User involvement in the illegal drugs field: what can Britain learn from European experiences?

Abstract

In Britain, the last two decades have seen a considerable increase in focus on service users' involvement in the provision of services that directly affect them, particularly where service users originate from a hard to reach population such as drug users. While the National Treatment Agency and drug and alcohol action teams often extol the virtues of the involvement of drug users in their service provision, participation of this type does not come without problems of its own. Experience of drug user involvement in service provision is much more established in Europe and this article seeks to utilise European examples in illustrating the potential pitfalls of such a strategy. Case studies are examined from three countries: the Netherlands, where drug policy is relatively liberal and drug user groups have been established since the 1970s; Denmark, where drug policy is fairly well balanced between repression and tolerance and drug user groups have been established since the 1990s; and Sweden, where drug policy is relatively repressive and drug user groups are only just emerging. Salient points from these case studies are then used to form the discussion, relating European experiences to the situation in Britain.

Key words

International drug policy; service user involvement; harm reduction.

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Introduction

By now the limitations of a drug policy based on prohibition and law-enforcement alone are well documented. The so-called 'war on drugs' has long been tempered by harm reduction measures, at least towards drug use and drug users. One facet of harm reduction that has received recent attention is the involvement of drug users both in the provision of their own services and in their wider national drug policy debates. In Britain, the National Treatment Agency (NTA) has published guidelines emphasising the importance of user involvement and seeking to establish it as a mandatory part of the efforts of local drug and alcohol action teams (DAATs). While the benefits of user involvement can be considerable, they are by no means assured and this article seeks to explore some of the limitations of drug user involvement, particularly where it is coerced by the government and where it remains almost totally reliant on the state for support and funding. In contrast, different types of user involvement that are practiced at a European level will be explored and used to inform the debate on the further development of involvement in Britain.

The situation in Britain

The last two decades have seen a considerable increase in focus, in a variety of fields, on service user involvement in the provision of services that directly affect them. This involvement has been linked with the rise of the consumer

10.5042/sc.2010.0585

society in general (Kolind, 2007); specifically, Schulte and colleagues (2007: 278) have suggested that '*individuals using health services should be seen as customers/consumers rather than patients*'. While this focus can be observed across social and health related services, it has perhaps been strongest in fields where some difficulty in achieving effective user involvement might be anticipated; for example, mental health service users and illegal drug treatment service users. The NTA has been very clear in its latest publications that the involvement of drug users in the provision of the services directed towards them is essential. For example, the NTA (2006: 1) guidance for local partnerships on user and carer involvement affirms the belief that '*service users should be involved in all key aspects of decision-making in relation to their care*'.

Furthermore, it has been suggested that drug users now occupy a central position in relation to the provision of drug treatment services, with all DAATs being required to involve drug users in their decision-making processes. (Mold & Berridge, 2008).

The recent call in Britain by the NTA for drug users to become involved in their service provision, however, does not mark the beginning of drug user groups in this country. In 1967 Release was founded, largely as a lobbying group campaigning for the rights of drug users. Among other things, the group was involved in seeking '*improvements in the treatment facilities provided for heroin addicts*' (Mold, 2006). While some of the founders of Release almost certainly used drugs themselves, their drug use was suppressed as it was not politic at the time to admit to their involvement if they wanted to be taken seriously (Mold & Berridge, 2008). This represents a significant contrast to the more recent groups and organisations that have emerged in this country. The emphasis has shifted to the involvement of current users and agencies have become willing to work with those who admit to current use themselves (McDermott, 1997).

Release still exists, although it markets itself as a centre for expertise on drugs and drug laws rather than a user group as such, and continues to campaign for a fairer and more compassionate drug policy. The increased emphasis on the involvement of users themselves in both the provision of drug-related treatment services and the wider drug policy debate that has been seen over the past two decades has resulted in the development or reinvigoration of many more organisations similar in structure to Release. Examples of pre-existing groups possibly galvanised by NTA guidelines are the UK Harm Reduction Alliance, which campaigns to put human rights at the centre of drug policy and includes drug users as an important part of its membership. Additionally, several user-oriented publications have been developed during this time period, for example *Black Poppy*, a publication on health and lifestyle choices created by drug users for drug users. Other groups have been formed at the behest of the NTA such as the Bolton Usergroup Service (BUGS), the Reading Users' Forum (RUF) and Southampton based MORPH.

