QUALITY AND EVIDENCE STANDARDS IN DRUG DEMAND REDUCTION
REFERENCE FRAMEWORK FOR PROGRAMME ACCREDITATION:

REVIEW AND ADAPTATION BY THE CARIBBEAN COUNTRIES

WORKING PAPER
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Executive and Coordination Body (ECB)
Cooperation Programme between Latin America, the Caribbean and the European Union in Drugs Policy (COPOLAD)
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Madrid, November 2016

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1. BACKGROUND

1.1. CONTENTS OF THIS WORKING PAPER

This document presents to the Caribbean countries joining the COPOLAD II programme, a Consensus Process developed in the framework of COPOLAD I (2011-2015), which was participated by the eighteen Latin-American countries, together with Spain and Portugal; and the key input provided by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), the multilateral agencies working in the field of Drug Demand Reduction in the Americas: the Inter-American Drug Abuse Control Commission (CICAD-OEA) and the Pan American Health Organization (PAHO); together with the two bi-regional networks of NGO collaborating in COPOLAD: the IDPC and the RIOD (please see the detailed list of participants in the process in Annex I).

In the present document, we are pleased to present to the Caribbean countries:

- A brief summary of the project developed to identify a list of standards of quality and evidence to be provided by the services and programmes operating in the field of Drug Demand Reduction (DDR): Chapter 2 of this document.
- A description of the participative methodology used for the definition of the standards within that project: Chapter 3.
- The standards of quality and evidence in DDR, adopted through the above mentioned consensus process: Chapter 4.
- Potential options to advance towards the accreditation of DDR services and programmes: Annex II.
- Agreements and recommendations provided by the Advisory Council of the project in phase I, to promote accreditation systems in DDR services: Annex III.
- Essential criteria for the opening and operation of treatment centres for people with psychoactive substance use disorders developed by the CICAD: Annex IV.

1.2. BACKGROUND SITUATION AND CHALLENGES AHEAD

Reducing drugs demand from a public policy standpoint requires developing strategies, plans, programmes and a legal framework for planning and capacitation, in a highly uncertain, evolving and difficult context. This reality derives mainly from the many contextual challenges and considerable risk factors, which, from the mid-20th century to date, have emerged and conditioned the contemporary use of psychoactive substances.

The rapid changes in market circumstances and drug consumption patterns pose an enormous challenge to governments: the need to articulate immediate political responses, effective and efficient, in order to control and reduce the complex problems related with drugs and their use, even when, in many cases, there is a lack of sufficient evidence on the efficiency of the different potentially viable options to adequately respond to the needs of the different population groups.
As this is an issue dealing with a highly dynamic phenomenon, of multifactorial origin and versatile and multi-dimensional manifestation, a high level of prevision, readiness and constant actualisation is required, as well as a considerable multi-sectoral coordination effort, capable of managing, guiding and shaping global interventions, that are holistic, integrated, cross-cutting and sustainable, with often limited resources. This need for cooperation and agreement, not only among public institutions, but also between these and civil society, adds complexity to an already arduous task. Last, but not least, the relative youth of a field of action which started its development less than half a century ago, creates a scenario where insecurities are, in some cases, superior to the certainties and where progress goes through a continuous process of learning and changing, as more evidence becomes available derived from the evaluation of the global impact of drug policies implemented to date, as well as the increasing number of experimental studies dedicated to validating the different intervention models for drug demand reduction (DDR) tried out during the past decades.

The need to articulate immediate responses in face of this emerging phenomenon (e.g., the exponential increase of different violent manifestations and death rates reaching epidemic levels, linked to drug use; breakout of social alarm in face of these facts, etc.) caused that initial drug policies, and therefore DDR interventions, be planned purely on ideological standpoints, probably well-intentioned, but precarious and not supported by effectiveness criteria. These were policies and interventions based on a logic of what could be considered to be a magical thinking, which would lead to the possibility of reaching significant achievements in relation to the problems related to drug use even when lacking sufficient empirical support on which such results could be based on.

In four decades, this situation has changed significantly. Thanks to the growing availability of results derived from research and evaluation of the policies pursued, in this relatively short period of time considerable advances have occurred in the identification of factors associated with the initiation, maintenance and reduction of the problematic use of psychoactive substances. The bases of this progress are found in the joint analysis of the results provided by epidemiological, longitudinal and transversal studies; experiments in neuroscience; prospective socio-sanitary research; rigorous economic analysis; as well as clinical trials and other controlled experimental designs aimed at assessing the effectiveness of regulatory and training developments applied to the implementation of various preventive, treatment and social integration interventions, intended to result in changes in behaviour, attitudes and knowledge concerning drugs. Good part of this progress has been possible thanks to the establishment of a growing number of drug observatories, both national and international, that have allowed the progressive availability of information systems capable of monitoring key indicators in a sustained – and sustainable – manner on a medium and long term.

In this context of greater certainty and evidence, a number of national and international institutions have been emphasising, over the last few decades, the need to move toward the construction of a reference framework capable of informing the policies, programmes and actions of DDR according to criteria of quality, safety and effectiveness, comparable to those that are expected in any other area of intervention, whether it be of a commercial, social or health nature, and very especially - but not only - when the aim is regulating goods or services that have a direct impact and decisive role in the lives of people (e.g., requirements and guidelines for the approval and administration of medicines, requirements for granting licenses of safe handling of food, criteria for sanitary treatment...).
of drinking water, toys’ safety requirements, regulation and accreditation for the practice of different therapeutic procedures, etc.).

Considering this need and starting point - from different approaches and with different emphases - progress is being made towards the definition of certain standards that will not only guide the activities and programmes of DDR, but also facilitate the development of resources and accreditation processes capable of promoting the necessary regulation of services and programmes on an increasingly robust basis, so that interventions in DDR can be more effective, more efficient and, ultimately, be able to ensure a better future for our communities, families, the general population, and especially, for the new generations.

At the international level, this effort has been reflected in several initiatives of broad scope, which will be covered in more detail in this publication such as pioneer projects led for several decades by the World Health Organisation and currently channelled through its WHO Quality Rights programme in the field of mental health; projects funded by the European Union, like the one led by the Research Institute for Public Health and Addiction at Liverpool John Moores University; the European Monitoring Centre of Drugs and Drug Addiction (EMCDDA), which – through its Best Practice Portal – synthesises, disseminates and promotes the adoption of best practice in DDR; or previous and on-going initiatives on evidence based criteria promoted by the United Nations Office of Drugs and Crime (UNODC), both in the field of prevention as well as treatment.

In summary, although quite a number of uncertainties remain, we already have enough evidence on the effectiveness of DDR to go forward in the practical application of the requirements and criteria derived from the certainties currently available. The need to appropriately cover the gap between research and the real world, can materialize through the identification and application of criteria capable of guiding and governing the services provided in the daily practice of prevention, treatment and harm reduction and social inclusion. To achieve this goal, in addition to considering the available evidence, it is essential to attend to the reality and context framing the implementation of programmes, in each country.

Therefore, COPOLAD’s starting point is, to enhance ongoing efforts in the field, considering:

- the evidence available,
- the resources invested in the field by each country,
- the developments supported by other ongoing and complementary projects, such as professional capacity building initiatives, i.e. the PROCEED programme, as well as other initiatives supported by the CICAD and the CARICOM, etc.

1.3. AIM OF THIS DOCUMENT

This document has been prepared after the initial valuable input provided by Trinidad and Tobago, as one of the countries which responded to the open invitation made by Spain, in June 2015, to participate in the planning of COPOLAD II.

At that point, and along with other inputs in different areas, it was considered that the consensus process developed in COPOLAD I to identify quality criteria in DDR, could be of key interest to the Caribbean countries, to enhance their ongoing efforts in providing the best possible services in this area. It was also pointed out, the need to perform an
adaptation exercise based upon **sociocultural adequacy and feasibility considerations** in order to facilitate their future adoption using the most appropriated and realistic approach.

Therefore, the aim of this document is to facilitate this adaptation exercise taking into account the reality framing DDR services and programmes in the Caribbean countries, providing both:

- A summary of the consensus process followed by Latin-American countries to identify and agree the quality criteria.
- An English translation of the final list of the agreed criteria.

In this framework the stated adaptation exercise can only be provided through the expert opinion of professionals and experts who—from their deep knowledge of the realities faced by Caribbean countries—can explore how these criteria can be *landing* in the field, and therefore could be further adopted and regulated by public institutions responsible for DDR policies. The future adoption of the criteria, will enable to enter in a context where the services and programmes implemented in this area respond to a basic framework of effectiveness in terms of results and efficiency in the use of public resources. Both considerations are inherent to democratic societies committed to informed, transparent and oriented decision-making in order to reach the best possible results in all areas related to the promotion and protection of Public Health and the respect of Human Rights.

Achieving these two basic objectives will demand initiating actions that facilitate and actively promote the implementation of these criteria, through an unavoidable process of capacity building, adoption by each interested country (regulation), and support without which limited progress would be made in improving programmes and services in the field of drug demand reduction.

Therefore, we are pleased to share with the Caribbean countries joining now COPOLAD II, an on-going project, started in 2011. We sincerely hope that this document will provide the required bases to facilitate the above mentioned processes in the Caribbean region.
2. COPOLAD’S QUALITY AND EVIDENCE PROJECT: EXECUTIVE SUMMARY

The Cooperation Programme between Latin America the Caribbean and the European Union on Drugs Policies (COPOLAD) recognises that drug use-related problems require global transnational and integrated responses, based on solid foundations arising from the growing scientific knowledge and the increasing availability of evaluation of the policies implemented so far.

Through COPOLAD therefore, cooperation processes and consensus of a bi-regional dimension (CELAC–EU), are being promoted, focused on increasing the coherence, balance and the impact of drugs policies, in this case, in the scope of drug demand reduction (DDR).

Thus, in the framework offered by COPOLAD, the advances resulting from the knowledge currently available in DDR combined with the application of a culture of quality, besides a careful consideration of the tangible possibilities to move forward in all these dimensions in the current context have been taken into account for the development of this project. All this through a broad representation of countries and institutions that form part of the Ibero-American community1.

The criteria or principles identified and agreed upon as a result of this exemplary collaborative effort can and should facilitate the implementation of the accreditation of drug demand reduction programmes (DDRP) in an increasingly closer horizon.

2.1. WHAT IS THE PURPOSE OF THE QUALITY AND EVIDENCE PROJECT?

The purpose of the present project is to identify, agree on and spread criteria that allow the consideration of quality and evidence in the implementation of drug demand reduction programmes (DDRP).

In this framework, the project is articulated around the following criteria:

— **Quality, with regard to contexts and processes.** The *Project Quality and Evidence* intends to facilitate the implementation of programmes and services based on rigorous standards provided by mainstream management systems, available in the fields of health and social interventions; both in terms of the context where they are developed, as well as their management processes, including the incorporation of tools and resources to ensure their adequate planning, implementation and evaluation.

— **Evidence-based, with regard to content.** This aspect of the *Project Quality and Evidence*, being as important as the previous one, includes an explicit intention of emphasising the need — and facilitating the incorporation — of a theoretical model validated as the basis of the programme to be implemented. I.e., to promote that the programmes undertaken be provided with conceptual guidance (in terms of content) whose effectiveness has been empirically demonstrated in similar contexts. To choose the

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1 National agencies: CONADIC-Mexico; CONSEP-Ecuador; DGPNSD-Spain; DEVIDA-Peru; ICD-Costa Rica; MOJ-Colombia; SEDRONAR-Argentina; SENAD-Brazil; SICAD-Chile; SICAD-Portugal and JND-Uruguay. Other institutions: Inter-American Drug Abuse Control Commission (CICAD-OEA); European Monitoring Centre for Drugs and Drug Addiction (EMCDDA); Pan American Health Organisation (PAHO / WHO) and Ibero-American Network of NGOs working in Drug Abuse (RIOD).
theoretical model most appropriate in each case, it is essential to define beforehand what needs are to be responded to through the programme and, based on the available resources, select the objectives (results to be achieved), i.e. what variables are aimed to be modified through the implementation of the programme. This implies a baseline evaluation and objectives prioritisation exercise that will allow the identification of the theoretical model more suitable to work with (and modify) these variables.

After their identification, all the criteria should be agreed upon by a wide representation of countries and institutions with responsibilities in the field of DDR. Once agreed upon, the project aims to support their endorsement and use in order to advance towards the accreditation of the programmes developed in this key sector of drugs public policies in Latin America.

2.2. WHAT RESULTS HAS THE QUALITY AND EVIDENCE PROJECT REACHED?

The activities already carried out during the 1st phase of the Quality and Evidence Project allowed the achievement of some important milestones in the identification of benchmarks in drug demand reduction (DDR), as well as facilitated the design of programme accreditation systems and promoted the desirable spread of a culture focused on improving quality and effectiveness in DDR. All backed up by a broad consensus of experts and institutional representatives who have participated in the stages developed during the 1st phase of the project.

The main achievements so far are:

— The availability of a tangible and integrated relationship of quality and evidence-based criteria which should be required for the accreditation of DDR programmes and services.

— An updated diagnosis that explores the feasibility to create or improve the contextual conditions or prerequisites necessary to promote a framework of accreditation of DDR programmes and services.

— The identification of strategies and accompanying or support measures to facilitate the progress towards the establishment of national or supra-national accreditation systems.

— The commitment of national and multilateral institutions to work autonomously and at the same time coordinated, in the dissemination and adoption of the criteria agreed upon during this process.
2.3. WHAT IS THE QUALITY AND EVIDENCE PROJECT ABOUT?

During its 1st phase, the project has integrated the following steps:

— **Update of the results of the research in drug demand reduction (DDR).** Through an initial review to update the evidence available in each of the areas of DDR in order to identify criteria and potentially enforceable standards for accreditation of demand reduction programmes.

— **Selection of quality and evidence-based criteria by consensus.** Through a Delphi study in which 3 groups were formed (Group 1: Prevention – risks reduction related to drug use; Group 2: Treatment – harm reduction related to drug use; Group 3: Social inclusion) in which 169 experts participated, designated by the Commissions or National Drug Agencies from the eight partner countries of COPOLAD.

The study allowed the identification of criteria considered "essential" for accreditation by at least 60% of the participating experts. The criteria agreed upon through the Delphi study were subsequently revised by integrated Focus Groups, as well as by experts and institutional representatives of the Commissions or National Drug Agencies of the countries (partners and collaborators) of COPOLAD, in order to incorporate both the institutional vision as well as an objective feasibility analysis considering the reality of the countries participating in the project. On the basis of this filtering process, the final criteria were sorted into two categories according to whether the requirements were considered **basic** to be met by all programmes, or requirements considered more **advanced** aimed to making progress towards the achievement of excellence. The set of *Quality and Evidence-based criteria* agreed upon in its final formulation: basic and advanced, is reflected in the following chapters of this publication.

In turn, these two sets of criteria, are complemented with a list of essential requirements identified by the Group of Experts in drug demand reduction of the Inter-American Drug Abuse Control Commission (CICAD-OAS), which are considered prior to and indispensable in the area of treatment to start and maintain the process of establishment of treatment resources in all those situations where they are not yet being taken into account (Annex IV). Certain essential criteria for the opening and operation of treatment centres for people with psychoactive substance use disorders.

— **Exploring strategies and proposals to facilitate progress toward the accreditation in DDR.** In this phase three actions were carried out:

  - Proposals were developed to facilitate the implementation of national and supranational accreditation systems of DDR programs, resulting from the contributions of the two Focus Groups composed of experts and institutional representatives of the Commissions or National Drug Agencies of the countries participating in the project.

  - Additionally, the participating countries proposed to develop a Study on the situation of the legal framework that regulates the DDR programmes accreditation in those countries.
Finally, the basic and advanced criteria agreed upon through the process described above were endorsed by all the institutions (countries and collaborating institutions) that have participated in the various phases of the project. These exercises have allowed for an updated diagnosis of the state of DDR programmes accreditation systems in the different countries participating in the first phase of the project, as well as to explore potential initiatives that, from the current reality, would facilitate the implementation of such systems (Annex II. Strategic framework and potential options to move toward the accreditation in drug demand reduction).

Agreements and recommendations of the Advisory Council. The agreements adopted are geared towards providing impulse to the creation of the DDR accreditation systems grounded on quality and evidence-based criteria.

Recognising that to reach such goal intermediate actions are required, the agreements and recommendations of the Advisory Council affect those previous aspects considered as facilitators and/or preconditions which are vital for the implementation in the medium term of accreditation systems based on the criteria agreed in the first phase of the Project (Annex III. Agreements and recommendations of the Advisory Council to promote accreditation systems in drug demand reduction).

The content and results in full text of the studies generated as the basis for the Project are available in COPOLAD’s webpage (see Reports section at www.copolad.eu).

Dissemination of results achieved and support to the start of the criteria implementation process in the countries concerned. In the new stage emerging from the agreements and recommendations issued by the Advisory Council, COPOLAD, in close coordination with the collaborating entities of multilateral character that form the consortium, aims to disseminate, promote, facilitate and accompany the adoption of the criteria agreed upon by each country concerned.

Taking into account the significant context diversity existing in the countries, the most appropriate way of contributing to the optimisation of programmes and services will be evaluated according to the needs, priorities and legal frameworks that exist in each case.

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2 Ibid
4 Available in: https://www.copolad.eu/c/document_library/get_file?uuid=4f833171-8105-464c-85b7-f9d1bc0d8f7b&groupId=1015720-b
2.4. WHAT DOES THE QUALITY AND EVIDENCE PROJECT BRING IN RELATION TO OTHER DEVELOPMENTS UNDERTAKEN SO FAR?

The work of COPOLAD stems from the consideration of the developments already existing in this field. At the international level, this effort has been reflected in several initiatives or projects of broad scope, among which the following deserve to be highlighted:


— Those funded by the European Union, such as the one led by the Research Institute for Public Health at the Liverpool John Moores University with the support of the EMCDDA (EMCDDA, 2011; Brotherhood, Sumnall and the Prevention Standards Partnership, 2011) and by the Research Institute for Public Health and Addiction (Uchtenhagen and Schaub, 2011).

— Those promoted by the Canadian Centre on Substance Abuse, CCSA (CCSA, 2010 and 2011).


— A resource driven by the EMCDDA through its Best Practice Portal, recently updated with a practice-oriented focus, user friendly and of easy access5.

The common element between the preceding initiatives and the Project Quality and Evidence, developed in the framework of COPOLAD, is the commitment of the interested institutions to contribute to improving the quality, effectiveness and the best adjusted cost-effectiveness relationship of DDR activities and programmes, through the definition of operative tools that guarantee the maximum effectiveness to meet the needs of the beneficiary population in the best possible manner, as well as the maximum efficiency in the investment of public resources earmarked for the development of policies, programmes and DDR services, which is not other than a form of proven effectiveness to promote their return to society in terms of social and health improvements. These developments have also been accompanied by numerous publications, especially in the field of prevention, as guides or "principles" of action and good practice, by inventories and information systems on evidence-based prevention and assistance programmes and, to a lesser extent, in the field of social inclusion.

