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INTRODUCTION

Stakeholders in Opioid Substitution Treatment Policy: Similarities and Differences in Six European Countries

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Based on the research papers within this special issue, this overview discusses similarities and differences in stakeholding in drug user opioid substitution treatment policy in Britain, Denmark, Italy, Austria, Poland, and Finland. It explores factors that have influenced stakeholder activity, including the importance of crisis, the impact of evidence, the availability of resources, the wider political context, the influence of moral frameworks and ideologies, and the pressure of external influences. The paper highlights the important differences in the emergence and evolution of stakeholder groups and in the political, cultural, and economic circumstances, which both constrain and enable their activities.

Keywords stakeholders, substitution treatment, drug user treatment policy, Europe, abstinence, harm reduction, evidence-based policy, addictions, window of opportunity, problem stream, policy stream, political stream

INTRODUCTION

The papers presented in this special issue derive from the ALICE RAP project (Addictions and Lifestyles in Contemporary Europe: Reframing Addictions Project), financed by the EU FP7 Framework program. ALICE RAP is a multidisciplinary research program that employs a wide range of theoretical and methodological approaches to examine the "addictions" in contemporary European countries in relation to governance, public policy, and responses (http://www.alicerap.eu/).

As a complex policy arena—which crosses governmental, professional, and disciplinary boundaries—the question of "Who owns the addictions?" is particularly pertinent and draws attention to the changing roles of different actors and networks over time and place in formulating policy and practice responses to substance use(rs) and planned interventions. Although the concept of "evidence-based" policy and practice has gained international consensus and support, it is recognized that complex interactions between many mediating and confounding factors mean that other influences need to be considered in explaining policy and practice approaches and outcomes (Hillebrand & Burkhart, 2009). The role of stakeholders—the policy actors, their networks and alliances—is one such consideration (Berridge, 2005). Stakeholder involvement is of crucial importance, not only in the production and dissemination of "evidence" but also in determining what kinds of evidence are used as well as not used, how and when it is used, and how different types or sources of evidence are balanced against one another to inform decision-making (Anderson & Baumberg, 2005). Shifts in stakeholder groups over time and place, the variable power of different groups to produce or promote particular bodies of evidence, the institutional embedding of stakeholders, and the resultant effects on policy agendas and practice implementation are only some of the issues to be taken into account (Fischer & Rehm, 1998). Of equal importance is the effect of political and policy changes on the position and influence of policy actors, on established networks and on the formation of new alliances (Kingdon, 1984). Thus, from both an historical and contemporary point of view, understanding the dynamics of stakeholder activity opens a window into the real world of agenda and policy-making and furthers understanding of how and why some policy options are favored over others.

Responses to the use of illicit drugs regularly provoke considerable controversy and this topic illustrates well how differing worldviews vie for position within the policy arena (McKeganey, 2011). Substitution treatment—the focus of the papers in this collection—has

Participant organizations in ALICE RAP can be seen at http://www.alicerap.eu/about-alice- rap/partner-institutions.html.
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been a contested topic since the 1980's when, in many countries, the HIV/AIDS crisis prompted widespread consideration of the use of methadone as one of a number of harm reduction approaches to address the threat of HIV spreading through injecting drug use; it continues to be one of the most widely discussed drug use(r) intervention-related topics in Europe and constitutes a matter of considerable political and public interest. Even if substitution treatment has grown steadily in Europe since its introduction in the 1960s and is now quite widespread and accepted, the political debate has been cyclical and heated, moving into the spotlight in the mid-1990s and clearly highlighting the different interests in this field (EMCDDA, 2000; Mold, 2008).

The history of how substitution treatment has developed in six European countries—Austria, Denmark, Britain, Finland, Italy, and Poland—illustrates the diversity and strength of stakeholder activity in this policy sphere. While the country stories have some similarities, there are also important differences in the emergence and evolution of stakeholder groups and in the political, cultural, and economic circumstances, which both constrain stakeholder activity and open up opportunities for specific actors at particular points in time.

The papers in this collection illustrate the many factors that interact with, and influence, stakeholder activity and that have played a part in the development of contemporary policy approaches to substitution treatment. In all countries, crisis in the form of HIV—as mentioned above—had a notable impact; the role of evidence as a basis for policy has been an equally important, if contested, influence; the availability of sufficient and appropriate resources and political change had an effect; moral frames and ideologies have underpinned stakeholder activities and policy "narratives;" and external pressures, for instance, from the European Union, the United Nations organizations, or from "donor" country activity played a part in policy decisions in some countries. Ahead we will discuss some of the differences and similarities between the six countries. However, first we will outline the overall conceptual framework that has been used by all or most of the studies in the six countries and the methodology applied.

