Implementation of Quality Standards in Drug Demand Reduction: Preliminary Findings from the FENIQS-EU Project

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INTRODUCTION: Quality Standards (QS) are an important priority in European drug policy, although the extent of their application remains unclear. The FENIQS-EU project (Further ENhancing the Implementation of Quality Standards in drug demand reduction across Europe) was set up to foster the use of QS. The objective of this paper is to present the main findings of the first 18 months of this project. **METHODS:** A multi-method study design was used to assess the application of QS. It consisted of: 1) an online survey and brief interviews with key stakeholders in various areas of drug demand reduction across Europe; 2) the development of criteria and selection of examples of inspiring practices; 3) a Delphi study to reach consensus around successful QS implementation strategies. **RESULTS:** QS have been implemented in the prevention domain, with the European Drug Prevention Quality Standards being the most commonly implemented standards. In the treatment/social reintegration domain, national standards and the Standards and Goals of Therapeutic Communities are most commonly used, while the EU Council conclusions on the implementation of minimum quality standards are primarily applied in the field of harm reduction. In total, 14 inspiring examples of practice were selected. Three rounds of a Delphi study resulted in consensus on successful implementation strategies, covering five core themes: collaboration, communication, support structure, education, and funding. **DISCUSSION:** Despite the recognition that the implementation of QS is important, these efforts vary across European countries and are unevenly spread across DDR areas. **CONCLUSION:** This paper focuses on the relevance of QS availability, and emphasises key factors influencing successful implementation.

Keywords | Quality Standards – Implementation – Addiction – Prevention – Treatment/Social Reintegration – Harm Reduction – European Union

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1 INTRODUCTION

Quality Assurance (QA) and Quality Control mechanisms present relevant efforts to ensure the quality of drug demand reduction (DDR) interventions, i.e. prevention, treatment/social reintegration, and harm reduction (EMCDDA, 2011a; EMCDDA, 2021; Ferri et al., 2016). As an important tool to enhance the quality of services and to bridge the gap between science and practice, Quality Standards (QS) represent a priority in the previous and present EU Drug Strategies (Council of the European Union, 2012; 2020). QS reflect evidence-based scientific knowledge and professionally established quality criteria for the processes, content, and structure of services and interventions (EMCDDA, 2021) and thus form a reference framework for QA (Autrique et al., 2016). When implemented, QS help to cultivate practices based on recent scientific knowledge and insights. Although there is an apparent drive to implement QS, little is known about the processes and outcomes of their implementation in practice (Miovský et al., 2021). Additionally, an imbalance can be observed in the degree of the implementation of QS in different DDR areas, with the prevention area being more strongly influenced by implementation strategies.

However, several initiatives have been taken to promote the application of QS in initiatives for persons who use drugs. Following the EQUS project (Building a European Consensus on Minimum Quality Standards for Drug Treatment, Rehabilitation, and Harm Reduction), a consensus-based minimum set of QS was proposed in 2011 (Uchtenhagen & Schaub, 2011; Schaub et al., 2013). In September 2015, a condensed version of these standards was adopted by the Council of the European Union as EU Council conclusions on the implementation of Minimum Quality Standards (MQS) for prevention, harm reduction, treatment, and social reintegration (Council of the European Union, 2015). Furthermore, international organisations such as the United Nations Office on Drugs and Crime (UNODC) and World Health Organization (WHO) have launched quality standards for drug prevention (UNODC & WHO, 2018) and treatment (UNODC, 2012; WHO & UNODC, 2020). However, despite the existence of many QS and other QA mechanisms (Ferri et al., 2018), the extent and ways in which QS are implemented in daily practices for persons who use drugs in the EU vary substantially (EMCDDA, 2019). Even though QS can be understood as guiding principles, appropriate implementation should be ensured (Ferri & Bo, 2012). As QS are often non-binding for national governments, their implementation reflects the political will to promote evidence-based interventions (Ferri & Griffiths, 2021).

