Annexes

Appendix 10.1

List of experts (national and international project partners)

1. The following experts could be recruited initially as collaborating partners inb the EQUS project:

In the *Area of prevention,* a European project on quality standards co-funded by the Executive Agency for Health and Consumers (EAHC) has already been performed at the Centre for Public Health, John Moores University Liverpool, UK (Dr. Harry Sumnall, MA Angelina Brotherhood). In addition, special ad hoc advisors for our project are Dr. Alfred Uhl, Vienna, and Dr. Amador Calafat, Palma de Mallorca.

The *Area of treatment and rehabilitation* is coordinated at the Research Institute for Public Health and Addiction at Zurich University (Prof. Ambros Uchtenhagen, Dr. Michael Schaub). Experts with known competency in the field and in collaborative studies have been invited to participate. The following agreed to participate:
National experts for Germany: PD Dr. Uwe Verthein, Dr. Peter Degkwitz, Dr. Heike Zurhold from Hamburg University; for Scandinavia: Prof. Anders Bergmark at Stockholm University (Special advisor: Prof. Kerstin Stenius, STAKES Helsinki); for Italy / Spain: Dr. Maurizio Coletti, Dr. Diletta Dottori, Rome; for Austria: Prof. Gabriele Fischer, MA Verena Metz, Dr. Bernadette Winklbaur, University of Vienna; for UK: Dr. Alex Stevens, University of Kent; for The Netherlands: Prof. Gerard Schippers, University of Amsterdam; for Poland / CEEC: Prof. Jacek Moskalewicz, Warsaw; for Switzerland / France: Dr. Michael Schaub, Dr. Severin Haug, MA Esther Grichting, Zurich; for *USA*: Prof. Rudolf Moos, Stanford University CA (Special Advisor: Prof. Keith Humphreys, Stanford University CA); for *Canada:* Prof. Michael Krausz, MA Kirstin Marchand, University of British Columbia, Vancouver; for *Australia:* Prof. Robin Room, Dr. Lynda Berends, MA Janette Mugavin, Turning Point, Fitzroy, Victoria.

The *Area of harm reduction* is coordinated by Dr. Charlie Lloyd, York University, and Dr. Neil Hunt, University of Kent. Consultant for Germany: Prof. Heino Stöver, University of Frankfurt a.M. Special advisor: Prof. Pat O'Hare, past Director and Honorary President IHRA, Liverpool. Special advisor for CEEC: Dr. Simona Merkinaite, EHRN, Vilnius.

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

Old and new 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 Group, Rome
- WHO Division of Mental Health and Substance Abuse, Geneva
- WHO Regional Office for Europe, Copenhagen.

2. Additional experts were recruited in the course of the project. The following is the final list:

Area of prevention: Dr. Harry Sumnall (coordinator) and Dr. Angelina Brotherhood Kurtev, both at the Centre of Public Health, John Moores University Liverpool
Dr. Amador Calafat (special advisor), Palma de Mallorca
Dr. Alfred Uhl (special advisor), Vienna

Area of early intervention, treatment & rehabilitation:
Prof. Ambros Uchtenhagen (coordinator), Dr. Michael Schaub (senior researcher and deputy to Uchtenhagen), Dr. Severin Haug, lic.phil. Esther Grichting (collaborating partners for Switzerland, France and Belgium), all at Research Institute for Public Health and Addiction at Zurich University
PD Dr. Uwe Verthein (collaborating partner for Germany), Dr. Peter Degkwitz, Dr. Heike Zurhold, all at the Centre for Interdisciplinary Addiction Research of Hamburg University
Prof. Gabriele Fischer (collaborating partner for Austria and gender issues), Dr. Margareta Zentzi, Dr. Bernadette Winklbaur, MA Verena Metz, MA Birgit Köchl, all at Vienna University
Prof. Alex Stevens (collaborating partner for the UK), Dr. Polly Radcliffe, at University of Kent in Canterbury
Prof. Gerard Schippers (collaborating partner for the Netherlands), Dr. Masha Spits, at University of Amsterdam
Prof. Anders Bergmark (collaborating partner for Scandinavia excl. Finland), at Stockholm University
Prof. Kerstin Stenius (collaborating partner for Finland), at STAKES Helsinki and Stockholm University
Prof. Jacek Moskalewicz (collaborating partner for Poland and CEEC), Dr. Marta Welbel, at Institute for Psychiatry and Neurology, Warsaw
Dr. Maurizio Coletti (collaborating partner for Italy and Spain), Dr. Diletta Dottori, at Research Institute ricerca, Rome
Mr Kurt Doms (special expert for Belgium), Ministry of Health, Brussels
Mr Sébastien Tiran (special expert for France), Mission Interministérielle de Lutte contre la Drogue et la Toxicomanie (MILDT), Paris
Ms Tonia Bayada (collaborating partner for Cyprus), Cyprus Anti-Drugs Council,

CEEC project partners, coordinated by Prof. Jacek Moskalevicz:

Mr Alexander Kantchelov (Bulgaria)
Mr Emilis Subata (Lithuania)
Ms Marcis Trapencieris (Latvia)
Ms Airi-Alina Allaste (Estonia)
Ms Zsuzsanna Elekes, Anna Péterfi (Hungary)
Mr Ladislav Csemy (Czech Republic)
Mr Lubomir Okruhlica, Ms Jana Hasenohrlova (Slovakia)
Mr Dusan Nolimal (Slovenia)
Mr Andrei Botescu (Romania).

Area of harm reduction

Dr. Charly Lloyd, at York University, and Dr. Neil Hunt, University of Kent (coordinators)
Prof. Heino Stöver (collaborating partner for Germany), at Frankfurt and Oldenburg Universities
Prof. Pat O'Hare (special advisor), University of Liverpool
Simona Merkinaite (special advisor), EHRN Vilnius

Extra-European experts

USA: Prof. Rudolf Moos (collaborating partner), Stanford University,
Prof. Keith Humphreys (special advisor), Stanford University
Canada: Prof. Michael Krausz (collaborating partner), and MA Kirstin Marchand, (research assistant), at Vancouver University of British Columbia
Australia: Prof. Robin Room (collaborating partner), PhD Lynda Berends, and MA Janette Mugavin, at Turning Point, Fitzroy, Victoria

Appendix 10.2

Members of the Steering Group

A steering group was set up by DG Justice, including representatives from the Commission, from EMCDDA Lisbon and the project coordinating institute.

Members are:

Maurice Galla, DG Justice, European Commission, Brussels
Caroline Hager, DG Justice, European Commission, Brussels
Roland Simon, EMCDDA Lisbon
Marica Ferri, EMCDDA Lisbon
Richard Velleman, EMCDDA Lisbon
Ambros Uchtenhagen, ISGF Zurich
Michael Schaub, ISGF Zurich

Appendix 10.3

First interim report (25.07.2010)

In line with the Technical Specifications (1.3.2), set out in the Call for Tender, this first interim report covers the tasks 1 and 2 of the project and will inform on:

- Any problems encountered and solutions proposed
- Main findings of the work undertaken, in particular regarding tasks (1) and (2) of the study; and
- An updated work-plan for the remaining tasks, in line with the time table set out for this contract.

Task 1: **"**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. The expert group should reflect expertise in the broad range of demand reduction interventions".

1.1 A steering group was set up by DGJ, including representatives from the Commission, from EMCDDA Lisbon and the project coordinating institute. A kick-off meeting of the steering group took place at EMCDDA in Lisbon, on May 4th. An important number of issues could be clarified and decisions taken for the implementation of the project. The minutes of this meeting are attached as Annex 1 to this report. Furthermore, EQUS was presented at the REITOX meeting in Lisbon (May 26th); national focal points will be included in the consensus building process (task 3 ff.)

1.2 The EQUS expert group which was proposed in the tender could be fully realised. No expert has declined to participate. A few additional members have been recruited: Prof. Kerstin Stenius, Helsinki, for Finnland, and Dr. Margareta Zentzi for the Austrian team. Steps have been taken to recruit also collaborating partners for Greece and Portugal. These new members are needed mainly on the basis of language problems. Funds for the reimbursement of additional members will be taken from the total budget.

Old and new 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 complete list is attached as Annex 2 to this report.

1.3 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 will also act as reviewers of the draft national inventories and the sets of European minimal quality standards and benchmarks which are to be prepared by the project coordinator. Furthermore, they will participate in the consensus building process by identifying the national stakeholders to be included.

1.4 Collaborating partners have been invited to a kick-off meeting which took place in Zurich on June 12-13. 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 minutes of this meeting are attached as Annex 3.

1.5 Collaborating partners have received a contract describing the tasks, liabilities and payment regulations; the draft text of the contract was submitted to DGJ and finalised according to its instructions. The revised text is attached as Annex 4.

Task 2: "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".

2.1 This task was approached with the following steps:

- 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 12-13th in Zurich)
- piloting the draft templates and manuals at national level for 2-3 selected documents (deadline July 5th)
- 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 9th)
- adapting and disseminating template and manual for harm reduction standards.

The document search and the transmission of templates will end by September 30th, as set out in the tender time table.

The final templates and manuals are attached as Annexes 6,7,8 and 9.

2.2 In the area of drug prevention, the situation is different, due to the fact that another European project has already identified quality standards and produced a comprehensive list of standards (the list was attached to the tender). However, the procedures for establishing this list were different, and the basis of the identified standards are expert opinion and expert consensus only.

A meeting of the expert group on quality standards in prevention, taking place in Milan 9th of June, was used by the EQUS project coordinator to present the design and procedures of EQUS, and to discuss further steps to be made for an adaptation of prevention standards to the requirements of EQUS. This includes mainly a revision of the essential documents for identifying the research evidence available.

2.3 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 (EQUS@isgf.uzh.ch). Also, steps have been taken to set up a data bank and master file for all

incoming information from templates. The responsible persons for the data bank, for controlling the incoming templates (completeness of information, plausibility, errors) are Dr. Michael Schaub and Dr. Severin Haug. Access to the data bank have exclusively these two persons.

2.4 The master file will be the basis for setting up national inventories of existing quality standards and benchmarks, separately for the areas of prevention, treatment/rehabilitation and harm reduction, as well as European inventories in these three areas.
2.5 The deadline for presenting the draft inventories is end of February 2011.

3. Conclusions
Problems:
So far, no problems were encountered delaying or altering the implementation of the EQUS project. No new solutions had to be made for the work plan or the time table.

Main findings for tasks 1 & 2:
Task 1: The expert group is established as planned; a few additional experts seemed necessary and are recruited in order to include practically all national languages. Contracts with national collaborating partners describe the rules and duties.
Task 2: The kick-off meeting with national collaborating partners 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 adaptation of the existing prevention quality standards to the EQUS concept is under way. The infrastructure for adequately controlling and storing of incoming information via templates from collaborating partners is ready.

Other results:
A steering committee with representatives of the European Commission, DGJ, of EMCDDA and of the coordinating institute at Zurich University is established and has set the rules for project implementation.

Updated work plan:
The time table set out in the tender is still valid.
A next meeting of the expert group, on invitation from the Commission, will be scheduled for late november 2010. A concrete proposal for dates and place, agenda, participants is attached as Annex 10.

Zurich, July 25th, 2010

Appendix 10.4

Instructions for document search and transmission

Step 1: document search

- Systematic search of national documents from data banks
- Search from specific sources (national focal point, national/regional health authorities, professional associations, research centres, NGOs etc.)

Inclusion criteria

- published documents providing information on quality indicators and/or standards on specific interventions and/or specific settings and/or regional / national networks
- international documents (e.g. from WHO, EMCDDA) should only be included if they are declared to be relevant at the national level

Priority if given toofficial documents (e.g. by health authorities, professional associations, major service providers, insurances)research reviews, indicating the grade of evidence for the findingsresearch reports specifically focusing on quality indicators, standards and/or benchmarks.Exclusion: unpublished grey literature, documents on local standards, and documents without declaration of their origin

Step 2: screening criteria for inclusion into templates

For quality standards:

- the origin and the status on the national level is indicated
- author(s) and publication details are indicated
- the evidence base is indicated

For benchmarks:

- the origin and status on the national level is indicatedauthor(s) and publication details are indicatedinstruments and procedures for measurement are indicated
- the evidence base is indicated

In the templates there is room for indicating the legal status of a document (mandatory vs recommended standards) and the grade of evidence (if provided in the document).

Documents giving no information on the legal status and the grade of evidence must not be excluded if they respond to the other criteria mentioned above.

Manual for the use of the electronic template on treatment/rehabilitation

For every document selected for systematic evaluation, one (or eventually more than one) template must be used. The document code (ID) will allow to identify which templates belong to which document. The following instructions indicate where to enter the information. Do not use the fields marked with yellow for entering information. Whenever column D has not

enough space, refer under column D to column I and enter the full text there. For all items marked "other (which ?)" use columns D and I to specify.

General information

Document ID : enter in field D4. Composition: country code / document running nr / researcher initials / date (dd/mm/yy)
If two or more templates are used for entering information from the same document, add a running number after the date (e.g. country code/document running nr/researcher initials/date/_01, 02 etc.

Country code	Austria	01	Latvia	15
	Belgium	02	Lithuania	16
	Croatia	03	Luxemburg	17
	Czech Rep.	04	Netherlands	18
	Cyprus	05	Norway	19
	Denmark	06	Poland	20
	Estonia	07	Portugal	21
	Finland	08	Romania	22
	France	09	Slovenia	23
	Germany	10	Slovakia	24
	Greece	11	Spain	25
	Hungary	12	Sweden	26
	Ireland	13	Switzerland	27
	Italy	14	UK	28
	Australia	31	Canada	32
	USA	33		

Author(s): enter in field D5.
person name(s) of author(s) (first 3 in case of multiple authors) or organisation name
Document title: enter in field D6.
full original title (plus English translation if original is non-English)
Publication details: enter in fields D7-10
Provide in column D : website address,
journal title/year/volume/pages,
book title/authors/publisher/year,
book chapter: book title/editor(s)/publisher/year, chapter title/chapter author(s)/pages
Origin of document : enter in fields D11-17
Provide in column D the name of public authority, professional association, NGO, research institute, insurance company or authority, UN agency or other source.

For the following items under "General information", the columns E-H must be used.
Geographical scope :
If the document covers the national level, tick in field E18
If the document covers the regional / provincial level, tick in field E19
If the scope is nor national nor regional, tick in field E20 and explain in D20
If the scope is not known, tick in fields G18,19,20
Intervention level :
If the document covers one or more specific interventions (concerning a therapeutic approach or method), tick in field E21
If the document covers one or more types of treatment/rehabilitation services (offering one or more therapeutic approaches), tick in field E22

If the document covers a treatment system or treatment network in a given country or region (including more than one service), tick in field E23

If the document covers all 3 levels of intervention, tick in fields E21, 22, 23

If the document does not indicate the level of intervention, tick in field G21, 22, 23

Intervention type :

If the document covers any or several intervention types indicated in column C, tick in the appropriate fields in column E24-34. For intervention types not covered, tick in the appropriate fields F24-34

If the document covers intervention types not listed here, use item C34, tick in E34 and describe in D34

If the document does not indicate the intervention types, tick in the fields G24-34.

Setting type :

If the document covers one or several types of settings indicated in column C, tick in the appropriate fields in column E35-41. For settings not covered, tick in the appropriate fields F35-41

Specialised settings are caring mainly for patients/clients with substance abuse problems

If the document covers setting types not listed here, use item C41, tick in E41 and describe in D41

If the document does not indicate any setting types, tick in the fields G35-41.

Target population :

If the document covers one or several types of target populations indicated in column C, tick in the appropriate fields in column E42-50. For target populations not covered, tick in the appropriate fields F42-50

If the document covers target populations not listed here, use item C49 orC50, tick in E49 or E50 and describe in D49 or D50

If the document does not indicate which target populations are covered, tick in the fields G42-50.

Substances :

If the document covers the treatment of one or several types of substances indicated in column C, tick in the appropriate fields in column E51-59. For substances not covered, tick in the appropriate fields F51-59

If the document covers substances not listed here, use item C59, tick in E59 and describe in D59

If the document does not indicate any substances, tick in the fields G51-59.

<u>Specific information</u>

All standards in the document must be labelled as being mandatory or a recommendation, and the evidence base for the standard must be indicated if available.

- if the standard is mentioned in the document to be mandatory, tick in the respective field in column F
- if the standard is not marked to be mandatory, tick in the respective field in column E ("recommendation")
- if the basis for a standard is mentioned, enter the respective grade of evidence in column G
- if a standard is not mentioned in the document, tick in the appropriate field in column H ("not applicable").

The column I "Text" should be used for additional information on a given standard (e.g. in all cases where the subcategory "other" applies).

Grading of evidence : The following definitions apply:

A highest degree of evidence: review from multiple randomised controlled studies (RTC) 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 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.

For **structural standards**, use column I for describing the details of the respective standard. The following provides examples illustrating what the standards may cover. Describe the standards mentioned in the document under column I and tick the respective subcategory in column E ("recommended") or F ("mandatory")

physical environment hygiene: e.g. separate bathrooms for men and woman etc.
safety: e.g. equipment for fire emergencies, reanimation etc.
spacial adequacy: e.g. separate rooms for individual counselling

accessibility geographical location e.g. easy to reach by public transport
needs adjusted opening hours: e.g. opened in 1-2 evenings per week for patients/clients unable to attend during daytime
waiting lists: e.g. within which period must access be available
costs: e.g. how much of the costs are not covered by insurance etc.

indication criteria age limits: e.g. minimal age for being admitted
diagnosis: e.g. only for patients with opioid dependence
restrictions: e.g. exclusion of persons with HIV/Aids, with criminal record

staff composition disciplines: e.g. staff must have doctors, nurses and social workers
minimal number: e.g. a service must have a minimum of 4 staff
staff-client ratio: e.g. not more than 20 clients per staff
ex-users in staff: e.g. at least one ex-user per team

staff qualification proportion with special training: e.g. how many staff must have special training or experience in working with addicted persons
minimal qualifications: e.g. at least half of staff must have a diploma in nursing, social work or psychology

For **process standards**, use column I for describing the details of the respective standard. The following provides examples illustrating what the standards may cover:

assessment procedures
diagnosis: e.g. ICD-10 is used for assessing dependence
psychiatric status: e.g. a mental health checklist is used, referral to a psychiatrist is optional
somatic status: e.g. systematic check for blood borne infections
social status: e.g. living conditions are checked by a social worker
treatment history: e.g. registering which former treatments, when, how long, outcome

individualised intervention planning
e.g. discussing and implementing a regime or treatment plan tailored to the patients/clients needs

informed consent e.g. patients/clients receive information on available treatment options and agree with a proposed regime or plan

written patient/client records

e.g. assessment results, intervention plan, interventions, expected changes and unexpected events are recorded

confidentiality of patient/client data

e.g. records are exclusively accessible to staff involved in a patients/clients treatment or regime

routine cooperation with other agencies

e.g. whenever a service is not equipped to deal with all needs of a given patient/client, an appropriate other service is at hand for referral

intervention manuals or staff

e.g. written instructions for all routine procedures and for special situations are available

continued staff training

e.g. updating staff on relevant new knowledge in their field of action

regular supervision of staff

e.g. individual or group supervision by an external supervisor 1-2 times every month

user involvement in programming

e.g. patients/clients are involved in the design and implementation of an intervention programme; if so, how ?

sanctions / exclusion criteria

e.g. exclusion after 3 urine tests positive for drug use

For **outcome standards**, use column I for describing the details of the respective standard. The following provides examples illustrating what the standards may cover:

patient/client satisfaction

e.g. is satisfaction periodically measured ? If recommended, tick in field E100, if mandatory, tick in field F100

staff satisfaction e.g. is satisfaction periodically measured ? If recommended, tick in field E101, if mandatory, tick in field F101

utilisation monitoring e.g. routine data on bed occupancy etc. If recommended, tick in field E102, if mandatory, tick in field F102

discharge monitoring e.g. ratio of regular / irregular discharges, retention rates etc.

follow-up monitoring e.g. checking on follow-up regimes/treatments, re-contacting patients/clients for follow-up data etc.

coverage e.g. which proportion of estimated persons in need of treatment/rehabilitation are covered at national or at regional / local level ? what method for estimation was used ?

treatment goals e.g. substance use reduction, crime reduction, health improvement, social integration: use column E107-110 if recommended, F107-110 if mandatory, G107-110 if not mentioned

outcome evaluation indicate if internal (in-service) or external evaluation is considered to be a standard, use column E111-112 if recommended, F111-112 if mandatory, G111-112 if not mentioned

measurement of goal attainment

e.g. is it a standard to measure outcomes in relation to treatment goals routinely ? How often ? If recommended, tick in field E117, if mandatory, tick in F117

benchmarks please indicate standard rates and describe which methods have been used for determining costs, benefits, effectiveness etc. (if possible with references); use column I and eventually an additional word document.

basis of standards please indicate on which basis the standards in the document have been identified or set up

Not to forget: Additional information and problems in using the template can be provided on a separate sheet in plain tex (word format) !

Thank you for answering all items if possible !

Manual for the use of the electronic template on harm reduction

For every document selected for systematic evaluation, one (or eventually more than one) template must be used. The document code (ID) will allow to identify which templates belong to which document.
The following instructions indicate where to enter the information. Do not use the fields marked with yellow for entering information. Whenever column D has not enough space, refer under column D to column I and enter the full text there. For all items marked "other (which ?)" use columns D and I to specify.

General information

Document ID : enter in field D4. Composition: country code / document running nr / researcher initials / date (dd/mm/yy)
If two or more templates are used for entering information from the same document, add a running number after the date (e.g. country code/document running nr/researcher initials/date/_01, 02 etc.

Country code	Austria	01	Latvia	15
	Belgium	02	Lithuania	16
	Croatia	03	Luxemburg	17
	Czech Rep.	04	Netherlands	18
	Cyprus	05	Norway	19
	Denmark	06	Poland	20
	Estonia	07	Portugal	21
	Finland	08	Romania	22
	France	09	Slovenia	23
	Germany	10	Slovakia	24
	Greece	11	Spain	25
	Hungary	12	Sweden	26
	Ireland	13	Switzerland	27
	Italy	14	UK	28
	Australia	31	Canada	32
	USA	33		

Author(s): enter in field D5.
person name(s) of author(s) (first 3 in case of multiple authors) or organisation name
Document title: enter in field D6.
full original title (plus English translation if original is non-English)
Publication details: enter in fields D7-10
Provide in column D : website address,
journal title/year/volume/pages,
book title/authors/publisher/year,

book chapter: book title/editor(s)/publisher/year, chapter title/chapter author(s)/pages

Origin of document : enter in fields D11-17

Provide in column D the name of public authority, professional association, NGO, research institute, insurance company or authority, UN agency or other source.

For the following items under "General information", the columns E-H must be used.

Geographical scope :

If the document covers the national level, tick in field E18

If the document covers the regional / provincial level, tick in field E19

If the scope is nor national nor regional, tick in field E20 and explain in D20

If the scope is not known, tick in fields G18,19,20

Intervention level :

If the document covers one or more specific interventions (concerning a therapeutic approach or method), tick in field E21

If the document covers one or more types of treatment/rehabilitation services (offering one or more therapeutic approaches), tick in field E22

If the document covers a treatment system or treatment network in a given country or region (including more than one service), tick in field E23

If the document covers all 3 levels of intervention, tick in fields E21, 22, 23

If the document does not indicate the level of intervention, tick in field G21, 22, 23

Intervention type :

If the document covers any or several intervention types indicated in column C, tick in the appropriate fields in column E24-34. For intervention types not covered, tick in the appropriate fields F24-34

If the document covers intervention types not listed here, use item C34, tick in E34 and describe in D34

If the document does not indicate the intervention types, tick in the fields G24-34.

Setting type :

If the document covers one or several types of settings indicated in column C, tick in the appropriate fields in column E35-42. For settings not covered, tick in the appropriate fields F35-42

Specialised settings are caring mainly for patients/clients with substance abuse problems

If the document covers setting types not listed here, use item C42, tick in E42 and describe in D42

If the document does not indicate any setting types, tick in the fields G35-42.

Target population :

If the document covers one or several types of target populations indicated in column C, tick in the appropriate fields in column E43-50. For target populations not covered, tick in the appropriate fields F43-50

If the document covers target populations not listed here, use item C49 orC50, tick in E49 or E50 and describe in D49 or D50

If the document does not indicate which target populations are covered, tick in the fields G43-50.

Substances :

If the document covers the treatment of one or several types of substances indicated in column C, tick in the appropriate fields in column E51-59. For substances not covered, tick in the appropriate fields F51-59

If the document covers substances not listed here (e.g. steroids), use item C59, tick in E59 and describe in D59

If the document does not indicate any substances, tick in the fields G51-59.

