Quality Assurance Policy in Harm Reduction Services in the Czech Republic: A Case Study of a National System

MIOVSKÝ, M.[1,2], ČERNÍKOVÁ, T.[1,3], KALINA, K.[1,2], NOVÁKOVÁ, E.[1]

1 | Charles University, First Faculty of Medicine, Department of Addictology, Prague, Czech Republic
2 | General University Hospital in Prague, Department of Addictology, Prague, Czech Republic
3 | National Monitoring Centre for Drugs and Drug Addiction, Prague, Czech Republic

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BACKGROUND: In the field of harm reduction (HR), an established quality assurance system with implemented quality standards is rather rare in practice. Together with limited evidence in this area, this leads to an imbalance in the basic segments of drug demand reduction and their lack of compatibility and alignment in terms of therapeutic continuity. **AIMS:** The paper presents case study analysis of the context and a description of the original quality management system in harm reduction at the national level. **METHODS:** The case study design is based on a narrative review from a search of databases, including grey literature for the period from 1990 to 2022, followed by subsequent qualitative content analysis. **RESULTS:** After 1989, there was an exponential increase in HR services, with a strong initiative of non-governmental organisations (NGOs) and significant professionalisation from the beginning of the HR services network. It is the NGO initiative that has contributed significantly to the introduction of a certification and quality standards since 1995. In the following period, the system was expanded to include other quality management components (system for monitoring, ethical standards). **CONCLUSIONS:** In terms of national drug policy and the continuous development of drug services, the introduction of a quality assurance system was a critical point with dozens of implications, including balancing and equalising the position of harm reduction in the drug demand reduction system in the Czech Republic.

Keywords | Harm Reduction – Quality Assurance – Quality Management – Quality Standards – Certification – Drug Policy – Qualitative Case Study – Continuous Development

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Corresponding author | Professor Michal Miovský, PhD, Charles University, First Faculty of Medicine and General University Hospital in Prague, Department of Addictology, Apolinářská 4, 128 00 Prague, Czech Republic **michal.miovsky@lf1.cuni.cz**

1 INTRODUCTION

In the context of European countries, since the 1960s there has been an increase in heroin use, especially injecting, with a subsequent rise in the number of associated serious health consequences such as HIV/AIDS and overdose (Hartnoll et al., 1989; Bargagli et al., 2001; Kringsholm et al., 1994; Lepère et al., 2001; Hedrich et al., 2008). This was perceived as a major public health problem at both the national and European levels because of the associated health complications associated with increased drug use (Hedrich et al., 2008). Thus, the harm reduction (HR) approach gained in importance in the 1980s, when it became a key part of drug policies in addition to treatment and prevention.

HR refers to concepts, programmes, and activities aimed primarily at reducing the adverse health, social, and economic impacts of the use of legal and illegal substances and the term is used with many meanings: as a pillar of drug policy, as a direct intervention to people who use drugs (henceforth PWUD), as a needle and syringe programme, and others. However, it should not be forgotten that the term primarily declares an approach through the lens of which the entire drug issue and policy can be viewed. The concept of HR can be understood as a kind of antithesis to the war on drugs, which is characterised by zero tolerance of drug use (Janíková, 2015).[1]

Globally, HR is becoming the dominant policy response to problem drug use and the associated harms. The best-known examples of HR are the provision of sterile injecting equipment to people who inject drugs and the provision of opioid agonist treatment. However, HR as a 'combination intervention' comprises a set of much larger interventions tailored to local settings and needs (Rhodes & Hedrich, 2010) and HIV and other infectious diseases are not the only target of HR interventions. Many programmes focus their efforts on other aspects of substance-related harm, addressing them at both the individual and community level. Some European countries have introduced drug consumption rooms as a necessary response to the open drug scene and public drug use with a public health and public order objective (EMCDDA, 2018).

HR services operated by various providers represent the latest segment of drug services linked to the strengthening of human rights and increasing respect for individual rights and public safety, usually integrated into the broader context of the public health approach and measures. Babor et al. (2017) provide an inspiring framework reflecting the broad scale of professional careers closely linked to an astonishing number of drug service profiles and the emerging concept of drug studies. HR services represent an integral part of this picture and, as shown by the first case studies (e.g. Miovský et al., 2019), this segment of services has been successfully established and integrated into the national drug policy in some countries, and includes a high level of professionalism of staff and linkages to existing qualification systems, competency models, and academic institutions.

The establishment and development of HR services in many European countries was supported by a number of strategic and policy documents, on the international level, for instance, by WHO et al. (2009); Rhodes & Hedrich (2010); EU Council (2015); Murray (2008); Schaub et al. (2013) ; Uchtenhagen & Schaub (2011); Autrique et al. (2016); Ferri et al. (2018), and on the national level by e.g. Kalina (1993); Kalina et al. (2001) and the Secretariat of the Government Council for Drug Policy Coordination (2020a, 2021). Despite the positive development of HR, we cannot speak about a balanced approach and equal position of HR services compared to traditional abstinence-oriented treatment services. This is demonstrated by the brittle financial support, which in many countries continues to rely predominantly on the subsidy system and not on the health and social insurance system/payment (by institutional payers), with logical consequences in the unstable financial support affected by every significant crisis, as has been described and demonstrated, for instance, in Central Europe (Miovský et al., 2020).

