

The shifting roles of medical stakeholders in opioid substitution treatment: A comparison between Denmark and the UK

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Introduction

Denmark and the United Kingdom (UK) are welfare states, which have often been described respectively as “social democratic” (Scandinavia) and “liberal” (Anglo-Saxon countries) (Esping-Andersen 1990). Historically, the two countries have often chosen quite dissimilar pathways with regard to societal challenges such as poverty, health care, unemployment, education and child care. However, both countries are amongst those few European countries that have a long tradition and an elaborate system for providing opioid substitution treatment (OST) (for example methadone) to heroin users (Dahl 2005; Duke, Herring et al. 2013; Frank, Bjerge et al. 2013; Thom, Duke et al. 2013). In Denmark, OST has been offered to drug users since the 1960’s. In the UK, medical doctors could prescribe addictive drugs (including heroin and injectable opioid substitutes) as part of treatment since 1926, but there was a shift towards prescribing oral methadone by the 1970s. In both countries, the increasing use of substitution treatment was implemented as a response to a growing population of young, recreational heroin users. Due to the fact that opioid substitution medications are prescription drugs, medical professionals have always played key roles in treatment, although to varying degrees (Dahl 2005; Frank, Bjerge et al. 2013; Thom, Duke et al. 2013; Berridge, 2013; Bjerge, Houborg et al. 2015). In this article, we examine how different treatment policies and treatment philosophies have increased the position of medical professionals as stakeholders in substitution treatment policies and practices. We define a stakeholder as any actor who can affect and/or be affected by the activities (e.g. policies, practices, interventions) in question (Freeman 1984, Orts & Strudler 2002). In our case study, these actors or stakeholders include medical professionals, such as general practitioners (GPs), psychiatrists, doctors working in substitution treatment centres, nurses or social and health care assistants, who are engaged in policy in relation to substitution treatment or the practices of this work.

The idea to explore the different spaces medical professionals occupy as stakeholders in policy and practice emerged from an ongoing study with researchers from Austria, Denmark, Finland, Italy, Poland and the UK focusing on various stakeholders’ roles and influence in

the addiction fields.¹ The project formed a part of the EU-funded project: *Addictions and Lifestyles in Contemporary Europe: Reframing Addictions Project (ALICE RAP)*.² When analysing the materials for the overall project, it became clear to us that the role of medical professionals had developed quite differently in Denmark and the UK, despite the similarities with regard to the increasing use of OST programmes as a response to new heroin users in both countries in the 1960s/1970s. The UK has a long history of dominance of medical professionals (both generalists (GPs) and specialists (psychiatrists)) in drugs treatment (Mold, 2008; Berridge, 2013; Duke, Herring et al, 2013). In Denmark, the medical perspective has evolved over time, and for many years a social problem approach dominated the field (Frank, Bjerger et al. 2013; Bjerger, Houborg et al; 2015). However, within the past fifteen years, a shift can be identified in both countries. In Denmark, a trend towards medicalisation can be traced in substitution treatment. This is in contrast to the UK, where a recent trend towards de-medicalisation can be traced. As in all kinds of policy changes, multiple factors are at play when shifts occur (Kingdon 1995), including changing political, economic and social contexts, new technology, changing user groups, the rise of new problems – and not least the changing roles of prominent stakeholders in a given field. On the one hand, the rise of the medical voice in the Danish substitution treatment field was promoted by a group of entrepreneurial medical stakeholders as well as changes in the organisation of drug treatment, broader societal focus on health and medication, and changes in the drug user population. On the other hand, the British medical voice has recently been challenged by a “recovery” movement led by a number of advocacy organisations, recovery advocates from the United States, the residential rehabilitation sector, some researchers and media stakeholders. Both countries’ developments relate to broader societal developments, and we investigate how such divergent developments emerge and how medical professionals as stakeholders enhanced their role as experts in the field, through a variety of tactics, including the use and production of “evidence”, which became a key tool to promote specific stakeholder’s perspectives in these processes.

When analysing debates in substitution treatment practices and wider issues surrounding the development of drug policy, key questions include ‘what counts as expertise’, ‘what counts as evidence’ and ‘who decides what counts?’ (cf. Duke & Thom, 2014). This refers to the continuing struggle over which groups “own” the right to define and act on the issue. There are often conflicts between those stakeholders who define drug use as a medical problem for

¹ For further descriptions of results of this project, see Beccaria & Rolando, 2013; Frank et al, 2013; Duke et al, 2013; Moskalewicz and Welbel, 2013; Eisenbach-Stangl, 2013; Beccaria & Rolando, 2014; Thom et al, forthcoming; Houborg & Frank 2014; Houborg, Frank & Bjerger 2014; and Bjerger, Duke et al. 2015.

