PILOTING AND VALIDATION OF QUALITY AND EVIDENCE CRITERIA FOR DRUG PREVENTION AND TREATMENT PROGRAMMES IN REAL CONTEXTS

EXECUTIVE SUMMARY

COMPONENT 2 DRUG DEMAND REDUCTION (DDR)

Activity 2.1.: Validation of agreed quality criteria identified through the consensus process initiated in COPOLAD I

This project is funded by the European Union

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PROGRAMA DE COOPERACIÓN ENTRE AMÉRICA LATINA, EL CARIBE Y LA UNIÓN EUROPEA EN POLÍTICAS SOBRE DROGAS
COOPERATION PROGRAMME BETWEEN LATIN AMERICA, THE CARIBBEAN AND THE EUROPEAN UNION ON DRUGS POLICIES

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Introduction

The countries initially involved in the design of the **COPOLAD I Programme,** recognized the need for a broad consensus process on quality and evidence criteria in Drug Demand Reduction (DDR). This request was therefore included in the programme proposal, and actioned, from 2011 onwards, as a comprehensive participatory consensus process to identify quality criteria in DDR. More than 250 professionals, with extensive experience in the sector, have since contributed, including: representatives of all National Drug Agencies of the 33 member countries of the Community of Latin American and Caribbean States (CELAC); independent experts; representatives of the COPOLAD's multilateral collaborating agencies (CICAD/OAS, EMCDDA and PAHO/WHO); representatives of the bi-regional civil society networks integrated in COPOLAD, the IDPC and the RIOD. COPOLAD II also facilitated the input and cooperation of the CARICOM and the active involvement of Caribbean countries.

The COPOLAD I consensus process, for identifying quality criteria in DDR, was informed by work produced in the previous decade by organizations such as PAHO/WHO, CICAD/OAS, EMCDDA and UNODC.

This collective effort in the CELAC region has enabled the development of a set of agreed quality criteria, sensitive to the reality of DDR in the Region. Twenty-two Latin American and Caribbean countries[1] have already successfully validated prevention and/or treatment criteria, as is summarized in this document. Additionally, within the framework of this programme, both the participating countries and the collaborating institutions of COPOLAD have diagnosed existing contextual conditions and determined prerequisites necessary to progress towards quality assurance and the establishment of regulatory/legal frameworks of accreditation in interested countries.

This decade-long process has recently been strengthened by a collaborative agreement between COPOLAD and the United Nations Office on Drugs and Crime (UNODC) and the World Health Organization (WHO), which have developed the *international standards of quality in treatment*[2]*.* Therefore, considering the evident similarities within the quality standards now developed by these organizations, this agreement aims to immediately join efforts in supporting the improvement of stable regulatory frameworks, in interested countries, to ensure the quality of treatment programmes. Accordingly, this agreement includes a subset of common "Essential Standards", and a definition of a common "quality assurance" mechanisms based on both initiatives. The agreement also implies the importance of maintaining compliance with both processes separately in those countries that have already validated the criteria under either UNODC/WHO or COPOLAD separately.

In summary, the work carried out thus far provides a valuable basis for coordinated institutional efforts to promote, now more than ever, the development of quality assurance processes and the establishment of regulatory accreditation frameworks in the fields of prevention, treatment and harm reduction of problematic use of drugs in the CELAC countries.

[1] 18 countries in treatment, 15 countries in prevention (some countries have validated both the Prevention and Treatment criteria).

[2] Under the support of the *Bureau of International Narcotics and Law Enforcement Affairs* (*INL),* U.S. Department of State.

Aim and objective of the COPOLAD II piloting and validation exercise

The piloting and validation performed through COPOLAD II was aiming at advancing the short and medium term inclusion of operational, regulatory and training procedures, necessary for the establishment of "quality assurance" for the prevention, treatment and harm reduction programmes implemented in the field of DDRin each interested country.

The main objective of this activity was to pilot and validate quality criteria together with the competent authorities responsible for Drug Demand Reduction (DDR) strategies, plans, programmes, and services, in interested countries from Latin American and Caribbean. It must be noted that these criteria were developed in accordance with the available evidence, as well as taking into consideration the existing contexts in each participating country and agreed upon by these countries.