Specific information

All standards in the document must be labelled as being mandatory or a recommendation, and the evidence base for the standard must be indicated if available.

- if the standard is mentioned in the document to be mandatory, tick in the respective field in column F
- if the standard is not marked to be mandatory, tick in the respective field in column E ("recommendation")
- if the basis for a standard is mentioned, enter the respective grade of evidence in column G
- if a standard is not mentioned in the document, tick in the appropriate field in column H ("not applicable").

The column I "Text" should be used for additional information on a given standard (e.g. in all cases where the subcategory "other" applies).

Grading of evidence : The following definitions apply:

A	highest degree of evidence: review from multiple randomised controlled studies (RTC) 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 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.

For **structural standards**, use column I for describing the details of the respective standard. The following provides examples illustrating what the standards may cover. Describe the standards mentioned in the document under column I and tick the respective subcategory in column E ("recommended") or F ("mandatory")

physical environment	
	hygiene: e.g. separate bathrooms for men and woman etc.
	safety: e.g. equipment for fire emergencies, reanimation etc.
	spacial adequacy: e.g. separate rooms for individual counselling
accessibility	geographical location e.g. easy to reach by public transport
	needs adjusted opening hours: e.g. opened in 1-2 evenings per week for patients/clients unable to attend during daytime
	waiting lists: e.g. within which period must access be available
	costs: e.g. how much of the costs are not covered by insurance etc.
indication criteria	age limits: e.g. minimal age for being admitted
	diagnosis: e.g. only for patients with opioid dependence
	restrictions: e.g. exclusion of persons with HIV/Aids, with criminal record
staff composition	disciplines: e.g. staff must have doctors, nurses and social workers
	minimal number: e.g. a service must have a minimum of 4 staff
	staff-client ratio: e.g. not more than 20 clients per staff
	ex-users / current users in staff: e.g. at least one ex-user per team
staff qualification	proportion with special training: e.g. how many staff must have special training or experience in working with addicted persons

minimal qualifications: e.g. at least half of staff must have a diploma in nursing, social work or psychology

For **process standards**, use column I for describing the details of the respective standard.
The following provides examples illustrating what the standards may cover:

assessment procedures

complete needs assessment: not just based on client's demands, but on the judgment of staff, e.g. using a checklist
priority needs identification: determining which needs must first be attended to (based on the judgment of staff)
risk behavior assessment: e.g. using a checklist on risk behaviors
health status: e.g. systematic check for blood borne infections
social status: e.g. living conditions are checked by a social worker
intervention history: e.g. registering which former treatments and criminal justice interventions, when, how long, outcome

individualised intervention planning

e.g. discussing and implementing a regime or intervention plan tailored to the patients/clients needs

informed consent e.g. patients/clients receive information on available intervention options and agree with a proposed regime or plan

written patient/client records

e.g. assessment results, intervention plan, interventions, expected changes and unexpected events are recorded

confidentiality of patient/client data

e.g. records are exclusively accessible to staff involved in a patients/clients treatment or regime

routine cooperation with other agencies

e.g. whenever a service is not equipped to deal with all needs of a given patient/client, an appropriate other service is at hand for eventual referral (with informed consent)

intervention manuals or staff

e.g. written instructions for all routine procedures and for special situations are available

continued staff training

e.g. updating staff on relevant new knowledge in their field of action every 6 or 12 months

regular supervision of staff

e.g. individual or group supervision by an external supervisor 1-2 times every month

user involvement in programming

e.g. patients/clients are involved in the design and implementation of an intervention programme; if so, how ?

sanctions / exclusion criteria

e.g. exclusion after selling drugs on the premises, denies access for one month after violent behavior

neighbourhood / community consultation

e.g. meeting with community representatives, identifying mechanisms for dealing with neighbour complaints

For **outcome standards**, use column I for describing the details of the respective standard.
The following provides examples illustrating what the standards may cover:

patient/client satisfaction

e.g. is satisfaction periodically measured ? If recommended, tick in field E101, if mandatory, tick in field F101

staff satisfaction e.g. is satisfaction periodically measured ? If recommended, tick in field E102, if mandatory, tick in field F102

utilisation monitoring e.g. routine data on bed occupancy etc. If recommended, tick in field E103, if mandatory, tick in field F103

discharge monitoring e.g. ratio of regular / irregular discharges, retention rates etc.

coverage e.g. which proportion of estimated persons in need of treatment/rehabilitation are covered at national or at regional / local level ? what method for estimation was used ?

treatment goals e.g. substance use reduction, risk behavior reduction, referral to other services in case of need: use column E107-110 if recommended, F107-110 if mandatory, G107-110 if not mentioned

outcome evaluation indicate if internal (in-service) or external evaluation is considered to be a standard, use column E111-112 if recommended, F111-112 if mandatory, G111-112 if not mentioned

measurement of goal attainment

e.g. is it a standard to measure outcomes in relation to treatment goals routinely ? How often ? If recommended, tick in field E117, if mandatory, tick in F117

benchmarks please indicate standard rates and describe which methods have been used for determining costs, benefits, effectiveness etc. (if possible with references); use column I and eventually an additional word document.

basis of standards please indicate on which basis the standards in the document have been identified or set up

Appendix 10.5

List of templates (treatment/rehabilitation and harm reduction)

Templates Treatment and Rehabilitation

Austria

1. Novelle zur Suchtgiftverordnung BGBI II Nr. 451/2006 (amendment of addictive drug law BGBI II Nr. 451/2006)
2. Novelle zur Suchtgiftverordnung BGBI II Nr. 112/1997 (amendment of addictive drug law BGBI II Nr. 112/1997)
3. Novelle zur Suchtgiftverordnung BGBI II Nr. 314/2005 (amendment of addictive drug law BGBI II Nr. 314/2005)
4. Novelle zur Suchtgiftverordnung BGBI II Nr. 485/2009 (amendment of addictive drug law BGBI II Nr. 485/2009)
5. Substanzabhängigkeit vom Morphintyp - State-of-the Art der Erhaltungstherapie mit synthetischen Opioiden (Psychiatrie & Psychotherapie (2006) 2/2: 39-54, Addiction to Morphin - State-of-the-Art of opioid maintainence therapy with synthetic opioids, Psychiatry & Psychotherapy (2006) 2/2:39-54)
6. Bericht zru Drogensituation 2009-Gesundheit Österreich GMBH/ Drug report 2009 - health Austria GMBH
7. Erweiterung des ÖGPP Konsensus-Papiers: Substanzabhängigkeit vom Morphintyp - State-of-the-Art der Erhaltungstherapie mit synthetischen Opioiden Die Therapie mit einem Buprenorphin/Naloxon-Kombinationspräparat (Extension of the consensus statement of the Austrian Society of Psychiatry and Psychotherapy on: Dependence from Morphine-type-state-of-the-art of maintenance therapy with synthetic opioides: Treatment with a Buprenorphine/Naloxone combined formulation)
8. Bericht zur Drogensituation 2009-Gesundheit Österreich GMBH/ Drug report 2009 - health Austria GMBH
9. Substanzabhängigkeit vom Morphintyp - State-of-the Art der Erhaltungstherapie mit synthetischen Opioiden
10. Konsensus-Statement: Substitutionsgeschützte Behandlung Opioidabhängiger, ÖGABS-Konsensustext Substitutionsbehandlung (State-of-the-Art therapy: Consensus-Statement about the opioid maintenance therapy)
11. Qualitätsrichtlinien für Suchteinrichtungen in NÖ, 2006 - Quality guidelines Lower Austria in 2006
12. Suchtbericht 2007- drug report 2007
13. Rahmenplan für die Suchtarbeit in Niederösterreich/ Framework addiction in Lower Austria
14. Bericht zur Drogensituation 2010-Gesundheit Österreich GMBH/ Drug report 2010 - health Austria GMBH

Belgium

15. Between Dream and Reality: Implementation of case management among drug abusers in the treatment and criminal justice system. Summary.
16. Evidence-based practice in substance abuse treatment in Belgium : a state of the

art: summary

17. Substitution treatments in Belgium, Development of a model for the asessment of different types of services and patients, Summary, Research Programme on the Federeal Policy Document on drugs
18. Adaptation française et néerlandaise des critères de l'ASAM dans le choix du mode de prise en charge des toxicomanes
19. Effects of Alternative Measures for Drug Users

Bulgaria

20. Закон за контрол върху наркотичните вещества и прекурсорите/ Law on control of narcotic substances and precursors
21. Наредба №24 от 2000 г. За условията и реда за осъществяване на субституиращи и поддържащи програми за намаляване на здравните щети за лица, зависими от наркотични вещества/ Regulation N. 24 / 31.10.2000 on the conditions and rules for substitution and maintenance programs for harm reduction for drug addicted individuals
22. Наредба № 30 от 20.12.2000 г. За реда за участие в долечебни и рехабилитационни програми на лица, които са били зависими или са злоупотребили с наркотични вещества/ Regulation №30 / 20.12.2000 on the rules for participation in pre-treatment and rehabilitation programs for individuals that had previously been addicted or had abused narcotic substances
23. Наредба №24 от 7 юли 2004 г. за утвърждаване на медицински стандарт "Психиатрия"/ Regulation N. 24/ 07.07.2004 for the approvement of medical standard "Psychiatry"
24. Консенсусно становище относно препоръчителен подход за лечение на зависимости/ Consensus statement on recommended approach for treatment of drug addiction, National Centre for Addictions, Sofia, 2002
25. Консенсусно становище относно препоръчителен подход при рехабилитация на зависимостите/ Consensus statement on recommended approach for rehabilitation of drug addiction
26. Насоки за добра практика в субституиращото лечение/ Guidelines for good clinical practice in substitution treatment
27. Насоки за добра практика в психосоциалната рехабилитация на зависимости/ Guidelines for good practice in psycho-social rehabilitation in addictions
28. Насоки за работа по изграждане на социални умения за зависими и злоупотребяващи с психоактивни вещества в лечебни и рехабилитационни програми/ Guidelines for building social skills for drug abusers and drug addicted people in treatment and rehabilitation programs
29. Therapeutic communities. Standards of good practice

Czech Republic

30. Standard substituční léčby.[Standard of substitution treatment.] In: Věstník Ministerstva zdravotnictví ČR. [Bulletin of the Ministry of Health CR.] Ročník 2008, částka 3, strany 10 – 26.
31. Conception of psychiatric care - 1st revision, 2008 (Koncepce oboru psychiatrie - 1. revize, 2008)
32. Nešpor K. Terapie poruch působených alkoholem a jinými návykovými látkami. [Treatment of alcohol and psychoactive use disorders.] In: Seifertová D., Praško J., Höschl C. (Eds.) Postupy v léčbě psychických poruch [Approaches in treatment of

psychiatric disorders]. Praha, Academia Medica Pragensis, 2004, pp. 19 – 44. ISBN 80-8669406-2.
33. Nešpor K. Syndromy závislosti a patologické hráčství. [Syndroms of dependence and pathological gambling.] In: Raboch J., Anders M, Hellerová P. Uhlíková P.: Psychiatrie. Doporučené postupy psychiatrické péče III. [Psychiatry. Recommended approaches in psychiatric care III.] Praha, Tribun EU, 2010, pp. 53 – 101. ISBN 978-8 -7399-984-1
34. Popov P., Nešpor K. Závislost na psychoaktivních látkách [Dependence on psychoactive substances]. In: Raboch J., Anders M, Praško J., Hellerová P. (Eds.) Psychiatrie. Doporučené postupy psychiatrické péče II. [Psychiatry. Recommended approaches in psychiatric care II.] Praha, Infopharm, 2006, pp. 38 – 54. ISBN 80-239-8501-9.

Cyprus

35. ΟΔΗΓΟΣ ΘΕΡΑΠΕΙΑΣ- TREATMENT GUIDE

Denmark

36. Prescription of injectable diacetylmorphine (heroin) in case of opiod dependence
37. Guidance on Medical Treatment of Drug Abusers in Substitution Treatment for Opiod Dependence

Estonia

38. Sotsiaalhoolekande seadus (Social Welfare Act)
39. Guidelines for the Treatment of Drug Addiction

Finland

40. Päihdepalvelujen laatusuositukset (Recommendations concerring the quality of services for substance abusers)
41. Käypä-hoito. Huumeongelmaisen hoito (Treatment of Drug-Abusers. Current Care guidelines)
42. Sosiaali- ja terveysministeriön asetus opiodiriippuvaisten vieroitus- ja korvaushoidosta eräillä lääkkeillä (Decree from the Ministry of Social Affairs and health concerning withdrawal- and substitutionstreatment of opioiddependent persons with certain medications)
43. Vankien terveydenhuollon järjestäminen (Regulation of health care for prisoners)
44. Law on substance abuse treatment 1986
45. Uniform criteria for access to non-emergency treatment 2009. Reports of the Ministry of Social Affairs and Health 2009:5

France

46. Réduction des risques chez les usagers de drogues - Synthèse et recommandations / Harm reduction among drug users - synthesis and recommendation
47. Modalités de sevrage chez les toxicomanes dépendant des opiacés. Texte long des recommandations. Conférence de consensus des 23 et 24 avril 1998. (Detoxificatio modalities for opiate dependent drug users. Recommandations. Consensus conference 23/24 april 1998)

48. Stratégies thérapeutiques pour les personnes dépendantes des opiacés : place des traitements de substitution. Conférence de consensus, 23 et 24 juin 2004. Textes des recommandations (version longue). (Therapeutic strategies for persons dependant on opiates: place of substitution treatments. Consensus conference 23 and 24 juin 2004. Recommendations (long version)).

Germany

49. Akutbehandlung opioidbezogener Störungen (acute treatment of opiate-related diseases)
50. Rahmenvereinbarung zur Kooperation "Suchtgefährdete und suchtkranke schwangere Frauen und Familien mit Kindern bis zu einem Jahr" (framework for cooperation "pregnant women at risk for addiction and addicted pregenant women and their families with children up to one year")
51. Mindeststandard der ambulanten Suchthilfe (minimal standards of outpatient community drug services)
52. Mindesstandards der ambulanten Suchthilfe / Minimal standards for outpatient community drug services
53. Mindesstandards der ambulanten Suchthilfe / Minimal standards for outpatient community drug services
54. Rehabilitation und Teilhabe von Menschen mit Abhängigkeitserkrankungen an der Schnittstelle von medizinischer Rehabilitation in einer Fachklinik und Eingliederungshilfe in Sozialtherapeutischen Wohnheimen (Rehabilitation and participation of substance-misusers with in the context of medical rehabilitation in a specialised clinic and reintegration in a therapeutic community)
55. Rehabilitation und Teilhabe von Menschen mit Abhängigkeitserkrankungen an der Schnittstelle von medizinischer Rehabilitation in einer Fachklinik und Eingliederungshilfe in Sozialtherapeutischen Wohnheimen (Rehabilitation and participation of substance-misusers with in the context of medical rehabilitation in a specialised clinic and reintegration in a therapeutic community)
56. Rahmenstandards für Tagesstätten der Eingliederungshilfe für mehrfach beeinträchtigte suchtkranke erwachsene Menschen (standards for reintegration in day-care centres adressing adult substance misusers with comorbidity)
57. Mindeststandards für die Betreuung und Behandlung suchtmittelkonsumierender Jugendlicher an den Schnittstellen der Hilfesysteme (minimalstandards for the treatment of drug using adolescents - coordination within the care-systems)
58. Handreichung Leistungsvereinbarungen für Suchtberatung nach § 16 (2) SGB II (assistance for contracts between the addiction care centres and job centres according to social law)
59. Richtlinien des Ministeriums für Arbeit, Soziales, Gesundheit und Familie über die Gewährung von Zuwendungen an die Landkreise und kreisfreien Städte für ambulante Beratungs- und Behandlungsstellen für Suchtkranke und für Kontakt- und Beratungsstellen für psychisch Kranke (guideline of the Brandenburg ministry on funding for outpatient counselling and treatment services for substance misuse and mental health disorders)
60. Richtlinie "Methoden vertragsärztlicher Versorgung", Anlage I: Anerkannte Untersuchungs- oder Behandlungsmethoden; Nr. 2 Substitutionsgestützte Behandlung Opiatabhängiger (guideline on medical care provide by accredited physicians attachment I: approved examination or treatment methods; Nr. 2 substitution maintenance treatment for opiate addicts)
61. Richtlinien der Bundesärztekammer zur Durchführung der substitutionsgestützten Behandlung Opiatabhängiger (guideline of the German Medical Association for the

substitution maintenance treatment of opiate addicts)
62. Leistungsbeschreibung für ambulante Beratungs- und Behandlungsstellen der Suchtkrankenhilfe (specifications of outpatient counselling and treatment services for the addiction care)
63. Leistungsbeschreibung für ambulante Beratungs- und Behandlungsstellen der Suchtkrankenhilfe (specifications for outpatient counselling and treatment services for the addiction care)
64. Leistungsbeschreibung für ambulante Beratungs- und Behandlungsstellen der Suchtkrankenhilfe (specifications for outpatient counselling and treatment services for the addiction care)
65. Leistungsbeschreibung für ambulante Beratungs- und Behandlungsstellen der Suchtkrankenhilfe (specifications for outpatient counselling and treatment services for the addiction care)
66. Leistungsbeschreibung für ambulante Beratungs- und Behandlungsstellen der Suchtkrankenhilfe (specifications for outpatient counselling and treatment services for the addiction care)
67. Vereinbarung über die Zusammenarbeit der Krankenkassen und Rentenversicherungsträger bei der Akutbehandlung (Entzugsbehandlung) und medizinischen Rehabilitation (Entwöhnungsbehandlung) Abhängigkeitskranker (agreement between health and pension funds for withdrawal treatment and medical rehabilitation of addicts)
68. AWMF Leitlinien: Cannabis-bezogene Störungen (AWMF-guideline: disorders related to Cannabis)
69. Gemeinsames Rahmenkonzept der Deutschen Rentenversicherung und der Gesetzlichen Krankenversicherung zur ambulanten medizinischen Rehabilitation Abhängigkeitskranker (framework of the german pension funds and health insurances for the outpatient medical rehabilitation of addicts)
70. Landeseinheitliche Standards der Suchthilfe in Baden-Württemberg für die psychosoziale Betreuung bei Substitutionsbehandlung (Standards of the addiction care in Baden-Württemberg for the psychosocial assistance for clients in substitution treatment)
71. Leitlinien der psychosozialen Betreuung Substituierter (guidelines for the psychosocial assistance for clients in substitution treatment)
72. AWMF Leitlinien: Postakutbehandlung bei Störungen durch Opioide (AWMF guidelines: Postacute treatment of opiate abuse and dependence)
73. Leitfaden zur männerspezifischen Sucht- und Drogenarbeit. Handlungsempfehlungen für die Praxis (Manual for male-specific addiction and drug-care)
74. Rahmenkonzept zur Beteiligung der Suchtberatung der Diakonie an den Eingliederungsleistungen der Jobcenter nach SGB II (framework for the cooperation of the addiction care by the Diakonie and the job centres according to social law)
75. Psychosoziale Betreuung substituierter Drogenabhängiger — Leitlinien und Finanzierungsmodelle (psychosocial treatment of patients in substitution maintenance treatment - guidelines and financing modells)
76. Standards für Arbeits- und Beschäftigungsprojekte der Suchthilfe (Standards for vocational- and occupational projects of the addiction care)

Hungary

77. Professional guidance - Daytime care institute for addicted persons in the scope of basic care
78. Professional recommendations - Community social care provided for addicted persons

79. Regulation 1/2000. (I. 7.) SzCsM of the Ministry of Family and Social Affairs on the professional tasks and conditions of operation of social institutes providing personal care
80. Regulation 60/2003. (X.20.) ESzCsM of the Ministry of Health, Family and Social Affairs on the personal and material conditions of providing health services, and on the minimum professional conditions of providing health services
81. The professional protocol of the Ministry of Health – On disorders related to cannabis use
82. The professional protocol of the Ministry of Health – On the treatment of clinical patterns associated with amphetamine use
83. The professional protocol of the Ministry of Health – On the treatment of diseases related to opioid use
84. The methodological letter of the Ministry of Health – The methadone treatment

Italy

85. Guidelines on prevention and treatment for Regional Network
86. Residential and Middle Residential Accreditation
87. Operational protocolo of dual diagnosis
88. Intake guidelines
89. Recognition of Treatments
90. Guidelines of Network
91. Regional Guidelines to built care and organizational paths for Addiction Departments functioning of ASUR
92. State Region Agreement for Reorganization of the Addict Care System
93. Accreditation System of the Addiction Department's Organization (Public and Private)
94. Guidelines for the Treatment of Opiate Addiction with Substitution Treatment
95. The Principles and Practice of Methadone Treatment

Latvia

96. Medical Treatment Law (Ārstniecības likums)
97. Law on patient rights (Pacientu tiesību likums)
98. Procedures for the Development, Evaluation, Registration and Implementation of Clinical Guidelines (Kārtība, kādā izstrādā, izvērtē, reģistrē un ievieš klīniskās vadlīnijas)
99. Procedure for detecting the influence of alcohol, drugs, or toxic substances (Alkohola, narkotisko, psihotropo vai toksisko vielu ietekmes pārbaudes kārtība)
100. Procedures by Which Persons Addicted to Psychoactive Substances Receive Social Rehabilitation Services (Kārtība, kādā no psihoaktīvām vielām atkarīgās personas saņem sociālās rehabilitācijas pakalpojumus)
101. Rules on minimum requirements for medical institutions and their departments (Noteikumi par obligātajām prasībām ārstniecības iestādēm un to struktūrvienībām)
102. Procedures for the Treatment of Patients Addicted to Alcohol, Narcotics, Psychotropic and Toxic Substances (Alkohola, narkotisko, psihotropo un toksisko vielu atkarības slimnieku ārstēšanas kārtība)
103. Guidelines for the Treatment of Drug-Dependent Patients (Narkoloģisko pacientu ārstēšanas vadlīnijas)
104. Guidelines for the Treatment of Misuse and Dependence on Sedative Medications (Sedatīvo un miega zāļu lietošanas un atkarības ārstēšanas vadlīnijas)

105. Guidelines for the medical examination of effects of alcohol, narcotic, psychotropic, and toxic substances (Medicīniskās pārbaudes vadlīnijas alkohola, narkotisko, psihotropo un toksisko vielu ietekmes noteikšanai.)
106. Long-Term Pharmacotherapy of Opioid-Dependent Patients using Methadone and Buprenorphine (Opioīdu atkarīgo pacientu ilgtermiņa farmakoterapija, izmantojot metadonu un buprenorfīnu.)

Lithuania

107. Sveikatos apsaugos ministro 2002 m. gegužės 3 d., įsakymas Nr.204 "Dėl priklausomybės ligų gydymo ir reabilitacijos standartų patvirtinimo" (Žin., 2002, Nr 47-1824); Written Order of the Minister of Health Nr. 204 of May 3, 2002 “On standards of dependence treatment and rehabilitation”
108. Priklausomybės nuo opioidų gydymo naltreksonu metodika. “Guidelines of treatment of opioid dependence with naltrexone”
109. Priklausomybės nuo opioidų gydymo metadonu metodika. “Guidelines of treatment of opioid dependence with methadone ”
110. Priklausomybės nuo opioidų gydymo buprenorfinu ir buprenorfinu/naloksonu metodika. “Guidelines of treatment of opioid dependence with buprenorfine and buprenorphine/naloxone ”
111. Vaikų, vartojančių narkotines, psichotropines, kitas psichiką veikiančias medžiagas ankstyva diagnostika ir gydymas pirminės asmens sveikatos priežiūros įstaigose “Early diagnosis and treatment of children, who use narcotic, psychotropic and other psychoactive substances”
112. Vaikų ir paauglių, vartojančių psichoaktyviąsias medžiagas, gydymo ir skausmo malšinimo opioidais rekomendacijos. “Guidelines of treatment and pain management of children and adolescents, who use psychoactive substances”
113. Asmenų, priklausomų nuo narkotinių ir psichotropinių medžiagų vartojimo, reintegracija į visuomenę ir darbo rinką: socialinės atskirties problemų sprendimas. Narkotikų kontrolės departamentas prie LR Vyriausybės, 2008. “Reintegration of individuals, dependent from illegal drugs into the society and labor market”

Luxemburg

114. Consensus médical au sujet de la prise en charge adéquate d’une substitution de dépendants à l’héroïne au cabinet médical (Medical consens about adequate substitution treatment of heroin dependants in medical practice)
115. Traitement de la Toxicomanie par Substitution. Sommaire. Règlement grand-ducal du 30 janvier 2002 déterminant les modalités du programme de traitement de la toxicomanie par substitution (Drug Treatment by Substitution. Summary.).

