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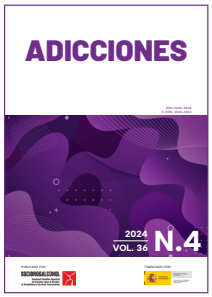

ORIGINAL

Implementation of quality standards in drug demand reduction: Insights from FENIQS-EU project and ways forward

Implementación de estándares de calidad en la reducción de la demanda de drogas: Perspectivas del proyecto FENIQS-EU y caminos a seguir

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Abstract

Quality standards have been recognized as an important tool for improving the quality of drug use prevention, treatment, and harm reduction services and for bridging the gap between science and practice. The aim of this paper is to describe the state of implementation of quality standards in drug demand reduction in the European Union and to identify barriers, needs, and challenges to implementation and future pathways. Between June and November 2021, an online survey (n = 91) and follow-up interviews (n = 26) were conducted with key informants - experts in drug demand reduction and quality assurance. Data were analyzed using descriptive statistics and thematic analysis. The survey showed that most countries have implemented the European Drug Prevention Quality Standards (EDPQS) in the prevention domain and the Minimum Quality Standards (MQS) in drug demand reduction. A variety of standards are applied in the treatment area and the EQUS minimum quality standards are widely known. The application of quality standards is least reported in the harm reduction service area. Mentioned challenges and barriers to implementation included lack of funding, unrecognized importance of evaluation, professional competencies, and system fragmentation. Mentioned supportive factors included appropriate materials and training, as well as political support and professional networks. The study shows that quality standards are inconsistently implemented in all areas of drug demand reduction. According to respondents, implementation could be improved by advocating for the need to implement quality standards, ensuring sustainable funding for interventions, and providing education and training.

Keywords: quality standards, implementation, drug demand reduction, alcohol, drugs, Europe

Resumen

Los estándares de calidad constituyen una herramienta para mejorar la calidad de la prevención, el tratamiento, y la reducción de daños del uso de drogas y para unificar ciencia y práctica. Este artículo tiene como objetivo describir el estado de la implementación de los estándares de calidad en la reducción de la demanda de drogas en la Unión Europea e identificar las barreras, las necesidades y los desafíos para su implementación. Entre junio y noviembre (2021) se realizó una encuesta en línea (n = 91) y entrevistas de seguimiento (n = 26) con informantes clave, expertos en reducción de la demanda de drogas y sistemas de garantías de calidad. Se emplearon estadísticos descriptivos y análisis temáticos. La mayoría de los países ha implementado los Estándares europeos de calidad en prevención de drogas (EDPQS) en el ámbito de la prevención y las Normas mínimas de calidad (MQS) en la reducción de la demanda de drogas. En el área de tratamiento, los estándares mínimos de calidad EQUS son ampliamente conocidos. La aplicación de estándares de calidad es menor en la reducción de daños. Se identificaron distintos retos y barreras: la falta de financiación e importancia concedida a la evaluación, las competencias profesionales y la fragmentación del sistema. Los factores de apoyo fueron materiales y formación, apoyo político y redes profesionales. Los estándares de calidad no se implementan en todas las áreas de reducción de la demanda de drogas. Los informantes clave sugirieron la necesidad de fomentar la implementación de los estándares de calidad, asegurar financiación y formación.

Palabras clave: estándares de calidad, implementación, reducción de la demanda de drogas, alcohol, drogas, Europa

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In the past decades researchers, practitioners and policymakers have recognised the importance of effective Drug Demand Reduction (DDR) interventions. The main European strategic document in this field, the EU Drugs Strategy 2013-2020 (Council of the European Union, 2012) identified two policy fields: drug demand reduction and drug supply reduction. Drug demand reduction was described as a range of equally important measures: prevention (environmental, universal, selective and indicated), early detection and intervention, risk and harm reduction, treatment, rehabilitation, social reintegration and recovery. The objective of these measures was to contribute to the reduction of illicit drug use, delay the age of the onset, and to prevent and reduce problem drug use, dependence and related health and social risks and harms. In the meanwhile, newly adopted EU Drug Strategy 2021-2025 (Council of the European Union, 2020) made a distinction between drug demand reduction and harm reduction activities and introduced a change within priorities. Three policy areas were identified: I. Drug supply reduction: Enhancing security, II. Drug demand reduction: prevention, treatment and care services and III. Addressing drug related harm. The objectives of the drug demand reduction area stayed the same as in the previously mentioned document, with the exception that drug related risks and harms were placed within a separate area. In that context, addressing drug related harm focuses on measures and policies that prevent or reduce the possible health and social risks and harm for various target groups, such as users, society and prison settings. Risk and harm reduction interventions and measures to protect and support people who use drugs (such as prevention of drug-related infectious diseases, prevention of overdose and drug-related deaths, promotion of civil society organisation and enabling sustainable funding, and providing alternatives to coercive sanctions) became priority areas.

