European Monitoring Centre
for Drugs and Drug Addiction

EMCDDA
MANUALS

European drug prevention quality standards

A manual for prevention professionals

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A list of the organisations participating in the structured consultations is available as an online supplement to this manual at
http://www.emcdda.europa.eu/publications/manuals/prevention-standards/annex

Preface

Prevention is one of the first approaches to be mentioned when public debate and policy address drug use and drug-related problems. Regularly, measures of prevention are presented as a means to overcome existing or future problems. However, evidence of 'what works' in practice is often overlooked. Similarly, research has shown examples where preventive efforts produced no or detrimental effects.

This publication will help steer efforts in the right direction. Using an empirically derived reference framework, it bridges the gaps between science, policy and practice. Based on an overview of existing standards in Europe and beyond, a number of highly respected experts from EU Member States and international organisations worked together to prepare the publication. More than 400 national experts and stakeholders were included in a Delphi panel study and in a number of focus groups, which produced in-depth discussions as well as a consensus on the most important recommendations. The European Commission provided the funding for the original project on prevention standards and its results are now published within the EMCDDA Manuals series.

In this series, information, advice, and guidance are offered to professionals and practitioners. Well structured and with many useful tables and figures, this publication will help its users as they progress from a first needs assessment to the delivery of an intervention and its final evaluation. Correct implementation of prevention measures with evidence-based components and anchoring them within existing structures and services (or activities) is key to ensuring effectiveness and it helps to avoid unintended iatrogenic effects. This manual will provide valuable guidance in this respect and allow preventive interventions to reach their full potential.

Wolfgang Götz
Director, EMCDDA

Preface by the Prevention Standards Partnership

This publication is the result of a two-year project to publish European standards in drug prevention, co-funded by the European Commission (EC) (60 %) and the respective project partner organisations (40 %). The standards were developed by the Prevention Standards Partnership, a multi-disciplinary and multi-sectoral collaboration of seven organisations across Europe, led by Dr Harry Sumnall and Angelina Brotherhood of the Centre for Public Health at Liverpool John Moores University (LJMU), UK, who are also the authors of this publication.

European Union (EU) policy, such as the EU drugs action plans for 2005–08 and 2009–12, has expressed an intention to develop and implement best practice in drug prevention, but so far has not been able to provide a reference framework on how to do this. Guidance on drug prevention interventions is available in some Member States of the EU, but it varies in terms of its content, methodological rigour, and its applicability to the wider European context. In response to this situation, this project aimed to provide a commonly agreed reference framework that could help improve the state of drug prevention in the EU.

Initially, available European and international drug prevention guidance was collated and reviewed. Quality standards matching specific selection criteria were synthesised through qualitative content analysis to form the first draft of the European drug prevention quality standards. In the next stage, the relevance, usefulness, and feasibility of these draft standards was assessed through structured consultations in six EU countries. Delegates provided specific feedback on the content of the standards but also outlined a number of challenges that would be faced during their implementation. Based on this feedback, the draft standards were modified several times. The final version of the standards incorporates input from all consultations, suggestions received at conference presentations, informal and formal discussions with prevention experts, and conclusions drawn at Partnership meetings.

As a result, it was possible to define basic as well as expert standards for drug prevention in the EU. The standards will be of interest to all professionals who directly or indirectly contribute to drug prevention. The European drug prevention quality standards outline the necessary steps to be taken when planning, conducting, or evaluating drug prevention programmes. Moreover, the standards can be used to inform the development of prevention strategies, to assess and develop organisations providing prevention services, or as a reference framework in professional development. The

standards are a tool for self-education and self-reflection with the aim of improving drug prevention efforts.

A project cycle with eight project stages forms the basis of the standards, covering: needs assessment; resource assessment; programme formulation; intervention design; management and mobilisation of resources; delivery and monitoring; final evaluations; and dissemination and improvement. Additionally, four standards are of relevance to each project stage, namely: sustainability and funding; communication and stakeholder involvement; staff development; and ethical drug prevention. Each project stage is divided into several components which outline what actions to take. Attributes constitute the third level of detail, demonstrating how each component can be achieved.

The standards themselves are supplemented with a detailed introduction explaining how they can be used in practice. Moreover, considerations regarding the real-life implementation of the standards are provided for each standard component, as well as in relation to the project partner countries (online supplement). The Appendix includes additional guidance to aid implementation and an extensive glossary. A self-reflection checklist is available as an online supplement to this manual.

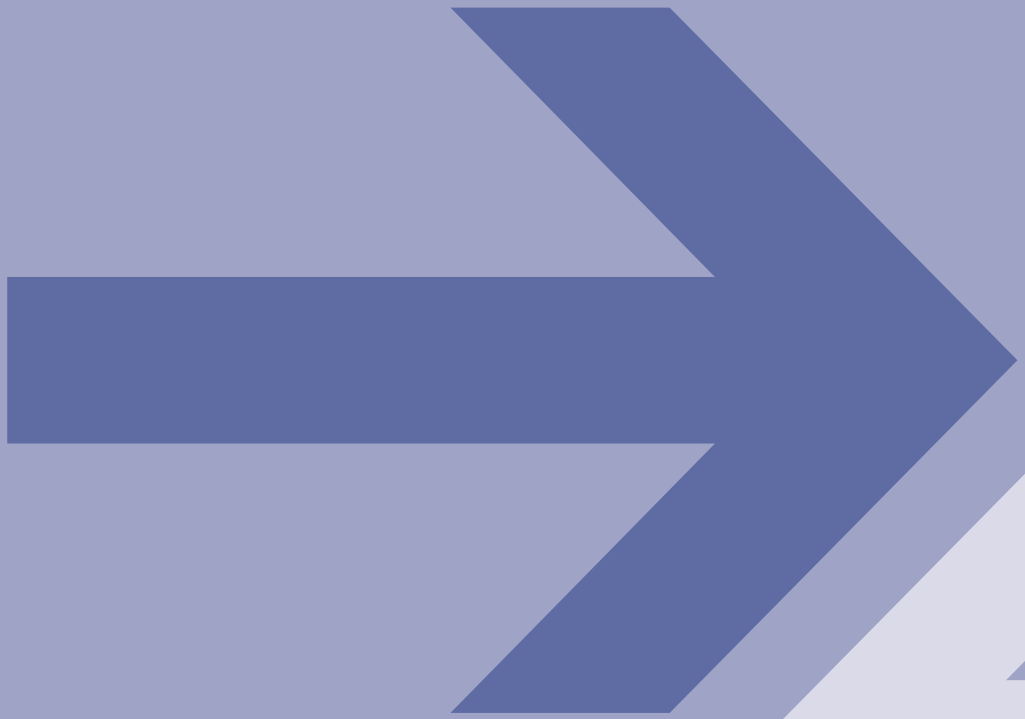
It is anticipated that if further funding is obtained the Partnership will develop activities that will embed the standards in a robust framework which will include further supporting materials, training and education for a wide range of drug professionals, and accreditation of model programmes. These activities will ensure that the standards do not remain 'on paper', but make a real difference to drug prevention practice in the EU. As the standards are applied and tested in practice, it is hoped that new, revised versions with additional possibilities for use can be released in the future.

Publication of the standards as part of the EMCDDA Manuals series is an important first step in disseminating the standards. The EMCDDA has contributed greatly to the advancement of drug prevention in Europe. Its publications and tools, such as the *Prevention and Evaluation Resource Kit* (PERK), the guidelines for the evaluation of drug prevention and the Exchange on Drug Demand Reduction Action (EDDRA) database, have increased awareness of the need for quality in prevention. It is hoped that these standards will provide a further milestone in this progress. The Prevention Standards Partnership therefore wishes to express its gratitude to Marica Ferri, Rosemary de Sousa, Roland Simon and Marie-Christine Ashby at the EMCDDA for enabling publication of the standards. In particular, the Partnership would like to acknowledge Gregor Burkhart for initiating this project and providing strong support throughout its realisation, and for drafting the sections on current approaches to drug prevention and the current drug situation in Europe.

The Prevention Standards Partnership extends its thanks to the Reitox focal points and EDDRA Managers, to Katri Tala and Giovanna Campello at the United Nations Office on Drugs and Crime (UNODC), and Asma Fakhri at the Canadian Centre for Substance Abuse (CCSA) for their assistance in locating and discussing relevant guidance.

Most importantly, the Partnership would like to thank all professionals who provided important feedback on earlier drafts via email, through completion of the online survey, attendance at focus groups, or during conferences.

The Prevention Standards Partnership encourages users of the standards to send details of how they used the standards in practice as well as suggestions for future improvement. Enquiries about the European drug prevention quality standards can be directed to any member of the Partnership (see authors and contributors on the Acknowledgements page). The project website http://www.cph.org.uk/drugprevention/ contains contact details of the lead authors as well as additional information on the standards.



PART **ONE**

Introduction

CHAPTER
ONE

Chapter 1
Current approaches to drug prevention in Europe

The common view of drug prevention, particularly in lay audiences, is that it consists of informing (generally warning) young people about the effects (most commonly the dangers) of drug use. Prevention is then often equated with (mass media) campaigns. However, there is currently no evidence to suggest that the sole provision of information on drug effects has an impact on drug use behaviour, or that mass media campaigns are cost-effective.

In reality, the challenge of prevention lies in helping young people to adjust their behaviour, capacities, and wellbeing in fields of multiple influences such as social norms, interaction with peers, living conditions, and their own personality traits. This view is also reflected in current prevention approaches. To provide a simplified overview, environmental prevention strategies target social norms, universal prevention targets skills development and interaction with peers and social life, selective prevention focuses on living and social conditions, and indicated prevention facilitates dealing and coping with individual personality traits and psychopathology.

This classification of prevention strategies (Mrazek and Haggerty, 1994), which is based on the overall vulnerability of the people addressed, has superseded the previously used medical paradigm of primary, secondary, and tertiary prevention. While this earlier classification is useful to describe the development of pathologies, the medical paradigm is regarded as less suitable to describe complex human behaviour, particularly that which is not dysfunctional or pathological. Only a relatively small proportion of individuals that experiment with drugs such as cannabis and cocaine progress to more frequent use patterns (see also online supplement on *The current drug situation in Europe)*.

Universal, selective, and indicated prevention are consequently distinguished through the assessment of vulnerability (and risk). In universal prevention, all members of the population share the same general risk for drug use, although the risk may vary greatly between individuals. In selective prevention, social and demographic indicators are used that roughly indicate higher levels of vulnerability. This allows targeting particular groups, such as marginalised ethnic minorities, youth in deprived neighbourhoods, young (drug law) offenders, vulnerable families, or certain settings, like nightlife environments. While these indicators are useful to identify groups where drug use is more likely to occur, it is not possible to draw conclusions on the vulnerability of any individual in these groups. In indicated prevention, however, a vulnerable individual might have received screening and

assessment and been diagnosed by a professional to have a condition which increases the risk of drug use (attention deficit disorder, conduct disorder, etc.).

Universal prevention — intervening on *populations*

Universal prevention strategies address an entire population (e.g. local community, pupils, neighbourhood). The aim of universal prevention is to deter or to delay the onset of drug use by providing all necessary information and skills. Universal prevention programmes are delivered to large groups without any prior screening for their risk of drug use and assume that all members of the population are at equal risk of initiating use.

School-based universal prevention is reported to take place in all European countries, although with varying content and levels of coverage. The overall effectiveness of school-based (universal) prevention has been repeatedly questioned in the past (Coggans, 2006; Gorman et al., 2007). Recent literature reviews show, however, that certain *components* of school-based prevention, such as the focus on normative beliefs and life skills, seem to be effective ([1]), and European research is beginning to emerge demonstrating that school-based programmes can be effective in reducing some types of drug use (Faggiano et al., 2010; Lammers et al., 2011). However, monitoring information on the contents of school-based prevention in several countries indicates that non-evidence-based activities (e.g. stand-alone information provision about drugs, drug information days, external 'expert' visits, theatre workshops) appear to be the most common. While some evidence-based activities (e.g. social and personal skills training) are widespread, intervention types that are more strongly supported by evidence (e.g. structured intervention protocols ('programmes'), carefully delivered peer approaches, interventions specifically for boys) are reported only in a few countries. Such evidence-based interventions aim to improve communication skills, increase abilities in handling conflicts, stress, and frustration, or correct normative misperceptions about drug use. This so-called normative education is very underdeveloped despite the positive available evidence.

Family-based prevention is another widely utilised approach in universal prevention. In 2007, 11 European countries reported full or extensive provision of family meetings and evenings to the EMCDDA. However, similar to school-based prevention, current family-based prevention seems to focus mainly on providing information. Intensive coaching and training for families, although showing

([1]) See the EMCDDA's Best practice portal at: http://www.emcdda.europa.eu/best-practice and the *Additional guidance* section in the Appendix and online supplement.

consistent efficacy across studies (Petrie et al., 2007), is offered on a limited basis, with only seven countries reporting the highest provision levels.

Selective prevention — intervening with (vulnerable) *groups*

Selective prevention serves specific subpopulations whose risk of a disorder is significantly higher than average, either imminently or over a lifetime. Often, this higher vulnerability to drug use stems from social exclusion (e.g. young offenders, school drop-outs, pupils who are failing academically). The main advantage of focusing on vulnerable populations is that they are already identified in many places and contexts. However, risk conditions of young vulnerable groups, such as young offenders, homeless, truant, disadvantaged, and minority youth, are rarely addressed despite increasing political importance.

Since 2004, an increasing number of drug policies have indicated these populations as primary targets for prevention, but the reported level of intervention provision has not increased during this period. Only a few countries report interventions addressing social disadvantage (e.g. unemployment), helping with criminal justice problems, or assisting marginalised families from ethnic minorities and families coping with mental health needs. While 13 countries report that most of their family-based prevention is selective, only seven report full or extensive provision of interventions targeting drug use in families. This is despite the proven effectiveness of interventions for vulnerable families in different studies (Petrie et al., 2007). Because of the difficulty of implementing experimental evaluation designs, evidence of the effectiveness of other types of selective prevention carried out in Europe is limited.

Available data from Member States indicates the level of provision — how much is done for a given (vulnerable) target population — but information about *what* is actually the content of preventive work with these target populations is currently missing because comparable monitoring systems are not yet in place. This is of great concern because the effectiveness of prevention differs greatly depending on whether evidence-based activities — targeting motivation, skills, and decision-making in this case — are implemented, or whether there is, for example, simply a distribution of information leaflets (Sussman et al., 2004).

Indicated prevention — intervening with (vulnerable) *individuals*

Indicated prevention aims to identify and target individuals who are showing indicators that are highly correlated with an individual risk of developing drug use later in their life (such as psychiatric

disorder, school failure, 'antisocial' behaviour) or who are showing early signs of problematic drug use (but not clinical criteria for dependence). The aim of indicated prevention efforts is not necessarily to prevent the initiation of drug use but to prevent the (fast) development of dependence, to diminish frequency of use, or to prevent progression to more harmful patterns of drug use (e.g. injecting).

Identifiers for increased individual risk can be falling school grades or alienation from parents, school, and positive peer groups. Children with behavioural disorders, such as coexisting attention-deficit/hyperactivity disorder and conduct disorder, are also at high risk of developing drug use problems later on. Intervening with these children requires close cross-sector cooperation at community level between medical, social and youth services, from childhood on. This is rarely achieved besides isolated examples in Germany and Ireland, where counselling for parents and carers, concurrent medical, psychotherapeutic and psychosocial support, and educational support in the kindergarten or school are combined. Overall, interventions in this field are limited, with six countries reporting interventions for children with attention-deficit/hyperactivity disorder or disruptive behaviour, and 10 countries reporting early intervention and counselling to individuals who have started using drugs.

Nevertheless, indicated prevention programmes — despite few in numbers — tend to be better designed and evaluated than universal or selective approaches, and they often show high levels of effectiveness (EMCDDA, 2009). For instance, an intervention study conducted in the Netherlands with young people (aged 8–13) exhibiting disruptive behaviours showed significantly better follow-up outcomes on smoking and cannabis use compared to treatment as usual (Zonnevylle-Bender et al., 2007). Indicated prevention can also consist of specific parent training in contingency management of children with disruptive behaviour disorders. For example, the 'Komet för föräldrar' method, applied in nearly 30 % of Sweden's municipalities, targets parents of children showing externalising behaviour problems combined with difficulties in establishing positive peer relations. A randomised controlled trial involving 159 families showed significantly improved competences in parenting among participating parents and reduced behavioural problems among their children (Kling et al., 2010).

Both selective and indicated prevention may moderate the effect of an early developmental disadvantage, its translation into social marginalisation and subsequent progression to drug use. Several research studies have shown that interventions delivered during the early school years, aimed to improve educational environments and reduce social exclusion, also have a moderating effect on later drug use (Toumbourou et al., 2007), despite not being drug-specific.

Environmental prevention strategies — intervening on *societies (and systems)*

Environmental strategies are aimed at altering the immediate cultural, social, physical, and economic environments in which people make their choices about drug use. This perspective takes into account that individuals do not become involved with drugs solely on the basis of personal characteristics. Rather, they are influenced by a complex set of factors in the environment, such as: what is expected or accepted in the communities in which they live; national rules or regulations and taxes; the publicity messages to which they are exposed; and the availability of alcohol, tobacco, and illegal drugs.

Therefore, environmental strategies often include unpopular but effective components, such as taxation, publicity bans, age controls, and tobacco bans. In the school setting, environmental strategies are delivered through school policies which may include regulations on tobacco and alcohol use for both pupils, staff, and adult visitors. Almost all Member States report total smoking bans in all schools, and a majority of countries report full or extensive provision of drug policies in schools. By aiming to create protective and normative social environments, such interventions can influence young people's choices about drug use (Toumbourou et al., 2007). They may also be complemented by non-coercive measures, such as improving the design of school buildings and school life.

Despite targeting predominantly legal drugs at current, environmental strategies are important for the whole drug prevention field because early, widespread, and accepted alcohol and tobacco use is related to illegal drug use in many countries.

CHAPTER TWO

Chapter 2

Using the quality standards

What are the European drug prevention quality standards?

Quality standards are generally accepted principles or sets of rules for the best/most appropriate way to implement an intervention. Frequently they refer to structural (formal) aspects of quality assurance, such as environment and staff composition. However, they may also refer to process aspects such as adequacy of content, process of the intervention or evaluation processes.

(EMCDDA online glossary: 'Quality standards') ([2])

Quality standard: A benchmark that helps judge whether an activity, a provider, etc. represents high quality. Quality standards are typically based upon professional consensus. Their main focus is on structural and procedural aspects of quality assurance, e.g. evaluation, staff composition and competencies, participant safety, etc.

(Glossary for use with the European drug prevention quality standards, see Appendix)

The European drug prevention quality standards provide the first European framework on how to conduct high quality drug prevention. They reflect an internally consistent and long-term view on prevention, supporting the importance of integrated approaches to working with young people, and valuing and rewarding the contributions of professionals in the field. The standards outline the necessary steps in planning, implementing, and evaluating drug prevention activities. They help users of the manual to understand how people, interventions, organisations, and (governmental) strategies contribute to drug prevention. They encourage users to think about how existing efforts can be improved in order to obtain (even) better and sustainable results.

Drug prevention work in line with the standards is likely to be: relevant (focussed on fulfilling the needs of participants, while making reference to relevant policy); ethical (incorporating the principles specified in D: *Ethical drug prevention,* such as ensuring voluntary participation and providing real benefits for participants, as much as is possible given the practical circumstances of the programme);

([2]) See http://www.emcdda.europa.eu/publications/glossary

evidence-based (making use of the best available scientific evidence); effective (achieving set goals and objectives without causing harm); and feasible (achievable within available resources, and marked by a logical and coherent approach).

The standards represent a summary of the evidence on *how* to conduct drug prevention. They are in accordance with other major documents in the field, such as the *Prevention and Evaluation Resources Kit* (PERK) (EMCDDA, 2010) and the *Declaration on the Guiding Principles of Drug Demand Reduction*, adopted by the United Nations General Assembly at its Special Session on Drugs in 1998 (United Nations General Assembly, 1998).

What definition of drug prevention is used?

In the standards, drug prevention is understood as any activity that is (at least partially) aimed at preventing, delaying or reducing drug use, and/or its negative consequences in the general population or subpopulations. This includes: preventing or delaying the initiation of drug use, promoting cessation of use, reducing the frequency and/or quantity of use, preventing the progression to hazardous or harmful use patterns, and/or preventing or reducing negative consequences of use. Consequently, the aims of drug prevention activities covered by the standards are in line with those listed in the EU drugs strategy 2005–12 ('preventing people from starting to use drugs; preventing experimental use becoming regular use; early intervention for risky consumption patterns', European Council, 2004, p. 10), but may also focus on harm reduction. **To be classed as drug prevention activities in the context of these standards, activities must make explicit reference to one or more of the aims outlined above in their project documentation.**

Drug prevention activities targeted by these standards may focus on any psychoactive substance, i.e. a substance that, if taken in sufficient dose, can alter mental and physiological processes. This includes legal drugs, such as alcohol or tobacco, illegal drugs (i.e. those whose production, sale, or use is forbidden or limited under international and national drug control laws and treaties), volatile substances (gases, fumes from glues, aerosols, and similar products), over-the-counter and prescription medicines, and new psychoactive drugs that are uncontrolled in law (e.g. 'legal highs'). It is acceptable that drug prevention programmes or strategies focus on certain drugs as long as they specify the drugs in question; equally, drug prevention programmes or strategies may choose not to target specific drugs but drug use in general. Some activities may address drug use directly, while other activities may promote health in general and encourage people to make healthy choices, thereby indirectly preventing or reducing drug use.

The standards are consequently applicable to a wide range of drug prevention activities (e.g. drug education, structured programmes, outreach work, brief interventions), settings (e.g. school, community, family, recreational settings, criminal justice), and target populations (e.g. school pupils, young offenders, families, ethnic groups), regardless of the duration of the programme (i.e. from one-off to long-term activities). In line with the categorisation used by the U.S. Institute of Medicine, this includes universal prevention (addressing the entire population regardless of risk factors), selective prevention (addressing specific subpopulations with an above-average risk of drug use), and indicated prevention (addressing individuals who have an increased individual risk or are showing early signs of problematic drug use) (Mrazek and Haggerty, 1994; Springer and Phillips, 2007). Additionally, most standards are also relevant to environmental interventions that aim to change behaviours by targeting the environment in which people live and consume drugs (e.g. social norms, built environment, taxation).

Identifying the best means of supporting young people, particularly young drug users, and providing help through difficult times in their lives is one of the main objectives of contemporary drug prevention. Generally speaking, herein drug prevention interventions are those that promote health; help people make healthy and informed choices; reduce vulnerabilities and risk behaviours; and/or increase inclusion and social/health equity. The standards may consequently provide useful guidance for the wider prevention and health promotion field, for example in relation to youth work (e.g. violence prevention), other health behaviours (e.g. eating disorders), or addictive behaviours (e.g. gambling).

How can the standards be used, and what is their intended purpose?

In comparison with other areas of drug demand reduction work, the status of prevention and the extent to which it has been integrated into national drugs policies, as well as the resources historically spent on professional development in this area, vary greatly between EU Member States. The European drug prevention quality standards recognise these differences and can therefore be used in a variety of ways that support different types of working. It is not the aim of these standards to standardise prevention practice across Europe, but rather to achieve a similar level of high quality across Europe while acknowledging diversity of practice.

The European drug prevention quality standards can be used for a range of purposes; however, professionals will benefit the most from the standards if using them as described in this section.

Table 1 shows what purposes this version of the standards should be used for, and what uses might be less appropriate. This information is based on consultations undertaken with drug prevention professionals across the EU.

Table 1: Proposed use of version 1 of the European drug prevention quality standards

Purpose	Recommended	
Information, education and guidance	✓	
Developing or updating quality criteria	✓	
Self-reflection	✓	
Discussion in group settings	✓	
Performance appraisals	✓	
Formal self-assessment	Not yet	Further work is planned to make the standards suitable for these purposes
Funding decisions	Not yet	
External accreditation	Not yet	
Substitute for outcome evaluation	No, although the standards provide guidance on how to conduct evaluation	

- **For information, education and guidance:** By defining basic and expert levels of quality, the standards clarify what drug prevention professionals should be aiming towards. All professionals contributing to drug prevention can use the standards to improve their knowledge and understanding of good and best practice in drug prevention. The standards can also be used to promote better planning in prevention policy and strategy, and to promote drug prevention as a science on equal grounding to, for example, drug treatment. They may also serve as a reference framework in the training of prevention professionals. In more practical terms, the standards can be used as a checklist to ensure that all aspects of high quality prevention work have been considered, for example when applying for funding.

- **Developing or updating quality criteria:** The standards are not prescriptive, but they provide a benchmark for the high standards of practice that target populations deserve and which can be achieved by all types of organisations. The standards can be used to develop own quality criteria

and best practice guidance, or to review and update existing criteria or guidance, in line with local, regional, and/or national circumstances. Funders may, for example, use the standards as a basis for constructing their own criteria for awarding funding or to specify criteria of what should be described in funding applications.

- **For self-reflection:** A top-down approach whereby standards are imposed from 'above' does not provide as strong an incentive for real development as when professionals themselves are convinced of their benefits. All professionals contributing to drug prevention (from government representatives to practitioners) are therefore encouraged to use the standards to reflect upon their own work and working practices, e.g. their development as practitioners, specialists or researchers, the structure of their prevention programme, their organisation, and/or their prevention strategy. The standards help professionals to understand their current position, gain confidence where standards are already met, and identify areas for improvement. If current practice does not adhere to the standards, professionals must not discontinue their work but use the standards to improve existing efforts. The standards can then serve as a tool to support a long-term process of development ([3]).

- **For discussion in group settings:** The standards can help initiate discussion and reflection in group settings (e.g. during team meetings, during funding negotiations). Self-reflection as described above can also be carried out in a group setting. For example, one staff member could be appointed to read the standards in full and to conduct a draft reflection on the programme or organisation using the 'self-reflection checklist' (see online supplement). This could then be used in the group setting to gain consensus and more information on the position of the programme or organisation. In this way, the standards can inform organisational planning processes, and they can help establish a common understanding of what high quality drug prevention is, particularly in teams with a variety of professional backgrounds.

- **For performance appraisals:** The standards might also be used as a reference framework in professional development and performance reviews, for example to identify staff training needs and potential for future development.

These are the recommended uses for this version of the standards. It is intended to expand this list in the future by developing the standards further and trialling them in practice. Tables 2 and

([3]) A 'self-reflection checklist' is available as an online supplement to this manual that professionals can use to document their reflections on their own prevention practice in relation to the standards.

3 provide example scenarios of how the standards *could* be used. The scenarios highlight that the standards could improve prevention practice and inform decision making in a wide variety of situations.

However, this version of standards may not be suitable for some purposes, including those described below.

The current set of standards should not be used directly to make funding decisions. Such decisions must take into account, for example, the applicability of the standards to local circumstances and the opportunity costs of choosing one programme over another. The current document does not provide guidance on how to make such complex decisions, and therefore using the standards for this purpose is discouraged. Funders may, however, use the standards as a basis for constructing their own criteria to award funding.

Some standards contain examples of how achievement could be evidenced in tangible terms. Sources of evidence may include written evidence, for example in the project plan or the description of the organisation, direct observations of work procedures or programme implementation, or interviews with staff, participants, and/or other stakeholders. However, evidence indicators are not provided for all standards because of the standards' general nature. Moreover, the primary aim of the standards is to stimulate reflection and to improve prevention practice. It should therefore not be expected of organisations to demonstrate in writing how they have met the standards in order to receive funding. For smaller funding applications in particular, the resources required to evidence the standards may not be proportionate to the requested amount of funding.

For the same reasons, the current set of standards cannot be used to conduct formal self-assessment or as a basis for external accreditation. The main benefit of the standards lies in motivating professionals to reflect on their work and to align their practice with the standards. This is better achieved by asking professionals to engage with the document rather than focussing on quantitative assessment of achievement. However, future versions will include the necessary guidance to conduct formal assessments using the standards.

It must also be highlighted that conducting self-reflection with the standards cannot replace process and/or outcome evaluations. Adherence to the standards will help achieve better results on these evaluations; however, in order to prove effectiveness of interventions and to understand how they were implemented, process and outcome evaluations will still form necessary activities alongside using the standards.

Table 2: Example scenarios of how the standards could be used (part 1)	
The senior management team of a large prevention provider uses the standards in a monthly meeting to discuss strengths and weaknesses of the organisation. A staff member highlights that there are insufficient measures in place to promote collaboration with other organisations as outlined in standard B: *Communication and stakeholder involvement*. She suggests organising a regional meeting with other providers through the regional drug prevention planning team.	A practitioner working for a charity reads the standards for general information. The standards under component 3.2*: Using a theoretical model* encourage him to find out more about prevention theories and to identify theoretical models that might lead to improvements in his own working approach. At his next professional development and performance review, he asks if the organisation would support him taking time off to pursue a part-time university course in health promotion.
A prevention provider is preparing a project proposal to a funding body. The lead applicant consults the standards to ensure that all project stages have been considered sufficiently. The standards under A: *Sustainability and funding* encourage him to search on the Internet for projects that have been funded by this funding body in the past. He finds a description of previous projects which helps him develop his own funding application further.	A commissioner is not satisfied with the quality of update reports received by providers. She develops a standardised reporting format for use by providers based on the standards under component 8.2*: Disseminating information about the programme* and *If producing a final report*. This will ensure in the future that she receives comprehensive, well-structured, and comparable information across providers.
A prevention scientist is planning an outcome evaluation for a drug prevention intervention. In doing so, she wishes to follow a standardised evaluation protocol. She consequently refers to standards 4.4: *If planning final evaluations* and 7.1: *If conducting an outcome evaluation* when developing the evaluation methodology.	A prevention policy lead wishes to review existing national standards for accreditation of model programmes. He uses the European drug prevention quality standards to identify major gaps in the existing standards. He consequently revises them and includes a new section on ethical drug prevention.

What can be 'assessed' with the standards?

The standards are based on a review of available drug prevention guidance, most of which concerned drug prevention interventions in general and not specific types of activities (see Appendix). Therefore, the standards are applicable to a wide range of drug prevention intervention

types, settings, and target populations. The standards give advice on how to plan, implement, and evaluate interventions, and they can be used to reflect on new, ongoing, or completed activities.

However, interventions form part of a wider professional environment which is just as important in ensuring high quality drug prevention work. General issues (e.g. staff development, resource management, funding and sustainability, communication and stakeholder involvement) must be addressed at an organisational level. Additionally, the priorities and strategies set out by local, regional, national, and/or international government and funding bodies must promote good practice in prevention. The European drug prevention quality standards acknowledge the need for a good foundation upon which interventions can be delivered. Therefore, they provide guidance not only on specific drug prevention interventions, but also on organisational and strategic aspects of prevention work.

Although the standards refer to programmes, they can be used to reflect on prevention work at several levels of delivery, including:

- **People:** individual staff members or teams. The standards can be used for professional development, to reflect upon current practice, and to gain a better understanding of their role within the wider context of prevention.
- **Activities:** singular interventions or wider programmes comprising several interventions. The standards can be used to plan, resource, and deliver prevention activities in a consistent and high quality manner that provides the best chances for success.
- **Organisations:** organisations involved in drug prevention, such as service providers or schools. The standards can be used to improve organisational configuration and strategy so that professionals are best supported in their work and so that target populations receive optimum care.
- **Strategies:** priorities, action plans and tenders set out by government or funding bodies. The standards can be used to define policy objectives, to support thinking on the realities and ambitions of prevention, and to assist in funding and commissioning activities.

Not all standards are equally relevant to all these levels of delivery, but this multi-level approach encourages users of the document to consider the strong relationship between people, activities, organisations, and strategies. This wider perspective can help identify strengths and weaknesses that were previously invisible.

Who should use the standards?

The standards will be of interest to all professionals working in the field of drug prevention. Although the standards may also inform the general public (including young people, families, and community members) on what to expect from drug prevention work, they are primarily targeted at drug prevention professionals. These professionals are likely to be involved in one or more of the following activities:

- **Policy- and decision-making:** those who work on a strategic level, for example government representatives, commissioners, regional planning teams, funders. The standards provide guidance on how to set priorities, how to conduct needs assessments, how to coordinate prevention activities, and how to ensure the sustainability of drug prevention efforts. They may also help to better understand what prevention providers are aiming to achieve through their work, and to reflect on prevention strategies. The standards can also be used to develop new or review existing best practice guidance, and/or to develop new or update existing quality criteria (e.g. to award funding or model programme status). These professionals may also be interested in the evidence into practice briefing produced as part of the standards project (Sumnall et al., 2011).

- **Service management:** those who are in charge of managing drug prevention activities at an organisational level within prevention providers. Typical responsibilities include planning activities, management of financial and human resources, and fulfilling reporting duties to commissioners and funders. The standards provide guidance on how to plan, manage, and evaluate interventions, but they also consider organisational aspects (e.g. staff development, health and safety). Service managers may use the standards in team meetings and to support their work when communicating, for example, with commissioners and funders.

- **Front-line work/work in direct contact with the target population:** those who conduct, or contribute to, drug prevention in (direct) contact with the target population, such as psychologists, youth workers, social workers, outreach workers, teachers, pharmacists. The standards can inform their work by emphasising the need to engage with the target population, to tailor activities to target population needs, to ensure that delivery is of high quality, and to refer individuals to specialist services where required.

- **Training:** those who provide training in drug prevention. Training may be directed at practitioners (e.g. social workers), or it may take place in a higher education setting (i.e. university students). The standards can serve as a textbook outlining all aspects of high quality drug prevention work.

- **Supervision:** those who supervise and support drug prevention professionals (particularly practitioners). This includes line managers as well as external supervisors who are employed to assist with staff development. The standards can be used as a reference framework to identify training needs and potential for further development.
- **Programme development:** those who design and develop drug prevention interventions. These interventions may be developed as copyrighted manualised programmes or they may be developed for a specific project or organisation. The standards provide general guidance on intervention design, but they also emphasise the need to consider conditions of real-world implementation when developing interventions.
- **Consultancy/evaluation/academic research:** those who provide consultancy on prevention issues, for example with regard to effective drug prevention, prevention policy development, adaptation of programmes, evidence into practice translation, and/or evaluation. The standards provide a comprehensive checklist and reference framework, as well as benchmarks for evaluation and research. These professionals may also be interested in the feedback received from professionals during the development of the standards, which is documented in the evidence into practice briefing and the final project report (Sumnall et al., 2011; Brotherhood et al., 2011).

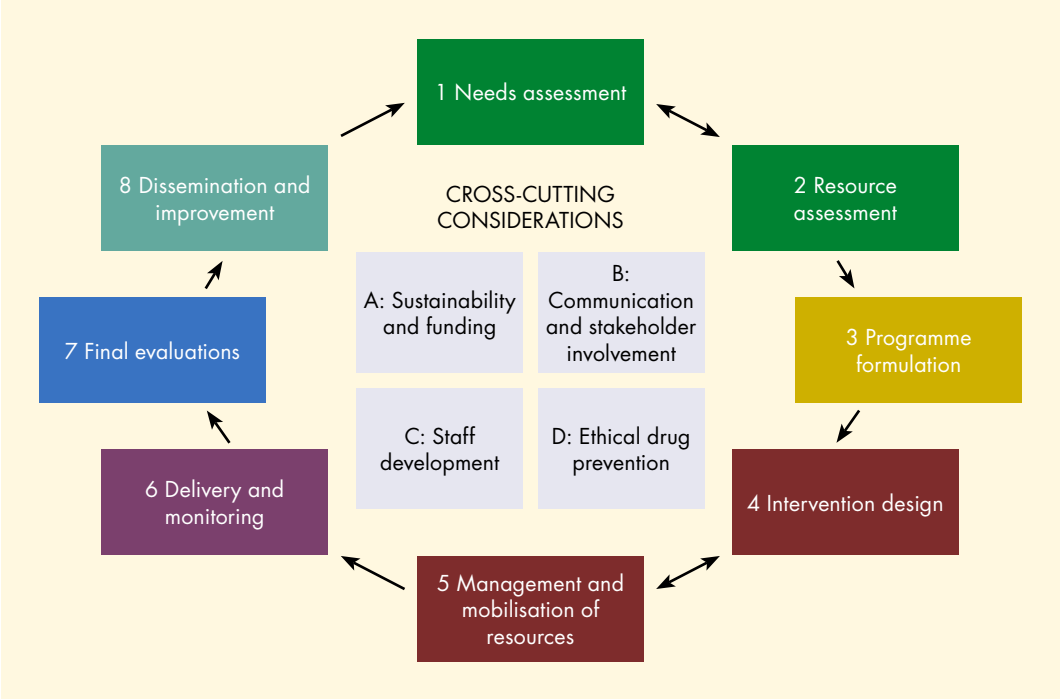
Although all professionals working in drug prevention are encouraged to engage with all standards, it is likely that not all standards will appear equally relevant to all. As part of the development process, the Partnership explored the possibility of including a table that showed which standards are most relevant to which professional group. However, due to differences in work practices between countries, sectors, and individual organisations, this was not deemed feasible. It is recommended that professionals obtain an initial overview of all standards, for example through the project cycle and list of components, before determining which standards are most relevant to their current professional needs. Engaging with the standards should be seen as a long-term process whereby professionals consult them over time to gradually develop their knowledge and work.

Table 3: Example scenarios of how the standards could be used (part 2)	
A service manager has noticed that certain clients are less likely to attend an intervention. She uses the standards under Project stage 4: *Intervention design,* component 5.4: *Recruiting and retaining participants,* and Project stage 6: *Delivery and monitoring* to review the service and to discuss potential barriers with clients. It becomes clear that some clients cannot attend the intervention regularly because of family commitments. The service manager consequently considers developing a specific outreach project for this client group.	A programme developer is designing a new school-based prevention programme. He reads the considerations at the beginning of each component and notes the differences between basic and expert level standards to understand what the practical challenges of implementing the new programme might be. The standards encourage him to consider how flexibility can be built into the intervention design to minimise the need for unplanned deviations during implementation.
A commissioner refers to the standards to conduct a local needs assessment using Project stage 1: *Needs assessment.* The findings show that current services do not offer any family-based prevention programmes despite there being a need for them. She consequently ring-fences a proportion of funding for family-based prevention programmes and issues a call for tenders.	A prevention training provider is reviewing the feedback forms received after a course. According to the feedback, attendants felt there should be a stronger emphasis on how to respond to the individual needs of clients. The standards under C: *Staff development* suggest that he could amend the course contents to include a module on meta-competencies.
A university lecturer uses the standards document as a reference book to inform students about current best practice in drug prevention. In particular, she uses some of the considerations at the beginning of each component to initiate discussion among students. The students hold a debate on the principles of ethical drug prevention outlined in D: *Ethical drug prevention.*	A treatment provider wishes to diversify the portfolio of activities by offering a prevention service to young people. The service manager uses the standards to consider how the new service can be integrated into the existing one. The standards under component 2.2: *Assessing internal capacities* highlight that the organisation currently lacks staff members who are specialised in prevention with young people.

How are the standards structured, and what content do they cover?

The European drug prevention quality standards are ordered chronologically in a project cycle, describing the development, implementation, and evaluation of drug prevention work (Figure 1).

Figure 1: The drug prevention project cycle



Within the cycle, the standards comprise three levels of detail.

1. Project stages

The project cycle is made up of eight stages: needs assessment; resource assessment; programme formulation; intervention design; management and mobilisation of resources; delivery and monitoring; final evaluations; and dissemination and improvement. Needs assessment and resource

assessment, as well as intervention design and management and mobilisation of resources, are likely to be conducted simultaneously and are therefore presented in the same colour. The centre of the cycle contains standards that are not specific to a certain project stage but should inform prevention work at all times.

In the standards, each project stage starts with a brief introduction indicating its position in the project cycle and providing a short description of the contained standards. For ease of use, the standards are colour-coded in line with Figure 1.

The project cycle should be understood as a simplified model of drug prevention. While the project cycle structure was identified as the best means of presenting a comprehensive set of quality standards, in reality, prevention work may be organised differently than shown in the project cycle. **Users of the standards should carefully adapt the project cycle to the individual circumstances of their prevention work**. Possible considerations include: which project stages have already been completed; which components might not be necessary in this particular project; should the order of the standards be changed to reflect particular circumstances (i.e. users may move from one stage to another in a non-chronological order)? Users can make justifiable changes to the structure of the project cycle, as this flexibility ensures that the standards are relevant, useful, and feasible across all areas of drug prevention.

It is also important to note that the standards should be considered in relation to each other. For example, the findings from the needs assessment will inform the programme formulation, which in turn will determine what resources are required. **It is therefore recommended to obtain an overview of all standards rather than reading singular chapters in isolation**. The level of detail may at first appear daunting, but its practical usefulness lies in providing a step-by-step guide of how to conduct high quality drug prevention work.

2. Components

Each project stage is divided into several components (see Table 4, page 53). They outline the actions which should be taken at that point in the project. Overall, there are 31 components within project stages and four cross-cutting considerations at the centre of the project cycle. Cross-cutting considerations, while perhaps not the most important aspects of prevention work as such, contain themes that should be reconsidered at each project stage; they were placed in the centre to reduce duplication between project stages.

The number of each component is made up of the project stage and the component, while cross-cutting considerations in the centre of the project cycle are given capital letters (A–D). **The numbering of components does not necessarily indicate priority or chronological order**. Some components are not always required or feasible, and the standards therein only apply if that action is taken. These components start with 'If'; for example, component 4.2: *If selecting an existing intervention*.

In the standards, each component starts on a new page with considerations regarding its application in practice. The content of considerations is mostly derived from consultations with drugs professionals and discussions within the Partnership. The considerations typically outline the rationale for a certain component, discuss potential barriers to implementation of the standards in practice, as well as ways of overcoming these barriers, and they highlight if a component is not applicable to all prevention work. References to additional guidance and other components that support implementation of the particular component are also made. Users are encouraged to read the standards in conjunction with the glossary providad in the Appendix.

3. Attributes

The third level of detail contains further descriptions of the components, distinguishing between basic standards and expert standards (see next section). The left-hand column contains the actual standards (see Figure 2). If used for reflection on prevention work, these attributes define attainment towards the particular component. The standards are numbered in line with their relation to project stages and components to enable easy referencing; the numbering does not necessarily indicate priority or chronological order.

The right-hand column contains notes to help clarify the purpose or content of the standards, as their meaning may depend on the context in which they are used. The notes also indicate if a standard reflects basic level in certain cases ('basic standard if'), or if there are additional considerations that should be taken into account. Examples show how achievement of the standards could be evidenced. However, examples given within the right-hand column should not necessarily be seen as the only appropriate ways to achieve or evidence the standards. Where there is a lot of text in the notes, it is displayed horizontally under the standards instead of in the right-hand column.

Figure 2: Layout of attributes

Basic standards:	
D.1 The knowledge of general policy and legislation is sufficient for the implementation of the programme.	
	i.e. staff members and participants are aware of generally binding regulations, their legal responsibilities, and internal rules and procedures. *Note:* It depends on the particular programmes which policies and pieces of legislation are most important; further considerations can be found under 1.1 Knowing drug-related policy and legislation. *Examples of policy and legislation:* equal opportunities policy, confidentiality policy, child protection policy, health and safety policy, laws on waster and environmental protection.
D.2 A code of ethics is defined.	
Additional expert standards:	
D.15 Alcohol, tobacco, and illegal drugs are banned in the facilities of the programme.	**Basic standard if required by law.** *Note:* Adherence to this standard may not be feasible under certain circumstances, for example if the intervention is delivered in an external recipient organisation (e.g. nightclub).
D.16 The programme complies with national and international standards and guidelines.	**Basic standard if required by existing policy and legislation.** *Example of standards:* national occupational standards in drug prevention, if available.
D.17 The participants' code of rights is publicly posted and easy to understand.	

What is the difference between basic and expert standards?

Drug prevention covers a wide range of activities that may differ, for example, in terms of their aims, scope of work, target population, setting, methods, duration, and/or available and required resources. Certain standards may therefore seem more relevant or feasible for some interventions than for others.

In terms of relevance, drug prevention professionals contributing to the development of these standards argued that ongoing participant- and needs-led services (e.g. outreach work, drop-in centre, brief intervention) should be distinguished from structured long-term interventions with predetermined content (e.g. manualised school programme). For example, it may not always be possible to engage with participants over a longer period of time in participant-led services, and therefore those standards assuming a long-term relationship with participants might not apply (e.g. standards on participant retention).

In terms of feasibility, the consultations suggested that certain standards were not always feasible. Delegates highlighted, for example, the limitations of providing drug prevention in settings where providers did not have full control over implementation (e.g. schools, night-life setting). They also argued that the standards should be applied more rigorously to large-scale projects, while small-scale projects could not be expected to adhere to all standards. The distinction between large-scale and small-scale work refers to the size and scope of projects and organisations, for example with regard to how many staff members are involved, how much budget is available, the duration of projects, and/or the number of participants. A long-term government programme with nationwide dissemination would be an example of large-scale work, while a one-off intervention organised by a school for a small number of pupils could be classed as a small-scale project. Smaller organisations often have fewer capacities than larger organisations, and might therefore struggle to achieve all standards. However, achieving the standards should be a professional aim of all types of organisation.

The standards therefore offer three levels: 'basic', 'basic if', and 'expert'. This distinction is based on the consultations that were held during the development of the standards.

- **Basic standards:** these standards should be applicable to all drug prevention work, regardless of its particular circumstances. Basic standards provide a reference framework for those professionals, projects, organisations, and strategies that could not currently achieve all standards due to limited resources or a very basic starting point. This might include organisations that do not specialise primarily in prevention work, such as schools. These organisations would be considered to be performing very well if they achieved the basic quality level. However, even basic users should not simply read the basic standards, but also consider the relevance, usefulness, and feasibility of all expert standards. The expert standards contain more detailed guidance than the basic standards, and thus they may be helpful in guiding work at basic level. Additional basic standards ('basic standard if') may also apply under particular circumstances.

- **Additional basic standards ('basic standard if'):** these standards are highlighted in bold font and reflect the basic level under particular circumstances. For example, some standards may be considered basic if an outcome evaluation is planned, but they would not apply if an outcome evaluation was not planned. Depending on how many basic standards there are, they are listed following the basic standards, or indicated in the right-hand column of the additional expert standards. Basic users of the standards should scan the expert standards to identify any additional standards that may reflect basic level for their project.
- **Additional expert standards:** these standards are to be seen in addition to the basic standards, representing a higher level of quality. Expert standards provide a reference framework for those professionals, projects, organisations, and strategies that have more resources available, as well as those smaller projects and organisations that have already achieved most basic standards. While adherence to all expert standards is desirable, they may not always be applicable. Therefore, expert users will have to determine which expert standards are relevant, useful and feasible with regard to their particular prevention work.

Professionals using the standards for reflection on their work can refer to this distinction to determine their current position, and to identify areas for improvement. Once most basic standards have been achieved, professionals should strive to achieve the expert standards that are relevant to their work.

CHAPTER
THREE

Chapter 3

About the quality standards

Why were the standards developed?

The overall predominance of interventions in Europe that lack, or have only a weak, evidence base, as well as the weak implementation of prevention in general are striking. While this may be due to the fact that such approaches require fewer resources (e.g. less staff training), effectiveness can only be achieved through correct implementation of prevention activities with evidence-based components. Even well-intended and well-planned interventions can have harmful instead of preventive effects (Moos, 2005; Werch and Owen, 2002). For these reasons, standards and their reinforcement through funding requirements are not only needed to improve the effectiveness of prevention but, above all, they are ethically necessary to guarantee that no harm is done through preventive interventions, which in most cases have not even been asked for by the target population.

