Adequacy in Drug Abuse Treatment and Care in Europe (ADAT)

Part III: Professionalism in Treatment and Care of Drug Addicts

Country Reports, Guidelines, Materials

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Content

1. Introduction

In ADAT Part II the adequacy of treatment and care is assessed primarily by the extent to which these are able to meet the needs of clients as well as the satisfaction of the clients with the treatment offered and received.

There are numerous aspects, however, which are unavoidably concerned with a quality defined by experts. Because clients cannot assess the adequacy of a service sufficiently for areas where expert knowledge is required, expert assessments have to be considered rather than customer satisfaction (Schubert and Zink 1997, 3).

Professionalism is based on professional ethical principles, on professional experience as well as on sound scientific knowledge. In the treatment and care of drug addicts, however, the empirical basis is as before limited. The boundary between ethical guidelines and professional standards (quality criteria defined by experts on the basis of professional experience and empirical knowledge) is therefore fluid. Since the ethical principles are given their own section as part of the ADAT, in the following chapter professional quality on the basis of knowledge gained from experience as well as scientific knowledge stand to the fore.

Professionalism as an indicator for the adequacy of treatment and care does not mean, however, that this field of work should be regulated in every detail or that good addiction care can only be achieved through training and further education at the highest level. It also does not mean that drug abusers can only be healed through professional care. What we do mean by professionalism, however, is the systematic endeavour of specialists to base their work on existing empirical knowledge, to examine the effectiveness of interventions and to constantly reflect upon the ethical adequacy of their work.

Professional quality criteria and standards can apply to various levels of the care system as well as to aspects of the structural, process and results quality. Professions which are of interest are those involved in providing treatment and non-therapeutic care to drug addicts, these being mainly social workers, psychologists and the medical professions.

Other themes, which will be discussed in the following chapter, are aspects of training and further education of addiction professionals as well as forms of networking. Both serve the exchange, imparting and continuing development of specific knowledge and competencies as well as the joint reflection on the addiction problem, addiction care and research.

The following country reports provide a cross-section of current projects and strategies for ensuring and fostering professionalism in the treatment and care of drug addicts in the participating countries. The reports are followed by a summary on the relevance of professionals standards, on methods of approach for ensuring and developing professionalism as well on developments in training and further education. (Ch. 2).

In Chapter 3 several projects are described which are being conducted at European level and which are concerned with fostering professionalism, in particular through the improvement of training and further education as well as through professional networking.

Chapter 4 contains the guidelines for the training and further education of professionals in addiction care recommended by the ADAT working group, a checklist for the identification of professional quality criteria and standards as well as a description of existing guidelines and criteria for professional quality. The annex includes several examples from the participating countries.

2. Country Reports

The ADAT Principal Investigators were asked for the country reports to investigate the following questions as well as to provide corresponding documents (guidelines, instruments):

- Which explicit professional quality criteria and standards exist in the countries for the treatment and care of drug addicts and to what extent are these binding?
- How is the observance of the standards checked? How is the organisation regulated. Which instruments and which indicators are implemented?
- How is the training and further education of professionals organised? Which contents are imparted? How is it ensured that the adequacy accords with the needs of the professionals?

2.1. The Czech Republic[1]

2.1.1. Professional networking and capacity building

In The Czech Republic there are no explicit regulations concerning professional standards in the area of drug abuse treatment and care up to the present. However, Minimal Standards of health care are currently in the phase of preparation. They have been developed from standards proposed by the World Health Organization and are now being commented on by the service providers. Basic criteria for various services[2] are defined for the following areas: accessibility of services; intake, admission examination; scope of services and principles of service provision; organisational aspects; financial aspects; patient's/client's rights; staff, further education, supervision; and environment[3].

The Association of Non-governmental Organisations working in the drug field. (A.N.O.) and the Czech Medical Society – Association for Addict Illnesses J. E. Purkyn are the two main bodies of professionals working in the field of drug abuse treatment and care. Within the A.N.O. three sections for various types of

[1] Based on text prepared by Josef Radimecky, Executive Secretary of the National Drug Commission, Prague, The Czech Republic, 1999.
[2] Including out-reach, low-threshold centres, detoxification, day-care centres, residential short-term treatment and TCs, after-care, methadone maintenance programmes.
[3] The Ministry of Social Affairs is working on professional standards which should be ready by the end of December 2001.

services have been established until today (30. 11. 2000): Harm reduction – 10/99; TC´s – 9/00; Day-care and After-care – 11/00. It is planed to establish further sections (e.g. detoxification, substitution treatment). Sections define their own minimal standards (corresponding with the standards of the Ministry of Health) and ethical codices. The fulfilment of these standards is a precondition for membership in each section.

Activities in the area of professional networking and capacity building are beginning slowly. The National Drug Commission initiates networking and tries to bring various service providers together:

National conference and summer school on harm reduction and low-threshold centres

A first conference of Czech organisations providing harm-reduction programmes and/or low-threshold services took place in May 1999, followed by a one-week Summer School in June 1999. They were both organised by the Association of Non-governmental Organisations, which intends to become an umbrella organisation for all non-governmental organisations working in the field of addiction, and took place within the framework of the Phare Technical Assistance to Drug Demand Reduction Project. About 80 professionals from many different backgrounds[4] participated at the conference and the summer school. They were all representatives of harm reduction and/or low-threshold centres from all over the country (2 - 3 representatives from each facility). The conference and the summer school dealt with the networking and capacity building of these kinds of services, including in particular:

- the *establishment of a professional organisation* for harm reduction and low-threshold centres to act as collaborating partners with certain state institutions
- the initiation of the discussion on *Minimal Standards* for these kind of services
- a discussion of the services offered, including *the quality and evaluation of quality*.

Subjects of discussion were the type and aims of common organisation, ethical aspects in working with addicts, the presentation of model programmes, questions on the assessment of clients' needs, as well as the needs for training and further education of professionals working in low-threshold centres and in street work[5]. The final outcome should be a proposal for Minimal Standards for these kinds of services, which will be discussed in the future with representatives of

[4] E.g. psychiatrists, psychologists, social pedagogues, counsellors, ex-users working in the field of addiction treatment, street workers, and social workers.

[5] The participants were asked about what kind of knowledge, skills they think they would need to learn, what form of education they prefer, and what theory background they would need.

state institutions responsible for Minimal Standards and for Minimal Services Network Development.

Therapeutic Communities' Representatives Work Meeting

In June 1999 a two-day meeting was organised by the National Drug Commission with the aim of establishing a professional organisation of Therapeutic Communities (TC) as a partner for state institutions in the development of Minimal Standards for residential treatment, network strengthening, capacity building, and quality improvement of services. In the future this group shall also define the training needs for staff in TCs. 16 professionals with different educational backgrounds[6] from 8 different TCs participated in the meeting.

The aim of the meeting was to discuss organisational questions (need of TC organisation, its goals and tasks), the Ethical Codex of TCs (developed by the European Federation of TCs), the therapeutic principles of TCs, Minimal Standards, and the funding situation. Prior to the meeting the participants had to prepare their recommendations on the above mentioned subjects based on distributed materials. The meeting was conducted in the form of a discussion on these materials. The outcome should be a proposal for Minimal Standards for these kind of services, which will be discussed in the future with representatives of state institutions responsible for Minimal Standards and for Minimal Services Network Development.

Representatives of both bodies also participated in the work on the National Strategy for the Drug Policy 2001 - 2004, prepared by the secretary of the National Drug Commission. The Czech drug policy is now based on the four basic pillars of primary prevention, treatment, harm reduction (new), and drug supply.

National Alcohol and Non-Alcohol Drugs Conference

This conference takes place annually and consists of various presentations of Czech experts involved in alcohol as well as in drug addiction treatment[7]. The purpose of the conference is the exchange of information and experiences between professionals[8] working in the field of addiction treatment. It is initiated by the Czech Medical Society for Addict Illnesses and is conducted by the Board of Society.

[6] Psychiatrists, psychologists, social pedagogues, counsellors, ex-users working in the field of addiction treatment, street workers, social workers.

[7] There is no special publication on this occasion. However, some presentations are published in the specialist magazine "Confrontations".

[8] Psychiatrists, psychologists, social pedagogues, counsellors, and ex-users.

In 1999[9], organisational questions, current therapeutic approaches as well as developments in aftercare and prevention had been discussed. The unofficial main topic of the meeting was the confrontation between psychiatrists, who mostly prefer drug-free approaches, and other professionals, who have established new kinds of services in the Czech Republic (e.g. programmes for harm reduction, low-threshold centres, non-medical treatment in therapeutic communities, aftercare modalities).

Regional networking

In the Czech Republic there are so-called *Regional Drug Commissions* which meet approximately once a month/ every two months. They are co-ordinated by regional drug co-ordinators, which are nominated by the head of the regional government. The purpose of these meetings is the exchange of knowledge, experience and information between its participants, who are representatives of various types of facilities and institutions (police, School Office, Hygiene Service, universities, governmental and non-governmental service providers etc.). They can discuss problems according to their needs, prepare regional drug policy strategies based on the guidelines defined in the National Drug Policy Strategy, and organise their co-operation. The actual functioning of the Regional Drug Commissions varies from region to region, depending on the regional co-ordinator.

2.1.2. Training and further education of professionals

In The Czech Republic the majority of professionals are young people who have recently left high school or graduated from university, and who are without specialised experience (the need for further education is usually not defined by the staff members themselves). Hence, every programme manager is responsible for the further education of his/her staff. However, this obligation is restricted by the lack of money at the level of the facilities. Staff members feel the need for further education and are interested in participating in a long-term training programme. There is also a considerable lack of qualified and experienced supervisors, which is why a lot of programmes do not have an external supervisor, and many professionals, especially in low-threshold services and in street work, suffer from burn-out syndromes.

Until now there has been no specific training programme for professionals in the field of drug abuse treatment and care. However, several initiatives are currently being taken:

[9] The conference took place in the "Psychiatric Clinic Bílá Voda u Javorníka" from 3-5 June 1999 with about 100 participants.

The ”unofficial” training of drug workers, which has a long tradition in the Czech Republic, consists of *psychotherapeutic self-experience training* over five years. This training was originally developed by professionals working in the treatment of alcohol abusers. However, it is not accepted by the state institutions as an official qualification for professionals who do not have a psychiatric background (graduate psychiatrists can provide individual and group psychotherapy which is paid for by the health insurance). Nevertheless, the majority of drug workers in various types of services intend to complete this psychotherapeutic training which is based on self-experience since it is recommended as the best education for working with drug addicts by their "older" colleagues. In addition, the Minimal Treatment Standards which are being currently proposed suggest that there should be mandatory further education for drug workers, and has recommended the psycho-therapeutic self-experience training.

A one-year[10] theory-based *programme for medical as well as non-medical drug workers* is organised by the Institute for Further Education of Medical Workers[11]. The graduates of this programme receive a certificate for their work in the treatment of drug addicts which is accepted by the state institutions. The curriculum is based on the British educational programme of SCODA[12]. The Institute for Further Education for Medical Professions prepares the initial training for all professionals working with drug addicts.

Furthermore, the development of a consistent educational programme was begun within the framework of the Drug Demand Reduction Staff Training Project (DRSTP II; see also XXX) co-ordinated by the Group Pompidou. It includes the preparation of the content as well as the formulation of educational approaches. A national team is preparing a curriculum for employees in the area of treatment and rehabilitation, which should be adopted by the Ministries of Health and Social Affairs. Universal curricula (for employees in all types of services) include a glossary to unite the terminology in addiction treatment and a textbook (educational guidelines). In preparation is also the institutionalisation of an educational programme at university level (bachelor type).

Finally, the Ministry of Health established a Methadone Working Group which was commissioned to prepare a curriculum for professionals working in methadone maintenance treatment programmes[13].

Another working group was established to prepare - in collaboration with Dutch experts - a *training curriculum for staff working in aftercare programmes*. Its realisation is funded by the National Drug Commission.

[10] Three terms in one calendar year.
[11] In September 1999 the first course started with 30 people, in January 2000 a second one started.
[12] Standing Conference on Drug Abuse.
[13] Initial training of the 25 professionals started in autumn 1999.

2.1.3. The accreditation system and the assessment of quality characteristics in treatment and care facilities

Up to now, there has been no systematic way of surveying the quality of treatment and care facilities. However, as a form of *quality guarantee* all central institutions require from funds applicants (service providers) to engage an *expert* who supervises the professional working in any institution funded by the state.

The Ministries of Health and Social Affairs are now preparing a *system of accreditation for treatment and care facilities for drug addicts* which shall change this situation. The system will include the definition of requirements which must be met by all service providers (see minimal standards; 2.1.1), and will be tested by a nominated expert commission. Accreditation should be the mark of service quality and not the precondition for financial contributions by the state. The relevant criteria have been defined and adopted by the Ministry of Health in October 2000. In 2001 a pilot phase will be carried out by the interministerial accreditation committee.

Until now, every organisation or institution (private, NGO, state) which requests grants from the state budget (Ministries of Health and Social Affairs and the National Drug Commission) must describe its project/programme on the same standard form[14]. They are required to send in an obligatory evaluation report by the end of each year containing the following information: a description of the current situation (kind of problems solved by the project), project goals, target population (in detail, number of clients), means for project realisation (concrete activities), methods used in the project realisation, ways for evaluating effectiveness, concrete outcomes, time schedule and co-operation with other institutions working with drug abusers. As a guarantee of quality, the applicants require the signature of an expert supervising the professional working of the respective institution. In addition, the qualifications and experience of the project management must be disclosed.

Currently, the National Drug Commission is working on a *Central Database* where all project standard forms shall be collected. The database shall facilitate the Ministry of Health, the Ministry of Social Affairs and the National Drug Commission in the co-ordinated funding of existing programmes. Additionally, it includes basic information about existing programmes, their capacity, staff and qualifications. It will be an important instrument within the planning process of the accreditation system. The only disadvantage of the data base is that there are no project descriptions from institutions which do not request state grants. In particular these include medical facilities which are financed through health insur-

[14] The State Grant is the only statute of most of the NGO non-medical facilities (street work, low-threshold centres, therapeutic communities or aftercare programmes).

ance. A structured questionnaire for facilities which did not request grants from the state budget is now in preparation.

Within the framework of the project ”Development of Social Services in the City of Ústí nad Labem” (see Czech report on needs) a questionnaire was developed which is now being distributed once a year to all kinds of social services to assess various information used by the local authority for the planning of treatment and care in the city. The questionnaire includes information on the following issues: address of facility, contact person, target group, type of services provided, capacity of services, conditions of admission, composition of team in terms of professions, methods of working with clients, number of clients in the previous year (according to target groups, age, diagnosis, etc.), costs per client, duration of treatment/care per client, kinds of co-operation with related facilities, recommendations, and the needs of the facility within the framework of city services.

Refernces:

Ministry of Health. Standardy substitucní lécby (Standards on Substitution Treatment) Prague, 2000.

Ministry of Social Affairs. Akreditace a standarddy kvality sociálních sluzeb (Accreditation and Quality Standards of Social Services) Prague, 2000.

National Drug Commission. Národní strategie protidrogové politiky 2001 – 2004 (National Drug Policy Strategy 2001 – 2004) Prague, 2000.

National Drug Commission. Katalog sluzeb poskytovanych v protidrogové prevenci (Catalogue on Services Provided in Drug Prevention Field) Prague, 2000.

2.2. Denmark[15]

2.2.1. Efforts of the professional associations

None of the relevant professional organisations dealing with drug addicts have worked out a specific set of standards for treatment and/or care of drug abusers. This applies for the medical professions as well as for psychologists, social workers and social pedagogues - the most relevant professional groups. However, a few initiatives are relevant to this issue:

The *Danish Association of Social Workers* (Dansk Socialrådgiverforening, DS) in 1997 published a policy statement for the drugs field advocating more treatment and care rather than control. The statement includes claims which mostly concern the organisation of treatment and care in general (see Danish report on ethics) as well as some more specific professional quality criteria. These concern, among other issues, the coherence and co-ordination between the correctional system and the social service system, as well as the establishment of an experiment involving the medical prescription of heroin to the hardest group of addicts.

The *Danish Psychiatric Association* has formed a special group dealing with drug issues (Dansk Psykiatrisk Selskab´s Misbrugsgruppe) which has been holding a number of professional meetings. A group of physicians have formed the *Danish Association for Addictive Medicine* (”Dansk Selskab for Addiktiv Medicin”) which holds meetings on drug-related topics, e.g. on substitution treatment, on the conditions for and the practices of urine analysis, on ecstasy etc. But none of the two organisations have issued any professional standards relating to treatment of drug abuse.

A subgroup under the Danish Association of Psychologists have formed the *Professional Association on Abuse* (”Fagligt Selskab for Misbrug”) which holds regular meetings for a small group of psychologists working in the field of abuse. The group has not worked out any guidelines for treatment or ethics.

After the publication of the Government’s White Paper on the Drug Problem (”Regeringens Redegørelse”) in March 1994, the *Danish Medical Association* published a statement[16] criticising the drug policy which had been conducted so

[15] Based on text prepared by Jørgen Jepsen, Centre for Alcohol and Drug Research, University of Aarhus, Denmark, 2000.

[16] ”Lægeforeningens redegørelse om narkotikapolitik” (The Danish Medical Association’s” Statement on Drug Policy”), published in the weekly professional magazine of the Danish Medical Association, ”Ugeskrift for Læger”, 1994, p. 670-77.

far, in the repressive as well as in the treatment sphere[17]. The statement includes general principles for a future drug policy (see Danish report on ethics) as well as some more concrete claims which are of some relevance with regard to professional quality. The latter include the necessity of cross-professionalism (by pointing out the significance of medical doctors for the co-operation between primary and secondary health services as well as for diagnosis, treatment and research), evaluation of services, as well as measures to be taken to limit the risk of the spread of infections in prisons.

2.2.2. Professional participation in advisory bodies

Representatives of the various organisations have participated in official committees of experts, most notably the Danish Narcotics Council - an advisory body to the government.

In 1996, one of its subgroups issued a proposed set of standards titled *"What is good treatment" (Hvad er god behandling)* (see Annex I). They had been influenced to a large extent by the socio-medical drug expert Peter Ege, who also played a substantial role in formulating the Danish Medical Association's policy statement of 1994 (see above). The standards are a rather simple listing of demands or recommendations for the system, with very few quantitative indications. Covered are accessibility of services, physical environment, professional expertise, adequate methods, flexibility and comprehensiveness of services, capacity, waiting times, and institutional equipment. Qualitative demands include visible goals and methods, individual treatment plans, and institutional filing.

In 1999 *Peter Ege* published an article in the magazine of the Narcotics Council[18] which elaborated upon the viewpoints in "What is good treatment", a statement which as a result gained some official backing[19].

The publication includes the following sections: What is good treatment? What do we mean by treatment? What do we know about the effects of treatment? On which criteria should treatment be evaluated? Assumptions on the correlation between treatment method and effect; What is a good treatment system? "Good Treatment": The effect of concrete services - intensity, differentiation and matching; On counselling in particular; On methadone treatment in particular.

The conclusions, probably accepted by a large number of professionals working in the Danish drug treatment system, focus on long-term treatment taking place in

[17] The statement is today somewhat outdated by later developments upon which the statement had some influence. However, the document was later supplemented by a less extensive statement of the principal views of the Medical Association on drug policy. The main points are in line with the statements summarised here.

[18] Peter Ege (1999). Behandling gør en forskel (Treatment makes a difference), "Stof" (three-monthly official magazine of the Danish Narcotics Council), Dec. 10, 1999.

[19] This does not necessarily mean that the Council endorses it all, but that it finds the contribution relevant as a professional declaration.

a special millieu, governed by a treatment model which mobilises the resources of the client, and offers services and rituals in continuation of the model used for the explanation. Frequent group- and individual counselling, as well as differentiated services directed at drug dependence, are considered necessary. Services matching the problems of the client enhance the effect of the measures. An emphatic, reflective, non-confronting approach to clients further the therapeutic alliance and thus the treatment effects. The work with clients should be well organised, systematic and borne out by a plan. In addition, social or health-professional education, after-care and supervision are necessary.

In 1999 another subgroup of professionals and practitioners published a set of recommendations - with practical examples - on *harm reduction*, including a recommendation for a legal provision allowing for the creation of ”health rooms” in Denmark.

In 2000 another subcommittee of the Narcotics Council issued a publication on *substitution treatment,* which also contains a number of criticisms of current and former policy and suggests some main points for future substitution policy and practice (see Annex II). The recommendations have no binding effect, but must be assumed to express relevant demands for acceptable standards of treatment. The arguments behind the recommendations must also be considered as important statements of principles and standards.

Finally, a similar cross-disciplinary working group of the Danish Narcotics Council, but consisting mainly of practitioners from the treatment field[20], has issued a series of recommendations on ”*What is good aftercare*” and ”*What is good follow-up of methadone maintenance”*[21]. The recommendations were issued in two connected sections of which the latter is largely a reiteration of the former. The guideline for the follow-up of substitution treatment does not deal with aftercare after the termination of substitution treatment, but deals rather with the social-psychological support of the substitution in terms of its medical aspects[22].

Thus the situation in Denmark is that there are no strict professional standards on drug abuse treatment, but only more generalised statements of policy and/or ethics. However, the relevant professions, through their selected representatives in advisory bodies, have contributed to the formulation of recommendations for treatment, including substitution/maintenance and low-threshold services, and harm reduction measures.

[20] The working group consisted mainly of practitioners from Centres for Treatment of Addicts, either on the county or municipal level (5 members) or from institutions for in-patient treatment (2 members from institutions building upon the Minnesota or 12-step model) and one from the Department of Prisons and Probation.

[21] ”Hvad er god efterbehandling” (What is good after-care) and ”Hvad er god opfølgning på substitutionsbehandling” (What is good follow-up on substitution treatment); Recommendations published by the Danish Narcotics Council in 1999.

[22] The two in many locations are geographically separated and thus need co-ordination.

2.2.3. Post-graduate education and training for drug treatment staff

None of the professional organisations have developed regular post-graduate training on drug treatment for their members, nor do these exist at universities or other professional schools (except for a few elements included in the programme ”Master of Public Health” at the Universities of Aarhus and Copenhagen).

With support provided by the Ministry of Social Affairs, a *further education programme* was introduced in 1996 for various (semi-)professional groups such as social pedagogues, social workers, nurses, psychologists, etc. The training programme is conducted over five 4-days' modules at the Municipal High School in Grenaa (in co-operation with the section on further education within the school of social work in Esbjerg) and also includes the preparation of group project reports, integrating theoretical questions and their practical application. The capacity of this *”diploma programme”* is rather limited - a group of 20 participants per year. A broad working group is currently working on a revision and expansion of this programme and on developing similar programmes for drug prevention counsellors. It is also revising the corresponding training programmes for alcohol treatment and prevention staff. Guidelines for the revision have not yet been published.

2.2.4. Other measures of quality control

At present there are no standards or guidelines published in Denmark for the certification of drug abuse treatment personnel. In some of the many small, recently created, institutions working on the 12-step model (”Minnesota-institutions”) ex-addicts make up a significant proportion of the treatment staff. Their qualifications are not officially verified.

