NAD

Nordic Studies on Alcohol and Drugs
2020, Vol. 37(4) 323–337
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DOI: 10.1177/1455072520941977
journals.sagepub.com/home/nad

Successes and failures in treatment of substance abuse: Treatment system perspectives and lessons from the European continent*

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Abstract

Objective: The article offers an inventory of controversial basic issues related to treatment responses and their sociocultural political context, highlighting policy failures and successes, with a focus on Europe. As a reference point for this assessment, serves a conceptual framework of an “ideal type of treatment system”, which is built upon the following normative assumptions: the objective of harm minimisation or preventing substance-use-related consequences, evidence-based decision making, securing equity and accessibility also from a user perspective as well as efficiency in terms of the diversity and choice of treatment options. **Method:** Five major issues of addiction treatment systems, as identified and exemplified by an expert survey among 14 countries conducted in 2014, served as a reference for discussing fundamental gaps between an assumed ideal type of treatment system and the treatment response in practice: (1) Resistance to

*This article is partially based on the author’s presentation at the SYMPOSIUM ON DEALING WITH SUBSTANCE MISUSE: LESSONS FROM THE WEST, Shanghai, China, March 17th-18th, 2017 Jointly Organized by East China University of Political Science and Law (ECUPL) and San Diego State University (SDSU) University of California in Los Angeles (UCLA)

Submitted: 29 November 2019; accepted: 9 June 2020

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change, consensus building and innovation, (2) Political influence and target group bias beyond evidence, (3) Assumptions about rationality and universal evidence, (4) Myths of addiction and ethical deficits and (5) The treatment gap and user perspectives. **Results/conclusions:** Recommendations relevant for politicians, system planners, and clinicians are formulated for each of the five issues, specifically focusing on embeddedness of treatment systems in macro-societal conditions, the abstinence paradigm and outcome diversity, ethnocentric biases of the "evidence credo", learning from self-change as the major road to recovery, and questioning implicit conceptions of the "addict as a human being". Furthermore, it is concluded that theories regarding the diffusion of innovation and knowledge exchange can inform future research.

Keywords

addiction treatment systems in Europe, ethnocentric bias, self-change, treatment ethics, treatment gap, user perspective vs. top down

Treatment systems from a global perspective

The substantial worldwide burden of substance use and addiction problems – mainly from licit drugs, with alcohol as the most important in emerging economies (Rehm, Taylor, & Room, 2006) – calls for adequate policies and interventions to address this issue. Cross-cultural studies on alcohol and drug treatment systems (e.g., Klingemann, 1992; Klingemann & Hunt, 1998) have described the diversity of national and local responses to substance misuse and identified socio-political key parameters. Additionally, supranational organisations, such as the World Health Organization (WHO) and European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), have conducted treatment system mapping exercises, such as the WHO ATLAS – SU project survey in 147 countries (WHO, 2010) and drug treatment profiles for the 27 European Union (EU) member states (EMCDDA, 2013). The former showed that the availability of specific treatment types varied significantly by region, and the latter highlighted problems in improving comparability between countries and participation rates. Furthermore, recent reviews of the relevance of Western addiction research in developing countries have pointed to a North–South divide for substance use and in responses to drug problems:. Among other issues, Obot (2016) mentions a knowledge and information gap, a neglect of substitution therapy and harm reduction in many developing countries, as well as disparity in the availability of opioid analgesics (Obot, 2016, pp. 550–552). This discourse implicitly assumes that knowledge transfer (not exchange), notably from highly developed Western treatment systems, and simply closing an information gap, would be feasible and potentially beneficial for countries in Asia and Africa.

Regarding feasibility, policy discourse and treatment system designs are often dominated by a national focus. The international framework of 12-step groups (Mäkelä, 1991) and the historical international orientation of temperance organisations (Klingemann, 1992) are exceptions. Furthermore, language barriers impede international exchange. In China, for example, available topical reviews selectively open a window, such as an overview by Tang, Hao, and Leggio (2012) based on 110 publications from Chinese-language literature on treatment for alcohol-related disorders in China, focusing on specific types of treatment (including traditional Chinese medicine, such as the application of Xingnaojing and Kudzu root), and

an overview of current treatment approaches and both population and treatment staff surveys by Tang and Hao (2007). However, it remains unclear to what extent research and policy findings from Western countries have been adopted in China and developing countries.