While the EU MQS provide a general reference framework, more detailed and comprehensive QS exist in each of the DDR domains. In the area of prevention, the widely disseminated European Drug Prevention Quality Standards (EDPQS; EMCDDA, 2011b) address a broad range of process issues in implementing prevention practices, while the International Standards on Drug Use Prevention (UNODC & WHO, 2018) primarily refer to the content of these interventions. Despite these developments in the prevention area in the last decade, the efforts that have been made have not resulted in substantial improvements in prevention practices (EMCDDA, 2019). In the area of treatment, generic national QS have traditionally played a greater role because of their historical links with the healthcare sector. For some types of treatment (e.g. substitution treatment, therapeutic communities) and specific populations (e.g. adolescents, persons with dual diagnosis), the use of QS is well-established, but not for others. In the area of harm reduction,[1] an area of rapid growth in most EU countries in the last decade, a range of standards and indicators have been developed for diverse settings and challenges (e.g. Duch et al., 2011; Gamberini, 2013; Wiessing et al., 2017). However, the extent to which these QS are used in daily practice is unclear (EMCDDA, 2019).

According to a 2016 EMCDDA survey (Ferri et al., 2018), the degree of implementation of QS differs substantially between EU countries. When one considers the acceptability of QS, language and cultural perspectives play an important role. A study conducted by Graf and Stöver (2019) in Germany showed a big gap between the availability of QS and their actual implementation in the treatment of adolescents who use drugs. On the other hand, some countries have implemented QS to a great extent, and in some countries (e.g. the Czech Republic) QS are even linked to certification and funding practices (Miovský et al., 2022). The successful implementation of QS may therefore appear to be highly context-specific and not widely applicable (Autrique et al., 2018). However, inspiring practices in the implementation of QS need to be disseminated to inspire further efforts in the field and promote the understanding of transferable lessons that can guide the implementation of QS in various contexts across the EU.

Following the above-mentioned developments, the FENIQS-EU project was set up (Further ENhancing the Implementation of Quality Standards in drug demand reduction across Europe), with the general aim being to enhance the implementation of QS in drug prevention, treatment/social reintegration, and harm reduction throughout the EU, with more services, organisations, and countries applying QS in daily practice. The project has been funded by the DG Justice Programme of the European Commission – Drug Policy Initiatives (FENIQS-EU - 957826 - JUST-2019-AG-DRUGS), with a planned duration of 24 months (2021–2023). The aim of this paper is to present the activities conducted and preliminary results of the first 18 months of the project by addressing three research questions:

1. Which QS have been implemented in the EU?;
2. Which are examples of inspiring practices of the implementation of QS?;
3. What generic recommendations can be formulated for successful QS implementation?

1 | This project was drafted before the present European Drug Strategy 2021–2025 (Council of the European Union, 2020) was adopted, and therefore DDR activities refer not only to prevention, treatment, and social reintegration, but also to the harm reduction field.

2 METHODS

2.1 Design of the study

The FENIQS-EU project objectives translate into four work packages (WP 2–5), each applying a specific methodology. The various work packages form a comprehensive multi-method study design involving stakeholders at various levels of policy and practice. Active involvement of all key stakeholders is crucial to the project and has been stimulated by the methods used, the support of international experts, and active involvement of pan-European DDR networks as project partners: European Institute of Studies on Prevention (IREFREA), Correlation European Harm Reduction Network (C-EHRN), European Treatment Centers for Drug Addiction (Euro-TC), and European Federation of Addiction Societies (EUFAS). The project further applies a strengths-based approach, starting from successful experiences and promising practices.

To answer the first research question, the application of QS was assessed in all EU countries. Through a secondary analysis of available studies on the implementation of QS (Ferri et al., 2018; Wiesing et al., 2017) and consultation with the EMCDDA REITOX national focal points and country representatives we made an inventory of the application of QS in prevention, treatment, and harm reduction throughout the EU. Three slightly different versions of the online survey were developed (one for each DDR area). The focus was on collecting information on the level of implementation of international QS, but also regarding the implementation of national QS in each country. In the survey, key informants reported on the status of the implementation of the following international QS:

1. Council conclusions on the implementation of the EU Action Plan on Drugs 2013–2016 regarding Minimum Quality Standards in drug demand reduction in the European Union (Council of the European Union, 2015; all DDR areas);
2. Minimum Quality Standards in Drug Demand Reduction – EQUS (Uchtenhagen & Schaub, 2011; Schaub et al., 2013; all DDR areas);
3. European Drug Prevention Quality Standards – EDPQS (EMCDDA, 2011; prevention);
4. International Standards on Drug Use Prevention (UNODC & WHO, 2018; prevention);
5. International Standards for the Treatment of Drug Use Disorders (WHO & UNODC, 2020; treatment/social reintegration; harm reduction);
6. Standards and Goals of Therapeutic Communities (World Federation of Therapeutic Communities)[2] (treatment/social reintegration).