Netherlands

116. Middelenafhankelijkheid en depressie (substance addiction and depression)
117. Richtlijn Detox, Verantwoord ontgiften door ambulante of intramurale detoxificatie (guideline detox)
118. Cannabisbehandeling bij jongeren en jongvolwassenen (CB-J), Richtlijn en protocol voor de behandelaar (UK:Treatment for cannabis for adolescents, guideline and protocol)
119. Kortdurende klinische crisisinterventie (shortterm clinical crisis intervention)
120. Richtlijn voor casemanagers in de verslavingzorg (guideline for casemanagers in the addiction care)

121. Richtlijn Behandeling opiaatverslaafden in politiecellen (Guideline treatment opiate addicts in police cells)
122. Guideline substance abuse or dependence and anxiety disorders (richtlijn middelenmisbruik of - afhankelijkheid en angststoornissen). Draft version
123. Richtlijn Opiaat Onderhoudsbehandeling (guideline opiate maintenance treatment)
124. Richtlijn Beoordeling Intoxicaties bij ingesloten personen (Guideline for the assessment of intoxications of addicts in police cells)
125. Leefstijltraining 1, werkboek voor cliënt en handleiding voor trainer (Lifestyle training 1, workbook for patient and manual for clinican/trainer))
126. Leefstijltraining 2, werkboek voor cliënt en handleiding voor trainer (Lifestyle training 2, workbook for patient and manual for clinican/trainer))
127. Leefstijltraining 3, werkboek voor cliënt en handleiding voor trainer (Lifestyle training 3, workbook for patient and manual for clinican/trainer))
128. Leefstijltraining 4, werkboek voor cliënt en handleiding voor trainer (Lifestyle training 4, workbook for patient and manual for clinican/trainer))
129. MATE, handleiding en protocol (MATE manual and protocol)
130. Nazorg na deeltijd en klinische behandeling (aftercare after clinical treatment)
131. Onbenutte mogelijkheden, een handleiding voor de aansluiting tussen verslavingszorg en zelfhulpgroepen. (Unfulfilled potentials: a manual for the connection between addiction care and selfhelp groups)
132. Suicide in de verslavingszorg. Richtlijn voor preventie, handelen na suicide en nazorg voor hulpverleners. (Suicide in addiction care: guideline for prevention, handling after suicide and aftercare for staff
133. Protocol ADHD bij verslaving (protocol adhd with addiction)
134. Multidisciplinary guideline of Personality Disorders (Multidisciplinaire richtlijn Persoonlijkheidstoornissen)- chapter comorbidity with addiction
135. Module Indicatiestelling en trajecttoewijzing (needs assessment / indication and treatment allocation)
136. Richtlijn Medicamenteuze zorg voor gedetineeerde verslaafden
137. Richtlijn benzodiazepinten dosisreductie

Norway

138. National retningslinje for legemiddelsassistert rehabilitering ved opoiodavhengighet (National giudelines for substitution rehabilitation for opiod dependence)

Poland

139. Assesment of a system of treatment and rehabilitation of drug dependance in Poland Ocena Systemu leczenia i rehabilitacji osób uzależnionych od substancji psychoaktywnych w Polsce
140. Regulation of the Minister of Health of 6 October 2010 on changing of regulation on specific conditions and ways of conduct in substitution treatment and detail conditions of health care facilities providing substitution treatment
141. Rozporządzenie Ministra Zdrowia z dnia 6 października 2010 r. zmieniające rozporządzenie w sprawie szczegółowego trybu postępowania przy leczeniu substytucyjnym oraz szczegółowych warunków, które powinien spełniać zakład opieki zdrowotnej prowadzący leczenie substytucyjne
142. The Accreditation Standards for outpatient services for alcohol and psychoactive substances addiction treatment
(Standardy akredytacyjne dla placówek ambulatoryjnych leczenia uzależnienia od

alkoholu oraz leczenia uzależnienia od środków psychoaktywnych)

143. The Accreditation Standards for day-care services for alcohol and psychoactive substances addiction treatment
(Standardy akredytacyjne dla oddziałów dziennych leczenia uzależnienia od alkoholu oraz leczenia uzależnienia od środków psychoaktywnych)
144. The Accreditation Standards for inpatient services for alcohol and psychoactive substances addiction treatment
(Standardy akredytacyjne dla placówek stacjonarnych leczenia uzależnienia od alkoholu oraz leczenia uzależnienia od środków psychoaktywnych)
145. Ustawa o przeciwdziałaniu narkomanii z dnia 29 lipca 2005 r. (z późn. zm,)
Act of 29 July 2005 on counteracting drug addiction (with further ammendments)
146. ROZPORZĄDZENIE MINISTRA SPRAWIEDLIWOŚCI z dnia 17 maja 2007 r. w sprawie szczegółowych warunków i trybu postępowania leczniczego, rehabilitacyjnego i reintegracyjnego w stosunku do osób uzależnionych umieszczonych w zakładach poprawczych i schroniskach dla nieletnich Regulation of the Minister of Justice of 17 May 2007 on detailed conditions and course of treatment, rehabilitation and reintegration as regards the addicted placed in remand homes or shelters for minors
147. Rozporządzenie Ministra Sprawiedliwości z dnia 21 grudnia 2006 r. w sprawie szczegółowych warunków i trybu postępowania leczniczego, rehabilitacyjnego i reintegracyjnego w stosunku do osób uzależnionych, umieszczonych w jednostkach organizacyjnych Służby Więziennej
Regulation of the Minister of Justice of 21 December 2006 on specific conditions and ways of conduct in treatment, rehabilitation and re-adaptation of addicts placed in organizational units of the Prison Service
148. Rozporządzenie Ministra Zdrowia z dnia 1 grudnia 2006 r. w sprawie szczegółowych warunków i trybu postępowania w przedmiocie leczenia lub rehabilitacji osób uzależnionych, skazanych za przestępstwa pozostające w związku z używaniem środków odurzających lub substancji psychotropowych
Regulation of the Minister of Health of 1 December 2006 on specific conditions and ways of conduct in drug treatment and rehabilitation of addicts who were sentenced in relation to committing a drug-related crime
149. Rozporządzenie Ministra Zdrowia z dnia 13 lipca 2006 r. w sprawie szkolenia w dziedzinie uzależnień
Regulation of the Minister of Health of 13 July 2006 on trainings in addictions
150. Raport z III etapu prac dotyczących opracowania oraz zarekomendowania testów, które mogłyby być wykorzystywane do diagnozy w obszarze uzależnienia od narkotyków
Report from the III stage of works on evaluation and recommendation of psychological tests, which can be used for diagnosis in drug addiction field
151. Rozporządzenie Ministra Zdrowia z dnia 4 sierpnia 2000 r. w sprawie określenia wykazu specjalności lekarskich oraz zawodów niemedycznych uprawniających do prowadzenia leczenia i rehabilitacji osób uzaleznionych
Regulation of the Minister of Health of 4 August 2000 on the list of medical specialisations and non-medical professions authorised to provide addiction treatment and rehabilitation
152. KODEKS ETYCZNY TERAPEUTY UZALEŻNIEŃ / Codes of Ethics for Addiction Therapists
153. Optimum model of meeting demand for treatment of people addicted to illicit psychoactive substances in Poland. Report from the study ordered by the National Bureau for Drug Prevention:
1. Accessibility of care for people with disorders caused by using psychoactive

substances in 2004 in Poland
(Optymalny model zaspokajania potrzeb leczniczych ludzi uzależnionych od nielegalnych substancji psychoaktywnych w Polsce. Raport z badań zleconych przez Krajowe Biuro Przeciwdziałania Narkomanii.
1. Dostępność opieki dla osób z zaburzeniami spowodowanymi używaniem substancji psychoaktywnych w Polsce w 2004 r.)

154. Optimum model of meeting demand for treatment of people addicted to illicit psychoactive substances in Poland. Report from the study ordered by the National Bureau for Drug Prevention:
2. Treatment and rehabilitation services for people addicted to illicit psychoactive substances in Poland. Results from the survey.
(Optymalny model zaspokajania potrzeb leczniczych ludzi uzależnionych od nielegalnych substancji psychoaktywnych w Polsce. Raport z badań zleconych przez Krajowe Biuro Przeciwdziałania Narkomanii.
2. Placówki leczenia i rehabilitacji dla uzależnionych od substancji psychoaktywnych w Polsce. Ankieta pocztowa)
155. Optimum model of meeting demand for treatment of people addicted to illicit psychoactive substances in Poland. Report from the study ordered by the National Bureau for Drug Prevention:
3. Summary of the monographic study
(Optymalny model zaspokajania potrzeb leczniczych ludzi uzależnionych od nielegalnych substancji psychoaktywnych w Polsce. Raport z badań zleconych przez Krajowe Biuro Przeciwdziałania Narkomanii.
3. Podsumowanie badań monograficznych.)
156. Programme for Counteracting Drug Addiction 2006-2010
KRAJOWY PROGRAM PRZECIWDZIAŁANIA NARKOMANII NA LATA 2006-2010
157. Act of 6 November 2008 on the patients' rights and Patients' Rights Ombudsman
USTAWA z dnia 6 listopada 2008 r. o prawach pacjenta i Rzeczniku Praw Pacjenta
158. Regulation of the Minister of Health of 10 Nov. 2007 on professional and sanitary requirements for premises and facilities in health care / Rozporządzenie Ministra Zdrowia z dnia 10 listopada 2006 r. w sprawie wymagań, jakim powinny odpowiadać pod względem fachowym i sanitarnym pomieszczenia i urządzenia zakładu opieki zdrowotnej
159. National Health Programme for 2007-2015
Narodowy Program Zdrowia na lata 2007-2015
160. Ustawa z dnia 19 sierpnia 1994 r. o ochronie zdrowia psychicznego z pózn. zm. / Mental Health Act of 19 August 1994 with further ammendments
161. Narodowy Program Ochrony Zdrowia Psychicznego na lata 2011 - 2015 / National Mental Health Protection Programme Mental Health 2011 - 2015
162. ROZPORZĄDZENIE MINISTRA ZDROWIA z dnia 30 sierpnia 2009 r. w sprawie świadczeń gwarantowanych z zakresu opieki psychiatrycznej i leczenia uzależnień / Regulation of the Minister of Health of 30 August 2009 on guaranteed services in mental health and addiction

Romania

163. The standards of the national assistance system of medical, psychological and social care for legal and illegal drug users 2005(Standardele sistemului national de asistenta medicala psihologica si sociala a consumatorilor de droguri licite si ilicite 2005)
164. The compulsory minimum standards of the case management in the care of drug

users approved by the decision no. 16/2006 of the National Antidrug Agency's president(Decizia Preşedintelui Agenţiei Naţionale Antidrog nr. 16 din 2 octombrie 2006 pentru aprobarea Standardelor minime obligatorii privind managementul de caz în domeniul asistenţei consumatorului de droguri)

165. The methodology for the formulation, amendment and implementation of the the customized care plan for drug users approved by Decision no. 17 of 2 October 2006 of the National Antidrug Agency's president(Decizie nr. 17 din 2 octombrie 2006 pentru aprobarea Metodologiei de elaborare, modificare şi implementare a planului individualizat de asistenta a consumatorului de droguri)
166. The standards and the methodology for authorising drug related services for drug users an the minimum compulsory standards for the organisation and operation of the centres that provide services for drug users approved by the Common Regulation no. 1389 of august 2, 2008 of the Minister of Health, Minister of Labour, family and equal opportunities, Minister of interior and administrative reform (Ordinul comun 1389/513/2008/282/2007 din 4 august 2008 (Ordinul 1389/2008) Ordinul ministrului sănătăţii publice, ministrului muncii, familiei şi egalităţii de şanse şi ministrului internelor şi reformei administrative nr. privind aprobarea Criteriilor si metodologiei de autorizare a centrelor de furnizare de servicii pentru consumatorii de droguri si a standardelor minime obligatorii de organizare si functionare a centrelor de furnizare de servicii pentru consumatorii de droguri.
167. Law no. 522 amending and supplementing the law no. 143/2000 on countering the illicit drug trafficking and use (Lege nr. 522 din 24 noiembrie 2004 pentru modificarea si completarea Legii nr. 143/2000 privind combaterea traficului si consumului ilicit de droguri)
168. Clinical Guide for methadone substitution treatment services (Ghidul de practica clinica pentru serviciile de tratament substitutiv cu metadona)
169. Methdology of the Programme to extend the voluntary HIV counselling and testing capacity – revised and updated edition 2006 (METODOLOGIA Programului de Extindere a Capacitatii de Consiliere si Testare Voluntara HIV - Editie revizuita si actualizata 2006)
170. The medical and health measures for drug-addicted people in prison settings approved by the Joint Regulation no. 898/725/2002 of the Ministry of Health and Family and the Ministry of Justice (Ordin comun al ministerului sănătăţii şi familiei şi al ministerului justiţiei nr. 898/725/2002 privind măsurile medicale şi educative aplicate toxicomanilor în penitenciare.)
171. The means to carry out integrated medical, psychological and social care for drug users in custody approved by common Regulation no 1.216/C/2006 of the Ministry of Health, Ministry of Justice , Ministry of Administration and Interior (Ordin nr. 1.216/C din 18 mai 2006 privind modalitatea de derulare a programelor integrate de asistenta medicală, psihologică şi socială pentru persoanele aflate în stare privativă de libertate, consumatoare de droguri.)
172. The quality standards of the medical facilities abilitated for drug related treatment and of the nonguvernamental organisations abilitated for drug related harm reduction services approved by regulation no 187/2002
(Ordin Nr. 187 din 19 martie 2002 pentru definirea tipurilor de unitati medicale ce pot fi abilitate sa asigure asistenta medicala persoanelor dependente de droguri, precum si a organizatiilor neguvernamentale ce pot fi abilitate sa desfasoare
173. National interest programe for prevention and care in case of use of tobacco, alcohol and drug 2009-2012 approved by the Governmental decision no. 1101/2008
(HG nr. 1101/2008, hotarare privind aprobarea Programului de interes national de

prevenire si asistenta pentru consumul de tutun, alcool si droguri - 2009-2012)

174. Medical, psychological and social care national programme for drug users 2009-2012 as amended and supplemented, approved by the Governmental decision no.1102/2008 (Decision 939/2009)(HG nr. 1102/2008 privind aprobarea Programului national de asistenta medicala, psihologica si sociala a consumatorilor de droguri - 2009-2012. cu amendamentele ulterioare (Hotararea 939/2009))
175. Law no. 116/2002 on prevention and combating social marginalisation(Legea nr. 116 din 15.martie.2002 privind prevenirea si combaterea marginalizarii sociale)
176. Regulation no. 1416 of 27 October 2000 on financing desintoxication, medical supervision and legal-medical expertise for drug- addicted people (Ordin nr. 1416 din 27 octombrie 2000 privind finanţarea curei de dezintoxicare, supravegherii medicale şi efectuării expertizei medico-legale pentru persoanele dependente de droguri)
177. Law no. 584 of October 27, 2002 on AIDS prevention measures and the measures to protect HIV infected people or people living with AIDS.(Lege nr.584 din 29 octombrie 2002 privind măsurile de prevenire a răspândirii maladiei SIDA în România şi de protecţie a persoanelor infectate cu HIV sau bolnave de SIDA)
178. Aurora Lefter
179. National Anti-Drug Strategy 2005-2012 approved by Governmental Decision no. 73 of January 27, 2005
(Strategia Nationala Antidrog 2005-2012 aprobata prin hotararea guvernului nr. 73 din 27 Ianuarie 2005)
180. Standard guidelines for psychological evaluation of drug users (Protocol de evaluare psihologica a consumatorilor de droguri)
181. Mental Heath Strategy 2006-2014 approved by Regulation no. 374/10.04.2006 with further amendments (Ordinul nr. 374/10.04.2006 privind aprobarea Strategiei în domeniul sănătăţii mintale, 2006-2014 cu amendamentele ulterioare)
182. National Anti-Drug Strategy 2005-2012 approved by Governmental Decision no. 73 of January 27, 2005
(Strategia Nationala Antidrog 2005-2012 aprobata prin hotararea guvernului nr. 73 din 27 Ianuarie 2005)

Slovakia

183. Odborné usmernenie o štandardoch pre diagnostiku a liečbu v odbore drogové závislosti. / Vocational regulation concerning standards for diagnostics and treatment in drug dependencies specialisation.
184. Kvalita resocializačných stredísk pre drogové a iné závislosti. / Quality at social reintegration centres for drug addicts and other dependencies in Slovak Republic.
185. Smernice k metadónu. / Methadone Guidelines.
186. Metodický pokyn na zabezpečenie metadonovej udržiavacej liečby (MUP) pre pacientov so závislosťou od opiátov s chronickým priebehom ochorenia. / Methodical Instructions for providing Methadone Maintenance Programme (MMP) for patients with chronic course of opioid dependence.
187. Koncepcia zdravotnej starostlivosti v odbore medicína drogových závislostí / Conception of health care within specialisation Medicine of drug dependencies
188. Koncepcia odboru medicína drogových závislostí / Conception of specialisation Medicine of drug dependencies
189. Výnos Ministerstva zdravotníctva Slovenskej republiky č.09812/2008-OL z 10. septembra 2008 o minimálnych požiadavkách na personálne zabezpečenie a materiálno technické vybavenie jednotlivých druhov zdravotníckych zariadení / Regulation of Ministry of health num. 09812/2008-OL from septembre 10th about

minumum requirement for personnel, material and technical equipment of different kinds of health care facilities

190. Normatívy minimálneho personálneho obsadenia sestrami pri posteli chorého a ďalším ošetrovateľským personálom / Standards of minimum personnel staffing with nurses near the bed of patient and with other nursing personnel

Spain

191. Services Accreditation
192. Services Accreditation
193. Center and Service Accreditation
194. Methadon Treatments Accreditation
195. Center and Services Accreditation
196. Manual de Buena Práctica para la Atención a Drogodependientes en los Centros de Emergencia
197. Drug Intervention in Prisons

Sweden

198. Nationella riktlinjer för missbruks- och beroendevård; National Guidelines for substance abuse treatment
199. Nationella riktlinjer för missbruks- och beroendevård; National Guidelines for substance abuse treatment
200. Nationella riktlinjer för missbruks- och beroendevård; National Guidelines for substance abuse treatment
201. Your rights and options in treatment and care of drug addicts
202. Läkemedlesassisterad behandling av heroinmissbrukare en kunskapsöversikt; Maintence treatment of heroin misuse a review
203. Barn och unga i familjer med missbruk; Children and adolescents in families with substance abuse
204. Ekonomiska utvärderingar av missbruksvård; Economic evaluations of substance abuse treatment

Switzerland

205. Das modulare QuaTheDA-Referenzsystem: Die Qualitätsnorm für den Suchthilfebereich (Modul "stationäre Suchttherapie und -rehabilitation")
206. Das modulare QuaTheDA-Referenzsystem: Die Qualitätsnorm für den Suchthilfebereich (Modul "Ambulante Beratung, Begleitung und Therapie")
207. Das modulare QuaTheDA-Referenzsystem: Die Qualitätsnorm für den Suchthilfebereich (Modul "Substitution")
208. Das modulare QuaTheDA-Referenzsystem: Die Qualitätsnorm für den Suchthilfebereich (Modul "Begleitetes Arbeiten")
209. Das modulare QuaTheDA-Referenzsystem: Die Qualitätsnorm für den Suchthilfebereich (Modul "Begleitetes Wohnen")
210. Handbuch Heroingestützte Behandlung (Manual Heroin Assisted Treatment)
211. Substituion Therapy for the Treatment of Opioid Addiciton - Substitutionsgestützte Behandlungen bei Opioidabhängigkeit
212. Medical recommendations for opioid substitution therapy (Medizinische Empfehlungen für substitutionsgestützte Behandlungen (SGB) bei Opioidabhängigkeit)

213. Hepatitis C therapy for parients in opioid substitution therapy - recommendations from the Swss Society of Addiction Medicine (Hepatitis C Therapie bei Patienten unter Opioidsubstitution - Empfehlungen der Schweizerischen Gesellschaft für Suchtmedizin SSAM)
214. How to catch youth - Early recognition and intervention for youth at risk (Jugendliche richtig anpacken - Früherkennung und Frühintervention bei gefährdeten Jugendlichen)
215. Integrative Psychotherapy of the co-morbidity of Anxiety or Depression and Substance use Disorders
216. Dual diagnoses. Co-morbidity of psychiatric disorders and addiction. (Doppeldiagnosen. Komorbidität psychischer Störungen und Sucht)
217. Leitlinien zum Einbezug von Genderaspekten in der Suchtarbeit / Guidelines for consideration of gender aspects in drug-related work
218. Leitlinien zum Einbezug von Migrationsaspekten in der Suchtarbeit / Guidelines for consideration of migration aspects in drug-related work
219. Hepatitis C manual (Hepatitis C Handbuch)

UK

220. Drug Misuse and Dependence.UK guidelines on clinical management
221. Routes to Recovery. Psychosocial Interventions for Drug Misuse
222. NATIONAL QUALITY STANDARDS FOR SUBSTANCE MISUSE SERVICES
223. Guidance for the pharmacological management of substance misuse among young people
224. Models of residential rehabilitation for drug and alcohol misuers
225. Assessing Yount People for Substance Misuse
226. Young people's substance misuse treatment services – essential elements
227. non medical prescribing, patient group directions and minor ailments in the treatment of drug users
228. Renewed Guidance for Treating Heroin Addicts in Prison
229. Towards successful treatment completion
230. NTA POLICY ON INVOLVEMENT OF USERS AND FAMILY MEMBERS
231. Supporting and Involving Carers. A Guide for Commissioners and Providers
232. Drug Misuse:Opioid Detoxification. The NICE Guidelines
233. Quality in Alcohol and Drug Services. Organisational Standards for Alcohol and Drug Treatment
234. Auditing drug misuse treatment
235. Clinical Governance in Drug Treatment: A good practice guide for providers and commissioners
236. Improving Services for Substance Misuse Diversity and Inpatient and Residential Rehabilitation Services
237. Improving Improving Services for Substance Misuse Diversity and Inpatient and Residential Rehabilitation Services
238. Improving Services for Substance Misuse. Joint Review. Community Prescribing
239. Improving Services for Substance Misuse. Joint Review. Care Planning and coordination
240. Naltrexone for the management of opioid dependence
241. Methadone and buprenorphine for the management of opioid dependence
242. Improving services for substance misuse Commissioning drug treatment and harm reduction services.

243. Models of care for treatment of adult drug misusers: Update 2006
244. Commissioning for recovery Drug treatment, reintegration and recovery in the community and prisons: a guide for drug partnerships
245. Health Care Providers and Partners Treatment Outcomes and Effectiveness

Australia

246. Clinical Guidelines and Procedures for the Use of Naltrexone in the Management of Opioid Dependence
247. Drug and Alcohol Psychosocial Interventions Professional Practice Guidelines NSW Department of Health 2008
248. Interagency guidelines for the early intervention, response and management of drug and alcohol misuse
249. Drug and Alcohol Withdrawal Clinical Practice Guidelines
250. National clinical guidelines and procedures for the use of Buprenorphine in the maintenance treatment of opioid dependence
251. Clinical guidelines and procedures for the use of methadone in the maintenance treatment of opioid dependence
252. Youth Alcohol and Drug Outreach
253. Drug and alcohol treatment guidelines for residential settings

Canada

254. Best Practices: Concurrent mental health and substance use disorders
255. Cocaine use: recommendations in treatment and rehabilitation
256. Methadone Maintenance Guidelines
257. Best Practices: Methadone Maintenance Treatment
258. Best Practices: Substance abuse treatment and rehabilitation

USA

259. Guideline for Management of Substance Use Disorders (SUDs) (Version 2.0 - 2009)
260. American Psychiatric Association Practice Guideline for the Treatment of Patients with Substance Use Disorders (Second Edition – 2006)

Templates Harm Reduction

Global

1. Guide to starting and managing needle and syringe programmes

Austria

2. Bericht zur Drogensituation 2009-Gesundheit Österreich GMBH/ Drug report 2009 - health Austria GMBH
3. Bericht zur Drogensituation 2009-Gesundheit Österreich GMBH/ Drug report 2009 - health Austria GMBH
4. Verein Wiener Sozialprojekte - Ganslwirt Tätigkeitsbericht 2009
5. Verein Wiener Sozialprojekte - Infektionsphrophylaxe: Tätigkeitsbericht 2009

6. Verein Wiener Sozialprojekte - fix und fertig: Tätigkeitsbericht 2009 (social projects Vienna - fix und fertig: Progress report 2009)
7. Verein Wiener Sozialprojekte - betreutes Wohnen: Tätigkeitsbericht 2009 (social projects Vienna - assisted living: Progress report 2009)
8. Verein Wiener Sozialprojekte - check it: Tätigkeitsbericht 2009 (social projects Vienna - Check it: Progress report 2009)
9. Wiener Drogen Konzept 1999
10. Konsensus-Statement: Substitutionsgestützte Behandlung Opioidabhängiger.
11. Suchtbericht 2007- drug report 2007

Belgium

12. Adaptation française et néerlandaise des critères de l'ASAM dans le choix du mode de prise en charge des toxicomanes

Bulgaria

13. Насоки за добра практика в намаляването на вредите от употребата на наркотични вещества/ Guidelines for good practice in harm reduction of drug use, National Centre for Addictions, Sofia, 2008
14. Наредба № 30 от 20.12.2000 г. За реда за участие в долечебни и рехабилитационни програми на лица, които са били зависими или са злоупотребили с наркотични вещества./ Regulation №30 / 20.12.2000 on the rules for participation in pre-treatment and rehabilitation programs for individuals that had previously been addicted or had abused narcotic substances
15. Закон за контрол върху наркотичните вещества и прекурсорите/ Law on control of narcotic substances and precursors

Estonia

16. National strategy of preventing drug addiction
17. Narkootiliste ja Psühhotroopsete ainete seadus (Narcotic Drugs and Psychotropic Substancies Act)

Finland

18. Vinkkejä (Tips)
19. Law on infectious diseases and regulation for law on infectous diseases

France

20. Réduction des risques chez les usagers de drogues - Synthèse et recommandations / Harm reduction among drug users - synthesis and recommendation
21. Vaccination agains the hepatitis B virus. Consensus conference, 10-11 September 2003. Guidelines.