1.1 Czech historical background: harm reduction behind the Iron Curtain

Until 1990, addiction treatment was carried out in state healthcare facilities and the focus was mainly on an abstinence-oriented approach. In 1948, Professor Jaroslav Skála, a key figure in Czech addiction medicine, founded the first specialised treatment department for men, called Apolinář, as a branch of the Psychiatric Clinic at the Charles University Hospital in Prague. Over the following years, a broader range of services became available. In 1971, an outpatient treatment for PWUD called the Centre for Drug Addictions was opened (see Skála, 1998; Skála et al., 1994 in Kalina, 2007). This brought a historical breakthrough, as the communist regime was confronted with the necessity of admitting the existence of the drug market and the use of illicit drugs. Despite this fact and the official doctrine that illicit drugs and users were not present in a socialist society, it was possible to recognise some first increasing trends related to injecting medicaments (e.g. Hampl, 1985).

Until 1980, addiction treatment services were classified as psychiatric and were mainly for people who used alcohol. In 1980, however, the treatment of 'alcoholism and toxicomanias' was established as a new medical specialisation, and these facilities were formally separated, although they were still officially linked to psychiatry. These services were strongly affected by many negative phenomena, such as administrative rigidity, lack of funding, lack of communication with the international professional community, and impersonal attitudes towards patients (Kalina et al., 2003a; Kalina et al., 2003b; Kalina, 2007).

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1 | For the purposes of the article, HR refers to a standardised type of addiction services in the Czech Republic as defined by the concept of the development of addiction services (Secretariat of the Governmental Council for Drug Policy Coordination et al., 2021). These services mainly target the population of PWUD, defined according to the traditional European definition of 'problem drug use' as 'injecting drug use or long duration/regular use of opioids, cocaine and/or amphetamines' (European Monitoring Centre for Drugs and Drug Addiction, 2009). Thus, in the article, the concept of HR is narrowed down to only providers of these addiction services for this target group.

In the 1970s and 1980s, crude homemade potent injectable stimulants and opioids spread through underground drug user networks throughout the former Czechoslovakia (Zábranský, 2007). Over the next few years, the Centre for Drug Addictions carried out pioneering work on HR strategies and in 1987 the first (rather unofficial) needle and syringe exchange programme (NSP) was launched and people who used opioid drugs were issued ethylmorphine, which was legally prescribed by physicians as a substitute (Kalina et al., 2003a; Kalina, 2007). The psychiatrist Jiří Presl and clinical psychologist Ivan Douda stood behind these activities and were tolerated by the official head of the addiction department, Jaroslav Skála, and supported by his key co-workers (Rubeš and Urban) and represented the de facto first critical movement in this area (Kalina et al., 2008) followed in the 1990s by a real wave of newly-established professional HR activities, programmes, and facilities.

1.2 Quality in the context of national drug policy

Standards and guidelines are essential tools for quality management aiming at dissemination and implementation of evidence-based interventions (Ferri & Griffiths, 2015). Quality standards usually focus on the procedural and structural aspects of quality assurance, e.g. service planning and evaluation (process) and the content of interventions, staff competencies, and the service environment (structure). Standards tend to be based on professional consensus and produced by recognised national or international bodies (Ferri & Griffiths, 2015; EMCDDA, 2011). Another component of quality assurance is the control mechanisms to assess the extent to which the established reference frameworks are met in practice. These mechanisms include formal ways such as on-site inspections/field visits, accreditation, certification, or licensing (Mravčík et al., 2010), but also comprehensive workplace quality management, benchmarking, internal and external auditing, and others. Quality assurance is a part of a quality management system that includes quality planning, quality control, and quality improvement (Gabrhelík, 2015).

In the context of the Czech Republic, quality control of addiction services refers to assessment and formal recognition of compliance with the determined quality, competence, and comprehensiveness criteria set by the standards built on professional consensus. The assessment is carried out as part of an on-site investigation by a team of certified examiners, who verify the fulfilment of the criteria. The process and the responsibility of all actors is described in detail in the so-called Certification Rules. The quality assurance standards are aspirational; however, the interconnectedness of quality assurance and public funds forms the quality control mechanism. In addition, an essential component of the practical implementation of quality assurance and control is adherence to ethical standards developed on professional consensus. The information system for the mapping of activities related to work with the target group represents another practical tool. The staff requirements are, as an integral part of quality assurance and control, reflected in e.g. legislation, QS, and educational curricula.

With the development of HR services, there was a growing need to assure their adequate quality. In practice, however, it is possible to encounter diverse and often different interpretations of the terms 'quality' and 'efficiency'. Kalina (2000) and Kalina et al. (2001b), who had a fundamental influence on the topic of quality and effectiveness with regard to, inter alia, the national drug policy and addiction treatment scene, state that quality can be derived in different ways, e.g. from methods and interventions, from the way they are applied in practice, from service providers and staff (quality derived from qualifications), and from ethical values, target groups, and their needs (Miovský et al., 2015).

Despite the definition of quality being almost impossible, the desired level of quality in HR can perhaps be derived from the objectives of the interventions. HR is a human-centred approach that respects the human rights of people who use drugs. The inclusive and compassionate principle of HR interventions and strategies is essential to achieving good health for individuals and communities. The availability of HR services, sufficient research data and information, supportive policy settings, and a reduction in the level of marginalisation, criminalisation, and stigmatisation of PWUD are essential for the good quality of HR services (Harm Reduction International, 2020).

For services, it is necessary to continuously evaluate their scope, results, and objectives both internally and externally. This ensures the fulfilment of the goals and principles of the services and their continuous and meaningful development and increases their efficiency. Furthermore, it ensures the participation and reflection of the needs of clients, the reflection of the needs of the staff, and the fulfilment of formal requirements for the functioning of the service (Secretariat of the Government Council for Drug Policy Coordination, 2021).