The online survey covering key country informants was conducted in two waves using the SurveyMonkey tool. Key informants were identified by project partners, International Advisory Board (IAB) members, and national focal point contact persons on the basis of their specific knowledge and contacts and information in the public domain. The key informants completed a separate survey for each DDR area (prevention; treatment/social reintegration; harm reduction) that they could provide information for. The first wave lasted from June to September 2021. After the survey was completed, there was still some missing information, either for some countries or DDR areas. Therefore, a second wave of the survey was launched in September–October 2021. This resulted in a country-by-country analysis of the implementation of QS and the related challenges. To get a deeper insight into the needs and challenges associated with implementation, 26 semi-structured online interviews were conducted and recorded via MS Teams between September and November 2021, involving key informants from EU countries who reported about the implementation of QS in the online survey and expressed their interest in providing more detailed information about its implementation in their country. For the analysis of the online survey we used descriptive statistics (using SPSS), while thematic analysis was used to analyse the narrative responses from the interviewees.

To respond to the second research question, a case study methodology for in-depth investigation of selected inspiring practices of the implementation of QS ('quality champions') was developed, including on-site visits, interviews, and document analyses. After all the existing examples of implementation across European countries had been identified (without further selection criteria) in WP2, the next step was to detect inspiring practices relevant to other countries and stakeholders. In order to collect information on promising examples of practice of the implementation of QS in the field of DDR, key informants (see WP2) were asked to provide in-depth information on inspiring QS implementation practices through the Case Study Report (Form A). Together with the questionnaire, criteria for selecting inspiring practices were developed, as well as a glossary of quality assurance terms in order to standardise the terminology for the survey. In Form A, information about the national and local implementation of QA and control systems, as well as QS in the context of specialised services and service providers in DDR, was collected. This information included the level of implementation, type of QS implemented, background to the implementation process, and a description of the QA and control system. If the key informants could not provide sufficient information about the selected practices, additional contact information was sought in the public domain. Countries and practices outside the European Union, such as Switzerland, were also eligible for this part of the study. Each case that was identified was assigned a project partner to document these potentially interesting practices. The assignment was based primarily on geographical proximity and/or acquaintance with the project partner. People involved in the cases that were identified received an invitation to participate in the case study. During the first round, nine cases in prevention, three in treatment and social reintegration, and eight in harm reduction were identified as 'potentially eligible'. In the second round, three additional cases in prevention, three in

2 | http://wftc.org/wps/78-2/

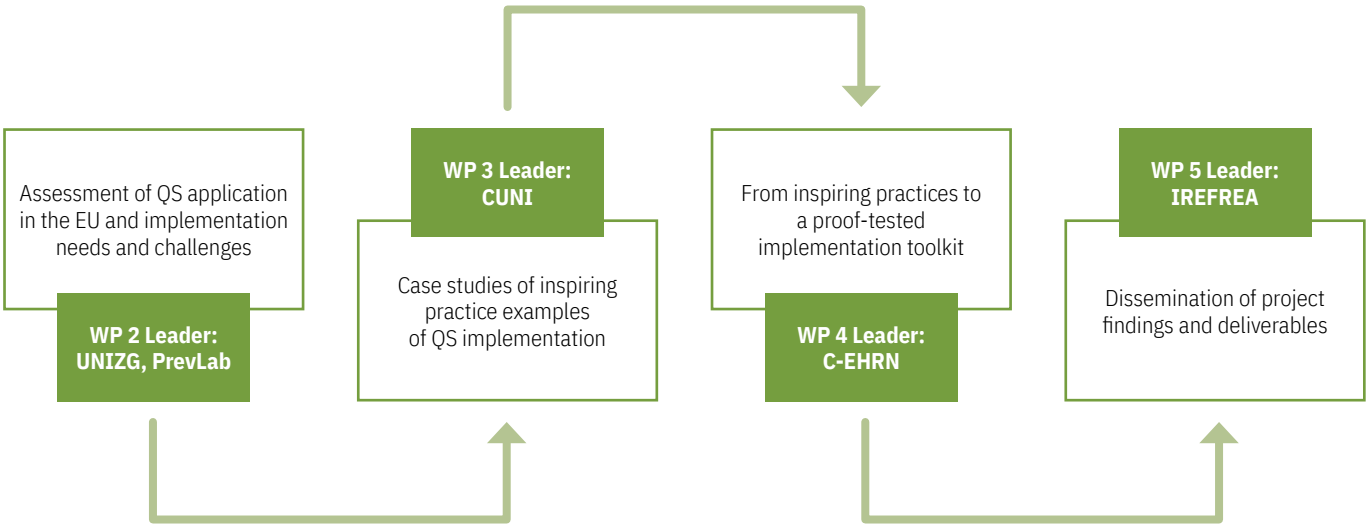
Table 1 | A list of selected examples of the implementation of QS on the basis of the WP 3 methodology