Germany

22. Drittes Gesetz zur Änderung des Betäubungsmittelgesetzes (Drittes BtMG-Änderungsgesetz - 3. BtMG-ÄndG) vom 28. März 2000; Hier: Dokumentation des § 10a BtMG (Erlaubnis für den Betrieb von Drogenkonsumräumen) - § 10a

23. Verordnung über den Betrieb von Drogenkonsumräumen vom 26. September 2000; (Rechtsverordnung NRW)
24. Verordnung über die Erteilung einer Erlaubnis für den Betrieb von Drogenkonsumräumen, 25. April 2000
25. Verordnung über die Erteilung einer Erlaubnis für den Betrieb von Drogenkonsumräumen
26. Verordnung über die Erlaubnis für den Betrieb von Drogenkonsumräumen
27. Verordnung über die Erlaubnisvoraussetzungen für den Betrieb von Drogenkonsumräumen
28. Verordnung über die Erteilung einer Erlaubnis für den Betrieb von Drogenkonsumräumen
29. Leitlinien der akzeptierenden Drogenarbeit

Hungary

30. Professional recommendation - Low-threshold services provided for addicted persons

Ireland

31. Needle exchange provision in Ireland

Italy

32. Regional Recommendation on Harm Reduction
33. Regional Plan for Harm Reduction and Low-Threshold Services
34. Actions to Prevent Diseases Correlated to Drug Addiction

Lithuania

35. Narkotinių ir psichotropinių medžiagų žalos mažinimo programų vykdymo tvarkos aprašas "Description of the Procedure for Narcotic and Psychotropic Substance Harm Reduction Programmes"

Netherlands

36. Gebruiksruimten in beeld, handreiking bij de organisatie en inrichting (Locations for use, guidance for the organization and facilities)
37. Spuitomruil (Needle Exchange - recommendations, effectiveness and facilities in the Netherlands)
38. Intramuraal Motivatie Centrum (Intramural motivation centre)

Poland

39. Programme for Counteracting Drug Addiction 2006-2010
    KRAJOWY PROGRAM PRZECIWDZIAŁANIA NARKOMANII NA LATA 2006-2010
40. Narodowy Program Zdrowia na lata 2007-2015 / National Health Programme for 2007-2015
41. National Programme for Combating AIDS and Preventing HIV Infections for the years 2007-2011
    Krajowy Program Zwalczania AIDS i Zapobiegania Zakażeniom HIV na lata 2007-2011
42. Monitoring system of infectious diseases among intravenous drug users,

System monitorowania zjawiska chorób zakaźnych związanych z narkotykami

43. Estimation on prevalence of infectious diseases (HCV, HIV) among intravenous drug users in cities with different level of harm reduction programme coverage
Oszacowanie występowania chorób zakaźnych (wirusowe zapalenie wątroby typu C i B, HIV) wśród narkomanów przyjmujących środki odurzające w iniekcji w miastach o różnym stopniu realizacji -programów redukcji szkód

Romania

44. The standards of the national assistance system of medical, psychological and social care for legal and illegal drug users 2005(Standardele sistemului national de asistenta medicala psihologica si sociala a consumatorilor de droguri licite si ilicite 2005)

45. The methodology for the formulation, amendment and implementation of the the customized care plan for drug users approved by Decision no. 17 of 2 October 2006 of the National Antidrug Agency's president(Decizie nr. 17 din 2 octombrie 2006 pentru aprobarea Metodologiei de elaborare, modificare şi implementare a planului individualizat de asistenta a consumatorului de droguri)
46. The standards and the methodology for authorising drug related services for drug users an the minimum compulsory standards for the organisation and operation of the centres that provide services for drug users approved by the Common Regulation no. 1389 of august 2, 2008 of the Minister of Health, Minister of Labour, family and equal opportunities, Minister of interior and administrative reform (Ordinul comun 1389/513/2008/282/2007 din 4 august 2008 (Ordinul 1389/2008) Ordinul ministrului sănătăţii publice, ministrului muncii, familiei şi egalităţii de şanse şi ministrului internelor şi reformei administrative nr. privind aprobarea Criteriilor si metodologiei de autorizare a centrelor de furnizare de servicii pentru consumatorii de droguri si a standardelor minime obligatorii de organizare si functionare a centrelor de furnizare de servicii pentru consumatorii de droguri.
47. Methdology of the programme of extending the voluntary HIV counselling and testing capacity – revised and updated edition 2006 (METODOLOGIA Programului de Extindere a Capacitatii de Consiliere si Testare Voluntara HIV - Editie revizuita si actualizata 2006)
48. The means to carry out grated intmedical, psychological and social care for drug users in custody approved by common Regulation no 1.216/C/2006 of the Ministry of Health, Ministry of Justice , Ministry of Administration and Interior (Ordin nr. 1.216/C din 18 mai 2006 privind modalitatea de derulare a programelor integrate de asistenta medicală, psihologică şi socială pentru persoanele aflate în stare privativă de libertate, consumatoare de droguri.)
49. Policy brief: Reduction of HIV transmission in prisons 2004 (Policy brief: reducerea transmiterii hiv în sistemul penitenciar 2004.)
50. Policy brief: Outreach based HIV reduction of 2004(Policy brief: reducerea transmiterii HIV prin programele de outreach)
51. The quality standards of the medical facilities abilitated for drug related treatment and of the nonguvernamental organisations abilitated for drug related harm reduction services approved by regulation no 187/2002
(Ordin Nr. 187 din 19 martie 2002 pentru definirea tipurilor de unitati medicale ce pot fi abilitate sa asigure asistenta medicala persoanelor dependente de droguri, precum si a organizatiilor neguvernamentale ce pot fi abilitate sa desfasoare
52. National interest programe for prevention and care in case of use of tobacco, alcohol and drug 2009-2012 approved by the Governmental decision no. 1101/2008
(HG nr. 1101/2008, hotarare privind aprobarea Programului de interes national de prevenire si asistenta pentru consumul de tutun, alcool si droguri - 2009-2012)

53. National Anti-Drug Strategy 2005-2012 approved by Governmental Decision no. 73 of January 27, 2005
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GB	IHRA Guterman L & Curtis M (2009)	Overdose Prevention and Response: A Guide for People Who Use Drugs and Harm Reduction Staff in Eastern Europe and Central Asia (English). USA: Open Society Institute			
GB	World Health Organization (2009)	Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence. Switzerland: WHO.			
Canada	Public Health Agency of Canada, 2006	Specific populations: substance use. Canadian guidelines on sexually transmitted infections	x		
Canda	Health Canada, 2006	Injection Drug Use and HIV/AIDS. Health Canada's Response to the Report of the Canadian HIV/AIDS Legal Network		x?	
Canada	Bony, Rehm, Ashley, Walsh, Single, & Room, 1999	Low-risk Drinking Guidelines: The Scientific Evidence			x
Canada	Diane Zilkowski, Strategic Planning Division, Correctional Service of Canada, 2001	Canada's National Drug Strategy	x		
Canada	Zarina Mulla/Donald MacPherson , City of Vancouver , 2007	Drug Substitution and Maintenance Treatment	x		
Canada	Canadian AIDS Society and The Canadian Harm Reduction Network, 2008	Learning from each other: Enhancing community-based harm reduction programs and practices in Canada		x	
Canada	Giesbrecht & Haydon, 2006	Community-based interventions and alcohol, tobacco and other drugs: foci, outcomes and implications			x
Canada	Canadian Centre on Substance Abuse, 2008	Second forum on the National Framework for Action to reduce the harms associated with alcohol and other drugs and substances in Canada			x
Canada	CCSA, CCSA, CAMH, BCMHAS	A Systems Approach to Substance Use. Recommendations for a National Treatment Strategy (background and summary)			x
Canada	CCSA - CCLAT	A Systems Approach to Substance Use. Recommendations for a National Treatment Strategy (overview)			x
Canada	CCSA - CCLAT, 2010	Moving Ahead with A Systems Approach to Substance Use: National Treatment Strategy Leadership Team			x
Canada	Lightfood, Panessa, Hayden, Thumath, Goldstone, &	Gaining insite: Harm reduction in nursing practice		x	

	Pauly, 2009			
Canada	Strike, Watson, Lavigne, Hopkins, Shore, Young, Leonard, Millson, 2010	Guidelines for better harm reduction: Evaluating implementation of best practice: recommendations for needle and syringe programs (NSPs)		x
Canada	BC Ministry of Health Services	Service Model, Standards and Guidelines for Adult Residential Subst Use Services and Supports	x	
Canada	Department of Justice Canada, Evaluation Division, Office of Strategic Planning and Performance Measurement, 2010	NATIONAL ANTI-DRUG STRATEGY IMPLEMENTATION EVALUATION	x	
Canada	CARBC, 2006	Following the evidence. Preventing harm from substance use in BC		x
Canada	Health Canada, 2002	Best practices. Treatment and Rehabilitation	x	
Canada	Health Canada, 2002	Methadone Maintenance Treatment	x	
Canada	Health Canada, 2002	Literature review: Methadone Maintenance Treatment	x	

Appendix 10.6

Inventory of quality standards (extracted from templates)

Treatment/Rehabilitation:

1. Structural Standards of Services: Accessibility: location (service can easily be reached by public transport)
2. Structural Standards of Services: Physical environment: space (e.g. service has separate rooms for individual counselling)
3. Structural Standards of Services: Physical environment: safety (service is equipped for reanimation and other emergencies like e.g. management of overdose)
4. Structural Standards of Services: Indication criteria: diagnosis (treatment indication is always made on the basis of a diagnosis)
5. Structural Standards of Services: Staff composition: education (e.g. at least half of staff has a diploma in medicine, nursing, social work, or psychology)
6. Structural Standards of Services: Staff composition: transdisciplinarity (e.g. service employs a multidisciplinary team composed of at least 3 professions)
7. Structural Standards of Services: Goal: health stabilisation/improvement (treatment must be aimed at improvement or stabilisation of health)
8. Structural Standards of Services: Goal: social stabilization/integration (treatment must be aimed at improvement of social stabilisation or integration)
9. Outcome Standards at the System Level: Goal: reduced substance use (treatment must be aimed at a reduction of substance use e.g. helping the client/patient to reduce the use or to abstain from psychotropic substances)
10. Outcome Standards at the System Level: Utilisation monitoring (services must report periodically the occupancy of treatment slots or beds)
11. Outcome Standards at the System Level: Discharge monitoring (e.g. ratio of regular / irregular discharges, retention rates etc. have to be periodically monitored)
12. Outcome Standards at the System Level: Internal evaluation (services must regularly perform an internal evaluation of their activities and outcomes)
13. Outcome Standards at the System Level: External evaluation (services must regularly allow an evaluation of their activities and outcomes by an independent external evaluator)
14. Outcome Standards at the System Level: Cost-effectiveness ratio (positive outcomes like e.g. number of abstinent patients in relation to treatment costs)
15. Outcome Standards at the System Level: Cost-benefit ratio (tangible benefits like e.g. years of increased life expectancy in relation to treatment costs)
16. Process Standards at the Service Level: Assessment procedures: substance use history, diagnosis and treatment history have to be assessed
17. Process Standards at the Service Level: Assessment procedures: somatic status and social status have to be assessed
18. Process Standards at the Service Level: Assessment procedures: psychiatric status has to be assessed
19. Process Standards at the Service Level: Individualised treatment planning (treatment plans are tailored individually to the needs of the patient)

20. Process Standards at the Service Level: Informed consent (patients must receive information on available treatment options and agree with a proposed regime or plan before starting treatment)
21. Process Standards at the Service Level: 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)
22. Process Standards at the Service Level: Confidentiality of client data (patient records are confidential and exclusively accessible to staff involved in a patient's treatment or regime)
23. Process Standards at the Service Level: 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)
24. Process Standards at the Service Level: Continued staff training (staff is regularly updated on relevant new knowledge in their field of action)

Harm reduction:

1. Structural Standards of Interventions: Accessibility: location (service can easily be reached by public transport)
2. Structural Standards of Interventions: Accessibility: opening hours (adjusted to the needs of clients/patients, e.g. evenings & week-ends)
3. Structural Standards of Interventions: Accessibility: costs to be paid by clients (exclusion of costs which limit the accessibility for poor clients/patients)
4. Structural Standards of Interventions: Indication criteria: age limits (e.g. minimal age required for admittance)
5. Structural Standards of Interventions: Indication criteria: diagnosis (treatment indication is always made on the basis of a diagnosis or, if not possible, a detailed assessment of the current substance use)
6. Structural Standards of Interventions: Staff qualification: minimal qualification (e.g. at least half of staff has a diploma in nursing, social work, or psychology)
7. Structural Standards of Interventions: Staff composition: transdisciplinarity (e.g. service employs a multidisciplinary team composed of at least 3 professions)
8. Process Standards of Interventions: Assessment procedures: complete needs assessment and priorisation (e.g. 1. harm reduction of intravenous drug use and, 2. reduction of used syringes in public spaces etc.)
9. Process Standards of Interventions: Assessment procedures: client/patient status (the client's/patient's health status is assessed)
10. Process Standards of Interventions: Assessment procedures: risk behavior assessment (client's/patient's risk behaviour is assessed)
11. Process Standards of Interventions: Individualised treatment planning (intervention regime and intervention plans, if applicable, are tailored individually to the needs of the client/patient)
12. Process Standards of Interventions: Informed consent (clients/patients must receive information on available service options and agree with a proposed regime or plan before starting an intervention)
13. Process Standards of Interventions: Confidentiality of client data (client/patient records are confidential and exclusively accessible to staff involved in a client's/patient's intervention or regime)

14. Process Standards of Interventions: Written client records (assessment results, intervention plan, interventions, expected changes and unexpected events are documented complete and up to date for each client/patient in a client/patient record)
15. Process Standards of Interventions: Continued staff training (staff is regularly updated on relevant new knowledge in their field of action)
16. Process Standards of Interventions: 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)
17. Process Standards of Interventions: Neighbourhood/community consultation (avoiding nuisance and conflict with other people around the service)
18. Outcome Standards at the System Level: Goal: reduced risk behavior (reducing unsafe injections, unsafe drug use and unprotected sex)
19. Outcome Standards at the System Level: Goal: referrals (treatment services must be prepared to refer clients/patients to other health/social/treatment services if needed and agreed)
20. Outcome Standards at the System Level: Goal: reduced substance use (treatment must be aimed at a reduction of substance use e.g. helping the client/patient to reduce the use or to abstain from psychotropic substances)
21. Outcome Standards at the System Level: Utilisation monitoring (services must report periodically the occupancy of service slots)
22. Outcome Standards at the System Level: Internal evaluation (services must regularly perform an internal evaluation of their activities and outcomes)
23. Outcome Standards at the System Level: External evaluation (services must regularly allow an evaluation of their activities and outcomes by an independent external evaluator)
24. Outcome Standards at the System Level: Cost-effectiveness ratio (positive outcomes like e.g. number of abstinent clients/patients in relation to service costs)
25. Outcome Standards at the System Level: Cost-benefit ratio (tangible benefits like e.g. years of increased life expectancy in relation to service costs)

Appendix 10.7

Correspondence of EQUS prevention standards and European drug prevention quality standards published by EMCDDA in Manual No. 7

In the following overview, each EQUS prevention standard is matched to the corresponding component in the European drug prevention quality standards (referred to as EDPQS for the purposes of this overview), as published in the EMCDDA Manual No. 7. This allows identification of the original placement in the EDPQS and consequently i) illustrates how the EQUS prevention standards have been derived from the original standards and ii) facilitates use of the EMCDDA Manual on European drug prevention quality standards when working towards achievement of the EQUS prevention standards.
Note: The symbol ≈ is used to indicate that the EQUS standards represent an adaptation (not a direct 'translation') of the EDPQS standards as they have been modified through additional consultation and in line with the other areas of EQUS standards (see main project report).

***Prevention**: Structural Standards of Services*
EQUS P1 Ethical principles ≈ EDPQS D: Ethical drug prevention
EQUS P2 Policy and legislation ≈ EDPQS 1.1 Knowing drug-related policy and legislation
EQUS P3 Routine cooperation with other agencies ≈ EDPQS B: Communication and stakeholder involvement
EQUS P4 Financial requirements ≈ EDPQS 5.2 Planning financial requirements
EQUS P5 Internal resources and capacities ≈ EDPQS 2.2 Assessing internal capacities
EQUS P6 Staff composition ≈ EDPQS 5.3 Setting up the team
EQUS P7 Staff support ≈ EDPQS C: Staff development

***Prevention**: Process Standards of Services/Interventions*
EQUS P8 Ethical standards ≈ EDPQS D: Ethical drug prevention; 1.3 Describing the need – Justifying the intervention; 5.5 Preparing programme materials
EQUS P9 Assessment procedures ≈ EDPQS 1.2 Assessing drug use and community needs
EQUS P10 Assessment procedures ≈ EDPQS 1.4 Understanding the target population
EQUS P11 Assessment procedures ≈ EDPQS 1.2 Assessing drug use and community needs; 1.4 Understanding the target population
EQUS P12 Assessment procedures ≈ EDPQS 2.1 Assessing target population and community resources
EQUS P13 Assessment procedures ≈ EDPQS 1.3 Describing the need – Justifying the intervention
EQUS P14 Stakeholder involvement ≈ EDPQS B: Communication and stakeholder involvement
EQUS P15 Sustainability ≈ EDPQS A: Sustainability and funding
EQUS P16 Goal definition ≈ EDPQS 3.3 Defining aims, goals, and objectives
EQUS P17 Service/intervention design ≈ EDPQS 3.2 Using a theoretical model
EQUS P18 Service/intervention design ≈ EDPQS 3.5 Referring to evidence of effectiveness; 4.1 Designing for quality and effectiveness
EQUS P19 Service/intervention design ≈ EDPQS 4.3 Tailoring the intervention to the target population

EQUS P20 Service/intervention design ≈ EDPQS 4.1 Designing for quality and effectiveness
EQUS P21 Service/intervention design ≈ EDPQS A: Sustainability and funding; 3.1 Defining the target population; 3.4 Defining the setting; 3.6 Determining the timeline
EQUS P22 Adaptation ≈ EDPQS 4.2 If selecting an existing intervention
EQUS P23 Staff training and development ≈ EDPQS C: Staff development
EQUS P24 Recruitment ≈ EDPQS 5.4 Recruiting and retaining participants
EQUS P25 Implementation ≈ EDPQS 5.1 Planning the programme - Illustrating the project plan
EQUS P26 Implementation ≈ EDPQS 6.3 Monitoring the implementation
EQUS P27 Implementation ≈ EDPQS 6.2 Implementing the intervention; 6.4 Adjusting the implementation
EQUS P28 Process evaluation ≈ EDPQS 6.2 Implementing the intervention; 7.2 If conducting a process evaluation
EQUS P29 Dissemination ≈ EDPQS 5.6 Providing a programme description
EQUS P30 Dissemination ≈ EDPQS 8.2 Disseminating information about the programme

***Prevention**: Outcome Standards at the System Level*
EQUS P31 Goal of prevention ≈ EDPQS definition of drug prevention; not included as a separate standard in EDPQS
EQUS P32 Evaluation ≈ EDPQS 4.4 If planning final evaluations; 7.1 If conducting an outcome evaluation; 7.2 If conducting a process evaluation
EQUS P33 Evaluation ≈ EDPQS 8.1 Determining whether the programme should be sustained

Appendix 10.8

Minutes of first expert seminar (6.-7.12.2010 in Brussels)

Part I: document search, templates, masterfile

- *Participant round: procedures and experience with document search and use of templates (all)*

Explanation and a written statement on methodology for document search and filling in templates provided by each participating country:

- 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 1. there was a lack of objective criteria (Gerard Schippers); 2. some evidence already had a national grade, therefore it was difficult to covert such grade to the one provided in the template (Heike Zurhold); 3. difficulties in grading were also mentioned by Jacek Moskalewicz (who is also responsible for other Eastern European countries) and Birgit Koechl.

- Some experts also outlined that it was troublesome to include certain specific activities such as 'drug consumption rooms' (Neil Hunt) or counselling activities (Birgit Koechl) into the template. Templates were generally more applicable for clinical type activities and consequently, some areas were covered better than others.

    - *Comments on document lists, template quality, state of masterfile (ISGF)*

    - *Presentation on document lists, template quality, state of masterfile (ISGF)*

- Templates were received from partners, together with the feedback if something was not clear. Then completed information went to the masterfile.
- Data cleaning was processed. It was checked whether the received data was completed and in proper order. A problem that partners faced was which template to use for certain guidelines – harm reduction or treatment.

- To improve the quality of the template ISGF will introduce a web-based template which will replace a current excel-sheet based template. Web-based template will be more user-friendly and in some areas there will be a list of answers available.

- There are some countries that had not sent their templates (Czech Republic, Slovenia, Portugal, Greece).

    - *Discussion, remaining problems (all)*

- One of the problems was missing templates. It was decided to contact Czech Republic and Slovenia through Poland and to encourage them to send the template by 29th December. Ambros Uchtenhagen would contact partners in Greece and Portugal and will try to contact them with regard to missing templates.

- The EMCDDA had recommended that templates should be completed by 2 experts. It was not possible to implement this suggestion - it would create a double workload. Only Zurhold had followed this approach, confirming that it was an extremely time consuming activity.

- The question was raised whether all possible guidelines from all possible fields were included in templates. Neil Hunt mentioned that certain information could have been missed out due to tight time frame. However it was emphasized that countries were asked to send two lists of documents – list of included documents and list of excluded documents. That way it will be ensured that none of the important information is missed out.

- Another 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. Were they sufficiently represented by the templates. It must bare in mind that the templates are limited exclusively to drug relates issues as well as the overall focus of the project.

Part 2: template analysis:
Treatment/ rehabilitation: presentation of first analysis results: general information (ISGF)

- Presentation of first analysis results – general information. Different templates for treatment and for harm reduction. Geographical scope of documents mostly covers national level. Origin of documents is public sector, also professional associations. Most covered intervention types by origin are psychosocial interventions and substitution treatment.

- Concerning the intervention type per setting – there are more documents for specialized settings than non-specialized. Moreover, if document mentions several settings, both settings should be marked in template – they are not exclusive.

- In the area of intervention type per treatment - psychosocial intervention and substitution treatment are covered best. It does not mean that substitution treatment is an intervention for each substance, but rather document looks at the situation when people continue to use other type of drugs instead the one they are being treated for. This approach is in line with WHO guidelines for substitution treatment.

- Some problems occurred with regard to targeted population. Most of the countries have marked both categories (for example males and females) if guideline did not indicate the targeted group precisely. Therefore, data could be misleading.

Nevertheless, Ambros Uchtenhagen reminded that countries were asked to provide the name of the included document; therefore in the future it will be possible to distinguish whether it was a guideline intended for a specific group.

