Health Research Board

HRB drug and alcohol evidence reviews

Evidence review on the distribution, organisation, and administration of drug and alcohol services in other European jurisdictions



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HRB drug and alcohol evidence reviews to date

1. Munton T, Wedlock E and Gomersall A (2014) *The role of social and human capital in recovery from drug and alcohol addiction*. HRB Drug and Alcohol Evidence Review 1. Dublin: Health Research Board.
2. Munton T, Wedlock E and Gomersall A (2014) *The efficacy and effectiveness of drug and alcohol abuse prevention programmes delivered outside of school settings*. HRB Drug and Alcohol Evidence Review 2. Dublin: Health Research Board.
3. Nic Gabhainn S, D'Eath M, Keane M and Sixsmith JA (2016) *Scoping review of case management in the treatment of drug and alcohol misuse, 2003–2013*. HRB Drug and Alcohol Evidence Review 3. Dublin: Health Research Board.
4. Murphy L, Farragher L, Keane M, Galvin B and Long A (2017) *Drug-related intimidation. The Irish situation and international responses: an evidence review*. HRB Drug and Alcohol Evidence Review 4. Dublin: Health Research Board.
5. Bates G, Jones L, Maden M, Cochrane M, Pendlebury M and Sumnall H (2017) *The effectiveness of interventions related to the use of illicit drugs: prevention, harm reduction, treatment and recovery. A 'review of reviews'*. HRB Drug and Alcohol Evidence Review 5. Dublin: Health Research Board.
6. Minyard K, Manteuffel B, Smith CM, Attell BK, Landers G, Schlanger M and Dore E (2019) *Treatment Services for people with co-occurring substance use and mental health problems. A rapid realist synthesis*. HRB Drug and Alcohol Evidence Review 6. Dublin: Health Research Board.
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8. Pratschke J, Glanville J and Engling F (2022) *An integrative evidence review on service user participation in the design and delivery of drug treatment, recovery and harm reduction services*. HRB Drug and Alcohol Evidence Review 8. Dublin: Health Research Board.
9. Pratschke J, Glanville J and Kelly P (2024) *Integrative review on place-based and other geographically defined responses to drug-related threats in communities*. HRB Drug and Alcohol Evidence Review 9. Dublin: Health Research Board.

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Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
CHN	Community Healthcare Network
CMHT	Community Mental Health Team
CST	Community Specialist Team
EUDA	European Union Drugs Agency
GMS	General Medical Services
GP	General Practitioner
HRB	Health Research Board
HSE	Health Service Executive
ICP	Integrated Care Pathway
ICS	Integrated Care System
IHA	Integrated Health Area
ISA	Integrated Service Area
MeSH	Medical Subject Headings
NCP	National Clinical Programme
NGO	Non-governmental Organisation
NHS	National Health Service
NPM	New Public Management
NTA	National Treatment Agency for Substance Misuse
OAT	Opioid Agonist Therapy
OECD	Organisation for Economic Cooperation and Development
PICO	Population, Intervention, Comparison, Outcome
PITS	Population, Intervention, Themes, Study design
PRISMA	Preferred Reporting Items for Systematic reviews and Meta-Analyses
RHA	Regional Health Authority
SLA	Service Level Agreement
SUD	Substance Use Disorder
UK	United Kingdom
USA	United States of America

Executive Summary

Background and Context

The Department of Health is considering how drug and alcohol treatment, harm reduction, prevention and recovery services will be arranged following the introduction of Regional Health Areas. Regionalisation of health services will have a major impact on the location and work of drug services. The Department would like to learn from the experiences in other countries that manage these services on a regional basis. They are particularly interested in clinical governance, how regional services link to national strategies, the role of NGOs in delivering service and the interaction between drug services and the primary care system. This review examines the different approaches that European countries have pursued in organising drug and alcohol treatment services, balancing decentralisation and national administration. During the 1990s and early 2000s, reforms inspired by New Public Management (NPM) transferred decision-making to regional and local levels to improve responsiveness, efficiency and patient choice. Following the 2008 financial crisis and the COVID-19 pandemic, governments increasingly sought stronger national coordination to reduce fragmentation, ensure equitable access and improve system resilience.

Understanding Regionalisation

Regionalisation involves transferring selected powers from central government to lower levels of administration, including funding, management, implementation and evaluation. However, decentralisation is rarely complete; most systems retain strong national oversight through legislation, standards, performance monitoring and funding frameworks. Ireland's HSE Health Regions represent managerial decentralisation rather than political devolution.

Comparative European Experience

The review examines a range of models including Spain and Italy (regional systems), Germany and the UK (devolved or federal arrangements), France (centralised administration), Norway and Sweden (decentralised administration), and Portugal (a centralised system experimenting with decentralisation). No country relies solely on either centralisation or decentralisation. Successful systems seek to combine local flexibility with national consistency.

Implications for Drug and Alcohol Services

Drug and alcohol treatment increasingly operates within integrated health, mental health and social care systems. Regional authorities often work alongside primary care providers and civil society organisations. Decentralisation can improve local responsiveness, but it also requires strong coordination mechanisms to avoid inequalities and fragmentation.

Research Objectives and Methodology

The review addressed the following five key questions:

1. What arrangements are made for the clinical governance of drug services that are administered at a regional level?
2. In what manner do regionally administered drug services demonstrate adherence to national policy as articulated in drug strategies or similar documentation?
3. Describe the management of relations between regional health authorities and non-government organisations or other civil society actors charged with implementing policy and delivering services.
4. What is the nature of the relationship between regionally administered drug services and primary care services?
5. What indicators/metrics have been used to monitor the regionalisation of drug services?

A comprehensive evidence review was conducted using peer-reviewed literature, grey literature, policy documents, official reports and expert interviews across eight countries. This study is an "integrative evidence review" because it draws on several different sources of information on regionalisation.

Key findings

» Most of the countries reviewed during this project adopt a similar approach to clinical governance. In most European countries, guidelines for drug and alcohol treatment services are subsumed within the broader system of clinical governance for health care. From the perspective of clinical governance, this is one of the benefits of integrating drug and alcohol treatment services within the publicly funded health service.

» In most European countries, regional administrations are expected to apply these national guidelines and care pathways, to assign responsibility for their implementation, and to provide training to support practitioners and managers to carry out their clinical roles. National governments and regional administrations often use certification processes to determine whether service providers can operate in specific areas of the welfare system However, cultural and political disparities at regional level often led to heterogeneity in treatment practices and service organisation.

» Centralised monitoring systems are used to ascertain whether regions are making good use of public funding, whether they provide essential services, whether the quality of services is satisfactory, and whether outcomes are in line with national targets. These assessments generally require the same kind of data and institutional arrangements within a clinical governance system.

» At national level, the information and assessments carried out at regional level are analysed in a comparative fashion, in collaboration with the decentralised administrations, with a view to identifying underserved areas. It is complicated to evaluate quality and outcomes, and this is the domain of clinical governance.

» Private firms and voluntary organisations have come to play an important role in the delivery of treatment services for substance use disorders (SUDs) in Europe. Third sector organisations have demonstrated an ability to collaborate with statutory services, to adapt to local conditions, to meet the needs of service users, and to promote user involvement. This is one of the positive results of the decentralising tendencies that characterised NPM-inspired policies during the 1990s and early 2000s.

» In countries where drug and alcohol treatment services are managed at the regional level, there are typically pressures to maintain quality and to improve population health while controlling costs. These pressures encourage regional managers to pursue efficiencies by integrating and coordinating the delivery of services. This process has followed two broad models: (1) strengthening collaboration between GPs and a network of specialised services; and (2) the construction of multidisciplinary primary health care centres that can provide some specialised services.

» Some European countries have sought to develop treatment services for SUD that are based on concepts like ‘shared care’, or services seek to develop integrated pathways that bring specialised treatment services for SUD into closer alignment with primary care, mental health services, and social care. Others have adopted a more multidisciplinary and territorial approach to the provision of services which poses different challenges.

» The regionalisation of drug and alcohol treatment services takes many forms and usually comprises a combination of decentralising and centralising. Change tends to involve an ongoing, incremental process, marked by unexpected changes of direction and corrections that are rarely based on evidence. With regionalisation, different solutions may be adopted at local level, which further complicates the task of monitoring and assessing services.

» Scientific research often relies on qualitative methods when studying treatment systems, and these studies typically do not use standardised indicators and metrics to capture important aspects of service development within the context of institutional reforms. Nevertheless, most European countries have systems for gathering and sharing data, with Norway and Sweden having national registries that contain comprehensive information on diagnoses, treatment, and outcomes.

» As we have shown in this report, research on the regionalisation of drug and alcohol treatment services in Europe is in its infancy, and many of the policies described in this review are still being implemented. This topic seems destined to receive greater attention in coming years, as regionalisation will have far-reaching effects on the organisation, management and delivery of drug and alcohol treatment services. One of the goals of this evidence review is to identify the issues that policy-makers, administrators and service providers will need to tackle in coming years, and to indicate the role of research in relation to regionalisation.

» Within the broad area of regionalisation, as we have seen, different types of deconcentration and decentralisation are observed. A theoretical framework is needed which can help researchers to track this complex, multidimensional process across time and space.

» Research is needed on the organisational implications of regionalisation (what happens within treatment systems) and how this process affects local populations (the impact of treatment systems). It is both difficult and important to measure treatment outcomes in systems where policymaking and administration are decentralised.

» It is important to focus not only on the nature of regionalisation processes but also on their impact on treatment outcomes and population health. This means that appropriate ways of measuring these crucial outcome variables must be identified, and baseline measurements obtained, so that impact can be measured. Routine administrative data can play a valuable role in the monitoring and assessment of outcomes in this field, and across the whole healthcare system, in the future.

1 Introduction

European countries have developed a range of models for the funding, administration, governance, and delivery of drug and alcohol treatment services. These models have undergone changes in recent decades as treatment services have been brought into alignment with wider health, mental health, and social services, and as reforms inspired by various approaches have been introduced in an effort to improve efficiency, reduce spending, improve quality, enhance coordination, and reduce disparities.

An important dimension of these reforms relates to the centre-periphery distinction. During the 1990s, neoliberal policies originating in the Anglo-Saxon countries began to influence service provision across Europe, leading to competition-based models that sought to make service providers more responsive to patients. At the same time, advocacy groups were calling for changes that could empower users, practitioners were looking for greater clinical freedom, and policy-makers were exploring ways of improving the integration of services. These policies all tended to lead to a greater decentralisation of decision-making and the development of strategic management at sub-national level. In several European countries, there was already a long history of decentralised administration, linked with political representation at local level.

Following the Great Recession (2008), however, many European countries adopted austerity measures which led to funding restrictions on health and social services. The COVID-19 pandemic (2019) and subsequent interventions by national governments aimed to build more resilient and responsive welfare systems that could ensure equal access to essential services. As a result of these trends, policy-makers were increasingly interested in strengthening central coordination in order to avoid the inflationary tendencies and fragmentation of services that had emerged as a result of earlier New Public Management (NPM)-inspired reforms.

The timing of these shifts has contributed to changes in decision-making, administration, funding, and service provision across the broad field of health, mental health, and social care services, including drug and alcohol treatment. It would be misleading to describe recent trends as involving either the decentralisation or recentralisation of authority, as each system manifests a unique combination of centralising and decentralising policies. In practice, it is very difficult to analyse the former without simultaneously considering the latter.[1]

1. Exworthy *et al.* (2010) observe that "decentralisation and centralisation usually exist together" (p. 8).

Attempts to decentralise decision-making (through greater local autonomy) are often accompanied by some form of recentralisation (for example, through national guidelines, standards, and priorities). The systems that emerge from this balancing act are invariably complex, involving a range of different forms of governance and control that are distributed across different levels. If a government wishes to exploit the positive features of decentralisation, it will likely need to find a complementary form of centralisation that can avoid fragmentation and inequalities, and vice versa.

Decentralisation is often viewed as increasing the accountability of service providers, improving collaboration across different sectors, and ensuring responsiveness to the needs of local people. It may also be seen as facilitating patient choice and the involvement of third sector organisations. By contrast, centralisation is often treated as ensuring equity, improving national coordination, and reducing waste and inefficiency. As all of these principles are valuable, it is easy to understand why governments might seek to identify an appropriate point of equilibrium that enables them to maximise the benefits of both decentralisation and centralisation. However, no single model of administration can perform in an optimal way in all countries, given their distinct institutional, political, and cultural features.

These considerations help us to appreciate the complexity of debates about regionalisation. In political theory, there are two main ways of thinking about this, the first of which involves geopolitical integration (involving greater coordination between countries in a certain region, for example, Europe), and the second of which involves separation (via the division of a country into smaller jurisdictions). So, even when we use this term, we need to describe the policies that we are interested in analysing. The unintended consequences of reforms can also be important, and can strongly influence their outcomes. For example, the commissioning of drug treatment services is highly decentralised in Sweden, but small municipalities often come together to form consortia in order to simplify this process and to obtain more favourable conditions from private suppliers. A similar situation is observed in the United Kingdom (UK), where local authorities often commission services from large private firms or third sector organisations that may operate on a large scale across the country.

In this report, we assess the experience of European countries with different institutional arrangements. There are countries that rely on 'systems of regions' (like Spain and Italy), those that have devolved administrations (like the UK and Germany), those that rely on a strong central administration (like France), and those that have a more decentralised administrative system (like Norway and Sweden). Portugal, like Ireland, has a centralised administration but has recently experimented with decentralisation. As we will see, all of these countries have specific combinations of centralising and decentralising tendencies.

In the policy literature, decentralisation is treated as involving a shift of decision-making powers from the central State to a lower level of the administration. These powers relate to areas like funding, policy-making, management, and assessment. Consequently, decisions about the distribution of funds may be decentralised, the power to legislate may be devolved to a lower level, authority to implement policies may be shifted from the centre to the local level, and the distribution of power to carry out evaluations may also be altered. To further complicate matters, this process has a multilevel structure, which means that countries may decentralise powers to regions and regions to municipalities and so on.

In federal systems, the devolution of power to constituent states tends to be normalised to such an extent that this is not even perceived as involving regionalisation. As mentioned above, decentralisation may proceed within just one of these domains, and may be accompanied by the recentralisation of authority in others. The Health Service Executive (HSE) Health Regions in Ireland are a result of the partial decentralisation of managerial authority within a single policy area without altering taxation, accountability, or policy-making. They cannot be compared directly with the Italian or Spanish regions, which have their own legislative assemblies, raise their own taxes, and can legislate (within constraints) across many different areas. The Irish Health Regions are more similar to the managerialised local health units that were implemented in Italy during the 1990s, and there are similar institutions elsewhere.

The value of comparative research rests with the way that it helps us to understand how the different elements that compose each system fit together and to identify the risks and benefits associated with different policies. We need to study these different systems in detail so that we can understand how they use decentralisation and recentralisation in order to activate certain mechanisms and to achieve specific results. We are unlikely to find a model that can simply be emulated in Ireland, and any policies that are borrowed from other jurisdictions must be carefully recontextualised. As we will see, a number of lessons can be learned by making cross-national comparisons, some of which are relatively straightforward while others are extremely complex.

As the request for tenders states, the Department of Health wishes to learn from the experience of other European countries regarding the regionalisation of drug and alcohol treatment services. The lessons learnt from these different experiences will inform the process of integrating drug and alcohol treatment services within the new HSE Health Regions. The Department of Health asked the Health Research Board to commission an evidence review on this topic, with the following objectives:

» To gain an understanding of how regionally administered drug services in other European countries are managed and governed

» To describe the relationship between these services and the national government, regional administration, other parts of the health service, and civil society

» To identify metrics that have been used to assess the operation of these services, in comparison to both other health services and drug services operating prior to regionalisation

» To describe how data systems are used to support the implementation of drug policy through regionally administered services.

The research questions closely reflect these aims:

1. What arrangements are made for the clinical governance of drug services that are administered at a regional level?

2. In what manner do regionally administered drug services demonstrate adherence to national policy as articulated in drug strategies or similar documentation?

3. Describe the management of relations between regional health authorities and non-government organisations or other civil society actors charged with implementing policy and delivering services.

4. What is the nature of the relationship between regionally administered drug services and primary care services?

5. What indicators/metrics have been used to monitor the regionalisation of drug services?

The Health Research Board (HRB) specified that an evidence review was to be completed, including a comprehensive summary of the existing peer-reviewed and grey literatures. A systematic approach was needed so that all relevant papers could be identified and assessed, leading to the extraction and synthesis of data in line with a systematic and transparent set of methods. In order to satisfy these requirements, we employed state-of-the-art information search and retrieval techniques to maximise the probability of finding relevant academic articles, official reports, theses, unpublished research, and advocacy documents. Our extensive and systematic literature review meets the standards set by the Cochrane Collaboration, being based on a clear set of objectives, predefined criteria for determining eligibility, an explicit and reproducible methodology, a powerful search strategy, and a systematic synthesis of their design and findings (Higgins *et al.*, 2019).