Regarding benefits, the benchmarking idea – surveys highlighting changes and trends in selected treatment systems – has arguably shown quite an incoherent picture, hardly qualifying as a reference model for other countries. More specifically, Klingemann and Storbjörk (2016) conducted a brief expert mail survey in 14 countries to identify current trends and changes. Ten European countries participated in the study: Denmark, England, Finland, Hungary, Iceland, the Netherlands, Norway, Poland, Sweden, and Switzerland (for credits to the experts see: Klingemann & Storbjörk, 2016). Feedback by country pointed to the following:

- A rather slow pace of innovation, and the experience of early adopters, in experimental countries such as Switzerland, the Netherlands, and partially England, for alcohol and drug policies only recently had an impact on countries with similar problems. Norway, Sweden, Iceland, Finland, and Germany are among the late adopters when it comes to heroin prescriptions, assisted treatment, needle exchanges, supervised injection facilities, drug testing, and wet places/managed alcohol programmes.
- The influence of general political and health policy changes – independent of arguments specific to addiction treatment – on national treatment systems. Examples include the Hungarian government's measures to decrease harm reduction policies and alcohol treatment capacities and eliminate training programmes for first-time offenders, centralisation (Norway) and decentralisation (Denmark) of policies, and merging addiction treatment with mental health care or general public healthcare systems under the umbrella of the non-communicable diseases (NCD) concept (Switzerland).
- Increased efforts in many countries to make treatment systems more controllable, standardised, and efficient. Monitoring exercises have been implemented in many countries that aim for mandatory quality control for treatment providers (e.g., Switzerland and Denmark). The diffusion of various guidelines and quality protocols is intended to provide a more systemic view (e.g., Denmark, Finland, the Netherlands, Norway, Sweden, and Switzerland). Finally, a trend toward new public management methods can be observed in England and some Nordic countries.
- The impact of the partial revival of moral conceptualisations of addiction and limited scientific/professional paradigms. In Switzerland, right-wing parties (e.g., Swiss People's Party [SVP]) launched initiatives to impose costs for hospitalisation on the parents of young, acutely intoxicated binge-drinking individuals, and Hungary returned to forms of coercive training. Both are examples of regressing to the concept of individual guilt. At the same time, partially promoted by the pharmaceutical industry, an increasing medicalisation of treatment responses at the expense of socio-therapeutic treatment modes is reported in Denmark, Finland, Norway, Poland, and Switzerland. Similarly, integration with mental health care (Finland) and primary healthcare (Iceland, the Netherlands) has stoked fears of medicalisation and restricted treatment choices.
- A continuing bias when it comes to recognition of a treatment gap, that is the limited acceptance and outreach of treatment offerings. A focus is placed first on young people and women, and trauma victims and individuals with double diagnoses are also reported. Left out or only reluctantly addressed are older adults and topics related to men's health. Only Denmark, Norway, and Iceland indicated initiatives that include

hard to reach groups, such as older drug users and injection drug users (IDU).

The tentative results of this survey exemplify numerous fundamental gaps between the treatment response in practice and conceptual designs of treatment systems and will serve as a starting point for the following broader in-depth analysis of these gaps, followed by suggested recommendations. For this attempt of benchmarking, an "ideal type" of treatment model is used, based on general and more specific requirements, which have been forwarded and shared in the field of addiction research. Treatment systems are part of general substance-use-related policies, which – taking the example of alcohol policy – can be defined "...as any purposeful effort...to minimize or prevent alcohol-related consequences" (Babor, 2004, p. 34) or expressed more concretely "to minimize the effects of alcohol on the health and safety of the population" (Babor, 2004, p. 31). Consequently, in order to pursue the ultimate goal of reducing human suffering with the best allocation of resources, it is furthermore assumed that the make-up of the treatment response should be evidence-based, and barriers, meaning reasons for a lack of evidence-based policy-making, ought to be identified (Garretsen & van de Goor, 2004, p. 147). This general requirement has been further qualified by drawing upon the actor-network theory (ANT), which highlights the situation-related production and "negotiation" and therefore variability of evidence (Bergmark, 2020). Based on these general requirements, more specific norms have been formulated and will be used as yardsticks. First, equity, regarding the necessity to facilitate and secure accessibility and acceptability of services as concerns culture, language and location. This implies the inclusion of the perspective of potential users and not only of the providers. Second, efficiency, requiring an appropriate mix of services, in other words the provision of a wide range of options for potential clients (Babor, Stenius, & Romelsjo, 2008; Eagar, Garret, & Lin, 2001).