The resulting criteria of the process developed in the framework of COPOLAD represent an advancement in relation to previous developments in the following:

— They allow the establishment of a common framework to facilitate DDR accreditation in the context of Latin America, insofar as they are the outcome of consensus among a wide representation of the member countries. Thus, they respond well to the need for a reference framework designed, developed and disseminated from this reality, which

5 Available in: www.emcdda.europa.eu/best-practice
allows the inclusion of the plurality of perspectives existing in the Latin-American context.

— They update the evidence available to date, incorporating all the contributions developed in this field in Latin-America and that, for different reasons – among them linguistic ones – are not captured in English-written documents.

— They are a tool easy to understand and manage, cohesive and intended to facilitate the management, planning and implementation tasks of all those involved (political, institutional and technical decision-makers), who should join efforts in the application of best practices in DDR.

— The Project does not end by merely providing lists of quality criteria. Its aspiration is that these criteria may constitute the basic means to address a broader challenge: to promote the creation of accreditation systems of DDR programmes and services, stage at which progress on quality and evidence-based DDR currently is in the international context.

2.5. **HOW CAN THESE CRITERIA CONTRIBUTE TO IMPROVING THE EFFECTIVENESS AND EFFICIENCY OF THE INTERVENTIONS?**

Having and implementing quality and evidence-based references:

— Grants coherence and firmness to the actions to be developed from this point forward, supporting a substantial gain in methodological rigour during the process of design, implementation and evaluation of DDR programmes and services.

— Facilitates the evaluation of programmes and services, promotes the possibility of incorporating changes and improvements to those already existing.

— Allows improvement of results, as the programmes come closer to complying with these standards.

— Highlights and promotes the strengthening of institutions which support them and increases the visibility of their work, while strengthening the sustainability of the programmes.

— Allows to solve the uncertainty that investing in programmes of which we do not know their end results generates, as well as decreases the effort involved in the continuous testing of new programmes.

— Contributes to savings in public investments to prevent, alleviate or minimise the problems associated with drug use, as well as to significantly reduce unnecessary resource allocation for the maintenance of ineffective programmes, which, due to not solving the problems in which resources are invested, generate still higher added costs in the short, medium or long term.
2.6. WHO MAY BENEFIT FROM THE RESULTS OF THE QUALITY AND EVIDENCE PROJECT?

The incorporation of quality and evidence-based criteria in regulatory frameworks of the performances of DDR directly benefits:

— **The institutions** responsible for the design and implementation of public policies in drug demand reduction. I.e. the agencies responsible for addressing the social and health-related impact caused by the drug use related problems.

— **The decision-makers and planners of services and programmes in this area**, both at the political level as well as at the technical planning and management levels.

— **Organisations and services** whose purpose is to prevent, address, mitigate and cope with the problems related to drug use, either in the general population or in populations that are affected by other different problems associated to drug use.

— **The beneficiary population of DDR policies**. Facilitating the development of contexts where the State guarantees the consolidation of a society in which every boy and girl, every young person and every adult, can live their lives in the freest manner, minimally conditioned by external factors, vulnerabilities or pressures from sectoral interests not related to their own interests. A society where people who face problems associated to drugs see their rights respected and can receive the assistance needed to overcome them. Ultimately, a society where rule of law guarantees respect for Human Rights, as well as the fostering, protection, care and promotion of the Public Health of its citizens and, in particular, of the population groups exposed to contexts and situations of risk and vulnerability.

2.7. WHAT ARE THE BENEFITS TO ADOPT QUALITY CRITERIA?

They provide operational guidance to:

— **Plan, implement, and evaluate programmes and services** using the quality criteria as appropriated tools to improve formal contexts and the management of services in this sector and, therefore, improve the quality of the programmes that these services develop.

— **Include evidence-based criteria** derived from the results of the relevant available research in DDR, thus increasing the efficacy and efficiency of the implemented programmes.

2.8. IT SEEMS ATTRACTIVE BUT, IS IT FEASIBLE?

Generally, the human and material resources available in drug demand reduction (DDR) tend to be scarce and insufficient. By this, the question regarding the applicability of an accreditation framework based on quality and evidence criteria is very relevant.

The incorporation of these criteria does not necessarily mean increasing investment in DDR, neither to work more. It implies refocusing the resources available towards measures proven to be more efficient and more effective to reach the desired objectives.
Although the adoption of these criteria initially requires the necessary regulatory and staff capacity build effort, as well as – in some cases – an initial investment in the adaptation of material resources, in the medium term it is more efficient, since it allows to achieve best results with the – always limited – available resources.

2.9. WHAT WOULD BE THE NEXT STEPS FOR THE INTERESTED COUNTRIES?

The criteria agreed upon and presented in this document can serve as reference for all those countries that want to use and adopt them as instruments for the development of their respective national services accreditation systems.

Depending on the degree of development of the field of DDR, as well as on the existing needs, each interested country can:

— **Opt to select the basic or advanced criteria** presented in this publication, or even – in the case of treatment – begin with the *essential* criteria proposed by CICAD (*Annex IV*).

— **Select one or several priority areas in each context**, depending on the needs of the population and of the services existing in the country (e.g., choose to start the incorporation of criteria in the field of care, or prevention, etc.).

— **Request the support of institutions and multilateral networks collaborating in the development of the Quality and Evidence Project**: CICAD, PAHO, RIOD and the IDPC contributed to the achievement of the results obtained to date and reiterated its commitment to advancing the process of incorporating the criteria agreed upon in the interested countries, in order to facilitate the development and adoption of national accreditation systems. This support may consist of:

  • *Providing their input in the piloting of the criteria* in the “real” world.

  • *Promoting the incorporation of the concept of accreditation in the national agendas on drug policies in the countries of its scope.*

  • **Participating in actions aimed at facilitating the incorporation of the criteria agreed upon in the interested countries**, e.g., by participating in professional trainings, by promoting projects aimed at validating the implementation processes, etc. In this regard, PAHO has expressed – as reflected in the agreements of the Advisory Board (see *Annex III*) – its willingness to support the validation process in implementing the criteria through its National Offices in the member countries. There is also the will of coordination in this field between the Pan American Health Organisation (PAHO/WHO), the Inter-American Drug Abuse Control Commission (CICAD) and the Latin-American Network of NGOs working in Drug Addiction (RIOD), coordination that can be articulated in the framework of their respective memorandum of understanding.

  • **Facilitating the development and use of resources allocated** to monitor and support the progress made in each country in order to strengthen the implementation of criteria and frameworks of accreditation adapted to the needs of each country.

  • **Contributing to the international dissemination of the experiences of the participating countries**, so that they can serve as a point of reference to motivate action in other interested countries.
— Benefit from the exchange of experiences and tools of reference provided in the e-room of COPOLAD\(^6\), a forum that:

- Offers access to information on experiences available in the field of accreditation. It allows to share information on good practices related to the implementation of accreditation systems for DDR programmes and services.

- Provides specialised documentation. It has an inventory of specialised publications and key tools available to facilitate action in this field.

- Facilitates the exchange of experiences between countries. It offers optimal space for interaction and debate on the development of accreditation systems.

— Participate in the directory of centres and services that COPOLAD\(^7\) provides. The countries that do not yet have an inventory of DDR resources and services can, if considered of interest, benefit from the support that this directory offers to facilitate the compilation, update and continuous monitoring of basic information on services and interventions that are developed in each country, as a prior step to the implementation of programme accreditation systems. Most of the countries in Latin America\(^8\) have already begun to collate information in this manner.

The availability of a national inventory of services and programmes can facilitate, among others, the following progress:

— Mapping of available resources. As it allows an easy and continuous identification and update of existing resources in the country, as well as its formal characteristics such as: institutional dependence, funding sources, visibility before society, etc.

— Identification of needs. Given that it facilitates the analysis of the DDR situation both in terms of coverage and geographical distribution of services, as well as in terms of gaps or space for improvement of the centres or staff capacity (e.g., training needs, provision of working tools, coordination resources, etc.).

— Facilitation of information systems on drugs. To the extent that it enables the collection and monitoring of key indicators in DDR, as well as the development of cross-cutting and cross-sectional studies to diagnose problems related to the use of drugs and observe trends. In this sense it can be a resource to support the work of the National Drugs Observatories.

— Evaluation of the effectiveness and efficiency of existing resources. The information collated in the directory can also facilitate the development of studies on the cost-benefit and cost-effectiveness of the resources invested.

In the future, this directory could be expanded to incorporating information about programmes, thanks to a project currently under development, which will make it possible to establish synergies between CICAD, PAHO, RIOD and COPOLAD.
REFERENCES


3. CONSENSUS PROCESS DEVELOPED WHITING LATIN AMERICAN COUNTRIES FOR THE DEFINITION OF THE CRITERIA AND SUMMARY THE APPROACH ADOPTED

The quality and evidence-based criteria agreed upon in the framework of COPOLAD, constitute the nuclear element that can support the development and adoption of accreditation systems for drug demand reduction programmes (DDRP).

Their application can contribute to improving the quality and effectiveness of DDRP implemented in all Latin American countries. The ultimate aim is to standardise key criteria which, according to a comprehensive preliminary analysis of the evidence currently available, and considering the real contexts where the programmes are developed, have been identified as reference to improve the effectiveness and efficiency of programmes currently implemented.

3.1. DEFINITION AND SELECTION PROCESS OF QUALITY AND EVIDENCE-BASED CRITERIA

The definition of quality and evidence-based criteria for the accreditation of drug demand reduction programmes (DDRP) was developed along the different stages that integrated the 1st Phase of the Project, which are presented in summary form below.

3.2. CONCEPTUAL DEFINITION ADOPTED

The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) defines the concept of quality standards as “principles and sets of rules generally accepted for the best or most appropriate form of implementing an intervention”. They can refer to content issues, to processes, or to structural aspects of quality assurance, such as the ones on which an intervention is based, the context where it is implemented, or the composition of the team that will carry it out.

3.3. IDENTIFICATION OF INITIAL CRITERIA TO START THE CONSENSUS PROCESS

The workgroup formed for the development of the studies initially planned as basis of the Quality and Evidence Project conducted a literature review to begin identifying a list of criteria that serve as fundamental support for the consensus process to be carried out in the Project’s framework. This research was carried out taking into consideration:

— The evidence available in relation to the efficiency, and especially effectiveness of DDRP, highlighted by research already conducted in the various areas related to drug demand reduction (prevention, risk reduction, treatment and harm reduction and social integration).

— The proposals and recommendations made by various international bodies on standards of quality and evidence.
In cases where the evidence does not refer to Structural criteria or process, the following sources were used:

— The standards and guidelines set out in the general quality systems/framework.
— The principles recommended in guidelines and manuals of good practice that contain standards or quality criteria developed by different institutions.

Through this comprehensive review exercise a total of 336 baseline criteria were identified.

3.4. WORKGROUPS SET-UP FOR THE SCREENING PROCESS AND TO AGREE UPON THE FINAL STANDARDS

The initial list of 336 criteria arising during the above described review was subject to a process of "cleansing" to obtain a final set of criteria as presented in this publication.

To do so, various working groups were set up to participate in the screening process, in order to – taking into consideration quality and evidence – incorporate a perspective derived from the institutional and professional experience of the participants in the development of the DDRP. The groups established are described below:

**Delphi Groups**

A panel was formed with 172 DDR experts selected by the National Drug Agencies from participating countries during the initial phase of the project. These experts were assigned to the following three thematic groups:

— Group Delphi 2: Treatment – Harm reduction related to drug use.
— Group Delphi 3: Social inclusion.

Through an online application, the experts participating in the Delphi groups completed a general questionnaire with the accreditation criteria common to all DDR programmes and another one with specific accreditation criteria related to their designated group programmes (prevention, treatment or social inclusion); in both cases, they were asked to decide on the relevance that, in their view, each of the proposed criteria has for the accreditation of the different categories of DDR programmes. This process happened in two consecutive rounds.

The proposed initial criteria on which the Delphi groups worked, counted with a high level of acceptance and support from the participating experts. The high number of criteria that the participants in the Delphi groups considered "essential" highlights the commitment of professionals and institutions of this sector towards increasing the quality of the programmes.

The following graphic summarises the work followed by the Delphi groups during the initial consensus process:

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9 The total number of experts participating was 162. Given that ten of them were involved simultaneously into two Delphi groups, the number of professional participants in the groups was therefore 172 experts.
Focus Groups

Once the Delphi study was completed, the following focus groups were formed:

— **A technical group.** Integrated by technical level personnel, affiliated to the agencies or institutions responsible for the drug policies of the participating countries (partners and collaborators of COPOLAD) and with in-depth knowledge of the field of DDR. This work was focused on the analysis of the suitability of the criteria identified by the Delphi groups and allowed to:
  
  • Confirm a very positive general assessment of the Project initiated in the framework of COPOLAD, as well as of the agreed criteria.
  
  • Describe potential difficulties to bear in mind for the integration of processes and instruments for accreditation in DDR.
  
  • Collect key ideas to confront and overcome these challenges successfully.

— **Two institutional groups.** Composed of institutional representatives of the same public agencies responsible for decision-making in DDR which, in virtue of their position within the institution, are capable of rating and eventually incorporating the agreed criteria. Their task focused on exploring the feasibility of utilising the criteria, considering the institutional and contextual reality of DDR in each country, in order to obtain equally relevant conclusions for the filtering of the criteria to be included in the final list; these groups in particular allowed, among other results:
  
  • To categorise and/or rank the criteria and quality standards for the establishment of a system of accreditation with two levels of requirements: (1) criteria considered basic; and (2) a list of additional criteria considered as highly recommended or advanced for those countries which have the capability of meeting other requirements, beyond the basic references.
To consider the need to distinguish between the concept of "enabling/licensing" (minimum requirements necessary or mandatory to authorise a programme or treatment service); and basic and advanced "accreditation" criteria in all areas of DDR (criteria linked to the pursuit of quality and excellence).

To retrieve certain criteria that did not obtain sufficient consensus in the Delphi groups, such as those related to the generation of synergies with other organisations, the integration of national programmes in the national drug policies, financial transparency, collaboration with information systems, the inclusion of the gender perspective and the programmes external evaluation.

To describe a wide repertoire of advantages that setting up an accreditation system brings, both operational and related to building staff capacity, as well as strategic and timely to increase the efficiency in public investment of resources.

Finally, within this 2nd focal group, it emerged the appropriateness to carry out a study on the regulatory developments or legal frameworks related to the authorisation or accreditation of DDRP existing in the countries participating in the project, either globally or by areas of intervention. With this proposition it is intended to also analyse and weigh the relevance of actions – already applied in each country – that could facilitate the establishment of systems of national of accreditation of DDRP.

This study also allowed to look into the viability of incorporating the proposed criteria into national or supra-national accreditation systems by providing highly relevant additional information on aspects of accreditation feasibility, considering the current contexts in the countries. A summary of the conclusions reached by the focus groups is presented in Annex II.

Advisory Council

The Project Advisory Council was composed of institutional representatives of the countries participating in the first phase of the Project and of expert representatives of the three multilateral, collaborating entities of COPOLAD. Their work focused on making contributions to the initial literature review, rating and finally approving the criteria agreed upon throughout the process, as well as issuing recommendations for the future advancement in the accreditation of DDRP in the Ibero-American context, taking into consideration the suggestions of the focus groups. As already noted above, Annex III reflects the agreements and recommendations adopted by the Advisory Board at the end of the process.

3.5. ORDER AND LOGIC USED TO PRESENT THE AGREED CRITERIA

In order to present the criteria in a way that is orderly and based on a rational approach, a multidimensional presentation was adopted, taking the following angles into consideration:

3.5.1. ACCORDING TO THE SCOPE OF INTERVENTION IN DDR

They were grouped depending on whether the accreditation criteria relate to main areas of intervention accepted by most of the highly recognised DDR institutions, i.e.:
— Common to all the programmes of drug demand reduction (CDDR)
— Specific to the prevention programmes (P)
— Specific to risks reduction programmes (RR)
— Specific to treatment programmes (T)
— Specific to harm reduction programmes (HR)
— Specific to social inclusion programmes (SI)

According to this, in the criteria listings presented in the two following chapters, the programme type is defined by its acronym, preceded by the number assigned to each criterion (i.e., T.2.: Treatment Programme, criterion 2).

3.5.2. ACCORDING TO ITS NATURE

After the first classification was done and depending on the field of DDR within each of the areas listed above, the criteria was further classified in the following three broad categories:

— **Structural:** This category includes material and financial aspects of the services/programmes, the composition, qualification and experience of the teams that provide them, etc.

— **Functional or of process:** Among them are the accessibility to the programmes/services, the organisation and coordination of services, the objectives and contents of the programme/service.

— **Evaluation:** These standards relate to the mechanisms and procedures of internal and external assessment that should allow to determine the effectiveness of the interventions.

3.5.3. ACCORDING TO PLANNING NEEDS AND REQUIREMENTS EXISTING AT DIFFERENT AREAS OF INTERVENTION

The criteria are also organised by headings (or categories) that correspond to each area of DDR (prevention, risks reduction, treatment, harm reduction and inclusion) based on planning processes and their suitability to the needs inherent to each of them, therefore:

— **Common criteria** are organised according to basic structural aspects, i.e. the ethical principles and rights of the target group, regulatory issues, financial aspects, etc.

— For **prevention and risk-reduction criteria** adjustment to the logical framework model (assessment and needs analysis, evaluation of resources, design/formulation of the programme, etc.) is adopted

— The **treatment, harm reduction and social inclusion criteria** are categorised according to principles of regulatory frameworks applicable to services and assistance programmes in the healthcare field.

In short, any of these categories allow for – and are proposed to – facilitate planning based on the needs, development and assessment of the services and programmes.
In order to facilitate the identification of each dimension within the listings, these appear shaded as subtitles within each area, interspersed throughout the lists of criteria presented in the following chapters.

3.5.4. ACCORDING TO THE LEVEL OF VALUE ATTRIBUTED AND FEASIBILITY CONSIDERATIONS

Starting from the consensus to distinguish between essential criteria and those that can be considered complementary to advance toward the achievement of excellence, it was decided to submit the agreed criteria in two levels:

— **Basic criteria**: those that, depending on the evidence available, are considered essential for a DDRP to be accredited.

— **Advanced criteria**: those that, in addition, are desirable to be met by programmes oriented toward achieving excellence.

The **basic** and **advanced** are presented next in two separate chapters in order to facilitate the use of one or the other, depending on the level of demand which — in each case — is considered more suitable to work with. With the objective of ensuring a global and simple use of both listings, the **basic criteria** are also included in the list of **advanced criteria**.

4. **BASIC CRITERIA**

4.1. **COMMON CRITERIA TO ALL DRUG DEMAND REDUCTION SERVICES/PROGRAMMES (CDDR)**

**STRUCTURAL CRITERIA**

**Ethical principles and rights of the programme beneficiaries**

**CDDR.1**

Conditions of access and retention in the programme or service are available for all potential patients, ensuring that discrimination based on sex, age, race, political opinions, legal or social status, religion, physical or psychological conditions or socioeconomic opportunities do not occur.

