

**Minimum Quality Standards in Drug Demand Reduction  
EQUUS**

**Contract nr.**

JLS/2010/DPIP/PR/1023 – 30-CE-0336534/00-50

**Executive summary of final report**

**(incl. list of proposed minimum quality standards)**

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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

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***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)