The following critical discussion is informed by this general framework and based on related empirical evidence and findings.

Paradigms and beliefs impeding evolution and adaptation of treatment systems

Resistance to change, consensus building, and innovation

A major feature of most treatment systems and policies is how willing they are to change. Even when overwhelming evidence contradicts the current make-up of systems, they evolve rather slowly, as opposition toward an integrated approach has been demonstrated (Wahlbeck, 2010). Further, factors that promote or impede change are under-researched. However, experience from various European countries highlights key parameters related to prevailing beliefs about addiction among professionals and the general population, as well as at the level of political culture. As to the latter, Swiss addiction policies exemplify a shift from moral crusades to pragmatism. Compared to Germany, where "*Prinzipientreue*" (clinging to principles) or even "*Verbissenheit*" (doggedness) prevailed for a long time (e.g., search for the true cause of addiction; abstinence only, quest for the best and only way to treat; Bühringer, 1998), Switzerland managed to adopt a pragmatic, non-dogmatic approach. This was triggered mainly by the dramatic situation with open drug scenes and the spread of the HIV epidemic. The cornerstone of the new policy framework was a combined four-pronged, four-pillar strategy introduced in 1991, including treatment, harm reduction, prevention, and control. It is essential that these elements are seen as complimentary, as a recent review by Stöver (2016) points to the necessity of bridging harm reduction and recovery.

In retrospect, the challenge of the open drug scene was first addressed at the political level by coordinating and balancing efforts on federal, cantonal (state), and municipal levels, and

adapting treatment responses (Kübler, 2001). More specifically, decentralisation of available treatment options, thus shifting the burden from big cities to regions and eliminating pull effects, as well as launching heroin prescription trials (1994–1996), were key for success (Klingemann, 1996, 1998). The Netherlands followed a similar approach and conducted trials of a morphine distribution programme in Amsterdam, in which injectable morphine was dispensed (Derks, Hoekstra, & Kaplan, 1998; Lewis, Gear, Läubli Loud, Langenick-Cartwright, & Rihs-Middel, 1997). The lessons of this pragmatic approach in "experimental countries" paved the way for the gradual acceptance of harm reduction as a valid concept in the alcohol treatment field and treatment outcomes other than abstinence. Controlled drinking and managed alcohol programmes (wet places) have been introduced and discussed in the Netherlands and Switzerland, as well as in Germany, Poland, and France (Kleinhubert, 2010; Klingemann & Rosenberg, 2009; Klingemann, 2016; Körkel, 2002; Luquiens & Reynaud, 2011). Suspicion that any deviance from total abstinence was a conspiracy by the alcohol industry could only be overcome slowly. In Poland, efforts to impose medicalised approaches motivated treatment providers to consider reduced-risk drinking as a "counter framework" (Klingemann, 2016). Further, the acceptance of such policy shifts by the general population is essential for their success and sustainability. From this macro-societal policy level we will highlight next the dynamics of changes and functionality of the make-up of the treatment system and more specifically its outreach and acceptance by various client groups.

Political influence and target group bias beyond evidence

The specific make-up of addiction treatment systems is not largely determined by the relative importance of addiction-related problems and their prevalence in societal groups, but subject to political forces and influence from lobbyists and social movements. The development of differentiated and highly developed alcohol treatment systems in Europe – and more specifically in the Nordic countries, Germany, and Switzerland – has historically been linked to strong temperance and abstinence movements, such as the Blue Cross and Good Templars in the late nineteenth century (Blocker, Fahey, & Tyrell, 2003). A major success was the Swiss Federal Alcohol Legislation passed in 1886, which introduced provisions that 10% of the net revenues from the partial monopoly for all distilled spirits would be earmarked for "combating the causes and effects of alcoholism" (Alcohol Tithe; Klingemann, 1992, p. 167). This strongly promoted the development of alcohol treatment institutions. More generally, the comparative analysis of alcohol treatment systems in 10 European and six other countries led to the conclusion that "the size, expansion and character of alcohol treatment seem to depend less on the amount of, or changes in alcohol consumption, or on any well defined treatment needs, or even economic resources, than on the ways in which societies perceive alcohol and alcoholism" (Klingemann Takala & Hunt, et al., 1992, p. 297).