**CDDR.2**

The programme or service recognises that users/beneficiaries have the right to:

— Autonomy, including the option to choose to participate or not in the programme or service.

— Safety and respect for human dignity.
— Health, physical, psychological, integrity and morality.
— Non-discrimination.
— Equal opportunities, rights and obligations.
— Protection from degrading and inhuman treatment.

CDDR.3
Potential programme or service user groups are offered the most appropriate intervention, scientifically proven, according to their personal situation and other related circumstances.

CDDR.4
Interested parties are advised about the possible disadvantages and risks for participants and their consent is obtained before the intervention.

CDDR.5
The participation of minors in programmes and services counts with previous authorisation of the parents or guardians.

CDDR.6
All participants’ data are treated confidentially.

Regulatory aspects

CDDR.7
The programme/service meets the legislation and regulations applicable in fiscal matters related to labour, data protection and equal job opportunities.

Financial aspects

CDDR.8
Regular reporting is presented to funding institutions and organisations and to all stakeholders.

Human resources

CDDR.9
Sufficient technical staff is available to ensure the implementation of the activities envisaged in the programme or service.

CDDR.10
The personnel that integrates the team responsible for the development of the programme/service counts with the professional skills needed (possesses the titles and diplomas required and the professional experience essential to develop the programme).
Infrastructure and facilities

CDDR.11
The facilities and equipment are appropriate to reach the goals of the programme, in line with the general conditions of development of the community where they are being carried out.

Collaboration and coordination mechanisms

CDDR.12
The programme or service counts with referral procedures to other centres or community services that meet the needs (educational, social and health) of its potential beneficiaries.

FUNCTIONAL OR PROCESS-RELATED CRITERIA

Information systems and documentation

CDDR.13
A registry of the programme beneficiaries is kept.

CDDR.14
Information and programme registration systems include data on variables that are key to the continuous assessment of the needs of people attending the programme, as well as of the changes or effects derived from their participation in it.

CDDR.15
The programme includes collaboration with local, regional and national information systems existing in the field of demand reduction, through the use of indicators and standardised procedures for collecting information, and its transfer to the "central information units" for their processing and use or for their inclusion into centralised databases.

CDDR.16
Process and procedure guidelines are in place to allow for a harmonised implementation of the interventions that integrate the programme.

EVALUATION CRITERIA

CDDR.17
The organisation has designed a programme evaluation plan which sets out the following elements:

— Evaluation content (evaluation of processes, coverage, results, etc.).
— Procedures and instruments to be used in the evaluation.
— Evaluation indicators.
— Type of evaluation to be carried out (internal, external or mixed).
— Intended use of the evaluation results (continuity, refocusing or changing the programme, etc.).
— The means and mechanisms for the dissemination of results and the recipients of the results.

CDDR.18

Measurements or records of the situation of the programme beneficiary population are made prior to their joining the programme and at a later stage in order to evaluate its effectiveness.
4.2. CRITERIA FOR THE ACCREDITATION OF PREVENTION SERVICES/PROGRAMMES (P)

FUNCTIONAL OR PROCESS-RELATED CRITERIA

Evaluation and needs analysis

P.1
The relevant, up-to-date and reliable information collected and reviewed on drug use among the target population includes: types of drugs consumed, rates and trends of consumption, ages of onset, risk perception, cultural factors related to the drug use and problems related to the consumption.

P.2
An analysis of the resources available in the community has been carried out.

P.3
The target population(s) is/are described including its/their size, characteristics, culture and perspectives in relation to drugs.

P.4
Regardless of whether the prevention programme is selective or indicated, explicit inclusion and exclusion criteria are in place (socio-demographic, socio-economic, psychobiological, geographical, etc.), criteria that: define the target population(s) in an appropriate manner, allow a clear differentiation between populations, justified according to the needs evaluation.

P.5
Risk and protective factors associated to drug consumption that affect the programme’s target population are described as well as who the programme is attempting to change.

P.6
The programme uses a theoretical model to explain drug consumption and its associated problems, which:

— Is evidence-based or based on the relevant literature review.
— Is accepted by the scientific and/or prevention communities.
— Allows the comprehension of the specific needs related to drug use and its causes.
— Allows the understanding of behavioural change.

P.7
Through a theoretical model a relationship between risk and protective factors, and the behavioural change related to drug use is established.
Identification and stakeholder involvement

P.8
The interested parties are identified and include: the target population, representatives from funding agencies, those responsible for community resources, association representatives, community leaders, institutional representatives, the media, etc.

P.9
Alliances are formed with other organisations, institutions and community groups.

P.10
If it is foreseen that the programme will be carried out in a receiving organisation (e.g., an educational centre for a school programme) considered a programme stakeholder; its needs will be evaluated to determine if the programme is appropriate and whether the information provided is understandable and allows it to make informed decisions.

Resource evaluation

P.11
The capacity of the target population is evaluated as well as other parties interested in participating in the programme or supporting its development.

P.12
If the staff lack the necessary capacity, a training plan is prepared.

Design/formulation of the programme

P.13
A written project plan exists which: is clear, realistic, comprehensive and accessible to all involved stakeholders; describes and logically connects the main components of the programme; provides information on the theoretical model adopted; specifies the intervention strategies selected, the definition of the different scenarios, the material and human resources required, the procedures to gain and retain the support needed, the processes to select the participants, the planned activities, the monitoring procedures, the process design and results evaluation; and allows the monitoring of the actual programme progress during its implementation.

P.14
The project describes the criteria for ending the intervention (achievement of objectives, end of the planned activities, number of planned participants, duration of the intervention).

P.15
The object of prevention or modification is clearly defined.
The objectives: are determined on the basis of the needs analysis (baseline indicators that intend to be changed); are clear, comprehensible, realistic; are time-bound and are quantifiable; maintain a logical relationship with the mediating variables that are to be modified and are related to specified risk and protective factors; have a relationship based on the theoretical model utilised; and are formulated in terms of the participants expected changes (in terms of results).

The objectives are compatible with the priorities established by the local, regional, national and/or international strategies and policies, in the area of prevention of drug use.

When selecting the existing interventions, the following is taken into consideration:

— Whether the selected intervention is adequate to the context of the planned programme.
— Whether the underlying assumptions identified in the needs evaluation are similar to those in the model/pilot programme.
— Whether the results achieved by the pilot programme are in line with the aims and objectives of the planned programme.
— Whether the resources needed are in line with the resources available.
— The benefits and disadvantages of the intervention, including its potential negative effects.
— The balance between potentially modifying the pilot programme and adhering to it.
— The feasibility of the intervention (whether the activities can be implemented, if there is adequate expertise, whether the complexity of the programme is excessive, etc.).

The selected programme is adequate and adapted to the circumstances related to: the needs age, level of development, gender and culture of the participants; the scenario; and the operating environment.

The design of the intervention is adjusted to the characteristics of the target population, through the adaptation of: the language, the activities and methods of application, the messages of the intervention, its duration, frequency and pace as well as the number of participants per activity.

The original programme is clearly referenced and its authors identified.
The content of the intervention is based on the available evidence and on good practice recommendations, and incorporates the largest possible number of elements from the evidence and recommendations.

The programme has the intensity and duration most appropriate for the target group: the higher the risk of consumption is, the more intense and prolonged the intervention should be, and vice versa.

The programme helps participants to discover and realise their own resources by: highlighting the strengths of the participants and underlining alternatives to high risk options, supporting the participants in caring for their own health and fitting into a positive climate of health promotion.

Financial, human, material as well as community available resources are provided to guarantee the planned interventions.

The activities are adapted to fit the characteristics of the target population and of the participants.

Activities are consistent with the above objectives (have the capacity to modify the risk and protective factors envisaged in the objectives).

The programme includes a timetable of interventions/activities to perform.

Programme monitoring

The intervention is implemented following the project plan.

The manner in which the programme will be monitored is specified.

EVALUATION CRITERIA

From the planning phase, an evaluation plan has been drafted that includes:

— Indicators to be used to measure the results.
— The moments in time when the measurements will be taken.
— Measurement and data collection tools to be used.

P.32

The evaluation result indicators selected are related to the objectives of the programme.

P. 33

These evaluation result indicators are clearly described and measurable in quantitative and/or qualitative terms.

P.34

The methods and tools used for the collection of outcome data:

— Are clearly described.
— Provide information relevant to the evaluation indicators.
— Are existing tools previously tested or new tools adequately developed and validated.
— Are consistently utilised (the same tools are used in the different moments when measurements are taken).

P.35

The outcome data (indicators) are measured before and after the intervention.

P.36

A written evaluation plan of the process exists and includes:

— The indicators to be used.
— The moments in time when the indicators will be measured.
— The data collection and measurement instruments, when required.

P.37

The indicators of the evaluation process:

— Are related with the activities carried out.
— Are clearly described.
— Are measurable in quantitative and/or qualitative terms.

P.38

The preparation of a final report is envisaged containing the main data and conclusions of the processes and results evaluation.

P.39

The mechanisms, procedures and tools selected to evaluate the programme results allow the verification of whether its "preventive" objectives were attained in relation to the use of different substances:

— Whether abstinence in the consumption has been maintained or increased.
— Whether it has delayed the age of onset in the consumption.
— Whether it has reduced the frequency of use and the quantities consumed.
— Whether the abusive or harmful consumption has been reduced.
— Whether the problems associated with use have been reduced.
— Whether certain mediating variables have been modified.

P.40

The mechanisms, procedures and tools selected to evaluate the programme results allow verification of whether the results are obtained within the planned timeframe.

P.41

Internal evaluation mechanisms of the results are considered.

P.42

External evaluation mechanisms of the results are considered.

4.3. CRITERIA FOR THE ACCREDITATION OF RISK REDUCTION RELATED TO DRUG USE SERVICES/PROGRAMMES (RR)

FUNCTIONAL OR PROCESS-RELATED CRITERIA

RR.1

The risk reduction programmes developed in the health sector systematically provide health-related advice at different levels to persons with risk and harmful alcohol consumption who attend primary health care services.

RR.2

They are dedicated to providing specialised treatment or counselling programmes to drivers suspended from their driving licence and with dependency problems or with problematic alcohol use.

RR.3

The programmes for risk reduction related to alcohol use in the workplace incorporate mechanisms that allow the early detection of risk consumption, offer brief advice to workers that maintain this pattern of consumption, and refer them to specialised services dealing with alcohol abuse or dependency problems.

EVALUATION CRITERIA

RR.4

Risk reduction interventions for alcohol and tobacco use have a regular internal evaluation system of processes and results, aimed at achieving the following objectives:

— To reduce the proportion of non-smokers exposed to smoke in an enclosed space.
— To decrease the number of people killed and injured in traffic accidents related to alcohol consumption.

— To reduce the rate of problems associated with alcohol abuse: emergency hospital admissions, homicides, injuries caused by aggression, negligence and abuse of children, and people intoxicated assisted in the streets.

— To decrease the morbidity and mortality directly associated with smoking and with the risk and harmful consumption of alcohol.

Note: The small number of criteria for risk reduction programmes could suggest its inclusion as a sub-section within the criteria for accreditation of prevention programmes.

4.4. CRITERIA FOR THE ACCREDITATION OF TREATMENT SERVICES/PROGRAMMES (T)

STRUCTURAL CRITERIA

Regulatory Aspects

T.1
The centre or service complies with the requirements that the laws of the specific country have in order to be granted the licence to open and run a specialised centre, both those arising from implementing the general standards that govern health and social centres, as well as those specifically applicable to drug addiction treatment centres (basic technical team is in place, it has the correct safety and health conditions, physical barriers free, etc.).

T.2
The programme or treatment centre has been authorised/accredited as such by the competent Authority.

Patients’ rights

T.3
The service or treatment centre guarantees an adequate treatment and recognises the following rights for the patients attending it:

— Access to health, psychological and social assistance, and services that are integral to the care process within a known and defined timeframe, and without limitations due to lack of economic resources.

— A free choice between the different therapeutic options available.

— The free will to enter into, remain or leave a therapeutic process, except in the cases specified by the legislation in force.

— To know the regulations of the centre (internal rules) on all those aspects that may affect them, as well as the name and professional qualification of the persons responsible for their assistance.
— Access to verbal or written information provided by the therapeutic team with respect to the various available services, the treatment proposed according to their clinical aspects and the process that is being followed, the reasons that informed it and the benefits and risks expected.

— To have a record of the following, either in written form or in other technically supported format:
  • The complete treatment process, information that could be later incorporated to the patient’s clinical history.
  • The consent before performing any diagnostic or therapeutic procedures involving a potential risk or health hazard.
  • Experimental diagnostic or therapeutic procedures carried out which might have been part of an educational project or research.

— To have a signed therapeutic contract that clearly explains and justifies the treatment to follow, the patient’s rights and obligations.

— To receive a discharge report once the treatment process has been completed.

T.4

Patients following residential treatments are entitled to remain in contact with friends or family and to receive visits from them.

Accessibility to treatment services and programmes

T.5

The centre or service contemplates different ways of providing access to treatment and has defined and written therapeutic indication criteria, based on the biopsychosocial diagnosis of the patients.

T.6

The centre or service has a set of criteria for inclusion and exclusion that adequately restricts or allows patients’ access to different treatment options.

T.7

Defined criteria for referral, inclusion, therapeutic indication and exclusion for detoxification in hospital environments are in place.

T.8

Defined criteria for referral, inclusion, therapeutic indication and exclusion for admission into a therapeutic community are in place.

Human resources

T.9

All the professionals that are part of the multidisciplinary team have experience and specific training recognised in the field of drug addiction.
Infrastructures and facilities

T.10
The size of the facilities fits the volume of patients treated.

T.11
The treatment centres have a duly authorized medicine storage facility, a safe area to file records and built in protective features in computer systems to prevent access to patients’ data by unauthorised persons.

Collaboration and coordination mechanisms

T.12
The centre or service has coordination and cooperation procedures with other centres providing assistance to drug users, as well as consultation and referral to general services (health, social, legal, mental health, etc.).

FUNCTIONAL OR PROCESS-RELATED CRITERIA

Service organisation

T.13
The centre/service is based on a multidisciplinary and interdisciplinary approach to drugs abuse.

T.14
The design of the centre/service has been preceded by a needs assessment and situation analysis.

T.15
A reference model that establishes the role of the treatment centre/service within the health care network (population profiles attended, objectives, services, etc.) is available, as well as the processes and procedures to follow to access it, and the mechanisms of patient referral between the network services.

T.16
There is a personal record of each patient in which the responsible therapist is registered as well as the patient’s clinical history.

T.17
There is an information system in place that registers the kind of interventions provided by the centre/service, compatible with the local, regional and national information systems.

Service portfolio

T.18
The treatment includes an evaluation diagnostic, health, psychological and social care (within the framework of individualised therapeutic plans) and the development of
different activities oriented to improve the health and the quality of life of the people affected, through the reduction of their drug dependency, decreasing morbidity and mortality rates caused by substance use, the strengthening of skills and human resources and access to programmes of social inclusion.

T.19
The portfolio of services of outpatient treatment includes at least: information and orientation, assessment and diagnosis, treatment and therapeutic control, family care and support for social inclusion.

T.20
Residential treatment centres have a programme for the prevention, identification and control of infections potentially acquired in the centre itself and/or introduced from outside.

**Key healthcare processes**

T.21
The centre/service has a guide of procedures and processes that allows to formalise the care provided to its beneficiary population, ensures equity and quality of care and facilitates the establishment of information systems and the evaluation of the healthcare provided.

T.22
The centre/service identifies, describes and documents the key processes that make up the treatment process and have a greater impact on the strategic objectives of the centre or service: reception/admission requests, diagnosis evaluation, individualised therapeutic plans, implementation of the therapeutic plans, monitoring, evaluation and completion of the treatment.

T.23
Information is provided to the patient and their families about the therapeutic options available and the content of the service portfolio offered by the centre, as well as its rules and regulations.

T.24
There are comprehensive evaluation and diagnosis, of a biopsychosocial nature, of patients accessing treatment according to the manuals, standards, criteria and already standardised international procedures.

T.25
Diagnosis evaluation data are put in the patient’s integrated clinical history.

T.26
An individualised treatment plan for each patient is designed (type of intervention, therapeutic goals, activities, resources, duration and phases) based on a previous diagnosis where somatic, psychological, psychiatric improvement or stabilisation and social integration goals are set, as well as a reduction or abstinence plan from drug use.
T.27
It takes into consideration the gender-sensitive perspective in the design of the treatment plan.

T.28
The therapeutic plan is communicated and agreed with the patient, the terms of the agreement are collected in a written document signed by the patient (therapeutic contract). In the appropriate cases the therapeutic proposal includes the interventions offered to the relatives of the patient.

T.29
The treatment plan includes strategies to reinforce the adherence to the treatment.

T.30
A "reference professional" is assigned to each patient, in charge of decentralising the information flow and who is responsible for the follow-up of the treatment plan.

T.31
Both outpatient centres and therapeutic communities offer a multi-component therapeutic programme of a biopsychosocial character, which combines drug therapy with psychological and cognitive behavioural treatment, and group, family and couple therapy.

T.32
Regardless of whether the aim of the treatment is to achieve abstinence or not, all patients are provided with guidelines on the risk and harm reduction related to drug use.

T.33
Regular meetings of the technical team of the centre/service take place in order to assess treatment progress and articulate possible changes in the treatment plan, as well as potentially involving other services to ensure the continuity of care.

T.34
A “reference professional” examines periodically, along with the patient, the progress of the treatment provided, introducing changes if necessary to ensure the fulfilment of the goals envisaged in the individualised treatment programme.

T.35
The duration of the treatment will be determined by the patient’s level of compliance with the objectives pursued by his/her joining the treatment centre, and depending on the reasons for termination of treatment (therapeutic and voluntary discharge, referral, abandonment, force majeure).

T.36
The internal regulation of the programme or service clearly specifies expulsion or exclusion criteria for treatment, as well as the procedures to follow in these cases.
RESULTS EVALUATION CRITERIA

T.37
Methods and instruments which have proved their effectiveness in prior research and evaluation of health care activities carried out by other institutions are used to assess the effectiveness of treatment programmes.

T.38
The centre/service includes the results evaluation of the care process, identifying the indicators that should be used.

T.39
A regular evaluation system of the care provided is in place, based on objective indicators (employment, retention rates, level of admissions, results achieved, etc.).

4.5. CRITERIA FOR THE ACCREDITATION OF HARM REDUCTION SERVICES/PROGRAMMES (HR)

STRUCTURAL CRITERIA

Programme and service accessibility

HR.1
The opening hours and timetable of the services are wide and coincide with the needs of the targeted users.

FUNCTIONAL OR PROCESS-RELATED CRITERIA

HR.2
The programme includes the assessment of risk behaviour related to addiction (intravenous drug use, a history of overdose, drug use in combination with depressants and their potential synergic effect on the CNS, sharing drugs or supplies, public use).