A working group under the Danish Narcotics Council on ”Quality Assurance” is at present considering the issue of certification and other matters of education and training of drug abuse treatment personnel. This group is also working on other aspects of drug abuse treatment quality, e.g. on referral systems and on the various levels of treatment, including standards for substitution treatment. However, the work (autumn 2000) is only now in its inception.

A system of official certification for (in-patient) treatment institutions for drug abusers has been discussed for some time and there have been demands made for such a system. The Ministry of Social Affairs is currently working on the matter. Each county is being given responsibility for the supervision of such institutions within its local area.

For some years now, the Association of Danish Counties (Amtsrådsforeningen) has been visiting and collecting information on in-patient institutions for drug

abusers. This information is collated together in a database in one of the counties (Frederiksborg Amt), and a book containing the information has been distributed to counties and municipalities. The idea was that only institutions considered as satisfactory from the point of view of the counties would be recommended for the referral of clients. However, the system has not worked satisfactorily. Several counties and communes base their evaluation of the qualities of the institutions they use for referral (the great majority are private) upon visits, the level of communication and co-operation, and upon the personal evaluation of the staff. Some referrals based upon such evaluations have turned out to be quite problematic.

There is a clear desire, centrally as well as locally, to develop a more efficient system of supervision and quality control.

2.3. Germany

2.3.1. State and standing of quality assurance and standardisation

Addiction care in the Federal Republic of Germany is separated into various fields which are neither uniformly planned, organised, financed nor evaluated. As a consequence, both the extent of standardisation in the care system and the number of those carrying it out varies considerably. What has increasingly become the connecting link between the efforts to increase the qualifications and quality in addiction care is the debate about quality assurance, which is being taken more and more seriously, both by the funding bodies as well as the professional organisations and the service providers.

Possible causes for the underdevelopment in the area of standardisation and qualifications are:

- few resources available for these activities,
- the competition factor involved with standardisation with different professional fields and/or service providers which are simultaneously active (medicine, social work, psychology, others),
- the underdeveloped state of treatment research in the Federal Republic of Germany and the non-existent/ hardly existent research funding as well as
- the lack of willingness of the funding bodies to adopt existing standards in treatment practice even with corresponding financial control.

Thus in some fields there is the strange/depressing situation that the patients are unable to benefit from the professionally formulated and consensual standards because the funding bodies, e.g., in the field of substitution the health insurance institutions, do not finance the corresponding service.

2.3.2. Quality assurance in addiction care as a guiding process for standardisation

Legal basis

In the Federal Republic of Germany the main requirements for quality assurance are formulated in general laws and the specially reached outline agreements. In §§ 135 - 137 of the SGB V, the obligation to provide quality assurance for the outpatient sector of the health service and the hospitals was explicitly codified for the

first time in 1989: "The measures shall be applied to the quality, course and results of the treatment". These guidelines present a clear widening of the previous understanding of quality. The law is based on a dynamic, rather than static concept of quality.

These special legal regulations should be understood in connection with the provisions of §§1 and 2 of the SGB V: The task of health insurance is to "maintain or restore the health of those insured or to improve their state of health " (from §1). The standards for quality and efficacy of the services shall, in accordance with §2, take into consideration the "general standard of medical knowledge... and medical progress". Medical insurance institutions and service providers shall guarantee treatment of those ensured that corresponds to their needs and the state of medical knowledge (§ 70).

The previous emphasis of the partners of the self-governing administration - the hospitals and the health insurance schemes, whose attention was previously mostly directed towards comparative tests - has thus been qualified. This is highly significant for the dynamically developing and still not very codified fields of medicine, including substitution treatment and other fields of addiction therapy. Since the introduction of the *Bundespflegesatzverordnung* [federal regulation for the daily charges in hospitals and for nursing (§§ 7 and 9)], as a logical consequence the costs of quality assurance measures are also eligible to be covered by these daily charges.

According to the legally binding professional code[23] for German doctors, each doctor "who practises his profession ... is obliged to undertake further professional training and to inform himself about the respective requirements which apply to his professional training". The professional code also includes the duty to "implement the measures introduced by the *Ärztekammer* [Medical Council] to ensure the quality of the medical profession" (here according to BMG 1996).

A specific reference for quality assurance in out-patient and in-patient psychiatry is the *Psychiatrie-Personalverordnung* [Psychiatric Personnel Regulation][24]. The regulators have empowered the health insurance institutions to examine "whether the provision of personnel in accordance with this regulation has been translated into a corresponding treatment service" (§ 4 Par. 4 No. 2). The regulation provides an important point of reference for quality assurance because the allocation of personnel is based on specific services for patients which are based on a therapeutic concept with definite structural and organisational premises. This still applies given the limitation that the personnel quota for out-patient sub-

[23] The content of the professional code became legally binding for doctors as a result of its adoption in the professional codes of the regional medical councils.

[24] The Psych-PV can only provide an orientation in terms of the required team. It is not the agreed basis for the provision of personnel in substitution treatment.

stitution treatment is not embodied in the regulation which is not generally recognised as a basis.

In positive cases these general requirements are stated more precisely within regional or establishment-related regulations such as, for example, within the framework of quality management in the drug out-patient clinics in Hamburg.

Concepts, models and trends in quality management

There are a large variety of concepts, models and trends in quality management for services in general and specifically for health-related services. The discussion process concerning these models and concrete standards is not yet concluded. Thus every organisation must, by weighing up the advantages and disadvantages, decide for themselves the solution which best corresponds to their situation. In the field of addiction the bases are:

- *Guide for quality assessment in psychiatric clinics* (Federal Ministry of Health 1996): This guide is not a comprehensive system for quality management but an instrument for assessing quality at the level of individual fields of work. This assessment assumes that there is agreement concerning quality requirements. The emphasis here is on assessing the quality of client-related activities.
- Based on the concept of quality of the guide mentioned above, *drug-related target parameters* have been developed with which the method of approach for substitution treatment can be put into concrete terms (akzept e.V., 1998).
- The *"European Model for Total Quality Management"* from the EFQM (European Foundation for Quality Management). This model concentrates on the development of a quality management system from the managerial side. Above all it provides the framework for a diagnosis of the quality management of an organisation and the evaluation of the quality system of the organisation. It deals with the central question: what has the organisation attained in terms of quality? Using this model, instruments to assess personal- and organisation-related quality are developed.
- The *Qualitätssicherungssystem in den Drogenambulanzen Hamburg* [Quality assurance system in the Drug Out-patient Clinics, Hamburg] follows, in the individual fields, the systems of the "Good Practice" guidelines, the guiding principles of the ISO 9000 standards and the Quality Awards (EFQM). All fields attempt to put these tools for improving quality into concrete form.
- Besides the explicitly quality-related management systems, the *findings of substitution research* also form the basis of the above mentioned system. The findings of evaluation research on substitution treatment provide information on the quality-relevant processes in medical and psycho-social treatment as

well as on the main client-related indicators for development in the most important target areas for therapy.

Thus, the quality management system for the field of addiction is founded on current knowledge. However, the development is not yet concluded which is why current systems are designed to be open-ended so that they are capable of being extended and supplemented.

2.3.3. Qualitative and professional standards

2.3.3.1. Methods of standardisation

The form of the elaboration and thus also the validity and relevance of the published qualitative and professional standards varies considerably. Contrary to the USA, a real tradition comparable to the consensus conferences of the National Institute of Health (NIH) has not yet developed in Germany and is also neither funded nor organised by the state. The professional associations of the various participating occupational groups, the funding bodies and also the industry are involved in the debate on standards, in different areas and to some extent with very opposing interests.

In the field of addiction care various **professional associations** are making efforts to develop treatment modules, professional and qualitative standards. These are, however, very contradictory and until now have had little influence on the organisation of the treatment:

- Die *Deutsche Gesellschaft für Suchtforschung und Suchttherapie* [German Society for Addiction Research and Addiction Therapy (DGS)] has formulated, for example, "Standards for Catamneses". In addition, it is participating in the development of treatment modules and in the activities of the *Deutsche Hauptstelle gegen Suchtgefahr* [German Office Against Dangers of Addiction (DHS)].
- The *Bundesverband Akzeptierender Drogenarbeit* [Federal Association for Acceptance-oriented Drug Work (Akzept e.V.)] has published, for example, standards and guidelines for psycho-social care within the framework of substitution treatment.
- The *Deutsche Gesellschaft für Suchtmedizin* [German Society for Addiction Medicine (DG Suchtmedizin)] is working on, for example, guidelines for anesthetic-supported opiate detoxification, substitution and other treatment guidelines.
- The *Deutsche Gesellschaft für Psychiatrie, Psychotherapie und Nervenheilkunde* [German Society for Psychiatry, Physiotherapy and Neurology] as

well as the *Deutsche Gesellschaft für Allgemeinmedizin* [German Society for General Medicine] have signalised their interest in participating in the further discussion on standards as well as in the development of treatment modules.

A single initiative has been made up to now using state funding. Based on the initiative of the **Federal Ministry of Health** (BMG), an attempt was made to elaborate standards for methadone substitution in an interdisciplinary working group under Gerhard Bühringer (Institut für Therapieforschung, IFT) (Bühringer et al. 1995).

After intensive debate with the providers of in-patient addiction care, guidelines for quality assurance in this area were elaborated by the **pension scheme authorities**.

The consensus conferences sponsored by the **industry**, e.g., on the use of Buprenorphin in substitution treatment, have not been based until now on systematic efforts by the professional associations or other legitimised committees.

All in all, there are no standardised methods for the elaboration of professional or qualitative standards.

2.3.3.2. Qualitative standards in addiction care according to the intervention and setting

There has been progress in the discussion over standards and/or suggestions have been formulated for corresponding approaches particularly in three fields of addiction therapy:

- in substitution treatment for heroin abusers,
- in detoxification treatment for alcohol and drug abusers
- in the field of in-patient long-term therapy.

On the other hand, the discussion about the general medical treatment of addicts as well as about diagnoses or other aspects of the therapy has only just begun.

Suggestions for standards in the substitution treatment of drug abusers

"Bühringer Standards"

These standards are oriented to all those working in the field of substitution treatment. Published in the mid-1990s (i.e., during the period with the greatest spread of substitution treatment in Germany), these were produced by an interdisciplinary working group of experts from German-speaking countries. The main concern, apart from developing an approach for the field of pharmacology, was to establish the importance of psycho-social evaluation and therapy.

Standards of the *Bundesärztekammer* [Federal Medical Council]

These recommendations are directed towards doctors. They are intended to present the complex possibilities of the addiction care system and provide for the establishment and long-term maintenance of the *co-operation between the doctors conducting treatment and the addiction care system*. The possibilities for psyco-social care are presented in detail. They do not represent instructions for psycho-social care. Recommendations for the work of the addiction care system fall within the responsibility of the corresponding professional and supporting organisations.

The *conducting of substitution therapy for opiate abusers* is regulated by the guidelines of the *Bundesärztekammer*. Moreover, the guidelines for substitution-supported treatment of opiate abusers from the *Bundesausschuss der Ärzte und Krankenkassen* [Federal Committee of Doctors and Medical Insurance Institutions] apply for contractual medical treatment. The regulations of the Narcotics Act (BtmG) and the Narcotics Prescription Regulation (BtmVV) provide the legal basis for the substitution treatment of opiate abusers. In the BtmVV, psycho-social care is specified as a main component of substitution treatment.

Pyscho-social care is intended to be target-oriented, and, with regard to each individual case, provide appropriate care measures within and outside the addiction care system. The doctor conducting substitution treatment should have sufficient knowledge of the different services of the psycho-social care systems and be able to co-operate with the different facilities and/or providers. With these recommendations, the Federal Medical Council intends to make a contribution in collaboration with other experts and organisations from the addiction care system.

Standards from Akzept

The "Guidelines for psycho-social evaluation within the framework of substitution treatment" (Akzept Materials No. 1, 1995) are in particular directed to institutions and occupational groups concerned with psycho-social care. As a professional association concerned with drug policies, Akzept e.V. attaches great importance to the fundamental importance of substitution and its widespread availability.

Standards for detoxification treatment

Standards for opiate-supported withdrawal

There are still no suggestions for standards from the professional organisations for the conventional detoxification of opiate addicts. The pharmacological as well as psycho-social approaches differ widely from facility to facility. For opiate-supported withdrawal, cornerstones have been suggested by the Deutsche Gesellschaft für Suchtmedizin (DGS, 2000).

Standards for professional withdrawal treatment for alcohol abusers

For withdrawal therapy with alcohol abusers, most efforts have been made in trying to standardise the treatment settings, the pharmacological approaches and the psychotherapies within the framework of the treatment. The reason for this is the treatment situation of these patients, of whom only a small minority are able to receive specific therapies[25]. The overall majority in Germany are still cared for by general medicine not only during the detoxification phase but beyond it as well. Moreover, the funding bodies are trying to increasingly regulate and limit the treatment periods during the detoxification. For instance, in Bavaria only in-patient detoxification lasting for less than 10 days is paid for.

Essential for "professional" detoxification are: the linking of pharmacological and psycho-social interventions, the conducting and/or provision of psychiatric and psychological therapies, the focussing on the motivation process, including for the long-term participation in out-patient treatment and self-help.

Professional standards according to the disciplines

Accompanying the discussion on quality assurance, the question is being increasingly raised as to the necessary professional qualifications needed for conducting more diversified measures.

Addiction medicine

It is precisely in the field of addiction medicine that the discussion is already well developed in the USA and other countries. A first step in this direction has been made in Germany with the *Leitlinien der Bundesärztekammer zur "Fachkunde Sucht"* [*Guidelines of the Federal Medical Council on the specialist field of "addiction*"] which, however, still do not solve the problem in any way and represent only the beginning of the debate about further training in addiction medicine. As a prerequisite for definite fields of work such as substitution, 40 hours of comprehensive further training are specified as a basic qualification.

The discussion over the organisation of further training in psychiatry and beyond is not yet concluded. Models such as the creation of an additional title or the definition of a further training module are currently being discussed in the professional organisations and the constituent medical profession.

Standards in case management

Case management is a person-oriented service which is organised in a clearly structured form and is seen as having essentially a linking function: clients with their individual care needs (demand side) are intended to be brought together with available care resources (service side) (see, for example, Wendt 1997).

[25] Cf. Wienberg, 1995. Die vergessene Mehrheit.

Case management ideally works as a regulated process. By means of recourse to various approaches (see, for example, Moxley 1989; Ballew, Mink 1995; Weil 1995; Raiff, Shore 1997; Wendt 1997), it is possible to illustrate the several process stages:

- Agreement on co-operation and "assessment"
- Agreement on objectives and care planning
- Implementation (including referral, organisation, co-ordination)
- Monitoring and reassessment
- Evaluation of the results

Psycho-social counselling

Counselling services exist in numerous psycho-social fields. The instruments and intervention strategies which are used vary considerably within the context of the individual institutions. There are no general standards available.

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2.4. Greece[26]

2.4.1. Relevance and promotion of professional standards

The *law 1729/87* was the first legislative act, which acknowledged the importance of creating treatment and care services to counteract the problem of drug addiction, which in Greece was becoming more and more serious. This law signified the change from a policy mainly oriented to reducing the availability of illegal drugs to a policy mainly oriented to reducing the demand while offering medical, psychological and social support to the addicts. A central *inter-ministerial commission* was created with a co-ordinating function with regard to actions in the field of drug abuse prevention and treatment. Furthermore, a *network of treatment agencies* was set up, called KETHEA (Therapy Centre for Dependent Individuals), offering drug-free in-patient and out-patient treatment programmes based on the principles of the Therapeutic Community. KETHEA incorporated several treatment centres already working in the field. Nevertheless, the law did not refer to quality and professional standards of the treatment services, either for the services already operating, or for the new ones.

In 1993, a *new law* was adopted which is more oriented to the *harm reduction approach*. The new law has for the first time allowed the possibility of treatment with substitutes in Greece. Furthermore, a new central institution, the OKANA (Organisation Combating Drugs), was created to co-ordinate the actions in the field of prevention and treatment of drug abuse at national level. The law explicitly mentioned the introduction of pilot treatment programmes with substitutes by OKANA.

However, the current national law regulating the treatment and care system for drug abuse and addiction does not refer to specific quality and professional standards related to the support system, to the working conditions and processes, or to training and further education of the professionals employed in the field. Despite the *lack of regulation at national level*, the large majority of the treatment and care agencies apply what are effectively *non-explicit professional standards* based on ethical principles, scientific knowledge, institutional experience and shared clinical methodologies. The only methodological aspect explicitly regulated by the current national law is related, as mentioned above, to the use of substitutes in the treatment of heroine addiction. The same lack of definition of quality/professional standards exists at the level of single institutions. Usually, each single treatment institution periodically produces documents de-

[26] Based on text provided by Valeria Pomini, Athens University Medical School, Department of Psychiatry, "Eginition" Hospital, "ATHENA" Programme, Greece, 2000.

scribing their current activities and treatment methodology/ philosophy, without specifying quality and professional standards.

During the last two years, KETHEA has paid particular attention to the *evaluation* of its service as a means for their continuous improvement (Annual Report KETHEA 1998). One of the main goals of the KETHEA evaluation is to define several minimum quality standards for its services. The Continuous Quality Improvement Effort consists of two levels of evaluation: the internal evaluation involves staff members, clients and family members, the external evaluation is carried out by an International Committee of three experts. A tool of instruments has been created for the assessment of client and staff satisfaction. KETHEA's evaluation activities are still currently being conducted and the instruments are not yet available for external use. Their English version will be published by KETHEA in the future.

2.4.2. The current situation in training and the further education of professionals

Professionals working in the field of drug addiction treatment and care in Greece are mainly psychiatrists, social workers, psychologists and sociologists. There is no explicit regulation concerning their required specific skills and knowledge concerning drug abuse and drug abuse treatment.

Furthermore, in Therapeutic Communities a considerable number of *non-graduate staff members*, mainly ex-users, are employed. There are no specific national regulations defining their professional profile and competencies. At national level, there are still no education and training programmes developed to enable non-graduate professionals to qualify to practice in treatment services. At the academic level, the same *lack of specific qualifications and specialisation* for drug abuse treatment and care can be observed for graduate professionals.

Usually, each treatment institution provides some form of practical training for new staff members which lasts for 1-3 months, often including theoretical aspects (Douzenis et al., 1996; Annual Report KETHEA 1998). However, this kind of training is carried on mainly at internal level. There are three main consequences of this practice:

- The internal training allows the new professionals to have a wider knowledge of the specific institution (philosophy, therapeutic methodologies, practices, organisation, general climate, clients, colleagues, etc) and to "adjust" himself/herself to the specific context where they are expected to work.
- The internal training, however, excludes the development of wider, theoretical as well as methodological knowledge of different therapeutic approaches,

and it often mostly excludes knowledge of how other treatment agencies are working in the same field (sometimes in the same neighbourhood!).

- Usually the internal training is not subject to an evaluation process.

The need of a more systematic, nation-wide acknowledged training programme on drug addiction treatment and care has often been expressed by the professionals in the field. The definition of professional standards and ”good practice” would help the development of adequate training programmes, and the development of systematic training programmes would help in defining professional standards.

Educational programme of KETHEA

KETHEA has organised an educational programme for professionals working in the field of drug addiction treatment, entitled *”Addiction counselling competencies: the knowledge, skills and attitudes of professional practice”*, in collaboration with the University of San Diego, California (UCSD).

The first programme was carried out during 1998 and 1999 and was attended by 52 professionals from KETHEA and other treatment agencies from Greece and Cyprus (Annual Report KETHEA 1999). The programme is being repeated during 2000 – 2001. It is organised in the following thematic units:

- Recent research and findings on drug abuse treatment
- Overview on the therapeutic community
- Drug dependence and family therapy
- Health management
- Treatment planning
- Cognitive - behavioural therapy
- Adolescence and drug addiction
- Relapse prevention
- Evaluation issues and concepts

The professionals successfully completing the programme are certified as drug addiction counsellors by UCSD. It represents the first educational initiative providing a systematic training for a group of professionals already working in the field and coming from different treatment institutions.

Need for education for postgraduate medical students in substance abuse treatment

A lack of education in substance abuse and substance abuse treatment has been identified for *postgraduate medical students* (Kokkevi 1995)[27]. Kokkevi and Stefanis (1996) describe as inadequate the information and the education given to both undergraduate and postgraduate medical students regarding the prescription of psychoactive pharmaceuticals. The results of two national surveys on the school population aged 14-18 and on the general population showed a correlation between the use of prescribed psychoactive pharmaceuticals and the use/abuse of non-prescribed psychoactive pharmaceuticals as well as of illegal drugs. Based on these findings, the authors propose to implement the education offered by academic medical courses. In fact, they considered it to be of crucial importance that especially paediatricians and psychiatrists are educated as to correct practice in prescribing psychoactive pharmaceuticals in order to prevent abuse.

Training programmes for professionals in the drug abuse treatment field

Tsiboukli (1997), chair of the educational programmes of KETHEA, analyses the necessity of educational and training programmes for both new staff members who will be employed in the drug abuse treatment field, and professionals already working in the field. The document reflects the growing interest by KETHEA in implementing educational and training activities, monitoring the needs of the professionals employed in the organisation and taking important initiatives to respond to them. Tsiboukli examines the difference between the two groups of professionals (university and programme graduates (ex-users)), and suggests the development of common training programmes for both groups, at least in the context of ”drug-free” organisations[28].

The programmes must aim for the further development of professional competence in order to compensate for inadequate training received in the past, to minimise the burn-out syndromes, to develop staff competencies to deal with new demands that arise in the field, and to match personal and organisational needs for training.

Furthermore, Tsiboukli (1997) suggests among other things that when an institution is designing a training programme it should ensure that individual as well as organisational needs are met, and that the programme is run on a voluntary basis for a mostly homogenous group with a limited number of people (i.e. not more

[27] Kokkevi makes several proposals for improving the current academic education.

[28] Although major differences are highlighted in the needs of the different categories of professionals (new and older staff members, programme graduates and university graduates), the author does not consider these differences to be of much relevance, proposing the design of common training programmes.

than 20). It should also ensure that there are highly qualified trainers, that the staff are given incentives, and that recognised certificates are granted for course attendance.

However, the document does not give any mention of the contents which would characterise a training programme, including the skills which the professionals would need to learn or implement, specific knowledge on issues related to drug abuse and drug abuse treatment, or the specific competencies which they would need to develop in accordance with their professional role. However, it is one of the few Greek documents which focuses on the necessity of systematic, eventually continuous education and training programmes for the professionals in the field.

Problems in the training of new staff in Therapeutic Communities and the requirements for a common curriculum

According to Tsiboukli (1996)[29], the needs of two different groups of professionals (social sciences graduates and therapeutic programme graduates) must be considered when training new staff members in Therapeutic Communities. Furthermore, Therapeutic Communities usually face two major kinds of problems in the training of the two groups:

- *Internal problems* relate mainly to the informal training, which is usually carried out in the T.C.s: internal training is often linked with inadequate supervision; it is difficult to involve new staff in daily activities and responsibilities; older staff members are required to act as trainers; and new staff sometimes drop out during the training period.
- The *external problems* are the following: lack of academic courses offering adequate theoretical and practical qualification for working in the drug abuse field and in drug-free programmes in particular; the demand to increase the quantity and quality of the T.C.s requires new skills and up-dated competencies; apart from formal academic qualifications, personal qualities and values are also important for people working in the drug-free T.C.s, a fact which makes it even more difficult to recruit new staff members.

