Towards the integration of treatment systems for substance abusers

Report on the Second International Symposium on Substance Abuse Treatment and Special Target Groups

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Submitted to the Journal of Psychoactive Drugs, January 31, 2002
Accepted for publication February 15, 2002
Published in the Journal of Psychoactive Drugs, Volume 35(2) (April-June 2003), 237-245

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ABSTRACT

The central ideas of this paper are the result of intensive discussions during a symposium that was organized following structural changes in European substance abuse treatment. Therapeutic communities were concerned about their approach being replaced by other treatment modalities. Participants focused on the question of whether the emerging harm reduction paradigm can be combined with the principle of recovery and how its integration in a comprehensive treatment system can be beneficial or detrimental to therapeutic communities.

This article defines integrated treatment systems for substance abusers from a conceptual, etymological, ethical and ideological point of view. In addition it focuses on old but ongoing contradictions and discussions between drug-free, methadone-maintenance and harm reduction approaches. Several prerequisites for the integration of treatment systems are discussed, and parallels and discrepancies between the American and European situation are explored.

An integrated and comprehensive system of treatment services is put forward as an alternative to the present-day gap between conventional abstinence-oriented programs and harm reduction initiatives. Participants maintain that collaboration between these apparently incompatible treatment paradigms will depend on mutual respect, the introduction of a common language and a thorough analysis of client’s treatment demands.

KEYWORDS

Substance abuse treatment, integrated treatment systems, therapeutic communities, harm reduction, managed care
INTRODUCTION

In some European countries (e.g., Germany, the Netherlands, Norway) attempts have recently been made to reorganize the field of mental health care and substance abuse treatment towards more integrated systems (Koller 1999; de Weert-Van Oene & Schrijvers 1992). A similar evolution can be observed in Belgium, where the National Council for Hospital Facilities has proposed establishing integrated treatment systems for special target groups (including substance abusers). In this way they hope to better meet clients' multiple and complex needs and to improve the continuity of care and co-ordination and co-operation between treatment services (Vanderplasschen et al. 2001). As this topic has been discussed intensively for the last 2 years in Belgium, the organizing committee of the International Symposium on Substance Abuse Treatment and Special Target Groups (i.e. the European Federation of Therapeutic Communities (EFTC) and the Department of Orthopedagogics, Ghent University) decided to approach the above mentioned theme from an international perspective during the annual symposium in the year 2000.

During the last decade, the European Federation of Therapeutic Communities experienced a shift of treatment methods and perspectives in most of its membership countries: the therapeutic community approach has been complemented and sometimes even superceded by low threshold methadone centers, free heroin-distribution and flexible co-operation between treatment interventions which initially appeared incompatible (Marset 1999). In certain European countries such as Switzerland (Klingeman 1996), the Netherlands (Kooyman 2001), Sweden (Göransson 1997) and the United Kingdom (Tomlinson 1994) an important decrease in the number of therapeutic communities has been noted, the only exception being TC’s located within prisons (Turnbull & Webster 1998). Moreover, the 1999 annual report of the European Monitoring Center for Drugs and Drugs Addiction (EMCDDA 1999), which reports on drug problems and their treatment, barely mentioned the drug-free approach. EFTC was concerned about the adulteration of its value-based and abstinence-oriented approach due to the decline of the recovery-principle and the establishment of a new harm reduction paradigm, in which drug use is considered acceptable (Inciardi 1999; Rosenbaum 1996). Simultaneously the gap between the United States – where this harm reduction movement remains less influential and is mainly limited to methadone-maintenance – and Europe and Australia became apparent (Harm Reduction Coalition 2001; Drucker 1995). Moreover, European therapeutic communities had a less prominent tradition of prohibition and – due to the influence of milieu therapy and psychoanalysis – were not as moralistic (Broekaert et al. 1999). Therapeutic community staff-members also affirmed the importance of increased co-operation and more flexible care systems, and strove to enlarge the TC-method in order to include such special target groups as prisoners, homeless, dually diagnosed drug abusers, adolescents, etc. (Martin 1999; De
Leon 1997b; Van der Meer 1997). Therapeutic communities realized that – due to the increased prevalence of substance abuse and the complexity and variety of needs presented by substance abusers – one single treatment-modality could not hope to solve all problems. Consequently, substance abuse treatment cannot be limited to one single treatment, but should consist of various phases and diverse modalities of treatment with continuity of care presenting an important challenge (Vanderplasschen, De Bourdeaudhuij & Van Oost 2002). Finally, the economic reality has led to structural changes and a demand for more collaboration and a better modulation of different initiatives (Hagedorn 1998).