Despite the evidence presented so far, a point that may surprise is that Britain has been rather slow in developing user participation, at least in international terms (Bunce, 2005; Fischer *et al*, 2005; Patterson *et al*, 2010). Schulte and colleagues' (2007: 277) study indicated that 16% of user services were still operating without any user involvement, citing '*discrepancies regarding both desired level of user involvement and priorities for service developments between service users and providers*'. Bunce (2005) and Patterson and colleagues (2010) have suggested that this discrepancy may be due to a lack of clear national strategy outlining models of best practice and a lack of consensus in defining terms such as 'user' and 'involvement' or 'participation'. User involvement in the provision of drug services is still relatively new in Britain, which may be responsible for '*the large variation in practice and implementation*' (Patterson *et al*, 2009: 374) so evident in this country.

Benefits and limitations of drug user involvement in the provision of their services

It is important to understand the motives behind the increased emphasis on drug user involvement in service provision. Liddell & Brand (2008) summarise these as leading to more efficient and effective running

of services, more informed decisions being made about how to treat illegal drug users, a change in public attitudes towards illegal drug users and a development of the skills of drug users themselves. Charlois (2009) further suggests that the involvement of drug users ensures that a hard-to-reach, hidden population of heavy drug users is more likely to be contacted and supported by the service providers. Finally, Asmussen (2003) proposes that involvement of drug users in their own service provision brings empowerment, increases quality of life and allows drug users a forum through which to participate and influence illegal drug policy-making.

It is vital not to accept these benefits, however, without subjecting them to critical analysis and it is also the case that many academics have noted limitations to the increased involvement of users. The first set of problems encountered relates to the ability to achieve and maintain a commitment to involvement on the part of the users themselves. It has long been recognised that drug users can be a difficult population to work with. The nature of heavy, long-term drug use is that it brings instability to the lives of those involved:

> *'Taking drugs in itself is likely to lead to unpredictability in terms of housing, friends and relations and income. Poor physical and mental health tend to accompany life as an active user, along with crime and longer or shorter spells behind bars.'* (Willersrud & Olsen, 2006: 95)

These factors mean that it can be difficult for drug users to commit to regular participation in groups or organisations as the circumstances of their daily lives are constantly changing and reflect significant competing interests. The participation of drug users in their own service provision is therefore often described as transient (Patterson *et al*, 2010) or fluctuating (Bunce, 2005) as groups or initiatives quickly spring up and then disappear almost before they can begin to make their mark (Jauffret, 1999). Working within such an uncertain and inconsistent framework can prove frustrating to the relevant social agencies and health services and can lead to pessimistic attitudes about the fruitfulness of continuing to work to increase levels of participation by drug users.

A further problem in this area is that it is also impossible to present a definitive representation of the views of drug users. Drug users are not a homogenous group (Mold & Berridge, 2008; McDermott, 1997) – there are users of different types of drugs, users with different levels of drug use, users encountering different kinds of problems etc. While this is by no means a problem unique to the drug field – it is also very difficult to present a homogenous picture of the needs of the disabled, the elderly or those with a mental health issue (Forbes & Sashidharan, 1997) – it does bring into question the usefulness of user participation on a small scale, as it is unlikely to represent the needs of the wider drug using population. This issue becomes particularly salient when drug users attempt to enter the debate on national drug policy. While current paradigms of drug policy, focused on prohibition and law enforcement, are undeniably causing many harms to users, it is highly unrealistic to imagine that drug users as a group will have a single vision of how to change policy, or even on what areas to focus the efforts of their input. While this is likely to be most significant at the national level, similar problems will also be incurred at the local level.

This first set of problems is centred firmly on the users of illegal drugs themselves, but this is by no means typical of the many criticisms laid at the door of user involvement. Successful user participation suggests the building of a relationship or partnership between users and providers that is based on equality, but this can be difficult, particularly where the user is perceived to be in some way less reliable than the provider. Bunce (2005: 1) found that service providers in Britain did not see *'any merit engaging with users prior to, or at the early stages of, treatment'*, despite the NTA's objective to engage users currently involved in active drug use. Patterson and colleagues (2009: 374), in their recent evaluation of British drug user involvement, found an enduring culture that *'providers know best'*, suggesting that this power imbalance remains and that everyday interactions between service users and providers in this area are unchanged. Asmussen (2003) further argues that equality of power is unrealistic, while professionals remain in charge of both services and funds.