The aim of the study was to identify and describe the process and background of the development and implementation of an original national quality assurance and control system (quality management) for HR services in the Czech Republic – for service providers, staff, methods and clinical practice and ethical issues, and demonstrate the entire process in a broad context and with possible implications for transferability in different settings.

2 METHODS

2.1 Design

A narrative review was used for describing and analysing the full story of the emergence of the nationwide quality system in harm reduction. The entire narrative review was prepared according to SANRA (the Scale for the Assessment of Narrative Review Articles) (Baethge et al., 2019).

2.2 Setting

Czech Republic; period from 1990 to 2022.

2.3 Information/data sources

For the development of the case study, we used retrieved literature originating from searches of computerised databases, manual searches, and authoritative texts (Baethge et al., 2019; Green, Johnson, & Adams, 2006). The following databases were searched: Academic Search Ultimate, Charles University Central Catalogue, EBSCO eBooks, Electronic Journals Library Charles University, Institute of Scientific Information, JSTOR, Kramerius 5, Oxford University, SALIS, Science Direct, Google Scholar, Scopus, Springer, Taylor & Francis, and Web of Science. After the searching, key information sources were identified, including grey literature: unpublished reports, working versions of documents drawn up as part of implementation-related projects, and the available strategic and working documents of participating governmental and non-governmental institutions.

2.4 A search was conducted in the Czech language using the search terms

Drop-in centres, harm reduction, risk reduction, outreach-work, service providers, quality, quality standards, quality control, certification, tertiary prevention and their combinations.

2.5 Data collection and content analysis process

We selected duplicated documents and according to a topic-relevance review a final set of documents for further analysis was prepared. The data sources were screened, categorised, and systematised. The subsequent content analysis of all the texts was focused on the identification of relevant thematic areas and their content. The following categories were created with the purpose of identifying and describing (an identical methodological procedure was used in a similar review process in Miovský et al., 2022):

1. the temporal consecution of the fundamental decisions and steps associated with the concept of a quality management system and its implementation;
2. the key stages of the entire process and their relationship with the major factors influencing the development, course, and outcome of a given stage (such as specific projects, institutions, strategies adopted by the government, and associated tasks);
3. the milestones in the development of the quality management system and the context of changes in the core concept, and factors that had a bearing on such changes;
4. the barriers to full implementation and factors that play a critical role and moderate the establishing process to provide a better understanding of this complex process.

One reviewer (MM) screened the titles/abstracts and analysed the full texts of the texts that were identified.

3 RESULTS

Stage I (1990–1995): Can harm reduction can be an official part of a national drug policy and institutional network in addiction medicine?

Activities from the early 1990s were crucial for the development of HR strategies and facilities and the establishment of the foundations of the drug policy. After the change of political regime in 1989, many experts issued warnings about the rapid spread of illicit drugs in the context of open borders and the introduction of a market economy (Kalina, 2007; Zábranský, 2007). In the former Czechoslovakia, the Federal Commission on Narcotics was established in 1991 as an advisory body to the government, but its activities were severely limited by jurisdictional complications and did not continue after the 1992 elections.

After 1990, there were significant changes in the healthcare system that led to different ways of treating people who use drugs or alcohol. The new model was based on mandatory health insurance, a combination of public and private services, and the creation of contractual relationships between service providers and health insurance companies. It became possible for special addiction healthcare to be covered by public health insurance, a situation which persists to this day. For the first time in the history of the country, drug and alcohol services could thus be provided outside the public sector, as healthcare funding became available to private NGO providers. However, the intended changes to the funding system were not fully implemented in practice for a number of reasons. Many innovations in drug treatment were dependent on external funding through government subsidies or grants (see also Miovský et al., 2020). However, reforms in the healthcare system raised concern about the quality of care, helped to increase the flexibility of service providers, and fostered concern for the needs of clients and patients (Kalina, 2007).

In 1991, the first two NGOs for PWUD were established, soon followed by several others. These emerging services established themselves as providers of a range of interventions and programmes for PWUD and responded rapidly to the changing needs of the target population. This led to the development of a strong non-governmental service sector providing professional care in the areas of counselling, HR, and all the available treatment and social rehabilitation modalities (Kalina, 2007).

At the end of 1992, civil society[2] mobilised and addressed the government with a warning of the imminent threat of a drug epidemic, called for action, and expressed a readiness to cooperate in the document called the Christmas memorandum (Kalina et al., 2001a). Thus, in 1993, the government established the National Drug Commission as an advisory body to the government (Kalina, 2007; Kiššová, 2009; Kalina et al., 2003a). In the same year, the government approved the Commission's proposed Drug Policy Concept and Programme for 1993–1996. It

2 | Leading national experts particularly associated with the emerging non-profit sector in the field of addiction medicine.

was based on a balanced pragmatic approach, rejecting the legalisation of drugs but also the criminalisation of PWUD. HR became one of the four pillars of the national drug policy, placing it on the same level as prevention, treatment/social reintegration, and supply reduction measures. Priority was given to the fight against organised crime and the development of services for PWUD. It also expressed the indispensable role of NGOs as service providers for PWUD (Kalina, 2007; Kalina, 1993). Thanks to its highly professional approach and well-established services the NGO sector became a significant partner to governmental bodies. NGOs were less dependent on international financial support and were better integrated into the national system of drug policy and services – which was probably the crucial factor that helped NGOs operating HR programmes to be less affected by system changes, for instance during the financial crisis that had a negative impact on the HR segment in some Central European countries (Miovský et al., 2020).