The influence of socioeconomic political forces as predictors of treatment responses becomes evident when comparing the relative burden of disease for various types of addiction with the resources countries spend to address these problems. There is no "war" on alcohol and tobacco with powerful industries in the background, but instead on illicit drugs, which comparatively represent only a minor burden of disease. Estimates for WHO regions in 2016 showed a global burden attributable to alcohol of 4.2% DALYs (disability-adjusted life years), compared to 1.3% attributable to drugs (in Central Europe 9,4% vs 1.2%; Degenhardt et al., 2016).

However, the EMCDDA, an agency of the EU established in 1993, deals with alcohol and tobacco only with respect to polydrug use, and from the perspective of combined use of licit

and illicit psychoactive substances. This limitation, regardless of the public health problems of critical alcohol consumption, is the result of political agenda setting, which merits further analysis from a political science viewpoint. At the same time, the mission of the proven "Reitox Network", a group of focal points for regular data collection in each of the 28 EU member states, Norway, and candidate countries to the EU, could be redefined to include alcohol and tobacco; however, this is contingent upon political decisions. Notably, the implementation of an integrated approach across substances (Bergmark, 1998) might be even easier for developing countries that, for economic reasons, do not already have highly differentiated treatment structures for substance use disorders (Klingemann & Storbjörk, 2016, p. 268).

Furthermore, selecting groups with special needs is subject to biases, independent of their burden or vulnerability. A prominent example is the quest for gender-specific treatments. The feminist movements in the 1970s, as a response to the "male gaze in studies of alcohol and drugs", managed to emphasise women's needs in addiction treatment and fought increasingly successful campaigns for specific treatment programmes (Vogt, 1998). However, increasing awareness of the feminist perspective for treatment and policy (Hunt, Antin, Bjonness, & Ettorre, 2016) only partially represents the general concept of "gender", as included in the 2002 WHO strategy "Integrating Gender Perspectives in the Work of WHO" (WHO, 2002). Viewing gender as socially constructed roles and not biological categories is at the core of this concept. Even though risk-taking and self-destructive behaviours are closely linked to masculinity and "doing gender" (Kilmartin, 1994), treatment programmes catering to specific needs of various types of men are the exception in most countries. It is true that men continue to represent the majority in most treatment programmes; however, treatment modalities such as talking and group therapies are more "feminine", and do not match traditional ideas of masculinity. Sexual abuse of men, violence, childhood trauma, and addiction-related sexual problems tend not to be addressed in treatment (Klingemann & Gomez, 2010).

Specific programmes for clients with an immigration background are very much needed in Europe, particularly after the current major influx of refugees and asylum seekers. According to the EMCDDA's recent country profiles of the EU, member countries pay more attention to these groups, with undocumented refugees struggling to access any type of healthcare. In addition to the challenge of treatment rooted in culture and ethnicity, treatment providers have to take into account that refugees from countries affected by war often experience post-traumatic stress disorder and other mental health problems. At the 59th meeting of the Commission on Narcotic Drugs in Vienna in March 2016, the executive secretary of the Pompidou Group stressed the importance of developing appropriate services to avoid stigmatisation and the formation of ghettos, as well as to promote prevention and treatment (Malinowski, 2016).

Unfortunately, a systematic overview of the prevalence of drug use among migrants, their treatment needs, and available programmes and their features is not currently available. Language skills are the first hindering factors. Furthermore, the term "migrant" refers to very different things in different EU member states. Sinti in Hungary, persons with Turkish roots in Germany, and Pakistani individuals in the UK are quite different from one another and can hardly be discussed or treated as one group. Refugees and asylum seekers, which have been more important in recent debate, are again different. Drug abuse and criminality – heroin use among unaccompanied refugee minors (URMs) in Sweden as an example (TT/The Local, 2017) – is often referred to in terms of coping with trauma and painful experiences (Ivert & Magnusson, 2019). For understandable reasons, these groups are often not very willing to share information on these problems, as it might undermine their status as asylum seekers

(personal communication, EMCDDA, December 2016). But even when these risk groups are enabled to access treatment, their treatment is problematic. Qualitative data from 16 European countries showed similar findings, in that mental health services are challenged when treating immigrants with complicated diagnoses, difficulties in developing trust, and increased risk of marginalisation (Sandhu et al., 2013).