	DDR area		
	Prevention	**Treatment/Social reintegration**	**Harm reduction**
Countries	Croatia	Belgium	Cyprus
	Czech Republic	Croatia	Czech Republic
	France	Ireland	Slovenia
	Spain	Lithuania	Switzerland*
	Sweden		
	United Kingdom		

Note: The countries are listed in alphabetical order.

* Besides harm reduction, the system covers two other areas.

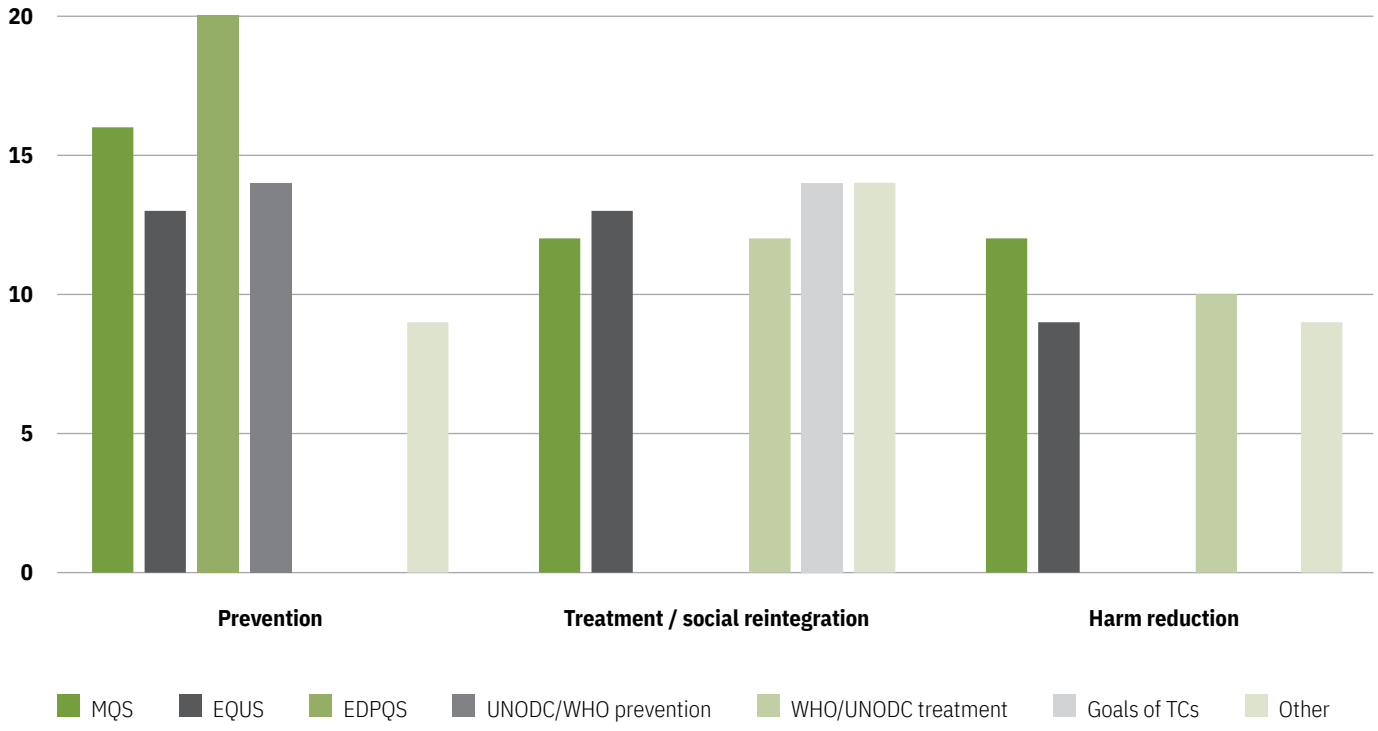
Figure 1 | FENIQS-EU Work packages and leading organisations



