

# **Minimum Quality Standards in Drug Demand Reduction EQUS**

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**Final report**

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## **Executive summary**

### *Project objective*

The main objective of the EQUUS project, as set out in the call for tenders, is to collect existing national and international information on quality standards and benchmarks in drug demand reduction, to set up an inventory of these standards and benchmarks, and to extract from the inventory lists of minimum quality standards to be submitted to a range of relevant stakeholders for approval. The result is intended to facilitate a quality awareness and improvement process throughout the EU Member States.

The various elements of the project are summarised as follows:

- a. To describe the background and the tasks of the project
- b. To describe the methods used for developing the inventories
- c. To describe the consensus building process for the final results of the project
- d. To outline problems and perspectives for the implementation of the proposed minimum quality standards at European level
- e. A summary of project results

### *Background*

All approaches to drug demand reduction have expanded and diversified considerably during the last two decades. New intervention types are developed and evaluated, new settings are included in the treatment and prevention networks, special target populations have gained more attention. A main focus was and is on capacity building in order to reach out to those in need of interventions and to increase coverage of prevention, treatment and harm reduction services. However, services must be of good quality in order to be effective. The quest for quality standards is essential. Using available knowledge from research evidence on «what works», overriding discriminatory and negative attitudes towards people with substance abuse problems, respecting human rights and medical ethics are all part of quality. But while research evidence on efficacy and effectiveness of interventions is growing and can be accessed through reviews and guidelines, a consensus on quality standards still needs to build up.

The European Action Plan on Drugs 2009-2012 agreed by the EU member governments therefore asked the European Commission to develop an EU consensus of minimum quality standards in the field drug demand reduction. To underpin its work, the European Commission (DG Justice) contracted the Swiss Research Institute for Public Health and Addiction (ISGF) to carry out a study to collect information on quality standards and benchmarks in Member States and to propose options for minimum quality standards for drug demand reduction.

The options proposed by the ISGF consist of the three lists of proposed minimum quality standards in drug prevention, treatment/rehabilitation and harm reduction, and of reflections and recommendations for the implementation of those standards.

The project contract did not envisage new research to develop best-evidence or best-practices in those areas where this is not already available.

The list proposed by the ISGF describes quality standards at the intervention level (mainly of interest for professionals working in prevention, treatment and harm reduction services), at the service level (mainly of interest for service directors) and at the system level (mainly of interest for policy planners and managers).

This project is understood as the start of a longer term consultation process with stakeholders to build a consensus on minimum quality standards for drug demand reduction interventions and services which EU Member States have or are planning to implement in their own country.

It is important to note that the project gives no information about the benefits of any specific service or intervention in the field of drug demand reduction, or about the acceptability of implementing those, but only on the acceptability of minimum quality standards in case a specific intervention or service is already implemented or will be implemented.

### *The tasks of the project*

The tasks were presented in the call for tenders and formed the core of the work plan of the project. They are:

- To establish an expert group consisting of Commission, EU and international experts with ample experience in the implementation and evaluation of demand reduction interventions as well as the formulation and application of quality standards for interventions and services in this field.
- To identify, map and review existing quality standards and benchmarks in drug prevention, early detection and early intervention, treatment, harm reduction and social rehabilitation and reintegration in EU Member States and/ or at European and/ or international level, and to provide a gap analysis for those areas where these do not exist so far.
- To propose and help set up a consultation and consensus building mechanism for relevant stakeholders at EU level.
- To develop a design for a framework of quality standards and benchmarks, identifying the structure, key aspects, type and level of specification/ detail of these standards and benchmarks. This design should also reflect on potential risks, uncertainties and other factors that may be of importance in the design of quality standards at EU level.

- To apply this framework by populating it with options and suggestions for quality standards and benchmarks and which can form the basis for discussions between experts and policy makers in this area.
- To prepare a set of working papers on each of the relevant areas, which are to be prepared before and discussed during two seminars for experts to be organised in cooperation with the European Commission in the course of 2010.
- To draft – on the basis of the feedback received – an overall working document for a European Conference for policy makers, researchers and professionals to be organised in 2011.
- To prepare for the Commission a final report consisting of options on EU minimum quality standards and benchmarks in the field of drug demand reduction.

### *Methods used for developing the inventories*

In the fields of treatment/rehabilitation and harm reduction, the collection of relevant documents for setting up the inventory of existing quality standards and benchmarks (task 2) was organised in collaboration with a range of experts (task 1) as project partners. They received detailed instructions for the selection of relevant documents and for transmitting structured information from these via on-line templates to a central electronic file at the coordinating institute.

In the field of prevention, another European project carried out by John Moores University Liverpool in collaboration with EU partners had already performed a search of relevant documents and extracted quality standards.

### *The consensus building process*

Treatment/rehabilitation and harm reduction: On the basis of the inventory, a set of quality standards (24 for treatment/rehabilitation, 25 for harm reduction) was extracted and submitted to the collaborating project partners in an expert seminar and then to 514 stakeholders from all Member States in two on-line surveys. The participant stakeholders rated the proposed standards as already implemented, acceptable without problems, acceptable with problems or unacceptable. The ratings resulted in separate lists of minimum quality standards with high consensus of acceptability (<80% of acceptance), with moderate consensus (50-80% of acceptability) and low consensus (>50% of acceptability).

The stakeholders participating in the European Conference on the EQUUS project (Brussels, June 15-17 2011) discussed these lists and some modifications. The resulting final list of proposed minimum quality standards and benchmarks is added at the end of this executive summary.

Prevention: A consensus building process including Delphi surveys and focus groups was part of the above mentioned project.

## *Problems and perspectives for the implementation of the proposed minimum quality standards at European level.*

The questionnaire for the on-line surveys included questions about the expected implementation problems (political, professional, legal, ethical, financial problems). The results were presented at the European Conference, and examples of establishing good quality systems at national level were explained. The debate pointed out a general consensus that there is no major opposition against implementing minimum standards and benchmarks, but that further steps at national and regional level must follow to bring the consensus building process and the implementation of minimum standards further ahead.

### *A summary of project results*

The work plan could be realised step by step as it was proposed in the tender. The highly qualified expert group contributed, in addition to collecting and screening the relevant documents, by making some methodological adjustments and by participating actively in the consensus building process. A well documented list of proposed minimum quality standards resulted; problems and models of implementation could be explored and recommendations for further steps presented.

The final list of experts collaborating in the project (task 1) contains overall 52 experts from 25 countries.

The inventory (task 2) contains 350 documents (260 for treatment/rehabilitation, 90 for harm reduction) from 27 countries

The provisional list of quality standards and benchmarks, extracted from the inventory, contains 78 standards (prevention 29, treatment/rehabilitation 24, harm reduction 25)

The two on-line surveys of stakeholders were answered by 241 professionals (47% of 514 invited stakeholders) from 20 countries

128 stakeholders from 34 countries participated in the European Conference on the EQUUS project

The *final list of proposed minimum standards* contains 33 standards for prevention, 22 standards for treatment/rehabilitation and 16 standards for harm reduction ; no benchmarks are identified.

## *Next steps*

The list of proposed minimum quality standards are recommendations addressed to the European Commission to underpin its work on a proposal for an EU consensus on minimum quality standards, now planned for 2013.

European level minimum quality standards will need to add value to what exists in the EU member states and take account of different health systems and capacities across Member States.

Political choices still have to be made and further research carried out to strengthen available the evidence base as described in the gap analysis.

It is highly recommended to continue the consensus building process with stakeholders, in parallel to the political decision-making process, to promote a common understanding of the need and objectives of the proposed quality standards in the field of drug demand reduction.

As an incentive and to encourage the consensus building process at national and EU level, the European Commission has confirmed that will propose EU funding for such initiatives under its Drug Prevention and Information Programme 2012 as well as funding for further research to support the evidence base of the quality standards.



## **EQUS List of Minimal Quality Standards**

(comments and exceptions are inserted in chapter 6)

### ***a. Prevention standards***

#### ***Prevention: Structural Standards of Services***

- P1 Ethical principles: adherence to ethical principles (e.g. service must protect participants' rights, provide services/interventions that have clear benefits for participants, must not provide a service/intervention where evidence shows that it could harm participants (e.g. increase drug use, stigmatise participants))
- P2 Policy and legislation: reference to drug-related policy and legislation as required for the implementation of the service/intervention
- P3 Routine cooperation with other agencies: the organisation cooperates with other agencies and institutions in correspondence with the multi-service nature of drug prevention (e.g. health and social services, criminal justice services, educational services)
- P4 Financial requirements: a clear and realistic cost estimate is provided; available funding streams are sufficient to cover costs
- P5 Internal resources and capacities: sufficiently available for implementation (e.g. human, technological, financial resources)
- P6 Staff composition: transdisciplinarity and qualifications of staff are appropriate for the service (e.g. type of roles, number of staff, level of education)
- P7 Staff support: staff members are supported in their work as appropriate

#### ***Prevention: Process Standards of Services/Interventions***

- P8 Ethical standards: adherence to ethical standards (e.g. intervention is only carried out if there is a need for it, procedures in place to ensure informed consent, confidentiality, protect safety of participants and staff members, information about drugs and related behaviours is accurate where it is provided)
- P9 Assessment procedures: detailed and diverse information on drug use in the community/target population/environment of interest has to be collected through primary or secondary study (e.g. types of drugs used, drug use rates and trends)
- P10 Assessment procedures: target population's culture (1. relation to drug use, 2. relation to the service/intervention activities) has to be assessed

- P11 Assessment procedures: other relevant characteristics of the community/target population/environment have to be assessed (e.g. cognitions, attitudes, risk behaviours, criminality, social status, drug availability)
- P12 Assessment procedures: target population and community readiness for the service/intervention has to be assessed (e.g. sources of opposition or support)
- P13 Assessment procedures: gaps in current service provision have to be assessed
- P14 Stakeholder involvement: all stakeholders relevant to the service/intervention are involved in its development and implementation as required (e.g. target population, other agencies)
- P15 Sustainability: long-term strategy for drug prevention or wider health promotion (all activities form part of the long-term strategy)
- P16 Goal definition: service/intervention goals are specific, realistic and informed by assessment procedures (e.g. what types of drug use or behaviours are targeted)
- P17 Service/intervention design: the service/intervention is based on a scientifically derived understanding (theoretical models) of drug-related behaviours and behavioural change
- P18 Service/intervention design: the service/intervention is evidence-based (it is based upon the findings of novel or existing literature reviews on scientific evidence of effectiveness, or professional experience where reviews are not available)
- P19 Service/intervention design: services/interventions are tailored according to individual and population characteristics (e.g. language, activities, messages, timing, number of participants)
- P20 Service/intervention design: criteria for end of the service/intervention are defined (e.g. goals achieved, mandatory number of sessions completed, number of participants reached, duration of the intervention)
- P21 Service/intervention design: service/intervention activities are feasible and internally consistent (e.g. activities are linked to objectives, target population is chosen in line with needs assessment, target population can be reached, setting is suitable for good functioning)
- P22 Adaptation: existing interventions (e.g. manualised programmes, service models implemented elsewhere) are adapted considering the differences between the original and the actual circumstances (e.g. target population characteristics)
- P23 Staff training and development: those delivering the service/intervention (e.g. staff members, teachers, parents, former drug users) have the competencies which are required for a successful implementation

- P24 Recruitment: participants or participating units (e.g. schools, communities) are drawn from the defined target population
- P25 Implementation: a systematic project plan exists in writing (e.g. including main service/intervention elements and procedures, risk assessment and contingency plans)
- P26 Implementation: the implementation is monitored and necessary adjustments identified (e.g. reviewing preliminary outcome and process data, project plan, resources)
- P27 Implementation: the service/intervention is implemented according to the project plan and adjusted in line with the monitoring findings
- P28 Process evaluation: the implementation is documented and explained (failures and deviations from the original plan, target population involvement, activities, service/intervention delivery, use of financial, human, and material resources)
- P29 Dissemination: a written and clear description of the service/intervention is made (at least partly) available to relevant groups (e.g. participants) before and/or during the service/intervention
- P30 Dissemination: information about the service/intervention is disseminated in an appropriate format (e.g. evidence briefings, report to funders, feedback to participants) at the end of the service/intervention

***Prevention: Outcome Standards at the System Level***

- P31 Goal of prevention: reduced drug use (prevention must be aimed at abstention, delayed drug use, reduced drug use, and/or prevention of dependence)
- P32 Evaluation: an appropriate evaluation is carried out as part of the service/intervention (e.g. outcome evaluation, process evaluation)
- P33 Evaluation: the service/intervention is continued on the basis of evidence provided by monitoring or evaluation

***b. Treatment/rehabilitation standards***

***Treatment/rehabilitation: Structural Standards of Services***

- TR1 Accessibility: location (service can easily be reached by public transport)
- TR2 Physical environment: adequate spacing for the activities in the service (e.g. service has separate rooms for individual counselling)

- TR3 Physical environment: safety (service is equipped for emergencies like e.g. management of overdose, fire or aggression on the premises)
- TR4 Indication criteria: diagnosis (treatment indication is always made on the basis of a diagnosis)
- TR5 Staff education: basic education (e.g. at least half of staff has a diploma in medicine, nursing, social work, or psychology)
- TR6 Staff composition: transdisciplinarity (e.g. service employs a multidisciplinary team composed of at least 3 professions)

***Treatment/rehabilitation: Process Standards at the Service Level***

- TRs7 Assessment procedures: substance use history, diagnosis and treatment history have to be assessed
- TRs8 Assessment procedures: somatic status and social status have to be assessed
- TRs9 Assessment procedures: psychiatric status has to be assessed
- TRs10 Individualised treatment planning (treatment plans are tailored individually to the needs of the patient)
- TRs11 Informed consent (patients must receive information on available treatment options and agree with a proposed regime or plan or a change of plan before starting treatment)
- TRs12 Written client records (assessment results, intervention plan, interventions, expected changes and unexpected events are documented complete and up to date for each patient in a patient record)
- TRs13 Confidentiality of client data (patient records are confidential and exclusively accessible to staff involved in a patient's treatment or regime)
- TRs14 Routine cooperation with other agencies (whenever a service is not equipped to deal with all needs of a given patient, an appropriate other service is at hand for referral)
- TRs15 Continued staff training (staff is regularly updated on relevant new knowledge in their field of action)

***Treatment/rehabilitation: Process Standards of Interventions***

- TRi7 Assessment procedures: substance use history, diagnosis and treatment history have to be assessed
- TRi8 Assessment procedures: somatic status and social status have to be assessed

- TRi9 Assessment procedures: psychiatric status has to be assessed
- TRi10 Individualised treatment planning (treatment plans are tailored individually to the needs of the patient)
- TRi11 Informed consent (patients must receive information on available treatment options and agree with a proposed regime or plan or changes of plan before starting treatment)
- TRi12 Written client records (assessment results, intervention plan, interventions, expected changes and unexpected events are documented complete and up to date for each patient in a patient record)
- TRi13 Confidentiality of client data (patient records are confidential and exclusively accessible to staff involved in a patient's treatment or regime)
- TRi14 Routine cooperation with other agencies (whenever a service is not equipped to deal with all needs of a given patient, an appropriate other service is at hand to referral)
- TRi15 Continued staff training (staff is regularly updated on relevant new knowledge in their field of action)