For the organisation of training programmes, Tsiboukli (ibid.) recommends recognising the value of theory in supporting practice and to introduce the new staff to a set of values and principles that are characteristics of the T.C.s. Different experiences, cultures and educational backgrounds present amongst the trainees need to be respected. Prejudices existing amongst the two groups of professionals, the university graduates and programme graduates, must be corrected. In

[29] It is the only document within the Greek bibliography which refers to standards for the training of professionals and which defines contents and main issues.

conclusion, Tsiboukli (ibid.) underlines the *need to develop a common curriculum* of high standard and quality, which includes the following basic elements:

- Addiction history, theory and treatment models
- Therapeutic Community general theory and practice
- Experience workshops and social skills training
- Introduction to basic therapeutic techniques used in the T.Cs.
- Research and programme evaluation techniques
- Practical experience training in a T.C.

Conclusions

During the last decade, most of the energy has been spent on the development of drug abuse treatment and care services, in an attempt to respond to the increased demand, and to understand and meet the clients' needs. The national legislative framework on drug abuse treatment does not help treatment institutions to define their professional standards. The curricula of professionals employed in the field represent a kaleidoscope of different educational experiences, usually based on personal initiatives and clinical practice. However, the interest in training and educational activities expressed by professionals is constantly growing, together with a larger awareness on the quality of the services offered. This has been highlighted by the large participation of professionals in many scientific initiatives (meetings, workshops, seminars, etc.) carried out in the country during recent years. Furthermore, the institutions' efforts to implement treatment and care services have to be oriented not only to quantity but towards quality, otherwise there will be a risk of creating and maintaining a non-effective, self-referential treatment system.

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2.5. Italy[30]

2.5.1. Regulations concerning professional standards in drug abuse treatment and care

In Italy there are regulations concerning professional standards in drug abuse treatment and care both at a national level for professionals operating in *public and private services*[31], and at a regional level (Veneto Region) for *outreach work professionals*. These regulations mainly concern admission and inclusion criteria which perhaps should not be perceived, however, as professional standards in the strict sense.

Public Service Professionals

The most recent regulation for public service professionals is contained in Law No. 44 of 18/02/1999, which defines the *characteristics of public service professionals* and divides them into low and high-user services. The corresponding professional profile is that of first-level health care directors of the National Health Service. Therefore, this is not a selection of standards which is strictly pertinent to specific skills in the area of drug abuse treatment. Following this law, a decree law was approved (No. 444/99) which defines more specifically the *professional profile* of those who work in public services for drug abuse treatment:

With regard to *psychologists* and *social workers*, a degree is sufficient. In the hiring and assignment of psychologists, a specialisation in clinical psychology, social psychology or psychotherapy is preferred.

With regard to *doctors*, in addition to a degree they must also have at least a four-year post-graduate qualification. The type of speciality is not indicated (the discussion as to which specialities are best is still open). In another decree (No. 229 of 1999), it is indicated that ”curricula and specialities will be determined by a special decree”. In the recent past, the specialist professions allowed to compete

[30] Based on text by Maurizio Coletti, Centre for Addiction Research (Centro per la Ricerca dei Comportamenti Additivi), Rome, Italy, 2000.

[31] In Italy, there are about 530 public services (SerT) and more than 1,200 private facilities of different dimensions and organisation. The latter includes both professionalised and non-professionalised centres based on volunteers.

for the post of public services professionals have been as follows: psychiatry, hygiene, pharmacology and toxicology.

As far as *educators* are concerned, reference is made to regional standards which have not yet been clarified.

These guidelines were developed on the basis of a consensus conference between state and regional administrations and representatives of public service professionals. Public Health Care Administrations (ASL) are responsible for the implementation of these guidelines after the regional administrations have converted them into regional laws. Failure to comply with these guidelines will invalidate the hiring of the personnel or the appointment of service co-ordinators.

With regard to Public Service Professionals, there are three different levels of staff depending upon the number of users they are in charge of (that means really in charge of and not just a file):

QUALIFICATION	Public Services with less than 60 users	Public Services with 60 to 100 users	Public Services with more than 100 users
Physicians	2	3	4
Nurses	2	3	4
Psychologists	2	3	4
Social Workers	2	3	4
Professional Educators	1	2	2
Administrative Personal	1 (part time)	1	1
Others	1	1	1
TOTAL	**10+1**	**16**	**21**

However, the number of staff according to the law does not correspond with reality for several reasons.

Private Service Professionals

The *characteristics of professionals operating in private services* are regulated by the Memorandum of Understanding Between the State and the Regions of 1999, which updates the previous version of 1993. This document also provides *minimum criteria*, which should not be understood to be professional standards as such.

One of the reasons for choosing to prescribe minimum criteria lies in the fact that, in Italy, most of these private services are therapeutic communities based on a non-specialised volunteer work tradition. The document in question (see Annex III) reports on previous guidelines and also prescribes the number of professionals necessary for a treatment service with regard to the number of users. Furthermore, it establishes that the person in charge of the facility requesting

”accreditation”[32] must meet two fundamental requirements: 1. academic qualification or registration in a professional register; 2. previous and documented experience of at least two years in this field.

With regard to professionals involved in treatment programmes, they too must meet requirement 1, but are only required to have one year of experience in this field. These guidelines were developed as a result of a consensus conference between state and regional administrations and representatives from private facilities. Regional administrations then convert these guidelines into regional laws. Failure to comply with such provisions may determine the invalidity of the public recognition.

Outreach service professionals

Guidelines on the professional profile are contained in a book (Serpelloni & Rossi 1996) and refer only to the Veneto region. The aim of the guidelines is to define tools for personnel selection. The indications for the areas to explore for personnel selection are: specific professional experience; motivations and expectations; specific knowledge; personality traits; operating reliability and availability; past and present behavioural characteristics. The suggested selection criteria are as follows:

- general and specific knowledge of the work topics;
- attitude to team work, work with drug abusers and work in unstructured environments;
- availability in terms of time, attitude, training and for exchanges;
- sufficiently structured personality (absence of psychopathological disorders);
- proximity to the work place, driver’s licence; awareness and control of one’s reactions and capacity for insight;
- no previous and/or present involvement with drugs and personal involvement with relatives that abuse drugs or that are HIV positive.

2.5.2. Recommendations for the training and further education of professionals

The only document containing general recommendations for basic education, training and the further education of professionals working within drug abuse at a national level is contained in the book of proceedings of the Second National Conference on Drug Abuse, which took place in Naples in 1997. A working group prepared a document which was approved by the Conference. The docu-

[32] As private institutions dealing with drug abuse are considered to be social or public health services, they need to be officially recognised. If they do not have this recognition or they lose it, they are not allowed to function.

ment contained a number of premises and operational conclusions. Such conclusions are reported in the following paragraph:

- It was considered of paramount importance to introduce notions on diagnosis, prognosis and treatment of drug abuse to all degrees in medicine and psychology.
- It was suggested that postgraduate internships should also be introduced, which may also be performed in drug abuse treatment services.
- It was suggested that common refresher courses should be fostered among professionals operating in public services and in the private sector.
- It was suggested that clinical supervision activities be stepped up.
- It was suggested that specialised documentation data banks should be improved in order to provide professionals with updated information.

The document did not produce many concrete effects.

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2.6. The Netherlands[33]

2.6.1. Regulating Professional Standards

Regulations at a *national level*[34] concerning professional standards in all areas of drug abuse treatment and care are laid down in *specific legal acts*. The Professions in Individual Health Care Act (Wet BIG), the Medical Treatment Agreement Act (WGBO), the Quality Act for Care Institutions (Kwaliteitswet Zorginstellingen), and the Special Admissions Act for Psychiatric Hospitals (BOPZ) are briefly described in the Dutch report on ethical issues.

At the *level of institutions*, the *ISO-PLUS+ standards for addiction care*, as drawn from the international standards for quality NEN-ISO (9004-2, 9001, 9002) were accepted by the Dutch Association of Addiction Care Institutions (NeVIV) in the general meeting of March 1997. Since 1995, departments, programmes, projects, management and personnel management of addiction care institutions have been checked as to whether they are meeting these guidelines. As a result, institutions are increasingly developing (new) protocols for (new) programmes and carrying out research in order to evaluate outcomes. For the development of expertise, (new) training programmes are being developed. The ISO-PLUS+ standard (Ooyen-Houben 1996) includes guidelines on three central aspects of quality:

- Management of processes (i.e. products or treatment/care programmes, the primary process for a client from first contact to finishing treatment, and customer-orientation)
- Policy and management tasks
- Management of personnel (expertise, satisfaction) and means.

The best practices, resulting from an institutional visitation procedure using the ISO-plus+ checklist, are described and used as *examples of good practice* (The Netherlands Institution of Mental Health and Addiction and GGZ-Ned 1999). GGZ-Ned is developing a website (www.ggz-ned.nl) where these examples will be published (in Dutch and English).

In collaboration with addiction institutions, clients, the ministry and inspection bodies, the *'certificate scheme' standard* is currently being developed, based

[33] Based on text prepared by Monique Nieuwenhuijs and Wim van den Brink, The Amsterdam Institute for Addiction Research, The Netherlands, 2000.

[34] No regional regulations concerning professional standards in drug abuse treatment and care could be found.

upon the Lexicon of Good Practice projects and the ISO-PLUS+ standard. The certification scheme is a structure (concerning management) which is compatible with the ISO standards but much more specific to care institutions. Specific criteria should be filled in by the institutions themselves. The scheme is meant to be binding for all addiction care providers and institutions in the Netherlands and will be finalised in 2001.

A group of addiction treatment centres has recently taken the initiative to improve the quality and effectiveness of the treatment of alcohol, drug and gambling addicts in The Netherlands: *"Scoring Results"*. With financial support of the Ministry of Health, Welfare and Sports and co-ordinated by the Netherlands Mental Health Care Institute (GGZ-NL), this initiative aims at improvements of addiction treatment and care based on empirical evidence, standardised and computer assisted allocation procedures, treatment protocols and benchmarking. In addition, this initiative will provide training programs and implementation procedures.

2.6.2. Guidelines and recommendations relevant to professional quality

All Dutch guidelines and recommendations relevant to professional quality have been discussed within the framework of the Dutch ethics report. However, for the sake of completeness they are briefly summarised at this point:

- (The Royal Dutch Medical Association 1999)) published a comprehensive policy document containing a precise description of 22 *tasks, roles and responsibilities of physicians in drug-related problems*. The document is the result of an extensive process with the aim of clarifying the medical role in assistance, prevention and care as well as to reach agreement on the question as to the ways in which physicians can combat drug-related problems.
- *Methadone treatment in prison* (Ministry of Justice, 1997): Advice to doctors of the prison staff on methadone prescription.
- *Prescription of heroin to heroin addicts* (Health Council of the Netherlands, 1995): Recommendations for the experiment concerning the medical co-prescription of heroin to chronic, treatment-resistant methadone patients which is currently running.
- *Drug testing in prison*: Binding regulations of the Minister of Justice on urine checks in penitentiaries (Ministry of Justice, 1999); guidelines for urine checks on use of drugs (Health Council of the Netherlands, 1998).
- *Drug testing in the work place*: The Dutch Association of Industrial Medicine defines its attitude regarding the role of the company doctor in the alcohol and drug policy within companies.

2.6.3. Training and further education of professionals

Within the basic professional training programmes for physicians, nurses, social workers, psychiatrists and psychologists, still very little attention is paid to the knowledge and practice of addiction care. It is only recently that the need for more specific training courses during the basic training has started to be fulfilled (Loth, et. al., 1999). Workers in specialised addiction care are usually trained in further special training courses where they make use of their work experience.

- *Psychology Faculties* in Dutch Universities conduct addiction research and provide courses and practical experience in addiction treatment and care for psychology students and researchers (e.g., the Faculty of Psychology of the Catholic University of Nijmegen, Department of Addiction and Eating Disorders). Therapists working with addicts develop their expertise in special training courses using their experience.
- *Psychiatrists* in training are obliged to spend an unspecified number of therapy hours devoted to addiction problems and addiction care in their first three years of training. Different subjects can be chosen in the last year and a half of the training, and it is at this stage of the training that psychiatrists have the possibility to specialise in addiction problems and care. As the training programme is dependent upon the person's own interests, their knowledge of and experience with addiction problems and care, the training of psychiatrists is highly arbitrary. Furthermore, several training clusters exist in the Netherlands, organised on a regional basis. The contents of the training programmes of these clusters are, however, quite different, being based upon fairly general standards [35].
- The professional training programme for *nursing* in Amsterdam reports that addiction care is only focussed on as a special topic in several modules, both theoretical and practical, which are usually within the framework of psychiatry. Loth and Rutten (1999) describe the current situation of nursing training and education, and of the need for a more central position of addiction care in the training and education of nurses.
  The Netherlands Institute of Mental Health and Addiction (1997) carried out a study aimed at supporting the implementation of nursing education (HBO-V = Higher Vocational Education for Nursing) within professional practice in addiction care. Three years later, changes are beginning to be made at the different HBO-V levels, e.g., implementation of exercises for discussing alcohol problems, discussion of prejudices, etc.

Furthermore, the institutions themselves develop and offer specific training programmes for their personnel. Of the institutions where training programmes are

[35] This information was obtained from the principal training psychiatrist of Cluster North Holland.

actively being developed for inexperienced as well as experienced workers, three are mentioned here:

- *The Netherlands Institute of Mental Health and Addiction*, *Utrecht*, offers a variety of courses in the general training programme, as well as courses as part of special projects. Furthermore, it organises forums, conferences and study days.
- EuropASI training is organised by the *Amsterdam Institute for Addiction Research (A.I.A.R.*). Training courses take place all over the country.
- The training programme of *The Jellinek School* results from the following procedure: programme managers indicate the need for specific training in their teams. Subjects for training include computerisation, project management, psychopathology, transcultural care, coping with aggression, gender-specific care and time management. The Jellinek School meets specific training needs and adapts the training programme. This results in a diversity of further training courses, including motivating communication techniques, working with treatment protocols, team building and further training for addiction care.

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Netherlands Institute of Mental Health and Addiction and GGZ-Nederland (1999). *Lexicon van voorbeeldprojecten van en voor instellingen voor verslavingszorg*. GGZ-Ned.Utrecht.

Ooyen-Houben M van (1996) *ISO-PLUS+ Toetsingskader kwaliteit verslavingszorg.* Trimbos, Utrecht.

The Netherlands Institute of Mental Health and Addiction (1997). *Gekwalificeerd voor verslavingsonderwijs? Eindrapport van het driejarig project over alcohol en drugs in het HBO-V.* (Final report of a three-year-project on alcohol and drugs in the professional training of nursing). Trimbos, Utrecht.

The Royal Dutch Medical Association (1999). *Tasks, roles and responsibilities of physicians in drug related problems.* Results of a conference held by the Royal Dutch Medical Association, KNMG Drugsproject, September 1998.

2.7. Poland[36]

2.7.1. Professional standards in treatment and care

Three groups of questions can be identified when looking at professional standards in drug addiction treatment:

- Standards to be applied in drug treatment
- Standards required from a drug treatment service
- Standards required to perform a job of drug treatment professional

Standards to be applied in drug treatment and required from drug treatment services

Until the beginning of the 1990s, no documents existed which provided professional standards specific to drug treatment and care. There were, however, three monographic publications that offered relevant guidance (Kubikowski & Wardaszko-Lyskowska 1978; Thille & Zgirski 1976; Zgirski 1988).

Diagnostic and treatment guidelines in mental disorder related to the use of psychoactive substances:

In 1993, *specific standards for diagnosing and treating drug addicts* were for the first time elaborated and published. In a manual for diagnostic recommendations with regard to mental disorders based on ICD 9, one chapter was devoted to drug treatment (Piotrowski & Habrat 1993). The manual was written by experienced clinical professionals who formulated certain guidelines based on current literature and their own experience. Its draft was circulated for comments, revisions and corrections among all heads of university psychiatric departments as well as among a number of other prominent drug professionals. The final publication was addressed to psychiatrists and psychologists involved in mental health treatment, including drug treatment. Even though the recommended guidelines had no legal powers, they are still treated as binding standards by many clinicians and researchers. Currently, a new edition is under preparation that takes into consideration advances in diagnostic criteria (ICD 10) as well as treatment experiences cumulated in recent years.

In 1999 Baran-Furga and Steinbarth-Chmielewska published a *manual (dependencies, clinical picture and treatment)* that takes into consideration the implications of introduction of ICD 10 into diagnostic and treatment practices. The target group of the manual are psychiatrists and other doctors. Diagnostic stan-

[36] Based on text prepared by Katarzyna Przymuszewska, Boguslaw Habrat and Jacek Moskalewicz, Institute of Psychiatry and Neurology, Warsaw, Poland, 2000.

dards based on ICD 10 are presented alongside with basic guidelines concerning treatment of disorders related to psychoactive drugs. Pharmacological treatment was given special attention.

Standards for methadone therapy:

The drug law of 1997 laid down legal grounds for methadone treatment in Poland. Until then, several methadone substitution programmes had experimental status. Standards for these programmes were formulated in the Institute of Psychiatry and Neurology after the first phase of its experimental methadone programme was completed, and then published (Baran-Furga & Steinbarth-Chmielewska 1994).

The following *admission criteria* were adopted: persons aged 20+, with five years of opiate dependence, with numerous treatment attempts that failed. Married couples and siblings were also admitted. In-patient detoxification had to precede maintenance. The initial *dose of methadone* was 5mg and then doubled to 10mg. The frequency of the methadone application during the first 24 hours was varied so as to prevent the second phase of the withdrawal syndrome. The maintenance dose was established during the second or the third day of residential treatment. During the following 5-6 days, half of the maintenance dose was served every 12th hour and then a full dose once a day. *To reduce the maintenance dose*, attempts were made to prescribe 5 mg of methadone less. If the withdrawal syndrome of the first phase did not appear, a further reduction of the dose was attempted. For the majority of patients their maintenance dose was reduced by 10-15mg. The final dose ranged between 20 and 120mg, with an average of 80mg every 24 hours.

The executive ordinance on substitution treatment of 6th September 1999 is an executive act issued by the Minister of Health and Social Welfare following the drug law of 1997. The document specifies criteria for admission, standards of treatment as well as criteria for discharge. Only adults with a long drug history in which other methods of treatment failed may be admitted. Exceptions are possible provided other important medical indications are present. In addition to the daily doses of methadone, patients shall be offered psychotherapy, rehabilitation and re-adaptation. Urine tests for drugs are obligatory. Patients may be discharged from the programme if drug taking is confirmed. Any methadone programme should employ a psychiatrist and trained staff.

Recommendations for health insurance and service renders

A Commission composed of representatives of the Institute of Psychiatry and Neurology, health insurance companies and professional associations agreed upon *standards of medical services in psychiatry* which were published and recommended by the Ministry of Health and Social Welfare (Ministerstwo Zdrowia i Opieki Spolecznej 1999) in negotiations between health insurance companies

and drug treatment and rehabilitation services. Requirements are recommended for different types of services (In-patient unit for treatment of withdrawal syndromes; In-patient drug treatment ward; Out-patient drug treatment clinic; Methadone maintenance programmes). General standards or norms are proposed (see Annex IV).

Standards required to be a drug treatment professional

An executive ordinance of the Minister of Health and Welfare (29 March 1999) specifies the *professional requirements for positions in public health services*. The document lists professional standards for different positions:

- A *head of a drug treatment service* needs to be a person with a university education in medicine, or a person with a university education in other relevant subjects and with specific training.
- A *specialist in drug therapy* needs to be a person with university medical education or a person with other relevant university education and with specific training. 3 years of professional experience are also required.
- For a *senior instructor of drug therapy,* secondary school and specific training is required as well as 3 years of professional experience.
- For an *instructor of drug therapy,* primary school as well as specific training is requested.

2.7.2. Training and further education of professionals

Habrat and Ostaszewski (1998) carried out a study aimed at assessing the curricula of Medical Academies with regard to questions of addiction. The study based on questionnaires was distributed among all heads of university psychiatric departments in Poland. The central issues being asked about were as follows: number of hours spent on aspects of addiction, content of curricula and the professional background of the faculty. The study served as a significant background documentation for the drafting of a Polish-American programme of training on addiction for Polish family doctors (see also Murray & Fleming 1996).

There are no relevant guidelines and recommendations for training of professionals working with drug addicts. The Bureau for Drug Addiction (the major governmental agency for dealing with drug demand reduction) is considering a programme of training and certification, which would benefit from experiences of relevant systems of training elaborated for professionals in alcohol addiction.

References:

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Baran-Furga H., Steinbarth-Chmielewska K.: Uzaleznienia. Obraz kliniczny i leczenie. (Dependencies. Clinical picture and treatment) PZWL, Warszawa 1999

Habrat B., Ostaszewski K.: Próba oceny stanu nauczania o uzaleznieniach w polskich Akademiach Medycznych. Alkoholizm i Narkomania. 1998, nr 4 (33), 479-491

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Ministerstwo Zdrowia i Opieki Spolecznej. Standardy Swiadczenia Uslug Medycznych. Psychiatria. Zalecenia dla platników i swiadczeniodawców. (Standards of medical services. Psychiatry. Recommendations for health insurance and service renders) Warszawa, 1999

Murray M., Fleming M.: Prevention and treatment of alcohol-related problems: An international medical education model. Acad. Med. 1996, 71, 1204-1210

Piotrowski A., Habrat B.: Zaburzenia psychiczne zwiazane z uzywaniem substancji psychoaktywnych (Mental disorders related to the use of psychoactive substances). in: Puzynski S., Beresewicz M. (eds.): Zasady rozpoznawania i leczenia zaburzen psychicznych (Diagnostic and treatment guidelines in mental disorders). Instytut Psychiatrii i Neurologii, Warszawa 1993, 21-31

Thille Z., Zgirski L.: Toksykomanie. zagadnienia spoleczne i kliniczne (Drug dependence, social and clinical questions). PZWL, Warszawa 1976,

Zgirski L.: Toksykomanie w praktyce lekarskiej (Drug dependence in medical practice). PZWL, Warszawa 1988

2.8. Spain[37]

2.8.1. Dissemination and significance of professional standards

There is a lack of documents on professional standards for the social/health professions concerning the treatment of drug addicts. Most of the work done in Spain in that area has been concentrated in the elaboration of basic guidelines for the use of general practitioners[38], pharmacists[39], and other professionals (e.g. forensic experts[40], social workers[41], etc.). These guidelines have generally been prepared by small groups of experts and are sometimes submitted to professional organisations for review, but are only rarely actually reviewed by a large number of professionals.

Published standards focused on specialised treatment procedures which reflect the point of view of a large number of experts in the field could not be found. Some official regulations have been published in order to prevent the misuse of opiate substitutes (specially methadone) and to protect the rights of patients in residential facilities (therapeutic communities)[42].