Both EU Drug Strategies (Council of the European Union, 2012, 2020) emphasise the importance of implementing Quality standards (QS) as a way for the improvement of the quality of drug services and to bridge the gap between science and practice (Council of the European Union 2012, 2020). Various Quality Assurance (QA) and Quality Control mechanisms should ensure the quality of drug prevention, treatment and harm reduction and Quality Standards (QS) are regarded as one of the crucial tools in this process (European Monitoring Centre for Drugs and Drug Addiction [EMCDDA], 2011a; Ferri et al., 2018). QS provide guidance on general principles and rules that should be followed when implementing recommended interventions and practices (Brunsson and Jacobsson, 2000; according to Ferri & Bo, 2012). Some examples of QS, based on the Council of the European Union Minimal Quality Standards include following recommendation: "Prevention interventions form part of a coherent long-term prevention plan, are appropriately monitored on an ongoing basis allowing for necessary adjustments, are evaluated and the results disseminated so as to learn from new experiences."; "Risk and harm reduction measures, including but not limited to measures relating to infectious diseases and drug-related deaths, are realistic in their goals, are widely accessible, and are tailored to the needs of the target populations."; "Treatment and social integration interventions and services are based on informed consent, are patient-oriented, and support patients' empowerment." (Council of the European Union, 2015: 4-6).

Several benefits have been linked to QS implementation such as reducing the gap between available evidence and practice, improving the quality of service delivery, enhancing transparency towards service users and civil society, and facilitating evaluation and feedback (Autrique et al., 2016). Although QS are aspirational (World Health Organization [WHO] & United Nations Office on Drugs and Crime [UNODC], 2020) and need to be seen as guiding principles (EMCDDA, 2014), it is important to guarantee appropriate implementation (Ferri & Bo, 2012). QS promote quality by translating knowledge into practice and by including all relevant stakeholders into the implementation process, which facilitates successful QS implementation (Ferri & Griffits, 2021).

Quality standards differentially respond to interventions, services and people (Burkhart, 2015) and can be intended for stakeholders involved in various phases of intervention development, such as planning, funding, delivery, monitoring, and evaluation. QS can be related to content issues, processes, or structural aspects of QA (EMCDDA, 2017a), which makes the implementation process quite complex and challenging.

In the last few years, a wide range of international QS have been developed in the area of DDR, such as the European Drug Prevention Quality Standards (EDPQS) (EMCDDA, 2011b), the European minimum Quality Standards in drug demand reduction (EQUS) (Schaub et al., 2013; Uchtenhagen & Schaub, 2011), the EU Council conclusion on Minimum Quality Standards in drug demand reduction (MQS) (Council of the European Union, 2015), the UNODC/WHO International Standards on Drug Use Prevention (UNODC & WHO, 2018), the WHO/UNODC International Standards for the Treatment of Drug Use Disorders (WHO & UNODC, 2020). Other standards are more topical and refer to specific interventions (e.g. Standards and Goals of Therapeutic Communities (World Federation of Therapeutic Communities, n.d.) or limited to a specific country or region. A previous overview of QA in DDR in Europe (Ferri et al., 2018) emphasized that though evidence-based interventions are becoming more acceptable, implementation issues have not been addressed in a sufficient way. QS are often non-binding for national governments and present the political will of a certain

community to address interventions with an evidence-based approach (Ferri & Griffiths, 2021). Adoption of QS is also challenging due to the high heterogeneity of interventions and services, as well as the diversity of stakeholders involved in it (Autrique et al., 2016). Several factors have been identified that contribute to successful QS implementation, such as expert consensus, training, accreditation, certification and evaluation whether providers understand the rationale behind the standard (EMCDDA, 2012, 2014). The complexity of the above-mentioned factors leads to variations in QS implementation between and within countries, as well as between DDR areas (EMCDDA, 2022).

Although QS have been recognised as an important quality assurance tool by a wide range of researchers, experts and policy makers, few information is available on the degree of implementation and local factors affecting it for better or worse (EMCDDA, 2022). In addition to having a clearer picture of the implementation of QS, it is also important to understand the factors that facilitate or hinder the implementation process. Understanding these factors could help to improve the quality of service delivery, increase the degree to which QS are implemented in daily practise, improve accountability, and create minimum quality guarantees across and within countries. Consequently, this paper aims to describe the situation in implementing quality standards by DDR areas - prevention, treatment/social reintegration and harm reduction - and to identify barriers, needs and challenges in implementing QS in Europe.