***Treatment/rehabilitation: Outcome Standards at the System Level***

- TR16 Goal: health stabilisation/improvement (treatment must aim at improvements or stabilisation of health)
- TR17 Goal: social stabilization/integration (treatment must aim at improvements of social stabilisation or integration)
- TR18 Goal: reduced substance use (treatment must aim at a reduction of substance use e.g. helping the client/patient to reduce the use or to abstain from illegal or nonprescribed psychotropic substances)
- TR19 Utilisation monitoring (services must report periodically the occupancy of treatment slots or beds)
- TR20 Discharge monitoring (e.g. ratio of regular / irregular discharges and retention rates have to be monitored periodically)
- TR21 Internal evaluation (services must regularly perform an internal evaluation of their activities and outcomes)
- TR22 External evaluation (services must regularly allow an evaluation of their activities and outcomes by an independent external evaluator)

### ***c. Harm reduction standards***

#### ***Harm Reduction: Structural Standards of Interventions***

- HR1 Accessibility: location and opening hours (services have to match the needs of their clients; costs should never be a barrier to a service)
- HR2 Staff qualification: minimal qualification (staff has to be qualified and the staff qualification has to be made transparent, e.g. amongst two trained peers involved in the service, two have a diploma in social work and further two in nursing)
- HR3 Indication criteria: age limits (1. Services have to be age appropriate and staff has to be trained to meet age appropriate clients needs, 2. There should be no age limits in harm reduction services)

#### ***Harm Reduction: Process Standards of Interventions***

- HR4 Assessment procedures: risk behaviour assessment (client's/patient's risk behaviour is assessed)
- HR5 Assessment procedures: complete needs assessment and prioritisation (e.g. 1. Harm reduction of intravenous drug use and, 2. Reduction of used syringes in public spaces etc.)
- HR6 Assessment procedures: client/patient status (the client's/patient's health status is assessed)
- HR7 Informed consent (Clients/patients must receive information on available service options and agree with a proposed regime or plan before starting an intervention. Interventions should not be based on written informed consent, but rather on a transparently information about all the offers by a service.)
- HR8 Confidentiality of client data (client/patient records are confidential and exclusively accessible to staff involved in a client's/patient's intervention or regime)
- HR9 Individualised treatment planning (intervention regime and intervention plans, if applicable, are tailored individually to the needs of the client/patient)
- HR10 Routine cooperation with other agencies (whenever a service is not equipped to deal with all needs of a given client/patient, an appropriate other service is at hand for referral)
- HR11 Continued staff training (staff is regularly updated on relevant new knowledge in their field of action)

HR12 Neighbourhood/community consultation (avoiding nuisance and conflict with other people around the service)

***Harm Reduction: Outcome Standards at the System Level***

HR13 Goal: reduced risk behaviour (reducing unsafe injections, unsafe drug use and unprotected sex)

HR14 Goal: referrals (treatment services must be prepared to refer clients/patients to other health/social/treatment/legal services if needed and agreed)

HR15 Internal evaluation (services must regularly perform an internal evaluation of their activities and outcomes)

HR16 External evaluation (services must regularly allow an evaluation of their activities and outcomes by an independent external evaluator)

## **1. Introduction**

Drug demand reduction approaches have evolved over more than 40 years, since the use of illicit drug use started in the late 1960ties. During this period, major changes in the concepts and methods occurred. Prevention developed into a highly professional activity, including health education as well as substance specific approaches in various settings (schools, workplace, recreational settings) and for various target populations (general public, populations at risk, people engaged in hazardous or harmful use). Treatment approaches have diversified, for specific substances, specific target groups, in a range of specialised settings and in primary health and social care. Harm reduction started as a reaction to the Aids epidemic, aiming at the protection of injectors against blood borne infectious diseases. In general, objectives moved from a primarily abstinence-oriented focus to an integrated view of offering appropriate interventions tailored to the needs of users, from emergency interventions and harm reduction measures for chronic users, to motivational interventions for those in need of behavioural change, to structured therapy for those in search of abstinence.

An inventory of available treatments for drug abuse and drug dependence in the European Union includes pharmacological and psychosocial approaches (Haasen 2008). Pharmacological methods are used in detoxification therapy, in opioid substitution therapy (mainly using Methadone and Buprenorphine as maintenance medications replacing illegal opioids) and in relapse prevention (mainly using Acamprosate and Naltrexone, an opiate antagonist, as medications in a maintenance regime). Psychosocial methods include cognitive behavioural therapy (e.g. contingency management and community reinforcement (especially for non-opioid abuse and dependence) and family therapy (especially for adolescent drug abuse); motivational enhancement methods are used to increase willingness to engage in treatment or as an adjunct during treatment.

An inventory of available harm reduction approaches and services includes needle and syringe exchange programmes, low threshold consultation and treatment services, drug consumption facilities and activities in recreational settings (Rhodes & Hedrich 2010). Data are available on effects and side-effects, on experience and comments from various stakeholders and on the various ethical aspects.

Diversification and accumulated experience made it necessary to systematise the know-how in these fields of action. Evaluation research was increasingly encouraged and funded, with an aim to provide guidance on “what works”, and an increasing number of reviews and guidelines helped professionals to keep themselves informed on evidence-based recommendations for their work. Evaluation methodology, review methodology and guidelines how to produce guidelines, were set up in order to guide this development. Cochrane and Campbell reviews are setting the standards for



reviewing outcome studies<sup>1</sup>, World Health Organisation has pioneered the development of international evidence-based treatment guidelines<sup>2</sup>.

In recent years, the debate on the quality of prevention, treatment and harm reduction systems has gained momentum. Standards can provide an important quality management tool for improving the effectiveness and efficiency of drug prevention programmes, drug treatment interventions and harm reduction services. A world-wide project of UNODC, designed to upscale evidence-based treatment facilities in 20 countries and to support the respective governments in developing national networks of community-based drug treatment centres and social services providers, has recently engaged in setting up standards for quality of care (UNODC 2011).

Quality as an issue in drug demand reduction activities was at first mainly envisaged in attempts to formulate good practice or best practice in prevention, treatment and harm reduction. As stated in the EU action plan on drugs 2005-2008, “effective dissemination of evaluated best practices” should be made available. The Directorate of Health and Consumer Affairs SANCO launched in 2006 a European project on models of good practice in treatment, and EMCDDA has collected relevant information from national Focal Points. The results are accessible via the science-based Best Practice Portal.<sup>3</sup>

In this context, EMCDDA has defined quality standards as «generally accepted principles or sets of rules for the best/most appropriate way to implement an intervention. Frequently they refer to structural (formal) aspects of quality assurance, such as environment and staff composition. However they may also refer to process aspects, such as adequacy of content, process of the intervention or evaluation processes».<sup>4</sup> The Best Practice Portal of the European Monitoring Centre for Drugs and Drug Addiction became an increasingly important resource for professionals, policymakers and researchers in the drugs field. The portal also provides an overview of the available quality standards and guidelines in the European Union (EU) Member States.

Improving the quality and effectiveness of prevention, treatment, harm reduction, rehabilitation and social reintegration is a priority under the EU Drugs Strategy 2005-2012.

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<sup>1</sup> For Cochrane reviews see [www.2.cochrane.org/reviews](http://www.2.cochrane.org/reviews); for Campbell see [www.campbellcollaboration.org/library](http://www.campbellcollaboration.org/library)

<sup>2</sup> Best example are the International Guidelines for psychosocially assisted pharmacological treatments of opioid dependence », Geneva 2008. They also include a list of minimal requirements. Another document jointly published by the United Nations Office on Drugs and Crime UNODC and World Health Organisation are the «Principles of drug dependence treatment, a discussion paper », Vienna and Geneva 2008. It summarises the state of knowledge on drug dependence treatment, but without indicating minimum quality standards.

<sup>3</sup> <http://www.emcdda.europa.eu/best-practice>

<sup>4</sup> [www.emcdda.europa.eu/best-practice/standards](http://www.emcdda.europa.eu/best-practice/standards)

By adopting the Strategy<sup>5</sup>, the EU Member States agreed the following goal:

*"A measurable reduction of the use of drugs, of dependence and drug-related health and social risks through the development and improvement of an effective and integrated knowledge-based demand reduction system including prevention, early detection, treatment, harm reduction, rehabilitation and social reintegration measures within the EU Member States".*

To implement this important goal, the EU Member States agreed, in the EU drugs action plan 2005-2008, the development of a wide range of drug demand reduction interventions covering prevention, treatment, harm reduction, rehabilitation and social reintegration. They also called for the further improvement of the quality, accessibility, effectiveness and coverage of drug interventions and services.

In 2008 the European Commission carried out an evaluation of the measures taken by the EU countries towards meeting the aims of the EU drugs action plan 2005-2008 and concluded that<sup>6</sup>:

- *Member States have invested in universal, selective and indicated prevention programmes across the board, but the evidence base underpinning these programmes is still weak and they are seldom evaluated.*
- *Only a handful of Member States have introduced general quality guidelines for prevention.*
- *An increasing number of Member States have also developed quality guidelines for treatment programmes, but the level of application is still unclear. (...)"*
- *"The availability of standardised information and data on the social consequences of drug use is very limited. This also includes information on the efforts made by Member States to rehabilitate and reintegrate (problematic) drug users in society."*

The Commission's evaluation report therefore recommended that "greater attention should be paid to the development and actual implementation of quality guidelines and benchmarks for effective interventions in the field of drug demand reduction"<sup>7</sup>.

This recommendation was subsequently translated into the EU Drugs Action Plan 2009-2012<sup>8</sup> through the adoption of a specific action that aimed:

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<sup>5</sup> 15074/04, CORDROGUE 77, 22.11.2004, section 22;

<sup>6</sup> Final Evaluation of the EU drugs action plan 2005-2008, SEC (2008) 2456, 18.9.2008;

<sup>7</sup> Ibid, § 6.2.2, p. 69;

<sup>8</sup> OJ 326, 20.12.2008, Action 19;

*"To develop an EU consensus on minimum quality standards and benchmarks for prevention, treatment, harm reduction and rehabilitation interventions and services, taking into account needs of specific groups and the work done at national and international level".*

The EU Drugs Action Plan requests that by 2012 the European Commission tables a proposal to the Council (made up of the 27 EU government's representatives) for an *EU Consensus on minimum quality standards and benchmarks in drug demand reduction*.

With the entry into force of the Lisbon Treaty, the scope for EU cooperation and coordination towards improving public health was strengthened<sup>9</sup> and provides a legal basis for the Commission, in close contact with the Member States, to take any useful initiative to – inter alia – promote such coordination, in particular initiatives aiming at the establishment of guidelines and indicators, the organisation and exchange of best-practice, and the preparation of the necessary elements for periodic monitoring and evaluation.

The development of a set of minimum quality standards and benchmarks at EU level is an ambitious challenge given the national differences in terms of drug use and drug problems as well as the differences in the organisation of public health care systems, cultural and socio-economic factors. Nevertheless, there is considerable scope to improve the quality of interventions, programmes and services in the drugs field. Sharing experience and learning from best practice has a valuable role to play at the EU level.

Therefore, the European Commission (Directorate General for Justice) launched a study in May 2010 to help prepare its proposal for a European consensus on minimum quality standards.

In the specifications to the tender, the final task is defined:

**(7) To prepare for the Commission a final report consisting of options on EU minimum quality standards and benchmarks in the field of drug demand reduction.**

The options consist of the three lists of proposed minimum quality standards in drug prevention, treatment/rehabilitation and harm reduction, and of reflections and recommendations for the implementation of those standards.

The project contract did not ask for new research designed to develop best-evidence or best-practices in those areas where this is not already available.

This project is intended as the start of a longer term consultation process with stakeholders to build a consensus on minimum quality standards for drug demand reduction interventions and services which EU Member States have or are planning to

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<sup>9</sup> OJ C 115, 9.5.2008, Art. 168 (1),(2),(6)

implement in their own country. It is important to note that the project gives no information about the benefits of any specific service or intervention in the field of drug demand reduction, or about the acceptability of implementing those, but only on the acceptability of minimum quality standards in case a specific intervention or service is already implemented or will be implemented.

This report will, in addition to the options, summarise the background of the project and how the tasks of the tender have been dealt with, including methodology, in order to provide the basis on which the options have been built.

The target audiences for minimum quality standards are diverse: professionals performing interventions, service directors and managers responsible for the functioning of their institutions and staff, and health authorities, planners and policy makers who are mainly concerned with the drug demand reduction activities at the system and network level. In addition, all users - patients and their families as well as professionals referring patients to services – have an interest in knowing the quality requirements. Not all standards are of equal interest for these audiences; structural standards are especially relevant for service directors, process standards for service directors and professional staff, outcome and economic standards and benchmarks for authorities and policy makers. For user groups, especially the structural and process standards are of interest.

## 2. Mandate and project outline

### a. Mandate

The European Commission (Directorate General for Justice) launched a study in May 2010 to help prepare its proposal for a European consensus on minimum quality standards.

The study on minimum **E**uropean **Q**uality **S**tandards (**EQUS**) in the field of drug demand reduction is carried out by the Research Institute for Public Health and Addiction, Zurich University, in cooperation with the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) and in contact with the World Health Organisation (WHO).

The scientific work within the project is supported by a European and international group of experts with significant experience in the implementation and evaluation of demand reduction interventions<sup>10</sup>. The EQUS group includes experts from across the EU Member States as well as Norway, Switzerland, USA, Canada and Australia. The role of the experts is to review the inventories of quality standards and the list of minimum quality standards proposed.

In summary, the EQUS project consists of the following tasks<sup>11</sup>:

- To identify, map and *review existing quality standards and benchmarks* in drug prevention, early detection and early intervention, treatment, harm reduction and social rehabilitation and reintegration in EU Member States and/ or at European and/ or international level, and to provide a *gap analysis* for those areas where these do not exist so far.
- To set up a *consultation and consensus building mechanism* for relevant stakeholders at EU level, involving scientific experts, professionals/practitioners, policy makers and other important stakeholders, including organised representatives of relevant target groups of interventions.
- To develop a *design for a framework of quality standards and benchmarks*, identifying the structure, key aspects, type and level of specification/ detail of these standards and benchmarks.
- This design should also reflect on potential risks, uncertainties and other factors that may be of importance in the design of quality standards at EU level.

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<sup>10</sup> See chapter 4a and Annex 1 for list of EQUS experts

<sup>11</sup> From specifications in the call for tenders JLS/2010/DPIP/PR/1023, part 1.2.2

- To present a number of *options and suggestions for quality standards and benchmarks* and which can form the basis for discussions between experts and policy makers in this area.
- To prepare for the Commission a *final report consisting of options on EU minimum quality standards and benchmarks* in the field of drug demand reduction.

## ***b. Project outline***

The project has the overall aims to:

- *Document the present state of quality standards in drug demand reduction within the European Union and internationally*
- *To proceed from the available documentation to a selection of proposed minimum quality standards*
- *To set up a consensus building process among a range of stakeholders throughout the European Union, in order to test the acceptability of minimum quality standards and to collect information on expected implementation problems.*

For the field of **treatment and harm reduction**, the working program covered the following parts:

1. A search of existing standards, guidelines and other relevant documents on quality in drug demand reduction within the EU Member States and at international level.

