European Monitoring Centre
for Drugs and Drug Addiction

European
drug prevention
quality standards

European drug prevention quality standards: a quick guide

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Foreword by the EMCDDA

This 'quick guide' version of the European drug prevention quality standards was prepared by Angelina Brotherhood and Harry R. Sumnall and was financed by the EMCDDA as part of its project: 'Preparation of IPA beneficiaries for their participation in the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA)', Project No 2011/280–057, funded by the European Commission's Instrument for Pre-Accession Assistance (IPA). It is based on an EMCDDA manual on the topic published in 2011.

The aim of the guide is to make practical information on prevention quality standards available outside the European Union. It includes a description of the eight stages involved in the drug prevention cycle, along with a self-reflection checklist that can be used when planning and implementing prevention activities. It has been designed for practitioners and those working in the field.

This product will be available online, initially in English and then in other languages, as the EMCDDA's technical cooperation projects develop.

We would like to take this opportunity to thank Angelina Brotherhood and Harry R. Sumnall for their contribution to the present publication.

Introduction

About the quality standards

The *European drug prevention quality standards*, published as Manual No 7 by the European Monitoring Centre on Drugs and Drug Addiction (EMCDDA) ([1]), provide the first European framework on how to conduct high quality drug prevention. The standards highlight the following aspects of quality in prevention work:

- relevance of activities to target populations and (inter)governmental policies
- adherence to accepted ethical principles
- integration and promotion of the scientific evidence base, as well as
- internal coherence, project feasibility and sustainability.

The standards contained in the manual were developed during a two-year project with co-funding from the European Union under the Programme of Community Action in the field of Public Health (2003–08) (Project No 2007304). The project was carried out by the Prevention Standards Partnership, a multi-disciplinary and multi-sectoral collaboration of seven organisations across Europe, led by the Centre for Public Health at Liverpool John Moores University, UK ([2]). The EMCDDA supported the Partnership throughout the development process and has also funded the publication of the standards as a manual as well as the production of this quick guide.

At the start of the project, guidance on how to plan and deliver effective drug prevention was available only in some Member States of the European Union (EU). Available guidance varied in terms of its quality, content and applicability, and a common European framework for quality in drug prevention was missing. Thus, the quality of drug prevention services would often rely upon the discretion of individual service providers and local authorities. The project therefore aimed to improve European drug prevention policy and practice by developing a common reference framework for drug prevention activities.

To develop the standards, available European and international drug prevention guidance was collated and reviewed. At this stage, a distinction was made between guidance focussing on the content of interventions (the 'what') and guidance focussing on formal aspects of prevention work (the 'how'). The Partnership chose to focus on guidance on 'how' to do prevention ([3]). Nineteen sets of quality standards matching specific selection criteria were synthesised through qualitative content analysis to form a first draft. In the next stage, the relevance, usefulness, and feasibility of these draft standards was assessed through online surveys and focus groups in six EU countries. Over 400 delegates from different professional groups gave feedback on the content of the draft standards and highlighted barriers to implementation. Based on these consultations, the Partnership revised and finalised the standards and produced the self-reflection checklist presented in this quick guide. Further information on the development of the standards can be found in the EMCDDA manual.

Following completion of the project, the European drug prevention quality standards were also adapted to form the prevention strand in a study on the development of an EU Framework for minimum quality standards and benchmarks in drug demand reduction (EQUS) ([4]).

([1]) Brotherhood, A., Sumnall H., R. and the Prevention Standards Partnership (2011), *European drug prevention quality standards: a manual for prevention professionals*, EMCDDA Manuals No 7, Luxembourg. Publications Office of the European Union.

([2]) The partner organisations were: ASL di Milano (Italy), Consejeria de Sanidad – Servicio Gallego de Salud (Xunta de Galicia) (CS–SERGAS) (Spain), Azienda Sanitaria Locale n. 2 – Savonese (ASL2) (Italy), Institute for Social Policy and Labour – National Institute for Drug Prevention (SZMI-NDI) (Hungary), National Anti-Drug Agency (NAA) (Romania), and National Bureau for Drug Prevention (NBDP) (Poland). Please see the manual for names of individual contributors.

([3]) Standards focussing on 'what' to do in prevention have been published by the United Nations Office on Drugs and Crime (UNODC), see the *International Standards on Drug Use Prevention* at http://www.unodc.org/unodc/en/prevention/prevention-standards.html

([4]) The EQUS project was led by the Research Institute for Public Health and Addiction at the University of Zurich and was also co-funded by the European Union. Further information can be found at http://www.isgf.ch/index.php?id=59&uid=41