Young people and older adults are equally subject to group bias in addiction treatment and prevention, and should be at least briefly mentioned. Youth are preferred target groups when it comes to prevention efforts, which are usually met with wide support across the political spectrum. Binge drinking and other risk behaviours are disproportionally attributed to young people. Media images strengthen this risk perception, often independent of actual epidemiological trends, screening out alcohol-related risk profiles among middle-aged men and upward trends for adult drug use (Williams & Askew, 2016, p. 451). Additionally, although older adults represent the fastest growing segment of the population in Western society, only a slowly increasing awareness of addiction problems in this group can be observed. Single older men are a high-risk group, and are often unwilling to seek treatment. Additional issues include diagnostic problems caused by the co-occurrence of age-related health problems and signs of addiction, lack of group-specific screening instruments (Johnson, 2000), and lack of coherent intervention policies in retirement homes (Müller & Meyer, 2009).

At the organisational level, treatment providers as key actors in the treatment system share beliefs and orientations which influence therapy in practice beyond guidelines and methodological approaches. The following section highlights the quest for "the best treatment method".

Dreaming of rationality and universal evidence

Influenced by paradigms of natural science and, more specifically, pharmacological research discourse, significant effort has been devoted to identifying the best treatment methods, based on the best evidence.

Randomised controlled experiments and systematic reviews have been the cornerstones of the evidence movement's methodological programme. Even though the quest for the best treatment method has been addressed by large randomised clinical trials such as Matching Alcoholism Treatment to Client Heterogeneity (Project Match), the United Kingdom Alcohol Treatment Trial (UKATT) and the COMBINE study (Bergmark, 2008; Klingemann & Storbjörk, 2016, p. 269), a review by Hesse, Thylstrup, and Soegaard Nielsen (2016) concluded "...the two major matching studies, conducted in the alcohol field have been inconclusive to date and have not helped us to come closer to understanding, whether matching particular patient characteristics to particular treatment models would improve care" (p. 293). The general finding that "everything seems to work equally" and "everybody is a winner" has been long known as the "dodo bird verdict" (Duncan, 2002). In a qualitative reanalysis of the UKATT trial, Orford, Hodgson, Copello, and the UKATT Research Team (2006) found that the uncritical adoption of pharmaceutical top-down trials failed to capture treatment as an interactive and interpretive process. As Bergmark and Hübner (2016) posited from a more general point of view, the idea of science producing rules and evidence, which work independently of sociocultural settings and performers, is in itself not empirically based. Performer effects tend to be much larger than the effects of specific applied treatment methods (Bergmark & Hübner, 2016, p. 625; Hesse et al., 2016).

The more specific professional beliefs of the treatment providers are underpinned by mostly latent convictions about the nature of addiction and the addicted individual, the acceptable gold standard of treatment outcomes and a clinical bias in terms of profiles of (potential) clients as will be highlighted by the following section.

Perpetuating myths of addiction and ethical deficits

Controversial discussions on issues such as "controlled drinking", "abstinence", and "coercion in treatment" often show few results and go round in circles. They tend to be unsatisfying, as participants do not make their fundamental conceptions of "the nature of addicts" as human beings and "addiction" transparent or a topic of discussion. This can be exemplified by the resistance the concept of natural recovery still meets among professionals in the addiction field. Belief in a deterministic and progressive disease concept of addiction focuses on perpetuating, and not exiting, addiction careers (Wiens & Walker, 2015). Furthermore, by assuming that "loss of control" is a central feature of addiction, the fact that most people quit addiction on their own – as most ex-smokers will testify – and may also choose to return to risk-reduced consumption is often rejected against all evidence (Klingemann, Sobell, & Sobell, 2010). Generally, "addicts" are considered to be unable to make informed choices or regain control over their lives. If they do, the face-saving circular conclusion is that they were not addicted to begin with, as they were in control. More specifically, motivation to change is only seen as a result of "hitting rock bottom", and the behaviour of substance users is qualified as anti-social. The latter assessment does not take into consideration the skills that deviant behaviour requires (Klingemann, 1999), which could potentially be used in treatment. Confrontational programmes such as SYNANON (Janzen, 2001) aim to "destroy the old addicted personality" and "shape a new person". Strength-based approaches and concepts have slowly gained ground in European countries such as the Netherlands, Germany, Switzerland, France, and Italy. Early examples are campaigns in Switzerland that aimed to strengthen the general population's belief that individuals with addiction problems deserve support and have the potential to change (Blomqvist et al., 2016; Klingemann & Klingemann, 2007).