The quality and evidence base of prevention is rarely subject to control or quality-conditioned funding. Nevertheless, the need to improve prevention is increasingly recognised in Europe, with half of EU Member States reporting on efforts to develop drug prevention quality standards. At the time of starting the European drug prevention standards project, drug prevention quality standards and guidelines were available only in some Member States of the EU. The available guidance varied in terms of its content, methodological rigour, and applicability beyond the regional or national context. Consequently, a common European framework on high quality drug prevention was missing. It was also not clear to what extent internationally available guidance was relevant to drug prevention in Europe, and how it could be adapted to the European context (for example, the USA *Standards of Evidence* (Flay et al., 2005)).

The need for a European drug prevention framework is also apparent in EU policy documents, such as the EU drugs action plans (European Council, 2005 and 2008). These have expressed an intention to develop and implement best practice in drug prevention, but without being able to provide a reference framework on how to do this.

Therefore, the aim of the standards is to improve European drug prevention practice by providing an empirically derived reference framework to bridge the gaps between science, policy and practice.

The specific objectives of the project were:

- To develop and present a toolkit of criteria for assessment of prevention standards and guidelines and apply them to demonstration projects;
- To collate and review existing national standards of evidence and evidence-based guidelines in the EU and worldwide;
- To identify and discuss national standards and guideline implementation modifiers;
- To publish EU standards and guidelines in evidence-based drug prevention.

This document focuses on the standards that were produced as part of this process.

What policies do the standards support?

The standards directly support the main actions and priorities outlined in the EU drugs action plan (2009–12) and the EU drugs strategy (2005–12) in relation to drug demand reduction and the improved understanding of the drugs phenomenon, including:

- Action 17: 'To develop, implement and exchange good practice guidelines/quality standards for prevention, treatment, harm reduction and rehabilitation interventions and services';
- Action 19: 'To develop an EU consensus on minimum quality standards and benchmarks for prevention, treatment, harm reduction and rehabilitation interventions and services taking into account needs of specific groups and the work done at national and international level';
- 'A better understanding of the drugs problem and the development of an optimal response to it through a measurable and sustainable improvement in the knowledge base and knowledge infrastructure' (European Council, 2004, p. 18; 2008, p. 13).

The standards will also support Member States in achieving the actions outlined in the United Nations Plan of Action adopted at the high-level segment of the fifty-second session of the Commission on Narcotic Drugs in 2009, such as:

- 'Deliver prevention programmes based on scientific evidence, both universal and targeted, in a range of settings (such as schools, families, the media, workplaces, communities, health and social services and prisons)';
- 'Ensure that drug demand reduction measures respect human rights and the inherent dignity of all individuals and facilitate access for all drug users to prevention services and health-care and social services, with a view to social reintegration';

- 'Involve all stakeholders at the community level (including the target populations, their families, community members, employers and local organizations) in the planning, delivery, monitoring and evaluation of drug demand reduction measures';
- 'Support the development and adoption of appropriate health-care standards, as well as ongoing training on drug demand reduction measures' (UNODC, 2009b, p. 24, item 18(a)).

The availability of a common framework that is adaptable to local circumstances should provide an incentive for EU Member States to develop local, regional, and/or national quality standards where these did not previously exist, or to review and update existing quality standards, and adopt these quality standards for their own use. Adoption of the standards will improve drug prevention practice and efficiency of funding, and reduce the likelihood of implementation of interventions that are ineffective or have iatrogenic effects. Thus, the standards will support the fulfilment of local, regional, national and international drugs strategies and policies.

How were the standards developed?

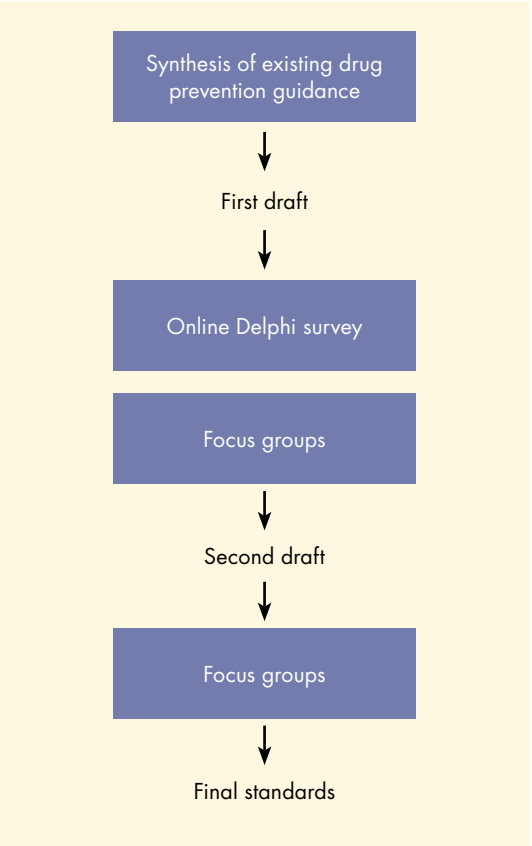
The European drug prevention quality standards were drafted through a review and synthesis of nineteen European and international documents containing drug prevention quality standards, and finalised through consultations with drug professionals across Europe. In developing the standards, the Partnership used methods that were not only valid and reliable, but that also enabled detailed knowledge of local professional cultures and practices (e.g. values and preferences, organisational structures). Figure 3 provides an overview of the development process.

Existing drug prevention guidance was identified in 2008/09 by contacting relevant representatives in the 27 EU Member States, i.e. the national focal points of the EMCDDA's Reitox network, the European Information Network on Drugs and Drug Addiction, or the national managers responsible for the Exchange on Drug Demand Reduction Action (EDDRA). Additionally, prominent organisations working in drug prevention, such as the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), the United Nations Office on Drugs and Crime (UNODC), the Canadian Centre on Substance Abuse (CCSA), and the Australian National Drug Research Institute (NDRI) were contacted to retrieve materials. Internet and literature searches were also carried out.

In total, 77 documents were retrieved. From these, quality standards focussing on drug prevention with a national or, where national guidance did not exist, regional scope were selected. Materials were also required to be of official standing, i.e. published or recognised by government or a

leading agency in drug prevention. The final selection comprised 19 documents; non-English language materials were translated into English. The documents included in the review are listed in the Appendix. A first draft of the European drug prevention quality standards was produced by synthesising the quality standards contained in these documents.

Figure 3: Development of the standards



The draft standards were then refined in consultation with drug prevention professionals. Participants were invited from all professional levels and a wide range of professional fields contributing to drug prevention, namely: regional planning teams; education; health; mental health; social services;

criminal justice; voluntary and community sector; government; research and consultancy; and media. Consultations were carried out by all members of the Prevention Standards Partnership, and included the following countries or regions: Galicia (region of Spain); Hungary; Liguria (region of Italy); Lombardy (region of Italy); Poland; Romania; and the United Kingdom.

In a two-round online Delphi survey, professionals rated the priority of the draft standards from 'high priority' to 'not a priority at all' at component level. Across all countries and regions, 423 professionals completed both survey rounds. In the following round of consultations, 122 professionals attended fourteen focus group events in five countries to discuss the standards in detail, particularly with regard to their relevance, usefulness, and feasibility. The feedback obtained through the Delphi survey and focus groups was used to produce a second draft of the standards.

In the final round of consultations, 72 professionals from five countries helped define how the standards could be implemented in practice, and provided final suggestions for improvement. The final version was produced incorporating input from all consultations, suggestions received at conference presentations, and conclusions drawn at Partnership meetings.

Further information on the development of the standards and a list of the professionals who contributed to the consultations can be found in the final project report (Brotherhood et al., 2011).

What are the conditions for standards implementation, and what could be potential barriers?

It was clear from the onset of this project that the final standards would only become a useful tool to inform everyday practice if they are relevant and useful to a multitude of professionals across countries, and if they are applicable to a variety of settings and other circumstances. This was largely achieved through the consultations outlined above; it is evident in practical considerations at the beginning of each component and the distinction between basic and expert level standards.

However, the conversations with drug prevention professionals also indicated a range of conditions and potential barriers that, while required for uptake of the standards in practice, could not be addressed during standards development. The following paragraphs briefly describe what cultural, organisational, and structural changes are required to achieve widespread implementation.

- **Promote the use of quality standards:** Encouragingly, the consultations suggested that many actions described in the standards are already common practice, even though they are often

not implemented to the high quality specified in the standards. Professionals could therefore build upon and improve existing efforts, rather than having to start from nothing. It was also noted that a good project would naturally end up adhering to the quality standards. However, it became clear that a majority of professionals may not be familiar with the concept of quality standards, programme certification, and professional guidelines. Even though they may welcome the introduction of standards, these professionals may be unsure about how to use them in their everyday practice. It would therefore be required to support implementation of the standards by providing targeted training events and educational materials. It is recommended that the standards, and their use, are introduced in a stepwise manner; firstly by introducing the field to the need for quality standards, then beginning a process of introducing the standards themselves, and finally familiarising potential users with their content in a targeted manner.

- **Develop content guidelines:** The consultations indicated that there is a need for guidance on the content of evidence-based prevention work. The quality standards provide a consistent framework for the delivery of prevention, and suggest how decisions on content might be reached, but they are not intended to specify what activities should be delivered. In contrast to the availability of national prevention quality standards, only two documents containing robust guidelines were considered to be of relevance to the EU (NICE, 2007; UNODC, 2009a). Both of these concerned family-based approaches to prevention, and were biased towards the well developed prevention delivery structures mostly seen in west European states. The success of the standards in the future is likely to depend on the concurrent availability of high quality drug prevention guidelines. Although systematic reviews and meta-analyses present international evidence summaries, they lack details on implementation and local adaptation. Accessing and interpreting complex and often contradictory evidence is also a challenge for many professionals. It is therefore clear that more work needs to be conducted to allow professionals to make decisions on how best to work with their target populations.

- **Attract funding:** The standards are designed to be challenging yet realistically achievable. Through the distinction between basic and expert levels, they take into account the current situation of drug prevention practice and resource availability in the EU. Ideally, the (basic) standards can be implemented by using or realigning existing resources. However, organisations with limited capacities may need to attract additional funding, particularly if they wish to achieve the expert level standards.

- **Prioritise and support prevention:** In comparison to treatment and rehabilitation, prevention receives relatively less (financial) attention and may therefore appear to be less important. Predictable and stable financial support is a condition for sustainable high quality drug prevention work. Adoption of the standards will promote the importance of prevention within the drug demand reduction framework. However, in order to improve the quality of drug prevention (e.g. by conducting scientific outcome evaluations), commissioners and funders must invest more money in prevention. The current standards do not provide detailed guidance on how to allocate funding, and commissioners and funders may require further training in this regard (e.g. how to consider opportunity costs).

- **Establish and strengthen central prevention agencies:** The consultations highlighted the importance of government-funded regional and national coordination bodies that implement drugs strategies, commission and coordinate drug prevention work, conduct needs assessments, promote adherence to quality standards, issue best practice guidance, organise training and networking events for prevention providers, facilitate collaboration between different providers, etc. The discussion highlighted the benefits where such structures are in place, as well as the problems that arise where such structures are weak or non-existent (e.g. not all countries have prevention policy located in one particular department or organisation), or under threat of being abandoned.

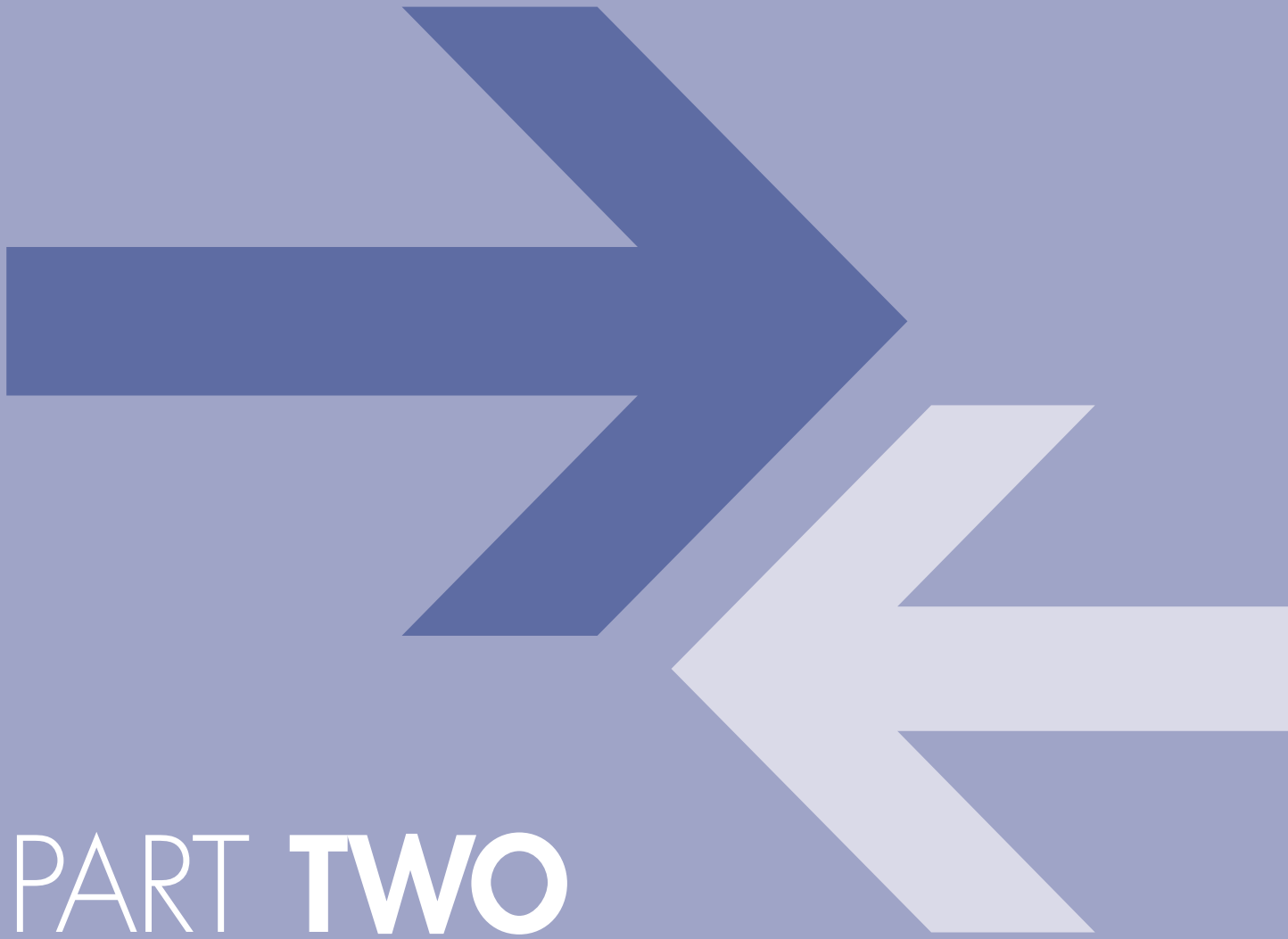
- **Consider differences in prevention practice:** Drug prevention practice differs between countries, localities, and professional fields (e.g. different professional cultures between social and medical services). Although the standards are widely applicable, delegates questioned whether they could be adapted to match individual circumstances (e.g. local target population, national structures of delivery). This version of the standards does not contain detailed instructions on how to integrate them into existing systems and structures of delivery. It is intended that future versions of the standards will illustrate better how they can be applied in practice, based on real-life trials under different circumstances.

- **Create synergies:** Another possible challenge relates to the lack of coordination and collaboration between professional groups and stakeholders in the drug prevention field. Delegates provided several examples, such as duplication of efforts by prevention services that were unaware of each other's work, or lack of communication between researchers and practitioners that meant that evidence was not adapted and disseminated in a manner that was useful to practice. Communication can be hindered by different perceptions of the aims and

methods of drug prevention. Component B: *Communication and stakeholder involvement* targets this challenge specifically, recognising that better coordination would enable more targeted services and a better distribution of resources. However, implementation of the standards requires buy-in from multiple stakeholders, i.e. collaboration can only occur where several parties are interested in collaborating. Additionally, introduction of standards into practice will affect stakeholders who have not traditionally been involved in prevention work in the past, and who may thus be unclear about their role in contributing to drug prevention (e.g. teachers, pharmacists, housing officers).

- **Develop professional attitudes and skills:** A further theme was the competence and willingness of staff to put the standards into practice. Knowledge gaps in the prevention workforce were reported in relation to, for example, evidence-based approaches, evaluation, adaptation, or strategic project planning. There appears to be a divide between the theory and practice of prevention (e.g. what is known to be effective versus what is actually done). The discussions also indicated that professionals may be hesitant to use the standards, dismissing them as 'too complex' or 'too difficult to achieve'. Practitioners may also worry that the standards could devalue their professional experiences. The aim of the standards is to promote better practice, and therefore they cannot simply affirm current practice. Through the distinction between basic and expert standards and the promotion of self-reflection, the standards can become a useful tool *if* practitioners are willing to engage with them. It is important that the standards become a means of improving professional practice and making real changes about the way prevention is planned and delivered, not a bureaucratic device. While the standards could improve the understanding of prevention among professionals and provide important additions to occupational standards (e.g. C: *Staff development*), prevention-specific training and further education would also be needed. Moreover, a deep change in professional attitudes can only be achieved as part of a long-term process involving all relevant levels.

These considerations highlight that the standards cannot be implemented in isolation, detached from the realities of drug prevention. On the contrary, implementation of the standards must be accompanied by a process of change in the very foundations of drug prevention towards a more integrated and evidence-based approach. Project partners have also summarised considerations that are of particular relevance to their country, although it is likely that other countries may face similar challenges. These country considerations are available as an online supplement to this manual.



PART **TWO**

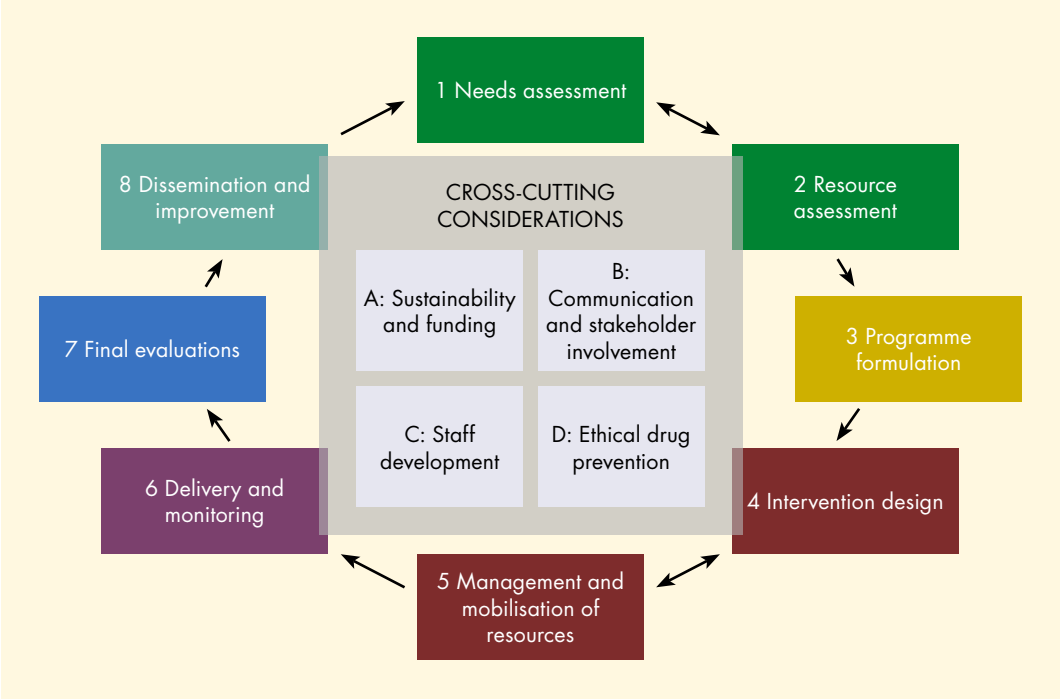
The standards

Table 4: Project stages and components within the European drug prevention quality standards

Cross-cutting considerations
A. Sustainability and funding
B. Communication and stakeholder involvement
C. Staff development
D. Ethical drug prevention
1. Needs assessment
1.1 Knowing drug-related policy and legislation
1.2 Assessing drug use and community needs
1.3 Describing the need – Justifying the intervention
1.4 Understanding the target population
2. Resource assessment
2.1 Assessing target population and community resources
2.2 Assessing internal capacities
3. Programme formulation
3.1 Defining the target population
3.2 Using a theoretical model
3.3 Defining aims, goals, and objectives
3.4 Defining the setting
3.5 Referring to evidence of effectiveness
3.6 Determining the timeline
4. Intervention design
4.1 Designing for quality and effectiveness
4.2 If selecting an existing intervention
4.3 Tailoring the intervention to the target population
4.4 If planning final evaluations
5. Management and mobilisation of resources
5.1 Planning the programme - Illustrating the project plan
5.2 Planning financial requirements
5.3 Setting up the team
5.4 Recruiting and retaining participants
5.5 Preparing programme materials
5.6 Providing a project description
6. Delivery and monitoring
6.1 If conducting a pilot intervention
6.2 Implementing the intervention
6.3 Monitoring the implementation
6.4 Adjusting the implementation
7. Final evaluations
7.1 If conducting an outcome evaluation
7.2 If conducting a process evaluation
8. Dissemination and improvement
8.1 Determining whether the programme should be sustained
8.2 Disseminating information about the programme
8.3 If producing a final report

CROSS-CUTTING CONSIDERATIONS

Cross-cutting considerations



There are many recurring themes that do not concern only one project stage, but the entire project cycle. For the purposes of these standards, four of these themes have been placed in the middle of the project cycle as they should be reconsidered at each project stage.

A: Sustainability and funding — Programmes should be seen as embedded in a wider framework of drug prevention activities. The long-term viability of prevention work should be ensured as possible. Ideally, programmes can continue beyond their initial implementation and/or after external funding has stopped. However, sustainability depends not only upon the continued availability of funding but also upon the lasting commitment of staff and other relevant stakeholders to the organisation and/or the field of drug prevention. The standards in this component outline how sustainability can be

ensured by 'anchoring' programmes within existing systems and by developing strategies to secure necessary resources, particularly funding.

B: Communication and stakeholder involvement — Stakeholders are individuals, groups and organisations that have a vested interest in the activities and outcomes of the programme, and/or who are directly or indirectly affected by it, such as the target population, the community, funders, and other organisations working in the field of drug prevention. Relevant stakeholders should be contacted and involved in the programme as necessary. The support and cooperation of the target population will be a requirement for any programme. Other forms of stakeholder involvement may include establishing links with community 'leaders' or the local media who subsequently support the programme and increase its visibility. Involving other organisations working in the field is useful to coordinate efforts, share lessons learnt, and establish joint planning and budgeting. A communications strategy enables exchange between the various groups involved in the programme.

C: Staff development — This component consists of three pillars: staff training; further development; and professional and emotional support. Staff training needs should be assessed before implementation, and staff members should be trained to ensure that the programme is delivered to a high standard. The standards also facilitate the development of training plans. Continuous staff development is a means of rewarding and retaining staff members and ensuring that their knowledge and skills are up-to-date. During the implementation of the programme, it is important to give staff members the opportunity to reflect on their work and to improve on the job.

D: Ethical drug prevention — The standards outline principles of ethical drug prevention which focus on: the providers' lawful conduct; respect for participants' rights and autonomy; real benefits for participants; no harms for participants; providing truthful information; obtaining consent; voluntary participation; ensuring confidentiality; tailoring the intervention to participants' needs; involving participants as partners; and health and safety. While it may not always be possible to adhere to all principles of ethical drug prevention, an ethical approach must be clearly evident in every project stage. Consequently, protocols are developed to protect participants' rights, and potential risks are assessed and mitigated.

A: Sustainability and funding

Programmes must be designed to ensure the continuity of drug prevention activities. They should be part of a wider set of drug prevention activities (e.g. within an organisation or a region), and ideally, programmes can continue beyond their initial implementation and/or after external funding has stopped (e.g. they can be repeated with a new group of participants once the first group of participants has successfully completed the intervention). Sustainability depends upon the logical coherence of the programme, continued availability of necessary resources (e.g. money, staff, participants) (see component 5.2: *Planning financial requirements*), and support by relevant stakeholders (see B: *Communication and stakeholder involvement*).

The standards in this component encourage providers to consider how different activities at each project stage relate to each other and how they can contribute to the sustainability of the programme. They outline also how sustainability can be ensured by 'anchoring' programmes within existing systems, and by developing strategies to secure necessary resources. Some of these standards are likely to be more relevant on an organisational or strategic level than on the level of individual programmes.

Providers are encouraged to seek and apply for a variety of funding schemes. However, it may not always be necessary to seek external support. Funding may have already been obtained independently of the programme, or the nature of the intervention may not require additional resources. Ideally, programmes can be delivered by using or realigning existing resources. Where additional resources are required, sustainability can be achieved by securing external support. Depending on the scope of the programme, potential sources of income may vary from governmental funds to less formal sources, such as the community or individual donations.

The idea of active fundraising targeting a range of funding sources, as suggested in the standards, may seem new. Providers may feel that their abilities or opportunities to attract funding are limited. Funding practices differ, but local or regional government funds are often the main source of income for drug prevention providers. However, these funds cannot always provide the long-term support that programmes need. They may also be earmarked for certain activities, thus limiting providers in what they can do. A dedicated strategy targeting different types of governmental and non-governmental funding maximises the chances of implementing and sustaining prevention work.

When applying for funding, the potentially long time spans between submission of the funding application and the receipt of respective grants should be considered, particularly with larger funding bodies (e.g. EU funding streams). If the programme proposal will be evaluated by a funding

body to determine whether the programme should be funded, applicants should consider the relevant external criteria.

However, it is equally important that funders and commissioners of drug prevention work ensure that sufficient funding is available to sustain promising and effective programmes (see component 8.1: *Determining whether the programme should be sustained*).

Further information on how to ensure the sustainability of programmes can be found, for example, in the handbook *Guide to implementing family skills training programmes for drug abuse prevention* (UNODC 2009a, p. 47).

Please see the glossary for definitions of key terms used in the standards.

Basic standards:	
A.1 The programme promotes a long-term view on drug prevention.	i.e. working against cycles of 'panic' and 'indifference' toward drug-related needs, and enabling continuous drug prevention.
A.2 The programme is not a fragmented short-term initiative.	Examples of evidence: it is embedded in a wider set of activities within the organisation; it contributes directly or indirectly to a wider strategy.
A.3 The programme is coherent in its logic and practical approach.	

Note: the coherence of the programme should be assessed for each project stage by examining each element of the programme in relation to the other elements.

Purpose: to ensure and demonstrate that the programme is well designed, relevant, and practically feasible in the long term.

Example elements to consider: target population needs; aims, goals, and objectives; theoretical model; evidence base; setting; methods and activities; resources.

Example aspects to consider: are activities suitable to achieve goals and objectives? Do activities target relevant mediators identified in the theoretical model? Are methods correctly chosen for the implementation of activities? Are resources sufficient for the implementation of the programme?

Examples of evidence: the logical interrelation between the elements of the programme is presented in a programme logic model; connections between programme elements are described.

Additional guidance: Further guidance can be found in the *Prevention and Evaluation Resources Kit* (PERK) (EMCDDA, 2010).

Basic standards (cont.):	
A.4 The programme seeks funding from different sources.	
Note: even if funding is already secured from a particular source, additional funding should be sought to allow the implementation of additional activities, e.g. a diversification of interventions (e.g. offering additional services) or organisational activities (e.g. staff development). Examples of different funding sources: • (re-allocation of) internal resources; • sharing of resources with other agencies; • community resources and local government; • private grants and individual donations; • non-governmental and private agencies; • national government and EU support.	

Additional expert standards:	
A.5 A clear statement of factors to assure the programme's sustainability after its initial completion exists in writing.	
A.6 The programme is linked with existing delivery systems.	Example of evidence: drug education is integrated into existing school subjects.
A.7 The drug awareness of relevant stakeholders is increased, where appropriate.	
Purpose: to obtain ongoing support for the programme. Examples of relevant groups: community members, family members, commissioners, staff members, target population. Examples of evidence: organising an awareness-raising event, supplying relevant groups with accurate data on the needs of the community or target population, organising a theatre play dealing with drug issues.	
A.8 Partnerships are established with community groups.	

Additional expert standards (cont.):	
A.9 The organisation has obtained and/or is seeking independent accreditations and quality certificates.	Example of certification: International Organization for Standardization (ISO) certifications. Examples of awards: European Drug Prevention Prize (Council of Europe Pompidou Group), Mentor Award (The Mentor Foundation). Example of evidence: accreditations and quality certificates of the organisation are listed.
A.10 A strategy for long-term funding and attraction of resources exists.	
A.11 The strategy:	
• specifies a person or team for the active identification and attraction of funding sources;	Example of evidence: a fundraising manager is appointed.
• identifies all possible sources of funding as well as other organisations interested in supporting the programme;	Note: funding from sources that are not drug-specific can be attracted by taking a comprehensive view on drug prevention (UNODC, 2004); relevant funding streams may focus on, for example: reducing HIV/AIDS, reducing crime, improving youth wellbeing.
• considers the specific criteria for the receipt of funding.	Examples of resources: studying funding guidelines, consulting with project officer at the funding body, considering previously funded programmes, considering funding body's strategic direction (UNODC, 2004).
A.12 It is considered whether the programme requires adaptation to fit funding criteria; and if necessary, the programme is adapted accordingly.	Note: when fitting a programme to funding criteria, the needs of the target population and the theoretical bases of the intervention (i.e. theoretical model) should not be overridden.
A.13 The programme description matches the requirements of the funding body.	i.e. it fulfils administrative prerequisites. Example of evidence: presented in the required format.
A.14 Rules for the acceptance of donations are defined.	Examples of relevant donations: donations made by businesses and other private organisations.

B: Communication and stakeholder involvement

For any drug prevention programme, there are individuals, groups and organisations that have a vested interest in its activities and outcomes, and/or who are directly or indirectly affected by it. Providers should identify these stakeholders, assess their relationship to the programme, and decide how and at what project stages they must be involved for a successful programme implementation. The standards in this component outline some key aspects of communication and stakeholder involvement. However, the precise nature and level of involvement will depend on the particular circumstances of the programme.

Involving stakeholders such as the target population, the community, or the media can be challenging. It may require additional resources and can slow down the process. Providers may also find that stakeholders are not initially interested in contributing to or supporting the programme (see component 2.1: *Assessing target population and community resources*). The standards in this component encourage providers to account for the requirements of stakeholder involvement when designing the programme. By involving the target population in the programme formulation, the programme will be more relevant to participants and consequently more likely to achieve its goals and objectives. Providing feedback to participants, for example of evaluation results, is also a principle of ethical drug prevention (see D: *Ethical drug prevention*). Support from the community and the media can ensure long-term sustainability (see A: *Sustainability and funding*).

The consultations that informed the development of these standards indicated that providers of drug prevention should collaborate more, and that the level of exchange between professional groups should be increased (e.g. between researchers and practitioners). Communication is important to coordinate efforts and resources, to share lessons learnt, and to promote evidence-based approaches. It can be difficult to involve other organisations, which is why the standards present different levels of involvement from mere awareness of their existence (e.g. for referral of participants) up to formal collaboration (e.g. joint budgeting). Sometimes it is easier to collaborate on an individual level than on an institutional level, although providers should seek to establish a formal relationship if this is required. Local or regional drug prevention planning teams may be able to provide information on relevant stakeholders in the area and facilitate collaboration.

The involvement of recipient organisations, commissioners and funders is often a requirement when conducting drug prevention work. It is important to consider how the interests of these organisations relate to the needs of the target population and participants at each project stage. Commissioners

and funders must acknowledge the need for flexibility (e.g. tenders may need to be revised after the needs assessment, implementation may differ from the original plan to accommodate participants' needs better). Certain parameters, such as how much flexibility is possible without seeking formal approval, should be negotiated as part of the grant or service agreement. Nevertheless, continuous two-way communication throughout implementation ensures that the programme is relevant to participants as well as to those commissioning or supporting it.

Finally, communication between staff members working on the programme is important to establish a common understanding of drug prevention in general and the programme in particular. In multidisciplinary teams, differences in professional background can make it difficult to maintain the focus on the desired outcomes (e.g. due to different problem definitions). This highlights the need for a common professional language and a communications strategy (see component 5.1*: Planning the programme — Illustrating the project plan*). During implementation, timely feedback helps to identify necessary modifications and modify the intervention accordingly (see Project stage 6: *Delivery and monitoring*).

More guidance on stakeholder involvement can be found in the *Handbook Healthy Nightlife Toolbox* (Trimbos-instituut, 2010).

Basic standards:	
B.1 The multi-service nature of drug prevention is considered.	i.e. it is recognised that many different organisations and structures contribute to drug prevention: there are multiple providers, multiple policy drivers, multidisciplinary contributions, etc.
B.2 It is considered that different stakeholders may have different problem definitions.	Note: this could also refer to different staff members within the team. Example consideration: what is the common goal that all stakeholders can work toward? Stakeholders may work toward a common goal, even if they have different reasons for pursuing it and/or choose different approaches to achieving it.

Basic standards (cont.):	
B.3 Relevant stakeholders for the programme are identified.	Note: stakeholders can be involved at various project stages, for example to consult on programme development, or to collaborate during implementation. Staff members are also stakeholders, but they are discussed under C: *Staff development* and component 5.3: *Setting up the team*.
B.4 The terms of reference for stakeholder involvement for a successful programme implementation are defined, and appropriate action is taken.	
Example aspects to consider: • which groups to involve; in what form, for example consultation, collaboration; • at what project stage, for example in the data collection process during needs assessment, programme formulation, implementation, etc., or continuously. Examples of evidence: relevant contacts have been identified; coordination and cooperation have been initiated; written terms of reference.	
B.5 The target population is considered as a stakeholder in the programme.	Note: the target population represents the group from which participants will be drawn. Advocates of participants may also need to be considered (e.g. parents of young people).
B.6 The organisation cooperates with other agencies and institutions:	
Examples of agencies and institutions: local entities and administrations, government agencies, organisations active in health education and the promotion of young people, regional drug teams, youth and healthcare services, schools, police, neighbourhood and residents' associations, NGOs. Examples of evidence: partnerships and collaborations are listed.	
• The existence of relevant agencies and institutions in the area is assessed.	Note: such information may be readily available from local or regional prevention planning teams.
• Staff members have information on other agencies' work and use this to refer participants as necessary.	Example of evidence: staff members know about related services in the area; written information on referral paths is available to staff members.

Basic standards (cont.):	
• The team communicates with other agencies.	i.e. it shares its expertise and takes on information from others.
• The team coordinates its efforts with other relevant stakeholders in the area.	Purpose: to ensure that the programme does not unnecessarily duplicate existing efforts unless to offer choice of service.
• The team collaborates with others agencies.	Purpose: to support or complement efforts. Examples: joint action, joint budgeting, sharing of resources. Examples of evidence: the team invites other agencies to meetings concerning the programme; the team asks other agencies to participate in the programme.
B.7 Mechanisms are in place for communication and regular exchange within the team.	i.e. internal coordination between all professional levels of staff. Purpose: to assess progress and quality of the programme, for example by discussing the monitoring findings. Examples of communication mechanisms: meetings, notification tools, discussions.

Additional basic standards if the programme is conducted for a recipient organisation:	
B.8 The recipient organisation is considered as a stakeholder in the programme.	Examples of recipient organisation: schools, community centres.
B.9 The recipient organisation's needs are assessed to determine if the programme is adequate.	
B.10 Information provided about the programme is comprehensible and enables the recipient organisation to take an informed decision.	See also component 5.6: *Providing a programme description*.

Additional expert standards:	
B.11 Stakeholders to consider include:	
• community members;	**Basic standard if the programme requires community involvement.** Examples of relevant community members: community 'leaders', shop owners, residents.
• representatives from other organisations;	Examples of other organisations: prevention providers, social services, law enforcement, public health officials, local hospital emergency personnel, educationalists.
• the funding body;	**Basic standard if funding is received from an external funding body.**
• the (local) media;	
• any other stakeholders.	Examples of other stakeholders: government, academic researchers.
B.12 The conditions governing relevant stakeholders' work are considered.	Example of conditions: mandatory guidelines.
B.13 The target population is involved at all stages as a partner in the programme development.	
B.14 The community relevant to the target population is involved:	
• The programme promotes open communication and dialogue with the general public.	
• The community is encouraged to participate in the programme, where appropriate.	
• Links are established with relevant members of the community.	Example of relevant community members: community 'leaders'.
B.15 A written service agreement or contract between the providing organisation and the recipient organisation is set up.	

Additional expert standards (cont.):	
B.16 Necessary support and agreements to collaborate are obtained from other agencies and institutions.	**Basic standard where these are required for a successful implementation of the intervention.** Examples of 'collaborators': school head teacher, teachers, administrative staff. Example of evidence: a formal letter of participation and collaboration is obtained.
B.17 The organisation is represented in existing networks or coordinating bodies, or establishes new networks.	Example of coordinating body: local or regional drug prevention coordinating teams, prevention committees, expert groups.
B.18 The (local) media are involved in the programme, where appropriate:	
• The media are asked to promote the programme among the target population, or to support its aims.	Examples of media involvement: media advertise the programme, promote drug prevention values.
• The media are asked to promote the programme among potential funders or donors.	Example of media involvement: media report on the successes of the programme.
• The media are asked and enabled to help change negative attitudes towards the target population, where appropriate.	Example of media involvement: media avoid labelling the target population. Additional resources: see *Additional guidance* section for media guides.
B.19 Obligations towards the funding body are adhered to.	**Basic standard if funding has been provided by an external body.**
B.20 Mechanisms are in place for communication and regular exchange:	
• between various agencies involved in the programme;	**Basic standard if several agencies are involved in the programme.**
• between staff members and participants.	

Additional expert standards (cont.):	
B.21 Updates on the progress of the programme are communicated:	
• to all persons involved or interested in the programme;	i.e. to all stakeholders that have been identified as relevant, including team members and the senior management of the organisation. Note: the funding agreement may include specific update requirements (e.g. frequency and format of updates).
• regularly;	
• in a user-friendly format that is adequate for the target audience.	

C: Staff development

Staff members are a key resource of drug prevention programmes. However, they must have the right set of knowledge, skills, and behaviours if the programme is to be implemented successfully. Competencies can be distinguished into four broad categories: basic intervention competencies (e.g. knowledge of effective drug prevention approaches); specific intervention competencies (e.g. knowledge and skills specific to the intervention); general competencies (e.g. generic social skills, project management); and meta-competencies which enable staff members to respond to individual participant needs (e.g. cultural sensitivity) (adapted from Pilling et al., 2010). The standards encourage professionals to consider the different requirements of, and opportunities for, staff development throughout the project cycle.

Staff members are sometimes expected to bring all necessary training and qualifications with them when they join an organisation, and staff training is consequently not always provided. However, it is the responsibility of providers to ensure that staff members' competencies match the requirements of the programme and to reduce the likelihood that staff members (inadvertently) conduct interventions that are ineffective or have iatrogenic effects. Providers must consider what competencies are required for successful implementation, and conduct a training needs analysis with staff members (including volunteers). The analysis may show that staff members already have all required competencies, but where gaps are identified, bespoke training must be provided as necessary. The standards outline the content of the training as well as the competencies that staff members should meet.

While staff training is important to ensure that the programme is delivered to a high quality, the standards also highlight the need for further staff development. These standards are likely to be more relevant on an organisational or strategic level than on the level of individual programmes. Staff development beyond the immediate needs of the programme is a means of rewarding and retaining staff and of ensuring that their knowledge and skills are up-to-date with current developments in the field. New guidance issued by the government or other bodies may also introduce a requirement for additional skills training. Regular professional development and performance reviews provide staff members with the opportunity to discuss career plans and development needs.

Staff training and development can be offered 'on the job' (for example by senior members of the team), by organising in-house courses, or by encouraging and supporting staff members to take external opportunities (e.g. nationwide training events, conferences, higher education). Some organisations may be hesitant to support staff members in taking part in external training,

particularly if attendance is not essential for the programme at hand. However, external events can be particularly useful in sharing experiences of best practice and establishing links with other organisations (see B: *Communication and stakeholder involvement*). A common barrier to providing staff training and development in any form is the perceived lack of funding for such purposes. Commissioners and funders should be mindful of the benefits of further staff development and ensure that sufficient funds are available. Ideally, they should provide or at least facilitate regional or nation-wide training and networking events.

The third pillar within this component is professional and emotional support for staff members during implementation (particularly for those in direct contact with the target population). It provides an opportunity for staff members to reflect on their experiences of implementation and to develop their skills on the job, while providers benefit from identifying and fulfilling staff needs as well as programme needs (e.g. if staff members report problems during implementation) (see component 6.3: *Monitoring the implementation*). The level of support that staff members receive is often dependent upon line managers' individual working styles and levels of personal engagement. Adherence to the standards will ensure a minimum level of support during implementation. Where possible, the adequate form of support should be determined together with staff members (e.g. whether staff members prefer one-on-one sessions or group discussions).

Further information on how to select, train and support staff members can be found in the *Additional guidance* section.

Note: Component 5.3 contains standards on the selection of staff members.

Basic standards:
C.1 It is specified which competencies are required for a successful implementation of the programme.
C.2 Competencies to consider include:
• basic intervention competencies;
i.e. general knowledge and skills relating to effective drug prevention. Example competencies: theoretical and practical knowledge on drug use and effective responses to drug use (e.g. knowledge on drugs and their effects, antecedents of drug use, risk and protective factors, drug and alcohol issues, effective evidence-based drug education, evidence from research and previous evaluations on prevention, treatment, care and support, local drug situation and services, national drugs strategy and practice, reducing negative impacts of interventions), acting as a role model (e.g. drug prevention workers do not take drugs), consideration of own experiences of and attitudes towards drug use, open-mindedness toward participants' views.
• specific intervention competencies;
i.e. specific knowledge and skills relevant to the intervention. Example competencies: knowledge of aims, goals and objectives of the programme, identification with programme aims, programme rationale, core values of the programme, knowledge of the project plan, intervention delivery and content, theoretical model, benefits for participants, relevant stakeholders, services for referral of participants, knowledge of the target population (e.g. target populations' perceptions and experiences of drug use).
• general competencies;
Example competencies: knowledge of participant-centred, interactive methods, 'holistic' approaches, interacting with participants, being non-judgemental towards participants, skills in leadership, being comfortable with sharing leadership, networking abilities, communication, decision making, problem solving, conflict resolution, creative thinking; project management (e.g. administrative tasks, long- and short-term planning); methodological skills (e.g. knowledge of monitoring and evaluation, importance of fidelity, feeling of accountability for quality of delivery), confidence, motivation, commitment to the programme.

Basic standards (cont.):	
• meta-competencies. i.e. competencies that enable staff members to respond to individual participant needs. Example competencies: cultural sensitivity, e.g. acknowledging cultural differences, respecting culturally defined needs, being aware of different types of 'culture' (e.g. culture of poverty, exclusion, drug use), recognising multiple identities (e.g. high achieving drug user), recognising that cultural diversity increases the overall capacity; ethics, e.g. participants' rights; needs satisfaction; how to deal with sensitive situations, empathy.	
C.3 A training needs analysis is conducted with those staff members who are in direct contact with the target population.	i.e. their skill level is assessed to identify training needs. Note: this may be conducted on a periodic basis rather than for each intervention.
C.4 Staff members are trained prior to implementation of the programme in line with the findings from the training needs analysis.	Note: the training needs analysis might conclude that there is no need for training, in which case training is not required.
C.5 The training is of high quality. This includes:	
• The training is appropriate for the staff.	Examples: culturally sensitive, in line with staff members' needs and preferences.
• The training includes participatory methods.	i.e. rather than lecture format.
• Training providers are suitably qualified.	Note: where suitable qualifications are not available, training providers should be suitably experienced.
• Staff members are clear about the goals of the training.	
C.6 Training outcomes are assessed.	Purpose: to assess whether staff training needs have been fulfilled, and if additional training is required.
C.7 Prior to implementation, it is ensured that staff competencies match the required competencies for the programme implementation.	i.e. in line with the four categories of competencies outlined above.
C.8 Staff members are supported during implementation.	

Basic standards (cont.):	
C.9 Support to staff members during implementation:	
• is delivered in a professional and appropriate manner;	
• takes place on a regular and ongoing basis, based on staff members' level of need and involvement in the programme;	
• is equally accessible for all staff members.	i.e. including volunteers, part-time staff, etc.

Additional basic standards if a staff development plan exists:	
C.10 The staff development plan:	
• is in line with professional regulations and recommendations for further education;	
• gives staff members the possibility to regularly discuss their professional career and opportunities for further education with their manager;	Purpose: to set development goals, identify training needs. Example of evidence: regular performance appraisals.
• ensures equal access to further education;	
• is reviewed regularly.	

Additional expert standards:	
C.11 The training needs of those who do not have direct contact with the target population but are in a position of influence are considered.	Examples of staff: administrative staff, management, commissioners. Example of evidence: They are asked to attend an introductory session about the programme.
C.12 A defined procedure for staff training exists.	
C.13 The training is nationally accredited.	
C.14 The training is evaluated.	Example aspects to consider: number of attending staff members, staff satisfaction, learning outcomes.

Additional expert standards (cont.):	
C.15 A staff development plan exists and is adhered to.	
C.16 The staff development plan:	
• outlines career goals and progression paths for staff;	
• encourages or obliges staff members to engage in further training and education;	Example of further training: on models of drug dependence, developments in the field of drug prevention.
• is seen as a means for rewarding and retaining staff members.	i.e. as an opportunity to improve qualifications, and a means for recognising staff's value.
C.17 The funding for staff training and further development is sufficient.	
C.18 Support to staff members during implementation includes:	
• emotional support;	Example of emotional support: possibility for staff members to talk about their (stressful) experiences in a semi-structured conversation ('debriefing').
• external supervision;	Examples of content: checking staff members' knowledge and attitudes, functioning of the team.
• structured support between colleagues;	Example of method: a member of staff presents a problem, and other staff members help to resolve the problem in a structured discussion.
• on-the-job support.	Example: peer mentoring.

D: Ethical drug prevention

While it is relatively common to discuss the ethics of drug treatment, harm reduction, and research, it is less common to scrutinise the ethics of drug prevention. Drug prevention activities may not require physical or clinical intervention, but they represent a form of intervention in people's lives nonetheless. All drug prevention programmes are underpinned by judgements about what is 'good' or 'bad' for participants (expressed, for example, in the programme aims). Drug prevention interventions may also be introduced as a result of society's perceptions of a particular behaviour, which may not be shared by the target population. Moreover, prevention is typically targeted at young people, and in the case of targeted prevention these young people can be among the most vulnerable in society.

Ethical questions arise therefore on a variety of levels, starting from the justification of drug prevention work itself. Professionals should not assume that drug prevention activities are per definition ethical and beneficial for participants. The principles of ethical drug prevention in the standards are:

- adhering to legal requirements;
- respecting participants' rights and autonomy (e.g. as defined in international frameworks on human rights and the rights of children — see *Additional guidance* section);
- providing real benefits for participants (i.e. ensuring that the programme is relevant and useful for participants) (see component 1.3: *Describing the need — Justifying the intervention*);
- causing no harm or substantial disadvantages for participants (e.g. iatrogenic effects, illness or injury, exclusion, stigma);
- providing transparent, truthful and comprehensive information (see components 5.4: *Recruiting and retaining participants* and 5.6: *Providing a programme description*);
- obtaining participants' consent before participation;
- ensuring that participation is voluntary;
- treating participant data confidentially;
- tailoring the intervention to participants' needs (see components 4.3: *Tailoring the intervention to the target population* and 6.4: *Adjusting the implementation*);
- involving participants as partners in the development, implementation, and evaluation of the programme (see B*: Communication and stakeholder involvement*); and
- protecting participants' and staff members' health and safety.