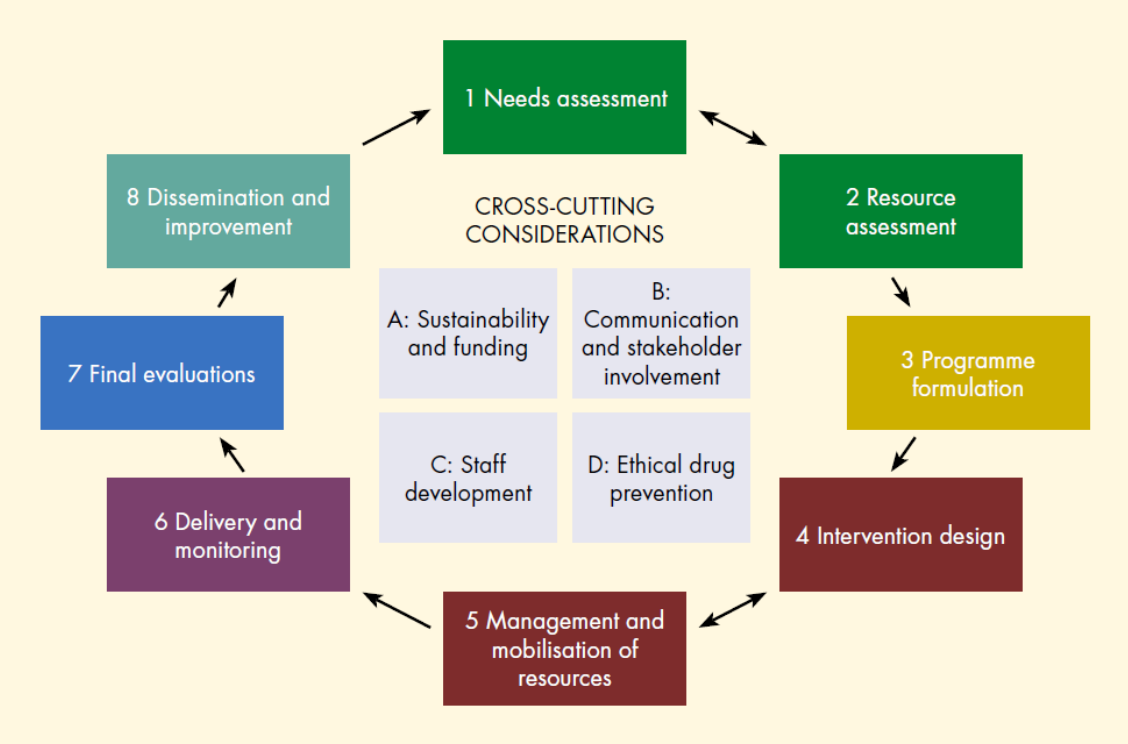
The availability of an agreed framework that is adaptable to local circumstances should provide an incentive for EU Member States and other countries to develop quality standards where these did not previously exist (or to review and update existing quality standards), and to adopt these quality standards for their own use. Adoption of the standards will improve drug prevention practice and efficiency and effectiveness of commissioning, and reduce the likelihood of implementation of interventions with no or iatrogenic (i.e. negative) effects. Thus, the standards will support prevention professionals in the development and promotion of best practice, and will allow them to demonstrate success in reaching specific objectives of local, regional, national and international drug strategies and policies.

The manual containing all standards is available for free from the EMCDDA: http://www.emcdda.europa.eu/publications/manuals/prevention-standards

Find out more about the quality standards, contact the Prevention Standards Partnership and access supporting materials at: http://www.prevention-standards.eu

The project cycle – three levels of detail

Figure 1: The drug prevention project cycle



The standards are organised chronologically in a project cycle. The project cycle was found to represent the best means of structuring the standards, based on the review of existing standards and the consultations with drug prevention professionals.

The project cycle contains eight stages: needs assessment; resource assessment; programme formulation; intervention design; management and mobilisation of resources; delivery and monitoring; final evaluations; and dissemination and improvement. In addition, cross-cutting considerations in the centre of the project cycle highlight aspects which are relevant to every project stage, namely: sustainability and funding; communication and stakeholder involvement; staff development; and ethical drug prevention (see Figure 1).

The cycle provides a template that professionals can *adopt* when planning and implementing prevention activities. However, it is also a simplified model of drug prevention work which

professionals should carefully *adapt* to the particular circumstances of their prevention work. For example, if an activity is already in the implementation phase, then the later project stages will be more relevant than the earlier project stages on programme planning.

Each project stage is divided into several components which outline what actions to take. In total, there are 31 components across all project stages and 4 components within the cross-cutting considerations (see Table 1). In the manual, each component contains an introductory text which outlines why this component was included in the standards and what considerations should be taken into account during implementation. The numbering of components does not necessarily indicate priority or chronological order.

Attributes constitute the third level within the standards, defining each component in greater detail. At this level, basic and expert standards are distinguished to account for the variety of prevention work and the different capacities of organisations. Only the basic standards are summarised in this document but all standards can be found in the full manual.