CONCEPTUAL FRAMEWORK

Theoretical approaches for examining stakeholding and the role of stakeholders within the policy process are legion (Brugha & Varvasovszky, 2000). Within the broad historical-chronological approach needed to explicate shifts in policy on substitution treatment across time, Kingdon's (1984) classic study was chosen, as it provided a useful model for understanding policy formation and implementation as a process that is influenced by many diverse factors. It sheds light on how some policy ideas may emerge and flourish at particular points of time, while other policy options fade away. Stakeholders, both visible and invisible, are at the forefront of Kingdon's work and, in particular, the concept of "window of opportunity" seemed useful for analyzing why policy change regarding substitution treatment occurred at some times and in some countries, whereas other countries displayed a more stable response and were more resistant to adopting substitution treatment as a harm reduction measure.

In choosing Kingdon's theory as a conceptual framework for the country analyses, we were aware that its application would vary depending on the detailed story of substitution treatment in each country. We were also aware that the debates around substitution treatment were unlikely to fall neatly into "pro" and "con" categories and that stakeholders may well shift their positions on its use over time. In the contemporary period post the HIV/AIDS crisis with which we are concerned, policy ideas and policy options were likely, then, to coexist and assume prominence in particular circumstances rather than "wither and die." In particular, the case studies presented here illustrate the changing fortunes of abstinence-based approaches in relation to substitution approaches although both policy "ideas" continue to remain options in all six countries.

Furthermore, Kingdon's three streams facilitate examination of the processes by which the issue of substitution treatment became defined as a solution to a problem and then redefined as a problem in itself (problem stream), of the activities of stakeholders in promoting their preferred solutions and policy options (policy stream) and of the influence of wider political, cultural, and economic pressures on government decision-making (political stream).

Like any other policy, substitution treatment policy is based on different ideological or moral stances that are expressed in norms and values that justify the way a society organizes services for drug users (Houborg, Bjerge, & Frank, 2008). While most of the papers in this collection deal with this more implicitly, the paper on Finnish substitution treatment takes this as a point of departure for their analysis. By using Boltanski and Thévenot's (2006) theory on justification and their concept of six "worlds" that differ in relation to what and how values are distributed and prioritized, the paper analyzes in more detail how stakeholders justify their positions within this policy field.

Lastly, based on Varvasovszky and Brugha's (2000; p. 341) discussion of the concept, the country partners adopted a broad definition of stakeholder as "*an individual, group or network of people involved with, or with interests in, or affected by a particular area of activity or a particular policy*." In our case, the area of interest was policy around substitution treatment. Stakeholders could encompass a wide range of individuals and groups—such as politicians, government departments and civil servants, different professional groups, treatment service workers, church and faith groups, the pharmaceutical companies, drug users, researchers, the general public, the media, etc.—and were expected to vary between the six countries. Additionally, it was recognized that stakeholders operate at different levels within the policy arena—national, regional, local—and that some groups or individuals are closer to the scene of action than others. For example, although there is overlap, frequently there is a divide between stakeholders involved in policy formulation at

national level and the stakeholders involved in implementing policy at more local levels. In the country studies presented here, the focus is on policy approaches at national level although some country accounts do highlight the divide between national policy and local implementation, indicating how the power and influence of stakeholders is located within specific social contexts (cf. Lipsky 1980). Thus, in the papers, stakeholding is seen as a dynamic process, evolving and changing over time, in the nature and composition of the groups involved and in the "narratives" that they produced—the rationale or justification for their perspectives on the issue of substitution treatment. Interactive factors, for instance, relationships between groups or changes in the political, social, and economic situations within countries are likely to influence and change stakeholder groups and alliances, producing conflicting narratives and reflecting power dynamics.

DATA AND METHODS EMPLOYED

The six countries adopted a common framework for conducting the research guided by Varvasovszky & Brugha (2000). As a policy analysis research tool, stakeholder analysis is primarily a qualitative and retrospective analysis drawing a picture of how particular policies have come into being. Varvasovszky & Brugha (2000; p. 338) define stakeholder analysis as "*a tool or set of tools for generating knowledge about actors—individuals and organizations—so as to understand their behaviour, intentions, inter-relations and interests; and for assessing the influence and resources they bring to bear on decision-making or implementation processes*." The toolkit consisted of two main parts: (1) documents and available literature and (2) qualitative interviews.

Each country has used policy documents and available literature as part of the descriptive history of the emergence and evolution of opioid substitution treatment and the factors that appeared to have influenced its development. Using policy documents and available literature gave the researcher insight into key events, prevalence and change of opioid use and numbers in treatment, continuity and change of local, national, and/or international stakeholders over time, developments in wider ideological/structural/political and economic contexts. Policy documents and available literature were also used to identify possible stakeholder groups and individuals for interview.

