GUIDELINES AND RECOMMENDATIONS

FOR THE IMPLEMENTATION OF MINIMUM QUALITY STANDARDS IN DRUG DEMAND REDUCTION IN THE EUROPEAN UNION BY CIVIL SOCIETY ORGANISATIONS (CSOs)

CIVIL SOCIETY FORUM ON DRUGS IN THE EU

utrip Inštitut za raziskave in razvoj

IREFREA

ANA LIFFEY DRUG PROJECT

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Guidelines and
Recommendations
for the implementation
of Minimum Quality Standards
in drug demand reduction in
the European Union by Civil
Society Organisations (CSOs)

TABLE OF CONTENTS

INTRODUCTION

In September 2015, the Council of the European Union adopted **Council conclusions on the implementation of minimum quality standards in drug demand reduction in the EU**. This innovative initiative lists 16 standards that represent a minimum benchmark of quality for interventions in: prevention, risk and harm reduction, treatment, social integration and rehabilitation. Although non-binding for national governments, this document represents the political will of EU countries to address demand reduction interventions through an evidence-based perspective. These guidelines have been drawn up in the context of Action 9 of the EU action plan on drugs (2013–2016).

In 2014, the Civil Society Forum on Drugs (CSFD) prepared and published the **thematic paper on the EU minimum quality standards for drug demand reduction**. The paper presents the context in which the EU Member States as well as candidate and potential candidate countries for EU membership are recommended to promote and enforce the minimum quality standards in drug demand reduction and provides a brief overview of associated issues and opportunities for consideration (including assessment and evaluation of the implementation of standards).

Since then, the CSFD has operated a working group on minimum quality standards, and the work of this group is enhanced by the CSFD project, co-funded by the European Commission under the Justice Programme (Drug Policy Initiatives). Work under this aspect of the project is led by the Institute »Utrip« from Slovenia (**www.institut-utrip.si**) and IREFREA Spain (**www.irefrea.eu**), and is carried out with the input of the members of the working group of the CSFD and with the broader CSFD membership. Objectives under the project in this area are as follows:

1. TO PROMOTE THE IMPLEMENTATION OF MINIMUM QUALITY STANDARDS IN EU MEMBER STATES (ADVOCACY), AND,

2. TO IMPROVE KNOWLEDGE AND SKILLS AMONG CSOs ON HOW TO IMPLEMENT MINIMUM QUALITY STANDARDS ON THE NATIONAL LEVEL.

TO FACILITATE THIS, WORK UNDER THIS WORK PACKAGE HAS:

1. Developed an assessment tool to allow CSOs to monitor and assess implementation of minimum quality standards in their own countries and organizations. The initial 16 drug demand reduction standards have been broken down into 52 sub-standards, 64 questions and 222 assessment indicators (excluding non-defined indicators, e.g. other). The online tool works as a self-assessment tool with automatic feedback of results (using traffic light system rating).

2. Developed a method of examining the feasibility of implementation of minimum quality standards among CSOs. The feasibility tool was incorporated in assessment tool and includes additional 52 questions and 144 feasibility indicators.

During the process of tool testing, we received more than 100 inputs from diverse CSOs across Europe representing different areas of work (prevention, risk and harm reduction, social integration, rehabilitation and recovery). However, following data review, only 46 of them were selected as eligible for further analysis and inclusion in the written feasibility study.

The assessment tool is available at the following link:
http://self-assessment.institut-utrip.si/index.php/71231?lang=en

The feasibility study is available on the CSFD website at:
http://www.civilsocietyforumondrugs.eu/tf4-working-group-on-quality-standards-in-drug-policy/

Building on the insights gained from the assessment tool and feasibility study, the CSFD has now developed this guidelines and recommendations document. The aims of these guidelines and recommendations are to help and support CSOs working in the drug demand reduction field to:

1. assess and implement their interventions according to these standards
2. identify potential barriers for incorporation; and
3. assess the potential need to provide training for practitioners and developers in the drug demand reduction field in line with these standards

TERMINOLOGY AND DEFINITIONS

Terminology can differ across languages and locations. To help with ensuring consistency in understanding the guidelines and recommendations, we use the following definitions:

PREVENTION

A prevention intervention promotes activities to prevent substance use behaviour. The goal is to reduce risk factors and enhance protective factors. Prevention is achieved through the application of multiple strategies; can be realised in different settings and with different methods and contents. The duration can vary between one-off activities and long-term projects. Prevention interventions are commonly classified in four categories: environmental, universal, selective and indicated interventions.

