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Consensus building on minimal and ideal quality standards for prevention, treatment and harm reduction of substance use disorders

(COMIQS.BE)

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1. Introduction

During the last decade, the use of evidence-based interventions ('evidence-based practice') for the prevention, treatment and harm reduction of alcohol and drug problems has been emphasized increasingly (Berglund, Thelander & Jonsson, 2003; Miller, Sorensen, Selzer & Brigham, 2006). In Belgium, this resulted in a BELSPO-funded study "Evidence-based substance abuse treatment" which focused on the efficacy of available interventions and on the implementation of evidence-based guidelines (Autrique, Vanderplasschen, Pham, Broekaert & Sabbe, 2007). The evolution towards evidence-based practice is supported by an increasing number of systematic reviews, meta-analyses and evidence-based guidelines that provide insight in 'what works' and how these interventions should be implemented in daily practice (Autrique, Vanderplasschen & Sabbe, 2008). Despite clear indications regarding the effectiveness and applicability of specific interventions (e.g. contingency management, community reinforcement approach (CRA), multisystem family therapy (MST)), few standards are available for ensuring the overall quality of service delivery in substance abuse treatment and prevention. However, the implementation of quality standards and development of indicators for service delivery gained increasing importance for a variety of health problems at regional, national and international levels. This evolution is based on the assumption that quality standards are important tools to improve the effectiveness and quality of support and service delivery (UNODC, 2012). Quality standards should be regarded as 'generally accepted principles' or 'sets of rules for the best/most appropriate way to implement an intervention' (EMCDDA, 2013). Often, a distinction is made between minimum and ideal quality standards. Minimum quality standards are standards which should be met by all services. Ideal quality standards are standards that should be met ideally by all services, but which might not be feasible yet.

Given the limited application of quality standards in drug prevention, treatment and harm reduction across the EU, the European Commission decided in 2010 to tender a study on the development and implementation of quality standards and criteria for effective substance abuse treatment and prevention, involving more than 500 stakeholders from all over Europe. The EQUS-study on Minimum Quality Standards in Drug Demand Reduction, which was finalized in December 2011, resulted in a consensus list of over 70 quality standards that were accepted by a large group of practitioners, service providers and scientists across Europe (Uchtenhagen & Schaub, 2011). These quality standards refer to structural aspects, process components and outcomes at different levels (intervention, organisation and system level). Although the appropriateness of the suggested quality standards was acknowledged by experts from various countries, substantial differences were observed regarding patterns of drug use and drug policies, organization of health care and substance abuse services, and the degree to which quality standards were implemented (Schaub, Uchtenhagen & EQUS Expert Group, 2013). Consequently, these minimal consensus standards should be regarded as general guidelines and directives that need to be further adapted to meet the specific context and needs of Member States.

In Belgium, the development of quality standards and guidelines for prevention, treatment and harm reduction of alcohol and drug problems, is still in its infancy. Overall, there is a lack of generally accepted standards for the sector as a whole and quality requirements vary greatly depending on the type of facility (eg. hospitals, mental health centres and specialized drug treatment centres) and region (services that are financed by the regions have to follow different requirements). Some services are not required to meet any quality standards at all (eg. municipal prevention services), which creates uncertainty and offers few guarantees in terms of quality of care for both service users and providers. Given the availability of a list of minimum quality standards at EU-level, the increasing emphasis on quality and effectiveness of substance abuse services and the lack of quality standards regarding drug demand reduction in Belgium, the aims of the COMIQS.BE-study were threefold:

1. To study available quality standards for drug demand reduction in the EU and document the critical ingredients and prerequisites for successful implementation of such standards, based on a selection of good practices;

2. To assess the acceptability, priority and actual implementation of the EQUS standards for drug treatment, prevention and harm reduction among various stakeholders and to build consensus regarding (adapted) minimum standards that can be implemented in Belgium; also, we want to further specify and operationalize these minimal consensus standards.
3. To determine potential standards of excellence for prevention, treatment and harm reduction in Belgium.

2. Methodology

To attain the objectives which were mentioned above, a multi-method study design is proposed including a review of the literature and quantitative and qualitative research methods. The study consists of five work packages in which a specific methodology is applied or two methods are combined.

To achieve the first objective, we build on the aforementioned EQUS study (Uchtenhagen & Schaub, 2011) and the EMCDDA-study on European Drug Prevention Quality Standards by Brotherhood, Sumnall and the Prevention Standards Partnership (2011). In addition, an update of the literature on quality standards and/or guidelines for drug demand reduction was conducted from 2010 until present. We examined the developments since 2010, in terms of quality standards, at national and international level. We organized an international seminar in Brussels on April 29th 2014, hosting two international experts (Michael Schaub and Harry Sumnall) who presented a state of the art regarding the development and implementation of quality standards for prevention, treatment and harm reduction of alcohol and drug problems. During the final months of the project, we visited selected good practices abroad and studied the critical ingredients and prerequisites for the successful implementation of quality standards in these countries. Information about these on-site visits is described in chapter 7 of the final report.

Secondly, we tried to find consensus regarding a set of minimal quality standards. We started from the original EQUS standards and translated these to French and Dutch using the forward-backward method[1]. Subsequently, we developed an online survey which was completed by policy makers, researchers, service users and staff working in the field of drug prevention, treatment and harm reduction (cf. 2.1. Online Survey). In analogy with the EQUS-study, the questionnaire included three domains: prevention, treatment and harm reduction (Uchtenhagen & Schaub, 2011). However, this study was not limited to illegal drugs but also included services and organizations involved in alcohol prevention and treatment. A maximum of one respondent per participating service could fill in the questionnaire. Each respondent could decide which domain(s) he or she filled out in the questionnaire. For each domain, we assessed the level and process of implementation (barriers and facilitating factors), and the prioritization of the proposed standards that resulted from the EQUS study and the EMCDDA study. For each standard, stakeholders were asked if they would accept this standard as a minimum standard or ideal standard. When a standard was accepted by more than 80% of the respondents, we decided to 'accept' this standard. When a standard was accepted by 50 to 80% of the respondents, we decided that the standard was 'controversial'. When a standard was accepted by less than 50% of the respondents, we considered this standard as 'rejected' (cf. Uchtenhagen & Schaub, 2011).