The NGO sector in the field of addiction medicine was essentially shaped and the foundations of the Czech drug policy were laid (Miovský et al., 2014). Some of the state hospitals responded flexibly to the new situation and emerging needs by creating detoxification units and/or starting outpatient methadone maintenance programmes (Kalina, 2007).

Stage II (1995–1998): Joint National Accreditation Commission: a heresy against the National Drug Commission and Ministry of Health

The first national drug policy strategy (Kalina, 1993) was adopted shortly after the 1989 Velvet Revolution and HR became one of the pillars of the national drug policy. In 1993, the National Drug Commission was officially established. However, apart from the national drug policy strategy, HR services were not anchored in legislation during this period.

With the rapid development of HR services, there was a growing need to ensure good quality and service delivery. Since 1995, national quality standards have been formulated. The first version, the so-called “Minimum Standards”, was published by the National Drug Commission in 1996 as a set of recommendations for service providers and as a stimulus for professional discussion (Kalina, 2007). The first standards were based on the principle of recommendations and their implementation was not systematically monitored either by the state authorities or the professional community (Kalina et al., 2003b).

On the other hand, the Joint Commission for Accreditation (JCA) became a significant element in the quality assurance system in the healthcare sector, including the medical aspect of addiction services, especially of the residential kind. The JCA has been performing accreditation since 1998. Healthcare facilities must meet the conditions of the accreditation standards. Once accredited, the facility receives a certificate valid for three years. The standards respect the variability of health services and so are generally not prescriptive but guide the facility to develop internal regulations based on current legislation, the professional opinion of managers, and published best practice. The stated aim of accreditation is to continuously improve the quality and safety of healthcare (Nováková, 2021). Although the terms ‘accreditation’ and ‘certification’ are often used interchangeably, they are not synonymous in meaning. Accreditation is granted by an accreditation body and confirms that the accredited body is competent to carry out specific activities. Certification is a process at the end of which a decision is made to grant or not to grant a certificate, which is a written confirmation by an independent third party that a product, management system, or professional competence shows compliance with predefined requirements and the certified entity is thus able to systematically meet the requirements of the product or service provided (Czech Institute for Accreditation, 2010). Accreditation is mainly associated with the healthcare segment.

Stage III (1998–2005): From first experiences to a comprehensive national system for quality management

The second Government Drug Policy Concept and Programme for 1998–2000 can be characterised as an attempt to develop systematic tools to measure the quality and effectiveness of the services (Kalina et al., 2003a). In addition to the development of the quality standards and the related certification process, the efforts were directed towards the improvement of collaboration between various institutions and the development of education and funding (Kiššová, 2009).

In 1998, two years later after the launching of the “Minimum Standards”, work began on a more elaborate version of quality standards (QS) under the leadership of Associate Professor Kalina. This extensive work was based on a broad discussion and several pilot projects and was not fully completed until 2003 (Kalina, 2007; Secretariat of the Governmental Council for Drug Policy Coordination, 2004). The basis for the QS was formed by the WHO Minimum Standards, the Methodological Measure of the Ministry of Health of the Czech Republic, the SCODA standards from the UK, and the basic quality manual recommended by the European Union. The QS also included and reflected the requirements set by the Ministry of Health and the quality standards and guidelines of the Ministry of Labour and Social Affairs.

In the following year, the certification process (verification of the fulfilment of QS in practice) was supposed to start, but for political reasons it was postponed and did not start until 2005 (Kalina, 2007). In addition, for the first time since 1993, the PAD[3] research project succeeded in comprehensive mapping of the situation of illicit drug use and the measures put into practice and their impact on the drug situation (Kiššová, 2009).

The Concept developed for the period 2001–2004 became a strategic plan for the first time and HR was one of the four pillars of government drug policy (Kiššová, 2009, Radimecký et

3 | The project on the analysis of the impact of the amendment of drug legislation (PAD), a research study conducted in 1999–2001, dealt with the mapping of the consequences of the implementation of the amended drug legislation in practice.

al., 2004). The plan focused on maintaining continuity of development and on improving the quality and efficiency of services for PWUD *(Table 1).*

The National Drug Commission was transformed into the Government Council for Drug Policy Coordination (GCDPC)[4] in 2002. In the same year, an institutional framework for evaluating drug policy measures was established with the aim of ensuring that the measures proposed and implemented were evidence-based. The National Monitoring Centre for Drugs and Drug Addictions (NMC) was established at the GCDPC and became responsible for the collection, analysis, and distribution of data. This period also involved the establishment of interdisciplinary education and training programmes integrating the HR concept into the curricula. Two of these programmes were transformed into the first model of a bachelor's university programme focused on addictions (Miovský et al., 2016). Moreover, in 2003, an essential monograph for national addiction science was published (Kalina et al., 2003a; Kalina et al., 2003b). It summarised the evidence, knowledge, and national developments to date and revealed HR as a necessary part of the professional and policy approach to addictions and the service system. In 2003–2004 a list and definition of the performance of addiction services was created with the aim of unifying and standardising the method for evaluating the quality and effectiveness of services intended for PWUD and their relatives, including the preparation of a unified reporting system for these services (GCDPC, 2020). The UniData application, managed by the NMC, was created to manage the complete work with clients of addiction services. It served as a reporting application and as an information system mapping the full range of activities related to work with clients. In this period, solid foundations were created for quality in HR services, but also for an evidence-based drug policy.

