Alcohol and drug treatment systems research: a question of money, professionals, and democracy

IN A THEMATIC MEETING on treatment systems research (Stockholm 7–9 October, 2009), the Kettil Bruun Society elaborated on “Models, implications and meanings of alcohol and drug treatment systems”. Following the meeting, the organising committee (Jan Blomqvist, Mads Uffe Pedersen, Pia Rosenqvist, Kerstin Stenius and Constance Weisner) invited a number of participants to submit an article to this special issue on treatment systems research and asked me to serve as guest editor. The issue presents peer-reviewed articles on theoretical perspectives on addiction treatment systems, and analyses, comparisons and historical accounts of national systems and experiences. Sets of articles are followed by commentaries by conference participants.

There are several reasons why we should do treatment systems research and devote a special issue to this research area.

People have used intoxicants for thousands of years. Some substances are viewed as more serious and they clearly cause more problems than others. Every known society responds to defined health and social problems and designates certain persons or professionals as healers – shamans, priests, doctors, police officers, social workers or former misusers in recovery (Twaddle 2004). Some countries also have long histories of treating people with alcohol and drug problems. Others have only come to terms with this issue more recently (Muscat 2010), which is especially true for developing countries.

For some time now, the focus of research on such treatment has moved away from evaluations of specific techniques in clinical research to real-world-settings, studies of common and environmental factors important for treatment outcomes/problem remission, the role of treatment in the way societies handle substance use, the organisation/financing of treatment, access, paths to treatment, utilisation (Booth et al. 2001; Humphreys & Tucker 2002; McCarty et al. 2001) and characteristics of treatment systems and evaluations of population effects of these qualities (Babor & Poznyak 2010; Holder 2010).

Clinical treatment research maintains that there are effective treatment methods (Berglund et al. 2003). These techniques shall prefer-
ably be delivered in certain manual-based ways. The treatment systems that have emerged and shall provide this treatment are, however, organised in different ways and guided by different and changing principles. Not only do (views of) substance use problems differ between countries, so do the societies’ response to these problems. Treatment, “evidence-based” or not, is thereby provided and received in diverse local contexts.

Twaddle (2004) constructs a useful framework in distinguishing between three ideal types of organising human services: democratic, professional and market models. These models show that treatment systems – in different locations and throughout history – can be characterised by their dominant actors such as democratically elected politicians serving the citizens, civil servants, various professionals, business owners and customers/service users. The systems are also marked by values, including equity/equality, effectiveness/quality and efficiency; goals, such as democracy, profit, enhancement of knowledge and techniques, and; regulations, ranging from elections to socialisation, ethical standards and competition. Given the range of these aspects and that a well-functioning system should fulfil certain criteria of availability, accessibility, acceptance by the population, relevance, affordability/costs and flexibility, it is obvious that treatment systems offer an interesting area of study. When some actors believe that the system is guided by the wrong principles or does not meet these criteria, tensions may emerge between groups. In such situations, the “defects” may be viewed as problems that call for reforms (Twaddle 2004).

Invited articles and some aspects of and trends in treatment systems research

The majority of studies in general health services and systems research are devoted to efficiency and quality improvement. Significantly less attention is given to the organisation, cohesion, and needs and demands of care. A fraction, some 10 per cent, address problems of inequality and the distribution of services. In fact, “health services and systems research tends to overemphasize the importance of doing things right (quality and efficiency), perhaps at the expense of doing the right things (arrangement/cohesion) for the right people (inequality)” (Delnoij & Groenewegen 2007,13). Attention is still and increasingly steered away from democratic models to professional and market models (Twaddle 2004).

Historically, national addiction treatment systems have developed without overall planning and evaluation. The costs of addiction treatment as well as other health/welfare services have increased over time, inviting criticism – also because of alleged inefficiencies. Many reforms, in affluent societies, too, seek to lower the costs and find how best to allocate treatment resources. Such cost containment reforms follow from the increased importance of market models (Bergmark) and demands of productivity, choice and competition. Some claim that reforms driven by markets and profit have no documented benefits to service users and may cause professionals/care planners to put other needs than those of the clients first (Twaddle 2004).

Bergmark (2010) observes that calls for tender in the public purchasing of treat-
ment are evaluated separately which is destructive for the linkage between services, as it works against a constituted whole and the interconnection of system components. Cameron (2010) also addresses the effects of Thatcherite competition on the treatment system of Leicestershire, developed from below as a working entity. Simultaneously, constituted wholes are conceptualised and sought to be put in place (Berends & Hunter 2010; Holder 2010; Rush 2010). According to Bergmark, treatment systems are not, however, the product of rationality. There is no coherent system at hand. The rapid growth of knowledge and technological capacity of the treatment systems have led to a specialisation and rationalisation (and increased costs) which the clients and the care providers may experience as fragmentation (Nesvåg & Lie 2010; Twaddle 2004).