After analysing the data of the online survey, we organized two rounds of focus groups (cf. 2.2 Focus groups and email survey). Each round consisted of six focus groups with 6 to 12 stakeholders: two groups for prevention, two for harm reduction and two for treatment, including one Dutch speaking and one French speaking group for each domain (this was merely done for practical reasons, i.e. the language

[1] There might be small differences between the formulation of the French and Dutch standards. This is a consequence of the translation procedure and the adjustments that were proposed by the participants during the two focus groups. We kept these nuances as long as they did not alter the meaning of the standards significantly.

barrier). All six focus groups met two times: the same stakeholders participated in round 1 and 2 of the focus groups.
At the start of the first round of focus groups, we reported the results of the online survey. The controversial standards (between 50 and 80% consensus) were discussed to reach consensus. The reasons for rejecting standards in the focus groups were further motivated.
During the second round of focus groups, we asked the stakeholders to further discuss the standards for which no consensus was found and to further elaborate and concretize some of the minimum standards that were still unclear. These minimum standards that needed further concretization were either accepted during the online survey or were accepted during the first round of focus groups. The standards 'to be concretized' were selected by the research team in cooperation with the regional umbrella organisations VAD, Eurotox en FEDITO-BXL, based on the notion that they were too abstract or unclear. In In attachment you will find a more detailed description of this discussion.
After the second round of focus groups, some standards remained controversial as there was no consensus between the Dutch and the French-speaking focus groups. We reformulated these standards and resubmitted them to the participants of the focus groups via an email survey and added an explanation of the process that had led to the reformulation of the standards. We then asked again whether these standards could be accepted as minimal or ideal standards. When 80% or more of the participants in both groups accepted the standard, we decided to accept him. If not, the standard was rejected.

The ultimate goal of the COMIQS-study was to reach consensus on a list of minimum and ideal quality standards and to clarify and explain these minimum quality standards. This list of quality standards can be found in the next section.

3. COMIQS-consensus standards

Based on the consensus procedure described above, we identified per domain about 20 quality standards that were accepted by the vast majority of respondents (>80%). For the domain 'Prevention', we withheld a total of 32 approved standards of which 28 minimum and 4 ideal standards. With regard to the domain 'Treatment', we reached consensus regarding 24 standards: 21 minimum and 3 ideal standards. Concerning the domain 'Harm Reduction', a total of 20 standards were accepted by the respondents of which 17 minimum and 3 ideal standards.
Below you can find the minimum and ideal COMIQS quality standards per domain as accepted by the respondents. These are divided in 'structural' standards, which mainly refer to some organisational and structural preconditions; 'process standards', which refer to the intervention itself and the implementation process; and 'outcome standards' which refer to the outcomes achieved. Each standard has a code that refers to the original EQUS-standards (Uchtenhagen & Schaub, 2011). When the identification code of the standard does not correspond with the EQUS-standard codes, this should be read as a new standard or a supplementary standard. Also, we mention per domain the rejected standards, illustrating which standards (for the reasons mentioned above) were not accepted by the study participants.

3.1. Prevention

PREVENTION : MINIMAL STANDARDS	
	Structural standards of services
P1	Ethical principles: adherence to ethical principles (e.g. service must protect participants' rights, provide services/interventions that have clear benefits for participants, must not provide a service/intervention where evidence shows that it could harm participants (e.g. increase drug use, stigmatise participants))
P2	Policy and legislation: reference to drug-related policy and legislation as required for the implementation of the service/intervention
P3	Routine cooperation with other agencies: the organisation cooperates with other agencies and institutions in correspondence with the multi-service nature of drug prevention (e.g. health and social services, criminal justice services, educational services)
P4	Financial requirements: a clear and realistic cost estimate is provided; available funding streams are sufficient to cover costs
P5	Internal resources and capacities: sufficiently available for implementation (e.g. human, technological, financial resources)
P7	Staff support: staff members are supported in their work as appropriate
	Process standards of services/interventions
P8	Ethical standards: adherence to ethical standards (e.g. intervention is only carried out if there is a need for it, procedures in place to ensure informed consent, confidentiality, protect safety of participants and staff members, information about drugs and related behaviours is accurate where it is provided)
P10	Assessment procedures: target population's culture (1. relation to drug use, 2. relation to the service/intervention activities) has to be assessed. Note: The culture of the population may be limited to what is shown between parentheses
P11	Assessment procedures: other relevant characteristics of the community/target population/environment have to be assessed (e.g. cognitions, attitudes, risk behaviours, criminality, social status, drug availability) Note: An in-depth analysis is not required
P12	Assessment procedures: target population and community readiness for the service/intervention has to be assessed (e.g. sources of opposition or support)
P13	Assessment procedures: gaps in current service provision have to be assessed
P14	Stakeholder involvement: all stakeholders relevant to the service/intervention are involved in its development and implementation as required (e.g. target population, other agencies)
P15	Sustainability: long-term strategy for drug prevention or wider health promotion (all activities form part of the long-term strategy)
P16	Goal definition: service/intervention goals are specific, realistic and informed by assessment procedures (e.g. what types of drug use or behaviours are targeted)
P17	Service/intervention design: the service/intervention is based on a scientifically derived understanding (theoretical models) of drug-related behaviours and behavioural change