- *Treatment/ rehabilitation: presentation of first analysis results: specific information on standards from documents (ISGF)*

- *Discussion of presented results and needs for further analysis (all)*

  Specific information. Structural standards per level – none of the standards are more outstanding than others. This means that they are all equally important in the guidelines. Process standard per level outlines the outstanding figure of individualised treatment planning. However, the geographical representation is not reflected. Ambros Uchtenhagen reminded that this exercise was intended only to check how often standards are mentioned in guidelines.

  Evidence grades of structural standards, process standards and outcome standards are considerably low. Level A is almost non-existent.

- *Harm reduction: presentation of first analysis results: general information from documents (ISGF)*

  Experts questioned the data on intervention type per setting and intervention type per substance. There was confusion regarding the data which, according to the template, provided that there is a pill testing in prisons (type per setting) and pill testing for cannabis (per substance). The confusion appeared due to the mistaken marking in the template or by misinterpreting the term pill-testing.

- *Harm reduction: presentation of first analysis results: specific information on standards from documents (ISGF)*

- *Discussion of presented results including conflicting findings and lacunas (all)*

  Structural standard per level: accessibility standard was outlined as many guidelines recommend that measures should be accessed by drug users as easily as possible. It was explained to experts that accessibility is of utmost importance in the area of harm reduction, for example - location for needle exchange is crucial.

- *Presentation on evidence rating of standards from documents (ISGF)*

- *Discussion of evidence rating results (all)*

  Evidence grades for structural standards, assessment standards and process standards as well as evidence grades for intervention goals and outcome standards are considerably low. But it is worth noting that evidence grade D is available for evidence of structural standards.

- *Short information on prevention project*

Minimum standards on how to run a successful drug prevention programme have been presented. They do, however, represent only the process of creating a prevention programme and therefore are just good practice recommendations.

It was noted by experts, that even with the proposed standards, the intervention will not necessarily be successful. Ambros Uchtenhagen outlined that the project refers to 'evidence of effectiveness'; therefore, it gives more credibility for the minimum standards presented.

Katalin Felvinczi explained that due to the fact that there exist many uncertainties when evaluating and measuring the effectiveness of prevention programme, the EMCDDA recommended to concentrate on the process of creating such programme. Minimum standards were defined from literature reviews and international organizations' standards on prevention activities, also Delphi survey was conducted and standards redefined. There are two choices – either to point out which programmes are effective or to indicate the process to successful prevention programme. The second option was selected for the prevention project.

Part 3: Construction of draft minimal quality standards:

- *Criteria for good quality standards (proposal by ISGF)*
- *Discussion of proposal (all)*
- *Criteria for minimal quality standards (proposal by ISGF)*
- *Potential risks of and barriers for minimal quality standards (all)*
- *Further procedures for establishing model of minimal quality standards (ISGF.all)*
- Proposition from ISGF how to proceed from collected data to actual minimum standards. The main questions are: 1. to establish criteria for reference documents. 2. to identify which evidence grades are needed for good quality standards and which for minimum standards. 3. to identify how important it is that fact that recommendation has been mentioned many times. 4. should we have one list for treatment and one for harm reduction, or detailed list per intervention?
    - *Discussion of proposal (all)*
- Step 1: criteria for reference documents. ISGF suggest having as reference documents the ones that 1. are national 2. evidence graded as A or B level 3. based on research, literature, expert opinions. Therefore, the first criterion shows acceptability of the document, the second criterion - the grade of the scientific evidence and the third criterion on which basis the recommendation was made. After applying these criteria ISGF came up with 29 documents for treatment and 9 documents for harm reduction.
- The experts decided to include documents that have an evidence grade A or B in the treatment area (around 29 documents) and an evidence grade A, B or C in the harm reduction area.
- The question was raised what is going to happen with the rest of the documents that do not correspond to the criteria. It was noted that the aim of the exercise is to create a

selection of reference documents that have more weight than the others. The selected documents will provide a good evidence base and will be regarded as core documents. The 3 criteria for documents are cumulative.

- Step 2: determination as to what is a good standard and what is a minimum standard. There are two ways to identify what is a good quality standard: either to identify the quality and the available evidence or to start with the intervention itself and if there is no evidence base – to proceed with research. However, the standards will be mainly used by the practitioners and their first question will be about the intervention itself rather than the ways of procedure. Therefore, it was decided when evaluating good quality standard to start from identifying intervention itself.

- The scheme of proceeding from all the gathered information to presenting actual minimum standards:

    - ✓ Minimum standards are going to be organized according to the list of interventions.
    - ✓ Interventions will be organized according to the target group (if there is sufficient information it will include adolescences, females, females in prison and etc.).
    - ✓ It will include standards per structure, process and outcome (specific setting, structure level and system level).
    - ✓ Per intervention:

    1. Grade of evidence. 2. Basis of standard (literature, expert consensus). 3. Countries where standard is mentioned.

- Consequently, the strength of the standard will come from the evidence grade given the basis of the standard and how many countries have mentioned the standard. This is the formula for minimum standards. This formula will be a basis for the Delphi survey to seek expert consensus.

- In order to achieve qualitative results in the Delphi survey it was decided to launch a pilot Delphi. Experts will be the first to receive the questionnaire and to give feedback.

<u>Part 4: Consultation and Consensus building process:</u>

- *Stakeholders to be included in the process: identification, availability, list (ISGF, all)*

- *Finalisation of model to be submitted (ISGF, all)*

- A list of experts for Delphi survey will be provided by each country. It will include the name and e-mail address of the selected expert. There will be two separate lists – one for treatment and one for harm reduction (in case of necessity same person can be included in both lists).The composition of the list should be trans-disciplinary (not only medical but also social professions included).

- The main stakeholders: Representatives of public authorities - health and social affairs, justice, police, local authorities, specialized national agencies, organizations responsible for quality of health care. Representatives of NGOs also private health sector, professional associations, major health insurance bodies, representatives of

user groups. Representatives of church. Specialized media representatives. The number of stakeholders agreed is maximum 25, but at least 10 per list.

- National Focal Points will be also requested (by Roland Simon) to nominate experts. The information from Focal Points will be advisory only. Delegates themselves should choose which way to approach the experts. The list of experts provided by Focal Points is expected the **second week of January**.

- In order to simplify the task of approaching the stakeholders, it was decided that Commission will draft a letter inviting them to answer questionnaire. The letter to be drafted and signed **before Christmas.**

- The remuneration for experts completing the questionnaire for Delphi survey could take a form of the official letter of thanks from the Commission.

- The first round of the Delphi survey will be launched **20th January 2011**. Therefore, the list of contacts should be provided **7th of January**.

- *Questionnaire to be used in Delphi survey (ISGF, all)*

  Focus of the first Delphi round will be on:

  - ✓ Agreement with the proposed model
  - ✓ Expected obstacles
  - ✓ Proposal for implementation
  - ✓ Resources available for implementation
  - ✓ Ethical questions

  All information received so far will be extracted from the templates and together with the grade of evidence and the country where such standard is mentioned will be provided in the Delphi survey. The experts will be asked (for each intervention type) whether it is possible to implement such standard in their country and is it acceptable in the opinion of the stakeholder. That way expert consensus will be achieved.

  Experts will be directed to look at the grade of evidence for each standard. It is also advisable to provide some short background information on minimal standards and interventions. 3 weeks time will be given for participants to answer the questionnaire (**by 10th February 2011**). The reminder will be sent to those who did not reply.

- *Evaluation of Delphi survey and dissemination of results (ISGF, all)*

  The results from the first Delphi round will be evaluated and modifications of standards will be identified (if any). If there is a consensus achieved in first round – the second round will not be needed.

- *Finalising model of minimal quality standards (Commission, ISGF, all)*

  AGREE II is an instrument for assessing guidelines. It will be applied for the assessment of the final product. Therefore, it is essential to select six independent and knowledgeable reviewers (3 for treatment and 3 for harm reduction). The final list of the suggested reviewers should be received before the second expert meeting (3d of

March 2011). Everyone is expected to contribute to the list in order to have more sources of choice. Moreover, the availability of the EMCDDA's Scientific Committee will be check with the possibility to include them among reviewers.

- *Planning of next expert meeting (Commission, ISGF)*

Decision was taken to hold the second expert meeting between the first and second Delphi rounds. The meeting will take place on the **3-4 of March 2011 in Brussels**. It will be decided at the next expert meeting whether to do the second Delphi round, which to start 14th of March 2011.

- *Remuneration of project partners (ISGF)*

The contract provides that 50% of the payment is due after providing the templates and another 50% is due at the end of 2011 (end of project). Therefore, partners are asked to send back an invoice, indicating place, date names, days of work spent and bank details. Eastern European partners will be paid through Jacek Moskalewicz, who is a contact person for these countries.

- *Other business (all)*

- European Conference (11-13th May 2011). The main idea of the Conference is to introduce the project to wider stakeholders, that is - experts, policy makers, NGOs. The programme is not yet confirmed. Conference should not concentrate on the discussion of evidence for certain standards but rather whether such standards are acceptable and what is to be done next in the area of implementation. The programme for the conference should be finalised by the **end of January**. There is funding available from the Commission for 120 experts – 60 from Member States and another 60 nominated by the Commission.

- It was suggested to shape the discussion either around each intervention, or group countries according to similar background or possible according to the similarity of obstacles that were identified during Delphi survey.

- After the conference the final report of the project and the list of minimal standards will be provided to the Commission, which will make a proposal to the Council in 2012. Timeline for the final product is end of 2011. After the conference consultations with experts will be continued, however no more expert meeting are foreseen.

Appendix 10.9
Minutes second expert seminar (3.-4.03.2011, in Brussels)

The third EQUS expert meeting discussed the state of play on the data collection for the inventory, the outcome of the Delphi survey and the organisation of the stakeholder conference to take place in Brussels on 15-17 June.

Chair: Caroline Hager (CH), European Commission and Ambros Uchtenhagen (AU), ISGF.

List of participants is attached. A working paper was prepared for information at the EQUS expert seminar and Delphi survey results are available on the ISGF powerpoint presentations.

Main Points

1. Data collection

AU reported on the continued inflow of late-coming templates and of templates expected to come. Due to failures to comply with the deadline for submitting templates, additional effort was made in order to integrate late-coming templates into the inventories. Also, a few more documents are pending for future integration into the data base.

2. Delphi survey (pilot)

MS presented the questionnaire which is organised around process and structural standards for interventions and for services; 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. According to decisions taken during the last expert meeting, a piloting of the questionnaire among the project partners was implemented in January 7-16, 2011.

2.1. Feedback on the questionnaire and adaptations

The pilot survey resulted in a number of comments (ca. 80 feedbacks) which led to the adaption of the on-line survey. It is made up 6 structural standards, 9 process standards, 9 outcome standards and benchmarks for treatment/rehabilitation and 7 structural standards, 8 process standards, 10 outcome standards and benchmarks for harm reduction.

MS presented the reformulated standards. Points raised:

- Treatment, process standard at the service level: 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)
- Treatment, process standard at the service level: 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)
- Clustering of assessment procedures – 1) substance use history, diagnosis and treatment history; 2) somatic status and social status; 3) psychiatric status

- Outcome standards at the system –level – cost-benefit ratio – needs to be viewed as goal as it is not used
- HR - Structural standards of interventions – accessibility – costs to be paid by clients needs to clarified to "no prohibitive costs to prevent accessibility"
- HR intervention – important to make clear that these standards are applicable where these interventions are practised and not a proposal to introduce the intervention

2.2. Participant round: stakeholder recruitment

EQUS experts provided national lists for stakeholders to be consulted in the Delphi 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 NGOs and professional associations, insurance bodies, research groups, user groups, church and media representatives. EMCDDA asked the National Focal Points to nominate participants.

The Delphi survey first round started on January 20, 2011. Participants were invited to answer within 3 weeks time, and after the second week a reminder was sent out.

ISGF presented the data on participation of stakeholders, including those who completed the questionnaires, and those who started the survey without completing:

- 469 identified stakeholders from EU Member States and Switzerland were invited to participate
- Total number of completed questionnaires 164 of 118 stakeholders – 30% response rate - low response rate due to short time span. Personal contacts were v important
- Types of stakeholders were quite representative, nursing staff low, big majority were NGOs, government organisations and health sector.
- B, CY, DK, GR, M, SL stakeholders did not respond at all.

Action

- To launch a second round of the questionnaire contacting those stakeholders who have not responded and those countries who have not responded at all (see 2.4.).

2.3. Results of Survey

ISGF presented an analysis of the survey results in detail, including information for every individual standard on acceptability, implementation status and expected implementation problems.

Treatment Standards

- Many services are run by non specialised teams – therefore some standards will be more relevant than others.
- Non specialised teams in CEEC want standards and training.
- Need to clarify what implementation means: standard exists or services are provided according to the standard. Interpretation needs to be clear (see below under 2.6).

Conclusions for Treatment Standards

- A high number of standards are already implemented or are feasible without problems
- Acceptability of the standards is around 80% and implementation is around 40% : High consensus
- A number of standards – external evaluation, cost effectiveness ratio – have high acceptability, but problems to implement
- Conference to discuss gaps between the state of affairs as it should be and what it is
- Important caveat of results: web-based survey does not allow in-depth analysis
- There is a low evidence rate for standards

Harm Reduction Standards

- Interpretation of some standards needs to be clarified – indication criteria and diagnosis
- Staff composition is not relevant for HR as you do not have several professions involved (e.g. needle exchange, mobile services)
- Cost-benefit analysis – lack of expertise
- No referrals without consent

Conclusions for HR Standards

- RS, EMCDDA, to provide an overview of HR interventions in the MS.

2.4. Delphi survey (second round)

Discussion on the need for a second round led to the conclusion that, although there are no big dissent points, a second round makes sense to increase the response rate. Normally the objective of the Delphi survey is to have several reiterative rounds to reach a sustainable agreement among expert opinion.

In this case, EQUS questionnaire is a pseudo Delphi as not following the method

Action

- ISGF will prepare list of those stakeholders who have not responded and send to EQUS partners by 9 March 2011 (meanwhile done)

- EMCDDA (RS) will contact the Heads of NFPs in those countries that have not responded to give an answer and fill in questionnaire.

- ISGF will send reminder on 1st April and final deadline on 8th April. The results will be available by mid-April 2011 (in time for discussion of EQUS Steering Committee on 15 April).

2.5. European Quality Standards in the field of prevention

Harry Sumnall (HS), Liverpool John Moores University project leader for the Prevention Partnership, presented the project on European drug prevention quality standards funded by the EU Health Programme. The consortium was made up of organisations from 6 MS (PL, IT, HU, RO, ES, UK) with other organisations collaborating, including the EMCDDA.

The project provides a European framework on delivering high quality drug prevention and the process standards agreed set out the necessary steps in planning, implementing and evaluating drug prevention activities, including universal, selective and indicated prevention. The target audience are practitioners, programme developers and policy-makers.

The methodology to develop the empirically based evidence underpinning the standards included a Delphi survey and discussions in focus groups in the partner countries.

Results from this project will provide the basis for minimum quality standards in the field of prevention and will be published in an EMCDDA Manual during the summer. Funding is now being sought to promote the use of the standards in the member states.

Discussion on adapting the prevention standards for the EQUS project which share similar outcomes but different approaches. HS will adapt the prevention the standards for the EQUS project.

Action

HS will send ISGF list of adapted prevention standards

2.6. Construction of draft minimal quality standards

The model design for minimal quality standards has been structured as follows:

- structural standards are formulated in relation to different types of services
- outcome standards are formulated at the system level
- process standards are formulated in relation to different types of interventions.

This design allows for a meaningful differentiation of standards for various settings and interventions, and at the same time reduced the number of questions in a way acceptable to survey participants.

AU presents an overview of guidelines with good quality standards from US, WHO, UNDOC, Beckley Foundation, EMCDDA. He concludes that a list of good quality standards in drug demand reduction cannot be provided on the basis of the accumulated inventories alone, as originally intended. Previous work on identifying principles of good quality in drug demand reduction must be taken up and contrasted to the present state in EU. This was not included as a task in the call for tender which focused on minimal quality standards only.

Additional data from EU Member States are needed to learn about the meaning of implementation in regard to system development. To do this it is proposed to send out a questionnaire to MS covering system development ahead of the conference. What actions are considered at national level to implement a set of minimal quality standards as recommendations or guidelines for services, and to integrate treatment and harm reduction services in a comprehensive system, and to what extent are services already organised according to recommendations?

The experts discussed which changes are needed on the basis of the information received from the Delphi survey and ISGF analysis of the information from the inventories.

ISGF proposed to identify list of minimum quality standards where these were acceptable for over 50% of survey respondents. Experts thought this % too low for consensus and only those standards with 80% of above are acceptable. Proposal to divide the list of minimum quality standards into three categories for discussion at the stakeholder conference: high consensus, 50%-80% consent to be debated and lack of consensus.

Moreover, implementation is a major issue and examples to overcome implementation problems should be addressed at the European conference in June . AU proposes to include a short description of different national approaches (NL, UK, CZ and CH) in the background paper.

Action

- ISGF will prepare a list of minimum standards, specifying three categories of standards: high consensus, 50%-80% consent to be debated and lack of consensus.

- Four different models of implementation will be presented at the conference: NL (voluntary approach), Cz (accreditation), CH (use of financial incentives) and UK (evaluated guidance?).

2.7. Application of AGREE II

The meeting discussed the application of AGREE II for measuring expert consensus on the minimum quality standards to be proposed at the conference. AGREE II requires a lot of information to validate the standards and it is tool to measure the effectiveness of guidelines and not standards. There is also an issue of identifying and funding independent experts in a short timescale.

Action

EQUS Steering Committee to decide on the applicability of AGREE II on the basis of further information.

2.8. Stakeholders Conference - June 15-17, 2011

CH presented the draft agenda for the conference, including objectives and expected outcomes.

- Conference objective: to discuss with stakeholders the preliminary findings of the EQUS study regarding minimum standards in drug treatment/harm reduction, taking into account the project on *European drug prevention quality standards*. Aim to build on the acceptability of the minimum quality standards to be recommended by the ISGF and taken up by the Commission to develop the EU consensus in 2012.

- Stakeholder conference will take place in Brussels on 15-17 June as no venue was booked in HU - HU Presidency of the EU will still be associated with the conference.

- Up to 125 participants: Participation will be by invitation mainly and should include policy-makers, professionals/practitioners, healthcare authorities, non-government organisations and researchers. Commission will fund one expert per member state, the EQUS expert group, up to 30 stakeholders and any speakers not covered by the above

groups. This will leave around 40 places for participants to register on a first come first serve basis (no conference fee).

- Draft programme: 2 days with plenary sessions plus two parallel sessions. parallel sessions to discuss the EQUS minimum quality standards, their applicability and implementation approaches with feedback and discussion in plenary.

Following discussion, agreement that the second parallel session would discuss implementation problems in prevention, treatment and HR (for service providers, practitioners, user groups) with one session on policy perspectives. This parallel session would be preceeded by presentations on four different approaches to implement standards.

The added value of US experts seems limited as US has quality standards in drug demand reduction, but these are not implemented in practice.

- **Czech Seminar – Standards as a Tool for Quality Management of Drugs Services**

Irena Tomesova from the Czech Centre for Quality and Standards in Social Services provided an overview of an international seminar on quality standards for drug services being organised in Prague from 18-20 May 2011. 40 participants will be invited, half from Czech Republic and the other half will be participants from the six participating countries in UK, AU, D, NL, SL and PL who will be asked to provide presentations on the situation in their countries. The objective of this seminar is to exchange best practice and experience and it will provide information on the system of certification of professional competence in drug services.

It was agreed that it would be useful for EQUS project member to attend the Czech seminar and to have a presentation of the Czech accreditation process at the EQUS conference.

Action

- CH will revise conference programme and draw up participants list with ISGF.

- EQUS partners will be invited to recommend who should be invited to participate in the conference, e.g. from the stakeholders who answered the Delphi questionnaires, and other experts and organisations.

- HS will recommend relevant participants for the parallel session on prevention standards.

- Irena Tomesova , Czech Centre for Quality and Standards in Social Services, to recommend speaker for presentation of the implementation of quality standards in the Czech Republic. EQUS steering committee to consider nomination to Czech seminar.

- A conference background paper will be prepared by AU. Paper to include two page descriptions of national implementation approach in NL (Gerard Schippers), Irena Tomesova (CZ), AU (CH) and UK (Colin Bradbury, National Treatment Centre)

3. Other Issues

It was decided that another expert meeting is not necessary. The EQUS steering committee (ISGF, Commission and EMCDDA) will meet on 15 April 2011 to review the project and the conference preparations. 11 March 2011

Appendix 10.10

Second interim report

In line with the Technical Specifications (1.3.2), set out in the Call for Tender, this second interim report covers the tasks 3, 4 and 5 of the project and will inform on:

- Any problems encountered and solutions proposed
- Main findings of the work undertaken, in particular regarding tasks (3) and (4) of the study
- Regarding task (5) of the study, the report shall include a set up and discussion plan for the two invitational seminars with experts
- An updated work-plan for the remaining tasks, in line with the time table set out for this contract.

Task 3: **"**To propose and help 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 audiences of interventions".

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 below under Task 5).

A *first step* was an agreement on the *structure of the questionnaire* for the Delphi survey. This questionnaire is now 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 (Annex 1), also a separate list of the quality standards in the questionnaire (Annex 2).

A *third step* was the setting up of *national lists for stakeholders* to be consulted in the Delphi 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 (see Annex 15). All project partners were required to present lists and EMCDDA asked the national Focal Points to nominate participants. The comprehensive list covers 368 stakeholders from EU Member States and Switzerland (Annex 3). WHO and special advisers are also invited to

make nominations and more are expected. An official letter was set up and signed by the Commission, to acknowledge the efforts of participating stakeholders (Annex 4).

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

In a *fifth step,* remaining dissent among participants in the survey will eventually be the focus of a second Delphi round. The product of this process will be submitted to external experts not involved in the project) who are familiar with the instrument AGREE II for an assessment, The result will be used as the basis for a proposal on minimal quality standards to be submitted at the European Conference. A major issue at the Conference will be to discuss problems and ways of implementation of standards in the Member States.

Task 4: **"**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".

As set out in the tender, model-designs will be prepared and proposed separately for the three areas prevention, treatment / rehabilitation and harm reduction. Inevitably there will be some overlapping between the three models, but for the consensus building process as well as for implementation purposes it is preferable to work on them separately. In a second round of analysis, shared standards will emerge, and possibly also standards for a joint improvement process in drug demand reduction systems.

The model design for minimal prevention standards has already been developed in a separate project, on the basis of the consensus process as described in the tender. A comprehensive list of 489 prevention standards is available; out of these, the core minimum standards cover needs assessment, resource assessment, programme formulation and intervention design, as well as some cross-cutting topics: sustainability, stakeholder involvement, workforce development and ethical aspects (Annex 5).

The model design for treatment /rehabilitation and for harm reduction follows the same basic procedure :

- structural standards are formulated in relation to different types of services
- outcome standards are formulated at the system level
- process standards are formulated in relation to different types of interventions.

This design allows for a meaningful differentiation of standards for various settings and interventions, and at the same time reduces the number of questions in a way acceptable to survey participants.

In line with the expectations formulated in the call for tenders, questions on the acceptability and the nature of expected eventual implementation problems are to be answered (including legal, political and ethical acceptability).

The outcome of the survey, the clarification of remaining issues in a second survey round, and the application of AGREE II to the product of this process will allow for a well balanced proposal to be submitted to the European Conference and finally to the Commission.

Task 5: **"**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. Other reflection and consultation mechanisms may be proposed by the contractor".

Both seminars have been organised in cooperation with the European Commission. The kick-off meeting was held in Zurich in June, the first expert seminar in Brussels in December 2010. The working papers for the kick-off meeting were attached to the first interim report, the papers for the first seminar are attached to this report (see Seminar 1 below).

Kick-off meeting for experts (12-13 June 2010)

Collaborating partners have been invited to a kick-off meeting. We reported on this seminar in the first interim report by July 25, 2010. All project partners from European countries were invited, and also all members of the steering group. Participants 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 procedures for data collection and transmission, for data control and storing in a masterfile were proposed, discussed, agreed and documented in the minutes of this meeting. The deadline for the document search and the transmission of templates was confirmed to be September 30th, as set out in the tender time table. The minutes of this first seminar were attached to the first interim report.

The *interval* between the kick-off meeting and the first seminar was used by project partners for the document search and the template transmission. Data control, data cleaning and the setting up of a masterfile were performed at the Zurich Research Institute for Public Health and Addiction. Unclear and missing data have been clarified and completed in direct contact with the respective partners. The deadline was not kept by all partners, mainly due to absences during the summer holidays. In some countries, there were delays in identifying the relevant persons contributing to the document search. At present, some templates from a few residual countries are still expected; they will be included in the final analysis of the document base for setting up proposals for minimal quality standards. Also, not all partners established yet the requested lists of documents which were used or excluded for the templates.