Some academics have gone further and suggested that the drive behind user involvement in services

may have hidden undertones. Bryant and colleagues (2008: 130) state that *'including consumers' views adds legitimacy to the decisions made by service providers'*. The danger here is that by involving themselves in the provision of drug-related treatment services, users run the risk of lending a credibility to their service providers that may not be justified. Others (Mold & Berridge, 2008; Willersrud & Olsen, 2006) have suggested that user involvement can be little more than a box-ticking exercise where users are consulted as a matter of course, but their suggestions are not acted upon. Further evidence to support this thesis is offered by Sweeney (2006: 2) writing for the User News who suggests that the pressure that DAATs are under to involve users has led to a *'top-down approach* [that] *is tokenistic and characterised by a "tick-box approach" rather than any concern to increase service users input'*. In contrast, a more fruitful form of user involvement would presumably be a 'bottom-up' approach led by the concerns of users themselves and not necessarily elicited at the behest of the NTA.

A further criticism that has been levied on the call for increased involvement of drug service users is that, to some extent, a loss of independence and right to challenge law enforcement and prohibition related drug policy measures may be experienced. Working independently, drug users may be able to lobby for alternatives to control should they wish to do so, however, working as part of the system it becomes very difficult to offer any effective challenge to the system itself. If drug users become dependent on funding and support from the authorities in order to effect their participation, then their participation may become funding led rather than driven by their own concerns (Branfield & Beresford, 2006). Patterson and colleagues (2010: 12) summarise:

> *'Service users … may find themselves in a double-bind situation: engagement with services that is necessary to service improving quality … requires acquiescence to the very power they wish to challenge … and a sense of alienation from user issues. In the context of mandated user involvement, user groups are at risk of becoming servants of the more or less benevolent master.'*

Obviously, these problems are not encountered by all user groups at all times, but it does seem possible that the recent call for drug user involvement in Britain runs the risk of encountering many of them. NTA guidelines making it compulsory for all DAATs to try to engage drug user involvement in their service provision means that, in some cases, drug users are not becoming involved through their own volition, but as part of national requirements. Under such a system, it would appear highly possible that drug users who are not fully engaged may be participating in a certain legitimising of the services they are receiving without gaining the benefits of making meaningful contributions to either local level policy implementations or national level drug policy debates. This situation is further complicated by the fact that, under current national UK drug policy, drug users can be forced to attend DAAT related services, resulting in a situation where drug users who do not wish to receive services in the first place are being coerced into providing input on the running of those services. The meaningfulness of drug user input under such circumstances is highly questionable. As was noted in the introduction to this article, drug user involvement in service provision and national policy debates is still in its infancy in Britain, at least in comparison to some European countries. In an effort to further understand the potential benefits as well as the significant limitations of drug user involvement, an examination of drug user involvement in different European countries will be made in the next section.

Drug user participation in Europe

Drug user groups from three different European countries will be explored in an effort to represent the different types of user group currently in operation on an international scale and the relative successes and failures that they have experienced during their history. The salient points will be related back to the situation in Britain in the discussion of this article. Case studies are taken from the Netherlands where drug policy is relatively liberal and drug user groups have been established since the 1970s, Denmark where drug policy is balanced between tolerance

and repression and drug user groups have been established since the 1990s, and Sweden where drug policy is relatively repressive and drug user groups are only just beginning to emerge.

The Netherlands

In European terms, the Netherlands has one of the most liberal drug policies, based as it is on the principles of normalisation of drug users and separation of the markets for hard and soft drugs (van Vliet, 1990). It is perhaps unsurprising then that drug user involvement in the development of treatment initiatives and the influence of policy began here in the late 1970s (Jauffret, 1999; McDermott, 1997). Rather than being in response to a particular emphasis by the authorities, Trautman (1995: 2) describes this involvement as being autonomous: '*independent of professional institutions*'. Dutch drug addicts were tired of the treatment they received at the hands of the authorities and wanted to do something to change their own situations (van Dam, 2007). As the AIDS epidemic broke in the early 1980s, prompting governments to make greater efforts to connect with drug users and engage them in harm reduction measures to help prevent the spread of the disease, so the influence of the Junkiebonden or user groups escalated. While the number of these user groups, or user unions (Junkiebonds) as they are sometimes known, has fluctuated within the Netherlands, they have retained a not insignificant place in the history of Dutch drug policy. For the purposes of this article, one of these groups – the Medical-Social Service for Heroin Users (MDHG) will now be examined in more detail.