Methods

Participants and procedure

This study was conducted between June and November 2021 as part of the Further ENhancing the Implementation of Quality Standards in drug demand reduction across Europe (FENIQS-EU) project that aims to improve the implementation of QS in drug demand reduction across Europe, with more services, organizations, and countries applying QS in daily practice. To achieve these aims, multiple research methods were used.

First, Country drug reports (EMCDDA, 2019) and countries' Best practice workbooks (EMCDDA, 2020) were consulted to identify available QS initiatives in the European Union (EU) and the United Kingdom (UK). In addition, with support from the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), key informants (individuals most knowledgeable about national implementation of QS) from the EMCDDA's REITOX National Focal Points were identified.

Second, an online survey was set up, consisting of three versions: Prevention, Treatment/Social reintegration, Harm reduction. Of note is that Harm reduction was included within the drug demand reduction field as per the EU Drugs Strategy 2013-2020, given that the updated 2021-2025 was not available at the time of the project submission to the funding authority in 2019. Questions in the online survey focused on the use of QS (whether QS is implemented in the country or not), if "yes", to what extent QS is implemented, coverage of the MQS (Council of the European Union, 2015), main reasons for implementation, challenges and barriers to implementation, support needs, and examples of good QS implementation practices. In addition, contacted participants were able to recommend other key informants to the EMCDDA National Focal Points, who were later asked to provide information on national implementation of QS. The *online survey* was administered using the Survey Monkey tool. An email with a link to the survey was sent to all identified key informants. After a first wave of the survey (between June 10, 2021 and September 13, 2021), the number of responses was limited, not allowing to draw firm conclusions. To collect more information, project partners and International Advisory Board (IAB) members identified additional key informants for the online surveys (mainly from established Non-Governmental Organisations (NGOs) in the field, other relevant country institutions, and the academic community), and it was decided to launch a second wave of the survey (between September 17, 2021, and October 15, 2021). The second wave focused on obtaining information about countries for which there were either no data at all or no data for some of the DDR areas. Third, *follow-up interviews* were conducted with key informants from countries that confirmed broader implementation of QS and agreed to participate. The idea was to learn more about the practice of implementing QS in different countries. Related to that, the focus of the follow-up interviews was to review compliance with MQS, discuss the situation in the countries historically and critically, and provide additional information on specific implementation issues. The interviews were conducted through videoconference from September 17, 2021, to November 24, 2021.

All participants were country representatives (from EMCDDA National Focal Points) or other key informants (recommended for contact by EMCDDA National Focal Point experts) who were able to provide information on whether or not QS are being implemented in their country and, if so, to provide an overview of the level of QS implementation in a particular drug demand reduction area, as well as information on the needs, barriers, and challenges to implementing QS. Approximately 230 key informants were identified and contacted in the European Union (EU) and the United Kingdom (UK). A total of 91 surveys was completed and information was collected for 27 countries. Most participants worked as experts in the EMCDDA National Focal Point and, to a lesser extent, in other relevant national institutions, established NGOs in the field, or academic institutions (universities or institutes).

Information on QS implementation by DDR area was as follows: prevention (n = 35), treatment/social reintegration (n = 25) and harm reduction (n = 31) surveys. The number of completed surveys per country and per DDR area is shown in Figure 1.

A total of 26 follow-up interviews were conducted: 8 in the area of prevention, 9 around treatment/social reintegration area and 9 around harm reduction (shown in Table 1). In three countries, a follow-up interview was conducted with a key informant who reported about treatment/social reintegration as well as harm reduction.

Ethical approval for the study was obtained from the Ethical Committee of the Faculty of Psychology and Educational Sciences, Ghent University (reference number 2021-101). For participation in the online survey, consent was obtained online from participants after the aims of the study had been explained to them and before the survey was taken. To participate in the interviews, participants received an information sheet and signed an informed consent form before participating in the follow-up interviews.

Table 1
Conducted follow-up interviews

Prevention	Treatment/Social reintegration	Harm reduction
Cyprus	Austria	Croatia
Germany	Belgium	Czech Republic
Greece	France	Denmark
Italy	Ireland	Luxembourg
Latvia	Italy	Portugal
Netherlands	Lithuania	Slovakia
Sweden	Luxembourg	Slovenia
UK	Netherlands	Netherlands
	UK	UK