It is thus not surprising that many frameworks and reforms aim at a better usage and co-ordination of the systems (Berends & Hunter 2010; Holder 2010; Rush 2010). Such reforms, often relying on top-down implementation, may be rational and logic but they may lead to problems in practice. Treatment staff and street-level bureaucrats facing the clients may seek ways to get round what are seen as flaws in regulations/organisations (Nesvåg & Lie 2010), and treatment-experienced clients learn how to navigate the system. It is possible that bottom-up alternatives such as the “experiment” in Leicestershire (Cameron 2010) become rarer with the increased demands for evidence-based methods that allow less spontaneity and flexibility.

An interesting aspect of treatment systems research is that many system reforms result from political, cultural or organisational changes elsewhere. This explains at least some of the differences between countries, and it is now the case in Finland (Kuussaari & Partanen 2010). Societal change may also imply the emergence of new “problem groups” with “special needs” that must be addressed by the system (“women”, “youth”, “people with dual diagnoses”, etc.). The emergence of a new needy group may change resource allocation and thereby access for other groups. In addition, the views of what constitutes a substance use problem influence social pressures/controls from family and societal actors to seek treatment and who will enter or be coerced into treatment (Weisner et al. 2010).

Some “evidence-based treatments”, such as substitution treatment for opiate users, are widespread. Still, we can see national differences in the use, organisation and regulation of such treatment (Skretting & Rosenqvist 2010). Similarly, when certain ways of organising treatment spread from one country to another, the implementation and outcomes vary depending on the local context, local stakeholders, problems and systems (Berends & Hunter 2010; Kuussaari & Partanen 2010).

Various life-area problems (mental/physical health, family problems, criminality) often co-occur with substance use problems. Co-morbidity adds to the importance of a good linkage between different care systems (mental health, somatic care, etc.). This also encompasses the criminal justice system, which carries a great responsibility for handling substance misuse, especially drug misuse(rs), in many societies. To what extent misuse is treated or punished is yet another question to discuss when comparing national treatment
systems. There are also extensive debates (and changes in practice) whether misuse shall be viewed as a medical/biological, social, psychological or legal problem, to be treated mainly by the health, social welfare, psychiatric or criminal justice system. Opinions diverge, and shifts have been plentiful throughout history (see Cameron 2010).

It is interesting how countries seek to tackle their misuse problems and problems with clients falling through the cracks in their systems by moving the responsibility for treatment from one organisation to another (for example, from social welfare to the health system in Norway) or from one societal level to another (such as decentralising responsibility from the counties to municipalities in Denmark, etc.) (Nesvåg & Lie 2010; Kuussaari & Partanen 2010; Muscat 2010; Twaddle 2004). Research has not provided comprehensive evidence on which organisation or level best helps to reduce problems on the individual and societal level. Every re-organisation will in fact draw new boundaries. While old problems may abate, new problems may arise. Notable, too, in many countries is the development of treatment guidelines and the various efforts to implement these (Muscat 2010). How such guidelines will change the treatment systems in the long run is yet to be seen.

It is known that misusers are found in all societal handling systems, including systems of addiction treatment, primary/mental health and criminal justice (Weisner & Schmidt 1995). In this issue, Weisner et al. (2010) question (and confirm) the distinctiveness and treatment of substance use problems: How are substance use problems different from other “chronic” medical diseases and conditions, obesity for example? Do we need a special addiction treatment system that may in fact detain the stigma still attached to alcohol and drug problems? Similarly, Rush (2010) and Holder (2010) proclaim specialised addiction treatment as just one piece in a broader policy response to (mis)use, arguing that addiction treatment should be more closely integrated with other societal services, systems and policies.

Conclusion – continuation
When I entered addiction treatment systems research in 2000, I found the system difficult to grasp. When listening to experienced researchers in Stockholm, I noticed that neither did they know or agree on how to organise and conceptualise treatment systems. An observation of this kind could have led to disappointment and confusion, but I chose not to despair. Such questions and disagreements imply that treatment systems research – like society and (social) science in general – is vivid, complex and changeable. The research area will go on, take new turns and maybe return to previous questions and solutions.

If I may speculate, I wonder if and maybe hope that the market model, with an increased focus on service users as customers and on patient rights, will strengthen the clients in treatment and the client perspective in treatment systems research. Also, while treatment and treatment systems research are still mainly features of the Western world, I assume that these areas will develop in developing countries as well. Instruments like the one described by Babor and Poznyak (2010) may help this expansion. Examining the distinctive features of alcohol and drug problems/treat-
ment in relation to other health problems and social conditions may lead to interesting comparisons of substance misuse and, as an example, obesity—a condition that includes consumption, may be viewed as self-inflicted, may be stigmatised and which increasingly causes problems and rising costs.

All societies seem to have substance misuse problems and they handle them in different ways. Still, we don’t know what really works in reducing problems on the population level (Babor & Poznyak 2010). It is possible that treatment will increasingly be viewed as a policy measure to reduce problems regardless of its integration with prevention and other policy interventions. It is clear, though, from treatment systems research and this special issue that there is more to treatment than carrying out a certain treatment technique. The variations and local contexts enable absorbing studies from various scientific perspectives. Evidently, money matters—we cannot let treatment bankrupt society—but maybe the systems and research will shift toward a changed relation, or power balance, between the market, the professionals, the needs of the substance users and democracy?

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REFERENCES


Editorial