Table 1: 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 programme 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

Using the quality standards manual

This quick guide is a summary of the quality standards manual which can be accessed via the website indicated in the box on page 5. In the manual, quality standards are understood as benchmarks that help prevention professionals judge whether an activity, a provider, etc. represents high quality. The standards manual encourages practitioners and other professionals working in the prevention field to think about how existing activities relate to the standards and how they can be improved using the standards in order to obtain (even) better and more sustainable results.

The manual provides detailed guidance on how the standards should and should not be used. Briefly, professionals will benefit the most from the standards manual if they use it:

- for information, education and guidance (e.g. university courses, supervision)
- for self-reflection or discussion in group settings (e.g. by practitioners who are in (direct) contact with the target population, by service managers or regional planning teams)
- as a checklist during service development or evaluation (e.g. for programme developers, evaluators)
- for developing or updating quality criteria (e.g. policymakers, funders)
- for performance appraisals (e.g. to identify professional development needs).

The standards are intended for 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. young people, families, ethnic groups). Drug prevention activities targeted by these standards may focus on legal substances, such as alcohol or tobacco, and/or illegal substances.

In recognition of this diversity within prevention work, the full standards offer two different levels: 'basic' and 'expert'. Basic standards should be applicable to all drug prevention work, regardless of its particular circumstances. Expert standards represent a higher level of quality; however, they may not always be applicable and users of the standards will have to determine whether they are relevant, useful and feasible with regard to the particular prevention activity. For simplicity, the present quick guide refers to the basic standards only.

Although the focus of the standards is on interventions, they can also help professionals appreciate how people, organisations, policies and (governmental) strategies contribute to drug prevention. In fact, some standards can only be achieved by considering and improving the practical and strategic context within which interventions are embedded. For example, priorities and strategies set out by government and funding bodies must promote good practice in prevention.

Based on the consultations undertaken to develop the standards, the manual is less appropriate for certain purposes. Using the quality standards cannot replace process and outcome evaluations. Although the standards can help achieve better evaluation results, evaluations are still required to understand whether and how interventions work. As presented in the manual, the standards are also less suitable for formal self-assessment, structured training, external accreditation or funding decisions. However, a follow-up project entitled 'Promoting Excellence in Drug Prevention in the EU — Phase 2 of the European Drug Prevention Quality Standards Project' is taking place from April 2013 to March 2015 to make the standards more suitable for these particular purposes. It will also explore how the standards can improve prevention activities in the 'real world' and how achievement of the standards can be formally evidenced. As part of this follow-up project, examples of how the standards are being used in Europe and abroad, as well as toolkits to support standards implementation, will be published on www.prevention-standards.eu.

Using this quick guide and the checklists

This quick guide is aimed at:

- professionals who are not yet familiar with the concept of quality standards in prevention and who wish to find out more about this topic
- professionals who need more information about the standards in order to decide whether the manual could usefully support their work
- professionals who wish to take a first step in conducting self-reflection using the standards.

In terms of professional groups, policymakers and commissioners at national, regional and local levels as well as service managers will find this document particularly useful.

Although the manual has already been translated into several languages (see the EMCDDA website for details), the present document is also intended to facilitate introduction of the standards in countries where translations of the full manual are not yet available.

This document does not replace the existing manual. Instead, this quick guide summarises the content of the manual and encourages professionals to start using the standards for self-reflection. Several important differences between the manual and this quick guide exist. Most importantly, the manual lists the actual standards, distinguishing between basic and expert level standards. The present document does not contain the actual standards — it provides only a summary of the basic standards. In addition, the manual contains a detailed introduction, further information on how to use the standards, a comprehensive glossary, as well as the list of original documents upon which the standards are based. This information is necessary for a good understanding of the context and meaning of the standards.

Where possible, users of the quick guide should consult the full manual to obtain a better understanding of the standards. Additional materials are also available electronically on the EMCDDA website and the project website (see links in box on page 5).

Due to the limited detail provided in this document and its focus on general information and initial self-reflection, the quick guide is less suitable for other purposes (e.g. development of quality criteria). Professionals interested in using the standards for such purposes should refer to the full manual only.

In the next part of the guide, all project stages and components of the standards are briefly introduced, highlighting why they are important and beneficial to prevention professionals and target populations. The basic standards are summarised in the form of self-reflection checklists, which also provide users with a dedicated space to reflect on their work in relation to each component. The tables in the checklists consist of five columns: summary of the basic standards; three checkboxes to determine the extent to which the standards are currently met; a checkbox 'Not applicable'; a space for making notes on the current position; and a space for recording necessary follow-up actions. At the end of the quick guide, a summary page encourages readers to record the main findings and actions emerging from completing the checklists.

The table 'How to fill in the checklists' shows the sections of the checklists and how they can be completed.