Stage IV (2005–2015): Emergence of a new doctrine: a comprehensive approach towards addiction services based on equal positions

Treatment for PWUD was predominantly provided at the interface between health and social services. This entailed challenging coordination, funding, and quality assurance activities across ministries. Therefore, it was an important step in framing the quality assurance system for addiction services. The Czech Republic was one of the first EU countries to make an attempt to formulate quality standards and put them into practice, and the first EU country to link quality standards to funding (Pavlas Martanová, 2012). The system of certification was approved by a government resolution,[5] with the aim being to ensure the quality of services provided in the HR, treatment, and aftercare sectors. Since 2007, certification has been a prerequisite for obtaining government subsidies. The key documents of this process include the Certification rules, which set out the roles, status, and responsibilities of the various actors, and, above all, the Standards of Professional Competence for Addiction Services (hereinafter referred to as the 'Standards'), a reference framework defining the minimum requirements for the quality and professional competence of addiction services. The Standards have contributed significantly to the professionalisation of services.

In 2006, after many years of preparation, the Act on Social Services was adopted, setting out the types of social services and the system for their funding, accessibility, and quality assurance. PWUD are listed in the law as the target group of some types of services, especially in the field of HR (Miovský et al., 2013). In 2008, a revised version of the tasks list called the MES – Minimum Evaluation Set – was developed within the then Centre for Addictology – currently the Department of Addictology (Miovský, 2008). It became the basis for later reporting tools.

In 2013, the first Concept of a network of specialised addiction services in the Czech Republic was approved by two professional societies. However, no full consensus was reached on the Concept with the addiction services representing the social segment of care (Miovský et al., 2013).

It has been shown that defining the performance of health and non-health professionals can have a positive impact on bridging the divergence across ministries, especially the health and social sector (Miovský et al., 2013). In 2005, the Centre of Addictology was established at the Psychiatric Clinic of the First Faculty of Medicine of Charles University and the General University Hospital in Prague. The Centre acted as a multidisciplinary research and educational workplace, and its establishment anchored addiction science and medicine as transdisciplinary fields of science. Undergraduate education in addictions was initiated, later complemented by master's and doctoral degrees. In the context of the study programme, the Act on Non-Medical Health Professions was amended in 2008 and the professional competence to practise this profession was defined (Miovský et al., 2016). According to the law, an addiction professional can perform a number of activities without a physician's/psychiatrist's indication and professional supervision, including actively carrying out targeted searches in the population to identify persons at risk and reducing the harm of substance use (Fidesová, 2013). Soon after, a professional association of addictologists was established.

Over time, the need to revise the Standards arose. As part of the evaluation of the first stage of certification since its beginning in 2005, the independent certification agency collected substantive suggestions from the professional community in 2007. A working group to revise the Standards was estab-

4 | The GCDPC secretariat is part of the Office of the Government and provides drug policy coordination, monitoring of the drug situation, and funding for drug policy programmes under the grant scheme; the GCDPC also manages national policy and the system of quality assurance in drug services. While the development of the network of drug services is coordinated and supported by the GCDPC, the prevention system was subject to rather specific developments.

5 | Government Resolution No. 300/2005 of 16th March 2005.

Table 1 | Overview of the development of HR services in the Czech Republic (1998–2021)

Year	High-risk drug users (est.)	HR programmes (NSPs)	Needles and syringes distributed
1998	–	42	486,600
1999	–	64	850,285
2000	–	80	1,152,334
2001	–	77	1,567,059
2002	–	88	1,469,224
2003	29,000	87	1,777,957
2004	30,000	86	2,355,536
2005	31,800	88	3,271,624
2006	30,200	93	3,868,880
2007	30,900	107	4,457,008
2008	32,500	98	4,644,314
2009	33,600	95	4,859,100
2010	35,000	96	4,942,816
2011	36,200	99	5,292,614
2012	36,000	103	5,356,318
2013	40,000	110	6,175,118
2014	41,900	105	6,594,069
2015	42,200	104	6,403,404
2016	40,800	104	6,469,441
2017	41,700	108	6,401,662
2018	43,700	107	6,932,269
2019	45,100	106	7,459,123
2020	44,200	111	8,889,377
2021	44,900	112	9,379,090

Source: Chomynová et al. (2022)

lished in 2010,[6] which was based on other related input from the professional community, the evolution of the professional debate, and the requirements for addiction services (Libra et al., 2012). The revised version included a new service type, and thus the special section consisted of ten service types, including outreach programmes, low-threshold centres, and substitution treatment. The general part included a description of the service and the rights of the clients, personnel work and the ensuring of expertise, access of the clients to the service, and the principles of the care provided. It also included a description of the organisational aspects, the environment of the service, including dealing with possible incidents and emergency situations, and, last but not least, the requirements for the evaluation of quality, safety, and efficiency (Libra et al., 2012).