Methodology

The system of quality standards and evidence arising from the aforementioned consensus process, which started in COPOLAD I, gathered 174 criteria that were grouped into ***common standards, prevention standards, risk reduction standards, treatment standards, harm reduction standards and social integration standards.*** They were then classified according to their level of exigency, into ***basic*** and ***advanced.***[3]

The validation and piloting process in real-world contexts of COPOLAD II, focused on prevention and treatment programmes, with the voluntary participation of 22 countries in Latin America and the Caribbean. It was organized according to the type of criteria to be validated, under the leadership of Chile, Costa Rica and Trinidad & Tobago **(Table 1).**

Table 1. Countries participating in the process of validating and piloting quality and evidence criteria in real contexts, COPOLAD II

Context: Prevention Latin America	Context: Treatment Latin America	Context: Prevention and Treatment in the Caribbean
Leading country: Costa Rica Commission: ICD	**Leading country: Chile Commission: SENDA**	**Leading country; Trinidad and Tobago Commission: NDC**
Argentina **Chile** **Colombia** **Costa Rica** **Guatemala** **Honduras** **Mexico** **Panama** **Peru** **Venezuela**	**Argentina** **Colombia** **Costa Rica** **Cuba** **Ecuador** **El Salvador** **Guatemala** **Honduras** **Mexico** **Panama** **Paraguay** **Peru** **Uruguay** **Venezuela**	**Antigua and Barbuda** **The Bahamas** **Dominica** **Guyana** **Jamaica** **Saint Lucia** **Trinidad &Tobago**

[3] COPOLAD (2014), Calidad y Evidencia en Reducción de la Demanda de Drogas, Marco de referencia para la acreditación de programas. (‘*Quality and Evidence in Reducing Drug Demand, Framework for programme accreditation’*). http://copolad.eu/es/publicacion/45

Additionally, expert groups were created in participating countries, with professionals who were knowledgeable in the field of the DDR and familiar with the legal/regulatory framework, evaluation and research methodologies. They conducted the initial validation process, as it related to the languages to be used, taking into account the linguistic diversity of countries that have a common language and, where necessary, terms were adapted to ensure the comprehensiveness of the text in each local reality.

In order to measure each standard in the services or programmes, it was necessary to identify the indicator, specify how it would be verified during fieldwork and determine the accepted degree of accomplishment. Among other methodological aspects, technical assistance focused on developing a manageable number of indicators and verifiers, which were: a) easily understood; b) measurable with a reasonable effort; c) feasibly measurable; d) culturally acceptable; e) acceptable to stakeholders; and f) defined using qualitative or quantitative expressions.

For the piloting fieldwork the following activities were encouraged: the approval of selected services or programmes, operational coordination with these agencies, informed consent, caution in accessing sensitive user data, an agenda for visits, and feedback on the programme evaluated, among other aspects.

Piloting was implemented in 37 addiction treatment services and in 26 prevention programmes. The number of quality criteria piloted by treatment services ranged between 57 and 83 whilst the prevention area piloted between 60 and 77 criteria based on the selected level of either basic or advanced.

The majority of the piloted treatment services were government administered programmes, and all participating non-governmental services received public funds **(Figure 1 and Figure 3 respectively).** In treatment there was a balance between outpatient, residential and mixed services **(Figure 2),** and in prevention, the programmes were primarily universal type, followed by selective prevention **(Figure 4).**

Although treatment services mostly assisted the adult population, some also assisted children and adolescents. Prevention programmes were mainly aimed at school contexts, therefore for children and adolescents, followed by the family and community.

Therefore, quality and evidence criteria could be piloted in the various types of DDR programmes that countries typically implement.