During the second International Symposium on Substance Abuse Treatment and Special Target Groups concerning ‘Integration of different treatment models’ in De Haan (Belgium), more than 100 participants discussed the integration of treatment systems for substance abusers from a conceptual, etymological, ethical and ideological point of view. Attempts to bridge the gap between various forms of treatment revealed fundamental differences. Key speakers and other participants debated whether the emerging harm reduction paradigm could be combined with the principle of recovery and how a neo-liberal approach towards managed care could benefit or damage therapeutic communities (Broekaert, Vanderplasschen & Bradt 2000). In the United States the debate concerning the integration of harm reduction with traditional substance abuse services is seen as an important challenge (Gleghorn, Rosenbaum & Garcia 2001; Marlatt, Blume & Parks 2001). A comprehensive system of treatment services is proposed as a way of breaching the present-day gap between conventional abstinence-oriented and harm reduction initiatives.

The concept of integrated treatment systems has been implemented in some European countries and seems a satisfying way of dealing with the multiple and often chronic problems of substance abusers, as well as an effective way of unifying the often fragmented services available to this target group. For this reason the findings of this symposium might well be of interest to those facing a similar integration of different treatment models. The participants largely focused on ideas, experiences and concerns expressed by management and staff members of therapeutic communities. However, input from other drug-free programs and harm reduction-initiatives is included, as well as feedback from scientists and policy-makers.

DEFINITION

The term ‘integrated treatment systems’ is a relatively new concept, and little has been published concerning it; therefore the term is defined from etymological, conceptual, ethical and ideological points of view. The combination of these 3 words is particularly noteworthy as most articles refer to ‘integrated treatment’ or ‘integrated systems’ or ‘integrated approaches’. Sometimes the word ‘integrated’ is replaced by ‘integrative’.
Etymological

‘Integration’ is derived from the Latin words ‘integer’ or ‘whole’ and ‘integrare’ or ‘renewal’. It pursues new unity and can be considered as “alternatively going together where unity is pursued” (Rucker 1986, 218). ‘Treatment’ (from the Latin ‘tractare’: ‘to handle’ or ‘what to do’) refers to the content, whilst ‘system’ (derived from the Greek ‘systema’ or logical order) refers to the organizational aspects of the integration. Integrated treatment thus differs from a multi- (Latin for ‘many’) or mixed- (‘mixtus’ in Latin means ‘assorted’) modality (‘modus’ is Latin for ‘means’ and/or ‘way’) approach. The term ‘multi-modality’ stresses the multiplicity of the approach but not the striving for unity or co-ordination within that multiplicity. However, the specific meaning of ‘integrated treatment systems’ and ‘multi-modality approaches’ is seldom emphasized in daily reality.

Conceptual

Most articles (cited in the Social Sciences Citation Index) containing the terms ‘integrated treatment (systems)’ and ‘substance abuse’ refer to the integration of (aspects of) mental health care and substance abuse programs for dually diagnosed patients (co-morbidity of substance abuse and severe mental illness). Conceptual definitions of ‘integrated treatment’ are seldom used and the meaning can usually be derived from the context (cf. Hellerstein, Rosenthal & Miner 2001; Weisner et al. 2001; Fiorentine & Hillhouse 2000; Drake et al. 1998; Drake et al. 1997; Bachmann et al. 1997; De Leon 1996; Grella 1996; Sciacca & Thompson 1996).

