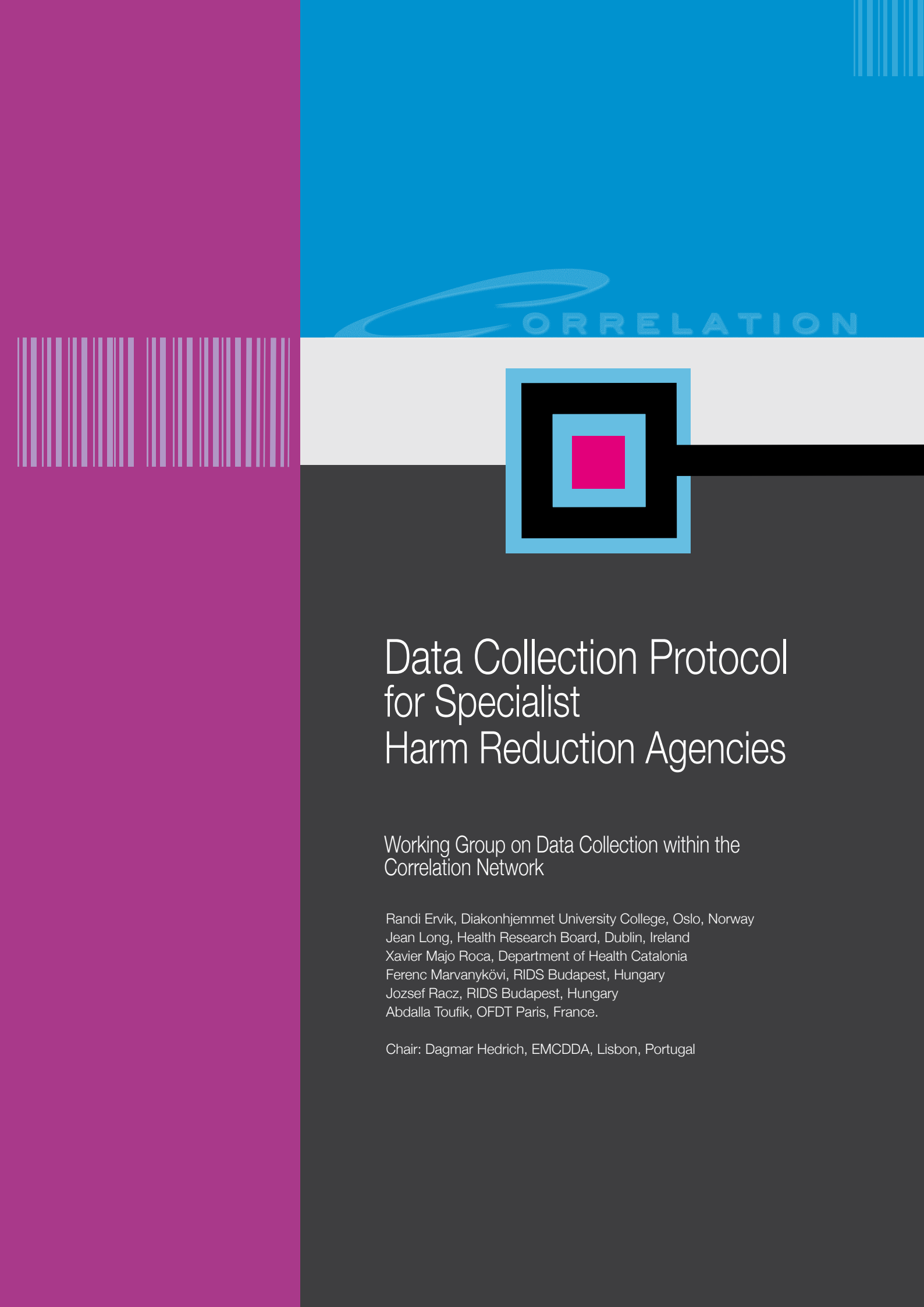

Data Collection Protocol for Specialist Harm Reduction Agencies

Working Group on Data Collection within the Correlation Network

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Colophon

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- Associació pel Benestar i el Desenvolupament of Barcelona (community intervention and mobile unit, and Baluard drug consumption room)
- CAS Vall d'Hebron of Barcelona
- Centro Social de Paramos - Espinho, Portugal
- Drugprevention Foundation, Budapest, Hungary
- Espoir Goutte d'or, Paris, France
- Fundació Mercè Fontanilles of Lleida
- Initiative for Health Foundation, Sofia, Bulgaria
- Krakowskie Towarzystwo Pomocy Uzaleznionym, Krakow, Poland
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Amsterdam, March 2008

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Contents

Part II:

Part I

Development of a Data Collection Protocol for Specialist Harm Reduction Agencies

Final report of the
Working Group on Data Collection
within the Correlation Network

Executive Summary

This project report summarizes the work of a joint expert group on data collection of the Correlation network, the EMCDDA and National Reitox Focal Points (1) to develop a protocol for collecting data on harm reduction services provision. This protocol is aimed for the use by specialist agencies which provide health and social services to current drug users. The underlying purpose of such a protocol is to increase the quality of information on harm reduction, including at national, regional and EU levels, by collecting data on availability and access to services in a standardized way.

The core-element of the protocol is an **agency inventory**, a questionnaire where each agency describes its operational framework, characteristics and the services it provides. It includes: administrative information on staffing, management and funding; data on the range of facilities and services offered at the agency; on quality standards and on data-collection routines. It also contains information on the target population and on new drug use-related phenomena or problems that have come to the attention of the agency's staff in the course of their work with current drug users.

The protocol has its **technical manual** which provides instructions on how to complete the inventory and defines the terms that have been used. It furthermore contains a list of core-services, representing different areas of activity of harm reduction agencies, which have been selected as proxy indicators for ongoing monitoring. A description of different approaches to monitoring the level of access to these core-services is also provided.

The present report provides a description of the field test, conducted in Summer/Autumn 2007 with 15 voluntary agencies from Austria, Bulgaria, Catalonia, France, Hungary, Poland and Portugal as well as by the main harm reduction agency in Teheran (Iran) and presents an evaluation of the results. The final version of the data collection protocol is annexed to this report.

1 The European Monitoring Center for Drugs and Drug Addiction (EMCDDA) coordinates a network of National focal points (NFPs) set up in the 27 EU Member States, Norway, the European Commission and in the candidate countries to the EU. Together, these information collection and exchange points form Reitox (Réseau Européen d'Information sur les Drogues et la Toxicomanie), the European Information Network on Drugs and Drug Addiction. National Focal Points are the national authority providing drug information to the EMCDDA and act as an interface between Member State and EMCDDA, coordinating and stimulating data collection.

1. Context and objectives

1.1 Role of harm reduction in Europe

The aims of a harm reduction approach are to prevent and reduce health-related harm associated with drug dependence, in particular the incidence of blood-borne viral infections and overdoses, and to encourage active drug users to contact health and social services. A broad agreement on the relevance of the approach, as part of a comprehensive strategy to respond to drug use, is reflected in previous and current EU drugs strategies (2), which include besides prevention, treatment and supply reduction also measures to prevent and reduce health-related harm.

To increase drug users' access to services that help prevent and reduce health-related harm associated with drug use has become a public health objective in the European countries. Within the comprehensive systems of care for drug users that are common in the EU, low-threshold agencies play an important role for increasing drug users' access to care. These agencies are not only considered essential for delivering basic health and social care to current drug users, but are recognized as important points for entering into contact with populations of drug users that are 'hidden', that are more difficult to reach or have lost contact with the care system.

1.2 European data collection on harm reduction

A Council Recommendation, adopted on 18 June 2003(3), recommends a number of facilities and services for the prevention and reduction of health-related harm associated with drug dependence that the EU Member States should provide. The implementation of the Recommendation was evaluated through a consultant study(4) which formed the basis for a report by the European Commission to the European Parliament and the Council (5).

The consultant report documented that all Member States have policies and actions in place that to a large extent reflect the recommended measures, but that the level of implementation is variable within and between countries. While it was still early to assess the real impact of the Recommendation, it was also concluded that the Recommendation had set a 'benchmark' for policies. The available data showed that the prevention and reduction of health-related harm is a defined public health objective in all countries, and that services and facilities are available (although in some countries to a lesser extent).

However, the report also highlighted the need to improve data on accessibility and utilization of services and facilities, and to strengthen monitoring, research and evaluation of harm reduction in future years. Only few countries have defined national standards for the documentation of service delivery at specialist harm reduction agencies or are recording data according to the EMCDDA Treatment Demand protocol. Documentation at the agencies is primarily orientated to fulfill obligations of accountability towards funding bodies. Where harm reduction funding comes from local budgets, data-flow does not go beyond city or regional level. The lack of standardized reporting is a handicap to obtaining a reliable overview at national (and subsequently European) level.

The report by the European Commission confirmed the results of expert meetings organized by the

2 The EU Drugs Strategy (2005 – 2012) is available online at: http://register.consilium.europa.eu/pdf/en/04/st15/st15074.en04.pdf ; and the EU Drugs Action Plan (2005-2008) at : http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=CELEX:52005XG0708(01):EN:NOT

3 Available online at http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2003:165:0031:0033:EN:PDF

4 Trimbos Institute (2006). Prevention and reduction of health-related harm associated with drug dependence. An inventory of policies, evidence and practices in the EU relevant to the implementation of the Council Recommendation of 18 June 2004. Netherlands Institute for Mental Health: Utrecht.