According to the Spanish Constitution, health and social services may be part of the political competence of the regional parliaments and governments. That might help to explain the diversity of professional standards in different regions of the country, even though the Spanish "National Plan on Drugs" has played an important co-ordinating role since 1985.

2.8.2. Professional standards in drug abuse treatment and care[43]

The pharmacist faced with drug-related problems

The publication (Delegación del Gobierno para el Plan Nacional sobre Drogas 1990) aims at increasing pharmacists' awareness of the needs when faced with drug-related problems as well as scientific knowledge on psychoactive drugs

37 Based on text prepared by Josep M. Suelves, Departament de Sanitat i Seguretat Social (Department of Health and Social Security), Barcelona, Spain, 1999.
38 Delegación del Gobierno para el Plan Nacional sobre Drogas, 1992.
39 Delegación del Gobierno para el Plan Nacional sobre Drogas, 1990.
40 Delegación del Gobierno para el Plan Nacional sobre Drogas, 1992a.
41 Alonso, Duran & Larriba, 1998.
42 Delegación del Gobierno para el Plan Nacional sobre Drogas, 1992b.
43 Commented references.

and drug-related problems, providing information on the pharmacological effects of drugs and drug-related problems, offering intervention criteria to meet demands from drug users, and providing telephone numbers and addresses where information on specialised treatment of drug addiction is available.

This book is the result of the work of a group of 15 experts, members of the Spanish Plan on Drugs and other areas in the Ministry of Health, and the Official Colleges of Pharmacists. Issues discussed include: Problems associated with drug use; The pharmacist and the family of the drug user; Treatment alternatives for the opiate addict; Harm reduction programmes: the role of the pharmacist; The pharmacist facing a demand for psychoactive drugs; Basic guidelines to dispense narcotics and psychoactive drugs; pharmacological information; Useful addresses. Standards of care for different situations in daily practice are suggested, but no bibliographical/statistical information is provided to justify suggested standards.

The primary health care professional faced with drug related problems

The publication (Delegación del Gobierno para el Plan Nacional sobre Drogas 1992) aims to stimulate self-consciousness among primary health care professionals on their important role in the response to drug-related problems, and to increase the knowledge about the pharmacological effects of drugs and drug-related problems. It offers protocols for the specific demands received from drug users, provides information to help doctors avoid becoming misused by psychoactive drug-suppliers, and includes telephone numbers and addresses where information on specialised treatment of drug addiction is available.

The book is the result of the work of a group of 14 experts, most of them members of the Spanish Plan on Drugs and/or other areas in the Ministry of Health. Issues discussed include: Answering the questions of parents; The doctor and the demand of psychoactive drugs; The primary health care professionals and the risk behaviours of drug users; The primary health care professional facing a treatment demand; The doctor facing a demand for detoxification; Basic guidelines for taking charge of a drug addict; pharmacological information; Useful addresses. Standards of care for different situations in daily practice are suggested, but no bibliographical/statistical information is provided to justify the standards.

Intervention of forensic doctors and judicial social services regarding drug users

Objective of the publication (Delegación del Gobierno para el Plan Nacional sobre Drogas 1992a) is to increase forensic doctors' awareness on their important role in the assistance of arrested drug-users and to suggest a simple and practi-

cal questionnaire to register data during the examination of arrested drug-users. It offers intervention criteria to meet demands of arrested drug-users and provides guidelines when writing medical and legal reports and giving advice to judges. It aims at improving co-ordination between judicial health/social services and prisons, the police, and drug treatment centres, and provides telephone numbers and addresses where information on specialised treatment of drug addiction is available.

The book is the result of the work of a group of 12 experts, members of the Spanish Plan on Drugs, drug treatment centres and forensic professional organisations. Issues discussed include: Role of the forensic doctor and the drug user. Limitations; Guidelines for the intervention of forensic doctors: data collection, examination and assessment, basic guidelines, forensic medical report; Therapeutic options for opiate addicts. Standards of care for different situations in daily practice are suggested, but no bibliographical/statistical information is provided to justify the standards.

What can primary social services do with regard to drug dependence?

The publication on what primary social services can do with regard to drug dependence (Alonso, Duran & Larriba, 1998) is the result of the work of a wide group of 26 experts, mainly social workers from primary social services. It aims at increasing social workers' capacity to face the demands of drug users in primary social services and suggests guidelines for intervention. It covers different misused substances (both legal and illicit ones) and underlines the role of primary social services in community prevention.

Issues discussed include: General information on alcohol and illicit drugs; Care of drug abusers in Catalonia; How to develop community prevention interventions from primary social services? How to provide social care from primary social services? Information, orientation and assessment of drug users; Referral, treatment and social rehabilitation; Intervention guidelines; Available resources. Standards of care for different situations in daily practice are suggested. Some bibliographic, statistical and legal references are included in the text to justify the guidelines.

Minimum common criteria for care of health problems

The publication (Servei Català de la Salut 1995) includes minimum criteria for care of drug use and other health problems/risks in primary health care centres, intended to be used in the evaluation of health centres in Catalonia. The document is the result of the work of several groups of experts/general practitioners. A

draft was sent to relevant professionals and medical/scientific societies to promote consensus.

Issues discussed include target population, screening tools, diagnostic criteria, control criteria, intervention criteria, and other information (drug-related medical conditions; ICD-10 criteria for drug dependence, intervention with drug dependent patients). The publication suggests standards of care for different situations in daily practice. No bibliographic/statistical references are included in the text to justify the guidelines.

Minimum requirements for residential facilities for the rehabilitation of drug addicts

A national consensus on minimum requirements (mainly infrastructure and staff) for therapeutic communities for drug users in order to obtain administrative authorisation is published in a short document (Delegación del Gobierno para el Plan Nacional sobre Drogas 1992b). It is the result of the work of a group of 17 co-ordinators of Regional Drug Plansand members of the Spanish Plan on Drugs, and it is based on common regulations for therapeutic communities already established in the 17 Spanish Autonomous Communities (regional authorities). Issues discussed include:

- The need of a therapeutic programme - including treatment goals, activities, maximum length of treatment, and maximum number of users admitted in the community
- Professional staff
- 24-hours professional assistance
- Medical assistance
- Basic contents of clinical records
- User’s rights.

2.8.3. Professional education and training

Training on drugs and drug dependence in Spanish universities

A study was conducted to investigate the state of training on drug use and abuse in the curriculum of several disciplines (Psychology, Medicine, Nursing, Social Work, Information Sciences, Pharmacy, Education, Teaching, Law, Political Sciences, and Sociology) in 14 selected Spanish universities (Ferrer, Torres-Hernández, Duran et al. 1995). The purpose of the study was to assess training on drug dependence in selected university curricula, to determine characteristics of that training, to assess training needs perceived by undergraduate students,

teachers and staff, to analyse potential gaps in training, and to suggest new contents and methods to improve training on drug dependence in university.

After a pilot study in the University of Barcelona, a study was performed based on several sources of information: Analysis of study curricula of 14 selected universities covering 80% of university students in Spain; Structured interviews (face-to-face and telephone) of an intentional sample of university staff (n=1,200, participation rate <10%); Application of a semi-structured questionnaire in a sample of undergraduate and postgraduate students (n=261).

The study was intended to assess undergraduate training of psychologists, physicians, nurses, social workers, journalists, pharmacists, school teachers, lawyers, sociologists, and other professionals with some relationship to drug use. The study was mainly focused on basic training. A general dissatisfaction of students with the training received was observed. More than half of them reported having not been trained on drug dependence. Academic staff also consider the training to be insufficient. There has been an increase in the quantity and quality of the content concerned with drugs in university curricula. Several suggestions to improve training on drug use/abuse are included.

Postgraduate education

Different administrations and professional organizations offer postgraduate education on drug abuse to professionals from various disciplines (medicine, psychology, social work, nursing, etc.). Some of these education programmes are aimed at general practitioners in order to improve their skills in the diagnosis, tratment and health education of substance abusers and users at risk, and include training on motivational enhancement, the implementation of specific intervention protocols (such as the Euro-WHO Drinkless Program in Catalonia), etc.

In 1986, the University of Barcelona started a master-level programme on drug dependence. Various Spanish universities have been offering similar courses aimed at the training of specialists on drug abuse prevention and treatment. A distance-learning version of the Master on Drug Dependence from the University of Barcelona is available since year 2000.

References:

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Delegación del Gobierno para el Plan Nacional sobre Drogas (1990). El farmacéutico ante los problemas derivados del consumo de drogas. Madrid: Ministerio de Sanidad y Consumo. [The pharmacist faced with drug-related problems]

Delegación del Gobierno para el Plan Nacional sobre Drogas (1992). El profesional de atención primaria de salud ante los problemas derivados del consumo de drogas. Madrid: Ministerio de Sanidad y Consumo. [The primary health care professional faced with drug related problems]

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Ferrer X, Torres-Hernández MA, Duran A, et al. (1995). La situación de la formación sobre drogas y drogodependencias en las universidades españolas. Unpublished document. [The situation of training on drugs and drug dependence in Spanish universities].

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2.9. Sweden[44]

2.9.1. Lack of educational requirements and other professional standards

One of the most important characteristics of Swedish drug treatment is the almost total absence of regulations concerning which professions are allowed to offer substance abuse treatment. Within the inpatient sector, which by and large is non-medical and financed by the social services, the majority of the staff (about 60 percent) lacks any education that can be considered as suitable for their treatment (Bergmark & Oscarsson 1995). Apart from methadone prescription and detoxification, which requires medical doctors, there are no restrictions whatsoever concerning the qualifications of the individuals that offer drug treatment

This situation can be illustrated by the following quotes from two government reports. In 1978 one report stated: *"Specific drug treatment for drug abuse has existed for little more than ten years. Within the drug treatment system there is a lot of knowledge and experience. It is now urgent to collect this knowledge and to transmit it to the new personnel in the treatment system"* (Socialdepartementet, 1978, p. 64; author's translation). The statement refers to the early and middle '70s. Six years later, another government report stated that the treatment approaches during the same period had been based on an *esprit de corps* rather than on knowledge, and that a *"fosterage or Hassela approach"* – rather than the psychotherapeutic approach of the '70s – was the most appropriate. Such inconsistency in government recommendations has been the rule in the short history of Swedish drug treatment; the position taken at any particular point of time is most likely to be based on the treatment ideology that has dominated drug treatment practice in Sweden during the previous one or two years.

This situation may be attributable to the lack of a professional body that could act as 'gatekeepers' before different treatment entrepreneurs. As a result, it is not by chance that residential treatment units prefer to recruit their staff on the basis of life experience rather than on formal education (Bergmark & Oscarsson, 1995).

[44] Based on text prepared by Anders Bergmark, University of Stockholm, Department of Social Work, Sweden, 1999.

2.9.2. Drug abuse treatment as a subject in basic training and further education of professionals

The present author[45] has been unable to find any published study that deals with professional education in drug abuse treatment and care. The only possible exception is a study that has not yet been published, but where there are some empirical results that can be regarded as related to the topic at hand:

The study is directed towards the character and amount of mandatory courses that deal with substance abuse problems and treatment. The median values of academic points[46] for medical doctors, social workers, nurses and psychologists varies between 3 to 0.1, with social workers in the top sector and psychologists in the low one.

From the glimpse the present author has been given concerning the content of these courses, it might be possible to conclude that they represent a very wide spectrum of ideas and approaches in the drug treatment field. Put differently, it might be said that the lack of gatekeepers with a professional anchorage is also reflected in the educational sphere. Consequently, there are no guidelines for the training and further education of professionals.

Most recently, the National Board of Health and Welfare has initiated a work with the ambition to establish guidelines for treatment and care but up to this date (December 2000) not publications has come out of this work.

References:

Bergmark A & Oscarsson L (1995) Den socialtjänstbaserade institutionsvården, Socialstyrelsen, Stockholm.

[45] Text prepared by Anders Bergmark, University of Stockholm, Department of Social Work, Sweden, 1999.
[46] Academic points can be seen as equivalent to the number of study weeks.

2.10. Switzerland

2.10.1. The addiction-specific quality management system QuaTheDA

Since the beginning of the 1990s, the discussion on quality has concentrated above all on the agendas of the occupational and professional organisations. The actual introduction of measures to assure quality was expedited as a result of the provision made by the social security institutions to only pay their contribution of the costs for in-patient facilities if the services and facilities making claims for money can prove that they have introduced a QM system. Thus, at least in the field of in-patient therapy facilities this led to the effectively "blanket" introduction of QMS.

Aside from the numerous private providers, whose systems are normally oriented to ISO standards and occasionally also to models such as EFQM or TQM, the Swiss Federal Office of Health has taken the opportunity of conceiving an addiction-specific QMS in collaboration with interested institutions as well as with external quality experts. Approximately 80 in-patient[47] establishments (that corresponds to about two thirds of all in-patient therapy facilities for drug abusers) have decided to introduce this system which is given the abbreviation "QuaTheDA"[48]. When it is a matter of establishing the same rights and responsibilities for comparable services[49], the use of the same system is just as advantageous for comparability and exchanges between institutions as it is for the administration.

QuaTheDA has thus become a piece in the mosaic of addiction policy aims which form part of the "MaPaDro" packet of measures put forward by the government, and will contribute to answering the four leading questions: "which treatment for which patients with which means and with which results?" Furthermore, it should ease the selection of suitable establishments by the referral personnel and help in the optimal matching of patient and treatment.

QuaTheDA is made up of four closely connected but clearly identifiable parts:

- Long-term outline programme for improving quality in the drug addiction field
- Description of addiction-specific quality requirements

[47] QuaTheDA is intended to be used, at least in its basic form, in all segments of addiction care, i.e., in the out-patient and low-threshold fields as well.

[48] QuaTheDA stands for "Quality of the Therapies in the Drug and Alcohol Field".

[49] e.g., when concluding service contracts between public sector and private providers, in matters concerned with approval and recognition, and naturally also in matters concerned with pricing the services rendered.

- Quality management system (QMS) for in-patient therapy facilities
- Training for in-patient therapy facilities responsible for quality in regional groups.

A central element of QuaTheDA is the systematic formulation of requirements and standards. How they are elaborated is described below:

The QuaTheDA specifications

The QuaTheDA specifications were commissioned by the Federal Office of Health and produced under the overall control of APEQ (Agency for the Promotion and Evaluation of the Quality of the Health) with the support of the ISF (Addiction Research Institute, Zurich) and were widely examined in professional circles. The reference framework is nearly completed and will be published at the end of 2000. It is conceived for the in-patient field; the specific further development for the out-patient field is currently under consideration. In particular the following sources were taken into account:

- The *qualitative requirements of the Federal Office of Social Security*[50] *(BSV) for hostels and workshops* (Art. 73 IVG).
- The *APEQ Standards* (see above), in particular the system for the improvement and evaluation of quality in facilities for reintegration; this is concerned with a outline structure for characteristics relevant to the health sector based, amongst others, on the ISO/DIN series 9000 standards and the EFQM Model for Excellence.
- The *QuaFOS Standards*, which were developed by the Addiction Research Institute (ISF) in Zurich on the basis of interviews with practising professionals[51].

Thus QuaTheDA on the one hand contains general specifications for a quality system which take into consideration the main managerial themes. On the other hand the special concerns of the addiction field are also integrated. The QuaTheDA specifications are intended to be periodically adapted. They can be used in three ways:

- As a reference system for institutions for in-patient addiction treatment wanting to establish a quality system or further develop an existing system.
- As a questionnaire for self-assessment or for external evaluation (criteria for the external evaluation and certification are currently being developed).

[50] These provisions are themselves the product of a working group set up by the BSV which included practising professionals.

[51] A pioneering aid to orientation was provided by the studies from Wettach et al. (1997) and from Schaaf et al. (1997), which were based on the established organisation research of FOS with its pilot studies in the in-patient field.

- Cantons and other funding bodies can base their work on the reference system as well as the institution-based certificate.

The aim of the Federal Office of Health (BAG) is to make the QuaTheDA specifications compulsory throughout Switzerland; for this, however, no legal basis exists. Legitimate provisions can only be provided by the Federal office of Social Security (BSV) for facilities which provide social security services in accordance with Art. 73 IVG as well as by the cantons for establishments on their territory. The reference system is divided in to the fields Services (1), Resources (2) and Management (3), (for an overview of the quality criteria see annex V). This is primarily concerned with characteristics for structural quality and partly with process quality (in the form of procedural instructions). The formulation of outcome-related standards has been dispensed with up to now. Aspects of the course of therapy, the attaining of therapy objectives, the termination of therapy and therapy motivation are intended to be looked at more closely within the framework of research projects. Furthermore, it is primarily concerned with quality criteria and/or characteristics. These are only occasionally quantified in the form of standards because the basis is still lacking. However, a more long-term aim is to produce actual standards.

2.10.2. Quality assurance in heroin-supported treatment (HegeBe)

Heroin-supported treatment is the most recent service to be offered as part of the Swiss addiction care palette. At the end of 1999 there were 937 persons undergoing treatment. After the opening of additional treatment centres there are now 1,200 slots available in the year 2000. The treatment results of this severely stressed target group in terms of their physical and mental state of health, their parallel consumption and their general social behaviour, are very promising, which is why heroin-supported treatment has developed into a firmly established component[52]. As these forms of treatment have been consolidated and standardised in conformity with the regulations, the fields of quality improvement and research[53] have taken on particular importance, whereby the following elements can be mentioned:

- The general development of a management and treatment concept for all treatment centres
- Further education courses for the employees

[52] All that still needs to be discussed in the future is the extent of the supporting psycho-social care, which until now has been regarded as indispensable, as well as whether the previously valid requirements for admission into prescription programmes should be rigorously observed.

[53] For the year 2000 the following main research areas have been determined: the consolidation and continuation of the existing data collection, additional evaluations and the examination of specific questions concerning the continuing development of patients from the years 1994 to 1996, the focussing on special target groups; the international transfer of knowledge (Federal Office of Health, 2000).

- Development of a treatment manual with treatment guidelines and recommendations (see below)
- Further development of the sub-project "Improvement in Quality of Heroin-supported Treatment (QE-HeGeBe)", which is based on improved patient monitoring and a more intensive transfer of know-how between the individual treatment centres.

Guidelines and recommendations

In heroin-supported treatment, guidelines and recommendations exist for the areas of admission criteria and procedures, the prescribing of substances, treatment planning and management organisation.

In the case of the admission criteria and procedures, the prescribing of substances and the management organisation, these are mostly concerned with provisions laid down by the Federal Office of Health. In the case of the guidelines affecting treatment planning, the standardisation of the procedural methods in the various treatment centres stands to the forefront, whereby research plays an important role. In all fields the recommendations and guidelines are based, however, on joint discussions between representatives from the treatment centres, research and the Federal Office of Health. The maintaining of these provisions by the treatment centres is a prerequisite for being granted approval to operate by the Federal Office of Health. In particular they refer to aspects of the structure and quality. The quality of the results is also observed by means of treatment monitoring. Moreover, there are also efforts to support internal quality improvement.

2.10.3. Developments in further intervention fields

Methadone treatment

With around 18,000 treatments currently being conducted in specialised centres or in private practices (1999), substitution treatment with methadone is by far the most-used service in addiction care in Switzerland. The control of the prescription of methadone lies with the cantons; in the course of time - as a result of various influencing factors - often quite different requirements and outline parameters have been developed. In the near future it will be the co-ordinating role of the government, together with the cantons and the professional groups involved here, to develop specifications which are as uniform as possible nation-wide, and to establish a consensus in defining parameters for qualitatively satisfactory substitution treatment. Under the auspices of the Federal Office of Health, a national conference is being prepared for the summer of 2001 to deal with aspects of substitution treatment.

Requirements for infection prophylaxes in the penal system

Within the framework of various model and pilot projects, measures for an effective infection prophylaxis within the penal system are being tested[54]. The suitability of the following services was able to be established in the Realta Men's Prison:

- Issuing of condoms and disinfectant
- Possibility of participation in a methadone programme
- Information and training services for employees and inmates
- Installation of a freely available needle dispenser in the prison.

The positive and negative effects of the measures on drug consumption and infection risks were investigated[55]. The assessment of the acceptance of the various prevention measures (provision of information material and condoms, issuing of condoms. heroin-supported treatment, coercive therapies) showed that the opinion of the inmates and the employees - who by the way were in considerable agreement with each other - hardly changed during the period of the evaluation. Most controversial is the issuing of needles. Although it is recognised that the risk of HIV and hepatitis infection is reduced, the fear has been expressed that the issuing of needles promotes i.v. drug consumption. In a more in-depth analysis it was able to be shown that the acceptance of the individual measures depends upon the fundamental attitude of the individual interviewees with regard to drug policy.

In order to emphasise the importance of preventative measures within prisons, Switzerland has joined the programme "Health promotion in prisons" under the patronage of the WHO.

Recommendations for short-term withdrawal under anaesthetic

In Switzerland, short-term withdrawal under anaesthetic and deep sedation (ultra rapid opiate detoxification) have been conducted for some time. The discussion has mostly concentrated up to now on professional aspects such as contraindications, location and responsibility of the indication centres and aspects concerned with the obligation to seek approval; these recommendations find expression in an abbreviated form in the regulation for services covered by obligatory health insurance (KLV): a service obligation for "mono-opiate-addicted patients who are willing to undergo withdrawal" is confirmed if the procedure "is used within the framework of comprehensive physical withdrawal treatment in an in-

[54] e.g., a needle exchange programme in the Hindelbank Women's Prison, a prevention programme in the Realta Men's Prison as well as a project for heroin-supported treatment in the Oberschöngrün Men's Prison.

[55] The evaluation was commissioned by the Federal Office of Health and conducted as a research project by the University Psychiatric Service Bern. As a survey instrument, standardised questionnaires were used for the inmates with approx. 300 questions, with a considerably abridged version used for the employees.

stitution recognised by the canton which is participating in a multi-centric study with a joint protocol under the co-ordination of a university clinic".

In everyday reality this means that there are high administrative hurdles to be overcome: after an expert assessment, the approval for the clinic and the insurance of the patient are only resolved after admission to a project. A decision is then made by the ethics commission. Since the withdrawal is conducted using medication, the project must also be notified by the IKS (Intercanton Control Centre for Medication). After the notification it still must be waited until the end of a 30-day objection period given to the canton health authorities[56].

However, the initially high expectations have been replaced with a certain sobriety; the knowledge that drug addiction is not overcome when the physical withdrawal has taken place, and that parallel care measures of the social-educational-psychological kind are indispensable for a sustained treatment success, have been confirmed once more. Also problematic has proven to be the fact that it has not been possible to permanently provide everywhere the necessary parallel medical treatment, including the basic structural conditions. Several hospitals which were initially interested in collaboration found themselves to be overburdened following the admission of drug abusers (security aspects, problematic behaviour of the patients, etc.).

2.10.4. Further education policies in the field of addiction[57]

In Swiss addiction care both a pluralism of the institutional forms (e.g., fields of work, organisation forms, ideological orientations) as well as a pluralism of professional qualifications can be observed. This leads to a heterogeneity of knowledge and ability which enormously complicates the development of standards in concrete work (Weber, 2000).