The collected information had to be categorised, analysed and screened for relevance;

2. On the basis of the screening process, to set up a comprehensive inventory of quality standards and guidelines in the field of drug demand reduction
3. Developing a model-framework for the draft quality standards, using selection criteria to select from the inventory those standards with the best potential for EU wide acceptability. Where available, the evidence base for each standard has to be provided through a systematic review of the scientific literature.
4. The final inventory consisting of a draft list of quality standards for drug treatment and harm reduction, to be translated into an on-line stakeholder survey to canvas expert opinion on the acceptability and feasibility of implementing each individual standard within their country.

5. To discuss the outcome of the survey, combined with the evidence gathered through the inventory, in a European Conference, where expected obstacles and options for implementation should also be discussed.

In the field of **drug prevention**, the development of minimum quality standards had to take a different approach. In 2007, the European Commission (EC) provided co-funding under the Programme of Community Action in the field of Public Health (2003-2008) for a separate project entitled ‘European standards in evidence for drug prevention’. This project was carried out by the Prevention Standards Partnership, led by the UK Liverpool John Moores University, and completed in November 2010<sup>12</sup>.

This project systematically reviewed existing drug prevention quality standards in the EU and at international level and developed a set of quality standards in the field of drug prevention. The experience and information produced through this project was adapted for the development of the EQUS project, and where necessary, differences in methodological approach were reconciled and are highlighted in this report.

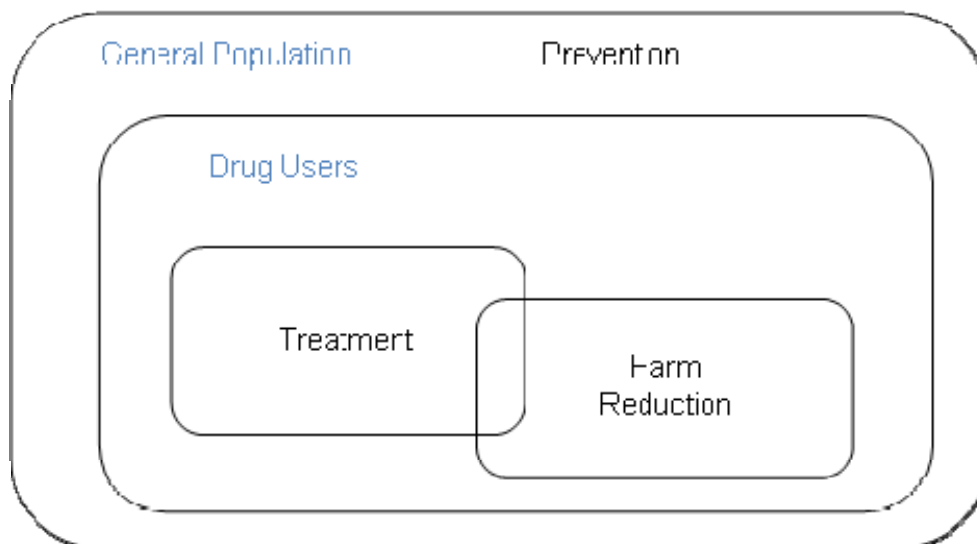
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<sup>5</sup> Now known as ‘European drug prevention quality standards’. Further information is available on the project website ( <http://www.cph.org.uk/drugprevention/> ).

### 3. Conceptual clarifications

#### a. About Treatment, Harm Reduction and Prevention

Treatment, harm reduction and prevention are not strictly separate fields of interventions; they overlap in terms of aims, activities and target populations.



#### Target of responses:

Prevention:	general population
Treatment:	drug users seeking treatment
Harm reduction:	drug users in treatment, drug users not in treatment and general population

For this project, the following definitions apply (provided by EMCDDA):

#### **Treatment**

Drug treatment is defined as an activity that directly targets people who have problems with their drug use and that aims at achieving defined goals with regard to the alleviation and/or elimination of these problems, provided by experienced and accredited professionals, in the framework of recognized medical, psychological or social assistance practice. (*DRAFT definition* - EMCDDA Treatment Demand Indicator Protocol version 3.0, 2011).

#### **Harm reduction**

Harm reduction encompasses interventions, programmes and policies that seek to reduce the health, social and economic harms of drug use to individuals, communities and societies. Harm reduction is considered as a 'combination intervention', made up of a package of interventions tailored to local setting and need, which give primary emphasis to reducing the harms of drug use. (EMCDDA monograph, 2010)



## Prevention

A prevention intervention promotes activities to prevent substance use behaviour among other problems. The goal is to reduce risk factors and enhance protective factors. Prevention is achieved through the application of multiple strategies; can be realised in different settings and with different methods and contents. The duration can vary between one-off activities and long-term projects.

Prevention interventions are commonly classified in three categories: universal, selective and indicated interventions. In addition there are environmental approaches which are prevention measures that operate on the level of the social, formal and cultural norms tackling both licit and illicit drugs. Universal prevention targets the whole population, while selective prevention targets (vulnerable) groups, both with the aim of deterring or delaying the onset of substance use. Indicated prevention acts at the individual level to: prevent the development of a dependence; to stop progression, diminish the frequency; and consequently to prevent 'dangerous' substance use (EMCDDA BPP).

### *b. About Best Practice, Quality Standards and Guidelines*

Discussions on quality standards can sometimes be confusing without a clear definition of terminology. For the purpose of this debate, the EMCDDA definitions for the terms '*best-practice*', '*quality standards*' and '*guidelines*' are used:

**Table 1** Definition of best practice, quality standards and guidelines

<b>Best Practice</b>	<p><i>The best application of available evidence to current activities in the drugs field.</i></p> <ol style="list-style-type: none"><li>1. <i>Underlying evidence</i> should be relevant to the problems and issues affecting those involved (professionals, policymakers, drug users, their families);</li><li>2. <i>Methods</i> should be transparent, reliable and transferable and all appropriate evidence should be considered in the classification process;</li><li>3. <i>Experience</i> in implementation, adaptation and training should be systematically collected and made available;</li><li>4. <i>Contextual factors</i> should be studied by modeling different prevalence levels so as to assess the impact of an intervention on the population; and</li><li>5. <i>Evidence of effectiveness</i> and feasibility of implementation should both be considered for the broader decision-making process.</li></ol>
<b>Quality Standards</b>	<p>Generally accepted <i>principles or sets of rules</i> for the best/most appropriate way to implement an intervention. Quality standards frequently refer to structural (formal) aspects of quality assurance, such as environment and staff composition. However they may also refer to process aspects, such as</p>

adequacy of content, process of the intervention or evaluation processes.

### **Guidelines**

Clinical practice guidelines are statements that include recommendations intended to optimize patient care that are informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options (Institute of Medicine. Clinical practice guidelines we can trust. Washington, DC: The National Academies Press; 2011.).

In practice however, standards and guidelines may sometimes not be clearly differentiated from each other. Guidelines may include underlying standards or vice versa.

### ***c. A quality concept for drug demand reduction***

In medical sciences, *quality standards are determined by different stakeholders*: health authorities, insurance companies, service providers, professionals and patients. The goals, interests, priorities and scientific evidence behind these standards are quite diverse. In analysing the available documents on standards, this diversity has to be respected and eventual conflicting standards need to be thoroughly discussed. For sake of transparency and acceptability, it is essential to make visible where any proposals for minimum quality standards come from and which interests are behind them.

Several *levels of demand reduction provision* must also be considered. The "*quality of interventions*" has a different meaning than the "*quality of services and settings*".

### **Quality factors usually are broken down the following headings:**

1. *Structural quality*, e.g. standards relating to the physical environment, staff, training, etc.
2. *Process quality*, e.g. standards relating to the process of an intervention, e.g. such as diagnostic assessment
3. *Outcome quality* and economic quality, e.g. standards to measure the cost-benefit ratio
4. *Benchmarks* in this study are addressed as the (desired) reference values or ratio by which quality can be measured.

**Table 2**            **Types of quality standards**

	<b>Level 1: interventions</b>	<b>Level 2: services</b>	<b>Level 3: systems &amp; policies</b>
<b>Structural quality</b>	Type of setting needed for implementation	Resource standards (infrastructure, human resources)	Legal & ethical adequacy standards (adequate to legal & ethical national norms)
<b>Process quality</b>	Procedural standards	Procedural standards	Standards for networking & cooperation among services
<b>Outcome quality</b>	Efficacy standards (having the intended effect)	Effectiveness standards (reaching useful results)	Coverage standards (proportion of those in need who are covered)
<b>Economic outcome quality</b>	Cost-benefit ratio (economic benefits in relation to costs)	Cost-utilisation ratio (utilisation in relation to costs)	Cost-effectiveness ratio (positive results in relation to costs)

Some of these standards have to be met entirely to improve effectiveness of interventions (such as complying with legal and ethical conditions), others will need an acceptable degree of compliance or approximation to a norm (as expressed by benchmarks).

For some key aspects of demand reduction (prevention, rehabilitation but also harm reduction) quality standards cannot be based on medical research and its methods alone, as interventions in these areas can often not be evaluated in a controlled research setting and by using randomised controlled trials. They are more frequently developed in practice and based on expert opinion.

Previous work on a quality framework for addiction treatment programmes has demonstrated that a difference has to be made between “best practice” and “performance”. While various stakeholders have their views on good practice, the performance of an intervention is based on outcome evidence. Evidence from clinical trials may present different findings than “real life” experience. Both aspects will be considered when setting up minimum standards in this project.

## 4. Methodology

### *a. National and international project partners*

In the Area of prevention, we choose to cooperate with the coordinator of another European project on quality standards, co-funded by the Executive Agency for Health and Consumers (EAHC) which has already been performed at the Centre for Public Health, John Moores University Liverpool, UK. Additional special ad hoc advisors were engaged with extended expertise in the drug prevention field at European level.

The Area of treatment and rehabilitation, the coordinating Research Institute for Public Health and Addiction at Zurich University recruited experts with known competency in the field and in past collaborative studies. The main criteria were the expected knowledge of and access to relevant documents, to guarantee completeness of the inventories on existing quality standards, and their scientific qualifications, to guarantee competent performance of the tasks. Experts with whom good scientific collaboration had been experienced in the past, were preferred. For an inclusion of non-European expertise, prominent researchers from USA, Canada and Australia were approached and engaged.

In the Area of harm reduction, we also could build upon an established team of specialists at the Universities of York and Kent, UK, already involved in the identification of quality standards. Additional consultants with outstanding experience at European and international level were engaged.

The complete list of experts participating as project partners can be found in Annex 1.

A steering group was set up by Directorate General Justice (DGJ), including representatives from the Commission, from EMCDDA Lisbon and the project coordinating institute.<sup>13</sup> A kick-off meeting of the steering group took place at EMCDDA in Lisbon, on May 4<sup>th</sup>. An important number of issues could be clarified and decisions taken for the implementation of the project. Furthermore, EQUUS was presented at the REITOX meeting in Lisbon (May 26<sup>th</sup>); national focal points to be included in the consensus building process.

The EQUUS expert group which was proposed in the tender could be fully realised and additional members could be recruited. No invited expert has declined to participate.

All Member States of the European Union can be adequately covered by this group, as well as Norway and Switzerland. The international arena is respected by including high level experts from USA, Canada and Australia.

The following institutions provided access to their relevant documents: EMCDDA, Lisbon, COCHRANE Drugs and Alcohol Editorial Group, Rome, WHO Division of

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<sup>13</sup> See list of steering group members in Annex 2

Mental Health and Substance Abuse, Geneva, WHO Regional Office for Europe, Copenhagen.

All experts acting as collaborating partners have taken the responsibility to search and screen the existing relevant national documents on quality standards and benchmarks in their respective areas of drug demand reduction. They also acted as reviewers of the draft national inventories and the sets of European minimal quality standards and benchmarks. Furthermore, they participated in the consensus building process during two expert meeting and in the European stakeholder conference, and by identifying national stakeholders to be included in the surveys and the conference.

### ***b. Methodology used for drug treatment and harm reduction***

#### *Document search*

A range of previous studies and reviews were researched and selected from national and international sources. These documents were screened for quality standards and benchmarks. The complete range of interventions, services, drugs and target populations had to be covered.

This task was approached with the following steps (see first interim report Appendix 3):

- Drafting detailed instructions for the national document search and screening by collaborating project partners
- Drafting electronic templates for the extraction and transmission of relevant information from the selected documents
- Drafting a manual for the use of the templates
- Discussion of draft instructions and templates during the kick-off meeting (May 12-13<sup>th</sup> in Zurich)
- Piloting the draft templates and manuals at national level for 2-3 selected documents (deadline July 5<sup>th</sup>)
- Evaluating the pilot phase, including feedback and comments made to the templates and the manual
- Finalising and dissemination of templates and manual for treatment and rehabilitation standards to collaborating partners (July 9<sup>th</sup>)
- Adapting and disseminating template and manual for harm reduction standards.

Collaborating partners have been invited to a kick-off meeting which took place in Zurich on June 12-13 2010. They received previously a draft agenda for the meeting, draft instructions for the document search and a draft template for electronic evaluation of the selected documents. The meeting was attended by 12 participants and proved to be instructive and helpful. Further steps have been discussed and agreed upon. An important new decision concerned the search and evaluation of documents on harm reduction standards by all collaborating partners at the national level, in addition to the international documents collected and evaluated by the coordinators in

the harm reduction area (Dr. Charlie Lloyd and Neil Hunt, UK). The kick-off meeting and the ensuing pilot phase testing the template instruments and the manuals for their use were helpful for clarifying the tasks and procedures, in order to best prepare the document search and information collection.

The instructions and manuals are attached as Annex 4.

The selection criteria for documents to be integrated into the inventory were:

- Published documents providing information on quality indicators and/or standards on specific interventions and/or specific settings and/or regional / national networks
- International documents *only* if made relevant at national level
- Priority was given to official documents (e.g. by health authorities, professional associations, major service providers, insurances), research reviews and research reports.
- Standards/guidelines were included which are relevant exclusively for the drugs field and not the broader healthcare or social care fields.

#### Categories of services and interventions

For systematic collection of information about quality standards, it was necessary to establish a typology of services and interventions.

- Types of services for treatment/rehabilitation::
- Out-patient services for ambulatory treatment
- In-patient services for residential treatment
- Prison-based services for intramural treatment
- Office-based services for treatment in private practice (e.g. family doctors)
- Teams specialised in addiction treatment (having specialised training)
- Teams not specialised in addiction treatment (e.g. general hospital emergency teams)

For harm reduction, the same typology was used, with two more (pharmacies and clubs).

- Types of interventions in treatment/rehabilitation:
- Counselling and early interventions
- Psychosocial interventions (psychological and social support, psychotherapy)
- Substitution maintenance (replacing street opioids by prescribed medication)
- Heroin-assisted treatment (replacing street heroin by pharmaceutical diamorphine)
- Other pharmacological intervention
- Detoxification (assisted withdrawal of substances of abuse)
- Aftercare
- Vocational rehabilitation (facilitating re-entry into the labour market)
- Other rehabilitation (e.g. social contacts, legal assistance etc.)