In order to provide some context for our analysis of the regionalisation of drug treatment services in Europe, we also reviewed recent (2020–2024) reports published by the World Health Organization/European Observatory on Health Systems and Policies for the case study countries (Appendix C), as well as national reports published by the European Union Drugs Agency (EUDA), mainly in 2019 (Appendix D). These publications describe the structure of the national health service in each of the countries we studied, the degree of integration of drug treatment services within the health care system, and the organisation of these treatment services at national, regional, and local level.

In Chapter 2, we provide an introduction to the concept of regionalisation and discuss the reorganisation of health service provision in Ireland. This initial discussion is important in order to ensure that we get as much value as possible from the subsequent analysis. A greater awareness of the context in which reforms are being implemented in this country will enable us to draw attention to relevant policies in other countries. In Chapter 3, we provide a detailed overview of the literature searches that we carried out, including screening, assessing, and synthesising relevant publications. These searches were carried out using two different approaches: searching bibliographical databases on the one hand, and analysing institutional websites on the other. At the end of Chapter 3 we also summarise the discussions that we held with experts in some of the case study countries. In Chapter 4, we describe the administration and governance of drug and alcohol treatment services in each country, drawing on the evidence that we uncovered. Finally, in Chapter 5, we draw these different strands together with the aim of answering the research questions that were originally posed by the HRB.

This evidence review has three main strengths. Firstly, it covers the existing literature very comprehensively by using state-of-the-art techniques and technologies for searching databases, repositories, and websites. This is important when studying topics which have not yet received a significant amount of research attention. Secondly, it is structured around a comparison between eight countries, which provides insights into the similarities and differences that exist between regionalisation processes as they are implemented in distinct national contexts. Thirdly, by incorporating evidence from interviews with experts in these countries, the review provides more policy-relevant information than would otherwise have been possible, shedding light on how managers, service providers, and professionals respond to these policies.

There are also a number of weaknesses, however, which should be borne in mind when interpreting the results and when seeking to draw lessons from this review. Firstly, it is based primarily on policy documents and descriptive accounts of regionalisation, rather than rigorous empirical research which addresses specific aspects of this process. The scientific literature on the regionalisation of drug and alcohol treatment services is at an early stage, which means that existing accounts are rather informal and focus primarily on policy documents and institutional arrangements. Secondly, regionalisation is a path-dependent process which is heavily influenced by existing state forms and administrative traditions. As this study covers eight countries, it does not provide a comprehensive picture of regionalisation in Europe; at the same time, there is not enough space to provide a detailed account of regionalisation processes within each national context. What emerges from the review is thus an overview of strategies, policies, and organisational forms across a range of different contexts.

2 Regionalisation

2.1 Recent trends and debates

Before summarising recent debates, it may be helpful to clarify a few key concepts. The first of these is obviously regionalisation, which can assume many forms, as we noted in Chapter 1. This concept raises the issue of how services are managed across the national territory in relation to the spatial articulation of administration (Quigley *et al.*, 2019). In all forms of regionalisation, power sharing is of central importance, and the distribution of funds, legislative mandates, responsibilities, and roles are generally set out in law. Regionalisation may sometimes involve decentralisation, with the shifting of certain activities and responsibilities away from the central administration.

The concentration of specialised procedures in high-volume hospitals (rather than small local hospitals) is sometimes referred to as regionalisation (Ramos *et al.*, 2020). In Canada, the division of the national territory into 10 autonomous provinces and 3 territories is taken for granted, and the term 'regionalisation' is only applied to the decentralisation of decision-making at a sub-provincial scale. Because of the variety of organisational forms and institutional structures involved, it is impossible to provide a generally valid answer to questions about the efficiency or effectiveness of health care regionalisation (Costa-Font and Turati, 2018; but see Montero-Granados *et al.*, 2007).

Devolution refers to the transfer of political accountability to a lower level in the administrative hierarchy, but it is possible for administrative control to be decentralised without any shift in political accountability; this kind of change is often referred to as 'deconcentration'. In some cases, only a single service or procedure is regionalised, while in others, responsibility for the entire health service is devolved.

Health policy decentralisation is currently advocated by the International Monetary Fund, the World Bank, and the European Union on the grounds that it improves efficiency (Rincker and Battle, 2011). Several European countries – including the UK, Italy, France, Belgium, Portugal, and Spain – introduced regionalising health reforms during the last two decades of the 20th century (Montero-Granados *et al.*, 2007). One of the reasons for regionalising in recent years is widespread concern about rising costs; governments often view regionalisation as having the potential to improve efficiency and to enhance efficacy, ultimately reducing costs (Nesvaag and Lie, 2010). In Europe, interest in health care regionalisation dates back more than 100 years:

> *The literature shows the Dawson Report as one of the first and main documents to concern regionalization in 1920. The author pictured an integrated healthcare system wherein the prevention of diseases and healthcare promotion would be coordinated, including primary, secondary and tertiary care of both short and long term serving to organize health services in territories specifically selected for such services. (Ramos et al., 2020, p. 2)*

In economics, the 'theorem of decentralisation' (Oates, 1972) states that shifting responsibility for the production of public goods and services away from the central State is generally more efficient, although this can give rise to problems of fiscal discipline and accountability (Ferrario *et al.*, 2023). Second-generation economic models suggest that a better alignment of spending and tax autonomy leads to stronger electoral accountability of local politicians. In the case of administrative autonomy, incentives and accountability are structured differently, which suggests that health regionalisation in countries that implement reforms based on deconcentration rather than devolution is likely to work in a different way than in countries that have also decentralised fiscal responsibility and political decision-making (e.g. federal countries, regional states, decentralised political systems).

Several positive mechanisms have been associated with health service regionalisation: (1) greater sensitivity to and understanding of local needs and conditions; (2) greater potential for service integration due to the concentration of services under a single manager; (3) a clearer definition of the population to be served; (4) greater ease of participation by service users and citizens; and (5) stronger incentives to reduce demand for treatment. Regionalising reforms may meet with resistance, to the extent that they place pressure on hospitals to reduce expenditure, push health workers to increase productivity, and call into question the long-standing boundaries between sectors and professions (Marchildon, 2019).

The second concept relates to drug and alcohol treatment services, which are provided by a range of organisations that are funded and coordinated in different ways. They include inpatient services such as detoxification units; hospital-based treatment units; residential or outpatient drug and alcohol treatment centres; therapeutic communities; and treatment units in prisons. Outpatient drug and alcohol treatment services are typically provided by specialised organisations, including pharmacotherapy and/or socio-psychological services (e.g. counselling, therapy, training, practical assistance). In addition to treatment services, we will refer to prevention and recovery services as appropriate.

This study tackles the issue of governance in regionalised drug and alcohol treatment systems, and this is mentioned in the research questions. Governance refers to the way in which society manages its affairs through interactions within and among state agencies, voluntary organisations, and private firms (Holt *et al.*, 2018). In the context of drug and alcohol treatment services, the concept of governance raises the issue of how these services are coordinated and administered at different levels, against the backdrop of decentralisation/deconcentration policies (Exworthy *et al.*, 2010). The failure to ensure effective governance of mixed, regionalised treatment systems is likely to generate dissatisfaction and criticism, as well as obstructing the achievement of policy goals.

During the 1980s and 1990s, networks of public and private organisations which were seeking to tackle drug-related harms emerged in many European countries, and similar governance structures were set up in several cities, often involving a body with a consultative function that included representatives from a wide range of organisations. Wälti and Kübler (2003) describe how a 'new governance' approach developed as policy-makers were unsure about how to respond to the rapid increase in drug-related problems; the new system provided them with a way of retaining their legitimacy while devolving authority to a new arena of policy-making that included relevant organisations and agencies. This is a good example of how the processes of decentralisation and governance can be linked.

The main tasks of clinical governance are to: (1) continuously improve the quality of services; (2) safeguard standards of care, ensuring optimal outcomes; and (3) actively involve patients in the planning, provision, and evaluation of their care (National Treatment Agency for Substance Misuse, 2006). The logic of clinical governance relies on the generalisation of best practices based on clinical evidence, ensuring that these practices are implemented at local level. The implementation of standardised models of treatment and care pathways needs to be monitored, through clinical audit or the use of performance indicators.

Finally, it is helpful to mention three concepts that are often used when discussing decentralised treatment systems: integration, collaboration, and coordination. The greater integration of services – across different fields of health care or distinct sectors of provision – has been a strategic goal of policy-makers and administrators for more than two decades, and is associated with themes that are central to policy-making. Integration is sometimes seen as holding potential for improving the quality of care while reducing costs:

> *Integrated care encompasses acute, primary, community and social care services/ local authorities and involves public and private providers; patients and service users, and their families and carers; health and social care professionals; and the voluntary sector. They all work together in a joined-up way around the assessed needs of the person and the population. (Department of Health, 2023, p. 13)*

Closely associated with service integration is collaboration, which refers to interactions between members of different specialties, sectors, and disciplines. One way of achieving integrated service provision is through the promotion of inter- and trans-disciplinary collaboration. Bjørkquist and Hansen (2018) provide a useful description of the different forms of collaboration that are possible:

> *Information exchange is the simplest form, often involving casual contact between employees from different agencies … Case coordination usually indicates that an employee of one of the agencies providing services works across agencies to create a common and comprehensive program for a client. Interagency meetings involving staff from different organizations are used to discuss and coordinate measures for common clients. In multidisciplinary teams, employees work together for a long period. … Co-location can enhance collaboration, since employees are in close physical proximity, and clients will often get "one door" to access services. Pooled budgets are the most complex form of collaboration and generally also include the other forms. (Bjørkquist & Hansen, 2018, p. 235)*

Finally, while collaboration refers to horizontal interactions at the same level of the system, the term 'coordination' is generally used to describe the organisation of service provision from above (Bjørkquist and Hansen, 2018). This does not imply that the same actions are implemented in each locality, but rather that local actions may be considered appropriate in terms of national policies and strategies. As Holt *et al.* (2018) observe, coordination is about aligning and orchestrating tasks and activities in order to achieve shared goals. So, in a regionalised system, regional managers might be tasked with playing a coordinating role when defining actions which are appropriate to their local context, but which are also capable of achieving national goals (Oldeide *et al.*, 2019). Inter-organisational relationships tend to be crucial to the exercise of decentralised powers, as the decline in vertical concentration permits more intense horizontal interactions if these are encouraged and incentivised (Exworthy *et al.*, 2010).

In short, contemporary systems of welfare provision involve both coordination from above and horizontal collaboration, using multilevel governance arrangements that are characterised by a division of roles and responsibilities involving public and private actors. This generates a complex institutional structure that seeks to encourage appropriate forms of service provision using incentives and standards. At the same time, however, this structure is influenced by powerful actors and interests both inside and outside the welfare system, giving rise to a dynamic balance between centralising and decentralising tendencies.

In the next section we will describe one of the most important theoretical models that influenced the reform of welfare systems in Europe during the 1990s, which is generally referred to as New Public Management (NPM) (Hood, 1991). Inspired by right-wing think-tanks and implemented by Margaret Thatcher's government in the UK, this philosophy emphasises the importance of market-based competition and performance measurement as ways of achieving efficiency gains and improving public services. Following the implementation of marketisation and managerial reforms in the UK, many other European countries emulated this approach, while adapting these policies to their own institutional context (Storbjörk and Stenius, 2019a).

2.2 NPM and post-NPM reforms

NPM reforms typically involve structural devolution, marketisation, and managerialism, as they characterise the central State as overloaded and inefficient. In classical liberal political theory, the state administration is treated as a means of forcing inefficient and potentially unreliable politicians to delegate tasks to a competent bureaucracy (Ferrera, 2014). Neoliberalism recognises that the state bureaucracy may also be inefficient, and this position also influenced NPM. The latter challenges the socio-democratic welfare state and seeks to shift the welfare system towards market-based delivery, transforming 'citizens' into 'customers'.

Christensen and Lægreid (2009) draw a distinction between 'input democracy' and 'output democracy', with the former involving elections and the latter involving direct connections between citizens and the state bureaucracy. Output democracy focuses on managerial rather than political accountability, including the ex-post measurement of performance. This notion enables us to appreciate how NPM reforms also recast the relationship between citizens and the state by emphasising service users' ability to modify state welfare by choosing between rival services ('voting with their feet') or by expressing their preferences in various ways (customer satisfaction forms, complaints procedures, ratings, etc.). This aspect of NPM has been described as 'empowering the people', as it presents itself as democratic and participatory.

By contrast, post-NPM reforms focus on restoring central control and coordination (Christensen and Lægreid, 2009, p. 6) and tend to adopt a more holistic strategy. These reforms, adopted in the late 1990s under the banner of 'joined-up government' (the term used in 1997 by the Blair government), recognise the potential inefficiencies of markets and decentralised systems of provision. At the same time, key elements of NPM policies are maintained, albeit with greater emphasis on the coordination and integration of devolved and outsourced services. In the UK, this has led to a combination of centrally defined standards and decentralised commissioning of services, which requires a complex (and costly) governance structure (Exworthy *et al.*, 2010). Over the past 10 years, a similar tension has become visible along the spectrum between patient choice and standardised clinical pathways, further complicating the process of clinical governance. Integration between and within different forms of service provision is the main concern of these reforms, as NPM is widely perceived to have led to excessive fragmentation:

> *In response to these challenges and NPM's emphases on efficiency, control, and narrow responsibilities, post-NPM reforms and philosophies have sought to attenuate the problems or even replace NPM by various coordination and cooperation improvement efforts; re-centralization and functional or horizontal re-integration; partnerships; and by encouraging values such as equity, citizenship, and democracy (including re-politicization and political accountability). (Stenius and Storbjörk, 2023, p. 37)*

Because post-NPM reforms seek to improve the coordination and integration of services without returning to the organisational forms associated with the post-war welfare state, they tend to focus on accountability and monitoring (Christensen and Lægreid, 2009). In this way, those who exercise delegated authority as a result of decentralisation or outsourcing are held accountable to the central State. Accountability is achieved by assessing the ability of service providers (and those involved in commissioning services) to achieve specified objectives. For these reasons, post-NPM policies tend to emphasise the role of service managers in achieving organisational change; rather than exacerbating competition between service providers (as in NPM), administrators are viewed as essential to the new balance between centralising and decentralising tendencies.

Another important component of post-NPM policies is that they seek to involve civil society actors in designing and delivering services. Once again, this coincides with a 'Goldilocks' strategy which seeks to plot a course between the competitive private market on the one hand and self-referential state bureaucracies on the other. The participation of citizens and service users and the involvement of voluntary organisations within the welfare system is a hallmark of this strategy. These forms of participation tend to lead to pressures for the greater decentralisation of decision-making, which is why governance structures must simultaneously be strengthened. Once again, managers are tasked with mediating between these different pressures and ensuring that services are effective from the perspective of local people and efficient from the perspective of central government.

The preceding discussion helps to explain why the success or failure of post-NPM policies often depends on the kind of regional administrative structures that are put in place. Regional managers exemplify the search for a balance between different pressures originating at the centre and the periphery of the welfare system. They are called upon to find ways of modifying service delivery to satisfy the needs and respond to the preferences of service users and local communities, primarily by pursuing new forms of integration, coordination, and involvement. At the same time, they are expected to be accountable to the central administration and to national policy-makers. This accountability is often operationalised through the adoption of national plans, guidelines, and indicators.

Christensen and Lægreid (2009) describe the 2009 Norwegian White Paper *An Administration for Democracy and Community* (St. meld. nr. 19) as an example of a post-NPM reform. Underlying this White Paper is an awareness of the need to find a balance between local autonomy and equal treatment, and between organisational specialisation and the integration of services. It emphasises that true democracy implies the possibility of participating in decisions outside the context of elections:

> *One major post-NPM element is the view that the major challenges in contemporary society demand that more societal sectors work together. The paper asserts that such challenges, whether national or international, create the need for new collaborative forms and new competence, without being very specific on this point. A post-NPM perspective is also evident in the statement that decisions further down in the hierarchy must have a clear anchoring on the central level, sending a message of more central control to balance autonomy. Post-NPM concerns are also obvious in the requirement that increased variety must be met by standardization, more holistic competence developed, and that service should be more seamless across sectors and have clearer overriding priorities. (Christensen and Lægreid, 2009, p. 17)*

The Norwegian White Paper emphasises the importance of maintaining a high level of involvement of trade unions and other organised interests in the formulation of policy, which is a traditional element of the cooperative Nordic model. This raises the question of path-dependency, which is discussed in the next paragraph; we will return to the Norwegian case later in this report.