The purpose of the checklists is to facilitate initial self-reflection, i.e. to determine one's own position in relation to the standards and to identify areas for improvement. The precise nature of this exercise will depend on the particular circumstances of the programme or organisation ('What do I/we *want* to achieve?') and on what is realistic ('What *can* I/we actually achieve?'). In the manual, some standards contain examples of how achievement can be evidenced in practice; this can help professionals judge whether standards are met. The follow-up project being implemented from April 2013 to March 2015 will also provide specific indicators for evidencing achievement of the standards. Sources of evidence may include written evidence, for example the project plan or descriptions of the organisation (e.g. on the company/service website), direct observations of work procedures or programme implementation, or conversations with staff members, participants, and/or other stakeholders. However, the checklists do not require users of this document to formally evidence achievement of the standards. Professionals interested in conducting formal self-assessment using the standards will benefit from the toolkits which are being developed as part of the follow-up project (www.prevention-standards.eu).

How to fill in the checklists

Basic standards (summary):	Not met	Partially met	Fully met	Not applicable	Notes on current position	Actions to take
This section contains the titles of the components and *summarises* the *basic* standards contained within each component. While considering each component, users should consult the full version of the standards to find out about the relating basic and expert standards in detail. This will help them to reflect on and determine their position.	This part of the checklist enables users to rate their work (e.g. professional development, activity, organisation, strategy, etc.) in relation to the standards by ticking the category 'Not met', 'Partially met', or 'Fully met'. Positioning their own work along this scale will help professionals to identify areas for improvement and to track progress over time. Generally speaking, the category 'Not met' should be chosen if none or very few standards are met, the category 'Partially met' should be chosen if all or most basic standards are met, and the category 'Fully met' should be ticked if all basic *and* all or most expert standards are met, although this will also depend on the particular circumstances of the programme or organisation.			The option 'Not applicable' should only be ticked if required and after thorough consideration of the standards' relevance. Users should beware of choosing this option too easily, acknowledging instead that perhaps the standard *is* applicable but not currently feasible. If choosing the option 'Not applicable', a brief comment in the column 'Notes on current position' should be provided, clarifying why the component was not (currently) considered applicable.	This column allows users to comment on their rating. It gives an opportunity to describe what standards have been achieved already and to provide the evidence to support the rating (by referring to tangible pieces of evidence where possible). This is a chance to make explicit the good work that is already being done. Users should also use this space to point out weaknesses and areas for improvement (e.g. what standards have not yet been met and why).	Actions and changes required to improve current efforts should be outlined in this column. This could include, for example, the need to review the project plan or the need for additional staff training. Actions and changes should be realistic in order to make the reflection practically relevant: 'What actions and changes can I/we take now (or in the foreseeable future) to improve my/our drug prevention efforts?'. However, it may also be useful to note long-term actions and aims that can be tackled at a later point in time (e.g. following the next review). In order to make actions more specific, it can be helpful to think about and note: *when* these changes will happen; *who* will be involved; and what *resources* will be required.

Please refer to the full list of basic and expert standards in the EMCDDA manual when conducting your self-reflection, see:
http://www.emcdda.europa.eu/publications/manuals/prevention-standards

The standards and checklists

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 far 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. Although professional competencies as such are not a focus of the standards, the standards can facilitate the development of training plans by outlining the types of professional competencies that staff members should have ([5]). 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
Drug prevention activities may not require physical or clinical intervention, but they represent a form of intervention in people's lives nevertheless. Moreover, prevention is typically targeted at young people, and in the case of selective and indicated prevention these young people can be among the most vulnerable in society. Professionals should not assume that drug prevention activities are per definition ethical and beneficial for participants. 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 at every project stage. Consequently, protocols are developed to protect participants' rights, and potential risks are assessed and mitigated.

([5]) For an example resource dedicated to this topic see the 'Competencies for Canada's Substance Abuse Workforce' developed by the Canadian Centre on Substance Abuse (CCSA), available at www.ccsa.ca/eng/priorities/workforce/competencies/

Cross-cutting considerations

Basic standards (summary):	Not met	Partially met	Fully met	Not applicable	Notes on current position	Actions to take
A: Sustainability and funding: The programme promotes a long-term view on drug prevention and is not a fragmented short-term initiative. The programme is coherent in its logic and practical approach. The programme seeks funding from different sources.	☐	☐	☐	☐		
B: Communication and stakeholder involvement: The multi-service nature of drug prevention is considered. All stakeholders relevant to the programme (e.g. target population, other agencies) are identified, and they are involved as required for a successful programme implementation. The organisation cooperates with other agencies and institutions.	☐	☐	☐	☐		

Please refer to the full list of basic and expert standards in the EMCDDA manual when conducting your self-reflection, see **http://www.emcdda.europa.eu/publications/manuals/prevention-standards**

Cross-cutting considerations (cont.)