² The research leading to these results or outcomes has received funding from the European Union's Seventh Framework Programme (FP7/2007-2013), under Grant Agreement n° 266813 - Addictions and Lifestyle in Contemporary Europe – Reframing Addictions Project (ALICE RAP – www.alicerap.eu). Participant organisations in ALICE RAP can be seen at <http://www.alicerap.eu/about-alice-rap/partner-institutions.html>. The views expressed here reflect those of the authors only and the European Union is not liable for any use that may be made of the information contained therein.

which medical intervention is needed and those who define drug use more as a social problem which require interventions from a wider range of services, professionals and non-professional groups. There can also be challenges to the dominance of professional definitions and ownership of the drug issue by consumers or the 'objects' of these definitions, policies and practices. The increasing emphasis on service user involvement and incorporating user groups and experiential knowledge into the development of treatment provision and in wider policy development initiatives can be identified as key trends in both countries (see Bjerger, Duke, Frank et al, 2015).³

In order to compare and contrast the role of medical stakeholders in the development of substitution treatment policy and practice in Denmark and UK, we begin by outlining the research design and methodology employed in the study; we then briefly summarize the key historical shifts in relation to their role in drugs policy and practice in both countries; we then draw on our case studies to examine the current activities and influence of stakeholders (with a focus on medical professionals); and finally we explore the key similarities and differences in terms of the medical profession's involvement in drug policy and practice and the factors which have impacted on their roles in both countries.

Research Design and Methodology

The article is based on previous research literature on opioid substitution treatment and policy in Denmark and UK⁴, on documentary analyses (mainly key policy and treatment-related documents), as well as qualitative, in-depth interviews with various stakeholders and stakeholder groups, including medical professionals, in both countries. In Denmark, seventeen key informants were interviewed (including civil servants, treatment providers, researchers, non-governmental organisations (NGOs), and professional organisations in the field). In the UK, twenty key informants were interviewed (including policy makers, researchers/scientists, and representatives from advocacy organisations, the treatment sector, pharmaceutical industry and social enterprises). In both countries, all of the interviewees were asked to reflect on the role and influence of different stakeholders and stakeholder groups, including medical professionals, in the development of policy and practice.⁵

³ This article focuses on the comparative aspect of the shifting role of medical stakeholders in OST. For more in-depth information of the history of OST in Denmark and the UK see Frank, Bjerger & Houborg (2013) and Duke, Herring, Thickett and Thom (2013).

⁴ The UK devolved administrations (Northern Ireland, Scotland, and Wales) have their own strategies around drugs and alcohol in areas where responsibility is devolved. Some of the policy areas covered by the Drug Strategy 2010 (HM Government, 2010) including health, housing, education and social care therefore only cover England.

⁵ For more in-depth descriptions of data used in Denmark, see Frank, Bjerger & Houborg (2013) and in the UK, see Duke, Herring, Thickett & Thom (2013).

A brief historical account of medical stakeholders in Danish and British drugs policy and practice.

Denmark

Medical stakeholders have played a role in treatment for drug addiction in Denmark since the 1940s when treatment was placed within the psychiatric system (Dahl 2005). Up until the 1960s drug addiction was, however, a very rare condition (Ringgaard 2010). Only in the 1960s when morphine and heroin started to be used as an intoxicant among young people, and became symbols of particular youth groups and subcultures, substitution treatment inspired by clinical trials in the US using methadone supplemented with psychosocial treatment (Dole, Nyswander & Kreek 1966) started to emerge in Denmark and began to be prescribed to drug users by GPs. When drug addiction became a growing problem in the 1970s, new policy initiatives were developed and implemented. Drug treatment was framed as a social problem and moved from a topic that primarily should be dealt with by the national health services to the social welfare system (Houborg, 2006; Winsløw, 1984). In the 1970s, drug treatment was placed under the control of the municipalities. It was only abstinence-based treatment models and it was kept primarily within the social care services. GPs were, however, still able to prescribe methadone as a treatment for drug addiction (Houborg, 2006; Winsløw & Ege, 1983). Different stakeholders were involved in drug treatment, especially social workers and social-pedagogical counsellors, whereas medical professionals were fewer in numbers, less visible, and less vocal as stakeholders during this period. Substitution treatment policy was defined locally by GPs and depended on their willingness to prescribe methadone, in an era where the dominant policy definition of drug addiction was that it was a social, rather than a medical problem (Houborg, 2006). In effect, a two-tier treatment system was developed in which little or no co-operation existed between the two sectors – municipal drug free treatment initiatives and GPs prescribing of methadone. The two tier system was also represented structurally in that treatment for drug addiction was placed both in the Ministry of Health and the Ministry of Social Affairs.