Environmental prevention strategies aim to change the cultural, social, physical and economic environments and include measures such as alcohol pricing and bans on tobacco advertising and smoking, for which there is good evidence of effectiveness. Universal prevention targets the whole population, while selective prevention targets (vulnerable) groups, both with the aim of deterring or delaying the onset of substance use. Indicated prevention acts at the individual level to: prevent the development of a dependence; to stop progression, diminish the frequency; and consequently to prevent substance use. (*Adapted from EMCDDA Best Practice Portal*)

RISK AND HARM REDUCTION

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

TREATMENT, SOCIAL INTEGRATION, REHABILITATION (INCLUDING RECOVERY)

Treatment, social integration, rehabilitation and recovery is defined as a set of activities that directly target people who have problems with their substance use and that aims at achieving defined goals with regard to the alleviation and/or elimination of these problems, provided by experienced and accredited professionals, in the framework of recognized medical, psychological or social assistance practice. (*Adapted from EMCDDA Treatment Demand Indicator Protocol*)

FORMAL EDUCATION AND/OR TRAINING

Education and training typically provided by an education or training institution, structured (in terms of learning objectives, learning time or learning support) and leading to certification. Formal learning is intentional from the learner's perspective. (*Definition by UNESCO*)

NON-FORMAL EDUCATION AND/OR TRAINING

Education and training which takes place outside the formal system either on a regular or intermittent basis. (*Definition by UNESCO*)

INFORMAL EDUCATION AND/OR TRAINING

Learning resulting from daily life activities related to work, family or leisure. Informal learning is part of non-formal learning. It is often referred to as experience based learning and can to a certain degree be understood as accidental learning. (*Definition by UNESCO*)

WIDELY ACCESSIBLE SERVICES (ESPECIALLY RISK AND HARM REDUCTION SERVICES)

Widely accessible service is one, which can be accessed by a large majority of the people that need it in a jurisdiction.

NON-EXCLUSION POLICY

A non-exclusion policy means that service users (e.g. people who use/inject drugs) are not excluded or rejected in any way from services they need. Some services might have limitations (e.g. age, gender, status), but there should be services available which are tailored to the needs of any target population.

REASONABLE TIME (IN TREATMENT, SOCIAL REINTEGRATION, REHABILITATION AND RECOVERY)

In case of a crisis attendance for substitution treatment, intervention has to be available immediately and to be continued until necessary legal procedures (depending on legal situation of the country) are fulfilled for long-term substitution treatment. Residential non-abstinence rehabilitation treatment (combined with substitution treatment) should be available after a maximum of two weeks preparation phase. Detox treatment followed by abstinence oriented rehabilitation treatment should be available after a maximum of two weeks preparation phase with immediate admission after detox phase. Relapse (crisis intervention) treatment after a successful recovery intervention has to be available immediately. If the issue includes minors or persons at risk for their life, all services should be available without any delay (immediately).

HOW TO USE THESE GUIDELINES

For each of the 16 standards in the Council Conclusions, these guidelines provide:

- A copy of the text of the standard
- An insight into what the utilisation of the assessment tool by CSOs has told us about this standard
- An insight into what the feasibility analysis has told us about this standard
- Based on the insights above, (a) recommendation(s) to CSOs, highlighting key issues that may be of use as they work on implementing the standards

The guidelines can be used in conjunction with the assessment tool, the feasibility study and other relevant resources as supports to CSOs working on standards implementation.

PREVENTION

STANDARD 1: PREVENTION (ENVIRONMENTAL, UNIVERSAL, SELECTIVE AND INDICATIVE) INTERVENTIONS ARE TARGETED AT THE GENERAL POPULATION, AT POPULATIONS AT RISK OF DEVELOPING A SUBSTANCE USE PROBLEM OR AT POPULATIONS/INDIVIDUALS WITH AN IDENTIFIED PROBLEM. THEY CAN BE AIMED AT PREVENTING, DELAYING OR REDUCING DRUG USE, ITS ESCALATION AND/OR ITS NEGATIVE CONSEQUENCES IN THE GENERAL POPULATION AND/OR SUBPOPULATIONS; AND ARE BASED ON AN ASSESSMENT OF AND TAILORED TO THE NEEDS OF THE TARGET POPULATION.