Instruments

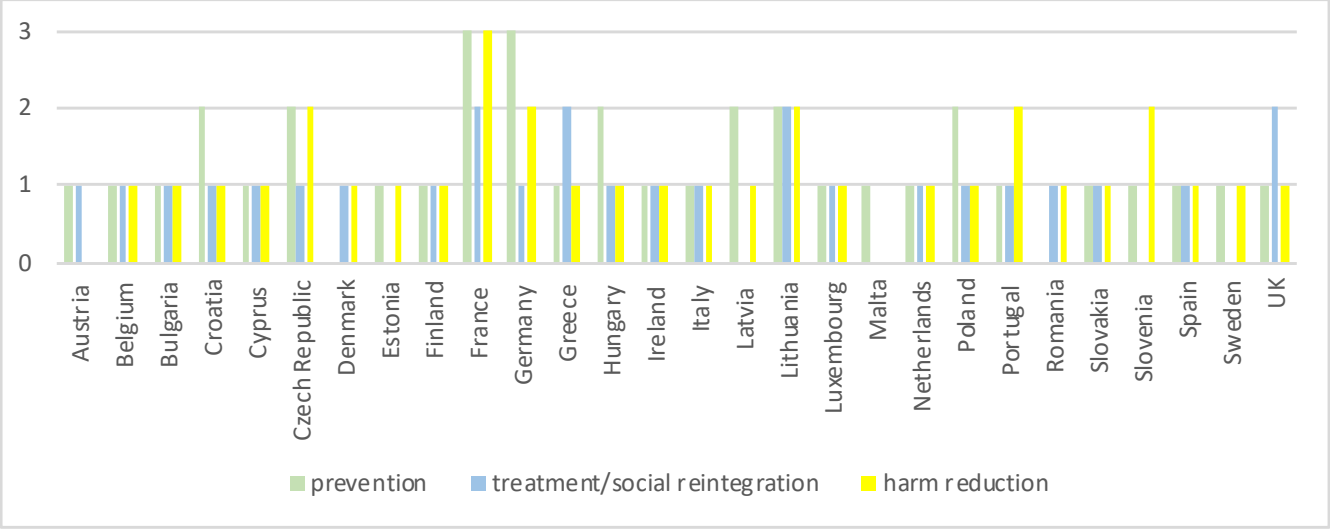
Online survey in three versions: Prevention, Treatment/Social reintegration, Harm reduction

The objective of the survey (60 questions in total) was to collect information on the level of implementation of some recent international QS, but also on national QS implementation in each country. The survey was anonymous, although participants could provide contact information and reveal their identity. Survey questions focused on the professional background of study participants (e.g., affiliation, professional position, years of experience), though these questions were not mandatory. In a second section, implementation of some widely known QS were assessed for all/specific drug demand reduction areas:

1. EU Minimum Quality Standards for drug demand reduction interventions (MQS) (Council of the European Union, 2015) – all DDR areas.
2. European minimum Quality Standards in Drug Demand Reduction (EQUS) (Uchtenhagen & Schaub, 2011) - all DDR areas.
3. European Drug Prevention Quality Standards (EDPQS) (EMCDDA, 2011b) – prevention.
4. UNODC & WHO International Standards on Drug Use Prevention (UNODC & WHO, 2018) - prevention area.
5. WHO & UNODC International Standards for the Treatment of Drug Use Disorders (WHO & UNODC, 2020) – treatment/social reintegration, harm reduction.
6. Standards and Goals for Therapeutic Communities (World Federation of Therapeutic Communities, n.d.) – treatment/social reintegration area.

Respondents provided the following information on the implementation of each QS in their countries: DDR area, adoption (yes/no), implementation period, territorial

Figure 1
Number of surveys completed per country and per DDR area



level of QS implementation (national, regional (e.g., state or county), local (e.g., city or local community), domains where QS was implemented (health, social welfare, law enforcement, justice, education, other), and assessment of the extent of QS implementation (yes, fully; yes, to some extent). Participants could also indicate adoption of other national or international QS implemented in their country in any of the DDR areas.

The final section consisted of questions addressing barriers, needs and challenges in implementing QS. In addition, participants could mention examples of inspiring QS implementation practices in their country and briefly describe these. At the end of the survey, participants also had the opportunity to recommend other key informants in their country and to indicate whether they were willing to participate in a follow-up interview.

Follow-up interviews

The interview was semi-structured (approximately 30 minutes long), and respondents were asked to describe the process of implementing QS, identify factors that support the implementation process of QS (strengths), and identify challenges or barriers to implementing QS in their countries. Respondents were also asked what they thought the progress in implementing QS would be over the next two years in their countries.

Data analysis

To analyse the data collected during the online survey, descriptive statistics was used to determine the sample characteristics and to assess implementation of QS by DDR areas. All analyses were performed using SPSS 21.0 (IBM, Armonk, NY, USA). Interview data and open-ended responses were analysed using an inductive approach to thematic analysis, a method for analysing and identifying rich data patterns (Braun & Clarke, 2021; Joffe, 2011). This type of analysis was deemed most appropriate to capture the goal of the study without being limited to an a priori theory. The open-ended questions in the online survey were reread, notes were taken, and a preliminary coding structure was developed according to the aim of the study. Follow-up interviews were transcribed, notes were taken, and were then coded by the researchers. The coding process was conducted independently by three researchers, and then the key areas were discussed among the researchers and grouped into key themes.