It is important when analysing the ways in which welfare policies have evolved over time in different countries to recognise the ways in which previous decisions place constraints on current reforms. The nature of existing structures, interests, and forms has a considerable influence on the policies that are adopted in each country, leading to a degree of continuity over time. This implies that new ideas and approaches are inevitably reinterpreted and modified when they are adopted within a given country. For example, the implementation of NPM reforms was different in Southern Europe than it was in Anglo-Saxon countries, and the same is true of the Nordic countries. In some countries, attempts to introduce reforms have failed. In Greece in 2001, the Socialist Government approved a law to establish regional health authorities, bringing hospitals and primary health care centres under a unitary management structure. This was intended to encourage the administration to implement more efficient and effective health policies. However, this reform was never implemented as intended and decision-making authority was never transferred:

> *State-government's lack of political will to push for regional health policy, a culture of bureaucratically centralised governments, opposition to decentralising reforms from key interest groups and lack of political consensus among political parties in order to provide broader access to health services, have all proven to be the main obstacles to equitable regional distribution of health services and resources. (Athanasiadis et al., 2015, p. 63)*

In conclusion, it is apparent that as the wave of NPM reforms reverberated across Europe during the 1980s and 1990s, the policies adopted at national level often involved modified neoliberal solutions that were quite different to those originally implemented in the Anglo-Saxon countries. There were even differences between the reforms implemented in the UK, Australia, and New Zealand, with Ireland following an alternative model that involved a stronger degree of conservative subsidiarity, as opposed to radical, market-based decentralisation. Over time, most European countries have reformulated or even abolished their NPM policies, due to internal obstacles and conflicts. In Italy, for example, regional devolution in the 2000s enabled many parts of the country to resist the marketising thrust of the reforms that had been introduced during the 1990s. In the next section, we will describe the evolution of the Irish welfare system from the perspective of NPM and post-NPM reforms, which will provide further insights into the context of the contemporary regionalisation process.

2.3 The Irish context

Ireland is often described as a unitary country with limited local autonomy; local government spending and local tax revenues are among the lowest in Organisation for Economic Co-operation and Development (OECD) member countries (Turley, 2025). Prior to the establishment of the HSE in 2004, the Irish health service was governed centrally and care was delivered through a system of Health Boards. Healthcare was delivered by services that were owned and administered by Health Boards, voluntary organisations, and private practitioners. The Irish health service is also characterised by a two-tier structure where those who can afford to pay for services have better access to treatment, and Ireland is the only European Union country that does not have a primary health care system with universal coverage.

The Sláintecare programme aims to reduce these disparities (Fennelly *et al.*, 2024) by moving towards an integrated model of care that is delivered through six Health Regions, which operate as geographically aligned, integrated subdivisions of the HSE (Department of Health, 2022).[2] These Health Regions do not have autonomous legal status, and the Department of Health (2023) describes them as "operational regions with responsibility for the planning and coordinated delivery of health and social care services within their respective defined geographies". They are led by a Regional Executive Officer who reports directly to the Chief Executive Officer and Board of the HSE. As such, the HSE Health Regions follow a trend that is often found in Anglo-Saxon countries; in recent years, Canada, New Zealand, and (parts of) Australia have also created health regions that have no accountability to local government (Marchildon, 2019).

2. The Health Regions are named as follows: HSE West and North West; HSE Dublin and North East; HSE Dublin and Midlands; HSE Mid West; HSE Dublin and South East; and HSE South West. The Greater Dublin area is thus split between three different Health Regions, without following the boundaries of the *local authorities*. See: https://assets.gov.ie/static/documents/hse-health-regions-implementation-plan.pdf (consulted in September 2025).

Although the rationale for this reform has never been set out clearly (Schulmann *et al.*, 2024), a number of considerations appear to have led to the introduction of the HSE Health Regions, including a perceived lack of flexibility and accountability within the centralised HSE, poor coordination across administrative levels, obstacles to integrated care, and a need to improve the system of resource allocation (Quigley *et al.*, 2019). As Barry *et al.* (2021) observe, in recent years the Irish health system has been "caught in a series of reorganisational reform false starts, a pattern of repeating phases of *a)* policy intent and planning that *b)* remain substantively unimplemented" (p. 6). The publication of the Sláintecare Report signals, for the first time, cross-party political consensus on the direction of health reforms:

> *Central to Sláintecare's vision is a decentralised health service wherein resources are allocated based on population health need, and delivery is integrated across primary, acute and social care services and settings. The introduction of new regional health structures, known as Health Service Executive (HSE) Health Regions (previously termed Regional Health Areas, RHAs), planned for the first months of 2024, represents a significant structural reorganisation of the health service. (Schulmann et al., 2024, p. 3)*

Because procurement and overall responsibility for spending remain centralised, contracts with private firms and voluntary organisations will potentially cover multiple regions. This is particularly important at the interface between the health service and the social care system, which includes many different kinds of organisations working at different scales:

> *The Health Region will agree the contractual relationship with the voluntary organisation and define the service level agreement (SLA) within agreed national standards. This will allow them to incorporate their own region-specific service delivery needs into the SLA, within the limits of national standards and guidelines. Consideration will be given to having a singular SLA with entities that provide services across multiple Health Regions. (Department of Health, 2023, p. 19)*

The boundaries of the Health Regions were determined to accommodate existing patterns of access to services, which means that they are relatively self-contained in terms of health needs. In contrast with the Community Health Organisations and Hospital Groups which preceded them, the HSE Health Regions have a clearly defined role in meeting the health needs of a specific population. This feature removes any remaining obstacles to the system-wide adoption of the population-based resource allocation model developed by the HSE National Health Intelligence Unit, similar to the systems in use in countries such as Scotland and New Zealand.[3] MacGregor and Thickett (2011) argue that as social problems (including drug- and alcohol-related harms) are concentrated in specific areas, it is necessary to redistribute resources from richer to poorer localities and to ring-fence resources for vulnerable and stigmatised groups. The HSE Health Regions are expected to distribute resources within their boundaries using similar techniques in order to target services at the communities and social groups that are in greatest need of them.

3. The 2021 report by Dame Carol Black also recommends this form of resource allocation.

On 1 October 2024, the Health Region management structure officially replaced the Community Healthcare Organisations and Hospital Groups, which had previously been reponsible for managing the primary health and hospital care systems, respectively.[4] Hirschovits-Gerz *et al.* (2019) maintain that "needs assessments are best when performed at the local level, close to decision makers, to ensure accountability, responsibility, and the accuracy of information" (p. 77). Within the confines of national frameworks and clinical programmes, the HSE Health Regions will seek to analyse the health needs of their populations and to develop plans to meet them:

> *The organisation of the HSE along clear regional lines aims to facilitate the delivery of integrated health and social care designed around people and planned around communities. Integration will be achieved through the alignment of hospital- and community-based services and through a holistic partnership with general practitioners (GPs), Pharmacists, and the fuller range of health service providers at regional and at national level. This will see Health Regions function as part of a strengthened national health and social care service with their own budget, their own Executive Management Team, and increased local autonomy and decision-making. (Department of Health, 2023, p. 10)*

The Sláintecare programme aims to exploit synergies between services and to provide timely, free, and integrated health and social care to the population (Oireachtas Committee on the Future of Healthcare, 2017). This will facilitate waiting time guarantees for hospital care, expanded hospital capacity, and the phased elimination of private care in public hospitals. Community mental health services are to be improved and expanded in order to ensure easier access to services within the primary care system (Oireachtas Committee on the Future of Healthcare, 2017, p. 16). Sarah Treleaven (formerly Principal Officer at the Department of Health and Lead for the introduction of the HSE Health Regions) provides the following outline of the rationale underlying this process:

> *The idea was that if you were doing this, if you were setting up catchment areas or geographies that they would be closer to knowing what it is that their particular population needs. And therefore, it would make sense to have a degree of more decentralised decision-making. Not entirely - we're having this push-pull between national consistency and regional decision-making. It was this perspective, it was this spectrum, where we were always trying to find the sweet spot. … What the Department wants to do is focus on what priorities or outcomes they want to see, and then leave the how and the mechanisms to the Regions. (Interview with Sarah Treleaven, 30 October 2025)*

Implementation of the Sláintecare programme is also expected to lead to a stronger integration of drug and alcohol treatment services within the wider health service. As a consequence, these services must be brought into alignment with the emerging regional institutional structure in terms of geography, referrals, the integration of services, and the participation of non-state organisations:

4. "HSE Health Regions aim to facilitate comprehensive integrated, person-led, community-first health and social care through the alignment of acute and community-based services." See https://www.gov.ie/en/department-of-health/publications/hse-health-regions/#hse-health-regions-a-case-for-change (accessed in September 2025).

> *The coordination and delivery of health and social care services along regional lines aims to facilitate more integrated care for patients and those who use our services across the country. It also aims to enable a coherent population-based approach to service planning and delivery, where care is planned and funded in line with people's needs at regional and local level. (Interview with Sarah Treleaven, 30 October 2025)*

It is therefore necessary to determine: (1) the appropriate spatial level of service delivery for drug and alcohol treatment; (2) how people will access these services; (3) how they will be integrated with mental health services, social/employment/housing/social care services, and general health services; (4) how private and voluntary organisations will contribute to service delivery; and (5) how clinical and corporate governance will be ensured. As we noted previously, the present report aims to contribute to the identification of appropriate solutions to these challenges. At the same time, it is important to be aware that there is a lack of clarity surrounding the HSE Health Regions themselves, and a range of tensions and conflicts are likely to influence their development in the coming years (Schulmann *et al.*, 2024).

Each of the 6 HSE Health Regions will have between 2 and 4 Integrated Health Areas (IHAs), each of which will have in the region of 150,000–300,000 residents.[5] Each IHA will be divided into Community Healthcare Networks (CHNs), each of which will have about 50,000 inhabitants. The catchment areas of the CHNs are designed to respect administrative boundaries and to ensure a degree of continuity between the old and new systems of service delivery (Department of Health, 2023). The CHNs form a set of low-level spatial units that can be used for evaluating existing services or planning new ones. Each group of three CHNs will have one or more Community Specialist Teams (CSTs), which are multidisciplinary health care providers that aim to avoid unnecessary hospital referrals for elderly people and those with chronic conditions. Sarah Treleaven describes how these boundaries were defined:

> *It was a big mapping exercise to actually map patient pathways. So if a patient in a particular area lives here… so there's an empirical side to it as well. And there were a number of options considered. There were several, I think there were eight different options considered, when it came to setting the six regional boundaries. And then similarly for the IHA boundaries, I'd say that per region… I think that for one region, we had five different options to consider. (Interview with Sarah Treleaven, 30 October 2025)*

Service integration is expected to take place at all levels of the system based on incidence rates; more common conditions should be addressed at local level, while rare or more complex conditions should be managed by national centres. As primary care plays an essential role in the integration of services across the continuum of care (Marchildon, 2019, p. 4), this is a crucial aspect of the Irish reform:

> *The existing 96 Community Healthcare Networks (CHNs) and the Community Specialist Teams (CSTs) will act as the building blocks of integrated service delivery, and each Integrated Health Area will be comprised of multiple CHNs/CSTs and will have primary access to at least one hospital. Integrated Health Areas will also partner with local social services, non-governmental organisations (NGOs), local authorities, and other public bodies. (Department of Health, 2023, p. 27)*

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5. The IHAs are not to be confused with the Integrated Service Areas (ISAs), which were established by the HSE in 2010 to deliver regionalised, integrated care from a population health perspective, but never achieved their goals (see Barry *et al.*, 2021).

It is expected that some highly specialised services will continue to be centralised within the HSE. For example, the National Working Group for Dual Diagnosis (2023) calls for the establishment of a single National Dual Diagnosis Rehabilitation Centre. Nevertheless, a key aim of integrated service provision is to improve the management of chronic conditions at local level, as these tend to absorb a large share of resources within the health service. By enhancing the ability of the primary care network to provide care, it is believed that better outcomes can be achieved while reducing hospitalisation rates. The Oireachtas Committee on the Future of Healthcare (2017) notes the need for clinical leadership within primary care in order to reach this goal, and underlines the importance of instituting a system of free primary care for the entire population.

Substance use disorders (SUDs) are frequently described as chronic, relapsing health conditions with many similarities with other chronic conditions such as diabetes, epilepsy, depression, and hypertension.[6] One way of approaching the integration of drug and alcohol treatment services within the new regionalised health service is thus to follow the recommendations of the Oireachtas Committee on the Future of Healthcare, the Department of Health, and the HSE regarding the treatment and management of chronic conditions. This is in line with the prevailing approach in many other European countries, as we will see in later sections of this report.

The key features of national strategy in this regard are: (1) the grounding of service provision in a strengthened and universal primary care system; (2) the establishment of clinical leadership within primary care for each condition or type of condition; and (3) the provision of specialist care at an appropriate geographical level, outside the hospital system, via a network of service providers, preferably located in or near disadvantaged communities. By integrating treatment services for SUD within the regional health system in this way, the capacity of the system to promote population health and well-being will be enhanced, with positive externalities for the other services that form part of the regional network.

A key component of national strategy in relation to the prevention and treatment of SUD is the network of Local Drug and Alcohol Task Forces. These were originally established in the 1990s to provide a coordinated response to the harms associated with drug use, particularly in disadvantaged urban areas. A key aspect of the so-called 'Drugs Initiative' was its determination to respond to the concerns of local communities by working with them, following the decentralised governance model we described earlier. Local Drug and Alcohol Task Forces were expected to bring together organisations and individuals from the statutory, community, and voluntary sectors to develop an integrated, locally based response to problem drug use in specific areas. The Drugs Initiative is widely perceived to have been a success, as it was followed by a reduction in drug-related deaths and crime. Nevertheless, this aspect of national strategy is likely to be revised once the role of drug and alcohol treatment services within the HSE Health Regions has been determined.

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6. The National Institute on Drug Abuse (in the United States of America (USA)) treats SUD as "a chronic, relapsing disorder characterized by compulsive drug seeking and use despite adverse consequences" (https://nida.nih.gov/publications/drugs-brains-behavior-science-addiction/drug-misuse-addiction, consulted in September 2025). SUD is defined as a brain disorder because it involves functional changes in the brain circuits involved in reward, stress, and self-control. In 2013, the American Psychological Association updated the *Diagnostic and Statistical Manual of Mental Disorders* to include a category for SUD (which can be mild, moderate, or severe), suggesting that the term 'dual diagnosis' refers to a situation where SUD co-occurs with another type of mental health disorder. The World Health Organization (2020) also observes that drug use disorders "often take the course of a chronic and relapsing disorder" (p. 6).

One way in which clinical leadership is currently exercised within the Irish health service is through Integrated Care Programmes for chronic disease. Another form of leadership involves National Clinical Programmes (NCPs),[7] which: (1) indicate models of care based on population health; (2) are patient-centred; (3) promote a multidisciplinary approach; and (4) are integrated across service domains. There are currently 32 NCPs relating to a range of fields, including Disability, Mental Health, Obesity, and Self-Harm. Barry *et al.* (2021) argue that NCPs should be the main reference point when seeking to develop new models and pathways of care based on the needs of a population (see also Department of Health, 2023). The introduction of an NCP for SUD would help to focus attention on the identification of evidence-based clinical pathways, treatment options, and the integration of services (Doyle and Ivanovic, 2010). This could build on the HSE's National Drugs Rehabilitation Framework[8] and the 2013 evaluation of the pilot project that was carried out at 10 sites (Barry and Ivers, 2014).

The 2021 mid-term review of the national drug strategy *Reducing Harm, Supporting Recovery: A health-led response to drug and alcohol use in Ireland 2017-2025* included the aim of developing integrated care pathways for high-risk drug users. Coordinated reform at local level will be required in order to promote multidisciplinary teamwork and seamless care provision for this group, as "Community-based clinical leads are ideally placed to provide clinical leadership to a multidisciplinary team that is tasked to provide seamless integrated care for patients" (Oireachtas Committee on the Future of Healthcare, 2017, p. 77).

When considering the organisation of treatment, it is important to consider the relationship between: (1) drug and alcohol treatment services; (2) primary care services; and (3) mental health services. The Oireachtas Committee on the Future of Healthcare (2017) identified a need for a significant improvement in access to psychological therapies within primary care:

> *Given the limited availability of talk therapies in community mental health teams, extending counselling in primary care is a way of addressing mental health needs at a lower level of complexity, providing universal access to 6-8 counselling sessions for those whom their GP determines is in need of the service. (Oireachtas Committee on the Future of Healthcare, 2017, p. 63)*

The National Working Group for Dual Diagnosis (2023) observes that approximately one-half of those attending community mental health services have a comorbid SUD, and that between 75% and 85% of those attending alcohol and drug treatment services have a recent history of psychiatric disorder. The solution it proposes is the following:

> *In the HSE, Dual Diagnosis services will be a tertiary level service providing support to Community Mental Health Teams, Community Child and Adolescent Mental Health Teams, acute inpatient psychiatric units for both adults and adolescents, HSE addiction services (HSE Social Inclusion), community, voluntary and HSE-funded organisations, including Section 39 agencies. (National Working Group for Dual Diagnosis, 2023, p. 10)*

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7. See: https://www.hse.ie/eng/about/who/cspd/about/ (consulted in September 2025).
8. This is a set of practice guidelines for addiction services, which were developed by the National Drug Rehabilitation Implementation Committee.

This implies that mental health services and addiction services will function at the secondary level in collaboration with primary care providers and social care services. The role of Dual Diagnosis services will be to support other services and to promote collaboration; they would share responsibility for clinical governance in the case of patients with dual diagnosis (National Working Group for Dual Diagnosis, 2023, p. 10). This approach is in line with recommendations by the UK National Institute for Health and Care Excellence, which suggested in 2016 that the creation of separate services for dual diagnosis patients would not represent the best evidence-based practice (cf. Weaver *et al.*, 2004).

