- → sexual risk behaviour
- → health services access
  - → blood-borne testing uptake
  - → sterile needle/syringe access
  - → drug dependence treatment access (opioid substitution therapy)
- → Socio demographic conditions: gender, age, homelessness or other risk factors for infection that allow the surveillance data to be contextualised

The core data: testing and sharing

Chart Area ing risk behaviour	Current IDUs	Indicator C1	% sharing used needles/syringes in the last 4 weeks (receiving or passing on)
		Indicator C2	% sharing any used injecting paraphernalia in the last 4 weeks other than needles/syringes (using together, receiving or passing on).
Blood borne virus testing uptake	Ever-IDUs excluding known positives	Indicator C3	% who received an HIV test in the last 12 months.
		Indicator C4	% who received an HCV test in the last 12 months.

Data collection →reporting

- Data is collected by EMCDDA through part 3 of Standard Table 9 for those studies providing prevalence data
- Testing and injection data is also collected through the TDI indicator



Completeness and what do the data tell us

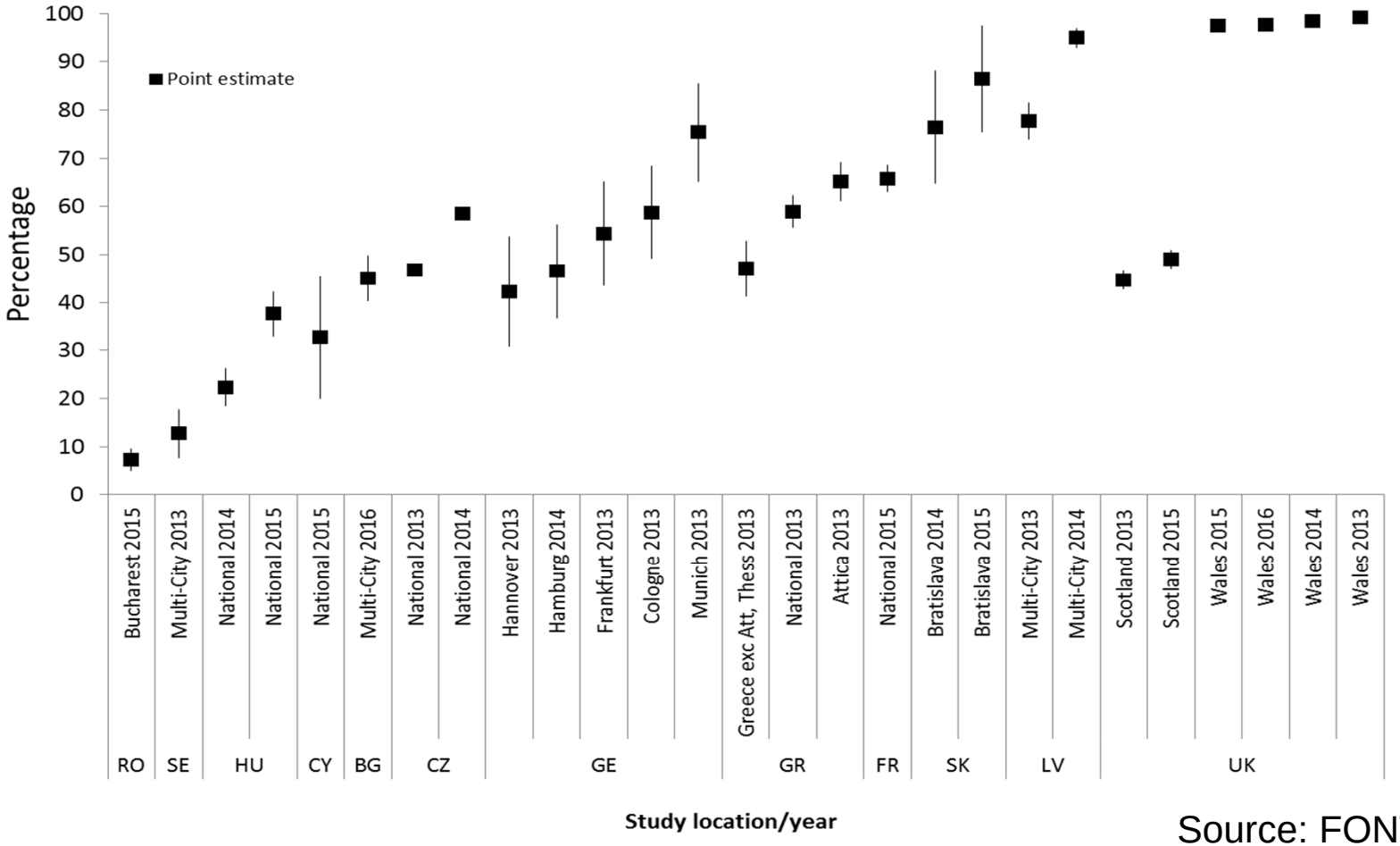
- Reports using ST9 - ~1/3 countries*
- Reports using TDI ~2/countries