Depending on the type of programme, it may be difficult or not feasible to adhere to all principles of ethical drug prevention. Obtaining informed consent and ensuring voluntary participation may be a challenge in universal prevention programmes or, for example, in criminal justice interventions, where participants may be legally required to take part in such programmes. In relation to the principle of causing no harm, it is noteworthy that targeted prevention approaches may stigmatise participants (EMCDDA, 2009, p. 48). Different principles may be in conflict with each other. For example, participants may wish to engage in behaviours that cause them harm (e.g. drug use), or, as partners in the programme development, participants may ask for intervention approaches that have been shown to be potentially iatrogenic (e.g. talking to a former drug user or drug using peer). It can also be difficult to judge the ethics of the programme before it has been implemented (e.g. forecasting benefits and harms). Finally, all principles are, to some extent, subject to interpretation (e.g. what constitutes a benefit?). The standards provide an incentive for providers to verbalise and reflect on the underlying values and principles of their programme.

An ethical approach must be clearly evident at every project stage. Providers must consider what is possible within the programme (e.g. if written consent is not possible, obtaining verbal consent may be) and pay special attention to any specific issues arising from the programme. They should also take into account that different stakeholders (e.g. staff members, participants, general public, government) may have different viewpoints on what is 'ethical'. However, participants should always be in the focus of attention.

Basic standards:
D.1 The knowledge of general policy and legislation is sufficient for the implementation of the programme.
i.e. staff members and participants are aware of generally binding regulations, their legal responsibilities, and internal rules and procedures. Note: It depends on the particular programme which policies and pieces of legislation are most important; further considerations can be found in component 1.1: *Knowing drug-related policy and legislation*. Examples of policy and legislation: equal opportunities policy, confidentiality policy, child protection policy, health and safety policy, laws on waste and environmental protection.
D.2 A code of ethics is defined.

Basic standards (cont.):	
D.3 Participants' rights are protected:	
• The programme respects and promotes human and other basic rights of the participants and members of their social network.	Examples of rights: right to information useful to oneself, right to equality and non-discrimination. Example members of social network: friends, relatives.
• Potential situations in which participants' rights could be violated are identified, and ways to handle them are specified.	
• Rules on participants' rights are established.	Purpose: for example, to prevent abuse of power due to organisation's or staff members' status in relation to participants. Note: this could be part of a wider strategy (e.g. wider school drugs policy) or specific to a particular intervention.
D.4 Staff obligations include:	
• adherence to a staff code of ethics;	
• acting upon recommendations regarding professional or ethical conduct.	Note: particularly where complaints or cases of discrimination or abuse are upheld or proven.
D.5 Staff violation of participants' rights, and measures taken in response, are documented in personnel records.	
D.6 The programme has clear benefits for participants.	
	i.e. it is not a self-referential and self-promoting activity or policy in benefit of the organisation providing or commissioning it. Note: the programme's benefits can relate to individual members of the target population or to the target population as a community (if appropriate). Benefits need not relate directly to drug use, but may also include welfare and general health issues.

Basic standards (cont.):	
D.7 Potential disadvantages and risks for the target population and likely participants are outlined and considered.	
Note: the nature and likelihood of disadvantages and harms should be forecast, and measures for their reduction and control taken; if the risks are too high or the disadvantages too severe, the intervention should be dismissed or suitably modified. Examples of disadvantages: iatrogenic effects, opportunity costs, illness or injury, exclusion, stigmatisation, restriction of leisure activities. Examples of situations to consider: outdoor activities, violence between participants.	
D.8 The values and principles underlying the programme are clear.	i.e. values and principles are clear to all stakeholders, particularly participants. Example of evidence: the organisation's views on drug use and drug users' rights are described in the programme description.
D.9 The 'rules' of the programme are made clear to participants.	
D.10 Participant data is treated confidentially. This includes:	
• Clear confidentiality and disclosure protocols and procedures are in place.	Note: this could be part of a wider strategy (e.g. wider school drugs policy) or specific to a particular intervention.
• Participants' confidentiality is ensured when collecting and handling data.	
D.11 The programme reflects cultural sensitivity.	i.e. demonstrates awareness of participants' values, and respect for participants' views on the intervention and the staff. Example aspects to consider: importance of community 'leaders' and gatekeepers, cultural aspects of staff-participant interaction (e.g. what gender, age, ethnicity are acceptable to the target population).

Basic standards (cont.):	
D.12 The safety of staff members and participants is ensured:	Example of evidence: the facility is perceived as safe by staff members and participants.
• Minimum rules on safety are defined.	i.e. health and safety requirements are considered and adhered to. Examples: appropriate level of cleaning and disinfection to prevent the spread of infectious diseases; laws on food safety are considered if participants want to cook or bring meals.
• Measures and internal rules for staff protection exist in writing, and they are known and adhered to.	Example aspects to consider: adequate working conditions, liability insurance for volunteers.
• Accidents, emergencies, and extraordinary incidents are defined, and procedures for dealing with them are written and known to staff members.	Example of evidence: defined in an organisational code and operational manuals.
D.13 Participants with drug-related needs that cannot be responded to within the programme are referred to specialist services.	
D.14 Participants having additional drug-related needs feel safe and comfortable enough to ask for help.	

Additional expert standards:	
D.15 Alcohol, tobacco, and illegal drugs are banned in the facilities of the programme.	**Basic standard if required by law.** Note: Adherence to this standard may not be feasible under certain circumstances, for example if the intervention is delivered in an external recipient organisation (e.g. nightclub).
D.16 The programme complies with national and international standards and guidelines.	**Basic standard if required by existing policy and legislation.** Example of standards: national occupational standards in drug prevention, if available.
D.17 The participants' code of rights is publicly posted and easy to understand.	
D.18 A complaints procedure is in place.	Example of content: participants can obtain information about how their complaint has been settled. Examples of evidence: the complaints procedure is known to participants and staff members; the complaints procedure is defined in writing.
D.19 The programme supports the relationships within families and communities.	
D.20 A detailed programme description is provided to participants.	Examples of content: duration, form, and contents of programme, expected effects, benefits and risks, rules and obligations, expected participants' behaviour. See also component 5.6: *Providing a programme description.*
D.21 Participants' access to documentation of the programme is defined.	
D.22 Intended aims, goals, and objectives are stated to participants at the beginning of each session.	Note: these could be defined together with participants.

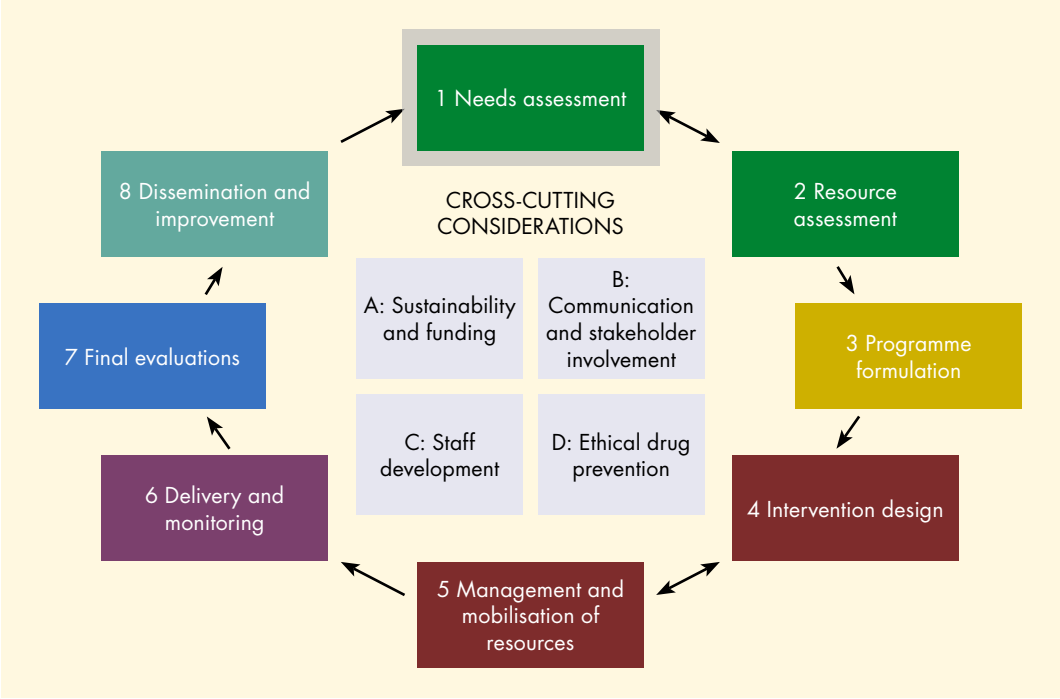
Additional expert standards (cont.):	
D.23 The roles and tasks as well as rights and responsibilities of participants and staff members are defined.	Example of evidence: ground rules are set for each session or group.
D.24 A learning contract is negotiated with participants.	Note: the contract could be in verbal or written form. Example of content: participants' expectations of the intervention.
D.25 The rules of the programme are fair.	Example: rules apply to participants as well as staff members.
D.26 Participation in the programme is based on informed consent.	**Basic standard if feasible within the intervention.**
D.27 Participation in the programme is voluntary.	i.e. participants are not obstructed from withdrawing from the programme. **Basic standard if participation is not a legal requirement.** Note: this standard may not apply under certain circumstances, for example in criminal justice interventions, or in the case of universal school-based interventions.
D.28 The community or participants agree to how their culture is incorporated into the programme.	Example aspects to consider: use of cultural symbols or community knowledge. Example of evidence: the programme is designed in consultation with representatives of the community or target population.
D.29 The programme's structures and processes reflect democratic values.	Examples of evidence: participants can provide feedback on the programme; participants are consulted during the delivery of the programme.

Additional expert standards (cont.):	
D.30 Staff members are present during external agency involvement.	Note: this standard may not be applicable where it would breach participants' confidentiality or where it would not be in line with programme aims. Example of external agency involvement: external lecturer (e.g. police officer) talking to school class.
D.31 Responses to drug-related incidents occurring during programme delivery are prepared. This includes:	
• Drug use and other problem activities on or near the premises of the organisation or intervention are monitored.	
• Procedures are in place regarding infractions, complaints, and disciplinary measures.	
• The management of drug-related incidents corresponds to the overall aims of the programme.	
• A support system is in place for any participant having drug-related needs.	
• Assessment procedures and referral routes are transparent.	

PROJECT STAGE
ONE

Project stage 1

Needs assessment



Before the intervention can be planned in detail, it is important to explore the nature and extent of drug-related needs, as well as possible causes and contributing factors to those needs. This ensures that the intervention is necessary, and that it will address the correct needs and target population(s). Four types of needs are distinguished: policy needs; (general) community needs; needs defined by gaps in the provision of prevention; and (specific) target population needs.

1.1 Knowing drug-related policy and legislation: Drug-related policy and legislation should guide all drug prevention activities. The team must be aware of and work in correspondence with drug-related policy and legislation at the local, regional, national, and/or international level. Other guidance, such as binding standards and guidelines, should also be considered where appropriate.

1.2 Assessing drug use and community needs: The second component in this project stage specifies the requirement to assess the drug situation in the general population or specific subpopulations. The assessment can utilise quantitative and/or qualitative methods, and should draw upon existing data where relevant data of high quality is already available. Other relevant issues, such as deprivation and inequalities, should also be assessed to account for the relationship between drug use and other needs.

1.3 Describing the need — Justifying the intervention: The findings from the community needs assessment are documented and contextualised to justify the need for the intervention. Existing drug prevention programmes are analysed to gain an understanding of how the programme can complement the current structure of provision.

1.4 Understanding the target population: The needs assessment is then taken further by gathering detailed data on the prospective target population, such as information about risk and protective factors, and the target population's culture and everyday life. A good understanding of the target population and its realities is a prerequisite for effective, cost-effective and ethical drug prevention.

This stage may be conducted at the same time as, or after, the resource assessment.

1.1 Knowing drug-related policy and legislation

In order to have an impact, all drug prevention activities must strive toward the same end, albeit through different means. By defining the aims of drug prevention work, drug-related policy and legislation act as signposts guiding drug prevention activities on a local, regional, national and international level. It is therefore essential that all professionals — not only those working 'at the top' — are aware of relevant policy and legislation, as this enables everyone to contribute to these aims. Other guidance, such as binding standards and guidelines, should also be taken into consideration where appropriate.

It is equally important to stay up-to-date with changes in drug-related policy and legislation, as these may affect different aspects of the programme. For example, changed funding priorities may require a new strategy to ensure the programme's sustainability (see A: *Sustainability and funding*); or, where participants receive information about drugs as part of the intervention, changes in legislation may require an update of the intervention content (e.g. reflecting changes in the legal status of drugs such as 'legal highs').

Moreover, by showing awareness of, and correspondence with, drug-related policy and legislation, providers maximise their chances of obtaining necessary support from commissioners and funders. In some countries, demonstrating support of relevant strategies is a criterion for obtaining government funding. However, these standards should not prevent programmes from addressing needs that are not current policy priorities. For example, the identified needs of the target population or community may not be explicitly targeted by existing policies and funding (see component 1.2: *Assessing drug use and community needs*). In such cases, programmes should still support the wider drug prevention agenda as defined by national or international strategies and make a case for the response to other needs.

While it is ultimately up to funders and commissioners to ascertain that programmes are in line with policy and legislation, all professionals should have a general level of knowledge in this area. Practitioners who spend a large amount of time working in direct contact with the target population may feel that learning about drug-related policy and legislation, and staying up-to-date with new developments, is beyond the remit of their work. It is the responsibility of providers to support staff members in achieving these standards, for example by holding in-house training events (see C*: Staff development*).

It can be difficult to judge which policies and pieces of legislation are most relevant. Policy priorities can change frequently, coinciding with a new government, shifts in society's concerns, or an important new piece of research. The *Additional guidance* section contains a selection of important contemporary documents in relation to international and national drug policy and legislation. However, the relevance of documents can depend on the type of the programme. For example, a local programme would be expected to prioritise local or regional documents over national and international ones, as these would be less relevant to the local context.

Note: Component D: *Ethical drug prevention* contains standards on general policy and legislation.

Basic standards:	
1.1.1 The knowledge of drug-related policy and legislation is sufficient for the implementation of the programme.	Examples of policy and legislation: relevant legislation covering drugs, alcohol, tobacco, medicines, and volatile substances; health education policy.
1.1.2 The programme supports the objectives of local, regional, national, and/or international priorities, strategies, and policies.	Note: local/regional programmes should pay particular attention to local/regional policy documents. Example of evidence: the programme description provides clear references to the most relevant strategies and policies, and it positions itself in relation to these.

Additional expert standards:	
1.1.3 The programme complies with relevant local, regional, national, and/or international standards and guidelines.	**Basic standard if required by existing policy and legislation.** Example of standards: existing standards on making services young-people friendly (e.g. Department of Health, 2007).

1.2 Assessing drug use and community needs

Drug prevention programmes must respond to the needs of the target population in order to be ethical and effective. It is therefore not sufficient to rely on assumptions or ideology when planning prevention work. Instead, drug prevention programmes must be informed by an empirical assessment of people's needs, regardless of whether it is a universal or targeted prevention programme. This assessment can target the general population or a subpopulation which is usually defined through a common social feature (e.g. ethnic community), a particular setting (e.g. school), or a geographic area (e.g. neighbourhood).

Depending on the type of organisation and programme, it may not be necessary to conduct a needs assessment for each individual programme, and one needs assessment may inform several different programmes across a defined time span. Nevertheless, as drug trends can change rapidly, it is important to ensure that findings are updated frequently. The assessment can be conducted by collecting and analysing new data using quantitative and/or qualitative methods (e.g. surveys, focus groups, observation), and/or by drawing upon existing (epidemiological) data to conduct a secondary data analysis. Basic data on drug use is often already available for the general population and/or subpopulations (e.g. young people, people in treatment), as it is collected as part of routine surveys and monitoring (see *Additional guidance* section). However, the potential caveats of existing data must be taken into account (e.g. quality, topicality, and relevance). For example, only national data may be available, which can be useful to interpret local data, but cannot replace local data. It is recommended to consult multiple and differing data sources to gain a comprehensive picture of the situation. Detailed guidance on how to conduct needs assessments can be found in the *Additional guidance* section.

The consultations that informed the development of these standards indicated that there was often a lack of communication between those who collect data on a regular basis (e.g. regional drugs coordination teams, public health observatories, researchers) and those who could use the data to develop programmes (e.g. commissioners, providers). For example, although schools are often researched they do not usually have access to the data in order to ensure pupils' confidentiality. Consequently, existing data is not always used to inform programme development. However, even in the above example data may be provided to schools if several schools are included in an anonymised dataset with a large sample size. If needs assessments are not conducted by providers themselves, then structured collaboration is required to ensure that they receive the data (see B:

Communication and stakeholder involvement). Local or regional drugs coordination teams could be well suited to coordinate regional data collection and analysis to reduce duplication of efforts. Indeed, drugs coordination teams should consider the possibility of conducting regular needs assessments or consolidate data from different sources to inform the work of prevention providers in the area.

The standards in this component focus on the assessment of drug-related needs in order to identify the appropriate target population and setting for the programme. However, data on drug use alone is often not sufficient to design an adequate and tailored intervention. Other needs, such as health and social inequalities or levels of deprivation, should also be assessed to understand the complex nature of drug use. It is useful to consider already at this project stage which theoretical model will guide the programme, as it can determine what data to collect and how to interpret it. Component *Understanding the target population* in Project stage 1 presents the opportunity to conduct a more in-depth analysis of the target population.

Basic standards:	
1.2.1 A study of the initial situation is conducted.	
1.2.2 The study utilises existing epidemiological knowledge.	
1.2.3 The study is ethically sound.	Examples of ethical soundness: the study ensures confidentiality and anonymity of respondents; it does not stigmatise or disadvantage informants. See also: D: *Ethical drug prevention*.
1.2.4 Detailed and diverse information on drug use is gathered or reviewed. This includes:	Examples of groups to describe: general population, subpopulations differentiated by sex, age, ethnicity, vulnerability.
• types of drugs used;	Examples of drugs: legal, illegal, and medically controlled drugs.
• drug use rates and trends.	Examples of indicators: incidence and prevalence rates, use-rates in the last 30 days/last year/lifetime, proportion not using any drugs.

Basic standards (cont.):	
1.2.5 Other relevant needs in the community or setting are assessed.	Purpose: to account for the relationship between drug use and other needs. Examples of needs: problems, wishes, (historical) prevalence of problematic behaviour, levels of socio-economic deprivation and inequalities.
1.2.6 The study is documented, and sources of the data or information are indicated.	Purpose: documentation of the study is useful for the justification of activities and as a record.

Additional basic standards if existing data is used:	
1.2.7 Existing data is:	Examples of resources: local, regional, national datasets.
• up-to-date;	
• adequate for the programme scope and target population;	Example of adequacy to programme scope: local data for local projects.
• valid in terms of the indicators used;	Example of indicators: drug use prevalence data is used rather than intentions to use drugs or perceived use in peers.
• reliable.	i.e. in regard to the data collection methodology and analysis.

Additional expert standards:	
1.2.8 The study of the initial situation:	
• enables knowledge of the operating environment within which the intervention will take place ('climate' of the environment);	i.e. of the community or setting (e.g. recipient organisation) in which the intervention will take place. Example aspects of environment and its culture: norms, goals, values, relationships, practices, organisational structures that are relevant within the local community.

Additional expert standards (cont.):	
• is done in a systematic and rigorous manner;	i.e. the study uses a recognised needs assessment methodology. Example of evidence: the instruments and tools used to assess community needs are described. Additional guidance: Detailed guidance on how to conduct needs assessments can be found in the *Additional guidance* section.
• is done by spending time in the community;	Examples of evidence: field research, discussions with community stakeholders.
• seeks expert guidance on methodology, if needed.	Examples of 'experts': academics, local intelligence managers.
1.2.9 A team to oversee data collection and data analysis for this phase is assembled.	i.e. roles and responsibilities are assigned. Examples of responsibilities: planning and coordinating needs assessment, data collection, analysis, and interpretation, writing up findings from the needs assessment.
1.2.10 The population size in the area or community is given or estimated:	Examples of data sources: statistical institutes, local councils, educational bulletins.
• for the total population;	**Basic standard if such information is available.** Examples of total population: general population, all school children, all members of an ethnic community. Example of resources: census data.
• for the likely target population.	i.e. those who are likely to be targeted by (e.g. participate in, exposed to) the intervention. **Basic standard if such information is available.** Example: target population estimated as a proportion of the total population.

Additional expert standards (cont.):	
1.2.11 Information that is gathered or reviewed includes:	
• drug use patterns and trends;	Examples of indicators: frequency of use, situation and circumstance of use, functions of use, age of initiation, age of peak use, frequency and extent of occasional, regular, and/or heavy use, hazardous practices, populations at greater risk.
• differentiated adverse effects of drug use;	Examples of indicators: nature of harm and affected people, individual and community impact of drug prevalence, drug dependence.
• drug-related perceptions;	Examples of indicators: perceived harm of drug use, perceived availability of drugs, perceived disapproval and acceptability of drug use.
• existence of drug markets.	
1.2.12 The obtained data is compared with similar data from other localities or regions, or with national data.	Purpose: to assist with the justification of the intervention. Examples of comparisons: drug use prevalence, analysis of drug problem at individual, institutional, and societal levels.

1.3 Describing the need — Justifying the intervention

The need for the intervention is defined by drug-related policy (see component 1.1: *Knowing drug-related policy and legislation*), target population and community needs (see 1.2: *Assessing drug use and community needs* and 1.4: *Understanding the target population*), and the existing level and nature of prevention provision. In this component, the findings from the previous components are documented and contextualised to justify the need for the intervention.

In these standards, organisations are asked to provide an overview of the main need(s) of the community, point toward particular issues, explain why these issues are relevant, and identify necessary actions to improve the situation (or to prevent an undesirable development). This description will help determine whether the correct target population is chosen for consideration in subsequent components such as 1.4: *Understanding the target population*, and also inform the choice of programme aims (see 3.3: *Defining aims, goals, and objectives*).

The justification should take into account the views of the community to ensure that the programme is relevant to them (see D: *Ethical drug prevention,* B: *Communication and stakeholder involvement*). It is therefore important to involve the community and other relevant stakeholders when describing needs; this is essential if the community needs assessment was based on a secondary data analysis (e.g. using routine data). However, communities may not be willing to accept that there is a need for an intervention, as this can be interpreted as admitting that there is a (drug) problem. For example, school head teachers may worry that the introduction of a drug prevention intervention could damage the reputation of their school. There may be less of a stigma if school-based drug prevention is a statutory part of government policy. Providers and policy makers should avoid focussing on 'problems' but consider 'needs' instead — there can be a need for a prevention programme before a problem has developed.

It is likely that there are already some drug prevention programmes in operation. Existing and recent programmes that contribute to drug prevention are therefore analysed to gain an understanding of how the new programme can fit in. Local or regional drug prevention planning teams may be able to provide information on existing programmes in the area. The new intervention should complement existing efforts by filling gaps in the current provision of drug prevention. For example, low coverage of the target population may indicate the need for additional programmes. If the target population is already well covered through existing effective drug prevention programmes, providers may want to focus on a different target population to avoid duplication of efforts. However, they may also decide,

for example, to offer a different type of intervention for the same target population in order to increase choice and diversity of provision.

In some cases, the justification and direction of the intervention may have already been set out by a specific tender for projects, and providers may feel that the tender itself is the justification for the programme. Nevertheless, it is important that the justification of the intervention is based on factual information about the community, not assumption. Commissioners and funders must consequently acknowledge the need for flexibility (e.g. tenders may need to be revised after the needs assessment). Communication between providers and commissioners or funders ensures that the programme is relevant to the community as well as those enabling its implementation (see B*: Communication and stakeholder involvement*).

Basic standards:	
1.3.1 The main needs of the population are described and, if possible, quantified.	Example aspects to consider: drug-related needs, health, policy, and social needs.
1.3.2 The description is informed by the needs assessment.	
1.3.3 The description illustrates the potential future development of the needs without an intervention.	Examples of indicators to consider: rate of growth of illegal drug use, rate of transmission of blood-borne viruses.
1.3.4 The organisation is aware of existing and recent programmes that contribute to drug prevention.	
Note: such information may be readily available from local or regional prevention planning teams. Examples of programmes: existing social and health services, previous programmes for the target population, regional and local strategies. Example considerations: what other organisations there are, what services they offer.	
1.3.5 Existing and recent programmes that contribute to drug prevention are analysed according to their correspondence with target population and community needs.	Purpose: to identify gaps in service provision. Example considerations: which target populations are covered, what needs are addressed by existing services.

Basic standards (cont.):	
1.3.6. The programme complements other health promotion or drug prevention programmes locally, regionally, and/or nationally.	Example: the programme focuses on groups that are not already well covered by several other programmes and services (e.g. targets different age groups).
1.3.7 The need for an intervention is justified.	Example aspects to consider: the programme's usefulness, expected cost-effectiveness.

Additional expert standards:	
1.3.8 The description of the main needs of the population:	
• includes an estimate of costs associated with the (potential) problem;	Examples of costs: financial, health, social, and community costs.
• identifies specific subgroups or places;	
Purpose: to determine relevant subgroups or places for consideration, see 1.4: *Understanding the target population*, 3.1: *Defining the target population and 3.4: Defining the setting*. Examples: identifying groups and/or places for prevention work by using incidence and prevalence data to establish local ages of drug use onset (target population's age would be below the age of onset); identifying groups and/or places for reduction of drug use by using prevalence data to identify 'who', 'what', and/or 'where' are contributing most to drug use rates (CSAP, 2002).	
• determines other factors associated with (potential) drug use;	Examples of other factors: non-drug related needs of the community; political, structural, economic issues, e.g. deprivation, poverty, inequalities.
• takes into account the views of the community or likely target population on the identified drug-related needs;	Purpose: to ensure that the intervention is relevant and likely to be accepted. Example of finding: target population may not view drug use as a problem.
• identifies changes necessary for an improvement in the situation;	Examples of changes: policy changes, macro-level interventions.

Additional expert standards (cont.):	
• differentiates between changes that are necessary but are beyond the programme's capacities, and changes that can be covered by the programme.	
1.3.9 Existing and recent programmes that contribute to drug prevention are analysed according to their:	Purpose: to identify gaps in service provision.
• coverage of the target population;	i.e. percentage of target population. Example: if the target population is defined as 'at-risk youth', coverage can be expressed as the number of at-risk youth participating in existing programmes given as a percentage of all at-risk youth in the catchment area.
• design, delivery, and impact.	Examples of indicators: programme fidelity (whether previous programmes were implemented as designed), staff competency, effectiveness and impact of the intervention.
1.3.10 The intervention addresses needs that are:	
• urgent and important;	
• costly and/or common;	i.e. the consequences of unmet needs have high social and financial costs; and/or they have a high prevalence in society or the community. Note: some behaviours can be uncommon but very costly to society, for example heroin dependence.
• defined as drug prevention priorities by local, regional, national, or international agencies.	

1.4 Understanding the target population

A good understanding of the target population and its realities is a prerequisite for (cost-) effective and ethical drug prevention. Drug prevention must be carried out not only *for* people, but also *with* people, and therefore drug-related needs must also be viewed from a wider cultural and social perspective. The general assessment of drug-related and other needs in the general population or a specific subpopulation (see 1.2: *Assessing drug use and community needs*) indicates what the programme's aims and target population could be, i.e. who the intervention should be directed toward, and why. However, a more in-depth analysis of the prospective target population at this point ensures that the design and content of the intervention are well chosen in the later project stages (see 4.3*: Tailoring the intervention to the target population*).

This component specifies the requirement to explore the target population's culture, its position in the wider community, and its perspectives on drug use. This data complements the drug use data gathered earlier, and provides important indications for the intervention design. Where the target population has been chosen prior to the needs assessment (e.g. as part of a project tender), this step may be carried out together with the community needs assessment in 1.2: *Assessing drug use and community needs*. Apart from obtaining a general knowledge of the target population's culture, it is important to understand the role of drug use in the culture (UNODC, 2004, p. 9). For example, certain drug use may be acceptable as part of a cultural custom (e.g. the use of alcohol to mark a celebration such as New Year; drug use as part of initiation rituals in certain youth cultures), while other forms of drug use may be sanctioned. Knowledge of drug-related cultural norms and practices should inform intervention design to ensure that the intervention is culturally relevant.

Relevant factors that reduce or increase the likelihood of drug use in the target population should also be mapped and assessed. The findings from this analysis help define the target population (see 3.1: *Defining the target population*), choose goals and objectives (3.3: *Defining aims, goals, and objectives*), and design the intervention (see Project stage 4: *Intervention design*). It is also possible to assign a risk level to the target population depending on the concurrence of risk and protective factors. However, the analysis of risk and protective factors is not essential for universal prevention programmes, as these do not single out individuals or groups with a higher risk of drug use.

In some programmes, there is a distinction between the ultimate target population (e.g. young people at risk of drug use) and the intermediate target population which is believed to have a strong

influence on the ultimate target population (e.g. parents of these young people). These interventions are carried out with members of the intermediate target population in order to indirectly influence the behaviour of the ultimate target population. In such cases, the provider must understand important aspects about both the intermediate and the ultimate target population, such as risk and protective factors relating to the ultimate target population, the intermediate target populations' views on drug use, and details on the interaction between the intermediate and the ultimate target population.

Detailed information on the target population may already be available (e.g. research reports). It is therefore recommended to consult relevant literature to gain a better understanding of the target population. Additional information about the target population may also be obtained by contacting relevant stakeholders (e.g. regional drugs coordinating team, health and social services operating in the area) (see B: *Communication and stakeholder involvement*).

Basic standards:	
1.4.1 A potential target population is chosen in line with the needs assessment.	
	Note: the final choice of the target population may depend on the findings from the analysis of risk and protective factors. Decisions on the target population may have already been taken prior to the needs assessment, for example through tenders for funding. If the needs assessment shows that an alternative target population would benefit more from an intervention, the original strategy should be developed further.
1.4.2 The target population's culture and perspectives on drug use are included in the needs assessment.	Purpose: this will inform the design of the intervention as well as its tailoring to the target population. Note: differences within the target population should be taken into account.

Additional expert standards:	
1.4.3 Risk and protective factors for drug use are explicitly mapped. This includes:	i.e. the numbers, types, and scale of main risk and protective factors are assessed. Notes: the analysis of risk and protective factors is not as relevant to universal prevention. It is most relevant as a means for describing the target population, for example in terms of conduct disorders or sensation seeking.
• Risk and protective factors are differentiated according to the characteristics of the target population.	Examples of indicators: age, sex, culture, vulnerability.
• Risk and protective factors that are unique to the target population are identified.	Example aspects to consider: mental health issues, gender, sexual orientation, culture, ethnicity, environment.
• The impact of broad health determinants is assessed.	Examples of indicators: family income, parent educational levels, early childhood experiences.
• The role of the community as a risk or protective factor is assessed.	Examples of indicators: indices of deprivation, availability of drugs, structural support, community norms.
• The strength of risk and protective factors is estimated.	i.e. they are quantified or qualified in terms of their relevance to drug use. Example aspects to consider: relevance to the individual, the family, peer, school, workplace, community.
• Similar risk factors or protective factors are grouped together.	Examples of categories: genetic, biological, social, psychological, familial, contextual, educational, economic, cultural.
• Clusters of risk or protective factors that could be addressed together are identified.	Example: a community regeneration/ cohesion programme would address several community-related factors.

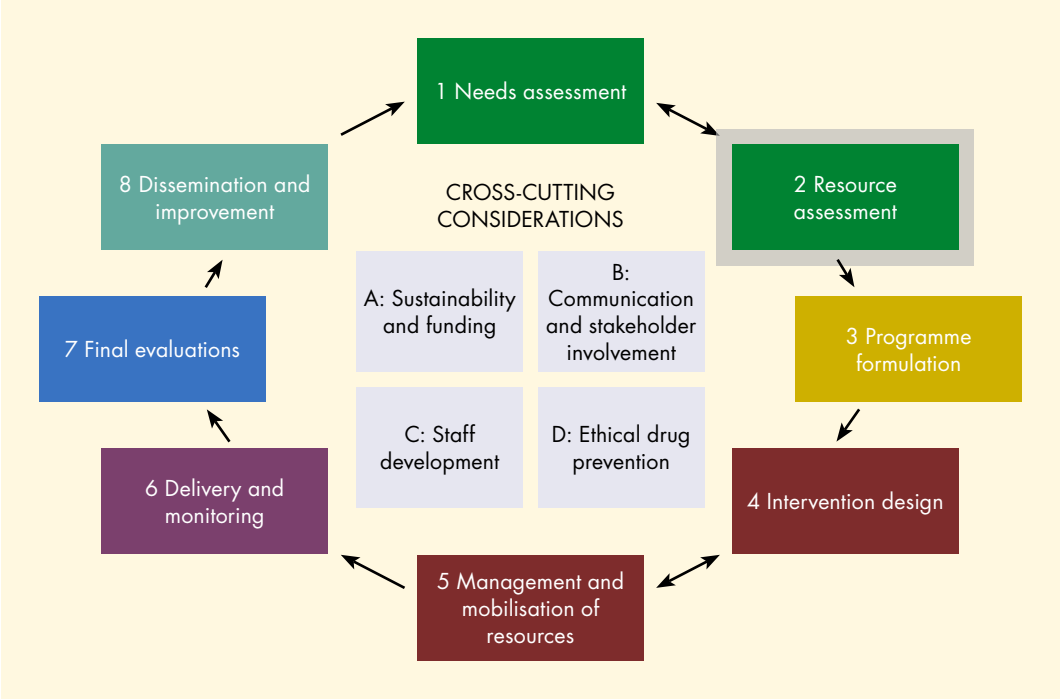
Additional expert standards (cont.):	
1.4.4 Factors which can be modified are distinguished from factors which cannot be modified by the programme.	Examples: health literacy can be improved, but national public health policy is unlikely to be changed by a small-scale intervention.
1.4.5 Modifiable factors to be targeted by the programme are specified.	Example of evidence: presented in a logic model.
1.4.6 The risk level of the target population is defined.	Example of risk level definition: 'high risk' of early onset of drug use due to diagnosis of behavioural conduct disorder. Example consideration: which type of intervention (universal, selective, indicated) is appropriate for this risk level?
1.4.7 Perspectives to consider when assessing the target population include:	Note: differences within the target population should be taken into account.
• self-perception of the target population;	Example of indicators: perception of impact of drug use on own health and that of others.
• cultural aspects;	Example aspects to consider: general traditions and habits, beliefs and social rules, values. Examples of indicators: hierarchies and types of relationships in the family, school, or workplace; beliefs about how to cope with stress.
• general problems and needs, expectations, opinions and attitudes;	Example of indicators: situation of drug use in the wider biography of members of the target population.
• the 'language' of the target population;	Examples of indicators: music, books, magazines, Internet, television programmes that the target population consumes; how members of the target population express ideas about drug use and prevention (e.g. youth rejection of 'Just say NO to drugs' messages).

Additional expert standards (cont.):	
• persons and institutions that are important to the target population;	Examples of persons and institutions: community figures, celebrities, role models, school.
• motivations for drug use;	Examples of indicators: functions of drug use, drug effect expectations.
• perceptions of harms and benefits of drug use;	
• existing knowledge, and need for information or education;	Example indicator: knowledge of national laws on drug use.
• views on the media and drug prevention or drug 'promotion' messages in the media;	Example indicator: media literacy skills.
• expectations of the aims, goals, and objectives of drug prevention programmes;	Examples of expectations: target population expects programmes that are empowering, that grant access to specialist services.
• views on providers and staff members.	Example of provider: drug service.
1.4.8 Relevant stakeholders are involved in determining target population needs.	Examples of stakeholders: family members of the target population (where appropriate), for example parents of school children. Examples of stakeholder contributions: perspectives on target population's drug use, ways of responding to drug use, expectations towards prevention providers (e.g. drug services).
1.4.9 The nature of the relationship between the target population and the community is included in the needs assessment.	Example aspects to consider: the target population's perception of the community; community's perception of the target population; the target population's position and level of integration in the community. Examples of indicators: levels of social/ educational/ economic/ service inclusion and exclusion.

PROJECT STAGE
TWO

Project stage 2

Resource assessment



A programme is not only defined by target population needs, but also by available resources. While the needs assessment (see Project stage 1: *Needs assessment*) indicates what the programme should aim to achieve, the resource assessment provides important information on whether and how these aims can be achieved. Thus, resources must be assessed to gain a realistic understanding of the desirable type and possible scope of the programme.

2.1 Assessing target population and community resources: Drug prevention programmes can only be successful if the target population, community and other relevant stakeholders are 'ready' to engage, e.g. able and willing to take part or support implementation. They may also have resources that can

be utilised as part of the programme (e.g. networks, skills). The standards in this component describe the requirement to assess and consider potential sources of opposition and support, as well as available resources of relevant stakeholders.

2.2 Assessing internal capacities: The analysis of internal resources and capacities is important, as the programme will only be feasible if it is in line with available staff, financial, and other resources. This step is carried out before programme formulation to gain an understanding of what types of programmes might be feasible.

This stage may be conducted at the same time as the needs assessment, or at the beginning of the project before the needs assessment.

2.1 Assessing target population and community resources

Drug prevention programmes can only be successful if they are supported by all relevant stakeholders, such as the target population, the community, and the recipient and referral organisations (where applicable). The main condition of support is that these stakeholders are 'ready' to engage with the programme, i.e. aware of the (drug-related) needs, as well as interested, willing, and able to support (e.g. take part in) the programme (NIDA, 2003).

The standards in this component describe the requirement to assess the level of readiness among the target population, the community, and any other relevant stakeholders (see B: *Communication and stakeholder involvement*). The findings of this assessment will indicate, for example, what must be done to obtain the necessary level of support and what difficulties might occur during implementation (e.g. when enrolling and retaining participants). Consequently, a more realistic estimate of the timeline and other necessary resources is possible. Research has identified distinct stages of community readiness that can help determine the current level in the target population or community (e.g. Plested et al., 1999).

The target population or wider community may also have resources that can be utilised in the programme. Some resources may facilitate implementation of the programme from a practical point of view (e.g. community members have good relationships with members of the target population and can help providers to establish contact). Other resources may be relevant and useful to the design and content of the intervention (e.g. providers plan intervention activities that make use of participants' existing skills and talent) (see Project stage 4: *Intervention design*). This component therefore also examines existing strengths and weaknesses within the target population or community.

Consequently, while components 1.2*: Assessing drug use and community needs* and 1.4: *Understanding the target population* are about gaining a better understanding of the context within which drug use may occur, this component assesses the relationship between the programme itself and the target population or community in which it will take place.

Basic standards:	
2.1.1 Sources of opposition to, and support of, the programme are considered, as well as ways of increasing the level of support.	Note: this is not limited to the target population and the community, but could include other stakeholders, such as school head teachers, media, national government.
2.1.2 The ability of the target population and other relevant stakeholders to participate in or support the programme is assessed.	
	i.e. their availability (e.g. time, physical presence) to participate in or support the programme. **Basic standard includes the community if community members (e.g. general public, officials) will be involved in the programme or where parts of the intervention are delivered in the community.** Note: relevant stakeholders should be identified in line with B: *Communication and stakeholder involvement*. Example conclusions: social inclusion programmes should take place in school holidays or after school; brief interventions should be delivered at a suitable point in service utilisation.

Additional expert standards:	
2.1.3 The readiness of the target population and other relevant stakeholders for the programme is assessed, including their:	
• awareness of drug use and related needs;	
• interest in the prevention programme;	
• willingness to participate in or support the programme.	
2.1.4 The resources of the target population and other relevant stakeholders are assessed.	Purpose: to inform the project plan as well as intervention content and design. Example of other relevant stakeholders: community. Examples of resources: social capital, existing knowledge and skills, strengths, vulnerabilities, material and human resources.
2.1.5 The possibility to utilise components of other local, regional, national, and/or international drugs strategies and activities is assessed.	Examples of other activities: national or regional drink-drive campaigns, World AIDS Day.

2.2 Assessing internal capacities

Drug prevention programmes are only feasible if they operate within the limits of available resources, such as staff, competencies (e.g. skills, knowledge, experience), materials (e.g. equipment), and professional networks. It is therefore essential to assess what internal resources and capacities are currently available and/or likely to be available when the programme is implemented.

This assessment must be carried out early on in the project cycle to gain an understanding of what types of programme might be feasible. For example, a specialist intervention might require a staff member with a certain type of qualification; outreach work may require staff transport; interventions using information and communication technologies would require good technological skills; and certain settings or target populations may only be accessible if providers have already established a good professional relationship with relevant stakeholders. If the necessary resources are not available and cannot be secured, then these types of interventions are not feasible, and providers must modify their plans accordingly.

As the purpose of the assessment is to inform programme planning, it does not have to be 'formal'. Depending on the size and nature of the organisation or programme, the assessment may consist of an informal discussion between staff members to identify strengths and weaknesses of the team and, where relevant, the wider organisation in relation to different types of resources (as outlined in this component). This discussion will indicate what types of interventions would (or would not) be feasible and what additional resources might be required. In most cases, it will not be necessary to ask an external organisation to carry out the assessment.

The assessment can be documented as part of the project plan (see 5.1: *Planning the programme — Illustrating the project plan*). It is also useful to include such information in funding applications.

Note: Resources are further discussed in Project stage 5: *Management and mobilisation of resources*.

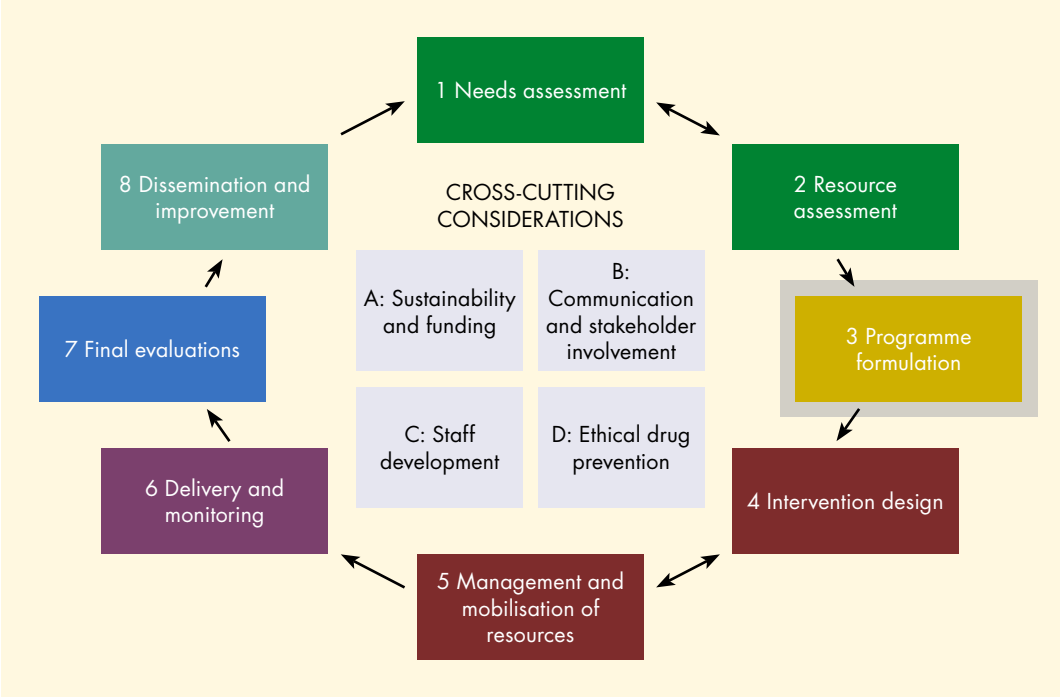
Basic standards:	
2.2.1 Internal resources and capacities are assessed. Resources to consider include:	Note: the actual as well as the likely availabilities of these resources for the programme are assessed.
• human resources and staff competencies;	Examples of human resources: time availability, different types of knowledge and skills (e.g. project management, leadership, creativity, cultural sensitivity). See also: C: *Staff development;* 5.3: *Setting up the team.*
• previous experience;	Example of relevant previous experience: conducting similar interventions in the past.
• organisational resources;	Examples of organisational resources: operating facilities and equipment, and their suitability for delivery of a wide variety of activities.
• technological resources;	Examples of technological resources: computers, Internet, software package to conduct evaluation; technical support for project management, such as a tracking or management information system.
• financial resources;	
• connections to the target population;	Note: connections to the community should be assessed if the community could be relevant to the programme.
• professional network;	Example of professional network: political resources.
• any other resources relevant for programme implementation.	Example of other resources: transportation.

No additional expert standards.

PROJECT STAGE
THREE

Project stage 3

Programme formulation



The programme formulation outlines the programme content and structure, and it provides the necessary foundation to allow targeted, detailed, coherent, and realistic planning. Based on the assessment of target population needs and available resources, the programme's core elements should be clearly defined. These standards aim to stimulate a change in professional culture towards a more systematic and evidence-based approach to drug prevention work.

3.1 Defining the target population: A good definition of the target population ensures that the intervention is targeted at the right people. The target population may consist of individuals, groups, households, organisations, communities, settings, and/or other units, as long as they are identifiable and clearly defined. Some programmes may need to distinguish the ultimate target population (e.g. young

people at risk of drug use) from the intermediate target population (e.g. parents, teachers, peers of these young people). The definition should be specific and appropriate for the scope of the programme.

3.2 Using a theoretical model: A theoretical model is a set of interrelated assumptions explaining how and why an intervention is likely to produce outcomes in the target population. Using a theoretical model that is suitable for the particular context of the programme increases the likelihood that the programme will successfully achieve its objectives. It helps identify relevant mediators of drug-related behaviours and determine feasible goals and objectives. All interventions should be based on sound theoretical models, particularly if they are newly developed.

3.3 Defining aims, goals, and objectives: Without clear aims, goals, and objectives, there is a serious risk of conducting drug prevention work for its own sake, instead of for the benefit of the target population. The standards use a three-level structure of aims, goals, and objectives. Aims describe the programme's long-term direction, general idea, purpose, or intention. Goals are clear statements on the programme's outcome for participants at the completion of the intervention. Objectives describe the immediate or intermediate change in participants that is necessary to achieve a final goal. Finally, operational objectives describe the activities that are required to achieve goals and objectives.

3.4 Defining the setting: The setting is the social and/or physical environment in which the intervention takes place, such as family, school, workplace, nightclub, community, or society. The needs assessment may show that one or more settings are relevant; however, practical considerations (e.g. ease of access, necessary collaborations) must also be taken into account when deciding on the setting. A clear definition of the setting is essential so that others may understand where, and how, the intervention was delivered.

3.5 Referring to evidence of effectiveness: When planning drug prevention work, it is important to be aware and make use of existing knowledge on 'what works' in drug prevention. The existing evidence base on effective drug prevention should be consulted, and the findings relevant to the programme highlighted. The evidence must be integrated with the professional experience of practitioners to design an intervention that is relevant to the specific programme context. Where evidence of effectiveness is not available, professional experiences and stakeholder expertise may be described instead.

3.6 Determining the timeline: A realistic timeline is essential in the planning and implementation of the programme (e.g. so that staff members can target and coordinate their efforts). It illustrates the planned schedule of activities and applicable deadlines. However, the timeline may be updated during the implementation of the programme to reflect its actual development.

3.1 Defining the target population

A good definition of the target population is essential for a successful drug prevention programme to ensure that the intervention is targeted at the right people. The target population may consist of individuals, groups, households, organisations, communities, settings, and/or other units, as long as they are identifiable and clearly defined. A precise definition is particularly important in targeted prevention approaches (i.e. selective and indicated prevention). The definition of the target population should draw upon the information obtained in the needs assessment. How the target population is chosen and defined has implications for other aspects of the programme; for example, it determines the choice and design of the intervention (see Project stage 4: *Intervention design*). It also enables other providers, commissioners and researchers to understand for whom the intervention is thought to be effective.