Drug policy in Denmark is, however, apparent not only welfare initiatives such as drug treatment, but also defined by the control system. Parallel to treatment initiatives, the control of drugs has been part of the political landscape since 1955, when the first drug law was implemented in Denmark (Laursen & Jepsen, 2002). However, spanning 35 years from 1969 to 2004, Denmark also has had a more liberal policy on drugs characterized by decriminalisation of possession for own use of cannabis and a legal differentiation between users and dealers (ibid). The balance between these two perspectives on drug policy - welfare and control – has changed over the years (Houborg, 2010), especially from the mid-1980s when harm reduction ideas and initiatives began to gain importance in Denmark, among other things due to HIV/AIDS and later on Hepatitis epidemics. The liberal drug policy in Denmark has not only been defined as such because of the decriminalisation of personal use of cannabis, but also because of the early development of harm reduction initiatives and hence a more intense focus on health and the health-related harms of drug addiction. Since the mid-1990s, harm reduction initiatives such as needle exchange, street

level nursing, low threshold methadone treatment and drop-in centres have gradually expanded and become part of services offered to drug users, followed by the recent implementation of heroin-assisted treatment and drug consumption rooms in 2012. The balance between welfare and control also changed with the 2004 changes in drug laws. While there was a particular shift in drug laws in 2004 as outlined above, the length of possible sentences has increased regularly since 1955 (Laurson & Jepsen, 2002) to today's level of sentencing for possession, dealing and smuggling of drugs (for details see Frank, 2008, Houborg, 2010).

The involvement of medical professionals and the conceptualization of drug addiction as a medical problem became more and more prominent in the 1990s with organisational changes to the public drug treatment system in 1996. Here the government made all drug treatment a public monopoly with county-based drug treatment centres the only entry point for drug users to any kind of drug treatment, including OST. The prescribing of methadone was no longer possible for GPs (unless it was delegated from a county treatment centre), and methadone prescribing was to become more common with the implementation of the *Circular on the Prescription of Addictive Drugs* by the National Board of Health (Sundhedsstyrelsen, 1995). The previous locally determined policy on methadone prescribing by GPs was now moved to doctors employed by county drug treatment centres who would now follow national guidelines on methadone prescribing. The *Circular on the Prescription of Addictive Drugs* was updated in 2008 (Sundhedsstyrelsen, 2008) and made more detailed on how to implement substitution treatment compared to the previous circular from 1996. Whereas the old circular was only advisory, the new one became statutory. Prescribing methadone or other substitution drugs has thus been regulated by circulars and guidelines. After the update of the prescription guidelines, the Board of Social Services launched a new set of guidelines for the psycho-social part of treatment (Servicestyrelsen, 2010). The changes in 1996 also meant that medical stakeholders involved in substitution treatment were now moved to the county-based treatment centres and should work along with other kinds of stakeholders (e.g. counsellors, psychologists, or social workers), at least in relation to outpatient and day treatment. Residential treatment was still placed in other institutions, but drug users had to be referred to residential treatment through the county-based treatment centres. A broad spectrum of stakeholders was thus involved in shaping substitution treatment policy and practice, including social workers, bureaucrats, researchers, psychologists, medical doctors, nurses, psychiatrists, and social and health care assistants. The organisational changes also made different stakeholders 'speak' from the same platform – the county drug treatment centres. The 'professionalisation' of drug treatment – as the changes were defined as – created a platform where medical doctors could deliver methods and treatment models that supported this 'professionalisation'. The increased focus on health and health-related harms with the spread of harm reduction perspectives in Danish drug policy also made other medical professionals, such as nurses, a more prominent group of stakeholders in substitution treatment. The changes in 1996 led to an increase of drug users in treatment. The overall idea was that it was better to have drug users in treatment than not in treatment became prominent, and that this would not only result in better health and

lower overdose rates for the drug users, but also reduce their criminal activities and nuisance to the public.

Despite the unification of drug treatment in county-based drug treatment centres, substitution treatment is still embedded in two policy areas: health policy (prescription of substitution medicine) and social policy (provision of the psychosocial treatment elements in substitution treatment) and consequently is regulated by two sets of guidelines, as discussed above. It is, however, not only drug treatment that makes up Danish drug policy, but also control policy and harm reduction initiatives. The focus of our analyses below is limited to how and what role medical professionals have played in drug policy developments during the past ten to fifteen years in Denmark, including how the increasing trend to medicalisation has given space to medical professionals and their perspectives as well as practices in substitution treatment.