The aforementioned Dual Diagnosis Teams would cater for catchment areas of around 300,000 but, according to the National Working Group for Dual Diagnosis, they would only coordinate services for individuals with more severe mental illness and less severe SUDs. The assignment of patients based on vague definitions like 'severity of illness' or 'main diagnosis' appears unsatisfactory. Both *Sláintecare* (2017) and *Sharing the Vision* (2020) – the national mental health policy – call for an integrated approach to service provision for those with comorbid mental illness and SUDs. *Sharing the Vision* thus reverses the recommendation that was in *A Vision for Change* regarding the role of Dual Diagnosis Teams. These are no longer to be restricted to those 'whose primary difficulty is mental health', and this report indicates that "a tiered model of integrated service provision for individuals with a Dual Diagnosis (e.g. substance misuse with mental illness) should be developed to ensure that pathways to care are clear" (Action 57):

> *[A Vision for Change] recommended that specialist mental health services should support only individuals 'whose primary difficulty is mental health'. This recommendation is now reversed. Individuals with co-existing mental health difficulties and addiction to either alcohol or drugs should not be prevented from accessing mental health services. Consequently, it will not be necessary to establish whether a mental health difficulty is 'primary' for an individual to access the support of a mental health team. (Department of Health, 2020, p. 53)*

It is likely, therefore, that Dual Diagnosis Teams will operate as a specialist resource for Community Mental Health Teams (CMHTs) and addiction services to draw on without creating barriers for people with SUD to access mental health care. This is also in line with World Health Organization (2020) guidelines, which state that "abstinence from substance use cannot be a condition for initiating the treatment of comorbid mental disorders" (World Health Organization, 2020, p. 67). This issue was highlighted in the *Report of the rapid expert review of the National Drugs Strategy 2009–2016*:

> *The problem of access to mental health services was raised time and again during the review. As highlighted above there is a need to take the opportunity of the update of the Mental Health strategy to recognise the importance of addiction and mental health services jointly addressing the needs of people with co-occurring addiction and other mental health problems. (Griffiths et al., 2016)*

As recommended in *A Vision for Change*, it is essential to establish clear and unequivocal linkages between addiction services, primary care, and mental health services, without duplicating services, in order to facilitate the development of an integrated approach. *A Vision for Change* makes a strong case for radically rethinking the provision of mental health care in Ireland, noting the lack of development of a range of services:

> *A comprehensive mental health system exists when mental health activities – from community support groups, to voluntary groups, to primary care, to specialist mental health services – work in an integrated, coordinated fashion for the benefit of all people with mental health difficulties. There is currently no such system in Ireland. The current structure of mental health services, where they are seen as not only separate from other health services, but separate from the community in which they operate, promotes the continuing exclusion and stigmatisation of people with mental health problems. (Expert Group on Mental Health Policy, 2006, p. 6)*

The co-location of services and coterminous catchment areas would promote an integrated approach and encourage collaboration under regional management structures: "One model uses colocation services, described as a 'one-stop shopping' centralized approach in which substance abuse treatment, primary medical care, and mental health services are accessible at a single site. Alternatively, in a distributive model, the sites providing care can be linked by more effective systems to refer patients between sites" (Samet *et al.*, 2001, p. 86).

A Vision for Change observes that "purpose-built, 'multi-function', health centres allow much greater integration between the services located there, and create a natural communication network between the services located under one roof" (Expert Group on Mental Health Policy, 2006, p. 66). The National Working Group for Dual Diagnosis (2023) suggests that, as a starting point for patients with comorbid mental illness and SUDs, there should be monthly case meetings between the specialist Dual Diagnosis Team, CMHT, SUD Team, and any Section 39 agencies involved in the provision of care, and this also reinforces the rationale for co-locating services.

The national drugs strategy *Reducing Harm, Supporting Recovery 2017-2025* also recommends an integrated approach to service delivery, with partnership between the statutory, community, and voluntary sectors. Extending the concept of service integration to embrace non-state organisations is arguably useful in this context. However, this kind of integration will require the development of joint protocols between mental health and SUD services with strong clinical and corporate leadership.

The National Working Group for Dual Diagnosis (2023) states that a full network of CMHTs has yet to be created, although *Sharing the Vision* (Department of Health, 2020) states that there were 114 such teams in 2017. The national strategy refers to the need for one CMHT per CHN, based on a population of around 50,000, which suggests that the network may only need to be aligned more precisely with the CHNs (recommendation number 75 in *Sharing the Vision*). Policy-makers and administrators argue that it will be easier to construct integrated services in the context of regionalisation due to the adoption of a unitary management structure, the shared sense of commitment to promoting the health of the regional population, and the greater ease of building collaborative relationships within a more circumscribed geographical area.

Specialised services for people with SUD may not be appropriate at the CHN level, but it would be appropriate to take the emerging spatial organisation of services into account when thinking about the role of drug and alcohol treatment services in the future regionalised health service. When planning services, the metaphor of the treatment 'pyramid' (or Kaiser Triangle) is a useful one: whereas relatively few individuals have very serious disorders, at lower levels of severity there are typically many more people whose needs can be met by less intensive and less specialised services (World Health Organization, 2020).

When thinking about the different tiers of treatment and their spatial distribution, it is important to base policy on population needs and distributions so that service users can access appropriate types of treatment (Rush, 2010). This helps to explain the importance of rooting treatment systems for both mental health problems and SUD within the primary care system. Hirschovits-Gerz *et al.* (2019) explain one reason for pursuing this objective: in both the general health system and the mental health system, SUD are frequently underdiagnosed. Improving the capacity of the primary care system to identify SUD and to make appropriate interventions and referrals is an essential step towards improving population health. This was one of the principal lessons of the Norwegian reforms in the mid-2000s, as we will see later in this report. *Sharing the Vision* (Department of Health, 2020) makes the following observation:

> *Over 90% of mental health needs can be successfully treated in a primary care setting, while the remaining 10% referred to secondary care services are greater and more clinically complex. In line with Sláintecare, this policy envisages an increasing role for the primary care sector which, if appropriately resourced and with appropriate governance, can provide a comprehensive range of interventions. … this policy contains several recommendations advocating additional universal supports delivered by appropriately qualified therapists to provide care to individuals with mental health needs, including those presenting with co-existing health requirements such as addiction. (Department of Health, 2020, p. 40)*

One possibility would be to establish a specialised SUD team alongside one of the CMHTs in each IHA. As CMHTs will ideally be located near a primary care centre (Department of Health, 2020), it would be possible to use co-location to enhance collaboration between these three services, which is recommended by the World Health Organization (2020). If this is not an option, an effective and integrated community-based network could be developed, again following the authoritative World Health Organization guidelines.

For more than two decades, government policy in Ireland has focused on the need to develop primary care using a team approach, with co-located multidisciplinary teams serving populations of roughly 3,000–7,000 people, supported by a network of specialised services (Department of Health and Children, 2001, p. 21). This is in line with the proposals originally made in *A Vision for Change*:

> *One multidisciplinary CMHT should be available in each 300,000 catchment area to provide a substance misuse mental health service for all adults in the catchment with mental illness comorbid with a complex or severe substance misuse problem. … these teams to work closely with … substance misuse services in the community to ensure appropriate referral and provision for individuals with comorbid substance misuse and mental illness. (Expert Group on Mental Health Policy, 2006, p. 76)*

A modular, tier-based approach to the distribution of services across each region could then be adopted, which would have advantages from the perspective of planning, coordinating, and addressing challenges to population health and well-being (see, for example: National Working Group for Dual Diagnosis, 2023, pp. 27–28). The use of co-location to promote collaboration between services would arguably improve access for vulnerable groups:

> *Delivery of integrated care requires both 'horizontal' co-ordination, spanning professional and departmental boundaries, such as interdisciplinary team working, as well as 'vertical' coordination between primary, secondary and tertiary care domains, such as the design of optimal care pathways. (Oireachtas Committee on the Future of Healthcare, 2017, p. 73)*

In the next section, we will describe the literature searches that we carried out as part of this evidence review, before summarising how drug and alcohol treatment services are organised across different regions and localities in our case study countries. We will return to the five key research questions in the final section of the report.

3 Literature searches

3.1 Systematic database searches

The organisation and governance of drug treatment services at the regional level is a difficult topic to research as there are few articles and research projects which focus specifically on this issue. Where research touches on processes of regionalisation or decentralisation, these keywords are rarely used (cf. Exworthy *et al.*, 2010). There is some international literature on health service regionalisation, but this rarely mentions drug treatment systems. Conversely, the literature on drug and alcohol treatment systems rarely mentions regionalisation (or institutional arrangements in general), as studies are typically confined to a specific jurisdiction whose institutional features are taken for granted.

With these limitations in mind, we began by studying the terms of reference and searching for relevant publications using informal techniques. We then examined the terminology and keywords used in these documents with a view to refining and expanding our search. Using artificial intelligence search tools (Elicit, Consensus, Undermind) and large research collections (Dimensions AI and Lens.org), we further expanded the scope of our database searches. At this stage, we considered whether to include terms for named regions within European countries, but decided against this, as we found that research on regionalisation tends to use more general concepts and descriptions, while publications mentioning specific regions tend to be case studies that do not discuss decentralisation.

As the research questions do not follow a standard PICO (Population, Intervention, Comparison, Outcome) structure, we set out the eligibility criteria using our own PITS (Population, Intervention, Themes, Study design) headings, which are described in Sections 3.1.1–3.1.6.

3.1.1 Population

The research questions refer to European regions.

3.1.2 Intervention

Eligible interventions include all forms of reorganisation of drug and alcohol treatment services that alter the division of roles and responsibilities across levels of the system, from the national level to the intermediate level of regions/states to local areas or municipalities.

3.1.3 Themes

Following the terms of reference, we included studies that explore any of the following themes:

» Forms of management or organisation

» Clinical governance

» Adherence to national policies/strategies

» Involvement of non-governmental organisations and firms

» Relationships with other sectors (including primary care, mental health care, and social care services)

» Data, indicators, monitoring, and evaluation.

3.1.4 Study design

Qualitative, quantitative, and mixed methods research designs were all considered eligible for inclusion. Case reports restricted to a single person, non-systematic reviews, and commentaries were excluded, in line with standard practice.

3.1.5 Year of publication

No limitations were imposed in relation to year of publication.

3.1.6 Countries and languages

The systematic literature search was confined to European Union countries.

3.2 Search strategy

The basic strategy covers four concepts, with the following structure:

Concept 1	Treatment services
(Substance abuse treatment services OR (substance abuse AND treatment services))	
Concept 2	Regionalisation
(regionalisation OR decentralisation)	
Concept 3	Relevant countries
NOT (USA OR Canada OR Australia (NOT European countries))	
Concept 4	Relevant documents
NOT (animal studies OR letters OR editorials OR news stories)	

By searching for documents that discuss regionalisation, we hoped to identify publications that address the issues at the centre of this project: management, governance, accountability, relationships with other services, data systems, and evaluation. If we were to include these as search terms, we would greatly reduce the number of documents identified and potentially fail to identify important sources of evidence. Rather than specifying them as part of the search, therefore, we decided to apply these concepts exclusively during the screening process.

By excluding papers that are indexed as relating to the USA, Canada, and Australia, we were able to identify a larger number of records relating to European countries. This approach is preferable to searching directly for the latter, as abstracts may not always mention them. Table 3.1 shows our matrix of search terms (complete with Medical Subject Headings (MeSH) terms), while Table 3.2 illustrates our PubMed search.

Table 3.1: Search terms

Substance use services	Health care facilities
Substance Abuse Treatment Centers[mesh:noexp] OR needle-exchange programs[mesh:noexp]	Health facilities[mesh:noexp] OR ambulatory care facilities[mesh:noexp] OR community health centers[mesh:noexp] OR rehabilitation centers[mesh:noexp] Health planning[mesh:noexp] OR Health care reform[mesh:noexp] OR Health plan implementation[mesh:noexp] OR Health planning organizations[mesh]
"needle exchange"[tiab:~4] OR "needle exchanges"[tiab:~4] OR "Supervised Injection"[tiab:~4] OR "Supervised Injecting"[tiab:~4] OR "Syringe Exchange"[tiab:~4] OR "Syringe Exchanges"[tiab:~4] OR "Addiction services"[tiab] OR "addiction programs"[tiab] OR "addiction programmes"[tiab]OR "addiction centres"[tiab] OR "addiction centers"[tiab] "Drug Abuse Treatment Centers"[tiab] OR "drug abuse treatment centres"[tiab] OR "Drug Rehabilitation Centers"[tiab] OR "drug treatment rehabilitation centres"[tiab] OR "Drug Treatment Centers"[tiab] OR "drug treatment centres"[tiab] OR "substance abuse treatment centers"[tiab] OR "substance abuse treatment centres"[tiab]	"treatment centres"[tiab] OR "treatment centres"[tiab] OR "treatment service"[tiab] OR "treatment services"[tiab] "Service planning"[tiab:~4] OR "Services planning"[tiab:~4] OR "Program planning"[tiab:~4] OR "Programs planning"[tiab:~4] OR "Programme planning"[tiab:~4] OR "programmes planning"[tiab:~4]

Substance abuse	Regionalisation
Substance abuse, intravenous[mesh:noexp] OR Substance-related disorders[mesh:noexp] OR Amphetamine-related disorders[mesh:noexp] OR Cocaine-related disorders[mesh:noexp] OR Drug misuse[mesh:noexp] OR Inhalant abuse[mesh:noexp] OR Marijuana abuse[mesh:noexp] OR Narcotic-related disorders[mesh:noexp] OR Phencyclidine abuse[mesh:noexp] OR Substance abuse, oral[mesh:noexp] OR Morphine dependence[mesh:noexp] OR Opioid-related disorders[mesh:noexp] OR Heroin dependence[mesh:noexp] OR Opium dependence[mesh:noexp] OR Drug users[mesh:noexp] OR Opiate substitution treatment[mesh:noexp]	Regional medical programs[mesh:noexp] OR regional health planning[mesh]
"drug abuse*"[tiab] OR "drug rehabilitation"[tiab:~5] OR "drug treatment*"[tiab] OR "drug misuse*"[tiab] OR "drug use"[tiab] OR "drug users"[tiab] OR "substance abuse*"[tiab] OR "substance misuse*"[tiab] OR "substance use"[tiab] OR "opioid abuse*"[tiab] OR "opioid* rehabilitation"[tiab] OR "opioid* misuse*"[tiab] "drug depend*"[tiab] OR "opioid* depend*"[tiab] OR "opioid* addiction"[tiab] OR "Opiate* abuse"[tiab] OR "Opiate* depend*"[tiab] OR "Opiate* addiction"[tiab] OR "morphine abuse"[tiab] OR "morphine depend*"[tiab] OR "morphine addiction"[tiab] OR "heroin abuse"[tiab] OR "heroin depend*"[tiab] OR "heroin addiction"[tiab] "narcotics abuse"[tiab:~4] OR "narcotics dependent"[tiab:~4] OR "narcotics addiction"[tiab:~4] OR "narcotics dependence"[tiab:~4]	Region*[tiab] OR Area[tiab] OR areas[tiab] OR Areawide[tiab] OR "Local responsibil*"[tiab] OR "local autonomy"[tiab] OR "local administration"[tiab] OR "local government"[tiab] OR Decentral*[tiab] Slaintecare[tiab]

Table 3.2: PubMed search

Search number	Query	Results	Notes
31	#29 NOT #30	1,233	Results excluding studies indexed as USA, Canada, or Australia
30	(united states[mesh] OR canada[mesh] OR australia[mesh]) NOT europe[mesh]	1,785,721	Records indexed as being about USA, Canada, or Australia, but not about Europe
29	#25 NOT #28	2,125	Results excluding letters, etc. OR animal studies
28	#26 OR #27	7,251,327	Letters, etc. OR animal studies
27	letter[pt] OR comment[pt] OR news[pt]	2,020,115	Letters, news, and comments
26	animals[mesh] NOT humans[mesh]	5,313,187	Animal studies
25	#15 AND #24	2,138	Regionalisation OR decentralisation AND substance abuse treatment
24	#16 OR #17 OR #18 OR #19 OR #20 OR #21 OR #22 OR #23	5,171,355	Regionalisation OR decentralisation
23	"administrative units"[Title/Abstract]	625	Regionalisation OR decentralisation
22	"institutional structure"[Title/Abstract] OR "institutional structures"[Title/Abstract] OR "institutional form"[Title/Abstract] OR "institutional forms"[Title/Abstract] OR "institutional architecture"[Title/Abstract] OR "institutional architectures"[Title/Abstract] OR "institutional role"[Title/Abstract] OR "institutional roles"[Title/Abstract] OR "institutional mandate"[Title/Abstract] OR "institutional mandates"[Title/Abstract]	832	Regionalisation OR decentralisation
21	devolv*[tiab]	906	Regionalisation OR decentralisation
20	central[tiab] OR centralis*[tiab] OR centraliz*[tiab]	1,042,986	Regionalisation OR decentralisation
19	localis*[tiab] OR localiz*[tiab]	701,217	Regionalisation OR decentralisation
18	Slaintecare[tiab]	26	Regionalisation OR decentralisation