Note: The small number of criteria for harm reduction programmes could suggest its inclusion as a sub-section within the criteria for accreditation of treatment programmes.
4.6. CRITERIA FOR THE ACCREDITATION OF SOCIAL INCLUSION SERVICES/PROGRAMMES (SI)

STRUCTURAL CRITERIA

Access to programmes and services

SI.1
Some precise criteria of inclusion and exclusion in the programme is in place.

SI.2
The programme target population is described accurately, having defined its profile and characteristics.

SI.3
It has a protocol that regulates the access/admission of potential users to the programme or at least the programme describes the admission procedures in place.

SI.4
The programme services portfolio has been disseminated among the potential beneficiaries and among the entities/services that work in the field of drug use or social exclusion.

Collaboration and coordination Mechanisms

SI.5
Collaboration agreements exist with various programmes and services (social, employment, etc.) that facilitate access to these by the beneficiaries of the social inclusion programmes.

SI.6
Alliances have been established with other organisations, institutions or community groups that work in favour of the social integration of different groups: creation of networks and structures of inter-agency cooperation.

FUNCTIONAL AND PROCESS-RELATED CRITERIA

Evaluation and needs assessment

SI.7
The programme is properly justified, supported by a previously carried out needs assessment.

SI.8
The needs and common demands of the drug dependent population potentially covered by the programme have been analysed, in particular those connected with certain social and health problems: employment, economic, family, housing-accommodation, legal-
judicial, social isolation and mental disorders associated with drugs dependency and disability or serious physical diseases.

SI.9

The programme analyses the influence that the social and economic environment has on the processes of exclusion and social integration of its potentially beneficiary population, taking into account: the economic situation of the country, region or community where the programme will be implemented and the current employment policies; the dominant attitudes and stereotypes towards people using drugs among the community where the programme is run; the measures to support their social integration, the existing social policies to prevent situations of social exclusion and poverty; and the support for the processes of social integration.

SI.10

The collection of the necessary information for the elaboration of the social diagnosis of the programme beneficiaries is done using standardised instruments (socio-occupational history, etc.) that allow for the assessment of the following areas: history of participation in other social inclusion programmes; accommodation facilities and its characteristics; the type of coexistence and family relationships, economic status and sources of income; current employment situation, employment background and attitudes towards employment (which will serve as the basis for employability diagnosis); educational level, social relations and social support networks; forms of leisure activities; legal situation; health state (physical and mental); degree of personal autonomy, personal resources, attitude and disposition to accept change; current drug use situation and, in some cases, development of the drug treatment.

Design/formulation of the programme

SI.11

A document is available describing all the relevant elements of the programme, in particular:

— The main conclusions of the needs assessment and the priorities identified in light of the results of the needs analysis.

— The parties interested in the programme and the procedures to guarantee their participation.

— The beneficiary population of the programme (target population and intervening population) and the procedures for their selection.

— The theoretical model that supports the programme.

— The objectives pursued by the programme.

— The selected intervention strategies.

— The areas that will be affected by the programme.

— The human, material and financial resources available.

— The internal and external coordination procedures.

— The activities planned, their duration and the timeframe for their implementation.
— Procedures for programme monitoring and for process and results evaluation.

SI.12
Internal coherence exists between the theoretical programme support, the situation analysis (evaluation of needs), the objectives, intervention strategies and the activities planned.

SI.13
The programme includes general, specific and operational objectives formulated in such a way that can be objectively evaluated with the appropriate indicators.

SI.14
The programme includes strategies intended to facilitate the access to its potential beneficiaries, taking into account the organisational, economic, structural, social and cultural barriers that can hinder or prevent the access to the programme, especially in the case of women, migrants or homeless people. The programme includes among others strategies of active approach to reach drug users who stay away from specialised drug treatment services and/or from general health and social services, to prevent situations of exclusion and/or marginalisation.

SI.15
The intervention strategies envisaged in the programme are planned taking into account the fact that social integration is an individual process and that there are a wide range of paths to achieve this goal. The objectives and contents of each social inclusion journey are flexible and depend on:

— The starting point of the individual (problems and needs, health situation, both physical and mental, etc.).
— Their attitude and commitment to change.
— The personal resources, skills and abilities.
— His/her social and family support network.

EVALUATION CRITERIA

SI.16
The programme provides a plan to assess its implementation, coverage and outcomes, that include: the data to be collated to facilitate programme evaluation and the sources of information to be used, as well as the instruments, tools and procedures to be followed to perform the programme assessment (measurement of the initial, intermediate and final situation of the beneficiaries of the programme and/or services).

SI.17
The programme evaluation plan describes the process indicators that will allow to monitor the activities developed, among which it is worth mentioning the number of beneficiaries who:
— Have accessed the programme through the different mechanisms or means put in place for this purpose.
— Have accessed/used the different services or activities that integrate the programme (employment guidance, social counselling, pre-employment training, etc.).
— Have been referred to a drug abuse treatment centre.
— Have individualised programmes of social inclusion.
— Have successfully completed the individualised programme of social inclusion (IPSI), performing all the intended activities and/or reaching the planned objectives.
— Participate in treatment programs.
— Are referred to the social services network to attend to their basic social needs.
— Are referred to employment services.

SI.18

The programme evaluation plan describes the indicators that will be used to evaluate its coverage, in relation to the population potentially benefiting from it.

SI.19

The programme evaluation plan describes the indicators that will be used to evaluate the programme results.
5. ADVANCED CRITERIA

5.1. CRITERIA COMMON TO ALL DRUG DEMAND REDUCTION SERVICES/PROGRAMMES (CDDR)

STRUCTURAL CRITERIA

**Ethical principles and rights of the programme beneficiaries**

**CDDR.1**

Conditions of access and retention in the programme or service are available for all potential patients, ensuring that discrimination based on sex, age, race, political opinions, legal or social status, religion, physical or psychological conditions or socioeconomic opportunities do not occur.

**CDDR.2**

The programme or service recognises that users/beneficiaries have the right to:

— Autonomy, including the option to choose to participate or not in the programme or service.

— Safety and respect for human dignity.

— Health, physical, psychological, integrity and morality.

— Non-discrimination.

— Equal opportunities, rights and obligations.

— Protection from degrading and inhuman treatment.

**CDDR.3**

Potential programme or service user groups are offered the most appropriate intervention, scientifically proven, according to their personal situation and other related circumstances.

**CDDR.4**

Interested parties are advised about the possible disadvantages and risks for participants and their consent is obtained before the intervention.

**CDDR.5**

The participation of minors in programmes and services counts with previous authorisation of the parents or guardians.

**CDDR.6**

All participants’ data are treated confidentially.
Regulatory aspects

CDDR.7
The programme/service meets the legislation and regulations applicable in fiscal matters related to labour, data protection and equal job opportunities.

Financial aspects

CDDR.8
Regular reporting is presented to the funding institutions and organisations and to all stakeholders.

Human resources

CDDR.9
Sufficient technical staff is available to ensure the implementation of the activities envisaged in the programme or service.

CDDR.10
The personnel that integrates the team responsible for the development of the programme/service counts with the professional skills needed (possesses the titles and diplomas required and the professional experience essential to develop the programme).

Infrastructure and facilities

CDDR.11
The facilities and equipment are appropriate to reach the goals of the programme, in line with the general conditions of development of the community where they are being carried out.

Collaboration and coordination mechanisms

CDDR.12
The organisation promoting the project favours synergies with other institutions, associations and groups who share common interests and strategies in the field of drug demand reduction.

CDDR.13
Mechanisms and procedures for collaboration and coordination with various institutions and social organisations that participate in the programme or support its development have been established.

CDDR.14
The programme is integrated within existing comprehensive plans with a certain strategic parallel, either in the field of demand reduction (e.g., community plans for drug use prevention), or when addressing cross-cutting issues (e.g., plans to prevent social exclusion).
CDDR.15
The programme or service counts with referral procedures to other centres or community services that meet the needs (educational, social and health) of its potential beneficiaries.

FUNCTIONAL OR PROCESS-RELATED CRITERIA

Organisational aspects

CDDR.16
The organisation promoting the programme has a clearly defined mission and vision.

CDDR.17
The organisation has a defined structure known to all stakeholders interested in the design, implementation and evaluation of the programme.

CRD.18
The organisation promoting the programme counts with a quality management system to ensure the provision of the best available programme or service to its beneficiaries.

Information systems and documentation

CDDR.19
A registry of the programme beneficiaries is kept.

CDDR.20
Information and programme registration systems include data on variables that are key to the continuous assessment of the needs of people attending the programme, as well as of the changes or effects derived from their participation in it.

CDDR.21
The programme includes collaboration with local, regional and national information systems existing in the field of demand reduction, through the use of indicators and standardised procedures for collecting information, and its transfer to the "central information units" for their processing and use or for their inclusion into centralised databases.

CDDR.22
Process and procedure guidelines are in place to allow for a harmonised implementation of the interventions that integrate the programme.

CRDD.23
The necessary materials are used for the implementation of the programme (learning materials, staff training manuals, etc.).
EVALUATION CRITERIA

CDDR.24
The organisation has designed a programme evaluation plan which sets out the following elements:

— Content of the evaluation (evaluation of processes, coverage, results, etc.).
— Procedures and instruments to be used in the evaluation.
— Evaluation indicators.
— Type of evaluation to be carried out (internal, external or mixed).
— Intended use of the evaluation results (continuity, refocusing or changing the programme, etc.).
— The means and mechanisms for the dissemination of results and the recipients of the results.

CDDR.25
Measurements or records of the situation of the programme beneficiary population are made prior to their joining the programme and at a later stage in order to evaluate its effectiveness.

5.2. CRITERIA FOR THE ACCREDITATION OF PREVENTION SERVICES/PROGRAMMES (P)

FUNCTIONAL OR PROCESS-RELATED CRITERIA

Evaluation and needs analysis

P.1
The relevant, up-to-date and reliable information collected and reviewed on drug use among the target population includes: types of drugs consumed, rates and trends of consumption, ages of onset, risk perception, cultural factors related to the drug use and problems related to the consumption.

P.2
An analysis of the resources available in the community has been carried out.

P.3
The target population(s) is/are described including its/their size, characteristics, culture and perspectives in relation to drugs.

P.4
Regardless of whether the prevention programme is selective or indicated, explicit inclusion and exclusion criteria are in place (socio-demographic, socio-economic, psychobiological, geographical, etc.), criteria that: define the target population(s) in an
appropriate manner, allow a clear differentiation between populations, justified according to the evaluation of strict needs, including its size, characteristics, culture and perspectives in relation to drugs.

P.5
Risk and protective factors associated to drug consumption that affect the programme’s target population are described as well as who the programme is attempting to change.

P.6
The programme uses a theoretical model to explain drug consumption and its associated problems, which:

— Is evidence-based or based on the relevant literature review.
— Is accepted by the scientific and/or prevention communities.
— Allows the comprehension of the specific needs related to drug use and its causes.
— Allows the understanding of behavioural changes.

P.7
Through a theoretical model a relationship between risk and protective factors, and the behavioural change related to drug use is established.

Identification and involvement of interested parties

P.8
The interested parties are identified and include: the target population, representatives from funding agencies, those responsible for community resources, association representatives, community leaders, institutional representatives, the media, etc.

P.9
Alliances are formed with other organisations, institutions and community groups.

P.10
If it is foreseen that the programme will be carried out in a receiving organisation (e.g., an educational centre for a school programme) considered a programme stakeholder; its needs will be evaluated to determine if the programme is appropriate and whether the information provided is understandable and allows it to make informed decisions.

Resource evaluation

P.11
The capacity of the target population is evaluated as well as other parties interested in participating in the programme or supporting its development.

P.12
If the staff lack the necessary capacity, a training plan is prepared.
Design/formulation of the programme

P.13

A written project plan exists which: is clear, realistic, comprehensive and accessible to all involved stakeholders; describes and logically connects the main components of the programme; provides information on the theoretical model adopted; specifies the intervention strategies selected, the definition of the different scenarios, the material and human resources required, the procedures to gain and retain the support needed, the processes to select the participants, the planned activities, the monitoring procedures, the process design and results evaluation; and allows the monitoring of the actual programme progress during its implementation.

P.14

The project describes the criteria for ending the intervention (achievement of objectives, end of the planned activities, number of planned participants, duration of the intervention).

P.15

The object of prevention or modification is clearly defined.

P.16

The objectives: are determined on the basis of the needs analysis (baseline indicators that intend to be changed); are clear, comprehensible, realistic; are time-bound and are quantifiable; maintain a logical relationship with the mediating variables that are to be modified and are related to specified risk and protective factors; have a relationship based on the theoretical model utilised and are formulated in terms of the participants expected changes (in terms of results).

P.17

The objectives are compatible with the priorities established by the local, regional, national and/or international strategies and policies, in the area of prevention of drug use.

P.18

When selecting the existing interventions, the following is taken into consideration:

— Whether the selected intervention is adequate to the context of the planned programme.
— Whether the underlying assumptions identified in the needs evaluation are similar to those in the model/pilot programme.
— Whether the results achieved by the pilot programme are in line with the aims and objectives of the planned programme.
— Whether the resources needed are in line with the resources available.
— The benefits and disadvantages of the intervention, including its potential negative effects.
— The balance between potentially modifying the pilot programme and adhering to it.
— The feasibility of the intervention (whether the activities can be implemented, if there is adequate expertise, whether the complexity of the programme is excessive, etc.).

P.19
The selected programme is adequate and adapted to the circumstances related to the needs, age, level of development, gender and culture of the participants; the scenario; and the operating environment.

P.20
The design of the intervention is adjusted to the characteristics of the target population, through the adaptation of: the language, the activities and methods of application, the messages of the intervention, its duration, frequency and pace as well as the number of participants per activity.

P.21
The selected theoretical model is compatible with: the explanatory theoretical model used for the intervention and the risk and protection factors identified among the target population.

P.22
The original programme is clearly referenced and its authors identified.

P.23
The most relevant literature and/or publications have been consulted.

P.24
The revised information is scientific, updated, relevant to the programme and accepted by the scientific and/or prevention communities.

P.25
The content of the intervention is based on the available evidence and on best practices, and incorporates the largest possible number of elements from the evidence and recommendations.

P.26
The programme has the intensity and duration most appropriate for the target group: the higher the risk of consumption is, the more intense and prolonged the intervention should be, and vice versa.

P.27
The programme helps participants to discover and realise their own resources by: highlighting the strengths of the participants and underlining alternatives to high risk options, supporting the participants in caring for their own health and fitting into a positive climate of health promotion.
P.28
Financial, human, material as well as community available resources are provided to guarantee the planned interventions.

P.29
Mechanisms to recruit participants are clearly defined.

P.30
Concrete measures are taken to maximise recruitment and retention of the participants, ensuring that the programme: is affordable for the target population, offers schedules and places suitable to the target population, guarantees confidentiality, prevents the stigmatisation of participants or of the broader population and facilitates material incentives to capture populations at risk.

P.31
The activities are adapted to fit the characteristics of the target population and of the participants.

P.32
Activities are consistent with the above objectives (have the capacity to modify the risk and protective factors envisaged in the objectives).

P.33
The programme includes a timetable of interventions/activities to perform.

Programme monitoring

P.34
The intervention is implemented following the project plan.

P.35
If a pilot intervention is made, it is properly documented including:

— Monitoring the pilot initiative.
— The difficulties encountered and the solutions proposed.
— The modifications made to the intervention design.

P.36
The implementation is documented, being recorded:

— Regular monitoring data of the implementation, in line with the project plan developed at the planning stage.
— Identification of constrains and/or failures and the manner in which they were corrected.
— Adjustments and changes made to the original project plan.
— Unexpected challenges encountered and responses adopted to deal with them.
The manner in which the programme will be monitored is specified.

EVALUATION CRITERIA

From the planning phase, an evaluation plan has been drafted that includes:

— Indicators to be used to measure the results.
— The moments in time when the measurements will be taken
— Measurement and data collection tools to be used.

The evaluation result indicators selected are related to the objectives of the programme.

These results evaluation indicators are clearly described and measurable in quantitative and/or qualitative terms.

The methods and tools used for the collection of outcome data:

— Are clearly described.
— Provide information relevant to the evaluation indicators.
— Are existing tools previously tested or new tools adequately developed and validated.
— Are consistently utilised (the same tools are used in the different moments when measurements are taken).

The results evaluation follows a research design, allowing a clear analysis of the relationship between the intervention and the outcomes.

The outcome data (indicators) are measured before and after the intervention.

A written evaluation plan of the process exists and includes:

— The indicators to be used.
— The moments in time when the indicators will be measured.
— Measurement and data collection tools to be used.
— The data collection and measurement instruments, when required.
The indicators of the evaluation process:

— Are related with the activities carried out.
— Are clearly described.
— Are measurable in quantitative and/or qualitative terms.

The target audience is specified, including those participating in the programme and its evaluations, as well as other stakeholders.

The form and the media channels adopted are adequate for the target audience.

The preparation of a final report is envisaged containing the main data and conclusions of the processes and results evaluation.

The mechanisms, procedures and tools selected to evaluate the programme results allow the verification of whether its “preventive” objectives were attained in relation to the use of different substances:

— Whether abstinence in the consumption has been maintained or increased.
— Whether it has delayed the age of onset in the consumption.
— Whether it has reduced the frequency of use and the quantities consumed.
— Whether the abusive or harmful consumption has been reduced.
— Whether the problems associated with use have been reduced.
— Whether certain mediating variables have been modified.

The mechanisms, procedures and tools selected to evaluate the results of the programme allow verification of whether the results are obtained within the planned timeframe.

Internal evaluation mechanisms of the results are considered.

External evaluation mechanisms of the results are considered.
5.3. CRITERIA FOR THE ACCREDITATION OF RISK REDUCTION RELATED TO DRUG USE SERVICES/PROGRAMMES (RR)

FUNCTIONAL OR PROCESS-RELATED CRITERIA

RR.1
The risk reduction programmes developed in the health sector systematically provide health-related advice at different levels to persons with risk and harmful alcohol consumption who attend primary health care services.

RR.2
The programmes that incorporate short-term interventions aimed at alcohol users count with clear guidelines that provide short-term health advice, tools for short-term interventions and incorporate training and support to general practitioners, which includes answers to the main obstacles perceived by health professionals when implementing these interventions.

RR.3
They are dedicated to providing specialised treatment or counselling programmes to drivers suspended from their driving licence and with dependency problems or with problematic alcohol use.

RR.4
The programmes for risk reduction related to alcohol use in the workplace incorporate mechanisms that allow the early detection of risk consumption, offer brief advice to workers that maintain this pattern of consumption, and refer them to specialised services dealing with alcohol abuse problems or dependency programmes.

EVALUATION CRITERIA

RR.5
Risk reduction interventions for alcohol and tobacco use have a regular internal evaluation system of processes and results, aimed at achieving the following objectives:

— To reduce the proportion of non-smokers exposed to smoke in an enclosed space.