UK

In the UK medical stakeholders have been involved in the development of drugs treatment policy and practice since the latter half of the 19th century (Berridge, 2013). By 1926, the Rolleston report⁶ defined addiction as a 'disease' and legitimized heroin maintenance prescribing. GPs were the key professional stakeholders within this framework and decisions about prescribing were a matter of their clinical judgment. This phase of policy from 1926 to the early 1960s is often referred to as the 'British system' of drugs control. However, rather than representing a victory of medicine over criminal justice, this was an alliance between the medical profession and the state and also between the Home Office and the Ministry of Health (Berridge, 1984). Similar to Denmark, there were low numbers of 'addicts' at this time, mainly middle class, middle-aged and of a therapeutic origin (ie. those who had become dependent as a result of taking opiate drugs for another condition) (Mold, 2008, p. 20), which allowed for a general 'laissez faire medicalised approach' towards addiction to emerge during this period. By the 1960s, the growing drugs subculture and the over-prescribing by some doctors were important factors prompting a shift in policy (Berridge, 1999). In this period drugs treatment shifted from the general practitioners in the community towards specialist addiction psychiatrists in hospital-based settings. Although addiction was re-defined to include a social dimension, medical professionals - now including both psychiatrists and GPs - were important stakeholders in the field (Berridge, 2013). In practice, policy was determined locally by the individual psychiatrists in the new Drug Dependence Units (DDUs) which effectively functioned as prescribing centres (Mold, 2008). While discussions around what drug, oral methadone or heroin, should be used in treatment as well as discussions around what

⁶ The Departmental Committee on Morphine and Heroin Addiction (known as the Rolleston Committee and chaired by Sir Humphrey Rolleston) was appointed by the Ministry of Health in 1924 to investigate morphine and heroin use. The membership of the Committee was composed entirely of medical men who viewed heroin use at the time as a medical problem which could be controlled through treatment by the medical profession (see Mold, 2008, pp. 18-21).

the goal of treatment should be, maintenance or abstinence, the medical professionals were still key stakeholders in defining substitution treatment (Hartnoll et al, 1980; Stimson and Oppenheimer, 1982; Strang and Gossop, 1994). By 1976, oral methadone replaced injectable drugs (including heroin and methadone) as the main form of treatment for patients new to the DDUs (Mold, 2008)

By the late 1970s and early 1980s, many of the key assumptions underpinning drug treatment were challenged. For example, the use of indefinite maintenance prescribing was being questioned and a wider social approach for dealing with drug problems was advocated which included addressing housing, employment and training issues (MacGregor and Ettore, 1987). In 1982, the Advisory Council on the Misuse of Drugs (ACMD) argued that drug problems extended beyond the clinical discourses of dependence and required more than just a medical response (ACMD, 1982). In 1984, new guidelines for the management of drug dependence were published for general practitioners on short-term prescribing and less complicated cases of methadone maintenance treatment (Farrell and Raistrick, 2005). However, just as these new ideas and conceptualisations began to embed themselves in policy and practice, British drugs policy was shaped by a heroin epidemic associated with a younger group of 'new heroin users' who tended to be concentrated in areas with high levels of unemployment and social deprivation (Pearson, 1987). The 1985 drug strategy marked an important shift in emphasis as enforcement and penal measures were given much more prominence to control the growing drugs problem (Home Office, 1985). However, by the late 1980s, the advent of HIV/AIDS ensured that a harm reduction and public health perspective was revived and co-existed within this overall penal and enforcement framework. Harm reduction initiatives, such as needle exchange and a renewed emphasis on methadone prescribing, were introduced. New guidelines were published in 1991 which included advice for injectors on how to clean injecting equipment in order to reduce the risk of HIV transmission (Farrell and Raistrick, 2005). Psychiatry remained in a dominant, directive position in drugs treatment, particularly in relation to maintenance prescribing, but general practitioners re-emerged again to play roles in caring for drug users (Mold, 2008). A new layer of community-based drug treatment services funded through the Central Funding Initiative (CFI) were also created (MacGregor, 1994). The policy community around drugs broadened during the 1980s and 1990s to include new stakeholders such as social workers, probation officers, infectious disease specialists, public health professionals, GPs, and a reshaped voluntary sector. Medicine continued to play a central role as doctors remained in their formal expert advisory positions and medical civil servants played important roles influencing policy. At the same time, there was a downgrading of medical advice in relation to drugs as they became the focus of a wider range of stakeholders with the rise of the non-medical voluntary sector (Berridge, 1997). In 1996, despite fears that substitution treatment would be limited, a Task Force reviewed current treatment approaches and supported the role methadone maintenance treatment and further investment in treatment interventions (Farrell and Raistrick, 2005). By the 1990s, there were also new emphases in British drugs policy on drug-related crime, involvement of the wider community and partnership

approaches following the publication of the new national drugs strategy, *Tackling Drugs Together* (HM Government, 1995).