5 Report COM (2007) 199 final of 18.4.2007 - Commission of the European Communities (COM). (2007). Report from the Commission to the European Parliament and the Council on the implementation of the Council Recommendation of 18 June 2003 on the prevention and reduction of health-related harm associated with drug dependence. (Available at: http://eur-lex.europa.eu/LexUriServ/site/en/com/2007/com2007_0199en01.pdf).

EMCDDA in 2004 and 2005 (6), where data collection routines and monitoring tools used in different European countries had been analysed and ways to obtain a more reliable overview of levels of service provision and utilisation in Europe been discussed. The meetings showed that a range of data were collected but remained at the level of the agency or sometimes at city or regional level, were often not accessible to decision makers at national levels, and that data could rarely be compared across services or between countries. Research on harm reduction service delivery was limited, and the few available studies and analyses concentrated on local service evaluation or planning. There was a general lack of information on the clients using low-threshold harm reduction agencies: the use of client-based monitoring systems that allow the collection of data according to the European standard protocol was rare.

The project to develop a European standardised data collection protocol started in September 2005 under the umbrella of the Correlation network. The project was carried out by a joint expert group, chaired by the EMCDDA, bringing together experts from Catalonia, France, Hungary, Ireland, Slovenia, Norway and the Ukraine.

1.3 Objectives and activities of the project

The overall goal of the project was 'to contribute to increasing reliability and comparability of information on harm reduction service provision in Europe' through the development a draft European protocol for standardised annual reporting. This should cover service delivery, structure and functioning of agencies delivering harm reduction services. The protocol should be evaluated by specialist harm reduction agencies in different countries (see the logical framework in Table 1 below).

Activities of the group included: the definition of the objectives of such documentation with regard to information needs at the levels of the agency, and at local, national and EU levels; the collection and compilation of already existing questionnaires and other tools used by low-threshold agencies in EU Member States; the assessment of the items covered and the analysis of the structure of the tools; the selection of core-services, and the drafting of a standard protocol for the documentation of services, and of a technical manual with glossary.

6 Meetings were held in December 2004 and in June 2005 and addressed the topics: 'Data collection at Low-threshold services for Drug Users: Tools, Quality and Coverage' and 'Data collection at low-threshold agencies: increasing availability and quality of information at European level".

Table 1: Logframe matrix

Project description	Indicators	Means of verification (MOVs)	Assumptions
1. Goal To contribute to increasing the reliability and comparability of information on low-threshold harm reduction service provision in Europe.	10. Indicators European protocol for standardised data collection on provision and utilisation of harm reduction services	11. MOVs Information collected with the European protocol is included in the Report on the evaluation of the EU Drug Strategy 2005 - 2012	9. Assumptions Harm reduction remains among the main objectives of the second EU Drugs Action Plan (2009-2012)
2. Purpose 1. To develop a draft European data collection protocol for standardised annual reporting of harm reduction service delivery at low-threshold agencies as well as on structure and functioning of the agency, number of clients and/or of contacts 2. To evaluate the draft protocol indifferent European countries 3. To revise and produce a final European protocol	12. Indicators 1. Draft protocol in English language, including questionnaire on service provision, utilisation, clients and the agency itself as well as a glossary and manual are made available before expert meeting Spring 2006 2. Pilot test of the protocol is conducted in a number of different European countries (exact number depends on resources) 3. Tested version of a European data collection protocol is available at Final Conference of the Project	13. MOVs 1. Standardised activity reports from small and big low-threshold agencies from different countries (exact number depends on resources), testing the protocol 2. Report on pilot study on Correlation network website at time of Correlation Conference (2007) 3. Conference report, protocol uploaded in Correlation website at end of project	8. Assumptions 1. English is acceptable as reporting language across European agencies./ or there are different language versions available (resource-implications) 2. Standardised reporting tool (draft) has been made known and accessible to potential candidates for pilot study 3. Sufficient number of agencies have been motivated to participate in pilot study, representative sample of small and larger agencies.

3. Outputs	14. Indicators	15. MOVs	7. Assumptions
1. Draft data collection protocol (form, glossary and manual) for pilot test 2. Final data collection protocol in English language	See outputs	1. Meeting report data report group, January 2006 2. Progress report presented at expert meeting Spring 2006 3. Final data collection protocol presented at Final Conference Correlation Project Autumn 2007 - Report on Conference, Final project report Correlation	1. Low fluctuation among working group members throughout the project duration 2. Working group members have agreement with their employers to participate and take over tasks in the project (they have reserved working time and can use e-mail, internet and telephone facilities at workplace) 3. Regular expert meetings are held 4. Active cooperation of other Correlation network members is obtained and participation in pilot test phase is sufficient
4. Activities 1. To collect and compile already existing data collection tools used by low-threshold agencies to report on harm reduction services 2. To draw up an item list and develop a template for a questionnaire (incl. glossary and technical instructions) 3. To conduct a pilot test in selected services in different countries and evaluate the results 4. To finalise the protocol according to the results of the pilot phase			

The expert group held four meetings: in September 2005 (Egmond aan Zee) the logical framework for the work on the data collection protocol was developed and the work plan drawn up; in January 2006 (Barcelona), results of the analysis of data collection tools were presented and discussed and core-services identified; in March 2006 (during the 2nd Correlation Network meeting in Krakow), the first draft list of services was developed, and a discussion of data collection methodologies took place. Furthermore, the technical manual and necessary instructions and definitions were discussed. Finally, in a meeting in July 2006 (Dublin), a first draft of the protocol was discussed and the selection of core-services finalised.

The field test version of the protocol was finalised in May 2007 and the pilot test of the agency inventory carried out between in Spring - Summer 2007. Preliminary outcomes of the field test were presented In the Correlation Conference in September 2007 and a second field test on monitoring of core-services was planned, which took place during the Autumn. The project results were analysed and written up in December 2007 and January 2008.

2. The data collection protocol

2.1 Overview

The protocol consists of the agency inventory and of a technical manual providing instructions and definitions for its use. It also contains a list of core-services and a description of different approaches for carrying out an ongoing monitoring of the delivery of these core-services to drug users.

2.2 The agency inventory

The inventory describes the general type and profile of the agency, its scope of service provision, staffing, management and functioning. If implemented at national scale (either in all target agencies or in a representative sample), the results could be used to characterise the scope of national harm reduction activities and the geographical distribution of agencies.

It is presented in six sections. Section A records the administrative, contact details for the agency and its parent organisation and the operating hours for the different facilities provided. Section B contains questions about the population that the agency targets, and about the characteristics of the clientele it serves. Section C helps to describe which type of staff and volunteers work for the agency and how they are trained. Section D contains a comprehensive list of facilities and services of harm reduction agencies where those that the agency de-facto delivers should be indicated. Section E addresses quality standards and management issues as well as the funding. Section F is intended to help document new phenomena in relation to drug use.

2.3 Selected core-services

The working group selected 18 (16 + 2) core-services representing the different fields of activity, which are listed in Table 2 below. Experts suggested to collect data on the delivery of these core-services as indicators of the overall level of service provision. Monitoring should be on an ongoing basis and results reported yearly.

Table 2. List of selected core services

1 Syringes distributed
2 Syringes returned
3 Male condoms distributed
4 Hepatitis B vaccination
5 Infectious disease counselling episodes that inform about testing
6 Diagnostic testing of HIV infection
7 Diagnostic testing of HBV infection
8 Diagnostic testing of HCV infection
9 Woundcare treatments
10 Social care provision
11 Psychological care provision
12 Referral to drug treatment services
13 Referral to social services
14 Referral to medical services
15 Opioid overdose interventions
16 Stimulant overdose interventions (amended after field test)
Core services only for agencies with Drug consumption rooms:
17 Supervised injecting drug consumptions
18 Spervised non-injecting drug consumptions (amended after field test)

3. The field test (text provided by RIDS, Budapest)

The field test covered the testing of the agency inventory and the services-based data collection sheet.

3.1 Objectives and target agencies of field test

Objectives

The main objective of the filed test was to address the comprehensiveness and relevance of the 'agency inventory' for documenting service provision and the feasibility of the services-based data collection method to monitor the utilisation of core-services.

Target agencies

The field test was implemented in specialist agencies that

- provide low threshold drug, medical or psychosocial services to current drug users and in addition
- distribute sterile drug using equipment to current drug users (have needle and syringe pro gramme, NSP).

Examples of such specialist agencies included:

- low threshold / 'drop-in' centres for drug users,
- drug consumption facilities,
- open health facilities for current drug users,
- 'street-hospitals', outreach agencies that provide care, advice and hygienic drug use
- equipment in street settings
- mobile units

3.2 Data collection procedures

Sample and sampling methods

Contacts of Correlation Network were used to collect participants for the pilot test on voluntary basis. A total of 15 agencies undertook to participate on voluntary basis from 8 European countries and one agency volunteered from Iran. The sample was not representative of the European harm reduction agencies, however, this was not the main objective. An effort was made to involve agencies from different parts of Europe to partly ensure geographical and cultural heterogeneity (for agencies that participated, please see 3.3).

Monitoring data collection

During the field test, either the manager of the agency or a staff member of the participating agency completed the agency inventory and the services-based data collection sheet as well as a specifically developed questionnaire to evaluate the two data collection tools. The inventory and the evaluation sheets were in English. The tools for Catalonian agencies were translated into their native language. The rest of the agencies undertook to use the English versions of the inventory and the evaluation sheets.

