Conference Summary

European Conference

Building an EU Consensus for
Minimum Quality Standards in the Prevention,
Treatment and Harm Reduction of Drugs

15-17 June 2011

Résidence Palace, Brussels

BUILDING AN EU CONSENSUS FOR MINIMUM QUALITY STANDARDS IN THE PREVENTION, TREATMENT AND HARM REUCTION OF DRUGS

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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 in contact with 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. [1]

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 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 on the European Commission website[2]

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

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

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
- 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 on 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 transparent information about all the offers by a service.

- the confidentiality of client data should be intervention specific. Also, it was pointed out 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, on 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 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.

Brussels, 22 August 2011