P18	Service/intervention design: the service/intervention is evidence-based (it is based upon the findings of novel or existing literature reviews on scientific evidence of effectiveness, or professional experience where reviews are not available)
P19	Service/interventiondesign:services/interventions are tailored according to individual and population characteristics (e.g. language, activities, messages, timing, number of participants)
P20	Service/intervention design: criteria for end of the service/intervention are defined (e.g. goals achieved, mandatory number of sessions completed, number of participants, duration of the intervention) Note: The intervention must have a target
P21	Service/intervention design: service/intervention activities are feasible and internally consistent (e.g. activities are linked to objectives, target population is chosen in line with needs assessment, target population can be reached, setting is suitable for good functioning)
P22	Adaptation: existing interventions (e.g. manualised programmes, service models implemented elsewhere) are adapted considering the differences between the original and the actual circumstances (e.g. target population characteristics)
P23	Staff training and development: those delivering the service/intervention (e.g. staff members, teachers, parents, former drug users) have the competencies which are required for a successful implementation
P27	Implementation: the service/intervention is implemented according to the project plan and adjusted in line with the monitoring findings
P29	Process evaluation: the implementation is documented and explained (failures and deviations from the original plan, target population involvement, activities, service/intervention delivery, use of financial, human, and material resources)
P30	Dissemination: a written and clear description of the service/intervention is made (at least partly) available to relevant groups (e.g. participants) before and/or during the service/intervention
P31	Dissemination: information about the service/intervention is disseminated in an appropriate format (e.g. evidence briefings, report to funders, feedback to participants) at the end of the service/intervention
	Outcome standards at the system level
P33	Goal of prevention: reduced drug use (prevention must be aimed at abstention, delayed drug use, reduced drug use, and/or prevention of dependence)
P34	Evaluation: an appropriate evaluation is carried out as part of the service/intervention (e.g. outcome evaluation, process evaluation)
P35	Evaluation: the service/intervention is continued on the basis of evidence provided by monitoring or evaluation

PREVENTION : IDEAL STANDARDS	
	Structural standards of services
P6	Staff composition: transdisciplinarity and qualifications of staff are appropriate for the service (e.g. type of roles, number of staff, level of education). Note: This can be achieved by working together in a network of services
	Process standards of services/interventions
P25	Implementation: a systematic project plan exists in writing (e.g. including main service/intervention elements and procedures, a risk assessment which prepares for potential unforeseen circumstances). Note: This only applies to projects and not to every activity within the project.
P28	Process evaluation: the implementation is documented and explained (failures and deviations from the original plan, target population involvement, activities, service/intervention delivery, use of financial, human, and material resources)
	Outcome standards at system level
P32	Evaluation (ADAPTED): a final report documents all major elements of programme planning, implementation, and (where possible) evaluation in a clear, logical, and easy-to-read way.

PREVENTION : REJECTED STANDARDS	
	Process standards of services/interventions
P9	Assessment procedures: detailed and diverse information on drug use in the community/target population/environment of interest has to be collected through primary or secondary study (e.g. types of drugs used, drug use rates and trends)
P24	Recruitment: participants or participating units (e.g. schools, communities) are drawn from the defined target population
P26	Implementation: the implementation is monitored and necessary adjustments identified (e.g. reviewing preliminary outcome and process data, project plan, resources)

3.2. Treatment

TREATMENT : MINIMAL STANDARDS	
	Structural standards of services
TR1	Accessibility: location (service can easily be reached by public transport)
TR2	Physical environment: adequate spacing for the activities in the service (e.g. service has separate rooms for individual counselling)
TR3	Physical environment: safety (service is equipped for emergencies like e.g. management of overdose, fire or aggression on the premises)
TR4	Indication criteria: diagnosis (treatment indication is always made on the basis of a diagnosis)
TR5	Staff education: basic education (e.g. at least half of staff has a diploma in medicine, nursing, social work, or psychology)
TR6	Staff composition: transdisciplinarity (e.g. service employs a multidisciplinary team composed of at least 3 professions)
	Process standards of services/interventions
TR7	Assessment procedures: substance use history, diagnosis and treatment history have to be assessed
TR8	Assessment procedures: somatic status and social status have to be assessed
TR9	Assessment procedures: mental health has to be assessed (except for early intervention) Note: It is not necessary that the assessment is done by a psychiatrist. It is a 'stepped' approach (screening, assessment or diagnosis are possible)
TR10	Individualised treatment planning: treatment plans are tailored individually to the needs of the patient
TR11	Informed consent: patients must receive information on available treatment options and agree with a proposed regime or plan or a change of plan before starting treatment
TR12	Written client records: assessment results, intervention plan, interventions, expected changes and unexpected events are documented complete and up to date for each patient in a patient record
TR13	Confidentiality of client data: patient records are confidential and exclusively accessible to staff involved in a patient's treatment or regime
TR14	Routine cooperation with other agencies: whenever a service is not equipped to deal with all needs of a given patient, an appropriate other service is at hand for referral
TR15	Continued staff training: staff is regularly updated on relevant new knowledge in their field of action
	Outcome standards at system level
TR16	Goal: health stabilisation/improvement (treatment must aim at improvements or stabilisation of health)
TR17	Goal: social stabilization/integration (treatment must aim at improvements of social stabilisation or integration)

TR18	Goal: Depending on the patient's request, the treatment must aim at stopping, reducing, stabilising or better handling of drug use Note: The reduction of drug use is not always the primary goal. The objective of the treatment is part of the treatment plan, which differs for each patient. The often chronic nature of addiction must be taken into account
TR19	Utilisation monitoring: services must periodically monitor the occupancy of treatment slots or beds
TR19ter	Treatment monitoring: the service evaluates the evolution of each patient and determines whether the treatment should be continued or not Note: The staff evaluates the evolution of patients. This evolution should be discussed in a team. The team decides on what to do
TR21	Internal evaluation: services must regularly perform an internal evaluation of their activities and outcomes

TREATMENT : IDEAL STANDARDS	
	Outcome standards at system level
TR19bis	Utilisation monitoring: services are committed to inform the network about available treatment slots or changes in availability.
TR20	Monitoring of the end of treatment: e.g. ratio of regular/irregular discharges and retention rates have to be monitored periodically. Note: Monitoring can also be qualitative
TR22	External evaluation: services must be open to an evaluation of their activities and outcomes by an independent external evaluator. Note: The external evaluation must be realized in collaboration with the service. It must be transparent: who will perform the evaluation, which indicators will be used, what and how will the results be used and what is the purpose of the evaluation needs to be clearly defined. The independent evaluators must also be independent of their financers. Accepting this standard does not entail that the service is required to finance the evaluation. Evaluations should focus on the organization and the client.