From 1997 to 2010, Labour governments had a profound impact upon developments in drugs treatment, particularly in relation to methadone maintenance prescribing. Drawing on evidence from the US that treatment within the criminal justice system could be effective, crime reduction had become a key priority of drugs treatment policy. The discourses of ‘tough on crime’ and ‘tough on the causes of crime’ (i.e. drugs use) allowed both criminal justice and health to have an input into drugs policy which had universal political appeal (Duke, 2006). Most importantly, it enabled support for more resources and long-term investment in the drug treatment infrastructure. Over this period, spending on treatment increased dramatically from £142 million in 2001/02 to £406 million in 2009/10 (Drugscope, 2009), increasing numbers of drug users entered formal treatment, waiting times for treatment decreased, and the drugs workforce also increased substantially (National Treatment Agency, 2009).

Under the rhetoric of evidence-based policy, the Labour government also invested substantial sums of money in research which expanded the knowledge and understanding of drugs treatment. A clear conclusion which emerged from various pieces of research was that ‘treatment works’ (Godfrey et al, 2004; Donmall et al, 2009). Methadone prescribing became one of the key tools to reduce drug-related crime. The primary focus of policy was to expand treatment which left medical stakeholders, particularly addiction psychiatrists and general practitioners in their prescribing roles, in control of drug treatment policy and practice. In 1999, revised clinical guidelines (known as the ‘Orange Book’) were published which recommended a tighter monitoring and supervision of methadone to reduce diversion of drugs and overdoses and three levels of skill and corresponding training were defined – the ‘generalist’, the ‘specialist-generalist’ and the ‘specialist’ (Farrell and Raistrick, 2005). A shared medical hegemony between psychiatry and public health dominated drugs policy-drugs treatment during this period. Key roles were played by addiction psychiatrists, such as Prof Dr John Strang and Dr Brian Kidd, and by general practitioners, such as Dr Chris Ford and Dr Roy Robertson. Their work was underpinned by powerful historical institutions such as the Royal College of Psychiatrists and the Royal College of General Practitioners, as well as the organisation, Substance Misuse Management in General Practice (SMMGP). However, the overriding goal of the new treatment interventions, particularly in the criminal justice system, had become the reduction of drug-related crime and regulating the behaviour of problem drug users (see Duke, 2006; Seddon et al, 2008; Parker, 2004; Stevens, 2010; Shiner, 2012). Challenges to this medical hegemony began to appear as methadone maintenance was questioned and a new ‘recovery’ discourse emphasizing abstinence emerged in British drugs policy and practice.

The next sections of the paper will explore the ways in which medical stakeholders have navigated through the current shifts within drugs policy and practice in Denmark and the UK.

From social problem to medical issue: The Danish case

The dual responsibility for drug treatment in Denmark, where the Ministry of Health and the National Board of Health are responsible for prescription drugs and the Ministry of Social Affairs is responsible for drug free treatment as well as the psychosocial aspects of substitution treatment, has resulted in strong platforms for different stakeholders. Medical professionals have been able to make their voices heard through the channels related to the Ministry of Health and the National Board of Health and Medicine, while other stakeholders, such as current or ex-drug users, politicians or social workers, have leaned towards the Ministry of Social Affairs' policy on the topic. The relationship between the two ministries has also been a matter of balance and/or dominance. As outlined above, drug addiction was from the early 1970's to the mid-1990's understood as a social problem rather than a health problem. Services were directed mainly towards addressing social problems and an understanding of addiction as rooted in social circumstances (e.g. lifestyle, poverty, unemployment, lack of education). While it has never been an 'either/or' in Denmark, but rather a situation where both understandings have operated simultaneously, with 'drug addiction as a social problem' being the dominant understanding, we see a shift in this balance around 2000. Drug addiction becomes more and more a 'health problem', not only in relation to how to treat the problem, but also in relation to drug use as a health damaging lifestyle that needs health interventions which target complications following drug use. Three areas of change provided platforms for medical stakeholders to challenge hitherto the dominating social problem perspective on drug treatment.

One key issue regarding this shift can be traced to the fact that addiction medicine became more professionalized (Frank, et al, 2013). In the wake of the re-organisation of the field in 1996 to make it more unified, there was a growing debate about the lack of guidelines and standard for the medical part of substitution treatment. Such tools were almost non-existent, meaning that dosages of substitution medicine, control measures, sanctions etc. were managed more or less randomly according to local doctors' judgments (Narkotikarådet, 1998). According to one of the founders of Danish Society for Addiction Medicine in 1999, the entire Society revolved around these issues. Drawing on international experiences and work especially in the UK and the US, where addiction medicine had a very dominant role, the founders of the Society, who all held important positions in the field, managed to influence the policy processes leading to the 2008 prescription guidelines (see above). The aims of these guidelines were to standardize and to a larger extent unify Danish methadone prescription practices and at the same time to ensure the rights of the users in medical substitution treatment. The voices of the medical stakeholders coincided with broader societal developments including the increasing demands towards evidence-based treatment practices, monitoring and documentation in welfare and health services (Frank et al., 2013; Bjerger, 2012). In that sense, the agenda of the medical stakeholders

fitted nicely together with the political context at the time which made it fairly easy for these stakeholders to get their voices heard.