Sciacca and collaborators investigated ‘Integrated Treatment (Across) Systems for dual diagnosis: Mental Illness, Drug Addiction, and Alcoholism (MIDAA)’, as mental health and substance abuse programs were traditionally designed to deal with singular disorders (Sciacca & Thompson 1996). Due to conflicting and incompatible philosophies and treatment methods within different systems, IT(A)S aims at providing comprehensive services within each program of each delivery system. The programs are cost-effective, make use of existing facilities, train staff in the issues of incompatible treatment interventions, fill the gaps between services and expand referral resources. Clients’ needs are met in each phase of their recovery. In the course of time the program covers comprehensive assessment, motivation, stabilization, education, rehabilitation and relapse prevention. Symptoms of dual or multiple disorders are accepted without demur (Sciacca & Thompson 1996; Sciacca 1991).

De Leon and his colleagues refer to an integrated systems approach and define it as “interrelated clinical interventions and social services that are guided by a common social-psychological vision of the individual and of recovery” (De Leon 1997b, 268). This shared vision of recovery entails following residents in their recovery process, assessing their needs and providing them with the most effective form of treatment. This integrated system approach, in which the concept of recovery and treatment is seen as
primordial, has been applied in a modified TC for criminal delinquents, to substance abusers suffering from mental illness and to mentally ill homeless abusers referred from shelters. Prescription of methadone or other harm reduction interventions can contribute to the partial or total realization of this goal. The main focus is thus not society, nor the program, setting or modality but the development of the individual. During the symposium in De Haan, the following definition was used to describe integrated treatment systems (Broekaert, Vanderplasschen & Bradt 2000, 3): “Integrated treatment systems refer to sensible action within a global context and are based on the needs of clients on the one hand and on co-ordination of policy, co-operation of services and availability of a large range of treatment modalities on the other”.

**Ethical**

From an ethical point of view integrated treatment systems are influenced by questions concerning the goals of treatment and the nature of recovery: should substance use be dissuaded or tolerated? This controversy is reflected in a gamma of recovery strategies that vary from total abstinence to controlled heroin distribution. Some of these strategies aim at personal development (e.g. drug-free therapeutic communities (Kooymans 1993)), others at psychiatric treatment (e.g. psychiatric hospitals), and still others at substitution therapy with methadone, LAAM or buprenorphine (Newman 1990). Harm reduction initiatives promote needle exchange, health awareness, prevention of infectious diseases, safe injection rooms and controlled heroin trials (Drucker 1995). Recently, a new tendency arose whereby the protection of society and concern for the individual were no longer seen as mutually incompatible (Fridell 1999). Finally, the debate also includes the question of whether substance abuse should be decriminalized, depenalized or even legalized (Inciardi 1999).

**Ideological**

The current neo-liberal ideological viewpoint sees integrated treatment systems as part of new managed care. The cornerstones of this approach are satisfaction of the individual, privacy, productivity, efficiency, effectiveness and quality of care (Fridell 1999). Quality must be made explicit and be translated into concrete norms and standards that are measurable at the level of the product, structure and process (Brook, McGlynn & Shekelle 2000). Regular tests and checks are required to ascertain that standards are met (VOCA 1998). Due to the introduction of economic thinking in all social sectors, evaluation of substance abuse treatment became an important research topic and one of its main objectives was to improve the quality of care (Vanderplasschen, De Bourdeaudhuij & Van Oost, 2002). Co-ordination, continuity, effectiveness and efficiency are considered vital characteristics of quality care (de Weert-
Van Oene & Schrijvers 1992). Effectiveness denotes the relationship between achievements and resources, whilst efficiency refers to the relationship between effects and resources. Co-ordination relates to the functional cooperation between various services, and continuity to the length of treatment and the individual nature of the approach.