treatment and social reintegration, and four in HR were found. The project partners were trained to align the procedure for the final selection of promising and successful examples of the implementation of QS. After Form A had been completed and returned by the practices that had been identified (30 in total), each project partner randomly received ten project descriptions for assessment. This resulted in a shortlist of inspiring examples that were invited to complete Form B (Case study/Example of promising praxis), including more detailed information and a self-assessment on the implementation of QS. Form B focused on the national/local context behind the QA and control policy, the factors that led to the implementation of QS, the reasons for selecting/adopting/developing specific QS, the selection of the formative or normative model, a description of the implementation process, key stakeholders involved, legal and technical aspects of implementation, and practical impact of the implementation of QS on quality/sponsors/service users, information on evaluations that were conducted, and the potential for transferability and availability of supporting data. Together with Form B, a cover letter, glossary of terms, and case study report about the Czech Republic in the prevention area was sent as an example to the project partners, who addressed the selected practices to complete and return Form B.

To reach consensus about successful QS implementation strategies (research question 3), QS experts from across Europe were invited to participate in a Delphi study. The first round of the Delphi study was organised as a live event on May 6th, 2022 in Palma de Mallorca, where quality champions from across Europe and DDR areas brainstormed about factors that influence successful QS implementation. After this brainstorming session, the participants ranked the five most relevant factors per DDR area. After discussion of these rankings, second and third (online) rounds of the Delphi study were conducted following a Delphi study protocol. The second Delphi round was conducted as a written online survey via the SurveyMonkey

Figure 2 | Number of countries implementing QS per DDR area



tool in July and August, 2022. The participants were asked to express their agreement (Agree, Partially agree, Disagree), with the statements gained from the first round, with the possibility of adding new statements and/or rephrasing those with which they expressed partial agreement. The third round was also conducted via the SurveyMonkey tool. The participants were then asked to rate the statements from the second round on a five-point Likert scale (1 = strongly disagree, 5 = strongly agree), which resulted in a consensus among key informants and quality champions regarding successful QS implementation strategies.

2.2 Project Consortium

The partners in this project are four academic institutions: Ghent University (UGent, Belgium), University of Zagreb (UNIZG, PrevLab, Croatia), Charles University (CUNI, Czech Republic), and the Claude Bernard University Lyon 1 (UCBL, France), as well as four pan-European networks: IREFREA, C-EHRN, Euro-TC, and EUFAS, covering all EU member states and DDR areas. Ghent University is responsible for the project management and coordination (WP 1), which is illustrated in *Figure 1,* showing the various work packages and leading organisations.

2.3 Ethics

Ethical approval was sought for the three WPs that involve the participation of identifiable key stakeholders and relevant organsations. Approval was granted by the Ethical Committee of the Faculty of Psychology and Educational Sciences of Ghent University (WP2 no: 2021-101; WP3 no 2021-211; WP4 no: 2022-095). Appropriate data protection measures were ensured for all study participants (pseudonymisation). Informed consent forms were obtained and saved on a secured share of the project coordinator. All data and related documentation will be stored for a minimum of five years after the project funding has ended.