- Sheltered day/night programmes
- Self-help approach

Types of interventions in harm reduction:

- Needle exchange program (changing used syringes and needles against sterile ones)
- Supervised injection room (injecting under sterile conditions, support available)
- Outreach work / street work
- Drug checking (analysing drugs on the spot in discos, clubs, during raves etc.)
- Blood borne virus infection testing
- Vaccination (mainly hepatitis B)
- Referral to other services if needed
- Safer sex education
- Safer use education
- Sheltered housing

Categories of target populations

- All types
- Females
- Males
- Adolescents
- Dual diagnosis patients
- Somatic co morbidity
- Prison inmates
- Other marginalised population

Categories of substances

- Cannabis
- Heroin
- Cocaine
- Amphetamine
- Methamphetamine
- Ecstasy
- Hallucinogenic substances

Categories of quality standards

To allow for a meaningful differentiation of standards for various settings and interventions, the model design for standards in the fields of treatment /rehabilitation and for harm reduction was divided into:

- structural standards formulated in relation to different types of services, e.g accessibility of the service, the physical environment and staff composition

- process standards formulated in relation to different types of services and interventions, e.g. assessment procedures, data handling, staff training, cooperation between agencies
- outcome standards formulated at the system level, e.g. goals of treatment and harm reduction, evaluation of outcomes, monitoring, referrals.

Finally, for each standard it had to be documented if it is mentioned as mandatory or recommended only, and which grade of evidence – if any – is available for that standard. The definitions used in the EQUUS project are a simplified version based on the work of the GRADE working group<sup>14</sup>, in regard to the difficulties to train the experts in such a specialised methodology and due to the less defined nature of the documents which were assessed.

**Table 3**            **Grading of evidence**

<b>Grade</b>	<b>Definition</b>
A	Highest degree of evidence: review from multiple randomised controlled studies (RCT) with convergent results
B	High degree of evidence; results from single RCT and controlled clinical studies
C	Moderate degree of evidence: prospective comparative longitudinal studies (observational studies without control design)
D	Low degree of evidence: single intervention/service follow-up studies, case studies
E	Very low degree of evidence: non-systematic observations
Z	Not known.

*Analysing and transmitting information from the selected documents*

The non-English documents selected by project partners for inclusion could not be translated into English (for financial reasons). Information from these documents had to be extracted under the supervision of senior scientists and entered into the structured English templates in order to receive comparable information from all documents. Detailed instructions for the analysis of original documents had been prepared and accepted. All templates were transmitted electronically to the Zurich coordinating institute, where they were screened for errors, plausibility and missing information.

*Integration of information in a centrally administered masterfile*

In order to prepare the organisation of incoming information from the templates, the coordinating institute in Zurich has set up a specific mail address for sending the templates ([EQUUS@isgf.uzh.ch](mailto:EQUUS@isgf.uzh.ch)). Also, steps had been taken to set up a data bank and master file for all incoming information from templates. The master file was the basis for setting up national inventories of existing quality standards and benchmarks,

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<sup>14</sup> See GRADE working group (2004). Grading quality of evidence and strength of recommendations. BMJ 328:1490



separately for the areas of prevention, treatment/rehabilitation and harm reduction, as well as European inventories in these three areas.

For the areas of treatment/rehabilitation and harm reduction, a special category of “reference documents” was created, as not all documents were equally important, with the following criteria:

- national document
- evidence grade A or B for treatment/rehabilitation, evidence grade A or B or C for harm reduction (cf. point 5.2.2).
- based on systematic literature research or expert consensus.

In total 29 documents for treatment/rehabilitation and 9 documents for harm reduction were identified as reference documents on the basis of these criteria.

#### Setting up the inventory

The retrieved documents were analysed. In order to extract comparable information from the selected documents, structured electronic templates were prepared in an Excel format and submitted to project partners for approval. The manuals how to use the templates are in Annex 4.

Following a meta-analysis of the collected data, a total of 349 relevant documents (259 for treatment and rehabilitation, 90 for harm reduction) at national and international level could be identified, screened and the structured contents integrated into an electronic master file. The file results in a list of transmitted templates per country (See Annex 5).

Are the sources of information in the relevant documents equally distributed among the European Union ? The following tables show the distribution across three regions (South-West includes Austria, Belgium, Cyprus, France, Germany, Greece, Italy, Netherlands, Portugal, Spain, Switzerland; Central-East includes Bulgaria, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Romania, Slovakia, Slovenia; North includes Denmark, Finland, Ireland, Sweden, United Kingdom). There are no major differences, except the overall considerably lower number of documents for harm reduction compared to treatment/rehabilitation.

**Table 4 Sources of relevant documents: regional distribution (Treatment/rehabilitation)**

<b>Source</b>	<b>South-West</b>	<b>Central-East</b>	<b>North</b>
Lit. review	41	23	20
Exp. opinion	40	43	23
Exp. consensus	61	51	25
Research project	22	15	12
Practice experience	40	36	19

**Table 5** Sources of relevant documents: regional distribution (Harm reduction)

<b>Source</b>	<b>South-West</b>	<b>Central-East</b>	<b>North</b>
Lit. review	7	8	7
Exp. opinion	9	7	6
Exp. consensus	8	13	6
Research project	3	7	7
Practice experience	10	4	7

The resulting *inventory* contains a comprehensive list of quality standards and benchmarks emerging from the analysis of the templates (Annex 6).

**c. Methodology used for prevention standards<sup>15</sup>**

The prevention strand of this project differed from the areas of treatment and harm reduction in that a set of EU quality standards in drug prevention had already been developed as part of a separate study on standards and guidelines for drug prevention<sup>16</sup>. This project had been carried out by the Prevention Standards Partnership and completed in November 2010. These European drug prevention quality standards are published as an EMCDDA Manual for practitioners (EMCDDA, 2011).

Therefore, unlike other strands in this project, original standards documents were not reviewed in the prevention part of EQUUS. Instead, the existing European standards were adapted to the requirements of the EQUUS project. Adaptation was carried out by Dr Harry Sumnall and Angelina Brotherhood (Liverpool John Moores University, UK), the lead partners in the Prevention Standards Partnership.

The first part of this section provides an overview of how the European drug prevention quality standards were developed in the separate project (highlighting differences to the areas of treatment/rehabilitation and harm reduction); followed by a description of the adaptation process for the EQUUS project. Further information on the Prevention Standards Partnership and the development of the European standards is available in the EMCDDA Manual (EMCDDA, 2011) and in the methodological report (Brotherhood et al., 2011).

*Development of European drug prevention quality standards in previous project*

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<sup>15</sup> The sections describing the prevention standards in this report were prepared by Dr Harry Sumnall and Angelina Brotherhood of the Centre for Public Health, LJMU, UK.

<sup>16</sup> Project name ‘European standards in evidence for drug prevention’, co-funded by the European Commission (EC) under the Programme of Community Action in the field of Public Health (2003-2008).

The document search for prevention standards was comparable to that carried out in the areas of treatment and harm reduction (e.g. using similar selection criteria). However, the drug prevention study did not distinguish between different types of services and interventions as the majority of identified quality standards referred to general drug prevention (i.e. not limited to a particular intervention type). In total, 77 documents were retrieved and screened, out of which 19 documents containing quality standards were selected for inclusion. Where necessary, materials were translated into English.

The analysis of existing standards also differed in the prevention strand. Firstly, the identified standards were based upon expert/stakeholder opinion, expert consensus, reviews of previously existing standards, and/or literature reviews. It was therefore not appropriate to grade the evidence of identified standards. Instead, each selected document was described separately (including details of standards development; see Brotherhood et al., 2011). Secondly, the prevention study did not utilise a predetermined template for extracting standards. Instead, a data-driven approach was taken and quality standards were synthesised through a structured qualitative content analysis; i.e. relevant standards in the documents were identified and extracted into a spreadsheet, categorised thematically and sorted, and similar standards were merged. This method produced a long list of standards combining all reviewed documents. The resulting standards were structured along a project cycle with distinct project stages (i.e. differing from the typology of structural, process, outcome standards used in treatment/rehabilitation and harm reduction).

The draft standards were refined in consultation with drug prevention professionals through a two-round online Delphi survey<sup>17</sup> and focus groups<sup>18</sup> in the partner countries (Hungary, Italy, Poland, Romania, Spain, and UK). The revised standards were finally ‘field tested’ in their entirety in additional focus groups to obtain a better understanding of opportunities and challenges for their uptake in practice. Further details on these consultations are provided in this report in the section “Stakeholder surveys”.

In the final version, the European drug prevention quality standards cover the following eight project stages:

1. Needs assessment;
2. Resource assessment;
3. Programme formulation;

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<sup>17</sup> Delphi surveys are conducted in several rounds, whereby the results of previous rounds are fed back to participants. The aim of Delphi surveys, as with other consensus methods, is to measure the extent to which experts agree about a given issue. This agreement is comprised of two elements: firstly, the respondents’ agreement with the issues in question, and secondly, the level of agreement between respondents (Jones & Hunter 1995).

<sup>18</sup> Focus groups are a form of group interview where data is generated by encouraging group interaction (Kitzinger 1995).

4. Intervention design;
5. Management and mobilisation of resources;
6. Delivery and monitoring;
7. Final evaluations; and
8. Dissemination and improvement

The actual standards are presented on two further levels of detail:

- Components – actions to take within the project stages (31 components across the eight project stages, and four additional components (‘cross-cutting considerations’) that are of relevance to each project stage, namely: (A) sustainability and funding; (B) communication and stakeholder involvement; (C) staff development; and (D) ethical drug prevention);
- Attributes – most detailed level of standards which can be used to evidence achievement in practice; distinguishing between ‘basic’ and ‘expert’ level standards.

#### *Adaptation of the European drug prevention quality standards to the EQUUS project*

In June 2010, the EQUUS project coordinator attended a meeting of the Prevention Standards Partnership to present the design and procedures of EQUUS, and to discuss further steps to be made for an adaptation of the prevention standards to the requirements of EQUUS.

The following adaptation requirements were identified following this meeting:

1. Clarify evidence base underpinning prevention standards
2. Apply template used in treatment/rehabilitation and harm reduction to prevention standards (including typology of structural, process and outcome standards)
3. Reduce list of standards to ‘minimum’ standards
4. Adopt language of prevention standards to that used for treatment/rehabilitation and harm reduction

The following paragraphs describe how each of these requirements was addressed by the Prevention Standards Partnership in the adaptation process:

1. In order to clarify the evidence base underpinning the standards, general information about the 19 underlying original standards documents was extracted using similar templates as in the areas of treatment/rehabilitation and harm reduction. The existing *‘Manual for the use of the electronic template on treatment/rehabilitation’* was used to guide completion of the General Information sheets for each standard document. Additional answer responses were used in some of the categories to optimise the manual for prevention practice.

2. A structured electronic template was developed to categorise the standards in line with the methodologies used in treatment/rehabilitation and harm reduction (i.e. Structural, Process, and Outcome standards as well as relevant sub-categories). Each

'basic' standard was labelled according to the template categories, allowing adaptation of the prevention standards to the format of the other two areas treatment/rehabilitation and harm reduction. Further feedback received at the European conference of stakeholders (see below) was used to refine the categorisation for the final version of the EQUUS prevention standards.

Consequently, as in the areas of treatment/rehabilitation and harm reduction, lists were developed for

- Structural standards for services
- Process standards for services and interventions
- Outcome standards for treatment/harm reduction systems and networks.

Thus, whilst the content of the European drug prevention quality standards was not changed for this project, the structure was. Annex 7 contains an overview of how the EQUUS prevention standards correspond to the European drug prevention quality standards published in the EMCDDA Manual.

3. The procedure of allocating standards to template categories was conducted only with 'basic' standards as the EQUUS project sought to identify only minimum standards (i.e. all 'expert' level standards were removed for the purposes of the EQUUS project). However, additional reduction was required as this list was not sufficiently concise to fulfil EQUUS project aims. Therefore, a further revision was made and the final list of EQUUS prevention standards was based upon the 'component' level rather than the very detailed 'attribute' level used in the European drug prevention quality standards (as described above). The proposed list of minimal quality standards for prevention reflects a summary of the basic standards included in the EMCDDA publication. The full prevention standards (including all basic and expert level standards) are available through the EMCDDA manual publication (EMCDDA, 2011).

4. Finally, the wording of the prevention standards was changed in order to ensure correspondence with the treatment/rehabilitation and harm reduction standards, although careful attention was given to preserve the meaning of the standards. Additionally, feedback received at the European conference of stakeholders (see below) highlighted the need to change some standards terminology so that the EQUUS prevention standards could be read as a stand-alone document independently of the EMCDDA manual publication.

Thus, by reanalysing and reorganising the prevention standards as described above, it was possible to ensure that all three areas are comparable in terms of their development, content, and presentation. The list of proposed prevention quality standards presented in chapter 6b is the final list produced through this process.

## **5. Consensus building process in the EU**

### ***a. Expert seminars***

A first expert seminar was held in Brussels in December 6-7, 2010. It was attended by 19 experts (minutes in Annex 8).

In the first part, the results of the document search and data analysis were presented and discussed.

Most of the documents were found in national databases, only a few in international databases. The main sources were institutional pages of national agencies, regional official documents and professional literature. Some countries such as Germany or Spain have faced difficulties because of the regional system in the country. The greatest amount of documents came from regional authorities, and only a small part from national government therefore, it was difficult to come up with single national guidelines.

The main problem most of the countries faced was grading the evidence. It was difficult to grade the evidence because there was a lack of objective criteria, and some evidence already had a national grade, therefore it was difficult to convert such grade to the one provided in the template.

To improve the quality of the template ISGF introduced a web-based template which replaced the current excel-sheet based template. Web-based template is more user-friendly.

Some concern was raised with regard to documents from countries where drug treatment or harm reduction could possibly be included under the general health care system. Some guidelines are provided for broader fields – psychological treatment, for instance. Those are not represented in our database; the templates are limited exclusively to drug relates issues as well as the overall focus of the project.

The first analysis results showed: the origin of documents is mainly the public sector, also professional associations. The most frequently mentioned intervention typey are psychosocial interventions and substitution treatment. There are more documents for specialized settings than for non-specialized settings. Some problems occurred with regard to the targeted population. Most of the countries have marked all categories if a given document did not indicate the targeted group precisely.

Evidence grades of structural standards, process standards and outcome standards were found to be considerably low. Level A is almost nonexistent.

Several important procedural decisions were taken. One decision was about extracting minimum quality standards from the inventories. There was consensus not to prose

lists of minimum standards by the expert group, but to prepare comprehensive lists from the inventories and to present those in stakeholder surveys, together with pertinent information about each standard, so that stakeholder consensus can be used as a basis for identifying minimum standards. The criterion should be a high degree of consensus (>80%).

A next step was an agreement on the structure of the questionnaire for the online survey. The questionnaire informed about the basis of the individual quality standards and includes questions on the acceptability of the standard for specific interventions and on eventual problems for implementation.

The expert group also decided to have a piloting of the questionnaire among the project partners, to take place January 7-14, 2011.