— To decrease the number of people killed and injured in traffic accidents related to alcohol consumption.

— To reduce the rate of problems associated with alcohol abuse: emergency hospital admissions, homicides, injuries caused by aggression, negligence and abuse of children, and people intoxicated assisted in the streets.

— To decrease the morbidity and mortality directly associated with smoking and with the risk and harmful consumption of alcohol.
Note: The small number of criteria for risk reduction programmes could suggest its inclusion as a sub-section within the criteria for accreditation of prevention programs.

5.4. CRITERIA FOR THE ACCREDITATION OF TREATMENT SERVICES/PROGRAMMES (T)

STRUCTURAL CRITERIA

Regulatory Aspects

T.1
The centre or service complies with the requirements that the laws of the specific country have in order to be granted the licence to open and run a specialised centre, both those arising from implementing the general standards that govern health and social centres, as well as those specifically applicable to drug addiction treatment centres (basic technical team is in place, it has the correct safety and health conditions, physical barriers free, etc.).

T.2
The programme or treatment centre has been authorised/accredited as such by the competent Authority.

Patients’ rights

T.3
The service or treatment centre guarantees an adequate treatment and recognises the following rights for the patients attending it:

— Access to health, psychological and social assistance, and services that are integral to the care process within a known and defined timeframe, and without limitations due to lack of economic resources.

— A free choice between the different therapeutic options available.

— The free will to enter into, remain or leave a therapeutic process, except in the cases specified by the legislation in force.

— To know the regulations of the centre (internal rules) on all those aspects that may affect them, as well as the name and professional qualification of the persons responsible for their assistance.

— Access to verbal or written information provided by the therapeutic team with respect to the various available services, the treatment proposed according to their clinical aspects and the process that is being followed, the reasons that informed it and the benefits and risks expected.

— To have a record of the following, either in written form or in other technically supported format:
  • The complete treatment process, information that could be later incorporated to the patient’s clinical history.
The consent before performing any diagnostic or therapeutic procedures involving a potential risk or health hazard.

Experimental diagnostic or therapeutic procedures carried out which might have been part of an educational project or research.

— To have a signed therapeutic contract that clearly explains and justifies the treatment to follow, the patient’s rights and obligations.

— To receive a discharge report once the treatment process has been completed.

T.4

Patients following residential treatments are entitled to remain in contact with friends or family and to receive visits from them.

Accessibility to the services and treatment programmes

T.5

The centre or service contemplates different ways of providing access to treatment and has defined and written therapeutic indication criteria, based on the biopsychosocial diagnosis of the patients.

T.6

The centre or service is accessible to all people with problems of drug use or drug dependence, regardless of their health condition (physical or mental), provided that the request for treatment falls within the centre’s criteria of admission and exclusion.

T.7

The centre or service has a set of criteria for inclusion and exclusion that adequately restricts or allows patients’ access to different treatment options.

T.8

Defined criteria for referral, inclusion, therapeutic indication and exclusion for detoxification in hospital environments are in place.

T.9

Defined criteria for referral, inclusion, therapeutic indication and exclusion for admission into a therapeutic community are in place.

Human resources

T.10

All the professionals that are part of the multidisciplinary team have experience and specific training recognised in the field of drug addiction.

T.11

A programme of continued training and lifelong learning for the professionals in the therapeutic team exists.
T.12
It provides all new personnel who join the centre or service with regular capacity building and updating in areas related to therapeutic procedures, management and evaluation of the problems associated to drug use.

**Infrastructures and facilities**

T.13
The facilities size fits the volume of patients treated.

T.14
The treatment centre has a duly authorized medicine storage facility, a safe area to file records and built in protective features in computer systems to prevent access to patients’ data by unauthorised persons.

T.15
The residential treatment centres are equipped with, in addition to functional areas common to all healthcare services, spaces and equipment suitable for its specific activities and tasks.

**Collaboration and coordination mechanisms**

T.16
The centre or service has coordination and cooperation procedures with other centres providing assistance to drug users, as well as consultation and referral to general services (health, social, legal, mental health, etc.).

**FUNCTIONAL OR PROCESS-RELATED CRITERIA**

**Service organisation**

T.17
The centre/service is based on a multidisciplinary and interdisciplinary approach to drug abuse.

T.18
The design of the centre/service has been preceded by a needs assessment and situation analysis.

T.19
The treatment service is integrated into a wide healthcare network that includes other types of outpatient and residential treatment centres.

T.20
A reference model that establishes the role of the treatment centre/service within the health care network (population profiles attended, objectives, services, etc.) is available, as
well as the processes and procedures to follow to access it, and the mechanisms of patient referral between the network services.

T.21
There are clearly defined mechanisms for admission and termination of the assistance network.

T.22
There is a personal record of each patient in which the therapist responsible for the case is registered as well as the patient’s clinical history.

T.23
There is an information system in place that registers the kind of interventions provided by the centre/service, compatible with the local, regional and national information systems.

Service portfolio

T.24
The treatment includes an evaluation diagnostic, health, psychological and social care (within the framework of individualised therapeutic plans) and the development of different activities oriented to improve the health and the quality of life of the people affected, through the reduction of their drug dependency, decreasing morbidity and mortality rates caused by substance use, the strengthening of skills and human resources and access to programmes of social inclusion.

T.25
The services portfolio for outpatient treatment includes at least: information and orientation, assessment and diagnosis, treatment and therapeutic control, family care and support for social inclusion.

T.26
The service portfolio for residential treatment centres includes, preferably, the following: diagnosis evaluation (in cases where it is lacking or incomplete), detoxification, withdrawal, support interventions for inclusion in society and the labour market, individual and group counselling, health care, social care, educational support, interventions with patients’ families, and accommodation and support services.

T.27
Residential treatment centres have a programme for the prevention, identification and control of infections potentially acquired in the centre itself and/or introduced from outside.

Key healthcare processes

T.28
The centre/service has a guide of procedures and processes that allows to formalise the care provided to its beneficiary population, ensures equity and quality of care and
facilitates the establishment of information systems and the evaluation of the healthcare provided.

T.29
The centre/service identifies, describes and documents the key processes that make up the treatment process and have a greater impact on the strategic objectives of the centre or service: reception/admission requests, diagnosis evaluation, individualised therapeutic plans, implementation of the therapeutic plans, monitoring, evaluation and completion of the treatment.

T.30
It has an admissions or entry registration system of patients that also records rejected requests.

T.31
Information is provided to the patient and their families about the therapeutic options available and the content of the service portfolio offered by the centre, as well as its rules and regulations.

T.32
The centre/service has a document of consent for the collection and processing of information, as well as the therapeutic programme that the patient will follow.

T.33
There is a comprehensive evaluation and diagnosis, of a biopsychosocial nature, of patients accessing treatment according to the manuals, standards, criteria and already standardised international procedures.

T.34
Diagnosis evaluation data are put in the patient’s integrated clinical history.

T.35
An individualised treatment plan for each patient is designed (type of intervention, therapeutic goals, activities, resources used, duration and phases) based on a previous diagnosis where somatic, psychological, psychiatric improvement or stabilization and social integration goals are set, as well as a drug use reduction or abstinence plan.

T.36
It takes into consideration the gender-sensitive perspective in the design of the treatment plan.

T.37
The therapeutic plan is communicated and agreed with the patient, the terms of the agreement are collected in a written document signed by the patient (therapeutic contract). In the appropriate cases the therapeutic proposal includes the interventions offered to the patient’s relatives.
The treatment plan includes strategies to reinforce the adherence to the treatment.

A "reference professional" is assigned to each patient, in charge of decentralising the information flow and who is responsible for the follow-up of the treatment plan.

The patient’s clinical history includes a copy of the individualised treatment plan and of the therapeutic contract agreed with him/her.

Clinical evidence-based guidelines are available as well as specific protocols applicable to certain relevant treatment processes (detoxification, opioid substitution therapy, control and treatment of infectious diseases, psycho-diagnosis, approach to dual pathology, etc.).

Both outpatient centres and therapeutic communities offer a multi-component therapeutic programme of a biopsychosocial character, which combines drug therapy with psychological and cognitive behavioural treatment, and group, family and couple therapy.

Regardless of whether the aim of the treatment is to achieve abstinence or not, all patients are provided with guidelines on the risk and harm reduction related to drug use.

Regular meetings of the technical team of the centre/service take place in order to assess treatment progress and articulate possible changes in the treatment plan, as well as potentially involving other services to ensure the continuity of care.

A “reference professional” examines periodically, along with the patient, the progress of the treatment provided, introducing changes if necessary to ensure the fulfilment of the goals envisaged in the individualised treatment programme.

The duration of the treatment will be determined by the patient’s level of compliance with the objectives pursued by his/her joining the treatment centre, and depending on the reasons for the termination of the treatment (therapeutic and voluntary discharge, referral, abandonment, force majeure).

The internal regulation of the programme or service clearly specifies the criteria for the expulsion or exclusion criteria for treatment, as well as the procedures to follow in these cases.
T.48
Residential treatment centres work with patients who are leaving the centre, emphasising the need for them to continue attending outpatient treatment services that will guarantee their uninterrupted care.

RESULTS EVALUATION CRITERIA

T.49
Methods and instruments which have proved their effectiveness in prior research and evaluation of health care activities carried out by other institutions are used to assess the effectiveness of treatment programmes.

T.50
The centre/service includes the results evaluation of the care process, identifying the indicators that should be used.

T.51
The centre/service includes the patient satisfaction evaluation with the treatment, practitioners and other interested parties (relatives).

T.52
A regular evaluation system of care provided is in place, based on objective indicators (employment, retention rates, level of admissions, results achieved, etc.).

T.53
There is a patient’s follow-up programme after treatment, which includes periodic monitoring of relapses through objective methods.

5.5. CRITERIA FOR THE ACCREDITATION OF HARM REDUCTION SERVICES/PROGRAMMES (HR)

STRUCTURAL CRITERIA

Programme and service accessibility

HR.1
People entering the programme/service are informed about the portfolio of services available as well as the access conditions.

HR.2
Both the regulation for running the service, as well as the rights and duties of the users, are found in a place visible and accessible to all the people who attend the service.

HR.3
The opening hours and timetable of the services are wide and coincide with the needs of the targeted users.
Human resources

HR.4
The composition of the teams involved in harm reduction is adapted to the needs of the target population and to the type of programme offered, ensuring that the team counts with the appropriate qualifications to carry out their functions correctly.

FUNCTIONAL OR PROCESS-RELATED CRITERIA

HR.5
The programme includes the assessment of risk behaviour related to addiction (intravenous drug use, a history of overdose, drug use in combination with depressants and their potential synergic effect on the CNS, sharing drugs or supplies, public use).

Note: The small number of criteria for harm reduction programmes could suggest its inclusion as a sub-section within the criteria for accreditation of treatment programs.

5.6. CRITERIA FOR THE ACCREDITATION OF SOCIAL INCLUSION (SI) SERVICES/PROGRAMMES

STRUCTURAL CRITERIA
Access to programmes and services

SI.1
A precise inclusion and exclusion criteria is in place.

SI.2
The programme target population is described accurately, having defined its profile and characteristics.

SI.3
It has a protocol that regulates the access/admission of potential programme users or at least the programme describes the admission procedures in place.

SI.4
The programme services portfolio has been disseminated among the potential beneficiaries and among the entities/services that work in the field of drug use or social exclusion.

SI.5
It takes into account barriers that gender-sensitive issues can pose to limit accessibility to the programme.
Human resources

SI.6
The programme has qualified personnel capable of working towards improving the patients’ personal and social skills, in particular those related to seeking employment.

Collaboration and coordination Mechanisms

SI.7
Collaboration agreements exist with various programmes and services (social, employment, etc.) that facilitate access to these by the beneficiaries of the social inclusion programmes.

SI.8
Alliances have been established with other organisations, institutions or community groups that work in favour of the social integration of different groups: creation of networks and structures of inter-agency cooperation.

SI.9
The programme is integrated within plans or broader strategies aimed at the prevention of social exclusion and/or to support the social integration of vulnerable or disadvantaged groups.

FUNCTIONAL AND PROCESS-RELATED CRITERIA

Evaluation and needs assessment

SI.10
The programme is properly justified, supported by a previously carried out needs assessment.

SI.11
The needs and common demands of the drug dependent population potentially covered by the programme have been analysed, in particular those connected with certain social and health problems: employment, economic, family, housing, legal-judicial, social isolation and mental disorders associated with drugs dependence and disability or serious physical diseases.

SI.12
The programme analyses the influence that the social and economic environment has on the processes of exclusion and social integration of its potentially beneficiary population, taking into account: the economic situation of the country, region or community where the programme will be implemented and the current employment policies; the dominant attitudes and stereotypes towards people using drugs among the community where the programme is run; the measures to support their social integration, the existing social policies to prevent situations of social exclusion and poverty; and the support for the processes of social integration.
SI.13
The programme establishes mechanisms and procedures that ensure that the people that join it have a customised social diagnosis that sets out their needs in social inclusion matters.

SI.14
The collection of the necessary information for the elaboration of the social diagnosis of the programme beneficiaries is done using standardised instruments (socio-occupational history, etc.) that allow for the assessment of the following areas: history of participation in other programmes of social integration; housing and its characteristics; the type of coexistence and family relationships, economic status and sources of income; current employment situation, employment background and attitudes toward employment (which will serve as the basis for employability diagnosis); educational level, social relations and social support networks; forms of leisure activities; legal situation; health state (physical and mental); degree of personal autonomy, personal resources, attitude and disposition to accept change; current drug use situation and, in some cases, development of the drug treatment.

Design/formulation of the programme

SI.15
A document is available describing all the relevant elements of the programme, in particular:

— The main conclusions of the needs assessment and the priorities identified in light of the results of the needs analysis.
— The parties interested in the programme and the procedures to guarantee their participation.
— The beneficiary population of the programme (target population and intervening population) and the procedures for their selection.
— The theoretical model that supports the programme.
— The objectives pursued by the programme.
— The selected intervention strategies.
— The areas that will be affected by the programme.
— The human, material and financial resources available.
— The internal and external coordination procedures.
— The activities planned, their duration and the timeframe for their implementation.
— Procedures for programme monitoring and for process and results evaluation.

SI.16
The programme leans on a logical theoretical analysis that establishes how its strategies and actions will contribute to prevent/reduce the difficulties faced by the beneficiary population in the field of social integration.
SI.17
Internal coherence exists between the theoretical programme support, the situation analysis (evaluation of needs), the objectives, intervention strategies and the activities planned.

SI.18
The objectives and aims to be achieved have been clearly specified.

SI.19
Objectives are closely related to the needs and priorities identified in the needs assessment.

SI.20
The programme includes general, specific and operational objectives formulated in such a way that can be objectively evaluated with the appropriate indicators.

SI.21
The program sets realistic objectives that bear in mind the limitations of the beneficiary population and the social, cultural and economic features of the context in which the intervention will take place and which can hinder the process of social inclusion.

SI.22
The programme includes intervention procedures and techniques whose quality has been proven, perfectly defined and documented, and consistent with the evidence and/or the best practice recommendations available in the field of social integration of the drug using population.

SI.23
The intervention strategies selected meet the specifications and needs of the beneficiary population.

SI.24
The intervention strategies proposed are viable given the context where they are to be implemented.

SI.25
The programme includes strategies intended to facilitate the accessibility of its potential beneficiaries, taking into account the organisational, economic, structural, social and cultural barriers that can hinder or prevent the access to the programme, especially in the case of women, migrants or the homeless. The programme includes among others strategies of active approach to reach drug users who stay away from specialised drug treatment services and/or from general health and social services, to prevent situations of exclusion and/or marginalisation.

SI.26
The programme includes basic skills and knowledge training, prior to access the resources and services intended to promote social integration.
SI.27

The intervention strategies envisaged in the programme are planned taking into account the fact that social integration is an individual process and that there are a wide range of routes to achieve this goal. The objectives and contents of each social inclusion journey are flexible and depend on:

— The starting point of the individual (problems and needs, health situation, both physical and mental, etc.).
— Their attitude and commitment to change.
— The personal resources, skills and abilities.
— His/her social and family support network.

SI.28

The content of the individualised programmes of social inclusion will be agreed with the interested person, and the agreements and commitments reached will be reflected in a "contract of social inclusion" signed by the latter.

SI.29

The activities and the methodology envisaged for his/her development are in accordance with the characteristics of the target population.

SI.30

The activities are consistent with the goals and strategies laid down in the programme.

EVALUATION CRITERIA

SI.31

The programme includes a plan to assess its implementation, coverage and outcomes, that include: the data to be collated to facilitate programme evaluation and the sources of information to be used, as well as the instruments, tools and procedures to be followed to perform the programme assessment (measurement of the initial, intermediate and final situation of the beneficiaries of the programme and/or services).

SI.32

The programme evaluation plan describes the process indicators that will allow to monitor the activities developed, among which it is worth mentioning the number of beneficiaries who:

— Have accessed the programme through the different mechanisms or means put in place for this purpose.
— Have accessed/used the different services or activities that integrate the programme (employment guidance, social counselling, pre-employment training, etc.).
— Have been referred to a drug abuse treatment centre.
— Have individualised programmes of social inclusion.
— Have successfully completed the individualised programme of social inclusion (IPSI), performing all the intended activities and/or reaching the planned objectives.

— Participate in treatment programs.

— Are referred to the social services network attend to their basic social needs.

— Are referred to employment services.

SI.33

The programme evaluation plan describes the indicators that will be used to evaluate its coverage, in relation to the population potentially benefiting from it.