Search number	Query	Results	Notes
17	Region*[tiab] OR Area[tiab] OR areas[tiab] OR Areawide[tiab] OR "Local responsibil*"[tiab] OR "local autonomy"[tiab] OR "local administration"[tiab] OR "local government"[tiab] OR Decentral*[tiab]	3,797,512	Regionalisation OR decentralisation
16	Regional medical programs[mesh:noexp] OR regional health planning[mesh]	41,053	Regionalisation OR decentralisation
15	#4 OR #14	13,933	Substance misuse treatment OR Health care services for substance misusers
14	#9 AND #13	5,386	Health care services for substance misusers
13	#10 OR #11 OR #12	306,100	Substance misuse
12	"drug depend*"[tiab] OR "opioid* depend*"[tiab] OR "opioid* addiction"[tiab] OR "Opiate* abuse"[tiab] OR "Opiate* depend*"[tiab] OR "Opiate* addiction"[tiab] OR "morphine abuse"[tiab] OR "morphine depend*"[tiab] OR "morphine addiction"[tiab] OR "heroin abuse"[tiab] OR "heroin depend*"[tiab] OR "heroin addiction"[tiab]	20,243	Substance misuse
11	"drug abuse*"[tiab] OR "drug rehabilitation"[tiab:~5] OR "drug treatment*"[tiab] OR "drug misuse*"[tiab] OR "drug use"[tiab] OR "drug users"[tiab] OR "substance abuse*"[tiab] OR "substance misuse*"[tiab] OR "substance use"[tiab] OR "opioid abuse*"[tiab] OR "opioid* rehabilitation"[tiab] OR "opioid* misuse*"[tiab]	207,188	Substance misuse
10	Substance abuse, intravenous[mesh:noexp] OR Substance-related disorders[mesh:noexp] OR Amphetamine-related disorders[mesh:noexp] OR Cocaine-related disorders[mesh:noexp] OR Drug misuse[mesh:noexp] OR Inhalant abuse[mesh:noexp] OR Marijuana abuse[mesh:noexp] OR Narcotic-related disorders[mesh:noexp] OR Phencyclidine abuse[mesh:noexp] OR Substance abuse, oral[mesh:noexp] OR Morphine dependence[mesh:noexp] OR Opioid-related disorders[mesh:noexp] OR Heroin dependence[mesh:noexp] OR Opium dependence[mesh:noexp] OR Drug users[mesh:noexp] OR Opiate substitution treatment[mesh:noexp]	175,129	Substance misuse
9	#5 OR #6 OR #7 OR #8	153,607	Health care services
8	"Service planning"[tiab:~4] OR "Services planning"[tiab:~4] OR "Program planning"[tiab:~4] OR "Programs planning"[tiab:~4] OR "Programme planning"[tiab:~4] OR "programmes planning"[tiab:~4]	26,926	Health care services
7	"treatment centres"[tiab] OR "treatment centres"[tiab] OR "treatment service"[tiab] OR "treatment services"[tiab]	7,565	Health care services

Search number	Query	Results	Notes
6	Health planning[mesh:noexp] OR Health care reform[mesh:noexp] OR Health plan implementation[mesh:noexp] OR Health planning organizations[mesh]	65,948	Health care services
5	Health facilities[mesh:noexp] OR ambulatory care facilities[mesh:noexp] OR community health centers[mesh:noexp] OR rehabilitation centers[mesh:noexp]	60,230	Health care services
4	#1 OR #2 OR #3	9,416	Substance misuse treatment
3	"Drug Abuse Treatment Centers"[tiab] OR "drug abuse treatment centres"[tiab] OR "Drug Rehabilitation Centers"[tiab] OR "drug treatment rehabilitation centres"[tiab] OR "Drug Treatment Centers"[tiab] OR "drug treatment centres"[tiab] OR "substance abuse treatment centers"[tiab] OR "substance abuse treatment centres"[tiab]	421	Substance misuse treatment
2	"needle exchange"[tiab:~4] OR "needle exchanges"[tiab:~4] OR "Supervised Injection"[tiab:~4] OR "Supervised Injecting"[tiab:~4] OR "Syringe Exchange"[tiab:~4] OR "Syringe Exchanges"[tiab:~4] OR "Addiction services"[tiab] OR "addiction programs"[tiab] OR "addiction programmes"[tiab]OR "addiction centres"[tiab] OR "addiction centers"[tiab]	2,961	Substance misuse treatment
1	Substance Abuse Treatment Centers[mesh:noexp] OR needle-exchange programs[mesh:noexp]	7,476	Substance misuse treatment

We ran our searches using a range of different databases at the beginning of June 2025, taking into account the different interfaces and indexing languages (Table 3.3). We also conducted forward and backward citation searches on eligible documents using citationchaser.[9]

9. https://www.eshackathon.org/software/citationchaser.html.

Table 3.3: Searches, deduplication, and screening

Database/resource	Number of records retrieved	Number of records deduplicated	Records screened
PubMed	1,236	2	1,234
Embase	5,440	853	4,587
Cochrane Library CDSR	128	20	108
Cochrane Library Central	3,513	140	3,373
Social Sciences Citation Index	947	469	478
Scopus	3,866	1,939	1,927
SocIndex	973	898	75
Google Scholar (top 100 records, 3 searches)	58	10	48
Europe PMC	459	18	441
Perplexity	8	0	8
Ai2 paper finder	76	19	57
Lens.org	481	3	478
citationchaser	274	16	258
Number of records	**17,459**	**4,387**	**13,072**

3.3 Targeted web searches

We also carried out targeted web searches using a range of different languages to search for grey literature such as research reports, policy documents, dissertations, and advocacy documents relating to Norway, Sweden, the UK, Portugal, Spain, France, Germany, and Italy. In addition, we carried out a search of relevant European and international organisations to provide context. Before carrying out these searches, we developed lists of terms in all relevant languages (see Appendix E).

3.3.1 International organisations

Table 3.4 lists the European and international resources that we searched in stages between June and September 2025, including the number of documents downloaded during this process.

Table 3.4: International resources (31 documents downloaded)

Website	URL	Searches carried out and number of documents downloaded
Pompidou Group	https://www.coe.int/en/web/pompidou https://www.coe.int/en/web/pompidou/publications	Searched interactively 1 document downloaded
Addiction Policy Forum	https://www.addictionpolicy.org/ https://www.addictionpolicy.org/publications	Searched interactively 3 documents downloaded
Civil Society Involvement in Drug Policy	https://csidp.eu/ https://csidp.eu/publications/	Searched using keywords 2 documents downloaded
Correlation – European Harm Reducation Network	https://www.correlation-net.org/	Publications selected from the Resources tab and searched interactively 1 document downloaded
International Network of People who Use Drugs	https://www.inpud.net/	Searched using keywords 1 document downloaded
European Union Drugs Agency	https://www.euda.europa.eu/index_en	Searched using keywords 10 documents downloaded
Nordic Welfare Centre	https://nordicwelfare.org/en/	Searched using keywords 1 document downloaded
World Health Organization/ European Observatory on Health Systems and Policies	https://eurohealthobservatory.who.int/	Searched interactively 8 documents downloaded
World Health Organization	https://www.who.int/	Searched using keywords 4 documents downloaded

3.3.2 Norway

Table 3.5 lists the Norwegian websites that we searched during the month of July 2025, again showing the number of documents downloaded.

Table 3.5: Norwegian resources (42 documents downloaded)

Website	URL	Searches carried out and number of documents downloaded
Kudos database (run by the Norwegian Agency for Public and Financial Management and the National Library)	https://kudos.dfo.no/	Large, searchable, full-text collection of publications from various public authorities Searched using keywords 23 documents downloaded
Regjeringen (Norwegian Government – mental health services (including drug and alcohol treatment))	https://www.regjeringen.no/no/tema/helse-og-omsorg/psykisk-helse/id11695/	Searched using keywords 8 documents downloaded
Helsedirektoratet (Directorate of Health)	https://www.helsedirektoratet.no/statistikk-registre-og-rapporter	Searched using keywords 4 documents downloaded
Helsebiblioteket (Electronic Health Library)	https://www.helsebiblioteket.no/	Searched using keywords No documents downloaded
Kompetansesenter for rusfeltet (National Advisory Unit for substance use)	https://korus.no/	Searched interactively No documents downloaded
Regionalt kompetansesenter for rusmiddelforskning i Helse Vest (Regional Advisory Unit for Substance Abuse Research)	https://www.helse-stavanger.no/fag-og-forskning/kompetansetjenester/regionalt-kompetansesenter-for-rusmiddelforskning-i-helse-vest-korfor/	Searched interactively No documents downloaded
Senter for rus- og avhengighetsforskning (Norwegian Centre for Addiction Research)	https://www.med.uio.no/klinmed/forskning/sentre/seraf/	Searched using keywords 5 documents downloaded
Folkehelseinstituttet (Norwegian Institute of Public Health)	https://www.fhi.no/	Searched using keywords 2 documents downloaded
Rusfeltet (Norwegian Confederation of Addiction)	https://www.rusfeltet.no/kunnskapsbase/	Publications database searched using key terms No documents downloaded
NIBR (Norwegian Institute for Urban and Regional Research)	https://www.oslomet.no/om/nibr	Searched using keywords 1 document downloaded
Helfo (The Norwegian Health Economics Administration)	https://www.helfo.no/	Searched interactively No documents downloaded
Nasjonalt kompetansesenter for rus- og avhengighetslidelser, alvorlige samtidige lidelser og personlighetsforstyrrelser (National Competence Centre for Substance Use and Addiction Disorders, Severe Co-occurring Disorders, and Personality Disorders)	https://www.oslo-universitetssykehus.no/fag-og-forskning/nasjonale-og-regionale-tjenester/nrapp	Searched interactively No documents downloaded
Blå Kors (Blue Cross – works mainly in the field of prevention, with a focus on young people)	https://www.blakors.no/fagside/	Searched interactively No documents downloaded

3.3.3 Sweden

Table 3.6 lists the Swedish websites that we searched during the months of June and October 2025, again showing the number of documents downloaded.

Table 3.6: Swedish resources (11 documents downloaded)

Website	URL	Searches carried out and number of documents downloaded
Regeringskansliet (Swedish Government – Ministry of Health and Social Affairs (Missbruksvård – substance abuse treatment and care))	https://www.regeringen.se/	Searched interactively 3 documents downloaded
Socialstyrelsen (National Board of Health and Welfare)	https://www.socialstyrelsen.se/en/	Searched using keywords 2 documents downloaded
Folkhälsomyndigheten (Public Health Agency of Sweden)	https://www.folkhalsomyndigheten.se/	Publications database Searched using key terms 2 document downloaded
Inspektionen för vård och omsorg (Health and Social Care Inspectorate)	https://www.ivo.se/	Searched using keywords No documents downloaded
Vård- och omsorgsanalys (Swedish Agency for Health and Care Services Analysis)	https://www.vardanalys.se/	Searched interactively 2 documents downloaded
Statens institutions styrelse (Swedish National Board of Institutional Care)	https://www.stat-inst.se/	Searched using keywords No documents downloaded
Centre for Social Research on Alcohol and Drugs – Stockholm University	https://www.su.se/department-of-public-health-sciences/about-the-department/centres-and-other-units/centre-for-social-research-on-alcohol-and-drugs-sorad-1.573064	Reports were accessed through DiVA (the Swedish national research repository) Searched using keywords 2 document downloaded
Karolinska Institutet (research centre)	https://ki.se/forskning/forskningsomraden-centrum-och-natverk/forskargrupper/epidemiologi-och-interventioner-psykisk-halsa-substansbruk-och-social-kontext-emilie-agardhs-renee-gardners-forskargrupp	Searched interactively No documents downloaded
Center for Education and Research on Addiction – University of Gothenburg	https://www.gu.se/en/cera	Searched interactively No documents downloaded
Forum för Health Policy – Swedish Forum for Health Policy	https://healthpolicy.se/rapporter/	Searched interactively No documents downloaded
Nationella vård- och insatsprogram (National Care and Intervention Programme)	https://www.vardochinsats.se/missbruk-och-beroende/	Searched interactively No documents downloaded

3.3.4 United Kingdom

Table 3.7 lists the UK websites that we searched during the month of September 2025, showing the number of documents we downloaded.

Table 3.7: UK resources (34 documents downloaded)

Website	URL	Searches carried out and number of documents downloaded
UK Government	https://www.gov.uk	Searched using keywords 9 documents downloaded
UK Parliament	https://committees.parliament.uk/	Searched using keywords 1 document downloaded
National Health Service (NHS) England	https://www.nhs.uk/	Searched using keywords No documents downloaded
Taking Action on Addiction	https://takingactiononaddiction.org.uk/	Searched interactively No documents downloaded
Care Quality Commission	https://www.cqc.org.uk/ https://www.cqc.org.uk/publications	Searched using keywords No documents downloaded
Public Health England	https://www.gov.uk/government/organisations/public-health-england	Searched using keywords 1 document downloaded
The King's Fund	https://www.kingsfund.org.uk/	Searched using keywords 1 document downloaded
Northern Ireland Audit Office	https://www.niauditoffice.gov.uk/	Searched using keywords 1 document downloaded
National Institute for Health and Care Excellence	https://www.nice.org.uk/	Searched using keywords 2 documents downloaded
Royal College of General Practitioners	https://www.rcgp.org.uk/	Searched interactively No documents downloaded
National Audit Office	https://www.nao.org.uk/	Searched interactively 2 documents downloaded
Nuffield Trust	https://www.nuffieldtrust.org.uk/	Searched interactively 1 document downloaded
Scottish Government	https://www.gov.scot/	Searched interactively 2 documents downloaded
Mental Welfare Commission for Scotland	https://www.mwcscot.org.uk/	Searched interactively 1 document downloaded
The Learning Exchange	https://lx.iriss.org.uk/	Searched interactively 1 document downloaded
The Health Foundation	https://www.health.org.uk/	Searched interactively 1 document downloaded
Royal College of Psychiatrists	https://www.rcpsych.ac.uk/	Searched using keywords 1 document downloaded

Website	URL	Searches carried out and number of documents downloaded
Centre for Mental Health	https://www.centreformentalhealth.org.uk/	Searched interactively 1 document downloaded
Swansea Bay University Health Board	https://sbuhb.nhs.wales/	Searched interactively 1 document downloaded
UK Drug Policy Commission	https://www.ukdpc.org.uk/	Searched interactively 1 document downloaded
The British Psychological Society	https://explore.bps.org.uk/	Searched using keywords 1 document downloaded
Department of Addictions, King's College London	https://www.kcl.ac.uk/academic-psychiatry/about/departments/addictions	Searched interactively 6 documents downloaded

3.3.5 Portugal

Table 3.8 lists the Portuguese websites that we searched during the month of August 2025, showing the number of documents that we downloaded.

Table 3.8: Portuguese resources (30 documents downloaded)

Website	URL	Searches carried out and number of documents downloaded
Instituto para os Comportamentos Aditivos e as Dependências (Institute for Addictive Behaviors and Addictions)	https://www.icad.pt/NewsArticle/Article/5?languageId=2 https://www.icad.pt/DocumentList/Index/66?languageId=0	Searched using keywords 7 documents downloaded
Serviço de Intervenção nos Comportamentos Aditivos e nas Dependências (General Directorate for Intervention on Addictive Behaviours and Dependencies)	https://sicad.pt/EN/Paginas/default.aspx	Publications and documents searched interactively 9 documents downloaded
Administrações Regionais de Saúde – Divisao de Intervencao nos Comportamentos Aditivos e nas Dependencias (Regional Health Administrations)	https://www.arslvt.min-saude.pt/comportamentos-aditivos-e-dependencias/	Searched interactively 3 documents downloaded
Agência Piaget para o Desenvolvimento	https://apdes.pt/en/research/	Searched interactively 1 document downloaded
Associação Portuguesa para o Estudo das Drogas e das Dependências (Portuguese Association for the Study of Drugs and Addictions)	https://www.adictologia.com https://www.adictologia.com/revistas	Searched the website interactively, including the annual journal *Adictologia* 1 document downloaded
Associação de Intervenção Comunitária (Association of Community Intervention)	https://crescer.org/en/	Searched interactively No documents downloaded

Website	URL	Searches carried out and number of documents downloaded
Grupo de Ativistas em Tratamentos (user group)	https://www.gatportugal.org	Searched interactively 1 document downloaded
Dianova (therapeutic community)	https://www.dianova.org/publications/	Searched interactively No documents downloaded
Universidade de Lisboa (University of Lisbon)	https://repositorio.ulisboa.pt/handle/10400.5/27209	Searched repository using key terms 2 documents downloaded
Universidade NOVA de Lisboa (NOVA University Lisbon)	https://novaresearch.unl.pt/en/publications https://run.unl.pt	Publications and repository searched using key terms as well as interactively 3 documents downloaded
NOVA Medical School – Universidade NOVA de Lisboa	https://www.nms.unl.pt/en-us/library/collections/theses-and-dissertations?utm	Archive of PhD and MA theses for recent years (2023–2025) searched interactively No documents downloaded
Universidade de Coimbra	https://estudogeral.uc.pt	Archive searched interactively 1 document downloaded
Universidade de Aveiro	https://www.ua.pt https://ria.ua.pt/	Searched research repository using key terms 1 document downloaded
Calouste Gulbenkian Foundation	https://gulbenkian.pt/en	Searched using key terms 1 document downloaded

3.3.6 Spain

Table 3.9 lists the Spanish websites that we searched during the month of September 2025, showing the number of documents that we downloaded.