In order to take account of this situation with an adequate further education policy, the Federal Office of Health (BAG) set up an expert commission in 1996 with the task of initiating a coherent, co-ordinated and appropriate further education scheme, whereby it was intended to take into consideration the field of addiction with legal and illegal drugs, regional and linguistic peculiarities, as well as addiction professionals and other professional categories which are affected by the government's drug policy.

[56] Further information can be found on the homepage of the Swiss Detoxification Co-ordination: http://welcome.to/swideco.

[57] The description is based on information available under http://www.cx.unibe.ch/kwb/sucht/, a conversation with Mr Herbert Brunold, *Koordinationsstelle für Weiterbildung der Universität* Bern, as well as the quoted literature.

Basic principles

The intention is to achieve a "regulated self-organisation" of further education in the 'addiction' field. Regulated are procedures, finance, roles and responsibilities of those involved as well as the content areas which promote collaboration between those working in the field of addiction. Profession-specific contents are the responsibility, however, of the self-organisation. A flexible system of further education should, through the bundling, use and strengthening of existing know-how, ensure the creation of centres of expertise, whereby the further education policy is in particular based on the following principles:

- *Programme funding instead of structural finance:* further education programmes are financed rather than facilities.
- *Establishment of further education schemes at existing education institutions:* Education facilities provide a guarantee for quality and continuity of the further education. They are eligible to provide certification and contribute through their image to the recognition of the further education which is offered.
- *Inter- and intraprofessional further education modules:* Interprofessionally available schemes should promote the collaboration between the professional groups. Intraprofessional modules enable a professional group to define their specific contribution to the solution of addiction problems.
- *A modular further education system:* Under the precondition that there is mutual recognition of the quality of the services, a setting for modules is being created which enables additional qualifications.

Organisation structure

The *Federal Office of Health* (BAG) is the highest decision-making authority for the determination of aims and basic structural conditions, the provision of financial means as well as the approval of educational institutions as service providers or module producers. The *expert commission*[58] is responsible for the strategic planning and control of the further education schemes. The *service providers providing the further education schemes* are generally recognised educational institutions[59] which are able to ensure the continuity of the further education in the field of addiction. Each service provider is responsible for the planning, implementation, checking of quality and the continuing development of the further education schemes for a definite occupational group. Service providers can pro-

[58] The expert commission is composed of representatives who are experts in the field of addiction for illegal and legal drugs, as well as experts in definite professional fields and the education sector. It also includes a representative of the BAG as well as the secretary of the commission. Other specialists are invited to participate as needed.

[59] These can be university institutes, colleges, technical colleges for social studies as well as specialist technical schools in the care sector. Private or education establishments linked to associations are not allowed to be module producers; they can, however, participate in the design of modules.

duce modules themselves or award them to another *module producer*. For the purposes of quality assurance the institutions which offer modules must be accepted as service providers or module producers. The acceptance is made according to the following criteria:

- Availability of resources for the conception, planning, implementation, evaluation and continuing development of further education schemes
- Acceptance and networking of the institutions in the individual professional fields
- Knowledge and experience in terms of the 'addiction' field of practice
- Potential for continuity in the further education field of 'addiction'

Target groups

The target groups are differentiated according to the level of education (secondary/tertiary qualifications) and the field of employment. As regards the field of employment, this is differentiated into three target groups:

- *Professionals who work specifically in the 'addiction' field* are the primary target group. This can be further differentiated according to the areas of work[60] as well as the occupational groups[61].
- *Those not specifically employed in the 'addiction' field,* i.e., persons who are only occasionally or incidentally concerned with certain aspects of addiction[62].
- *Volunteers who do not work professionally in the 'addiction' field,* e.g., parents and relatives, churches, charities, etc.

Service structure

The further education schemes are provided in the form of modules. Two types of module can be differentiated:

- *Interprofessional modules* are available to several occupational groups; they provide either general basic knowledge or specific knowledge and promote co-operation between the occupational groups.
- *Intraprofessional modules* are only available to definite occupational groups and provide further education which is specific to each occupational group.

[60] Prevention, out-patient counselling and treatment, in-patient treatment, survival help, withdrawal, aftercare.
[61] Social workers, social pedagogues, psychologists, psychiatric and hospital nurses, psychiatrists and doctors, professionals, others.
[62] Social professions, teaching professions, medical professions, administrative professions, para-medical professions, military professions, psychologists and psychotherapists, media professions, legal professions, police, professions within the penal systems.

As a result of the high homogeneity, there can be a greater consolidation of the entry qualifications.

Both interprofessional as well as intraprofessional modules are provided by each service provider, whereby both should be arranged so that they are mostly interdisciplinary. Several modules placed together in a definite combination lead to a qualification:

For the professional field of social work, the vocational course "*post-graduate studies in addiction*" (NDS) is offered which runs parallel with the employment. This course is directed at persons who have a qualification at tertiary level as well as at least one year of professional experience, and are currently actively working in the field of addiction. The NDS includes around 600 lectures, a degree dissertation as well as a degree examination. On the one hand the basics and general knowledge are developed, on the other hand it enables the acquisition and consolidation of the special knowledge which is individually required. It provides expertise and key qualifications which can be transferred to other professional fields. The basic module (basis for specialisation in the field of addiction) includes around 3000 lectures. As building modules several post-graduate courses can be selected, each with around 300 lectures[63]. In addition, modules from the entire further education scheme can be counted[64]. For the final qualification, the greatest recognition possible is striven for, whereby it is of course the market which finally decides.

For persons with a secondary education qualification (tradesmen, shop assistants, nurses, etc.), or those without a professional qualification, a *vocational course* which runs parallel to the work is offered. This is directed at professionals who work full-time in the field of addiction for legal or illegal drugs. The course consists of a 12-day basic module (including 3 days of supervision and 3 days of practical experience in another institution). The educational control consists of a short final dissertation. If the studies are successfully completed a certificate is granted which is recognised by the three most important professional associations (A+S, VSD, VCRD)[65].

The combination of various modules to achieve a qualification presupposes the mutual recognition of the modules by the module producers. This is taken into consideration by the expert commission[66] when it examines the applications for finance. This is oriented to the following criteria: expertise of the module producers; main content and themes; practical relevance of the courses offered; lectur-

[63] At present these include health promotion, counselling experts, management in social organisations.

[64] For further information contact Mrs Maja Schaub Fachhochschule Aargau, Stahlrain 2, 5201 Brugg. E-Mail: weiterbildung.sa@pop.agri.ch.

[65] For further information contact Mr Jörg Häfeli: HSA Luzern, Abteilung Weiterbildung, Zentralstr. 18, Postfach 3252, 6002 Luzern. E-Mail: jhaefeli@hsa.fhz.ch.

[66] The expert commission consists of 12 experts from various occupational groups, educational institutions and linguistic regions.

ers from various institutions and/or fields of work; methodical-didactic preparation of the courses offered[67]. In order to check "ex post" the quality of the further education courses, a systematic survey to evaluate the modules is conducted using a questionnaire. The questionnaire consists of a brief assessment as well as information about each person[68].

Outline programme of contents

For *interprofessional further education,* the expert commission compiles each year an outline programme consisting of different content areas in order to combine the individual modules into a coherent whole. The outline programme is determined according to the principles of rolling planning: suggestions can be put forward by all interested persons and institutions and end up in a pool. The expert commission studies the suggestions and selects individual modules which then become part of the specification. This procedure ensures that on the one hand the needs of the professional fields are dealt with while on the other the modules are given the greatest possible chance of being realised. The expert commission also selects for the specification its own themes corresponding to its funding policy. In addition, the expert commission defined minimum content areas, which belong within the outline programme (included in the ADAT guidelines under 4.1.7.).

Profession-specific profile development

Whilst for interprofessional further education an outline programme of contents is compiled, the supporting institutions determine for themselves the content of the intraprofessional modules, i.e., each profession defines for itself what members of their occupational group must know in order to work in the field of addiction and what sort of further education they should receive. Concrete information about the needs for intraprofessional further education is, however, almost completely lacking. For this reason corresponding need clarifications are being currently conducted for each occupational group ("profession-specific profile development"). These include a description of the profession-specific work profile in the field of addiction care, a survey of the existing profession-specific further education schemes, and the identification of gaps and deficits.

For the *care field*, focus group interviews were conducted with three groups (carers in hospitals, in domestic care as well as in specialised facilities for addiction care). In addition, traditional providers of further education in the field of care

[67] The didactic design of the further education modules is intended to be based on the principles of adult education. The modules are intended to be built on the previous theoretical and practical knowledge of the participants and to actively involve them in the learning process. The creation of definite teaching-learning relationships and processes which allow individual control of the learning are also intended to be promoted.

[68] The questionnaire can be downloaded in electronic form from the following address: http://www.cx.unibe.ch/kwb/sucht/evalsu.doc.

were interviewed (cf. Ernst, 2000). The results are included in annex VI. Corresponding projects are now under way in the fields of social work, psychology and medicine. The findings will be published by the middle of 2001.

The Swiss concept for promoting further education in the field of addiction has been applied with great success since its introduction. The way in which the programme is developed has proved to be particularly successful. In Switzerland there are around 1500 people working in addiction care. Thus the expenditure on further education relative to the number of professionals is considerable[69].

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[69] Current information about the programme "Further education in the field of addiction" is freely available on the Internet at the following address: http://www.cx.unibe.ch/kwb/sucht/index.html.

2.11. Summary and Discussion

2.11.1. Professional quality criteria and standards

There were considerable discrepancies in what was reported under the term ‘Professional Standards’ in the country reports. The reasons for this could be the wide subject area covered by addiction care, various developments in the countries, but also a lack of clarity concerning the term.

The extent of the existing, desired and possible standardisation in the various areas of work in addiction care varies considerably (for example, high in substitution treatment, rather low in outreach and low-threshold facilities). Moreover, it is often reported that non-standardised planning, organisation, financing and evaluation of addiction care has an aggravating effect on the formulation of common guidelines and criteria.

The efforts to achieve systematic quality assurance in the health and social fields has increasingly provided the driving force in several countries (esp. in Germany, the Netherlands and Switzerland) for a debate between the involved parties on quality criteria and standards. The majority of professionals in treatment and care facilities still mostly apply non-explicit professional standards based on ethical principles and professional experience. However, quality management systems require explicit quality criteria and standards, whose observance and/or achievement can be monitored.

In particular, existing guidelines, criteria and standards differ - apart from the subject area - in terms of their validity (depending upon the basis (evidence, consensus) on which they were produced) and relevance (their bindingness and concreteness).

Under 4.2 is a checklist for the identification of professional quality criteria and standards. On the one hand the checklist is intended to help structure the existing heterogeneity. On the other hand the list can also be used to determine more precisely where there is further need for development and how one should proceed further.

An overview summarising the guidelines, criteria and standards described in the country reports is included under 4.3. Some of the material from the country reports can be found in the annex.

2.11.2. Quality control at the level of treatment and care systems for drug dependence

All the country reports describe certain provisions for ensuring (mostly a minimum) quality in addiction care. The forms of quality control are dependent upon the organisation and financing of addiction care, whereby in particular provisions are embodied at legislative level and are a prerequisite for financing. The following is a brief overview of the methods of approach of the different countries:

In the *Czech Republic* every organisation requesting grants from the state budget must describe its project/programme on a standard form and send in an evaluation report by the end of each year. The report must contain a description of the current situation, project goals, target population, means for project realisation, methods used in the project realisation, ways of effectiveness evaluation, concrete outcome, time schedule, qualification and experiences of the project management, and the co-operation with other institutions working with drug abusers. In addition, the applicants require the signature of an expert, who supervises the professional working of the institution, as a guarantee of quality. All this information is currently being entered into a "Central Database" in order to facilitate a coordinated funding of programmes in the future.

In *Denmark* there is a clear desire, centrally as well as locally, to develop a more efficient system of supervision and quality control. The Danish Ministry of Social Affairs is currently working on the certification of treatment and care facilities. Responsibility for supervision of such institutions at county level is being established. To date no standards or guidelines exist for the certification of drug abuse treatment personnel. A working group has now been established to work on the issue.

From *Greece* no quality control measures are reported at a national level. The only methodological aspect explicitly regulated by the current national law is related to the use of substitutes in the treatment of heroin addiction. It is pointed out, however, that the large majority of treatment and care facilities apply non-explicit professional standards. KETHEA[70] pays particular attention to the evaluation of its service as a means for its continuous improvement. Its Continuous Quality Improvement Effort on the one hand consists of an internal evaluation, involving staff members, clients and family members, and on the other consists of an external evaluation.

In *Italy* guidelines at national level regulate the issuing of operational approvals as well as the accreditation of addiction care facilities under the provision of structural and functional requirements, the number, training and further education of the personnel, as well as planning, data collection and control. Failure to com-

[70] Therapy Centre for Dependent Individuals.

ply with these guidelines invalidates the hiring of personnel or the appointment of service co-ordinators, or may lead to statutory recognition being refused. The guideline for Private Service Professionals sets forth the number of professionals necessary for a treatment service according to the number of users. The person in charge of a facility must have the necessary academic qualifications or be professionally registered and have previous documented experience of at least two years in this field.

In the *Netherlands* the use of the 'certificate scheme' which is currently under development is intended to be binding for all addiction care providers and institutions. The certificate scheme is a structure for management based upon the Lexicon of Good Practice projects and the ISO-PLUS+ standard, which has been developed in collaboration with addiction institutions, clients, the ministry and inspectors for the entire field of mental health care. The ISO-PLUS+ standards for addiction care were accepted by the Dutch Association of Addiction Care Institutions in 1997. Since 1995 departments, programmes, projects, management and personnel management belonging to addiction care institutions are checked to ensure that they meet these guidelines. The best practices resulting from an institutional inspection procedure using the ISO-plus+ checklist are described in the Lexicon of Good Practice projects (see 4.2.1).

In *Poland* an executive ordinance of the Minister of Health and Welfare specifies the professional requirements for different positions in public health services (educational background, specific training, professional experience). Furthermore, a set of average standards is recommended for health insurance and service providers for in-patient units for treatment of withdrawal symptoms, in-patient drug treatment wards, out-patient drug treatment clinics, and for methadone maintenance programmes. The standards concern, for example, the number of beds, the duration of treatment, or the duration of daily/ weekly contacts with different professionals (see details in Annex IV). The standards were developed during negotiations between health insurance companies and drug treatment and rehabilitation services and are recommended by the Ministry of Health and Social Welfare.

In *Spain* minimum requirements have been defined for residential facilities for the rehabilitation of drug addicts in order to obtain administrative authorisation. The requirements represent a national consensus, mainly on questions of infrastructure and staff. Issues discussed include: the need of a therapeutic programme - including treatment goals, activities, maximum length of treatment and maximum number of users admitted in the community; professional staff; 24-hour professional assistance; medical assistance; basic contents of clinical records; user’s rights. Furthermore, some official regulations have been published in order to prevent the misuse of opiate agonists (especially methadone) and to protect the rights of patients in residential facilities.

In *Germany* the obligation of the out-patient sector of the health service and hospitals to provide quality assurance is formulated in general laws and outline agreements. Following an intensive debate with the providers of in-patient addiction care, guidelines for quality assurance in this field were elaborated by the health insurance institutions. In positive cases these general provisions have been stated more precisely within regional or institution-related regulations. Other obligations exists at personnel level. For instance the professional code of conduct for doctors includes the obligation of every practising physician to undergo further professional training as well as to carry out measures introduced by the medical council to ensure the quality of medical practice.

From *Sweden* a considerable lack of measures for quality control has been reported. The majority of staff within the in-patient sector (about 60 percent) lack any professional education that can be considered as suitable for their task. Residential treatment units prefer to recruit their staff on the basis of life experience rather than formal education. The only regulation is that methadone prescription and detoxification requires medical doctors.

In *Switzerland* a comprehensive system for quality assurance is currently being developed for in-patient rehabilitation facilities, which is intended to be extended later to the out-patient sector. This is not concerned, however, with a binding system (such as, for example, in the Netherlands). Until now, only the provisions of the Federal Office for Social Security have been binding, these playing a central role in the financing of the facilities. The provisions contain 18 qualitative requirements in the areas of organisation, clients and services. These are concerned with structural characteristics which, for example, also include the provision to document client satisfaction. In addition the institutions are obliged to introduce a quality management system.

2.11.3. Training and further education of professionals

Challenges in the training and further education of professionals

Professional education and training is structured differently in each country owing to differences in the health care, welfare and educational systems, as well as owing to varying degrees of professionalisation and to different traditions in the respective fields.

The educational background of professionals working in the field of addiction is also highly diverse. The professional qualifications range from social workers to psychologists, psychotherapists, medical doctors, psychiatrists and nurses. Ex-users working in addiction care represent yet another background. The importance of the respective occupational groups varies according to the country or region and to the area of work. The field is also characterised by different ideo-

logical perspectives. Both the existing knowledge and skills as well as the need for basic and further education is thus very heterogeneous. Here lies a considerable challenge for the development of training and further education for addiction professionals.

Almost all countries report on deficiencies in the training of professionals in the addiction field. A *deficit in the addiction-specific content of the basic training* is pointed out to various extents. Frequently, an examination of the addiction problem and ways of treating it are either not gone into or are only dealt with in passing. This applies in particular for medical doctors and psychologists where basic skills in diagnosis, prognosis and treatment of drug abuse need to be included in all educational degrees, and are criticised as being a deficiency by those starting their careers. In Spain a study was conducted to investigate the state of training on drug use and abuse in the curricula of several disciplines in 14 Spanish universities in order to determine the characteristics of training, to assess the training needs perceived by the undergraduate students, teachers and staff, to analyse potential gaps in training, and to suggest new contents and methods to improve training on drug dependence at university level (Ferrer, Torres-Hernández, Duran et al. 1995). In Poland a similar study was carried out to assess the curricula of medical schools with regard to questions of addiction (Habrat and Ostaszewski 1998).

In the case of vocational further education it has been established, particularly in Poland, that there is a need to *improve the competencies of practising family doctors*. In the field of addiction-specific training and further education for medical doctors, an important role needs to be attached to the newly created *associations for addiction medicine*.

An effective further education strategy also requires, besides needs-oriented education programmes, sufficient resources for financing the participation. For instance in the Czech Republic the *lack of financial means at the level of the facilities*, which greatly impedes the further education of the staff, is criticised.

In Denmark and Greece it is required that *ex-users* working in addiction care are given special consideration in terms of *further education*. In principle they have the same training needs, but their role in a facility must, however, be specially considered.

In Italy several measures are suggested for the improvement of professional competency, such as the introduction of *postgraduate internships* in drug abuse treatment services, the fostering of *joint refresher courses* for professionals, an increase in *clinical supervision activities*, as well as the improvement of *specialised data banks* to provide professionals with updated information.

Fundamentally there is *a lack of documentation and research on the training and further education of addiction care professionals*. There are just as few guide-

lines as there are evaluations of education strategies and programmes. It is largely unknown as to which educational forms and contents are successful for which target groups.

Training and educational programmes

In many countries a variety of educational programmes and training opportunities exist. The following is a brief overview of the programmes and projects described in the country reports. This does not go into the educational content. This has been included, however, in the Guidelines (4.1):

In the *Czech Republic* "psychotherapeutical self-experience training" has a long tradition. The majority of drug workers in the various types of services wish to successfully complete the programme which lasts for five years. However, it is not accepted by the state institutions as an official qualification for professionals with a non-psychiatric background. Nevertheless a "one-year theory-based programme for medical and non-medical drug workers", based on the British educational programme from SCODA[71], has recently been introduced in the Czech Republic. The graduates receive a certificate, which is accepted by the state institutions for the treatment of drug addicts. Specific curricula for professionals working in methadone maintenance treatment programmes as well as in aftercare programmes are currently being prepared.

In *Denmark* a continual educational programme is offered for various (semi-) professional groups such as social pedagogues, social workers, nurses, psychologists, etc. The programme is carried out over five 4-day modules and includes the preparation of group project reports, integrating theoretical questions and their practical application. A diploma is given for the successful completion of the programme.

In *Greece* the practical training of new staff members is mainly carried out at internal level, lasts 1-3 months and often includes theoretical aspects. Recently, KETHEA has begun offering an educational programme for professionals working in the field of drug addiction treatment in collaboration with the University of San Diego. Those successfully completing the programme are certified as drug addiction counsellors by UCSD. The first course was realised during 1998/1999. It is the first educational initiative to provide systematic training to a group of professionals already working in the field and coming from different treatment institutions.

In the *Netherlands* it is the treatment and care institutions themselves which generally develop and offer specific training programmes for their personnel (for inexperienced and experienced workers). At the Jellinek Centre programme man-

[71] Standing Conference on Drug Abuse.

agers indicate the need for specific training in their teams (see Annex VII for assessment tools). Subjects for training include computerisation, project management, psychopathology, transcultural care, coping with aggression, gender-specific care and time management. The Jellinek School responds to training needs and adapts the training programme. This has resulted in a diversity of further training courses including motivation and communication techniques, working with treatment protocols, team building and additional training in addiction care. The Dutch Institute of Mental Health and Addiction in Utrecht offers a variety of courses in the general training programme, as well as courses as part of special projects. Furthermore, it organises forums, conferences and study days. EuropASI training is organised by the Amsterdam Institute for Addiction Research.

In *Spain* different administrations and professional organisations offer post-graduate education on drug abuse to professionals from various disciplines. Some programmes are aimed at general practitioners in order to improve their skills in the diagnosis, treatment and health education of substance abusers and users at risk, and include training on motivational enhancement and the implementation of specific intervention protocols. The University of Barcelona offers a master-level programme on drug dependence. A distance-learning version of the programme has been available since the year 2000. Various Spanish universities offer similar courses aimed at training specialists on drug abuse prevention and treatment.

In *Poland* the Bureau for Drug Addiction is currently considering a training and certification programme which would benefit from the experience gained from relevant training systems elaborated for professionals in alcohol addiction. For Polish family doctors a Polish-American training programme on addiction is offered (Murray & Fleming 1996).

In *Switzerland* a comprehensive concept exists for promoting further education in the field of addition. The financing is through the Federal Office for Health. Educational establishments for the various occupational groups have been commissioned with the implementation. The system is modular in structure and is differentiated according to inter- and intraprofessional programmes. For the intraprofessional training the educational establishments enjoy a large degree of freedom. The Federal Office for Health sets the provisions for the interprofessional programmes. In order to ensure that there is a needs-oriented training programme, all addiction care facilities have the possibility to include their wishes in the twice-yearly tendering procedure.

3. Projects at European Level

At European level numerous projects are currently being conducted to promote professionalism in the treatment and care of drug addicts. In the following section a selection of projects will be briefly described which are concerned to a significant extent with professional quality, networking as well as training and further education. Guidelines, professional standards and examples of good practice that have been formulated at European level are listed under 4.3.