RIDS was responsible for monitoring the overall data collection procedure, members of the research group were also assigned to the participating agencies as supporting partner during the implementation of the field test. This basically included translation, consultation and the collection of the tools.

Data processing

The completed agency inventories and evaluation sheets were coded into a database which was then transferred into SPSS.

Two approaches were considered when analysing the data.

1. A quantitative approach was used to analyse agency inventory data. SPSS was used to run frequencies of each item in the agency inventory. The main aim was to monitor missing data, which allowed drawing conclusions particularly about the possible reasons for the lack or difficulties of data provision. Quantitative type of data in the evaluation sheets were also analysed with SPSS (closed-questions, ratings).

2. A qualitative approach was used to analyse open-ended questions in the evaluation sheets. Here a more theoretical aspect was taken into account. Answers to open-ended questions were categorized according to the type of problem that comments referred to.

The agency inventory was modified and finalised on the basis of the results of data analysis.

Agencies involved:

- Initiative for Health Foundation, Sofia, Bulgaria
- Drugprevention Foundation, Budapest, Hungary
- Krakowskie Towarzystwo Pomocy Uzaleznionym, Krakow, Poland
- Verein Wiener Sozialprojekte (Ganslwirt and Streetwork), Vienna, Austria
- Persepolis NGO, Tehran, Iran
- APDES – Agência Piaget para o desenvolvimento, Porto, Portugal
- Centro Social de Paramos - Espinho, Portugal
- Adeima, Guifões - Matosinhos, Portugal
- Red Cross of Tarragona
- AEC-GRIS (Grup de reinserció i inserció social) of Barcelona
- Associació pel Benestar i el Desenvolupament of Barcelona (community intervention and mobile unit, and Baluard drug consumption room)
- Fundació Mercè Fontanilles of Lleida
- CAS Vall d'Hebron of Barcelona
- Espoir Goutte d'or, Paris, France

3.3 Results

The main results of the pilot test of the agency inventory and the services-based data collection sheet were on the basis of the administered inventory and the services-based sheet and the related evaluation questionnaires.

Summary

On the basis of the analysis of the results of the pilot test, it can be hypothesised that data provision difficulties, which may manifest in missing data, partial, less reliable or estimated data, may be accounted for

- lack or incompleteness of definition of items and that of the context (which may also result in difficulties interpreting questions and items)
- problems arising from the complexity of services and the location of service provision (i.e. certain items in the inventory can not fully cover the complexity and particular nature of services provided by the agency)
- the lack of or limited data collection at the agency
- the lack or shortage of time to administer the inventory
- unclear or less clear instructions
- technical problems (difficulties with excel, arrangement of items)

Overall evaluation

Agencies were also invited to provide their overall feedback on the agency inventory as well as the clarity of the technical manual. Some basic background data was also collected on the pilot testing agencies.

Discussion

Results of the pilot test of the services-based data collection method suggest that the 15 core items can be good indicators not only to describe an agency's service provision profile but to evaluate its own activity. The information collected from these core items are good basis to present what these agencies do and how effective and active they are.

The results also suggest that reliable data can be collected on a number of core items: this is particularly true for syringe-related data, male condom distribution, hepatitis B vaccination, woundcare and social care. At the same time, certain items are not or less accessible or simply difficult to provide, particularly infectious counselling and blood-born test related data (VCT, HBV and HCV tests). It would be interesting to see whether these tests are part of a general health service and education in other countries as well. If this is the case, services-based data on these items would be difficult to collect. Further tests in other countries are required to better see data provision quality. As the results of the pilot test may reflect characteristics of agencies in one region, the results of the test must be interpreted with caution.

Part II

Data Collection Protocol for Specialist Harm Reduction Agencies

Final version 3 March 2008

Section A - Administrative information

Important note: Please consult the technical manual for details and definitions.

Q1. General information on contact person for the Agency Inventory

a. Contact person for this agency inventory _____

b. E-mail address of contact person _____

c. Phone (Country code, area code, number) _____

d. Person(s) filling in the inventory, if different from contact person _____

_____

e. Date this inventory was completed /updated ____ (day) ____ (month) _____ (year)

Comments: _____

_____

Q2. Parent organisation of the agency

a. Name of parent organisation _____

b. City/town (where headquarter is based) _____

c. Country _____

d. Status of parent organisation

d.1 Government

d.2 Non-government not for profit

d.3 Non-government for profit

d.4 Other If '*Other*', please specify: _____

_____

e. Web address parent organisation _____

Comments: _____

_____

Q3. Agency details

a. Name (or title) of agency _____

b. Street _____

c. Postcode & City / Town _____

d. Country _____

e. Status of agency (if not linked to any parent organisation or if different status)

e.1 Government

e.2 Non-government not for profit

e.3 Non-government for profit

e.4 Other If '*Other'*, please specify: _____

f. Web address agency _____

g. Year agency opened _____

Comments: _____

Q4.General agency type (choose one or more)

a. Social service provider
b. Low threshold health service provider
c. Drug consumption facility
d. Outreach work
e. Low-threshold substitution provider: prescribing or/ and dispensing
f. Other type(s) - please specify: _____
_____
_____

Comments: _____

_____

Please indicate all types of needle and syringe provision of your agency:

g. Fixed location
h. Mobile (van, bus)
i. Streetworker outreach
j. Other type of NSP, specify below:

_____

Comments: _____

_____

Q5. Total opening hours and operating hours of specific agency facilities

a. Total current opening hours for clients of your agency per week _____ hours
b. …of which _____ hours are in the evening/night (between 8 pm and 8 am)
c. …of which _____ hours are on Saturdays or Sundays
d. Indicate on which days your agency is closed:
Monday Tuesday Wednesday Thursday Friday Saturday Sunday

e. Total current operating hours per week of selected facilities listed below:

NSP	_____	Social care facilities	_____
Street outreach work	_____	Medical care facilities	_____
Drug consumption facility	_____		

f. Has there been a major expansion or reduction (of more than 20%) in current operating hours compared to last calendar year?

Expansion: Yes No Reduction: Yes No

Comments: _____

Section B - Target populations and data collection system

Important note: Please consult the technical manual for details and definitions.

Q6. Geographical location of agency (choose one)

a. Inner city b. Other urban c. Rural d. Other, specify below

Comments: _____

_____

Q7. Type of local drug scene (choose one main type)

a. Open/concentrated b. Dispersed c. Hidden d.Other, specify below

Comments: _____

_____

Q8. Specific target populations of the agency (choose one or more)

a. Opiate users
b. Cocaine & stimulant users
c. Imprisoned drug users
d. Adolescent drug users
e. Homeless people
f. Female drug users.
g. Migrants
h. Minority ethnic groups
i. Men who have sex with men
j. Sex workers (m/f)
k. Other main target population(s):_____

_____

Comments: _____

_____

Q9. Data collection system of the agency *(for definitions see manual)*

a. Services-based b. Contact-based c. Client-based
d. Mixed systems, or other data collection system
Please describe briefly below:

_____
_____
_____
_____

Comments: _____

_____

Client profiles in last calendar year

Q10. Profile of client group of the agency (latest completed year)

a. Year to which these data refer: _____

b. Total number of individual clients or estimate: _____ .

This is an estimation: Yes No

c. Percentage female clients or estimate: _____ % .

This is an estimation: Yes No

d. Age range of clients (in % of individual clients per age group):

_____ % are younger than 20

_____ % are between 21 and 40

_____ % are between 41 and 50

_____ % are over 51

The age distribution above is estimated: Yes No

Comments: _____

How many of your clients are problem drug users? ***(see definition in the manual)***

< 10% 11%-50% 51%-90% > 91%

Comments: _____

_____

Q11. Common drugs and routes of administration (RoA)

Name and rank the four drugs that are most commonly used by your clients (not including alcohol or tobacco) and indicate their respective main RoA:

From top to bottom –

□from most common to least common□ Injecting Sniffing Smoking

Other RoA

Drug: _____

Drug: _____

Drug: _____

Drug: _____

Drug: _____

Comments: _____

_____

Provide source / reference of data reported in Q 10 and 11: (e.g. annual statutory report, case statistics, client survey, expert estimate)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Section C - Staff at the Agency

Important note: Please consult the technical manual for details and definitions.

Q12. Profile of professions

a. Report how many hours of working time are dedicated to the different tasks per week. Report about the current situation (in the current month):

Type of work carried out	Approx. hours per week	
	Paid hours	Voluntary hours
Administration and coordination of agency		
Social and legal assistance to clients		
Psychological counselling or advice to clients		
Medical treatment		
Services of a nurse		
Other - specify type of work:		
Other:		
Other:		
Other:		

b. Does the agency employ current or former drug users as peer educators?

Yes No Please specify: _____

c. Have there been major increases in staffing levels compared to previous year?

Yes No Please specify: _____

d. Have there been major decreases in staffing levels compared to previous year?

Yes No Please specify: _____

Comments: _____

_____

Q13. Staff training (Please choose either yes or no)

a. Is the staff training policy of the agency laid down in writing? Yes No

b. Are staff trained in assessing sexual risk taking behaviour and providing risk reduction education? Yes No

c. Are staff trained in assessing risky drug using practices and providing risk reduction education? Yes No

d. If you answered yes under c., does this training address risk behaviour related to non-injecting drug use? Yes No

e. Are staff trained in intervening in drug-related emergencies? Yes No

Comments: _____

_____

Q14 Staff safety (Please choose either yes or no)

a. Are staff systematically informed about the relevance of Hep B immunization?