The MDHG was founded in 1975 in Amsterdam on the initiative of a local resident living in an area highly populated by drug users; drug users, outreach workers, physicians, pharmacists and the parents of drug users formed the original organising committee (van Dam, 2007). Tops (2006: 69) describes the main goal as being '*to promote an alternative drug policy, including the legalisation of drugs, and the normalisation, emancipation and public acceptance of the drug user*'. The MDHG was also instrumental in initiating a syringe exchange scheme. '*The drug aid services at the time refused to carry out syringe exchange, because they were afraid they would be supporting the practice of drug use instead of discouraging it*' (Trautman, 1995: 3). Suffering from no such reservations, the MDHG was able to take over this practice until it had become more established and was implemented on a national scale by the government of the time. Today, although the MDHG is made up of users, ex-users and non-drug using supporting members, the non-drug users do not have a vote on important issues raised at the annual general meeting and its board always includes two or more drug users (Tops, 2006). Its goal remains to '*represent and defend the interests and rights of drug users*' (Tops, 2006) while working towards the ultimate legalisation of hard drugs.

The case of the MDHG obviously differs to what is currently occurring in Britain, in that it sprang up autonomously, without the impetus of the authorities, rather than being spurred on by a call for increasing involvement of drug users by official agencies. It was during its initial fully autonomous period that the facilitation of syringe exchange programmes, which is arguably the MDHG's most influential contribution to Dutch drug policy and the quality of life of Dutch drug users, was implemented. Since the 1980s, the MDHG has continued to fight for the representation of local drug users, while at the same time pushing the boundaries of national drug policy; however, doing so has not always been as undeniably successful. From the 1990s onwards, the MDHG has become increasingly reliant on official funding from the Amsterdam Municipality to survive (Tops, 2006) and there is some evidence to suggest that this has had a limiting effect on the services they are able to provide. For example, throughout the 1990s the MDHG ran a drop-in centre for local drug users, which attracted considerable attention from the authorities. Tops (2006) describes how the organisation was forced to change the days and times that services were offered due to complaints from local residents. In 2004, the drop-in centre became an unofficial using room where local drug users could use their drugs without imposing on local residents or fearing discovery from the police. The success of this venture led to further complaints from residents that culminated in police surveillance and raids and a temporary closure of the premises. This provides an interesting contrast to the situation in the 1980s with the needle exchange provision. At this time, while fully autonomous, the group was able to provide

a service denied by the municipality itself. A decade later, and more reliant on official funding, and the same group proved unable to provide a controversial harm reduction service (the provision of a safe user room).

To some extent, this example highlights the frustrating situation in which user organisations of this type can be caught, pulled as they may be between the dual aims of representing user interests and attracting official funding in order to ensure their continued existence. Academic commentators in the Netherlands have recognised this and have emphasised *'the risk of co-optation, with the organisation becoming ever more closely integrated into the official assistance system and in this way making it harder to criticise the system'* (Tops, 2006: 77). Despite the considerable successes of a city-based user group, there is also a certain sense of disappointment at the lack of national influence on drug policy debates achieved: *'it is very hard to gain access to decision-making processes. The MDHG still has no part in commissions that are involved in activities directly aimed at drug users'* (Tops, 2006: 78). There is more to the story, however, than a loss of influence and autonomy as a direct response to accepting official sources of funding. The events must also be seen in their political context: during the 1990s, the Dutch general public became increasingly less tolerant of the public nuisance caused by drug users (Uitermark, 2004; Garretsen, 2003; Lemmens, 2003) and in the 2000s a new centre-right national government has adopted a tougher stance on the illicit drug problem. It is fairly likely that a hardening of national Dutch drug policy combined with a popular move against drug-related public nuisance has contributed to the changes in influence perceived by the MDHG and its supporters. A final point to consider is that in the 1980s, the municipality refused to offer needle exchange programmes, allowing the MDHG to step in and provide the service themselves. In the 1990s, safe user rooms were already provided by the municipality in Amsterdam (Hedrich et *al*, 2010) so the closure of the service provided by the MDHG holds significantly different connotations.