3.1. Projects in the Area of Professional Training and Education

Demand Reduction Staff Training Programme for Central and Eastern European Countries (DRSTP, Pompidou Group)[72]

The *Demand Reduction Staff Training Programme (DRSTP)* was part of the Council of Europe Pompidou Group activities for 1994-1998 to meet the needs for strengthening demand reduction activities in 12 central and eastern European countries. The programme offered short-term training courses for policy planners/ administrators and long-term in-service training for practising professionals in order to increase training activities in the field of drug demand reduction at national levels. DRSTP was demand driven and the topics chosen for in-service training of national experts were selected by the participating countries. Following this training the trainees were responsible for initiating training seminars in their own countries. DRSTP was aimed at

- providing participants with skills and knowledge in order to lay the foundations for the development and implementation of nationally based professional training relevant to demand reduction initiatives at grassroot and institutional levels in each participating country,
- supplementing and reinforcing on-going demand reduction activities at national level in the participating countries,
- promoting communication between practising professionals and policy planners/administrators in the participating countries, and

[72] Text based on information provided by the Pompidou Group and from http://www.pompidou.coe.int/.

- encouraging networking between both professionals in the host countries and in countries submitting for training and between the latter countries themselves.

The project initiated and supported a total of 49 national staff training events for about 1,700 professionals and volunteers involved in drug demand reduction in the participating countries. This significantly increased the awareness and interest in drug demand reduction staff training among administrators, practitioners and NGOs. The main conclusion emerging from the DRSTP programme was that a follow-up programme should be undertaken in order to support the development of more sustainable drug demand reduction staff training structures at national level:

The *DRSTP II* aims at supporting the development of sustainable national training materials for specific target groups involved in the implementation of drug demand reduction in the same twelve central and eastern European countries. A management committee[73] is monitoring the programme. The multidisciplinary approach advocated throughout the DRSTP is maintained and developed further. The following four high priority areas relevant for staff training and target groups were identified by the participating countries:

- *General drug demand reduction training for service planners and administrators* (policy development and implementation: informing politicians; the role of social services/social workers; rapid needs assessment methods)
- *Primary prevention* for professionals and volunteers / NGOs (community prevention, public awareness and mass media for journalists and other media professionals)
- *Early intervention and outreach work* for professionals and volunteers/NGOs (new trends and new drugs)
- *Treatment / social rehabilitation* for professionals and volunteers / NGOs (drug demand reduction in the correctional system for prison administrators, officers and other staff members responsible for health, education and reintegration; evaluation and qualitative research)

As the DRSTP II is a pilot project with limited resources, each national project team had to select only one high priority training area relevant for multidisciplinary drug demand reduction curriculum development. This selection was undertaken in co-operation with the relevant national authorities responsible for drugs policy and drug demand reduction staff training.

[73] The management committee includes representatives from two partner countries, the donor countries, the European Commission, ILO, UNDCP and the WHO.

National expert working groups are involved in the writing and the adaptation process needed for a curriculum to become relevant at national level. Each national expert group has been given five to six consultation sessions over a period of about one and a half years and is gradually extending their theoretical and practical knowledge and skills in the selected national high priority training area. The new training material is generated in different forms depending on the target groups. The most common is multidisciplinary material presented in the format of handbooks. Two countries are aiming at setting up specific university-based drug demand reduction courses (one course for graduate students and a post-graduate masters course). One country will be using distance education to disseminate the training material.

Another important issue is the identification of partners within existing and relevant educational institutions in order to provide a stable basis for sustainable curriculum implementation. This way the training can be formalised and possibly be given educational credibility. It is therefore recommended to integrate the training within the formal educational system.

Further information on this on-going programme can be obtained from: Groupe Pompidou, Conseil de l'Europe, Bâtiment B, 67075 Strasbourg Cedex, France, Fax: +33 3 88 41 27 85; http://www.pompidou.coe.int/english/formation/drstp.html

European Addiction Training Institute[74]

The European Addiction Training Institute (EATI)[75] organises international training courses for people working in the field of addiction in the European Community. The main objectives of EATI are to cultivate and exchange expertise and scientific knowledge about addiction at a European level, crossing national and institutional borders, and to improve the quality of interventions in the fields of treatment, prevention, policy and research.

The training courses are given by expert European trainers from different member states. The locations for the training courses are spread across the member states. EATI's main target groups for training courses and workshops include multidisciplinary treatment staff, prevention officers, researchers, managers and directors, and drug policy advisers. Some training courses are follow-up sessions in which participants from previous training courses are instructed in the transfer of new insights at their national or local level; they are trained to be local trainers. For many courses special training manuals and other educational materials are created.

[74] Text based on information obtained from http://www.eati.org.

[75] EATI was founded in 1994 by the Jellinek, Amsterdam. The initiative was supported by an international network of twelve other major European institutions for addiction care and research, including the European Association for Substance Abuse Research (EASAR).

EATI has set up a Staff Office at the Jellinek premises in Amsterdam. Together with experts they develop, plan and organise the various training courses, recruit participants and give support during the execution of the courses.

The EATI Advisory Board consists of experts from six renowned institutions from the United Kingdom, Germany, Greece, the Netherlands, Italy and the World Health Organization (WHO), Regional Office for Europe. Working relationships are maintained with the European Commission, the WHO, the Pompidou Group, the European Monitoring Centre on Drugs and Drug Abuse (EMCDDA) and the International Council on Alcohol and other Addictions (ICAA). For more information see: http://www.eati.org/

Information System on Training Activities (ISTRA)

EMCDDA has initiated an Information System on Training Activities in Drug Demand Reduction (ISTRA) in all EU Member States. ISTRA is based on a European report on university training programmes in the reduction and epidemiology of drug demand (Rigter et al. 1998) and includes university courses focusing on illicit drugs and addressing current demand reduction issues. To be included in the information system the courses must be linked to an accredited university, provide a formal and recognised qualification and be available to students outside the university. The system provides details on the size, duration, frequency, level, admission criteria, disciplines involved, topics covered, accreditation and associated research programmes. A census of non-university vocational training facilities is also under way along with an inventory of continuing training. Source of information: http://www.emcdda.org/activities/demand_info_istra.shtml.

3.2. Professional Networking

Professional Associations at European Level

ITACA (European Society of Professionals working with drug dependences) is a European network of professionals working in the field of drug dependences, including professionals from Italy, Spain, Switzerland, Belgium, Holland, France, Greece and Luxembourg. ITACA sees itself as a forum for exchanges between professionals from different intervention fields and for research. Further information can be found on the homepage: http://www.itaca-europe.org.

ERIT (Federation of European Professionals Working in the Field of Drug-Abuse) was founded in 1993 and includes associations of professionals working with drug addicts in all European countries, embracing approximately 9000 professionals. More information can be obtained under: http://www.erit.org.

Phare Technical Assistance to Drug Demand Reduction[76]

The Phare project Technical Assistance to Drug Demand Reduction assists the Central and Eastern European Countries with the elaboration, development and implementation of appropriate policies, strategies and actions in the crucial field of drug demand reduction. As a consequence of the political changes in the early 1990s, all Central and Eastern European Countries have been confronted with a considerable increase in the demand for drugs as well as in their supply. Close co-operation between the Phare partner countries and the member states of the European Union offers a major opportunity to foster the actual and potential strengths in tackling this problem.

The project's overall objective is to strengthen drug demand reduction strategies in the Phare partner countries in order to increase their preventative and harm reduction impact and to harmonise them more with the strategies which prevail in the European Union countries. To achieve this objective the programme aims at network strengthening, policy and strategy development and capacity building. Therefore, collaborative actions at interregional, regional, sub-regional as well as national levels are being developed. The major approach of the project is to facilitate the exchange and sharing of experiences and to initiate practical collaboration in the priority areas, taking into consideration the valuable varied experience that already exists in the Phare partner countries. The project facilitates the development and implementation of regional, sub-regional as well as

[76] Text based on information obtained from http://www.fad.phare.org/ddr/info.htm.

interregional action-oriented projects. For further information see: http://www.fad.phare.org/ddr/info.htm

Exchange on Drug Demand Reduction Action (EDDRA)[77]

EDDRA is an Internet-based database which provides details on a wide range of demand reduction programmes in the European Union member states (see http://eib.emcdda.org/databases/databases_eddra.shtml).

Focusing on experience and good practice in the field, the system caters for the needs of drug practitioners, policy-makers and decision-makers involved in planning and implementing demand reduction interventions.

The EDDRA system provides information on evaluated demand reduction interventions in the European Union, on the methods, implementation and outcomes of different demand reduction approaches, their results and impact, and on innovative or collaborative programmes in the field. Furthermore, it facilitates contacts between practitioners and the exchange of information on programme evaluation. EDDRA co-ordinates efforts with other European and international initiatives to pool expertise and to avoid the duplication of efforts.

The REITOX National Focal Points have organised national training courses in co-operation with the EMCDDA in order to strengthen evaluation skills and to improve the use of the EDDRA system.

[77] Text based on information obtained from http://eib.emcdda.org/databases/databases_eddra.shtml.

4. Guidelines, Checklists, Materials

On the basis of the country reports, the material from the participating countries and further specialist literature, the ADAT working group adopted the following recommendations for basic and further education in the field of treatment and care of drug dependence (4.1) as well as the Checklist for the identification of professional quality criteria and standards (4.2). Finally this is followed by an overview of existing guidelines and professional quality criteria in the field of drug abuse treatment and care together with information on where they can be obtained (4.2.1):

4.1. Guidelines for basic and further education in the field of treatment and care of drug dependence

4.1.1. Introduction

The educational background of professionals working in the field of treatment and care of drug dependence is highly diverse. And the field is characterised by different ideological perspectives. Both the existing knowledge and ability as well as the need for basic and further education is thus very heterogeneous. This situation must be taken into consideration in the provision of appropriate basic and further education.

Professional training in the area of dependencies is structured differently in each country owing to differences in the health care, welfare and educational systems as well as owing to varying degrees of professionalisation and to different traditions in the respective fields. The content and organisation of the education programmes must be appropriate to the regional and/or national situation. There are, however, numerous aspects that need to be considered when planning and examining the specific basic and further educational programmes. These are described below.

The Guidelines are oriented towards those responsible for strategic and operative tasks in basic and further education in the field of dependencies, in particular in treatment and care facilities, in educational institutions and at national level. Included are recommendations for the basic and further[78] education of people

[78] Further education refers to all forms of professional competence development and specialisation which are acquired parallel to professional practice (irrespective of the duration, type of education and qualification).

who work/will work in the field of dependencies or are confronted with aspects of addiction in their professional work. Excluded, however, is the field of primary prevention. Although training programmes throughout Europe often cover both issues of prevention and treatment, the ADAT reports and materials only deal with the adequacy of treatment and care of drug dependence. Recommendations can therefore be formulated only for the respective field.

The Guidelines are based on the ADAT country reports, materials provided by countries (studies, curricula), as well as other materials such as the WHO guidelines (WHO 1996) and a study on university training programmes in the EU Member States (Rigter, Ketelaars et al. 1998). It must be pointed out, however, that there is a considerable lack of empirical evidence for basic and further education in the field of treatment and care of drug dependence. The guidelines are based mainly on ethical considerations recommended by the ADAT expert group.

The Guidelines are structured as follows: general aims and requirements, target groups, organisational questions, educational approaches, educational content, and needs-led service planning:

4.1.2. General aims of basic and further education in the field of dependencies

Both basic and further education programmes must aim at

- promoting professional practice, and thus *improving the quality in addiction care* and related fields, through imparting specialised knowledge and the development of the reflection and action competencies;
- increasing *work satisfaction* for specialists working professionally in the field of dependencies (prevention of fluctuation and burn-out syndromes);
- increasing *interdisciplinary and interprofessional collaboration*; and
- furthering the *health and social sciences and their research* in the field of dependencies, as well as the dissemination and implementation of their findings.

4.1.3. General requirements for specific basic and further education in the field of dependencies

- *Continuity of vocational training:* Basic knowledge, skills, competencies as well as attitudes and values necessary for professional intervention in the area of dependencies must be integrated into basic education as a foundation for subsequent specific continuous education and training.

- *Multidisciplinary educational programmes*: The field of dependencies is multidisciplinary in nature. This aspect must be taken into account of in basic and further education.
- *Interprofessional and intraprofessional educational programmes*: It is both the task of further education to develop the specific knowledge and skills of individual occupational groups and to support their contribution to reducing the addiction problem, as well as to strengthening interprofessional communication and co-operation.
- *Needs-led educational programmes:* The educational programmes must meet the needs of the various target groups (4.1.4) and institutions active in the field of dependencies in the various regions (4.1.8).
- *Flexibility and diversity of the educational programmes*: It must be possible to fulfil the individual educational needs of the professionals (in terms of the educational content, setting, time needed, etc.; see modular programmes under 4.1.5).
- *Relevance of the educational services to practice:* Basic and further professional educational programmes must aim at developing staff competencies to deal with the demands that arise in the field, and also take into consideration new trends in drug use.
- *Efficient educational programmes:* This presupposes need-based programme planning (4.1.8), the imparting of current and scientifically based knowledge, the implementation of proven educational methods (4.1.6) as well as specific measures for evaluation and quality assurance (4.1.5).
- *Economic viability of the educational programmes:* This is achieved through the bundling, use and strengthening of existing know-how as well as through existing structures, measures for quality assurance and national and international networking.

4.1.4. Target groups of specific basic and further education programmes

The target groups to whom education programmes in the field of dependencies are oriented can be differentiated according to the field of employment, the sphere of activity, occupational groups, scientific disciplines and the level of education:

Field of employment:

- *Addiction specialists*: professionals working specifically in the field of dependencies
- *Persons not employed specifically in the field of dependencies:* Persons who deal professionally only with isolated aspects of addiction, (social, teaching, medical and paramedical professions, psychologists and psychotherapists, legal professions and the police, professions within the penal system, media, administrative and military professions)
- *Volunteers* who do not work professionally in the field of dependencies (e.g., relatives, churches, etc.)

Spheres of activity in the field of dependencies:

- Low-threshold social services (including outreach work, hygiene, nutrition, accommodation, work, training)
- Low-threshold medical care and harm reduction
- Substitution treatment
- Out-patient social services (counselling, psycho-therapeutic services)
- Detoxification
- In-patient treatment
- Aftercare/ reintegration
- Health promotion
- Services in the penal system
- Self-help groups
- Special services for certain subgroups of clients (young drug abusers, pregnant drug abusers, drug abusing parents, dual diagnosis patients, ethnic minority groups, sex workers etc.)
- Management and treatment planning in addiction care
- Supervision in addiction care
- Addiction research

Occupational Groups:

- Social workers/social pedagogues; psychologists; psychotherapists; care professions (incl. psychiatrist nurses); psychiatrists; medical doctors (esp. family doctors); tradesmen and other professions (outside appointments, ex-users)

Scientific disciplines:

- *Social disciplines* (psychology, sociology, social work, educational sciences, epidemiology, ethnographics, anthropology)
- *Biomedical disciplines* (general medicine, psychiatry, pharmacology, clinical chemistry, biology, genetics, nursing)
- *Other disciplines* (law, criminology, economics, history, political sciences information sciences, medical informatics)

Education level:

- Addiction-specific content in basic education with a secondary education qualification *(undergraduate)*
- Addiction-specific content in basic education with a tertiary education qualification *(undergraduate, university level)*
- Further education for persons with a secundary education qualification *(graduate)*
- Further education for persons with a tertiary education qualification *(post-graduate)*
- Further education for persons with a doctorate *(post-doc.)*
- Further education for persons without a professional qualification

4.1.5. Requirements for the organisation of addiction-specific basic and further education

Integration of addiction-specific contents into the basic training

- Each *profession* defines for itself what the members of their occupational group must know and be capable of in the field of dependencies, and what sort of basic and further education they should have.
- The development and provision of *profession- and discipline-specific contributions to reducing the addiction problem* should be promoted by providing financial means.

- *Exchanges between educational institutions within the same field* providing addiction-specific knowledge and skills should be promoted.

Modular structure of the further education system

- The further education programmes should be ideally provided in the *form of modules* so as to ensure a flexible further education system.
- Both *inter- as well as intraprofessional modules* should be provided: Interprofessional modules (available to several occupational groups) impart general knowledge and further interprofessional collaboration. Intraprofessional modules are oriented to definite occupational groups in order to convey specific knowledge and skills. The homogeneity of the participants enables more in-depth work.

Co-ordination of addiction-specific further education

- For the strategic planning and control of further education schemes the appointment of a *national advisory committee* is recommended. (Possible composition: representatives with competencies in the legal and illegal drug field, in definite professional fields and in the education sector, representatives of the various occupational groups, public authorities and NGOs. Possible tasks: assessment of educational and training needs, definition of minimum curricula, co-ordination, quality assurance.)
- *Providers of addiction-specific further education programmes* must ensure the continuity, quality and accreditation of the further education and be able to take on responsibility for the planning, implementation, quality testing and continuing development of further education programmes for definite occupational groups (particularly suitable are accredited and competent educational establishments).
- In view of the large variety of occupational groups and institutions involved, the appointment of a neutral authority is recommended for the *co-ordination of addiction-specific further education*.
- *In-company training* can be adequate for large treatment organisations. As a matter of principle, in-company further education programmes should meet these guidelines.
- For subject areas with a great need for *international exchange*, training should be organised at an international level.

Measures for quality assurance

Requirements for the providers of addiction specific further education programmes:

- *Availability of resources* for the conception, planning, implementation and evaluation of further education programmes
- *Acceptance and networking* of institutions in the individual professional fields (national, international)
- *Knowledge and experience* in the field of dependencies
- *Potential for the continuity* of the further education in the field of dependencies

Requirements for (external) further education programmes:

- Specialist and methodical *competence of the lecturers*
- *Methodical-didactic preparation* in accordance with the principles of adult education (4.1.6)
- Inclusion of *lecturers from various institutions and working areas* from home and abroad
- *Interdisciplinary programmes* which are relevant to practice
- Knowledge imparted is substantiated and of *current relevance*
- *Content* includes required essentials (4.1.7)
- For all programmes, the *target public*, *admission level* as well as the *teaching goals* must be clearly established and successful participation certified.
- Single modules as well as entire educational programmes must be *evaluated*.

Specific requirements for internal training programmes:

- Respond to a real demand for further training and ensure that *individual and organisation needs* are met
- Run programmes on a *voluntary basis*
- Provide staff *incentives* (i.e. training carried out during working hours)
- Run the programme for a *limited number of people* (i.e., not more than 20)
- *Announce the programme* time ahead
- Conduct the programme in a *pleasant environment*
- Ensure highly *qualified trainers*
- Care for *all groups of staff*

- Offer a recognised *certificate for course attendance*.

Mandatory nature of basic and further training

- In several countries *definite basic and further education as well as professional experience is required* in order to be able to carry out certain professional duties in the field of dependencies. It is a prerequisite for granting approval for the operation of facilities and/or their financing. Such provisions contribute to improving the quality of addiction care and are to be recommended.
- In the case of further education, accredited courses need to be identified. For the *accreditation of a further education course*, the following aspects must be established and examined to see that they are maintained: conditions for approval, extent, duration and content of the further education, recognition of studies, type of qualification, requirements for the final dissertation and/or examination.

4.1.6. Educational approaches and settings

Principles of adult education:

- Education programmes must be *based on the previous practical and theoretical knowledge of the participants* and make use of their experience.
- The participants should be *actively involved* in the learning process.
- Processes for *individual control of the learning* should be promoted.
- Definite *teaching-learning relationships* should be created.

Settings and forms of further education:

- *Training courses* (focused on skills, methods, competence development)
- *Educational seminars* (oriented towards knowledge and processes)
- Practical *project work*, individually or in groups
- Producing *project reports*, written diploma thesis
- Individual and group *supervision, Intervision*
- Attending other institutions, *study visits*
- *Internal training* at the workplace
- *Postgraduate internships* in drug abuse treatment and care services

4.1.7. Educational content

The determination of the content of the training at a general level is problematic owing to the heterogeneity of the knowledge and skills in the field of dependencies as mentioned in the introduction. However, in principle the following can be established:

- Further education in the field of dependencies must be oriented to increasing and deepening *expertise and professional capabilities* (skills, competencies) as well as to developing *reflection competence* (attitudes, values). In particular, action competence can only be developed in close connection with the practical work.
- Professional capabilities vary considerably between the different occupational groups whilst the reflection competence is equally applicable to all occupational groups. In terms of expertise it can be differentiated between knowledge required for specific occupational groups and spheres of activity and general knowledge.
- The required educational content must be determined on the one hand according to the *spheres of activity* and on the other hand be determined at *interprofessional level*.

Profession-specific knowledge and capabilities

Each profession defines for itself what its members must know and be capable of in the various spheres of activity within the field of dependencies, and what sort of basic and further education they should receive. Broad-based *profile development* is recommended for the respective professional fields. Fields of work outside the addiction care system as well as existing professional standards for each respective field of work should be taken into consideration.

Within the framework of the ADAT project, several countries report on the expertise and capabilities required of individual occupational groups. A list can be found in Annex VI.

Interprofessional knowledge and capabilities

Interprofessional education programmes promote collaboration between the occupational groups and contribute to a common understanding of the addiction problem. Of greatest importance is the teaching of the specialist knowledge and competencies, which all persons in the field of addiction require:

Fields	Content
Basics	Concepts, forms of addiction Substances (tobacco, alcohol, opiates, cocaine, amphetamines, XTC, LSD, hallucinogens) Epidemiological basics Causes and effects of addiction, addiction behaviour Medical, pharmacological, toxicological, neurological, psychiatric and diagnostic basics Medicament treatment possibilities
Basics	Health aspects (medical, psychiatric, pharmacological, neuro-biological aspects, hygiene, nutrition); addiction, accompanying ill-nesses, duel diagnoses Image of man and understanding of addiction, reflection on individual work motivation and individual addiction behaviour Historical, cultural and ethical aspects of addiction; transcultural and sexes specific care
Genesis and course of addiction (individual and social perspectives)	Addiction, identity and social change Addiction and social structure Theories of the genesis and course of addiction Legal and illegal drugs: common features and differences, causes, and treatment, etc
Diagnosis and interven-tion	Diagnostic models and procedures Therapeutic approach: treatment, evaluation, care Matching: which sort of treatment for whom? Therapeutic practice, situation of the staff Intervention models/strategies Relationship of the subject, aim and means, Developing the relationship with the clients: reflection on the motiva-tion to work, closeness-distance, conflict ability, dissolution of emotional ties Dealing with relapses Conducting conversations with addicts; solution-oriented counselling
Legal and social pre-conditions for addiction policy and addiction care	Drug policy models at home and abroad, intentional and unintentional effects Legal basis for addiction policy Legal, economic, social-political context of addiction care; guardian-ship and criminal aspects; financing of addiction care The way society deals with the addiction problem: historic, cultural and social-cultural aspects
Organisation and pro-fessions in addiction work	Addiction care: organisation, structures, professions, fields of work Interprofessionally co-ordinated provision of social and medical serv-ices for drug abusers and their environment (structures and proc-esses) Individual positioning within the addiction care system Models for addiction work (in-/out-patient), networking

Treatment planning and management in addiction care and prevention	Advising organisations in addiction care and prevention Building capacity to critically evaluate research results and theories Research, programme evaluation and quality assurance techniques Computerisation and the use of telematics Assessment and management of the most relevant substance use problems

4.1.8. Requirements for planning and examining needs-led programmes

Assessing the individual need for further education programmes

Each professional should develop his or her professional competence continuously according to his or her area of operation in the pursuit of ethical consciousness and in order to keep up with the opportunities provided by the available treatment and care models and with the advances of international science.