3 RESULTS

3.1 Implementation of QS in the European Union

The assessment of the implementation of QS resulted in answers from 96 participants from 27 countries. Information on the implementation of QS in the area of prevention came from 25 countries. For the area of treatment/social reintegration we received information about 22 countries and from 25 countries for the area of harm reduction. *Figure 2*[3] shows the number of countries that have implemented QS in at least one DDR area. QS have primarily been implemented in the area of prevention, with 20 countries reporting the implementation of the EDPQS in at least some services/organisations, followed by 16 countries reporting the implementation of MQS and 14 reporting on the use of the UNODC/WHO International standards on Drug Use Prevention. Nine countries mentioned the implementa-

3 | Data was not available for a limited number of countries in certain DDR areas: no data for Denmark and Romania in the area of prevention; no information for Estonia, Latvia, Malta, Slovenia, and Sweden in the area of treatment/social reintegration; and no data for Austria and Malta in the area of harm reduction.

tion of some other (mostly national) standards. In the area of treatment/social reintegration, 14 countries reported in the first place implementation of "other QS", while the same number of countries reported the implementation of the Standards and Goals of Therapeutic Communities in drug-free therapeutic communities in those countries. The EQUS standards have been implemented in 13 countries, followed by 12 countries that reported the implementation of MQS, as well as the implementation of the WHO/UNODC International Standards for the Treatment of Drug Use Disorders. The area of harm reduction was the one in which the lowest number of countries reported the implementation of QS compared to treatment and prevention. The most commonly implemented quality standards were MQS, reported by 12 countries. Ten countries mentioned the implementation of the WHO/UNODC International Standards for the Treatment of Drug Use Disorders in at least some services/organisations, while nine countries reported the application of the EQUS standards and "other" mostly national QS.

A total of 26 follow-up interviews were conducted – eight in the area of prevention, nine in the treatment/social reintegration area, and nine in the harm reduction area. Thematic analysis demonstrated that arguments were mainly related to three main topics: implementation needs, challenges and barriers to successful implementation, and factors supporting the implementation of QS. The findings show that in most countries the application of QS is not mandatory. Some of the interviewees think that political support and the inclusion of QS in strategic documents could enhance the implementation of QS. Lack of ongoing funding was recognised as a major obstacle to the implementation of QS in all areas, while training and networking were mentioned as factors stimulating implementation.

3.2 Inspiring practice examples of QS implementation

Based on the methodology for identifying inspiring practices, Form B was returned by the end of April 2022. Following internal evaluation, two focus groups were conducted in December 2021 and January 2022, including project partners and members of the IAB. On the basis of their assessments and the results of the focus groups, 14 inspiring practices were selected, taking into account the overall quality of the project, as well as the geographical spread and diversity of DDR.

The methodology used to obtain the selected cases introduced certain limits and possible bias. Established examples of the successful implementation of QS in practice may have had less motivation to engage in involvement in the FENIQS-EU project. The quality of the information provided in the assessment forms and any follow-up interviews was proportional to the informants' motivation to participate in the project. Consequently, some bias in the level of quality of implementation projects can be observed. An incentive that was provided to potential informants was participation in the Quality Champions event (project meeting) in Palma De Mallorca (May 5th, 2022) and the opportunity to publish a case study in a peer-reviewed journal, which may have been of interest to academics but less to practitioners. There was a considerable imbalance between the different DDR areas. Examples from the field of prevention were predominant, while the selection of inspirational practices in the field of treatment/social reintegration and harm reduction was limited by the small number of practices that were identified. Additionally, in most countries information on the implementation process and relevant documents are only available in the national language and have not been published in English or other widely spoken languages, thus reducing the potential for transferability and inspiration. Finally, in the context of the COVID-19 pandemic, the research methodology had to be modified. The data collection had to be shifted from the originally planned field visits and interviews to questionnaire surveys, which were in some cases combined with online interviews. This may have reduced the richness of the data collected as the description was directly dependent on the possibilities and capacities of informants to be interviewed online. The quality of the individual case studies varied considerably.