CRITICAL LIMITATIONS

The integration of different treatment paradigms is impeded by perpetual discussions between abstinence-oriented programs, substitution and harm reduction approaches. Although narrowing the gap between these divergent approaches is a slow process and the debate continues, daily practice proves that many drug abusers make use of several services simultaneously or within a short period of time (Vanderplasschen, Lievens & Broekaert 2001; Friedman et al. 2000). Both the advantages and disadvantages of the respective approaches are elucidated in this section.

Drug-free treatment

The discussion goes back to the late sixties, when therapeutic communities defined their identity in terms of a drug-free lifestyle and absolute recovery from drugs (Broekaert et al. 2000; Broekaert & van der Straten 1997; O’Brien 1993; Bratter & Forrest 1985; Bassin 1977; Glaser 1977; Mowrer 1976; Yablonsky 1965). They severely criticized Dole and Nyswander’s ‘no exit’-approach towards heroin addiction. Acampora & Stern (1994, 8) reported ironically “how a teaspoon of medicine taken daily in a cup of orange juice is changing former dope addicts into decent law abiding citizens”. Bratter (1978) maintained that the individual’s belief in recovery worked as a self-fulfilling prophecy; to remove this and replace it with the demands of society was to condemn the abuser to relapse. Lennard, Epstein & Rosenthal (1972) saw methadone as an ordinary street drug and considered methadone treatment an illusion: methadone was often used in combination with other substances, led to heavy withdrawal symptoms, and condemned the abuser to life-long ‘street psychiatry’.

At the same time, the validity of the therapeutic community was questioned. French social workers openly criticized the authoritarian nature of the American hierarchical drug-free therapeutic communities (Ottenberg 1984). Synanon – the birthplace of the drug-free therapeutic community – gradually became a cult (Mitchell, Mitchell & Ofshe 1980; Deitch & Zweben 1979).

Methadone substitution

On the other hand, proponents of methadone substitution praised Dole and Nyswander’s approach which “does not impair an addict’s functioning and
costs as little as ten cents a day” (Smith & Luce 1969, 337). They supported the ‘British system’ for “making narcotics legally available and thereby making it unnecessary for addicts to steal in order to support their habits” (ibid., 336).

In the seventies, American therapeutic communities reached the peak of their development and expanded to Europe and other continents (Broekaert & Slater 2001). From the beginning of the eighties onwards, methadone maintenance gained ground due to the prevalence of HIV and AIDS amongst drug users (Uchtenhagen 1997; Drucker 1995). In the ensuing years methadone proved to be an excellent tool for fighting the enormous increase in substance abuse. Treatment for substance abusers became more client-centered and, if sufficient psychological and social support was provided, dropout rates in methadone programs were lower than in drug-free programs (De Leon 1997a). Moreover, methadone programs led to a decreased (intravenous) use of heroin (Hartel et al. 1995), less criminal behavior and fewer arrests (Ezard et al. 1999) and higher employment figures (Newman 1985).

Harm reduction

Methadone maintenance became a central intervention of the harm reduction-approach, which aims at reducing the negative consequences of drug use and incorporates a spectrum of strategies which range from safer use to managed use and finally to total abstinence (Harm Reduction Coalition 2001). This harm reduction paradigm no longer focuses exclusively on recovery as the ultimate goal, but views respect for the client’s autonomy as a guiding principle (Denning, 2001). Criminal law enforcement and medical treatment are used to optimize the drug users’ quality of life with or without drugs.