Figure 1

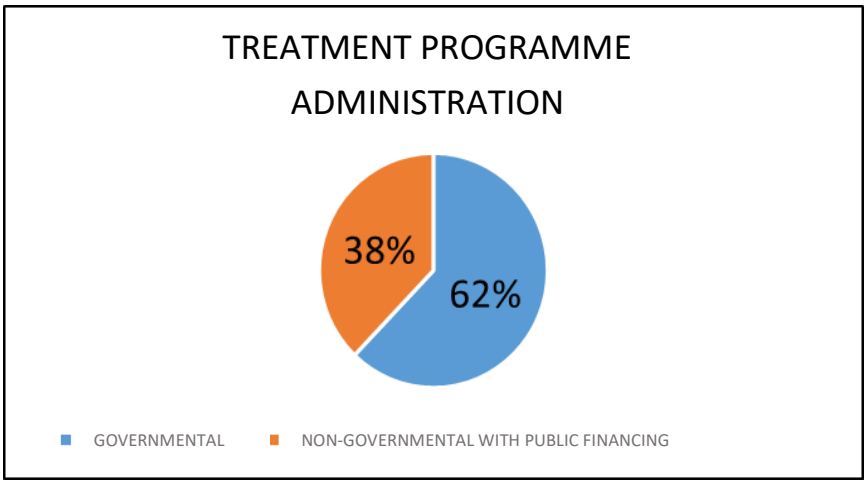
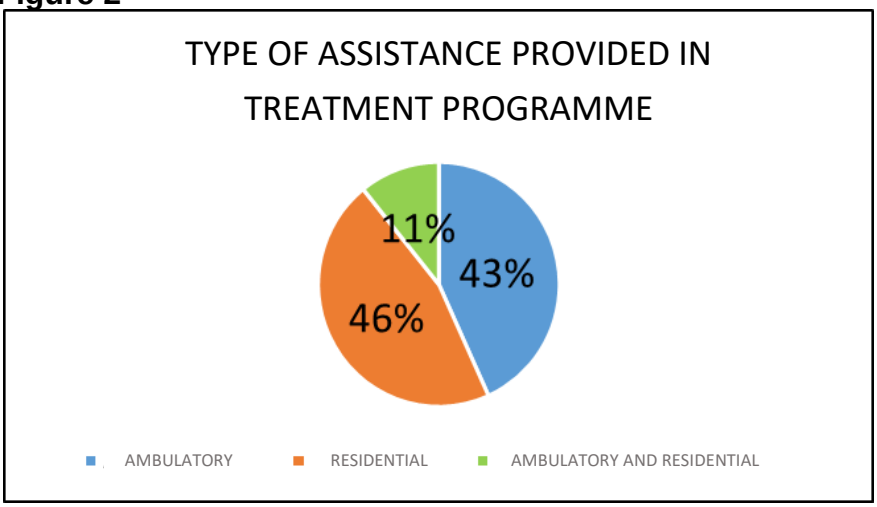


Figure 2



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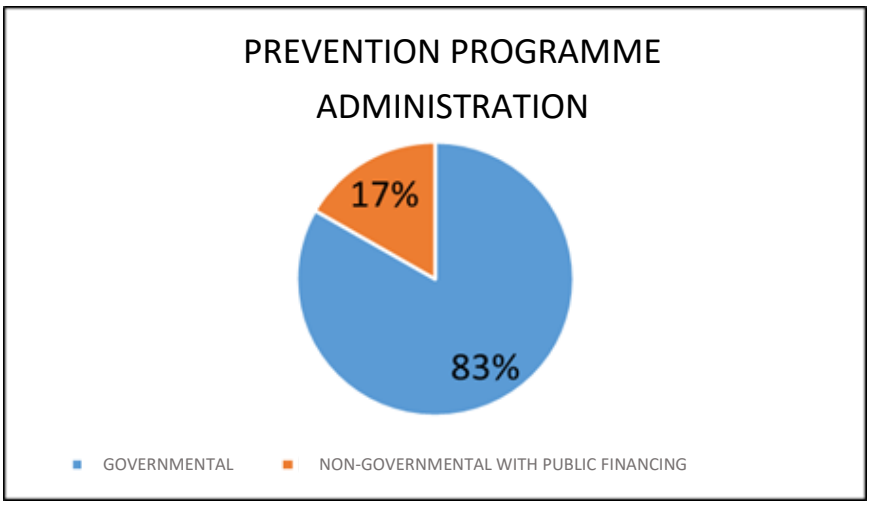