Qualitative interviews were chosen to explore the experiences, attitudes, and relationships of stakeholders and how these may have changed over time. However, an interview schedule was developed jointly by the research partners and included two main sets of questions. The first set of questions was designed to explore the influence of stakeholders' activities on policy, and the commonalities and differences in interpretation of opioid substitution treatment policy. The next questions aimed to explore the effects of policy and policy change on stakeholders' position and influence in the policy arena and to gain an insight into the dynamics of stakeholder activity, including the formation of alliances and consensus building activities. The researchers from all of the six countries, however, adopted an open interviewing technique, which allowed maximum opportunity for respondents to provide their perspectives on the issues. This also facilitated an approach that recognized that the "*process of data collection and analysis needs to be iterative; the analyst needs to revise and deepen earlier levels of the analysis, as new data are obtained.*" (Varvasovszky & Brugha, 2000; p. 338).

The initial list of interviewees drawn up from the documents and available literature was expanded, as the research proceeded, by suggestions from interviewees; the researchers—who have all been active in research on drug use(r)-related issues for many years—also drew on their own knowledge of the field and their own contacts. The 15–20 stakeholders interviewed in each country eventually came to represent different kinds of stakeholders—groups or individuals as defined above—that were involved in either the most recent or more historical developments, policy shifts and policy debates.

ETHICS

All countries complied with ethical research standards as applied in their own universities and organizations. Confidentiality and anonymity were offered to interviewees and respected. Some interviewees were unconcerned about anonymity and felt that the field they worked in was so small that they would, anyhow, be identifiable.

DIFFERENCES AND SIMILARITIES IN OPIOID SUBSTITUTION DRUG USER TREATMENT POLICIES IN THE SIX COUNTRIES

Although there are historical, political, religiosity and, socio-economic differences among the six countries involved in the present studies, it is still possible to carve out some issues that can either explain or cut across these differences. In the following, we will discuss both the differences and the similarities that occur in the six papers related to: stakeholder groups: administrative and regulatory structures; debates about abstinence as a goal of treatment versus substitution treatment and, how problems are defined and legitimized in substitution treatment debates.

Stakeholders: Power, Dynamics, and Diversity

The six case studies reveal that stakeholding is a dynamic process, which varies across time and place. The studies show how stakeholders have changed and shifted over time in relation to their size, composition, behavior, and interests. Some stakeholders occupy central positions within the policy space, while others operate on the periphery of debates; some have survived for decades, others have disappeared and new stakeholders have emerged. In different ways they reflect and form part of the wider economic, political, and social contexts of the various countries. The case studies reveal a fascinating complexity within and between different stakeholder groups regarding the actions they take in their attempts to influence substitution treatment policy; the stories reveal conflicts,

changing positions, and alliances; new or dissolved coalitions; official and hidden agendas; and more or less subtle shifts in perspectives on substitution treatment over time.

There are differences regarding which stakeholders are the most powerful and influential in the six countries, although medical doctors (psychiatrists) appear to be relatively powerful in all countries. For example, a key conclusion of the Austrian case study is that psychiatrists were viewed as being the "established owners of addiction" but with the introduction of substitution treatment, general practitioners came to the fore. Britain, too, has a long history of psychiatrists playing central roles in the treatment of addiction with general practitioners—often reluctantly—taking on a role. While historically the medical profession has played a central role in both Austria and the UK, the Danish case study traces a much more recent shift toward medicalization, which has placed doctors as central stakeholders. This shift is underpinned by increasing professionalization and specialization as doctors trained in addiction medicine became more dominant in the field. A similar process is shown in the Finnish case, where all interviewees named physicians as being the most powerful group in shaping the development of substitution treatment, although other stakeholders representing nonmedical treatment models were influential in introducing psychosocial treatment practices. In Italy—as well as in Denmark—there are key differences between physicians and nonmedical staff (i.e., psychologists, educators, and social workers) in their views regarding substitution treatment. By contrast, in Poland there is no consensus within professional groups and NGOs on substitution treatment; here professional groups such as psychiatrists, physicians, psychologists, and addiction therapists are divided in their opinion of substitution treatment and how and by whom it should be provided. The empirical case studies thus show how different the powers of stakeholders can be in each country.