Seminar 1 for experts (06-07 December 2010)

In collaboration with the European Commission, the first seminar was organised in Brussels, with the support of a contractor mandated by the Commission. 19 participants were able to attend. An agenda for the seminar (Annex 6) and a working paper guiding the participants preparation for the seminar (Annex 7) were sent out beforehand.

In Part I of the meeting, participants had to *report on their experience with the document search and the use of the electronic templates*. The main problems were mentioned (in general the restrictive time frame, and specifically the difficult document search in federal states, and missing information in many documents on the evidence grade of standards). The contractor then reported on the *quality of incoming data, on the state of the masterfile and on the provisional document inventories at national level* (Annex 8). In addition to an overview of templates and document lists from participating countries (Appendix 9), updated lists of documents used for templates are available (Appendix 10). One important limitation of the document base was confirmed: general treatment / rehabilitation guidelines, not specifically geared towards the management of drug-related conditions, could not be included.

In Part II, a first *analysis of the available data* followed, in separate presentations for treatment / rehabilitation and for harm reduction (Annexes 11 & 12). Most information covers the national level and stems from public sources or professional associations. In the area of treatment / rehabilitation, the best documented interventions are psychosocial interventions and substitution treatments for opioid dependence. Relevant standards can be identified. Some confusion about the findings on harm reduction standards could be discussed. The relevance

of accessibility was highlighted. For both areas, evidence grading is missing in the majority of evaluated documents, but it is possible to separate recommended and mandatory standards.
The state of the project on quality standards in drug prevention was shortly presented and discussed (Annex 13).
Part III was dedicated to the *construction of minimal quality standards* on the basis of the available information from the masterfile. Proposed steps were presented to introduce the discussion (Annex 14). A first proposal to differentiate the relevance of the evaluated documents was accepted: criteria for earmarking especially important documents as reference or resource documents were agreed; they should have more weight for defining minimal standards. An intensive discussion resulted in a proposal to organise quality standards as per interventions, listing for each intervention standard which countries have this standard, based on which source, and backed up by which evidence grade. This formula was accepted as a starting point for the on-line survey, and it should be tested in a pilot survey with project partners participating in it.

Part IV was concerned with the *on-line survey* as the initial element of the consensus building process. Criteria for selecting stakeholders to be included, nominations from the National Focal Points, timing for the piloting and for the first round of the survey, construction of the survey questionnaire, the procedures in case of major dissent resulting from the on-line survey (Annex 15), and the application of the AGREE II to the final product (Annex 16) were proposed, discussed and agreed. An official letter signed by the commission was planned for acknowledging the participation of stakeholders. Another expert meeting of project partners was scheduled for March 3-4, 2011, in order to discuss the survey results and to plan an eventual second survey round.
At the end of this part, a model invoice was presented for the remuneration of the performed work, in line with the agreements made earlier individually.

The following actions and deadlines were confirmed (see also seminar report Annex 17):

Official letter by Commission	Dec 24, 2010
List of stakeholders for survey (all)	Jan 7, 2011
List of stakeholders for survey from Focal Points (EMCDDA)	Jan 14, 2011
Programme for European Conference (steering committee)	Jan 31, 2011
Pilot survey	Jan 7-14, 2011
Online survey first round	Jan 20 – Feb 10, 2011
Next expert meeting	March 3-4, 2011
Online survey second round (if needed)	March 14-Apr 2, 2011
European Conference	(May 11-13, not confirmed)
End of project	Dec 31, 2011

3. Conclusions

Problems:

The time available for the document search and data transmission from project partners to the contractor proved to be insufficient for some partners. All efforts are made to include late incoming templates into the data analysis, so no relevant information should be lost to the final product of the project.
Some difficulties in understanding the preliminary questionnaire for the Delphi survey were identified in a pilot and resulted in an updated version which is now used for the survey. The survey could not start for all countries at the same time, because the recruitment of stakeholders to be involved in the survey was not ready in some countries. Late incoming lists of stakeholders will be used for completing the survey as planned.
A remaining question about prevention standards is the limitation to process standards and a lack of evidence backing up the individual minimal standards. It must be acknowledged

however, that any outcome of prevention interventions depends largely on socio-cultural factors and is less clearly to be evaluated on a general scale. The focus on process standards to be followed in case of implementing prevention activities is well justified.

Main findings for tasks 2, 3, 4 & 5:
Task 2:
The number and nature of relevant documents and of data from these documents is very satisfactory. Most deficits in data transmission could be corrected, and the masterfile is easy to handle. All data on standards from national documents can be organised according to the origin of the document, the sources of information, and the available scientific evidence and evidence grade, as well as in regard to their status (recommendation or mandatory condition). The data base is a useful instrument for extracting proposals for minimal quality standards according to defined criteria.

Task 3:
The consultation and consensus building mechanism was started according to plan. Proposals for initiating the process were prepared for the second expert seminar, discussed and finalised. Main instrument are Delphi surveys in all participating Member States with a wide range of stakeholders in various professions and functions. The implementation started with a pilot survey, involving the project partners. Numerous feedbacks resulted in an improvement of the questionnaire. The first round of the survey started by January 20, with a deadline of 3 weeks. An agreement on the following steps was set up during the second expert seminar.

Task 4:
The basic design for the framework of minimal quality standards could be determined at the second expert seminar and refined on the basis of a pilot survey among project participants. It is now submitted to a large range of stakeholders in a Delphi survey and will be further adjusted in the course of the consensus building process.

Task 5:
The first expert seminar with national collaborating partners 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 (see first interim report of July 25th, 2010).
The second expert seminar resulted in discussing the findings from the data collection process, and in shaping the questionnaire and procedures for the Delphi survey.

Updated work plan:
The time table set out in the tender is still valid. An updated list of activities and dates includes the following:

Pilot survey	Jan 7-14, 2011
Delphi survey first round	Jan 20 – Feb 10, 2011
Next expert meeting	March 3-4, 2011
Delphi survey second round (if needed)	March 14-Apr 2, 2011
European Conference	(May 11-13, not confirmed)
End of project	Dec 31, 2011

For more details, see Task 5, seminar 2 for experts, above and Annex 17.

List of annexes

Annex 1	On-line questionnaire for Delphi survey
Annex 2	List of quality standards for treatment/rehabilitation and for harm reduction
Annex 3	List of stakeholders recruited for Delphi survey

Annex 4	Official letter from Commission to stakeholders participating in survey
Annex 5	Core minimum standards for drug prevention
Annex 6	Agenda second expert seminar
Annex 7	Preparatory paper for second expert seminar
Annex 8	Presentation on results of document search, data transmission, data cleaning, masterfile
Annex 9	Overview templates and documents
Annex 10	Lists of templates
Annex 11	Presentation on analysis of treatment/rehabilitation data
Annex 12	Presentation on analysis of harm reduction data
Annex 13	Presentation on quality standards in drug prevention
Annex 14	Presentation on steps to set up minimal standards
Annex 15	Presentation on Delphi survey
Annex 16	Presentation on AGREE II
Annex 17	Report on second expert seminar

Zurich, January 26th, 2010

Appendix 10.11

List of EQUS Conference Participants

SURNAME	Name	Organisation	Country
ALFÉ	Manuela	European Commission	
AUTRIQUE	Mieke	VAD	BELGIUM
BAFI	Ioulia	UNIVERSITY MENTAL HEALTH RESEARCH INSTITUTE	GREECE
BANKAUSKIENE	Inga	DRUG, TOBACCO AND ALCOHOL CONTROL DEPARTMENT	LITHUANIA
BELLO	Pierre-Yves	Addiction Bureau, Ministry of work, employment and health	FRANCE
BERGMARK	Anders	Stockholm University	SWEDEN
BERT	Hauspie	Vitalsounds	BELGIUM
BIJL	Murdo	Health Connections International	NETHERLANDS
BOLANU	Diana	National Anti-drug Agency	ROMANIA
BOONE	Bert	Vitalsounds (CAW Stimulans)	BELGIUM
BRADBURY	Colin	National Treatment Agency for Substance Misuse	UNITED KINGDOM
BRAVO	María J	Instituto Salud Carlos III-CNE	SPAIN
BROTHERHOOD	Angelina	Liverpool John Moores University	UNITED KINGDOM
BROWN	Andrew	Mentor UK	UNITED KINGDOM
CARLIN	Eric	Birkbeck College, London	UNITED KINGDOM
CASERO VILLAR	Lucia	Eurotox Observatoire socio-épidemiologique drogues alcool en Communauté Française	BELGIUM
CHARLOIS	Thierry	Association Française de Réduction des Risques	FRANCE
CLARK	Marilyn	National Commission for Drugs Alcohol and other Dependencies	MALTA
COLETTI	Maurizio	Itaca Association	ITALY
COLOM	Joan	DG of Public Health, Department of Health, Government of Catalonia,	SPAIN
D'ACAPITO	Paola	Executive Agency for Health and Consumers	LUXEMBOURG
DAVOLI	Marina	EMCDDA	ITALY
De ZWART	Wilhelmina	Ministry of Health, Welfare and Sport	NETHERLANDS
DEUGNIER	Dominique	Interministerial mission in the fight against drugs and drug addiction	FRANCE
DOMS	Kurt	Federal Public Service Health, Food Chain Safety and Environment	BELGIUM
DONINI	Rachele	Addiction Area-ASL 2 Savonese	ITALY
DONOGHOE	Martin	World Health Organization Regional Office for Europe	DENMARK
DOYLE	Joseph	Health Service Executive (HSE)	IRELAND
DUCH MOYÀ	Maria Angeles	IREFREA	SPAIN
EGLE	Andris	Ministry of Health	LATVIA

ERIKSSON	Anders	Social Development Unit, Social Affairs Administration, City of Stockholm	SWEDEN
ESTRADA	Maria	DG of Public Health, Department of Health, Government of Catalonia	SPAIN
FANFARILLO	Anna Maria	Dipartimento Politiche Antidroga	ITALY
FELVINCZI	Katalin	Eotvos University, Institute for Psychology	HUNGARY
FERRI	Marica	EMCDDA	PORTUGAL
FISCHER	Gabriele	Medical University of Vienna	AUSTRIA
GAGLIARDI	Mauro	European Commission	
GALLA	Maurice	European Commission	
GASULLA SURIOL	Laia		SPAIN
GOLOSHCHAPOV	Alexander	Permanent Mission of Russia to the European Union	BELGIUM
GREZSA	Ferenc Dezső	National Institute of Social Policy and Family, National Office for Drug Prevention	HUNGARY
GRIFFITHS	Paul	EMCDDA	PORTUGAL
HAGER	Caroline	European Commission	BELGIUM
HEDRICH	Dagmar	EMCDDA	PORTUGAL
HEISE	Christian	Euro-TC	GERMANY
JABLONSKI	Piotr Stefan	National Bureau for Drug Prevention	POLAND
JANDL	Mateja	NATIONAL INSTITUTE OF PUBLIC HEALTH	SLOVENIA
JELENKOVA	Zuzana	Governement Office of the Slovak Republic	SLOVAKIA
JETSU	Timo	European Commission	
JOHANSSON	Per	World Federation Against Drugs	SWEDEN
KAPOSI	Bernadett	Ministry of Interior	HUNGARY
KARSA VON SZENTKIRALYSZABADJA	Lawrence	International Agency for Research on Cancer	FRANCE
KERN	Albert	Federal Ministry of Health, Germany	GERMANY
KIŠŠOVÁ	Lucia	Office of the Government of the Czech Republic	CZECH REPUBLIC
KOECHL	Birgit	Medical University of Vienna	AUSTRIA
KOKKOLIS	Konstantinos	GREEK ORGANISATION AGAINST DRUGS (OKANA)	GREECE
KOOYMAN	Martien	Association of Friends of Drug Free Programs	NETHERLANDS
KOPPÁNY	Katalin	Ministry of National Resources	HUNGARY
KORSKE	Tove	NBV(Nykterhetsrörelsens Bildningsverksamhet)	BELGIUM
KRISTANCIC	Lidija	MINISTRY OF HEALTH	SLOVENIA
KURBATOVA	Aljona	National Institute for Health Development	ESTONIA
KUUS	Margit	National Institute for Health Development	ESTONIA
LODWICK	Alan	UK Focal Point	UNITED KINGDOM
LUPPI	Monica	San Patrignano Foundation	ITALY
MALCZEWSKI	Artur	National Bureau for Drug Prevention	POLAND
MALINOWSKA-SEMPRUCH	Kasia	Global Drug Policy program at Open Society Foundations	USA
MALLIORI	Minerva Melpomeni	GREEK ORGANIZATION AGAINST DRUGS (OKANA)	GREECE

MARTINS	Mário	IDT - Instituto da Droga e da Toxicodependência	PORTUGAL
MATHEÏ	Catharina	Katholieke Universiteit Leuven/Free Clinic, Antwerp	BELGIUM
MCCRACKEN	John	Department of Health	UNITED KINGDOM
MONCADA BUENO	Maria Sonia	Governement Delegation for the National Plan pon Drugs	SPAIN
MORAN IGLESIAS	Jesus A.	FIIAPP	SPAIN
MOSKALEWICZ	Jacek	Institute of Psychiatry and Neurology	POLAND
MUTATAYI	Ndaya Carine	OFDT French Monitoring Centre on Drugs and Drug Addictions	FRANCE
NADASHVILI	Nino	Global projects implementation center	GEORGIA
NESHEVA	Elmira	National Centre for Addictions	BULGARIA
NGJELINA	Enkelejda	"AKSION PLUS" DRUG PREVENTION AND TREATMENT	ALBANIA
NILSSON	Linda	Swedish National Association for a drug Free Society	SWEDEN
PAVICEVIC	Tijana	Juventas	MONTENEGRO
PETERSEN	Helle	National Board of Health, Denmark	DENMARK
PETTERSSON	Bo	Ministry of Social affairs	SWEDEN
PHELAN	Maria	Harm Reduction International	UNITED KINGDOM
PINTO DE PADUA	Jose Manuel	IDT - Portuguese Institute on Drugs and Drug Addictions	PORTUGAL
PIPITONE	Béatrice	Hill & Knowlton	BELGIUM
PLAKU	Erlind	Aksion Plus	Non EU countries
POZNYAK	Vladimir	World Health Organization	SWITZERLAND
QUARTERMAINE	Susan	European Commission	
RADIMECKY	Josef	Centre for Addictology, 1st Medical Faculty, Charles University in Prague	CZECH REPUBLIC
RAFLING	Claudia	Federal Ministry of Health	AUSTRIA
RAYCHEVA	Tsveta	National Addiction Center	BULGARIA
RICCI	Roberto	IDM	ITALY
RIVIÈRE	Claude	Ministry of Health	FRANCE
ROTBERGA	Signe	UNODC - United Nations Office on Drugs and Crime	LITHUANIA
RUBINI	Elisa	San Patrignano Foundation	ITALY
SAABYE	Mie	Ministry of the Interior and Health	DENMARK
SCHATZ	Eberhard	Correlation Network	NETHERLANDS
SCHAUB	Michael	Research Institute for Public Health and Addiction (ISGF)	SWITZERLAND
SCHERBAUM	Norbert	Klinik für abhängiges Verhalten und Suchtmedizin, LVR-Klinikum Essen	GERMANY
SCHIPPERS	Gerard	Academic Medical Center	NETHERLANDS
SERPELLONI	Giovanni	Dipartimento Politiche Antidroga	ITALY
SIMEONI	Elisabetta	Dipartimento Politiche Antidroga	ITALY
SIMON	Roland	EMCDDA	PORTUGAL
SOIKKELI	Markku	National Institute for Health and Welfare (THL)	FINLAND

SPINANT	Dana	European Commission	
SPITS	Masha	Amsterdam Institute for Addiction Research (AIAR/AMC)	NETHERLANDS
STAFFAN	Hübinette	Swedish National Association for a drug Free Society	SWEDEN
STAMM	René	Federal office of Public Health	Non EU countries
SUBATA	Emilis	Vilnius Centre for Addictive Disorders	LITHUANIA
SUMNALL	Harry	Liverpool John Moores University	UNITED KINGDOM
SYMEONIDOU	Eva	Cyprus Anti-Drugs Council	CYPRUS
TALIC	Sanela	Institute for Research and Development UTRIP	SLOVENIA
TERZIDOU	Maria	UNIVERSITY MENTAL HEALTH RESEARCH INSTITUTE	GREECE
TOPOLÁNSZKY	Ákos Péter	European Economic and Social Committee	AUSTRIA
TRAUTMANN	Franz	Trimbos Institute	NETHERLANDS
TSERETELI	Zaza	NDPHS	ESTONIA
UCHTENHAGEN	Ambros	Research Institute for Public Health and Addiction (ISGF)	SWITZERLAND
ULSTEIN	Anders	EURAD, Europe against Drugs	BELGIUM
VAN DAM	Jannigje	AIDS Foundation East-West	NETHERLANDS
VERTHEIN	Uwe	Centre for Interdisciplinary Addiction Research of Hamburg University	GERMANY
WEIGL	Marion	Gesundheit Österreich GmbH	AUSTRIA
WELBEL	Marta	Institute of Psychiatry and Neurology	POLAND
WELLE-STRAND	Gabrielle	Norwegian Directorate of Health	NORWAY
ZENELAJ	Blerta	Aksion Plus	ALBANIA
ZYGADLO	Marek	Polish Drug Policy Net	POLAND

Appendix 10.12

Working Paper
European Conference
Building an EU Consensus for
Minimum Quality Standards in Drug Demand Reduction
June 15-17, 2011
Résidence Palace Brussels

DISCLAIMER
The draft quality standards presented in this conference working paper have been developed by the Swiss Research Institute for Public Health and Addiction (ISGF) as part of a study funded by the European Commission in preparation of this conference. They do not necessarily reflect the opinion of the European Commission.

1. Introduction

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. 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.
This technical conference, hosted by the European Commission in association with the Hungarian Presidency of the EU, will bring together policy-makers, practitioners, NGOs and researchers in the fields of drug prevention, treatment and harm reduction to discuss the preliminary findings of a Commission study titled *'Developing and EU Framework for minimum quality standards and benchmarks in drug demand reduction'* (EQUS) to help develop *minimum quality standards* in the field of drug demand reduction.
This working paper provides information on:

- The political context at EU level relevant for the development of minimum quality standards
- A description of the EQUS project and the state of play
- Concept and definitions of quality standards
- An overview of the findings from an online-survey carried out in the first half of 2011
- Presentation of three lists reflecting expert consensus on proposed minimum quality standards for the fields of prevention, treatment and harm reduction (section 5) :
    - *minimum quality standards with a **high** level of consensus*
    - *minimum quality standards with a **moderate** level of consensus*
    - *minimum quality standards with a **low** level of consensus*

These lists will be presented in detail at the conference by the project coordinators and participants are invited to study and discuss these.
The first part of the conference will introduce the list of those standards which achieved a high level of consensus among experts and it will subsequently discuss **the list of those**

standards which achieved a moderate consensus in the expert on-line survey (section 5.2.).
The second part of the conference will focus on the implementation of standards in practice. You will find the results from the survey on the acceptability of the standards and the **expected problems of implementation** in Section 6.
The conference will include a number of plenary sessions to introduce the background and principles relevant for the process of achieving an EU-consensus on the development of minimum quality standards in the field of drug demands reduction. Furthermore, two rounds of parallel sessions will be organised to:

Parallel Session A

→ Discuss a draft list of minimum quality standards presented by the project coordinators and examine how feasible and applicable these are to support effective interventions, treatment and harm reduction services in the EU.

Parallel Session B

→ To discuss how minimum quality standards can be best translated into practice, while examining implementation problems from the perspective of policy-makers and professionals.

The specific questions to be addressed by the parallel sessions can be found in Section 8.

In conclusion

This conference should be 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.
The conference conclusions and recommendations for follow-up decisions will brought forward through the appropriate channels for EU drug policy making, including the Horizontal Working Party on Drugs, on the basis of possible initiatives from the European Commission. A further explanation of the political context of this project can be found in the next section.

IMPORTANT

While there has been a certain degree of convergence between the policies and interventions in the EU Member States in recent years. there are national differences in the types of interventions and services available across the EU.
The benefits of any specific interventions in the field of drug prevention, treatment or harm reduction are not the subject of this conference.
The conference will discuss which standards are acceptable and should be recommended to enhance the quality and effectiveness of specific intervention, in those situations where such interventions are chosen to be implemented in a given Member State.

2. Rationale of the Project and Perspectives

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

By adopting the Strategy[1], 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

[1] 15074/04, CORDROGUE 77, 22.11.2004, section 22;

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[2]:

- *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"*[3].

This recommendation was subsequently translated into the EU Drugs Action Plan 2009-2012[4] through the adoption of a specific action that aimed:

"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[5] 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.

[2] Final Evaluation of the EU drugs action plan 2005-2008, SEC (2008) 2456, 18.9.2008;
[3] Ibid, § 6.2.2, p. 69;
[4] OJ 326, 20.12.2008, Action 19;
[5] OJ C 115, 9.5.2008, Art. 168 (1),(2),(6)

The Best Practice Portal of the European Monitoring Centre for Drugs and Drug Addiction[6] provides an increasingly important resource for professionals, policymakers and researchers in the drug field. The portal also provides an overview of the available quality standards and guidelines in the European Union (EU) Member States.
The EU's Drug Prevention and Information programme[7] offers financial support for cross-border projects which expand the knowledge base in the field of drugs through the identification and dissemination of good practice. The EU's Health Programme

3. Project Outline and State of Play

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 which is due to be completed by December 2011.
The study on minimum **E**uropean **Qu**ality **S**tandards (**EQUS**) in the field of drug demand reduction is carried out by the Research Institute for Public Health and Addiction, Zürich University, in cooperation with the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) and 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[8]. 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:

- 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.
- 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.

For the **field of treatment and harm reduction**, the following tasks have been carried out so far:

[6] www.emcdda.europa.eu
[7] Drug Prevention and Information Programme, Official Journal L 257; 3 October 2007
[8] See Annex 1 for list of EQUS experts

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 was undertaken and collected;
2. The collected information was subsequently **categorised, analysed and screened** for relevance;
3. On the basis of the screening process, a comprehensive **inventory of quality standards and guidelines** in the field of drug demand reduction was created

4. A **model-framework** for the draft quality standards was developed, 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 was provided through a systematic review of the scientific literature.

5. The final inventory consisted of a **draft list of quality standards for drug treatment and harm reduction**, which were subsequently translated into an **online stakeholder survey to canvas expert opinion on** the acceptability and feasibility of implementing each individual standard within their country.

6. The outcome of the survey, combined with the evidence gathered through inventory form the basis for the **proposed list of minimum quality standards** as presented in **this discussion paper**.

In the field of **drug prevention**, the development of minimum quality standards has taken a different approach. In 2009, the Commission provided funding for a project titled 'European Drug Prevention Quality Standards'[9]. This project was carried out by the Prevention Standards Partnership, led by the UK Liverpool John Moores University, and completed in November 2010.
This project systematically reviewed drug prevention programmes and interventions in the EU and at international level and developed a set of process quality standards in the field of drug prevention. The experience and information produced through this project has been adapted for the development of the EQUS project, and where necessary, differences in methodological approach will be reconciled.

EQUS Project: Next Steps

Following further analysis of the evidence collected, feedback from the expert surveys and the European stakeholder conference, the study will set out a number of options for minimum quality standards in the fields of prevention, treatment and harm reduction for consideration by the European Commission at the end of 2011.
Drawing on these findings, the European Commission will assess what form its proposal for a European consensus should take, bearing in mind the need to respect national differences in the field of drug policy and healthcare and to complement existing systems.