Reference: Joint DRID TDI meeting, 2016. L. Montanari

Country	HIV testing		HCV testing		Sharing	
	DRID	TDI	DRID	TDI	DRID	TDI
Austria		√		√		√
Bulgaria	√	√	√	√	√	√
Croatia		√		√		√
Cyprus		√		√		√
Czech Republic	√	√	√	√	√	√
Estonia					√	√
Finland		√		√		√
France		√		√		√
Germany	√		√		√	
Greece	√	√	√	√	√	√
Ireland						√
Hungary	√		√		√	
Latvia		√		√	√	√
Lithuania	√				√	
Luxembourg		√		√		√
Malta		√		√		√
Poland		√		√		√
Portugal		√		√		√
Romania		√		√		√
Slovenia		√		√		√
Slovakia			√			√
Spain		√				
Sweden	√	√	√	√	√	√
Uk	√	√	√	√	√	√
Turkey		√		√		√
Total	**8**	**19**	**7**	**18**	**10**	**21**

Results: Testing

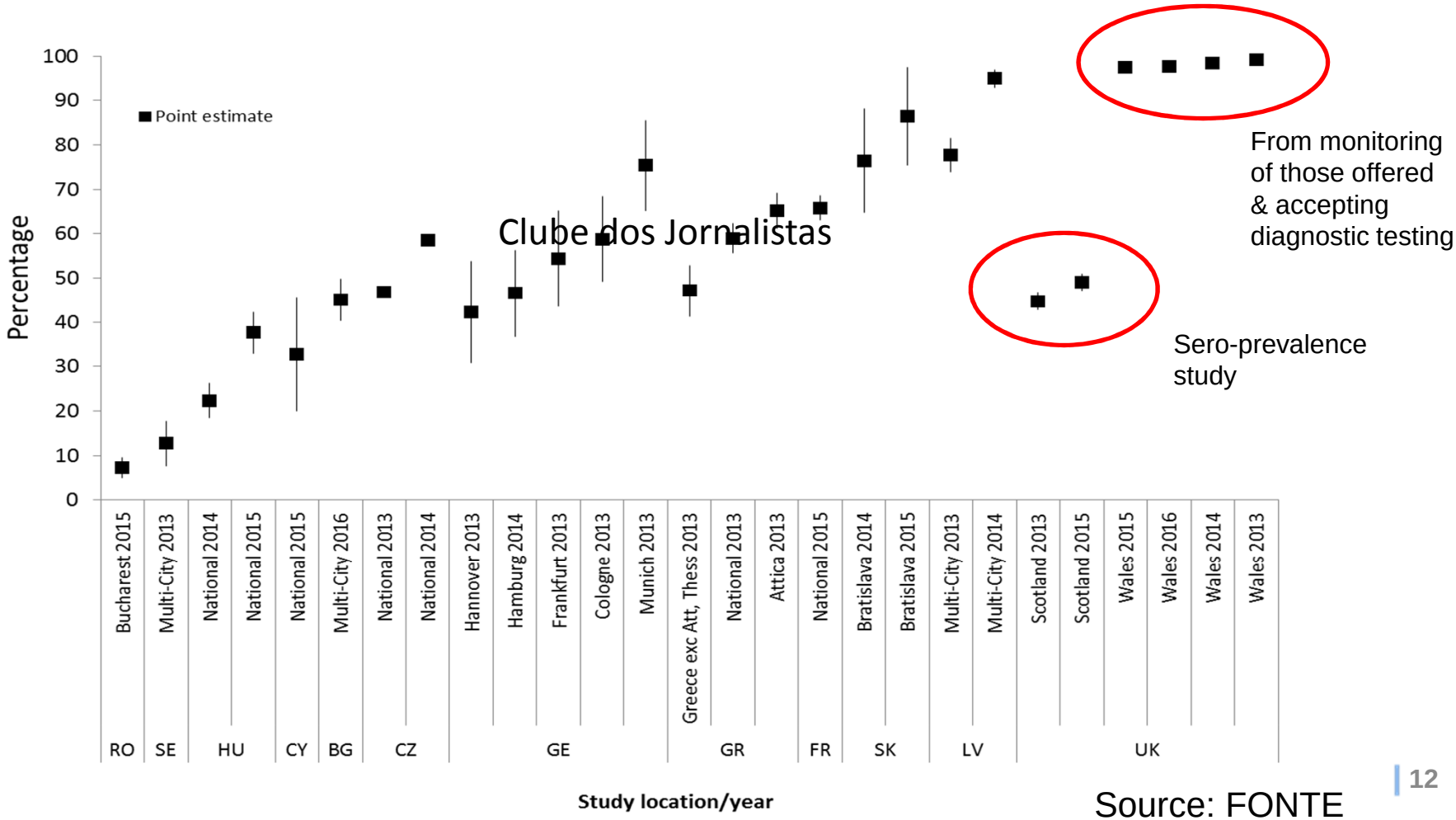
- Percentage of PWID (excluding known HCV-infected) reporting a HCV test in the last 12 months, European studies, 2013-16



Source: FONTE

Results: Testing (Something to note).

- Percentage of PWID (excluding known HCV-infected) reporting a HCV test in the last 12 months, European studies, 2013-16



Source: FONTE

Scoping options to strengthen DRID data collection: "DRID 2020"

This piece of work broadly explored a range of issues related to developing the DRID key indicator and to support EMCDDA in preparing DRID for the world as it is likely to be in the 2020's.

This scoping activity was based on reflective discussion with EMCDDA about the behavioural data collection.

Should the behavioural data collated form sero-surveys be reduced to a few core items?

Currently there are 21 items in the of ST9 part 3, these included four ‘core’ indicators. However, even these are only reported by one-third or less of the countries.

Suggested action:

EMCCDA to review the current ST9 part 3 with the aim of focusing more on robust indicators of the core items on risk behaviour and intervention uptake.

This should ensure these are aligned with the monitoring needs of the Global Viral Hepatitis Strategy (but reflect other infections incl. HIV and bacterial ones).

Should EMCDDA consider implementing a tool for the collation of behavioural data from standalone behavioural 'surveys'?

It is already possible to report behavioural data using ST9 Part 3 (behavioural data) even if there are no corresponding biological data in ST9 Part 2 (prevalence), however, this is not being done.

Suggested action:

Once EMCDDA has reviewed the current ST9 part 3, countries should be more actively encourage to report data from other appropriate sources particularly data from simple behavioural surveys and/or the routine monitoring of service activity (not reported thtrough TDI).

This could, for example, be facilated by making ST9 part 3 a 'standalone' tool.