An important theme across all the case studies is the power and autonomy of the treatment organizations that implement substitution treatment, whether these are public or private. For example, in Poland, the Institute of Psychiatry and Neurology in Warsaw has contributed at the level of practice in terms of ensuring correct threshold levels for prescribing. In Italy, local addiction services (SerDs), which operate on an outpatient basis, are considered to be core stakeholders. Even though they do not have a direct influence on policy, they have power and discretion at the level of practice. Therapeutic-communities—underpinned by abstinence-based ideologies—have long histories of providing services to drug users in some of the countries studied and have influenced the direction of policy and practice to varying degrees. For example, in Poland, the therapeutic community organization MONAR, which has a long-established reputation of providing abstinence-based treatment and being a strong opponent of substitution treatment, has recently softened its position and accepts substitution treatment for some clients on a limited basis. On the contrary, during the debates surrounding "recovery" in Britain, the residential rehabilitation sector challenged the existing drug user treatment system based on harm reduction and substitution treatment and argued for its reform toward an abstinence-based framework. The role of treatment organizations, whether these are public or private, abstinence oriented or not, thus plays an important role in many of the countries studied.

Also, the role and participation of drug and service user groups has varied across the countries studied. In some countries, they play active, visible roles as stakeholders while in others, they seem to be invisible and have not been engaged in public debates regarding policy. In Italy, user advocacy organizations have disappeared, although they were quite active in the 1990s. In Austria, drug users themselves were never given a "voice" within policy development, but their views have been put forward on their behalf by other stakeholders. By contrast, drug user organizations have always played important roles in the development of policy in Britain, even though they have been silent in the recent debates on abstinence-based recovery policies. Also, in Denmark, there has been a well-established user movement for decades, which has gained more power by making alliances especially with leading physicians and NGOs furthering harm reduction to drug users.

In general, new stakeholders or alliances between stakeholders have emerged in the different countries in response to the changing nature of the "drugs problem" and particular crises, such as HIV and injecting drug use, and due to changes within the wider political, economic and social contexts. The case studies show how these contextual changes and crises provide "windows of opportunity" in which new stakeholders can negotiate a space for their policy ideas. A prime example of this is Poland, where the economic and political changes post 1989, which coincided with the HIV epidemic, provided a "policy window" in which new international stakeholders such as the World Health Organisation (WHO), the United Nations Office on Drugs and Crime (UNODC) and the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) could influence and support a harm reduction agenda.

Substitution treatment in all the countries has, however, been affected by political changes. Politicians and political parties have played important roles in the development of both the political rhetoric surrounding the substitution treatment debate as well as the policy choices. While in some countries it is possible to place punitive turns within drug user treatment policy and advocates for abstinence oriented treatment in the conservative/liberal wing of the political spectrum—e.g., in Austria, Italy, and the UK—this is more complex in the rest of the case studies.

Other stakeholders, such as government departments and their civil servants, the Catholic Church, and the pharmaceutical industries have also been important. In the case of the current British drug user treatment strategy based on recovery, civil servants have played key roles in persuading against the adoption of a wholly abstinence-based strategy with time limited prescriptions. The Catholic Church in Poland exerts certain pressures on political

debates; its conservative approach has extended to substitution treatment and influenced key stakeholders, such as politicians at local and national levels. In Italy, the Catholic Church had an important influence in promoting and orienting the type of treatment offered in the private therapeutic communities. Their conservative views surrounding methadone maintenance treatment meant that an abstinent, drug-free approach was adopted in these settings. Even though research access to the pharmaceutical industry was limited in all case studies and in some countries, such as Poland, representatives of the pharmaceutical industry refused to be interviewed, it is seen as a powerful stakeholder in all the countries studied. For example, the Italian case study shows how the pharmaceutical companies, Molteni (producing methadone) and Reckitt Benckiser (producing buprenorphine) have funded scientific conferences and research meetings, which have resulted in an alliance between the industry and science.

At the widest level, there is a need to recognize the role of stakeholders and stakeholder groups at the international level. No international stakeholders, such as representative from WHO, EMCDDA, or other international organization were interviewed in the six cases. However, the role and influence of international stakeholders was mentioned by several stakeholders in each of the six case studies. In some cases, interviewees reported that international influence had resulted in policy changes; in other instances, there was resistance. In Italy for example, although the WHO guidelines on harm reduction and substitution treatment were considered influential by key stakeholders, they did not have the power to replace local regulations and practices. This, in itself, indicates the complex relationships and variable power between international, national, and local stakeholder groups and is reflected in several of the case studies. The influence of North American stakeholders—working both directly and indirectly through their influence on international groups—was also seen as being particularly strong in some of the case study countries. Again, taking Italy as an example, the Anti-Drugs Policies Department (DPA) Scientific Committee is composed mainly of American researchers who are not connected with the Italian drug user treatment system. In the British case study, we see the influence of key American recovery advocates including William White. Thus, although the case studies can not provide a viewpoint from the international stakeholder groups, we do see how national representatives interpret international activity and power to influence internal affairs, how they refer to international action to legitimize and support policy at national level, or to explain the acceptance of policy options, which may otherwise have been rejected.