The definition should be specific so that it is always clear whether a person is eligible to take part in the intervention or not. It should be broad enough to include all persons who are eligible to take part, but narrow enough to exclude anyone who should not take part (e.g. by listing inclusion and exclusion criteria). Above all, the definition must specify a target population that can actually be reached within the realities of the programme. The definition may have to be reviewed during later project stages (e.g. when recruiting participants) to ensure that it describes the intended target population well. When defining the target population, possible stigmatising effects should be considered if, for example, membership of a certain social group is linked with an increased likelihood of drug use (see *D: Ethical drug prevention*).

Where possible, the total size of the target population should also be given or estimated. This number shows how many people are (potentially) affected by the issues that the programme addresses, and consequently how many could benefit from taking part in it. Depending on the type of programme, this number may also determine how many people should be invited to take part. During the process evaluation, this type of information allows an understanding of how well the target population was covered by the intervention (i.e. whether participants represented a sufficiently large percentage of the target population) (see 7.2: *If conducting a process evaluation*).

Some programmes distinguish between the ultimate target population (e.g. young people at risk of drug use) and the intermediate target population which is believed to have a strong influence on the ultimate target population (e.g. parents, teachers, peers of these young people). These interventions are carried

out with the intermediate target population in order to indirectly influence the behaviour of the ultimate target population. In such cases, members of the ultimate target population are only indirect beneficiaries of the programme. Family-based programmes, peer-group, and other multiplier-centred programmes are all examples of such approaches (EMCDDA, 1998). For these programmes, it is essential to describe and, where possible, quantify both the intermediate and the ultimate target population. When working with the standards, organisations implementing such programmes must judge which target population is appropriate to consider where standards refer to 'the target population'. For example, both intermediate and ultimate target populations should be considered during the needs assessment, but the process evaluation may focus on the intermediate target population.

Basic standards:	
3.1.1 The target population of the programme is described.	Note: if the programme distinguishes between an intermediate and an ultimate target population, then both populations should be considered in this component.
3.1.2 The chosen target population can be reached.	

Basic standards for targeted prevention programmes:	
3.1.3 Explicit inclusion and exclusion criteria are provided.	
	Note: targeted prevention includes selective and indicated prevention. Examples of criteria: socio-demographic (e.g. age, sex, race or ethnicity, marital status, religion), socio-economic (e.g. education, profession), psycho-biological (e.g. developmental stage (e.g. neonatal, childhood, adolescence)), setting (e.g. institution such as school or workplace, geography such as town or region, certain locations or social scenes).
3.1.4 Inclusion and exclusion criteria:	
• allow for clear differentiation between populations;	
• define the target population appropriately;	
• are well justified.	Example of justification: according to the needs assessment.

Additional expert standards:	
3.1.5 Explicit inclusion and exclusion criteria are specified for each activity.	**Basic standard if the programme targets different target populations.** Note: it should be considered if the programme will target different target populations.
3.1.6 The total size of the target population is given or estimated based on the needs assessment.	Example: number of young people at risk.
3.1.7 Indirect beneficiaries of the programme are described.	Example of indirect beneficiaries: families of young drug users, members of the local community, employers, local health services, members of the target population who do not participate in the programme, ultimate target population.

3.2 Using a theoretical model

A theoretical model is a set of interrelated assumptions explaining how and why a drug prevention intervention is likely to produce outcomes in the target population, and it may also explain the causes of drug use. Thus, it is a way of showing 'what works' and 'why'. It must not be confused with a summary of the needs assessment or the justification of the intervention (see Project stage 1: *Needs assessment*). Theoretical models are often presented as flowcharts or graphical representations ('logic models') that illustrate how desired outcomes are achieved by changing drug-related mediators in the target population (e.g. attitudes and skills that have been shown to influence drug use). Consequently, theoretical models clarify which mediators should be targeted by the intervention (see 3.3: *Defining aims, goals, and objectives*). They also help decide on the intervention activities, ensuring that needs, activities and outcomes are well interlinked. Using a theoretical model is therefore essential for newly developed interventions, although ideally all interventions should be based on sound theory.

The choice of the theoretical model is determined by the findings from the needs assessment and identified programme aims. Theoretical models are usually based on existing research and theory relating to drug use, health promotion, or human behaviour and development in general (e.g. psychology, sociology). Using a theoretical model is an essential aspect of taking an evidence-based approach, which makes use of existing knowledge in the drug prevention field. Examples of theories include cognitive dissonance theory, social learning theory, and normative models. However, the standards should not discourage professionals from developing new theories based on a review of the literature. Where a new theory is developed, it should be described in detail so that others can understand it. Further information on theories can be found, for example, in health promotion or drug prevention reference books.

The chosen theory must be appropriate for the programme's particular circumstances (e.g. target population, patterns of drug use). Practitioners may have reservations about using theoretical models, perceiving them perhaps as too general, abstract or simplistic, thus not adding value to the specific and rich data obtained during the needs assessment. Likewise, practitioners may believe that theoretical models are too specific and hence not applicable to the programme's particular circumstances. This highlights the importance of choosing a theory that is most appropriate for the context of the intervention (e.g. that matches identified needs and aims). The correct theory helps to understand reality better and to grasp the complexity of drug use.

Practitioners may also feel that it is not necessary or too difficult to refer to theoretical models in everyday drug prevention work, as the needs assessment, the definition of goals and objectives, and/or practical experience from previous programmes appear to be sufficient to plan activities. However, these concerns can be mitigated if theoretical models are understood as a means of putting the findings from the needs assessment in relation to the activities and outcomes of the programme.

The consultations that informed the development of these standards indicated that practitioners may use theoretical models without being aware that they are doing so. They may struggle to recognise and describe theoretical models even though they apply them implicitly in their everyday practice. This highlights the need for a greater emphasis on the theory behind drug prevention in the education, training, and further development of drug prevention professionals. It is the responsibility of providers to support staff members in achieving these standards, for example by holding in-house training events (see *C: Staff development*). It also highlights the need for those who develop theories to demonstrate how these theoretical models can be used in a range of different circumstances and how they can be applied in everyday practice.

Basic standards if a theoretical model is used or if a new intervention is developed:	
3.2.1 The programme is based on a theoretical model.	
3.2.2 The theoretical model:	
• is evidence-based;	i.e. based on empirical studies.
• based on a review of relevant literature;	
• is (likely to be) accepted in the scientific and/or prevention community;	
• allows an understanding of the specific drug-related need and its causes;	i.e. it is in line with the findings from the needs assessment.
• allows an understanding of how the behaviour can be changed.	
3.2.3 The theoretical model is described and justified.	Examples of evidence: it is presented as a 'theory of change' showing the causal mechanisms to achieve change; illustrated graphically as a theory logic model.

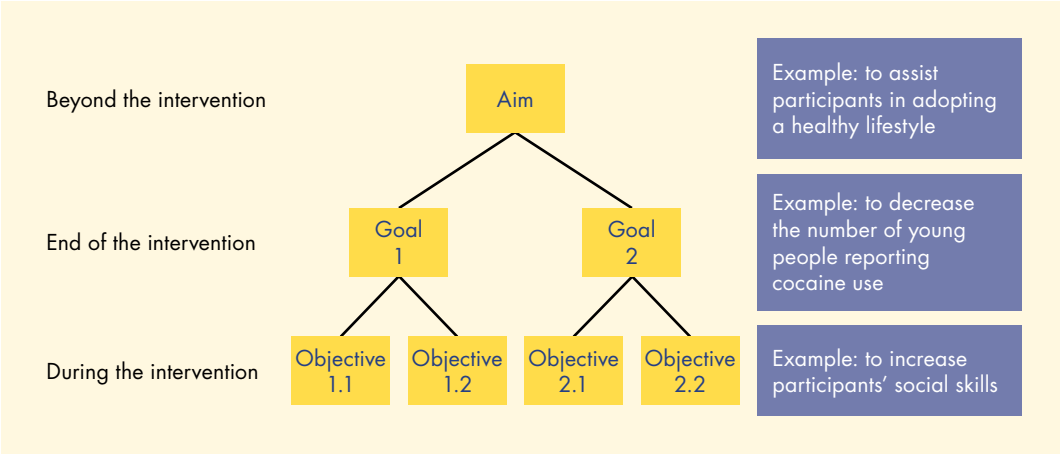
Additional expert standards:	
3.2.4 Adjustments are made to the initial theoretical model, where necessary, according to:	
• the target population;	
• the selected intervention;	
• the chosen setting.	
3.2.5 Adjustments to the theoretical model are justified and documented.	**Basic standard if adjustments are made.**

3.3 Defining aims, goals, and objectives

By defining aims, goals, and objectives, providers answer the most important question in drug prevention — what are the main benefits for participants? Without clear aims, goals, and objectives, there is a serious risk of conducting drug prevention work for its own sake, instead of for the benefit of the target population. The definition of goals and objectives is also essential in order to monitor the progress of the intervention during implementation and to conduct outcome and process evaluations after it has been implemented (see 4.4: *If planning final evaluations*).

The standards use a three-level structure of aims, goals, and objectives. Aims describe the programme's long-term direction, general idea, purpose, or intention. They need not be directly measurable or achievable within the current programme. For example, aims may be achieved several years after an intervention has finished, or an intervention may only partly contribute to the achievement of aims. However, in order to implement and evaluate programmes, precise goals and objectives are required. Goals are clear statements on the programme's outcome for participants at the completion of the intervention. They are developed from the overall aim by translating it into more specific and achievable targets. For example, different goals may reflect different aspects of the overall aim. Each goal is then used to formulate specific objectives, and consequently each objective is directly related to one goal. Objectives describe the immediate or intermediate change in participants that is necessary to achieve a goal at the end of the intervention. Consequently, aims, goals, and objectives form a logical progression. Figure 4 gives an example of how an overall aim translates into goals and objectives.

Figure 4: Connection between aims, goals, and objectives



There are two different types of objectives (see Figure 5, page 151). Specific objectives define the outcomes for participants (usually, the term 'objectives' refers to specific objectives), while operational objectives indicate what the provider must do to achieve these outcomes. Operational objectives hence describe programme outputs and necessary activities (e.g. content and delivery of the intervention, necessary preparations such as participant recruitment). For the purposes of monitoring and process evaluation, operational objectives are translated into process evaluation indicators with defined evaluation benchmarks (see 4.4: *If planning final evaluations*). The specification of operational objectives also helps formulate tasks in the project plan (see 5.1: *Planning the programme — Illustrating the project plan*).

Providers and commissioners may sometimes focus too much on the *activities* they want to carry out, thereby neglecting what they actually want to *achieve with participants*. Drug prevention programmes must be needs-led, not driven by output indicators (e.g. number of clients using a service). The choice of aims must be determined by the findings from the needs assessment. Aims must directly address target population needs, although they may also refer to drug-related policy (see Project stage 1: *Needs assessment*). Goals are then developed from these aims, and objectives are chosen by referring to the theoretical model (see 3.2: *Using a theoretical model*). A well chosen theory (i.e. one that suits the context of the intervention as defined by the needs assessment) shows how desired outcomes can be achieved by modifying certain mediators (e.g. participants'

knowledge, skills, attitudes). Consequently, objectives should address mediators that have an influence on the desired outcomes (e.g. as proven by previous research).

Aims, goals, and objectives need not relate directly to drug use. For example, goals and objectives may not relate to drug use if the programme hopes to prevent drug use that would potentially occur many years after the intervention (e.g. drug prevention activities with young children). Conversely, aims may address wider health or social issues (e.g. social inclusion projects), meaning that drug prevention might form only one aspect of the programme, expressed in a drug-related goal among other general goals. It also depends on the scope and duration of the individual drug prevention programme whether a certain target constitutes an aim, a goal, or an objective. For example, behaviour change may be an overall aim for a short-term programme, but could represent a feasible objective within a long-term programme.

Where appropriate, providers should strive to agree aims, goals, and/or objectives with participants or members of the target population. When doing so, it must be ensured that the agreed targets are relevant to the programme (i.e. contribute to drug prevention) and that they do not inadvertently cause negative outcomes for participants (see D: *Ethical drug prevention*).

Basic standards:	
3.3.1 It is specified what exactly is being 'prevented'.	Note: if the programme is targeting drug use, the drug(s) targeted should be specified. For example, does the programme target only illegal drugs, or are alcohol, tobacco, prescription medicines, and 'legal highs' also included? If the programme is targeting particular behaviours (e.g. risk-taking behaviours), they should also be defined.
3.3.2 The programme's aims, goals, and objectives are specified.	i.e. it is clear which specific need is addressed by the programme.
3.3.3 Aims, goals, and objectives are dependent on each other and form a logical progression.	i.e. the general aims of the programme are translated into more specific goals; and each goal is connected to objectives that are necessary for goal achievement.

Basic standards (cont.)	
3.3.4 Aims, goals, and objectives are:	Example of evidence: description of aims, goals, and objectives in the programme description is in line with the standards.
• informed by the needs assessment;	i.e. relevant to the target population and, for example, the local situation. Note: different target populations may require different aims, goals, and/or objectives.
• 'useful' for the target population;	i.e. will improve individuals' lives, not just satisfy moral concerns of public.
• clear, understandable, and easy to identify;	Note: for example, in the programme description or funding application.
• formulated in terms of expected change in participants ('outcomes');	i.e. show how participants will change over the course of the intervention and beyond; aims, goals, and specific objectives describe changes in participants, not planned programme activities ('outputs').
• in accordance with professional and good ethical principles.	See also D: *Ethical drug prevention.*
3.3.5 Goals and objectives are:	
• specific;	i.e. they can be related to particular activities.
• realistic.	i.e. achievable with the available resources and the defined target population. Example consideration: behavioural changes may not be achievable within a short-term intervention.
3.3.6 Specific and operational objectives are distinguished.	i.e. specific objectives that refer to outcomes, and operational objectives that specify how outcomes will be achieved (activities, outputs).

Additional basic standards if evaluations are planned:	
3.3.7 Goals and objectives are:	
• temporally defined;	i.e. it is described when changes are expected. Example of application: the timeframe for behavioural change is described, which may also be beyond the programme's lifespan.
• measurable.	

Additional expert standards:	
3.3.8 Aims, goals, and objectives:	
• are in line with the theoretical model;	**Basic standard if a theoretical model is used.** Note: the theoretical model indicates which mediators should be targeted by objectives.
• are in line with the strategic direction of the organisation providing the programme;	
• are agreed with the target population;	
• are socially desirable;	i.e. the society in which the intervention is delivered sees the goals as positive. Example: it is considered whether harm reduction is acceptable practice in this society.
• reflect sustainable change.	i.e. long-term changes in participants are preferred to short-term gains.
3.3.9 The targeted mediators are specified.	Examples of mediators: knowledge, attitudes, normative beliefs.
3.3.10 Multiple mediators are targeted.	

3.4 Defining the setting

The setting is the social and/or physical environment in which the intervention takes place, such as family, school, workplace, nightclub, community, or society. A clear definition of the setting is essential so that others may understand where, and how, the intervention was delivered, and how the intervention setting might contribute to the outcomes obtained. If a different provider wishes to replicate the intervention in a different setting, they will need a description of the original setting so that they can adapt the intervention to the new setting.

The description of the setting may be general (e.g. schools) or specific (e.g. naming a specific school), depending on the type of programme. Also, depending on the needs of the target population, the description may not be limited to one (type of) setting; it may refer to several (types of) settings, i.e. a range of locations where drug prevention activities will take place. During implementation, it may be necessary to revise the definition of the setting, for example, to reflect changed habits of the target population.

As indicated above, the choice of the setting should be informed by the needs assessment (see Project stage 1: *Needs assessment*). A setting may be chosen that has great relevance to the target population. For example, members of the target population may spend a large amount of time there, and/or this setting may hold a special meaning for them. Choosing such a setting (e.g. school, community centre) increases the chances of reaching and retaining a greater proportion of the target population in comparison to settings that are not part of the target population's everyday life (e.g. the providers' own premises). However, the aims of the programme and the type and content of the intervention may also indicate a setting that is not part of the target population's daily routine. For example, an intervention focussing on dance drugs may be best delivered in a nightclub, even though nightclubs may not represent a setting that individual members of the target population visit every day.

Practical considerations must also be taken into account when deciding on the setting. There may be particular implications if the intervention is delivered in a recipient organisation such as a school, nightclub, hospital, prison, etc. If the intervention is not commissioned by the recipient organisation, then access to the target population is determined by whether the recipient organisation wishes to collaborate with the provider or not. For example, the target population may spend a lot of time in a community centre that does not grant access to external visitors. Consequently, although the setting may be well chosen in theory, in practice it would not be feasible to carry out the intervention there.

Even if the recipient organisation agrees to collaborate, access to the target population may be lost if the organisation withdraws from participation in the programme at a later point in time. This highlights the need for providers to build strong professional relationships with relevant stakeholders (see B: *Communication and stakeholder involvement*).

Choosing a setting outside of providers' premises may also limit possibilities of intervention delivery, for example in relation to the scope of activities, certain aspects of intervention design (see Project stage 4: *Intervention design*), fidelity of implementation (see Project stage 6: *Delivery and monitoring*), or adherence to ethical principles such as confidentiality (see D: *Ethical drug prevention*). The recipient organisation may ask the provider to respect certain rules and regulations, or the physical surroundings of the setting may not be suitable for all aspects of the intervention. For example, it may not be allowed or physically possible to make changes to a school classroom.

These considerations should not discourage providers from choosing a setting that is outside of their own premises if it is the most relevant and suitable one for the target population and the intervention. However, the potential challenges posed by implementing a programme in a recipient organisation should be considered, and appropriate measures taken to reduce negative impacts on the programme.

Basic standards:	
3.4.1 The setting(s) for the activities is (are) described.	Examples of settings: schools, peer groups, workplaces, family or home, social services, recreational settings, prisons, society.
3.4.2 The setting:	
• is most likely to produce the desired change;	i.e. it is relevant to the target population.
• matches the programme aims, goals, and objectives;	
• matches the available resources.	Example resources to consider: existing networks, funding, transportation.
3.4.3 Necessary collaborations in this setting are identified.	Note: the analysis may show that no collaborations are required in this setting (e.g. if the intervention is delivered on the provider's premises). Example of necessary collaborations: if the intervention is based in a school, collaboration with the school head teacher is likely to be necessary.

Additional expert standards:	
3.4.4 The setting:	
• matches identified risk and protective factors;	**Basic standard if analysis of risk and protective factors was carried out.**
• matches likely activities with the target population;	
• makes participants feel comfortable.	

3.5 Referring to evidence of effectiveness

When planning drug prevention work, it is important to be aware and make use of existing knowledge on 'what works' in drug prevention. Drug prevention work is 'evidence-based' if it is based upon a systematic analysis of relevant professional literature (e.g. scientific journals), makes use of the evidence reported in the literature, and ensures correspondence with this evidence. Using an evidence-based approach prevents providers from pursuing activities that have already been shown to be ineffective or have iatrogenic effects, and it also reduces duplication of efforts (i.e. there is no need to 'reinvent the wheel'). Consequently, these standards describe the requirement to consult the existing evidence base on effective drug prevention, and to highlight how the programme incorporates these findings.

Evidence of effectiveness is usually derived from scientific research trials, outcome evaluations, practical experience, etc. There are different levels of evidence according to how the evidence was produced. Critical evidence appraisals usually consider the evidence produced by randomised controlled trials to represent the highest level of evidence, while professional opinions (based on subjective accounts, unstructured observations, etc.) are usually considered to represent the lowest level of evidence (OCEBM, 2009; Evans, 2003). Therefore, when reviewing evidence of effectiveness, priority should be given to studies that represent the highest available level of evidence.

Practitioners may feel that they do not have the resources to consider existing literature in the planning and implementation of prevention work. Many organisations, such as the EMCDDA, make accessible evidence briefings available. The *Additional guidance* section contains a selection of databases and other web services that provide evidence updates in drug prevention. Consequently, practitioners are not expected to review and synthesise the evidence themselves. However, service managers, commissioners and funders must support these standards by acknowledging the need for additional time (e.g. to consult literature) and, where necessary, funding (e.g. to attend training events and conferences on evidence-based drug prevention) (see C: *Staff development*).

Evidence is rarely 'clear cut', and it can be contradictory because it is often specific to particular target populations, geographies, environments (e.g. social, policy, normative), etc. Therefore, the evidence from scientific research must inform practice, but it cannot replace the professional experience of practitioners. Practitioners are 'experts by experience', as one delegate put it during the consultations to inform these standards. The challenge of conducting evidence-based drug

prevention lies in applying the scientific evidence in a way that is suitable for the specific local context. It is therefore essential that practitioners integrate the findings from the scientific evidence review with their own professional knowledge (e.g. local situation, target population preferences, availability of resources, previous experiences of delivery) in order to decide upon the best course of action for the target population.

Where scientific evidence of effectiveness is not available, professional experiences and stakeholder expertise may be described instead, and used to judge the effectiveness of previous and planned interventions. However, the limitations of these forms of knowledge compared to robust research evidence should be carefully considered. Professional opinion should not be considered scientifically valid (although it may be inherently valuable for some purposes). For example, it is important not to generalise from a small number of cases to a larger group, or to assume that personal opinion and experience hold wider validity. Circumstances that may have lead to bias and/or alternative explanations for previously observed outcomes should be identified. In addition, where scientific evidence is not yet available, it is recommended to conduct an outcome evaluation as part of the programme to contribute to the existing evidence base (see 4.4: *If planning final evaluations*).

Note: Evidence of effectiveness must not be confused with a summary of the needs assessment, the justification of the intervention (see Project stage 1: *Needs assessment*), or the findings from process evaluations.

Basic standards:	
3.5.1 Literature reviews and/or essential publications are consulted.	Example aspects to consider: effectiveness and outcomes of interventions for the same or similar target population(s), in the same or similar setting(s), targeting the same or similar needs. Example of evidence: references to relevant publications are provided.
3.5.2 The reviewed information is:	
• scientific;	i.e. using validated methodologies and reaching justifiable conclusions.
• up-to-date;	i.e. it has not been superseded by more recent reviews/publications, and/or it is still relevant to current practice.
• relevant to the programme;	i.e. the reviewed information provides the necessary evidence base to plan the intervention. Example aspects to consider: relevance for identified needs, target population, theoretical model, etc.
• accepted in the scientific and/or prevention community.	Note: a review may be of high quality but its recommendations may not correspond with the ethos of prevention work. For example, highly punitive criminal justice-led strategies may not be widely accepted in the prevention community.
3.5.3 The review of the literature is not biased.	i.e. a variety of sources is considered, including evidence that does not support effectiveness of particular approaches.
3.5.4 The main findings are used to inform intervention design.	

No additional expert standards.

3.6 Determining the timeline

It is essential to determine a timeline when planning a programme. The timeline allows staff members to work towards specified deadlines and to coordinate their work with other staff members and other work demands. It also defines what resources are necessary (e.g. ensuring that funding for staff salaries is in line with the programme duration) (see Project stage 5: *Management and mobilisation of resources*). If final evaluations are planned, the timeline will determine when process and/or outcome data should be collected (see 4.4: *If planning final evaluations*). It is also essential to have an original timeline that can be used to judge the progress of the programme during monitoring (e.g. are we behind schedule? Are modifications required?) and the final process evaluation (see 6.3: *Monitoring the implementation* and 7.2: *If conducting a process evaluation*). Finally, a description of the timeline can demonstrate to others that the programme has been well thought out. It is therefore essential to indicate the timeline, for example, in funding applications.

The timeline must be realistic and, where possible, it should be agreed with the staff members who are likely to work on the programme (see 5.3: *Setting up the team*). When planning the timeline, it can be helpful to take into account the shortest time in which the programme could be completed (i.e. if everything goes according to plan) as well as the longest time in which the programme could be completed (i.e. if there are difficulties in recruiting participants, delays in receiving funding, etc.). In 5.1: *Planning the programme — Illustrating the project plan*, contingency plans are developed that enable providers to deal effectively with emerging difficulties. This flexible approach is also necessary in relation to the timeline. Sufficient time must be allowed for activities, and if required the timeline must be updated during implementation to reflect the actual development of the programme. Project management reference books provide more in-depth information on how to estimate timelines and plan activities accordingly.

It may be argued that a defined timeline is most relevant for structured long-term programmes, but less so in the case of continuous participant- and needs-led services. Nevertheless, providers of participant-led services should also aim to determine a timeline, at least in approximate terms.

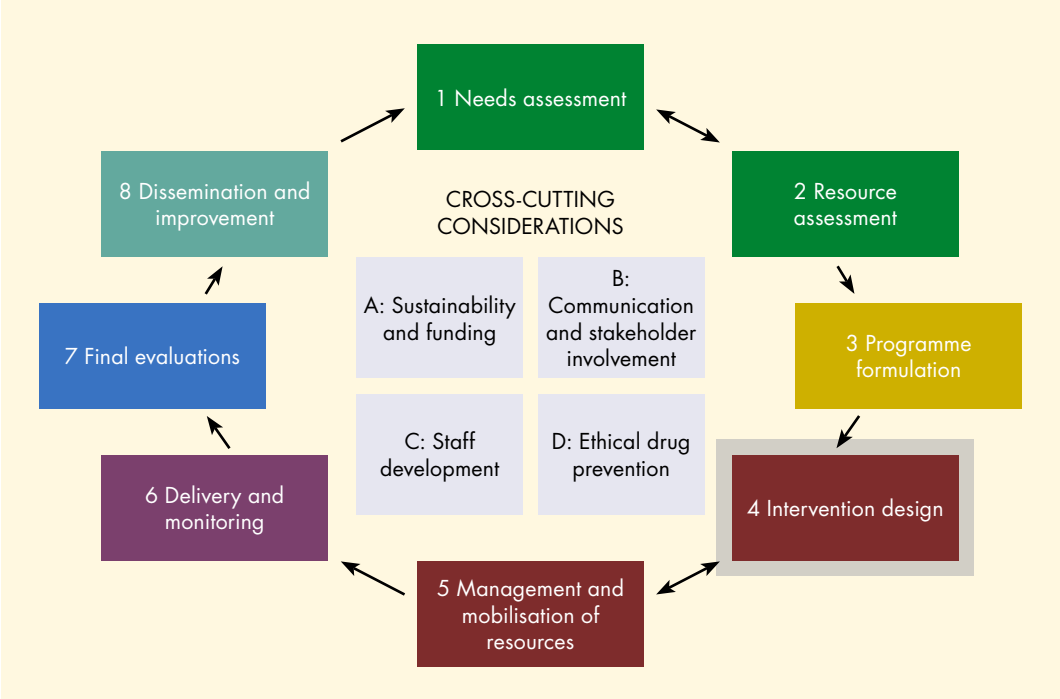
Basic standards:	
3.6.1 A timeline is provided for the programme.	
3.6.2 The timeline:	
• is clear and comprehensible;	
• is coherent;	
• is realistic;	
• illustrates the sequence of events and actions;	
• distinguishes between intervention activities, actions related to monitoring and evaluation, and administrative tasks;	
• illustrates milestones in the progress of the programme;	Examples of milestones: completion of different project stages; statutory monitoring reports and data submission.
• illustrates applicable deadlines.	
3.6.3 Timing, duration, and frequency of the activities are adequate to achieve the objectives.	Examples of adequacy: the time schedule is appropriate for the needs of the target population; the intensity of the intervention (for example, the number of sessions) is appropriate for the intended level of change.

Additional expert standards:	
3.6.4 The timeline:	
• is detailed;	
• is presented in a visual form.	Examples of visual presentation: matrix, graph, bar chart.
3.6.5 The timeline includes a testing period.	**Basic standard if a pilot intervention is required.**
3.6.6 The timeline includes an adaptation period.	**Basic standard if selecting an existing intervention.**

PROJECT STAGE
FOUR

Project stage 4

Intervention design



The content of interventions is usually covered in guidelines rather than quality standards, as it is specific to the needs of the target population, the aims of the programme, etc. However, there are some formal aspects that can be generalised. These standards assist in the development of a new intervention as well as in the selection and adaptation of an existing intervention. The standards also encourage the consideration of evaluation requirements as part of the intervention design.

4.1 Designing for quality and effectiveness: After the cornerstones of the intervention have been outlined, its details are specified. Planning evidence-based activities that participants are likely to experience as engaging, interesting and meaningful is an important aspect of achieving the set goals

and objectives. Where possible, the intervention should be designed as a logical progression of activities that reflects participants' development throughout the intervention.

4.2 If selecting an existing intervention: Before developing a new intervention, it should be considered whether an appropriate intervention might already exist, either in practice or in manualised form. Several factors need to be considered in the selection of an existing intervention to ensure that it is relevant to the particular circumstances of the programme (e.g. addressing the needs identified in the target population). The intervention is then adapted to match the specific situation of the programme.

4.3 Tailoring the intervention to the target population: Regardless of whether a new intervention is developed or an existing intervention adapted, the intervention must be tailored to the target population in line with the findings from the needs assessment. If an existing intervention is used, tailoring may be conducted as part of the adaptation process. Additionally, flexibility should be built into the intervention design, allowing practitioners to tailor the intervention during implementation without having to deviate from the original plan.

4.4 If planning final evaluations: Monitoring and final process and outcome evaluations should also be planned at this stage. An evaluation team should decide upon the appropriate type of evaluation for the programme, and define evaluation indicators in line with goals and objectives. It should be clarified what data will be collected, and how it will be collected (e.g. specification of timeline and data collection tools). Where an outcome evaluation is planned, the research design should be determined. Considering evaluation at this stage ensures that the data required for monitoring and final evaluations will be available in a satisfactory form when it is needed.

This stage may be conducted at the same time as the management and mobilisation of resources.

4.1 Designing for quality and effectiveness

After the cornerstones of the intervention have been outlined (see Project stage 3: *Programme formulation*), the intervention itself is designed. Planning activities that participants are likely to experience as engaging, interesting and meaningful is an important aspect of achieving the set goals and objectives. Where possible, the intervention should be designed as a logical progression of activities that reflects participants' development throughout the intervention. The principles of ethical drug prevention should also be considered in the intervention design (see D: *Ethical drug prevention*).

These standards assist in the development of new interventions, but should also be considered when selecting and adapting an existing intervention. However, their applicability depends on the type of the programme. For example, some standards may not be feasible within interventions where providers do not have the opportunity to build long-term relationships with participants (e.g. participant- and needs-led services, short-term programmes, brief interventions, outreach work).

Before designing the intervention, a variety of sources should be consulted, such as systematic reviews on the effectiveness of interventions (see 3.5: *Referring to evidence of effectiveness)*, outcome and process evaluations of previous programmes (including pilot interventions), and databases of model programmes (e.g. EDDRA quality levels 2 and 3, NREPP database — see *Additional guidance* section). This information will show what has worked well or not so well in the past, how results were achieved, and what lessons can be learnt for the intervention design. This evidence-based approach also prevents providers from pursuing activities that have already been shown to be ineffective or have iatrogenic effects. Programme developers or other providers may also be contacted to learn about implementation experiences of relevant programmes.

It is recommended to investigate whether an appropriate intervention is already available. If so, this existing intervention could be adapted instead of developing a new intervention. The standards in 4.2: *If selecting an existing intervention* provide guidance on how to select an existing intervention. However, where appropriate interventions are not yet available, programme developers and providers are encouraged to design new interventions that are based on a review of the evidence base.

Basic standards:	
4.1.1 The content of the intervention follows evidence-based good practice recommendations.	
4.1.2 The scientific approach used is outlined and, where possible, described in detail.	Example of evidence: citations are provided to prove the evidence base of the intervention.
4.1.3 The programme builds on positive relationships with the participants.	i.e. relationships between staff members and participants are marked by reciprocity, partnership, and mutual respect.
4.1.4 The programme values participants' experiences and acknowledges their (difficult) realities.	
4.1.5 The programme is respectful and inclusive of diversity.	Example aspects to consider: gender, culture, literacy requirements, disability, socio-economic differences.
4.1.6 Completion of the intervention is defined.	

Note: Successful completion of the intervention would generally mean that the defined goals have been achieved with participants. However, goals may not always be achieved, and it is thus important to establish other means by which the provider and participants will know that the intervention has been completed. Success should therefore also be defined on a delivery level (i.e. the intervention has been carried out as planned). Moreover, goals may not relate to individual participants, but to the group of participants (e.g. to decrease the number of young people reporting cocaine use). It is therefore also important to define completion of the intervention at the level of the individual participant (e.g. if participants are to receive a certificate of participation). The definition of completion must be appropriate to the type of the intervention (e.g. participant- and needs-led services would require a different definition than structured manualised programmes).

Example aspects to consider:

- how many sessions can be missed at the beginning of the intervention (e.g. participants must start the intervention no later than at the third session of the intervention);
- how many sessions participants need to attend to complete the intervention; and how many absences will be tolerated;
- if and how participants can compensate absences (e.g. through additional homework assignments, staff visits);
- if there are any mandatory elements in the intervention (UNODC, 2009a: 37).

Additional expert standards:	
4.1.7 The programme reflects a comprehensive approach towards health and social functioning. It:	i.e. it accounts for the biopsychosocial nature of drug-related needs.
• targets different aspects of an individual's life, and works across multiple life domains;	Example aspects to consider: mental wellbeing, social behaviours. Examples of life domains: school, family, community.
• consists of several components, and utilises a variety of methodologies;	Examples of different components: information provision, development of social and emotional skills, structural change (e.g. laws), service provision (e.g. counselling).
• is integrated in the community, where appropriate.	
4.1.8 The programme reflects progression. It:	
• is designed as a continuous long-term process;	i.e. it follows participants over a longer period of their lives. Example of evidence: indicates progression paths building on participants' growing repertoire of skills and knowledge.
• gradually increases its intensity;	i.e. more significant changes are achieved over time.
• offers different interventions or versions, as participants progress, and the progression through different phases reflects consistency, continuity, and logic;	Example of application: different interventions as children mature.
• identifies further learning opportunities for participants after the intervention;	
• is repeated with the participants after a set period.	**Basic standard if evidence base suggests that repetition is important for effectiveness.** Example: booster sessions in life skills training approaches.

Additional expert standards (cont.):	
4.1.9 The programme helps participants discover and realise their own resources. It:	
• is positively orientated towards participants' strengths, and highlights alternatives to unhealthy choices;	
• supports participants in caring for their own health;	Example of corresponding goal: develop health literacy.
• is set in a positive health-promoting climate;	
Note: 'climate' refers to how the provider (e.g. drug service) is experienced by participants and staff members (i.e. its 'character' or atmosphere). These are expressed in aspects such as prevailing norms, goals, values, interpersonal relationships and organisational structures (CCSA, 2009). The provider should aim to be, for example, friendly, open, supportive, engaging.	
• strengthens and recognises traditional cultural practice, where appropriate.	
Purpose: to support the aims of drug prevention by developing participants' confidence and encouraging participation in community activities (UNODC, 2004). Note: often traditional cultural practice will promote some types of drug use while prohibiting others. This may be at odds with the everyday life of some participants and/or the goals of the intervention. The intervention should not promote drug use, but its cultural significance should be recognised and the intervention tailored accordingly.	
4.1.10 The programme builds on positive relationships with the participants. This includes:	
• Staff members spend time in the field with the target population.	Note: The composition of the field team will depend on the target population (e.g. practitioners, peer-to-peer).
• The target population has a chance to become acquainted with the provider and its staff members.	Example of provider: drug service.
• The approach towards the target population is consistent.	

Additional expert standards (cont.):	
• Participants are likely to experience the intervention as meaningful, productive, and relevant.	
• The programme acknowledges persons who are important to the community.	Example of important persons: community 'leaders'.
• Family members or persons close to the target population are consulted or involved in the activities, where appropriate.	Example of family members: parents of school children.
• The programme engages excluded and/or marginalised groups.	
• Staff members are likely to be accepted by the target population.	
4.1.11 Activities are likely to ensure involvement of participants. They:	
• are likely to be attractive and enjoyable for participants;	
• are designed in an imaginative and innovative way;	Example of sources for innovation: identified deficiencies of other activities, using models from outside the drug prevention field, based on experience.
• balance interactive and didactic activities;	
• provide opportunities for individual and group activities;	Note: participants' history of group work should be considered, and necessary group work skills should be trained.
• encourage active participation;	Example of participation: give participants the opportunity to take leadership and express opinions, for example by leading a discussion group, organising a small event, being a peer leader.
• are orientated towards participants and flexible to their needs.	

4.2 If selecting an existing intervention

It is not always necessary or practically feasible to design a new intervention. Instead, it may be more effective and efficient to adapt an already existing intervention that addresses the identified needs (see Project stage 1: *Needs assessment*). The adaptation of existing interventions reduces duplication of efforts and makes use of existing knowledge about 'what works' in drug prevention. Replication is also important from a scientific point of view, as it tests whether previously found outcomes can be repeated. If the implementation takes place under new circumstances, it also tests whether statements about the intervention's effectiveness can be generalised (e.g. to a different target population or setting).

Providers can find out about existing interventions in databases and other collections of model interventions (e.g. EDDRA quality levels 2 and 3, NREPP database — see *Additional guidance* section). Online databases offer the possibility to filter interventions according to specific search criteria (e.g. by target population), so that those interventions that are most appropriate for the particular circumstances of the new programme can be identified. An existing intervention should only be chosen if it has a good 'fit' to the local circumstances of the programme. Consequently, the standards in this component outline what factors should be taken into account when choosing an existing intervention from a range of options. The selected intervention should also be in line with the standards in 4.1: *Designing for quality and effectiveness*. Additionally, it may be useful to consider how the proposed structure, content, and delivery of the intervention match the requirements of the new programme (NIDA, 2003). Furthermore, the USA *Standards of Evidence* can be used to determine the quality of existing interventions (Flay et al., 2005).

The consultations that informed the development of the standards indicated that in many countries there are insufficient measures in place to protect the copyright of programme developers. It was reported that sometimes providers use interventions without acknowledging or remunerating the original authors, thus infringing copyright. The standards therefore include the requirement to list the author(s) of the original intervention. Also, where interventions are not free of charge, providers must respect this and purchase the intervention licence and materials as required. Consequently, these costs must be considered in the financial plan and may limit the choice of affordable programmes. However, programme developers may be able to offer a more affordable package upon request (e.g. using less expensive materials) (see 5.2: *Planning financial requirements* and 5.5: *Preparing programme materials*).

When using an existing intervention, there is a danger of implementing its activities and applying its premises (e.g. theoretical model) without accounting for the findings from the needs assessment and the particulars of the programme formulation. Therefore, the component outlines the need for adaptation. Adaptation consists of careful intentional and planned changes made to the original intervention before implementation to ensure that it is appropriate for the particular circumstances of the programme (e.g. target population needs) and to maintain or increase its effectiveness. All changes must be well justified and be kept to a minimum so as not to impact on the quality or effectiveness of the intervention. Core elements of the original intervention must be identified and preserved as much as possible (NIDA, 2003; CSAP, 2002).

It may not be appropriate to use an existing intervention if relevant interventions are not yet available or where original approaches are to be developed and trialled. In such cases, programme developers and providers may design a new intervention that is based on a review of the evidence base (see 3.5: *Referring to evidence of effectiveness;* 4.1: *Designing for quality and effectiveness*). The standards in this component apply only if an existing intervention is utilised.

The standards under 4.3: *Tailoring the intervention to the target population* provide further guidance on what to consider when adapting the intervention. Further information on how to select and culturally adapt programmes can be found, for example, in the handbooks *Achieving Outcomes* (CSAP, 2002) and *Guide to implementing family skills training programmes for drug abuse prevention* (UNODC, 2009a), upon which these standards are also based.

Basic standards if selecting an existing intervention:	
4.2.1 The following factors are considered in the selection of existing interventions:	
• the intervention's benefits and disadvantages, including possible negative (iatrogenic) effects of the intervention;	Note: the nature and risk of unwanted outcomes should be forecast, and the intervention dismissed if the risks are too high or the unwanted outcomes too severe. Example aspects to consider: likely benefits and disadvantages for the provider, for participants, for any other relevant stakeholders. See also D: *Ethical drug prevention.*

Basic standards if selecting an existing intervention (cont.):	
• the balance between possible adaptation and fidelity;	
• the feasibility of the intervention.	i.e. whether the activities proposed in the existing intervention can be implemented. Examples: the financial resources and the knowledge about the methods are sufficient; the methods are not too complex.
4.2.2 The intervention's fit to the local circumstances is determined. This includes:	
• The achieved outcomes match the desired goals and objectives of the intended programme.	
• The existing intervention is suitable for the chosen setting of the intended programme.	
• The underlying conditions found in the needs assessment are similar.	Example: similar needs of target population, similar risk and protective factors.
• The necessary resources match the available resources.	
4.2.3 The authors of the original intervention or programme are listed.	
4.2.4 The existing intervention is adapted:	
• systematically;	
• by considering differences between the intervention's original and the actual circumstances;	
• by understanding the theoretical model underlying the original intervention;	
• by considering the balance between adaptation and fidelity;	i.e. fidelity to the evidence-based intervention is ensured.

Basic standards if selecting an existing intervention (cont.):	
• with respect to the available resources.	Note: resource considerations should not override the importance of fidelity where resource savings may impact on the quality or effectiveness of the intervention.
4.2.5 The level of adaptation is made explicit.	i.e. it is documented what elements have been changed.

Additional expert standards:	
4.2.6 It is considered whether a replication study of an existing intervention should be undertaken.	Examples of replication types: adaptation of an existing intervention with same or different conditions, such as different target populations, different intervention delivery agents or modes.
4.2.7 The following factors are considered in the selection of existing interventions:	
• the level of evidence of effectiveness;	
	i.e. the effectiveness of the intervention is sufficiently proven or at least indicated. Note: Preference should be given to the intervention with the highest level of evidence of effectiveness, for example with the greatest effect sizes. Additional guidance: effectiveness can be determined using the USA *Standards of Evidence* (Flay et al., 2005).
• whether the intervention has been accredited or given 'model' status.	i.e. preference is given to accredited or model interventions.
4.2.8 The theoretical models are compatible.	**Basic standard if a theoretical model is used.**
4.2.9 A skilled evaluator is consulted in making the selection, where needed.	
4.2.10 Previous organisations implementing the intervention are listed.	
4.2.11 A 'cultural adaptation' team is set up.	
4.2.12 The cultural adaptation team includes:	

Additional expert standards (cont.):	
• the programme developer (or a representative);	
• a translator, if necessary;	
• representatives from the evaluation team or a research institute;	
• representatives from the community, where appropriate;	
• representatives from the target population;	
• staff members, where appropriate;	Note: including volunteers, etc.
• a representative from the funding body, where appropriate.	
4.2.13 Translations are conducted by a professional translator.	Example: translations of intervention materials.
4.2.14 The 'lessons learnt' in previous similar programmes and adaptations are considered.	
4.2.15 The existing intervention is adapted:	
• minimally at first;	i.e. adaptation is undertaken in stages. For example, in the first stage only the language, pictures, and examples are adapted.
• by identifying and retaining the core elements of the original intervention;	
	i.e. core elements are not changed. **Basic standard if research on core elements has been conducted and is available.** Examples of possible core elements: theoretical model; number of recommended group leaders; number, type, and length of sessions; sequence of sessions; key messages, topics, information; targeted mediators; strategies.
• in consultation with the programme developer, if needed.	Note: this could be done via telephone, email or video conferencing.

4.3 Tailoring the intervention to the target population

Regardless of whether a new intervention is developed or an existing intervention chosen, the intervention must be tailored to the specific requirements of the programme. For example, intervention activities or materials may be modified to better suit the needs of the target population. The purpose of this is to maintain or increase the effectiveness of the intervention; it must not be confused with providing 'special treatment' for certain groups (UNODC, 2004). If an existing intervention is used, tailoring may be conducted as part of the adaptation process while maintaining the balance between adaptation and fidelity (see 4.2: *If selecting an existing intervention*).

An essential staff competency in this regard is cultural sensitivity (see C: *Staff development*). Cultural sensitivity describes the willingness and ability of staff members to understand the importance of culture, to appreciate cultural diversity, to respond effectively to culturally defined needs, and to incorporate cultural considerations into all aspects of drug prevention work. Culture, as the set of shared values, beliefs, behaviours, etc. that characterises a particular social group, can be relevant in many different ways. For example, it may refer to the different expectations of, and towards, people based on their age or gender, which may influence expectations towards staff members, beliefs about the risks of drug use, etc. It is important to recognise that there can be different types of culture (e.g. ethnic culture, youth culture, culture of poverty).

Cultural sensitivity ensures that the intervention is appealing to, and therefore more likely to be effective with, the target population. Lack of cultural sensitivity may be a barrier to recruiting and retaining participants (see 5.4: *Recruiting and retaining participants*). For example, signs within the venue of the intervention and intervention materials should be easily understood by the target population, and the content of the intervention should be culturally relevant (e.g. informed by knowledge of drug-related cultural norms and practices). Certain cultural practices may be in conflict with the principles of evidence-based and ethical drug prevention (e.g. practices that promote harmful patterns of drug use, discrimination and exclusion) (see D: *Ethical drug prevention;* 3.5: *Referring to evidence of effectiveness*). In such cases, it must be carefully considered how such practices can be addressed as part of the intervention. Individual differences within groups must also be respected. For example, 'culture' may not be equally important to all members of the target population, and an over-emphasis of culture may alienate some of them. Further information on how to consider ethnicity when planning programmes can be found, for example, in the handbook *Drug abuse prevention among youth from ethnic and indigenous minorities* (UNODC, 2004).

When tailoring the intervention to the target population, it is not sufficient to rely on assumptions about the target population. The modifications must be based on the findings from the needs assessment (see 1.4: *Understanding the target population*), and where possible members of the target population should be actively involved in the design and adaptation of the intervention (see B: *Communication and stakeholder involvement*).

The intervention must be tailored as much as possible prior to its implementation. Additional flexibility should also be built into the design, allowing practitioners to tailor the intervention during implementation without having to deviate from the original plan (e.g. by providing a range of options for activities, by outlining how the order of activities may be changed to suit participants' needs on the day). By incorporating this level of flexibility in the intervention design, the likelihood that unplanned modifications are made spontaneously during implementation can be reduced (see 6.4: *Adjusting the implementation*).

Basic standards:	
4.3.1 The programme is adequate for and tailored to its specific circumstances regarding:	
• participants' needs;	
• the chosen setting;	
• the operating environment;	i.e. the recipient organisation or community in which the intervention will take place.
• participants' age, and their developmental stage;	Examples: children, young adults, older people.
• participants' sex;	
• participants' gender;	
• participants' culture.	i.e. the programme genuinely incorporates cultural sensitivity.
4.3.2 The elements to tailor include:	

Basic standards (cont.):	
• the language;	Note: this includes written and oral communication. Examples: translations and interpreters are considered, multilingualism of staff, slang terms used by target population (e.g. specific name for a drug), information boards and signs in the facility, tools for monitoring and evaluation.
• the activities and methods for delivery;	
• the messages of the intervention;	Examples: messages contained in films, discussion points, legal status of drugs, normative data, songs, stories, dances.
• the duration, frequency, and pace of the intervention;	
• the number of participants per activity.	

Additional expert standards:	
4.3.3 The programme is adequate for and tailored to its specific circumstances regarding:	
• identified risk and protective factors;	**Basic standard if analysis of risk and protective factors was undertaken.**
• participants' norms and values;	
• participants' socio-economic situation;	
• the geographical area;	
• any other relevant characteristics of the target population;	
• differences between participants.	
4.3.4 The intervention materials are tailored to the target population.	**Basic standard if intervention materials are used (e.g. manuals, websites).** Examples: tailoring of designs, specific symbols, pictures in manuals.

4.4 If planning final evaluations

Evaluation is an integral aspect of high quality drug prevention work. Without evaluation, it is impossible to know whether the intervention works as intended: is it effective in producing the desired outcomes in participants, and does it produce any undesired outcomes? Does it achieve the set goals and objectives (see 3.3: *Defining aims, goals, and objectives*)? How do participants and staff members view the quality and relevance of the intervention? Providers may worry that evaluations will expose weaknesses in their programme. In fact, evaluation should be seen as an opportunity for providers to understand, improve, and promote their programme better. Evaluation findings help determine whether a programme should be continued and how it could be improved (see Project stage 8: *Dissemination and improvement*).