Results

Implementation of quality standards by areas - prevention, treatment/social reintegration and harm reduction

In the area of prevention, nine (9) key informants provided an overview of QS implementation at the local level, nine (9) at the regional level, and thirty-four (34) at the national level. In the area of treatment/social reintegration, six (6) key informants provided an overview of the implementation of QS at the local level, seven (7) at the regional level, and twenty-five (25) at the national level. Six (6) key informants in the area of harm reduction provided an overview of the implementation of QS at the local level, three (3) at the regional level, and twenty-seven at the national level.

Regarding QS implementation *in the prevention area*, most countries have implemented the EDPQS standards (n = 20), followed by the MQS, EQUS, and the UNODC & WHO International Standards for Drug Use Prevention. Nine (9) countries have adopted other standards, mostly national QS. Data on prevention are not available for two (2) countries – Denmark and Romania. The number of countries implementing various international QS in the area of prevention is shown in Figure 2. Key informants reported that most QS have been implemented in the health sector, followed by education, social welfare, and law enforcement. Implementation of QS is least common in the justice domain.

Key informants in the *treatment/social reintegration area* from thirteen (13) countries stated they have implemented the EQUS standards and twelve (12) also mentioned the implementation of MQS and the International Standards for Treatment of Drug Use Disorders. Although limited to a specific type of services, 14 countries refer to the implementation of the Standards and Goals for Therapeutic Communities and other national QS. Data are not available for five (5) countries - Estonia, Latvia, Malta, Slovenia, and Sweden. The number of countries implementing international QS in the area of treatment/social reintegration is shown in Figure 3.

In terms of policy domains in which QS have been implemented in each country, QS are primarily implemented in the health and social welfare domain followed by the education, justice, and law enforcement domain.

In the *harm reduction area*, key informants from 12 countries stated that EQUS standards have been implemented and other QS (mostly national), while the International Standards for the Treatment of Drug Use Disorders and

Figure 2
Number of countries implementing QS in the prevention area (N = 35)

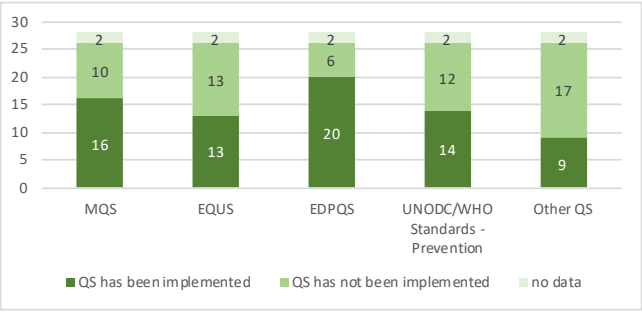


Figure 3
Number of countries implementing QS in treatment/social reintegration area (N = 25)

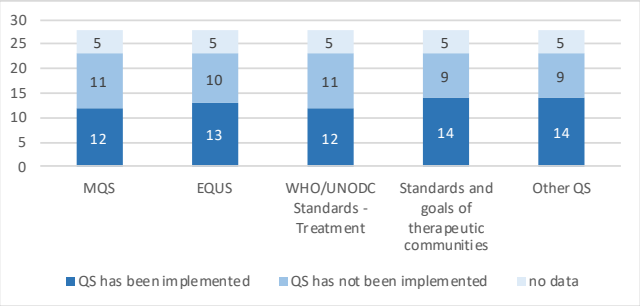
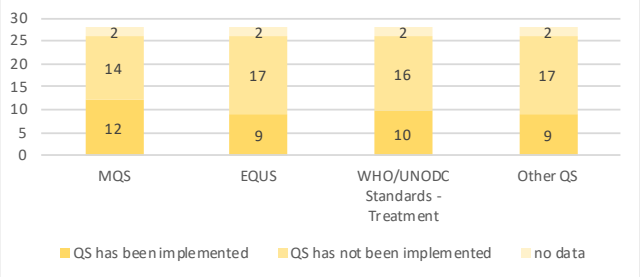


Figure 4
Number of countries implementing QS in harm reduction area (N = 31)



the MQS are applied to a lesser extent. Data are not available for two (2) countries – Austria and Malta. Most QS for harm reduction services are implemented in the health and social welfare domain, followed by the domains of law enforcement and justice. Figure 4 shows the number of countries implementing international QS in the domain of harm reduction.