Each programme manager is responsible for the further education of his/her staff. The need for further education according to the view of the staff and management should be assessed, planned and evaluated periodically. A checklist for determining individual needs for further education can be found in Annex VII.

Assessing the national need for further education programmes

1. Differentiated stock-taking of the further education programmes

- Which providers and which programmes exist for which target groups, with what content and capacity?

2. Differentiated survey of needs for specific further education programmes

Which needs must be considered?

- *Need of persons* employed in the field of dependencies and related areas (selection according to the sphere of activity, occupational groups, fields of employment; possible questions: how shall the content, setting, accessibility and flexibility of the further education programmes be assessed? What is missing? Which existing programmes are considered to be unsuitable?)
- *Need of private and public facilities* for addiction care and related fields of work[79] (possible questions: does the required education content exist? Do the facilities have sufficient financial means available to them? Are the education programmes available within a useful period and to all employees?)

[79] Social, teaching, medical and paramedical professions, psychologists an psychotherapists, legal professions and the police, occupations within the penal system, media professions, military professions

- Need according to the *professional organisations*
- Need according to the *educational facilities*
- Needs of the *health and social services*

Which aspects should be considered when clarifying the needs?

- Intra- and interprofessional content
- Knowledge, capabilities, reflections
- Number of places
- Deficits in addiction care and in related fields of work
- Consideration of needs in the fields of legal and illegal drugs as well as forms of addiction unrelated to substances
- Consideration of new trends and/or substances, forms of consumption and addiction
- Consideration of various regions and possible linguistic groups

Possible strategies and procedures

- *Interviewing* addiction professionals, institutions, professional organisations, ministries
- *Profile development* according to the occupational groups and the spheres of activity (description of the profession-specific work profile in the field of addiction care; inclusion of existing professional standards; inclusion of addiction professionals, addiction care facilities, educational institutions, etc.)
- *Evaluation of the existing education programmes* (adequacy of content, setting, time needed, costs, etc.)
- *International comparison* of basic and further education in the field of dependencies
- Enable *suggestions* for the content of further education to be received from practice

3. Drawing up of an action plan[80]

- *Identification of gaps and deficits* in terms of the neglected and/or missing target groups, education content, settings/ educational approaches, quality and quantity of the addiction-specific further education programmes; exact description of the deficits which are to be remedied by adjusting existing or developing new programmes

[80] Also see the Guidelines of the WHO (WHO 1996).

- *Determination of suitable further education providers and lecturers* and/or clarification of the need for new providers/structures for further education
- *Expanding existing curricula/modules and/or development of new curricula* which meet the determined need
- *Discussion of the suggested curriculum* among experts and professionals; adaptations if necessary
- *Evaluation* of new programmes (Could the desired target group be reached? Is the educational content considered relevant and useful from the view of the professionals? Is the didactical procedure appropriate? etc.)

Drafting a curriculum schedule

A curriculum schedule must include information on the content, time allocation and teaching methods for each component of the curriculum. The following questions need to be answered:

- Which aims should be attained (in terms of knowledge, capability, reflection)?
- When is basic knowledge provided and evaluated?
- When does practical experience start and how are the programmes structured?
- When and how are skills learned and evaluated?
- When are attitudes discussed and evaluated?
- Who gives supervision and how is it provided and evaluated?

4.2. Checklist for the identification of professional quality criteria and standards

The following checklist serves first of all to describe the existing guidelines and "standards" at institutional, national and international level which have been formulated for different areas of addiction care as well as with different claims of validity and bindingness. The checklist can be used to structure the existing heterogeneity. Moreover, using the list it can be more precisely determined as to where there is further need for clarity and development in the field of standardisation of professional quality and how one could proceed:

4.2.1. Types of qualitative requirements

The recommendations, guidelines and standards for the improvement of professional quality presented within the framework of the ADAT project can be characterised mainly according to the following criteria:

- Target group (of the guidelines)
- Subject area (for which the guidelines are formulated)
- Binding character
- Level of concreteness
- Basis of the guidelines (development procedure)

Target groups

- Professional groups (medical doctors, psychologists, social workers, nurses, pharmacists, etc.)
- Area of intervention (within and outside the treatment system)
- Individual facilities of treatment and care

Subject area

- Requirements for *specific modalities of treatment and care* in the area of substance abuse (harm reduction, substitution treatment, detoxification, etc.)
- Requirements for the *treatment and care of specific target groups* (e.g. young drug abusers, refugees, drug abusing women)
- Requirements for *specific activities* in substance abuse treatment and care (e.g. diagnosis, drug testing)

- Requirements for *professional care of drug abusers in other areas of the health care and social welfare system* (e.g. primary health care and primary social services, pharmacists, forensic doctors and judicial social services)
- Requirements for *quality and quality improvement in treatment and care facilities* (characteristics of structural, process, and outcome quality)

Binding character

- Obligatory guidelines (e.g. legislation)
- Recommendations (e.g. examples of good practice, recommended quality criteria)
- Voluntarily defined quality standards (e.g. for internal quality assurance)

Level of concreteness

In the literature on quality improvement often no consistent difference is made between quality standards, criteria and indicators. However, it is important to clarify these terms:

- *General recommendations and policy statements* form the basis for the definition of quality criteria.
- *Quality criteria* provide content for the term quality by defining aspects relevant to quality. Quality criteria can be defined from an experts', customers' and from an economic point of view, and it can be distinguished between structural, process and outcome criteria.
- *Quality standards* describe to what extent quality has to comply with the quality criteria defined (minimum, average or optimum standards).
- *Quality indicators* are neutral measures that allow the extent of the standards' success to be measured.

The quality criterion has a higher priority, which is only changed through new findings, while standards can be modified more quickly in response to changes in the resources or needs.

Basis of the guidelines (development procedure)

- Formulation of qualitative requirements through a *small group of selected experts* based on evidence and professional experience
- Formulation of qualitative requirements through a *wide-spread discussion among a great number and variety of professionals* based upon their professional experience and attitudes

- Formulation of qualitative requirements through a specific *interest group* (e.g. consumer group, political association)
- Mutual negotiation of qualitative requirements among a *variety of stakeholders* (e.g. professionals, clients, insurance companies, state representatives)

Qualitative requirements can also be derived from existing guidelines (e.g. law, ICD 10, WHO Standards, ISO 9000) or be recommended by the public administration. However, they always reflect one of the above mentioned four development procedures.

4.2.2. Negotiation of qualitative requirements

Purpose and suitability of different forms of qualitative requirements

- *Legal regulations* are suitable for the assurance of minimum quality (e.g. educational demands, experience and number of staff; physical environment; data protection; measures for quality assurance)
- *Professional guidelines* are important for the development and promotion of professionalism. And they are a necessary precondition to bring in the experts' point of view into the mutual negotiation process of quality criteria among a variety of stakeholders.
- *Mutual negotiation of qualitative requirements among stakeholders:* Quality criteria and standards for specific services have to be defined together with the stakeholders concerned (regional and/or national level). Primary task of the professionals in the area of substance abuse treatment and care is it to define quality criteria on the basis of scientific knowledge and professional experience and to bring them into the mutual negotiation process of quality criteria and standards.

Formulation of quality criteria from an experts point of view

- *Methodological procedures*: Scientific and professional discussion on a national and international level (consensus conferences, Delphi studies)
- *Examination of the empirical evidence* of quality criteria, systematic recording and documentation of available evidence
- Expert quality criteria can be defined at *institutional level* and at the *level of the system of treatment and care*
- *Quality criteria based on professional experience and values* should be discussed among a great number of professionals

- *Standards* should be recommended at a high (international) level only if they are based on empirical evidence

Mutual negotiation of quality criteria

- *Participants at the negotiation process:* users' and carers' organisations, consumer groups, relevant professional associations, representatives of drug abuse treatment and care services, health insurance companies, state representatives, and other cost units.
- *Resources for the negotiation process must be made available* for the participating interest groups and for the co-ordination of the negotiation process.
- *Subject-matter of the negotiation process:* quality criteria, indicators, possible standards, obligingness, forms of quality control.
- *Predefinition of standards:* owing to little empirical evidence standards should be defined primarily together with the stakeholders involved. When defining standards, the specific character of social services must be taken into account (importance of the personal relationship between the professional and client; involvement of clients in service delivery, etc.). Standards should be defined for major quality criteria only. Institutions should be given the necessary freedom. Instead measures of internal quality assurance should be supported and promoted.

4.3. Overview on reported guidelines and criteria for professional quality in substance abuse treatment and care

Ideally, at this point a systematic overview of the individual quality criteria, indicators and standards for the treatment and care of drug addicts would follow (effectively as a synthesis of ADAT Part III). Because of the very broad thematic spectrum as well as the considerable heterogeneity of the material, however, this work can unfortunately not be achieved within the framework of ADAT.

Instead, in the following section material from the participating countries as well as European documents will be briefly described which are concerned with professional quality in the treatment and care of drug addicts. The documents can be very helpful in the formulation of quality criteria, indicators and standards in the various countries since they reflect the experience and expert knowledge of numerous professionals.

The structure of the list is organised according to the existing material. First of all it is differentiated according to the subject area (substitution treatment, harm reduction and low-threshold services). This is followed by an overview of the framework concepts for quality management, quality criteria and standards. These mostly refer to abstinence-oriented in-patient therapy. To some extent, however, other treatment and care forms are also included. Important and detailed documents are each time described first of all. These are followed by less elaborated guidelines. National documents are often only available in the respective national language (where possible an English summary is included in the annex).

4.3.1. Substitution treatment

The Methadone Guidelines (Euro-Methwork)

The methadone guidelines have been developed by Euro-Methwork[81] and are based on the review of scientific evidence and long-term experience in different parts of the world. Existing guidelines from individual countries as well as crucial discussions with experts in the field have been included in the guidelines.

[81] Euro-Methwork is a forum for persons who are active in the methadone field in the European region (i.e. practitioners, researchers, policy makers, but also heroin users, friends and families). They collect information about intake criteria, waiting lists, treatment protocols, treatment regimes, etc. as well as methadone providers in the European region.

The following content is covered: history and state of the art of methadone treatment in Europe; introduction to methadone and its pharmacology, review of available scientific evidence; clinical practice of methadone treatment; organisational aspects of good practice; monitoring of activities and evaluation strategies.

With regard to the differences in the historical, cultural, social, economic and political background, the guidelines do not intend to dictate but rather provide guidance and recommendations for good clinical practice with respect to methadone treatment. The guidelines can be downloaded at http://www.euromethwork.org.

Methadone Standards, Germany (Bühringer et al., 1995)

The "Methadone Standards" (Bühringer, Gastpar et al. 1995) were elaborated between 1993 and 1995 by an expert group from Germany and Switzerland and are directed towards all those working in the field of substitution treatment. The standards contain general treatment principles, organisational and personal prerequisites, diagnostic clarification, indication and treatment goals, the carrying out of the substitution, medical, social and psychotherapeutic measures, documentation as well as substitution with other substances. "Methadone Standards" is available in bookshops (in German).

Guidelines for psycho-social care within the framework of substitution treatment, Germany (akzept e.V.)[82]

As a professional association concerned with drug policies, Akzept e.V. attaches great significance to the fundamental importance of substitution and its widespread availability. The guidelines contain information on treatment modalities, institutional prerequisites as well as programme structures for psycho-social care. The guidelines are directed in particular to institutions and occupational groups concerned with psycho-social care. The guidelines can be obtained in German from the following address:

Bundesverband für akzeptierende Drogenarbeit
und humane Drogenpolitik
Am Roggenkamp 48
D-48165 Münster

Standards for psycho-social care with opiate addicts undergoing substitution treatment in Germany

This is concerned with concrete recommendations for indication use, implementation, services and methods of psycho-social care, dealing with dual-use, treatment termination, supervision and continuation, as well as basic conditions for co-operation within psycho-social care. Adequate care measures should be available within and outside of the addiction care system. The medical doctor

[82] Akzept e.V. (1995). Materialien Nr. 1. Leitlinien für die psychosoziale Begleitung im Rahmen einer Substitutionsbehandlung. Berlin: Bundesverband für akzeptierende Drogenarbeit und humane Drogenpolitik.

conducting the substitution should have sufficient knowledge of the services of the psycho-social care systems in order to be able to co-operate with the various establishments. The recommendations were elaborated and published by the *Bundesärztekammer* (Federal Medical Council) in co-operation with the *Deutsche Hauptstelle gegen die Suchtgefahren e.V.* (German Federation of Associations Fighting Against Drug Addiction).

Guidelines for the Treatment of Heroin Addiction with Opioides, Germany

The guidelines (1996) of the *Deutsche Gesellschaft für Drogen- und Suchtmedizin e.V.* (German Association of Drug and Addiction Medicine) contain some important advice on diagnosis and treatment within substitution treatment (including determining doses and dealing with duel use). The guidelines are kept very brief and are only intended to provide preliminary information for physicians working in substitution treatment.

Recommendations of the Danish Narcotics Council's Substitution Working Group

A subcommittee of the Danish Narcotics Council (an interdisciplinary working group of experts) recently issued a publication on substitution treatment containing a number of criticisms on current and former policy and suggesting some main points for future substitution policy and practice. The recommendations have no binding effect but rather express relevant demands for acceptable standards of treatment in Denmark (for a summary and extracts see Annex II).

Average standards for methadone maintenance programmes in Poland

In Poland a commission composed of representatives from the Institute of Psychiatry and Neurology, health insurance companies and professional associations have agreed upon average standards for different types of medical services in psychiatry, including methadone maintenance treatment. The standards were recommended and published by the Ministry of Health and Social Welfare in 1999. The average standards are listed in Annex IV.

Prescription of heroin to heroin addicts

The guidelines and recommendations for the prescription of heroin to heroin addicts used in Switzerland can be obtained at the following address (in German and French):

GEWA
Büroservice
Tannenholzstrasse 14
3052 Zollikofen
Switzerland
Tel. 0041 31 919 13 13

In the Netherlands recommendations for the experiment concerning the medical co-prescription of heroin to chronic, treatment-resistant methadone patients have been published by the Health Council of the Netherlands (1995).

4.3.2. Harm reduction and low-threshold services

Principles for preventing HIV infection among drug users

In order to support national and local governments in their strategies to prevent HIV infection among injecting drug users the WHO has formulated, in co-operation with UNAIDS and the Council of Europe, basic principles for the effective prevention of HIV infection among injecting drug users on the basis of good practice throughout the world. The following principles are elaborated:

- Principle 1: Information, communication and education
- Principle 2: Providing easy access to health and social services
- Principle 3: Reaching out to injecting drug users
- Principle 4: Providing sterile injecting equipment and disinfecting material
- Principle 5: Providing substitution treatment

The guidelines can be obtained from the WHO Regional Office for Europe (Principles for preventing HIV infection among drug users, without year).

Principles for outreach work with drug users (Pompidou Group)

The Council of Europe has published a guide entitled “Outreach work with drug users: principles and practice” (Rhodes 1996) with the aim of helping local authorities set up outreach units. The guidelines provide a summary of principles and practices aimed at developing, implementing and undertaking health education and HIV prevention among drug users. The guide has been translated into ten languages (see http://www.pompidou.coe.int).

Guidelines for Acceptance-oriented Drug Work, Germany

The guidelines for acceptance-oriented drug work were formulated by the federal association *akzept* in co-operation with the German AIDS organisation *Deutsche AIDS-Hilfe* (1999). They contain moral concepts and objectives, principles and methods of acceptance-oriented drug work. They provide a basis for the formulation of concrete structural and procedural requirements for action in this field and are suitable as a basis for evaluation and quality assurance. The guidelines can be obtained from the following address:

akzept Bundesverband
Am Roggenkamp 48
D-48165 Münster
E-Mail: garry.kaspar@t-online.de

Guidelines for operating and using consumption rooms, Germany

The guidelines contain advice on the planning and use of consumption rooms, conceptional approaches, ways of working and methods, organisation and networking, establishment of health rooms in rural regions and small towns as well as consumption possibilities within other care services. The guidelines were developed under the auspices of the Federal Government Representative for Drugs, Christa Nickels[83]. They can be downloaded from the following address: http://home.muenster.net/~indro/Leitlinien%20Konsumraeume.htm

4.3.3. Framework concepts for quality management, quality criteria and standards in drug abuse treatment and care

WHO Standards of care in substance abuse treatment

The World Health Organization have developed an instrument for assessing the adequacy of systems of treatment and care that is aimed particularly at countries with systems that are less developed (World Health Organization 1993). A set of standards have been established for several aspects of adequacy: access, availability and admission criteria, assessment, treatment content, provision and organisation, discharge, aftercare and referral, outreach and early intervention, patient's rights, physical aspects of the treatment, setting and staffing. The countries choose for themselves the standard which is applicable and the areas that need to be tested. The question of how and where relevant information can be obtained is left to the countries.

The ISO-PLUS+ standards for addiction care, the Netherlands

ISO-PLUS+ describes guidelines for quality in addiction treatment and care that are derived from the international guidelines and standards for quality NEN-ISO (9004-2, 9001, 9002) and have been supplemented with practical experience, instruments and documents for addiction treatment and care. The framework for appraisal examines several aspects of quality within an institution: (1) management of processes (i.e. products or treatment/care programmes, the primary process for a client from first contact to completing treatment, and customer-orientation); (2) policy and management tasks; and (3) management of personnel (expertise, satisfaction) and means (also see 2.6.1).

For more information it is possible to consult the emcdda instrument bank http://eib.emcdda.org/eib/databases_eib.shtml or contact the ISO-PLUS+ author:

[83] "Konsumräume als professionelles Angebot der Suchtkrankenhilfe - Internationale Konferenz zur Erarbeitung von Leitlinien", 18 – 19 November 1999, Hanover. Organised by the Arbeitsstelle Sucht- und Drogenforschung of the Carl von Ossietzky University Oldenburg and the Bundesverband für akzeptierende Drogenarbeit und humane Drogenpolitik (Akzept e.V.).

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The Certificate Scheme, The Netherlands

The certification scheme is a structure[84] for quality management that is compatible with the ISO standards but is specifically developed for care institutions. The scheme is meant to be binding for all addiction care providers and institutions in the Netherlands (see 2.6.1.) and will be finalised in 2001. For further information contact:

Dutch Foundation for the Harmonisation
of Quality Evaluation in the Care Sector
Bureau HKZ
Drieharingstraat 6
3511 BJ Utrecht
Tel. +31 30 272 96 00

Quality criteria for in-patient treatment (QuaTheDA), Switzerland

QuaTheDA[85] contains general specifications for a quality system, taking into consideration the main managerial themes, as well as special concerns of the addiction field. The QuaTheDA requirements can be used as a reference system for institutions for in-patient addiction treatment wanting to establish a quality system or further develop an existing system, as a questionnaire for self-assessment or for external evaluation. Cantons and other funding bodies can base their work on the reference system as well. The system is divided into the fields Services, Resources and Management (for an overview of the quality criteria see Annex V). The QuaTheDA reference system is available in German and French and can be viewed at http://www.infoset.ch/inst/bag/quatheda/ or can be ordered at:

QuaTheDA - Referenzsystem
Bundesamt für Gesundheit
Sektion Drogen
Postfach
3003 Bern

[84] Specific criteria need to be filled in by the individual institutions.
[85] Quality in drug and alcohol therapy; for more details on QuaTheDA also see 2.10.1.

Checklist for assessing the process quality in rehabilitation treatment, Germany[86]

Within the framework of the REHA quality assurance programme of the state pension scheme a peer review procedure has been developed to assess the process quality in rehabilitation treatment. The checklist for the indication fields Psychosomatic and Dependence Illnesses is divided into the areas Anamnesis, Diagnosis, Therapeutic aims and planning, Course and epicrises, social-medical appraisal, Further measures/aftercare. The checklist and manual for the indication fields Psychosomatic and Dependence Illnesses is published by the Department of Medical Psychology, University Hospital Hamburg-Eppendorf (Prof. Uwe Koch), the *Verband Deutscher Rentenversicherer* (Federation of German Pension Institutions) as well as the *Bundesversicherungsanstalt für Angestellte* (Federal Insurance Institution for Salaried Employees) (3rd edition, December 1999).

Quality indicators for therapeutic communities (ERIT)

A working group from the Federation of European Professionals Working in the Field of Drug-Abuse (ERIT) has developed a list of basic quality indicators for therapeutic communities, whereby the most important ones have been included in a questionnaire used to survey a representative number of therapeutic communities in Europe. These are supposed to assess the extent to which the indicators are suitable for quality assessment and their relevance to quality. The findings are intended to serve as a basis for a statement on quality indicators and standards for therapeutic communities.

The questionnaire includes 12 quality indicators and standards which are divided into the following sections: Formal aspects; Material means; Environment, Health monitoring; Economic activities and financial matters; Composition; Training and supervision of professionals; Admission procedures; Diagnosis and evaluation of patients; Patient files; General treatment; Employment and educational programmes; Discharge, Referral and care; Patients' rights; relationship to the community and other services; Quality guarantee. ERIT can be contacted at http://www.erit.org.

Criteria for the operational approval and accreditation of private institutions, Italy

In Italy there is a outline agreement[87] between the state and the regions concerning the minimal standards needed for the approval and accreditation of private institutions in the fields of prevention, therapy and rehabilitation of drug-dependent persons. The agreement is intended to provide the regions with a framework for quality assurance. In particular it includes structural and functional

[86] Also see ADAT Part II: Treatment and Support Needs; German country report.

[87] Atto d'intesa stato-regioni su "determinazione dei requisiti minimi standard per l'autorizzazione al funzionamento e l'accreditameinto dei servizi privati di assistenza alle persone dipendenti da sostanze d'abuso". Gazzetta Ufficiale della Rebublica italiana. Serie generale, n. 231 del 1-10-1999.

preconditions, demands made on the personnel, aspects concerned with monitoring and control, and data collection (for a summary and extracts see Annex III).

What is good treatment? Standards proposed by the Danish Narcotics Council

The Danish Narcotics Council has published a statement on "What is good treatment"[88] that corresponds to a rather simple listing of demands and recommendations with very few quantitative indications (see Annex I for the statement).

Recommended average standards for health insurance and service providers in Poland

In Poland a commission composed of representatives of the Institute of Psychiatry and Neurology, health insurance companies and professional associations have agreed upon average standards for in-patient units for the treatment of withdrawal symptoms, in-patient drug treatment wards, out-patient drug treatment clinics and for methadone maintenance programmes. The standards were recommended and published by the Ministry of Health and Social Welfare in 1999. The average standards are listed in Annex IV.

Minimal treatment standards, the Czech Republic

In the Czech Republic basic criteria for various services (outreach, low-threshold centres, detoxification, daycare, residential short-term treatment, therapeutic communities, aftercare, methadone maintenance programmes) have been defined. The standards include the accessibility of services, intake procedures, the scope of services and principles for service provision, organisational and financial aspects, clients' rights, staff, further education and supervision, and the environment. The fulfilment of these criteria is examined within the framework of an accreditation system for treatment and care facilities. The material is available in Czech only.