Yes No

b. Are staff systematically offered Hep B vaccination through the agency?

Yes No

c. Is there a written Code of Practice (safety statement) on needle stick injuries?

Yes No

Comments: _____

_____

Section D - Agency services

Important: Please consult definitions & further instructions in the technical manual page 21 ff.

Q15. On-site facilities and range of services available (report current situation)

	Select Yes or No	If Yes, provide detail on services or activities ↓			Do clients pay a fee?	
a. Drop in / club / lounge (open access)	Yes No	1. Meal (min sandwich)	Yes	No	Yes	No
		2. Leisure activities (games, TV)	Yes	No	Yes	No
		3. Phone accessible to users	Yes	No	Yes	No
		4. Internet accessible to users	Yes	No	Yes	No
b. Street outreach work	Yes No					
c. Day resting room	Yes No	Number of day beds _____		—	Yes	No
d. Night sleeping facilities	Yes No	Number of night beds _____		—	Yes	No
e. Personal hygiene	Yes No	1. Bath/shower room	Yes	No	Yes	No
		2. Laundry	Yes	No	Yes	No
		3. Clothes distribution	Yes	No	Yes	No
		4. Condoms (male)	Yes	No	Yes	No
f. Services to reduce drug use-related health-related risks	Yes No	1. Syringes and needles	Yes	No	Yes	No
		2. Alcohol swabs	Yes	No	Yes	No
		3. Dry swabs	Yes	No	Yes	No
		4. Info material BBV/ injecting	Yes	No	Yes	No
g. Number of NSP provision points: *(enter numbers below ▼)* Number of fixed points of syringe provision *(include all fixed locations serviced by this agency)* _____ Number of syringe vending or exchanging machines serviced by agency _____		5. Citric or ascorbic acid	Yes	No	Yes	No
		6. Filters	Yes	No	Yes	No
		7. Sterile mixing containers	Yes	No	Yes	No
		8. Water (for dissolving, flushing)	Yes	No	Yes	No
		9. Sharp bins/ safe disposal containers	Yes	No	Yes	No
		10. (Aluminium) Foil for drug inhalation	Yes	No	Yes	No
		11. Crack pipe	Yes	No	Yes	No
		12. Straws f. intranasal consumption (sniffing)	Yes	No	Yes	No
		13. Other - specify:			Yes	No
		14. Other - specify:			Yes	No
		15. Other - specify:			Yes	No

h. Consumption room	Yes No	Number of places injection room ➔ _____ Number of places smoking / inhaling room ➔ _____
i. Prison outreach work	Yes No	Number of prisons regularly reached ➔ _____
j. Accompanied referrals	Yes No	
k. Follow-up of referrals	Yes No	

Comments:_____

_____

_____

Q16. Social care:

Specify below range of services available, report current situation.	**Select Yes or No**	**Do clients pay a fee?**
a. Basic social needs assessment	Yes No	Yes No
b. Legal issues advice	Yes No	Yes No
c. Shelter / housing advice	Yes No	Yes No
d. Social benefits advices / financial assistance / debts management	Yes No	Yes No
e. Assistance to obtain or retrieve personal documentation (e.g. health insurance card, social benefit documentation, driving license, identity card)	Yes No	Yes No
f. Employment advice/job finding	Yes No	Yes No
g. Brief information on health, social or legal issues and referral	Yes No	Yes No
h. Structured day employment (day job – mediated employment)	Yes No	Yes No
i. Parenting advice and support	Yes No	Yes No
j. Other social care, specify:	Yes No	Yes No
k. Other social care, specify:	Yes No	Yes No
l. Other social care, specify:	Yes No	Yes No

Comments:_____

_____

_____

Q17. Crisis intervention, counselling and other structured psychological care interventions

Specify below range of services available, report current situation.	**Select Yes or No**	**Do clients pay a fee?**
a. Crisis intervention	Yes No	Yes No
b. Counselling, brief interventions / motivational interviewing	Yes No	Yes No
c. Case management	Yes No	Yes No
d. Group work	Yes No	Yes No
e. Self-help groups	Yes No	Yes No
f. Other interventions, specify:	Yes No	Yes No
g. Other interventions, specify:	Yes No	Yes No
h. Other interventions, specify:	Yes No	Yes No

Comments: _____

_____

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Q18. Medical / nursing / paramedical care:

Specify below range of services available, report current situation.	Select Yes or No	Do clients pay a fee?
a. Basic health assessment	Yes No	Yes No
b. Assessment of drug use related risk practices	Yes No	Yes No
c. Assessment of sexual risk practices	Yes No	Yes No
d. Overdose (emergency) intervention	Yes No	Yes No
e. Wound management	Yes No	Yes No
f. STI clinic (screening and treatment)	Yes No	Yes No
g. Dentist/dental care	Yes No	Yes No
h. Gynaecologist / well-woman clinic / family planning service	Yes No	Yes No
i. Pregnancy test	Yes No	Yes No
j. DOT, management of medication for HAART, treatment of TB, hep C	Yes No	Yes No
k. HIV diagnostic testing	Yes No	Yes No
l. HCV diagnostic testing	Yes No	Yes No
m. HBV diagnostic testing	Yes No	Yes No
n. Hepatitis B vaccination	Yes No	Yes No
o. Tetanus vaccination	Yes No	Yes No
p. Prescribing of substitution drugs	Yes No	Yes No
q. Dispensing of substitution drugs	Yes No	Yes No
r. Are clients receiving substitution or other drug dependence treatment at the agency registered in (national) drug treatment reporting system?	Yes No	
Specify reporting system / client register:		

Comments: _____

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_____

Q19. IEC – Information, Education and Communication

	Select Yes or No	IEC subjects addressed	Select Yes or No
a. Agency organises IEC – group training sessions for drug users	Yes No	1. Safer injection	Yes No
		2. Safer sex (incl sexually transm. infections, STI)	Yes No
		3. Drug overdose prevention	Yes No
		4. Blood borne viruses (BBV)	Yes No
		5. Opioid overdose management (incl CPR)	Yes No
		6. Opioid OD management & naloxone distribution	Yes No
		7. Stimulant overdose response	Yes No
b. Agency organises IEC - training sessions for family members and peers	Yes No	1. Safer injection	Yes No
		2. Safer sex (incl. STI)	Yes No
		3. Drug overdose prevention	Yes No
		4. Blood borne viruses (BBV)	Yes No
		5. Opioid overdose management (incl CPR)	Yes No
		6. Opioid OD management & naloxone distribution	Yes No
		7. Stimulant overdose response	Yes No
c. Agency disseminates IEC - materials	Yes No	1. Safer injection	Yes No
		2. Safer sex (incl sexually transm. infections, STI)	Yes No
		3. Drug overdose prevention	Yes No
		4. Opioid overdose management	Yes No
		5. Stimulant overdose management	Yes No
		6. Blood-borne viruses (BBV)	Yes No
		7. Drug treatment	Yes No
		8. Safe disposal of syringes	Yes No

Comments: _____

_____

_____

Section E - Management

Important note: Please consult the technical manual page 21 ff for details and definitions.

Q20. Is there a written document on exchange of injecting equipment?
Yes No

If Yes, does this document address the following topics:
a. …a maximum number of syringes given out per exchange?
Yes No If yes, specify how many: _____
b. …the promotion of secondary distribution? (peer distribution or collecting equipment for partners or friends) Yes No
c. …the promotion of safe disposal ? Yes No
d. …a (lower) age limit for the provision of injecting equipment? Yes No
If yes, specify minimum age: _____
e. …the verbal communication of information on prevention of injecting-related health dam age to the client? Yes No
Please provide detail: _____
_____
f. …the handing out of printed information materials on prevention of injecting-related health damage to the client? Yes No
Please provide detail: _____
_____
g. Other topics (specify): _____
Comments:_____
_____

Q21. Disposal of used injecting equipment
Are any of the following methods used?
a. Sharp bins given out to NSP clients Yes No
b. Clients rewarded (e.g. paid) for safe return Yes No
c. Other (specify): _____
Comments: _____
_____
_____

Q22. Is there an initial assessment for new clients? Yes No
Comments: _____
_____

Q23. Is there a written care plan for individual clients? Yes No
Comments: _____
_____
_____

Q24. Criteria for non-admission to premises
a. No local residence Yes No
b. Under required minimum age Yes No If *Yes*, indicate which age: _____
c. Exclusion of undocumented migrants Yes No
d. Other (specify): _____

Comments: _____

_____

_____

Q25. Is there a written code on drug users rights and responsibilities (patients' charter)?
Yes No

Comments: _____

_____

Q26. Is there a client association linked to your organisation? Yes No

If *Yes*, please provide name, address and telephone or email contact of organisation:_

_____

_____

Comments: _____

_____

Q27. What was the total budget for this agency for the last three financial years?

Year	Budget (in Euro)	
200..	€ _____	
200..	€ _____	
200..	€ _____	= latest completed calendar year

Comments: _____

_____

_____

Q28. What percentage of the agency's last year budget was contributed by:

Last completed calendar year: _____ If different: Budgetary year: _____

Government grants	_____%
Non-government grants	_____%
Public fund raising / donations	_____%
Client fees or health insurance	_____%
From budget of own organisation	_____%
Other (specify: _____)	_____%

Total should add up to 100%

Comments: _____

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Q29. Is there a systematic evaluation of client satisfaction? Yes No

Comments: _____

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Q30. Evaluation of outcomes

a. Does this agency currently undertake or participate in any internal or external evaluation of the harm reduction process or clients' outcomes? Yes No

b. If ***Yes***, please specify which evaluation instruments are used:

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Comments: _____

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Section F - Early warning

Important note: Please consult the technical manual page 21 ff for details and definitions.