Denmark

Danish drug policy has been described as representing a precarious balance between the twin ideals of repression and welfare (Laursen & Jepsen, 2002). While proximity to the other, much more strongly control-orientated Nordic states has had an undeniable influence on Danish policy, relatively liberal ideas such as heroin on prescription and drug user rooms have long attracted strong support. Later than in countries like the Netherlands and Germany, and after the main crisis of the AIDS epidemic, drug user organisations began to be formed in Denmark. Anker (2008: 23) describes how a system under which Danish long-term drug users receive early retirement benefits provides:

> *'An opportunity for them to engage in organisational activities, such as in user organisations. The existence of a social security system in other words ensure that the energies of drug users may be channelled into activities that are not entirely a matter of physical survival.'*

The largest and most permanent of the Danish user organisations, the Danish Drug Users' Union (DDUU) was formed in November 1993 when a public centre for drug and methadone users in Copenhagen was closed down (Anker, 2006). It is a formal organisation with an elected chairperson and annual general meetings (Asmussen, 2003), and, in contrast to the MDHG, has relied almost solely on funding from the Danish Social Ministry since its inception. Its overall working ethos is *'to self-help and to work for needs and rights of drug users and against personal isolation, of both illegal drug users and clients of methadone treatment'* (Kekoni, undated: 4).

The DDUU is run by and for opiate and/or methadone users and can certainly claim significant success in the wide ranging services that it offers, which are aimed at improving the lives of its members. Its premises in Copenhagen boast a newspaper archive, library, gym, laundry facility and computer access. It also carries out social work by disseminating advice and information about drug use, gives lectures about drug use to police and social workers, accepts visits from students and academics and operates a syringe collection scheme. The primary concern of its members has been described as providing an alternative image of drug users in today's society: rather than being viewed as unable to self-organise and engage in constructive activity the drug users involved

in the DDUU hope to show that they can make a positive contribution to society (Anker, 2006). This concern with challenging the stigmatisation attached to drug users in Danish society, however, comes at a price; unlike the MDHG, for whom challenging national drug policy is a fundamental principle of the organisation, the aim of promoting an alternative drug policy must take a secondary place.

> '*The organisation has given priority to seeking legitimacy and providing an image of drug users as basically decent and able citizens instead of following a more disruptive and confrontational strategy.*' (Anker, 2006: 18)

Asmussen (2003) documents that between 1998 and 2002, the DDUU was invited to participate in the discussions of the Danish Board of Narcotics, which probably represents its greatest achievement, at least in terms of the potential to influence policy on a national basis. In this respect, the decision to sideline the promotion of an alternative drug policy paid off and may have provided a reason for the greater acceptance of the DDUU by Danish authorities than has thus far been afforded to the MDHG by Dutch authorities. By agreeing to work within the system the DDUU was able, for a short period at least, to claim real influence on national policy. The obvious potential downside to this is that users committed to promoting an alternative drug policy not based on law enforcement and prohibition would not have found an outlet as part of the Danish organisation. The Danish Board of Narcotics, however, was closed in 2002 and, since then, no offers to join comparable boards or institutions have been made. The members of the DDUU continue to discuss and promote visionary initiatives for dealing with drug use and drug users, for example, the dispensation of syringes in Danish prisons, the provision of heroin on prescription for the heaviest users and the provision of safe rooms for drug users to inject in (Asmussen, 2003), but, at a national level, these recommendations fall on deaf ears. One possible explanation for the decrease in influence of the DDUU is that recent evidence suggests that, after years of operating a middle position between legitimacy and repression, Danish drug policy, under a relatively new centre-right government, is finally aligning itself with the control oriented side (Asmussen, 2008).

Sweden

In Sweden, drug policy is strictly control-oriented and moralistic, operating as a cross-political party issue where policy is endorsed by wider society in its entirety (Boekhout van Solinge, 1997; Goldberg, 2004; Lenke & Olsson, 2002). Interestingly, despite this repressive national policy, Sweden does have some early experience with user involvement in drug policy at a time when national policy in this area was more liberal. In 1965, the National Association for Aid to People Addicted to Drugs and Pharmaceuticals (RFHL) was founded by drug users and their supporters and was not dissimilar to Britain's Release. Laanemets (2006: 113) describes its aim as '*to find democratic and humane alternatives for dealing with questions of exclusion and drug abuse*'. It was, however, '*at its prime in the late 1970s, and then began to slip down a slope of decline as the wave of radicalism ebbed away*' (Laanemets, 2006: 116). After its effective disappearance at the end of the 1980s, the issue of drug user influence on Swedish policy and treatment services was not raised again until the early 2000s when the Swedish User Organisation (SBF) was initiated in response to State calls, similar to those that have occurred in Britain.