However, the idea that the parameters of self-change processes are universal also needs to be put into perspective, assuming that research findings mostly from Western European and Anglophonic countries are applicable to other cultural contexts. A closer look at the few non-Western studies shows, for example, the relative importance and function of abstinence and drunkenness, as well as the importance of kinship responsibilities (Klingemann & Klingemann, 2019). Shared beliefs about the nature of addiction not only influence either social support or stigma in the general population but also impact the relative importance of "cure, care, and control" in treatment systems. Most prominently, control measures and coercive interventions are first contingent upon basic convictions about the "nature of addicts", and only then legitimised by evidence about the effects of coercive measures. Contrary to Asian countries such as Cambodia, China, Thailand, and Vietnam, the long-term trend in Europe is that compulsory care and civil commitments have been largely abandoned (Klingemann & Storbjörk, 2016, p. 269). Coerced treatment in addiction facilities most clearly highlights contradictions and raises ethical problems when following a loss of control concept. In an attempt to circumvent the implicit paradox, it is assumed without sufficient evidence (see also Wolf, 2003, p. 176) that addicts may be competent, but lack autonomy and self-determination. Consequently, denying them autonomy with the declared intention to restore it, does not appear any longer as an infraction of the primacy of autonomy in provider–patient relationships (Caplan, 2008).

In the next section, the provider view will be completed by the view of users and potential users of treatment options and show the interface between therapeutic recovery processes and self-change.

Ignoring the gap and user perspectives

For several decades, epidemiological research (for an overview, see Smart, 2007) and studies of natural recovery from addictive behaviour

(Klingemann et al., 2010) have shown that, to a large extent, interventions and treatment provisions fail to reach their target groups (Dawson et al., 2005). The clinical world of addiction tends to focus on "the tip of the iceberg", which includes chronic users and the minority who do accept and seek treatment. The gap between need and intervention has also appeared on the agenda of planners of alcohol interventions in Europe. Under the umbrella of the Alcohol Measures for Public Health Research Alliance (AMPHORA), a study was conducted in Austria, Italy, Germany, Spain, Switzerland, and England to explore this gap more in more detail (Drummond et al., 2011). However, as it only relied on epidemiological data and expert opinions, the project failed to provide valid measures of the basic concepts of "need" and "access". Furthermore, more general background factors are not taken into consideration, which additionally explains the crisis of legitimacy of the addiction treatment enterprise, such as increasing distrust in expert knowledge and evidence-based treatment, use of alternative medicine, complementary therapies, and self-management (Klingemann & Bergmark, 2006). The top-down approach of AMPHORA failed to include a "bottom-up" user perspective for designing interventions and understanding why programmes are not accepted by the people for whom they are meant. A vast body of research on natural recovery has produced ample evidence on the reasons why individuals do not seek help, including stigma, lack of information, self-management methods, cost, lack of trust in treatment providers, objectives other than abstinence, access, and opening hours (Klingemann et al., 2010; Tucker & Simpson, 2011, p. 375).

Furthermore, decisional balancing processes have been identified as a central feature of individual change. This also includes considering the pros and cons of continuing an addiction career (Sobell, 2007, p. 18), taking the element of pleasure into account (Herrick, 2016, p. 571). This type of research provides the groundwork for needs assessments of populations which have not been reached by treatment systems. Equally important is the understanding of the needs of service users and activist groups and their implementation in practice. Activist groups, such as the European Coalition for Just and Effective Drug Policies address wider issues, not only treatment (Hunt, Albert, & Sanchez, 2010). Since the early 1980s, organisations of IDU have been active in several countries, offering their members and clients various professional or semi-professional careers instead of, or as well as, their addiction careers. In 1980, in the Netherlands, the *junkibonden* was founded, which served as a model for "fixer unions", initiated in Germany in 1982 (Kaufungen, 1983) and later in Switzerland, including parents' associations (Basel Junkie Bund, 1996; Lewis et al., 1997, pp. 111–118).

WHO Europe had already endorsed the idea of involving service users in the development and implementation of welfare services by 1985. However, only recently has a rise in user perspectives in addiction treatment been observed, particularly in Nordic countries, such as Denmark and Sweden. Specific tools for professionals in treatment organisations to incorporate users' perspectives into their practice are individual action plans in which the service user is highly involved with his or her personal goals, participation of service users in joint meetings and daily activities at treatment centres, and service evaluations where users are invited to critically evaluate the quality of their treatment experiences (Bjerge, Brown, & Daniels, 2016, pp. 531–532).