TREATMENT : REJECTED STANDARDS	
	Outcome standards at system level
TR23	Cost-effectiveness has to be assessed (positive outcomes, e.g. number of abstinent patients in proportion to treatment costs)
TR24	A cost-benefit analysis is required (concrete benefits, e.g. increased life expectancy in proportion to treatment costs)

3.3. Harm reduction

HARM REDUCTION : MINIMAL STANDARDS	
	Structural standards for interventions
HR1	Accessibility: location and opening hours (services have to match the needs of their clients; costs should never be a barrier to a service)
HR2	Staff qualification: minimum qualification (staff has to be qualified and the staff qualification has to be made transparent, e.g. amongst two trained peers involved in the service, two have a diploma in social work and further two in nursing)
HR3	Staff composition: the service acts from a multidisciplinary perspective Note: This can be achieved through the collaboration within a network of services, taking into account ethical fields and professional identities. Involving peers is recommended and is part of the multidisciplinary framework
	Process standards for interventions
HR4	Indication criteria: Services have to be adapted to the age and profile of the user. Staff has to be trained to meet the client's needs. People of all ages should be to able to rely on the harm reduction services. Note: It is important to pay special attention to new users, regardless of age
HR6	Assessment procedures: risk behavior assessment (client's/patient's risk behavior is assessed)
HR7	Assessment procedures: complete needs and care assessment and priorisation, in consultation with the client
HR9	Informed consent: Clients/patients must receive information on available service options and agree with a proposed regime or plan before starting an intervention. Interventions should not be based on written informed consent, but rather on a transparent information about all the offers by a service
HR10	Confidentiality of client data: client/patient records are confidential and exclusively accessible to staff involved in a clients'/patients' intervention or regime
HR12	Individualized treatment planning: intervention regime and intervention plans, if applicable, are tailored individually to the needs of the client/patient
	Outcome standards at system level
HR13	Routine cooperation with other agencies: whenever a service is not equipped to deal with all needs of a given client/patient, an appropriate other service is at hand for referral
HR14	Continued staff training: staff is regularly updated on relevant new knowledge in their field of action
HR16	Goal: reduced risk behaviour (reducing unsafe injections, unsafe drug use and unprotected sex)
HR17	Goal: referrals (treatment services must be prepared to refer clients/patients to other health/social/treatment/legal services if needed and agreed)
HR19	Utilization monitoring : services must monitor internally and periodically the utilisation/occupation of their offer
HR20	Internal evaluation: services must regularly perform an internal evaluation of their

	activities and outcomes
HR21	External evaluation: services must be open to an evaluation of their activities and outcomes done by an independent external evaluator. The results of the evaluation should be transferred and explained to the service. Note: The external evaluation must be realized in collaboration with the service. It must be transparent: who will perform the evaluation, which indicators will be used, which results will be used and what is the purpose of the evaluation needs to be clearly defined. The independent evaluators must also be independent of their financers. Conflicts of interest must be disclosed. The service should have a say in the selection of the evaluator. Accepting this standard does not entail that the service is required to finance the evaluation.
HR25	User participation: harm reduction interventions should promote user participation

HARM REDUCTION : REJECTED STANDARDS	
	Outcome standards at system level
HR5	Eligibility criteria: Diagnosis: Eligibility is based on a diagnosis, or if not possible, on a detailed assessment of current substance use
HR22	Cost-effectiveness has to be assessed (positive outcomes, e.g. number of abstinent patients in proportion to treatment costs)
HR23	A cost-benefit analysis is required (concrete benefits, e.g. increased life expectancy in proportion to treatment costs)

4. Conclusions and recommendations

Based on the online survey regarding the degree of application, feasibility and acceptability of European quality standards for prevention, treatment and harm reduction of alcohol and drug problems (Uchtenhagen & Schaub, 2011; Brotherhood & Sumnall, 2013), we can conclude that the overall application of prevention standards – and to a lesser degree harm reduction standards – is low in comparison to the treatment standards: 75% of the participating prevention services applied 13 out of 34 prevention standards, while 75% of the participating treatment services applied 19 out of 24 treatment standards. The degree of application of harm reduction standards is situated in between, with 14 out of 23 standards being applied by 75% of the participating harm reduction centres. Respondents usually give a high priority to the applied standards, but are rather sceptical about the feasibility of standards that have not yet been applied because of practical and structural reasons. Earlier research has also shown that - without incentive or obligation– the rate of application of quality standards is rather low (Schaub, Uchtenhagen & the EQUS Expert Group, 2013). This was also reflected during our study visits in Bern and Prague (Miovsky, 2015 ; Stamm, 2015).

After a first comprehensive inquiry in the prevention sector (n = 74), a total of 20 out the 35 prevention standards (57%) were accepted as minimum standards. Controversial standards (which were accepted by <80% of the participants in the online survey) were primarily related to structural- and process aspects, such as staff composition and an assessment of prevention needs (e.g. drug use, risk behaviour, specific subcultures), which were – due to the small scale and limited resources of some organizations – not considered feasible. On the other hand, the controversial standards were related to aspects of implementation and evaluation, such as following a project plan and documenting, measuring and reporting on the results achieved (see Annex 1).
During the focus groups the so-called controversial prevention standards were further discussed and refined by a select group of Dutch and French speaking participants. Because of the language barrier, the focus groups with Dutch and French speaking experts were organized separately. This is the explanation why the two focus groups sometimes came to a different decision/conclusion. However, the research team gave feedback about the findings to both focus groups and reformulated, if necessary, the standards and resubmitted these afterwards to the respondents through an additional e-mail survey.
This consensus procedure ensured the approval of a total of 32 standards, including 28 minimum and 4 ideal standards. Most of these quality standards are related to process aspects, such as the evaluation of prevention needs, the development of a range of prevention activities and its implementation. Three standards, that were considered as minimum standards at the European level (Uchtenhagen & Schaub, 2011) and that are essential components of the drug prevention cycle (Needs assessment - Delivery and monitoring; cf. Brotherhood & Sumnall, 2011), were rejected by the Flemish and French-speaking experts in the focus groups. It concerns the need for a preliminary assessment of the substance use of the target group, recruitment from a predefined target population and monitoring of the outcomes of the intervention. Thus, disapproval with these standards was mainly based on practical reasons (lack of resources to identify the extent of substance use and to monitor outcomes), but also on the fact that respondents were reluctant to define or constrain 'a priori' the target population. However, foreign experiences (e.g. the 'Three Cities' project in Sweden) point at the importance of a step-by-step implementation and evaluation of prevention activities (Eriksson, 2015).