1.1.

According to the **assessment**, this standard appears to be well implemented in participating EU Member States. The contemporary classification of prevention (four types of approaches) is widely used in policy documents (e.g. drug strategies and action plans) across Europe. In general, the aims mentioned in the standards are typically included in strategies and action plans at a general population level, but not necessarily for subpopulations. Mostly national data sources are available for assessment of the target population. However, involvement of the target population in needs assessment in all phases, especially during intervention design and evaluation (both process and outcome) remains a challenge.

1.2.

According to the **feasibility study**, this standard is well implemented in CSOs, with universal and selective approaches widely used in their interventions and strategies. Mostly national and own data sources are used during the needs assessment. The needs of the target population are well assessed during all phases (intervention design, implementation and evaluation (both process and outcome).

1.3.

Recommendation(s):

For those CSOs interested in working on this standard, some things to consider are:

- Ensure that target populations are involved in all phases of the needs assessment, and in intervention design and evaluation.
- Consequently, for CSOs working with a particular target group, it makes sense to focus only on this group, meaning selective and indicated prevention interventions targeted at a specific subpopulation are likely to be the main focus.
- Have defined in advance how you will collect, analyse and manage the data on these types of interventions. It will be of value not only to your own analysis and evaluation, but also to further development of regional and local data and for data on subpopulations.

STANDARD 2: THOSE DEVELOPING PREVENTION INTERVENTIONS HAVE COMPETENCIES AND EXPERTISE ON PREVENTION PRINCIPLES, THEORIES AND PRACTICE, AND ARE TRAINED AND/OR SPECIALISED PROFESSIONALS WHO HAVE THE SUPPORT OF PUBLIC INSTITUTIONS (EDUCATION, HEALTH AND SOCIAL SERVICES) OR WORK FOR ACCREDITED OR RECOGNISED INSTITUTIONS OR NGOS.

2.1.

According to the **assessment**, this standard is poorly implemented in participating EU Member States. Specific competencies and expertise are rarely required for prevention workforce and governments or authorities very rarely officially accredit CSOs to work in prevention. There is almost no formal education and/or training available for prevention workforce. The situation is slightly better regarding non-formal and informal education and/or training. However, there is almost no support and funding for education and/or training of the staff in the field of prevention by public institutions, especially at regional and local level. Staff do not tend to be recognised as prevention professionals at national, regional or local level.

2.2.

According to the **feasibility study**, this standard is not well implemented either in participating EU Member States. CSOs in the field of prevention mostly require university degree in a relevant area and informal education and/or training. There is almost no official accreditation for CSOs to work in the field of prevention.

2.3.

Recommendation(s):

For those CSOs interested in working on this standard, some things to consider are:

- Explore options to work with national or local authorities to work towards ensuring this standard is better implemented and that those who are committed to prevention work are trained and supported to do so. Given its status as a council conclusion, governments and authorities in EU Member States should be interested in exploring how work in this area can best be supported, for example by accrediting and recognising CSOs to work in the field of prevention and by providing support and sustainable funding for education and training, which could significantly improve competencies and expertise in this area of work.
- Before implementing or designing any prevention projects yourself, ensure that the staff who have been designated to carry out the work are properly supported and equipped, and have the competencies and expertise necessary to do the job.

STANDARD 3: THOSE IMPLEMENTING PREVENTION INTERVENTIONS HAVE ACCESS TO AND RELY ON AVAILABLE EVIDENCE-BASED PROGRAMMES AND/OR QUALITY CRITERIA AVAILABLE AT LOCAL, NATIONAL AND INTERNATIONAL LEVELS.

3.1.

According to the **assessment**, this standard is poorly implemented in participating EU Member States. There are almost no registries of evidence-based interventions available at national, regional and/or local level. While there are existing internationally recognised evidence-based intervention (EBI) registries (such as the Xchange registry by EMCDDA, Healthy Nightlife Toolbox (HNT) registry, Blueprints Programs registry and SAMHSA Evidence-based Practice registry), these are very rarely used by prevention professionals. There are some standards and/or guidelines available (mostly at national level) in some EU Member States, but use of these is not always mandatory for funding support.