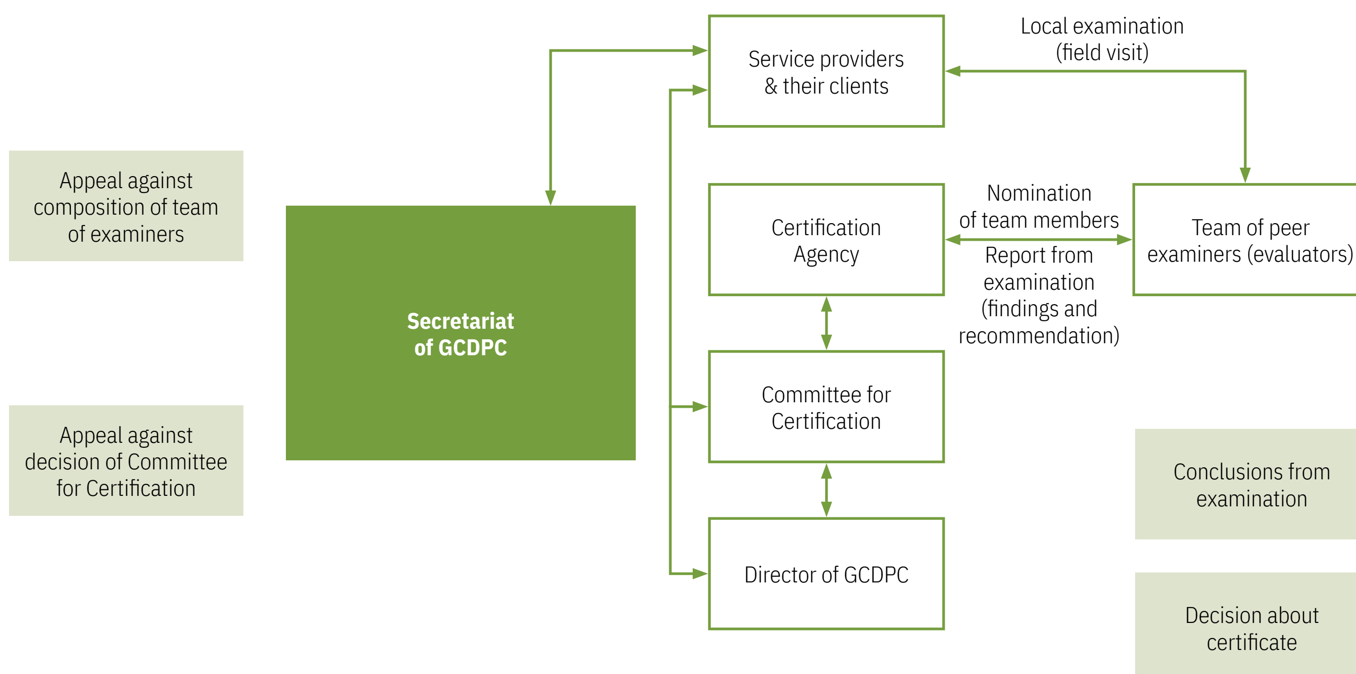
6 | Thanks to the project "Exchange of experience and dissemination of good practice in the field of quality management of services for drug users" funded by the European Social Fund and implemented by the Centre for Quality and Standards in Social Services of the National Education Fund (an independent certification agency).

A revised version of the Standards was referred for field testing (Miovský et al., 2013).

In 2010–2018, the first long-term National Drug Policy Strategy was in force. Therefore, the Strategy outlined the framework of the drug policy and the core approaches, principles, and objectives. HR was one of the core strategic approaches, and one of the four pillars of the drug policy. This period was an important milestone in the focus areas of the drug policy. In 2014, the concept of a so-called integrated drug policy started to be adopted by the Government; the gambling and tobacco policies were incorporated into the existing drug policy targeting illicit substances.

In addition to the importance for quality assurance of HR services and the HR approach, this stage was characterised by the fact that the scope of HR services went beyond the "traditional" area of PWUD at high risk by operating in nightlife settings (Saberžanovová & Vacek, 2010).

Figure 1 | Key actors and levels of their interaction in the certification process of addiction services in the Czech Republic



Source: Figure adapted and modified from Beránková et al. (2004).

Stage V (2015–2022): ...opening the door to a financial breakthrough

In 2015, the Standards were innovated in order to respond to legislative changes, to the introduction of social work QS into practice, and to changes in field terminology (Libra, 2015). However, the major revision of QS had yet to come later in this stage. The Concept of Addiction Services was revised (Secretariat of the Governmental Council for Drug Policy Coordination et al., 2021). According to it, the service must be provided in accordance with an evidence-based approach and the recommended practices of the relevant professional societies and authorities. It also sets out the requirement that the service is obliged to have an internal system of monitoring and improvement of quality and safety. Services must adhere to established organisational parameters and conduct regular self-assessments.

A major revision of the Standards was conducted in 2019–2021 within the RAS Project.[7] The revised version is in line with the new typology of addiction services[8] and the revised Certification rules. The division into a general part containing minimum requirements common to all types of addiction services and special standards reflecting the new service typology was maintained. Risk minimisation (HR) addiction services thus clearly define their position in the treatment continuum and system of addiction services, becoming equal to prevention and abstinence-oriented services. The standards establish minimum/basic conditions for the quality and effectiveness of addiction services and are consistent with other ministerial requirements (Secretariat of the Government Council for Drug Policy Coordination, 2021). The project also included a revision of the list and definitions of the performance of addiction professional services, which was also linked to a revision of the reporting system. The AdiData application, replacing the older version of UniData, was designed (Secretariat of the Government Council for Drug Policy Coordination, 2020b). Since 2019, the HR approach has become a core principle of the national drug strategy and reducing harm is part of its title. The goal of the strategy is to prevent and reduce the health, social, economic, and intangible harm related to the use of addictive substances and addictive behaviour, and to the existence of markets in products with addictive potential (Secretariat of the Government Council for Drug Policy Coordination, 2020a).

After years of preparation, in 2022 work began on formulating clinical guidelines in addiction medicine based strictly on an interdisciplinary approach and evidence-based principles. The development of the guidelines also covers their promotion in all relevant professional groups, discussion, and the building of consensus with key professional societies in the field. In line with developments to date, the guidelines fully integrate HR and risk reduction methods as a core component *(Figure 1* and *Figure 2).*

7 | "Systematic Support for the Development of Addiction Services within the Integrated Drug Policy". An ESF project focused on the systematic development of addiction services under the GCDPC (2016–2021).

8 | Addiction prevention services, risk minimisation (harm reduction) services, outpatient treatment and counselling services, short-term stabilisation services, residential treatment services, and after-care services.