4. Concepts & Definitions of Quality Standards in the Drugs Field

See chapter 3 of the final report

[9] European drug prevention quality standards – http://www.cph.org.uk/drugprevention/

5. Project Methodology and Preliminary Findings

As indicated in Section 2, the methodologies to reach a proposed list of recommended minimum quality standards for drug prevention and that of treatment and harm reduction was somewhat different. Both methodologies are briefly summarised below:

5.1. Developing a list of minimum quality standards - drug prevention

By the beginning of 2011, the Prevention Standards Partnership under the guidance of Dr. Harry Sumnall (Liverpool John Moores University) had already conducted an extensive study on standards and guidelines for drug prevention.
Quality standards were synthesised through a structured qualitative content analysis based on expert/stakeholder opinion, expert consensus, reviews of previously existing standards and literature reviews.
Subsequently, a substantive list of quality standards was generated through a review of existing guidance. These draft standards were refined in consultation with drug prevention professionals and prioritised through a Delphi-style online survey methodology and through focus groups in the partner countries. The refined standards were finally field tested in their entirety in additional focus groups so that their usability and feasibility could be determined.
The prevention standards cover the following eight project stages:

1. Needs assessment;
2. Resource assessment;
3. Programme formulation;
4. Intervention design;
5. Management and mobilisation of resources;
6. Delivery and monitoring;
7. Final evaluations; and
8. Dissemination and improvement

In addition, four standards ('cross-cutting considerations') are of relevance to each project stage, namely: (1) *sustainability and funding*; (2) *communication and stakeholder involvement*; (3) *staff development*; and (4) *ethical drug prevention*
For this overview, the Delphi results are 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 ultimate draft. It is likely that the final standards would receive a greater level of support in a new Delphi survey as some of the standards have been modified and rephrased.
This material was, for the purposes of the EQUS project, screened again for the evidence base of standards. The list of proposed prevention quality standards presented in Section 6 is the final list produced through this process:
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 consensus)
- standards with low acceptability (rated as mandatory by less than 50% of responding participants).
-

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

To adapt the prevention standards to the EQUS project, the template framework developed for the areas of treatment/rehabilitation and harm reduction was applied to the prevention standards, allowing an adaptation of the prevention standards to the format of the other two areas treatment/rehabilitation and harm reduction, and consequently a comparison between the three areas will be possible.

5.2. Developing a list of minimum quality standards - drug treatment and harm reduction

5.2.1. Document search

As indicated in Section 2, 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, target groups and target populations are covered. The best documented interventions are psychosocial interventions and substitution treatment. The best documented setting is outpatient services.

5.2.2. Setting up the inventory

The retrieved documents were analysed. In order to retrieve comparable information from the selected documents, structured electronic templates were prepared in an Excel format.

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 **selection criteria** for 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 included that **exclusively to the drugs field** and not the broader healthcare

The inventory contains a comprehensive list of quality standards and benchmarks emerging from the analysis of the templates. Standards and benchmarks are labelled on the basis of available evidence grading.

Grading of evidence

Grade	Definition
A	Highest degree of evidence: review from multiple randomised controlled studies (RTC) 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 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.

5.2.3. The model design for the draft minimum quality standards

A list of good quality standards in drug demand reduction cannot be provided on the basis of accumulated inventories alone. The consensus for each standard was identified by the following multiple-step process.
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 search or expert consensus
- 29 documents for treatment/rehabilitation and 9 documents for harm reduction were identified on the basis of these criteria.

The **criteria for selecting quality standard**s for the lists to be submitted in the stakeholder survey were:

- in how many of the screened documents and of the reference documents a specific standard is mentioned
- which countries have a specific standard already in a national document or guideline, issued by a national authority or professional association
- is the standard based on systematic literature search or expert consensus.
-

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 is divided into:

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

In addition, **the quality standards are categorised as follows:**

For **treatment/rehabilitation *services***

- 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

- Teams specialised in addiction treatment
- Teams not specialised in addiction treatment

For **harm reduction *services***

- additional categories were pharmacies and clubs

For ***interventions* in treatment / rehabilitation**

- early intervention (brief interventions in case of harmful drug use)
- detoxification (interventions to treat drug withdrawal symptoms)
- psychosocial intervention (psychological and/or social support)
- substitution maintenance (treatment supported by replacing illegal opiates by methadone or other medications)
- other pharmacological intervention (medically assisted relapse prevention, medications for somatic and/or psychiatric conditions)
- aftercare (continued support and counselling after the termination of treatment phase)
- vocational rehabilitation (interventions to support employment)

For **harm reduction *interventions***

- needle exchange program
- supervised injection room
- outreach work / street work
- drug checking
- blood borne virus infection testing
- vaccination
- referral to other services if needed
- safer sex education
- safer use education
- sheltered housing

5.2.4. Consultation and Consensus-Building: Expert Surveys

The next step was to canvas expert opinion on the proposed list of quality standards selected from the inventory in accordance with the above criteria.
Two on-line surveys carried out by the Swiss Research Institute for Public Health and Addiction between January-April 2011. The online survey was developed based on feedback from the EQUS 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 components in the final standards, serving as the basis for the proposal of minimum standards for **drug treatment/rehabilitation and harm reduction.**

In total **514 stakeholders were invited from all EU Member States**, including health and social professionals, representatives of public authorities, health insurance, user groups and church organisations. Stakeholders were proposed by the EQUS expert group and by the EMCDDA's national focal points.

In the survey questionnaire, stakeholders received information for each individual quality standard:

- 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.

The questionnaire then asked about the acceptability of each standard, separately for services and interventions, and about expected problems for implementation. In the second survey round, professionals received feedback on the results from the first round. Across all countries and regions, **241 out of 514 (≤46.9%)** invited professionals completed both survey rounds.

5.2.5 Proposed Lists of Minimum Quality Standards

On the basis of the results from the two surveys, the proposed lists of minimum quality standards in the areas of prevention, treatment and harm reduction differentiate 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%)**

Those with a **moderate consensus** will be discussed during the stakeholder conference for eventual inclusion, while those with **low consensus on acceptability** are proposed to be excluded.

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 below. In those standards where the stakeholders did not provide an answer on the acceptability of a standard by ticking "no answer" by personal or other reasons, their statements were not included for the calculation of the mean consensus levels.

NOTE: With regard to the standards proposed in the field of **harm reduction** part, the moderate rating on the acceptability of the standards was calculated only for stakeholders´ data from those countries where the corresponding services are actually available.

6. Proposed Lists of Minimum Quality Standards

6.1. QUALITY STANDARDS WITH HIGH CONSENSUS (more than 80%)

Prevention: *Structural Standards of Services*

1. Ethical drug prevention: A code of ethics is defined. Participants' rights are protected through informed consent. The programme has clear benefits for participants, and will not cause them any harm. Participant data is treated confidentially. The physical safety of participants and staff members is protected.
2. Staff composition: The staff required for successful implementation is defined and (likely to be) available (e.g. type of roles, number of staff). The set-up of the team

is appropriate for the programme. Staff selection and management procedures are defined.

3. Policy and legislation: The knowledge of drug-related policy and legislation is sufficient for the implementation of the programme. The programme supports the objectives of local, regional, national, and/or international priorities, strategies, and policies.
4. Staff composition: Internal resources and capacities are assessed (e.g. human, technological, financial resources). The assessment takes into account their current availability as well as their likely future availability for the programme.
5. Financial requirements: A clear and realistic cost estimate for the programme is given. The available budget is specified and adequate for the programme. Costs and available budget are linked. Financial management corresponds to legal requirements.

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

6. Goal: It is clear what is being 'prevented' (e.g. what types of drug use?). The programme's aims, goals, and objectives are clear, logically linked, and informed by the identified needs. They are ethical and 'useful' for the target population. Goals and objectives are specific and realistic.
7. Outcome evaluation: Evaluation is seen as an integral and important element to ensuring programme quality. It is determined what kind of evaluation is most appropriate for the intervention, and a feasible and useful evaluation is planned. Relevant evaluation indicators are specified, and the data collection process is described.
8. Monitoring the implementation: Monitoring is seen as an integral part of the implementation phase. Outcome and process data are collected during implementation and reviewed systematically. The project plan, resources, etc. are also reviewed. The purpose of monitoring is to determine if the programme will be successful and to identify any necessary adjustments.
9. Outcome evaluation: The sample size on which the outcome evaluation is based is given, and it is appropriate for the data analysis. An appropriate data analysis is conducted, including all participants. All findings are reported in measurable terms. Possible sources of bias and alternative explanations for findings are considered. The success of the programme is assessed.

***Prevention**: Process Standards of Interventions*

10. Assessment procedures: The needs of the community (or environment in which the programme will be delivered) are assessed. Detailed and diverse information on drug use is gathered. The study utilises existing epidemiological knowledge as possible, and adheres to principles of ethical research.
11. Assessment procedures: Sources of opposition to, and support of, the programme are considered, as well as ways of increasing the level of support. The ability of the target population and other relevant stakeholders to participate in the programme is assessed.
12. Assessment procedures: Justifying the intervention: The need for an intervention is justified. The main needs are described based on the needs assessment, and the potential future development of the situation without an intervention is indicated. Gaps in current service provision are identified.
13. Assessment procedures: The target population is chosen in line with the needs assessment. The chosen target population(s) can be reached. The needs assessment considers the target population's culture and its perspectives on drug use.

14. Intervention design: The programme is adequate for the specific circumstances of the programme (e.g. target population characteristics), and tailored to those if required. Elements to tailor include: language; activities; messages; timing; number of participants
15. Intervention design: The programme builds on positive relationships with participants by acknowledging their experiences and respecting diversity. Programme completion is defined.
16. Intervention design: If selecting an existing intervention, benefits and disadvantages are considered, as well as the balance between adaptation, fidelity, and feasibility. The interventions' fit to the needs assessment and other local circumstances are also examined. The chosen intervention is adapted carefully, and changes are made explicit.
17. Implementation: The programme is implemented according to the written project plan. The implementation is adequately documented, including details on failures and deviations from the original plan.
    Process evaluation: The implementation of the programme is documented and explained. The following aspects are evaluated: target population involvement; activities; programme delivery; use of financial, human, and material resources.
18. Staff development: It is ensured prior to the implementation that staff members have the competencies which are required for a successful programme implementation. If necessary, high quality training based on a training needs analysis is provided. During implementation, staff members are supported in their work as appropriate.
19. Dissemination: The final report documents all major elements of programme planning, implementation, and (where possible) evaluation in a clear, logical, and easy-to-read way. Details on implementation experiences and unintended outcomes are included. Legal aspects of reporting on the programme are included (e.g. copyright).

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

1. Physical environment: space (e.g. service has separate rooms for individual counselling)
   Exception: moderate consensus for non-specialized teams
2. Indication criteria: diagnosis (treatment indication is always made on the basis of a diagnosis)
   Exception: moderate consensus for GP´s office-based services and non-specialized teams
3. Staff composition: education (e.g. at least half of staff has a diploma in medicine, nursing, social work, or psychology)
   Exception: moderate consensus for GP´s office-based services and non-specialized teams

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

4. Goal: health stabilisation/improvement (treatment must be aimed at improvement or stabilisation of health)
   Exception: moderate consensus for non-specialized teams
5. Goal: social stabilization/integration (treatment must be aimed at improvement of social stabilisation or integration)
   Exception: moderate consensus for GP´s office-based and prison-based services and non-specialized teams

6. Goal: reduced substance use (treatment must be aimed at a reduction of substance use e.g. helping the client/patient to reduce the use or to abstain from psychotropic substances)
   Exception: moderate consensus for GP´s office-based services and non-specialized teams
7. Utilisation monitoring (services must report periodically the occupancy of treatment slots or beds)
   Exception: moderate consensus for GP´s office-based services and non-specialized teams
8. Internal evaluation (services must regularly perform an internal evaluation of their activities and outcomes)
   Exception: moderate consensus for GP´s office-based and prison-based services and non-specialized teams

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

9. Assessment procedures: substance use history, diagnosis and treatment history have to be assessed
   Exception: moderate consensus for GP´s office-based and non-specialized teams
10. Assessment procedures: somatic status and social status have to be assessed
    Exception: moderate consensus for GP´s office-based and non-specialized teams
11. Individualised treatment planning (treatment plans are tailored individually to the needs of the patient)
    Exception: moderate consensus for GP´s office-based and prison-based services and non-specialized teams
12. Informed consent (patients must receive information on available treatment options and agree with a proposed regime or plan before starting treatment)
    Exception: moderate consensus for GP´s office-based and prison-based services and non-specialized teams
13. 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: moderate consensus for non-specialized teams
14. Confidentiality of client data (patient records are confidential and exclusively accessible to staff involved in a patient's treatment or regime)
    Exception: moderate consensus for non-specialized teams
15. 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: moderate consensus for prison-based services and non-specialized teams
16. Continued staff training (staff is regularly updated on relevant new knowledge in their field of action)
    Exception: moderate consensus for non-specialized teams
17. Assessment procedures: substance use history, diagnosis and treatment history have to be assessed
    Exception: moderate consensus for non-specialized teams

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

18. Assessment procedures: substance use history, diagnosis and treatment history have to be assessed
    Exception: none

19. Assessment procedures: somatic status and social status have to be assessed
    Exception: none
20. Assessment procedures: psychiatric status has to be assessed
    Exception: none
21. Individualised treatment planning (treatment plans are tailored individually to the needs of the patient)
    Exception: none
22. Informed consent (patients must receive information on available treatment options and agree with a proposed regime or plan before starting treatment)
    Exception: none
23. 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: none
24. Confidentiality of client data (patient records are confidential and exclusively accessible to staff involved in a patient's treatment or regime)
    Exception: none
25. 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)
    Exception: none
26. Continued staff training (staff is regularly updated on relevant new knowledge in their field of action)
    Exception: none

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

1. Accessibility: location (service can easily be reached by public transport)
   Exception: moderate consensus for drug checking, BBV testing and counselling, and sheltered housing
2. Staff qualification: minimum qualification (e.g. at least half of staff has a diploma in nursing, social work, or psychology)
   Exception: moderate consensus for needle-syringe exchange, outreach/street work, safer use and safer sex counselling, and sheltered housing

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

3. Goal: reduced risk behaviour (reducing unsafe injections, unsafe drug use and unprotected sex)
   Exception: none
4. Goal: referrals (treatment services must be prepared to refer clients/patients to other health/social/treatment services if needed and agreed)
   Exception: moderate consensus for drug checking
5. Goal: referrals (treatment services must be prepared to refer clients/patients to other health/social/treatment services if needed and agreed)
   Exception: moderate consensus for drug checking
6. Internal evaluation (services must regularly perform an internal evaluation of their activities and outcomes)
   Exception: moderate consensus for drug checking
7. External evaluation (services must regularly allow an evaluation of their activities and outcomes by an independent external evaluator)
   Exception: moderate consensus for drug checking, referrals, and sheltered housing

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

8. Assessment procedures: risk behaviour assessment (client's/patient's risk behaviour is assessed)
   Exception: moderate consensus for drug checking, BBV testing and counselling, vaccination, and sheltered housing
9. Informed consent (clients/patients must receive information on available service options and agree with a proposed regime or plan before starting an intervention)
   Exception: moderate consensus for needle-syringe exchange, outreach/street work, drug checking, safer use and safer sex counselling, and sheltered housing
10. 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
11. 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
12. Continued staff training (staff is regularly updated on relevant new knowledge in their field of action)
    Exception: drug checking

6.2. QUALITY STANDARDS WITH MODERATE CONSENSUS

(more than 50% up to 80%) **FOR DISCUSSION**

Prevention*: *Structural Standards of Services

1. Sustainability: The programme promotes a long-term view on drug prevention and is not a fragmented short-term initiative. The programme is coherent in its logic and practical approach.
2. Planning the programme: A systematic programme plan is constructed. A written project plan outlines the main programme elements and procedures. Contingency plans and risk management strategies are developed.
3. Sustainability: A programme is continued on the basis of evidence provided by monitoring and/or final evaluations. If it is to be continued, opportunities for continuation are outlined. The lessons learnt from the implementation are used to inform future activities.

Prevention:* *Outcome Standards at the System Level

None

Prevention:* *Process Standards of Interventions

4. Communication and stakeholder involvement: The multi-service nature of drug prevention is considered. All stakeholders relevant to the programme (e.g. target population, other agencies) are identified, and they are involved as required for a successful programme implementation. The organisation cooperates with other agencies and institutions.
5. Physical environment: The setting(s) for the activities is (are) described. It matches the aims, goals, and objectives, available resources, and is likely to produce the desired change. Necessary collaborations for implementation of the programme in this setting are identified
6. Recruiting and retention: It is clear how participants are drawn from the target population, and what mechanisms are used for recruitment. Specific measures are taken to maximise recruitment and retention of participants

7. Intervention design: The programme is based on an evidence-based theoretical model that allows an understanding of the specific drug-related needs and shows how the behaviour of the target population can be changed. Scientific literature reviews and/or essential publications on the issues relating to the programme are consulted. The reviewed information is of high quality and relevant to the programme. The main findings are used to inform the programme.
8. Intervention design: Materials necessary for implementation of the programme are specified. If intervention materials (e.g. manuals) are used, the information provided therein is factual and of high quality.
9. Intervention design: A written, clear programme description exists and is (at least partly) accessible by relevant groups (e.g. participants). It outlines major elements of the programme, particularly its possible impact on participants.
10. Implementation: Flexibility is possible if required for a successful implementation. The implementation is adjusted in line with the monitoring findings, where possible. Issues and problems are dealt with in a manner that is appropriate for the programme. Adjustments are well-justified, and reasons for adjustments are documented. *(Not rated in Delphi survey. Included as a result of target group consultation)*

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

1. Accessibility: location (service can easily be reached by public transport)
   Exception: high consensus for outpatient and GP´s office-based services
2. Physical environment: safety (service is equipped for reanimation and other emergencies like e.g. management of overdose)
   Exception: high consensus for inpatient and prison-based services, and specialized teams
3. Staff composition: transdisciplinarity (e.g. service employs a multidisciplinary team composed of at least 3 professions)
   Exception: high consensus for in- and outpatient services; low consensus for prison-based services and non-specialized teams
4. Staff composition: education (e.g. at least half of staff has a diploma in medicine, nursing, social work, or psychology)
   Exception: high consensus for in- and outpatient services; low consensus for prison-based services and non-specialized teams

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

5. Discharge monitoring (e.g. ratio of regular / irregular discharges, retention rates etc. have to be periodically monitored)
   Exception: high consensus for in- and outpatient services
6. External evaluation (services must regularly allow an evaluation of their activities and outcomes by an independent external evaluator)
   Exception: high consensus for in- and outpatient services, and specialized teams
7. Cost-effectiveness ratio (positive outcomes like e.g. number of abstinent patients in relation to treatment costs)
   Exception: low consensus for GP´s office-based services and non-specialized teams
8. Cost-benefit ratio (tangible benefits like e.g. years of increased life expectancy in relation to treatment costs)
   Exception: low consensus for prison-based, GP´s office-based services and non-specialized teams

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

9. Assessment procedures: psychiatric status has to be assessed

Exception: high consensus for in- and out-patients services and specialized teams; low consensus for non-specialized teams

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

None

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

1. Accessibility: opening hours (adjusted to the needs of clients/patients, e.g. evenings & week-ends)
   Exception: high consensus for needle-syringe exchange, supervised injection rooms, and outreach/street work
2. Accessibility: costs to be paid by clients (exclusion of costs which limit the accessibility for poor clients/patients)
   Exception: low consensus for outreach/street work and referrals
3. Indication criteria: diagnosis (treatment indication is always made on the basis of a diagnosis or, if not possible, a detailed assessment of the current substance use)
   Exception: low consensus for outreach/street work, drug checking, safer use and safer sex counselling
4. Indication criteria: age limits (e.g. minimum age required for admittance)
   Exception: none
5. Staff composition: transdisciplinarity (e.g. service employs a multidisciplinary team composed of at least 3 professions)
   Exception: low consensus for needle-syringe exchange, drug checking, vaccination, safer use and safer sex counselling

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

6. Goal: reduced substance use (treatment must be aimed at a reduction of substance use e.g. helping the client/patient to reduce the use or to abstain from psychotropic substances)
   Exception: low consensus for needle-syringe exchange, supervised injection rooms, drug checking, and vaccination
7. Cost-effectiveness ratio (positive outcomes like e.g. number of abstinent clients/patients in relation to service costs)
   Exception: low consensus for needle-syringe exchange, supervised injection rooms, outreach/street work, and referrals
8. Cost-benefit ratio (tangible benefits like e.g. years of increased life expectancy in relation to service costs)
   Exception: none

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

9. Assessment procedures: complete needs assessment and priorisation (e.g. 1. harm reduction of intravenous drug use and, 2. reduction of used syringes in public spaces etc.)
   Exception: high consensus for needle-syringe exchange, and supervised injection rooms
10. Assessment procedures: client/patient status (the client's/patient's health status is assessed)
    Exception: high consensus for needle-syringe exchange, BBV testing and counselling, and vaccination
11. Individualised treatment planning (intervention regime and intervention plans, if applicable, are tailored individually to the needs of the client/patient)
    Exception: high consensus for referrals and low consensus for drug checking

12. Written client records (assessment results, intervention plan, interventions, expected changes and unexpected events are documented complete and up to date for each client/patient in a client/patient record)
    Exception: low consensus for needle-syringe exchange, outreach/street work, drug checking, and safer use and safer sex counselling
13. Neighbourhood/community consultation (avoiding nuisance and conflict with other people around the service)
    Exception: high consensus for needle-syringe exchange, supervised injection rooms, and sheltered housing

6.3. LOW CONSENSUS *(less than 50%)* *TO BE DROPPED*

Prevention: Structural Standards of Services

none

Prevention: Outcome Standards at the System Level

none

Prevention: Process Standards of Interventions

none

Treatment/rehabilitation: Structural Standards of Services

1. Accessibility: location (service can easily be reached by public transport)

Treatment/rehabilitation: Outcome Standards at the System Level

none

Treatment/rehabilitation: Process Standards at the Service Level

none

Treatment/rehabilitation: Process Standards of Interventions

none

Harm Reduction: Structural Standards of Interventions

1. Indication criteria: age limits (e.g. minimum age required for admittance)
   Exception: none

7. Lists on acceptability of proposed standards and expected problems for implementation

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

Treatment / rehabilitation: acceptability of proposed quality standards

Structural standards services		n	Imple-mented (%)	Feasible no problems (%)	Problems expected (%)	Not feasible (%)	No answer (%)
	Accessible location	153	22	30	39	4	6
	Safety provisions	150	27	19	33	9	11
	Adequate space	149	40	28	24	1	7
	Diagnosis mandatory	145	41	23	27	1	7
	Transdisciplinary staff	143	26	21	41	8	4
	Staff qualifications	142	48	24	17	6	5
Process standards Services / interventions							
	Drug use assessed	84	44/46	38/24	12/29	1/0	5/2

	Somatic status assessed	84	36/40	39/31	16/24	2/4	7/2
	Psych. status assessed	84	24/41	32/24	32/36	4/7	8/2
	Individual treatment plan	84	38/40	23/13	29/42	4/2	7/4
	Informed consent	84	43/40	39/26	12/29	0/4	6/2
	Written records	84	43/36	26/24	19/38	4/0	8/2
	Data confidential	84	56/60	26/26	12/13	0/0	3/2
	Routine cooperation	84	25/29	26/18	36/49	6/2	7/2
	Continued training staff	84	30/31	24/16	41/46	0/6	6/2
Outcome standards at system level							
	Goal health improved	142	42	29	22	1	6
	Goal social improved	142	29	28	34	4	6
	Goal less substance use	142	37	31	25	1	6
	Monitor utilisation	142	30	30	29	3	8
	Monitor discharge	142	15	25	40	12	9
	Internal evaluation	142	23	25	39	9	5
	External evaluation	141	8	16	53	17	6
	Cost-effectiveness	140	4	11	51	22	11
	Cost-benefit	139	2	9	42	32	15

Treatment / rehabilitation: expected problems for implementation

Structural standards services		n	Political problems (%)	Professional problems (%)	Legal problems (%)	Financial problems (%)	Ethical problems (%)	Other problems (%)
	Accessible location	25	16	16	14	34	4	16
	Safety provisions	17	13	16	10	42	10	10
	Adequate space	17	12	8	4	52	8	16
	Diagnosis mandatory	16	12	32	4	32	4	16
	Transdisciplinary staff	25	9	23	6	53	0	9
	Staff qualifications	11	6	25	0	50	0	19
Process standards services / interventions								
	Drug use assessed		4/7	21/29	11/0	29/43	18/11	18/11
	Somatic status assessed		5/5	27/27	5/9	50/46	5/5	9/9
	Psych. status assessed		4/0	29/34	2/6	39/43	8/6	18/11
	Individual treatment plan		6/5	33/30	3/5	39/45	0/3	19/13
	Informed consent		13/13	31/32	6/8	13/24	13/11	25/13
	Written records		0/0	17/31	4/6	30/34	0/6	30/23
	Data confidential		7/0	7/22	21/11	7/22	7/0	50/44
	Routine cooperation		2/9	26/33	13/7	23/38	9/2	26/11
	Continued staff training		2/0	17/23	0/3	67/71	0/0	15/3
Outcome standards at system level								
	Goal health improvement	17	22	19	11	24	8	16
	Goal social improvement	21	14	20	10	37	2	18
	Goal less substance use	17	16	23	10	26	10	16
	Monitor utilisation	17	4	28	4	36	12	16
	Monitor discharge	22	2	39	15	27	7	10
	Internal evaluation	21	3	43	3	30	5	18
	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

Harm reduction: acceptability of proposed quality standards

Structural standards interventions		n	Imple-mented	Feasible no problems	Problems expected	Not feasible	No answer

			(%)	(%)	(%)	(%)	(%)
	Accessible location	147	17	23	45	10	5
	Opening hours	140	16	24	44	14	1
	Low costs for patients	138	23	18	26	22	11
	Diagnosis mandatory	137	29	22	23	17	9
	Age limits	135	22	21	29	16	13
	Transdisciplinary staff	133	17	20	34	24	5
	Staff qualifications	133	35	27	23	11	5
Process standards interventions							
	Indiv. needs assessment	127	14	32	28	13	13
	Health status assessed	126	21	33	26	11	10
	Risk behavior assessed	125	24	35	25	10	6
	Individual treatment plan	125	20	26	33	17	5
	Informed consent	124	40	28	20	7	5
	Written records	124	21	26	26	19	8
	Data confidential	124	56	27	12	2	3
	Routine cooperation	124	35	20	40	4	2
	Continued staff training	123	25	28	42	5	1
	Neighbourhood consult.	123	23	23	33	15	7
Outcome standards at system level							
	Goal less risk behavior	133	40	19	35	4	2
	Goal less substance use	131	24	21	34	14	8
	Goal referrals if needed	130	42	19	31	5	2
	Monitor utilisation	130	29	31	25	9	6
	Internal evaluation	130	24	29	37	8	2
	External evaluation	129	9	16	54	16	5
	Cost-effectiveness	129	5	16	40	26	12
	Cost-benefit	128	2	17	38	31	13

Harm reduction: expected problems for implementation

Structural standards interventions		n	Political problems (%)	Professional problems (%)	Legal problems (%)	Financial problems (%)	Ethical problems (%)	Other problems (%)
	Accessible location	66	23	12	15	31	5	14
	Opening hours	61	14	18	9	48	3	9
	Low costs for patients	37	24	8	11	35	10	12
	Diagnosis mandatory	32	14	19	7	33	7	19
	Age limits	39	17	15	24	6	27	11
	Transdisciplinary staff	45	5	24	4	50	1	15
	Staff qualifications	31	4	10	12	51	2	20
Process standards interventions								
	Indiv. needs assessment	36	17	15	8	40	5	15
	Health status assessed	32	7	22	2	40	9	20
	Risk behavior assessed	31	4	21	4	31	13	27
	Individual treatment plan	42	8	20	5	37	8	22
	Informed consent	25	8	36	13	15	8	21
	Written records	32	2	26	17	24	10	21
	Data confidential	15	9	18	9	9	14	41
	Routine cooperation	49	7	32	10	28	5	17
	Continued staff training	52	5	12	1	66	1	15
	Neighbourhood consult.	42	27	21	11	16	11	15
Outcome standards at system level								
	Goal less risk behavior	47	20	16	12	30	11	11

	Goal less substance use	44	9	21	11	19	16	24
	Goal referrals if needed	40	6	26	11	32	3	22
	Monitor utilisation	33	4	26	9	30	8	23
	Internal evaluation	49	4	24	4	40	3	25
	External evaluation	70	9	27	3	45	3	14
	Cost-effectiveness	52	11	19	5	29	8	28
	Cost-benefit	48	17	14	4	30	4	32

These findings show

- 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

8. Questions for Conference Parallel Sessions

Parallel Session A Proposed List of Minimum Quality Standards

- 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 ?