In a second expert seminar (March 3-4, 2011, in Brussels), the experts discussed the outcome of the piloting exercise (minutes in Annex 9). It resulted in a number of comments (ca. 80 feedbacks) and improvements. Some changes were made in the formulation and explanation of the individual standards, in some answer categories in the overall format. Participants finalised the lists of stakeholders for the surveys and made preparations for the European conference.

### ***b. Stakeholder surveys***

In the areas of **treatment/rehabilitation and harm reduction**, the consultation and consensus building mechanism was started according to plan. The concept and the necessary preparations were discussed in the second expert seminar (see second interim report Annex 10)

Two online surveys were carried out by the Zurich coordinating institute between January and April 2011. The questionnaire was developed on the basis of feedback from the EQUUS expert group and the EMCDDA's REITOX national focal points.

The aim of the survey was to test expert opinion across the EU to assess the level of agreement for the inclusion of particular standards in the final lists of minimum standards for drug treatment/rehabilitation and harm reduction. The questionnaire also asked about the acceptability of each standard, separately for services and interventions, and about expected problems for implementation.

*A first step* was an agreement on the *structure of the questionnaire* for the on-line survey. This questionnaire is organised around process standards for interventions, structural standards for services and outcome standards at the system / network level. The questionnaire informs about the basis of the individual quality standards and includes questions on the acceptability of the standard for specific interventions (process standards) or services (structural standards) and on eventual problems for implementation.

In a *second step*, a *piloting of the questionnaire* among the project partners (January 7-14, 2011) resulted in a number of comments (ca. 80 feedbacks) and improvements, for a better understanding and acceptability of the tasks to be performed when participating in the survey. The main changes concerned the formulation and explanation of the individual standards, some answer categories and a more user-friendly format. The final questionnaire for the on-line survey is attached (See Annex 14).

A *third step* was the setting up of *national lists for stakeholders* to be consulted in the on-line survey, with separate lists for treatment / rehabilitation and for harm reduction (this process was already performed in the separate prevention project). The areas to be included in the nomination of stakeholders were defined: medical professions, social professions, public authorities (health, social, justice, police), relevant NGO's and professional associations, insurance bodies, research groups, user groups, church and media representatives. All project partners were required to present lists and EMCDDA asked the national Focal Points to nominate participants. WHO and special advisers are also invited to make nominations and more are expected.

The *fourth step* was the start of the on-line survey first round as agreed on January 20, 2011. Participants were invited to answer within 3 weeks time. The evaluation of answers by the contractor team was communicated to the Commission, the steering group and the project partners for comment and for discussion at the second expert meeting in March 2011.

The next step was to canvas expert opinion on the acceptability of quality standards derived from the inventory. In order to enable stakeholders to make informed decisions about the acceptability of each standard, they were provided with the following information:

- on the range of countries having mentioned the standard in guidelines or similar documents and in reference documents
- on the status of the standard in these countries (recommended or mandatory)
- on the source of information (literature search, expert consensus, research project)
- on the available evidence grade.

In the first survey round, 469 identified stakeholders from EU Member States and Switzerland were invited to participate. The total number of completed questionnaire was 164 (from 118 stakeholders). The low response rate (30%) was due to short time span. The types of stakeholders however were quite representative, the big majority were NGOs, government organisations and health sector.

In total 514 stakeholders were invited in the two survey rounds, from all EU Member States, including health and social professionals, representatives of public authorities, health insurance, and user groups organisations. In the second survey round, professionals received feedback on the results from the first round. Across all



countries and regions, a total of 241 out of 514 (<46.9%) invited professionals completed the survey rounds.

On the basis of the results from the two surveys, a difference was made between standards which reached high, moderate or low degree of consensus:

- Quality standards with a **high** degree of consensus (>80%)
- Quality standards with a **moderate** degree of consensus (>50-80%)
- Quality standards with a **low** degree of consensus (<50%)

If a given standard is considered to be overall acceptable (high level of consensus), but with the exception of specific settings or interventions, this is mentioned in the lists in chapter 6.

In **prevention**, stakeholder surveys were carried out as part of the earlier EC co-funded project to develop European drug prevention quality standards. As with the areas of treatment/rehabilitation and harm reduction, national lists for stakeholders to be consulted were set up for each country of the Prevention Standards Partnership (Hungary, Italy, Poland, Romania, Spain and UK). The sampling frame was constructed to reflect the range and scope of drug prevention delivery systems in project partner countries.

A two-round online survey was conducted in January and February 2010. Participants received information on the separate prevention standards project and on the methods used to develop the draft standards. However, additional information on every individual quality standard as in the areas of treatment/rehabilitation and harm reduction was not provided. Instead, participants were asked to make judgements based upon their professional experience as well as what standards they believed would improve the current quality of prevention. Respondents consequently rated the priority of the draft standards from 'high priority' to 'not a priority at all', and also whether they believed the standards should be mandatory as part of good quality drug prevention services. They were also able to provide text comments explaining their ratings. In the second survey round, those professionals who had completed the first survey received feedback on the results from the first round and were able to re-rate the standards in light of these findings. In total, 487 out of 987 invited professionals completed the first survey round, and 423 respondents completed both survey rounds (87% of those who completed the first round).

As part of the earlier prevention standards project, two rounds of focus groups were also held between March and September 2010. In total, 122 participants took part in the first round of focus groups to discuss the standards in detail, particularly with regard to their relevance, usefulness, and feasibility; and 72 participants helped define how the standards could be implemented in practice and provided final suggestions for improvement.

For the EQUUS adaptation of the prevention standards, no additional stakeholder surveys were carried out, although feedback received at the European conference of

stakeholders was incorporated to produce the final version of the EQUUS prevention standards (see below). The Delphi results obtained in the original research were used to indicate acceptability of the standards, more specifically the question on whether participants believed a standard should be mandatory as part of good quality drug prevention services. It is important to note that these Delphi ratings refer to the first draft of the standards and not the final version. It is likely that the final, improved standards would receive a greater level of support in a new Delphi survey.

The proposed prevention standards can consequently be distinguished as follows:

- standards with high acceptability (rated as mandatory by > 80% of responding participants)
- standards with medium acceptability (rated as mandatory by 50-80% of responding participants)
- standards with low acceptability (rated as mandatory by less than 50% of responding participants).

Those with a medium acceptability were discussed during the European conference. There were no standards with low consensus as these had already been modified as part of the standard development process.

### *c. European conference of stakeholders*

The development of any quality standards is a process which requires the involvement of a wide range of stakeholders to ensure that the standards gain support and acceptability. A European conference with the participation of a wide range of different stakeholders was therefore planned as an essential part of the consensus building process. This technical conference, hosted by the European Commission in association with the Hungarian Presidency of the EU, was designed to bring together such a range of stakeholders to discuss the preliminary findings of the EQUUS study.<sup>19</sup> It attracted over 100 participants including policy-makers, practitioners, NGOs and researchers in the fields of drug prevention, treatment and harm reduction from across the EU (list of participants in Annex 11).

The objectives of the conference included the discussion of the proposed list of minimum quality standards, as well as perspectives for their implementation.

The conference took place in Brussels on June 15-17, 2011. A steering committee meeting had prepared the details. A working paper provided preparatory information to participants (Annex 12).

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<sup>19</sup> :the website of the conference presents the programme and the speeches, as well as the preparatory documents and the conference summary [http://ec.europa.eu/justice/newsroom/anti-drugs/events/110615\\_en.htm](http://ec.europa.eu/justice/newsroom/anti-drugs/events/110615_en.htm)

## Conference programme

The conference started with a summary presentation of the EQUUS project, and the international context for their discussion was presented from the EU, from WHO headquarters and from EMCDDA<sup>20</sup>.

The proposed lists of minimum quality standards were discussed in parallel groups (prevention, treatment, harm reduction). In these parallel sessions, standards with a high consensus were presented for additional comment, standards with a moderate consensus were submitted for discussion for eventual inclusion, while those with low consensus on acceptability were proposed to be excluded.

In the second part of the conference, models of implementation were presented from the Czech Republic, the UK, The Netherlands and Switzerland<sup>21</sup>. In a new round of parallel sessions, barriers and options for implementation were discussed, from the perspectives of policy makers and practitioners respectively (see conference report in Annex 13).

## Conclusions of the conference

A concluding panel discussion with representatives from policy, practice and science highlighted important points to take forward the development of minimum quality standards in drug demand reduction:

- increasing acceptance by professionals through knowledge transfer/training new practitioners in drug treatment
- the evidence base behind the standards needs to be supported through further research
- need to operationalise the standards to develop measures for monitoring/evaluating
- EU standards must provide a tangible/operational tool for national stakeholders
- This is a long term process to be backed by sustainable funding
- international perspective: EU minimum quality standards relevant for countries outside EU need to develop common language in this field.

On the basis of the project conclusions, the Commission will reflect on how to develop this proposal and what form it will take. The process to develop, adopt and implement the EU guidelines on cancer screening provides a useful example to consider, but there may be others.

European level minimum quality standards must add value to what exists in the EU member states and take account of different health systems and capacities across Member States. Some countries have developed effective responses after implementing for three decades treatment measures, while others lack both funding

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<sup>20</sup> Presentations on conference website

<sup>21</sup> Presentations on conference website

and expertise to provide such services. A European framework is a way to encourage and guide good practice in accordance with national and local circumstances. It should provide an incentive to those countries where such standards do not yet exist and motivate other countries to review and update current practice to improve the effectiveness and outcomes of their measures.

Financial support could provide an important boost for countries wishing to share good practice in the field of quality standards in drug demand reduction. The EU's drug prevention and information programme could offer grants for such cross-border initiatives under its 2012 work programme.

In this time of economic crisis, resources must be invested wisely where the benefits are greatest. Outcome and evaluation standards provide a useful management tool to guide investment decisions of policy-makers, but further research will be necessary to develop these.

Working together with the European Monitoring Centre for Drugs and Drug Addiction, the Commission will consider what further research work may be necessary to strengthen the evidence base underpinning the minimum quality standards.

***d. Stakeholder comments on the proposed standards***

During the European conference, stakeholders were invited to discuss in parallel sessions the following topics:

- are the proposed lists of minimum quality standards (high consensus in surveys) acceptable ?
- for which types of services / interventions are they accepted ?
- which standards from the presented additional lists of quality standards (medium consensus in surveys) should be included in the definite lists of minimum standards ?
- for which types of services / interventions ?

The following paragraphs present a summary of comments made during the sessions.

Treatment/rehabilitation: Further elaboration was requested for:

- considering the role of peer support and non-professional staff and client involvement in programming and shared responsibility
- accountability of staff
- providing specific criteria for internal and external education of staff
- evidence-based treatment only
- periodical revision of treatment planning
- criteria for sharing responsibility in treatment choices
- standards on transparency in the use of funds.

The following standards were recommended to stay on the list of moderate consensus and not to be moved to the list of minimum standards:

- cost effectiveness ratio as an outcome measure
- cost-benefit ratio as an outcome measure.

Both standards are considered to be difficult to measure and the results difficult to interpret. These techniques need further development.

Final general recommendations made:

- check the wording of standards
- provide more examples
- specify the applicability per type of services and interventions.

#### Harm reduction:

- One important suggestion that came up was that opioid substitution therapy should be integral part of the harm reduction standards and not only of the treatment and rehabilitation standards.
- In the structural standards of interventions, there was consensus that the two accessibility standards on location and opening hours (previously classified as moderate consensus standard) should be taken together and classified as high consensus standard. The new formulation should be “Services have to match the needs of clients” and “Costs should never be a barrier to a service.”
- There was agreement that in the standard on staff composition, the inclusion of peers should also be taken into account. The new formulation should include that staff has to be qualified and that staff qualification has to be made transparent.
- There should be an additional standard on indication criteria / age limits. The formulation should include that services have to be age appropriate, that staff has to be trained to meet age appropriate clients needs, but that there should be no age limits. The standard on referrals should also include referrals to legal services.
- It should be mentioned that interventions should not be based on written informed consent, but rather on a transparent information about all the offers by a service.
- There was consensus that the standard on the confidentiality of client data should be intervention specific. Also, it was pointed that data should not be accessible without the agreement of the client and that the client’s needs should come first.

#### Prevention:

Participants agreed that the selection of ‘minimum’ standards depended on their intended use and audience. If used to inform funding decisions, it was felt that fewer

standards should be included in the list to allow greater flexibility in practice, whereas more standards could be included if the document was a guidance document for practitioners. With this in mind, it was argued that, although desirable, the standards on outcome evaluation should not be included in a ‘minimum’ list of standards because they were not always feasible due to practical or financial circumstances. From the list of standards with moderate consensus, six out of ten standards were acceptable with slight modifications (e.g. exceptions clarified).

More generally, it was noted that the structure used in the EQUUS standards (“structural standards”, “process standards”, “outcome standards”) was not commonly used in prevention, particularly in universal approaches (e.g. school curriculum). It was also argued that some standards should be merged to reduce redundancy, while other standards should be split up to increase specificity of the statements. The discussion showed that some terms used in the standards (e.g. “needs”, “harm”, “evidence-based”) were open to interpretation (e.g. had no standard clinical definition) and required clarification. It was also questioned whether the numbering was meant to indicate hierarchy or priority of standards.

It was agreed that the publication of the EMCDDA Manual on “*European drug prevention quality standards*” would increase acceptance of the EQUUS prevention standards, particularly if the correspondence between the two sets of standards was evident.

## 6. Proposed Lists of Minimum Quality Standards

The following lists are the outcome of the various steps of the consensus building process. The two stakeholder surveys allowed to identify the degree of acceptability (high-moderate-low degree of consensus), and the European stakeholder conference finalised the list of high consensus by adding some standards from the list with moderate consensus and by stating some standard explanations and examples more precisely.

The lists below are the updated lists of minimum quality standards which reached a high consensus. They provide information on the consensus basis of the standards (stakeholder survey and stakeholder discussions at the European conference, respectively). They also add information on exceptions from high consensus, if standards were not accepted for all types of services or interventions. Such exceptions are marked below each one of these standards.

The lists of minimum standards are structured in groups according to the types of standards (as set out in chapter 3c). The sequence of these groups and within groups is not meant to indicate any kind of priority.