Another key issue regarding an increased role of medical stakeholders is related to an increased focus on health care (Frank et al, 2013). From the 1990s, a concern amongst treatment professionals, administrators and relatives of drug users, and the general public can be traced to the fact that, a growing number of “older” drug users did not benefit from regular social and health services as their physical, social and mental conditions worsened due to long histories of intravenous drug use and associated illnesses e.g. hepatitis, HIV/AIDS, or different kinds of endocarditis. More specialized services were required, but it was not until the beginning of 2000 that medical professionals increased in numbers in treatment centres. As a treatment provider reported:

At the beginning of the millennium there were 10 nurses employed in services directed toward drug users in the municipality of Copenhagen. Today [2012] there are approximately 120 nurses employed in the municipality (quoted in Frank et al. 2013: 1003).

This trend is also seen in other municipalities in Denmark. In all large cities in Denmark, a variety of health services have now been established such as street nurses, services screening for hepatitis, safe injection rooms etc., which have pushed medical and health professionals into roles as agenda setting stakeholders in the field in the sense that their voices were now included as key to various local drug projects. Furthermore, this increased focus on health-related issues has provided space for the development of heroin-assisted treatment as a means to accommodate severely marginalized users in order to reduce their health risk behaviours and use of illegal substances, as well as to reduce crime and improve their social situations.

A third issue that has increased the position of medical stakeholders in the field relates to an increased focus on dual diagnosis. According to one stakeholder, a report published from the then Narcotics Council in 1999 (Narkotikarådet, 1999), an advisory body to the government, kick-started discussions of how to manage mentally ill drug users better in the drug treatment system. In the wake of these discussions, different local projects focusing on this particular issue were set-up and many of these were inspired by research and projects in the US, UK and other Nordic countries (Frank et al., 2013). Furthermore, in 2008 the revised *Circular on the Prescription of Addictive Drugs* included guidance on how the drug treatment system should diagnose mental illnesses and how dual-diagnosed users should be dealt with (Sundhedsstyrelsen, 2008). This development was not only supported by medical professionals, but also social treatment providers and users themselves wished for a broader understanding of explanations of drug use, according to stakeholders interviewed. Again, this parallels with broader societal developments towards increased focus on medical explanations and solutions to understanding and handling deviant behavior (e.g. the increased focus on ADHD and the use of Ritalin among

youth with challenging behaviour) (Jones 2014; Frank et al 2013). These developments provide yet another space for medical stakeholders to challenge the social problem approach to understanding and handling drug use.

In sum, the increasing medicalisation in Denmark is rooted in organisational changes in substitution treatment; the emergence of professional organisations of medical stakeholders; a push for documentation; evidence and international standards; intensified focus on health-related problems; and policies and local initiatives focusing on dual-diagnosis.

The rise of ‘recovery’ and the challenge to ‘medical hegemony’ in the UK

From 2005, methadone maintenance was re-framed as problematic by a number of stakeholders including researchers, think tanks, the media and those working in the abstinence-based residential rehabilitation sector (see Duke et al, 2013). Existing research evidence was re-interpreted to emphasise the low numbers exiting from drug treatment, rather than harm reduction benefits of keeping people in treatment (see Duke and Thom, 2014 for a more detailed analyses on how evidence was used by different stakeholders within the debates). At the same time, revised clinical guidelines were published in 2007 to provide frameworks for medical practitioners to develop good practice and cost effectiveness in pharmacological interventions. In the lead up to the general election in May 2010, the Conservatives promised to deliver an abstinence-based drug strategy. The right wing Centre for Social Justice argued that the Labour policy on drugs with its harm reduction ethos had failed and referred to the ‘entrenchment of addiction’ and ‘intergenerational cycles of addiction’ (Centre for Social Justice, 2007: 10). The report argued that the voluntary sector had become ‘colonised’ to promote harm reduction which had stifled innovation and the development of holistic services. The medical approach, particularly methadone maintenance prescribing, was blamed for perpetuating addiction and dependency. The role of the medical profession in dealing with addiction was subjected to challenge and the emerging critique is captured in this extract from an interview with a researcher who had become disillusioned with the ways in which drug treatment had developed:

“in essence what we had was a massively expanding industry, that essentially was hugely self-serving for lots of the people that worked in it, but just didn’t do much good for the clients who accessed it...we were living in a psychiatrist’s conspiracy that virtually all of the research pounds, the policy pounds and the intellectual attention, all the effort and focus was on an acute care system and with absolutely no interest in what happened to people that did manage to get through and come out the other end.”