Table 3.9: Spanish resources (27 documents downloaded)

Website	URL	Searches carried out and number of documents downloaded
Delegación del Gobierno para el Plan Nacional sobre Drogas (Government Delegation for the National Plan on Drugs)	https://pnsd.sanidad.gob.es/en/profesionales/publicaciones/catalogo/catalogoPNSD/home.htm	Searched interactively 7 documents downloaded
Ministerio da Sanidad (Ministry of Health – Interterritorial Council of the National Health System)	https://www.sanidad.gob.es/biblioPublic/portada/home.htm	Searched interactively 3 documents downloaded
Observatorio Español de las Drogas y las Adicciones (Spanish Observatory on Drugs and Addictions)	https://pnsd.sanidad.gob.es/profesionales/sistemasInformacion/	Searched interactively 1 document downloaded
Servei Català de la Salut & Agència de Salut Pública de Catalun (Catalan Health Services)	https://catsalut.gencat.cat/ca/inici/index.html#googtrans(ca|en)	Searched interactively 2 documents downloaded

Website	URL	Searches carried out and number of documents downloaded
Osakidetza – Departamento de Salud – Gobierno Vasco (Basque Country)	https://www.osakidetza.euskadi.eus/recursos-de-tratamiento-de-adicciones-y-drogodependencias-publicos-y-concertados-en-euskadi/webosk00-cercon/es/?	Searched interactively 1 document downloaded
La Red de Atención a las Adicciones (Network of Addiction Services)	https://www.unad.org/biblioteca/	Searched interactively 2 documents downloaded
Asociación, Bienestar y Desarrollo (Welfare and Development Association)	https://abd.ong/causas/drogas-y-salud/	Searched interactively 1 document downloaded
Socidrogalcohol (Spanish scientific society)	https://socidrogalcohol.org	Searched interactively 1 document downloaded
Addiciones Revista (journal)	https://adicciones.es/index.php/adicciones	Searched using keywords 2 documents downloaded
Red de Investigación en Atención Primaria de Adicciones (Network for Research on Primary Care of Addictions)	https://riapad.es/difusion/	Searched interactively 4 documents downloaded
Consejería de Sanidad (Madrid Ministry of Health)	https://www.comunidad.madrid/centros/consejeria-sanidad	Searched interactively 1 document downloaded
Servicio Andaluz de Salud (Provincial drug treatment service, Andalusia)	https://www.juntadeandalucia.es/organismos/saludyconsumo/areas/adicciones/atencion/paginas/centros-provinciales-drogodependencia.html	Searched using keywords No documents downloaded
Asociación Proyecto Hombre (association)	https://proyectohombre.es/informes-observatorio-y-estudios/	Searched using keywords No documents downloaded
Cruz Roja Española (Spanish Red Cross)	https://www2.cruzroja.es	Searched using key terms No documents downloaded
Fundación Atenea	https://fundacionatenea.org	Searched interactively No documents downloaded
Fundación Salud y Comunidad	https://www.fsyc.org	Searched interactively No documents downloaded
Federación Española de Municipos y Provincias (Spanish Federation of Municipalities and Provinces)	https://drogodependencias.femp.es/documentos	Searched interactively 2 documents downloaded
Red Iberoamericana de Organizaciones No Gubernamentales que trabajan en Drogas y adicciones (association)	https://riod.org	Searched interactively No documents downloaded

3.3.7 France

Table 3.10 lists the French websites that we searched during the month of August 2025, showing the number of documents that we downloaded.

Table 3.10: French resources (23 documents downloaded)

Website	URL	Searches carried out and number of documents downloaded
Mission interministérielle de lutte contre les drogues et les conduites addictives (Interministerial Mission for Combating Drugs and Addictive Behaviours)	https://www.drogues.gouv.fr/	Searched using keywords 4 documents downloaded
Observatoire français des drogues et des tendances addictives (French Monitoring Centre for Drugs and Drug Addiction)	https://www.ofdt.fr/alcool-synthese-des-connaissances-1722#consequ	Searched interactively 1 document downloaded
Santé publique France (Public Health France)	https://www.santepubliquefrance.fr/publications	Searched using keywords No documents downloaded
Académie Nationale de Médecine (National Academy of Medicine)	https://www.academie-medecine.fr/	Searched using keywords 3 documents downloaded
Ministère de la Santé, des Familles, de l'Autonomie et des Personnes Handicapées (Ministry of Health, the Family, Regional Autonomy and Disabled People)	https://sante.gouv.fr/ https://sante.gouv.fr/prevention-en-sante/addictions/	Searched using keywords 1 document downloaded
Intervenir Addictions (resources for professionals working in addiction services)	https://intervenir-addictions.fr/	Searched using keywords 1 document downloaded
Institut national de la santé et de la recherche médicale (National Institute of Health and Medical Research)	https://www.inserm.fr/en/home/ https://pro.inserm.fr/	Searched using keywords No documents downloaded
Psychotropes – Revue internationale des toxicomanies et des addictions (journal)	https://shs.cairn.info/revue-psychotropes?lang=fr	Searched using keywords 1 document downloaded
Inspection générale des affaires sociales (Observatory on social issues)	https://igas.gouv.fr/	Searched using keywords 1 document downloaded
Haute Autorité de Santé (National Health Authority)	https://www.has-sante.fr/	Searched using keywords 1 document downloaded
Fédération Addiction (publishes the journal *Addiction(s): recherches et pratiques)*	https://www.federationaddiction.fr/publications/revue/	Searched using keywords 2 documents downloaded
Institut pour la Recherche en Santé Publique (French Institute for Public Health Research)	https://iresp.net/thematiques/programme-addictions/	Searched using keywords No documents downloaded
Réseau de Prévention des Addictions (Network for the Prevention of Addiction)	https://www.respadd.org/	Searched interactively 7 documents downloaded

Website	URL	Searches carried out and number of documents downloaded
SOS Addictions (association)	https://www.sos-addictions.org/	Searched interactively No documents downloaded
Addict'AIDE (association)	https://www.addictaide.fr/	Searched interactively No documents downloaded
Coordination Régionale Addictions Nouvelle-Aquitaine (regional network)	https://www.coreadd.com/	Searched interactively No documents downloaded
Societé Française de Santé Publique (French Society for Public Health)	https://sfsp.fr	Searched interactively 1 document downloaded

3.3.8 Germany

Table 3.11 lists the German websites that we searched during the month of August 2025, showing the number of documents that we downloaded.

Table 3.11: German resources (30 documents downloaded)

Website	URL	Searches carried out and number of documents downloaded
Bundeszentrale für gesundheitliche Aufklärung (known as BZgA until 2025; Federal Centre for Health Education)	https://www.bioeg.de/	Database searched using key terms 6 documents downloaded
Deutsche Hauptstelle für Suchtfragen e.V. (German Centre for Addiction Issues)	https://www.dhs.de/	Library catalogue: https://www.dhs.de/bibliothek/ausleihe/ Searched using keywords 2 documents downloaded
Institut für Therapieforschung (Institute for Therapy Research)	https://ift.de/	Searchable publications database: https://ift.de/publikationen/ Searched using keywords 4 documents downloaded
Der Beauftragte der Bundesregierung für Sucht- und Drogenfragen (Commissioner of the Federal Government for Drug and Addiction Policy)	https://www.bundesdrogenbeauftragter.de	Publications: https://www.bundesdrogenbeauftragter.de/service/beratungsangebote/ Searched using keywords 2 documents downloaded
Bundesministerium für Gesundheit (Federal Ministry of Health)	https://www.bundesgesundheitsministerium.de/index.html	Publications: https://www.bundesgesundheitsministerium.de/service/publikationen/drogen-und-sucht.html Searched using keywords 1 document downloaded

Website	URL	Searches carried out and number of documents downloaded
Landesministerien für Gesundheit/Soziales (State Ministries of Health)	https://www.ms.niedersachsen.de/startseite/	16 states in total, responsible for the implementation and funding of addiction support at the state level Searched interactively No documents downloaded
Fachverband Drogen- und Suchthilfe e.V. (Association for Drug and Addiction Support)	https://fdr-online.info	Publications: https://fdr-online.info/shop/ Articles: https://fdr-online.info/fdr-wissen/ Searched using keywords 2 exemplary documents downloaded for assessment
Bundesverband für akzeptierende Drogenarbeit und humane Drogenpolitik (Federal Association for Accepting Drug Work)	https://www.akzept.eu	Publications: https://www.akzept.eu/publikationen/ https://www.akzept.eu/akzept-literatur/ Searched interactively 1 document downloaded
Bundesverband Suchthilfe e.V. (Federal Association for Addiction Support)	https://suchthilfe.de	Publications: https://suchthilfe.de/fachinformationen/ Searched interactively 2 documents downloaded
Gesamtverband für Suchthilfe e.V. (National Association for Addiction Support)	https://www-p2.archivportal-d.de	Publications: https://www.ade.findbuch.net/php/main.php Searched interactively No documents downloaded
Deutschen Zentrum für Suchtfragen des Kindes- und Jugendalters (German Centre for Addiction Research in Childhood and Adolescence)	https://www.uke.de/kliniken-institute/zentren/deutsches-zentrum-fuer-suchtfragen-des-kindes-und-jugendalters/index.html	Searched interactively No documents downloaded
Zentrum für Interdisziplinäre Suchtforschung (Centre for Interdisciplinary Addiction Research)	https://www.zis-hamburg.de	Publications: https://www.zis-hamburg.de/publikationen/ Searched using keywords 3 documents downloaded
ARCHIDO – Information and research centre for drug research	http://www.archido.info	Archive: http://archido.iserver-online.de Searched using keywords No documents downloaded

Website	URL	Searches carried out and number of documents downloaded
Institut für Suchtforschung (Institute of Addiction Research)	https://www.frankfurt-university.de/de/hochschule/fachbereich-4-soziale-arbeit-gesundheit/forschung-am-fb-4/forschungsinstitute/institut-fuer-suchtforschung-isff/	Publications: https://www.frankfurt-university.de/de/hochschule/fachbereich-4-soziale-arbeit-gesundheit/forschung-am-fb-4/forschungsinstitute/institut-fuer-suchtforschung-isff/publikationen/ Searched using keywords 4 documents downloaded
Deutsches Institut für Sucht- und Präventionsforschung (German Institute for Addiction and Prevention Research)	https://katho-nrw.de/forschung-und-transfer/forschungsinstitute/deutsches-institut-fuer-sucht-und-praeventionsforschung-disup	Searched interactively No documents downloaded
Deutsche Gesellschaft für Management und Controlling in der Sozialwirtschaft e.V. (Management and the social economy)	https://www.dgcs.de	Publications: https://www.dgcs.de/suchtberatung-wirkt-die-wertschoepfung-der-ambulanten-suchthilfe Searched interactively No documents downloaded
Deutsche Beobachtungsstelle für Drogen und Drogensucht (German Monitoring Centre for Drugs and Drug Addiction)	https://www.dbdd.de	Publications: https://www.dbdd.de/publikationen/zeitschriften-buecher Searched interactively 3 documents downloaded
Robert Koch Institut	https://www.rki.de/DE/Home/home_node.html	Publications: https://www.rki.de/DE/Aktuelles/Publikationen/Publikationen-in-Fachzeitschriften/publikationen-in-fachzeitschriften-node.html Searched interactively 1 document downloaded
Deutsche Gesellschaft für Suchtforschung und Suchttherapie (German Society for Addiction Research and Addiction Therapy)	https://www.dg-sucht.de	Publications: https://www.dg-sucht.de/zeitschrift-sucht Searched interactively No documents downloaded

3.3.9 Italy

Table 3.12 lists the Italian websites that we searched during the month of October 2025, showing the number of documents that we downloaded.

Table 3.12: Italian resources (20 documents downloaded)

Website	URL	Searches carried out and number of documents downloaded
Dipartimento delle politiche contro la droga e le altre dipendenze (Department for Anti-Drug Policies in Italy)	https://www.politicheantidroga.gov.it/it/	Searched interactively 2 documents downloaded
Ministero della Salute (Ministry of Health)	https://www.salute.gov.it/new/	Searched using keywords 5 documents downloaded
Osservatorio sulle Dipendenze (Observatory on Addictions)	https://www.osservatoriodipendenze.com/	Searched interactively 6 documents downloaded
Federazione Italiana degli Operatori dei Dipartimenti e dei Servizi delle Dipendenze (Italian Federation of Operators in Addiction Services)	https://www.federserd.it/index.cfm	Searched using keywords 3 documents downloaded
Agenzia Nazionale per i Servizi Sanitari Regionali (National Agency for Regional Health Services)	https://www.agenas.gov.it/	Searched using keywords No documents downloaded
Istituto Superiore di Sanità (National Health Institute)	https://www.epicentro.iss.it/	Searched using keywords 2 documents downloaded
Osservatorio Epidemiologico Dipendenze Patologiche (Epidemiological Observatory on Pathological Addictions, Bologna)	https://www.ausl.bologna.it/servt/dipt/dsm/oem	Searched interactively No documents downloaded
Documentazione salute mentale e dipendenze patologiche – Regione Emilia-Romagna (online archive on pathological addictions for the Emilia-Romagna Region)	https://salute.regione.emilia-romagna.it/salute-mentale/documentazione/documentazione	Searched interactively No documents downloaded
DRONET – Network Nazionale sulle Dipendenze (National Network on Addictions)	http://www.dronet.org/index.php	Searched interactively 1 document downloaded
Ministro dell'Interno – Direzione Centrale per i Servizi Antidroga (Minister of the Interior – Central Directorate for Anti-Drug Services)	https://antidroga.interno.gov.it	Searched interactively 1 document downloaded
Associazione Nazionale Comuni Italiani (Association of Italian Municipalities)	https://www.anci.it/	Searched interactively No documents downloaded
Forum Nazionale del Terzo Settore (National Forum for the Third Sector)	https://www.forumterzosettore.it/	Searched interactively No documents downloaded
Comunità San Patrignano (voluntary organisation)	https://www.sanpatrignano.org/	Searched interactively No documents downloaded

Website	URL	Searches carried out and number of documents downloaded
Rete Italiana Riduzione del Danno (Italian Harm Reduction Network)	https://www.itardd.it/	Searched interactively No documents downloaded
Società Italiana Tossicodipendenze (Italian Society for the study of Drug Addiction)	https://sitd.it/	Searched interactively No documents downloaded

3.4 Screening

The documents identified using our database searches were loaded into EndNote (N=17,459) and deduplicated as indicated in Table 3.3, leaving 13,072 records to be screened for relevance. Records that were obviously irrelevant – because of their subject area or another clear characteristic – were removed by one reviewer (JG), and after screening on title (JG), 597 documents were identified as potentially relevant. These records were screened for relevance (JP) using the information in their abstracts, and 43 publications were subsequently subjected to full-text screening; 10 of these were deemed relevant (see Appendix A).

The 277 records identified during the targeted web searches (including 36 relating to Ireland) were submitted for full-text screening, and 30 of these were found to be eligible (see Appendix B).

3.4.1 Full-text screening of publications

The full electronic text of each potentially eligible document was acquired and assessed for eligibility by one reviewer (JP). After a decision was taken, a reason for rejection was recorded.

3.4.2 Citation searches

Next, we carried out citation searches on all eligible documents, after excluding those without DOIs. We used citationchaser (https://estech.shinyapps.io/citationchaser/) in order to identify publications that had cited these articles or reports. This led to the identification of 234 publications (after deduplication), which were screened as before, but no additional publications were found to be eligible. A Preferred Reporting Items for Systematic reviews and Meta-Analyses (PRISMA) diagram depicting all aspects of our evidence search and screening is shown in Figure 3.1.