### *a. Prevention standards*

#### **Prevention: Structural Standards of Services**

- P1 Ethical principles: adherence to ethical principles (e.g. service must protect participants' rights, provide services/interventions that have clear benefits for participants, must not provide a service/intervention where evidence shows that it could harm participants (e.g. increase drug use, stigmatise participants))
- P2 Policy and legislation: reference to drug-related policy and legislation as required for the implementation of the service/intervention
- P3 Routine cooperation with other agencies: the organisation cooperates with other agencies and institutions in correspondence with the multi-service nature of drug prevention (e.g. health and social services, criminal justice services, educational services)
- P4 Financial requirements: a clear and realistic cost estimate is provided; available funding streams are sufficient to cover costs
- P5 Internal resources and capacities: sufficiently available for implementation (e.g. human, technological, financial resources)
- P6 Staff composition: transdisciplinarity and qualifications of staff are appropriate for the service (e.g. type of roles, number of staff, level of education)

P7 Staff support: staff members are supported in their work as appropriate

Prevention: Process Standards of Services/Interventions

P8 Ethical standards: adherence to ethical standards (e.g. intervention is only carried out if there is a need for it, procedures in place to ensure informed consent, confidentiality, protect safety of participants and staff members, information about drugs and related behaviours is accurate where it is provided)

*Exception: informed consent may not be feasible in some universal and environmental approaches (e.g. mass media)*

P9 Assessment procedures: detailed and diverse information on drug use in the community/target population/environment of interest has to be collected through primary or secondary study (e.g. types of drugs used, drug use rates and trends)

P10 Assessment procedures: target population's culture (1. relation to drug use, 2. relation to the service/intervention activities) has to be assessed

P11 Assessment procedures: other relevant characteristics of the community/target population/environment have to be assessed (e.g. cognitions, attitudes, risk behaviours, criminality, social status, drug availability)

P12 Assessment procedures: target population and community readiness for the service/intervention has to be assessed (e.g. sources of opposition or support)

P13 Assessment procedures: gaps in current service provision have to be assessed

P14 Stakeholder involvement: all stakeholders relevant to the service/intervention are involved in its development and implementation as required (e.g. target population, other agencies)

P15 Sustainability: long-term strategy for drug prevention or wider health promotion (all activities form part of the long-term strategy)

P16 Goal definition: service/intervention goals are specific, realistic and informed by assessment procedures (e.g. what types of drug use or behaviours are targeted)

P17 Service/intervention design: the service/intervention is based on a scientifically derived understanding (theoretical models) of drug-related behaviours and behavioural change

P18 Service/intervention design: the service/intervention is evidence-based (it is based upon the findings of novel or existing literature reviews on scientific



evidence of effectiveness, or professional experience where reviews are not available)

- P19 Service/intervention design: services/interventions are tailored according to individual and population characteristics (e.g. language, activities, messages, timing, number of participants)
- P20 Service/intervention design: criteria for end of the service/intervention are defined (e.g. goals achieved, mandatory number of sessions completed, number of participants reached, duration of the intervention)
- P21 Service/intervention design: service/intervention activities are feasible and internally consistent (e.g. activities are linked to objectives, target population is chosen in line with needs assessment, target population can be reached, setting is suitable for good functioning)
- P22 Adaptation: existing interventions (e.g. manualised programmes, service models implemented elsewhere) are adapted considering the differences between the original and the actual circumstances (e.g. target population characteristics)  
*Exception: novel services/interventions*
- P23 Staff training and development: those delivering the service/intervention (e.g. staff members, teachers, parents, former drug users) have the competencies which are required for a successful implementation
- P24 Recruitment: participants or participating units (e.g. schools, communities) are drawn from the defined target population
- P25 Implementation: a systematic project plan exists in writing (e.g. including main service/intervention elements and procedures, risk assessment and contingency plans)
- P26 Implementation: the implementation is monitored and necessary adjustments identified (e.g. reviewing preliminary outcome and process data, project plan, resources)
- P27 Implementation: the service/intervention is implemented according to the project plan and adjusted in line with the monitoring findings
- P28 Process evaluation: the implementation is documented and explained (failures and deviations from the original plan, target population involvement, activities, service/intervention delivery, use of financial, human, and material resources)
- P29 Dissemination: a written and clear description of the service/intervention is made (at least partly) available to relevant groups (e.g. participants) before and/or during the service/intervention

P30 Dissemination: information about the service/intervention is disseminated in an appropriate format (e.g. evidence briefings, report to funders, feedback to participants) at the end of the service/intervention

*Prevention: Outcome Standards at the System Level*

P31 Goal of prevention: reduced drug use (prevention must be aimed at abstention, delayed drug use, reduced drug use, and/or prevention of dependence)

P32 Evaluation: an appropriate evaluation is carried out as part of the service/intervention (e.g. outcome evaluation, process evaluation)

P33 Evaluation: the service/intervention is continued on the basis of evidence provided by monitoring or evaluation

**b. *Treatment/rehabilitation standards***

*Treatment/rehabilitation: Structural Standards of Services*

TR1 Accessibility: location (service can easily be reached by public transport)  
Added during conference  
*Exception: prison-based services*

TR2 Physical environment (adequate spacing for the activities in the service (e.g. service has separate rooms for individual counselling)  
Added during conference  
*Exception: non-specialised teams*

TR3 Physical environment: safety (service is equipped for emergencies like e.g. management of overdose, fire or aggression on the premises)  
Exception: non-specialised teams  
*(as far as not already required by national law)*

TR4 Indication criteria: diagnosis (treatment indication is always made on the basis of a diagnosis)  
*Exception: office-based services and non-specialised teams*

TR5 Staff education: basic education (e.g. at least half of staff has a diploma in medicine, nursing, social work, or psychology)  
*Exception: office-based and prison-based services, non-specialised teams*

TR6 Staff composition: transdisciplinarity (e.g. service employs a multidisciplinary team composed of at least 3 professions)  
*Exception: prison-based services and non-specialised teams  
(country differences have to be taken into account)*

Treatment/rehabilitation: Process Standards at the Service Level

- TRs7 Assessment procedures (substance use history, diagnosis and treatment history have to be assessed)  
*Exception: office-based services and non-specialised teams*
- TRs8 Assessment procedures (somatic status and social status have to be assessed)  
*Exception: office-based services and non-specialised teams*
- TRs9 Assessment procedures (psychiatric status has to be assessed)  
Added during conference  
*Exception: non-specialised teams*
- TRs10 Individualised treatment planning: (treatment plans are tailored individually to the needs of the patient)  
*Exception: office-based and prison-based services, non-specialised teams*
- TRs11 Informed consent: (patients must receive information on available treatment options and agree with a proposed regime or plan or a change of plan before starting treatment)  
*Exception: office-based and prison-based services, non-specialised teams*
- TRs12 Written client records: (assessment results, intervention plan, interventions, expected changes and unexpected events are documented complete and up to date for each patient in a patient record)  
*Exception: non-specialised teams*
- TRs13 Confidentiality of client data: (patient records are confidential and exclusively accessible to staff involved in a patient's treatment or regime)  
*Exception: non-specialised teams*
- TRs14 Routine cooperation with other agencies: (whenever a service is not equipped to deal with all needs of a given patient, an appropriate other service is at hand for referral)  
*Exception: prison-based services and non-specialised teams*
- TRs15 Continued staff training: (staff is regularly updated on relevant new knowledge in their field of action)  
*Exception: non-specialised teams*

*Comment: while these process standards are accepted for all interventions without exception, the same standards are not applicable in all types of services; exceptions are mentioned).*

Treatment/rehabilitation: Process Standards of Interventions

- TRi7 Assessment procedures (substance use history, diagnosis and treatment history have to be assessed)
- TRi8 Assessment procedures (somatic status and social status have to be assessed)
- TRi9 Assessment procedures (psychiatric status has to be assessed)
- TRi10 Individualised treatment planning: (treatment plans are tailored individually to the needs of the patient)
- TRi11 Informed consent: (patients must receive information on available treatment options and agree with a proposed regime or plan or changes of plan before starting treatment)
- TRi12 Written client records: (assessment results, intervention plan, interventions, expected changes and unexpected events are documented complete and up to date for each patient in a patient record)
- TRi13 Confidentiality of client data: (patient records are confidential and exclusively accessible to staff involved in a patient's treatment or regime)
- TRi14 Routine cooperation with other agencies: (whenever a service is not equipped to deal with all needs of a given patient, an appropriate other service is at hand to referral)
- TRi15 Continued staff training: (staff is regularly updated on relevant new knowledge in their field of action)

Treatment/rehabilitation: Outcome Standards at the System Level

- TR16 Goal: health stabilisation/improvement (treatment must aim at improvements or stabilisation of health)  
*Exception: non-specialised teams*
- TR17 Goal: social stabilization/integration (treatment must aim at improvements of social stabilisation or integration)  
*Exception: office-based and prison-based services, non-specialised teams*
- TR18 Goal: reduced substance use (treatment must aim at a reduction of substance use e.g. helping the client/patient to reduce the use or to abstain from illegal or non-prescribed psychotropic substances)  
*Exception: office-based services and non-specialised teams*
- TR19 Utilisation monitoring: (services must report periodically the occupancy of treatment slots or beds)

*Exception: office-based services and non-specialised teams*

TR20 Discharge monitoring: (e.g. ratio of regular / irregular discharges and retention rates have to be monitored periodically)

Added during conference

*Exception: office-based and prison-based services, non specialised teams*

TR21 Internal evaluation: (services must regularly perform an internal evaluation of their activities and outcomes)

*Exception: office-based and prison-based services, non-specialised teams*

TR22 External evaluation: (services must regularly allow an evaluation of their activities and outcomes by an independent external evaluator)

Added during conference

*Exception: office based and prison based services, non specialised teams*

### **c. Harm reduction standards**

#### Harm Reduction: Structural Standards of Interventions

HR1 Accessibility: location and opening hours (services have to match the needs of their clients; costs should never be a barrier to a service)

HR2 Staff qualification: minimal qualification (staff has to be qualified and the staff qualification has to be made transparent, e.g. amongst two trained peers involved in the service, two have a diploma in social work and further two in nursing)

*Exception: needle-syringe exchange, outreach/street work, safer use and safer sex counselling, and sheltered housing*

HR3 Indication criteria: age limits (1. Services have to be age appropriate and staff has to be trained to meet age appropriate clients needs, 2. There should be no age limits in harm reduction services)

#### Harm Reduction: Process Standards of Interventions

HR4 Assessment procedures: risk behaviour assessment (client's/patient's risk behaviour is assessed)

*Exception: drug checking, BBV testing and counselling, vaccination, and sheltered housing*

HR5 Assessment procedures: complete needs assessment and prioritisation (e.g. 1. Harm reduction of intravenous drug use and, 2. Reduction of used syringes in public spaces etc.)

Added during conference

*Exceptions: valid only for needle-syringe exchange, and supervised injection rooms*

- HR6 Assessment procedures: client/patient status (the client's/patient's health status is assessed)  
*Added during conference*  
*Exceptions: valid only for needle-syringe exchange, BBV testing and counselling, and vaccination*
- HR7 Informed consent: (Clients/patients must receive information on available service options and agree with a proposed regime or plan before starting an intervention. Interventions should not be based on written informed consent, but rather on a transparently information about all the offers by a service.)  
*Exception: needle-syringe exchange, outreach/street work, drug checking, safer use and safer sex counselling, and sheltered housing*
- HR8 Confidentiality of client data: (client/patient records are confidential and exclusively accessible to staff involved in a client's/patient's intervention or regime)  
*Exception: drug checking*  
*There was consensus at the conference that the standard on the confidentiality of client data should be intervention specific. Also, it was pointed that data should not be accessible without the agreement of the client and that the client's needs should come first.*
- HR9 Individualised treatment planning: (intervention regime and intervention plans, if applicable, are tailored individually to the needs of the client/patient)  
*Added during conference*  
*High consensus for referrals*
- HR10 Routine cooperation with other agencies: (whenever a service is not equipped to deal with all needs of a given client/patient, an appropriate other service is at hand for referral)  
*Exception: drug checking*
- HR11 Continued staff training: (staff is regularly updated on relevant new knowledge in their field of action)  
*Exception: drug checking*
- HR12 Neighbourhood/community consultation: (avoiding nuisance and conflict with other people around the service)  
*Added during conference*  
*Exceptions: valid only for needle-syringe exchange, supervised injection rooms, and sheltered housing*

Harm Reduction: Outcome Standards at the System Level

- HR13 Goal: reduced risk behaviour (reducing unsafe injections, unsafe drug use and unprotected sex)
- HR14 Goal: referrals (treatment services must be prepared to refer clients/patients to other health/social/treatment/legal services if needed and agreed)  
*Exception: drug checking*
- HR15 Internal evaluation: (services must regularly perform an internal evaluation of their activities and outcomes)  
*Exception: drug checking*
- HR16 External evaluation: (services must regularly allow an evaluation of their activities and outcomes by an independent external evaluator)  
*Exception: drug checking, referrals, and sheltered housing*  
*For the standards on external evaluation, there was no consensus what it should include in the harm reduction context and thus, there should be at least a minimal definition. There was clearly non-consensus that external evaluation should not be obligatory based on written record keeping, and that external evaluation is often not feasibly due to insufficient funding.*

## 7. Implementation of standards at national level

The EQUUS project collected systematic information on stakeholder views about the present state of implementation and the expected feasibility of implementation of the proposed minimum quality standards. This was part of the on-line surveys and of group discussions during the European conference.

### *a. Data on acceptability of proposed standards*

The questionnaire for the stakeholder surveys included questions about the acceptability of the proposed quality standards. The following tables present the findings from the responses to the questionnaire.

Prevention standards were not included in these stakeholder surveys; however, the findings of the equivalent survey and focus groups are available in the project report (Brotherhood et al., 2011).

**Table 6 Treatment/rehabilitation: acceptability of proposed quality standards**

<b>Structural standards services</b>		<b>n</b>	<b>Imple-mented (%)</b>	<b>Feasible no problems (%)</b>	<b>Problems expected (%)</b>	<b>Not feasible (%)</b>	<b>No answer (%)</b>
TR1	Accessible location	153	22	30	39	4	6
TR2	Adequate space	149	40	28	24	1	7
TR3	Safety provisions	150	27	19	33	9	11
TR4	Diagnosis mandatory	145	41	23	27	1	7
TR5	Staff qualifications	142	48	24	17	6	5
TR6	Transdisciplinary staff	143	26	21	41	8	4
<b>Process standards Services</b>							
TRs7	Drug use assessed	84	44	38	12	1	5
TRs8	Somatic status assessed	84	36	39	16	2	7
TRs9	Psych. status assessed	84	24	32	32	4	8
TRs10	Individual treatment plan	84	38	23	29	4	7



TRs11	Informed consent	84	43	39	12	0	6
TRs12	Written records	84	43	26	19	4	8
TRs13	Data confidential	84	56	26	12	0	3
TRs14	Routine cooperation	84	25	26	36	6	7
TRs15	Continued training staff	84	30	24	41	0	6
<b>Process standards interventions</b>							
TRi7	Drug use assessed	55	46	24	29	0	2
TRi8	Somatic status assessed	55	40	31	24	4	2
TRi9	Psych. status assessed	55	41	24	36	7	2
TRi10	Individual treatment plan	55	40	13	42	2	4
TRi11	Informed consent	55	40	26	29	4	2
TRi12	Written records	55	36	24	38	0	2
TRi13	Data confidential	55	60	26	13	0	2
TRi14	Routine cooperation	55	29	18	49	2	2
TRi15	Continued training staff	55	31	16	46	6	2
<b>Outcome standards at system level</b>							
TR16	Goal health improved	142	42	29	22	1	6
TR17	Goal social improved	142	29	28	34	4	6
TR18	Goal less substance use	142	37	31	25	1	6
TR19	Monitor utilisation	142	30	30	29	3	8
TR20	Monitor discharge	142	15	25	40	12	9
TR21	Internal evaluation	142	23	25	39	9	5
TR22	External evaluation	141	8	16	53	17	6
	Cost-effectiveness	140	4	11	51	22	11
	Cost-benefit	139	2	9	42	32	15

Note: Grey minimal quality standards without identification code were dropped from the minimal quality standard list after the online survey.