Basic standards (summary):	Not met	Partially met	Fully met	Not applicable	Notes on current position	Actions to take
C: Staff development: It is ensured prior to the implementation that staff members have the competencies which are required for a successful programme implementation. If necessary, high quality training based on a training needs analysis is provided. During implementation, staff members are supported in their work as appropriate.	☐	☐	☐	☐		
D: Ethical drug prevention: A code of ethics is defined. Participants' rights are protected. The programme has clear benefits for participants, and will not cause them any harm. Participant data is treated confidentially. The physical safety of participants and staff members is protected.	☐	☐	☐	☐		

Please refer to the full list of basic and expert standards in the EMCDDA manual when conducting your self-reflection, see **http://www.emcdda.europa.eu/publications/manuals/prevention-standards**

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. Where programmes address needs that are not current policy priorities, programmes should still support the wider drug prevention agenda as defined by national or international strategies. 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. It is 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. The assessment can utilise quantitative and/or qualitative methods, and should draw upon existing (epidemiological) data where relevant data of high quality is already available (e.g. from national drugs observatories). Other relevant issues, such as deprivation and inequalities, should also be assessed to account for the relationship between drug use and other needs. One needs assessment may inform several different activities across a defined time span, although it is important to ensure that the data is up-to-date. Regional drugs coordination teams can have an important role to play in the achievement of these standards.

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. The justification should take into account the views of the community to ensure that the programme is relevant to them. A focus on 'needs' rather than 'problems' can help engage stakeholders who may otherwise feel stigmatised. Existing drug prevention programmes are also analysed at this point 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. Where appropriate, the intermediate target population which will receive the intervention but is not in itself at risk of drug use (e.g., parents, teachers) may need to be considered in addition to the ultimate target population (e.g., young people at risk of drug use).

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

1. Needs assessment

Basic standards (summary):	Not met	Partially met	Fully met	Not applicable	Notes on current position	Actions to take
1.1 Knowing drug-related policy and legislation: The knowledge of drug-related policy and legislation is sufficient for the implementation of the programme. The programme supports the objectives of local, regional, national, and/or international priorities, strategies, and policies.	☐	☐	☐	☐		
1.2 Assessing drug use and community needs: The needs of the community (or environment in which the programme will be delivered) are assessed. Detailed and diverse information on drug use is gathered. The study utilises existing epidemiological knowledge as possible, and adheres to principles of ethical research.	☐	☐	☐	☐		

Please refer to the full list of basic and expert standards in the EMCDDA manual when conducting your self-reflection, see:
http://www.emcdda.europa.eu/publications/manuals/prevention-standards

1. Needs assessment (cont.)

Basic standards (summary):	Not met	Partially met	Fully met	Not applicable	Notes on current position	Actions to take
1.3 Describing the need — Justifying the intervention: The need for an intervention is justified. The main needs are described based on the needs assessment, and the potential future development of the situation without an intervention is indicated. Gaps in current service provision are identified.	☐	☐	☐	☐		
1.4 Understanding the target population: A potential target population is chosen in line with the needs assessment. The needs assessment considers the target population's culture and its perspectives on drug use.	☐	☐	☐	☐		

Please refer to the full list of basic and expert standards in the EMCDDA manual when conducting your self-reflection, see:
http://www.emcdda.europa.eu/publications/manuals/prevention-standards

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 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 to and support for the programme, 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. As the purpose of the assessment is to inform programme planning, it does not have to be a 'formal' assessment carried out by an external organisation but could, for example, consist of an informal discussion between staff members to identify organisational strengths and weaknesses in terms of resources.

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 . Resource assessment

Basic standards (summary):	Not met	Partially met	Fully met	Not applicable	Notes on current position	Actions to take
2.1 Assessing target population and community resources: Sources of opposition to, and support of, the programme are considered, as well as ways of increasing the level of support. The ability of the target population and other relevant stakeholders to participate in the programme is assessed.	☐	☐	☐	☐		
2.2 Assessing internal capacities: Internal resources and capacities are assessed (e.g. human, technological, financial resources). The assessment takes into account their current availability as well as their likely future availability for the programme.	☐	☐	☐	☐		

Please refer to the full list of basic and expert standards in the EMCDDA Manual when conducting your self-reflection, see:
http://www.emcdda.europa.eu/publications/manuals/prevention-standards

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. For example, an important consideration is whether the target population can be reached within the realities 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 (such as intentions and beliefs that influence drug use) 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 interconnected aims, goals, and objectives. Aims describe the programme's long-term direction, general idea, purpose, or intention. They may or may not be achievable within the specific intervention but provide a strategic direction for activities. Goals are clear statements on the programme's outcome for participants (in terms of behaviour change) at the completion of the intervention. Objectives describe the immediate or intermediate behaviour 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.

Page 120 of the manual in English contains a figure illustrating the connection between aims, goals and objectives, and provides further information on the difference between specific objectives (focussing on behaviour change) and operational objectives (focussing on activities).

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 scientific evidence base on effective drug prevention should be consulted, and the findings relevant to the programme highlighted. The scientific evidence must be integrated with the professional experience of practitioners to design an intervention that is relevant to the specific programme context. Where scientific evidence of effectiveness is not available, professional experiences and stakeholder expertise may be described instead. However, the limitations of these forms of knowledge compared to robust research evidence should be carefully considered (e.g. generalisability).