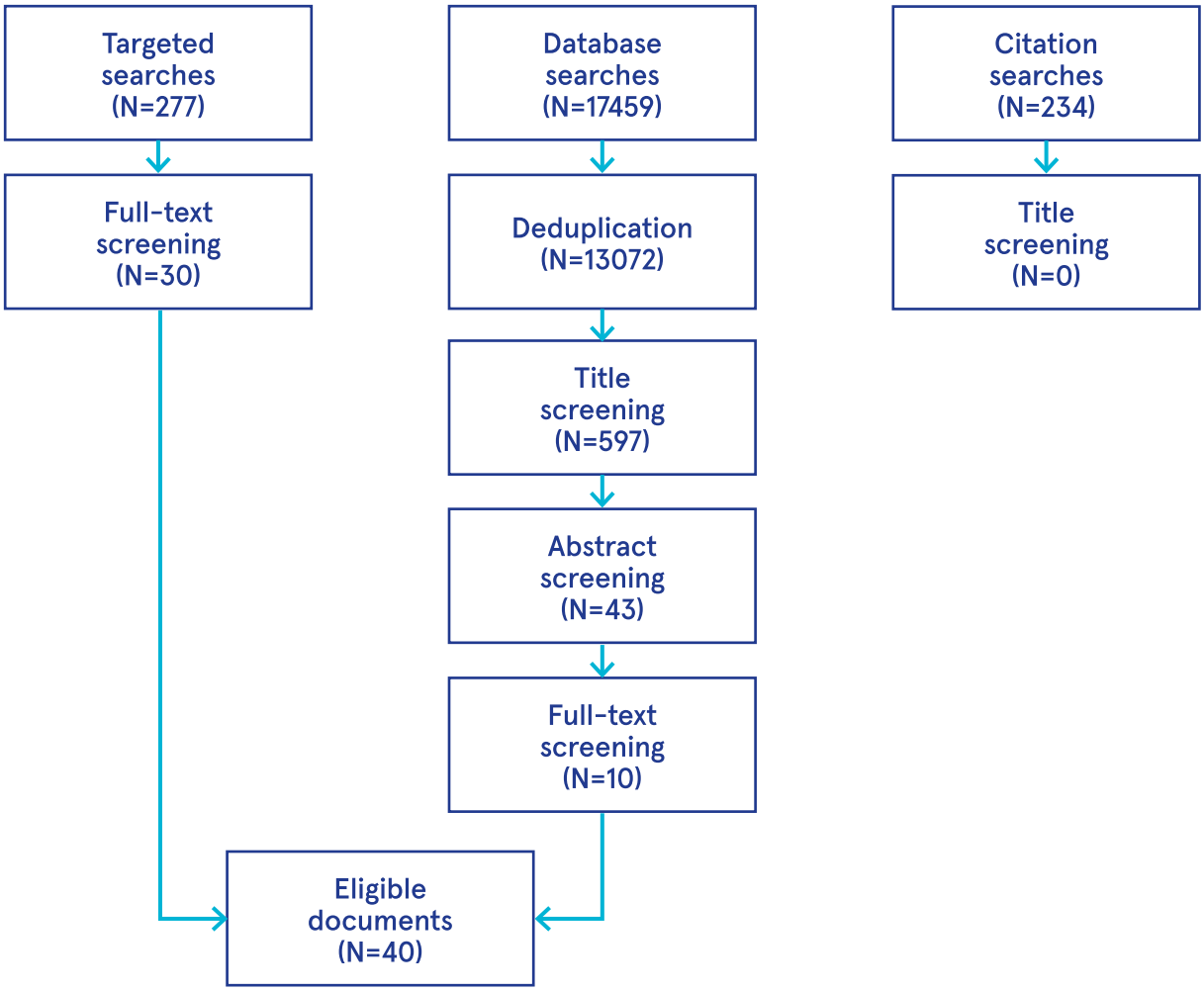


Figure 3.1: PRISMA diagram of extensive search and screening process, showing number of records remaining after each phase

We then constructed an evidence matrix by extracting information from the studies themselves, including location, type of publication, and a brief summary of their contents (Table 3.13).

3.4.3 Selecting and synthesising the research findings

Once we had identified the eligible studies, we carried out a narrative synthesis of the findings, following the topics indicated in the terms of reference. The narrative synthesis was based on a comparative analysis of the documents, set against the backdrop of a set of broader issues that cut across many or all of the studies, which are discussed separately in an earlier section of this report. As the publications (or sections of publications dealing with regionalisation) were largely based on informal policy analysis, we did not carry out any risk-of-bias assessments, which are often used to evaluate the design of empirical research reports. When drafting the following sections of this report, we did not reference only the eligible documents, as it was useful at times to provide contextual information derived from other publications, even where these did not discuss the regionalisation of drug treatment services.

Table 3.13: Synthesis of eligible studies

No.	Author, year, and country	Type of study	Summary
1	Besana, Pasquariello, Costa, and Negri, 2025, Italy	Policy analysis of addiction treatment in Italy from the post-war period to the present	Describes the origins of substance use disorder (SUD) treatment centres, which increasingly link service users to basic healthcare and other services. Given the complexity of addiction treatment, care also requires close coordination with general practitioners (GPs) and mental health services. The way these links have formed varies from region to region.
2	Black, 2021, UK	Policy review of drug treatment and recovery services	Observes that since 2012, the UK Government has entrusted drug treatment services to local authorities, with no accountability or standards. Makes various recommendations, such as local treatment plans, commissioning standards, and greater access to mental health services for people with SUDs.
3	Blomqvist, Palm, and Storbjörk, 2009, Sweden	Descriptive, qualitative analysis of the structure, organisation, and use of drug treatment services in Sweden and Stockholm	Provides an overview of the evolution of SUD treatment services, including a description of how County Councils set up their own facilities for medical and psychological treatment of addiction problems, despite the fact that this has been a formal responsibility of the regions since 1982. The article also discusses the role of national guidelines as well as regional and local disparities.
4	Clemente Rodrigues, 2015, Portugal (Portuguese)	Policy review and semi-structured interviews with individuals with experience or responsibility in the area of addiction services	The author proposes a model for treatment services which consists of a strong national framework that coordinates regional interventions, avoiding disparities.
5	Compagni, Gerzeli, and Bergamaschi, 2011, Italy	Policy analysis spanning 1980–2008, and a survey of managers working in mental health services	Describes inter-sectoral collaboration from the perspective of mental health services, including the impact of regionalisation. Provides insights into the relationship between GPs, treatment services, and mental health care in Italy.
6	Council of Ministers, 1999, Portugal	National drugs strategy	Although this document is rather out of date, it is the last published strategy for Portugal. It articulates the principles of subsidiarity and deconcentration – responsibilities should be entrusted to the level of administration that is closest to the population, except where objectives are better fulfilled at a higher level. The strategy emphasises the importance of coordination and effectively ensuring equal access to treatment.

No.	Author, year, and country	Type of study	Summary
7	Delegación del Gobierno para el Plan Nacional sobre Drogas, 2017, Spain	National drug strategy	The transfer of responsibilities to the Autonomous Communities means that services have developed differently in each region, which generates unevenness in treatment access and difficulties when seeking to align reporting structures, information systems, and referral and intervention methodologies.
8	Delegación del Gobierno para el Plan Nacional sobre Drogas, 2018, Spain	Action plan linked with national drug strategy	Key aims include the development of a system of comprehensive and multidisciplinary care for addictions, including gambling and behavioural addictions. There is an emphasis on implementing a harm reduction approach. National guidelines are to be used in order to reduce disparities and promote coordination within and between the Autonomous Communities and municipalities.
9	Delegación del Gobierno para el Plan Nacional sobre Drogas, 2023, Spain (Spanish)	Second action plan linked with national drug strategy	As above
10	Department of Health, 2020, Ireland	Mental health strategy document	Builds on the *Healthy Ireland, Sláintecare,* and *A Vision for Change* strategies to review policy goals for mental health, focusing on the role of primary care, co-location of multidisciplinary Community Mental Health Teams (CMHTs) with primary care providers, and integration of services for people with SUD in the context of health service regionalisation.
11	Department of Health and Children, 2001, Ireland	Strategy document for primary care	Although somewhat dated, this strategy was never updated and is important because of the emphasis it places on an integrated, multidisciplinary team approach to primary care and the use of co-location with specialised services to improve access to and collaboration with primary care centres situated near deprived areas.
12	Det Kongelige Helse- og Omsorgsdepartement, 2015, Norway (Norwegian)	National strategy to tackle substance abuse	This document summarises current knowledge of substance-related harms and treatment responses, noting the different roles of municipalities and the central State and the volume of services provided. The important role of the voluntary sector is noted, as is the link between tackling substance use problems and promoting public health. The 'escalation plan' emphasises the importance of coordinated efforts for prevention, harm reduction, and treatment, and the complex needs of service users must be addressed using coordinated and multidisciplinary approaches.

No.	Author, year, and country	Type of study	Summary
13	Det Kongelige Helse- og Omsorgsdepartement, 2024, Norway (Norwegian)	National strategy to tackle substance abuse	This document indicates that the Norwegian Government regards SUD as equivalent to other medical conditions, which means that the organisation of services should follow the same principles as health services more generally, avoiding the creation of parallel systems. GPs are obliged to conduct annual health reviews for patients with SUDs. Integrated and coordinated care pathways between service levels are to be supported.
14	Dipartimento delle Dipendenze, 2011, Italy (Italian)	Policy document that describes how addiction services should be organised	The emphasis in this document is on the coordination of services across the entire national territory so that clear national guidelines are provided to the regions, which will have responsibility for adapting them to local conditions. The government notes that the regions ignored a previous agreement obliging them to introduce *dipartimenti delle dipendenze*, exacerbating disparities and obstructing the involvement of voluntary organisations. Addiction services are to remain distinct from mental health services, and the role of the new departments is to improve clinical governance and coordination between local treatment centres and the welfare system as a whole.
15	Drug Commissioner of the Federal Government, 2012, Germany	National strategy for tackling substance abuse	Although rather dated, this is the most recent strategy document for Germany. It covers illegal drugs, as well as alcohol, tobacco, and psychotropic prescription drugs. The document describes the structure of the treatment system and the role of each level, and focuses on the need for networks and integrated care in order to manage the interface between sectors, levels, and services.
16	Expert Group on Mental Health Policy, 2006, Ireland	National mental health strategy	CMHTs should serve defined populations and operate from community-based mental health centres through reconfigured catchment areas covering 250,000–400,000 people. At the same level there should also be a specialist substance abuse mental health team for patients whose mental health problems are driven by substance misuse.
17	Gjersing, Waal, Røislien, Gossop, and Clausen, 2011, Norway	National cross-sectional multicentre design using information gathered as part of the annual assessment of the opioid agonist therapy (OAT) programme	Discusses the role of regional and municipal service providers and national organisations, and emphasises the fact that treatment in Norway relies on long-term three-way collaboration between a specialised OAT centre, a GP, and social services, with marked regional disparities in clinical practice even though regional managers meet each year.

No.	Author, year, and country	Type of study	Summary
18	Government of Sweden, 2022, Sweden	National strategy on addictions	This strategy covers alcohol, narcotics, doping, nicotine products, and gambling. It adopts a public health perspective, and gives the Public Health Agency of Sweden overarching responsibility for national coordination. Regions remain responsible for treatment and rehabilitation (to be provided by the health service), while municipalities remain responsible for prevention and social support, as well as for developing a local strategy that reflects national objectives but is adapted to local needs.
19	Häkkinen and Lehto, 2005, Finland	Descriptive, qualitative analysis of the reform of health service administration in Finland, including drug treatment	Describes the impact of regionalisation policies in the 1990s, the shift towards commissioning services from private firms and third sector organisations, and the role of national agencies in monitoring.
20	HM Government, 2021, UK	English drug strategy	This strategy aims to improve service delivery so that people everywhere in England can expect the same quality of service. Local areas will be held to account at national level, and are expected to build a strong partnership between all relevant organisations and individuals and to develop a local strategy. A new commissioning quality standard will be introduced to promote effective joint working and an outcomes framework will be published.
21	Irish Focal Point, 2019, Ireland	Country Drug Report for Ireland, submitted to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA)	Provides an overview of the structure of the drug treatment system in Ireland and the role of the Health Service Executive (HSE), non-governmental organisations (NGOs), and the Local Drug and Alcohol Task Forces.
22	MacGregor and Thickett, 2011, England	Descriptive analysis of changes to English drug policy since the 1990s	Describes ways of improving the democratic accountability of local authorities and the impact of various policies, including guidelines for commissioning services, changes to primary care, ways of targeting need, and new funding mechanisms.
23	Michels and Stöver, 2012, Germany	Descriptive analysis of harm reduction policies in Germany	Describes the organisation of treatment in Germany, focusing on the role of the regions and corporatist bodies. The authors note that OAT in Germany has been completely integrated into primary health care.
24	Michels, Stöver, and Gerlach, 2007, Germany	Descriptive analysis of the development of OAT in Germany	The integration of specialised addiction treatment within the regular health system is not complete, although cooperation at regional level is satisfactory. There are great variations in the provision and quality of psychosocial therapy across the regions. Despite the fact that social insurance guidelines are effective nationwide, there are variations among the *Länder*.

No.	Author, year, and country	Type of study	Summary
25	Ministerio de Sanidad, 2022, Spain	National action plan on addictions	As part of this plan, the government proposes the development of quality standards for treatment programmes and services throughout the country.
26	Ministro per le politiche giovanili, 2022, Italy	National action plan on addictions	This action plan aims to define the links between different forms of public planning at the local, regional, and national level, involving all key stakeholders in a process of joint planning. It refers to the need to develop standardised treatment pathways and to improve clinical governance, noting the confusing variations in how services are organised at regional and local level.
27	Mission interministérielle de lutte contre la drogue et la toxicomanie, 2013, France (French)	National strategy on addictions	This strategy covers all substances as well as behavioural addictions. It focuses on describing a number of principles that services should follow. It mentions local treatment centres and suggests that specialised addiction treatment should interface more effectively with the primary care system and that the treatment system should improve its ability to address the general health and mental health needs of people with addictions.
28	Mission interministérielle de lutte contre la drogue et la toxicomanie, 2018, France	National strategy on addictions	The previous focus on coordinated service delivery is maintained in this document, which discusses primary care and the system of microstructures. There is a network of 42 of these across the country, comprising a psychologist and a social worker, whose job it is to work alongside GPs to enhance their ability to treat patients with SUDs. The strategy mentions the need to improve the implementation of standardised pathways based on the multidimensional assessment of treatment needs.
29	Mission interministérielle de lutte contre la drogue et la toxicomanie, 2023, France	National strategy on addictions	There is a need for alliances of stakeholders at local level, including elected representatives, to implement policies to reduce drug-related harms. Regional prefectures should draw up regional plans, and project-based funding is to be made available to local authorities that wish to develop local responses. Ongoing reforms provide an opportunity to integrate addiction treatment into a regional health approach, focusing on multidisciplinary primary care centres.
30	National Treatment Agency for Substance Misuse, 2006, UK	An updated overview of evidence-based models of care for SUD based on consultations with commissioners, service providers, and service users	The NHS has moved rapidly from being a provider-driven service to a commissioning-driven service. The aim is that GPs will be responsible for assessing health needs and making commissioning decisions. Those involved need to consider how best to manage local drug treatment systems. Patients in all areas should have access to multidisciplinary support within the primary care setting.

No.	Author, year, and country	Type of study	Summary
31	National Working Group for Dual Diagnosis, 2023, Ireland	A model of care for people with dual diagnosis in Ireland	The strategic aim of the HSE is for dual diagnosis services to operate as a tertiary level service providing support to CMHTs, Community Child and Adolescent Mental Health Teams, acute inpatient psychiatric units for both adults and adolescents, HSE addiction services, and voluntary organisations working in this sector. The document states that "Dual Diagnosis teams will primarily provide services to those with severe mental illness and comorbid mild, moderate or severe disorders due to substance misuse and disorders due to addictive behaviours".
32	Nesvaag and Lie, 2010, Norway	Descriptive analysis of the reform of Norwegian SUD treatment policy during the 2000s	In 2004, responsibility for treatment provision was transferred from the county level to state-owned regional health care agencies. SUD patients and treatment systems were largely unknown to these agencies. New coordinating roles and collaboration networks were developed involving different sectors and disciplines, but procedures for determining eligibility absorb resources.
33	Roy and Buchanan, 2016, UK	Descriptive analysis of SUD treatment policy in the UK following the implementation of recovery-based policy	Following the abolition of the National Treatment Agency, treatment services must compete for resources locally. Local commissioning agencies may overlook the important structural and systemic context of problematic drug use.
34	Stenius and Storbjörk, 2020, Sweden	Article analysing recent procurement regulations for addiction treatment in four Nordic countries (including Norway and Sweden)	Historically, municipalities have a central responsibility in Nordic countries for providing treatment, and addiction problems are seen as social problems to be tackled mainly by social workers and with the involvement of service users in decision-making. The authors analyse some of the main differences between these countries.
35	Stenius and Storbjörk, 2023, Sweden	Article analysing whether organisational aspects of New Public Management (NPM) can generate difficulties for treatment services, using 29 semi-structured interviews with managers and professionals	Since the 1990s, Swedish municipalities have used local public procurement to provide treatment, often within local purchaser–provider models and a large share of contracted private, for-profit services. Problems in collaboration between municipally financed treatment and health care services were mentioned by most interviewees. An ideology emphasising the responsibilities of citizens was an obstacle to providing services for vulnerable groups.
36	Storbjörk and Stenius, 2019a, Sweden	Descriptive analysis of treatment providers, municipal spending, and ideology of local government spanning 1999–2014	Describes the main features of the decentralised Swedish SUD treatment system, focusing on local authorities and commissioning. Describes the arrival of larger corporate firms in Sweden as a result of large, formalised procurement.

No.	Author, year, and country	Type of study	Summary
37	Trinidad Requena, Martín-Lagos López, and Fernández Alonso, 2004, Spain (Spanish)	Descriptive analysis of administrative decentralisation of the Spanish drug treatment system	This study emphasises the difficulties faced by the central administration in coordinating care given the large regional differences in policy and practice. New forms of coordination are required in order to reduce disparities, reduce duplication of services, and improve outcomes. A national monitoring system is needed, based on performance indicators.
38	Vogt, 2009, Germany	Descriptive analysis of the evolution of local policy in Frankfurt in the 1990s and 2000s	In the 1990s, the city council of Frankfurt influenced policies not only at the local level, but also in relation to the region and national state. The article describes the development of innovative treatment centres and how the different levels of administration influenced this.
39	World Health Organization, 2009, International	International guidelines	This document proposes that drug treatment systems should be planned as part of the community's overall resources for dealing with health and social problems. Treatment within the primary care setting requires the integration of addiction, medical, and mental health services into mainstream services. Treatment services should aim to offer on-site, integrated, comprehensive psychosocial support to every patient.
40	World Health Organization, 2020, International	International guidelines	The authors point out that the relationship between SUD and other mental health disorders is very complex, and the latter often predate the onset of substance use. Drug use disorders often take the course of a chronic and relapsing disorder. Essential treatment services should be available at different levels of health systems, from primary care to specialised treatment programmes. Treatment systems should not be considered separately from broad health and social care systems.