3.3 Recommendations for successful QS implementation

The first round of the Delphi study involved 37 quality champions and key informants. The first brainstorming session resulted in 41 statements, covering six categories: collaboration, education, communication, political support, support structures, and funding. In the second round, out of 37 invited participants, 27 participants expressed their agreement, partial agreement, or disagreement with the importance of each statement for successful QS implementation and/or suggested that some of the statements be rephrased. On the basis of these responses, 34 statements were included in the third round, in which 26 experts participated in rating the statements. This resulted in 15 statements covering the following categories for successful QS implementation in all DDR areas: collaboration, communication, support structure, education and funding, for example: "Good communication between policymakers, researchers, and professionals about the needs and priorities of the target groups and the results of existing programmes is key to the implementation of QS". Based on the consensus gained regarding the most important factors that stimulate QS implementation, an Implementation Toolkit will be drafted and field-tested at 12 locations/organisations. When choosing locations/organisations, geographical diversity and equal representation of the three DDR areas were considered. By field-testing the toolkit with end users in various countries, including different contexts, policies, and target populations with differentiated needs, the participating organisations will provide feedback based on their experience with the implementation of the toolkit. This feedback will enable a better understanding of specific nuances that are culture-bound and need to be taken into account when building a comprehensive framework for promoting the implementation of QS.

4 DISCUSSION

The findings from the FENIQS-EU project highlight which international QS have been implemented in specific DDR areas and countries and which inspiring QS implementation practices were identified across Europe. On the basis of these preliminary steps, 15 consensus statements were formulated for the successful implementation of QS across DDR areas, covering collaboration, communication, support, education, and funding. Prevention, treatment/social reintegration, and harm reduction are complex, multidisciplinary, and dynamically changing areas of drug demand reduction. Even though numerous efforts have been invested in the development of QS in Europe in the last decade, our results show that the implementation of QS is spread unevenly between these domains and that the implementation of international QS is most advanced in the prevention domain. The preliminary findings from the FENIQS-EU project show that gaining expert consensus in DDR regarding the factors influencing the successful implementation of QS could be an important step towards ensuring the promotion and sustainability of the implementation of QS across Europe. This recommendation is in line with the literature that supports other QA strategies, such as promotion of the quality of services, interventions and methods, specific requirements for the training of professionals, involvement of peers and experts according to their experience, etc. (SAMHSA, 2017; 2021a; 2021b). Ensuring the implementation of QS, in combination with the consultation of registries of evidence-based programmes and interventions, such as the Best Practice Portal (EMCDDA, 2023), Blueprints,4 or iPREV,5 designed as a source of practical and reliable information on what works (and what does not) in prevention, treatment/social reintegration, and harm reduction, also contributes to the development of quality.

The implementation toolkit, as the main output of this project, will adequately address practical challenges when implementing QS in countries/DDR areas that have not yet done so. By bringing QS closer to practice, it can be more easily and realistically employed by organisations in the field. The field-tested implementation support and active promotion of the toolkit (which will be continued after the project is finalised) will contribute to the implementation of QS in the area of DDR throughout the EU. Besides organisations from within the EU, interest in the field testing was also expressed by service providers from non-EU countries such as North Macedonia and Ukraine. In addition to European civil society organisations (one organisation in the area of prevention, four in treatment/social reintegration, and five in that of harm reduction), organisations from EU candidate countries (one in the area of prevention in Bosnia and Herzegovina and one in the harm reduction area in North Macedonia) were included in the field-testing.

The results of this project can be used in multiple ways. One way is to identify DDR areas that require more support in the implementation of QS (e.g. harm reduction services). A second way is to map countries that have little or no experience in the implementation of QS, so that efforts to promote such implementation can be targeted on the basis of a needs assessment. To promote the application of the findings of the study, dissemination was performed continuously throughout the implementation of the project through the project website (https://feniqs.eu-net), electronic newsletters, peer-reviewed scientific papers, and conferences. In addition, live training sessions will be offered during the final conference and through a webinar and video tutorial that will be recorded to stimulate and support the application of the toolkit after the project has ended.

5 CONCLUSION

Identifying factors that influence successful QS implementation can help to improve the quality of service delivery, to increase the rate of implementation, and shape a 'minimum' level of good quality in services for persons who use drugs. This project emphasised not only the relevance of the availability of QS, but even more so the importance of key factors influencing successful implementation, which include communication, collaboration, a support structure, education, and funding. Each of these factors seems equally relevant for successful QS implementation, and all of these should be considered when implementing QS.

4 | Blueprints for Healthy Youth Development: https://www.blueprintsprograms.org

5 | Interactive platform for mental health support and prevention of risk behaviour: https://www.iprev.cz

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