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

3. Programme formulation

Basic standards (summary):	Not met	Partially met	Fully met	Not applicable	Notes on current position	Actions to take
3.1 Defining the target population: The target population(s) of the programme is (are) described. The chosen target population(s) can be reached.	☐	☐	☐	☐		
3.2 Using a theoretical model: The programme is based on an evidence-based theoretical model that allows an understanding of the specific drug-related needs and shows how the behaviour of the target population can be changed.	☐	☐	☐	☐		
3.3 Defining aims, goals, and objectives: It is clear what is being 'prevented' (e.g. what types of drug use?). The programme's aims, goals, and objectives are clear, logically linked, and informed by the identified needs. They are ethical and 'useful' for the target population. Goals and objectives are specific and realistic.	☐	☐	☐	☐		

Please refer to the full list of basic and expert standards in the EMCDDA manual when conducting your self-reflection, see:
http://www.emcdda.europa.eu/publications/manuals/prevention-standards

3. Programme formulation (cont.)

Basic standards (summary):	Not met	Partially met	Fully met	Not applicable	Notes on current position	Actions to take
3.4 Defining the setting: The setting(s) for the activities is (are) described. It matches the aims, goals, and objectives, available resources, and is likely to produce the desired change. Necessary collaborations for implementation of the programme in this setting are identified.	☐	☐	☐	☐		
3.5 Referring to evidence of effectiveness: Scientific literature reviews and/or essential publications on the issues relating to the programme are consulted. The reviewed information is of high quality and relevant to the programme. The main findings are used to inform the programme.	☐	☐	☐	☐		
3.6 Determining the timeline: The timeline of the programme is realistic, and it is illustrated clearly and coherently. Timing, duration, and frequency of activities are adequate for the programme.	☐	☐	☐	☐		

Please refer to the full list of basic and expert standards in the EMCDDA manual when conducting your self-reflection, see:
http://www.emcdda.europa.eu/publications/manuals/prevention-standards

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. Consulting a variety of sources on previously implemented programmes can help avoid pursuing activities that have already been shown to be ineffective or to have iatrogenic effects.

The United Nations Office on Drugs and Crime (UNODC) has published *International Standards on Drug Use Prevention*. The standards describe interventions and policies that have been found to produce positive drug prevention outcomes in children, adolescents and adults. They can be found at: http://www.unodc.org/unodc/en/prevention/prevention-standards.html

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, including whether it is relevant to the particular circumstances of the programme and (in the case of programmes not free of charge) whether it is affordable. The intervention is then adapted to match the specific situation of the programme. 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.

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. An essential staff competency in this regard is cultural sensitivity, i.e. the willingness and ability of staff members to understand the importance of (different types 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. 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. Outcome evaluation is a means to assessing whether goals and objectives were achieved, whereas process evaluation is a means of understanding how they were achieved or, in some cases, not achieved. 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.

The manual provides further detail on process and outcome evaluations, data collection considerations and how to formulate evaluation indicators and benchmarks based on the specified goals and objectives. See also the standards in project stage 7: Final evaluations.

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

4. Intervention design

Basic standards (summary):	Not met	Partially met	Fully met	Not applicable	Notes on current position	Actions to take
4.1 Designing for quality and effectiveness: The intervention follows evidence-based good practice recommendations; the scientific approach is outlined. The programme builds on positive relationships with participants by acknowledging their experiences and respecting diversity. Programme completion is defined.	☐	☐	☐	☐		
4.2 If selecting an existing intervention: Benefits and disadvantages of existing interventions are considered, as well as the balance between adaptation, fidelity, and feasibility. The intervention's fit to local circumstances is assessed. The chosen intervention is adapted carefully, and changes are made explicit. Authors of the intervention are acknowledged.	☐	☐	☐	☐		

Please refer to the full list of basic and expert standards in the EMCDDA manual when conducting your self-reflection, see:
http://www.emcdda.europa.eu/publications/manuals/prevention-standards

4. Intervention design (cont.)

Basic standards (summary):	Not met	Partially met	Fully met	Not applicable	Notes on current position	Actions to take
4.3 Tailoring the intervention to the target population: The programme is adequate for the specific circumstances of the programme (e.g. target population characteristics), and tailored to those if required. Elements to tailor include; language, activities, messages, timing, number of participants.	☐	☐	☐	☐		
4.4 If planning final evaluations: Evaluation is seen as an integral and important element to ensuring programme quality. It is determined what kind of evaluation is most appropriate for the intervention, and a feasible and useful evaluation is planned. Relevant evaluation indicators are specified, and the data collection process is described.	☐	☐	☐	☐		

Please refer to the full list of basic and expert standards in the EMCDDA manual when conducting your self-reflection, see:
http://www.emcdda.europa.eu/publications/manuals/prevention-standards

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.