Important to underline here is that stakeholders presented in the six case studies have different kinds of power and—whether visible or invisible—enter into different kinds of dynamics in the policy processes in each of the six countries. What is similar is that these processes can be traced and might be interpreted differently by different stakeholders.

Administrative and Regulatory Structures

The legal, institutional, and administrative setting for substitution treatment in each of the six countries is highly differentiated. This means that substitution treatment is managed in various ways, but also that stakeholders have different starting points for influencing shifts of agendas given the different administrative settings. In the following, we outline the most significant legal, institutional, and administrative settings for each of the six countries.

In Italy, substitution treatment became possible in 1975 and, 5 years later, specific treatment services were established, though with large variations throughout the country. Regional governments run the health system in which drug user treatment is also situated. Local public addiction services (*SerDs*) operate on an outpatient basis. Private organizations (mainly of religious inspiration) operate residential treatment services, primarily Therapeutic Community treatment. The coordination of actions against drug use and the monitoring of drug use are situated at a national level. Though substitution treatment has been possible since the 1970's, it was not until 1993 that substitution treatment was extended to most areas of Italy.

In Austria, long-term substitution treatment for (mainly) iatrogenic drug users was accepted by 1946 and trials with substitution treatment were initiated among pregnant women and in prisons during the 1970's. However, it was not until 1987 that substitution treatment became a legally approved form of drug user treatment for noniatrogenic or "hedonist" drug users as they were also called. Not many specialist services have been established and substitution treatment has developed unevenly with more than half of the clients in treatment situated in Vienna. Legally, public and private drug user services, general practitioners, and psychiatrists are allowed to prescribe opioid substitution medicine. The National Committee on Substitution is the deciding body, apart from decisions relating to drug user treatment in prison. This committee mainly consists of drug user treatment program administrators at both national and local levels, rather than medical doctors.

In Britain, restrictions on general practitioners' prescription of heroin and cocaine to dependent drug users were recommended in 1966 and drug dependency clinics were established and staffed by psychiatrists. Also, a growing number of voluntary organizations and therapeutic community-run treatment programs provided counseling and rehabilitation. In the 1970s and 1980s methadone was increasingly used in treatment and treatment was split between hospital-based consultants and community-based general practitioners. In the mid-1990s, drug user treatment increasingly became interlinked with the criminal system, drug-using offenders were introduced to treatment via the criminal justice system and crime reduction became a clinical goal for treatment. Though the drug user treatment system has developed toward more heterogeneity regarding treatment providers, psychiatry still maintains a dominant position.

Substitution treatment was not launched until 1992 in Poland on a trial basis in two cities via WHO's

program on prevention of drug use and concomitant with HIV-infections in the Countries of Central and East Europe. It was funded by the European Commission. Even though this can be considered late in relation to Austria and the UK, it was early compared to other Eastern European countries. In 1997 substitution treatment was recognized as a legitimate treatment approach and launched in other larger cities as part of the National Health Program. In 2005, nonpublic sector substitution treatment centers were allowed. Today, 2 out of 16 regions do not offer substitution treatment and clients often have to travel extremely far for treatment. Also, abstinence oriented treatment (mainly Therapeutic Community treatment) still absorbs more than 70% of resources in the field.

In Denmark, the responsibility for substitution treatment policy is administratively divided between the Ministry of Health (prescription medicine) and the Ministry of Social Affairs (psychosocial treatment). This has resulted in two different sets of guidelines on substitution treatment. In the 1970's, drug user treatment was framed as being a social rather than a medical matter. Treatment was thus restructured from the national health services (especially psychiatry) to the domain of the municipalities. General practitioners were responsible for prescribing methadone, while psychosocial elements of treatment were managed by social workers employed in municipal welfare services. In 1996, substitution treatment became a public monopoly and now only publicly run drug user treatment services are allowed to prescribe substitution medicine. Despite reorganizations in 2007, substitution treatment is only offered as a public welfare service and drug user treatment is still embedded in the two different administrative areas.

Lastly, in Finland today, substitution treatment is the prevailing mode of drug user treatment, although it was almost nonexistent in the 1990s. Substitution treatment is based on the opium treatment law of 2003, amended in 2008, whereby harm reduction was included as a goal for treatment. Substitution treatment is also based on national guidelines. It is included in the Treatment Guarantee by law from 2005, which states that people with certain chronic conditions have the right of access to treatment within 6 months after being diagnosed. It is, however, the municipalities that are responsible for the organization and implementation of substitution treatment, and there is autonomy in relation to the organization and implementation of treatment, as long as national laws and guidelines are followed.