SI.34

The programme evaluation plan describes the indicators that will be used to evaluate the of the programme results.
ANNEXES
Annex I

INSTITUTIONS AND PARTICIPANTS

PARTICIPATING INSTITUTIONS

1. National Commission for Development and Life without Drugs
   (DEVIDA)
   Comisión Nacional para el Desarrollo y Vida sin Drogas
   Peru

2. National Commission Against Addictions
   (CONADIC)
   Comisión Nacional contra las Adicciones
   Mexico

3. Technical Secretariat for Drugs
   (SETED)
   Secretaría Técnica de Drogas
   Ecuador

4. Government Delegation for the National Plan on Drugs
   (DGPNNSD)
   Delegación del Gobierno para el Plan Nacional sobre Drogas
   Spain

   (MINJUSTICIA)
   Ministerio de Justicia y del Derecho. Dirección de Política contra las Drogas y Actividades Relacionadas
   Colombia

6. Costa Rican Drugs Institute
   (ICD)
   Instituto Costarricense sobre Drogas
   Costa Rica

7. National Drugs Board,
   (JND)
   Junta Nacional de Drogas
   Uruguay

8. National Secretariat on Drug Policies
   (SENAD)
   Secretaría Nacional de Políticas Sobre Drogas
   Brazil

9. Secretariat of Programming for the Prevention of Drug Addiction and the Fight against Drug Trafficking,
   (SEDRONAR)
   Secretaría de Programación para la Prevención de la Drogadicción y la Lucha contra el Narcotráfico
   Argentina

10. National Service for the Prevention and Rehabilitation of Drug and Alcohol Use
    (SENDA)
    Servicio Nacional para la Prevención y Rehabilitación del Consumo de Drogas y Alcohol
    Chile

11. General-Directorate for Intervention on Addictive Behaviours and Dependencies
    (SICAD)
    Servicio de Intervención nos Comportamientos Aditivos e nas Dependências
    Portugal
WITH THE COOPERATION OF

- Inter-American Drug Abuse Control Commission, CICAD - OEA
- European Monitoring Centre for Drugs and Drug Addiction, EMCDDA
- Pan American Health Organisation, PAHO/WHO
- Ibero-American Network of NGOs Working in Drug Addiction, RIOD
- International Drug Policy Consortium, IDPC

ADVISORY COUNCIL

Luis ALFONZO BELLO
Brenda BARRIGUETE MÁZMELA
Cejana BRASIL CIRILO PASSOS
Gregor BURKHART
Karina C. CASAL
José L. CASTAÑO RODRÍGUEZ
Patricia CONTRERAS
Felipe LEYTON
Paula MARQUES
Elena MARTÍN MAGANTO
Javier MARTÍN NIETO
Eugenia MATA CHAVARRÍA
Sonia MONCADA BUENO
Marta OLIVA
Maria E. RIVEROS
Carmen L. SEVILLA CARNERO
Graciela SILVOSA RODRÍGUEZ
Marta SUANES BERON
José L. VÁZQUEZ MARTÍNEZ
Lorena VILLACÍS RENGIFO

DELPHI STUDY: PARTICIPANTS

Alicia ACERO ACHIRICA
César ACOSTA
Susana ALMENDARES
Jordi ALOS
Francisco ALVIRA
Paula ANDRADE
Gabriel ANDREUCCETTI
Victoria ÅNGELES
Mercedes ARANGUREN
Martín ARCILA MARTÍNEZ
Carles ARIZA CARDENAL
Sara ARROSPIDE
Gustavo ASCACIBAR
NOBLECILLA
Gabriel AVENA
Marco BARRIENTOS
SEGURA
Elisardo BECOÑA IGLESIAS
Pilar BERMÚDEZ GONZÁLEZ
Gustavo BIORZA
Francisco BRAVO
William CABANILLAS
ROJAS
Alberto CALABRESE
Amador CALAFAT FAR
Ana C. CAMAROTTI
Ana M. CANO RENTERÍA

Maria A. CAPRILE
Susana CARDOSO
Selva CAREAGA
Luis CARIS
Carlos A. CARVAJAL
Karina C. CASAL
Guillermo CASTAÑO PÉREZ
Liliana CASTRO DEZA
Pedro CATITA
Fabián CHIOSSO
Patricia CONTRERAS
Madalena CRUCHINHO
Gloria CUEVA VERGARA
Mauricio CUEVAS
Aldo DOMANICO
Maríana DRAGO
Arturo DUEÑAS YACTAYO
Domingos DURÁN
Mario ELIZALDE
Alejandro ESCOBAR LOBOS
Susana FERGUSSON
Juan FERNÁNDEZ
José R. FERNÁNDEZ
HERMIDA
Ricardo FLEITAS
Paula FRANGO

Maria I. GANDOLFO
CONCEIÇÃO
Nadía GARCÍA ALAS
Martha B. GARCÍA GARCÍA
Enrique GIL CARMENA
Luis F. GIRALDO FERRER
Alicinda GOMES
Eduardo GÓMEZ
José A. GÓMEZ FRAGUELA
Andrés GÓNGORA
Aida GONZÁLEZ
Juan C. GORLERO
Susana GRUNBAUM
Heliodoro GUTIÉRREZ
FUENTES
Esperanza HERNANDEZ
María HERRERA VIDIELLA
Carlos IBÁÑEZ
Silvia INCHAURRAGA
Federico INFANTE
LEMBECKE
Patricia INSÚA
Manuel ISORNÁ FOLGAR
Mario KAMENIECKI
Hugo KERN
Félix KESSLER
This Annex presents the main results derived from three additional exercises conducted along the consensus process performed in COPOLAD I, after the Delphi study:

— The work of several focus groups, designed to explore operational and implementation aspects of the criteria filtered through the Delphi exercise, both from an institutional as well as a technical perspective.

— A study of the situation of the existing legal framework in relation to the accreditation in drug demand reduction (DDR) in the countries participating in the project.

— Exploring potential strategies to advance in the field of accreditation in DDR.

The following is a synthesis of the results of these exploratory exercises, which, in turn, were presented — as a report — to the Advisory Council of the Project for evaluation (together with the criteria that emerged from the Delphi study).10

FEASIBILITY ANALYSIS CARRIED OUT BY THE FOCAL GROUPS

The three online focus groups, two of them formed by institutional representatives of the partner countries and partners, and the third by technical staff designated by the partners, sought to offer additional insights to those provided by the participants in the Delphi groups in a number of basic issues:

(a) The opinion of institutional representatives with respect to the agreed criteria at the Delphi.

The criteria agreed upon in the Delphi groups were perceived as an important step forward for the improvement of the quality of demand reduction programmes (DDRP), especially since they were identified and selected on the basis of a systematic review of the evidence that supports their incorporation to the accreditation systems. It was also considered that the process established to reach consensus on the definition of the criteria, with the participation of experts and institutional representatives of Latin America and the European Union, adds value to the potential employment of resources and/or instruments (system/s) of accreditation supported by these criteria.

b) The feasibility of putting in place a system of accreditation of DDRP of supranational character in the framework of COPOLAD, based on the agreed criteria in the Delphi.

The advantages that would come about by establishing accreditation systems in DDRP based on these criteria were analysed; among these advantages, their contribution toward the following was highlighted:

— Designing and implementing policies and programmes with a comprehensive approach to DDR.
— Setting up methodologically rigorous procedures for intervention and evaluation, to facilitate the comparability of the results obtained through the policies and programmes implemented, as well as the transfer of information.
— Helping establish objective and transparent criteria for the funding of programmes and services.
— Legitimising prevention and care interventions to develop in the field of the DDR, based on scientific evidence criteria and not on moral or ideological approaches.

The difficulties that would be encountered during the implementation of a supranational system of accreditation in the different countries were also identified and analysed, among which the following were mentioned:

— Difficulties to reach a consensus with all actors involved and to legitimise the implementation of the system.
— Suspicion on the part of many non-governmental organisations that the State would control their work or assume a regulatory role over it.
— Limited resources to meet the requirements related to certain needs to conceptually and financially support the process.
— Difficulties arising from cultural, political and resource differences.
— Difficulty in establishing who takes responsibility for the implementation and monitoring of the accreditation system and who "certifies" the accreditation.
— Need to establish some degree of standardisation of the intervention models before their accreditation.

In spite of the difficulties that would arise from the implementation of an accreditation system of DDRP, this measure was perceived as a unique opportunity to:

— Establish networks.
— Improve the management and allocation of public resources.
— Contribute to the improvement of the effectiveness and efficiency of DDRP.
— Agree on certain definitions and concepts.
— Improve and diversify the services offer.
— Harmonise criteria and standards at the supranational level.
— Legitimise public spending on DDR.
c) The identification of strategies that will allow for progress in the implementation of national or supra-national resources/tools/systems of accreditation of DDRP.

The advantages and disadvantages of adopting different strategies to facilitate the establishment of national or supranational accreditation systems were discussed, including:

— Establishment of a two-level system of accreditation with different requirements: 1) a small number of basic criteria (mandatory), and 2) a list of criteria "recommended" (voluntary).

— Phased accreditation of different categories and types of DDRP (advancing the accreditation of the health care programmes in the first place, and at a later stage of prevention programmes, etc.).

— Establishment of evidence-based quality criteria differentiated according to the type of programme (linked to the design of processes, of a structural nature, rights related, information systems related, etc.).

— Direct link between accreditation and public financing (accreditation as a requirement to be able to conclude service contracts with government agencies or receive public financial assistance).

— Granting endorsement by public institutions only to those programmes with prior accreditation.

On the basis of these considerations and in the framework of the focus groups, the following proposals were made:

— Carrying out a basic study to determine the initial situation of the different countries involved in the Project in relation to the accreditation systems.

— Creation of technical roundtables at national level to work on the topic.

— Development of manuals and methodological guidelines that support the process of establishing the accreditation systems.

**MAIN CONCLUSIONS REACHED BY THE FOCUS GROUPS**

1<sup>st</sup>) The general assessment of the project was very positive. It is defined as necessary, relevant, powerful (solid), applicable in some cases (not in others), a project which favours management transparency and helps to set a common language, sensitive both to the existing realities in the various territories, as well as to the evidence of effectiveness available. Furthermore, it represents a challenge that helps to rethink policies and programmes.

2<sup>nd</sup>) The implementation of the accreditation systems should be done with care, engaging all those involved and looking for incentives, not only economic ones, for its implementation. It is necessary to look for synergies and establish partnerships, both at the time of starting the process, as well as and above all, during its implementation.
3rd) Among the strategies or steps to follow in order to facilitate the implementation of an accreditation system of programmes at the national or supranational levels, the following were highlighted:

— The need to provide political, technical and social legitimacy to the accreditation process, before its implementation.

— The establishment of different levels of requirements in each category of DDRP (basic criteria or forced compliance and advanced optional criteria or, of voluntary compliance).

— The implementation of different accompanying measures to the accreditation process (e.g., vocational training).

4th) The need to differentiate and refine the concepts of empowerment/authorisation (administrative requirements that a service or programme should meet to become authorised) and accreditation (linked with the pursuit of quality and excellence) was raised.

5th) The challenge of moving forward the consolidation of a system of supranational accreditation should:

— Agree on certain definitions and concepts.

— Categorise and/or rank the criteria and standards of quality.

6th) It was suggested that certain evidence-based quality criteria that did not gain sufficient consensus in the Delphi groups should be recovered and incorporated into the accreditation systems, criteria such as those related to the generation of synergies with other organisations, the integration of programmes in national drug policies, financial transparency, collaboration with national information systems, inclusion of a gender perspective and external evaluation of the programmes.

7th) It was the general feeling that accreditation should not be gradually implemented by area of intervention, but rather oriented on the set of programmes included within the scope of DDR.

8th) The need to link public funding with the accreditation was noted, despite the difficulties and resistance that it entails.

9th) Agreement was reached on the need to set legal regulation that would cover the accreditation process.
KEY POINTS

— The assumption of the need to advance the development and use of resources/tools/systems of accreditation of drug demand reduction programmes (DDRP) by the institutions, aware of the significant benefits that this represents.

— The verification of the large existing differences in relation to the type of national policies and of the degree of development and consolidation of the various categories of DDRP, compels us to adopt different strategies to promote the development of resources or instruments that allow progress toward the implementation of accreditation systems both at national and supranational level.

— The successful implementation of national or supranational accreditation systems depends, to a large extent, on whether these are perceived as something useful, which adds value and pursues the improvement of the quality of the services and care provided to society; to increase the effectiveness and efficiency of DDRP; and to improve the public appreciation (general population) of the institutions responsible for socio-health care treatment policies of drug-related problems.
LEGAL FRAMEWORK FOR DDR PROGRAMMES ACCREDITATION IN THE PARTICIPATING COUNTRIES

The study sought to obtain an updated diagnosis of the state of the systems of accreditation of drug demand reduction programmes (DDRP) in the participating countries and to know the perspective of their National Agencies - responsible for drug demand reduction (DRR) policies – with regard to the feasibility of implementing accreditation systems at national or supranational levels, based on the criteria agreed upon.

The study aimed to cover the following objectives:

— To understand the normative developments approved in each country that regulate the authorisation and/or the accreditation of the different categories of DDRP.
— To understand the technical procedures, complementary to the adoption of regulatory standards, developed to facilitate the implementation of national programme accreditation systems.
— To identify the evidence-based quality criteria among those agreed upon within the Delphi groups’ framework, which each country considered viable to be incorporated as basic or binding requirements into a national or supranational accreditation system.
— To identify the measures considered necessary to be implemented to accompany or support the implementation of DDRP accreditation systems.

A questionnaire completed by the participating countries was designed for this purpose, and whose main conclusions are summarized below:

1st) The actions developed to date in the field of DDRP accreditation have focused on the processes and procedures of authorisation or certification of the centres and services intended for the treatment of people with problems of drug dependence or drug abuse.

2nd) The existence of rules of DDRP accreditation (complementary to those that strictly regulate the authorisation or certification of health care services) is very limited. Only three of the ten participating countries in the study claim to have rules governing the accreditation of these programmes in place, in some cases difficulties were encountered to identify the criteria incorporated in the accreditation systems.

3rd) Despite the fact that DDRP accreditation systems are currently not widely adopted, the interest that this type of process has awaken in most of the countries participating in the study was noted. This is confirmed by the fact that nine of the ten countries have created institutional working groups to advance the implementation of the accreditation systems of this type of programmes.

4th) There are important differences with regard to the feasibility of putting in place national or supranational accreditation systems. These differences are conditioned by both the nature of the programmes, as well as by variables of a national character. The feasibility of employing accreditation systems (national or supranational) is greater in the case of treatment programmes and prevention/reduction of risks. Social integration programmes would be placed at an intermediate level of feasibility and harm reduction programmes at the lower end of the spectrum.
5th) The degree of consolidation of policies and/or programmes in the respective areas of DDR directly conditions the feasibility of implementing accreditation systems. The more developed or consolidated general or sectoral policies (prevention, treatment, etc.) are, the greater the feasibility of launching these systems is and, on the opposite end, “emerging” policies and programmes or those that have a lower development over time, are those less viable.

6th) Despite the differences observed in the feasibility of the implementation of the accreditation systems of the various categories of DDRP, there is a broad base of consensus on the need to promote a supranational accreditation system within the framework of COPOLAD that, in the medium term, might arise as a benchmark for all Latin American countries wishing to have resources, instruments or DDR accreditation systems in place.

7th) The option of putting in place a unique system of accreditation applicable to all DDRP is less viable due to the fact that certain categories of programmes (as it is the case of harm reduction programmes) are perceived as scarcely viable by a good number of countries. The alternative would be to promote the implementation of the accreditation systems focusing, in an initial phase, on prevention and treatment programmes.

8th) There is a broad level of agreement at the time of identifying the accompanying measures that should be in place to support the implementation of DDRP accreditation systems. These measures are generally acceptable, not requiring excessive additional resources.

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KEY POINTS

— The implementation of accreditation systems of drug demand reduction programmes (DDRP) is perceived as a clear need for all the institutions participating in the Project who express their willingness to move in this direction.

— The degree of consolidation of DDRP in each country is crucial to move toward the establishment of the accreditation systems. In some countries the feasibility of putting in place systems of accreditation is reduced for all types of programmes, while in others it is considered feasible for virtually all categories.
POSSIBLE STRATEGIES FOR THE IMPLEMENTATION OF ACCREDITATION IN DDR

The information collected and the views and positions expressed by technical and institutional representatives who have participated in the various phases of the Project permit to establish a number of starting points, which influence the strategies to adopt in order to facilitate the development and implementation of tools, resources and forecasts (legal, training or any other type), which allow the implementation of national or supranational accreditation systems of drug demand reduction programmes (DDRP):

— The stage from which the various options and strategies must be valued to promote the implementation of the accreditation systems is conditioned by two mutually reinforcing emerging processes:
  — The consolidation of a new way of dealing with drugs consumption and the problems associated with it. There is a growing need to consider the results obtained and the available research, compared to ideological or moral viewpoints, previously more influential. This new perspective could be summed up as the need to promote policies and programmes based on scientific evidence, including the evaluation of results.
  — The incorporation of the culture of quality for the services provided by public institutions to the general population in the field of drug demand reduction (DDR). The improvement of the quality of programmes is imposed as an inexorable requirement between institutions and professionals responsible for the development of programmes, and the target beneficiaries. Process that is reflected in the recognition of the right of the programme beneficiaries to receive a specific set of quality services provided by the different institution and in the demand on the institutions to provide financial support only to programmes and services which have demonstrated their effectiveness and efficiency.

— The path toward the improvement of the quality and effectiveness of public services is irreversible, regardless of how much strategies or moves in this direction change.

— The current reality of DDRP in the countries that participate in COPOLAD is complex and heterogeneous, which forces the establishment of flexible strategies to advance in the field of the accreditation of the programmes.

However, the heterogeneity of the sector in the different countries does not justify immobility or a passive response to the accreditation process. It is not reasonable to expect to change certain national realities (that the different categories of programmes reach a high degree of development and consolidation in the country) to begin working on the development of instruments, resources and plans, to move forward toward the establishment of accreditation systems. It is the implementation of the accreditation systems what can decisively contribute to the establishment of increasingly better policies and programmes based on the available evidence.

Taking these considerations into account and the fact that the implementation of supranational accreditation systems is a complex process which must overcome many obstacles and resistance and that takes time to consolidate, it is suggested to adopt a progressive strategy that allows the employment in the medium term of a supranational
DDR-P accreditation system in which a relevant number of countries of the Ibero-American community can participate.

The Strategy described below is based on the following assumptions:

— Regardless of the willingness shown by technical experts and representatives from the participating institutions to support the implementation of a supranational system of accreditation, this is a goal that is only viable in the medium to long term.

— The achievement of this goal requires the adoption of a series of measures or preliminary and unavoidable steps.

— The steps proposed have a sequential character and must be undertaken gradually.

— The DDRP accreditation criteria agreed upon in the framework of the project should be considered as basic principles of this process in order to foster the development of the most harmonious national measures conducive to creating an accreditation system at supranational level.

— The ultimate reason for the implementation of the accreditation systems is not only to facilitate the control of the contents of DDRP, but also to encourage the improvement of their quality and, as a consequence, of their effectiveness and efficiency. Such systems should therefore contribute to the programmes gradually improving their design and implementation.

Considering these assumptions, it is proposed to adopt a potential strategy that incorporates the following phases:

| PHASE NO. 1: |
| Development of tools, resources and previsions (jointly in the Latin American context) to advance toward the accreditation of DDRP in each country |

The implementation of the accreditation systems, both national and supranational, requires certain instruments and resources that make it viable, among which it is worth highlighting:
— Training by responsible authorities to start a professional capacity building plan at the local level.

— Design of the instruments to be used for the collection of information on the programmes developed in the field of DDR, which define the content that is considered relevant to register for future possible accreditation.

— Development of tools to support the planning of programmes in each area of action in DDR.

— Preparation of guidelines for the implementation of a national accreditation system.

— Legal framework at the national level in each country concerned, which regulate the characteristics and minimum content requirements for the opening of services and the implementation of programmes in all areas of DDR.\(^\text{11}\)

PHASE NO. 2: Development of national accreditation systems

Once the instruments and resources described in the previous phase are developed, we would be in a position to set up national systems of accreditation, a decision that must be unavoidably accompanied by the development of a legal and regulatory framework for all processes, instruments, procedures and accreditation bodies.