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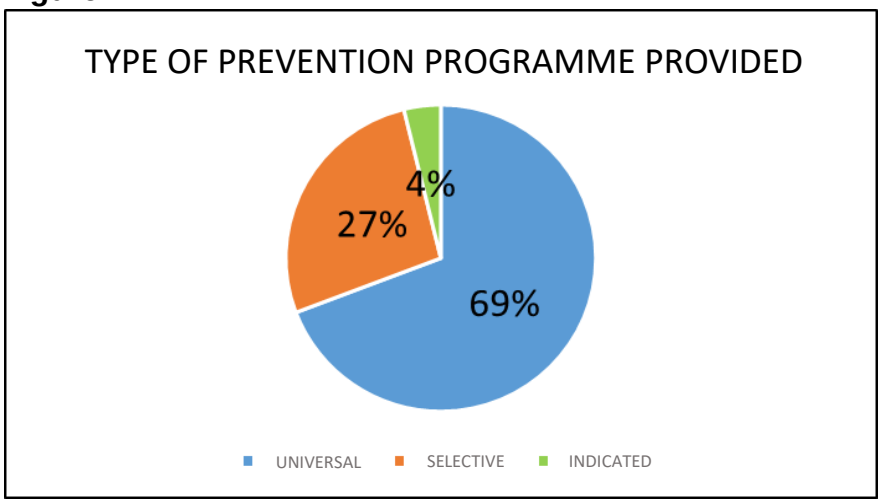
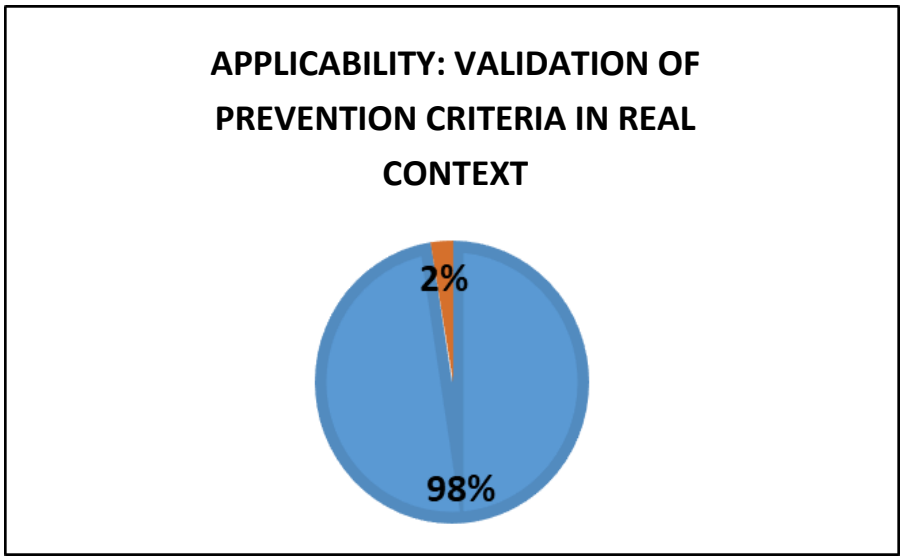


Results

Results in the field of Prevention

In the case of prevention programmes, 98% of the criteria were applicable (**Figure 5).** On average, prevention programmes achieved 58% compliance with the quality criteria and only 10% of programmes exceeded 90% crude compliance (**Figure 6).** There was also great variability between the programmes, and three out of the four piloted prevention programmes did not exceed 75% of quality criteria.