3.2.

According to the **feasibility study**, this standard is also poorly implemented by participating CSOs. Existing international and/or national EBI registries are rarely used by CSOs in the field of prevention. In most of the cases, prevention professionals use national standards and/or guidelines (if they exist).

3.3.

Recommendation(s):

For those CSOs interested in working on this standard, some things to consider are:

- Make sure it is part of your internal processes when designing and implementing prevention interventions that existing internationally recognised and national EBI registries are taken into account, so prevention professionals use them on regular basis while developing, adapting, transferring and evaluating best practices in their environments and settings.
- Ensure that it is part of induction and training for staff working on prevention interventions to receive input on how to use existing registries.
- Explore the possibility of working with local, regional or national authorities to ensure that funding for interventions in this area requires those seeking it to show how the proposed intervention is consistent with the good practices on registries such as Xchange.

STANDARD 4: PREVENTION INTERVENTIONS FORM PART OF A COHERENT LONG-TERM PREVENTION PLAN, ARE APPROPRIATELY MONITORED ON AN ONGOING BASIS ALLOWING FOR NECESSARY ADJUSTMENTS, ARE EVALUATED AND THE RESULTS DISSEMINATED SO AS TO LEARN FROM NEW EXPERIENCES.

4.1.

According to the **assessment**, this standard is poorly implemented in participating EU Member States. Interventions are rarely implemented based on priorities in the national, regional or local level and there is almost no long-term sustainable funding system at all levels. Monitoring, evaluation and dissemination systems and plans or policies in the field of prevention practically do not exist in most of participating EU Member States. Funding is mostly not available for outcome evaluation at all levels and is rarely related to monitoring and evaluation (both process and outcome).

4.2.

According to the **feasibility study**, this standard is reasonably well implemented by responding CSOs. Some CSOs have a long-term prevention plan in place for sustaining prevention activities. They often conduct monitoring and process evaluation, but rarely outcome evaluation. Most of them have dissemination system/plan in place.

4.3.

Recommendation(s):

For those CSOs interested in working on this standard, some things to consider are:

- If you have a long term plan, explore the possibility of working with local, regional or national authorities to explore how such a plan might be supported into the future to ensure sustainability
- Given that CSOs operating in this area see themselves as having existing strength in implementing this standard, consider forming a network of CSOs who can work together on elements of monitoring, evaluation and dissemination
- Work with a particular focus on outcome evaluation, as this is the area which CSOs currently self-report is weak. Explore with other stakeholders how outcome evaluation can best be supported to ensure coverage of target populations with effective prevention practices.

RISK AND HARM REDUCTION

STANDARD 5: RISK AND HARM REDUCTION MEASURES, INCLUDING BUT NOT LIMITED TO MEASURES RELATING TO INFECTIOUS DISEASES AND DRUG-RELATED DEATHS, ARE REALISTIC IN THEIR GOALS, ARE WIDELY ACCESSIBLE, AND ARE TAILORED TO THE NEEDS OF THE TARGET POPULATIONS.

5.1.

According to the **assessment**, this standard is poorly implemented in participating EU Member States. Evidence-based interventions such as drug consumption rooms (DCRs) and naloxone distribution exist in very few countries, with the exception of opioid substitution treatment (OST). Improvements are needed concerning other interventions as well (e.g. gender specific interventions, voluntary counselling and BBV testing). Target populations are very rarely actively involved in intervention design, implementation and evaluation (both process and outcome).

5.2.

According to the **feasibility study**, this standard is also poorly implemented by participating CSOs. Most frequent evidence-based interventions are needle and syringe exchange programme and information, education and communication. The input of the target populations are very often assessed during all phases of intervention, with the exception of outcome evaluation.

5.3.

Recommendation(s):

For those CSOs interested in working on this standard, some things to consider are:

- Ensure that planned activities are meeting an identified need. It is critical that target populations are involved in all phases of the needs assessment, and in intervention design and evaluation.
- In the future, more focus should be oriented towards development and implementation of interventions such as drug consumption rooms (DCRs) and naloxone distribution, taking into account gender specific measures as well. Target populations should be more often included in intervention design, implementation and evaluation (both process and outcome).