Discussion: Lessons to be learned

Taking current issues in the treatment systems of European countries as a baseline, the underlying concepts and dynamics at the societal, policy, and organisational levels have been outlined, focusing on barriers and mistakes impeding the evolution and adaptation of treatment systems. Tentative conclusions and recommendations can be formulated, keeping in mind the

limitations of an expert survey from selected countries.

Useful for the worlds of politicians and policy makers is the conclusion that successful adaptation and changes in the addiction treatment system require awareness of macro-societal conditions and should be embedded in a wider, holistic approach that specifically includes political consensus building; decentralisation and striking a balance between local, regional, and national involvement; conceptual integration of prevention, harm reduction, control and treatment; acceptance of multiple treatment goals; openness to controlled experiments and new approaches; and fighting stigma and changing images of addiction in the population. Furthermore, it seems worthwhile to be aware that the allocation of resources to address addiction-related problems among societal groups and by type of substance is often not guided by evidence, but by the interests of political and professional stakeholders and lobbyists. Policy-makers have to strike a balance and navigate accordingly to achieve a minimisation of addiction-related problems in society as a whole.

The rationality dream pursued by system planners, or the "search for the Holy Grail", is not a promising path. When it comes to the word "evidence," it is good to remember that "... 'people centered evidence', ... in contrast to the universal, nomothetic and generalizing tendencies of public health sanctioned evidence asks questions about the entanglements between systems and human experiences" (Herrick, 2016, p. 571). More specifically, people-centred care serves as "an approach ... that consciously adopts individuals', carers', families', and communities' perspectives as participants in, and beneficiaries of, trusted health systems that respond to their needs and preferences in humane and holistic ways" (WHO, 2015). Regarding monitoring exercises that are costly, require many resources, and create the illusion that some kind of yearly statistics help to improve treatment responses, there is no evidence that the published results of national client monitoring systems have been used to adapt treatment programmes or guide treatment system features (e.g., Stern, Stokar, Trageser, & Thomas, 2009). These observational studies need to be complemented by connecting monitoring with both qualitative and quantitative research (Simon, 2020).

A closer look at clinicians highlights the necessity that the process of designing efficient interventions and addiction treatment systems should include visibility and justification of the underlying general concepts of addiction. Using strength-based approaches potentially saves resources and increases acceptance. Shared beliefs about the nature of addiction tend to bias the perception of the treatment gap and lead to the recommendations of "do not forget the user perspective" and not to generalise from the minority of service users regarding the needs and profiles of potential users in general. More specifically, empowerment and inclusion of users and activist groups increases efficiency and outreach services and helps close the treatment gap as well as the use of digital tools (Mellor & Ritter, 2020). The limits and "local ambiguity" of so-called universal evidence and the "guidelines/handbook straitjacket" need to be recognised, and practice-related sources of knowledge should be respected.

Finally, future research should overcome the limitations of choosing countries and national treatment systems as units of analysis, and focus more on innovation and change in terms of adopting successful models, and learning about failures is contingent upon efficient *diffusion* at the global level. Models of innovation diffusion, both at the international and national levels, provide insight into barriers and facilitating factors. Examples include studies on the diffusion of prevention programmes (Rogers, 2002) and the analysis of endogenous (e.g., integration of drug and alcohol treatment and moral judgement in the population) and exogenous (e.g., adherence to international drug control and trade openness) factors influencing the adoption and implementation of such

programmes. As for the latter, Klingemann and Klingemann (1999), taking the potential adoption of heroin trials in 14 European countries (and five other countries) as an example, identified trade openness as a facilitating factor and moral judgment in the population as an impeding factor for the chances these programmes would be implemented. Relevant for practice, in addition to these macro-societal factors, are specific local beliefs and practices embedded in sociocultural context, which determine the eventual adoption or rejection of specific strategies or models. According to Rogers (2002), the "compatibility" of an innovation is pivotal, and has to be perceived as consistent with existing values, past experiences, and needs of the organisations and actors in the field (Rogers, 2002, p. 990). This is important to remember when considering the usefulness of "lessons from abroad".

Declaration of conflicting interests

The author declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author received no financial support for the research, authorship, and/or publication of this article.

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