A similar consensus process was adopted with regard to treatment standards. Based on the online survey of 84 organisations, 17 out of 24 quality standards were immediately accepted as minimum quality standards. The controversial standards were related to the need to assess the mental state, goals of treatment (i.e. reduced use), monitoring occupation and service utilization, discharge

registration, and internal evaluation of activities and outcomes. The EQUS standards on the assessment of cost-effectiveness and the need for cost-benefit analyses were rejected during the online survey by the respondents. During the subsequent focus groups, a consensus could be reached for most of the controversial standards, taking into account certain adjustments and additions (see chapter 4.2.). Eventually, 24 standards were accepted, including 21 as minimum and 3 as ideal standards. The rejected standards on cost-effectiveness and cost-benefit analysis were further discussed. On the one hand, respondents stated that treatment organisations cannot realize this task themselves, and, second, no consensus was found regarding suitable indicators for measuring the effectiveness of substance abuse treatment. Suggested indicators that have been put forward in the EQUS-standards (e.g. abstinence), were considered as "partial " and "not feasible in certain settings". Furthermore, during the focus groups, some of the participants warned for the potentially damaging impact of introducing cost-effectiveness standards for clients who, because they are difficult to treat or avoid care, might fall through the cracks of the treatment system (Bryssinck, Vandevelde & Vanderplasschen, 2015). Despite these objections, it is recommended for alcohol and drug services to participate in the development of quality indicators, since this will inevitably be requested by subsidizing authorities in the future. By participating in the Flemish Indicator Project for Patients and Professionals (VIP²), Flemish prevention and treatment services can be heard in this debate. This is likely to contribute to the development of feasible indicators that apply for specialized alcohol and drug services, as well as for generic mental health services.

The consensus procedure regarding the EQUS-standards in the field of harm reduction led to the least acceptance. After the online survey, in which 36 different organizations participated, only 11 out of the 23 standards (47.8%) were accepted as minimum standards. The lack of consensus regarding these standards can primarily – like with the prevention standards – be attributed to the great heterogeneity within the group of respondents, consisting of representatives of a wide range of harm reduction initiatives (e.g. needle exchange, harm reduction programs in nightlife settings) (Schaub, Uchtenhagen & the EQUS Expert Group, 2013). However, it is striking that controversial standards in this domain are similar to those in the domains of "prevention" and "treatment". In the focus groups on harm reduction, participants initially did not agree with the standards regarding staff composition, assessment procedure, registration and monitoring of outcomes and cost-benefit analysis. The standards on cost-effectiveness and objectives of the intervention (i.e. reduced use) were already rejected by the respondents during the online survey. During the focus groups, the controversial standards were further differentiated and adapted, resulting in consensus regarding most standards. Eventually, we reached consensus regarding 20 standards, including 17 minimum and 3 ideal standards, but 3 outcome standards were rejected. Comparable with the focus groups on ‘treatment’, the standards on 'cost-effectiveness' and 'cost benefit analysis' were rejected by the participants, because participants stated that they did not have the necessary manpower nor the resources to do this by themselves. They also stated that benefits in terms of harm reduction cannot be defined unambiguously and univocally. The standard suggesting that an intervention should always be based on a diagnosis (HR8) was rejected because of the low threshold philosophy of harm reduction initiatives, which makes it impossible, nor desirable to perform a detailed and comprehensive assessment at that stage. Also, the term "diagnosis" is associated with a specific medical-psychiatric model (Bryssinck et al, 2015;. Saleebey, 2006), but not all harm reduction services involve this discipline.

The results of the COMIQS.BE study showed a broad consensus with regard to the European minimum quality standards for drug prevention, treatment and harm reduction (Uchtenhagen & Schaub, 2011). Yet, the fact that "only" 70 to 83% of the minimal standards that were approved by hundreds of European experts in the EQUS study were accepted in our study, raises many questions. For the domain 'prevention', 80% of EQUS standards (28/35) were accepted by the Belgian respondents as minimal standards, while for the domain 'treatment' this proportion was 83% (20/24) and for the domain harm reduction it was 70% (16/23). Most other standards were accepted as

"ideal" standards or standards that should be pursued, while two or three standards were rejected on each of the domains.

The consensus procedure that we applied, in particular the focus group discussions, gave us an idea about the reasons for the relatively limited level of acceptance. First, the EQUS-standards are formulated in a general or generic way, making them less recognizable or applicable for some respondents or in some settings. Moreover, some of the examples that were added to the standards (e.g. reduced use/abstinence as an objective of an intervention) and the use of specific terms (e.g. diagnosis, evaluation, multidisciplinary), provoked resistance as this terminology did not fit with the philosophy and methods of some organizations. Second, the heterogeneous composition of the focus groups, which illustrated the diversity of substance abuse prevention and treatment services in Belgium, was an important reason why participants thought that certain standards were not feasible due to the small scale of these services. Compared with the EQUS study, the target population was expanded to alcohol and illegal drugs, which resulted in a more diverse sample – and thus a broader consensus – although it may have had a negative impact on the recognition and applicability of certain standards and the specifications/examples used, given the primary focus of the EQUS-standards on (illegal) drug use. Finally, a protectionist reflex played a significant role during the consensus procedure, resulting in the rejection and weakening of standards regarding outcome measurement and evaluation of (cost-)effectiveness. Similar reactions were heard in Switzerland, leading to the exclusion of outcome standards in the QuaThéDA protocol. Still, it is the plan to add these outcome standards in a later stage of the implementation process (Stamm, 2015). Also in Belgium, feasible and measurable outcome standards for substance abuse treatment and prevention will need to be determined – preferably in close collaboration with the sector – since this process is yet ongoing in other, sectors such as mental health care (VIP²) and child and youth care (PROSE) (Vyt, 2006). Experiences with the development of quality systems abroad and in other sectors illustrate that consensus building on quality standards should be regarded as "work in progress". Consequently, the COMIQS.BE-study is not an end, but rather the starting point for improving quality of care in substance abuse prevention and treatment.