As pointed out above, having legal or administrative developments in place that regulate the sectoral accreditation of certain categories of DDRP (e.g., treatment centres) does not imply that a national accreditation system is operative. The legal regulation of the processes and procedures for the accreditation of DDRP is a basic element and essential part of a system of accreditation, but it is not the only one.

The regulatory framework governing national accreditation systems of DDRP can only be considered completed insofar as certain issues have been resolved beforehand, such as the identification of the required criteria to obtain accreditation, the information to be provided by the programmes wishing to be accredited, the availability of a standardised instrument of collection and regular updating of such information, the weighting of the various criteria for the accreditation or identification of the agency or public or private body responsible for formally accrediting the programmes.

With independence of the capacity of national authorities to regulate their policies in the field of DDR, the development of national systems of accreditation should follow the basic criteria agreed upon within the framework of COPOLAD, which would lead to the convergence of what has already established in the respective national systems. This would facilitate the implementation of supranational accreditation systems on the basis of national systems that share a number of common elements, which in turn would provide added value to the national ones.

The implementation of national systems of accreditation is therefore considered, in the framework of an overall strategy, as a preliminary and necessary phase before proceeding

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\(^{11}\) It is necessary not to confuse this legal and regulatory framework for the minimum requirements to be met by DDR services and programmes with an accreditation system as such, which — in addition to these legal provisions — defines procedures, processes and accreditation bodies to be integrated.
to assess the implementation of a system of accreditation at supranational level, which the largest possible number of Latin American countries can join.

PHASE NO. 3: Development of supranational accreditation systems

The establishment of a supranational accreditation system constitutes the final stage of a process devised to be consolidated in the medium-long term. The contents of such a system could take different forms, each one of them with a greater or lesser degree of demand, which determines its viability and the number of countries that are in a position to join it.

It should be noted that having a supranational accreditation system in the Latin American context, which in addition may be in harmony with the processes currently being developed in the European Union (or at least in some of its member states), provides significant advantages, adding value to the efforts made at the national level in the area of accreditation. Among these potential benefits it is worth highlighting the cost and effort saved, the improvement of impact comparability of the implementation of DDR strategies in the different countries, or the availability of common capacity building tools.

Below we describe different options for the implementation of the accreditation systems of supranational character, pointing out their advantages and disadvantages. It is however necessary to bear in mind that the viability of the different options depends to a large extent on agreeing on what supranational12 entity will be assigned with the management of the system, which in turn reports to the institutions that decide to be involved in the project.

1st OPTION: Establishment of supranational accreditation systems independent for each of the different categories of DDRP, supported by a small number of "minimal" criteria shared by a set of countries and multilateral entities.

This strategy would ensure the adherence of the greatest possible number of entities to an accreditation system of supranational nature on the basis of globally reducing the requirements to be met for obtaining DDRP accreditation and being more accommodating when registering the different countries in the accreditation systems of the various categories of DDRP.

This option would look to facilitate the implementation of the accreditation systems shared by the largest possible number of Latin American countries who would like to be included, by significantly reducing the basic or mandatory criteria to comply with.

Based on the data provided in this study on the present situation of the regulatory frameworks of the programmes, the minimum criteria to be included by a supranational system could be those collected under the heading of "Basic Criteria".

12 Possibly non-governmental, although at the moment it is premature to speculate on such a degree of detail, given that previously would have to make all kinds of surveys, both legal and availability or sources of resources.
In addition to adopting the basic criteria required for accreditation, entities could also embrace one or more accreditation systems established for the various types of programmes (systems of accreditation of prevention, treatment programmes, etc.).

2nd OPTION: Establishment of unique supranational accreditation system for all categories of DDRP, to which countries adhere in order to implement all the criteria agreed upon for each of the categories of DDRP.

This strategy would focus on establishing a more demanding set of criteria to be met by the accreditation systems, which would imply assuming that only a limited number of countries would be capable of joining this single accreditation system for all DDRP programmes. The criteria that would integrate this system would be the one described under the 3rd option, with the requirement that entities that decide to join it agree to fulfilling all the basic or compulsory criteria, and not only those that apply to certain types of DDRP.

On a practical level, this strategy implies accepting the existence of different paces or speeds in the start-up of supranational accreditation systems. In an initial phase, only countries with more consolidated programmes might adhere to it, although at a later stage other interested countries in establishing accreditation systems might join, as they become more capable of meeting the commitments established for accreditation.

The initial inability of some countries to become part of this one supranational accreditation system for all DDRP, is not incompatible with their beginning to set up “sectorial” national systems of accreditation (applicable to prevention, treatment programmes, etc.) supported by criteria that coincides with the one proposed in the supranational accreditation system.

The advanced criteria identified in this Project would form the basis of this system of accreditation.

3rd OPTION: Establishment of supranational systems of accreditation for the different categories of DDRP, to which countries that so wish adhere freely.

The base of these systems would be the same, it would be formed by the same criteria as the used ones in the 2nd option (Advanced Criteria).

To consolidate the supranational character of these systems, every country would commit itself to implementing the accreditation criteria in only one area (e.g., in prevention programmes) or in several ones (e.g., in prevention and treatment programmes). In contrast, the countries that chose to adhere to a supranational system of accreditation should also aim at incorporating all the criteria agreed upon by consensus into their national accreditation systems.

The proposed strategy would be characterised by the flexibility of every country in the decision to adhere to the system and by their rigorous commitment to fulfil the criteria agreed between partners and collaborating entities.
The main advantages and disadvantages of each of the options mentioned above are summed up as follows:

<table>
<thead>
<tr>
<th>ADVANTAGES</th>
<th>DISADVANTAGES</th>
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<tbody>
<tr>
<td><strong>Phase no. 3 (1st Option)</strong></td>
<td></td>
</tr>
<tr>
<td>— The possibilities of starting up supranational accreditation systems of DDRP are increased.</td>
<td>— It does not ensure that the accredited programmes are in conformity with the evidence based quality criteria associated with the effectiveness and efficiency of DDRP agreed upon by the Delphi groups, within the framework of COPOLAD.</td>
</tr>
<tr>
<td>— It allows to expand the basic criteria for accreditation in the future (in the medium and long term the rigour required to accredit programmes can be strengthened).</td>
<td>— The accreditation criteria would only be required for certain programme categories, those to which each entity decides to join, without guaranteeing that all DDRP meet the required accreditation criteria within each country.</td>
</tr>
<tr>
<td>— It gives each entity or country the flexibility to decide what systems of accreditation of the different categories of demand reduction programmes to adhere to.</td>
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| **Phase no. 3 (2nd Option)** | |
| — The accreditation criteria would help to substantially improve the effectiveness and efficiency of DDRP. | — Only countries with a greater degree of development and consolidation of DDRP could be incorporated into a system of accreditation at supranational level. |
| — All the programmes, regardless of their typology, would have criteria for accreditation. | — Countries with greater delay in the establishing the accreditation systems would be initially excluded in the process. |
| — It would provide a harmonised response to the accreditation needs of the countries most committed to pursuing quality and excellence in their programmes. | |
| — It could serve as a stimulus or incentive to move forward to countries with greater delay in the implementation of the accreditation systems. | |
Phase no. 3 (3rd Option)

— It allows for heterogeneity in the development of policies and programmes at national level, enabling each country to implement accreditation systems in the areas which they consider more necessary or where the programmes are more consolidated.

— It follows in general terms the accreditation criteria of DDRP agreed upon throughout the Project.

— It allows to move forward in the implementation of accreditation systems in the most consolidated areas (prevention and treatment programmes).

— It facilitates that most entities and countries be linked to at least one of the "sectoral" accreditation systems.

— The accreditation criteria would only be required for certain programme categories, those to which each entity decides to join, without guaranteeing that all DDRP meet the required accreditation criteria within each country.

— Some countries would not be able to join any of the supranational accreditation systems, as they are incapable of fulfilling the required criteria agreed up for the national DDRP programmes, which would be in favour of reducing the basic criteria required for accreditation.

SET OF POSSIBLE MEASURES FOR SUPPORTING THE IMPLEMENTATION OF SUPRANATIONAL ACCREDITATION SYSTEMS

On the basis of the various measures suggested by the technical experts and institutional representatives participating in the Focus Groups, a series of procedures considered necessary to facilitate the implementation of supranational accreditation systems for drug demand reduction programmes (DDRP) were formulated.

— Dissemination of the results and conclusions of the Project by the Committees or National Drug Agencies of the countries that have taken part so far in this activity of COPOLAD, among the institutions, social organisations and professionals working in the field of drug demand reduction (DDR).

— Awareness raising by the Commissions or National Drug Agencies in those countries in favour of the implementation of programme accreditation systems, associating this measure with the rationalisation of public resources, the improvement of effectiveness and efficiency of the programmes and the quality of the services provided to the general public.

— Setting up at the national level, roundtables of sectoral work with representatives from the most relevant social institutions and organisations to promote the implementation of national systems of accreditation of DDRP (making the approval process and the implementation of the national accreditation systems as participatory as possible).
— Creation of supranational working groups that bring together countries with common realities with regard to the degree of development and consolidation of DDRP, to launch pilot projects of supranational accreditation systems. These working groups will also be able to move forward in:

— The content definition of capacity building programmes in order to provide training to the authorities responsible for starting vocational training plans at the local level.

— The design of an instrument for the collection of information on programmes, that sets the minimum requirements.

— The development of tools to support programme planning of in each area of intervention in DDR.

— The preparation of guidelines for implementation of national accreditation systems of DDR programmes.

— Creation of a technical assistance service designed to provide support to all the Commissions or National Drug Agencies of the partner countries and partners involved in the implementation of the accreditation systems, both national and supranational (this measure would be conditional to the securing of financial support).
Annex III

ADVISORY COUNCIL OF THE COPOLAD’S QUALITY AND EVIDENCE PROJECT: AGREEMENTS AND RECOMMENDATIONS TO PROMOTE ACCREDITATION SYSTEMS IN DRUG DEMAND REDUCTION SERVICES

On the 14 and 15 October 2013 the Project Advisory Council\textsuperscript{13} met in Madrid (Spain) in order to reach consensus on agreements and recommendations on the steps to prioritise to move toward the establishment of programme accreditation systems for drug demand reduction programmes (DDRP).

In the framework of this meeting and bearing in mind the Executive Report submitted to the Council, which summarised the proposals made by the different actors involved during the course of the project and identified actions and measures that can contribute to the setting up and development of accreditation in key drug policy areas, this Advisory Council:

— Having seen the content of the Executive Report submitted for the consideration of the members of the Advisory Board, including the listings of basic and advanced criteria agreed upon throughout the project.

— After analysing the current situation of the legal framework that regulates the accreditation in the various countries represented in the Advisory Council, and identified the main challenges to be addressed by the countries for the incorporation of various quality criteria based on the evidence that would facilitate the establishment of accreditation systems at national level.

— Having reviewed the legal, administrative and technical actions supported to date by the institutions and entities represented in the Advisory Council to encourage the implementation of DDRP accreditation systems, as well as the actions planned in the short term; and

— Having analysed the position of all entities of the Advisory Council with regard to the feasibility of establishing systems of accreditation for all DDRP:

The entities represented in the Advisory Council coincide in pointing out that the majority of the countries do not have a specific accreditation system for DDRP, in some cases there are regulation mechanisms for the different health areas and levels of care directed towards treating people with problems related to the use of psychoactive substances. These mechanisms are regulated inside each state by various government agencies and, on occasions, achieving the necessary inter-agency coordination has proven to be difficult.

\textsuperscript{13} Council formed by representatives from all the institutions participating in the first phase of the Project: National Agencies: CONADIC-Mexico; CONSEP-Ecuador; DGPNSD-Spain; DEVIDA-Peru; ICD-Costa Rica; MOJ-Colombia; SEDRONAR-Argentina; SENAD-Brazil; SENDA-Chile; SICAD-Portugal and JND-Uruguay. Other institutions: Inter-American Commission for the Control of Drug Abuse (CICAD-OAS); Execution and Coordination Body (ECB-COPOLAD); Institute of Social Work and Social Services (INTRESS); The European Monitoring Center for Drugs and Drug Addiction (EMCDDA); Pan American Health Organization (PAHO) and Ibero-American Network of NGOs working in Drug Addiction (RIOD)
In this context, the main challenges to be addressed by the countries to move toward the future establishment of national systems of accreditation are:

— Tackling in an efficient and operative manner the complex and necessary inter-agency and inter-ministerial coordination.

— Providing a greater degree of inclusion and participation of social partners in the planning of intervention strategies.

— Promoting processes of accreditation of programmes that are currently being developed both in the public and private spheres, either on the part of governmental entities or by civil society organisations.

On the basis of the challenges identified, the participants in the meeting of the Advisory Council, adopt the agreements and recommendations which are presented below.

**Agreements**

The countries and multilateral institutions represented on the Advisory Council express their agreement with a set of measures for the short and medium term that can contribute to driving, both to the adoption of the accreditation criteria agreed upon in the framework of this project, as well as the development and implementation of the accreditation systems of demand reduction programmes (DDRP). All participants expressed their commitment to implementing the systems, recognising that this is an attempt to establish the bases to face a challenge whose achievement in the short, medium and long term requires political will, a normative basis in each country, a minimal investment of resources, and the implementation of training activities, dissemination and awareness-raising, as well as count with the participation of all the social actors involved in the issue.

Some of these measures are raised in the aforementioned Executive Report submitted for evaluation to the Advisory Council, and others were raised during the meeting. These measures are the following:

— Dissemination of the results and conclusions of the project between the institutions, social organisations and professionals who work in the field of drug demand reduction (DDR). Responsible for such dissemination are the Commissions or National Drug Agencies of the countries that have so far taken part in this activity of COPOLAD, multilateral organisations collaborating in it (CICAD, PAHO, RIOD), and the Execution and Coordination Body (ECB) of COPOLAD. It is considered essential in these activities of dissemination of the results of the project to incorporate, among other key actors, professionals who participated in the Delphi groups.

— Publication by the COPOLAD Programme of the basic criteria for the accreditation of DDRP, agreed upon in the framework of the Project, organised according to the different areas of intervention to facilitate its dissemination, and which that can serve as a point of reference to countries that want to use them.

— Commitment on the part of the countries represented on the Advisory Council of:
  — Taking the criteria agreed upon within the framework of COPOLAD as reference in order to develop their respective national accreditation systems. Depending on the degree of development of each country, it will opt for the basic or the advanced criteria (listed and described earlier in this publication).
— The progressive establishment of national accreditation systems of DDR, incorporating at least the areas of prevention, treatment and social integration.

— Awareness raising by the Commissions or National Drug Agencies in the countries, in favour of implementing of systems of accreditation of programmes, associating this measure with the rationalisation of public resources, the improvement of the effectiveness and efficiency of the programmes and the quality of services provided to the general population. These dissemination and awareness activities will be more effective to the extent that they use differentiated strategies depending on the target audience they are intending to reach and by involving key actors in this field.

— Incorporation of evidence based quality criteria, as well as the reference to the need to put in place systems of DDRP accreditation on the agenda of the multilateral organisations that have participated in this Project (CICAD, PAHO, RIOD).

— Promotion of actions to achieve the cooperation of other multilateral agencies such as the United Nations, to support the establishment of the accreditation systems, within its field of competence.

— Development and promotion of the use of support resources to follow up the progress made in each country and strengthen its implementation, with the purpose of providing support to the Commissions or National Drug Agencies of all beneficiary countries of COPOLAD concerned in the implementation of the accreditation systems, both at national and supranational level.

Among these resources, in the framework of the COPOLAD Programme, in the short term will boost:

— The opening and promotion of an experience exchange platform in the COPOLAD e-room that facilitates interaction and debates on the development of accreditation systems, at the same time as enabling the sharing of information on best practices and available evidence in relation to the implementation of accreditation systems for DDRP; helping less advanced countries in the development and implementation of their accreditation systems.

— The progress of interventions to complement the portfolio14 of services and care interventions that are available in each country, as a prior step to the implementation of accreditation systems of programmes for the treatment of drug addiction.

— In the framework of the CICAD-PAHO cooperation, encourage the development of national systems of accreditation of DDRP, taking into consideration the criteria agreed upon within the framework of COPOLAD.

— The Pan American Health Organization (PAHO), as the agency responsible for health in the inter-American System and as a collaborating organisation in the COPOLAD consortium, is fully committed to:

— Providing technical support to the progress made on the issue of accreditation of DDRP in the Region of the Americas, in the framework of its Regional Strategy and Plan of Action on the use of Psychoactive Substances and Public Health, through its

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14 This recommendation has already been initiated in the framework of the COPOLAD Programme and consists in the development of a directory of centres and services, in which currently most of the countries of Latin America have already begun to enter information.

Available at: https://www.copolad.eu/directorio-de-centros-y-servicios
national representation offices and focal points in the health ministries of the member countries.

— Articulating the development of accreditation systems of DDRP, with the implementation of the programme Quality Rights (QR-WHO), aimed at assessing and improving the quality and Human Rights in mental health and social assistance services in the member countries.

— To coordinate with other agencies and international institutions (e.g.: CICAD/OAS, RIOD) support for the development of national and supranational systems of accreditation of DDRP.

Recommendations

Although all the measures agreed by the Advisory Council are considered as necessary in order to consolidate the accreditation systems of drug demand reduction programmes (DDRP), the recommendations under this heading are those whose implementation would require additional support by the countries or other institutions, in the form of human or economic resources, and that – in part – could be seen in a potential second phase of the COPOLAD Programme.

— Development of a glossary of terms related to the processes of accreditation in order to standardise the language used and the existing approaches.

— Launch at the national level roundtables of sectorial work with the representation of social institutions and organisations that are most relevant to promote the implementation of national systems of accreditation of DDRP (in order to make the process of approval and implementation of the national systems of accreditation as participatory as possible).

— Creation of supranational working groups that bring together countries with common realities with regard to the degree of development and consolidation of DDRP, to launch pilot projects of supranational accreditation systems. These working groups will also be able to move forward in:

  — The content definition of capacity building programmes in order to provide training to the authorities responsible for starting vocational training plans at the local level.

  — The design of an instrument for the collection of information on programmes that can help to guide the planning and development of these programmes, highlighting the minimum requirements that should be incorporated.

  — The dissemination of tools to support the planning of DDRP.

  — The preparation of guidelines to implement national systems of accreditation of DDRP.

  — Preparation of a set of arguments which demonstrate the advantages, solutions and opportunities of having a national accreditation system for DDRP, highlighting in particular the potential costs that would be incurred without it.

  — Promotion of differentiated dissemination/communication strategies on the need to establish systems of accreditation for DDRP and the benefits derived from having them, depending on the target audience (political and institutional leaders, NGOS, professionals in the sector of drug demand reduction, etc.).
— Creation of an instrument of support to facilitate and offer technical assistance to the National Drug Agencies that so wish and provide follow-up and visibility to the progress made in each country.