Q31. Does the agency have an emergency or help phone line or pay for the services of a helpline?

Yes No

Comments: _____

Q32. Does the agency participate in a formal early warning system? Yes No

Comments: _____

Q33. During the last 12 months, have you noticed a phenomenon, among drug users living in your catchment area, which is new or a significant change to an already known phenomenon, namely in the following areas? (Explain why and how the changes appeared. If there are no elements to explain it, you can just hypothesise).

a. An unknown product (drug): describe the form (powder, liquid, pill, spray, etc.), colour, presentation (paper pack, ball, plastic pack, etc.); mention the different denominations and the content supposed under each.

_____

_____

_____

_____

b. A new consumer profile among the users of the structure. By new profile, one understands a more or less homogeneous group on at least one aspect. This can be the age (adolescent, young people, adults between 30 and 40 years, etc), the place of dwelling (suburbs, city, town centre), a cultural characteristic (music, religion), the geographical origin (Eastern Europeans, Asians, north Africans etc), the way of life (wandering, sedentary, squatters etc), the type of occupation (lorry drivers, mason, restoration, show business, etc).

_____

_____

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c. A new route of administration, the spreading of a known route or of a combination of drugs. What are the expected and the actually felt effects of this administration route or drugs cocktail?

_____

_____

_____

_____

d. A new health problem among drug users (OD, abscesses, psychiatric problems, etc.) or the aggravation of a known problem. What, according to you, is the cause of this?

e. A new social problem (e.g. marginalisation, unemployment, poverty, violence, delinquency, etc.) or the noticeable aggravation of a known problem and what is it related to.

General comments:

_____

_____

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Many thanks!

Annex I: Technical Manual

Agency: Please note that the term 'agency' is used here to name a structure (low-threshold center, outpatient unit, day-care center, emergency shelter, drugs 'project') that employs staff to enter in direct contact with drug users and provides harm reduction services to them.

Service: The term 'service' is used to describe the concrete activities that are carried out by such an agency. For example exchanging syringes or counselling clients are 'services'.

An agency is a **service provider**. For example: the delivery of clean syringes is a service that a staff member employed at an agency provides to a client.

The agency inventory was developed for specialist agencies that offer low-threshold drug dependence and/or medical and/or psychosocial services to current problem drug users including a needle and syringe programme.

Section A: Administrative information

Q1 General information on contact person
The agency inventory instrument and data tables should be filled out by the manager of the agency or another staff member specifically assigned to this task, who should ideally also be the contact person in case questions arise or clarifications are needed by the data collecting body. A staff member of the parent organisation can also fill out the inventory/tables. The full contact details should be indicated.

Q2 Parent organisation of the agency
This question applies only to agencies that are in administrative terms part of a larger "parent" organisation. A parent organisation is the organisation that the service/agency belongs to, for example an larger non-governmental organisations, religious communities/churches, enterprises, or public health structures which run more than one agency. If your agency is self-contained, do not enter data here. Please ensure that details are correct and up to date. If a parent organisation runs several agencies that meet the criteria for the target agency, each of those should fill out the agency inventory instrument,

Q3 Agency details
Please fill out the information on your agency and ensure that details are correct and up to date.

Q4 General agency type
Tick one or more that best describe your agency, according to the services it provides to current (non-abstinent) drug users:

a. Social service provider
Agency that provides support on accommodation, employment, social benefits to current drug users.

b. Low threshold health service provider
Specialised agency that provides health care services to current drug users, including a basic health assessment, basic medical and nursing care, wound care and health education. There must be either a medical doctor or a nurse employed, or both. Some special provisions must be in place aimed at facilitating the access of current users to the provision of such services, e.g. location near street drug markets, no appointments required, extended opening hours during nights, etc.

c. Drug consumption facility
Drug consumption facilities also called drug consumption rooms, are official facilities where people can take illegal drugs under supervision by staff, who also gives advice on risks, educates clients about safer drug use techniques and provides emergency help in case of overdose or other adverse reactions.

d. Outreach work
Outreach work has been defined as "a community-oriented activity undertaken in order to contact individuals or groups from particular target populations, who are not effectively contacted or reached by existing services or through traditional health education channels" (Hartnoll R.L., et al. (1990), *A survey of HIV outreach intervention in the United Kingdom*, London: University of London, Birbeck College).

Three different working methods in outreach work have been distinguished: detached, domiciliary and peripatetic. Detached outreach, when agency outreach workers meet clients on the street to provide injecting equipment, information, referral or other services, is by far the most common. It is called domiciliary outreach when the outreach workers go to the home of clients, and the term peripatetic outreach describes that outreach workers of an agency go to other premises where clients can be found, in particular prisons or hospitals.

e. Low threshold substitution provider (prescribing and/or dispensing)
A low threshold substitution provider is an agency that is involved in prescribing drug substitution medication to drug users by accredited staff, or/and by dispensing the medication to clients that are in treatment at another agency. Some special provisions must be in place aimed at facilitating the access of current users to the provision of such services, e.g. location near street drug markets, no appointments required, extended opening hours during nights, etc.

f. Other type

Needle and syringe programme - NSP

Needle and syringe programme – sterile syringes and other equipment for hygienic drug injecting are distributed, exchanged against used ones, or sold and usually information about injecting risks, techniques and hygiene is provided at the same time to clients receiving the items.

If your agency provides a number of service types, please indicate all available types

g. Fixed NSPs
Fixed needle and syringe programmes are those located at a fixed address in a formal building.

h. mobile NSPs
A mobile NSP is run from a specially equipped mobile unit (van/bus) that attends different locations on a regular basis (daily or weekly)

i. Street outreach
This category includes detached outreach by agency staff but also domiciliary outreach – see definition of outreach above. Streetworkers carry drug using equipment and distribute to drug users in the street or to drug users' residence.

j. Other type of NSP
Please describe which other type.

Q5. Total opening hours and operating hours of specific agency facilities

Opening hours for clients

Please record the total number of hours during which any facility within your agency is open for clients during one week. Indicate the current situation (weekly opening house in the current month). For a permanently open facility this would be 168 hours.

Total operating hours per week of selected facilities/services
Please report during how many weekly hours any of these specific facilities are open / services are offered to clients. Data should only be supplied on those facilities/services that are provided by your agency. For street outreach work count only the time during which delivery of services takes place, not the time the workers need to reach the outreach location. Count the time of outreach service provision regardless of size of outreach teams (do not add up man-hours).

Section B: Target populations and data collection system

Q6. Geographical location of agency
Please classify the geographical setting of your agency using the guidelines below. Chose one setting according to definitions below.
If in doubt, choose setting where agency mostly provides its services.

a. An **inner city** area is the central area of a major city.
b. Other urban areas are non-central areas of a major city and other cities
c. A **rural area** is a less densely populated area with an agricultural influence

Q7. Type of local drug scene
Please classify the main type of drug scene that is of most relevance for your agency in terms of service provision, according to definitions below (Source: R. Bless, D.J. Korf, M. Freeman : Open drug scenes: A cross-national comparison of concepts and urban strategies, Eur Addict Res 1995; 1: 128-138). Choose only one option.

a. Concentrated open Scene : "Large permanent concentrations of drug users at a focal point, often an inner city area characterised by entertainment industries and/or a major transport node. Identified by the general public and the authorities as an open scene. High level of confrontation by the presence of obvious drug users and occurrence of public use of drugs
b. Dispersed open scene : "Small concentration of users at various places within the urban area, ranging from inner city to transport nodes to degraded residential districts. Individual scene are often mobile and do not occur all day."
c. Hidden scene : "No visible concentrations of users. There is a public awareness of local drug scene however, usually without distinction between hard and soft drugs. Actual confrontation is limited to residential premises where users and dealers live or to the relics of drug use, like discarded needles, in public places."

Q8. Specific target population(s) of the agency
Please indicate one or more target population(s) which the services provided by your agency are aimed at.

Q9. Data collection system of the agency
Indicate which of the following reflects best the general design of data collection, or describe other system.

a. Services-based data collection
Levels of service provision can be recorded in three different ways: based on services, contacts or clients. In the case of **'services-based' recording**, the agency collects information on total number of times a service was provided. E.g. number of syringes, condoms or other items given out, number of medical, psychological or referral services performed. No data on the users of the services are collected. The method helps to monitor the use of resources and provides a general overview of 'turnover', but it does not allow to distinguish how many and what type of clients have been reached.

b. Contact-based data collection
We have defined as **'contact-based' recording** a limited amount of information about the service users is recorded each time a service provision contact takes place. In our pilot study we used the three variables gender, age group, drug injector/ non-injector. The client information is assessed and recorded by the agency staff; clients do not have to provide any personal information, no identification is required to obtain the service. This approach is more complex and work intensive than services-based recording, as it requires the assessment of the three variables by staff at each time a service is delivered. However, the status of injector/non-injector can be difficult to determine which results in missing data. This method allows the monitoring of changing client characteristics, and the generation of basic statistical analyses of service delivery for various client groups. It is a feasible method of data collection even if the service provision contacts between staff and clients are of short duration, or take place in outreach/ street settings.

c. Client-based data collection
Finally, **'client-based' recording** of service provision requires that the agency has a system in place to identify its individual clients and keeps records of their socio-demographic and drug

use profiles (including the TDI dataset). There is a client-card system or other procedure in place to make sure that individual clients are easily identified each time a service is provided to them. Double-counting of persons within the agency, between institutions in the same location and ideally also at inter-institutional national level is herewith avoided or at least limited (nation-wide treatment client identifiers are however rare in the EU). There are also solutions where individual client codes are created each time a service is used. Client-based systems are easier to implement when electronic means (ID cards) are used and when the agency has a computer-network that links the various service provision areas to a central database. The system provides excellent monitoring possibilities to the agency. Detailed statistical analyses of service demand can be carried out and patterns of service use be analyses, at least within the agency but also in a wider network of agencies that uses the same client ID. While this model delivers the most relevant data, it is rarely implemented for reasons of data protection and problems related to lack of feasibility in typical harm reduction settings like 'drop-in' or streetwork.