Despite the lack of UK evidence on recovery (see Best et al, 2010) when the policy document was published, the overarching theme of the 2010 drugs strategy was ‘recovery’ and signaled a move away from a harm reduction perspective and the reliance on methadone maintenance as a

treatment tool. Although the strategy specifies that 'recovery involves three over-arching principles – well-being, citizenship, and freedom from dependence', it concedes that recovery would not be explicitly defined: "It is an individual, person-centred journey, as opposed to an end state, and one that will mean different things to different people" (HM Government, 2010:18). However, the focus would shift from process driven targets (e.g. accessing treatment) to outcome-based targets such as freedom from drugs and alcohol dependence; prevention of drug-related death and blood borne viruses; reduction in crime and offending; sustained employment; stable housing; improvements in physical and mental health; improved relationships with family and friends; and capacity to be an effective parent. The strategy would be underpinned by a 'whole systems approach' and would draw on a range of services including education, training, employment, housing, family support, health, prisons, probation and youth justice. The changes in drugs policy were occurring alongside shifts within the wider political, economic and social contexts with increasing emphasis on the neo-liberal agenda, massive cuts to the public sector and the global recession (Duke, 2013). In the drugs field, the closure of the National Treatment Agency (NTA), the government agency dedicated to drug treatment, is indicative of these trends. The community would be expected to fill the gaps left by the cuts and dis-investment in drug treatment provision. These changes coincided with the growing recovery movement which operates at the grassroots level where recovery communities and peer support play fundamental roles (Duke, 2013). There would be greater emphasis on abstinence, self-help and mutual aid forms of support, rather than relying on state provision and the traditional medical professionals, such as psychiatrists and general practitioners. At the level of official policy rhetoric, it appeared that the role of medical stakeholders in drug treatment would become less prominent under the new strategy.

After the publication of the 2010 drug strategy document, the NTA appointed Prof Dr John Strang, an addiction psychiatrist, to chair an expert group to review the evidence base and develop a clinical consensus around the use of OST within a recovery-oriented treatment framework. Based on this review of evidence, they concluded that OST "has an important and legitimate place within recovery-orientated systems of care" (NTA, 2012:5). There would be no time limits placed on prescriptions but equally rigorous monitoring systems would be established to ensure that a balance was achieved between promoting overcoming dependency and reduction of harm. Although the expert group included a diverse range of representatives from various perspectives, disciplines and backgrounds, some stakeholders saw the expert group as the continued dominance of psychiatry and protectionism around prescribing models and medical expertise. There was skepticism about how far recovery had developed the way it was originally envisaged:

"...the various bodies and chairs just make sure that all the nurses and doctor jobs are protected first and all the things that really the spirit of a recovery model was supposed to ensure, you know community focused activity, asset based community development, peer

empowerment, a much greater focus on community and residential rehabilitation, none of those things have happened.” (interview with recovery advocate)

Some recovery advocates suggested this was the case of the ‘old guard implementing new ideas’, growing ‘professionalisation of recovery’ and an extension of medical dominance. One researcher commented on the lack of engagement from some self-help organisations:

”AA, NA - those organisations have not really been very vocal in terms of the recovery agenda and regrettably so, because I think it’s rather allowed professionalization of recovery and the further extension of medical dominance.”

During the early days of the 2010 strategy, there was an indication that the medical hegemony of British drugs policy-drugs treatment was beginning to wane with the shift towards abstinence-based treatment and grassroots recovery movements. At the time of the interviews for this research in 2012, respondents referred to the ‘decline of addiction psychiatry’ and the field becoming less specialised as GPs and the voluntary sector played key roles in the development of services. However, the work of the NTA expert committee chaired by an addiction psychiatrist reinforced the continued role of OST with its robust evidence base demonstrating effectiveness in the development of a recovery oriented treatment system. Thus, medical stakeholders who have largely controlled and directed the development of drugs treatment historically appear to continue to play significant roles in future policy and practice although their positions have been recently challenged.

Same intervention – different pathways: Concluding remarks on the role of medical stakeholders in Denmark and the UK.