Should EMCDDA advocate for regular short simple behavioural surveys (with common data items) in low threshold services (i.e. services not reporting to TDI)?

These would increase the amount of behavioural data available and could be delivered for relative little cost. A template data collection tool might optimise usefulness for European monitoring.

Suggested action:

EMCDDA should explore this with countries and identify one or more Member States interested in piloting. This should align with any revisions to the behavioural data collection through ST9.

This would involve developing a brief ‘high level / overview’ protocol for quick short behavioural only surveys (drawing upon existing DRID resources), accompanied by short ‘template questionnaire’ that assess eligibility as well as collecting key data.

The development of an online survey site with integrated summative feedback reporting to both countries & EMCDDA could also be explored.

Suggested data items for survey & DRID Behavioural monitoring:

Suggested data items for survey, those in **bold are** suggestion for core DRID behavioural items:

Demographics: age, gender, and imprisonment, homelessness.

Drug use & injecting equipment: **main drug(s) injected, injection frequency** (past month/week), **number of needles obtained** (past month/week), **and equipment sharing** (as now)**.**

Infection related: **uptake HIV and HCV testing** (TDI format)**,** and HBV vaccination.

Optional DRID items: receipt of OST or drug treatment, access to HIV and HCV treatment, injection site injuries & infections, and use of other health services.

Other optional items: items of other areas drug related farm, such self reported overdose and Naloxone, could also be considered.

So three questions for us to explore?

1. Should EMCCDA undertake a review ST9 part 3 data items?
2. Should EMCCDA work to modify ST9 part 3 to make it easier to complete for behavioural only studies?
3. Should EMCDDA explore developing a package of tools to support DRID behavioural data collection through behavioural surveys?

Perspectives from 4 countries

Germany – Ruth Zimmermann

Hungary – Anna Tarján

Slovakia – Zuzana Kamendy

France – Anne-Claire Brisacier

More on testing→

- Behavioural data

Sharing injection material

Data on needle and syringe sharing was explored – though recent data on this risk is available from a number of countries, a range different definitions are used making comparison impractical.

Nine countries had recent data using the EMCCDA case definition, but only for four was this national level data.

Reported sharing levels varied between 1% and 43%.

However, the study designs varied, and so the compatibility of this data is not clear, as quality of self-reported data can be affect by the data collection processes, due to these effecting recall and disclosure biases.

Only six countries had time series using the EMCCDA definition.