Table 2
Identified themes: Open-ended questions and follow-up interviews (thematic analysis)

Areas	Themes
Needs	Mandatory QS
	Resources (materials, training, people, finance, infrastructure)
	Support at all levels (politicians, decision-makers, international organizations)
	Unrecognized importance of evaluation and monitoring
Challenges and barriers	Lack of funding
	Unrecognized importance of evaluation
	Practitioner competencies and positions
	Fragmentation and inertness of the system
Supporting factors	Materials and training
	Support and networking

Needs, barriers and challenges in QS implementation

Using a thematic analysis, several themes around three main topics were identified (Table 2).

Area 1. QS Implementation needs

According to the respondents, the development and adoption of *mandatory QS* for various health and social service systems is a recognized necessity when it comes to QS implementation. In most countries, QS implementation is not mandatory. The need for the use of strategic documents for the implementation of QS is also recognized, as well as the more systematic use of existing standards. In addition, in some countries there is a need to work on harmonizing existing QS and to include the use of QS as a funding criterion.

> *"[In country X] there is no one standard that everyone should apply, and everybody can invent their own."* (prevention)

Materials and training, people, finances, and infrastructure are referred to as necessary *resources* that must be considered when implementing QS. Education and training must be continuous and systematic and should include strengthening and developing advocacy skills. In addition, QS materials and guidelines should be accessible, visible, and user-friendly.

> *"Provide training to professionals and create the base of minimum standards which need to meet the criteria in order to get funding."* (harm reduction)

Key informants stated that greater political *support is needed at all levels*. Political willingness and support are needed to recognize the importance of QS and to implement them effectively. In addition, the need for collaboration among stakeholders and cooperation with international organizations was recognized by key informants. To provide support for the implementation of QS, some key informants believe that it is necessary to establish a specific institution (e.g., pre-certification counselling, development audit, quality methodologists and consultants) and scientific organisations that will promote QS implementation at the national level.

> *"…It is necessary to advocate effective prevention and application of standards among politicians. Also, the NGO sector needs to advocate that prevention is important even though the results may not be seen immediately."* (prevention)

Some key informants indicated that the *importance of evaluating, and monitoring* services provided in all DDR areas is *not sufficiently recognized*. This raises the need for continuous evaluation and the development of an effective evaluation system.

> *"There is no culture of evaluating [of] delivered interventions, not only in drug prevention but in prevention in general."* (prevention)

Area 2. Challenges and barriers related to the implementation of QS

Insufficient and discontinuous funding was regarded as a challenge/barrier by respondents in all DDR areas. For prevention, for example, some key informants indicated that there is no fixed funding for prevention and that non-governmental organizations (NGOs) mostly carry out their activities on the basis of calls for proposals from various ministries. In terms of funding, key informants pointed out that practitioners are underpaid for their work. In the area of harm reduction, the creation of secure and stable funding for services is recognized as a challenge.

"There is no funding for harm reduction, hence there are no QS." (harm reduction)

The *unrecognized importance of evaluation* was also identified as a challenge or barrier, as some countries do not see the need and value of evaluation, regardless of the DDR area.

"[What is missing is] ongoing evaluation during treatment and flexible adoption of strategies to be enhanced." (treatment/social reintegration)

Numerous challenges and barriers affect the *competence and position of practitioners*. In some countries, there is a lack of prevention work or lack of support to prevention workers, particularly in evaluating these programmes. From the perspective of some key informants, EDPQS was perceived as a very bureaucratic process. The weak position of professional associations was also seen as a challenge. In some DDR areas, practitioners are leaving the field and, as a consequence, others are overwhelmed with the work.

"Overworked staff. [There is] no time or energy to invest in their knowledge regarding QS implementation. Mostly social workers [have] no time and resources to participate at the conferences or new educations. [...] Budget is ensured for activities with clients, not for further professional development." (harm reduction)

The fragmentation and inertia of the system was further identified as an important challenge. In some countries, institutions responsible for prevention do not share a common vision of evidence-based interventions and the importance of QS. Key informants pointed out that different authorities are responsible and that there is a need to determine who is responsible for disseminating QS. In the treatment area, the main barrier is availability of the treatment (within a reasonable time frame). Systems are slow and inflexible in adapting to new discoveries and lack a good link to long-term planning. The dichotomy between abstinence and harm reduction-oriented services is one of the biggest challenges to treatment/harm reduction from a key informant perspective.