Figure 2 | Key steps in the certification process of addiction services in the Czech Republic

Source: Figure adapted and modified from Beránková et al. (2004).

4 DISCUSSION

The development of the quality assurance system, which was successfully linked to state funding for HR services, led to the formation of a network of HR services with relatively good coverage throughout the Czech Republic. Besides the first (rather unofficial) needle and syringe exchange programme before the 1989 Velvet Revolution, the first low-threshold drop-in centre was established in 1993 and the first outreach programme in 1994. For comparison, in 2021 112 needle and syringe exchange programmes were in operation across the country. The stability of the network of HR services has a positive influence on the number of needles and syringes distributed, leading to low HIV rates among PWUD; in recent years, the Czech Republic has been meeting the WHO 2020 target for needle and syringe distribution (Chomynová et al., 2022).

It is possible to recognise quite an interesting side effect of the broader and continual reflection of quality. Over time, the HR programmes have expanded their scope, e.g. interventions in nightlife settings and at music festivals. This also applies to the evolution of the HR approach in other areas than illicit drugs within the integrated addiction policy. Since 2020, a low-threshold HR facility for the target group of people who use alcohol has been operating; the main objective of the service is to reduce the social and health harms associated with the use of alcohol among predominantly homeless people. In addition, the extension of the target group to include people who use alcohol is recognised in a number of low-threshold drug services. Since 2022, the HR approach has been included in the recommended guidelines for the treatment of tobacco dependence (Králíková et al., 2022). The HR approach is also visible in the area of gambling; the intention of the "HRaní" project is to develop and implement a new method of preventive online outreach work linked to an HR mobile app aimed at preventing the development of problematic or pathological gambling, and thus reducing the harms that arise, e.g. the breakdown of relationships, indebtedness, or criminal activity.

The post-revolutionary developments in the Czech Republic subsequently allowed the introduction of the concept of risk minimisation, particularly in the area of illicit drugs. A modern integrated drug policy covers the area of legal and illegal substances, gambling, and the abuse of digital technologies. It is defined as a comprehensive and coordinated set of prevention, education, treatment, social, regulatory, control, and other measures, including law enforcement measures, implemented at the international, national, regional, and local levels (Secretariat of the Government Council for Drug Policy Coordination, 2020a).

In addition to quality standards and certification, there are several other key elements for quality assurance. The quality of methods and care delivery is assured through standards and the certification process, but after many years of development, clinical guidelines in addiction medicine, including HR meth-

Table 2 | Summary of the key periods in the development of the national quality control and management system in HR in the Czech Republic

Stage	Key steps and projects	Components and thematic focuses	Level of implementation
Stage I (1990–1995)	Interministerial Drug Commission Professional society	First awareness and mention of professional requirements and recommendations First National Drug Policy (Kalina, 1993) Development of the NGO sector	Formative promotion
Stage II (1995–1998)	Government Council for Drug Policy Coordination Professional society Joint Commission for Accreditation	First version of Minimum Standards (QS) Accreditation for healthcare services	Formative
Stage III (1998–2005)	Government Council for Drug Policy Coordination Phare Twinning 2000 project between the Czech Republic and Austria Academia (Centre of Addictology) Professional society	Quality standards for HR, treatment, and social reintegration (Kalina et al., 2001) Study programme in addictions	Formative
Stage IV (2005–2015)	Government Council for Drug Policy Coordination Academia (Centre/Department of Addictology) Professional society	Certification as a prerequisite for state subsidy Revised quality standards (Libra, 2015) Minimum evaluation set (Miovský, 2008) Code of ethics for professionals in addictology (Richterová Těmínová & Adameček, 2013)	Normative
Stage V (2015–2022)	Government Council for Drug Policy Coordination RAS project Professional society	Revised quality standards (Secretariat of the Government Council for Drug Policy Coordination, 2021) Revised list and definitions of interventions of addiction services (Secretariat of the Government Council for Drug Policy Coordination, 2020b) UniData/AdiData application Clinical guidelines in addiction medicine	Normative