The project plan should also illustrate and connect the main components of the programme, such as target population needs, goals and objectives, the theoretical model, evaluation indicators and benchmarks, activities and outcomes. This can be done using a logic model. The EMCDDA's Prevention and Evaluation Resources Kit (PERK) includes many examples of how to formulate and use logic models; accessible from: http://www.emcdda.europa.eu/publications/perk

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 the programme). 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 (i.e. those with suitable qualifications and/or experience). This component should be seen in conjunction with component C: Staff development.

5.4 Recruiting and retaining participants: 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). Participants should be recruited from the defined target population in a methodologically correct and ethical way. 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). This is particularly relevant for programmes that need to engage participants over long periods of time. Barriers to participation should be identified and removed to ensure that participants can take part in and complete the programme.

5.5 Preparing programme materials: The materials that are required for implementation of the programme should be considered, including intervention materials (where appropriate), 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 before its start and/or while it is ongoing. 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. The programme description differs from the project plan (which is an internal tool to guide programme implementation) and from the final report (which summarises the programme once it has finished).

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

5. Management and mobilisation of resources

Basic standards (summary):	Not met	Partially met	Fully met	Not applicable	Notes on current position	Actions to take
5.1 Planning the programme — Illustrating the project plan: Time is set aside for systematic programme planning. A written project plan outlines the main programme elements and procedures. Contingency plans are developed.	☐	☐	☐	☐		
5.2 Planning financial requirements: A clear and realistic cost estimate for the programme is given. The available budget is specified and adequate for the programme. Costs and available budget are linked. Financial management corresponds to legal requirements.	☐	☐	☐	☐		
5.3 Setting up the team: The staff required for successful implementation is defined and (likely to be) available (e.g. type of roles, number of staff). The set-up of the team is appropriate for the programme. Staff selection and management procedures are defined.	☐	☐	☐	☐		

Please refer to the full list of basic and expert standards in the EMCDDA manual when conducting your self-reflection, see:
http://www.emcdda.europa.eu/publications/manuals/prevention-standards

5. Management and mobilisation of resources (cont.)

Basic standards (summary):	Not met	Partially met	Fully met	Not applicable	Notes on current position	Actions to take
5.4 Recruiting and retaining participants: It is clear how participants are drawn from the target population, and what mechanisms are used for recruitment. Specific measures are taken to maximise recruitment and retention of participants.	☐	☐	☐	☐		
5.5 Preparing programme materials: Materials necessary for implementation of the programme are specified. If intervention materials (e.g. manuals) are used, the information provided therein is factual and of high quality.	☐	☐	☐	☐		
5.6 Providing a programme description: A written, clear programme description exists and is (at least partly) accessible by relevant groups (e.g. participants). It outlines major elements of the programme, particularly its possible impact on participants.	☐	☐	☐	☐		

Please refer to the full list of basic and expert standards in the EMCDDA manual when conducting your self-reflection, see:
http://www.emcdda.europa.eu/publications/manuals/prevention-standards

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, for example if an intervention is newly developed or is to be rolled out from local to national implementation, the intervention should 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, and which may be very costly to address once implementation is fully underway. 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). During the pilot intervention, process and (limited) outcome data are collected and used to perform a small-scale evaluation. Using the findings from the pilot, programme developers can make final and inexpensive adjustments to the intervention 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. However, this does not mean that the project plan must be strictly adhered to if there is an obvious need for modifications. 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, outcome and process data are collected and analysed periodically, 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. Regular reviews of the progress also help identify if there is a need for modifying the original 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. Delivery and monitoring

Basic standards (summary):	Not met	Partially met	Fully met	Not applicable	Notes on current position	Actions to take
6.1 If conducting a pilot intervention: A pilot intervention is conducted if necessary. It should be considered, for example, when implementing new or strongly adapted interventions, or if programmes are intended for wide dissemination. The findings from the pilot evaluation are used to inform and improve the proper implementation of the intervention.	☐	☐	☐	☐		
6.2 Implementing the programme: The programme is implemented according to the written project plan. The implementation is adequately documented, including details on failures and deviations from the original plan.	☐	☐	☐	☐		

Please refer to the full list of basic and expert standards in the EMCDDA manual when conducting your self-reflection, see:
http://www.emcdda.europa.eu/publications/manuals/prevention-standards

6. Delivery and monitoring (cont.)

Basic standards (summary):	Not met	Partially met	Fully met	Not applicable	Notes on current position	Actions to take
6.3 Monitoring the implementation: Monitoring is seen as an integral part of the implementation phase. Outcome and process data are collected during implementation and reviewed systematically. The project plan, resources, etc. are also reviewed. The purpose of monitoring is to determine if the programme will be successful and to identify any necessary adjustments.	☐	☐	☐	☐		
6.4 Adjusting the implementation: Flexibility is possible if required for a successful implementation. The implementation is adjusted in line with the monitoring findings, where possible. Issues and problems are dealt with in a manner that is appropriate for the programme. Adjustments are well-justified, and reasons for adjustments are documented.	☐	☐	☐	☐		