To sum up, in all countries, apart from Poland and Finland, the 1970s was the time where opioid substitution treatment began to gain ground. Though acceptance of this form of treatment differed between countries, the administrative structure for managing substitution treatment was founded in this period in most countries. In all countries except Denmark substitution treatment has primarily been regarded as a matter of health and medical regulation. As discussed above, the dominance of the health administration is also mirrored in the fact that the dominant stakeholders in most countries have been general practitioners, hospital physicians, and psychiatrists. Common to all countries is that substitution treatment is managed locally or regionally, based on national guidelines and action plans. It is, however, noticeable that Austria and Poland have not developed the necessary administrative structures or pressures to ensure access to substitution treatment in all regions of the country. The structural obstacles to implementing substitution treatment in these countries may also be reflected in the fact that Austria and Poland do not have the same heterogeneity of stakeholders as Italy, Britain and Denmark, despite the dominance of the medical sector.

Abstinence Versus Substitution Treatment as a Treatment Goal?

One—if not *the*—most discussed themes among stakeholders is the issue of abstinence versus substitution treatment. Abstinence can mean different things—complete abstinence from all forms of drugs, including tobacco and alcohol as well as illicit drugs—or abstinence from illicit drugs, especially opioids, which are the focus of substitution treatment programs. The research informants in the case studies were drawn from organizations that had different views on what constituted "abstinence" as a treatment goal; but the focus in our interviews was on abstinence from illicit drugs and we did not explore the wider meanings of the concept or its application in the different intervention programs.

In Italy the abstinence discourse is tightly connected to the large number of Therapeutic Community residential treatment providers that are privately run, often with a religious inspiration. From the 1970s and up until the HIV/AIDS epidemic increased (1986–1996), abstinence discourse had a very dominant voice in the debate. Due to the HIV/AIDS epidemic, a harm reduction intervention and treatment ideology became more acceptable—to accommodate the problems of blood borne diseases—and substitution treatment was generally accepted. However, the shift from using narcotic pharmaceuticals only for shorter or longer term detoxification to "maintenance" becoming a more long-term form of medicinal treatment had been under way for a long time. This was especially so among particular universities and researchers who were devoted to establishing evidence-based data on this form of treatment. This was an important counterweight to the more moralistic and political voices that denied substitution treatment as being a "proper" form of treatment for drug use interventions. Although the different discourses are still present at an ideological level today, in practice much collaboration is going on between therapeutic communities and the substitution treatment services, and the battle between the two approaches has calmed.

In Austria, the abstinence versus substitution treatment debate is related to the political party system. There is a historical and long-term difference between conservative and social-democratic politics, when it comes to drug user treatment policy and substitution treatment. Contrary to the conservatives, who see abstinence-based

treatment as being the solution to drug use problems, the social democrats emphasize health as the point of departure for drug user treatment interventions. It was, therefore, during the social-democratic parliamentary rule that substitution treatment was implemented in 1987. Whereas up to the implementation of substitution treatment, the debate revolved around the pros and cons of abstinence versus substitution treatment; after 1987 the debate evolved mainly around what kinds of substitution medicine to use and what sorts of regulations to develop. In comparison to, e.g., the Danish situation, medical doctors have always been the most powerful stakeholders in substitution treatment policy in Austria. However, similar to the Danish situation—as described below—the debate is mainly about *how* to improve and develop best practice in substitution treatment, rather than whether this treatment modality is feasible or not. The debate thus evolved around dispensing and control practices and ways of avoiding substitution medicine being diverted into the black market.

A prominent example of how the two approaches are much discussed is Poland. Until 1992, abstinence-based therapeutic community treatment was the major treatment type available in Poland. Legislation adopted in the 1980s emphasized drug-demand reduction and the depenalization of possession of any amount of drugs. This fostered a climate in Poland where drug use and its related problems were seen as being social rather than being medical issues. With the advent of the HIV/AIDS epidemic in the 1980s, a very quick response to the new situation was needed in order to halt the epidemic. The provision of syringe exchange and free condoms (from the NGO's outpatient facilities, in the first instance, and then later on also from public health outpatient centers) was effective in controlling the epidemic. In the wake of this—and in the context of the political, economic, and other general changes occurring from 1989 in the Eastern Block countries—opioid substitution treatment was launched in 1992. However, until 1997, it had the status of trials and research projects. It was only during the beginning of the millennium that this form of treatment began to be developed. However, the next shift in policy, toward the penalization of drug use and possession, changed the climate in terms of the implementation of substitution treatment and legislation in this field. Therefore, methadone maintenance treatment (the form of treatment in use) represented a highly controlled treatment modality with limited maintenance doses, use of urine tests, and compulsory discharge if supplementary use of illegal drugs were detected. This restrictive attitude toward substitution treatment is still present, if not in national level guidelines then in local political circles, which often resist implementing substitution treatment. Today, substitution treatment covers about 15% of those in need of treatment, and therapeutic community-based treatment modalities still absorb the largest percentage of funds. This has led several stakeholders in the Polish study to underline the economic aspects of this battle. Agreeing to substitution treatment, as a possible way of treating drug use(r)-related problems, is also potentially a threat to the financial and funding situations of therapeutic communities.