This component focuses on outcome evaluation as a means to assessing *whether* goals and objectives were achieved, and on process evaluation as a means to understanding *how* they were achieved or, in some cases, not achieved. It is important to distinguish these two types of evaluation, as they serve different purposes and use different types of data. There are also other types of evaluation that could be relevant to the programme, although these are not discussed in the standards (see Uhl et al., 2010). The standards on outcome evaluation research design in this component are based primarily upon the USA *Standards of Evidence* (Flay et al., 2005).

The outcome evaluation assesses how effective an intervention is in producing desired *outcomes*, i.e. changes in participants in line with goals and objectives. As a minimum, outcome data (e.g. on drug use) is collected from participants at the beginning ('pre-test') and at the end of the intervention ('post-test') (see Figure 6, page 153). The progress of the intervention is measured by comparing the post-test data to the pre-test data to see if there were any significant changes in participants between the beginning and the end of the intervention. If the evaluation is designed as a randomised controlled trial, it is possible to attribute observed changes to the intervention (i.e. to assume that changes were caused by the intervention). Different types of evaluation design can be distinguished, including non-experimental design, quasi-experimental design, and randomised controlled trial.

The process evaluation documents and analyses *outputs* (e.g. what activities were carried out, with and by whom). Process data is collected throughout the implementation of the programme (e.g. as part of monitoring), and it is analysed following the intervention to reflect on the programme and to understand how it can be improved. Aspects to consider include: reach and coverage (i.e. how well did participants represent the target population?); acceptance of the intervention by participants (e.g.

suitability of content and intervention materials); fidelity (i.e. was the intervention conducted according to plan; if an existing intervention was chosen, was implementation sufficiently true to the original evidence-based intervention?); use of resources (e.g. cost-effectiveness). These aspects are also considered during the implementation as part of monitoring to ensure that implementation is of high quality (see 6.3: *Monitoring the implementation*).

It is currently more common to conduct process evaluations than outcome evaluations. However, process evaluations cannot replace outcome evaluations if the provider wishes to understand what effects the intervention had on participants (e.g. participant satisfaction is not a suitable indicator for the effectiveness of the intervention).

Even though these evaluations are not conducted until after the intervention has been completed (see Project stage 7: *Final evaluations*), it is important to plan them at this stage. By doing so, evaluation is integrated into the intervention design. This will ensure that all relevant data and resources for evaluation will be available when they are needed.

The first standard within this component states that the most appropriate kind of evaluation must be determined. From a scientific point of view, all interventions should be evaluated to understand what makes drug prevention interventions effective. However, in reality there are many barriers that can prevent thorough evaluations. The consultations that informed the development of these standards indicated that common barriers included the costs associated with good quality outcome evaluations (e.g. in relation to data collection and analysis), lack of financial resources (e.g. funding available only for the intervention but not for evaluations), lack of human resources (e.g. necessary expertise), lack of technical support (e.g. for data collection and analysis), and practical feasibility (e.g. employing experimental research designs in participant-led health and social services, conducting long-term follow-up measurements). Most of these barriers concern process as well as outcome evaluations, although some are of particular importance to outcome evaluations. Additionally, the shift from information-based to skills-based approaches and the subsequent focus on behavioural outcomes (rather than knowledge) has added to the complexity of outcome evaluations. Nevertheless, delegates highlighted the importance of these standards, arguing that good quality evaluations are urgently needed to improve the evidence base on drug prevention in Europe.

Consequently, the type of evaluation must correspond to the resources that are (likely to be) available to the provider. Outcome and process evaluations should always be conducted as part of large-scale programmes (e.g. designed to demonstrate the efficacy or effectiveness of certain approaches, receiving large government support or being implemented nationwide). Randomised controlled trials

are the preferred design for such evaluations, as they produce the highest quality evidence, and other forms of evaluation should only be considered if these are not feasible. In the case of small-scale programmes with limited resources, a process evaluation should be conducted to obtain important information about the quality of the programme and to assess whether an outcome evaluation should be carried out (see 8.1: *Determining whether the programme should be sustained*). Less resource-intensive forms of outcome evaluations should also be considered (e.g. non-experimental design with measurements before and after the intervention, simple routine evaluations using only a few indicators).

It is also important to decide whether evaluations should be 'internal' or 'external', i.e. whether they should be conducted by a team or individual working within the organisation or for an external organisation (e.g. university, consultancy). There are advantages and disadvantages to both approaches. For example, an external evaluator may be more expensive but have more expertise and be able to make a more objective judgement; an internal evaluator may have better access to informal sources of information but lack the time and knowledge to conduct an evaluation. The use of internal evaluators also introduces an element of bias as the evaluator may wish to portray the organisation and the outcomes of its activities in a more positive light. External individuals or teams are generally considered more suitable to conduct outcome evaluations, while internal staff members may be better suited to conduct monitoring and process evaluations (EMCDDA, 2010).

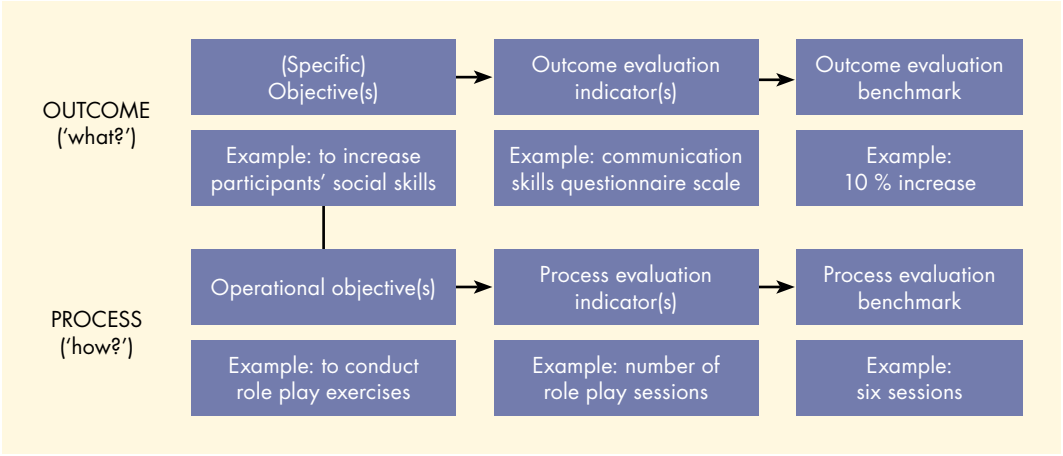
Once the most appropriate form of evaluation has been decided upon, evaluation indicators and benchmarks are defined. Evaluation indicators clarify what specific information (outcome and/or process data) must be collected prior, during and after the implementation of the intervention. Process indicators are derived from the operational objectives and concern the implementation of the programme, while outcome indicators are derived from the goals and specific objectives and concern changes in participants (see 3.3: *Defining aims, goals, and objectives*). Depending on the defined goals and objectives, outcomes may not focus on drug use but on other aspects in line with the identified needs and the theoretical model (3.2: *Using a theoretical model*).

The chosen indicators must be valid, i.e. appropriate for the concept they intend to measure ('construct validity'). For example, an instrument may accurately measure participants' attitudes toward drug use; however, attitudes toward drug use may not be a valid indicator for actual drug use in later life. Construct validity can be established by referring to the theoretical model and the existing scientific literature. Moreover, because indicators are only approximations of complex concepts, it is common to use several indicators.

An evaluation benchmark should also be defined for each indicator. It defines achievement on that indicator in numerical terms or, where that is not possible, in descriptive terms. The evaluation benchmark could specify, for example, that a 10 % average increase in social skills measured through a questionnaire would represent a successful intervention. Success can be graded by providing more than one evaluation benchmark, e.g. for minimum (e.g. 5 % increase), realistic (e.g. 10 %), and optimal (e.g. 15 %) achievement. In order to define a benchmark, it is useful to know what the current value on the respective indicator is (e.g. participants' score prior to the intervention) and what achievements can be reasonably expected over the course of the intervention (WHO, 1998). Distinct evaluation benchmarks should be formulated for outcome evaluation as well as for process evaluation indicators.

Figure 5 illustrates the relations between specific and operational objectives, evaluation indicators and evaluation benchmarks.

Figure 5: Connection between specific and operational objectives, evaluation indicators and benchmarks



Consequently, the following information should be provided for each goal and objective to facilitate monitoring and the outcome evaluation: timeframe within which the goal or objective will be achieved, target population, outcome evaluation indicator with defined benchmark, and details on measurement (e.g. evaluation instrument, data collection schedule). To help monitor and evaluate the process of the intervention, the following information should be provided for each operational

objective: output required to achieve specific objective, timeframe within which the operational objective will be achieved, process evaluation indicator with defined benchmark. The following examples illustrate how aims, goals, and objectives could be formulated.

Aim (example): To assist participants in adopting a healthy lifestyle.

Goal (example): To decrease the number of young people reporting cocaine use in the previous month by the end of the 12-month intervention. Evaluation indicator/benchmark: 25 % reduction in the number of participants reporting use of cocaine in the previous month compared to baseline. Data collection: Self-reported drug use will be measured using an existing scale at the beginning, after six months, and at the end of the intervention.

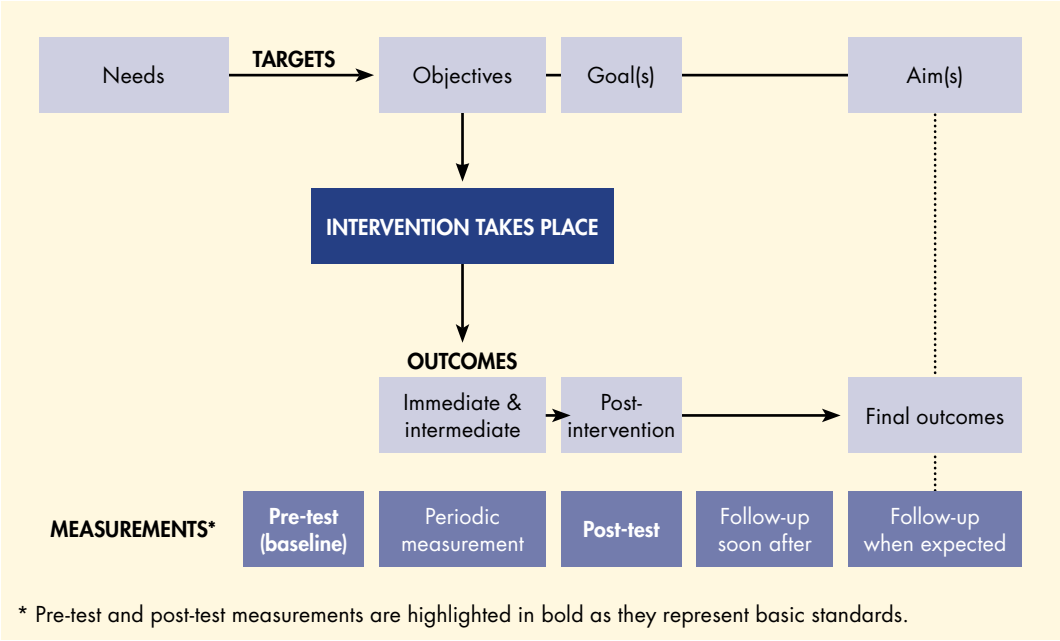
Specific objective (example): To increase participants' social skills by the end of the first six months of the intervention. Evaluation indicator: Assertiveness and communication skills as indicators for social skills. Evaluation benchmarks: 10 % average increase on 'assertiveness' scale, and 15 % average increase on 'communication skills' scale in comparison to baseline. Data collection: Questionnaires using existing validated scales will be administered at the beginning of the intervention, after six months, and at the end of the intervention.

Operational objective (example): To conduct role play exercises with participants within the first six months of the intervention to develop participants' social skills. Evaluation indicator/benchmark: Six role play exercises to be conducted in line with project plan.

It may be useful to involve relevant stakeholders (e.g. target population) in the definition of evaluation indicators and benchmarks, and in choosing methods for data collection and analysis, as this will increase the feasibility of the evaluations (e.g. participants may prefer to discuss the intervention in a focus group rather than complete a questionnaire) (see B*: Communication and stakeholder involvement*).

Aims, goals, and objectives, as well as the theoretical model, determine when to expect what outcomes, and consequently when to conduct measurements. Changes may occur on different evaluation indicators at different points in time (e.g. participants' knowledge may change before their behaviour). It is, however, important that the same evaluation indicators and evaluation instruments are used consistently throughout the programme to ensure comparability of the data. Figure 6 illustrates the relationships between targets, outcomes, and measurements.

Figure 6: Connection between targets, outcomes, and measurements



* Pre-test and post-test measurements are highlighted in bold as they represent basic standards.

Immediate and intermediate outcomes occur during the intervention, corresponding to the objectives. Post-intervention outcomes occur at the end of the intervention, corresponding to the goals. It is also common to consider longer term final outcomes which correspond to the programme's general aims. Data is collected at the beginning and end of the intervention to assess the effectiveness of the intervention, while periodic measurements help assess the progress of the intervention during implementation (e.g. as part of monitoring). After the intervention, follow-up measurements are conducted to test how long post-intervention outcomes are sustained (e.g. if participants demonstrated a change in attitude or behaviour at the end of the intervention, did they fall back into their old behaviours and attitudes after a couple of months?). The standards suggest the following intervals for follow-up measurements: up to 6 months after the intervention (short-term), >6 to 12 months after the intervention (medium-term), and >12 months after the intervention (long-term). An additional measurement may be conducted when the final outcomes are expected to occur. For example, if an intervention is carried out with very young children, final outcomes would refer to whether they develop harmful patterns of drug use many years after the intervention. In practice,

however, such longer term follow-ups can be difficult to achieve and have high resource implications. As a minimum, post-intervention outcomes should be assessed to establish whether the intervention was effective in achieving its goals. This highlights that the defined goals must be realistic and achievable within the course of the intervention.

Components 7.1: *If conducting an outcome evaluation* and 7.2: *If conducting a process evaluation* contain further standards on the analyses and documentation of findings that are conducted as part of final evaluations. Further information on evaluation can also be found in the *Additional guidance* section.

Where final outcome and process evaluations are not deemed appropriate or feasible, monitoring may be an acceptable alternative to conducting more comprehensive and formal evaluations (see 6.3: *Monitoring the implementation*). Consequently, the standards in this component apply only if final evaluations are planned.

Basic standards if any final evaluation is planned:	
4.4.1 It is determined what kind of evaluation is most appropriate for the programme.	Example consideration: while the process evaluation can help determine why successful outcomes arose, the outcome evaluation is more important than the process evaluation in determining an intervention's effectiveness.
4.4.2 An evaluation plan exists in writing.	Examples of content: type of evaluation, research model, illustrating evaluation indicators, data collection, monitoring, final evaluations, reporting, time schedules.
4.4.3 The planned evaluation is realistic and feasible.	i.e. it acknowledges what is feasible under real-world conditions and with available resources.
4.4.4 Evaluation is seen as an integral and important element in ensuring programme quality.	
4.4.5 An evaluation team is designated to oversee the evaluation.	Note: the 'team' may also only be one person.
4.4.6 The evaluation team:	
• develops the evaluation strategy and plan, the evaluation indicators, and data collection instruments;	

Basic standards if any final evaluation is planned (cont.):	
• prepares the evaluation report;	
• assigns relevant roles to specific persons.	Examples of roles: persons responsible for data collection, data recording, data analysis.
4.4.7 The human resources are sufficient to conduct an evaluation.	i.e. the team has a sufficient number of qualified staff to conduct an evaluation; the knowledge of evaluation is sufficient.
4.4.8 Evaluation indicators are specified.	
4.4.9 Evaluation indicators are:	
• clearly described;	
• measurable in quantitative and/or qualitative terms;	
• measurable using empirical techniques;	Example: observations.
• appropriate for the type of evaluation.	Example of evidence: if process and outcome evaluations are planned, separate indicators are specified for process and outcome evaluation.
4.4.10 The choice of evaluation indicators is informed by:	
• the goals and objectives of the programme;	i.e. each goal and each objective is connected with one or several evaluation indicator(s).
• the chosen activities.	
4.4.11 The process for participant selection is described.	Note: participants should be drawn from the defined target population. See also 3.1: *Defining the target population* and 5.4: *Recruiting and retaining participants.*
4.4.12 A timeline is specified.	i.e. it is clear when the evaluation(s) will be conducted. Example: brief questionnaire for staff members and participants after each session. Example of evidence: measurement schedules.

Basic standards if any final evaluation is planned (cont.):	
4.4.13 The persons to collect data from are:	
• specified;	
• adequate for the purposes of the evaluation.	
i.e. they are able to provide the information required for the evaluation indicators. Example: outcome data is collected from participants or from persons who can provide good quality proxy data (e.g. clinical rating, school teacher report on classroom behaviour, observation and recording of social interactions by staff members).	
4.4.14 Participants, staff members, and others feel comfortable enough to provide honest answers and opinions.	Example: they feel comfortable enough to report their drug use or to criticise the programme.
4.4.15 Methods and tools used for data collection are described.	
4.4.16 Methods and tools used for data collection:	
• are adequate for the programme;	i.e. the data collection method is commensurate with the level of the programme.
• retrieve information relevant to the evaluation indicators;	
• consist of previously tested existing tools or well-developed new tools;	
• are consistently used throughout the programme.	i.e. the same instruments are used throughout the programme (e.g. for baseline and final measurements). Purpose: to ensure comparability of data.
4.4.17 A system for information management is in place.	i.e. a set of procedures, paper and electronic supports, etc. Purpose: to facilitate data collection and processing.

Additional basic standards if an outcome evaluation is planned:	
4.4.18 The outcome evaluation follows a research design. The evaluation:	
• enables a clear analysis of the relationship between the intervention and the outcomes;	
• reflects the strongest possible research design given the circumstances of the intervention.	Example: if randomisation is not practical or possible, alternative designs are implemented, such as repeated time-series design without randomisation, regression-discontinuity designs, matched control designs.
4.4.19 The necessary sample size for a good research design is determined.	Example consideration: what is the minimum sample size that is required for the planned statistical analyses?
4.4.20 The method for data analysis is described.	
4.4.21 The persons to collect outcome data from are specified.	
4.4.22 Outcome data is collected from participants in the intervention group.	
4.4.23 Outcome data is measured:	
• at the beginning of the intervention or during needs assessment;	i.e. as baseline data to enable comparisons before and after the intervention.
• post-intervention.	i.e. at the end of the intervention.

Additional basic standards if a controlled design is chosen:	
4.4.24 At least one comparison condition (i.e. control group) is arranged.	
4.4.25 The participant selection criteria and the assignment procedure are described for intervention and control groups.	Example of assignment procedure: self-selection.
4.4.26 Measurements are conducted in both intervention and control groups.	i.e. outcome data is collected from participants in the control group.
4.4.27 Various characteristics are analysed in the intervention and control groups to ensure that they are similar; any identified differences are controlled for in the data analysis.	i.e. test for pre-test differences.

Additional basic standards if a process evaluation is planned:	
4.4.28 The persons to collect process data from are specified.	
4.4.29 The persons to collect process data from include:	
• participants in the intervention group;	
• staff members.	

Additional expert standards:	
4.4.30 The final evaluations assess the programme process as well as the outcomes of the intervention.	
4.4.31 The evaluation embraces various viewpoints.	Examples of viewpoints: evidence of effectiveness (outcomes), practical functioning (process), correspondence with best practice guidance, ethics.
4.4.32 The target population is involved at all stages of the evaluation.	
4.4.33 Relevant stakeholders are involved in the design of the evaluation.	

Additional expert standards (cont.):	
4.4.34 The evaluation team:	
• collects, analyses, and interprets data;	
• involves a range of representatives.	Examples of groups to consider: staff members, participants, academics.
4.4.35 Evaluation experts are consulted, where necessary.	Examples of experts: university and/or external consultants with expertise in evaluation.
4.4.36 Where possible, external evaluations are conducted.	i.e. as formal assessments by an individual or group working for an external organisation (e.g. university, consultancy).
4.4.37 Evaluation indicators:	
• acknowledge participants' development throughout the programme;	i.e. different indicators are chosen to represent different stages of progress in the intervention. Note: although a range of indicators is chosen to capture participants' progress over time, measurements must be conducted with the same indicators and instruments throughout the intervention.
• include evaluation benchmarks indicating minimum and optimal intended levels of change.	i.e. a specific value to be achieved on an evaluation indicator during or after the intervention. Example: the programme wants to achieve at least a 20 % decrease in drug use, and ideally (under perfect conditions) a 50 % decrease in drug use.
4.4.38 The choice of evaluation indicators is informed by the theoretical model.	**Basic standard if a theoretical model is used.** Example aspects to consider: mediators and moderators suggested by the theoretical model.
4.4.39 The evaluation is conducted under real-world conditions.	**Basic standard if the programme is an effectiveness trial (as opposed to an efficacy trial).** Example of real-world condition: teachers instead of researchers as deliverers of intervention.

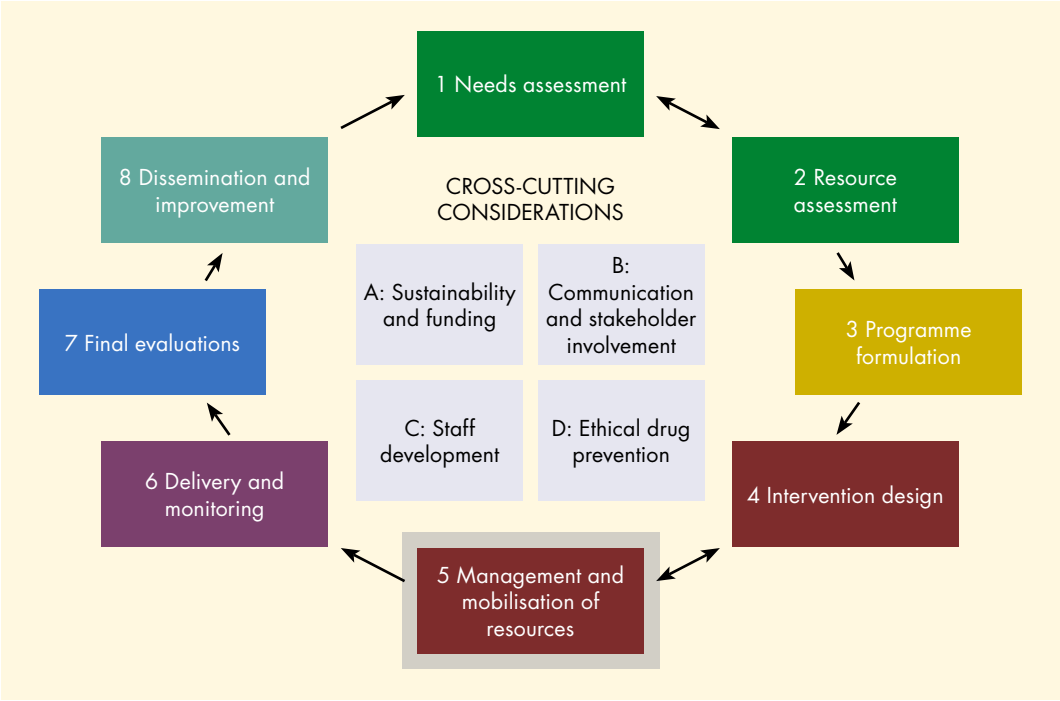
Additional expert standards (cont.):	
4.4.40 The research design incorporates a control condition.	Purpose: to be able to attribute effects to the intervention.
4.4.41 At least one form of data collection is blinded.	i.e. data collectors do not know whether participants received the intervention or whether they were in the control group.
4.4.42 The research design incorporates randomisation. This includes:	Purpose: to avoid obtaining a biased participant sample.
• Participants are randomly assigned to intervention and control groups ('randomisation').	**Basic standard if a randomised design is chosen.**
• Stakeholders are involved in the randomisation process as necessary.	
	Purpose: stakeholder assistance may be required to conduct randomisation (i.e. to obtain list of all eligible individuals or recipient organisations). Stakeholders must also understand why randomisation is important and the reasons why some individuals or organisations may not receive the intervention. Example of stakeholder involvement: school head teacher assists with allocation of classes to intervention and control conditions.
4.4.43 Methods and tools used for data collection:	
• comprise a range of tools and measures;	Examples of tools and measures: questionnaires, attendance registers, satisfaction scales, forms, checklists, independent observations.
• are psychometrically sound in term of their objectivity, validity, and reliability;	i.e. measure what they are intended to measure (validity); produce consistent results (reliability: internal consistency, test-retest, inter-rater reliability); produce results independently of who uses the instrument (objectivity). Note: construct validity must also be considered, i.e. are the indicators valid measures of targeted behaviour following the appropriate literature?

Additional expert standards (cont.):	
• are culturally adapted and pilot tested, where appropriate.	
4.4.44 Guidance on the data collection methods is provided.	Example of guidance: analytic strategies and detailed guidelines for field researchers.
4.4.45 Process data is collected from:	
• participants in the control group;	
• other relevant stakeholders, where appropriate.	Examples of stakeholders: funders, other agencies, community members, media.
4.4.46 Certain process data is collected at the end of each session.	Examples of process data: participants' satisfaction, feedback from staff members on the quality and success of the session.
4.4.47 Outcome data is measured:	
• periodically, where appropriate;	
• short-term;	i.e. within 6 months of completing the intervention.
• medium-term;	i.e. >6 to 12 months after completing the intervention.
• long-term.	i.e. >12 months after completing the intervention.
4.4.48 Interventions that anticipate longer term final outcomes incorporate data collection at an appropriate time when the outcome is expected.	Example consideration: for programmes targeting young children, outcome data is collected when final outcomes are developmentally expected.

PROJECT STAGE
FIVE

Project stage 5

Management and mobilisation of resources



A drug prevention programme consists not only of the actual intervention, but also requires good project management and detailed planning to ensure that it is feasible. Managerial, organisational, and practical aspects need to be considered alongside the intervention design. To start implementation, available resources must be activated and new resources accessed as necessary. Project management reference books provide in-depth information on how to plan and manage projects. However, together with Project stage 3: *Programme formulation* these standards highlight some of the main considerations in relation to drug prevention work.

5.1 Planning the programme — Illustrating the project plan: A dedicated procedure ensures that planning and implementation are conducted systematically. A written project plan documents all tasks and procedures that are required for the successful implementation of the programme. The

project plan guides implementation by providing a common framework that all staff members can work towards. In later project stages, the project plan is consulted to assess whether the programme is implemented as intended, and if any adjustments are required.

5.2 Planning financial requirements: The financial requirements (costs) and capacities (budget) of the programme must be determined to put necessary and available resources into context. The costs must not exceed the budget that is (or will be available) for the programme. If more resources are required than are available, the financial plan clarifies what additional funding might be required or how the project plan may need to be altered.

5.3 Setting up the team: The team consists of the people working on the programme (e.g. managing, delivering, evaluating). Staff members (including volunteers) should be chosen in correspondence with legal requirements and the needs of the programme. Roles and responsibilities should be distributed accordingly, guaranteeing that all necessary tasks have been assigned and are carried out by the most suitable persons.

5.4 Recruiting and retaining participants: Participants should be recruited from the defined target population in a methodologically correct and ethical way. Recruitment refers to the process of choosing eligible individuals from the target population, informing them about the programme, inviting them to take part, enrolling them, and ensuring that they begin the intervention, while retention refers to the process of ensuring that all participants remain in the intervention until it has finished and/or until the goals have been achieved. Barriers to participation should be identified and removed to ensure that participants can complete the programme.

5.5 Preparing programme materials: The materials that are required for implementation of the programme should be considered, including intervention materials, instruments for monitoring and evaluation, technical equipment, the physical environment (e.g. facilities), etc. This allows finalising the financial plan, and taking action to secure necessary materials. If intervention materials are used (e.g. manuals, films, websites), they should be of high quality and suitable for the intended users.

5.6 Providing a programme description: A written programme description provides a clear overview of the programme. It is produced so that interested stakeholders (e.g. target population, funders, other interested professionals) may obtain information about the programme. The intervention and its activities should be described in detail, although the level of detail will depend upon the scope of the programme and the likely readers of the description. If the description is used in participant recruitment, particular emphasis must be put on the potential risks and benefits for participants.

This stage may be conducted at the same time as the intervention design.

5.1 Planning the programme — Illustrating the project plan

A drug prevention programme comprises not only the intervention, but also the accompanying research (e.g. needs assessment, evaluation) and administrative structure (e.g. project management, fundraising, staff training, participant recruitment, dissemination, etc.). Only a dedicated planning procedure can ensure that all these aspects are well coordinated, and that preparations for the intervention and its implementation are conducted systematically. The most important part in this regard is a written project plan which illustrates the main tasks and strategies required for the successful implementation of the programme. It is not always necessary to produce the project plan from scratch; it can be adapted from existing funding applications or similar documents.

The project plan guides the implementation of the programme by providing a common framework that all staff members can work towards. During implementation, it can be used to track and document implementation, assess whether implementation follows the project plan, review the progress of the programme, and justify any changes (e.g. to the original timeline) (see Project stage 6: *Delivery and monitoring*). If used in this way, it will be a crucial source of information for the process evaluation and the production of the final report. This highlights that the project plan is an important tool even if actual implementation is not in line with the original plan (e.g. if timelines change). Moreover, contingency plans enable providers to deal effectively with emerging difficulties.

The project plan documents the decisions taken in the earlier project stages and outlines how they can be put into practice. The level of detail in the project plan depends on the circumstances of the programme. It should be comprehensive enough to be useful to the team and not be regarded as a bureaucratic 'tick-box exercise' that has no real value to the programme. It is recommended that representatives from all relevant stakeholder groups are involved in the planning (e.g. target population, recipient organisation). This will ensure that the programme meets their needs and expectations, and it will also help secure their support for the later stages of the programme (see B: *Communication and stakeholder involvement*). The project plan should be consulted regularly at planning meetings to discuss the progress of the programme and relevant next steps (e.g. as part of the monitoring procedure — see component 6.3: *Monitoring the implementation*).

Time spent on planning the programme may be perceived by some professionals as a luxury, or even as 'unproductive' time, because it is not time spent directly with the target population. However, taking time for reflection, literature review, discussion, etc. is an essential aspect of conducting high

quality drug prevention. Commissioners and funders must support the implementation of the standards by funding such time and allowing providers to include it in cost calculations.

The project plan differs from the programme description which informs external parties (e.g. target population, funders) about the programme (see 5.6: *Providing a programme description*). For new funding applications, it is recommended to produce a combined document incorporating the project plan and the programme description.

Basic standards:	
5.1.1 Time is set aside for the planning of the programme.	Example of evidence: resource estimate in funding application includes time spent on planning.
5.1.2 The programme is planned systematically.	i.e. by dedicating time to planning; by considering necessary actions for all project stages.
5.1.3 The planning and management process is transparent.	Example consideration: are all staff members aware of how the programme is planned and managed?
5.1.4 A written project plan exists.	Also called: work plan, action plan, implementation plan.
5.1.5 The project plan:	
• is clear and comprehensible for all;	
• illustrates and connects the main components of the programme;	Example: showing connections between target population needs, aims, goals, and objectives, evaluation indicators, evaluation benchmarks, activities, outcomes, and evaluations. Example of evidence: the logical flow of programme activities is illustrated in a graphical representation (i.e. in a programme logic model). Additional guidance: programme logic models are discussed in *Achieving outcomes* (CSAP, 2002).
• allows tracking actual progress of the programme during implementation;	
• is realistic;	
• is accessible by all involved staff members.	

Basic standards (cont.):	
5.1.6 The project plan outlines the following:	
• aims, goals, and objectives;	
• a set of actions for each objective;	
• the intervention;	Example aspects to consider: what intervention activities are to be conducted with participants, by whom, and how.
• a strategy for monitoring the programme quality;	Example aspects to consider: fidelity, effectiveness, participants' satisfaction.
• the programme's time schedule;	i.e. planned start and end dates for different stages and activities. Note: actual start and end dates should be added during implementation.
• the procedure for the recruitment and retention of participants;	
• staff selection procedures.	
5.1.7 A contingency plan is developed, outlining:	
• rules and procedures to prevent or handle potential problems;	i.e. potential scenarios that could jeopardise the implementation or success of the programme, as well as ways of preventing or handling these scenarios. Example of scenarios: not completing activities within specified timeframe.
• a solution strategy for problems with the organisational capacity.	Examples of scenarios: staff members leaving, overspending on budget.

Additional basic standards if evaluations are planned:	
5.1.8 The project plan outlines the following:	
• a strategy for data collection;	i.e. who will measure what, when and how.
• deadlines for final evaluations.	

Additional expert standards:	
5.1.9 A working group is established.	Note: this may include representatives from the target population and other stakeholder groups.
5.1.10 A procedure for programme planning is in place.	Example aspects to consider: responsibilities for planning, reporting arrangements, feedback, follow-up.
5.1.11 Planning sessions are held and minuted.	Example of evidence: regular meetings of the working group, meeting summaries available.
5.1.12 The programme takes short-term, mid-term, and long-term perspectives in planning and implementation.	
5.1.13 The written project plan:	
• is systematically arranged as a step-by-step sequence;	
• consists of a general project plan and more detailed action plans;	
• groups tasks into work packages or stages.	
5.1.14 The project plan outlines the following:	
• those activities that are most important for the success of the programme;	i.e. the 'critical' activities.
• a strategy to ensure the involvement of the target population in the programme development and implementation;	
• a schedule for regular review of the project plan;	

Additional expert standards (cont.):	
• preparatory tasks necessary to start the intervention;	
• the procedure for the recruitment and retention of external collaborators;	Example of external collaborator: recipient organisation (e.g. school).
• staff training procedures;	
• named persons responsible for the implementation of the plan;	i.e. distribution of roles and responsibilities.
• supervision of staff;	
• a strategy for programme documentation;	
• a communications strategy;	Example: a process to communicate monitoring feedback to staff members.
• procedures for cooperation with external persons and agencies.	Examples of external persons and agencies: social work case managers, probation officers, the media, police.

5.2 Planning financial requirements

Drug prevention programmes are only feasible and sustainable in the long term if the necessary resources match the available resources. Funding is a key resource, as it can (indirectly) determine the availability of all other resources. The standards outline the requirement to produce a financial plan specifying the financial requirements (costs) and capacities (budget) of the programme. A clear financial plan helps ensure that sufficient funding is available to carry out all planned activities. Otherwise, prevention activities run the risk of being discontinued because funds have been exhausted ahead of completion.

Costs refer to the amount of money which is (likely to be) required for the programme. It is important to remember that costs arise not only from the implementation of the intervention. The total costs are calculated by considering all resources that are necessary to put the project plan into practice (e.g. materials, staff training, project management, evaluation). Tools such as the *Drug Abuse Treatment Cost Analysis Program (DATCAP)* (French, 2004) can help provide a realistic estimate of total costs. Additionally, the standards encourage the consideration of opportunity costs which may include non-monetary items such as lost time (i.e. staff or participant time not spent on other activities). The analysis of opportunity costs should take into account a variety of perspectives, such as those of staff members, participants, and other stakeholders (CCSA, 2009).

Budget refers to the amount of money which is (likely to be) available for the programme. It also represents the maximum allowed spend (i.e. costs must not exceed the budget). Consequently, costs must be planned in line with the budget. If estimated costs are greater than the estimated budget, providers must either obtain additional funding (see A: *Sustainability and funding*) or modify the project plan so that the programme is achievable within the available resources. Programme developers may help refine costs, for example by offering an intervention version using alternative, less expensive materials. The pursuit of efficiency, however, must not compromise the quality or effectiveness of the intervention (e.g. using fewer staff members may reduce the quality of delivery). Where modifications made to reduce costs would threaten the quality or effectiveness of the intervention, commissioners and funders may need to appreciate better what the real costs of programmes and evaluations are, and allocate funding accordingly.

These standards apply regardless of whether funding is already available (e.g. as part of the organisational budget, as part of a grant that has already been received) and/or whether it is still to be secured externally (e.g. developing a programme in response to a specific tender for funding). By

providing a detailed breakdown of costs and funding streams and specifying which cost items will be covered by which types of budget, the budget can be earmarked for the specific programme and will thus be more likely to be available when it is needed.

If programme developers are designing a new intervention that is to be implemented separately by providers, it may not be possible or appropriate for these programme developers to estimate total cost and budget, as these will depend on the particular circumstances of the provider. In such cases, cost estimates may relate to costs of intervention materials, licence fees, etc.

Basic standards:	
5.2.1 A clear and comprehensible financial plan exists in writing.	i.e. costs and budget are specified.
5.2.2 A clear cost estimate for the programme is provided.	
5.2.3 The cost estimate is realistic for the envisaged programme.	
5.2.4 A realistic estimate of the total budget available to the programme is provided.	
5.2.5 The funding entities and other sources of income are stated.	
5.2.6 The available budget is adequate for the envisaged programme.	
5.2.7 Costs and available budget/funds are linked.	
5.2.8 It is clear who is responsible for control of the budget.	
5.2.9 Accounting is clear and transparent.	
5.2.10 The budgeting complies with legal and general requirements.	Example of legal requirements: accounting procedures, such as how long invoices have to be archived.

Additional expert standards:	
5.2.11 A detailed and comprehensive breakdown of costs is provided.	
Examples of items to be costed: • staff costs and time, including volunteers; • opportunity costs; • manuals and other materials; • overheads, such as rent, facility space, technical equipment; • project management and administration; • staff training; • participant recruitment and retention; • data collection, monitoring, and final evaluations; • dissemination of information about the programme.	
5.2.12 A detailed and comprehensive breakdown of the available budget is provided.	i.e. outlining different funding streams. Examples of funding streams: charitable contributions, internal resources. See also A: *Sustainability and funding*.
5.2.13 The financial requirements are reviewed in the implementation phase according to emerging new priorities or developments.	

5.3 Setting up the team

A drug prevention programme can only be successful if is carried out by the right people. Staff members (including volunteers) must be chosen in correspondence with legal requirements and the needs of the programme. Roles and responsibilities must be distributed accordingly, ensuring that all tasks have been assigned and will be carried out by the most suitable persons.

The type and scope of the programme will define what qualifications and competencies (e.g. knowledge, skills, attitudes) are required for a successful implementation of the programme. Component C: *Staff development* contains standards on staff competencies and the training, development, and support of staff prior to and during implementation.

If these standards are used during the planning of a programme, their practical meaning will depend on whether staff members are yet to be hired for the programme and/or whether existing staff members can be allocated to the programme. In either case, these standards specify what criteria to consider when assembling the team to work on the programme.

Basic standards:	
5.3.1 There is a written procedure for staff selection and hiring.	
5.3.2 Staff selection and hiring is in line with legal requirements.	
5.3.3 The structure and management of the organisation are defined in writing.	Note: in large organisations, a description of the specific department responsible for the programme may be sufficient.
5.3.4 The form of employment is clear and corresponds to national legislation.	Examples of evidence: working contracts include details on staff rights and benefits, accident insurance, unemployment insurance, overtime premium, salary, and other forms of compensation.
5.3.5 The staff required for the successful implementation of the programme is defined.	Note: staff may include professional staff, volunteers, interns, external contributors, etc.

Basic standards (cont.):	
5.3.6 The specification takes into account:	
• required type of roles;	Examples of roles: outreach worker, alcohol nurse specialist, administrative staff.
• required number of staff;	Example of evidence: staff-task ratio.
• required staff qualifications;	Examples of qualifications: university degree in a relevant field, training in prevention and health promotion.
• required staff competencies.	
i.e. as outlined under *C: Staff development*. Note: It is likely that there will be an overlap between different roles, i.e. the same individual(s) may have different functions. Examples of roles to consider: • leadership of the programme, i.e. sufficient knowledge and understanding of project work; • project management; • intervention delivery; • monitoring of the programme's quality and effectiveness; • administration and business tasks (e.g. book keeping, purchasing); • external coordination, i.e. building relationships and preparing cooperation, publicity.	
5.3.7 The set-up of the team is appropriate for the target population.	Example: ethnicity and diversity of staff members are (likely to be) acceptable for the target population.
5.3.8 Tasks and functions are distributed appropriately among staff members.	
Note: the distribution of tasks and functions should consider staff members' qualifications, their level of experience, and their workload balance. Example consideration: Specialised tasks are carried out by staff members with corresponding qualifications and licences (e.g. chartered psychologist status); if necessary, external specialist staff is sought.	

Basic standards (cont.):	
5.3.9 Required staff resources are (likely to be) available.	Example aspects to consider: time availability, availability of required roles and staff numbers. Example of evidence: existing staff members or networks.
5.3.10 Staff members are (likely to be) ready to engage in the programme.	Example of staff readiness: teachers accept the need for a school intervention.
5.3.11 Staff members are (likely to be) clear about their responsibilities and roles.	Example of evidence: the division of tasks is defined in writing for each project stage.
5.3.12 Staff members are selected according to the needs of the programme.	Note: this may to refer to the allocation of existing staff members to the programme as well as to the selection of new staff members.

Additional expert standards:	
5.3.13 The written procedure for staff selection and hiring specifies:	
• internal staff selection rules where the valid legislation is too general;	Example aspects to consider: professional qualifications and/or experience, target population expectations towards staff members.
• rules regarding the involvement of interns and volunteers in the programme;	**Basic standard if interns and/or volunteers are involved.** Note: for example, criminal records checks may be requested.

Additional expert standards (cont.):	
• rules regarding the involvement of staff members with previous or current problems.	
	Basic standard if, for example, former or current drug users are involved as staff members. Note: rules should be sensible to the value of employment in the rehabilitation and social reintegration of, for example, former or current drug users. The involvement of former or current drug users who wish to gain work experience should not generally be ruled out (UKDPC, 2008). Rules may specify staff development requirements (see C: *Staff development*). Examples of problems: previous or current problems with legal or illegal drugs, persons convicted of crimes, previous offences towards children.
5.3.14 The actual qualifications of existing staff members are described.	Examples of existing staff members: lead practitioner, service manager.

5.4 Recruiting and retaining participants

Participants are those who take part in, or receive, the intervention in a direct manner (e.g. by taking part in an activity, by being exposed to a drug prevention message). Depending on the type of programme, participants are drawn from the ultimate target population (e.g. young people at risk of drug use) or an intermediate target population (e.g. family, peers, teachers) (see 3.1: *Defining the target population*).

Recruitment refers to the process of choosing eligible individuals from the target population, informing them about the programme, inviting them to take part, enrolling them, and ensuring that they begin the intervention (e.g. attend the first session). Various means can be used to promote participation in the programme, e.g. outreach, word of mouth, advertisements, referral through other agencies (UNODC, 2009a). When recruiting participants, the principles of ethical drug prevention should be observed by providing, where possible, transparent, truthful and comprehensive information about participation in the programme and obtaining participants' consent (see D*: Ethical drug prevention*; 5.6: *Providing a programme description).*

The participant sample should be representative of the defined target population (i.e. mirror its characteristics), so that findings can be generalised to the wider target population. This requirement is essential where the intervention is part of a scientific research trial. In such cases, participants must be recruited in a methodologically correct way to avoid bias. This is best achieved by drawing a random sample so that each individual or natural group (e.g. school class) has the same probability of being selected into the sample. Random selection can be conducted, for example, by using a computer-generated list of random numbers. Furthermore, the participant sample should be large enough to enable a range of statistical analyses (i.e. to achieve sufficient statistical power). Where the intervention is not part of a scientific research trial (e.g. continuous participant-led services), other methods may be used for participant selection. It is then essential to document how participants are drawn from the target population, so that others may understand the procedure.

Retention refers to the process of ensuring that all participants remain in the intervention until it has finished and/or until the goals have been achieved (whichever is more appropriate) (refer also to the definition of 'completion' under 4.1: *Designing for quality and effectiveness*). Retention of participants is essential to ensure that the intervention is effective (i.e. participants cannot achieve goals if they drop out unplanned beforehand). Retention is particularly important where an outcome evaluation is planned (see 4.4: *If planning final evaluations;* 7.1: *If conducting an outcome evaluation*). If post-

intervention outcome data is not available for all participants, then a reduced sample size may mean that it is not be possible to conduct all intended statistical analyses. In such cases, analyses should be used which take into account withdrawal or dropout from an intervention (e.g. Intention-to-Treat (ITT) analysis). If the findings of the evaluation are to be generalised to the wider target population, it must also be considered how participants who dropped out differ from those that remained. Consequently, financial requirements must be planned so that sufficient funding is available to ensure that all participants can complete the intervention (see 5.2: *Planning financial requirements*).

The likelihood of successfully recruiting and retaining participants can be increased by taking special measures to make participation in the programme more attractive. An important aspect is to identify and remove potential barriers to participation. These may be practical (e.g. inconvenient location or timing, family responsibilities, illiteracy) or of a more subtle nature (e.g. risk of stigma for participants, programme is not culturally acceptable, intervention perceived as irrelevant). It is also possible to offer additional conveniences and incentives (e.g. paying for transportation, offering child care, offering a 'prize' for completion of the intervention). When intending to offer financial incentives, the potential advantages and disadvantages must be taken into account. Vouchers (e.g. to spend at supermarkets) are preferable over cash payments if there is a concern that participants will spend the incentive on drugs. Access can also be widened, for example, by making a special effort to include 'hard-to-reach' populations.

Retention rates can sometimes be regarded as an indicator for the overall quality of the programme (i.e. if participants 'like' the programme, they will take part). Even though participants with more severe needs may be more likely to drop out, retention can also depend on the programme itself. For example, aspects of staff composition and staff behaviour may have an impact on retention rates (see 5.3: *Setting up the team;* C: *Staff development*), or the content and delivery of the intervention. The consultations held to inform the development of these standards suggested that tailoring the intervention to the target population was an important factor in assuring retention (see 4.3: *Tailoring the intervention to the target population*). In certain cases, providers may choose to tailor the intervention while it is being delivered. For example, a practitioner may decide to conduct an interactive session in a school class full of tired pupils instead of the planned lecture to increase their level of engagement. However, such modifications must be well justified so that they do not have a negative impact on the fidelity and effectiveness of the intervention (see 6.4: *Adapting the intervention*); ideally, this level of flexibility is already included in the intervention design (e.g. by outlining how the order of activities may be changed to suit participants' needs on the day).

However, the pursuit of high retention rates must not override the principles of ethical drug prevention. Where participation is not a legal requirement, participation should be voluntary, and providers should respect participants' rights, including their right to withdraw their participation at any time without giving a reason. Participants should be treated as free individuals and not forced to remain in the programme if they wish to discontinue their participation.

It may not be possible or necessary to recruit and retain participants in all prevention activities as described above. For example, in outreach work, while observing the principles underlying this component, it may be necessary to take a less formal approach to recruitment. In other cases, recruitment and retention may refer to a larger unit (e.g. the recipient organisation) instead of individuals. For example, in universal school-based activities children may not have to be formally recruited and retained if drug education is part of curriculum requirements. Recruitment and retention would then refer to the schools themselves (e.g. informing schools about the programme and ensuring their continued collaboration) (see B: *Communication and stakeholder involvement*).

Further information on how to recruit and retain participants can be found, for example, in the handbook *Guide to implementing family skills training programmes for drug abuse prevention* (UNODC, 2009a), upon which these standards are primarily based.

Basic standards:	
5.4.1 It is clear how participants are drawn from the defined target population.	i.e. it is clear how participants are selected from all members of the target population.
5.4.2 The mechanisms used to recruit participants are defined.	i.e. it is clear how members of the target population are invited to take part in the intervention. Example of recruitment mechanism: posters displayed in sexual health clinics.
5.4.3 Specific measures are taken to maximise recruitment and retention of participants. The programme:	
• is affordable for the target population;	i.e. low-cost or free of charge.
• offers adequate timetables and locations for the target population;	
• ensures confidentiality;	
• avoids labelling participants or the wider target population.	Purpose: ensures that participants are not ashamed to take part in the programme.