STANDARD 6: APPROPRIATE INTERVENTIONS, INFORMATION AND REFERRAL ARE OFFERED ACCORDING TO THE CHARACTERISTICS AND NEEDS OF THE SERVICE USERS, IRRESPECTIVE OF THEIR TREATMENT STATUS.

6.1.

According to the **assessment**, this standard is poorly implemented in participating EU Member States. In general, there is a reported lack of standardized comprehensive needs assessment at all levels (national, regional and local). Responses indicate a need to focus on linking RHR interventions to other interventions where appropriate, particularly those in the areas of social integration, rehabilitation and recovery services. Currently, the most focus is seen as being on links to medical and non-medical treatment. Consistent with other areas, service users do not seem to be well consulted in terms of engagement in needs assessment and service design.

6.2.

According to the **feasibility study**, this standard is a bit better implemented by participating CSOs, except regarding the implementation of standardized comprehensive needs assessment, which rarely seems to be utilised in practice. Improvements are also needed concerning more consistent implementation of non-exclusion policies among CSOs. Some respondent CSOs offer or refer their service users to other interventions, especially non-medical treatment. They are also well connected with most of other services, including social integration, rehabilitation and recovery. Most of them have their own non-exclusion policy in place.

6.3.

Recommendation(s):

For those CSOs interested in working on this standard, some things to consider are:

- Ensure that a comprehensive needs assessment is in place
- Explore working with services providing social integration, rehabilitation and recovery to see how you can work together to provide a seamless continuum of care of people using your services
- Ensure that an explicit, written non-exclusion policy is part of your own policy suite, as well as part of the suite of policies implemented by the other services you work with

STANDARD 7: INTERVENTIONS ARE AVAILABLE TO ALL IN NEED, INCLUDING IN HIGHER RISK SITUATIONS AND SETTINGS.

7.1.

According to the **assessment**, this standard is poorly implemented in participating EU Member States. Interventions are rarely available to all in need; however, there is a bit better situation to some extent at local or regional levels. Higher risk situations are not very well addressed by RHR interventions (e.g. people who use drugs as victims of crime, people who use drugs in prisons). RHR services are very rarely provided in prison settings; however, improvements are needed also in other higher risk settings, such as open drug use scene, nightlife and festivals.

7.2.

According to the **feasibility study**, this standard is well implemented by participating CSOs as their interventions are mostly available to all in need.

7.3.

Recommendation(s):

For those CSOs interested in working on this standard, some things to consider are:

- Looking at your current service delivery and asking whether what you provide is available to all those who might need it and, if not, thinking about how you might work yourselves or in partnership to expand access, particularly in the context of higher risk settings.

STANDARD 8: INTERVENTIONS ARE BASED ON AVAILABLE SCIENTIFIC EVIDENCE AND EXPERIENCE AND PROVIDED BY QUALIFIED AND/OR TRAINED STAFF (INCLUDING VOLUNTEERS), WHO ENGAGE IN CONTINUING PROFESSIONAL DEVELOPMENT.

8.1.

According to the **assessment**, this standard is poorly implemented in participating EU Member States. Interventions are rarely coherent with existing evidence-based criteria (such as that provided by EMCDDA) at all levels (national, regional and local). There is almost no formal education and/or training available in the field of RHR. Most of the professionals in this field have to rely on non-formal or informal education and/or training options, but improvements are needed in this area as well, including continuing education and/or training options to assure continuing professional development.

8.2.

According to the **feasibility study**, this standard is also poorly implemented by participating CSOs. Mostly they do not require formal education and/or training for their staff, including volunteers, and they are not often engaged in continuing education and/or training as well.

8.3.

Recommendation(s):

For those CSOs interested in working on this standard, some things to consider are:

- Explore options to work with national, regional or local authorities to work towards ensuring this standard is better implemented and that those who are committed to RHR work are trained and supported to do so. Given its status as a council conclusion, governments and authorities in EU Member States should be interested in exploring how work in this area can best be supported, for example by accrediting and recognising CSOs to work in the field of RHR and by providing support and sustainable funding for education and/or training, which could significantly improve competencies and expertise in this area of work.
- Before implementing or designing any RHR projects yourself, ensure that the staff who have been designated to carry out the work are properly supported and equipped, and have the competencies and expertise necessary to do the job.