— Although recognising the sensitive difficulties that implies the establishment of a supranational system of accreditation of DDRP, all countries agree that it would be desirable to maintain this objective in the long term.
INTRODUCTION

The complex phenomenon of the use of psychoactive substances varies between the countries of Latin America and the Caribbean, as well as within them, and is determined by multiple biopsychosocial factors, ranging from an individual dimension to a broader radius embracing the entire population.

Among the varied aspects of this phenomenon, the consumption of different substances, depending on elements such as the dose, frequency, route of administration and the time of consumption, may result in chronic and acute negative health conditions, which require attention.

Additionally, a considerable number of elements that determine the environment of the person can contribute to his/her vulnerability rate, e.g. the level of development, urbanisation and the services available. That is why the consumption, its impact and implications are different in each case and therefore require an approach tailored to meet the individual needs. However, the common features the different cases share represent large areas of opportunity for the design and implementation of public policies.

From a modern perspective, the governments of the countries of the Americas agree that in order to develop viable response options to this problem, interventions focused on Public Health should be supported. Essential elements of such an approach are the different modalities of treatment services that offered to persons with problems of drug abuse. There is currently a significant gap between the care requirements and the level of services available to address the problems caused by substance consumption, progress should therefore be made toward the implementation of service treatment portfolio that is accessible, timely, without discrimination, in a framework of respect for Human Rights, with the greatest freedom, security and effectiveness possible.
To facilitate this process in the different countries a working group\textsuperscript{15} was formed within CICAD that compiled and revised regulation and normative instruments that are available in the different countries, as well as other valuable background of a range of international agencies such as the United Nations Office on Drugs and Crime (UNODC), the World Health Organization (WHO), the Pan American Health Organization (PAHO) and the Programme of Cooperation between Latin America and the European Union in Drug Policies (COPOLAD).

As a result of this work, this document presents a compilation of the essential characteristics that can and should be taken into account so that the countries of the Americas may develop their own guidelines, and by implanting them, promote the progressive increase in the levels of quality in the treatment of problems associated with the drug consumption. To guide this process three levels of criteria should be taken into consideration: 1) the essential, which refer to the minimum level expected; 2) the basic, as a prerequisite to continue the commitment toward quality improvement; and 3) the advanced, oriented toward achieving excellence.

**JUSTIFICATION**

It is the responsibility of governments to protect the health of the population, as well as to provide universal access to care services whose quality is guaranteed. For this reason, it is in their competence to develop laws, standards, public policies, strategies, programmes and interventions that will safeguard this warranty. With the intention of reaching this objective, policy instruments, strategies and hemispheric or regional\textsuperscript{16} plans of action should pay careful attention to the problems related to the use of psychoactive substances, which have been recognised as “Public Health issues” by the countries in the region of the Americas.

It is the responsibility of each country to define the model and way in which care services are to be organised that is best suited to their context and needs, as well as outlining the policies and management mechanisms that give viability to that model and translate it into effective responses, appropriate to the health related demands of the use of psychoactive substances.

To facilitate this task, reference documents have been developed at the global, regional and national levels, on the principles that should guide treatment service provision, the rules of operation, as well as standards and verification compliance procedures.

In the case of the Americas, the Basic Principles for the Treatment and Rehabilitation of Abuse and Drug Dependence in the Hemisphere, produced in 2009 by the Group of Experts on Demand Reduction of CICAD-OAS, specify a series of conditions to be considered in provision of services, such as guaranteeing access to them, the protection of Human Rights, the use of the scientific evidence as a guide in the intervention protocols, care provision

\textsuperscript{15} Working Group CICAD: Alexandra Hill, Chief of the Section of Drug Demand Reduction, CICAD; Jose Luis Vázquez-Martínez, Specialist in Drug Demand Reduction, CICAD; Luis Alfonzo Bello, Regional Adviser on Substance Abuse, Pan American Health Organization, PAHO/WHO. Consultants: Mariano Montenegro, Psychiatrist Specialist in Addiction Treatment; Bartholomew Perez-Gálvez, psychiatrist specialist in treatment of addictions; Juan Palacios, President of the Latin American Federation of Therapeutic Communities (FLACT).

\textsuperscript{16} Hemispheric Strategy on Drugs (CICAD, 2010) and Plan of Action; Strategy on the Use of Psychoactive Substances and Public Health (PAHO, 2010) and Plan of Action (PAHO, 2011); Basic Treatment Principles WHO-UNODC.
that is integrated into the health system, with different levels of complexity and by qualified personnel, as well as use of information as support for the planning and evaluation of activities.

However, in the current reality of the countries of the region\textsuperscript{17}, similarly to what occurs with health service provision in general, the attention provided to the population affected by problems caused by psychoactive substances is segmented and fragmented. The treatment services available have been developed mainly outside the public sector, within a weak healthcare network, composed mainly of establishments or units not integrated, which are in charge of individuals and non-governmental organisations, where religious associations have great relevance. The public services on offer are mainly represented by the network of mental health care and share with it a lack of appropriate resources, as well as the asylum features that predominate in the Hemisphere.

In this scenario, there is a great heterogeneity in the definition and application of the criteria that each country requires for treatment centres for people with drug use problems to operate. Definitions, legal terms, procedures and competent authorities are different, which make it difficult to establish homogeneous processes guided by international standards. There is also differences in the criteria that the different treatment centres already authorised must meet in order to either be able to continue working, or to be recognised, accredited or certified, as the case may be.

In order to develop a quality assurance process in this area, it is essential that each country may facilitate and support the joint participation of the responsible authorities for dealing with the drugs problem, different areas of the health sector, and other actors and institutions that are involved in the provision of care for people with problems linked to the consumption of alcohol, tobacco and other drugs\textsuperscript{18}.

Different initiatives are in progress in this field on the part of national and international agencies and regulation instruments have already been generated in several countries at different levels of development. Noteworthy are the efforts made by organisations such as WHO, with its projects of \textit{Evaluation of Care in the Treatment of the Abuse of Psychoactive Substances} in 1993 (which served as the basis for the \textit{Programme of Minimum Standards} developed jointly by PAHO and CICAD, then replicated by UNDCP in Central America) and \textit{Programme Quality Rights} (WHO, 2012). More recently, UNODC developed the Quality Standards for the project \textit{Treat Net II} (2010) and, without a doubt, the valuable work developed by the Programme of Cooperation between Latin America and the European Union in Drug Policies (COPOLAD) excels, which through a profound process of systematic review of the literature and evidence available, as well as the formation of focus groups and Delphi groups, has managed to consolidate a document that provides a definition of the criteria for the accreditation of demand reduction programmes (COPOLAD, 2014)\textsuperscript{19}.

With the support of this accumulated experience, the following pages represent a reference and supporting tool to increase the quality and efficiency of treatment services.


to address health problems linked to substance use, based on standardised criteria needed for defining the essential requirements for their implementation.

**SCOPE OF THE DOCUMENT**

The criteria presented are a proposal to be taken into consideration by the relevant authorities, so that respecting the sovereignty and the area of competence of the sanitary regulations, each country might take them into account as part of the requirements and elements that treatment centres for people with problems of drug use should follow.

Similarly, the characteristics and the type of interventions that are understood as treatment should also be determined. Ideally this should be stipulated in a law (commonly health laws), or at least in some regulatory or normative instrument that derives directly from the law. In this manner support is provided to the structure guiding the therapeutic interventions that are offered to the population. To this end, some useful references are:

— According to the Committee of Experts of the World Health Organization (WHO) on Drug Dependence, the term **treatment** applies to the "process that starts when users of psychoactive substances come into contact with a provider of health services or other community service and can continue through a succession of specific interventions until high possible level of health and well-being is reached."  

— The United Nations Office on Drugs and Crime establishes that treatment can be defined in general terms as one or more structured interventions to treat the health and other problems caused by the abuse of drugs and increase or optimise the personal and social performance.

A systematic approach is required to address the problems related to the consumption of psychoactive substances with a broad and integral perspective, through continuous articulated and interconnected interventions, counting with the participation of multiple relevant sectors in what is called "Comprehensive System of Services".

The recommendations contained in this document may well be applicable in several areas, for practical purposes we will focus on those specific services related to the treatment of people with a diagnosis of **mental behavioural disorders due to the consumption of psychoactive substances** (ICD-10, WHO) and which we will call in the context of this document "treatment centres". These are the operational specialised units that are linked with other type of public health sector services, such as primary health care units, general and specialised hospitals, and mental health services. In the social and private sectors there are the self-help groups and other forms of community organisations. Beyond the health sector, there is also a link with the criminal justice system and the Social and Educational Development sector, among others. There should also be coordination with universities and other educational institutions where various professional profiles are taught, such as those in the area of health.

For practical purposes, the criteria presented is dealt with from two axes of approximation:
— **Organizational axis**: it divides the criteria into two categories, depending on whether there are "structural" or "functional and process" aspects.

— **Temporary axis (sequential)**: it defines the starting point linked to a baseline or a minimum required to be included in the category "treatment centre", and also the follow-up, which raises the general characteristics of the requirements to be met or achieved in time.

**GENERAL RECOMMENDATIONS**

— Considering that the disorders caused by the consumption of psychoactive substances are linked to the health state of the person, they should be addressed by the public health sector, therefore the persons or institutions working in this field are subject to the regulations set by the government entity in the field of health, through policies, norms, regulations and other instruments applicable in each country. This is regardless of the sector to which they belong, whether public, social or private.

— The authorisation to initiate functions granted to the centres that meet the requirements of the competent authorities must be limited in time. Each country shall set the most convenient timeframe for the local settings.

— There should not be a qualifying period applicable to the indispensable requirements, as they all involve situations that affect the safety of users of the services. When it comes to criteria whose implementation corresponds to standards that exceed the essential level, a waiting time can be set to achieve them depending on the particular circumstances, this however should not exceed one year.

— The supervision of treatment centres must be done periodically, it is recommended that it should be carried out annually, increasing the frequency depending on the circumstances and the availability of resources.

— "Committees for Service Quality Assurance" should be set up and coordinated by the health authority, with the support of the commission on drugs, the local governments, community representatives and the service providers. These committees must schedule and run the supervisions, as well as prepare reports with recommendations for the continuous improvement of the quality of the services. The result of the monitoring should be shared with both, the competent authorities and with the establishments supervised.

— The regulations in force in each country must establish the impact or sanctions that are derived from the monitoring of treatment centres when misconduct is identified.

— Consideration should be given to the possibility of applying mechanisms of closure, temporary or definitive, for certain cases that deserve it, especially when the integrity, safety or life of the people attended is put in danger.
ESSENTIAL CRITERIA FOR OPENING AND OPERATION OF TREATMENT CENTERS

CRITERIA STRUCTURAL

Category 1: Infrastructure and facilities

— The facilities that house the treatment centre and the surrounding environment must comply with the requirements necessary to ensure the safety of the patients and staff:
  — Safe and resilient environment (e.g. in cases of natural hazards such as flooding, ground subsidence, etc.).
  — Compliance with rules and regulations in force on infrastructure and sanitation standards (earthquake-resistant, etc.).
  — Spacious surroundings avoiding overcrowding of patients and facilitating their evacuation in cases of emergency (evacuation routes clearly marked).
  — The residential treatment centres that perform functions of detoxification or hospitalisation shall be governed by the sanitary regulation in force.

Category 2: Ethical principles and rights of the beneficiaries of the programmes

— The centre must have specific rules that protect the rights of users, prohibiting degrading and inhumane treatment, in accordance with the practice set forth by the Charter on Human Rights of the United Nations.
— Prior to admission, it should be communicated in writing, adequately explain to ensure understanding, both to the user and to his family as well as to the competent authority, details on the treatment process and its costs, all should express their informed consent for the actions to be taken.

Category 3: Regulatory Aspects

— The centre must have legal personality and registration according to the legislation and regulations in force.
— The centre must have internal rules of operation and operation manuals, in writing and available, the contents of which must be reported to the staff, users and family members.
— The manual of the treatment programme developed by the centre should be available in writing, specifying the model of care developed and its scientific foundation, the timetable of activities and the staff responsible for its implementation.
— The centre must have specific procedures for the management of treatment of people in special situations (minors, population in conflict with the law, persons in situation of street, etc.).
— The centre must have a civil protection plan managed by a committee specifically designated to meet contingencies and emergencies.
Category 4: Financial Aspects

— The centre must have an administration unit responsible for all aspects relating to the financing of services and for keeping the corresponding records.

Category 5: Human Resources

— The treatment centre must have a clearly identified legally responsible person for its functioning.

— The treatment centre must count with a director or technical director, who should be professional or university educated and ideally have training and experience in the treatment and management of addictions.

— It counts with a minimum number of professionals and health technicians, according to the treatment plan designed and committed to implementing the programme. As a guideline, the parameters (ratios) of professionals by number of inhabitants set out in the treatment protocols should be followed.

— The professionals, technicians and assistants who participate in the programme have the necessary competence.

— There are mechanisms for monitoring and replacing of staff.

FUNCTIONAL AND PROCESS CRITERIA

Category 6: Organisational aspects

— A written report of the activities carried out and planned in accordance with the programme of treatment and rehabilitation should be in place.

— Staff and patients should be fully aware of the procedures to follow in the event of emergencies (e.g., evacuation plans and action before contingencies), based on a Civil Protection Plan.

— Regulatory compliance with labour and tax laws.

— There is a programme established for the regular monitoring of the performance of professional, technical and auxiliary staff.

— A continuous training plan and upgrading of professional, technical and auxiliary staff is in place based on the model of care developed by the treatment centre.

Category 7: Information and documentation systems

— The treatment centre must have a system of registration and monitoring of the patients attended. The process of safeguarding the information collected in the centres should be safe, guaranteeing confidentiality and a clinical follow-up.

— Treatment centres should be linked with relevant institutions in the areas of registration, analysis and dissemination of information on the activities carried out and their impact.

— The treatment centre reports on its activities and prepares statistical information collated in a central system, which is accessible to the...
authorities concerned (health, statistics and Commission on Drugs) in accordance with the laws and regulations in force.

**Category 8: Mechanisms for collaboration and coordination**

- The treatment centre should be linked to social institutions networks and to the existing health care system, as well as with community support services.

- A patient referral mechanism to various health, social and community support networks is defined and systematically used.

- Treatment centres, especially residential ones, should have clearly defined mechanisms through which a person accessed the treatment, in accordance with adequate legal and ethical standards.

- Treatment centres, especially residential ones, should have mechanisms of first aid and reference of emergency situations for its subsequent resolution, in accordance with their operational capacity and health legislation in force, and in line with human rights standards.
APPENDIX

Basic principles of the treatment and rehabilitation of drug abuse and dependence in the Hemisphere

Drug dependence is a chronic and recurrent disease with multiple determinants, both biological and psychological as well as social, which must be addressed and treated as a matter of public health, as other chronic diseases are.

The following basic principles derived from scientific research shall govern the policies and practices in the provision of services for the treatment of drug dependence:

Access, non-discrimination and respect for Human Rights

1. Prevention programmes as well as treatment programmes for drug and alcohol dependence and abuse must safeguard the respect for the human rights of the persons who access them. Treatment programmes will be offered in an environment which is as little restrictive as possible to ensure the safety of the user and the staff. The treatment plan should actively involve service users in its elaboration, jointly with the therapeutic team, on the basis of informed consent.

2. Treatment services should be accessible to the population that needs them, without discrimination on grounds of age, gender, race, religion, social or economic condition or political affiliation.

The treatment of drug dependence must be governed by specific protocols based on the scientific evidence available

3. The treatment protocols should offer therapeutic interventions derived from the scientific evidence available or, in the absence of convincing evidence, the consensus of experts in treatment. These protocols should define the duration of treatment, and recommend the most appropriate therapeutic options for each person, as well as the skills required by the different professionals that make up the treatment team.

4. The care services must be organised as a system of treatment based on public policy within a strategic framework to guide the different therapeutic interventions and services, that should be reflected in the provision of continuous care, ensuring their incorporation into the health system in coordination with other relevant social sectors, such as housing, social development, employment training, education and family support.

5. The treatment offered must be diversified to adjust it, in as far as possible, to the profile of the patients based on the prior determination of their health needs. These services should include strategies for screening, early problem detection, clinical diagnosis, motivation to treatment, brief intervention, psychological and medical care and clinical follow-up, as well as relapse prevention and social reintegration.

6. The treatment must be conceived as a long-term process, which may require the participation of actors from various disciplines and in which multiple treatment episodes of different kinds may be required, in different combinations and different in duration, to achieve therapeutic success.

7. When defining the therapeutic interventions offered to the population, the following should be given primary consideration: different models of psychotherapies derived from the scientific evidence available or, in the absence of convincing evidence, the consensus of experts in treatment; the use of pharmacological treatment when the clinical diagnosis so requires and, if necessary, of a combination of psychotherapy and medication, among other interventions of proven effectiveness.

8. Treatment services should integrate models of care for people with problems of abuse or dependence on drugs that present comorbidity with other mental or physical health problems.

9. The most important tools for the timely detection of people at high risk of developing a dependency include screening and structured interviews. In the cases that require monitoring, interventions or short treatments can favourably modify the consumption trajectory and its consequences.

10. The treatment programmes must include strategies for social reintegration that allow the effective and productive linking of the individual with his/her community.

**Organisation of treatment services**

11. Drug dependence treatment services must be integrated, insofar as possible, with health facilities and establishments within the health system, to avoid that the segregation of those dependent on drugs from other patients.

12. Special units of care for acute complications linked to consumption should be established, especially for the management of detoxification and acute withdrawal symptoms; these units are inefficient when in isolation, but constitute a valuable support during the various steps followed by any treatment strategy.

13. The community-based treatment options should encourage the participation of the family and the community in the therapeutic process, informing and advising the parents, teachers and other relevant actors, as they play a fundamental role in the achievement and maintenance of the success of the treatment and social reintegration.

14. Governments should seek adequate funding of drug dependence treatment programmes, ensuring that these meet quality and accessibility standards and have the widest possible coverage.

**Qualified treatment staff**

15. The skills of the staff in charge of treatment must be guaranteed by systematic selection procedures and strengthened through specific regular training programmes and courses to improve the knowledge of both professional and non-professional staff. Treatment
services should, wherever possible, count with a multidisciplinary team capable of addressing the various care needs of the population that requires these services. To do this, it must promote training programmes that enable the accreditation and/or certification of staff working in the treatment programmes.

**Information systems in the treatment of drug dependence**

16. Strategies for supervision, monitoring and ongoing evaluation of treatment programmes must be developed and implemented. The strategies should assess the structure and functioning as well as the effectiveness, coverage and cost-benefit of the programmes, to be able to continuously improve the quality and appropriateness of the services provided.

17. Organising the treatment services must be based on a reliable, updated and agile information system that includes the registration of the diagnosis and clinical needs of the patients, as well as the monitoring and tracking of changes that occur in their symptoms and their evolution in order to evaluate the results obtained through the therapeutic interventions.