This ideology contrasted sharply with the drug-free recovery paradigm that was considered as purist, based on belief in dogma-based values and lacking reference to research (Griffin 2001). Harm reduction is a pragmatic alternative to prohibition (Marlatt, Blume & Parks 2001), and incorporates a broad range of interventions including:

- Intravenous injection of morphine, methadone and heroin to opiate dependent persons with severe medical and social problems and to those for whom treatment has repeatedly failed in Switzerland (Küng 1997; Uchtenhagen 1997).
- Medical prescription of injectable drugs in, among others, Great Britain (Stimson & Oppenheimer 1982), the Netherlands (Derks 1990) and Australia (Bammer & Gerrard 1992).
- Needle exchange and syringe distribution programs in, among others, the United States (Des Jarlais et al. 1994), Switzerland (Office of the Chief Medical Officer 1994) and the Netherlands (Hartgers et al. 1998).
- Support of liberal laws that accept free availability of certain substances such as cannabis in the Netherlands (Korf 1990) or
decriminalization of all illicit substances in Portugal and non-problematic use of cannabis (e.g. Belgium) (EMCDDA 2001).
• Establishment of drug user organizations (Balian & White 1998).

Managed care

As far as the organization of services in the field of substance abuse is concerned, critical issues are service utilization, integration of services and the position of new managed care. Both in the United States and in Europe governments support new forms of cost-effective collaboration. For example, in the United States the ‘Integrated treatment and blended funding for co-occurring mental and addictive disorders’ (Nami 2001) and the ‘Arizona integrated treatment consensus panel’ (Arizona Department of Health Services) demonstrate this trend. Centralized intake procedures have been developed to facilitate access, co-ordination and continuity of treatment (Rohrer et al. 1996). Case management has been set up with several target-groups who experience similar difficulties in accessing treatment, or who have contacts with a variety of services due to their chronic and multiple problems (Siegal 1998). Matching of clients has become more important both in the United States (Hser 1995) and in Europe (Kersten et al. 1995), due to the differentiation of substance abuse treatment, the growing complexity of drug problems and the varying degrees of success obtained by different treatment modalities.

In Europe, networks of integrated services for substance abusers have been created in the Netherlands (de Weert-Van Oene & Schrijvers 1992) and Germany (Koller 1999; Däumling 2000). Case management had already been applied in the field of mental health care, but was only recently introduced in substance abuse treatment in order to assist - amongst others - drug users with multiple and complex problems (Vanderplasschen & Broekaert 2000).

These new forms of collaboration and managed care originated in the United States in the early seventies, when the ‘American Health Maintenance Organization’-act allowed the public sector to receive public funds. Ten years later, this practice was discontinued and the profit-making aspect penetrated the non-profit sector. This increased emphasis on profit making stimulated the development and application of more stringent cost-control procedures. Some years later a similar evolution took place in Europe, accelerated by the European Union’s struggle for economic power. The principles underlying this tendency are similar in both the States and in Europe and include: meeting clients’ needs in every phase of treatment; limiting the negative medical, social and economic consequences of substance abuse; integrating traditional and non-traditional approaches into a continuum of interventions; providing comprehensive services and key intervention strategies; creating prevention strategies; providing treatment including primary medical care; acknowledging the strengths and limitation of individual programs, etc. (Gleghorn, Rosenbaum & Garcia 2001).
Managed care and all its implications aroused much criticism. Zimmerman (1999, 289) noted “how the growing impact of economic thinking leads to an increased denial of the needs of the poor, the elderly, minority groups, the young and disabled”. Gould, Levin & McLellan (2000, 75) deplored that “Managed Care Organisations have taken the position that they are empowered to provide only those services that are medically necessary”. This leads the authors to conclude that MCOs contribute to the exclusion of social responsibility. Zarkin & Dunlap (1999, 33-34) described the implications of managed care for methadone treatment and concluded: “The treatment programs that we visited speculated that a Medicaid managed care system may limit access to methadone treatment and adversely influence retention in the program as well as the quality of care provided”. They further stated: “Treatment programs are worried that their patients may be required to go through an MCO-gatekeeper in order to gain access to treatment, but MCO-gatekeepers lack appropriate training in identifying substance abuse patients and in directing them to the appropriate treatment”.