The pilot study has explored some of these data collection systems. It is described in chapter 3 of the final report.

Q10. Profile of client group
Only applicable if the agency collects data number, gender-ratio and age range and drug use profile of individual clients served by the agency. The reporting period for questions 10 and 11 is from 1 January to 31 December of the last calendar year for which data are available. Enter the year to which these data refer.

Q11. Common drugs and routes of administration (RoA)
Indicate respective main route(s) of administration for those four drugs that have been most commonly reported as problem drug among your clientele during the reporting year. Excluding alcohol and tobacco. Sniffing = intranasal; smoking = pulmonary (includes chasing the dragon).

Problem drug use
Problem drug use is defined for EMCDDA purposes as 'injecting drug use or long duration or regular use of opiates, cocaine and/or amphetamines'. This definition specifically includes regular or long-term use of prescribed opiates such as methadone but does not include their rare or irregular use nor the use of ecstasy or cannabis.

Section C: Staff at the agency

Q12. Profile of professions
Please complete during how many paid and voluntary hours the different professional services are provided at the agency per week. Add up hours of all staff members that carry out the type of work. Report about the situation in the current month.
If there is no voluntary work, put "n.a." (not applicable). Calculate weekly paid hours as 25% of paid working hours per month. If any data are unknown, put "not known".
Indicate if current or former drug users are employed at the agency as peer educators, specify their tasks.
Indicate if there have been major de- or increases in staffing levels compared to previous year.

Q13. Staff training
This question is about training provided to the agency's staff. Please refer to the definitions below to ensure a common understanding of the questions.

a. Staff training policy
The minimum requirement to indicate that there is a staff training policy is the existence of a written training protocol listing training topics that are relevant to the work of the agency, or the definition of a minimum number of hours of training to be provided to each agency worker per year, or a similar formal and written commitment of the agency to commit funds for keeping professional competence of staff on a regular basis up-to-date.

b. Assessment of sexual risk taking practice and education on risk reduction
Some or all staff of the agency is trained to explore the current sexual practices and related risk taking of clients, their knowledge of sexually transmitted infections, of interaction between drug

use and risk taking, and their awareness of local services that provide sexual health services. Staff knows how to explore clients' attitudes towards condom use and other preventive measures, and management of risk (post-exposure prophylaxis).

c. & d. Assessment of drug use related risk taking practice and education on risk reduction
Some or all staff of the agency is trained to carry out an assessment of risk taking practices. Staff is trained to explore clients' current drug use, their current and past injecting practice (including skills and sharing practices), experience of overdose and overdose management skills, access to and interest in blood-borne viral testing, and uptake of hepatitis A & B vaccine.

e. Drug-related emergency interventions
Some or all staff of the agency is trained to intervene in case of overdose or other drug-related emergency. Such training should include the knowledge on typical risk factors (especially drug interactions, effects of central nervous system depressant drugs including alcohol); overdose risk settings and situations; assessment of clients' personal risk profiles (previous overdose experience, depressive symptoms, previous suicide attempts, current suicidal ideation). Staff should also be trained in recognising overdose signs ans symptoms and responding to manage overdose. For an opiate overdose, the appropriate response includes laying the person in a lateral position (on their side / recovery position), loosening tight clothing, ensuring their airway is clear, administering oxygen, naloxone if available, calling the emergency services. Manual cardio pulmonary resuscitation skills may also be trained.

Q14. Staff safety
Under **b.** the costs of the vaccination would be borne by the agency.

c. Code of practice on needle stick injuries
Written guidelines, outlining all steps to be taken to prevent and minimise the risk of needle stick injuries and to reduce their consequences (especially among NSP workers).

Section D Agency services

Q 15. On-site facilities and range of services available
It is important provide an objective picture of services that drug users can obtain/benefit from through your agency. Report about the availability of services and facilities as it is during the current month. Do not report services that have been available in the past but are no longer available now – and do not report about services that are planned to become available in the future. You should however indicate services and facilities that your agency offers, even if they are not being used.

Please read the definitions and further explanations below. Read the table row by row and, following the instructions in the column heading, and answer the questions. Indicate for each service is its available and if the clients have to pay a fee to receive it.

g. Number of NSP provision points, vending machines
Counted should be all physically distinct locations where your agency provides syringes and other injecting equipment for free, against payment or in exchange against used ones, usually together with information on injecting risks, techniques and hygiene. These can be other health services, hospital wards, or prisons (via peripatetic outreach). If the agency has no fixed NSP locations and does not service vending machines write "n.a." (not applicable). If the information is unknown write "not known".

f.2 Alcohol swabs and dry swabs
Alcohol swabs should be used to clean the skin before the injection. After the injection, dry cotton wipes/pads should be used, to cover the injecting point and protect it. Alcohol swabs should not be used after injection, because the alcohol prevents the injection wound from closing. Paraphernalia kits should contain both types of swabs.

j. Accompanied referral
The term 'accompanied referral' can be defined as liaising between the person requiring help, information or treatment and the person providing such assistance. The person brokering the

liaison between the service provider and the client may introduce the client to the provider face to face or follow a written protocol (including follow-up) that ensures the client receives the help required.

k. Follow up of referrals
The term referral is defined as directing clients to a source for help or information at another agency (this can also be another branch of the own parent organization) . There is an agency written -or other established- procedure to follow up clients which are being referred to other agencies. The follow up is either by phone, electronic mail, letter or other means, including accompaniment, and needs the agreement of the client.

Q16. Social care
Describe the range of social assistance that your agency provides, according to the definitions of services below.

a. Basic social needs assessment
A systematic assessment of the basic social needs of each client is made, which explores the clients current situation regarding housing, economy and social network, including specifically his/her access to proper food and hygiene.

b. Legal issues advice
The agency provides the services of a lawyer free of charge for their clients. The legal advice delivered may be related to judicial problems linked to drug use (e.g. dealing, arrest, probation) or might concern other social or personal issues (e.g divorce, custody of children, car accident).

c. Shelter / housing advice
The agency actively mediates (see * below) permanent or temporary accommodation for drug using clients – renting of an independent flat, accommodation in an apartment that belongs to the social or health administration or booking /providing overnight accommodation in an emergency shelter.

(*) To actively mediate means not only to make written or oral referral or provide information about temporary or permanent accommodation or shelter but to engage in a direct and active contact with agencies providing such services.

d. Social benefits advices / financial assistance / debts management
The agency has trained staff that helps drug users to solve their financials problems, including assessing eligibility and/or assisting with registration for social benefit payments. This can also include help to access credits that facilitate staggered re-payments of personal debts.

e. Personal documentation assistance (driving license, identity card, health insurance)
The agency systematically helps clients to recover or obtain replacement of personal documents such as identity card or passport, driving license; and medical or social benefits document.

f. Employment advice/job finding
The agency collects and disseminates on a regular basis information about the local job market and provides active job counselling through its own trained staff to support drug users to find a permanent or temporary employment.

g. Brief information on health, social or legal issues and referral
Used in situation of street outreach, when time only allows short information (not advice) on relevant topics, and where referral to competent agencies plays a major role. The term referral is defined as directing clients to a source for help or information at another agency (this can also be another branch of the own parent organization) .

h. Structured day employment (day job – mediated employment)
The agency regularly provides opportunities for paid work to its clients, on a day-by-day basis (different from contractual work or over longer periods)

i. Parenting advice and support
The agency has trained staff available who actively and systematically address those clients who are responsible for the care of one or more underage children, assess their need for support and advice with regard to their role as parents, and provide or help to access the necessary services. This includes support to parents who use drugs during the antenatal and postnatal period.

Q17. Counselling and other interventions
Support services aiming at reducing drug users' personal and emotional problems; covers a range of different approaches. Staff applying counselling techniques needs to have specific training.

a. Crisis intervention
Intervention by trained staff to manage acute, critical situations (e.g. serious emotional disabilities, paranoid or depressive episodes) in the 'natural environment' of the agency [as opposed to specific counselling or treatment settings] with the aim of restoring the person to the level of psychological functioning before the crisis and at reducing related physical and social harms.

b. Counselling, brief interventions / motivational interviewing
Trained counsellors support individual clients to develop coping strategies or resolve conflicts by providing a supportive and non-judgemental atmosphere. Counselling generally deals with concrete current life situations, and is a short-term, goal-orientated activity to enhance the clients' own capacities.

A brief intervention can range from 5-10 minutes of information and advice given to a drug user to 2-3 such sessions. Brief interventions are targeted at drug users who are not yet experiencing major problems from their consumption. They are not designed for dependent drug users. The aim of the intervention therefore is to encourage them to reduce their drug consumption to sensible limits in order to reduce the risk of future health problems.