Figure 5



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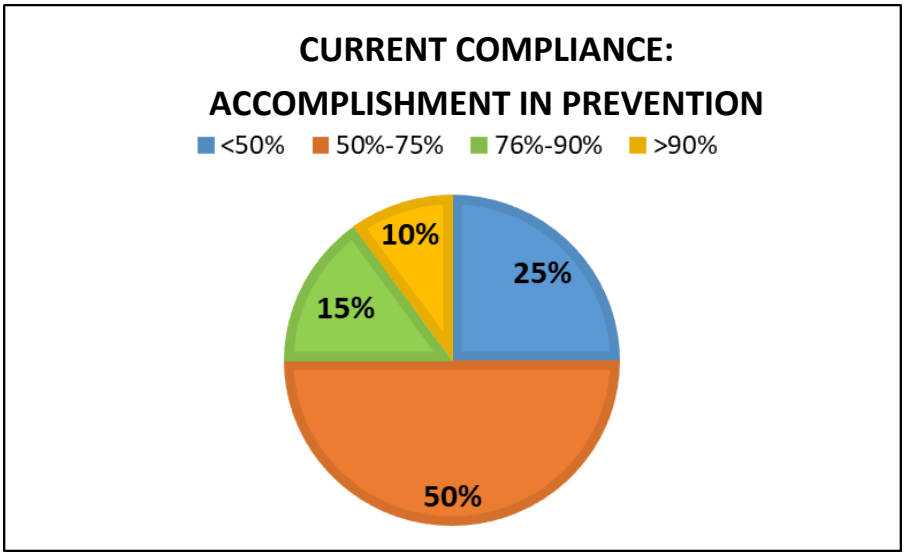


Results in the field of Treatment

In the case of treatment programmes, 93% of the quality standards were applicable to the actual context **(Figure 7).** This indicated that the system of criteria in the treatment context was valid for the majority of programmes.

On average, treatment programmes met **67% of the piloted criteria**. Only 16% of the piloted programmes achieved a crude compliance of 90%, which indicated an optimal level of quality of services, whilst there was significant variance in the overall results (**Figure 8**).

Figure 7

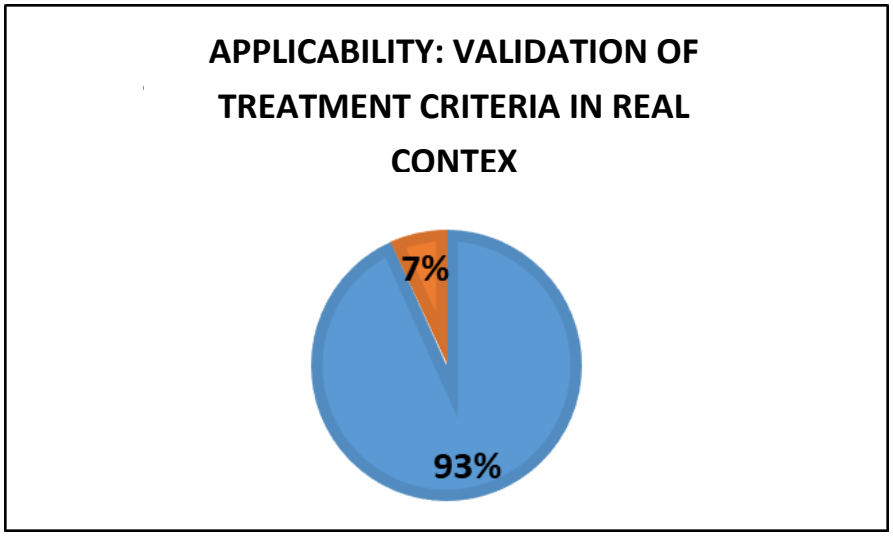
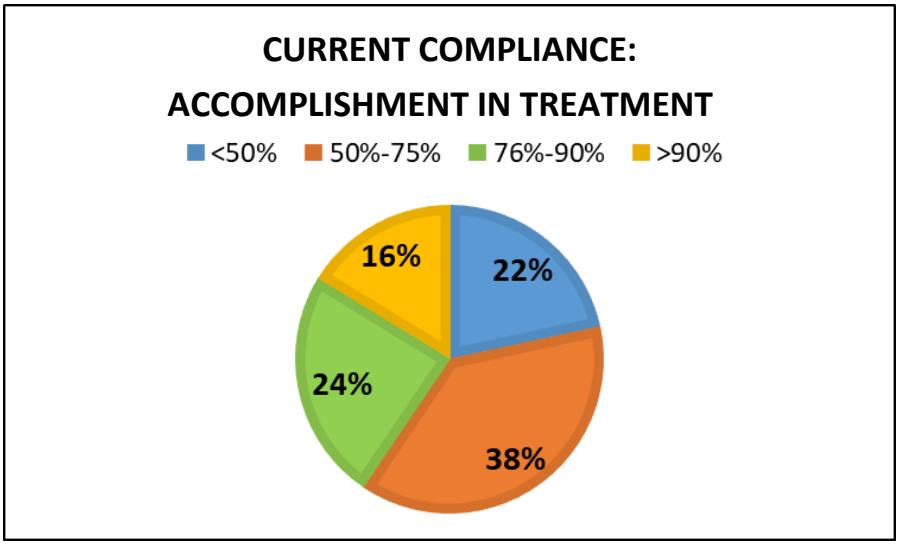