"The system is very slow to adapt to new developments." (treatment/social reintegration)

Area 3: Factors supporting the implementation of QS

Key informants indicated that the main factors that support the process of implementing QS are appropriate *materials and training*. Some of them emphasized the need for continuous education and training and the availability and dissemination of scientific knowledge. The availability of QS materials in the national language is also one of the important factors that can influence implementation of QS. QS should be accessible, visible and adopted by different sectors and disciplines. According to the respondents, practitioners should have advocacy skills, need to be focused on quality and the service user, and should continuously invest in education and knowledge.

"[It is very important] to embed professional development and education within existing career trajectories and pathways more effectively." (prevention)

Sufficient support and networking are also seen as important supportive factors. QS implementation requires support from ministers, government and decision makers at all levels, but also from the academic community, and collaboration between all sectors is required. Experts who know a lot about QS should advocate among policy and decision makers to enhance the implementation of QS.

"Availability and visibility of QS is very important (a good website, making promotion and advertisements on these QS, communication)." (treatment/social reintegration/harm reduction)

In some cases, supporting factors vary according to DDR area. Some key informants recognised the existence of a prevention law and national prevention plan as factors supporting QS implementation, while others mentioned evidence-based treatment done by quality specialists and regulation of treatment through professional training. Harm reduction experts emphasised the importance of having a strategic document.

Discussion

The results of this study show that QS are only implemented in half or two third of the EU countries and implementation of QS varies considerably across DDR areas. Implementation needs regarding QS were described in terms of mandatory implementation of QS, resources and support needed and monitoring and evaluation needs. Lack of funding, the unrecognised importance of evaluation, the competences of practitioners and decision makers, and the fragmentation of the system were cited as major challenges and barriers to implementation. Finally, the availability of materials and training, as well as available support and networks, were cited by key informants as supportive factors for the implementation of QS.

In recent years, it has become accepted that drug demand reduction services should provide evidence-based interventions and increased attention has also been paid to

the quality of the services offered (EMCDDA, 2021a). The EU Drug Action Plan for 2021-2025 considers the adoption of QS as one of it's the core strategic lines to improve the value and effectiveness of drug programmes, practices, and policies. Most – though not all – European countries appear to have implemented the EQUS and MQS standards, but no data were available for some countries. Prevention is one of the DDR areas that is implementing QS to a larger extent. Within this area, the EDPQS are the most widely used standards, while in the treatment/social rehabilitation area specific standards (e.g. the Standards by the World Federation of Therapeutic Communities and national/ sector specific QS have been implemented. In the harm reduction area, key informants indicated that the MQS are adopted in some countries, but it is worth noting that QS are adopted to a lower extent compared to prevention and treatment. This finding is in accord with the lack of reliable monitoring data on quality of interventions and service implementation that has been noted before in the harm reduction area (Larney et al., 2017; Petersen et al., 2013; Schaub et al., 2013). In response to this, a proposal of several potential indicators (e.g., syringes/person who inject drugs/year) has already been released (Wiessing et al., 2017), but pilot studies on its feasibility and applicability for monitoring harm reduction services are still needed. Alongside the MQS, such indicators may be useful to discourage services from using their own standards and indicators.

The mechanisms through which QS implementation can be enhanced pose several challenges, particularly for health professionals. The fact that QS is not mandatory but voluntary in some countries was highlighted by most of the key informants as a barrier that may compromise the implementation of QS across DDR areas, which has also been confirmed by other authors (Ferri & Griffiths, 2021). Voluntarism may account for the lack of information about several countries (e.g., Sweden, Malta) and can be explained, at the same time, by the absence of an accreditation systems (a form of quality assurance) that is usually placed at the national level. Relatedly, for many countries key informants provided information at the national level in a greater extent, suggesting QS may be scarcely implemented, or at least monitored, at local/regional levels. There are some examples of QS being a prerequisite for participating in publicly funded programs (Ferri et al., 2018), an aspect that may also encourage institutions and substance use facility centres to adopt the QS.

Aside from accreditation systems (i.e., ISO norms), increasing efforts can be observed to develop toolkits to analyze the quality of the services offered and to ensure continuous improvement based on ongoing evaluation of existing practices. The UNODC has led an initiative in this area (Busse et al., 2021) and all agents, including those involved in planning, funding, and monitoring, are expected to adopt appropriate mechanisms for ensuring compliance with QS implementation.