**PREREQUISITES FOR THE INTEGRATION OF TREATMENT SYSTEMS**

The symposium on the integration of different treatment models should be situated within this context of opposing paradigms and shifting policies. Based on the contribution of several speakers and the ensuing discussions, various prerequisites were formulated for the integration of treatment systems (Broekaert, Vanderplasschen & Bradt 2000).

First of all it was stipulated that the choice of treatment should be free of moral pressure. Moreover, the system should grant equal support to the medical model, the therapeutic community and the value-based approach. Mutual respect between all partners is crucial and the objectives of each modality should be made explicit. Historical and ideological differences should be taken into account when establishing an integrated treatment system, but it is essential that the network adopt a common and comprehensive approach towards drug abuse and its treatment. It is important to safeguard the uniqueness of each approach when integrating the diverse approaches into a comprehensive system.

A comprehensive treatment system should include various settings and modalities and be characterized by a multidisciplinary approach and continuity of care (Graham et al., 1995). Outreaching, prevention, early intervention, family involvement, self-help and relapse prevention should all have a place within this system. Depending on the individual and the situation, the treatment can be either care- or cure-oriented. Assessment, planning, monitoring and evaluation are all basic elements of the process of treatment. Particular attention must be paid to special target groups (e.g. drug abusers with children, immigrant drug abusers), as they often contact several services and fall through the cracks.

Dealing with the multiple and complex problems of drug abusers and safeguarding quality care (i.e. co-ordination, continuity, efficiency,
effectiveness) calls for more integrated and individualized treatment. The importance of networking and case management and the creation of a more centralized intake-system have been discussed (Vanderplasschen et al. 2001). Collaboration between different services and co-ordination of care is indispensable (Ottenberg 2000). One common language, applicable to all treatment settings and modalities, is essential to the realization of an integrated treatment system. Concepts such as ‘cure’, ‘care’, ‘network’; ‘method’, ‘follow-up care’, etc. should all be described in the same terminology. Group discussion should determine the choice of terminology and all those involved (including field-workers, counselors, directors, researchers; policy-makers and subsidizing authorities) should be heard. All partners involved in the treatment of drug abuse should participate in this network. Communication between different modalities is very important, as some clients move from one modality to another. Registration and maintenance of client files should be standardized in order to improve communication within and between services. Referral procedures should be clear to all parties and the accessibility of the system should be closely monitored. Although the establishment of an integrated system requires many arrangements and agreements this should not be at the expense of flexibility. Client participation is an important part of creating and monitoring an integrated treatment system.

A thorough qualitative and quantitative analysis of clients’ treatment demands is a necessary part of providing the best possible care and creating alternatives to present-day treatment services (Vanderplasschen et al. 2001). Treatment should be based on the demands of the client. Treatment adapted to the most prevalent problems would be available on a local or regional basis whilst the more specialized services would be available only at state- or county level. A regional inventory of all existing treatment facilities and modalities is the first step in the process of reorganizing and integrating treatment services. Further deliberation, based on the registration of treatment demands and following this inventory of existing services, may lead to the abolition of superfluous methods and modalities and the establishment of others not yet in place.

On an organizational level, national, regional and local funding agencies must take many factors into account; the client’s treatment demands must be considered as well as the philosophy and objectives of the various services. The transition towards an integrated treatment system will initially create much extra work and the authorities should provide financial support in order to help motivate staff. The development of measurable treatment processes should be closely followed, but utilization-studies and cost-benefit comparisons must not aim only at cost-reduction or stimulation of competition between services. Finally, co-operation between services should be based on a formal agreement signed by all parties in which individual responsibilities are clearly stated (Vanderplasschen et al. 2001). There are many theories and suggestions pertaining to the integration of treatment systems but many questions remain (Ottenberg 2000): What is the importance of ‘recovery’ in this integrated system? What are the benefits
of a natural health care approach (e.g. acupuncture) and how is it incorporated in an integrated treatment system? Not everything is measurable (e.g. humanistic qualifications). Is this view upheld by the system and, if so, how is it reflected in the philosophy of managed care?