Additional basic standards if information about the programme is provided to participants as part of the recruitment procedure:	
5.4.4 Information about the programme:	See also 5.6: *Providing a programme description.*
• corresponds to reality and is up-to-date;	
• is presented in a form that is comprehensible and adequate for the target population;	
• is distributed using appropriate media and channels.	

Additional expert standards:	
5.4.5 Participants are recruited from the defined target population:	
• using probability sampling;	**Basic standard if the intervention is delivered as part of a randomised controlled trial (RCT).**
• using existing networks and through other activities;	Examples: existing school or community networks, outreach work.
• at relevant transition points in their lives ('points of vulnerability').	Examples of transition points: expected events, such as move from primary to secondary school education; unexpected events, such as parents' divorce (UNODC, 2009a, p. 24).
5.4.6 Participation in the programme is open to all members of the target population.	
i.e. certain members of the target population are not discriminated against. Note: if there are justifiable reasons to exclude certain members of the target population, the definition of the target population may need to be revised. Example aspects to consider: equal access to the programme regardless of sex, age, race, or religious beliefs.	
5.4.7 The person recruiting potential participants is chosen appropriately.	Example: successful previous participant rather than university research staff.

Additional expert standards (cont.):	
5.4.8 Members of the target population are informed about the programme.	
5.4.9 Information about the programme is publicly available.	
5.4.10 In order to maximise recruitment and retention of participants, the programme:	
• is accessible without unnecessary delay;	Example: the gap between enrolment and the first session of the intervention is as short as possible.
• identifies potential practical barriers for participants, and takes measures to reduce these;	Example of barriers: illiteracy. Examples of measures to take: discuss issues with participants in the first session, brainstorm to find solutions.
• offers conveniences for participants;	Examples of conveniences: offering childcare, providing transportation and/or meals, possibility to bring other persons to some sessions (e.g. spouse, elders, employers).
• offers participants a choice of staff members, including staff members from the participants' own background;	
• offers incentives for participants;	Examples of incentives: small gifts or 'lottery', planning and organising graduation ceremony together with participants (UNODC, 2009a).
• makes additional efforts to increase the access for 'hard-to-reach' populations.	Note: hard-to-reach populations include people who do not have access to programmes and services because of social exclusion and marginalisation of their lifestyle. Example of hard-to-reach populations: pupils (and their families) who are excluded from school.

5.5 Preparing programme materials

The standards in this component refer to those materials that are required for the implementation of the programme. This includes instruments for monitoring and evaluation (e.g. questionnaires), technical equipment (e.g. computers, DVD players, projectors), the physical environment (e.g. indoor and outdoor facilities), etc. By specifying what materials are needed, the cost estimate in the financial plan can be finalised (see 5.2: *Planning financial requirements*), and relevant action taken to secure the necessary materials.

A particular emphasis is put in this component on materials that are used to deliver the content of the intervention ('intervention materials'), such as workbooks, DVDs, staff training manuals, presentations, websites, etc. The information contained therein and the type of media used must be suitable for the intended users. For example, intervention materials must be tailored to the specific needs and characteristics of the target population as identified in the needs assessment (see Project stage 1: *Needs assessment* and 4.3: *Tailoring the intervention to the target population*). Intervention materials must also correspond to the principles of ethical drug prevention, for example by providing accurate information and not trying to scare or manipulate participants (see *D: Ethical drug prevention*).

The type of media (e.g. Internet, books, films) should be chosen in line with the findings from the needs assessment, the theoretical model, and the scientific evidence (see Project stage 1: *Needs assessment* and 3.2: *Using a theoretical model* and 3.5 *Referring to evidence of effectiveness*). Although the budget may be limited, intervention materials should reflect the types of materials that are already used by the target population and/or that the target population is (likely to be) familiar with. Sometimes providers may wish to use a certain form of delivery because it is inexpensive, readily available, or perceived to be unique or innovative (e.g. social networking websites). However, such considerations must not override the requirement to choose intervention materials that correspond to target population needs (e.g. Internet-based drug prevention interventions may not be suitable for participants with low computer literacy).

Where possible, intervention materials should be tested and piloted with the intended target population to ensure that they are attractive, easy to comprehend, and (developmentally) appropriate (see 6.1: *If conducting a pilot intervention*). The materials should be adjusted in accordance with these findings.

As not all drug prevention programmes require intervention materials, the standards on intervention materials apply only where these are utilised.

Basic standards:	
5.5.1 Materials necessary for implementation of the programme are specified.	Examples of materials: intervention materials (e.g. workbooks, DVDs, staff training manuals), instruments for monitoring and evaluation, technical equipment, physical environment. Note: this specification may show that no particular materials are required.

Additional basic standards if intervention materials are used:	
5.5.2 The information provided in the intervention materials is:	
• specific;	
• relevant to the needs of the users (i.e. participants or staff members);	
• up-to-date;	
• factually correct;	
• balanced in terms of positive and negative aspects of drug use;	Purpose: to avoid distortion of information and manipulation of participants. Note: for some types of intervention (e.g. illustrating legal consequences of drug use), positive aspects of drug use may not be relevant. See also D: *Ethical drug prevention*.
• proofed.	i.e. accurate, formatted, and well presented.

Additional expert standards:	
5.5.3 The costs of materials are in line with the available budget.	**Basic standard if any materials are necessary.** Example aspects to consider: costs of materials, staff training needs.
5.5.4 Existing materials which could be used for the programme are identified and checked for suitability.	Purpose: to avoid duplication of existing efforts. Examples of existing materials: intervention materials (e.g. manuals), instruments for monitoring and evaluation.
5.5.5 The information provided in the intervention materials is:	
• not oversimplified;	
• referenced.	**Basic standard for staff manuals.**
5.5.6 Intervention materials are available for:	Examples of intervention materials: manuals, handouts.
• staff members and participants;	
• other relevant stakeholders.	Examples of other relevant stakeholders: members of the target population that are not taking part in the programme, experts, teachers, general public.

5.6 Providing a programme description

A written description of the drug prevention programme is produced so that interested parties, such as the target population, funders, and other relevant stakeholders, may obtain information about the programme while it is ongoing. Consequently, the aim of this description is to provide a clear overview of the programme. If the description is used to inform the target population about the programme (e.g. during recruitment), there should be a particular emphasis on the conditions and possible consequences of participation (e.g. price, benefits and risks).

The level of detail in the programme description depends upon the scope of the programme and the likely readers of the description. If the description is used to recruit participants, the intervention activities must be described in sufficient detail to allow members of the target population to take an informed decision about whether they wish to take part or not (see 5.4: *Recruiting and retaining participants;* D: *Ethical drug prevention*). However, it is possible that certain aspects of the programme will change during implementation, and if the description is too specific it may turn out to have been (inadvertently) false information. The description should therefore be general enough to allow a certain level of flexibility and modifications. This is particularly important when describing the programme as part of a funding application.

If the programme description is available for third parties during implementation (e.g. as part of a school drugs policy, on the provider's website), it must be updated regularly to ensure that the provided information is accurate and up-to-date. If the programme will be continued with new participants in the future, the programme description should be updated after the initial implementation to provide further details (in line with the implementation experience) and to reflect any changes that have been made to the programme.

The programme description differs from the project plan which is an internal tool to guide programme implementation (see 5.1: *Planning the programme — Illustrating the project plan*). For new funding applications, it is recommended to produce a combined document incorporating the programme description and the project plan. The programme description also differs from the final report which summarises the programme once it has finished (see 8.3: *If producing a final report*).

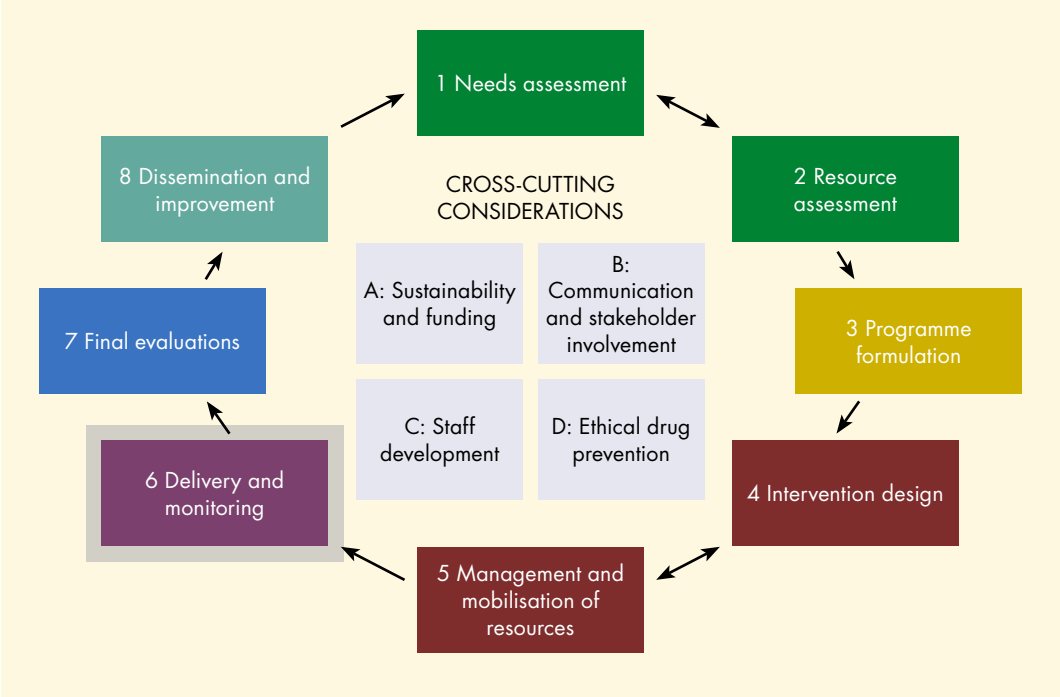
Basic standards:	
5.6.1 A written programme description exists.	
5.6.2 The programme description is:	
• clear and comprehensible for all intended target audiences;	
• (at least partly) accessible by all intended target audiences;	Examples of intended target audiences: target population, funders.
• regularly reviewed to reflect changes during implementation.	
5.6.3 The programme description outlines the following:	
• the rationale for the programme;	Note: staff members may wish to withhold some information (e.g. needs assessment data on sensitive issues; predictions of the likely consequences in the population if the intervention is not delivered). Example: findings from the needs assessment.
• aims, goals, and objectives;	
• definition of the target population;	
• the intervention;	
i.e. intervention activities with participants and content of the intervention. Example aspects to consider: duration, intensity, and frequency of activities, classification as universal, selective, indicated, or tiered prevention. Examples of structure: according to the objectives, according to the setting (if several settings).	
• the programme's time schedule;	i.e. planned start and end dates.
• benefits for participants;	
• risks for participants;	
• rules on participants' confidentiality.	

Additional expert standards:	
5.6.4 The logical flow of programme activities is illustrated in a graphical representation.	i.e. in a programme logic model.
5.6.5 The programme description outlines the following:	
• the theoretical model;	
• evidence of effectiveness;	Example of evidence: references to literature.
• evaluation indicators and benchmarks;	i.e. outcome and/or process measures and specific estimates.
• planned adaptations of an existing intervention;	
• the programme capacity;	i.e. maximum and minimum numbers of participants.
• a declaration on participants' rights;	
• minimum rules on safety;	
• the code of ethics;	
• the price for participation in the programme.	**Basic standard where participation is not free of charge.**

PROJECT STAGE
SIX

Project stage 6

Delivery and monitoring



At this stage, the plans developed earlier are put into practice. A particular issue at this point is the need to maintain a balance between fidelity (i.e. adhering to the project plan) and flexibility (i.e. responding to emerging new developments). The components outline how this balance can be achieved by questioning the quality and progress of the implementation, and making controlled modifications to improve the programme.

6.1 If conducting a pilot intervention: In certain cases the intervention must be tested first by implementing it on a smaller scale. This helps identify potential practical issues and other weaknesses that did not emerge during the planning. Consequently, programme developers have the chance to make final and inexpensive adjustments before the actual implementation.

6.2 Implementing the intervention: Once there is sufficient evidence to suggest that the intended drug prevention intervention will be effective, feasible, and ethical, the intervention is implemented as outlined in the project plan. To facilitate later evaluations and reporting on the programme, the implementation is documented in detail, including unexpected events, deviations, and failures.

6.3 Monitoring the implementation: While the programme is carried out, regular reviews of the progress help identify need for modification. Outcome and process data are collected and analysed periodically during implementation, for example with regard to the relevance of the intervention to participants, fidelity to the project plan, and effectiveness. Actual implementation of the intervention and other programme aspects is compared to what was set out in the project plan. Monitoring ensures that implementation is of high quality, but it also allows providers to improve prevention practice by identifying and responding to changed or additional requirements before these pose a threat to the success of the programme.

6.4 Adjusting the implementation: Implementation needs to remain flexible so that it can respond to emerging problems, changed priorities, etc. Where necessary and possible, implementation of the programme should be adjusted in line with the findings from the monitoring review. However, modifications must be minimal and well justified, and their potential negative impact on the programme must be considered. Consequently, if adjustments are made, they must be documented and evaluated to understand what effect they had on participants and the success of the programme.

6.1 If conducting a pilot intervention

Even if a programme is theoretically well planned, it is possible that in practice things work out very differently than expected. For example, the target population may not be ready to engage with the intervention, intervention materials may not be accepted by participants as intended, or there may be other unforeseen barriers to participation (see 5.4: *Recruiting and retaining participants*). Particularly where a new programme was developed without involving representatives of the target population, such issues can remain invisible during the planning stage. Once implementation is fully under way, it can be very costly to confront such problems, and if issues cannot be resolved satisfactorily the delivery of the programme may be delayed or even discontinued. It is therefore recommended to conduct a pilot intervention, as this allows providers to make inexpensive adjustments to the intervention design and the project plan before the programme is rolled out on a larger scale.

A pilot intervention (or pilot study) is a small-scale trial of the intervention prior to its full implementation (e.g. with fewer participants, in only one or two locations). It aims to identify weaknesses of the planned intervention, for example in relation to its feasibility (e.g. is the resource estimate correct, is the programme overambitious?), its effectiveness (e.g. do outcomes occur as expected?), and the appropriateness of the content, intervention materials, evaluation instruments, etc. (UNODCCP, 2000). During the pilot intervention, process and (limited) outcome data are collected and used to perform a small-scale evaluation. The findings of this preliminary evaluation are then used to inform and improve the proper implementation.

The consultations held to inform the content of this component suggested that because resources are often scarce, the requirement for a pilot intervention should depend on the particular circumstances of the programme. Consequently, pilot interventions are considered essential if:

- the intervention has never been implemented previously (i.e. it is a newly developed intervention);
- an existing intervention is being used but it has been modified significantly;
- the programme receives large financial support, for example from the government;
- the programme is intended for wide dissemination, for example nationwide;
- new intervention materials, such as manuals or a website, need to be tested;
- the intervention is delivered as part of scientific research, in which case the pilot intervention would represent an efficacy trial.

There may be other scenarios in which a pilot intervention is essential, and the above situations should therefore be regarded only as the most prominent examples. Conversely, a pilot intervention may not be required if the programme utilises a carefully adapted existing intervention that has already been implemented successfully in the past (see 4.2: *If selecting an existing intervention*).

However, pilot interventions may not always be feasible due to practical circumstances or the resources required. For example, it can be difficult to conduct a small-scale trial of a programme that is already small in scale (e.g. targeted prevention programme in a single school). In such cases, monitoring the implementation is particularly important (see 6.3: *Monitoring the implementation*). Where several rounds of delivery are planned, the initial implementation of the programme should inform future implementation.

In other cases, the available funding may not allow a trial run of the programme. This highlights that commissioners and funders must make funding available where pilot interventions are strongly advised (in line with the examples above). However, it has also been reported that the pilot intervention is sometimes indeed the final intervention, as funds are not available to continue the programme and implement it fully after its trial run. In such cases, a strategy for sustainability can help sustain the programme beyond the pilot phase (see A: *Sustainability and funding*; 8.1: *Determining whether the programme should be sustained*).

Case study 3 in *Developing and evaluating complex interventions: new guidance* (MRC, 2008) contains two examples of how pilot interventions were carried out, and how the findings were used to improve the full implementation of the intervention.

Standards

The reviewed drug prevention standards did not include detailed guidance on pilot interventions, and therefore this component does not list explicit standards.

6.2 Implementing the intervention

When there is sufficient evidence to suggest that the intended drug prevention intervention will be effective, feasible, and ethical, the intervention can be implemented in full (e.g. with many participants, in all locations, as a routine service) (see 3.5: *Referring to evidence of effectiveness;* 6.1: *If conducting a pilot intervention* and D: *Ethical drug prevention*).

The intervention must be conducted as outlined in the project plan (see Project stage 4: *Intervention design;* 5.1: *Planning the programme — Illustrating the project plan*). Fidelity describes the degree to which the actual implementation of an intervention corresponds to the original plan (or the carefully adapted intervention design). If, for example, staff members make unplanned modifications, such as reducing the number of sessions or changing the content, the effectiveness of the intervention can be affected. As a result, the intervention may become less effective, be ineffective, or have iatrogenic effects on participants. However, this does not mean that the project plan must be strictly adhered to if there is an obvious need for modifications. The standards in 6.3: *Monitoring the implementation* and 6.4: *Adjusting the implementation* outline how implementation must be monitored, and how careful adjustments can be made to ensure a balance between the need for implementation fidelity and flexibility.

When trying to understand how and why outcomes were (not) achieved, it is important to know what went on during the implementation of the intervention. It is thus essential to continuously document how the intervention was implemented, including an honest account of any deviations from the original plan, and any other noteworthy events (e.g. failures, accidents). Keeping such records facilitates reporting and process evaluation in the later project stages.

If an outcome evaluation is planned, outcome data is collected at least at baseline and at the end of the intervention so that changes can be observed. The standards in 6.3: *Monitoring the implementation* also highlight the need to collect outcome and process data to inform monitoring.

Further information on implementation fidelity, and guidance on how to assess it, can be found in the *Additional guidance* section.

Basic standards:	
6.2.1 The intervention is implemented:	
• according to the written project plan;	
• with high quality;	i.e. with sufficient knowledge and experience in drug prevention and project work, and following methodological requirements.
• with an orientation towards participants.	Example: by taking participants' perspective.
6.2.2 The implementation of the intervention is adequately documented.	
6.2.3 Documentation includes:	
• tracking implementation in line with the project plan developed in the planning stage;	Example of evidence: actual completion dates for completed programme stages are entered.
• failures, and how they were corrected;	
• adjustments and changes made to the original project plan;	
• extraordinary incidents, and responses to them.	Examples of extraordinary incidents: accidents, emergencies.

Additional basic standards if an outcome evaluation is conducted:	
6.2.4 Data for the outcome evaluation is collected:	
• at baseline;	i.e. initial assessment of outcome evaluation indicators.
• at the end of the intervention ('post-intervention').	Example of timing: assessment of change after last session.

Additional expert standards:	
6.2.5 The intervention is implemented:	
• in a systematic and sequential manner;	
• by involving participants in the implementation process.	Example of participant involvement: asking participants for feedback on the activities (this may also be part of the data collection for monitoring and process evaluation).
6.2.6 Data for the outcome evaluation is collected periodically during the intervention.	Example of timing: assessment of change after each session.

6.3 Monitoring the implementation

Even if a drug prevention intervention is well planned, tested, and carried out according to plan (see Project stage 3: *Programme formulation;* 6.1: *If conducting a pilot intervention* and 6.2: *Implementing the intervention*), there is no guarantee that implementation will run smoothly and that it will produce the desired outcomes. Therefore, implementation must be reviewed frequently so that emerging problems can be identified quickly and responded to (see 6.4: *Adjusting the implementation*).

The consultations held to inform the development of these standards indicated that in some countries, such as the United Kingdom, the term 'monitoring' may be associated with external quality control (e.g. requirement to provide regular update reports to funders) or with data collection for external analysis (e.g. data requested by commissioner to assess if regional targets are met). Although providers may use the findings from the monitoring reviews to provide update reports to commissioners and funders, in these standards the main purpose of monitoring is to stimulate internal quality control.

As part of monitoring, outcome and process data are collected and analysed periodically during implementation, and actual implementation is compared to what was set out in the project plan (see 5.1: *Planning the programme — Illustrating the project plan*). The aim of monitoring is to understand, for example, if the programme is:

- implemented as intended (e.g. as defined in the project plan);
- relevant to participants (e.g. does it correspond to participants' needs? Is the adaptation appropriate?) (see Project stages 1: *Needs assessment*; 4: *Intervention design*);
- ethical (e.g. have participants made any complaints? Do staff members behave appropriately?) (see D: *Ethical drug prevention*);
- effective (e.g. does the intervention produce changes as expected? Is participants' progress slower than expected?) (see 3.3: *Defining aims, goals and objectives*); and
- feasible (e.g. will resources suffice until completion of the programme? Can goals be achieved? Can fidelity be upheld?).

Consequently, monitoring concerns the intervention activities as well as other programme aspects, such as participant needs, resources, etc.

Monitoring ensures that implementation is of high quality. Additionally, it allows providers to improve prevention practice by identifying and responding to changed or additional requirements before

these pose a threat to the success of the programme. The intervals between monitoring reviews must be appropriate for the duration and intensity of the intervention. If the reviews are conducted very frequently, the intervals may be too short to notice change and the reviews may require too many resources. On the other hand, if the intervals between reviews are very long, then problems may develop and become difficult to resolve before they are noticed.

Where final outcome and process evaluations are not deemed appropriate or feasible (see 4.4: *If planning final evaluations*), monitoring may be an acceptable alternative to conducting more comprehensive and formal evaluations.

Further information on the quality of implementation can be found in the *Additional guidance* section.

Basic standards:	
6.3.1 Monitoring is seen as an integral part of the implementation phase.	i.e. staff members understand its usefulness.
6.3.2 A person or team responsible for monitoring the programme is specified.	
6.3.3 The monitoring process is specified.	
6.3.4 Outcome and process data are:	
• collected frequently during implementation;	
• reviewed at frequent intervals during implementation;	
• reviewed systematically.	i.e. compared to the written project plan.
6.3.5 Items considered in the monitoring review include:	
• the project plan;	i.e. whether it needs to be updated.
• whether participants represent the defined target population;	
• whether expected changes are being achieved;	i.e. differences between expected outcomes (set objectives) and actual outcomes.
• potential iatrogenic effects of the intervention (including 'side effects');	Example of potential 'side effects': increased attachment to drug-using peers through contacts made during the programme.
• practicability;	i.e. what 'works' or doesn't 'work' with participants.
• the quality of delivery and implementation fidelity;	i.e. whether the programme is implemented as set out in the project plan.
• resources.	Example aspects to consider: whether planned resources are actually available; whether available resources are sufficient for programme implementation; excessive or unexpected costs.
6.3.6 The conclusions indicate if and what elements of the programme need to be modified to complete it successfully.	

Additional expert standards:	
6.3.7 A structure for the monitoring process is specified.	Examples of evidence: a clear reporting procedure for the monitoring process is defined (e.g. showing how often and when review meetings will be held).
6.3.8 Items considered in the monitoring review include:	
• participants' needs;	i.e. whether participants' needs are met, and whether needs have changed since the initial needs assessment or in the course of the implementation.
• participants' responses to the intervention;	Example aspect to consider: readiness for the intervention.
• the adaptation process;	Example aspects to consider: whether the (cultural) adaptation is appropriate for participants; how it contributes to or hinders programme success.
• external input;	i.e. quality of contributions made by third parties. **Basic standard if external providers are used.**
• whether the programme's goals and objectives need to be adjusted;	Example aspects to consider: according to the level of success achieving them, according to changing needs of the participants.
• any other problems.	Example aspects to consider: ethical concerns.
6.3.9 Feedback is provided to staff members on the findings from the monitoring.	Note: staff includes volunteers, interns, etc.

6.4 Adjusting the implementation

If the intervention does not produce the desired outcomes, or if providers face difficulties during the implementation of the programme (e.g. struggling to recruit participants), then the implementation may need to be adjusted or, where that is not possible, discontinued (see 8.1: *Determining whether the programme should be sustained*). Emerging difficulties, changed priorities, etc. can be identified as part of regularly held monitoring reviews (see 6.3: *Monitoring the implementation*). So that the participants may benefit from the adjustments, these should be made as soon as possible (i.e. while the programme is still under way).

Nevertheless, it is essential that the intervention is conducted according to the project plan, and modifications should be made only if they are required to improve the programme (see 6.2: *Implementing the intervention*). The consultations held to inform the development of these standards indicated that changes were often not the result of considerations on how to improve the programme, but were due to a lack of knowledge (e.g. not recognising the importance of adhering to the project plan), lack of time or money (e.g. running out of time and therefore skipping some content of the intervention), or simply convenience (e.g. perceiving the planned activities as too much work). This highlights the need for communication so that all responsible staff members (e.g. practitioners, external contributors) and stakeholders (e.g. recipient organisation) understand the importance of following the original plan (see B: *Communication and stakeholder involvement*).

Changes must be well justified (e.g. based upon the findings from the monitoring review), and they must be in line with the programme formulation (e.g. support programme aims, not pose a threat to the evidence base underpinning the programme) (see Project stage 3: *Programme formulation*). It must be likely that the changes will produce positive outcomes without iatrogenic effects, and that the principles of ethical drug prevention will not be overridden (see D: *Ethical drug prevention*). Importantly, changes must be kept to a minimum to ensure a balance between fidelity and flexibility.

Practitioners should avoid making spontaneous adjustments while they are actually delivering the intervention. In some cases, however, it may be justified to make spontaneous changes to tailor the intervention better to participants' needs (see 4.3: *Tailoring the intervention to the target population*). For example, in a school class a practitioner may wish to conduct an interactive session instead of a lecture if the pupils are not willing to engage with the lecture format. During the consultations which informed these standards, one delegate described this as 'flexibility within the outcome' (i.e. the ability to achieve the same intended results with different methods). However, such a decision would

require careful consideration of how it might impact on the fidelity and effectiveness of the intervention. Ideally, this level of flexibility is already included in the intervention design (e.g. by outlining how the order of activities can be changed to suit participants' needs on the day) or in the project plan (e.g. contingency plans) (see 5.1: *Planning the programme — Illustrating the project plan*). Staff members may also receive guidance on how to resolve such issues as part of their training and ongoing support (see C: *Staff development)*.

Staff members should be informed of any changes to the programme; ideally, changes should be agreed between staff members. For example, if a session with participants did not go very well, a meeting may be held between staff members to discuss what went wrong and what could be done differently. Changes should also be agreed with other stakeholders where possible or required (e.g. participants, commissioners, funders). However, service managers, commissioners and funders must acknowledge the need for flexibility. This can be arranged, for example, by negotiating in advance how much flexibility is possible without the requirement to seek formal approval (e.g. as part of the grant or service agreement).

Where adjustments are made, it is essential to document and evaluate these, as otherwise the impact of the changes will remain unknown. Process and outcome data should be collected and analysed to understand if the adjustments really improved the quality and effectiveness of the intervention. If that is the case, then these findings represent an important contribution to the evidence base for drug prevention and should be disseminated (see 8.2: *Disseminating information about the programme*). Monitoring and evaluation will also show if the changes affected the intervention in a negative way, for example by producing iatrogenic effects, and if they should therefore be reversed.

In the case of scientific research trials, it is particularly important that implementation adheres strictly to the project plan. It may therefore not be allowed to adjust the implementation while the programme is still under way. In such cases, while the findings from the monitoring review cannot be used to adjust the programme in the current implementation, they form part of the process evaluation and are used to improve future versions of the programme.

Further information on the quality of implementation can be found in the *Additional guidance* section.

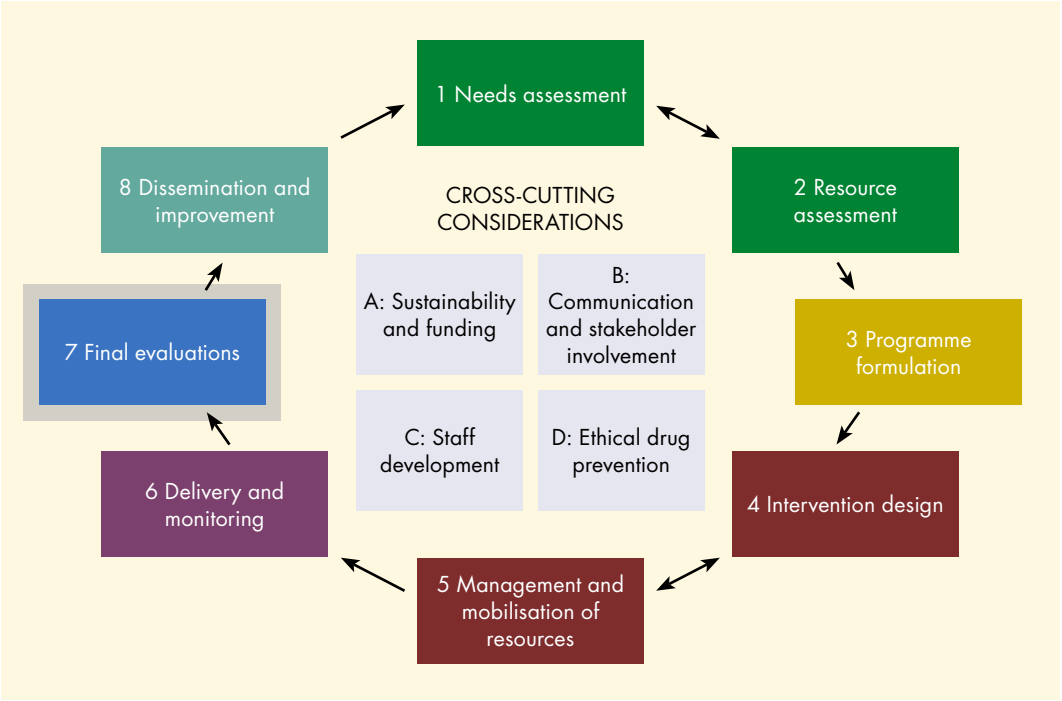
Basic standards:	
6.4.1 The implementation is flexible.	i.e. modifications of the programme are possible during the implementation phase, if required; staff members are given the flexibility to make decisions based on participants' individual needs and circumstances.
6.4.2 Implementation of the programme is adjusted in line with the monitoring findings, where possible.	Examples of adjustments: modification of goals and objectives, modification of activities, re-definition of needs, responses to unexpected issues, changes to project plan, trying a different strategy if initial strategy is not working, further cultural adaptation.
6.4.3 Issues and problems are dealt with in a manner appropriate to the programme.	i.e. adequate for the target population, for the programme's aims, goals, and objectives, and in relation to the size of the problem.
6.4.4 Adjustments are well-justified, and reasons for adjustments are documented.	Note: adjustments should be in line with aims and, where possible, goals and objectives. The documentation should outline why changes were made and who requested changes.

Additional expert standards:	
6.4.5 The programme is updated according to external developments.	Examples of external developments: changes in the local availability of drugs, changes in drug use patterns of the target population, new developments in the community, new developments in the field of drug prevention, emerging new evidence.
6.4.6 Participants are involved in adjusting the programme implementation.	

PROJECT STAGE
SEVEN

Project stage *7*

Final evaluations



After the intervention has been completed, final evaluations assess its outcomes and/or the process of delivering the intervention and implementing the programme. The standards in this project stage must be read in conjunction with component *If planning final evaluations* from Project stage 4, as that component describes evaluation in greater detail. It also highlights what preparations are necessary to ensure that relevant data is collected during implementation.

7.1 If conducting an outcome evaluation: All outcomes are reported as defined in the planning phase (i.e. in line with the defined evaluation indicators). Depending on the scale of the programme and the research design that was employed, statistical analyses are performed to determine the effectiveness

of the intervention in achieving the defined goals. Where possible, a causal statement on the intervention's effectiveness summarises the findings of the outcome evaluation.

7.2 If conducting a process evaluation: The process evaluation documents what happened during the implementation of the programme. Moreover, it analyses the quality and usefulness of the programme by considering its reach and coverage, acceptance of the intervention by participants, implementation fidelity, and use of resources. The findings from the process evaluation help to explain the findings from the outcome evaluation and to understand how the programme can be improved in the future.

The findings from the outcome evaluation and the process evaluation must be interpreted together in order to gain a thorough understanding of the success of the programme. This knowledge will inform the final Project stage 8: *Dissemination and improvement*.

7.1 If conducting an outcome evaluation

As part of the outcome evaluation, outcome data is systematically collected and analysed in order to assess how effective the intervention was. The standards in this component outline what sort of analyses should be carried out with the outcome data that was collected earlier, how findings should be reported, and how effectiveness of the intervention is to be determined and documented.

The basic level outcome evaluation aims to understand if the intervention produced change in participants in line with the defined goals and objectives without causing any harms (see 3.3: *Defining aims, goals, and objectives;* D: *Ethical drug prevention*), while expert level evaluations would seek to investigate, for example, how different components of the intervention impacted on the effectiveness of the intervention, how they affected participants differently, and whether findings can be generalised.

If the programme was designed as a randomised controlled trial, it is possible to attribute observed changes to the intervention (i.e. to assume that changes were caused by the intervention). If participants were not randomly selected or not randomly allocated to intervention and control groups, then selection bias must be ruled out before outcomes can be attributed to the intervention. The possibility of bias in its many forms must be considered and accounted for at all times. Likewise, limitations of the research design must be acknowledged and taken into account when conducting the outcome evaluation, particularly when making statements about the intervention's efficacy or effectiveness.

The basic standards in this component are likely to be appropriate for most outcome evaluations of small-scale programmes. However, large-scale programmes designed to demonstrate the efficacy or effectiveness of a particular intervention with a view to wider dissemination should also adhere to the expert standards in this component (i.e. all standards, including those marked as 'expert', would be considered basic level for these large-scale programmes). Large-scale evaluations should also adhere to the USA *Standards of Evidence* (Flay et al., 2005), upon which this component is based. However, the standards in this component apply only if an outcome evaluation is conducted.

The findings from the outcome evaluation must be contextualised with the findings from the process evaluation to understand how outcomes were (or were not) achieved (see *7.2: If conducting a process evaluation*). This allows providers to draw conclusions regarding whether and how the programme should be continued and improved (see Project stage 8: *Dissemination and improvement*).

Component 4.4: *If planning final evaluations* contains further information on the importance of, and differences between, outcome and process evaluations. Necessary preparations (e.g. data collection, specification of evaluation indicators) and possible challenges are also discussed in that component.

Further information on evaluation can be found in the *Additional guidance* section.

Basic standards if conducting an outcome evaluation:	
7.1.1. The sample size on which the outcome evaluation is based is given, and it is appropriate for the data analysis.	i.e. those participants where baseline and post-intervention measurements are available.
7.1.2 An appropriate data analysis is conducted. It includes:	
• a complete-case analysis;	i.e. all individuals assigned to the intervention group and, where applicable, control group are included in the analysis.
• consideration of bias caused by attrition in follow-up measurements across study groups, and efforts to minimise this bias;	Example of evidence: participants missing in follow-up measurements are described, and reasons for their loss reported.
• reporting and appropriate handling of missing data;	i.e. extent and patterns of missing data are reported.
• alternative explanations for observed effects.	Example of alternative explanation: reported increase of negative behaviour may be due to an increased awareness of the problem behaviour.
7.1.3 The findings are reported, including:	
• baseline data;	
• post-intervention outcomes.	i.e. values on the defined evaluation indicators.
7.1.4 Findings on every measured outcome evaluation indicator are reported, regardless of the results.	i.e. positive and negative outcomes are reported, as well as those that are not statistically significant.
7.1.5 Changes are expressed in quantitative and/or qualitative terms.	

Basic standards if conducting an outcome evaluation (cont.):	
7.1.6 Outcomes concerning behavioural changes are distinguished from other outcomes.	Example: intentions to use drugs and actual drug use are not considered to be equivalent.
7.1.7 The effectiveness of the intervention and the overall success of the programme are assessed by comparing the actual outcomes to:	
• the initial situation;	i.e. post-intervention outcomes are compared to the baseline data in line with the evaluation indicators.
• the programme's goals and objectives;	i.e. how adequate the intervention was for accomplishing these goals. Example of evidence: attainment of goals and objectives is graded (maximally, minimally, not at all).
• iatrogenic effects;	i.e. no negative impacts upon participants. Example of evidence: a risk-benefit analysis is conducted.
• the intervention's practical value and significance for public health.	

Additional expert standards:	
7.1.8 Follow-up measurements after the intervention include a large percentage of the original participants.	Note: >80 % retention rate is considered good (NICE, 2009, p. 219). However, this benchmark might be difficult to achieve under certain conditions (e.g. follow-up over several years).
7.1.9 The data analysis includes:	
• sub-group analyses on the effectiveness of the intervention for different groups of participants;	i.e. the different effect sizes, where the sample size is large enough.
• a comparison of how the activities impact on their own and cumulatively;	i.e. different activities are assessed for their effectiveness. Examples of comparisons: the effects of booster sessions versus no booster sessions; the effects of multiple interventions versus singular interventions.
• experimental dosage analyses;	i.e. the relationship between the amount of the intervention that was received and the outcomes.
• a statistical adjustment between intervention and control groups for differences caused by sampling error;	Example of adjustment: ANCOVA/RANCOVA used in analysis.
• adjustments for multiple comparisons;	
• an analysis not only on individual level but also on the level of randomisation.	Example: if randomisation or participant selection was based on school classes rather than individual pupils, the data analysis should account for cluster bias.
7.1.10 Reported findings include:	
• short-term, medium-term, and/or long-term outcomes;	i.e. up to 6 months, >6 to 12 months, >12 months after completing the intervention. Purpose: to establish how long post-intervention outcomes are sustained.
• final outcomes.	i.e. outcomes corresponding to the longer term aims (e.g. many years after the intervention).

Additional expert standards (cont.):	
7.1.11 The effectiveness of the intervention is assessed by comparing the actual changes to the expected changes.	i.e. the programme's success in meeting the set benchmarks on the defined outcome evaluation indicators.
7.1.12 The individual intervention is considered effective if:	
• at least one effect is statistically significant and positive in relation to the goals and objectives of the programme;	Note: a consistent pattern of statistically significant positive effects across multiple indicators is desirable.
• there are no negative (iatrogenic) effects on important outcomes;	Example: the intervention does not increase drug use.
• positive effects are found in the long-term follow-up measurement and are statistically significant.	i.e. >12 months after completing the intervention.
7.1.13 The findings are compared with findings of other evaluation studies of the same intervention.	Note: this may not be possible where other evaluations of the same intervention are not yet available.
7.1.14 If several studies are available, the studies of highest quality are considered in determining effectiveness.	
7.1.15 The intervention is considered overall effective if:	
• effect sizes between various trials of the intervention are similar;	
• consistent positive findings are available from at least two different high-quality studies/replicates with adequate statistical power;	
• positive findings are available from at least one replication study by independent investigators, i.e. not the programme developers.	
7.1.16 A causal statement on the intervention's efficacy/ effectiveness is provided.	i.e. 'intervention X is efficacious/effective for producing Y outcomes for Z population'.

Additional expert standards (cont.):	
7.1.17 The causal statement on the intervention's efficacy/ effectiveness:	
• is unambiguous;	
• specifies the target population;	
• specifies the outcomes;	
• indicates the time frame within which these effects are expected to be maintained.	Note: this should be based on the long-term follow-up measurement. Example: short-term up to 6 months, medium-term >6 to 12 months, long-term >12 months after completing the intervention.
7.1.18 It is clear under which conditions the intervention is expected to be effective.	
7.1.19 The population(s) to whom the findings can be generalised is (are) specified.	

7.2 If conducting a process evaluation

As part of the process evaluation, process data is systematically collected and analysed in order to assess why outcomes were (not) achieved and how the programme can be improved in the future. The process evaluation documents what happened during the programme (e.g. what activities were carried out, with and by whom, when and for how long) (CSAP, 2002). It is then analysed why the programme was carried out that way and how that might have impacted on the effectiveness of the intervention. Aspects to consider include: reach and coverage (i.e. how well did participants represent the target population?); acceptance of the intervention by participants (e.g. suitability of content and intervention materials); fidelity (i.e. was the intervention conducted according to plan?); use of resources (e.g. to inform cost-effectiveness) (CCSA, 2009). The data that was collected as part of the ongoing monitoring as well as the results of the monitoring reviews may be used to inform the process evaluation (see 6.3: *Monitoring the implementation).*

The findings from the process evaluation help to explain the findings from the outcome evaluation (see 7.1: *If conducting an outcome evaluation*), and they can also demonstrate that fidelity was upheld if an existing intervention was implemented. Based on the evaluation findings, providers should draw conclusions regarding whether and how the programme should be continued and improved (see Project stage 8: *Dissemination and improvement*). For example, high attrition rates should prompt those conducting the evaluation to investigate the causes of drop out (e.g. did participants move away or were they not satisfied with the intervention?). This can indicate sources of bias to be considered in the outcome evaluation, but it may also show how the programme should be improved in the future to increase retention rates. The process evaluation may also indicate, for example, that the definition of the target population should be revised or that the capacity of the service should be increased if participants represented only a very small percentage of the total target population.

These standards apply only if a process evaluation is conducted. Component 4.4: *If planning final evaluations* contains further information on the importance of, and differences between, outcome and process evaluations. Necessary preparations (e.g. data collection, specification of evaluation indicators) and possible challenges are also discussed in that component.

Further information on evaluation can be found in the *Additional guidance* section.

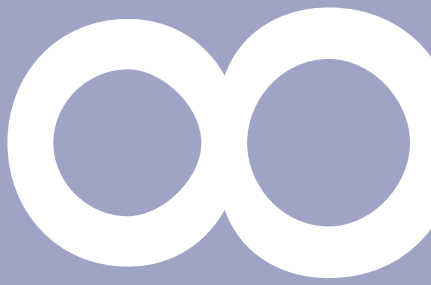
Basic standards if conducting a process evaluation:	
7.2.1 The process evaluation:	
• documents the programme implementation;	i.e. it illustrates how the intervention was carried out.
• explains why the programme was carried out in this way;	
• is done systematically;	i.e. using the written project plan and the defined process evaluation indicators.
• considers differences between operational objectives and actual outputs.	
7.2.2 The involvement of the target population is documented and evaluated. This includes:	
• the number of participants in the intervention;	
• the methods for participant recruitment;	
• whether actual participants represented the defined target population.	
7.2.3 The activities are documented and evaluated. This includes:	
• a description of the activities;	
• feedback from participants;	Example aspects to consider: whether participants found the intervention acceptable, enjoyable, satisfactory.
• feedback from other relevant stakeholders.	
7.2.4 The programme delivery is documented and evaluated. This includes:	
• feedback from staff members on the quality of delivery;	
• implementation fidelity;	i.e. to which extent the intervention was conducted as planned.

Basic standards if conducting a process evaluation (cont.):	
• unintended differences between planned and actual activities;	
• intended changes;	i.e. necessary adjustments made to the programme during implementation.
• any unexpected problems and other issues, and how they were controlled or dealt with.	
7.2.5 The use of resources is documented and evaluated. This includes:	Examples of resources: financial, human, and material resources.
• a definition of 'costs';	Examples of cost types: direct, indirect costs, opportunity costs.
• how many financial resources were spent;	
• costs for participant recruitment;	Example aspect to consider: costs for programme promotion.
• costs for data collection, monitoring, and evaluations;	
• how many human resources were spent;	Example aspects to consider: number of staff, working hours spent on the programme.
• whether staff members felt adequately trained and supported;	
• how many material resources were spent;	
• differences between actual and planned timelines;	
• whether resources were sufficient to achieve the set goals and objectives.	

Additional expert standards:	
7.2.6 The process evaluation:	
• explains how the outcomes of the intervention were achieved;	**Basic standard if an outcome evaluation was carried out.**
• considers differences between expected and actual results on process evaluation indicators.	i.e. using the defined process evaluation benchmarks.
7.2.7 The involvement of the target population is documented and evaluated, including:	
• success in engaging participants;	i.e. recruitment, attendance, and completion rates.
• problems regarding the participants' readiness for the intervention;	
• participants' characteristics;	Examples of characteristics: socio-demographic (e.g. age, developmental stage, sex, race or ethnicity, marital status), socio-economic (e.g. education, profession), cultural (e.g. religion), geographical (e.g. town, region).
• the (estimated) level of target population coverage.	
7.2.8 The activities are documented and evaluated, including the adequacy of the intervention materials.	**Basic standard if intervention materials were used.** Example aspects to consider: whether materials were understandable for participants, whether the content was adequate.
7.2.9 The programme delivery is documented and evaluated, including how much of the intervention was received by participants.	Example aspect to consider: whether all intended sessions took place.
7.2.10 The use of resources is documented and evaluated, including:	
• estimated costs experienced by participants and other stakeholders;	Example of costs: opportunity costs.

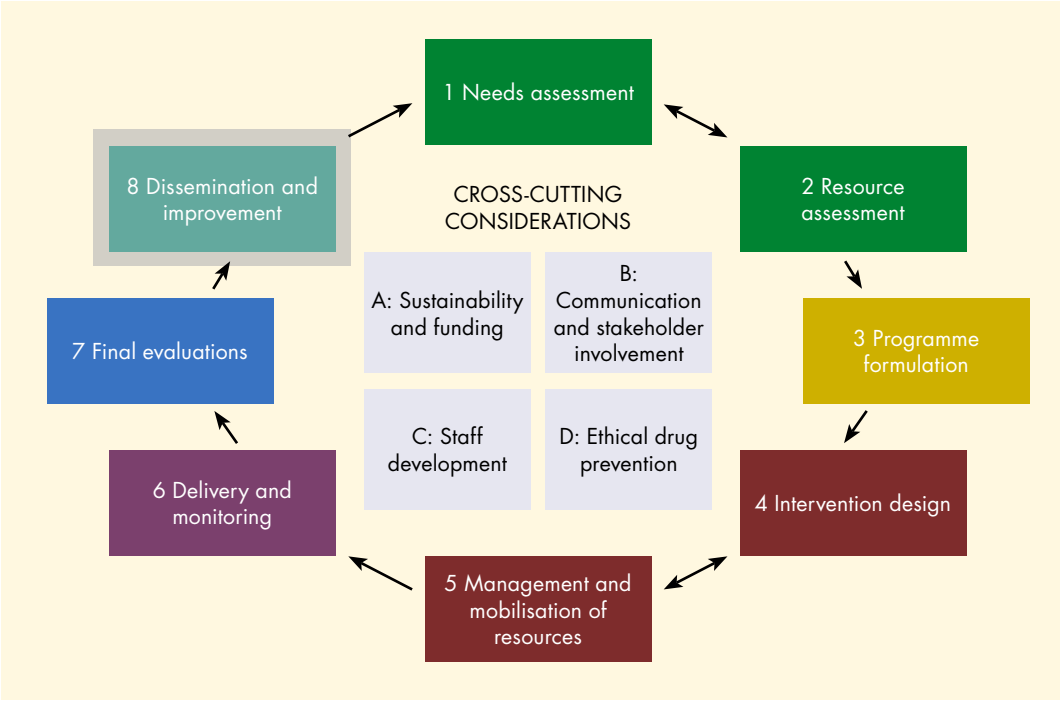
Additional expert standards (cont.):	
• the team performance;	Example aspects to consider: acting according to roles and responsibilities, keeping to schedules.
• whether staff members were actively involved in improving the programme quality;	
• the realised level of coordination and collaboration.	Example aspects to consider: number and type of participating organisations, number of meetings, conclusions and agreements.
7.2.11 Estimates on cost-effectiveness and cost-benefit ratios are provided.	Additional guidance: see Miller and Hendrie, 2009.

PROJECT STAGE
EIGHT



Project stage 8

Dissemination and improvement



In the final project stage, the future of the programme is of major concern: should the programme continue, and if so, how? Disseminating information about the programme can help to promote its continuation, but it also enables others to learn from the experiences of implementing the programme.