The SBF was founded in 2002 with an underlying aim to generally '*underline rights of drug users and clients of substitute treatment*... [and] *decrease powerlessness of drug users in decisions concerning their own lives*' (Kekoni, undated: 4), and to specifically criticise the strict regulations surrounding substitution treatment for heroin users in Sweden (Palm, 2006). Anker (2007) contrasts this emphasis on improved access to substitution treatment and the expansion of needle exchange programmes with the DDUU's more radical attempts to institute heroin on prescription and safe user rooms. The association has had some successes, for example the initiation of user councils at treatment clinics and public information campaigns raising awareness of the issues facing drug users in Sweden (Laanemets, 2006). It is, however, heavily dependent on the state for its funding and legitimacy and whether it can have more far-reaching success in terms of

fighting for drug users' rights and empowerment seems rather unlikely.

The SBF has, as discussed above, made its main area of focus the improvement of substitution treatment and needle exchange programmes in Sweden. Judged under these terms, it may be able to claim some success as the Swedish Drugs Commissioner has recently recommended that these programmes be expanded in Sweden (Goldberg, 2005; Johnson, 2006). Under any other terms than these, however, the impact of the SBF on Swedish drug policy and service provision has not been evaluated positively. Its inability to go beyond criticising the treatment system has been noted. Palm (2006: 177) recognises that its inability to fully represent the wider needs of drug users or provide a challenger to the dominant national paradigm of drug control may be a 'survival strategy', but, generally, it is condemned by Swedish academics as having an ever-diminishing influence on policy (Johnson, 2006). The repressive and moralistic measures surrounding drug policy in Sweden ensure that only those who are committed to giving up drugs are able to be given a voice, and that the chances of those who are heard making any impact are '*fairly slim*' (Laanemets, 2006: 107). These relatively negative evaluations are perhaps unsurprising in a country fully committed to maintaining a zero-tolerance policy towards drugs and motivated to achieve a drug free society (United Nations Office of Drugs and Crime, 2007).

Discussion

Clearly, the influence of drug users themselves on both the provision of local services and national policy in general is not a new phenomenon, either in Britain or Europe. What is new, in Britain at least, is the willingness of the government to work with active drug users and the mandatory involvement of drug users in the provision of services at a local level, as implemented through the DAATs. Pre-existing academic research has illuminated the benefits that can result from such an approach, but has also emphasised the limitations that can be experienced, particularly where drug user groups are engendered through state-sponsored rather than autonomous routes. If the British government and the National Treatment Agency are serious in their attempts to improve the effectiveness of national drug policy through user involvement they must pay attention to these limitations and work hard to minimise them. Failure to do so may result in a situation where user involvement becomes little more than a 'tick-box exercise' and commitment to improving national policy through such routes becomes no more than political rhetoric. The exploration of the European case studies provides much to influence the development of policy in this area in Britain.

The central message from the European case studies is that state-sponsored, almost coerced, involvement of drug users is not the most effective method of inspiring a meaningful contribution to the drug policy debate or the implementation of specific treatment-related services. The MDHG and the DDUU have both made positive and significant contributions to national policy. Although the MDHG achieved their most influential successes at a time when they were autonomous from the government, the experiences of the DDUU, which has always been a state-funded organisation, prove that such independence from the state is not necessarily a precondition of success. To a certain extent, challenging a control-oriented national policy has been rejected by the DDUU, but the services provided by its centre in Copenhagen together with its time on the Danish Board of Narcotics have made it a player in the development of drug policy at a national level. This has perhaps been facilitated by the fact that, despite being state funded, the DDUU was initiated at the inclination of drug users themselves in response to the closing of existing services.

The limitations of user involvement in Sweden, in contrast, are well documented. In terms of positive contributions, there is no doubt that the influence of the SBF on the improvement and extension of needle exchange programmes and heroin substitution programmes has been instrumental. Commentators, however, seriously question the ability for influence to go beyond the evaluation of specific services in a country wedded to a restrictive and control-oriented overall national policy. In some respects, the situation in Britain echoes that in Sweden as recently developed drug user groups have often been instigated at the request of the state themselves and consequently these groups rely heavily on the state for both

funding and support. Drug user groups of this type, limited in scope to evaluating hand-picked pre-existing drug treatment services, are likely to fall foul of the limitations outlined at the beginning of this article. Partnerships between drug users and professionals have not arisen naturally but have, to some extent, been forced by government calls for user participation in a variety of services. Consequently, there is little to suggest that input goes beyond a 'tick-box' regime and users may find that they are lending legitimacy to both specific services and an overall national policy that they may not wish to support, while at the same time not being given the space to provide a critique of national drug policy.