Motivational interviewing is a directive, client-centred counselling style for eliciting behaviour change. It aims to facilitate and increase a person's intrinsic motivation to change problematic behaviour in a supportive but strategically directed conversation about the person's use of substances and related life events. It also attempts to increase the awareness of patients of the health risks they are running and their capacity for doing something about this. The interview is normally conducted by staff with specialist training.

c. Case management
Management of care for a client is assigned to a single person (or small team) who coordinate all necessary medical, psychological and social care with the relevant in-house or external resources/agencies. Based on a needs assessment and a care plan definition with the client, and in collaboration with all service providers, the case manager links clients with appropriate providers and resources throughout the continuum of health and human services and care settings. The idea behind case management is to enhance access to care and improve the continuity and efficiency of services.

d. Group counselling, group work
Trained counsellors work with groups of clients in group settings. Important component of the work with the group is the exchange of experience between group members, mediated by the counsellor.

e. Self-help groups
These are voluntary groups that involve drug users and are facilitated by a layperson (current or former drug user). The purpose is to share information and to deal with concerns or problems of their members, and to provide mutual support in solving these problems.

Q18. Medical / nursing / paramedical care

a. Basic health assessment
A basic health assessment is carried out by a medical doctor or a nurse and consists of taking the history of: drug use, treatment for drug use, risk practices, blood-borne viral testing and

status, overdose, other consequences of drug use, and hepatitis B vaccine status. It includes a physical examination and, if necessary, the provision of physical health care advice.

b. and c. Assessment of drug use related and sexual risk practices
Clients' risk practices are assessed by agency staff at defined occasions (e.g. in early phase of contact, then repeated in regular intervals) with a view of providing information and skills for prevention of harm and reduction of risks.

Assessment of drug use related risk taking practice includes the exploration of clients' current drug use, their current and past injecting practice (including skills and sharing practices), experience of overdose and overdose management skills, access to and interest in blood-borne viral testing, and uptake of hepatitis A & B vaccine.
Assessment of sexual risk taking practice includes the exploration of clients sexual practices and related risk taking, their knowledge of sexually transmitted infections and prevention, awareness of the interaction between drug use and risk taking, and knowledge of available sexual health services.

d. Overdose emergency interventions
The emergency intervention is provided by trained staff and concern drug users who show severely impaired consciousness as a consequence of drug consumption, and to prevent overdose morbidity and mortality. In the case of an opiate overdose, the appropriate response may include putting the person in the recovery position, loosening tight clothing, ensuring their airway is clear, administering oxygen, providing cardio pulmonary resuscitation, administrating naloxone if available and necessary, calling the emergency services.

e. Wound management
Wound management consists of assessing the wound, providing treatment to heal the wound, monitoring of progress in relation to healing and advise how to deal with lack of progress.

f. STI clinic
STI clinics provide counselling, testing and treatment for Sexually Transmitted Infections (STI's). These infections include HIV, Chlamydia, genital warts, gonorrhoea, hepatitis A or B, herpes 1 and 11, non-gonococcal urethritis, intestinal parasites, and syphilis. STI clinics may also be known as GUM clinics (with reference to the genitourinary tract).

g. Dentist/dental care
The agency provides on a regular basis (at least once per week) on-site dental care by a trained dental professional (dentist, dental hygienist, dental nurse, dental technician).

h. Gynaecologist / well-woman clinic / family planning service
The agency provides a well woman clinic (see definitions below) on-site care by a medical gynaecologist and these services are offered at regular intervals. A well woman clinic provides specialised services regarding the diagnosis and treatment of minor gynaecological and sexual disorders, and offers advice on related health matters: may include advice on gynaecological problems, family planning (often including IUD fitting), cervical smears, breast disease and the menopause, emergency contraception.

i. Pregnancy test
The agency provides an on site (or take home) physiological test to determine whether a person is pregnant, usually through an early-morning urine sample where the presence of human chronic gonadotropin (hCG), the pregnancy hormone, is tested.

j. DOT for HIV, TB, hep C
The abbreviation DOT stands for directly observed therapy. DOT means that a care worker (usually a nurse) manages the medications for the treatment of a specific illness/infection of the client, reminds clients to take their medicines, observes the patient taking each drug dose and reports any side effects experienced. Relevant illnesses where DOT can be useful for drug users are HIV, Hepatitis C Virus infection and tuberculosis, as complex combinations of medications might be required which are difficult to manage under specific characteristics of drug use lifestyles or for homeless persons. The category should be answered with 'yes' if DOT for at least one of these illnesses is provided.

k. , l. and m. HIV / hepatitis C and B diagnostic testing
The agency provides on-site diagnostic testing of infectious diseases on a voluntary base after providing the right information to the client to make an informed decision about having a test or not and having their consent. Staff makes sure that pre and post test counselling is offered to help the client to cope with the psychological and health implications of the results.

n. Hepatitis vaccination
The category should be ticked if vaccination against Hepatitis B (or A/B) is provided at the agency, by medically trained staff.

o. Tetanus vaccine
Medically trained staff at the agency provides immunization against tetanus (the Td vaccine, T vaccine) or short-term protection (use of Tetanus immune globulin, when someone is believed to have recently been exposed to the bacteria).

p. Prescribing of substitution drugs
The pharmaceutical drugs used for substitution treatment are prescribed by suitably qualified medical practitioners. Includes low-threshold or emergency substitution while waiting for admittance into regular treatment programme.

q. Dispensing of substitution drugs
The substitution drugs (mainly methadone, buprenorphine) are given out by qualified and trained staff at the agency, often on a daily basis. Includes treatment in cooperation with external medical practice.

r. Report to the National drug treatment reporting system
Indicate whether clients receiving drug dependence treatment at the low-threshold agency are registered in a national database / to determine through which mechanism these treatments are recorded in national treatment registries.

Q19 IEC
IEC is the abbreviation for “information, education, communication”. Targeted IEC strategies in the field of harm reduction may involve organising trainings for different target groups to inform, educate and communicate about drug use-related risk and risk management. Indicate if your agency provides such trainings for the target groups of drug users and/or for family members and peers and if yes, specify the topics of such training. Indicate if your agency disseminates targeted IEC material (flyers, info cards, comics, brochures, etc for the target group of current problem drug users) and on which specific topics.

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Section E: Management

Q20. NSP guidance
Please indicate whether written guidelines for agency staff on NSP practice have been drawn up at your agency, and specify the contents further.

Q21. Disposal of used injecting equipment
Please indicate if the agency provides special sharps containers to clients to take away or rewards clients for returning syringes, for example through payment of money or other benefits.

Q22. Clients initial assessment
Please indicate either yes or no. See definition below.

> **Initial assessment**
> An initial assessment is a systematic evaluation of an individual's needs. The aim of assessment is to identify the requirements of the individual in order to inform decisions about care and support. It usually takes the form of one-to-one discussions between the service provider /staff member and the individual. The findings of this meeting are documented and form the basis for the care plan. The care plan are the actions that will be taken as a result of the key findings during the initial assessment.

Q23. Care plan
Please indicate either yes or no. See definition below.

> A care plan is a structured, often multidisciplinary, and task-oriented individual care pathway plan, which details the essential steps in the care of a drug user and describes the expected treatment and care course. The care plan involves the translation of the needs, strength and risks identified by the assessment into a service response. It is used as a tool to monitor any changes in the situation of the client and to keep other relevant professionals aware of these changes. (adapted from Models of Care, http://www.nta.nhs.uk/areas/models_of_care/default.aspx)

Q24. Non-admission
Indicate the conditions that lead to refusal to enter any of the agency's premises. Specify other criteria if necessary.

Q25. Code on drug users' rights and responsibilities
Document specifying rights and obligations of the drug users while using the agency's services.

Q26. Client association
Is your agency linked to a self-organised formal association of clients (current or former drug users), e.g. through voluntary work, joint initiatives, local round-tables or agreements regarding cooperation or exchange?

Q27. Budget for last three years
Please provide total amount of funding received to operate the agency in the previous three years, indicate which years these are, the latest completed calendar year should be reported.

Q28. Funding sources
Please provide the percentage of funding in the most recent budget that was contributed by the listed stakeholders. This is for the most recent completed calendar year, or if different for the latest completed budgetary year.

Q29. Evaluation of client satisfaction
Please indicate if satisfaction of clients with the agency is measured regularly and by using standardised tools.

Q30. Evaluation of outcomes
Please circle either yes or no to part a (see definitions below)
If yes, please write in exact text of the title of the evaluation instruments used

Section F Early Warning

Q31. Helpline
Please indicate either yes or no.

> **Helpline**
> A drugs helpline is a confidential, free telephone service offering non-directive support, information, guidance and referral to anyone with a question related to substance use or its consequences.

Q32. Participation in early warning
Please indicate either yes or no

> **Early warning system**
> System to detect new drugs and drug use patterns that could result in increased health risks. Addresses new phenomena or problems that came to the attention of staff at the agency.

Q33 a-e. New trends or substances
Please read the statements for each part of this question carefully and answer each considering the instructions.

Annex II: Core-services

Annex II provides a list of services which are indicators of the overall level of service provision at the agency. Data on the delivery of the core-services should be collected on an ongoing basis. Definitions and rules for recording service provision and a description of different approaches to monitoring service delivery are provided below.