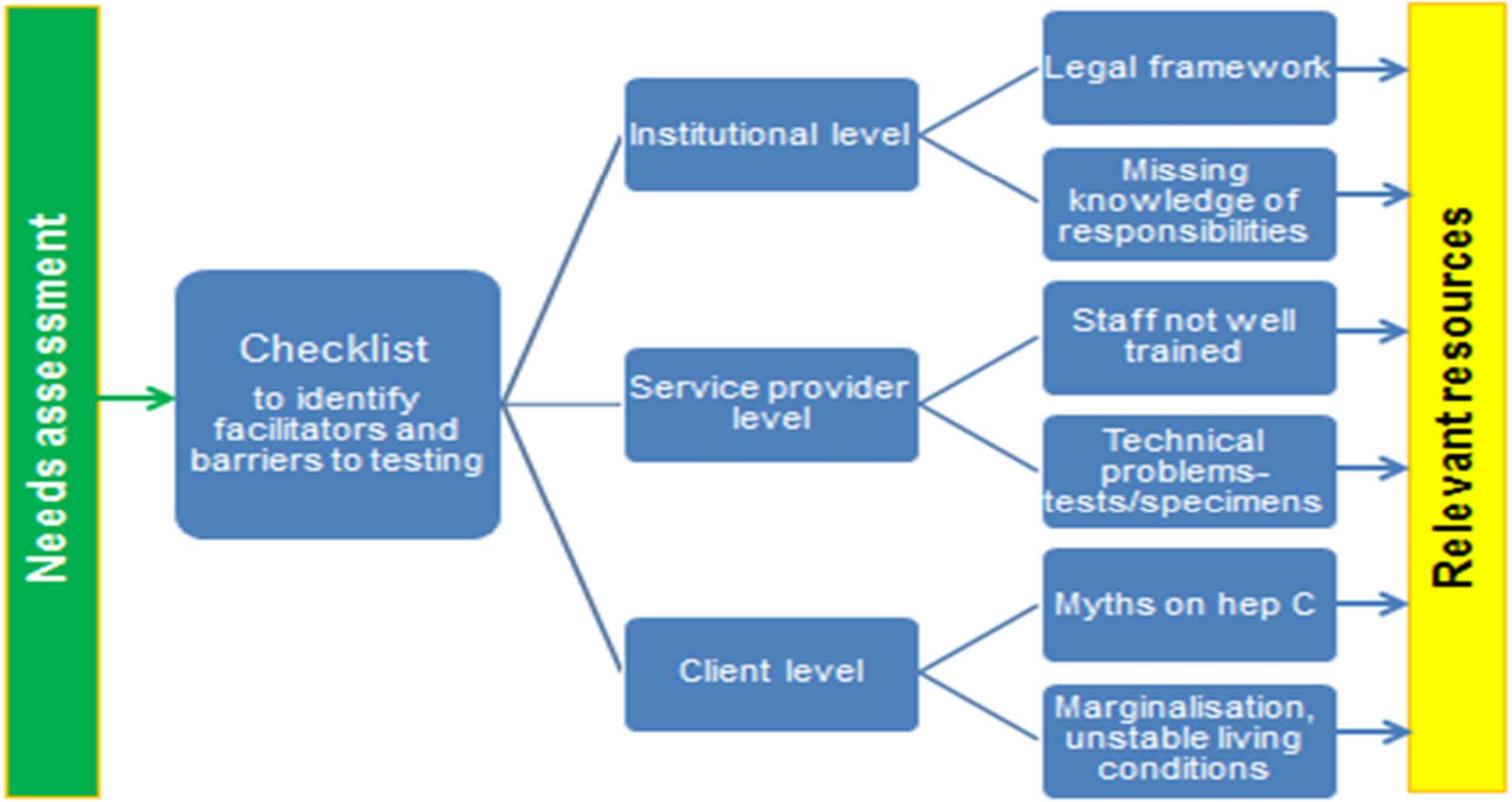
Available sources on testing and on sharing

	Strengths/potential	Limitations
DRID	• Local studies at regional/city level, valuable for local risk assessments • Trends available (repeated studies) • Various settings and various inclusion criteria providing a rich picture	• Missing in many countries • No national testing data • A selection (bias) of those in contact with services • Various settings and inclusion criteria
TDI	• Quite good coverage as could be included in the routine data collection for each patient • Robust – systematically collected • Sustainable • Should be available in many countries	• Still not all countries and not full coverage • Data quality issues • Testing and sharing data just 2 years of data – no trends

TDI ver. 3.0	DRID
HIV - HCV Testing **•never tested** **•ever tested** ❑tested, but not in the last 12 months ❑tested in the last 12 months **(all clients – not only injectors)** **Needles/Syringes sharing** **•never shared a needle or syringe** **•ever shared a needle or syringe** ❑ shared but not last 12 months ❑ shared last 12 months, not in the last 30 days ❑ currently shared (last 30 days) ever injectors	**HIV - HCV Testing** •last 12 months •% ever-IDUs who received a test excluding from numerator/denominator ❑ *known HIV+* ❑ *known or self-reported HCV+* **Needles/Syringes sharing** •last 4 weeks •current IDUs sharing used needles/syringes (receiving/passing) •current IDUs sharing any used injecting paraphernalia other than needles/syringes (using together, receiving or passing on)

Identifying barriers to testing of PWID

Diagnostic process/ mechanism concept



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