**Table 7 Harm reduction: acceptability of proposed quality standards**

<b>Structural standards interventions</b>		<b>n</b>	<b>Imple-mented (%)</b>	<b>Feasible no problems (%)</b>	<b>Problems expected (%)</b>	<b>Not feasible (%)</b>	<b>No answer (%)</b>
HR1	Accessible location	147	17	23	45	10	5
HR1	Opening hours	140	16	24	44	14	1
HR1	Low costs for patients	138	23	18	26	22	11
HR2	Staff qualifications	133	35	27	23	11	5
HR3	Age limits	135	22	21	29	16	13
	Transdisciplinary staff	133	17	20	34	24	5
	Diagnosis mandatory	137	29	22	23	17	9
<b>Process standards interventions</b>							
HR4	Risk behavior assessed	125	24	35	25	10	6
HR5	Indiv. needs assessment	127	14	32	28	13	13
HR6	Client status assessed	126	21	33	26	11	10
HR7	Informed consent	124	40	28	20	7	5
HR8	Data confidential	124	56	27	12	2	3
HR9	Individual treatment plan	125	20	26	33	17	5
HR10	Routine cooperation	124	35	20	40	4	2
HR11	Continued staff training	123	25	28	42	5	1
HR12	Neighbourhood consult.	123	23	23	33	15	7
	Written records	124	21	26	26	19	8
<b>Outcome standards at system level</b>							
HR13	Goal less risk behavior	133	40	19	35	4	2
HR14	Goal referrals if needed	130	42	19	31	5	2
HR15	Internal evaluation	130	24	29	37	8	2
HR16	External evaluation	129	9	16	54	16	5
	Goal less substance use	131	24	21	34	14	8
	Monitor utilisation	130	29	31	25	9	6

	Cost-effectiveness	129	5	16	40	26	12
	Cost-benefit	128	2	17	38	31	13

Note: HR1: These three standards were integrated into one but assessed separately in the online survey. Grey minimal quality standards without identification code were dropped from the minimal quality standard list after the online survey.

Are the status of standard implementation and the expected feasibility to implement them equally distributed among the European Union ? The following tables show the distribution across three regions (*South-West includes Austria, Belgium, Cyprus, France, Germany, Greece, Italy, Netherlands, Portugal, Spain, Switzerland; Central-East includes Bulgaria, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Romania, Slovakia, Slovenia; North includes Denmark, Finland, Ireland, Sweden, United Kingdom*).

**Table 8 Implementation status of treatment/rehabilitation standards**

Code	Already implemented (% within region)			Feasible without problems (% within region)			Problems expected (% within region)			Not feasible (% within region)		
	South - West	Centr al- East	North	South - West	Centr al- East	North	South - West	Centr al- East	North	South - West	Centr al- East	North
TR1	23	19	22	27	30	39	37	42	35	4	5	0
TR2	46	34	35	20	34	39	24	25	17	0	4	0
TR3	23	32	26	21	18	17	31	32	44	11	9	4
TR4	37	55	23	22	22	32	31	18	36	10	4	0
TR5	55	50	23	24	26	18	8	19	41	5	6	14
TR6	30	29	5	23	18	23	32	49	20	8	4	18
TRs7	38	54	46	38	31	54	13	15	0	2	0	0
TRs8	31	39	46	47	35	23	11	23	15	2	4	0
TRs9	16	35	31	38	27	23	33	35	23	2	4	8
TRs10	33	46	39	24	15	31	39	35	15	4	4	0
TRs11	33	62	39	42	35	39	16	4	15	0	0	0
TRs12	31	58	54	29	27	15	24	8	23	0	8	0
TRs13	51	65	54	29	23	23	11	12	15	0	0	0
TRs14	20	27	39	33	15	23	31	46	31	7	8	0
TRs15	29	35	23	24	19	31	38	46	39	0	0	0
TRi7	60	41	25	10	33	25	25	26	50	0	0	0
TRi8	45	37	38	30	37	13	15	22	50	5	4	0
TRi9	35	37	0	20	30	16	40	33	38	0	0	50
TRi10	45	41	25	5	22	0	40	33	75	5	0	0
TRi11	35	41	50	20	33	13	35	22	38	5	4	0
TRi12	45	37	13	10	33	25	40	30	63	0	0	0
TRi13	70	48	75	20	37	0	5	15	25	0	0	0
TRi14	35	30	13	15	26	0	45	41	88	0	4	0
TRi15	30	37	13	20	19	0	35	44	75	10	0	13

TR16	44	43	32	27	33	23	18	20	36	2	2	0
TR17	35	28	14	27	26	32	29	35	46	2	9	0
TR18	38	41	27	32	32	27	20	24	41	2	2	0
TR19	30	35	18	27	32	36	24	32	36	3	2	5
TR20	12	11	32	29	22	18	38	41	46	10	19	0
TR21	23	28	14	23	26	27	42	33	41	3	11	18
TR22	8	9	5	17	15	14	52	48	71	15	22	10

**Table 9 Implementation status of harm reduction standards**

Code	Already implemented (% within region)			Feasible without problems (% within region)			Problems expected (% within region)			Not feasible (% within region)		
	South - West	Centr al- East	North	South - West	Centr al- East	North	South - West	Centr al- East	North	South - West	Centr al- East	North
HR1	21	16	10	24	24	21	40	47	52	8	14	10
HR1	21	14	11	26	29	11	39	39	63	11	18	15
HR1	27	14	30	18	20	15	21	38	15	26	16	31
HR2	52	19	26	27	31	17	16	29	26	2	15	26
HR3	23	20	21	23	22	13	27	22	46	13	18	17
HR4	23	16	43	42	36	14	22	30	24	7	16	10
HR5	17	9	18	43	22	18	25	31	32	5	24	14
HR6	23	9	36	42	27	18	23	27	32	3	23	9
HR7	44	32	43	22	34	33	22	18	19	5	14	0
HR8	61	52	48	27	39	5	5	9	38	2	0	5
HR9	20	14	33	32	23	14	27	36	43	13	25	10
HR10	37	25	48	20	23	14	39	46	29	2	7	5
HR11	29	21	24	35	23	19	29	50	57	5	7	0
HR12	29	9	33	29	18	14	31	30	43	5	32	5
HR13	57	19	39	15	27	13	23	48	44	3	4	4
HR14	52	24	52	19	22	13	19	44	35	5	9	0
HR15	31	16	22	27	33	26	32	40	44	7	11	4
HR16	11	4	9	13	20	18	57	49	59	13	24	9

***b. Data on expected implementation problems***

In the stakeholder survey questionnaire, the answer option for expected problems for an implementation of the proposed minimum quality standards had to be specified on a separate page. The results of these specifications are presented in the following tables.

**Table 10 Treatment / rehabilitation: expected problems for implementation**

<b>Structural standards services</b>		<b>n</b>	<b>Political problems (%)</b>	<b>Professional Problems (%)</b>	<b>Legal problems (%)</b>	<b>Financial problems (%)</b>	<b>Ethical problems (%)</b>	<b>Other problems (%)</b>
TR1	Accessible location	25	16	16	14	34	4	16
TR2	Adequate space	17	12	8	4	52	8	16
TR3	Safety provisions	17	13	16	10	42	10	10
TR4	Diagnosis mandatory	16	12	32	4	32	4	16
TR5	Staff qualifications	11	6	25	0	50	0	19
TR6	Transdisciplinary staff	25	9	23	6	53	0	9
<b>Process standards services</b>								
TRs7	Drug use assessed	13	4	21	11	29	18	18
TRs8	Somatic status assessed	27	5	27	5	50	5	9
TRs9	Psych. status assessed	24	4	29	2	39	8	18
TRs10	Individual treatment plan	10	6	33	3	39	0	19
TRs11	Informed consent	16	13	31	6	13	13	25
TRs12	Written records	10	0	17	4	30	0	30
TRs13	Data confidential	30	7	7	21	7	7	50
TRs14	Routine cooperation	33	2	26	13	23	9	26
TRs15	Continued staff training	16	2	17	0	67	0	15
<b>Process standards interventions</b>								
TRi7	Drug use assessed	16	7	29	0	43	11	11
TRi8	Somatic status assessed	13	5	27	9	46	5	9
TRi9	Psych. status	20	0	34	6	43	6	11

	assessed							
TRi10	Individual treatment plan	23	5	30	5	45	3	13
TRi11	Informed consent	16	13	32	8	24	11	13
TRi12	Written records	21	0	31	6	34	6	23
TRi13	Data confidential	7	0	22	11	22	0	44
TRi14	Routine cooperation	27	9	33	7	38	2	11
TRi15	Continued staff training	25	0	23	3	71	0	3
<b>Outcome standards at system level</b>								
TR16	Goal health improvement	17	22	19	11	24	8	16
TR17	Goal social improvement	21	14	20	10	37	2	18
TR18	Goal less substance use	17	16	23	10	26	10	16
TR19	Monitor utilisation	17	4	28	4	36	12	16
TR20	Monitor discharge	22	2	39	15	27	7	10
TR21	Internal evaluation	21	3	43	3	30	5	18
TR22	External evaluation	30	5	29	11	38	6	11
	Cost-effectiveness	31	12	30	6	32	10	10
	Cost-benefit	23	14	29	6	33	10	8

Note: Grey minimal quality standards without identification code were dropped from the minimal quality standard list after the online survey.

**Table 11 Harm reduction: expected problems for implementation**

<b>Structural standards interventions</b>		<b>n</b>	<b>Political problems (%)</b>	<b>Professional problems (%)</b>	<b>Legal problems (%)</b>	<b>Financial problems (%)</b>	<b>Ethical problems (%)</b>	<b>Other problems (%)</b>
HR1	Accessible location	66	23	12	15	31	5	14
HR1	Opening hours	61	14	18	9	48	3	9
HR1	Low costs for patients	37	24	8	11	35	10	12
HR2	Staff qualifications	31	4	10	12	51	2	20
HR3	Age limits	39	17	15	24	6	27	11
	Transdisciplinary staff	45	5	24	4	50	1	15
	Diagnosis mandatory	32	14	19	7	33	7	19
<b>Process standards</b>								

<b>interventions</b>								
HR4	Risk behavior assessed	31	4	21	4	31	13	27
HR5	Indiv. needs assessment	36	17	15	8	40	5	15
HR6	Client status assessed	32	7	22	2	40	9	20
HR7	Informed consent	25	8	36	13	15	8	21
HR8	Data confidential	15	9	18	9	9	14	41
HR9	Individual treatment plan	42	8	20	5	37	8	22
HR10	Routine cooperation	49	7	32	10	28	5	17
HR11	Continued staff training	52	5	12	1	66	1	15
HR12	Neighbourhood consult.	42	27	21	11	16	11	15
	Written records	32	2	26	17	24	10	21
<b>Outcome standards at system level</b>								
HR13	Goal less risk behavior	47	20	16	12	30	11	11
HR14	Goal referrals if needed	40	6	26	11	32	3	22
HR15	Internal evaluation	49	4	24	4	40	3	25
HR16	External evaluation	70	9	27	3	45	3	14
	Goal less substance use	44	9	21	11	19	16	24
	Monitor utilisation	33	4	26	9	30	8	23
	Cost-effectiveness	52	11	19	5	29	8	28
	Cost-benefit	48	17	14	4	30	4	32

Note: Grey minimal quality standards without identification code were dropped from the minimal quality standard list after the online survey.

These findings show that:

- the rate of already implemented standards and of expected implementation without problems exceeds the number of expected problems for most standards in treatment/rehabilitation services and interventions, with the exception of three outcome standards (external evaluation, cost-effectiveness and cost-benefit analysis)
- for harm reduction interventions, the rate of expected implementation problems exceeds the rate of implementation and expected implementation without problems, even in the countries where harm reduction measures have been introduced

- the rate of standards for which an implementation is considered not to be feasible, is very low in treatment/rehabilitation (with the exception of the outcome standards mentioned above), but higher in harm reduction
- among the expected problems for implementation prevail the concerns about acceptance by professionals and the financial costs of implementation
- comparatively few problems are expected from political, legal and ethical concerns.

More information would be needed for identifying the practical consequences of standard implementation. This is the case for some of the structural standards of services; e.g. insufficient accessibility could lead to finding a new and better suited location for a given service, or insufficient space for confidential client assessment and counselling may result in reallocating rooms for other functions. For other standards, the national conditions must be considered, e.g. the education and training of the various professionals involved in services for substance abuse treatment and harm reduction is relevant for the standards on qualifications and transdisciplinarity of staff. Such implementation problems need to be handled at the national or local level.

### *c. Lessons from models of implementation*

Four different national approaches introduced in NL, Czech Republic, UK and CH to implement standards to improve the quality of drug services were presented at the conference: The Czech accreditation process, the outputs of drug treatment in the UK, the Dutch guidelines on the treatment of drug and alcohol abuse and the Swiss system of incentives for promoting quality norms for drug treatment services<sup>22</sup>.

While national approaches differ, the presentations all addressed the role of incentives as a key part of any strategy to implement quality standards in drug demand reduction: promotion via conferences/working groups/manual, training of practitioners, stakeholder participation and a certification and oversight system.

At the EU level, the development and adoption of the European cancer screening guidelines provided a thought provoking example of how to introduce standards in the healthcare field. The key pre-requisites include the involvement of civil society, good governance (long-term political commitment, adequate/sustainable resources and oversight of standard implementation), effective programme management and international collaboration.

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<sup>22</sup> For details see presentations on conference website [http://ec.europa.eu/justice/newsroom/anti-drugs/events/110615\\_en.htm](http://ec.europa.eu/justice/newsroom/anti-drugs/events/110615_en.htm)



## **8. Ideas for further research and follow-up projects**

### ***a. Missing Information: a gap analysis***

Further research should take into consideration the information gaps which were identified during the project.

One major gap concerns the type of quality standards. It must be remembered here that quality standards are intended to be useful for different target audiences: intervention standards are of greatest interest for professionals performing interventions, while service standards are most relevant for service directors and managers, and system standards for health authorities, planners and policy makers. It would make sense to involve all these different audiences in a process to identify priority needs for standards which are not sufficiently represented in the lists resulting from the EQUUS project. Such a needs assessment would be the appropriate methodology to find concrete proposals for a future research agenda.

In the inventory, we see a lack of legal and ethical standards, coverage standards and economic standards (in terms of cost-benefit ratio, cost-effectiveness ratio and cost-utilisation ratio). All these are priority items in a health policy perspective.

There is an uneven situation in regard to ethical and legal standards. The inventory of prevention standards includes standards on legal and ethical adequacy. Also, the EQUUS treatment/rehabilitation and harm reduction standards include some ethical standards as process quality standards - on informed consent (T11/19, HR5) and confidentiality of client data (T13/21, HR6). A comprehensive list of ethical standards in terms of structural quality standards would include items of professional competence and conduct in general, rights and obligations of patients and staff, transparency of such rights and obligations, responsibility of services and information towards the general public<sup>23</sup>.