The long history of substitution treatment in Britain has always contained debate about abstinence versus substitution treatment. However, the stakeholders and their role in political debates have changed. After the HIV/AIDS epidemic, Britain became famous for adopting a harm reduction policy approach and offering substitution maintenance treatment to as many drug users in need as possible. Numbers of methadone prescriptions doubled between 1995 and 2004. However, this policy has been criticized especially since the middle of the millennium. Stakeholders, such as Conservative politicians, researchers, and providers of residential rehabilitation treatment critiqued the results of maintenance treatment for not getting drug users out of addiction and keeping them in marginalized positions; they stimulated a renewed focus on abstinence within the emerging "recovery" agenda. These ideas became part of political debates and the term "recovery" became a part of the 2010 drug strategy. So, moving on from discussing substitution treatment versus abstinence, the debate now evolves around how to define "recovery." For some, it continues to signify the importance of abstinence; for others it covers a broader definition of what a drug user treatment pathway could look like.

In Denmark, substitution treatment was implemented in the beginning of the 1960s. An important focus in the stakeholder analysis presented in this volume, covering the period form 2000–2011, is not so much stakeholders' debate over abstinence or substitution treatment, but rather their views on how substitution treatment has changed, and how they have pushed forward particular developments. Unlike Poland, Italy and Britain, abstinence orientated stakeholders are not present and prominent in the Danish debate. Harm reduction ideas had already changed substitution treatment in Denmark from the mid-1980s onward. It was changed from a high-threshold to a low-threshold treatment form, making treatment entry easier and client retention routine. The philosophy became that the most important aim of treatment was to keep the clients in treatment, in order to reduce harm resulting from the often-harsh life of these clients. What has changed during the millennium is the switch toward medicalization of this form of treatment, the focus on standardization of treatment practices through the development of national guidelines, the inclusion of health personnel in treatment centers, and a general wish to professionalize substitution treatment. So, rather than a debate between abstinence and medically assisted drug user treatment, the Danish debate has been to improve substitution treatment.

The battles between abstinence and substitution treatment take different shapes in each of the different countries involved in this study. In Poland, e.g., it is both an ideological battle and also an economic one. In Britain, it becomes a debate about how to define "recovery;" in Austria, the debate revolves much more around what kind of medication to use in substitution treatment. The differences in how abstinence and substitution treatment are debated and take form depend, among other things, on

whether there are powerful and important stakeholders advocating for abstinence. The therapeutic community, e.g., plays a major role in both Poland and Italy. In Denmark, however, no powerful abstinence oriented stakeholders have been present in the past couple of decades. In all countries, however, the HIV/AIDS epidemic has had an impact on substitution treatment policy mainly by opening a "window of opportunity" toward implementing and including substitution treatment, or widening the substitution treatment offers already in place.

Problematization and Legitimization

There are similarities and differences in the ways in which different stakeholder groups have "problematized" the issues around substitution treatment and built consensus around their version of the debate. In all cases, problematization—whether in favor of or against substitution treatment—has entailed the employment by stakeholders of a raft of legitimization techniques. Research-based evidence, experience, moral argumentation, the need for international collaboration and consensus, economic and social pressures, all feature in the case studies in this collection of papers.

It is important to underline that the processes of problematization and legitimization are neither static nor unidirectional; in all cases, there has been a shifting problematization and solution seeking process regarding the provision of substitution treatment. As mentioned earlier, in Britain, by the late 1990s, substitution treatment on a maintenance basis was advocated by stakeholders as a key form of crime reduction for drug involved offenders. Subsequently, however, prolonged substitution maintenance was redefined as being a problem in itself by another group of stakeholders who were keen to promote an abstinence-based drug user treatment policy based on full recovery principles. In the Austrian case study, the focus of the debate among stakeholders was, for many years, the introduction of stricter dispensing regulations for morphine by medical doctors, but this was replaced with a growing concern regarding the simultaneous prescription of benzodiazepines in addition to substitution treatment. In general, the wider economic, political, and social contexts have impacted on how the substitution treatment debate has been framed and has been influential in shifting frames. As already pointed out, the far reaching political, economic, and social transformations, which took place in the late 1980s in Poland, along with the HIV crisis, enabled the introduction of harm reduction treatment ideologies and measures such as syringe exchanges and the development of the first substitution maintenance program in 1992.