**SIMILARITIES BETWEEN THE AMERICAN AND EUROPEAN SITUATION**

These prerequisites formulated by European workers from TCs and other services in the field of substance abuse treatment reflect the same ideas as those postulated during the ‘Bridging the gap’-conferences in San Francisco by American colleagues in the field of traditional substance abuse and harm reduction services (Gleghorn, Rosenbaum & Garcia 2001). While the principles for integrating harm reduction with traditional substance abuse treatment refer to a common approach shared by all in the network, the ‘De Haan’ prerequisites focus on structural elements necessary for the establishment of an integrated treatment system. Thus, although the European and American situation differs to a certain extent, the ‘De Haan’ conclusions complement those reached by the San Francisco ‘Bridging the Gap’-conference. This is due not only to a different approach towards ‘integrated treatment systems’, but also to the fact that the American and European situation originates from two distinct paradigms. Europe and the USA share many of the same principles although the choice of words differs slightly. Both believe that care should be delivered in a culturally competent, non-judgmental manner with respect for individual dignity (Gleghorn, Rosenbaum & Garcia 2001). Interventions should reduce the adverse social, physical, and economic consequences of substance abuse. New strategies should be developed to engage and motivate potential clients and to limit the long-term consequences of substance abuse. Harm reduction interventions should be applied to those unable or unwilling to stop drug use. Relapse should be regarded as an integral part of the recovery process. Treatment should be available to all, including patients requiring medical or psychiatric medication. Effective collaboration strengthens each separate program or modality (Broekaert, Vanderplasschen & Bradt 2000).

**CONCLUSION**

European professionals working in therapeutic communities and other services within the field of substance abuse treatment observed a shift in treatment paradigms and drug policy. An evolution towards integrated treatment systems for drug abusers was noted and accepted. Economic thinking in today’s society makes this evolution inevitable, as do the changing complexity of drug users' treatment needs and the lack of coordination and continuity of care. Moreover, there has been a growing acceptance of methadone-substitution and harm reduction initiatives. European TC-staff members emphasize individual development and consider it more important than the harm done to society. They favor a
recovery paradigm and believe in the durability of their identity. The symposium participants further concluded that prohibition is an intrinsic aspect of American morality and social structures, which may complicate the rapprochement with harm reduction.

An integrated and comprehensive system of treatment modalities and services is put forward as a way of breaching the present-day gap between conventional abstinence-oriented programs and harm reduction initiatives. Collaboration between these two apparently incompatible treatment paradigms will largely depend on mutual respect, the introduction of a common language to describe treatment, and the development of a fair subsidy system. An integrated treatment system for substance abusers should be based on a thorough analysis of clients’ treatment needs and should safeguard the unique qualities of each approach. Effective communication and collaboration between all services is crucial and should be supported by the authorities. There is still some dissent concerning certain issues (e.g. acceptance of drug use as normal behavior; the question of whether addiction is a disease; the importance of values) and the network must adopt a common approach towards substance abuse and its treatment in order to reconcile philosophical and ideological differences.

ACKNOWLEDGEMENTS

We would like to thank following persons for their contribution to this paper and for discussing the central theme during the symposium: M. Haack (Maastricht University, the Netherlands), C. Kaplan (Maastricht University, the Netherlands), M. Kooyman (Rotterdam, the Netherlands), J. Maertens (De Sleutel, Belgium), D. Ottenberg (Pennsylvania, United States), A. Slater (Phoenix House Haga - EFTC, Norway), D. Vandevelde (De Kiem, Belgium) and R. Yates (Stirling University, Scotland).

L. Bockaert, B. Hofman, D. Reynaert & K. Wuyts (Ma-students in Educational Sciences) for revising and editing this paper.
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