TREATMENT, SOCIAL REINTEGRATION AND REHABILITATION (INCLUDING RECOVERY)

STANDARD 9: APPROPRIATE EVIDENCE-BASED TREATMENT IS TAILORED TO THE CHARACTERISTICS AND NEEDS OF SERVICE USERS AND IS RESPECTFUL OF THE INDIVIDUAL'S DIGNITY, RESPONSIBILITY AND PREPAREDNESS TO CHANGE.

9.1.

According to the **assessment**, this standard is rather well implemented in participating EU Member States. Service users are very well informed about different options of treatment programmes (e.g. long-term, short-term and outpatient treatment, individual counselling), and a bit less about some other options (e.g. group counselling and in-prison treatment and care). There is a lack of information on gender specific treatment programmes. Service users are rather often involved in treatment design, implementation and evaluation (except a bit less in outcome evaluation). Treatment providers mostly respect service users' dignity, responsibility and preparedness to change; however, improvements are still needed concerning this part of the standard.

9.2.

According to the **feasibility study**, this standard is rather well implemented by participating CSOs. They provide different types of treatment for their service users, especially outpatient programmes, individual and group counselling. Improvements are needed especially regarding in-prison and gender specific treatment and care. The needs of service users are well assessed during the whole process of treatment by participating CSOs.

9.3.

Recommendation(s):

For those CSOs interested in working on this standard, some things to consider are:

- Focusing on those aspects of the standard that are less well implemented, such as those oriented towards development and promotion of in-prison treatment and care, and treatment, which addresses gender specific needs.

STANDARD 10: ACCESS TO TREATMENT IS AVAILABLE TO ALL IN NEED UPON REQUEST, AND NOT RESTRICTED BY PERSONAL OR SOCIAL CHARACTERISTICS AND CIRCUMSTANCES OR THE LACK OF FINANCIAL RESOURCES OF SERVICE USERS. TREATMENT IS PROVIDED IN A REASONABLE TIME AND IN THE CONTEXT OF CONTINUITY OF CARE.

10.1.

According to the **assessment**, this standard is very well implemented in participating EU Member States, except concerning the provision of treatment in reasonable time and to some extent the context of continuity of care as well. Improvements are needed concerning the availability of treatment to all in need, especially at national and regional levels. A non-exclusion policy is mostly operating, ensuring access regardless of the personal, social or financial situation of service users.

10.2.

According to the **feasibility study**, this standard is very well implemented by participating CSOs, including the provision of services in reasonable time and in the context of continuity of care. They mostly also have their own non-exclusion policy in place in relation to personal, social and financial situation of service users.

10.3.

Recommendation(s):

For those CSOs interested in working on this standard, some things to consider are:

- Focusing on those aspects of the standard that are less well implemented such as those oriented towards provision of treatment in reasonable time and the context of continuity of care, especially as a part of national, regional and/or local strategies and action plans.

STANDARD 11: IN TREATMENT AND SOCIAL INTEGRATION INTERVENTIONS, GOALS ARE SET ON A STEP-BY-STEP BASIS AND PERIODICALLY REVIEWED, AND POSSIBLE RELAPSES ARE APPROPRIATELY MANAGED.

11.1.

According to the **assessment**, this standard is rather well implemented in participating EU Member States. However, improvements are needed concerning periodical review of the goals in treatment and social integration services. Improvements are also needed concerning the management of possible relapses in treatment and social integration interventions.

11.2.

According to the **feasibility study**, this standard is very well implemented by participating CSOs with no special concerns or challenges for improvements.

11.3.

Recommendation(s):

For those CSOs interested in working on this standard, some things to consider are:

- Focusing on those aspects of the standard that are less well implemented such as those oriented towards better periodical review of the goals at national and/or regional levels, and better management of possible relapses in treatment and social integration.

STANDARD 12: TREATMENT AND SOCIAL INTEGRATION INTERVENTIONS AND SERVICES ARE BASED ON INFORMED CONSENT, ARE PATIENT-ORIENTED, AND SUPPORT PATIENTS' EMPOWERMENT.

12.1.

According to the **assessment**, this standard is rather well implemented in participating EU Member States. However, improvements are needed concerning patient-oriented and patients' empowerment approaches.