Figure 8



The piloting process also provided a brief overview of the level of quality achieved by the prevention and treatment programmes, which facilitated an exploration of the progress and outstanding challenges of the region, in terms of quality assurance.

The main focus of this project, however, was to assess the behaviour of the quality criteria with the aim of facilitating and promoting the development of national accreditation systems. A more detailed analysis of each standard (and not by programme) reiterated that most of the criteria for assessing the quality of

treatment and prevention programmes have a very high level of applicability, represented by the red line in **Figures 9 and 10,** in contrast with the raw compliance gap[4] that is still pending (orange line).

Figure 9

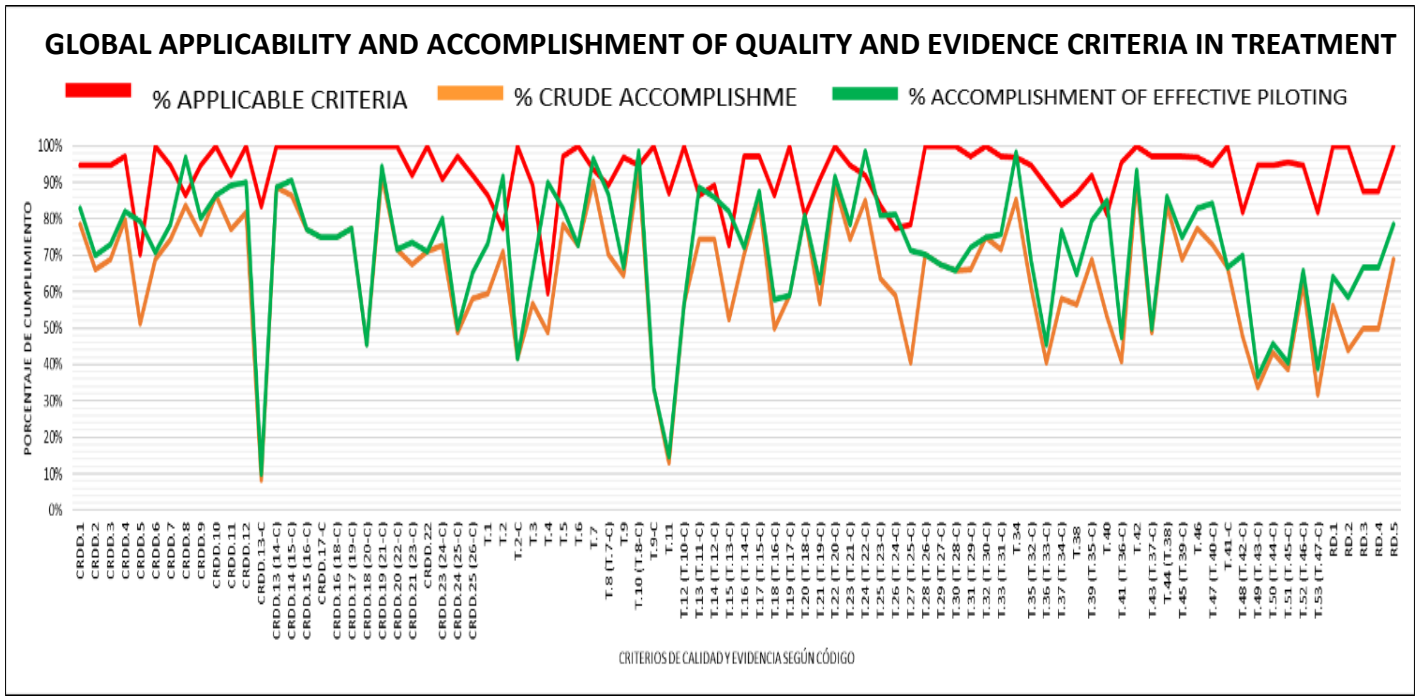
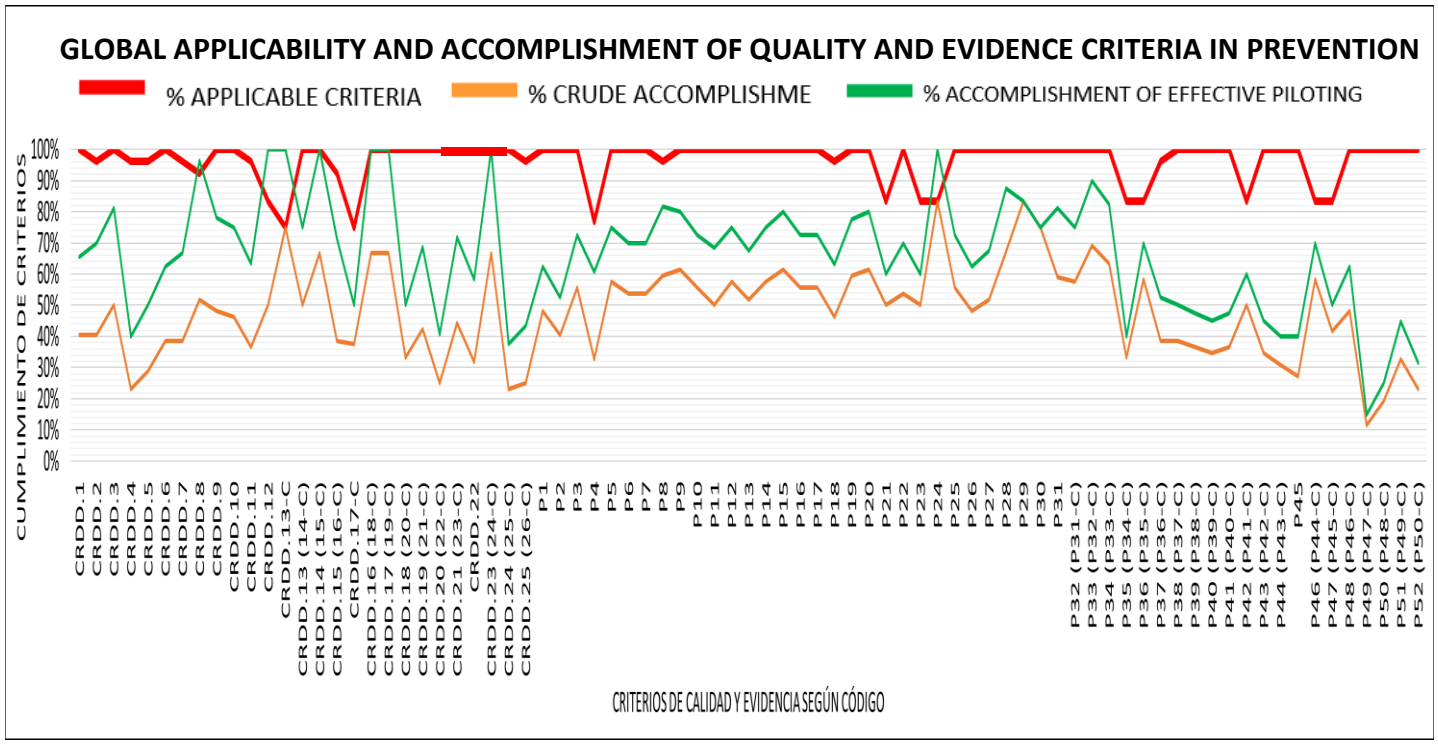


Figure 10



[4] Criteria met in relation to the total set of prevention or treatment criteria as appropriate.