Other aspects that might compromise the adoption of QS pertain to the un(der)recognized importance of evaluation and the lack of a common, evidence-based vision. Support by decision and opinion policy makers (DOPs) will be essential to change this scenario. In this regard, academics have an important role, not only in advancing knowledge about evidence-based treatment and interventions, but also in promoting the practical utility of QS (Fernandez Lynch et al., 2020). Evaluation pertains to a systematic gathering of data within a particular service/ program, so it can be used to improve existing services and make decisions on best practices. A major issue is the fact that evaluation requires some technical skills that practitioners usually lack. Evaluation and continuous monitoring are usually considered complicated and time consuming. In fact, evaluation is argued to cover the initial phases of program development, process evaluation, and outcome evaluation (Rush, 2003). The latter means evaluation should be implemented as a consistent basis and continuously to ensure the efficiency and cost-effectiveness of existing programs (EMCDDA, 2017b, 2021b). It is important that the budgets for conducting DDR practices include money for evaluation. It is conceivable that most health practitioners are subjected to high time pressure and workload. Consequently, if there is not a culture of evaluation, meaning that poor organization support is available, either process or outcome evaluation is not expected to occur.

Key informants indicated that mandatory application of QS and sufficient resources (materials, training and economic resources) could expedite the implementation of QS, which is supported in the literature (Autrique et al., 2016; Campello et al., 2014). Lack of training and education are commonly reported as challenges to advocate on the implementation of QS (Orte et al., 2020). Knowledge is also related to a 'culture of evaluation', meaning the recognition of ongoing monitoring and evaluation efforts in all substance use working areas. For example, The Science for Prevention Academic Network (SPAN) survey conducted in the prevention workforce indicated that low levels of advocacy for prevention are in fact due to training, and low funding may hamper effective implementation systems (Ostaszewski et al., 2018). Several initiatives (Agwogie & Bryant, 2021; Henriques et al., 2019) focused on increasing the knowledge and skills of the workforce in DDR areas have been launched in university and continuing education programs, but also targeted to law enforcement officers and health care professionals on a wide variety of topics (prevention, treatment, and early intervention). One example in Europe is the European Universal Prevention Curriculum (EUPC), a training course on evidence-based prevention developed for people working in the prevention

field, but also for those involved in prevention decisions, opinions, and policies in Europe. This training course is delivered in 5-half-days (if online) or 2 days (if face-to-face) and focuses on prevention science, theoretical models, epidemiology, different prevention areas (school, work, family, environmental) and the basics on the evaluation of prevention programs. The feasibility of implementing a training to practitioners in the substance use field has been previously evaluated. Agwogie and Bryant (2021) have provided evidence on the feasibility of implementing a six-day training course (based on the European Prevention Curriculum [EUPC]) to 202 practitioners in the substance use prevention area. Amongst others, authors noted knowledge gains in the science of evidence-based prevention, policy interventions, skills, and self-efficacy to communicate with stakeholders. Collectively, the results suggest that further enhancing the implementation of QS across DDR areas and countries can be successfully reached if all relevant decision, opinion and policy makers are involved. Conducting trainings of trainer's courses similar to the EUPC program in the treatment and harm-reduction areas is expected to contribute to increased QS implementation.

The results presented should be interpreted against the background of several limitations. First, the process for selecting key informants was not conducted randomly, in the absence of overviews of QS experts per country and drug demand reduction area. Also, the sample of study participants is rather small to allow generalization of the results on a national or EU level, and possibly, some important key informants were not reached, contributing to unequal representation across DDR areas and countries. Although the criterion for selecting participants was the ability to provide an overview of national implementation of QS, the sample of key informants was heterogeneous in terms of the institutions from which they came (national EMCDDA contact points, NGOs, other relevant national institutions in the field, academic community). Another limitation for drawing conclusions was the fact that some of the key informants reported on the implementation of QS only in cases where QS was formally adopted in their country, which in some cases led to conflicting information from key informants in the same country. Second, findings are based on experts' opinions and examining evidence of QS implementation by external evaluators (e.g., grades of evidence for actual implementation of specific QS) may have provided a more accurate assessment. Finally, the level of implementation of QS could not be measured and levels of implementation for each specific QS cannot be ascertained.

To conclude, The EU Drug Action Plan for 2021-2025 recognizes the relevance of offering services that consider QS in DDR. Within this context, FENIQS-EU project gathered important data on the implementation of QS across Europe. The findings reveal that QS are not consistently adopted across DDR areas, nor are they applied widely. Key informants in the prevention area described better scenarios in terms of QS implementation as compared to the areas of harm reduction and treatment. This finding is concerning as it suggests that some services may deviate from evidence-based practices. Several barriers such as lack of training, insufficient economic resources, and non-mandatory QS implementation may compromise the adoption of QS. This study identifies several steps to accelerate the implementation of QS. More efforts should be made to advocate for the need to implement QS. National authorities, especially at the local and regional levels, should be aware of the need to require proof of implementation of QS as a mandatory requirement for project funding. To achieve this goal, it is important to invest in the training of local experts, i.e., to enhance education and training of DDR workforce and to create a culture of continuous evaluation. Another important step for the future is to increase funding so that long-term contracts can be signed to ensure the sustainability of QS implementation.

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