Minimum requirements for residential facilities for the rehabilitation of drug addicts, Spain

In Spain minimum requirements have been defined as a precondition for therapeutic communities for drug users in order to obtain administrative authorisation (national consensus). The requirements include the need of a therapeutic programme (including treatment goals, activities, maximum length of treatment and maximum number of users admitted to the community), professional staff, 24-hour professional supervision, medical assistance, basic contents of clinical records, and users' rights (also see Ch. 2.8.2).

[88] Narkotikarådet (1996). Hvad er god behandlilng?

4.3.4. Guidelines for diverse subject areas

Guide for health and social care of addicted women and their children

Guidelines for good practice as apart of community-based intervention strategies for female drug users together with a compilation of case studies on highly regarded community-based projects in the field of women and drugs in Europe have been published by Dagmar Hedrich (2000).

A guide that looks at European good practice programmes and takes into account the health and social care of addicted women and their children is entitled “Special needs of children of drug misusers” (Leopold & Steffan 1997).

Drug testing

The Dutch Minister of Justice has issued binding regulations on urine checks in prisons (Ministry of Justice, 1999).

The Dutch Association of Industrial Medicine (NVAB, 1995) has defined its attitude regarding the role of the company doctor with regard to alcohol and drug policies within companies (including drug testing at the work place).

Standards for documentation in substance abuse treatment, Germany

The *Deutsche Gesellschaft für Suchtforschung und Suchttherapie e.V.* (German Association of Addiction Research and Therapy) has formulated standards for documenting the treatment of substance abusers. The standards refer to data collection at therapy admission, during the course of therapy, at the completion of therapy, in catamnesis, as well concerning the description of the therapy facility and programme. A new edition of the documentation standards will be published in 2001 by the Lambertus Verlag (http://www.lambertus.de).

Guidelines for pharmacists, forensic doctors and judicial social services, primary health care professionals and primary social services facing drug-related problems

See Spanish country report (2.8.2).

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Annex

Annex I: What is good treatment? Standards proposed by the Danish Narcotics Council

The Danish Narcotics Council in 1996 had published a statement on ”What is good treatment”[89]. It is a rather simple listing of demands or recommendations for the system with very few quantitative indications. It deals with needs as well as with normative (professional) standards:

Quantitative requirements of treatment

1. General requirements are:

- that the place of treatment - if daily contact is needed - is within a reasonable physical distance
- that reception, referral and enrolment takes place in a simple and undemanding manner
- that the institution has both the necessary professional and physical possibilities for taking care of the needs of the individual abuser
- that the individual abuser may maintain realistic and positive expectations of the capacity of the treatment provided to further the desired changes
- that methods are applied which will be seen by the individual drug abuser as good and realistic opportunities for the solution of his or her particular problems
- that the total provision of treatment contains the necessary professional special expertise and at the same time is so flexible that the service provided may be currently adjusted in accordance with changing needs.

2. Capacity:

- There must be ”a sufficient number” of treatment slots, e.g. defined as treatment slots for more than 30% of the group of active abusers.

3. Offers of service to all types of drug abusers (subdivided as to target groups):

- Broadness of treatment services (out-patient treatment, day treatment, in-patient treatment institutions, family care etc.)

[89] Narkotikarådet, Hvad er god behandlilng?

- Opportunity for post-institutional treatment and de-institutionalisation after a course of treatment
- Establishment of social networks, residence, work etc.

4. Prioritisation among treatment services and interventions
5. Waiting time for referral, for start of treatment and for the optimal treatment offer: waiting time for referral should be less than 14 days
6. Institutional equipment (facilities and personnel).

Qualitative demands at treatment

1. Visible goals and methods in treatment
2. Individual treatment plans for each client, including partial goals
3. Files
   - which meet formal requirements of institutional filing
   - which include anamnesis
   - which include file items on medical treatment
4. Quality standards
5. Differentiation in investments and services

Annex II: Conclusions and Recommendations of the Danish Narcotics Council´s Substitution group[90]

The *"Substitution Working Group"* consisted of the chairman and four members of the Narcotics Council (including a psychiatrist, a medical doctor, a social worker, and the chairman of the Danish Users´Union). From outside the council the group included the Director of the Drug Abuse Treatment Centre of Aarhus County, a doctor from a Copenhagen hospital specialising in drug treatment, a researcher from the Centre for Alcohol and Drug Research (anthropologist) and a representative of the relevant section of the Ministry of Social Affairs.

The recommendations of the working group were discussed and joined by the Council, who published them in June 2000.

The recommendations have no binding effect, but must be assumed to express relevant demands for acceptable standards of treatment. Also the arguments behind the recommendations must be considered important statements of principles and standards:

1. The expression "substitution treatment" should be used upon the basis of a clear and *unmistakable definition*. In the report the expression is used to signify (only) the purely medical treatment with a substitution drug, whereas the other elements of a total treatment intervention will be termed "follow-up-treatment". It should not be taken to mean, however, that this part of the treatment is less important.
2. It is well documented that by substitution treatment and relevant psycho-social follow-up treatment an immediate *improvement in health and a psychological and social stabilisation is achievable*, both immediately, but also - and in particular - in a longer perspective.
3. It is important that knowledge is still sought and mediated thereby to *reduce the mythology* about methadone treatment.
4. *Research in substitution treatment* should be supported - studies of practice and evaluation as well as qualitative and quantitative research.
5. Treatment should be offered with *the drug most suitable* for the individual abuser. Opioid dependence, combined with the abusers desire for long-term treatment is the primary *indication* for this form of treatment. A more or less sporadic abuse of opioids, however, is not an indication for long-term methadone maintenance. The Council is of the opinion that neither age, criminal record, the perceived "heaviness" of the client, the duration of the career of addiction or an HIV infection can form the basis for either acceptance or rejection of long-term methadone treatment.

[90] Summary and excerpts based upon the report by the Danish Narcotics Council´s Substitution group, 2000, p. 75-78.

6. It will normally be a precondition for an effective substitution treatment that a *coherent and co-ordinated professional social and medical programme* is instituted.
7. Social treatment should be instituted on the basis of *key concepts* such as: Clarity on basic values, clear communication, a holistic view, systematic work, voluntariness and involvement of users. Staff should see substitution treatment as acceptable as drug-free treatment. As a starting point the user´s motives for seeking treatment should not be questioned - at least it should not lead to exclusion from treatment or that the user is given inferior treatment.
8. As to the *supply of social treatment offers* adjunct to the methadone treatment, the Council finds:
    - A sufficient number of treatment slots should be available so as to avoid waiting time
    - Access to treatment should be easy, i.e. referral and admission procedures should be as simple and unbureaucratic as possible
    - The substitution services should be as close as possible to the user´s abode
    - An offer of treatment should be sufficiently varied an multifaceted so as to make it possible to make up treatment plans adjusted to the needs of the individual user
    - Treatment services should be available to fulfil the needs of special groups of abusers: Pregnant abusers with children, ethnic minority groups, HIV-positive individuals, the mentally ill and youth and seniors.
9. The Council considers the following points as essential to achieve a higher *quality of treatment*:
    - The treatment should be holistic and take into consideration the situation of each individual user
    - It shall be performed in a respectful manner and must not expose the user to degrading or patronising treatment
    - The treatment institution should have an expressly formulated, publicised statement of goals
    - The treatment shall utilize clear and unequivocal plans for each individual´user´s course of treatment in order to clarify primary as well as secondary goals
    - The institutions should apply a system of records which fulfills the demands at the record keeping of public institutions and is suitable for documenting the actual treatment performance
    - The users should be accorded full acces to their own records and should be informed about this, as they should be openly informed about avenues of complaint
    - The institution should currently evaluate the quality of the individual services or the individual methods of treatment. The evaluation should

include effects and harms, ethical sustainability, attractiveness and demand

- The institution should be supplied with staff possessing a relevant professional basis education. Staff at all levels should have access to supervision and continuous education.

10. Addicts should, as a reference- and interest group, be involved in the production of administrative regulations.

11. The Council considers *control* to be one of the more problematic elements of substitution treatment. It is the impression of the council that the counties differ widely in their practices and that examples may still be found representing an unnecessary and not professionally substantiated heavy and sanction-oriented style of control. The control element should be toned down and subordinated to the total aim of treatment. Negative sanctions and punishment, including reduction of dosage, as a means against the drug dependence and undesirable conduct related thereto should not be applied and must be considered unethical...

12. The council finds the practices - reported from some counties - of demanding acceptance of *"methadone contracts"*, the violation of which may lead to expulsion from the program - unethical. Also, there is no basis for considering such contracts as binding.

13. The Council proposes that more flexibility is developed in relation to *choice of place of treatment*...also to make possible for certain users - in particular those in border-areas - to choose a county whose substitution treatment they prefer.

14. The Council finds it unacceptable that drug users are forced to reduce their level of substitution drug use, only because of their having to serve a prison sentence. In such situations, the user should have the *opportunity to continue the program of substitution treatment in prison according to the treatment plan* developed by the relevant county.

Annex III: Criteria for operational approval and accreditation of private institutions in Italy

In Italy there is an outline agreement between the state and the regions concerning the minimal standards required for the approval and accreditation of private institutions in the field of prevention, therapy and rehabilitation of drug dependent persons. The agreement is intended to serve as a framework for the regions. In particular the following criteria are included:

Operational approval

Approval and the regional register

- The approval of the facilities in the field of addiction care is precisely regulated. The approval is necessary for all statutory financing.

Structural requirements

- List of all rooms which must be available.

Functional requirements

- There must be a programme which describes the individual activities.
- The internal organisation must conform with the programme, respect the law and exclude any physical, psychological or moral coercion. The voluntary nature of the admission / utilisation of the service and residence must be guaranteed.
- The programme must define the basic principles and intervention methods (medical, psychological, educational, social), the phases, the modalities with respect to family contacts and the approach to personnel and the facility. The target clientele must be described as well as the evaluation and testing modalities.
- The (house) regulations must set out the rights and obligations of the clients as well as the rules for cohabitation for the in-patient and semi-in-patient services, in particularly with respect to the behaviour of carers and clients.
- An up-to-date register of the clients must be kept. Any possible absences (including the reason) must be recorded.
- The facilities must be covered for their activities (damage and risk-compensation insurance).

Personnel

- Facilities which are active in the field of addiction must have suitable personnel in sufficient numbers (see below).
- A responsible person must be determined for each facility. This person must have the necessary certificate and fulfil the professional requirements. A working time of 36 hours per week must be guaranteed. Unless there are se-

rious - and documented - reasons, this person may not be replaced within the first 12 months. A deputy with the same qualifications must be available.

- The person in charge must be supported by qualified persons. For each 10 clients there must be at least one full-time position.
- The personnel must be present during the entire activities.
- The personnel must be employed in accordance with the valid legislation, Former clients who have successfully completed a therapy at least one year previously can be employed as personnel.
- Up to 50% of the personnel can be gaining practical experience with a minimum working time of 18 hours per week. In addition, a maximum of 25% can be undergoing training. The precondition is that at least 50% of the training programme has been completed. The minimum working time is 18 hours per week.

Training and further education of personnel

- The ministry regulates the preconditions in terms of training and professional qualifications for the management and staff. The conditions for approval, the length and content of the courses of treatment are correspondingly defined.
- For the salaried employees permanent further education opportunities must be provided. These should be adapted to conform with their previous experience.

Monitoring and control

- Executive bodies must be determined to monitor the operation. As a rule it is not the same bodies which are responsible for clinical control at patient level.
- Controls are made periodically when there are planned changes in the situation, when extremely serious situations occur, and without previous announcement.
- The findings of the control must be communicated to the institution / provider. These will state what changes need to be made.
- If the preconditions are not fulfilled then this can lead to the facility being closed or suspended. A resumption of the work requires a new approval. It is possible to appeal against a suspension in accordance with the laws.

Accreditation of facilities, corporate bodies and organisations

Criteria for accreditation

- The regions define the criteria and the quality standards for the accreditation of the facilities. They regulate the issuing of approvals, determine the control body, the criteria for the suitability of a facility, the modalities for the controls and the evaluation methods and criteria.

Criteria for multidisciplinary, integrated establishments

- The maximum waiting time should be defined.
- It is forbidden to limit admission. Every form of legally allowed care must be offered.

Personnel requirements

- The suitability of the personnel is shown through:
  a) studies / academic degree or membership/ registration in the professional register
  b) minimum of 1 year of experience in a recognised establishment
- For those responsible for the programme: with b) minimum of 2 years of experience, one of which must have been paid work.
- There must be sufficient personnel available. The attendance must be documented. For each intervention the number of personnel, the various competencies and possible aid must be defined. The personnel must be given contracts and the work must be paid.

Intervention programme

- In order to receive approval general and detail programmes must be presented. The activities must be listed in detail (number of personnel, working hours, infrastructure).
- The programme must provide for an evaluation phase.
- An inspection must be conducted annually (under the control of a professional inspector).

Planning the interventions

- The programme of the public as well as private establishments must correspond to the identified needs in the area concerned. The establishments participate in the elaboration of the respective regional programmes.

National advisory commission

- Nationally an advisory / supervisory commission has been set up (a total of 11 persons from politics, administration and practice).

Data collection

- Each year the facilities in the region must provide a progress report documented with figures. This is based on system recognised by the Health Ministry.

Annex IV:Recommended average standards for health insurance and service renders in Poland

In Poland a Commission composed of representatives of the Institute of Psychiatry and Neurology, health insurance companies and professional associations agreed upon average standards for different types of medical services in psychiatry. The standards were recommended and published by the Ministry of Health and Social Welfare in 1999.

In-patient unit for treatment of withdrawal syndromes

- Size - 10 beds
- Duration of treatment - 15 days
- Procedures to by applied according to ICD 9 - 94.0, 94.1, 89.0, 98.09, 94.62, 93.82, 99.99
- Initial diagnostic check up - 3-4 hours
- Daily contact with a doctor - 0.5 hour
- Daily contact with a psychologist or therapist - 2.5 hours
- Daily contact with a social worker - 0.5 hour
- Staff: one full time doctor with relevant specialisation, 0.5 psychologist, 0.5 therapist, 7 nurses, 0.5 social worker, 7 full time attendants, 0.5 medical secretary.

In-patient drug treatment ward

- Size - 25 beds (3.5 beds per 100'000 inhabitants)
- Duration of treatment programmes - up to 2 years, 7-12 months, 3-6 months
- Procedures to by applied according to ICD 9 - 94.3, 94.4, 94.64, 94,67, 93.8, 99.99, 94.2.
- Initial diagnostic check up - 3-5 hours
- Individual psychotherapy - 300 hours
- Group therapy and rehabilitation - 180 hours
- Nursing - 30 hours
- Individual rehabilitation - 180 hours
- Staff: one full time head doctor with relevant specialisation, 0.5 psychiatrist, 1 psychologist with relevant specialisation, 9 therapists, 1 nurse, 0.5 social worker.

Out-patient drug treatment clinic

- Number of clinics - not less than 3 per region (approx. 50 country-wide)
- Procedures to by applied according to ICD 9 - 94.1, 94.0, 94.65, 94.69, 94.3, 94.4, 93.8, 99.99
- Initial diagnostic check up - 2.5-3.5 hours
- Duration of one visit at psychiatrist - 20 minutes
- Duration of one visit at psychologist - 30 minutes
- Individual therapy - 60 minutes
- Rehabilitation - 45 minutes
- Support therapy - 45 minutes
- Crisis intervention - 60-90 minutes
- Family therapy - 60 minutes
- Interviewing and welfare interventions - 60 minutes
- Out-patient detoxification - 2-3 hours
- Staff of one out-patient clinic with 300 patients annually: 0.5 psychiatrist, 1 psychologist with relevant specialisation, 1 therapist, 1 nurse, 0.5 social worker.

Methadone maintenance programmes

- Optimal size: 50 patients (it is planned to include up to 15% of the drug dependent patients)
- Procedures to by applied according to ICD 9 - 94.2, 94.4, 94.3, 94.1, 94.0.
- Initial diagnostic check up - 4-8 hours
- Daily services (methadone distribution, abstinence control, medical consultations) - 60 minutes
- Psychotherapy - 6 - 12 hours
- Staff: full time head doctor, if a head doctor is not psychiatrist additionally 0.5 psychiatrist, 0.5 psychologist with relevant specialisation, 0.5 therapist, 2 nurses, 1 social worker, 2 attendants.

Annex V: Quality Criteria of the Quality Management System QuaTheDA (Switzerland)

QuaTheDA is a framework for quality management in substance abuse treatment and care for in-patient facilities that is currently being developed in Switzerland (for details see Ch. 2.10.1.). QuaTheDA contains on the one hand general specifications for a quality system that takes into consideration the main managerial themes. On the other hand the special concerns of the field of addiction are also integrated. The reference system is divided into the areas Services, Resources and Management. For each field quality criteria are defined as well as, to a certain extent, indicators and standards: (Overview):

Services

- *Rights and dignity of the clients:* Communication with the clients; respect for the rights, dignity and integrity of the clients; respect for the clients' property
- *Comprehensive care and treatment concept:* Interdisciplinary principles; therapeutic concept
- *Security concept*
- *Hygiene and refuge management concept*
- *Service processes:* Take up/admission / treatment plan and aims; therapy; recreational activities; discharge
- *Organisation of the service provider*
- *Client dossiers and comprehensibility*
- *Improvement of the services and organisation:* Concept for continual improvement; feedback from the clients; suggestions for improvement; target values, control points and indicators

Resources

- *Internal and external professionals:* Personnel concept; personnel qualifications; allocation of personnel; further education and evaluation; temporary personnel, voluntary work, co-operation with external professionals
- *Financial means*
- *Information distribution*
- *Infrastructure*
- *Material and measurement instruments*

- *Working environment*
- *Acquisition and storage:* Supplier evaluation and goods delivery check; food; nursing material; medicine; anaesthetics
- *Improvement of resources (efficiency)*

Management

- *Responsibility of the top-level management board:* Remit, strategy and vision; participation in the network; public relations work and marketing; relationship between the funding providers and the facility
- *Responsibility of the management:* Operational policy; management commitment; requirements, needs and expectations of the customers; legal requirements; organisation of the facility; changing management; Documentation and archiving
- *Responsibility of the management and specialists:* operational aims; management review; satisfaction surveys of the clients, customers and personnel; internal audits; treatment of deviations, prevention and correctional measures
- *Improvement of the quality system (effectiveness)*

The QuaTheDA quality criteria can be viewed on the following website: http://www.infoset.ch/inst/bag/quatheda/. In addition, the entire QuaTheDA reference system can be ordered from the following address:

QuaTheDA - Referenzsystem
Bundesamt für Gesundheit
Sektion Drogen
Postfach
3003 Bern

Annex VI: Required profession-specific expertise and capabilities according to the ADAT country reports

The following capabilities are not part of the ADAT guidelines, but a summary of individual aspects mentioned within the framework of the ADAT country reports:

Social workers

- Counselling work with individual clients and groups
- Case management, carer conference
- Systemic thinking in social work
- Principles of guardianship and criminal law
- Specialist aids for addiction work
- Training in communication, body language, interviewing in practice and theory
- Client-treatment matching
- Network facilitation (co-operation with other parts of the social service system, groups of relatives, voluntary organisations, ex-abusers and other actors)
- Creation of sustainable contact with the client; identification of the client's resources and problems; definition of treatment goals; development of a treatment plan; follow-up of the treatment plan.

Psychologists and Psychotherapists

- Diagnosis, prognosis and treatment of drug dependence
- Theory and treatment models
- Therapeutic techniques used in therapeutic communities

Therapists who are going to work with drug abusers and their families need a specific education, after or in parallel with the general *training in family therapy*. For further information see:

- J. Haley (1980). Leaving Home: The Therapy of Disturbed Young Peaople. New York: McGraw-Hill.
- M.D.Stanton, T.C.Todd (eds) (1982). The family therapy of drug abuse and addiction. New York: Guilford Press.

- S.Cirillo, R.Berrini, G.Cambiaso, R.Mazza (1996). La famiglia del tossicodipendente. Milano: Cortina Editore.

For specific *training in group and network therapy* see:

- M.Galanter, R.Castaneda, H.Franco (1998). Group Therapy, Self-Help Groups and Network Therapy. in: R.J.Frances, S.I.Miller (Eds). Clinical Text-Book of Addictive Disorders. New York: Guilford Press.

Physicians/ psychiatrists:

Knowledge of drug related problems and addiction diseases must form part of the physician's basic training. Physicians who are actively involved in prevention, diagnosis and treatment must specifically acquire these skills and undergo periodic refresher training (The Royal Dutch Medical Association 1999). Newly founded national Associations of Addiction Medicine perform an important function in identifying the necessary expertise. The following aspects are mentioned:

- Correct practice in prescribing psychoactive pharmaceuticals
- Diagnosis, prognosis and treatment of drug dependence
- Theory and treatment models

Care professions (nurses and psychiatric nurses)

Carers in addiction care institutions:

- Care treatment in the setting of an addiction institution taking into consideration interdisciplinary aspects
- Women-specific aspects, care of pregnant drug consumers
- Brief counselling of addicted people
- Professional identity in the setting of an addiction care facility

Carers in emergency clinics and domestic care:

- Basic knowledge about addiction, and aspects specific to women and phases of life
- Dealing with patients with known and/or hidden addiction problems; exercises in discussing alcohol and other drug problems, counselling competence
- Inclusion of doctors and the regional addiction care institutions
- Specific care competencies
- Addiction behaviour at work (affected employees)

Annex VII: Checklist for determining individual needs for further education[91]

Knowledge:

a) professional knowledge

b) practical application

Independence and efficiency in working:

a) initiatives concerning the progress of one's work

b) goal-directed division of one's own work

Social skills concerning:

a) colleagues

b) employees in other departments

c) clients

d) management

Communication skills:

a) spoken

b) written

Quality:

a) of the produced work

b) contribution to opinions and results of work consultations, working groups, committees, etc.

c) input of new ideas

Quantity:

a) amount of work produced

b) regularity of this amount of work

Other points of attention to be indicated by employee or head of the unit; general questions to be answered if necessary:

A. Are there less interesting parts of the work?

B. Is it possible to make improvements?

[91] The checklist is based on the corresponding documents provided by the Netherlands (”Evaluation of Forms of Functioning”). They are also used for the assessment of job satisfaction.

C. Possible development within the department (enrichment or enlargement of tasks)?

D. Possibility to prove oneself by replacing another or special tasks?

E. Which other tasks are interesting?

F. More knowledge and experience exist than are used in current work?

For employees who give guidance to other employees there are some more issues:

Division of the work:

a) efficiency in performing the collective tasks

b) delegate and expect reports

Accompanying and coaching:

a) mediate in conflicts

b) coaching of workers

c) confidentiality

Stimulate:

a) to achieve good performances (getting the attention of employees, getting them to improve)

b) to improve team spirit

c) sphere

Insight:

a) into the procedures in the department

b) into the management (effective use of communication lines)

Decision-making:

a) decision skills

b) informing employees about decisions taken

c) employees participate in making decisions

Being linking person:

a) translate policy to the group

b) pass signals on to the management/leadership.