Please refer to the full list of basic and expert standards in the EMCDDA manual when conducting your self-reflection, see: **http://www.emcdda.europa.eu/publications/manuals/prevention-standards**

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. Briefly, outcome evaluations focus on the behaviour change in participants (e.g. reduced drug use), whereas process evaluations focus on the outputs of the activity (e.g. number of sessions delivered, number of participants contacted). The standards in this project stage must be seen in relation to component 4.4 If planning final evaluations, which also highlights what preparations are necessary to ensure that relevant data is collected during implementation.

Under component 4.4 If planning final evaluations, the manual contains a brief introduction to process and outcome evaluation as conceptualised in the standards, and illustrates how specific aims, goals and objectives can be formulated and translated into evaluation indicators and benchmarks.

The EMCDDA has also published *Guidelines for the evaluation of drug prevention* (updated in 2012), which contain helpful examples of how to plan and report the different aspects of evaluation. They can be found at http://www.emcdda.europa.eu/publications/manuals/prevention_update

7.1 If conducting an outcome evaluation: As part of the outcome evaluation, outcome data is systematically collected and analysed to assess how effective the intervention was. All outcomes should be 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 should be 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. Final evaluations

Basic standards (summary):	Not met	Partially met	Fully met	Not applicable	Notes on current position	Actions to take
7.1 If conducting an outcome evaluation: The sample size on which the outcome evaluation is based is given, and it is appropriate for the data analysis. An appropriate data analysis is conducted, including all participants. All findings are reported in measurable terms. Possible sources of bias and alternative explanations for findings are considered. The success of the programme is assessed.	☐	☐	☐	☐		
7.2 If conducting a process evaluation: The implementation of the programme is documented and explained. The following aspects are evaluated: target population involvement; activities; programme delivery; use of financial, human, and material resources.	☐	☐	☐	☐		

Please refer to the full list of basic and expert standards in the EMCDDA manual when conducting your self-reflection, see: **http://www.emcdda.europa.eu/publications/manuals/prevention-standards**

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 (depending on what data is available), 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 should be 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 in as much detail as possible (depending on copyright requirements etc.).

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. As a final report is not always required and other means of dissemination may be more appropriate (e.g., oral presentations), this component is only relevant if a final report is produced.

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

8. Dissemination and improvement

Basic standards (summary):	Not met	Partially met	Fully met	Not applicable	Notes on current position	Actions to take
8.1 Determining whether the programme should be sustained: It is determined whether the programme should be continued based on the evidence provided by monitoring and/or final evaluations. If it is to be continued, opportunities for continuation are outlined. The lessons learnt from the implementation are used to inform future activities.	☐	☐	☐	☐		
8.2 Disseminating information about the programme: Information on the programme is disseminated to relevant target audiences in an appropriate format. To assist replication, details on implementation experiences and unintended outcomes are included. Legal aspects of reporting on the programme are considered (e.g. copyright).	☐	☐	☐	☐		
8.3 If producing a final report: The final report documents all major elements of programme planning, implementation, and (where possible) evaluation in a clear, logical, and easy-to-read way.	☐	☐	☐	☐		

Please refer to the full list of basic and expert standards in the EMCDDA manual when conducting your self-reflection, see:
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Self-reflection: action plan

This summary page provides an opportunity to summarise main findings from the self-reflection and major actions that should be taken to improve current activities. For future reference, it is important to note when the reflection took place and who was involved (this could be one person or, for example, the programme team). A date for the next review should also be specified, and marked in the office calendar. Although the standards should inform day-to-day practice, reflecting on and documenting achievement of the standards will usually be an infrequent and extraordinary activity. However, it is recommended to revisit the checklist at appropriate intervals to track progress and reinforce the motivation for improvement where necessary.

Summary of main findings and actions emerging from the self-reflection

Review date:	
Review undertaken by:	
Next review date:	

Further reading

EMCDDA European Monitoring Centre for Drugs and Drug Addiction (1998), *Guidelines for the evaluation of drug prevention: a manual for programme-planners and evaluators*, Luxembourg, Publications Office of the European Union.
http://www.emcdda.europa.eu/publications/manuals/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/publications/perk

EMCDDA European Monitoring Centre for Drugs and Drug Addiction (2011), *European drug prevention quality standards: a manual for prevention professionals*, EMCDDA Manuals 7. Luxembourg, Publications Office of the European Union.
www.emcdda.europa.eu/publications/manuals/prevention-standards

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

UNODC, United Nations Office on Drugs and Crime (2013), *International Standards on Drug Use Prevention*, Vienna, United Nations.
http://www.unodc.org/unodc/en/prevention/prevention-standards.html

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