12.2.

According to the **feasibility study**, this standard is very well implemented by participating CSOs with no special concerns or challenges for improvements.

12.3.

Recommendation(s):

For those CSOs interested in working on this standard, some things to consider are:

- Review your current processes and programmes to ensure all your interventions and services are as patient-oriented as they can be
- Work with people who use your services to ensure that they are empowered to provide input and feedback on the services that will make a difference in their lives.

STANDARD 13: TREATMENT IS PROVIDED BY QUALIFIED SPECIALISTS AND TRAINED STAFF WHO ENGAGE IN CONTINUING PROFESSIONAL DEVELOPMENT.

13.1.

According to the **assessment**, this standard is rather well implemented in participating EU Member States. However, improvements are needed concerning the development of specific job or profession-related qualification system at all levels and the provision of formal education and/or training and continuing (e.g. non-formal) education and/or training options for treatment professionals.

13.2.

According to the **feasibility study**, this standard is well implemented by participating CSOs. However, improvements are needed concerning the engagement of CSOs in continuing education and/or training of their staff at all levels.

13.3.

Recommendation(s):

For those CSOs interested in working on this standard, some things to consider are:

- Explore options to work with local, regional and national authorities to further enhance education and training in this area, particularly in the context of ongoing professional development.
- Within your own organisation, ensure that all staff have their own personalised training plan, which is focused on enhancing their own professional development.
- Work with partner agencies to explore non-formal training opportunities, such as staff swaps or agency placements. Such activities can both enhance individual skills, as well as improving organisational networking.

STANDARD 14: TREATMENT INTERVENTIONS AND SERVICES ARE INTEGRATED WITHIN A CONTINUUM OF CARE TO INCLUDE, WHERE APPROPRIATE, SOCIAL SUPPORT SERVICES (EDUCATION, HOUSING, VOCATIONAL TRAINING, WELFARE) AIMED AT THE SOCIAL INTEGRATION OF THE PERSON.

14.1.

According to the **assessment**, this standard is rather well implemented in participating EU Member States. However, improvements are needed concerning information for service users about different services, especially social integration, rehabilitation and recovery, and supporting service users in education, housing, vocational training and welfare.

14.2.

According to the **feasibility study**, this standard is well implemented by participating CSOs. Their services are well integrated within a continuum of care model and aimed at the social integration of service users. Some improvements are needed concerning supporting service users in education, housing and vocational training.

14.3.

Recommendation(s):

For those CSOs interested in working on this standard, some things to consider are:

- As in other areas, there is scope to ensure links between services are a focus to ensure a seamless continuum of care for service users. In this instance, CSOs could consider linking with other stakeholders to better support access to ancillary services, such as education, housing, vocational training and welfare.

STANDARD 15: TREATMENT SERVICES PROVIDE VOLUNTARY TESTING FOR BLOOD-BORNE INFECTIOUS DISEASES, COUNSELLING AGAINST RISKY BEHAVIOURS AND ASSISTANCE TO MANAGE ILLNESS.

15.1.

According to the **assessment**, this standard is rather well implemented in participating EU Member States. However, improvements are needed concerning the provision of voluntary testing for blood-borne infectious diseases, counselling against risky behaviour and assistance to manage illness at all levels.

15.2.

According to the **feasibility study**, this standard is very well implemented by participating CSOs with no special concerns or challenges for improvements, except regarding better provision of voluntary testing for blood-borne infectious diseases.

15.3.

Recommendation(s):

For those CSOs interested in working on this standard, some things to consider are:

- Ensure access to voluntary testing for blood-borne infectious diseases and promote such services to people who could benefit from them.

STANDARD 16: TREATMENT SERVICES ARE MONITORED AND ACTIVITIES AND OUTCOMES ARE SUBJECT TO REGULAR INTERNAL AND/OR EXTERNAL EVALUATION.

16.1.

According to the **assessment**, this standard is poorly implemented in participating EU Member States. Significant improvements are needed concerning the availability of funding for internal and external treatment outcome evaluation at all levels. Funding should be systematically related to monitoring and evaluation (both process and outcome). Improvements are needed as well concerning the development of monitoring system or plan, internal and external evaluation system or plan at all levels.