While the recent calls for user involvement by the NTA in Britain and the state-directed compulsion for DAATs to involve drug users in the provision of treatment services may bear considerable resemblance to the groups developed in Sweden, British user groups also show the potential to provide more influence and avoid many of the pitfalls that can come with increased drug user involvement. The work of the Alliance and the UK Harm Reduction Association is much closer to that of the MDHG and the DDUU. These British groups have emerged under the recent focus on user involvement in the provision of services in general, but without explicit coercion from the government itself and are comprised of a genuine partnership of users and professionals. Their missions are to evaluate local service provisions, but also to campaign for the rights of drug users and for fairer national policies and, as such, they arguably represent a much more useful type of drug user group. If the British are serious about its commitment to principles of harm reduction and the increase of drug user involvement in both the provision of local services and wider drug policy narratives, they must work to capitalise on both types of group discussed here. The influence of national policy on the development of drug user groups must not be underestimated and, in Britain, the success of this venture will depend on the direction that national drug policy takes in general. It will be interesting to document the effect of a newly established centre-right government on the issue in this country.

References

Anker J (2006) Active drug users – struggling for rights and recognition. In: J Anker, V Asmussen, P Kouvonen & D Tops (Eds) *Drug Users and Spaces for Legitimate Action*. Helsinki: Nordic Council for Alcohol and Drug Research.

Anker J (2007) Limits and opportunities for autonomous user organisations in Denmark and Sweden. *Journal of Social Sciences* **3** (2) 78–87.

Anker J (2008) Drug users and spaces for legitimate action. In: G Broring & E Schatz (Eds) *Empowerment and Self-Organization of Drug Users*. Amsterdam: Correlation Network.

Asmussen V (2003) User participation: possibilities and limitations in Danish social services directed towards drug users. In EH Pedersen & C Tigerstedt (Eds) *Regulating Drugs – Between users, police and social workers*. Helsinki: Nordic Council for Alcohol and Drug Research.

Asmussen V (2008) Cannabis policy: tightening the ties in Denmark. In: *A cannabis reader: Global issues and local experiences. Monograph series 8, Volume 1*. Lisbon: European Monitoring Centre for Drugs and Drug Addiction.

Boekhout van Solinge T (1997) *The Swedish Drug Control System: An in-depth review and analysis*. Amsterdam: Uitgeverij Jan Mets/Cedro.

Branfield F & Beresford P (2006) *Making User Involvement Work: Supporting service user networking and knowledge*. York: Joseph Rowntree Foundation.

Bryant J, Saxton M, Madden A, Bath N & Robinson S (2008) Consumer participation in the planning and delivery of drug treatment services: the current arrangements. *Drug and Alcohol Review* **27** (2) 130–137.

Bunce D (2005) Fumbling towards democracy. *Drink and Drugs News* **4** 8.

Charlois T (2009) *Drug User Participation and European Cities*. Presentation at the 6th EXASS Net meeting in Amsterdam, the Netherlands, 19–21 October 2009.

Fischer J, Jenkins N, Bloor M, Neale J & Berney L (2005) *Drug User Involvement in Treatment Decisions*. York: Joseph Rowntree Foundation.

Forbes J & Sashidharan SP (1997) User involvement in services – incorporation or challenge? *British Journal of Social Work* **27** (4) 481–498.

Garretsen H (2003) Guest editorial: the decline of Dutch drug policy? *Journal of Substance Use* **8** (1) 2–4.

Goldberg T (2004) The Evolution of Swedish Drug Policy. *Journal of Drug Issues* **34** (3) 551–576.

Goldberg T (2005) Will Swedish and Dutch drug policy converge? The role of theory. *International Journal of Social Welfare* **14** (1) 44–54.

Hedrich D, Kerr T & Dubois-Arber F (2010) Drug consumption facilities in Europe and beyond. In: T Rhodes & D Hedrich (Eds) *Harm Reduction: Evidence, impacts and challenges*. Lisbon: EMCDDA.

Jauffret M (1999) *Drug Users on Shaky Self-Support* [online]. Available from: http://www.drugtext.org/ (accessed September 2010).

Johnson B (2006) The development of user influence on Swedish drug policy, 1965–2004. In: J Anker, V Asmussen, P Kouvonen & D Tops (Eds) *Drug Users and Spaces for Legitimate Action*. Helsinki: Nordic Council for Alcohol and Drug Research.

Kekoni T (undated) *The Roles and Tasks of Nordic User Organizations* [online]. Available from: http://www.sky.org/data/politiikka/The_Roles_and_Tasks_of_Nordic_User_Organizations.pdf (accessed September 2010).