8.1 Determining whether the programme should be sustained: Ideally, a high quality drug prevention programme can continue beyond its initial implementation and/or after external funding has stopped. Using the empirical evidence produced through monitoring and final evaluations, it is possible to decide whether the programme is worthy of continuation. If it is determined that the programme should be sustained, appropriate steps and follow-up actions are specified and carried out.

8.2 Disseminating information about the programme: Dissemination can benefit the programme in many ways, for example by gaining support from relevant stakeholders for its continuation or by improving the programme through feedback. It also adds to the evidence base for drug prevention, thus contributing to future drug policy, practice and research. In order to give other providers the opportunity to replicate the intervention, intervention materials and other relevant information (e.g. costing information) should also be made available.

8.3 If producing a final report: The final report is an example of a dissemination product. It may be produced as a record of the implementation, as part of a funding agreement, or simply to inform others about the programme. The final report will often represent a summary of the documentation produced during earlier project stages. It describes the scope and activities of the programme, and, where available, the findings from the final evaluations.

This stage may represent the beginning of a new project cycle aimed at improving and developing the existing programme further.

8.1 Determining whether the programme should be sustained

Ideally, a high quality drug prevention programme can continue beyond its initial implementation and/or after external funding has stopped (e.g. it can be repeated with a new group of participants once the first group of participants has successfully completed the intervention). Component A: *Sustainability and funding* outlines some of the factors that influence the sustainability of programmes, and how the chances of continuation can be increased through a dedicated strategy for sustainability. However, once the intervention has been completed, it must be decided whether the programme is actually worthy of continuation.

A programme should be continued if there is a strong evidence-based argument to support its continuation. Ideally, this argument is derived from an outcome evaluation, demonstrating the intervention's (cost-)effectiveness in achieving positive outcomes with participants (see 7.1: *If conducting an outcome evaluation*). If the intervention was effective, the programme should be continued. If the intervention was ineffective or had considerable iatrogenic effects, the programme should be abandoned or at least not continued in its current form.

Where an outcome evaluation is not available, the results of a process evaluation may indicate that a programme should be sustained, for example if completion rates were high and participants and other stakeholders reported high levels of satisfaction (see 7.2: *If conducting a process evaluation*). Where no final evaluations were carried out, the findings from the monitoring reviews should be used to determine whether the programme should be sustained (see 6.3: *Monitoring the implementation*). Consequently, an outcome evaluation is not an essential requirement to determine whether a programme should be sustained. If there is evidence from the monitoring and/or the process evaluation to suggest that the programme is of high quality (e.g. relevant, well received, ethical, feasible, well implemented), it should be continued. However, in order to prove the effectiveness of the intervention (and sustain the programme in the long term), it is strongly recommended to conduct an outcome evaluation as part of future implementation. If the findings from the monitoring and/or the process evaluation indicate that the programme was not of high quality (e.g. difficult to implement, low retention rates), then it should not be continued in its current form.

If the evidence suggests that a programme should be continued, appropriate steps and follow-up actions must be specified and carried out in line with the strategy developed under A: *Sustainability and funding*. Unfortunately, even with a dedicated strategy to secure funding, financial sustainability is ultimately outside of the control of providers, as funds can be discontinued or allocated elsewhere

by commissioners and funders. The consultations that informed the development of these standards indicated that effective or promising programmes were sometimes discontinued because of changes in the availability of funding or because they were considered too expensive in the long term (e.g. due to large elements of intense individualised contact with participants). Consequently, it is the responsibility of commissioners and funders to recognise and sustain effective or promising programmes.

If the evidence suggests that a programme should not be continued, then the findings from the monitoring and, where available, the process evaluation should be inspected closely to determine why outcomes were not achieved, why participants were dissatisfied, why there were problems during implementation, etc. They may indicate how the programme could be improved, and provide support to trial a modified version of the intervention.

This component may initially seem less relevant to some programmes. It may be clear from the onset of the programme that it will not be sustained, depending on, for example, the type of programme, its aims, and/or its resources. The intervention may serve a specific purpose that limits its relevance to a particular time span. For example, an awareness-raising campaign on the risks of cocaine use may be launched before New Year to target those who use the drug on 'special occasions'; a youth group may decide to conduct a one-off intervention following a drug-related incident; a regional planning team may commission an intervention to reduce the drug use in a certain community and discontinue the programme once this goal has been achieved. In such cases, there may be no immediate need to continue the programme beyond its first implementation. Nevertheless, the organisation in charge of the programme should consider taking a long-term perspective on drug prevention (e.g. is it worth repeating this intervention again in a year? Is there a need for other drug prevention activities which build upon the outcomes of the first?). Even if sustainability is not necessary on the level of a particular intervention, it may be important at the organisational level (i.e. the organisation should continue to conduct drug prevention work) (see A*: Sustainability and funding*).

Basic standards:	
8.1.1 It is determined whether the programme should be continued ('sustained').	Note: this should be done by reviewing the findings from the monitoring, process evaluation, and/or outcome evaluation.
8.1.2 The lessons learnt from the initial implementation are used to inform future activities.	Note: based on results from monitoring and/or evaluations. Examples of evidence: adjustments are made to improve the programme's quality if it is continued in the future; recommendations for improvement are provided.

Additional basic standards if the programme should be continued ('sustained'):	
8.1.3 A strong evidence-based argument in favour of the programme exists.	Note: this argument should be based on findings from the monitoring, process evaluation, and/or outcome evaluation. Where such data is not available (in satisfactory form), (further) monitoring reviews and/or evaluations should be conducted that allow a decision on the programme's future.
8.1.4 Opportunities for continuation are considered and documented.	

Additional expert standards if the programme should be continued ('sustained'):	
8.1.5 Financial and other resources are sought.	**Basic standard if resources (e.g. funding) are time-limited to the initial project lifespan.**
8.1.6 Existing networks and links are utilised to promote programme continuation.	Examples of useful links: professional relations with commissioners, key agencies, members of the community.

8.2 Disseminating information about the programme

Once the intervention has been completed, information about the programme, and, where available, evaluation findings, should be communicated to relevant stakeholders (e.g. participants, the scientific and/or prevention community). Providers may feel that in comparison to planning, implementation, and evaluation, dissemination is the least important part of the project cycle. However, this component highlights that dissemination of information about the programme is an equally important aspect of high quality drug prevention work.

As dissemination occurs at the end of the project cycle, it is possible that all resources have been used up and that there is no money left to publicise the programme and disseminate its findings. It is therefore important to include the costs for dissemination in the financial plan (see 5.2: *Planning financial requirements*). Often, if the budget in a funding application has to be reduced, it is at the expense of dissemination activities. Such an approach does not consider that dissemination does not only benefit others, but benefits also the provider. Costs for dissemination can be reduced by targeting dissemination efforts (e.g. by identifying the most relevant groups). Careful planning ensures that the correct target audiences are supplied with relevant information in an adequate format. Depending on the specific purpose of dissemination, information may be communicated, for example, by using the Internet or producing printed leaflets, through presentations at workshops or scientific publications.

Disseminating information about the programme is an important aspect of starting the project cycle anew. It aids continuation and long-term sustainability of the programme by promoting it among funders, community members, and other essential stakeholders (see A: *Sustainability and funding*). It may lead to an increased interest from other organisations to contribute to or support the programme (e.g. joint activities with other agencies, interest from new recipient organisations such as schools) (see B: *Communication and stakeholder involvement*). It may also advertise the programme among the target population to increase readiness for participation and to recruit new participants for the next round of implementation (see 2.1: *Assessing target population and community resources* and *5.4: Recruiting and retaining participants*).

Dissemination may also help to improve the programme further or gain a new perspective on it through feedback (e.g. from other providers, academics). Feedback can prompt providers to review their initial programme formulation or intervention design, the project plan, or to reinterpret the findings from monitoring and evaluation. Feedback can also highlight relevant new developments

(e.g. in policy and legislation), additional evidence, resources, or materials that were not previously considered. Where feedback is received, its value must be carefully assessed, as modifications to the programme should only be made if they are well justified (see 6.4: *Adjusting the implementation*).

Moreover, dissemination of information enables others to learn from the (positive and negative) experiences of implementing the programme, and it adds to the evidence base for drug prevention. For example, if an outcome evaluation was conducted, others could refer to the evaluation findings when reviewing evidence of effectiveness and designing their intervention. Giving information on unintended negative outcomes, failures, and encountered difficulties is vital to enable others to understand the challenges of implementing the programme. Providers may be concerned that disclosing such information could damage their reputation and reduce their chances of receiving future funding. However, reporting negative outcomes is essential as otherwise the information may be misleading and have unethical implications (e.g. others might replicate the programme without being aware of the potential negative outcomes).

The standards also encourage providers to make the intervention available at a detail that allows other providers to (assess whether they wish to) replicate and adapt the programme. Such documentation would also include, for example, costing information, intervention materials (where used), etc. By allowing others to select an existing intervention instead of developing a new one, duplication of efforts can be significantly reduced. Replication of the intervention is also of benefit to the programme author, as it tests whether outcomes can be repeated in similar circumstances or generalised to another target population, setting, etc. If the intervention is found to be consistently effective, it is more likely to become a sustainable and well known programme.

The consultations that informed the development of these standards suggested that programme developers and providers may be hesitant to share materials (e.g. manuals) and detailed descriptions of 'their' programme. This is likely to be the case if, for example, the programme has been developed for a commercial purpose (i.e. it is not free of charge) or if it is essential to the provider in another way (e.g. exclusivity of offering a particular intervention). Programme developers and providers may worry that other providers would use the intervention (or certain aspects of it) without a licence or without asking for permission, without acknowledging or remunerating the original authors. Particularly in countries where there are only insufficient measures in place to protect the copyright of programme authors, such worries may be justified. Therefore, the legal aspects of reporting on the programme must be considered. If there are any concerns regarding copyright infringement, it is recommended to provide information at a level of detail that allows other providers to decide

whether they wish to use the programme but does not actually allow them to copy and implement the programme. Further details and materials could then be provided through a licence agreement (e.g. specifying under what conditions the intervention can be used) and, where necessary, against a licence fee.

Dissemination about the programme may not always seem useful, for example, if a programme was implemented poorly, if it did not produce the expected outcomes (it was ineffective or had iatrogenic effects), if it was developed for a specific purpose, or if there is no intention to continue implementation. However, as outlined above, even in these cases dissemination of information about the programme is important. It adds to the body of knowledge in drug prevention and can inform future programme development, drug research, and policy. If a programme was designed for a particular need or a particular target population, it may provide useful insights for another provider who is facing a similar situation in a different region. Even if a programme did not go well, it can still have a positive impact on drug prevention in the longer term by helping other providers avoid encountering the same problems.

Further information on what to consider when disseminating findings can be found, for example, in the handbook *Communicating research for evidence-based policymaking* (European Commission, 2010). Furthermore, the *Additional guidance* section provides guidance on how to disseminate evidence into practice, i.e. how the lessons learnt from the implementation of this programme can inform the everyday practice of (other) providers and practitioners.

Basic standards:	
8.2.1 Information on the programme is disseminated.	Note: dissemination of information may take place on a local, regional, national or international level.
8.2.2 An appropriate format for dissemination is specified.	Examples of formats: online, printed materials, presentations at workshops, scientific publications.
8.2.3 A person or team responsible for dissemination of information about the programme is specified.	Note: other responsibilities could include communication with stakeholders, programme promotion.
8.2.4 The target audiences are specified, including:	
• those involved in the programme and its evaluations;	Examples of groups: staff members, senior management, participants.
• other relevant stakeholders.	Examples of stakeholders: funders, community, project partners.
8.2.5 The means of dissemination are appropriate for the target audiences.	Example: different ways of dissemination for members of the community and for academics working in the field of drug prevention.
8.2.6 Legal aspects of reporting on the programme are considered.	Example aspects to consider: intellectual property, potential sale of products or prohibition thereof.
8.2.7 To assist replication, dissemination products include:	
• details on the experience gained during the implementation of the programme;	Example aspects to consider: theoretical and practical implications of the activities, knowledge and experience of innovative working.
• details on negative and other unintended outcomes.	
8.2.8 The level of detail in the dissemination allows interested parties to assess the programme.	i.e. whether the intervention should be adapted, replicated, implemented on a larger scale, whether it should be awarded model programme status, etc.

Additional expert standards:	
8.2.9 A plan for dissemination of the results exists.	
8.2.10 Specified target audiences include the target population.	
8.2.11 The timeline for dissemination is specified.	
8.2.12 The success in disseminating information about the programme is assessed.	
8.2.13 To assist replication, dissemination products include:	
• details on conditions and resources needed to support the adoption, implementation, and sustainability of the programme;	Example aspects to consider: necessary financial and human resources, qualifications of implementing staff.
• details on failures;	Example aspect to consider: unrealised goals.
• sample end products;	
• case studies;	Example consideration: illustrating the realities and potential outcomes of the intervention.
• the actual tools and materials used in the programme, together with detailed guidelines on how to use them.	Examples of tools and materials: intervention materials (e.g. workbooks, staff training manuals), monitoring and evaluation tools.
8.2.14 Dissemination products are presented with a level of detail that allows implementation/replication.	
8.2.15 Training and technical assistance are offered to interested parties.	Examples of evidence: incorporated as learning materials in existing training systems, training exchange with other providers.
8.2.16 Information on the programme is published.	Examples of publication: in scientific journals, as a final report on the provider's website.

8.3 If producing a final report

The final report documents the scope and activities of the programme and, where available, the findings from the final evaluations. The standards in this component outline briefly what the final report should contain. Further information on dissemination can be found under 8.2: *Disseminating information about the programme.* As the final report is an example of a dissemination product, those standards must also be considered in its production.

When writing the final report, it is useful to draw upon documentation produced in the earlier project stages (see 1.3: *Describing the need — Justifying the intervention;* Project stage 3: *Programme formulation;* 5.1: *Planning the programme — Illustrating the project plan;* 5.6: *Providing a programme description;* 6.2: *Implementing the intervention* and Project stage 7: *Final evaluations*). However, the content and format of the final report must be suitable for the intended target audiences. Therefore, if existing documentation is used it should be carefully edited. For example, if the report is written for the general public, it may not be appropriate to describe the evidence of effectiveness in as much detail as in the original programme formulation. Conversely, a detailed description of the evidence would be essential if the report was produced for the professional community.

The consultations held to inform the development of these standards indicated that in some areas it is common practice that providers produce regular update reports for commissioners and funders. However, these reports are not usually available for the professional community, the target population, or the general public. Delegates suggested that these reports should be edited and made publicly available (e.g. on the provider website). This would showcase the work of providers, but it would also aid dissemination and discussion of good practice within the prevention community.

However, a final report is not always possible or required, and the standards in this section apply only if a final report is produced. If a final report is not produced, information about the programme should be disseminated through other means, for example through presentations (see 8.2: *Disseminating information about the programme*).

Basic standards if a final report is produced:	
8.3.1 A final report is produced.	
8.3.2 The final report includes information on:	
• the justification for the programme;	Note: this would be a summary of the needs assessment.
• the target population;	
• programme aims;	
• the setting;	
• the intervention and its activities;	
• the project plan;	Note: this does not have to be the detailed project plan developed during programme planning, but can be an outline summary of major programme activities.
• information on the funding entities and sources of other income.	
8.3.3. The information in the final report is:	
• clear and easy to read;	i.e. understandable for a wide range of persons or, where a target audience has been specified, for the target audience.
• logically organised and consistent.	

Additional expert standards:	
8.3.4 The final report includes information on:	
• programme goals and objectives;	**Basic standard if report is produced for a professional audience.**
• the original intervention, and the level of adaptation;	**Basic standard if an existing intervention was used.**
• the theoretical model of the intervention;	**Basic standard if a theoretical model was used.**
• evidence of effectiveness;	**Basic standard if report is produced for a professional audience.**
• results of the outcome evaluation;	**Basic standard if an outcome evaluation was conducted.**
• results of the process evaluation;	**Basic standard if a process evaluation was conducted.** Note: where a process evaluation was not carried out, the findings from the monitoring could be described instead.
• information on costs of delivery.	
8.3.5 The report is later supplemented with the findings from the follow-up measurement(s).	Note: this should be based on the long-term follow-up, where available. Example: short-term up to 6 months, medium-term >6 to 12 months, long-term >12 months after completing the intervention.

Appendix

Appendix

Please note that an online supplement is also available to this manual at http://www.emcdda.europa.eu.publications/manuals/prevention-standards/annex. The online supplement contains:

- references to additional guidance relevant to selected standards themes (e.g. staff development, ethical drug prevention, drug-related policy and legislation, needs and resource assessment, evidence-based intervention design, databases of model programes, implementation fidelity, evaluation, dissemination);
- an abbreviated version of the standards in the form of a self-reflection checklist;
- considerations and recommendations with regard to the implementation of the standards;
- a list of organisations that participated in the structured consultations to inform the development of the standards;
- further information on the current drug situation in the EU.

Original standards documents

The first draft of the European drug prevention quality standards was produced by synthesising quality criteria contained in the documents listed in this section. The documents are sorted by region (Europe, North America, international) and, within the region, alphabetically by country. In some instances, the publication year is approximate. English translations of the institutions and publication titles have been added where applicable. These documents are not necessarily listed again as *Additional guidance*; however, many contain not only quality criteria but offer also general drug prevention guidance and can therefore be read in conjunction with the Standards.

All web pages were last accessed on 11.4.2011 unless otherwise stated.

Czech Republic

Ministerstvo školství, mládeže a tělovýchovy ČR (Czech Ministry of Education, Sport and Youth) (2008), *Standardy odborné způsobilostiposkytovatelů programů primární prevence užívání návykových látek (schválená revize) (Professional Qualification Standards for Providers of Primary Addictive Drug Use Prevention Programmes (revised edition))*. Prague: Ministerstvo školství, mládeže a tělovýchovy ČR.
http://www.emcdda.europa.eu/themes/best-practice/standards/prevention

Finland

STAKES (2006), *Reaching For The Quality Star: Quality criteria for substance abuse prevention*. National Research and Development Centre for Welfare and Health.
http://neuvoa-antavat.stakes.fi/NR/rdonlyres/73F39AD6-6A0B-41CD-BA0C-7D18AB0A6FB3/0/Reachingforquality.pdf

Germany

Bundeszentrale für gesundheitliche Aufklärung (BZgA) (Federal Centre for Health Education) & Universitätsklinikum Hamburg-Eppendorf (n.d.), *Qualität in der Prävention (Quality in Prevention)*.
http://www.emcdda.europa.eu/themes/best-practice/standards/prevention

Ireland

Drug Education Workers Forum (DEWF) (2007), *A manual in quality standards in substance use education*. Dublin: DEWF.

A copy may be requested by sending a request to info@dewf.ie.

Italy

Serpelloni, G. and Simeoni, E. (2002), La valutazione ex ante dei progetti di intervention contro l'uso di sostanze stupacenti (The ex ante evaluation of projects targeting drug consumption). In: Serpelloni, G., Simeoni, E. and Rampazzo, K. (eds.) (Ministry of Health) (2002), *Quality Management (Gestione della Qualità). Indicazioni per le Aziende Socio Sanitarie e il Dipartimento delle Dipendenze (Quality Management: Recommendations for the Sanitary Local Agencies and the Department for Addictions)*. Edizioni La Grafica, pp. 487–498.
http://www.dronet.org/pubblicazioni/monografie_dettaglio.php?monografie=2

Serpelloni, G. and Simeoni, E (2002), Elementi di tecnica progettuale per gli interventi nelle dipendenze: indicazioni pratiche (Basic elements of planning techniques for actions targeting addictions: practical instructions). In: Serpelloni, G., Simeoni, E. and Rampazzo, K. (eds.) (Ministry of Health) (2002), *Quality Management (Gestione della Qualità). Indicazioni per le Aziende Socio Sanitarie e il Dipartimento delle Dipendenze (Quality Management: Recommendations for the Sanitary Local Agencies and the Department for Addictions)*. Edizioni La Grafica, pp. 509–560.
http://www.dronet.org/pubblicazioni/monografie_dettaglio.php?monografie=2

Lithuania

Narkotikų kontrolės departamento prie Lietuvos Respublikos (Drug Control Department) (2007), *PSICHOAKTYVIŲ MEDŽIAGŲ VARTOJIMO PREVENCIJOS PROJEKTO VERTINIMO FORMA (Psychoactive substances abuse prevention project evaluation form)*.

Poland

Krajowe Biuro ds. Przeciwdziałania Narkomanii (National Bureau for Drug Prevention (NBDP)) (2008), *Projekt systemu rekomendacji programów profilaktyki i promocji zdrowia psychicznego (Draft*

recommendation system for prevention and mental health promotion programmes). Warsaw: Krajowe Biuro ds. Przeciwdziałania Narkomanii.
http://www.emcdda.europa.eu/themes/best-practice/standards/prevention

Portugal

Instituto da Droga e da Toxicodependência (Institute on Drug and Drug Addiction (IDT)) (2005), *Programa de Intervenção Focalizada — PIF (Focused Intervention Programme — FIP).*
http://www.emcdda.europa.eu/themes/best-practice/standards/prevention

Romania

Agenția Națională Antidrog (ANA) (National Anti-Drug Agency (NAA)) (2006), *Decision No 1.862.064 /23 January 2006 regarding minimum quality standards for school-based prevention programmes.*

Galicia (Spain)

General sub-directorate — Mental Health and Drug Dependency Galicia (SERGAS) (2007), *Prevention Processes and Portfolio of Drug Prevention Services of the Galician Plan on Drugs.*
http://www.sergas.es/Publicaciones/DetallePublicacion.aspx?IdPaxina=40008&IDCatalogo=1774

United Kingdom

Standing Conference on Drug Abuse (SCODA) (1999), *The right approach: Quality standards in drug education.* London: SCODA.

European Union

Council of Europe Pompidou Group (1998), *Handbook Prevention: alcohol, drugs and tobacco.*
http://www.emcdda.europa.eu/attachements.cfm/att_21033_EN_Prevention%20Manual%20Pompidou%20Group.pdf

Canada

Canadian Centre on Substance Abuse (CCSA) (2009), *Building on Our Strengths: Canadian Standards for School-based Youth Substance Abuse Prevention: A guide for education and health personnel (Version 1.0).* Ottawa, ON: Canadian Centre on Substance Abuse.
http://www.ccsa.ca/2009%20CCSA%20Documents/ccsa0117812009_e.pdf

Note: The European drug prevention quality standards are based upon Version 1.0 of this document. Version 2.0 was published in 2010. Major changes included: eliminating overlap between standards; reducing the number of standards (from 18 to 17); enhancing the section on 'Evaluation and Monitoring'; clarifying the standards' target audience; highlighting the principle of comprehensiveness throughout the document.

United States of America (USA)

Office of National Drug Control Policy (ONDCP) (n.d.), *Evidence-Based Principles for Substance Abuse Prevention*.
http://www.whitehousedrugpolicy.gov/PREVENT/practice.html

Flay, B.R. et al. (2005), Standards of Evidence: Criteria for Efficacy, Effectiveness and Dissemination. *Prevention Science*, 6 (3), pp. 151–175.

Society for Prevention Research (SPR) (2004), *Standards of Evidence: Criteria for Efficacy, Effectiveness and Dissemination*.
http://www.preventionresearch.org/StandardsofEvidencebook.pdf

National Institute on Drug Abuse (NIDA) (2003), *Preventing Drug Use among Children and Adolescents. A Research-Based Guide for Parents, Educators, and Community Leaders (second edition)*. Bethesda, Maryland: U.S. Department of Health and Human Services, National Institutes of Health.
http://www.drugabuse.gov/pdf/prevention/RedBook.pdf

Note: An Italian version is available as: Serpelloni, G. (2005), *Prevenire l'uso di droghe tra i bambini e gli adolescenti. Una guida per genitori, educatori e amministratori basata sulla ricerca scientifica a cura del National Institute on Drug Abuse*.
http://www.dronet.org/pubblicazioni/monografie_dettaglio.php?monografie=18

Center for Substance Abuse Prevention (CSAP) (2002), *Achieving Outcomes: A Practitioner's Guide to Effective Prevention (Conference Edition).* Rockville, MD.: CSAP.
http://www.eric.ed.gov/PDFS/ED469593.pdf

United Nations

United Nations Office on Drug and Crime (UNODC) (2009), *Guide to implementing family skills training programmes for drug abuse prevention*. New York: United Nations.
http://www.unodc.org/unodc/en/prevention/familyskillstraining.html

Note: An Italian version is available as: Dipartimento Politiche Antidroga (a cura del) (2009) *Guida alla realizzazione di programmi di formazione sulle abilità genitoriali per la prevenzione dell'uso di droghe*.
http://www.dronet.org/pubblicazioni/monografie_dettaglio.php?monografie=68

A Spanish version is available as: Naciones Unidas Oficina contra la Droga y el Delito (2009) *Guía para la ejecución de programas de desarrollo de aptitudes de la familia en materia de prevención del uso indebido de sustancias.* Nueva York: Naciones Unidas.
http://www.unodc.org/pdf/youthnet/family%20based/Spanish_Guide_Ebook.pdf

United Nations Office on Drug and Crime (UNODC) (2004), *Drug abuse prevention among youth from ethnic and indigenous minorities*. New York: United Nations.
http://www.unodc.org/pdf/youthnet/handbook_ethnic_english.pdf

Additional guidance

The following list includes a selection of general resources as well as links to drug-related policy and legislation on EU and international levels. All web pages were last accessed on 11.04.2011 unless otherwise stated.

References to further resources supporting the uptake of the standards in practice can be found in the *Additional guidance* section in the online supplement. The online resource includes links to databases of model programmes as well as to documents specifically relating to standards topics such as staff development, ethical drug prevention, needs and resource assessment, evidence-based intervention design, implementation fidelity, evaluation, and dissemination.

The online supplement to this manual is available at
http://www.emcdda.europa.eu/publications/manuals/prevention-standards/annex

General resources

CCSA Canadian Centre on Substance Abuse (ongoing), *Youth Drug Prevention*.
http://www.ccsa.ca/ENG/PRIORITIES/YOUTHPREVENTION/Pages/default.aspx

Council of Europe Pompidou Group (ongoing), *The Prevention Platform*.
http://www.coe.int/t/dg3/pompidou/Activities/prevention_en.asp

EMCDDA European Monitoring Centre for Drugs and Drug Addiction (ongoing), *Best practice portal*.
http://www.emcdda.europa.eu/best-practice

EMCDDA European Monitoring Centre for Drugs and Drug Addiction (2010), *Prevention and Evaluation Resources Kit (PERK). A manual for prevention professionals*. Luxembourg: Publications Office of the European Union.
http://www.emcdda.europa.eu/attachements.cfm/att_105843_EN_Manual4PERK.pdf

IREFREA European Institute of Studies on Prevention.
http://www.irefrea.org

UNODC United Nations Office on Drugs and Crime (2002), *A participatory handbook for youth drug abuse prevention programmes: A guide for development and improvement*. New York, United Nations.
http://www.unodc.org/pdf/youthnet/action/planning/handbook_E.pdf

UNODC United Nations Office on Drugs and Crime (ongoing), *Drug Prevention*.
http://www.unodc.org/unodc/en/prevention/index.html

UNODC United Nations Office on Drugs and Crime (ongoing), *The Global Youth Network*.
http://www.unodc.org/youthnet/

WHO World Health Organization (2010), *ATLAS on substance use (2010): resources for the prevention and treatment of substance use disorders*. Geneva, WHO.
http://www.who.int/substance_abuse/publications/Media/en/index.html

Drug-related policy and legislation

EU and UN documents are available in several EU languages.

EMCDDA European Monitoring Centre for Drugs and Drug Addiction (ongoing), *Drug policy and law*.
http://www.emcdda.europa.eu/policy-and-law

This website includes information on national strategies/actions plans and legislation.

EMCDDA European Monitoring Centre for Drugs and Drug Addiction (ongoing), *European Legal Database on Drugs (ELDD)*.
http://www.emcdda.europa.eu/html.cfm/index5029EN.html

EMCDDA European Monitoring Centre for Drugs and Drug Addiction (2005), *Illicit drug use in the EU: legislative approaches*. Lisbon, EMCDDA.
http://www.emcdda.europa.eu/attachements.cfm/att_34042_EN_TP_IllicitEN.pdf

European Council (2004), *EU drugs strategy (2005–12)*. 15074/04.
http://www.emcdda.europa.eu/attachements.cfm/att_10375_EN_EU%20Drugs%20Strategy_EN.pdf

European Council (2008), EU drugs action plan for 2009–12, *Official Journal of the European Union*, 2008/C 326/09, 20.12.2008.
http://www.emcdda.europa.eu/html.cfm/index66221EN.html

United Nations Single Convention on Narcotic Drugs of 1961 as amended by the 1972 Protocol.
http://www.unodc.org/unodc/en/treaties/single-convention.html

United Nations Convention on Psychotropic Substances of 1971.
http://www.unodc.org/unodc/en/treaties/psychotropics.html

United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances of 1988.
http://www.unodc.org/unodc/en/treaties/illicit-trafficking.html

United Nations General Assembly (1998), *Declaration on the Guiding Principles of Drug Demand Reduction*. A/RES/S-20/3, Annex.
http://www.un.org/documents/ga/res/20sp/a20spr03.htm

UNODC United Nations Office on Drugs and Crime (2009), *Political Declaration and Plan of Action on International Cooperation towards an Integrated and Balanced Strategy to Counter the World Drug Problem*. Adopted at the high-level segment Commission on Narcotic Drugs, Vienna, 11–12 March 2009. New York, United Nations.
http://www.unodc.org/documents/commissions/CND-Uploads/CND-52-RelatedFiles/V0984963-English.pdf

Glossary for use with the European drug prevention quality standards

The glossary provides brief explanations of key terms used in the standards. For ease of cross-reference, defined terms are highlighted in *italics* within the glossary, and where applicable relevant standards are listed in **bold** font; and the numbering is equivalent to that used in Part 2 of this manual. The term 'Standards' refers to the European drug prevention quality standards. Definitions are based on the original standards included in the review as well as the glossaries listed at the end of this section and the documents included as *Additional guidance* (online annex).

Access	The extent to which people (e.g. members of the *target population*) are able to receive information, *services*, etc. Barriers to access may be practical (e.g. location, timing, child care) or of a more subtle nature (e.g. risk of stigma, *cultural* acceptability). **Standards D: *Ethical drug prevention; 5.4: Recruiting and retaining participants***
Action plan	see *Project plan*
Activity	In the Standards, a generic term referring to *drug prevention* work, e.g. *strategies*, policies, practices, *programmes*. Programme activities are carried out to implement a programme, e.g. *staff development* activities, fundraising activities, *intervention* activities. Those activities that are most important for the success of the programme form the 'critical' activities. Intervention activities are a sub-set of programme activities, describing those elements of the intervention that are carried out with *participants*, e.g. role play, lecture, field trip.
Adaptation	Intentional and planned changes made to an *intervention*. Adaptations are made: 1) as part of a *replication* study to test the *effectiveness* of an intervention under the same or different circumstances (e.g. *target population*, *setting*, intensity of delivery); 2) to tailor the intervention to specific requirements (e.g. *culture* of the target population, economic realities) in order to maintain or increase effectiveness. Adaptation does not include unplanned modifications, as these may compromise effectiveness. Adaptation is also known as reinvention (EMCDDA, 1998). **Standard 4.2: *If selecting an existing intervention***
Agency	see *Organisation*

Aim	A statement on the *programme*'s general direction, purpose or intention. Aims can be formulated in less specific terms than *goals* and *objectives*, and need not be directly measurable or achievable within the current programme. For example, long term aims may be achieved several years after an *intervention* has finished, or an intervention may only partly contribute to the achievement of aims. Aims are not sufficient to *implement* and *evaluate* programmes; their purpose is to outline the general idea from which precise goals and objectives are developed. Aims, goals, and objectives form a logical *progression. Figure 4 (page 120) gives an example of how an overall aim translates into general goals and specific objectives.* **Standard 3.3: *Defining aims, goals, and objectives***
Anecdotal evidence	see *Evidence*
Attrition	An unplanned reduction in the number of *participants* after the start of the *intervention*. It is caused by participants who drop out of the intervention or *evaluation*, i.e. they take part in the first session(s) and initial data collection, but do not remain until the end of the intervention and the final data collection.
Attribute	The third level of detail within the Standards. Attributes contain the most detailed descriptions and distinguish between basic and expert standards. The other levels of detail in the Standards are made up of *components* and *project stages*.
Baseline data	Data that is collected from *participants* at the beginning of the *intervention*, e.g. to inform *monitoring* and *evaluations*. The progress of the intervention is measured by comparing the data collected during and at the end of the intervention to the initial baseline data.
Benchmark	see *Evaluation benchmark*
Beneficiary	1. Direct beneficiary: *see Participant* 2. Potential or indirect beneficiary: *see Indirect beneficiary*
Benefit	The advantage brought by a certain *activity* for a certain person (e.g. *participant*), group (e.g. *community*) or organisation (e.g. *recipient organisation*).

Bias	Distortion of results. Bias can be produced intentionally or unintentionally during all *project stages*. There are many different types of bias. For example, a literature review may be biased if only certain types of publications are included (e.g. only journal publications), and a report may be biased if certain findings are not reported (e.g. negative findings excluded). Bias may also occur during *participant recruitment*, data collection and data analysis. A participant *sample* is biased if it does not represent the intended *target population*. For example, highly motivated members of the target population may be more likely to take part in and complete the *intervention* (selection bias, attrition bias). As a consequence, the *effectiveness* of the intervention for the total target population might be overestimated.
Budget	The amount of money which is available, e.g. for the *programme*. The budget also represents the maximum allowed spend, i.e. programme *costs* must not be greater than the budget. Budgeting describes the process of managing the budget, e.g. allocating budget to cost items. Estimates on budget and costs are documented in the financial plan. **Standard 5.2: *Planning financial requirements***
Capacity	see *Resource*
Child	see *Young people*
Competency	In the Standards, the knowledge, skills, and behaviours that are required from *staff* members for a successful *programme implementation*. Competencies can be distinguished into four broad categories: basic *intervention* competencies (e.g. knowledge of *effective drug prevention* approaches); specific intervention competencies (e.g. specific knowledge and skills relevant to the intervention); general competencies (e.g. generic social skills, project management); and meta-competencies which enable staff members to respond to individual *participant* needs (e.g. *cultural sensitivity*) (adapted from Pilling et al., 2010). **Standard C: *Staff development***
Comparison group	see *Control group*

Component	1. The second level of detail within the Standards. Components represent the actions to take at each *project stage*. Overall, there are 35 components. Four components are located at the centre of the project cycle and should be reconsidered at each project stage ('cross-cutting considerations'). The remaining 31 components are allocated to specific project stages. The other two levels of detail in the Standards are made up of *attributes* and *project stages*. 2. One of several parts that, together, form a complete *programme*. A multi-component *intervention* includes a range of different intervention *activities*.
Community	1. Group of people living and/or working in a geographically defined area (e.g. neighbourhood, city district), and/or who have a shared social or *cultural* background, interest, or experience (e.g. ethnic, religious, linguistic). *Settings* may be specific to certain communities (e.g. school, youth centre). Depending on the community, a sense of shared identity may exist to varying degrees. Often, individuals belong to several communities based on, for example, geography, occupation, leisure interests (WHO, 1998). **Standards 1.2: *Assessing drug use and community needs;* 2.1: *Assessing target population and community resources*** 2. Professional community: The body of professionals working in a certain occupational field (e.g. scientific and/or prevention community).
Community readiness	see *Readiness*

Control group	A group of people who serve as a reference point to interpret changes in the *intervention group* during the *outcome evaluation*. The individuals in the control group are essentially similar to the intervention *participants* but do not receive the *intervention*. Instead, they may receive, for example, no intervention at all, an alternative intervention, or take part in a prevention-unrelated activity. Data is collected from the control group using the same procedures as in the intervention group. If changes occur only in the intervention group (assessed by statistical testing), it is more likely that they have been caused by the intervention. If changes occur in both groups, they may be unrelated to the intervention and caused by a different, unknown factor. Control groups are used in *quasi-experimental designs* and *randomised controlled trials*. Other terms indicating use of a control group include controlled design, control-group design, control condition. The control group is also known as the comparison group. **Standard 4.4: *If planning final evaluations***
Cost	1. Direct/indirect cost: The amount of money which is required for the *programme*. Two cost types can be distinguished: direct costs are directly related to the duration of the programme (e.g. *staff* salaries), while indirect costs are not directly associated with the duration of the programme (e.g. manuals and other *materials*). Estimates on budget and costs are documented in the financial plan. **Standard 5.2: *Planning financial requirements*** 2. Opportunity cost: The value (*benefit*) of the next-best alternative available to someone who chooses between several options. Opportunity costs are not restricted to financial costs, but include other aspects, such as lost time or pleasure. For example, participants may have to give up work or leisure time in order to take part in an *intervention*, and facilities may not be used for other activities.
Cost-benefit-analysis	The process of analysing the relationship between a *programme*'s *costs* and *benefits* on a variety of levels (e.g. individual, society). The results are expressed in monetary terms. See also: *Cost-effectiveness-analysis*.

Cost-effectiveness-analysis	The process of analysing the relationship between a *programme*'s *costs* and positive (health) *effects* for *participants*. If several *effective* programmes are available, a cost-effectiveness-analysis helps identify which programme achieves, in relative terms, the best *outcomes* with fewest *resources*. For example, a programme may cost more than an alternative, but also produce much better outcomes. It could therefore be more cost-effective than the cheaper alternative. Cost-effectiveness must be distinguished from *efficiency*.
Coverage	The extent to which an *intervention* reaches its intended *target population*. Coverage can be expressed in quantitative terms as the ratio of the number of actual *participants* to the number of individuals in the target population. This requires a precise definition of the target population and a quantitative estimate of its size.
Cultural sensitivity	The willingness and ability (e.g. of *staff* members) to understand the importance of *culture*, to appreciate cultural diversity, to respond effectively to culturally defined needs, and to incorporate cultural considerations into all aspects of *drug prevention* work. Cultural sensitivity may express itself, for example, in providing translations of signs and *materials*, ensuring that the content of the *intervention* is culturally relevant, or considering cultural aspects of *staff* composition and behaviour. Cultural sensitivity is also known as cultural competence. **Standards C: *Staff development*; D: *Ethical drug prevention*; 4.3: *Tailoring the intervention to the target population***
Culture	The set of shared values, attitudes, beliefs, behaviours (e.g. customs), forms of communication (e.g. language, arts, symbols, music), etc. that characterises a particular social group or organisation (see *Community*). The ability to integrate cultural considerations into prevention work is known as *cultural sensitivity*. **Standard 1.4: *Understanding the target population***
Data collection instrument	A device used to collect information, e.g. on the *target population*. Examples include self-report questionnaires, interview or observation protocols. Validated instruments are those that fulfil the criteria of *objectivity*, *reliability*, and *validity*. *Evaluation instruments* are data collection instruments that are used for *evaluation* purposes.
Delivery	see *Implementation*

Dissemination	1. Dissemination of information about the *programme*: Communicating details about the programme, and where available *evaluation* findings, to relevant *target audiences*, such as the scientific and/or prevention *community*, funders, and the *target population*. **Project stage 8: *Dissemination and improvement*** 2. Dissemination of the programme ('going to scale'): *Replicating* a programme on a large scale, e.g. with more *participants*, covering a greater geographical area, etc. In this scenario, the programme is initially tested on a small scale for its *effectiveness*, e.g. in a limited number of schools. Once its effectiveness has been demonstrated, it is rolled out on a large scale, e.g. to all schools nationwide.
Determinant of health	Any factor that is believed to affect health, such as biological (e.g. age, sex, genetic), individual (e.g. lifestyle, childhood experiences), socio-economic (e.g. education, occupation, income), environmental (e.g. pollution, working conditions), political (e.g. health policy), structural (e.g. *access* and availability of *services*) and *cultural* factors (e.g. *gender* roles). Proximal determinants of health, such as individual behaviour, are directly related to health; whereas distal determinants, such as cultural norms, are related to health more remotely.
Drug	Any psychoactive substance, i.e. a substance that, if taken in sufficient dose, can alter mental and physiological processes. Examples of drugs include alcohol, tobacco, illegal substances (i.e. those whose production, sale, or use is forbidden or limited under international and national drug control laws and treaties), volatile substances (gases, fumes from glues, aerosols, and similar products), over-the-counter and prescription medicines, and new psychoactive substances (e.g. 'legal highs'). Drugs are also known as substances or compounds; illegal drugs are also known as controlled or illicit drugs. Note: Food is excluded from this definition. **Standard 3.3: *Defining aims, goals, and objectives***
Drug demand reduction	A general term used in international *drug* control conventions to describe *activities* that aim to reduce consumer demand for (illegal) drugs. Drug demand reduction includes *drug prevention*, treatment and rehabilitation approaches. It differs from supply reduction which aims to limit the production and distribution of (illegal) drugs through law enforcement. In practice, drug demand reduction and supply reduction complement each other to form comprehensive drugs policies.

Drug prevention	Any *activity* that is (at least partially) aimed at preventing or reducing *drug use,* and/or its negative consequences in the general population or subpopulations, including preventing or delaying the initiation of drug use, promoting cessation of use, reducing the frequency and/or quantity of use, preventing the progression to hazardous or harmful use patterns, and/or preventing or reducing negative consequences of use. Prevention activities can be carried out with different *target populations* (e.g. school pupils, young offenders), in different *settings* (e.g. *community*, school, family), using different methods and contents (e.g. information provision, life skills training), and range from one-off to long-term activities. Some activities address drugs directly, while other activities promote health in general and encourage people to make healthy choices, thereby indirectly preventing or reducing drug use. Depending on how the target population is defined, the following types can be distinguished: *universal prevention*; *selective prevention*; *indicated prevention*; *tiered prevention*. *Environmental prevention* is another type of prevention activity. A previously used typology distinguished primary, secondary and tertiary prevention; however, the categorisation by target population has superseded this typology. Drug prevention is also known as, for example, substance abuse prevention. *To be classed as drug prevention activities in the context of the Standards, activities must make explicit reference to drug prevention in their project documentation.*
Drug prevention intervention	see *Drug prevention; Intervention*
Drug prevention programme	see *Drug prevention; Programme*
Drug use	The consumption of a *drug* for purposes other than prescribed medical treatment or scientific investigation. Drug use can be abstinent, infrequent (experimentation), occasional (e.g. less than weekly) or regular (e.g. at least once per week). According to the World Health Organization (WHO), hazardous use describes a use pattern that increases the risk of harmful physical, mental, and social consequences for users and their social environment (e.g. family, *community*), while harmful use describes a use pattern that is already damaging the mental or physical health of users, and may have social consequences. Drug use is also known as drug/substance misuse/abuse. However, terms such as 'misuse' or 'abuse' can be considered judgemental if used to describe drug use in general; they are more suitable for referring to harmful use only.

Effect	1. In *evaluation* research, a result, *outcome*, or impact of an *intervention* or set of interventions. *Outcome evaluation* research aims to understand the effects and the *effectiveness* of interventions. The 'effect size' provides a quantitative estimate of the effect. It can be calculated as the difference in means between the *intervention group* and the *control group* on a certain *indicator*, divided by the standard deviation of the control group or both groups (EMCDDA, 2011). 2. Drug effect: The mental, physiological, behavioural, etc. changes occurring in users as a consequence of their *drug use*.
Effective intervention	An *intervention* that produces the desired *outcomes* without causing harm. The USA Society for Prevention Research has defined the characteristics of an effective intervention in the 'Standards of Evidence' (Flay et al., 2005). **Standard 7.1: *If conducting an outcome evaluation***
Effectiveness	The extent to which an *intervention* produces, in practice, the desired *outcomes* without causing harm. In *outcome evaluation* research, effectiveness trials test whether interventions are effective under real-world conditions or in natural *settings* (Flay et al., 2005), e.g. when delivered by a typical classroom teacher rather than a specially trained professional in a research trial. They clarify under what conditions interventions are effective by considering the impact of variations (e.g. conditions of delivery, quality of *implementation*). Effectiveness trials are different from *efficacy* trials, which test interventions under ideal conditions.
Effect size	see *Effect*
Efficacy	In *outcome evaluation* research, the extent to which an *intervention* produces, under ideal conditions, the desired *outcomes* without causing harm, e.g. when delivered by the programme developer or specially trained professionals. Conditions are controlled to avoid any variation. Efficacy trials are different from *effectiveness* trials, which test interventions under real-world conditions and explicitly explore the impact of variations.

Efficiency	The optimal use of *resources*, i.e. a measure of the relationship between the *cost* and *outcomes* of a *programme*. A programme is inefficient if the same outcomes could be achieved with fewer resources (e.g. less expensive equipment, fewer *staff* members), or if the same resources could produce better outputs (e.g. engage with a greater number of *participants*). If several *effective* programmes are available, a *cost-effectiveness-analysis* can be carried out to identify which programme achieves, in relative terms, the best outcomes with fewest resources. However, efficiency differs from *effectiveness*.
Environmental prevention	*Drug prevention* activities that focus on changing the environment in which people live. Environmental prevention covers a range of activities, depending on how the term 'environment' is understood. Activities may address social norms (e.g. attitudes towards *drug use* in the *community*), regulations (e.g. written policies, public tobacco smoking bans), availability of *drugs* (e.g. policing, test purchasing), the built environment (e.g. improved lighting, video surveillance), etc. Consequently, environmental prevention can serve to reduce drug demand (see *Drug demand reduction*), supply, and/or drug-related harms.
Epidemiology	The study of the distribution and causes of health and disease, e.g. in relation to *drug use*. Epidemiological information provides the basis for *drug prevention activities* by indicating, for example, the prevalence of drug use and the extent and nature of *drug*-related needs in a *community*. Epidemiology typically employs quantitative study designs (e.g. prevalence surveys, cohort studies, routine statistics). Social sciences approaches (e.g. sociology, economics) are increasingly used to contextualise epidemiological findings. **Standard 1.2: *Assessing drug use and community needs***
Ethical drug prevention	In the Standards, *drug prevention* work that is characterised by an ethical and lawful conduct of the *provider* and orientation towards *participants'* rights, autonomy, and needs (e.g. positive outcomes without harms). In general, ethics provide guidance on how people ought to act and how to make decisions on what is 'right' and 'wrong'. **Standard D: *Ethical drug prevention***

Evaluation	The systematic collection, processing and analysis of data from the *programme* to assess whether *goals* and *objectives* have been achieved, and how. Methods can utilise qualitative and/or quantitative approaches. An evaluation is 'internal' or 'external' depending on whether the individual or *team* conducting the evaluation works within the organisation being evaluated or for an external organisation (e.g. university, consultancy) (EMCDDA, 2010). The Standards describe *monitoring* as a means of ongoing evaluation during *implementation*, and outcome and *process evaluation* as more scientific forms of evaluation that are conducted following implementation. **Standards 4.4: *If planning final evaluations;* 6.3: *Monitoring the implementation;* 7: *Final evaluations***
Evaluation benchmark	A criterion against which achievement of *goals* and (specific and operational) *objectives* can be measured. Each benchmark is linked to an *evaluation indicator* and defines achievement on that indicator in numerical terms or, where that is not possible, in descriptive terms. Evaluation benchmarks are also known as targets, performance indicators, or success indicators. *Figure 5 (page 151) illustrates the relations between specific and operational objectives, evaluation indicators and benchmarks.* **Standard *4.4: If planning final evaluations***

Evaluation indicator	A one-dimensional, substitute measure for a concept that cannot be measured or observed directly (EMCDDA, 1998), i.e. the specific information to be collected for *process evaluations* and *outcome evaluations*. *Goals* and *objectives* commonly address *outcomes* that cannot be measured directly (e.g. *drug use*, social skills). Therefore, they are translated into indicators that help assess the achievement of goals and objectives. Outcome indicators are derived from goals and specific objectives and concern the changes in *participants*. Examples include: self-reported drug use; self-reported intention to use drugs in the future; communication skills (e.g. questionnaire or observation). Process indicators are derived from the operational objectives and concern the *implementation* of the *programme*. Examples include: number of participants, participants' frequency of participation, number of *staff* members involved in the programme, participant and staff feedback, *fidelity* of implementation, etc. Because indicators are only approximations of complex concepts, it is common to use several indicators to measure one concept. Evaluation indicators are also known as process and outcome measures, evaluation criteria, etc. *Figure 5 (page 151) illustrates the relations between specific and operational objectives, evaluation indicators and benchmarks.* **Standard 4.4: *If planning final evaluations***
Evaluation instrument	A device used to collect information for *monitoring* and final *evaluations*, e.g. self-report questionnaire, interview or observation protocol. Validated instruments are those that fulfil the criteria of *objectivity*, *reliability*, and *validity*. The EMCDDA's Evaluation Instruments Bank (EIB) is an online archive of freely available evaluation instruments. **Standard 4.4: *If planning final evaluations***
Evaluation tool	Technical *resources* required to conduct *monitoring* and final *evaluations*, e.g. *evaluation instruments*.