16.2.

According to the **feasibility study**, this standard is well implemented by participating CSOs. They regularly conduct monitoring and evaluation (both process and outcome), but they do not receive any funding for this activity.

16.3.

Recommendation(s):

For those CSOs interested in working on this standard, some things to consider are:

- Explore options to work with local, regional and national authorities to enhance current approaches to systematic monitoring and evaluation (both process and outcome) of treatment services, in a manner that is consistent with such an approach being embedded in how services are delivered into the future. Within your own organisation, ensure that all your systems are oriented towards the evaluation of your service provision against good practice standards.

CONCLUSIONS

Drawing on the recommendations related to each specific standard, and on the feedback from the assessment and feasibility studies, there are a number of conclusions which are important to highlight. These are:

A) DISINVESTMENT FROM INEFFECTIVE AND HARMFUL INTERVENTIONS

Responses to the assessment and feasibility studies highlighted that there are still many interventions in the field of drug demand reduction, which are not being carried out in line with minimum quality standards. Governments and civil society organisations should be aware of this and consciously seek to disinvest and moving support away from ineffective services and interventions. Correspondingly, they should invest more resources towards implementation of evidence-based and effective interventions, especially in the fields of prevention and risk and harm reduction.

B) EDUCATION AND TRAINING & CONTINUING PROFESSIONAL DEVELOPMENT

The responses to the assessment and feasibility study pieces also reveal that there is a perceived gap in quality education and training for the drug demand reduction workforce (both in relation to basic training and in respect of continuing professional development). Governments and civil society organisations should investigate the long-term value of investment in this area, and look to invest more resources into developing and maintaining quality (formal and non-formal) education and training programmes for professionals and volunteers in the field of drug demand reduction.

C) MONITORING & EVALUATION

According to the results of assessment and feasibility study, the evaluation culture is weak in Europe in the field of drug demand reduction. There is very little demand by (funding) authorities for monitoring and evaluation of programmes and other interventions (especially concerning outcome evaluation). Without evaluation there is impossible to say, which programmes and interventions are effective and has significant impact on the situation in the field of drug demand reduction. Governments and civil society organisations are advised to invest more in monitoring and evaluation, which would significantly improve the quality of interventions and motivation of professionals to continue with quality work.

However, those involved in monitoring and evaluation need to make sure of selecting the correct and adequate metrics and evaluation methods in order to avoid large box-ticking exercises, that may draw time away from the provision of services. Therefore, a balance should be established between the time needed to provide quality services and conducting efficient monitoring & evaluation.

D) SUSTAINABLE FUNDING RELATED TO THE IMPLEMENTATION OF STANDARDS

According to the results of assessment and feasibility study, there is almost no sustainable funding for programmes and interventions in the field of drug demand reduction. States and funding bodies at all levels are advised to relate funding programmes and schemes to the implementation of minimum quality standards, but at the same time invest significantly more resources to improve the capacity of civil society organisations (technical and financial) to comply with those standards. Without sustainable funding, improved knowledge and skills of the workforce, and an improved monitoring and evaluation culture, we cannot expect significant improvements and developments in the field of drug demand reduction.

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Guidelines and
Recommendations
for the implementation of
Minimum Quality Standards
by Civil Society Organisations
(CSOs)

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GLOSSARY

BBV - BLOOD-BORNE VIRUS

CSFD - CIVIL SOCIETY FORUM ON DRUGS

CSO - CIVIL SOCIETY ORGANIZATION

DCRS - DRUG CONSUMPTION ROOMS

EBI - EVIDENCE-BASED INTERVENTIONS

EMCDDA - EUROPEAN MONITORING CENTRE FOR DRUGS AND DRUG ADDICTION

EU - EUROPEAN UNION

HNT - HEALTHY NIGHTLIFE TOOLBOX

NGO - NON-GOVERNMENTAL ORGANIZATION

OST - OPIOID SUBSTITUTION TREATMENT

RHR - RISK AND HARM REDUCTION

GUIDELINES AND RECOMMENDATIONS

FOR THE IMPLEMENTATION OF MINIMUM QUALITY STANDARDS IN DRUG DEMAND REDUCTION IN THE EUROPEAN UNION BY CIVIL SOCIETY ORGANISATIONS (CSOs)

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