A similar way to legitimize and support arguments for (or against) substitution treatment by stakeholders in most case studies is the use of (or call for) research evidence. For example, the Danish case study reveals the growing importance of evidence-based treatment as the drug use(r) intervention-treatment field became increasingly medicalized and professionalized. Evidence regarding the efficacy of certain treatment interventions surrounding dual diagnosis and the use of buprenorphine and pharmaceutical heroin began to accumulate and impact on the policy and practice agenda in Denmark. Similarly, substitution maintenance treatment gained popularity in Finland due to the influence of a growing body of international scientific evidence. Stakeholders produce, disseminate, and utilize research evidence. They play pivotal roles in determining what evidence gets produced, what forms of evidence get used to frame policy debates, and how different types of evidence/sources are balanced against one another (cf. Weiss, 1977). The case studies reveal instances of evidence being used in overtly political ways to support different positions in relation to substitution treatment over time. For example, in Britain, the discourse surrounding the use of methadone maintenance changed dramatically in 2005 from being viewed as a highly effective treatment to being seen as a failing treatment (McKeganey, 2012). Drawing on selected pieces of research, key stakeholders, including Conservative politicians, began to construct methadone as a "problem," which eventually evolved into a new policy framework with "recovery" at its center.

MacGregor (2011) has argued that international networks linking researchers to policy communities are important in the drugs field. These networks are important in relation to how drug use is shaped as a problem and what kinds of solutions are seen as relevant and acceptable. They have been particularly powerful in relation to the development of harm reduction initiatives, including needle exchange and methadone maintenance. In the case studies, international institutions, such as the World Health Organisation (WHO) and the United Nations (UN), have been reported as influential in promoting harm reduction responses to injecting drug use, particularly within the development of Polish policy. Similarly, according to accounts from interviewees, the dissemination of information and evidence concerning harm reduction and substitution treatment by the EMCDDA strengthened the position of Polish stakeholders at national level to argue for these initiatives within their policy development. As mentioned above, these are examples of the use of international action to legitimize and explain policy and practice developments at national level.

The role of expert committees, both at national and international levels, has been important in relation to defining the "drugs problem" and legitimizing different policy and practice options. Across the case study countries, researchers have played significant roles in providing evidence on the efficacy of substitution treatment to such committees. However, the degree to which they have participated in the policy debates and in advocacy has varied within countries, between countries and over time. In Italy, scientists with backgrounds in pharmacology, epidemiology, clinical medicine, and neuroscience were considered to be influential by other stakeholders. Interestingly, the scientists themselves did not regard themselves as particularly influential. None of the main Italian scientists are on the Anti-Drugs Policies Department (DPA) Scientific Committee as it is mainly composed of American researchers who are not

connected to the Italian treatment system. In the UK, the appointment of an expert committee was a key tactic in tempering the debate surrounding the role of substitution treatment within the development of the new recovery oriented system. This committee was chaired by an internationally recognized expert in the drug user treatment field, and supported by an International Advisory Group. The majority of stakeholders viewed the work of this expert committee, and their final report, as an attempt to built professional consensus within the field based on clinical judgment and evidence-based provision.

The six case studies thus show how problematization and solution seeking in relation to substitution treatment has been influenced by local, national, and international stakeholders. The relationship between these levels is examined in more depth in each of the six country papers.

CONCLUSION

Four factors are possibly important considerations when reflecting on the data and its analysis. Concern about being identified may have colored or restricted the information given by interviewees despite assurances of anonymity as many of the respondents were still involved in policy circles and treatment services or in other activities relevant to substitution treatment debates. Second, while the researchers' positions in the field were an advantage—as noted earlier—their partial "insider" status and their familiarity with some of the interviewees may have influenced the interview in unknown ways. Third, because of the need to ensure confidentiality when requested, some of the data on stakeholder dynamics, in particular contentious relationships and politically delicate situations had to be "smoothed out" in telling the story so that the narrative appears more consistent than it was in reality. Finally, as mentioned already, international actors were not included and a relatively small number of stakeholders were interviewed in each country. In particular, it was not possible to fully explore the divide between national policy developments and regional or local implementation and this aspect of the study remains open for future investigation.

However, the six case studies in this volume open up discussion on the role of stakeholders in influencing policy and practice on opioid substitution drug user treatment; in doing so, the research has revealed the complex relationships between groups of interested actors and a host of other factors, which impinge upon policy formulation and the policy process from agenda setting to implementation. While acknowledging the importance of national systems and institutions, there are similarities in the ways in which stakeholders seek to argue and legitimize their own agendas, build consensus, and position themselves within the core of the policy community. Furthermore, the case studies clearly highlight the value of adopting an historical perspective, which captures the shifting terrain of ideas, events, and contexts within which stakeholder groups emerge and evolve. Insights from the papers in this volume provide a basis for further development of cross national examination and analysis of stakeholder activity in the addictions.

Declaration of Interest

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