Kolind T (2007) Form or content: the application of user perspectives in treatment research. *Drugs: Education, Prevention and Policy* **14** (3) 261–275.

Laanemets L (2006) Organisation among drug users in Sweden. In: J Anker, V Asmussen, P Kouvonen & D Tops (Eds) *Drug Users and Spaces for Legitimate Action*. Helsinki: Nordic Council for Alcohol and Drug Research.

Laursen L & Jepsen J (2002) Danish drug policy – an ambivalent balance between repressionand welfare. *Annals of the American Academy of Political and Social Sciences* **582** 20–36.

Lemmens PH (2003) Dutch government backs down on heroin prescription, despite successful trial. *Addiction* **98** (3) 247–249.

Lenke L & Olsson B (2002) Swedish drug policy in the twenty-first century: a policy model going astray. *Annals of the American Academy of Political and Social Science* **582** (1) 64–79.

Liddell D & Brand B (2008) Developing a model of user involvement in social research in Scotland. In: G Broring & E Schatz (Eds) *Empowerment and Self-Organization of Drug Users*. Amsterdam: Correlation Network.

McDermott P (1997) *Will Drug Users Respond to the Challenge* [online]. Available from: http://www.drugtext.org/index.php?option=com_content&view=article&id=647%3Awill-drug-users-respond-to-the-challenge&catid=209%3Aself-help&Itemid=44&lang=en (accessed September 2010).

Mold A (2006) The welfare branch of the alternative society? the work of drug voluntary organisation Release, 1967–1978. *Twentieth Century British History* **17** (1) 50–73.

Mold A & Berridge V (2008) 'The rise of the user'?: voluntary organisations, the state and illegal drugs in England since the 1960s. *Drugs: Education, Prevention and Policy* **15** (5) 451-461.

National Treatment Agency (2006) *NTA Guidance for Local Partnerships on User and Carer Involvement*. London: NTA.

Palm J (2006) The consumer: the weak, the sick and the innocent. In: J Anker, V Asmussen, P Kouvonen & D Tops (Eds) *Drug Users and Spaces for Legitimate Action*. Helsinki: Nordic Council for Alcohol and Drug Research.

Patterson S, Weaver T, Agath K, Rutter D, Albert E & Crawford M (2009) User involvement in efforts to improve the quality of drug misuse services in England: a national survey. *Drugs: Education, Prevention and Policy* **16** (4) 364–377.

Patterson S, Weaver T & Crawford M (2010) Drug Service User Groups: only a partial solution to the problem of developing user involvement. *Drugs: Education, Prevention and Policy* **17** (1) 84–97.

Schulte S, Moring J, Meir PS & Barrowclough C (2007) User involvement and desired service developents in drug treatment: service user and provider views. *Drugs: Education, Prevention and Policy* **14** (3) 277–287.

Sweeney R (2006) 'Tickbox user involvement criticised' *User News Special Edition*, pp1 & 3. Available from: http://www.ldan.org.uk/documents/LDAN%20Special%20Edition%20Feb%20Newsletter.pdf (accessed September 2010).

Tops D (2006) Stretching the limits of drug policies: an uneasy balancing act. In: J Anker, V Asmussen, P Kouvonen & D Tops (Eds) *Drug Users and Spaces for Legitimate Action*. Helsinki: Nordic Council for Alcohol and Drug Research.

Trautman F (1995) Peer support as a method of risk reduction in injecting drug-user communities: experiences in Dutch projects and the European peer support project. *Journal of Drug Issues* **25** (3) 617–628.

Uitermark J (2004) The origins and future of the Dutch approach towards drugs. *The Journal of Drug Issues* **34** (3) 511–532.

United Nations Office on Drugs and Crime (2007) *Sweden's Successful Drug Policy: A review of the evidence*. Available from: http://www.ecad.net/svnet/etc/Swedish_drug_control_annex.pdf (accessed September 2010).

van Dam T (2007) *Users Unite* [online]. Available from: http://www.adviesbureautheovandam.nl/DrugUserMovement.htm (accessed September 2010).

van Vliet H-J (1990) Separation of drug markets and the normalization of drug problems in the netherlands: an example for other nations? *Journal of Drug Issues* **20** (3) 463–471.

Willersrud A & Olsen H (2006) Democracy or closer control? Emergence of drug user participation in Norway. In: J Anker, V Asmussen, P Kouvonen & D Tops (Eds) *Drug Users and Spaces for Legitimate Action*. Helsinki: Nordic Council for Alcohol and Drug Research.