Around the same time of the COMICS study and under the impetus of the Italian EU Presidency (July - December 2014), an attempt was made at European level to further operationalize the EQUS standards within the framework of the "EU Action Plan on Drugs 2013-2016", which contains a specific action on "minimum quality standards in drug demand reduction in the European Union". To this end, policy makers and experts from various Member States were consulted. On the 14th of September 2015, these efforts eventually resulted in a list of 16 standards that was adopted by the European Council: 4 prevention standards, 4 harm reduction standards and 8 standards regarding treatment and rehabilitation (Council, 2015). This limited list of "EU minimum quality standards in drug demand reduction" should be regarded as a compromise and substantial reduction of the initial list of EQUS-standards (Doms, 2014). As an illustration, two of these standards are mentioned below:

- "*Those developing prevention interventions have competencies and expertise on prevention principles, theories and practice, and are trained and/or specialized professionals who have the support of public institutions (education, health and social services) or work for accredited or recognized institutions or NGOs*." (Standard 2 Prevention);
- "*Appropriate evidence-based treatment is tailored to the characteristics and needs of service users and is respectful of the individual's dignity, responsibility and preparedness to change*" (Standard 11 Treatment and Rehabilitation).

Although these standards are not binding for Member States, they underline the importance the EU attaches to evidence-based substance abuse treatment and prevention and to the further professionalization of these practices. This short list of minimum standards – adopted after long discussions and considerable curtailments - illustrates that the development of quality standards is a delicate process that needs time and requires the involvement of all stakeholders (Schaub, Uchtenhagen & the EQUS Expert Group, 2013; Stamm, 2015). Further refinement and

operationalization of these standards will be the responsibility of the Member States and requires close involvement of prevention and treatment services.

4.1. Recommendations concerning the development of quality standards

The consensus procedure and study of inspiring practices, in Belgium as well as abroad, led to the identification of important barriers and facilitating factors resulting in clear guidelines regarding the development and implementation of quality standards.

First, it is important to have at national level (a limited number) *common and shared standards*, which ensure identical and binding quality standards within the same territory. The QuaThéDa experiences in Switzerland learnt that this creates clear expectations and a common language within the field of substance abuse treatment and prevention in a federated state, while leaving space for differentiation between regions and states (Stamm, 2015). To ensure clarity and transparency to all stakeholders about the motives for developing quality standards, this process should start from a shared vision and common goals. Some objectives (e.g. quality improvement, transparency and accountability for public funding) may indeed collide with some principles (e.g. therapeutic freedom of health care providers) or objectives (e.g. efficiency, participation and user involvement) of other stakeholders. While the objectives of the COMIQS.BE study were clear, the intentions of the policy makers, both at federal and community level, were less transparent. This may partly explain the suspicious and more protectionist attitude of some respondents. However, at the start of this study we clearly explained that the COMIQS-study was part of a bottom-up process in which the sector was to be heard and could anticipate on the implementation of quality standards by policy makers.

A related recommendation concerns the use of *a common language* (Brotherhood & Sumnall, 2013; OFSP, 2012; Eriksson, 2015). In Belgium, this is hampered by the use of several national languages and the limited bilingualism of some of the respondents. To avoid language problems as much as possible and to safeguard the optimal understanding and meaning of quality standards, we chose that participants could use their own mother tongue in the group discussions. During the study we used Dutch and French, which implied that all documents had to be translated and back-translated to respectively Dutch and French. This was not only time-consuming, but also led to a different pace resulting in obvious disparities in the consensus process between the Dutch- and French-speaking parts of Belgium. These differences are partly related to cultural differences, but given the method we used, it was not possible to organize focus groups involving Dutch- and French-speaking respondents. Still, we presented all focus group participants the findings and suggestions of the other group, so they could provide feedback on each other. It should be clear that the consensus procedure would have led to a different result, if we had opted for mixed (bilingual) focus groups. However, by providing feedback on the other focus group we ensured a widespread consensus concerning common standards for substance abuse treatment and prevention in Belgium, taking into account language and cultural differences which have undoubtedly influenced this process. Moreover, by choosing to organize this process separately for both language groups, policy makers at regional level will have a better understanding of the specific remarks and sensitivities among Dutch and French-speaking service providers (see Annex 1-3).

Although generic quality standards can be defined for (mental) health care, *specific quality standards* are needed for more specialized forms of prevention and treatment like substance use disorders. Consequently, the minimal consensus standards are probably just a stepping stone towards more specific standards in specific areas, e.g. for outpatient and residential care, aftercare, etc. (Miovsky, 2015; Stamm, 2015). It is appropriate to distinguish distinct activities within the continuum of care (i.e. prevention, treatment, harm reduction), given the significant differences in terms of organization, objectives and methods. To increase the involvement with and recognition of these

standards, it is recommended to differentiate between types of facilities (OFSP, 2012). However, the need for an ongoing dialogue between the different domains and types of services may not be neglected, if one wants to keep a common core of similar standards and to continue learning from each other (Stamm, 2015).

While prevention demands a specific kind of expertise and starts from a specific developmental and implementation cycle (Brotherhood & Sumnall, 2011), it was recommended that prevention standards are developed and classified in a similar way as treatment and harm reduction standards (Miovsky, 2015). In addition to structural, process and outcome standards, standards need to be developed at individual, organisational and system level (Dom, 2015). The COMIQS.BE consensus standards comply with this demand and for most of the structural and process standards a clear consensus was found, which suggests these standards are yet applied or – at the very least – that there is willingness to do so. Building consensus regarding evaluation and outcome standards appeared to be much more difficult, because respondents were cautious that such standards would be used to cut costs or to even close down some services. Consequently, a number of (outcome) standards were presented as ideal standards, which also raised many questions. What is the use of pursuing a standard, if it is not attainable for the moment? It can be assumed that funding bodies want to seek for the highest quality of services, but isn't this also the ultimate goal of service providers? Moreover, it is not unlikely that ideal standards will ultimately become mandatory as well. If quality improvement is seen as a process characterized by varying application rates between services (Vyt, 2006), ideal standards are particularly useful as they set the agenda for the future and allow to differentiate between services.
Further specification of these standards according to type (e.g. universal and indicated prevention; withdrawal or substitution treatment) and level of intervention (client, organization/service, system level) is an important step. This can be realized within the scope of a pilot project, incorporating evidence-based guidelines as well as international achievements and good practices. Also, translating the COMIQS-standards into measurable indicators will further be important. More specifically, linking with the VIP² project that aims at developing generic (and more specific) standards for mental health care will further advance the discussion about outcome standards (Van den Broeck, 2016).