If these results are adjusted, considering the sample of those criteria that were effectively piloted, and not the total criteria, a gap persists (green line), and runs the risk of selection only of favourable criteria.

Among the reasons given by the countries to explain the impossibility of effectively verifying some of the standards, they highlight the lack of national legal and regulatory frameworks that enable the evaluation of certain dimensions, contrasting with an expected ideal (e.g. staff standard, gender equity, public account policies, and even programme evaluation).

Some of the quality standards in which significant progress is observed, through a higher level of compliance with the criteria, are, for example:

- ***Mechanisms and procedures for collaboration and coordination with different institutions and social organizations have been established.***
- ***There are in the centre or service criteria of inclusion and exclusion that adequately define the access or not of users to the different treatment modalities.***
- ***A record of the beneficiaries of the programme is maintained.***
- ***A multi-component therapeutic programme of a biopsychosocial nature, combining pharmacological therapy and behavioural and cognitive-behavioural psychological treatment, group, family and couples' therapy,* is available.**

At the end of the validation work carried out, existing weaknesses were identified that should be addressed to ensure the effectiveness and quality of the programmes. Moreover, these programmes should incorporate essential requirements, such as respect for human rights. For example, a low compliance was observed in the following quality criteria, while they must be at the core of any programme:

- ***The programme has a quality management system to ensure the delivery of the best programme or service available to its beneficiaries.***
- ***A continuous training and permanent updating programme for the professionals of the therapeutic team are available.***
- ***The gender perspective is considered in the design of the treatment plan.***
- ***There are evidence-based clinical guidelines and specific protocols applicable to certain relevant treatment processes.***
- ***Methods and instruments that have proven useful in research and care assessment studies are used to assess the effectiveness of treatment programmes.***
- ***A follow-up programme is available after treatment, including periodic monitoring of relapses by objective methods.***

Challenges

Both the working meetings held with the groups of participating countries and the final reports identified challenges in moving towards the establishment of national systems and the accreditation of DDR programmes. In this context there is a great need to:

1. Promote legal and regulatory frameworks that are conducive to the development of national quality assurance systems, including specific rules for accrediting DDR programmes, so that countries can advance their commitment to their citizens on health protection and rights, including in the field of addictions, as a major public health problem.

2. Strengthen the institutional capacities of countries, already demonstrated and deployed in the validation and piloting exercise, particularly through:
    a. Professional training to optimize the technical competencies of national teams.
    b. Supporting and boosting their articulation capacity by setting up expert groups, which can evolve into more permanent cross-sectoral and inter-agency advisory councils, accompanying the implementation of the national accreditation system.
    c. The reinforcement of stable coordination mechanisms between the National Drug Commissions or Agencies and the Ministries of Health, also including those entities responsible for the health system's accreditation so that they can expand their actions towards DDR programmes.

3. Implement actions in the short term, optimizing the practices of the institutional actors involved, in particular to:
    a. Adjust the quality strategy in the annual work plans.
    b. Use the lessons learned and the gaps identified during the validation and piloting experience at the national level, and transform them into strategic lines of action in quality assurance.
    c. Maintain regular national self-assessment and cross-assessment exercises, particularly in prevention programmes and treatment services, among others.

Observations and next steps

The countries recognise the contribution of international initiatives and multilateral agencies that, in a coordinated manner, promote the development of quality policies in the field of DDR programmes, and in particular, the contribution of the most direct technical assistance provided to national teams of the countries by the team formed in COPOLAD II.

According to the countries, this aspect should be maintained to ensure technical support during the process of implementing national quality assurance and accreditation systems. These systems are already being built in various Latin American and Caribbean countries that have initiated the timely follow-up of the piloting and validation exercise carried out within the framework of COPOLAD II.

Clauses *ad cautelam,* clarifications and exemptions

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