Table 1. Core-services for monitoring

Core services	**Rules for recording the provision of the services**
1 Syringes distributed	Record the number of syringes given out by agency staff. If syringes are distributed in kits with more than one syringe, the total number of syringes should be recorded. Additional needles given out separately or in addition to syringes should not be counted.
2 Syringes returned	Record the number of syringes received back at agency, returned to outreach teams or collected by clients or staff. If syringes are given back in safe containers, the amount of syringes should be estimated according to a method defined beforehand at the level of the agency (weight, capacity of container). The estimation method should be described in the reporting table.
3 Male condoms distributed	Record the number of condoms given out to clients at the agency.
4 Hepatitis B vaccination	Record the number of individual doses of the vaccine that were applied to clients at the agency. All doses should be counted, not only the third dose.
5 Counselling on infectious disease testing	Record the number of all counselling sessions where clients received counseling that included information on relevance of diagnostic testing of infectious diseases (drug-related and STI). Sessions are recorded regardless of whether they finally resulted in carrying out a test for infectious disease(s) or not. Only counselling sessions that lasted 10 minutes or more and were delivered in a one-to-one setting should be recorded.
6 HIV testing	Record the number of times clients underwent a blood or saliva test at the agency for any of the three listed viruses, when this was done for diagnostic purposes. If several tests are based on same sample of body fluid, they should be counted separately. Testing for purely epidemiological purposes, when results are not communicated to clients, should not be recorded.
7 HBV testing	
8 HCV testing	
9 Wound care treatments	Record the number of times a treatment of any wounds resulting directly (e.g. abscesses) or indirectly (sore feet of homeless drug users) from drug use. Multiple wound treatments on the same person on the same day are summarised as one wound care treatment episode.
10 Social care provision	Record the number of times agency staff has provided advice and support regarding social issues, e.g. housing, employment, legal problems, childcare, parenting, debts: see range of services listed under question 16. Only social care intervention that last more than 10 minutes should be counted.
11 Psychological care provision	Number of times structured psychological care (see range of services listed under Q 17) was provided by trained agency staff. Care episodes should have a minimum duration of 10 minutes and be delivered in a one-to-one setting.

12 Referral to drug treatment services	Number of times clients have received referrals to other agencies or institutions in order to receive: drug treatment (including to a medical doctor for substitution treatment), social assistance (e.g. employment office, welfare office), medical consultations (e.g. specialist doctors, external testing and vaccination facilities, hospitals for detoxification). The term referral is defined as directing clients to a source for help or information at another agency (this can also be another branch of the own parent organisation).
13Referral to social services	
14 Referral to medical services	
15 Opioid overdose interventions	Number of emergency interventions carried out by agency staff in drug users who show severely impaired consciousness as a consequence of opioid (drug) consumption, and where oxygen mask **or** cardio-pulmonary resuscitation (CPR) **or** naloxone (a potent opioid antagonist to counteract respiratory depression) had to be used. Any overdose emergency intervention carried out by agency staff is counted, including when it took place outside of the premises of the agency.
16 Stimulant overdose interventions	Number of emergency interventions carried out by agency staff in drug users who show signs of cocaine overdose or other stimulant overdose. The signs of stimulant overdose are not as clear-cut as in opioid OD, but may include: acute agitation, excitement up to confusion; cardiac arrhythmias; and seizures. Any stimulant overdose emergency intervention carried out by agency staff is counted, including when it took place outside of the premises of the agency.

Table 2. Additional core-services for agencies with supervised consumption facility

17 Supervised injecting drug consumptions	Recorded should be the number of times drug users have stayed in the supervised consumption area of the agency for the purpose of drug injecting. Consumptions are counted as one incident or 'episode' even when repeated injections take place at the same occasion. When the same client uses the facility several times on the same day, each time is recorded separately.
18 Supervised non-injecting drug consumptions	Recorded should be the number of times drug users have stayed in the supervised consumption area of the agency for the purpose of non-injection drug use. Consumptions are counted as one incident or 'episode' even when repeated consumptions take place at the same occasion. When the same client uses the facility several times on the same day, each time is recorded separately.

'Services-based' monitoring

The easiest and probably most common approach to monitor the utilization of the core-services is to record the number of items given out, of medical, psychological or referral services performed during the reporting period and to report the total number according to reporting period (usually one year). The reporting table is simple, as shown in the example of a completed reporting table (Table 3) shown below.

Table 3. Example of a completed reporting table for 'services-based' monitoring

Core-services (indicators)	Number of times the service was provided during the reporting period
1 Syringes out	103.406
2 Syringes in	96.588
3 Male condoms	26.788
4 HepB vaccination	58
… etc.	…

15 Opioid overdose interventions	35
16 Stimulant overdose interventions	66
17 Supervised injecting drug consumption	3.689
18 Supervised non-injecting drug consumption	4.760

This system of documentation allows to obtain very basic information on the volume of service delivery but does not link any information to clients.

'Client-based' monitoring

To collect information about which individual clients' service use patterns, a client information system should be in place. In these cases, clients are provided with an individual code, or specific ID card, and have to identify themselves with this code in order to receive the services. Identification of the individual client is normally required for medical interventions like vaccinations. Specific identification systems can be established at the level of the agency, at regional service level, or nationally; records can be kept fully confidential when information is compiled in specific reporting tables. Where such identification is in place socio-demographic and drug use data according to TDI protocol or at least the 'reduced' set of client characteristics should be registered in a database. The protocol can be downloaded at http://www.emcdda.europa.eu/?nnodeid=1420.

The reduced dataset proposed as minimum dataset in client-based monitoring consists of the seven variables listed below. Clients are registered upon the first contact with the agency, their records are kept in a database. Service delivery is documented through the use of a client-ID.

(1) year of birth
(2) gender
(3) primary drug
(4) usual route of administration primary drug
(5) already receiving substitution treatment ([7])
(6) Ever/currently (last 30 days) injected (any drug).

Definitions and details are provided in the TDI protocol.

Variables (3) to (6) should be updated in the client database at least every 12 months. Rules for regular updating should be defined at the agency.

Clients datasets are centrally registered at the agency and updated in regular predefined intervals. Depending on the system, double-counting of clients can be prevented at national and inter-institutional level, or at least inside the agency different service provision areas. Such systems have to be designed within the local conditions and national data protection laws. They are easier to implement when electronic means (ID cards) are used and when the agency has a computer-network that links all service areas to a central database. They provide excellent possibilities for obtaining detailed statistical records of service demand which are needed to analyse patterns of service use. While this model delivers the most relevant data, it is rarely implemented for reasons of data protection and problems related to lack of feasibility in typical harm reduction settings like 'drop-in' centers or street work.

7 Variable included in the original TDI dataset but moved to voluntary collection in 2003.

'Contact-based' monitoring

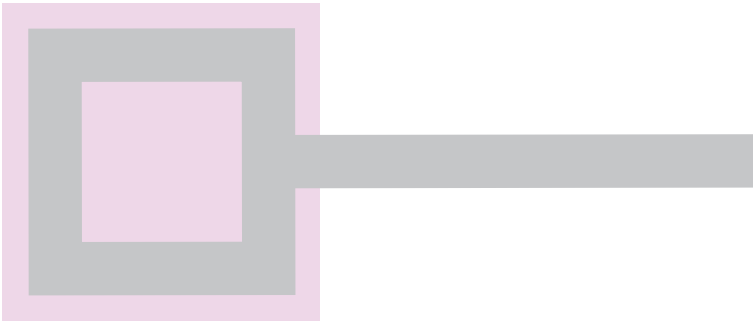
An alternative method to obtain core information about the characteristics of service users while not requiring identification, is based on staff observations during the contact with the client. Each time a core-service is utilized, during a contact with the client, staff classifies the client according to specific variables. In the example in Table 4 below, the chosen variables are: gender, injecting status and age group.

Table 4. Example of a completed reporting table for 'contact-based' monitoring

Core-service 4: Number of doses of Hep B vaccine provided during last calendar year to specified client groups:										
Gender	male			female			unknown			
Injecting status	injector	Non-injector	unknown/n.a.	injector	Non-injector	Unknown/ n.a.	injector	Non-injector	uknown/ n.a.	**Total**
Younger than 15	3	7	6	5	6	2	0	0	1	30
15-24	36	10	1	6	6	0	0	0	2	61
25-39	25	23	0	44	28	4	0	0	0	124
40 and older	7	9	0	10	6	0	0	0	0	32
unknown	7	0	0	3	1	0	0	0	0	11
Total	78	49	7	68	47	6	0	0	3	258

This approach is often chosen by agencies that don't require client identification but would still like to analyse their service provision in some detail, as the results give some insight into the service user populations. It is challenging for staff, who are required to assess the client variables each time they deliver a service and to note the frequencies of service delivery in a table prepared for the respective subgroups. Few variables result already in a complex reporting table; the example above gender x injecting x four age groups results already in a table with (3x3x5) 45 fields.

The limitations of the method are that certain variables can not always be properly assessed (e.g. drug injecting status or age group) which results in missing data. The short duration of contacts between staff and clients (e.g. syringe exchange at a large agency) and the conditions of service delivery in outreach/street settings can make it difficult to assess client data.



This booklet has been complied within Correlation – European Network Social Inclusion & Health. The project aims to improve access to and the improvement of health and social services for marginalised groups and people. Data collection and evaluation are considered as an important measure to improve the knowledge and evidence base in particular for low threshold services.

The booklet scribes the development and the field testing of a data collection protocol for harm reduction agencies and presents the final tool, including a manual. You can find additional information and the inventory on

www.correlation-net.org