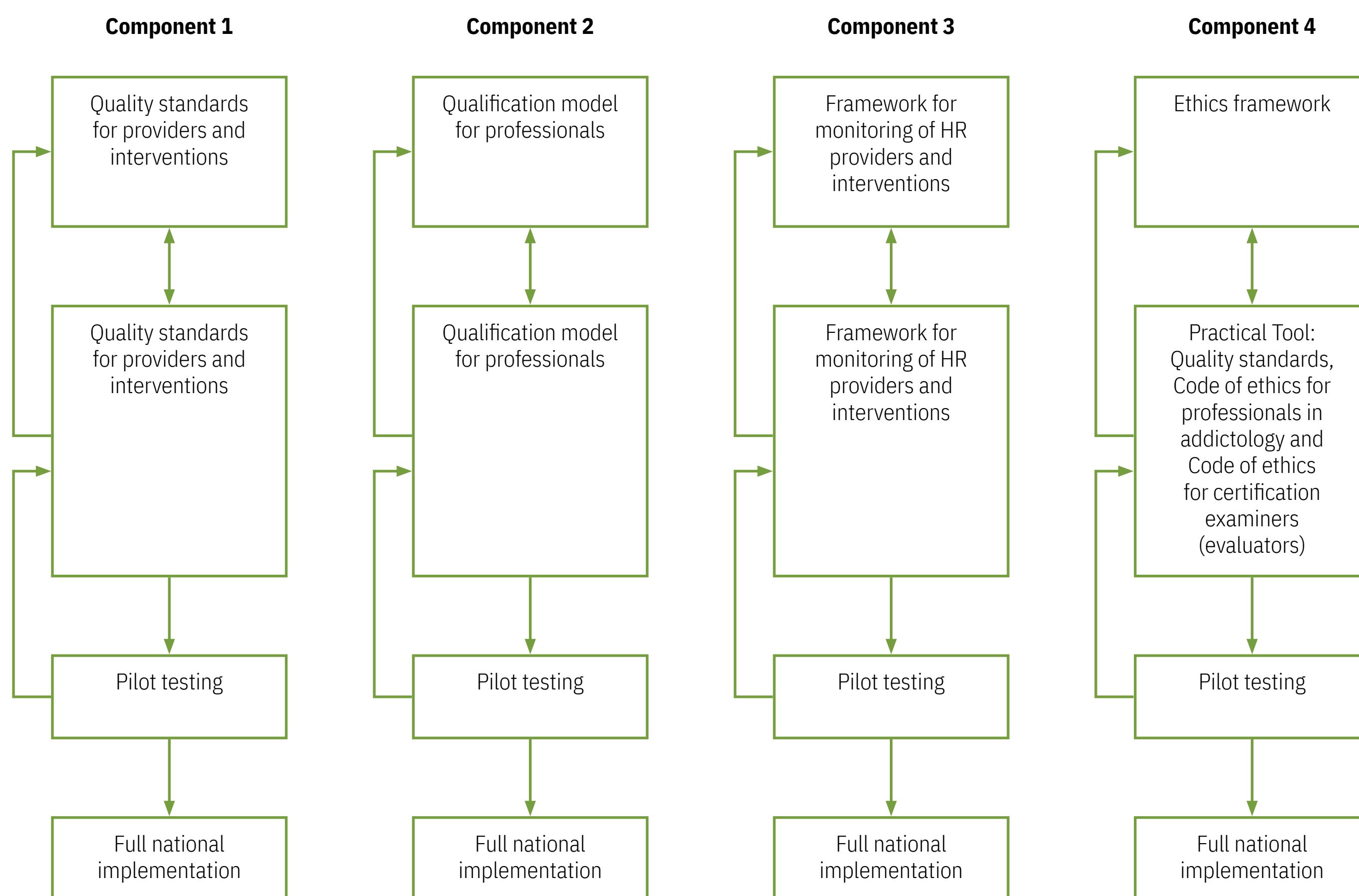
ods, are now also emerging. Before them, international recommended practices served solely as a kind of inspiration and had no binding force, so this is a breakthrough. The new AdiData application, which has evolved into its current form from the MES (Minimum Evaluation Set), is designed for monitoring and evaluation of the interventions provided. Qualification standards have not been developed, but requirements for providers are defined for sub-types of services. Regarding ethics, the standards stipulate that each service must have a written code of ethics. In addition, staff must follow the code of ethics for addiction professionals (Richterová Těmínová & Adameček, 2013; *Table 2*).

The Czech Republic is quite exceptional in that, unlike the area of prevention (Miovský et al., 2022), all components of the quality management system in HR have been fully implemented in practice *(Figure 3)*.

It is no coincidence that the story of the development and implementation of quality assurance in HR is closely intertwined with the whole system of the development of addiction services in this country. In a relatively short period of time, a functional, interconnected, and holistic system has been established, mainly thanks to the initiative and work of members of the professional community in addiction medicine and science.

There has been a shift away from an abstinence-oriented approach focused on a relatively narrow target group of people who use alcohol to the creation of a full range of services for a varied target group, from HR activities to highly specialised treatment. Over time, the HR programmes have expanded their scope, e.g. interventions in nightlife settings and at music festivals. This also applies to the evolution of the HR approach in other areas than illicit drugs within the integrated addiction policy. Since 2020, a low-threshold HR facility for the target group of people who use alcohol has been operating; the main objective of the service is to reduce the social and health harms associated with the use of alcohol among predominantly homeless people. In addition, the extension of the target group to include people who use alcohol is recognised in a number of low-threshold drug services. Since 2022, the HR approach has been included in the recommended guidelines for the treatment of tobacco dependence (Králíková et al., 2022). The HR approach is also visible in the area of gambling; the intention of the "HRaní" project is to develop and implement a new method of preventive online outreach work linked to an HR mobile app aimed at preventing the development of problematic or pathological gambling, and thus reducing the harms that arise, e.g. the breakdown of relationships, indebtedness, or criminal activity.

Table 3 | Schematic model of the national quality control and management system in HR in the Czech Republic



It is possible to recognise quite an interesting side effect of the broader and continual reflection of quality. However, because of the dynamic changes in the field, services are constantly stimulated to respond to the changing needs of target groups, society, and the environment. HR services are facing new challenges such as the ageing of the PWUD population (e.g. Richter & Pešek, 2018). Some familiar issues also remain, such as funding or the stigma associated with the field and PWUD. In the domestic context, the concept of quality and efficiency remains a problem. Despite long-standing efforts, especially by the GCDPC, the quality assurance systems of the different ministries are not mutually recognisable. Thus, even services that have been certified by the GCDPC have to meet the requirements of their respective ministries, e.g. Health, Social Affairs, or Education, which brings a high administrative and personnel burden.

All the steps in quality management development eventually led to the forming of a unique quality assurance system in HR. Along with this, it was feasible to systemically anchor the HR services as a fundamental element of the system of addiction care. The HR segment of services in the Czech Republic has emerged as a non-governmental sector in which providers of social services predominate. However, currently, the cultivated system of HR with a defined quality assurance system is opening up to the opportunities for funding from the public health insurance system and further anchoring of the system in the healthcare system.

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