Based on the study visits to inspiring projects in Bern and Stockholm, amongst others, it appeared that terminology, definitions and formulations can be major obstacles in the development of quality standards. For, similar concepts can be interpreted differently depending on the context, while also different terms are used to refer to the same concept. It is therefore crucial to explain the used terminology from the beginning and to create a glossary. This recommendation relates particularly to the creation of broad, general standards at national or at international level, as the concept 'evidence-based' may be understood differently by various stakeholders.
If quality standards are translated from another language, it is necessary to appoint a professional translator who is familiar with the specific jargon of this sector. Second, a reference group is needed to develop and evaluate the language, tone and degree of difficulty of the formulated standards. As mentioned earlier, we encountered some language barriers during the COMIQS.BE-project. The EQUS quality standards were translated from English into Dutch and French (and back-translated), but it was very difficult to incorporate all linguistic nuances from the original standards into the translated standards, in Dutch as well as in French. For example, the term 'treatment' covers a much broader spectrum in English than in Dutch or French. Also during the focus groups, discussions arose about certain terms or formulations, which we "solved" by adding a comment to the standard. This option was occasionally applied by the focus groups 'treatment' and 'harm reduction'. In order to disseminate the COMIQS.BE consensus standards and to stimulate an unambiguous interpretation of the standards, it is highly recommended to add a glossary containing an interpretation of central and potentially confusing concepts.

A *bottom-up development process* is most appropriate when trying to formulate widely supported quality standards. Available standards (developed abroad or in other sectors) can be used and adapted (as in the COMIQS.BE study), or new standards can be created based on everyday experiences (cf. development process in the Czech Republic and Switzerland). When using a participatory model, the development of quality standards is labour-intensive, but it ensures a broad and comprehensive base for standards that will be in line with existing practices (Stamm, 2015; Miovsky, 2015). A bottom-up approach was used in the COMIQS.BE study and was evaluated positively, both by researchers and participants. Furthermore, we reached consensus regarding a total of 32 standards for prevention, 24 standards for treatment and 20 standards for harm reduction during a 12 to 18 month period. Still, a follow-up study or project is recommended, if this consensus is to be extended to outcome standards and measurable indicators to assess the quality of service delivery. Ultimately, a bottom-up approach is best combined with a top-down approach in order to monitor the development process and to set clear guidelines and deadlines. Also, public authorities can provide 'incentives' to encourage participation and involvement of services in this process (Stamm, 2015).

Besides *involving all relevant stakeholders* (such as service users, practitioners, policy makers and academics), it is crucial to take into account the different expectations and agendas of various stakeholders, as well as cultural differences between sectors and facilities (e.g. psychiatric hospitals and specialized drug services) and between Dutch and French-speaking actors. Moreover, the multidisciplinary composition of substance abuse prevention and treatment teams urge for the involvement of various professional groups in the development of quality standards (e.g. social workers, psychologists, nurses, doctors, educators), in order that standards are sufficiently generic and clearly indicate what is or should be the norm when providing a specific intervention (Schaub & Uchtenhagen, 2013). Quality standards need to be developed in analogy with existing professional and deontological codes. Yet, an increasing number of private providers and experts are working in substance abuse prevention and treatment, who are not covered by a specific code of ethics. Consequently, the deinstitutionalisation and privatisation of health care brings new challenges as to the definition of quality of care in substance abuse treatment and prevention. Knowledge gained by experience or reference to a ‘model’ cannot be regarded sufficient in this perspective. Quality standards need to contribute to the professionalization of substance abuse treatment and prevention and to guarantee that there is no room for charlatans who run their business as "therapists" without justification (De Block, 2016) or may even cause harm by providing interventions without any proof of evidence (e.g. drug prevention by Scientology in the Czech Republic, Miovsky, 2015).

During the COMIQS-consensus procedure, we intended to involve representatives from various organizations, disciplines and sectors across Flanders, Brussels and Wallonia. Ultimately, only a limited number of them participated in the focus groups. Still, we listened to the voices of all respondents, so that the result of this research can be seen as a set of quality standards for which broad support is available in Belgium.

4.2. Recommendations concerning the implementation of quality standards

The previous recommendations concerned the development of standards. In this chapter, we formulate specific recommendations for the implementation of quality standards, based on the findings from the COMIQS-study and some inspiring foreign practices and from other sectors.

A *solid and coherent system* for the prevention, treatment and harm reduction of alcohol and drug problems is an important prerequisite for the implementation of quality standards. In the absence of an unambiguous alcohol and drug policy and a common financing and registration system, various

stakeholders may uphold different norms and expectations depending on the type of service or region. Proper alignment of these quality standards with policy priorities and an open dialogue with those directly involved facilitates the implementation process (OFPC, 2012). Given the fragmentation of substance abuse prevention and treatment authorities in Belgium, this alignment and standardisation is considered to be a major concern when implementing quality standards in Belgium.

Communication and training is a vital link when trying to introduce quality standards in daily practice. When implementing quality standards, a lot of new information and material is being produced (Brotherhood & Sumnall, 2011) but practitioners often lack the time to study this thoroughly. The development of a *'quick guide'* (a kind of reference guide), in which all necessary information regarding the quality standards is clearly and concisely resumed, can be regarded as an important addition and is also recommended for the implementation of quality standards in Belgium. Also, the involvement of regional focal points, professional and advocacy organisations may further enhance the implementation process, since these organisations are crucial for supporting the dissemination and promotion of quality standards and its implementation and monitoring. Moreover, training and supervision are needed to support services and practitioners during the implementation process and to further operationalize these quality standards. Coaching and support on demand is necessary, taking into account current practices regarding quality management and differences between services (Schaub, Uchtenhagen & the Equs Expert Group, 2013). Services can serve as a model for each other. In Belgium, training and supervision should focus primarily on accepted standards that are – to a limited extent – already applied, and on the development of acceptable outcome standards for substance abuse treatment and prevention services. The online survey already gave an indication as to which standards that are currently applied and which standards need further explanation and promotion.