Despite similar starting points in the 1960s/1970s, when both Danish and British OST services were based on oral methadone and some form of psychosocial treatment to respond to increasing numbers of young heroin users, the development of drug treatment and the roles that medical stakeholders occupy have been shaped by country-specific trajectories and contexts. That is, the article shows how different ways of defining, conceptualizing and problematizing drug use and treatment have led to the development of different kinds of spaces for medical professionals as stakeholders in particular substitution treatment policies and practices. The Danish case illustrates the impact of re-conceptualizing the drugs problem from social terms to medical terms and the resultant implications for stakeholder groups, particularly medical professionals. In contrast, the British case highlights the dominance of medical conceptualisations of the drugs problem historically and the various attempts at re-defining it through a wider social problematization in the early 1980s, as well as the inherent tensions with the criminal justice system which have persisted over time. Reflecting the strong social welfare tradition in Denmark, defining the drug

problem in social terms is much more prominent compared to the UK where the tensions between medical profession and criminal justice have dominated the development of policy and practice. British drugs policy has generally been molded through an accommodation between medical and criminal justice concerns (Berridge, 1978; Stimson and Oppenheimer, 1982; Pearson, 1991). These definitions of the drugs problem are important in determining which stakeholder groups and government departments have responsibility, power and influence in developing policy and practice. However, the ways in which addiction historically has been institutionalized in different sectors of the welfare state, (for example primarily in the health or the social sector), also loops back on how addiction is conceptualized (cf. Hacking, 1999). Furthermore, it is clear from the analyses above that different conceptualisations can operate simultaneously, but one form may be more dominant at particular junctures (Kingdon, 1995).

The British case demonstrates how the number of stakeholders in drugs policy has increased and changed over time. Since the 1990s, policy initiatives have placed emphasis on 'partnership' and 'multi-agency' working which has increased the number and diversity of stakeholders involved. Over time, this has presented challenges to the medical models dominating drug treatment. This can be seen especially in the recent phase of policy development with the emphasis on 'recovery' and the debates regarding what this shift means for policy and practice. Similarly, emphasis on abstinence, rather than maintenance, has also challenged the reliance on some forms of medical expertise, particularly in relation to prescribing. Recent research by Neale et al (2014, 2015) with a variety of stakeholders including addiction psychiatrists, staff from residential rehabilitation and detoxification units, and service users, has highlighted that there is growing consensus that 'recovery' extends beyond the simple measure of abstinence and encompasses a wide range of social, psychological, physical, financial and spiritual changes, but there is continued disagreement and debate on particular measures of progress. In a similar vein, the Danish case demonstrates that the variety of stakeholders in drugs policy has increased over time, but contrary to the UK, the balance between different stakeholders has changed so that medical professionals, especially doctors and nurses, are now much more prominent in the field. In this process the dominating social model of drug treatment has been challenged by medical models. Despite the increased focus on health related harm and maintenance, which has been a consequence of this shift towards OST, other kinds of treatment interventions have not been neglected in Danish treatment policies and services, including residential treatment and harm reduction services (Pedersen, Hesse & Bloomfield, 2011; Houborg, 2010) .

Shifts in the power and position of different stakeholder groups can occur because of changes in the extent and nature of drug use, perceptions of crisis/problem (i.e. HIV/AIDS or an aging drug user population), political influence, wider trends in social, health and criminal justice policy or external influences of research from other countries such as the increasing demands for evidence (cf. Kingdon, 1995). Furthermore, shifts can also be promoted by the work of

entrepreneurial stakeholders or stakeholder groups who take advantage of changing political contexts to create a more solid platform to get their perspectives heard.

In conclusion, the rise of the medical voice in the Danish substitution treatment field has challenged the dominant idea of drug use as a social problem. The medical model was promoted by a group of entrepreneurial medical stakeholders and facilitated by changes in the organisation of drug treatment, the broader societal focus on health, medication and the use of evidence, and demographic changes in the drug user population. The strong medical dominance within British drugs treatment has recently been challenged by a “recovery” movement led by a number of advocacy organisations; recovery advocates from the United States, the residential rehabilitation sector, some researchers and media stakeholders. However, medical stakeholders regained their authority through their positions as expert advisors and by their use of evidence within the wider debates about the future of opioid substitution treatment.

It is important to state that the shifting roles of medical professionals and challenges to the dominant conceptualisations in drug policies and practices are not to be understood as an “either- or” dichotomy in either of the two countries. In Denmark, the social problem approach is still recognized as key in drug treatment practices, but it has lost some dominance compared to fifteen years ago. The increased roles of medical professionals have been encouraged by social workers, as well as by the wider society, and more collaboration has resulted between the different areas of expertise (e.g harm-reduction focused services, such as heroin-assisted treatment, have been directed towards the most marginalized users). In contrast to the UK, the recovery movement has not had a strong voice in the Danish drug treatment system. However, the perspective has been highly influential in the psychiatric field in Denmark, so this may have a “spill over” effect on drug treatment. In the UK, medical professionals continue to play important roles in drug treatment and policies. Despite the fact that the role of substitution treatment within a recovery-oriented approach has been supported by a review of evidence, there continues to be skepticism both politically and in some sectors of the drug field towards this approach. In other words, there does not seem to be a reconciliation or merger of the two approaches as yet. In both countries, the struggle over who ‘owns’ the problem is ongoing.

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