Parallel Session B Implementation Issues

- What are the main challenges for implementation at the national level?
- How can the expected political and financial problems be met ?
- How can the expected professional concerns be met ?
- Which legal conditions must be prepared for the implementation ?
- Is cooperation between EU Member States useful for sharing experience and best practice and how can it be initiated or strengthened?
- What support could the EU provide?

Appendix 10.13

BUILDING AN EU CONSENSUS FOR MINIMUM QUALITY STANDARDS IN DRUG DEMAND REDUCTION 15-17 JUNE 2011 BRUSSELS

CONFERENCE SUMMARY

Objectives

This conference, hosted by the European Commission in association with the Hungarian Presidency of the EU, 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.

The key objective was to discuss the preliminary findings of a European Commission study to develop European Minimum Quality Standards (EQUS) carried out by the Swiss Research Institute for Public Health and Addiction at Zürich University (ISGF) in collaboration with European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) and the World Health Organisation (WHO).

Details regarding the EQUS project, including the list of minimum quality standards proposed by the EQUS project team, can be found in the EQUS conference working paper[10].

The conference discussion was organised in two parts: The first part focused on the three lists of minimum quality standards in the field of prevention, treatment and harm reduction which had been selected by the contractors on the basis of an extensive document review, an expert peer review and responses from two on-line surveys.

The second part of the conference focused on the translation of quality standards into practice by comparing four different national approaches to implement quality standards in drug demand reduction and through the experience of policy-makers, professionals and practitioners.

At EU level, a case study of the development, adoption and implementation of the European cancer screening guidelines was presented as a possible approach to follow for the follow-up development of minimum quality standards in the field of drug demands reduction.

The conference concluded with a panel discussion on the anticipated challenges and opportunities to take forward the consensus building process to develop EU minimum quality standards.

The conference provided an important opportunity to receive valuable feedback from experts on the draft lists of minimum quality standards proposed by the EQUS project team. It launched a longer term process towards achieving a consensus on the added value of an EU

[10] See http://ec.europa.eu/justice/newsroom/anti-drugs/events/110615_en.htm

framework for minimum quality standards in the prevention, treatment and harm reduction of drugs. The final EQUS report will be available by the end of 2011.

This paper provides an overview of the discussions in the parallel sessions. Copies of all presentations can be found at the conference homepage[11]

Drug policy, standards and guidelines at national, EU and international level

The kick off plenary session set the scene with regard to the EU political context in the field of drug demand reduction and took stock of the on-going work in the field of best practice, guidelines and standards undertaken by the Hungarian government, the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) and the World Health Organisation (WHO) and their links with the work undertaken by the EQUS project.

Proposed EQUS lists of minimum quality standards in the field of treatment, harm reduction and prevention

The EQUS project coordinators presented three lists of minimum quality standards in separate sessions on treatment, harm reduction and prevention. The three lists set out:

- *minimum quality standards with a **high** level of expert consensus*
- *minimum quality standards with a **moderate** level of expert consensus*
- *minimum quality standards with a **low** level of expert consensus*

Participants were asked to examine how feasible and applicable these standards would be to support effective interventions, treatment and harm reduction services in the EU.

Treatment

The session was led by Ambros Uchtenhagen, Research Institute for Public Health and Addiction at Zürich University (ISGF), who first presented the list of minimum quality standards with high consensus in surveys (>80%). The discussion raised the following issues:

There were general questions on the presentation and the need for clarification on the information provided to stakeholders in the surveys, selection of stakeholders involved in surveys. The wording of the standards presented should be carefully checked in order to avoid misinterpretation and to recognise differences in acceptance according to type of stakeholders.

There were also remarks on the need for examples on the practical implication of standards and the differences between more general standards and detailed guidelines. The list of 25 standards was considered to be acceptable as a whole. However, further elaboration was requested to address:

- the role of non-professional staff and client involvement in programming and shared responsibility
- the accountability of staff

[11] See http://ec.europa.eu/justice/newsroom/anti-drugs/events/110615_en.htm

- providing specific criteria for internal and external education of staff
- evidence-based treatment only in individualised treatment planning
- introducing periodical revision of treatment planning
- criteria for sharing responsibility in treatment choices
- standards on transparency in the use of funds

The second list of standards with moderate consensus (>50-80%) was presented and each standard discussed. The following standards were considered to be acceptable as minimum standards and were proposed to be moved to the list of high consensus:

- accessibility of services (not for prison services)
- having safety requirements for services (as far as not already required by national law)
- inter-disciplinarity of staff (taking into account country differences)
- discharge monitoring as an outcome measure
- external evaluation of services (with a need for sustainability, taking into account cost-effectiveness of evaluation)
- assessment procedures must include psychiatric status (at service and
- intervention level, providing access to internal or external psychiatric competence).

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. As a result, the proposed list of minimum quality standards will be enlarged to include 31 standards.

Final general recommendations were made to:

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

Harm Reduction

Delegates made comments the minimum quality standards proposed in the field of harm reduction. The audience agreed that more details should be provided for the definition of minimum quality standards. It was also agreed that separate standard formulations and questions for the investigated harm reduction services would have been more appropriate for the online survey, but that this would have doubled the length of the questionnaire and was also not possible due to budget restraints. One important suggestion that came up was that opioid substitution therapy should be an integral part of the harm reduction minimum quality standards and not only of the treatment and rehabilitation minimum quality standards.

The session continued with a presentation of harm reduction MQS with high consensus (>80%) by Michael Schaub, ISGF.

With regard to the list of structural standards for harm reduction interventions, there was consensus:

- to combine the two accessibility standards on location and opening hours (previously classified as "moderate" consensus standard) and classify these as "high consensus". The new formulation should be “services have to match the needs of clients”.

- to reformulate the standards on staff composition to also include peers and make transparent that staff had to be qualified. Also, 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.

- on the outcome standards at the system level, except for some that are not appropriate for pill testing according to the online survey. The minimum quality standards on referrals should also include referrals to legal services.

However, for the minimum quality standards on external evaluation, there was no consensus as to 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 feasible due to insufficient funding.

There was even more consensus on the process standards of interventions:

- With regard to informed consent, it should be mentioned that interventions should not be based on written informed consent, but rather on a transparently information about all the offers by a service.

- 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.

Michael Schaub presented the minimum quality standard list with "moderate consensus" (more than 50% up to 80%). The discussion concluded that:

- the minimum quality standards on indication criteria has to be dropped from the list.

- the other minimum quality standards were combined with a high consensus minimum quality standards or reformulated and then added to the high consensus minimum quality standard list.

- the minimum quality standards on accessibility should be reformulated into “costs should never be a barrier to a service.”

- with regard to the outcome standards at the system level, the goal of reduced substance use should be the reduction of harm and the promotion of well-being. However, it should stay as "a moderate consensus" . The other outcome standards at the system level can also be kept as "moderate consensus" as it was suggested in the online survey.

There was only limited discussion on the process standards of harm reduction interventions. However, based on the previous discussion, the minimum quality standards on the assessment procedures, on individualized treatment planning and neighborhood consultation on written client records should be kept as moderate consensus minimum quality standards as suggested by the EQUS project team.

Prevention

This session was led by Dr Harry Sumnall and Angelina Brotherhood of Liverpool John Moores University, the project partner responsible for development of the prevention component of the EQUS standards. The development of "European drug prevention quality standards" as part of a separate EC co-funded project was presented. The presentation illustrated the content and structure of these standards as they are expected to be published by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) in autumn 2011. It was explained that the EQUS prevention standards were developed by adapting these existing standards. Consequently, it was clarified that the methodology used to develop the prevention component of EQUS was different to that employed in the areas of treatment/rehabilitation and harm reduction. This was followed by an overview of the tasks undertaken to adapt the existing prevention standards to the requirements of the EQUS project. Finally, the adapted standards were discussed to determine their general acceptability, opinions on standards rated, as well as their applicability to different types of services and interventions.

Main discussion points:

- There are important differences between prevention and the areas of treatment/ rehabilitation and, to some extent, harm reduction. A major difference concerns how clients are approached as part of prevention or treatment interventions. In particular, treatment was seen to utilise a medicalised, clinical approach which is not common in prevention work (although indicated and selective prevention approaches can incorporate clinical work). While these different approaches are a natural consequence of different client needs in these areas, they also have an impact on the professional language used, the self-concept of professionals, the relative priority placed on prevention in policy and the organisation of work, etc.

- The audience perceived these differences to be a major challenge in the adaptation of the prevention standards to a wider set of drug demand reduction standards. For example, it was noted that the structure used in the EQUS standards ("structural standards", "process standards", "outcome standards") was not commonly used in prevention, particularly in universal approaches (e.g. school curriculum). Although it has been possible to adapt the prevention standards to the EQUS structure, some delegates argued that prevention practitioners would perceive it as "foreign" and perhaps illogical. There were concerns among the audience that a treatment-orientated template had been applied to the prevention standards, which was unsuitable. The structure used for the standards should be easy to understand and useful for the specific users of the standards. The project cycle used in the original "European drug prevention quality standards" project was believed to provide easier access to the standards. If the distinction between structural, process, and outcome standards is retained, it was suggested that it should be clearly explained and justified for the area of prevention.

- Several delegates questioned the logic behind the structure and order of standards (see also the point above regarding EQUS standards structure). One delegate asked whether the numbering used was meant to indicate hierarchy or priority of standards. The project partner clarified that this was not the case; however, this should also be recorded in writing. It also emerged from the discussion that some standards should be merged to reduce redundancy, while other standards should be split up in order to increase clarity and specificity of the statements. However, this needs to be weighed against the large number of prevention standards in EQUS. Furthermore, although following the format used in the draft treatment/rehabilitation and harm reduction standards, using the same title (e.g. "staff composition") for several standards was not considered useful. It was believed that the titles of the standards should reflect the specific meaning of each standard and differ accordingly.

- Delegates highlighted that some terms and phrases used in the standards (e.g. "needs", "harm", "programme", "evidence-based") were open to interpretation and consequently required clarification. Delegates suggested alternative expressions. Further concerns related to translation of the standards into EU Member State languages; in particular, how equivalent meaning of terms and standards would be ensured. There was agreement on the importance of a glossary of terms. A glossary already exists for the European drug prevention quality standards which can be adapted for use. It was suggested that the standards should be rephrased to ensure that they are clear and understandable without the need for a glossary or further information. This was thought to be more important than ensuring consistency with the formulation of standards in the "European drug prevention quality standards". However, as prevention crosses many different disciplines (e.g. health, social welfare, law enforcement, psychology), finding a simple, common language may be difficult. An example highlighted in the session was the use of the term 'needs' (as in 'needs assessment'). This is not a clinical term with a specific meaning although it holds substantive meaning for prevention practitioners. One delegate (a researcher) questioned the use of terms that did not have precise and clear scientific definitions. Use of such language in the standards reflects the attempt to incorporate language and terminology from different disciplines.

- Standards should not be a barrier to work. Concerns were voiced that certain standards (e.g. on outcome evaluation, sustainability) would set services up to fail because they were not achievable in practice. Strict enforcement of these standards (e.g. through legal requirements or funding allocation) could stop continuation of valuable ongoing work. This raised questions about the purpose of the standards: did the standards reflect an ideal situation that organisations would be expected to work towards; were they a practical tool that would be used, for example, by funders to select projects for funding; or were they meant as a useful but non-binding tool to support practitioners in their everyday work? The audience felt that the final selection of 'minimum' standards depended on the answer to this question. If used to inform funding decisions, delegates felt that fewer standards should be included in the list to allow greater flexibility, whereas more standards could be included if the document was a guidance document for practitioners. If the EQUS standards serve a different purpose than the "European drug prevention quality standards", then slight differences in what is defined as "minimum" (EQUS) or "basic" (EDPQS) would be sensible and justifiable.

- From the list of standards with high consensus, delegates argued that, although desirable, the standards on outcome evaluation should **not** be included in a 'minimum' list of standards. It was argued that funding for outcome evaluations in prevention was rarely available, outcome evaluations were not always required or possible due to practical reasons (e.g. routine prevention work based on an evaluated model where monitoring is more useful). However, evaluation in general was accepted as a minimum quality standard; in particular, process evaluations could be required at a minimal level. Another option would be to include outcome evaluation as a minimum standard but with exceptions (e.g. for previously evaluated approaches).

- From the list of standards with moderate consensus, delegates agreed to include six out of ten standards. In relation to the remaining four standards, delegates made arguments for and against their inclusion, and therefore agreement was not reached. Moreover, some delegates agreed with the inclusion of one sentence but not another within the same standard. There was an in-depth discussion of the proposed standard on evidence-based approaches. On the one hand, delegates felt that this standard would be too demanding for practitioners, particularly in smaller organisations; on the other hand, it was seen as a key indicator for quality. One delegate pointed out that particularly where no outcome evaluation is planned, basing the intervention on existing evidence of effectiveness must be mandatory. Delegates suggested that all standards could be included after being rephrased in line with delegate feedback or by adding "exceptions". The detailed feedback will be incorporated in the revision of the standards.

Translating the Standards into Practice

Conference delegates considered the challenges of implementing standards at national and EU level, how to meet the expected political and financial problems, how to address professional concerns, the legal conditions necessary and the role of EU cooperation and support.

Four different national approaches to implement standards to improve the quality of drug services were presented: The Czech accreditation process, the outcome of UK standards on the delivery of drug treatment, 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.

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) and effective programme management and international collaboration.

Policy Perspectives

Albert Kern, Ministry of Health (D), addressed the challenges for implementing EU standards at the national level and proposed a number of options to enhance the acceptability of EU standards: these included summaries in different languages, national conferences organised by focal points and the importance of providing arguments to justify the investments. Professional concerns could be addressed by via training programmes and research through EU funding. EMCDDA experts networks could have a key role to play to support the dissemination and information on standards.

Piotr Jablonski, National Bureau for Drug Prevention (PL), presented the experience and lessons learned from the implementation of the Polish voluntary accreditation system for health care centres delivering drugs/alcohol and harm reduction. The development of the

standards was time consuming and Poland would have benefited from access to experience in other countries.

The discussion raised the following key points:

- Increasing the level of awareness among professionals and practitioners is important (via conferences, focus groups, published documents translated in EU languages)
- Objective of the standards to improve healthcare systems needs to be clear and the process for agreeing the standards transparent, taking different needs into account.
- The experience of other countries provides useful benchmarks and European networks such as the EMCDDA experts groups could support implementation.
- Training programmes should aim to overcome professional concerns and improve knowledge of service providers.
- Sustainable funding is essential to support the long term implementation process.

Practitioner Perspectives

Prof. Norbert Scherbaum (D) presented the viewpoint of a medical practitioner/academic researcher. He stressed that guidelines and standards implementation is "daily business" for many professions, and that the financial obstacles that had been identified by the EQUS expert survey as the main obstacle were in practice very common, but may be not the main challenge. In his experience, further important obstacles to guideline implementation are the lack of coverage of services in rural areas and the complexity of responsibilities, e.g. in opioid substitution treatment in Germany, many players are involved (legal, social, health) and with a challenge to follow one common guideline. Prof. Scherbaum identified a need for more effectiveness research (and asked for EU funding) and promoted the integration of Quality Management in training in the education of all professions. He also said that qualifications of doctors and other staff in addiction medicine and psychiatry must be strengthened.

Jason Farrell, an independent consultant on harm reduction spoke about his experience in integrating consumers in service planning and delivery as manager of a comprehensive low-threshold facility in the United States. He mentioned several strategies to involve consumers in the development of harm reduction service standards and guidelines and proposed to make user involvement rights and obligations a standard in addiction care. He also illustrated that barriers to user involvement have to be overcome and that trust, accountability, commitment, and incentives have to be established. He showed some practical examples of models of user involvement (focus groups, statutory consumer advisory committee, interviews, and surveys) and presented outcomes achieved through active involvement of service users.

The general discussion led to the following conclusions:

- There is a need for minimum evidence-based standards in the EU
- There is a need for high-level EU statements defining a set of agreed standards
- There should be core standards that are non-conditional and have to be achieved by all
- In addition, there should be more specific differential standards for service types.
- These service types need to be flexible enough in order to adapt them to different settings and conditions
- A time-frame for the implementation at national level should be defined
- Cost-effectiveness of implementing (vs. not) of standards should be evaluated
- Progress of implementation of evidence-based guidelines standards should be monitored.

Prevention

The speaker was Dr Rachele Donini, a practitioner who had been involved in the development of the "European drug prevention quality standards". The presentation illustrated main issues relating to the implementation of the standards from three perspectives: macro (e.g. political and economic environment; structures of prevention delivery); meso (e.g. service organisation, inter-agency collaboration); and micro (e.g. practitioner attitudes and knowledge). The speaker also outlined possible actions to tackle the challenges faced in each of these areas. The audience was then invited to comment on the presentation and provide relevant examples based upon own experience.

Main discussion points:

- The EQUS prevention standards have an "advantage" over the EQUS standards in treatment/rehabilitation and harm reduction, as they can be supplemented with the forthcoming EMCDDA Manual on "European drug prevention quality standards". The EMCDDA Manual contains substantial additional detail in relation to the minimum standards as well as additional standards reflecting expert level. It can therefore serve as an in-depth resource to complement the EQUS prevention standards. Moreover, the EMCDDA Manual will contain materials to aid use and implementation of the standards, such as a glossary, example scenarios of using the standards, implementation considerations, a self-reflection checklist, etc. The audience felt that such materials were important and that users of the EQUS prevention standards would benefit greatly from co-use of these existing resources. The existence of the EMCDDA Manual on "European drug prevention quality standards" should be highlighted in the EQUS prevention standards documentation.

- There is a danger that the standards may be perceived as a bureaucratic burden or an instrument for external assessment, particularly as they will be promoted through a top-down approach (from the EU level to EU Member States to the field). However, practitioners will welcome the standards if their usefulness and added value for everyday practice is demonstrated clearly and convincingly. It should also be highlighted that in most cases the standards will not require a completely new approach; instead, they can build upon existing efforts. "Good" prevention activities will be naturally in line with the standards.

- Lack of professional skills and attitudes (e.g. evaluation mentality, accessing and using scientific evidence, knowledge of effective approaches, project management) can hinder implementation of the standards. In these areas, the standards can refer to existing resources such as the EMCDDA's Best Practice Portal. Statutory occupational standards and training opportunities in line with the standards would further facilitate their implementation. This is an area that could be promoted by the EU in the future.

- A common understanding of what prevention is, and what it is hoping to achieve (i.e. preventing all drug use? Mitigating harm? Promoting cessation? Developing resilience and reducing risk?), is still missing among those working in prevention as well as the wider drugs field. This is partly due to the wide variety of types of professionals that undertake prevention work (e.g. generic youth workers as well as specialist practitioners). This "misunderstanding" is evidenced by the (perceived) relatively minor role of prevention in comparison to treatment, which is also reflected in funding and delivery structures. For example, government agencies often conduct prevention *alongside* treatment rather than as a separate activity. It is also not unusual that prevention activities are carried out by organisations and staff members that are specialised in other areas (e.g. treatment, mental health) and not prevention itself. However, in order to ensure quality, specialist prevention organisations and staff members are required. Delegates agreed that quality

standards would not only increase the quality of prevention work, but also increase the political visibility and "confidence" of prevention and those working in the field.

- Changes in professional culture and delivery systems require time and must be seen as a continuous long-term process. The standards must therefore be implemented gradually and should not be used immediately to inform funding decisions. Practitioners and providers must be supported over time in achieving the standards. Continuity is crucial to the success of standards implementation. However, drugs-related issues are often subject to moral and ideological judgement. This prevents not only objective and evidence-based debate, but it also undermines the possibility of long-term progress as priorities, policies and strategies are frequently modified in response to political changes. Frequent policy changes are not seen as often in other areas of health promotion or clinical work. It may be beneficial to leave the drugs discourse behind, instead embedding drug prevention in the wider field of general prevention and health promotion.

- Implementation of the standards relies not only on uptake by practitioners but must also be addressed by politicians, commissioners, and funders at local, regional, national and international levels. These professionals should, for example: acknowledge that prevention is as important as treatment/rehabilitation and harm reduction; understand and promote prevention as a science; understand what prevention can realistically achieve (i.e. preventing young people from ever using drugs may be an unrealistic outcome); provide stable and predictable funding (e.g. for staff training, long-term activities, evaluation, and scientific research); develop an evidence-based long-term strategy for prevention that is not affected by short-term political changes (e.g. resulting in strategies that move between a criminal justice approach and a public health promotion priority).

- The EQUS project is a milestone in the establishment of prevention as an area that is separate from, but equally important as, treatment/rehabilitation and harm reduction. The introduction of the EQUS prevention standards will emphasise the need for prevention activities *as well as* the need for quality in prevention. One delegate noted that clients act as the drivers of services and service quality in the areas of treatment/rehabilitation and harm reduction; however, prevention advocates are yet to be identified. The EQUS prevention standards are well suited to fill this gap and initiate important future developments.

Conclusions and Next Steps

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 minimium quality standards relevant for countries outside EU and need to develop common language in this field.

The final EQUS project report will be ready by the end of 2011. On the basis of the project conclusions, the Commission will reflect carefully 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 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.

8 August 2011

Appendix 10.14

Questionnaire for on-line stakeholder survey (first round)

(112 pages to follow)