While quality standards are seen as generic guidelines with which prevention, treatment and harm reduction services should comply, *indicators* provide a more detailed, concrete and measurable definition of these standards (Vyt, 2006). Within the context of the VIP² project in mental health care in Belgium, seven indicators have been defined to measure the quality of general mental health care (including specialized services) (Flemish Agency for Care and Health, 2016a). This process, in which generic indicators are implemented for the entire sector, differs from the QuaThéDA methodology in which individual facilities converted quality standards into measurable indicators (Stamm, 2015). The advantage of the latter method is that this is in line with the bottom-up approach, giving services the opportunity to define and promote quality indicators that are based on their specific situation and program. On the other hand, the development of common indicators enables comparability and benchmarking with other services. Widely accepted indicators increase the motivation for application and the use of common measures. The development of Routine Outcome Monitoring (ROM) in the Netherlands is interesting from this perspective, in which four types of outcome areas are distinguished: 1) substance use, 2) signs and symptoms, 3) daily functioning, and 4) quality of life (Derks, Buwalda & De Weerdt, 2016). As mentioned above, the aim of mapping certain indicators should be clear from the start: will it be used as an internal tool for quality improvement and/or as an evaluation instrument by funding authorities?

Obviously, monitoring of quality indicators is important which, as evidenced by inspiring practices from the Czech Republic and Switzerland (Miovsky, 2015; Stamm, 2015) and can be achieved through a system of internal and external audits. In case of external quality control, criteria and procedures should be clear and transparent and should avoid any conflict of interest (Stamm, 2015). An independent auditing organisation offers most guarantees for an objective quality assessment, but auditing organisations should in turn comply with some quality requirements. The development of a certification procedure may result in a quality label, which services can use to prove their quality of care to the outside world. In Belgium, the accreditation of treatment programs has just started.

Although not Belgian, Flemish services are eligible for accreditation by the Dutch/international accreditation program NIAZ Qmentum of the Dutch Institute for Accreditation in Healthcare (NIAZ).

Finally, our contacts with foreign experts and programs have demonstrated that the implementation of quality standards helps to improve the professionalization and organisation of substance abuse prevention and treatment services in many ways. It stimulates communication and exchange of information within and between facilities and promotes the evaluation of the treatment process and outcomes. Also, it offers a clear framework for staff and new staff in particular (Stamm, 2015). Transparency, accountability for public resources and, above all, guaranteed quality of care are other undeniable advantages associated with the implementation of a system of quality standards. The importance of gradual and stepwise implementation of such standards needs to be emphasized. Moreover, authorities should provide incentives and support to stimulate organisations and services to participate in this process. Alternatively, pilot projects can be financed in which consensus standards are further operationalized and evaluated, prior to their further implementation and generalization. Development of a quality system takes time and it is important not to skip any steps!

4.3. Limitations of the study

The aim of the COMIQS-study was to reach – within a relatively short time period – consensus on a number of minimum quality standards for prevention, treatment and harm of addiction, building on two previous European studies in this area (Uchtenhagen & Schaub, 2011; Brotherhood & Sumnall, 2013). Although we were able to recruit a large number of respondents and to combine various research methods (triangulation), the applied study design had a number of obvious limitations. First, the study sample was to some extent biased, given the relative underrepresentation of survey respondents from Wallonia and Brussels. Due to the limited sample, we did not look for differences in response patterns between regions. During the focus groups, we aimed at an equal number of Dutch- and French-speaking respondents per domain (prevention, treatment, harm reduction). Consequently, a relatively greater weight was given to the voice of the French-speaking respondents. The objective of the focus groups – as opposed to the online survey – was not to recruit a representative sample, but rather to map the variety of responses of the heterogeneous group of practitioners and service providers involved in substance abuse prevention, treatment and harm reduction. Since we organized only one focus group for the Dutch and French-speaking respondents (Wallonia and Brussels) per domain this can be considered a limitation, but for practical reasons it was impossible to do this otherwise.

Second, much weight was given to the opinions and judgments of the focus groups participants, as they could – based on the initial evaluation of the standards by the survey participants – decide whether to accept or to reject a standard. Although the study sample was selected in close collaboration with the regional focal points including some renowned experts, the ultimate decision about whether a standard should be accepted or not was made by a small of 20 persons. Yet, both focus groups met twice and the conclusions about the standards were also presented to the participants in the other focus group.

Third, in line with the EQUS-study by Uchtenhagen and Schaub (2011) we used the arbitrary limit of 80% consensus as cut-off value. Consequently, a standard that was accepted by 75-79% of the respondents in the online survey could still be rejected by the focus groups respondents. The cut-off value of 80% consensus is a fairly high threshold; on the other hand, this proportion indicates that accepted standards (> 80% acceptance) are supported by the entire sector. Although we need cut-off values to be able to distinguish between 'acceptable', 'controversial' and 'rejected' standards, it would have been more appropriate to approach controversial standards on a dimensional scale. For, standards with 78% consensus were perceived as controversial standards, as were standards that were accepted by only 55% of the respondents.

Forth, during all stages and work packages of the study we aimed for a good representation of all stakeholders, but service users and their environment were relatively under-represented in this study. Client advocates and service users participated in one of the focus groups and some service users also answered the online survey, but their involvement was limited after all. It is recommended to include service users and their social networks in a more structural way in future development and implementation of quality standards, through advocacy groups of parents and service users, peer and self-help groups, etc.. Also, policy makers and scientists were not largely represented in this study. Consequently, these consensus standards should be viewed primarily as an assessment of quality standards by practitioners and service managers.
Finally, we agree that that the formulation of some quality standards could be improved. We adhered to the predetermined methodology and translated the standards literally, but it seems appropriate to further revise and optimize this formulation this in the future. For example, the terms 'client' and 'patient' were used interchangeably as in the original EQUS-standards, resulting in non-consistent terminology. A more substantial limitation concerns the fact that the quality standards are formulated in an imperative way (e.g. "services should" this or that), while a more positive formulation is recommended so that standards are not seen as something negative or binding but rather as an example and indicator of good practice. Therefore, the COMIQ-consensus standards should be regarded as a first step towards quality standards for substance abuse treatment and prevention that need to be further refined and concretized in the future at the level of services and specific types of services.

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