Proposals for the respective legal standards have to be checked on the basis of international and national legislation, on national documents on accreditation norms for services and specific interventions, and a consensus process will be needed for identifying shared minimum standards. Particularly in regard to non-clinical interventions, further legal guidance ('research governance') is needed. Although some legal standards are available (e.g. on compliance with health and safety laws, child protection, financial requirements etc.), there is a lack of prescriptive legal standards specifying what non-clinical interventions and procedures are acceptable. Such standards are available for clinical interventions (e.g. governing administration of methadone), but not for psychosocial interventions (including prevention).

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<sup>23</sup> A provisional list of ethical aspects in the treatment and care of drug users was set up in the framework of a project by WHO (WHO 2002a)

Benchmarks of coverage and cost-related outcomes must be based on generally accepted methodology and an expert consensus on minimum values acceptable as benchmarks. As the literature search performed for establishing the inventories did not result in relevant documents for these standards, new research to fill the gaps is recommended (see marked fields below). 24

**Table 12** Areas without available standards (in red) or insufficient availability (in green)

	<b>Level 1: interventions</b>	<b>Level 2: services</b>	<b>Level 3: systems &amp; policies</b>
<b>Structural quality</b>	Type of setting needed for implementation	Resource standards (infrastructure, human resources)	Legal & ethical adequacy standards (adequate to legal & ethical national norms)
<b>Process quality</b>	Implementation standards	Procedural standards	Standards for networking & cooperation among services
<b>Outcome quality</b>	Efficacy standards (having the intended effect)	Effectiveness standards (reaching useful results)	Coverage standards (proportion of those in need who are covered)
<b>Economic outcome quality</b>	Cost-benefit ratio (economic benefits in relation to costs)	Cost-utilization ratio (coverage in relation to costs)	Cost-effectiveness ratio (positive results in relation to costs)

Another gap exists in terms of available evidence for the proposed quality standards. As can be seen from the following tables, there is a major deficit of documents which provide grades of evidence for specific standards; most standards are based on expert opinion and expert consensus or on literature reviews without having an evidence base (this is also the case for prevention). A future research agenda could be based on a priority list of standards for which appropriate evidence should be available (Grade A and B are the ‘gold standard’ for therapeutic interventions and therefore especially relevant here for interventions and process standards, while grade C is relevant for the effectiveness in ‘real world’ settings and for economic standards).

**Table 13** Which evidence is appropriate for which type of standard?

<b>Grade</b>	<b>Definition</b>
<b>A</b>	Highest degree of evidence: review from multiple randomised controlled studies (RTC) with convergent results

<sup>24</sup> Materials and instruments for economic evaluations have been collected in the framework of a project by WHO (WHO 2002b)

- Relevant for comparing interventions and procedural standards
- B** High degree of evidence; results from single RCT and controlled clinical studies  
*Relevant for comparing interventions and procedural standards*
- C** Moderate degree of evidence: prospective comparative longitudinal studies (observational studies without control design)  
*Relevant for effectiveness and economic outcome standards*
- D** Low degree of evidence: single intervention/service follow-up studies, case studies  
*Relevant for some structural standards*
- E** Very low degree of evidence: non-systematic observations
- Z** Not known.

This seems especially important in the case of minimum standards for which no evidence grade A or B is available so far and for which an experimental testing through randomised controlled studies is feasible and useful. Testing is more relevant for intervention standards, while observational studies (grade C) can be more relevant for service and system standards. Expert consensus is the best guidance if no research evidence is available or feasible. Priorities must also be identified from the practitioners side; for some standards, more evidence would be welcome (e.g. staff education and transdisciplinarity), for others it seems less urgent (e.g. safety issues). About the level of education and transdisciplinarity of staff, the participants to the conference of Bruxelles (15-17 June 2011) clearly noted that as the education system for the non-medical professions is varied across Europe, some flexibility for adaptation should be left.

**Table 14 Accepted treatment and rehabilitation minimal quality standards: evidence grading and source of evidence**

	Number of Documents / Evidence Grade					Source of Document				
	A	B	C	D	E	Lit. Review	Exp. Opinion	Exp. Consensus	Research project	Practice experience
<b>Structural standards of services</b>										
TR1 Accessibility: location	0	0	1	4	6	22	28	31	14	26
TR2 Physical environment: space	0	1	0	5	4	19	32	39	6	32
TR3 Physical environment: safety	0	1	3	3	4	28	29	45	12	40
TR4 Indication criteria: diagnosis	5	1	8	4	11	49	58	74	22	54
TR 5 Staff composition: level	1	0	3	4	14	44	62	76	25	60

of education										
TR 6 Staff composition: transdisciplinarity	0	1	3	2	11	38	52	63	19	51
<b>Process standards at the service level</b>										
TRs7 Assessment procedures: substance use history, diagnosis and treatment history	13	3	21	36	37	78	89	105	40	78
TRs8 Assessment procedures: somatic status and social status	5	2	9	21	30	65	78	89	39	63
TRs9 Assessment procedures: psychiatric status	2	2	8	11	15	63	74	85	36	64
TRs10 Individualised treatment planning	4	6	7	15	15	83	98	116	46	86
TRs11 Informed consent	3	1	7	12	3	68	80	93	36	71
TRs12 Written client records	1	0	8	4	6	65	75	92	32	68
TRs13 Confidentiality of client data	2	1	5	10	3	60	75	83	34	64
TRs14 Routine cooperation with other agencies	1	2	6	15	10	62	85	102	30	74
TRs15 Continued staff training	3	0	3	12	8	55	74	86	31	64
<b>Process standards of interventions</b>										
TRi7 Assessment procedures: substance use history, diagnosis and treatment history	13	3	21	36	37	78	89	105	40	78
TRi8 Assessment procedures: somatic status and social status	5	2	9	21	30	65	78	89	39	63
TRi9 Assessment procedures: psychiatric status	2	2	8	11	15	63	74	85	36	64
TRi10 Individualised treatment planning	4	6	7	15	15	83	98	116	46	86
TRi11 Informed consent	3	1	7	12	3	68	80	93	36	71
TRi12 Written client records	1	0	8	4	6	65	75	92	32	68
TRi13 Confidentiality of client data	2	1	5	10	3	60	75	83	34	64
TRi14 Routine cooperation with other agencies	1	2	6	15	10	62	85	102	30	74
TRi15 Continued staff training	3	0	3	12	8	55	74	86	31	64
<b>Outcome standards at the system level</b>										
TR16 Goal of treatment: health stabilisation/improvement	2	0	9	5	4	66	77	93	31	58
TR17 Goal of treatment: social stabilization/integration	1	0	3	4	14	53	66	89	28	53

TR18 Goal of treatment: reduced substance use	4	2	9	5	8	62	78	93	37	65
TR19 Utilisation monitoring	0	2	2	4	0	18	33	37	15	29
TR20 Discharge monitoring	0	0	1	3	0	13	31	33	10	26
TR21 Internal Evaluation	2	0	4	6	6	27	46	55	18	41
TR22 External Evaluation	0	0	2	7	0	18	36	39	14	32

It is not surprising that there is less evidence for harm reduction standards, for a number of reasons. Harm reduction interventions and services have been developed later and less frequently than treatment and rehabilitation, and research concentrated more on collecting observational data than on experimental designs. Expert opinion and consensus play a major role.

Also, research has focused more on evidence for the effectiveness of harm reduction approaches for specific objectives (e.g. prevention of blood borne infections or overdose death) than on the role of quality standards to be observed in specific intervention types or services. Evidence for the effectiveness of harm reduction approaches has been carefully reviewed and the main knowledge gaps in this field have been identified (see Rhodes & Hedrich 2010). However, this type of evidence was not the focus in the EQUUS project. The question was not if recommendations can be made for the availability of an intervention or service, based on relevant evidence, but which quality standards should be observed if a specific approach is made available. The tables below document the present state of evidence and lack of evidence in regard to such standards, as a starting point of a future research agenda.

**Table 15 Accepted harm reduction minimal quality standards: evidence grading & source of evidence**

	Number of Documents / Evidence Grade					Source of Document				
	A	B	C	D	E	Lit. Review	Exp. Opinion	Exp. Consensus	Research project	Practice experience
<b>Structural standards interventions</b>										
HR1 Accessibility: services have to match the needs of their clients										
costs	0	0	1	0	0	7	7	3	4	10
location	0	0	2	2	1	11	10	8	11	17
opening hours	0	0	2	2	2	12	12	9	7	13
HR2 Staff qualification: minimal qualification	0	0	1	2	1	12	17	12	10	22
HR3 Indication criteria: age limits	0	0	0	5	3	9	13	11	3	11
<b>Process standards interventions</b>										
HR4 Assessment procedures: risk behaviour assessment	0	0	2	1	1	15	12	8	9	15
HR5 Assessment procedures:	0	0	2	3	2	9	11	9	8	13

complete needs assessment and prioritisation										
HR6 Assessment procedures: client/patient status	0	0	2	5	3	16	17	14	10	16
HR7 Informed consent	0	0	2	5	1	12	13	14	6	11
HR8 Confidentiality of client data	0	0	3	6	1	18	17	17	10	19
HR9 Individualised treatment planning	0	0	1	2	0	13	15	10	9	16
HR10 Routine cooperation with other agencies	0	0	3	9	1	22	23	22	15	22
HR11 Continued staff training	1	0	2	3	0	17	18	15	8	20
HR12 Neighbourhood/community consultation	0	0	2	1	1	9	12	10	7	8
<b>Outcome standards at system level</b>										
HR13 Goal: reduced risk behaviour	2	0	4	7	1	25	25	25	15	26
HR14 Goal: referrals	1	0	3	3	1	17	19	16	11	20
HR15 Internal Evaluation	1	0	0	0	0	9	15	12	8	11
HR16 External Evaluation	1	0	1	1	0	11	17	13	9	11

Finally, the present lists of minimum standards are not definite. It can be expected that additional standards will be proposed, e.g on the continuity of care (including aftercare for released prison inmates) or on specific assessment methods (urine screening for psychotropic substances). Especially controversial standards are of interest here, as they would need clarification and guidance.

Furthermore it must be mentioned, that if new research contributes to better and updated information, a revision of the lists is inevitable. It is recommended to set up plans, when and how a revision should be made.

In conclusion, the findings from the gap analysis provide an opportunity to formulate some implications for the *future research agenda* in the area of quality standards for treatment/rehabilitation and harm reduction:

- Standards have a different value, although not exclusively, for different target audiences; intervention standards are of greatest interest for professionals performing interventions, while service standards are most relevant for service directors and managers, and system standards for health authorities, planners and policy makers. It is therefore highly recommendable to *assess and consider the priority needs of these audiences* when setting up a research agenda, in regard to deficient evidence for proposed standards as well as to additional standards not included in the proposed lists
- New research on quality standards must consider the most *appropriate methodology per type of standard*
- New research on quality standards must consider the degree of documented acceptability of the proposed quality standards; the more *controversial*

*standards should have a priority over the well accepted and non-disputed standards*

- In view of the present trend towards an improved quality of action at the system level, a priority is recommended for *research on economic and coverage standards* and for the development of the methodologies for such studies.

***b. Proposal for an EU consensus on minimum quality standards***

The list of proposed minimum quality standards are recommendations addressed to the European Commission to underpin its work on a proposal for an EU consensus on minimum quality standards, now planned for 2013.

European level minimum quality standards will need to add value to what exists in the EU member states and take account of different health systems and capacities across Member States.

Political choices still have to be made and further research carried out to strengthen available the evidence base as described in the gap analysis.

It is highly recommended to continue the consensus building process with stakeholders, in parallel to the political decision-making process, to promote a common understanding of the need and objectives of the proposed quality standards in the field of drug demand reduction.

As an incentive and to encourage the consensus building process at national and EU level, the European Commission has confirmed that will propose EU funding for such initiatives under its Drug Prevention and Information Programme 2012 as well as funding for further research to support the evidence base of the quality standards.

***c. Proposals for an extended consensus building process***

Based on the outcomes of the consensus building process, options for concrete steps and procedures are proposed for further action. They focus is on the dissemination and implementation of the proposed lists of minimum quality standards. The options are:

- Editing of the proposed lists of minimal quality standards with a short commentary and glossary as a manual<sup>25</sup>. This would greatly facilitate the practical implementation of the standards and the adaptation to the diverse national situations

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<sup>25</sup> The European drug prevention quality standards, upon which the EQUS prevention standards are based, are published and available on the internet as EMCDDA Manual No 7 (EMCDDA, 2011); translated versions of the manual (e.g. Italian, Hungarian, Polish) are planned. Manualisation of the EQUS standards may take a similar approach.

- Access to the manual via internet, including a platform for the interactive exchange on implementation experiences
- Translation of the manual into national languages (plus internet access)
- National meetings / conferences for discussing the manual and the models of implementation, starting in pilot countries (e.g. Spain, Finland, Czech Republic)
- Regional meetings / conferences for an exchange of implementation experience
- Integration of workshops on the use of the manual into professional national and international conferences
- Support of such meetings and workshops by European Commission and EMCDDA, through technical assistance and incentives
- Assistance by EMCDDA to national authorities for monitoring their implementation activities
- Monitoring the implementation process
- Access to monitoring results via internet.

***c. Moving from proposed lists to international implementation guidelines***

Implementation of standards in everyday practice, not only in theory, profits from detailed guidelines about how to use and respect the standards, including guidance for exceptions and recommendations for training. Such guidelines are more comprehensive in comparison to a manual; they also indicate the evidence base for the recommendations. There is an interest for developing such guidelines, especially for low- and middle-income countries, also outside of the European region.

The results of the project have significant potential for developing and implementing minimum quality standards at a larger international scale, which may have a serious impact on coverage and quality of prevention and treatment interventions and services worldwide. Setting norms and standards for the global health is one of the core functions of the World Health Organization (WHO), and WHO would be the natural partner in further developments of the standards, following WHO procedures, and their adoption and implementation in different parts of the world. The EQUUS project provides a strong basis for engaging the collaboration with WHO, the global quality standards and support their implementation in other parts of the world.

In the area of prevention, follow-up work is currently being prepared which will seek to develop detailed guidance and training in relation to the quality standards for policy makers and practitioners in Europe. Moreover, efforts are also underway to develop international prevention standards and guidelines which will build upon the EQUUS prevention standards and other major developments in the field.



***d. Monitoring and evaluating the implementation process.***

The political decisions about implementation have yet to be taken. Based on this decision the Commission should decide how to monitor the process. The EMCDDA - in the framework of its mandate - should support the monitoring activities process and evaluation. However, it is recommendable to set up a concept paper and working plan for monitoring the implementation process in Member States, in order to learn from positive and problematic experience and to provide feedback to interested parties.

Finally, an independent evaluation of the process and the outcome of implementation efforts can provide insight and lessons for comparable project.

## 9. References, tables, technical terms, abbreviations

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## ***c. Explanation of technical terms***

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*d. List of abbreviations*

<b>DGJ</b>	Directorate General for Justice (JUST)
<b>EAHC</b>	Executive Agency for Health and Consumers
<b>EC</b>	European Commission
<b>EU</b>	European Union
<b>EMCDDA</b>	European Monitoring Centre for Drugs and Drug Addiction
<b>EQUUS</b>	Study on minimum European Quality Standards
<b>SANCO</b>	Directorate General for Health and Consumers
<b>UNODC</b>	United Nation Office on Drugs and Crime
<b>WHO</b>	World Health Organisation