Evidence	1. Empirical information, i.e. information based on observations, experiments, etc. 2. Evidence of *effectiveness*: Information on the effectiveness of *interventions* in achieving *outcomes*. This information is typically derived from scientific research trials and reported in the professional literature, e.g. scientific journals. Evidence may also be derived from *outcome evaluations* that were not part of research trials, as long as they were conducted in a scientifically sound manner. Scientific evidence is distinguished from anecdotal evidence which is based upon subjective accounts, e.g. professional experiences, unstructured observations. Consequently, different levels of evidence can be distinguished according to how the evidence was produced; for example, in critical evidence appraisals *randomised controlled trials* are usually considered to produce the highest level of evidence, while professional opinions are considered to represent the lowest level of evidence (OCEBM, 2009). **Standard 3.5: *Referring to evidence of effectiveness*** 3. Examples of evidence: In the Standards, examples of how achievement of the Standards could be evidenced (i.e. proven, demonstrated) in practice.
Evidence-based drug prevention	*Drug prevention* work that is based upon a systematic analysis of the best available *evidence*, making use of the evidence, and ensuring correspondence with the evidence. The term 'evidence-based' is often used interchangeably with terms such as 'research-based' and 'science-based' (Kellam and Langevin, 2003, p. 140), but differs from 'effective' (see *Effectiveness*) and 'efficacious' (see *Efficacy*).
Experimental design	see *Randomised controlled trial*
Experimental group	see *Intervention group*
External evaluation	see *Evaluation*
Fidelity	The degree to which the actual *implementation* of an *intervention* corresponds to the original plan of the programme developers (or the carefully adapted intervention design). Fidelity is reduced if, for example, *staff* members do not adhere to the original protocol and make unplanned modifications, e.g. by reducing the number of sessions, changing the content of the intervention.
Front-line worker	see *Practitioner*

Gender	In the Standards, the set of socially constructed roles, behaviours, etc. that are considered appropriate for men and women, e.g. what it means to be a 'boy' or a 'girl' in a certain *culture*. These beliefs can differ between *communities*. In the Standards, culturally defined 'gender' is distinguished from 'sex' which refers to the biological characteristics of men and women. However, some professionals use the terms interchangeably, acknowledging their interdependency (e.g. physical ability can influence possibility of activities; acceptability of certain activities can influence physiological characteristics).
Generalisability	The extent to which *intervention* designs, *theoretical models*, *evaluation* findings, etc. can be applied to other populations, *settings*, etc.
Goal	In the Standards, a clear statement on the *outcome* for *participants* at the completion of the *intervention*. A clear goal definition is necessary for an *outcome evaluation*. Goals are developed from the overall *aim* by translating it into more specific and achievable targets. For example, different goals may reflect different aspects of the overall aim. Each goal is then translated into specific *objectives*. Goals are also known as general objectives or global objectives. *Figure 4 (page 120) gives an example of how an overall aim translates into general goals and specific objectives, while Figure 5 (page 151) illustrates the relations between specific and operational objectives, evaluation indicators and benchmarks.* **Standard *3.3: Defining aims, goals, and objectives***
Guidance	In the Standards, a general term for written information aimed at directing public health actions, such as *guidelines* and guideline recommendations, *quality standards*, advice, suggestions, etc.
Guideline	1. A set of specific statements to inform the choice and design of the *intervention*. Guidelines are typically based upon systematic reviews of the literature. They often contain detailed step-by-step instructions (guideline recommendations) regarding the best option for a certain condition (e.g. how to respond to specific needs of the *target population*). Guidelines are also known as practice guidance, practice recommendations, etc. The Standards distinguish between guidelines and *quality standards*. 2. General instructions or rules governing (professional) action (e.g. methodological guidelines, guidelines for policy makers).
Harmful use	see *Drug use*

Hazardous use	see *Drug use*
Health determinant	see *Determinant of health*
High quality drug prevention	In the Standards, *drug prevention* work that is: in line with the needs of *participants*, makes reference to policy, and therefore likely to be relevant; underpinned by the principles of *ethical drug prevention,* and therefore likely to be ethical; informed by scientific theory and *evidence,* and therefore likely to be *effective*; and internally coherent, and therefore likely to be feasible. *Drug prevention activities that adhere to the Standards will meet these criteria, and will consequently be considered to be of high quality.*
Human resources	see *Staff*
Iatrogenic effect	Negative *outcomes* for *participants* which have been caused by an *intervention*. Iatrogenic effects of *drug prevention* interventions could be, for example, increased *drug use*, harms for participants, etc. Iatrogenesis can concern main outcomes, such as drug use, or increased incidence of other unwanted behaviours ('side effects'). An iatrogenic effect is different from no effect ('ineffective') as this would mean that there were neither positive nor negative outcomes.
Implementation	The process of taking action according to the *project plan*. In the Standards, 'implementation' usually refers specifically to carrying out the planned *intervention* with *participants*, while '*programme* implementation' includes other aspects such as participant *recruitment, staff* training, etc. Implementation is also called 'delivery' in the Standards. **Standard 6: *Delivery and monitoring***
Indicated prevention	In the context of *drug prevention*, *activities* that are targeted at individuals with an increased individual risk of (harmful) *drug use* (adapted from Springer and Phillips, 2007). This includes those who already use drugs (but are not dependent according to DSM-IV or ICD-10) and/or who have an increased individual risk of drug use in later life (e.g. due to childhood experiences, mental health or conduct disorders) (see *Risk factor*). Indicated prevention can aim to prevent the onset of drug use, but more often aims to reduce existing drug use and to prevent progression to harmful use. In practice, there can be an overlap between indicated prevention and *selective prevention* or treatment (EMCDDA, 2009, p. 10).

Indicator	A one-dimensional, substitute measure for a more complex concept that cannot be measured or observed directly. Indicators can be used for a range of purposes, e.g. to inform *needs assessment* or *evaluations* (see *Evaluation indicator*). Typically, several indicators are used to gain a comprehensive understanding of the concept.
Indirect beneficiary	A person who does not take part in the *intervention* but could potentially benefit from its positive *outcomes*. For example, *participants'* social environment (e.g. family, *community*) may benefit from the changes in participants' behaviour (e.g. reduced *drug use*, improved social skills). In addition, participants may pass on their knowledge and experiences from the intervention, e.g. to peers, members of the *target population* that did not take part in the intervention. This is utilised in some interventions, where participants do not represent the target population, but influence the target population indirectly. In such interventions, participants are, for example, peers, families, or teachers, while members of the target population are the indirect beneficiaries. Indirect beneficiaries are also known as potential beneficiaries.
Instrument	see *Evaluation instrument*
Internal evaluation	see *Evaluation*
Intervention	An *activity* or set of activities carried out in (direct) contact with the *target population* to produce a certain *outcome* (e.g. prevent or reduce *drug use*). In the context of *drug prevention*, the term is used in its generic sense and does not imply an actual treatment protocol. *Service* work is included in this definition. In the Standards, the term 'intervention' focuses on the activities aimed at changing *participants*, while 'project' refers to all other activities such as planning, participant *recruitment*, *staff* training, etc. All intervention and project aspects of prevention work are included in the overarching term *'programme'*. **Standard 4: *Intervention design***
Intervention activity	see *Activity*
Intervention group	A group of people who take part in or receive the *intervention*. In *evaluation* design, the intervention group is distinguished from the *control group*. The individuals in the control group do not receive the intervention, hence providing a reference point to interpret changes in the intervention group during the *outcome evaluation*. The intervention group is also known as the experimental group.
Intervention materials	*see Materials*

Logic model	A flowchart or graphical representation of the components of a *theoretical model* ('theory logic model') and/or a *programme* ('programme logic model') (CSAP, 2002). The theory logic model illustrates the theory of change, i.e. it identifies relevant *mediators* and shows how these achieve *outcomes* within a given context (e.g. *target population*). The programme logic model illustrates the logical flow of programme *activities* from start to finish, i.e. it identifies essential intervention and *project* activities and demonstrates the internal coherence of the programme. In practice, it is common to use only one logic model linking theoretical considerations and practical activities (e.g. showing how activities influence mediators).
Long-term outcome	see *Outcome*
Materials	In the Standards, all material *resources* required for the *implementation* of the *programme*, such as *intervention* materials, instruments for *monitoring* and *evaluation*, technical equipment (e.g. computers, DVD players, projectors), physical environment (e.g. indoor and outdoor facilities), etc. More specifically, 'intervention materials' are those materials specific to the intervention, such as workbooks, DVDs, *staff* training manuals, presentations, websites, etc. Materials can relate to *participants*' needs (e.g. illustrating the content of the intervention) and/or staff members' needs (e.g. providing instructions on delivery). **Standard 5.5: *Preparing programme materials***
Mediator	An intervening variable that explains how an *intervention* produces a certain *outcome*. *Drug prevention* interventions cannot usually target *participants' drug use* directly; instead, they target mediators that have an influence on drug use. Mediators can be directly related to drug use, e.g. knowledge about *drugs*, beliefs about the consequences of drug use, attitudes towards drugs, intention to use drugs, etc.; or they can be indirectly related to drug use, e.g. life skills, general *risk factors* and *protective factors*, etc.
Medium-term outcome	see *Outcome*
Mobilisation of resources	The process of activating *resources* that are already available (e.g. training *staff*) as well as accessing new resources (e.g. *recruiting participants*, fundraising). **Standard 5: *Management and mobilisation of resources***

Moderator	A variable that affects the relationship between the *intervention*, *mediators*, and the desired *outcome*, i.e. it has an influence on how *effective* the intervention is. The analysis of moderators frequently focuses on the circumstances of implementation, e.g. whether the intervention was carried out as planned (see *Fidelity)*, who delivered the intervention (e.g. teacher, researcher), number of sessions, inclusion of booster sessions, etc. The choice of moderators can also be determined by the *theoretical model*, e.g. prevailing social norms, differences in family structure, new policies.
Monitoring	In the Standards, the continuous gathering and analysis of process and *outcome* data during the *implementation* of the *intervention*. It can serve several purposes, such as: ensuring that the intervention proceeds according to plan (e.g. *fidelity*, *effectiveness*); identifying changed or additional requirements (e.g. *participant* needs, *resources*); improving the intervention while it is being implemented; documenting the implementation (e.g. for final report, final *evaluations*). Monitoring is also known as regular review, quality control, reflection, revision, a type of formative evaluation, etc. In the Standards, monitoring is distinguished from the *process evaluation* which analyses process data after implementation. **Standard 6.3: *Monitoring the implementation***
Needs assessment	A systematic assessment of the nature and extent of needs, as well as possible causes and contributing factors to those needs. Data is typically *epidemiological*, but can also be obtained using focus groups, etc. The aim is to identify unmet needs (e.g. gaps in *service* provision) and to plan *activities* that fulfil these needs. The Standards highlight needs as defined by policy and legislation, the *community* and its members, and, most importantly, the (potential) *target population* and its social environment. Needs assessment is also known as needs analysis. In the Standards, needs assessment is distinguished from *resource assessment* which focuses on assessing available *resources*. **Standard 1: *Needs assessment***

Non-experimental design	In *outcome evaluation* research, a study type where *outcomes* are measured only in the *intervention group*. If data is collected from the intervention group only after the *intervention*, it is not possible to make any statements about the *effectiveness* of the intervention. If data is collected before and after the intervention, the changes that occurred between both points in time can be described. However, it is not possible to prove that these changes were caused by the intervention, as this would require the use of a *control group*. This type of non-experimental design is also known as naturalistic design or pre-post design without control group. Study types with a control group include the *quasi-experimental design* and the *randomised controlled trial*.
Objective	1. Specific objective: In the Standards, a clear statement on an immediate or intermediate change that is necessary to achieve a *goal* at the end of the *intervention*. It need not necessarily relate directly to *drug use*. *Figure 4 (page 120) gives an example of how an overall aim translates into general goals and specific objectives.* **Standard 3.3: *Defining aims, goals, and objectives*** 2. Operational objective: A clear statement on the *output* required to achieve the specific objectives (e.g. number and type of *participant* contact) (EMCDDA, 2011). *Figure 5 (page 151) illustrates the relations between specific and operational objectives, evaluation indicators and benchmarks*.
Objectivity	An indicator for the quality of a *data collection instrument*. An instrument is objective if it produces results independently of who uses the instrument to take measurements. Other indicators of instrument quality are *reliability* and *validity*.
Organisation	1. In the context of *drug prevention*, an organisation that is active in, or contributing to, the field of drug prevention, e.g. *provider*, local authority, research institute. Organisations are also called 'agencies' or 'institutions' in the Standards. 2. In the Standards, an organisation that is using the Standards to reflect on their work, plan their *programme*, etc. This organisation is likely to be active in, or contribute to, the field of *drug prevention*. Examples include drug prevention charities, youth *services*, schools, local authorities, government, etc. *For specific information on how to use the Standards, please refer to the Introduction.*

Outcome	The change that occurs in *participants* as a result of their exposure to, or involvement in, the *intervention*. In the Standards, outcomes can be distinguished according to when they are expected and measured. Immediate and intermediate outcomes occur during the intervention, corresponding to the *objectives*. Post-intervention outcomes occur at the end of the intervention, corresponding to the *goals*. It is also common to consider longer term final outcomes which correspond to the *programme*'s general *aims*. In *outcome evaluation* research, follow-up measurements are conducted to test how long these outcomes are *sustained*. The Standards suggest the following intervals for follow-up measurements: up to 6 months after the intervention (short-term), >6 to 12 months after the intervention (medium-term), and >12 months after the intervention (long-term). Outcomes are distinguished from the *outputs* of a programme. *Figure 6 (page 153) illustrates the relationships between targets, outcomes, and measurements*.
Outcome data	*see Outcome evaluation*
Outcome evaluation	The systematic collection and analysis of *outcome* data to assess whether *goals* and *objectives* were achieved and to establish whether the *intervention* is *effective*. If the evaluation is conducted as a *randomised controlled trial*, it is possible to attribute observed *effects* to the intervention. The outcome evaluation is distinguished from the *process evaluation* which analyses how the intervention was delivered. **Standards 4.4: *If planning final evaluations;* 7.1: *If conducting an outcome evaluation***
Output	The products of *programme activities*, such as deliverables (e.g. sessions held), structures created (e.g. *community readiness*), opportunities given (e.g. number of *participants*), *materials* published (e.g. final report), etc. (EMCDDA, 2011). Outputs are distinguished from *outcomes*, which concern the changes in participants.

Participant	A person taking part in or receiving the *intervention* in a direct manner. Participants are drawn from the intermediate or the ultimate *target population*. The ultimate target population refers to the people that the intervention wants to produce positive outcomes for (e.g. young people at risk of *drug use*), while the intermediate target population describes people who have an influence on that target population (e.g. family, peers, teachers). Typically, participants represent only a *sample* of all eligible individuals (e.g. a number of children out of all vulnerable children in the *community*). In *evaluation* research, some participants do not receive the intervention because they have been assigned to a *control group*. Participants are also known as direct beneficiaries.
Pilot intervention	A small-scale trial of the *intervention* prior to its full *implementation* (e.g. with fewer *participants*). It aims to test the feasibility of the planned intervention (e.g. is the *resource* estimate correct?), its *effectiveness* (e.g. do *outcomes* occur as expected?), and the appropriateness of the content, intervention *materials*, *evaluation instruments*, etc. The insights gained from conducting the pilot intervention are used to improve the proper implementation. The pilot intervention is also known as a type of formative *evaluation*. **Standard 6.1: *If conducting a pilot intervention***
Post-test	The collection of data from *participants* at the end of the *intervention* to inform the *outcome evaluation*. The progress of the intervention is measured by comparing the post-test data to the *pre-test* data. If data is only collected from the *intervention group* after the intervention (*non-experimental design*), it is not possible to make any statements about the *effectiveness* of the intervention. *Figure 6 (page 153) illustrates the relationships between targets, outcomes, and measurements*.
Potential beneficiary	see *Indirect beneficiary*
Practitioner	A *staff* member spending a large amount of time working in direct contact with members of the *target population*, e.g. delivering the *intervention*. Practitioners are also known as field workers or front-line workers.

Pre-test	The collection of *baseline data* from *participants* before, or at the beginning of, the *intervention* to inform the *outcome evaluation*. The progress of the intervention is measured by comparing the *post-test* data to the pre-test data. However, it is not possible to prove that changes were caused by the intervention without using a *control group* (see *Quasi-experimental design, Randomised controlled trial*). *Figure 6 (page 153) illustrates the relationships between targets, outcomes, and measurements*.
Prevention	see *Drug prevention*
Process data	see *Process evaluation*
Process evaluation	The systematic collection and analysis of process data to understand why *outcomes* were (not) achieved and how the *programme* can be improved in the future. If an existing intervention was implemented, the process evaluation can also demonstrate that fidelity was upheld. Process data relates to the outputs of the programme (e.g. what *activities* were carried out, with and by whom). The process evaluation documents the outputs; it then analyses why the programme was carried out that way and how that might have impacted on the outcomes. Aspects to consider typically include: reach and *coverage* (i.e. how well did participants represent the *target population*?); acceptance of the intervention by *participants* (e.g. suitability of content and *materials*); *fidelity* (i.e. was the *intervention* conducted according to plan?); use of *resources* (e.g. *cost-effectiveness*). Process evaluations are also known as quality assurance reviews, output evaluations, implementation evaluations, programme assessments, etc. In the Standards, process evaluations are distinguished from *monitoring* which analyses data during *implementation*. They are also distinguished from *outcome evaluations* which analyse outcomes for participants. **Standards 4.4*: If planning final evaluations; 7.2: If conducting a process evaluation***
Programme	In the Standards, the sum of one (or several) *intervention*(s) as well as the accompanying research (e.g. *needs assessment, monitoring*, final *evaluations*) and the surrounding administrative structure (e.g. *project* management, fundraising, *staff* training, *participant recruitment, dissemination*, local structures and priorities). Thus, the term 'programme' is used as an overarching term for all intervention and project aspects of prevention work. A governmental *strategy* for *drug prevention* can be seen as a type of programme. *Service* work is also included in this definition.
Programme activity	see *Activity*

Project	A time-limited undertaking with a defined purpose. In the Standards, the term is used more specifically to refer to administrative work and business matters within a *drug prevention programme* (e.g. *resource* management). It is distinguished from a *strategy*, which is a broad plan specifying priorities and main activities in drug prevention.
Project cycle	see *Project stage*
Project plan	An internal tool to guide *implementation*, systematically illustrating the main tasks and *strategies* required to deliver the *programme*. It is produced as soon as the main programme elements are defined (e.g. *target population*, type of *intervention*). The project plan is essential to implement the programme, but also to document and review implementation. The project plan is also known as a work plan, action plan, or implementation plan. It differs from the *programme description* which informs external parties about the programme. **Standard 5.1: *Planning the programme — Illustrating the project plan***
Project stage	The first level of detail within the Standards. Eight distinct project stages are organised chronologically in a *project* cycle, illustrating the life cycle of a (*drug prevention*) *programme* from start (*needs assessment*) to finish (*dissemination*). The centre of the project cycle contains cross-cutting considerations that should be reconsidered at each project stage. The project cycle represents a model which, in practice, must be adapted to the particular circumstances of projects. The other two levels of detail in the Standards are made up of *attributes* and *components*.
Programme description	In the Standards, a description of the *programme* with a particular focus on the conditions and possible consequences of participation (e.g. price, risks and *benefits*). It is written prior to the start of the *intervention* to inform external parties about the programme (e.g. *target population*, funders). The programme description is also known as a programme outline or a policy (for example, in a school context). The programme description differs from the *project plan* which is an internal tool to guide project *implementation*; it also differs from the final report which summarises the programme once it has finished. **Standard 5.6*: Providing a programme description***

Protective factor	In the context of *drug prevention*, a factor that reduces the likelihood of initial *drug use* or the progression to more harmful forms of use. Protective factors can be found on different levels, such as individual (e.g. social competence, impulse control, high educational attainment), family (e.g. cohesive family unit, care and support, parental supervision), peers/*community* (e.g. norms against drug use), contextual (e.g. high socio-economic status). Drug prevention work aims to strengthen protective factors. Protective factors are distinguished from *risk factors*. **Standard 1.4: *Understanding the target population***
Provider	In the context of *drug prevention*, an organisation that is active in, or contributing to, the provision of drug prevention, e.g. drug prevention charity, youth *service*, school.
Quality standard	A benchmark that helps judge whether an *activity,* a *provider*, etc. represents high quality. Quality standards are typically based upon professional consensus. Their main focus is on structural and procedural aspects of quality assurance, e.g. *evaluation*, *staff* composition and *competencies*, *participant* safety, etc. The Standards distinguish between quality standards and *guidelines*. *For specific information about the European drug prevention quality standards, please refer to the Introduction.*
Quasi-experimental design	In *outcome evaluation* research, a study type where *outcomes* are measured in the *intervention group* and in the *control group* before and after the *intervention*, but where *participants* are not allocated randomly to intervention and control groups. Instead, as the intervention group may already be in contact with a *service*, people may be deliberately chosen for the control group to have similar characteristics as the people in the intervention group ('matching'). As allocation is not random, it is more likely that (unnoticed) differences between intervention and control groups occur and affect the outcomes. This study type is also known as pre-post design with control group. Other study types include the *non-experimental design* and the *randomised controlled trial*.

Randomisation	In *outcome evaluation* research, the process through which eligible individuals or natural groups (e.g. school classes) are randomly assigned to either an *intervention group* or a *control group*. The assignment is random if each unit (i.e. individual or group) has the same chance of being selected for the intervention or the control group. This reduces the likelihood of systematic differences between participants in the intervention and in the control group. Randomisation is a feature of *randomised controlled trials*.
Randomised controlled trial	In *outcome evaluation* research, a study type involving random allocation of individuals or natural groups (e.g. school classes) to *intervention groups* and *control groups*. *Outcomes* are measured in both groups before and after the *intervention*. Randomised controlled trials are considered to produce the most robust *evidence* of *effectiveness*. This study type is also known as experimental design or pre-post design with control group and *randomisation*. A common abbreviation is RCT. Less robust study types include the *non-experimental design* and the *quasi-experimental design*.
Readiness	*Stakeholders'* (e.g. *target population*, *community*) awareness of *drug*-related needs, and their interest, willingness and ability to support *drug prevention activities*. Lack of target population or community readiness may be a barrier to carrying out prevention work. Research has identified distinct stages of community readiness (e.g. Plested et al., 1999). **Standard 2.1: *Assessing target population and community resources***
Recipient organisation	In the Standards, an external organisation (e.g. school, community centre, nightclub) within which the *intervention* is delivered if it is not delivered within the premises of the *provider*. Reasons why an intervention is delivered externally vary, e.g. the recipient organisation commissioned the intervention, it provides access to the *target population* on request of the provider, etc. The recipient organisation is also known as the host institution.
Recruitment	The process of drawing a *sample* of *participants* from the wider *target population*. In some interventions, participants are not drawn from the target population, but from a group of people who have an influence on members of the target population (e.g. family). Recruitment consists of choosing eligible individuals, informing them about the *programme*, inviting them to take part, enrolling them, and ensuring that they begin the *intervention* (e.g. attend the first session). **Standard 5.4: *Recruiting and retaining participants***

Reliability	An *indicator* for the quality of a *data collection instrument*. An instrument is reliable if it produces consistent results, e.g. with the same subjects time after time ('test-retest reliability'), across people who use the instrument ('inter-rater reliability'), or across items within the same instrument ('internal consistency'). Test-retest reliability is an important prerequisite for *outcome evaluation*; the use of reliable instruments ensures that observed changes are due to real changes in *participants*, and not caused by an unreliable *evaluation instrument*. Other indicators of instrument quality are *objectivity* and *validity*.
Replication	The *implementation* of an *intervention* that has already been implemented at least once in the past. Replication of existing interventions can be more *efficient* than designing a new intervention, as it utilises existing *materials*, etc. It is also important from a scientific point of view, as it tests whether previously found *outcomes* can be repeated ('replicated'). If the replication takes place under new circumstances, it also tests whether statements about the intervention's *effectiveness* can be *generalised* (e.g. to a different *target population* or *setting*). **Standard 4.2: *If selecting an existing intervention***
Resource	Money, time, people (e.g. *staff* members, *target population*), *competencies* (e.g. skills, knowledge, experience), information, networks, *materials* (e.g. equipment), etc. that are available or required to implement a *programme*. **Standards 2: *Resource assessment*; 5: *Management and mobilisation of resources***
Resource assessment	An assessment of all *resources* that are available to an individual, *organisation*, *community*, etc., with a particular emphasis on those resources that could be utilised in the intended *programme* (e.g. community *readiness*). In the Standards, resource assessment is distinguished from *needs assessment* which aims to identify unmet needs. **Standard 2: *Resource assessment***
Retention	The process of ensuring that *participants* remain in the *intervention* until it has finished or until the *goals* have been achieved (whichever is more appropriate). **Standard 5.4: *Recruiting and retaining participants***

Risk factor	In the context of *drug prevention*, a factor that increases the likelihood of initial *drug use* or the progression to more harmful forms of use. Risk factors can be found on different levels, such as individual (e.g. antisocial behaviour, lack of self-esteem, poor school performance), family (e.g. parental drug use, lack of support, lack of parental supervision), peers/*community* (e.g. drug-using peers), contextual (e.g. low socio-economic status, high *drug* availability). Drug prevention work aims to reduce risk factors. Risk factors are distinguished from *protective factors*. **Standard 1.4: *Understanding the target population***
Sample	A subset of a population. *Participants* are a sample of the *target population*. The participant sample should be representative of the target population (i.e. mirror its characteristics), so that findings can be *generalised* to the wider target population. In *evaluation* research, this is best achieved by drawing a random sample so that each individual or natural group (e.g. school class) has the same probability of being selected into the sample. Random selection can be conducted, for example, by using a (computer-generated) table of random numbers. Furthermore, the participant sample should be large enough to enable a range of statistical analyses.
Selective prevention	In the context of *drug prevention*, activities that are targeted at individuals with an above-average risk of *drug use* by virtue of their membership in a particular population group (adapted from Springer and Phillips, 2007), e.g. school drop outs, young offenders, children of drug users, clubbers (see *Risk factor*). These groups are also known as vulnerable populations.
Service	An organisation which is usually commissioned by the government (e.g. local authorities) to fulfil people's needs. For example, social services assist vulnerable people with everyday life, such as children in need of support, people with physical or mental disabilities, etc. The term can refer both to the organisation itself as well as to the work done by this organisation. In Europe, services do not typically implement structured, manualised *drug prevention programmes*. Instead, they are usually *participant*- and needs-led and therefore less structured (e.g. outreach work, drop-in centre, brief intervention). Services also often offer generic support in addition to specific drug prevention activities, and prevention might not be the primary focus of the service. In the Standards, the terms 'programme' and 'intervention' include service work.

Setting	The social and/or physical environment(s) in which the *intervention* takes place, e.g. family, school, workplace, nightclub, *community*, society. The term can also refer to the social and/or physical environment(s) in which people engage in daily activities, e.g. work, leisure. The setting is also known as domain, location, environment, or implementation level. **Standard 3.4: *Defining the setting***
Sex	In the Standards, the biological characteristics of men and women. 'Sex' is distinguished from *gender* which refers to the set of socially constructed roles, behaviours, etc. that are considered appropriate for men and women. However, some professionals use the terms interchangeably, acknowledging their interdependency (e.g. physical ability can influence possibility of activities; acceptability of certain activities can influence physiological characteristics).
Short-term outcome	see *Outcome*
Side effect	see *Iatrogenic effect*
Significance	see *Statistical significance*
Staff	In the Standards, all individuals working for the *organisation* that conducts the *programme*, including those working full- or part-time, those who are paid or unpaid (e.g. volunteers, interns), and those on permanent or renewable short-term contracts, regardless of qualification, experience, or responsibility (e.g. managers, administrative staff). In the Standards, the term is also used to refer specifically to *practitioners*, i.e. those in direct contact with the *target population*. Staff members are also known as human resources, personnel, employees, workers, or the workforce. **Standards C: *Staff development*; 5.3: *Setting up the team***
Staff development	The process of enhancing *staff* members' *competencies* (i.e. knowledge, skills, behaviours) through training programmes, regular review, emotional support, supervision, encouraging self-reflection, etc. **Standard C: *Staff development***

Stakeholder	Any individual, group, organisation, etc. who has a vested interest (a stake) in, and/or who is directly or indirectly affected by, the *activities* and/or *outcomes* of the *drug prevention programme*. Examples include: *target population*, *participants*, *staff* members, *community*, *recipient organisation*, funders, government, media, voluntary sector, health and social *services*, etc. **Standard B: *Communication and stakeholder involvement***
Standard	see *Quality standard*
Statistically significant	A result that is verified by statistical testing to be unlikely to have occurred by chance. In *outcome evaluation* research, the statistical significance of findings is tested to understand if, for example, *outcomes* were really caused by the *intervention*. **Standard 7.1*: If conducting an outcome evaluation***
Strategy	1. A broad plan specifying the priorities and main activities of an entire *project* or organisation. In *drug prevention*, the most important strategies of this type are the drugs strategies set up by local, regional, national, and international governments (e.g. European Union, United Nations). **Standard 1.1: *Knowing drug-related policies and legislation*** 2. A broad plan specifying the priorities and main *activities* regarding a particular *project* aspect, such as communication, fundraising, *evaluation*, documentation, *dissemination*. In the Standards, these strategies are summarised in the *project plan*. **Standard 5.1: *Planning the programme — Illustrating the project plan***
Substance	see *Drug*
Supply reduction	see *Drug demand reduction*

Sustainability	1. The likelihood that a *drug prevention programme* will continue beyond its initial *implementation* and/or after external funding has stopped, as well as the factors that contribute to this likelihood. **Standards A: *Sustainability and funding;* 8.1: *Determining whether the programme should be sustained*** 2. The likelihood that positive *outcomes* of the *intervention* are maintained in *participants* after the intervention has stopped, i.e. that they are found in the long-term follow-up. 3. The likelihood that the *intervention* is *implemented* with high quality once programme developers are no longer directly involved (e.g. once the *programme* has been *disseminated* on a large scale). Sustainability trials seek to determine the conditions for continued implementation *fidelity* (Kellam and Langevin, 2003).
Tailored intervention	In the Standards, an *intervention* that has been *adapted* to the specific requirements of the *target population*, the *setting*, etc. in order to maintain or increase its *effectiveness*. **Standard 4.3: *Tailoring the intervention to the target population***
Target audience	In the Standards, people who receive information about the *activities* and *outcomes* of the *programme*, e.g. through regular updates during *implementation*, the final report, workshops, etc. *Stakeholders* such as the *target population*, funders, the professional *community*, etc. represent common target audiences. **Standard 8.2: *Disseminating information about the programme***

Target population	The people towards which the *drug prevention intervention* is directed, e.g. those who are eligible to take part in or receive the intervention, those for who the intervention is thought to be *effective*. The target population may consist of individuals, groups, households, organisations, *communities*, *settings*, and/or other units, as long as they are identifiable and clearly defined. *Participants* are usually drawn from the target population. However, in some interventions, participants are not drawn from the target population, but from a group of people who have an influence on members of the target population. In these cases, the intermediate target population that is eligible to take part in the intervention (e.g. peers, family, teachers) is distinguished from the ultimate target population that will be changed indirectly (e.g. young people at risk of *drug use*) (EMCDDA, 1998). The target population is also known as the target group. **Standard 3.1: *Defining the target population***
Targeted prevention	In the context of *drug prevention*, *activities* that are targeted at individuals or groups with an increased risk of *drug use (*see *Risk factor)*. There are two types of targeted prevention: *indicated prevention* (increased risk due to an individual characteristic) and *selective prevention* (increased risk due to membership of a certain group).
Team	In the Standards, all *staff* members working on the *programme*. Within the team, smaller teams can be formed to deal with particular issues, such as fundraising, cultural *adaptation*, *evaluation*, *dissemination*, etc. These sub-teams may consist of one person only.
Theory	see *Theoretical model*
Theoretical model	A set of interrelated assumptions (hypotheses) explaining how and why the *drug prevention intervention* is likely to produce *outcomes* in the *target population*. It may also explain the rationale behind *drug use*. The theoretical model helps decide on appropriate *aims*, *goals*, *objectives*, *mediators*, intervention *activities*, etc. Theoretical models are usually based on existing research and theory relating to drug use, health promotion, or human behaviour and development in general. Examples of such theories include cognitive dissonance theory, social learning theory, normative models. The theoretical model is also known as theory, theoretical framework, theory of change. **Standard 3.2: *Using a theoretical model***

Tiered prevention	A prevention approach that gradually progresses from general to more specialised *interventions*. For example, a tiered *drug prevention programme* may start with a *universal prevention* intervention (e.g. drug education in the classroom). During this intervention, individuals with an above-average risk of (harmful) *drug use* may be identified and referred on to take part in an *indicated prevention* intervention (e.g. specialised after-school *activity*).
Tool	see *Evaluation tool*
Universal prevention	In the context of *drug prevention*, *activities* that are targeted at groups with an overall average risk of *drug use* (adapted from Springer and Phillips, 2007). Often, such *interventions* will address the entire population within a *setting* (e.g. school, *community*, society). Universal prevention typically aims to prevent or delay the onset of drug use. Individuals or groups with an above-average risk of drug use are not singled out (see *Risk factor; Targeted prevention*).
Validity	An *indicator* for the quality of a *data collection instrument*. An instrument is valid if it actually measures what it is intended to measure. Other indicators of instrument quality are *objectivity* and *reliability*.
Young people	In the Standards, anyone under the age of 18 years, including children. Different age ranges may apply where suggested by local, regional, national, or international customs, laws, and policies; or where it is more appropriate for the *target population*, *setting*, *intervention*, etc.

Glossaries

EMCDDA European Monitoring Centre for Drugs and Drug Addiction (2011), *EMCDDA online glossary.*
http://www.emcdda.europa.eu/publications/glossary

North East Public Health Observatory (2008), *Public Health Language. Version 2.0.*
http://www.nphl.nhs.uk/

Prevention by Design (2009), *Prevention Science Terminology*. Community Prevention Planning Program at the Institute for the Study of Social Change, University of California at Berkeley.
http://socrates.berkeley.edu/~pbd/glossary.html

Skills for Health (2009), *Glossary of Terms for use within competences.*
http://www.skillsforhealth.org.uk/~/media/Resource-Library/PDF/glossary09.ashx (accessed 01.06.2010)

Smith, B.J., Tang, K.C. and Nutbeam, D. (2006), WHO Health Promotion Glossary: new terms. *Health Promotion International*, 21 (4), pp. 340–345.

UNODCCP United Nations Office for Drug Control and Crime Prevention (2000), *Demand Reduction. A Glossary of Terms*. New York, United Nations.
http://www.unodc.org/pdf/report_2000-11-30_1.pdf

WHO World Health Organization (1994), *Lexicon of alcohol and drug terms*. Geneva: WHO.
http://www.who.int/substance_abuse/terminology/who_lexicon/en/

WHO World Health Organization (1998), *Health Promotion Glossary.* WHO/HPR/HEP/98.1. Geneva, WHO.
http://www.who.int/hpr/NPH/docs/hp_glossary_en.pdf

Bibliographical references

All web pages were last accessed on 11.04.2011 unless otherwise stated.

Brotherhood, A., Sumnall, H.R. and the Prevention Standards Partnership (2011), *European drug prevention quality standards: Final project report.* Liverpool, Centre for Public Health.

CCSA Canadian Centre on Substance Abuse (2009), *Building on Our Strengths: Canadian Standards for School-based Youth Substance Abuse Prevention: A guide for education and health personnel (Version 1.0).* Ottawa, ON, CCSA.
http://www.ccsa.ca/2009%20CCSA%20Documents/ccsa0117812009_e.pdf

Coggans, N. (2006), 'Drug education and prevention: has progress been made?', *Drugs: Education, Prevention and Policy,* 13 (5), pp. 417–422.

CSAP Center for Substance Abuse Prevention (2002), *Comparison Matrix of Science-Based Prevention Programs: A Consumer's Guide for Prevention Professionals (Conference Edition).* Rockville, MD., CSAP.
http://www.eric.ed.gov/PDFS/ED469592.pdf

EMCDDA European Monitoring Centre for Drugs and Drug Addiction (1998), *Evaluating Drug Prevention in the European Union*, EMCDDA Scientific Monograph Series No 2. Luxembourg, Office for Official Publications of the European Communities.
http://www.emcdda.europa.eu/attachements.cfm/att_44761_EN_Monograph2.pdf

EMCDDA European Monitoring Centre for Drugs and Drug Addiction (2009), *Preventing later substance use disorders in at-risk children and adolescents: a review of the theory and evidence base of indicated prevention*, EMCDDA Thematic papers, Luxembourg, Office for Official Publications of the European Communities.
http://www.emcdda.europa.eu/publications/thematic-papers/indicated-prevention

EMCDDA European Monitoring Centre for Drugs and Drug Addiction (2010), *Prevention and Evaluation Resources Kit (PERK). A manual for prevention professionals*. Luxembourg, Publications Office of the European Union.
http://www.emcdda.europa.eu/attachements.cfm/att_105843_EN_Manual4PERK.pdf

EMCDDA European Monitoring Centre for Drugs and Drug Addiction (2011), *EMCDDA online glossary.* http://www.emcdda.europa.eu/publications/glossary

European Commission (2010), *Communicating research for evidence-based policymaking: A practical guide for researchers in socio-economic sciences and humanities (EUR 24230).* Luxembourg, Publications Office of the European Union. http://ec.europa.eu/research/social-sciences/pdf/guide-communicating-research_en.pdf

European Council (2004), 'EU drugs strategy (2005–2012)', 15074/04. http://www.emcdda.europa.eu/attachements.cfm/att_10375_EN_EU%20Drugs%20Strategy_EN.pdf

European Council (2005), 'EU drugs action plan (2005–2008)', *Official Journal of the European Union*, 2005/C 168/01, 8.7.2005. http://www.emcdda.europa.eu/html.cfm/index10360EN.html

European Council (2008), 'EU drugs action plan for 2009–2012', *Official Journal of the European Union*, 2008/C 326/09, 20.12.2008. http://www.emcdda.europa.eu/html.cfm/index66221EN.html

Evans, D. (2003), 'Hierarchy of evidence: a framework for ranking evidence evaluating healthcare interventions', *Journal of Clinical Nursing* 12, pp. 77–84.

Department of Health (2007), *You're Welcome quality criteria: Making health services young people friendly*. Gateway Ref: 7972. London: DH. http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_073829.pdf (accessed 06.06.2009) http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_073586

Faggiano, F., Vigna-Taglianti, F., Burkhart, G. et al. (2010), 'The effectiveness of a school-based substance abuse prevention program: 18-Month follow-up of the EU-Dap cluster randomized controlled trial', *Drug and Alcohol Dependence*, 108 (1–2), pp. 56–64. http://www.sciencedirect.com/science/article/B6T63-4Y648DM-1/2/a33c4c53bc9065aea7bcf0489e259b46

Flay, B.R., Biglan, A., Boruch, R. F. et al. (2005), 'Standards of Evidence: Criteria for Efficacy, Effectiveness and Dissemination', *Prevention Science*, 6 (3), pp. 151–175. http://www.preventionresearch.org/StandardsofEvidencebook.pdf

French, M. (2004), *Drug Abuse Treatment Cost Analysis Program (DATCAP)*. University of Miami.

http://www.datcap.com/

Gorman, D.M., Conde, E. and Huber, J.C. (2007), 'The creation of evidence in "evidence-based" drug prevention: a critique of the strengthening families program plus life skills training evaluation', *Drug and Alcohol Review*, 26, pp. 585–93.

Kling, A., Forster, M., Sundell, K. and Melin, L. (2010), 'A Randomized Controlled Effectiveness Trial of Parent Management Training With Varying Degrees of Therapist Support', *Behavior Therapy*, 41 (4), pp. 530–542.

http://www.sciencedirect.com/science/article/B7XMW-514R6H6-3/2/17522cc84879451a13b7dbeb25e052be

Lammers, J., Goossens, F., Lokman, S. et al. (2011), 'Evaluating a selective prevention programme for binge drinking among young adolescents: study protocol of a randomized controlled trial', *BMC Public Health* 11, p. 126.

http://www.biomedcentral.com/content/pdf/1471-2458-11-126.pdf

Miller, T. and Hendrie, D. (2009), *Substance Abuse Prevention Dollars and Cents: A Cost-Benefit Analysis, DHHS Pub. No (SMA) 07-4298*. Rockville, MD, Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration.

http://store.samhsa.gov/shin/content//SMA07-4298/SMA07-4298.pdf

Kellam, S.G. and Langevin D.J. (2003), A Framework for Understanding 'Evidence' in Prevention Research and Programs, *Prevention Science*, 4 (3), pp. 137–153.

Moos, R. H. (2005), 'Horizons Review Iatrogenic effects of psychosocial interventions for substance use disorders: prevalence, predictors, prevention', *Addiction*, 100 (5), pp. 595–604.

MRC Medical Research Council (2008), *Developing and evaluating complex interventions: new guidance*.

http://www.mrc.ac.uk/complexinterventionsguidance

Mrazek, P.J. and Haggerty, R.J. (eds.) (1994), *Reducing risks for mental disorders: Frontiers for preventive intervention research*, Washington DC, Institute of Medicine, National Academy Press.

NICE National Institute for Health and Clinical Excellence (2006), *Community-based interventions to reduce substance misuse among vulnerable and disadvantaged children and young people*. London, NICE.

NICE National Institute for Health and Clinical Excellence (2009), *Methods for the development of NICE public health guidance (second edition)*. London, NICE.
http://www.nice.org.uk/media/2FB/53/PHMethodsManual110509.pdf

NIDA National Institute on Drug Abuse (2003), *Preventing Drug Use among Children and Adolescents. A Research-Based Guide for Parents, Educators, and Community Leaders (second edition)*. Bethesda, Maryland, U.S. Department of Health and Human Services, National Institutes of Health.
http://www.drugabuse.gov/pdf/prevention/RedBook.pdf

OCEBM Oxford Centre for Evidence-based Medicine (2009), *Levels of Evidence.*
http://www.cebm.net/index.aspx?o=4590

Petrie, J., Bunn, F. and Byrne, G. (2007), 'Parenting programmes for preventing tobacco, alcohol or drugs misuse in children <18: a systematic review', *Health Education Research*, 22 (2), pp. 177–191.

Pilling, S., Hesketh, K. and Mitcheson, L. (2010), *Routes to Recovery: Psychosocial Interventions for Drug Misuse. A framework and toolkit for implementing NICE-recommended treatment interventions*, London, National Treatment Agency for Substance Misuse.
http://www.nta.nhs.uk/uploads/psychosocial_toolkit_june10.pdf

Plested, B., Smitham, D. M., Jumper-Thurman, P., Oetting, E. R. and Edwards, R. W. (1999), 'Readiness for Drug Use Prevention in Rural Minority Communities', *Substance Use and Misuse*, 34 (4–5), pp. 521–544.

Springer, J.F. and Phillips, J.L. (2007), 'The Institute of Medicine framework and its implication for the advancement of prevention policy, programs and practice', *Prevention Policy Paper Series*, EMT Associates, Inc, Folsom, CA.
http://www.ca-cpi.org/document_archives/iomarticle3-14-07fs.pdf (accessed 21.07.2009)

Sumnall, H.R., Brotherhood, A. and the Prevention Standards Partnership (2011), *European drug prevention quality standards: Evidence into Practice,* Liverpool, Centre for Public Health.

Sussman, S., Earleywine, M., Wills, T., et al. (2004), 'The Motivation, Skills, and Decision-Making Model of Drug Abuse Prevention', *Substance Use and Misuse,* 39 (10), pp. 1971–2016.

Toumbourou, J. W., Stockwell, T., Neighbors, C., Marlatt, G. A., Sturge, J. and Rehm, J. (2007), 'Interventions to reduce harm associated with adolescent substance use', *The Lancet*, 369 (9570), pp. 1391–1401.

Trimbos-instituut (2010), *Handbook Healthy Nightlife Toolbox: How to create a healthy & safe nightlife*. Utrecht, Trimbos-instituut.
http://www.hnt-info.eu/File/handbook_section.aspx?id=1

Uhl, A., Ives, R. and Members of the Pompidou Group Prevention Platform (2010), *Evaluation of Drug Prevention Activities: Theory and Practice*. P-PG/Prev(2010)6. Strasbourg Cedex, Council of Europe.
https://wcd.coe.int/wcd/com.instranet.InstraServlet?Index=no&command=com.instranet.CmdBlobGet&InstranetImage=1702660&SecMode=1&DocId=1657600&Usage=2

UKDPC UK Drug Policy Commission (2008), *Working towards recovery. Getting problem drug users into jobs*. London: The UK Drug Policy Commission.
http://www.ukdpc.org.uk/reports.shtml

United Nations General Assembly (1998), *Declaration on the Guiding Principles of Drug Demand Reduction*. A/RES/S-20/3, Annex.
http://www.un.org/documents/ga/res/20sp/a20spr03.htm

UNODC United Nations Office on Drug and Crime (2004), *Drug abuse prevention among youth from ethnic and indigenous minorities*. New York, United Nations.
http://www.unodc.org/pdf/youthnet/handbook_ethnic_english.pdf

UNODC United Nations Office on Drug and Crime (2009a), *Guide to implementing family skills training programmes for drug abuse prevention*. New York, United Nations.
http://www.unodc.org/unodc/en/prevention/familyskillstraining.html

UNODC United Nations Office on Drugs and Crime (2009b), *Political Declaration and Plan of Action on International Cooperation towards an Integrated and Balanced Strategy to Counter the World Drug Problem*, Adopted at the high-level segment Commission on Narcotic Drugs, Vienna, 11–12 March 2009, New York, United Nations.
http://www.unodc.org/documents/commissions/CND-Uploads/CND-52-RelatedFiles/V0984963-English.pdf

UNODCCP United Nations Office for Drug Control and Crime Prevention (2000), *Demand Reduction, A Glossary of Terms*, New York, United Nations.
http://www.unodc.org/pdf/report_2000-11-30_1.pdf

Werch, C. E. and Owen, D. M. (2002), 'Iatrogenic Effects of Alcohol and Drug Prevention Programs', *Journal of Studies on Alcohol*, 63, pp. 581–590.

WHO World Health Organization (1998), *Health Promotion Glossary*, WHO/HPR/HEP/98.1. Geneva: WHO.
http://www.who.int/hpr/NPH/docs/hp_glossary_en.pdf

Zonnevylle-Bender, M. J. S., Matthys, W., van de Wiel, N. M. H. and Lochman, J. E. (2007), 'Preventive effects of treatment of disruptive behavior disorder in middle childhood on substance use and delinquent behavior', *Journal of the American Academy of Child and Adolescent Psychiatry,* 46 (1), pp. 33–39.

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