3.5 Consultation with experts

Because the existing scientific literature has not systematically addressed the topics at the centre of this research project, we consulted with a group of experts. We drew up a list of academic researchers and qualified administrators in each of the case study countries (plus Ireland), and sent out more than 20 invitations by email. We held online discussions with seven people who responded to our invitations, and each encounter lasted approximately 1 hour. Each discussion was recorded and transcribed in full, and relevant extracts were identified using the terms of reference.

List of participants:

1. **Norway:** Espen Andreas Enoksen, Director of the Centre for Alcohol and Drug Research, Stavanger University Hospital.
2. **Sweden:** Johan Franck, Clinical Director of the Stockholm Centre for Dependency Disorders and Professor of Psychiatry at the Karolinska Institutet in Stockholm.
3. **Ireland:** Dr Sarah Treleaven, former Principal Officer at the Department of Health and Lead for the introduction of the HSE Health Regions.
4. **Portugal:** Kerstin Hoffmeister, Head of Referral and Integrated Care Unit, Institute for Addictive Behaviours and Dependencies (Instituto para os Comportamentos Aditivos e as Dependências).
5. **Spain:** Rosario Sendino Gómez, Deputy Director for Programme Coordination, Government Delegation for the National Plan on Drugs.
6. **Germany:** Ingo Ilja Michels, former Head of the Office of the Federal Drug Commissioner.
7. **Italy:** Professor Gilberto Turati, Università Cattolica del Sacro Cuore, Milan.

4
The regional organisation of drug and alcohol treatment services

In this section, we aim to provide a detailed account of regionalisation processes in eight European countries: Norway, Sweden, the UK, Portugal, Spain, France, Germany, and Italy. To facilitate comparisons, we adopt a structured approach that starts by providing some background information on the national context and the regional structure of the health service in each country, before describing the organisation of the drug and alcohol treatment system and more specific issues such as clinical governance, national coordination, and assessment.

There are considerable differences between European countries in terms of the institutional structure and organisation of welfare. In the Nordic countries, responsibility for many aspects of social care, public health, and prevention is assigned to municipalities, which play an important role in the organisation of drug and alcohol treatment. As a result, the Nordic treatment systems for SUD are based on a close collaboration across different administrative levels and involve social workers in key positions (Storbjörk and Stenius, 2019a).

Local authorities also play an important role in the organisation of treatment in other countries, including the UK and Germany. Indeed, municipalities were often on the front line as the heroin epidemic swept across Europe during the 1980s and 1990s. In many cases, municipalities played a role in developing new kinds of services, with local government in cities such as Liverpool (Ashton and Seymour, 2010) and Frankfurt (Vogt, 2009) adopting innovative approaches to harm reduction that were modelled on the response to acquired immune deficiency syndrome (AIDS) in cities in the United States of America (USA). Vogt (2009) notes that the municipality of Frankfurt was actively involved in debates about drug policy at the regional and even federal level in the first half of the 1990s, and similar experiences emerged during our interviews:

> *But in Germany, it started on the local and municipality level. Cities like Hamburg, for example, and Frankfurt started also with these kinds of action plans. And later on, the federal government also started. The coordination of drug policy was based in the Ministry of Interior. … Later on, when there was a change of government in 1988, that change led to the implementation of the National Drug Commissioner in the Ministry of Health. (Interview with Ingo Ilja Michels, former Head of the Office of the Federal Drug Commissioner in Germany, 16 October 2025)*

Because of the multidimensional nature and complex aetiology of SUDs, there is considerable variability in the treatment settings in which services are delivered, including social care, the general health service, specialised addiction services, psychiatric clinics, and the criminal justice system (Babor *et al.*, 2008). This leads to further differences and complexity when seeking to compare treatment systems. In European countries, specialised outpatient treatment services for SUD are usually provided either by health professionals (perhaps with the involvement of social workers) or within mental health services. In some countries (primarily in continental Europe), drug treatment services can be provided in one or the other of these settings based on the local or regional context.

Another key aspect of drug and alcohol treatment services is their articulation across different levels of organisation, from primary care to specialised inpatient treatment. As the World Health Organization (2009) observes, there are a number of advantages to grounding SUD treatment in the primary health network:

> *Treatment in primary care also has the advantage of integrating addiction, medical and psychiatric services into mainstream services, reducing the stigma of addiction and the professional isolation of medical staff. Integration also reduces some of the problems that clinics can develop when large numbers of patients on opioid agonist maintenance are aggregated. (World Health Organization, 2009, p. 12)*

Although collaboration between mental health care and addiction treatment services is essential for the development of effective services, the relationship between these areas is often characterised by tensions:

> *Following many decades of separation, the mental health and addiction fields have developed independent interventions, workforces, clinics, concepts of recovery, and funding streams … Despite enormous rates of overlap between mental illnesses and substance use disorders (greater than 50% comorbidity for some conditions; Kessler et al., 1996; Regier et al., 1990), both fields have been slow to modify their approaches to serve clients with co-occurring disorders… (Drake and Bond, 2010, p. 252)*

A similar observation is made by Kunnes *et al.* (1993), who suggest that the different languages, values, and practices of these disciplines could potentially enrich services, if they can overcome the aforementioned obstacles:

> *…in general, the field of substance abuse has evolved in isolation from the primary health care, mental health, and public health systems. This isolation is so notable that it has been suggested that medicine, mental health, public health, and alcohol and drug treatment represent separate cultures, with different languages and values. Effective action to reduce or eliminate alcohol and drug abuse must draw upon the strengths of each of these fields and unify them into a comprehensive system. (Kunnes et al., 1993, p. 26)*

In Sections 4.1–4.8, we will describe regionalisation processes in our case study countries, drawing on all available sources of information on drug and alcohol treatment systems and how they relate to the wider health service.

4.1 Norway

Norway is a constitutional, parliamentary monarchy with a national parliament, 15 County Councils and 357 Municipalities. There is a comprehensive National Insurance Scheme funded by contributions by employers, employees, the self-employed, and the State, but general taxation is the main source of revenue for the health service. The role of national Government (in the form of the Ministry of Health and Care Services) is to pass legislation, to oversee the implementation of national policy, and to supervise health and social care services. All residents are entitled to receive essential health care, although there is no defined package of essential services.

4.1.1 Regional structure of health service

In 2020, the Norwegian Parliament reduced the number of counties from 19 to 11, but this reform was modified in 2024. Until 2002, the counties were responsible for planning, building, and managing hospitals, and in 2004, most of these responsibilities were transferred to five (now four) regional health authorities (RHAs).[10] Each year, the Ministry of Health and Care Services sets goals for the RHAs, and they receive a block grant based on a funding formula. Each region has one university hospital which offers a wide range of services, and some hospitals are also national nodes for the treatment of conditions requiring a high degree of specialisation.

The counties still exist and are responsible for the secondary education system, public transport, cultural activities, and monitoring the health status of the population. There is a network of County Medical Officers who represent the Ministry of Health and Care Services at this level. The Municipalities are responsible for the provision of primary care as well as health care for elderly people and those with disabilities. A universal GP scheme was introduced in 2001, and the majority of GPs are self-employed, with nationally agreed contracts with Municipalities.

Patients are generally free to choose a GP, and this is encouraged, as GPs act as gatekeepers for specialist services and elective procedures. Patients can also choose which hospital to attend, including those located in other European Union countries. GPs typically work at a joint practice, with between two and six physicians and some nurses and auxiliary personnel (Sperre Saunes *et al.*, 2020). GPs carry out shifts at local emergency centres in order to provide out-of-hours emergency care. There is some cost-sharing, with annual limits on individual spending (roughly €200 at present) that are set by law. A split between purchasers of services and providers, following the NPM model, was introduced in the early 1990s, under the influence of developments in Sweden. However, this experiment was mainly limited to the provision of care services by Municipalities. This system is still used, and is appreciated by local authorities and service users, with outsourced services generally being of good quality (Sperre Saunes *et al.*, 2020).

The Norwegian health service is relatively decentralised, and over the past decade, most reform efforts have focused on improving coordination between RHAs and Municipalities:

10. These are as follows: (1) Northern Norway (Helse Nord); (2) Central Norway (Helse Midt Norge); (3) Western Norway (Helse Vest); and (4) South-Eastern Norway (Helse Sør-Øst).

> *According to this Plan, which at the time of writing in December 2019 has not yet been fully implemented, all hospitals are envisaged to be organized in networks, with regional hospitals, larger acute care hospitals (providing specialized emergency care for 60,000–80,000 or more inhabitants) and acute care hospitals with elective surgery and some acute care functions (specified and planned according to local needs). Within this network there are about 50 highly specialized competence centres providing services on a national scale. … Specialist care is concentrated in urban areas, and people living in rural areas have to travel longer distances to access specialist services. (Sperre Saunes et al., 2020, pp. 104–105)*

The RHAs are responsible for the provision of specialised care, including mental health care and treatment for SUDs. Most outpatient care is provided by hospitals via 'polyclinics' that treat general health conditions as well as mental health problems and SUDs. Mental health centres also provide acute treatment and rehabilitation services outside the hospital network. About one-quarter of specialised outpatient care is provided by self-employed physicians who have contracts with the RHAs. While in the second part of the 20th century most reforms in Norway had the effect of devolving decision-making from the central to the municipal level, a combination of centralising and decentralising tendencies has been observed in recent years (Sperre Saunes *et al.*, 2020, p. 20).

4.1.2 Drug and alcohol treatment system

Norway and Sweden have in common a history of treating addiction problems "as social problems, handled within the social services, by social workers and with lay persons' involvement in decision-making, rather than as medical problems" (Stenius and Storbjörk, 2020, p. 9). There are a number of similarities between the Nordic countries in this regard, in terms of the ethos and organisation of drug treatment services (see, for example, Häkkinen and Lehto, 2005). In 2015, the Norwegian Government presented a new action plan addressing substance use and addictions entitled *Prop. 15 S: Action Plan for Alcohol and Drugs (2016-20)* (Det Kongelige Helse- og Omsorgsdepartement, 2015). This was followed in 2024 by a White Paper entitled *Safety, community and dignity: The reform of prevention and treatment services for substance abuse* (Det Kongelige Helse- og Omsorgsdepartement, 2024). This plan describes SUD as an important factor contributing to social disparities in health and notes how the stigmatisation of problem substance use exacerbates inequalities in access to health and social care. In order to address these issues, it is necessary to implement evidence-based treatment and to improve coordination between services and sectors:

> *This means applying a normalisation perspective to care and follow-up: the organisation of services should follow the same principles of priority and structure as for any other group of patients, avoiding the creation of parallel or overly specialised systems that drain resources. (Det Kongelige Helse- og Omsorgsdepartement, 2024, p. 13, our translation)*

Since 2004, the RHAs have had responsibility for SUD treatment, with service provision carried out in collaboration with Municipalities, which provide social care (Nesvaag and Lie, 2010). This represents a partial break with the traditional view of SUD as social problems, and was motivated by the need to improve integration between general health, mental health, and SUD treatment. Clinical pathways for substance abuse treatment are currently being developed based on the principle that treatment should start immediately after detoxification:

> *When we had the hospital reform in 2002, the counties still had responsibility for alcohol and drug treatment, because they didn't do anything about that in 2002. But the question came, and it was seen as strange that the counties should have responsibility for it. (Interview with Espen Andreas Enoksen, Director of the Centre for Alcohol and Drug Research, Stavanger University Hospital, 17 October 2025)*

Patients need a referral (often from the social care system) in order to access specialised treatment services. The system comprises specialised inpatient and outpatient services, community teams, low-threshold services, and rehabilitation services (Stallvik *et al.*, 2019). In general, drug and alcohol treatment in Norway relies on a long-term three-way collaboration between a specialised treatment centre, a GP, and municipal social services (Gjersing *et al.*, 2011). These services are referred to as multidisciplinary specialised services for substance abusers (*tverrfaglig spesialisert rusbehandling*) within the context of the Rusreform (substance treatment reform) of the early 2000s (Nesvaag and Lie, 2010, p. 655). This formulation acknowledges that although SUD treatment forms part of the wider health service, it has a number of specificities:

> *We use a very strange term, I don't remember the word in English now, but it's something like 'special interdisciplinary treatment'. … I think that people – the service users, the clinicians and the leaders – are quite happy with this idea of interdisciplinary health services. Because that's a way of trying to keep everybody happy, but also, I guess, not completely disturbing what's working at the moment and maintaining a sense of involvement of the different levels. (Interview with Espen Andreas Enoksen, Director of the Centre for Alcohol and Drug Research, Stavanger University Hospital, 16 October 2025)*

Following the shift towards viewing SUD as primarily a health condition, efforts are being made to improve the integration of SUD treatment within the regional health system while maintaining a link with municipal social services. This reflects the Nordic focus on resolving social issues like housing and employment and tackling health issues in a holistic manner in SUD treatment (Stallvik *et al.*, 2019), as well as reflecting the preferences of the powerful organisations of service users. The Norwegian Focal Point on Drugs (2019) provides the following summary:

> *…the drug policy reform of 2004 stipulates that the four regional health authorities in Norway are responsible for the specialist treatment of drug and alcohol users, while the municipalities bear overall responsibility for providing general and mental healthcare services, outreach outpatient services/community teams, services for next of kin, low-threshold services, assessment and referral to treatment, and follow-up during and after treatment in the specialist health services or in prison. … In general, OST provision follows a basic model of a tripartite collaboration comprising social security offices, general practitioners and the specialist health services. (Norwegian Focal Point on Drugs, 2019, p. 19)*

Nesvaag and Lie (2010) provide some useful insights into the challenges faced by the Norwegian administration during the process of reform, as administrators sought to construct an effective regionalised drug and alcohol treatment system that was integrated into the wider health service. The budget for SUD treatment was initially increased by 40%, which still was not sufficient to accommodate the increased demand, because treatment systems were becoming more effective at identifying patients and responding to their problems, which meant that more people were being referred for treatment.

Recent proposals for improving drug and alcohol treatment have focused on increasing capacity and improving integration between addiction services and mental health services (Stenius and Storbjörk, 2020). Although the relationship between these systems is by no means perfect, progress has been made over the past two decades; improving collaboration between general health and mental health care services was also one of the strategic aims of the reforms of the early 2000s (interview with Espen Andreas Enoksen, Director of the Centre for Alcohol and Drug Research, Stavanger University Hospital, 17 October 2025).

Nesvaag and Lie (2010) note, however, that these reforms have created a need for many formal assessment procedures. The time-consuming and bureaucratic nature of these procedures has diverted many highly qualified professionals away from treatment and created friction at the interface between services (see Oldeide *et al.*, 2021). As we noted previously, this problem is frequently generated by NPM-style reforms, and Nesvaag and Lie (2010) emphasise the role played by direct, informal personal relationships (as opposed to formal or bureaucratic procedures) in facilitating the integration of services.

Oldeide *et al.* (2021) point out that when service providers (like outreach social workers, for example) build up a strong relationship with their clients, they are more likely to understand their multifaceted needs and to activate links with other services. Conversely, if each service is disconnected, and cooperation is rare and highly bureaucratised, it becomes more difficult to develop therapeutic relationships. Operators working in specific services can sometimes lose sight of broad, aspirational policy goals and forget that they should come before organisational rules, which is why proactive management and professional development are important. Oldeide *et al.* (2021) observe that professional groups with a higher level of intrinsic motivation and a less conventional approach to service delivery (like outreach social workers helping young people with SUDs) tend to be more willing to step outside the perimeter of existing work practices in order to find integrated solutions that meet the needs of their clients. This also suggests that integration and collaboration require innovative actions on the part of operators, who must be empowered by managers and administrators to 'think outside the box'.

Another strategy that has been pursued in certain areas of Norway involves the creation of hybrid services that do not rely on inter-organisational cooperation because they bring together different disciplines and sectors within a single structure, which is jointly funded by a Municipality and a specialised health care provider:

> *One other kind of strategy that can be observed locally, and which tries in a more fundamental way to avoid this problem, is a bottom-up organizational strategy where local service managers, both in the specialized healthcare and primary care systems, develop new treatment delivery organizations that structurally cross the borders between these systems… By placing themselves at the border between existing services at different organizational levels, they try to fill the gaps between services and thereby also prevent breaches in the treatment and rehabilitation processes. (Nesvaag and Lie, 2010, pp. 663–664)*

These authors argue that the challenges posed by the reorganisation of treatment services in the context of regionalisation can only be overcome by investing additional resources in training programmes, service development, and recruitment, under the guidance of a proactive management team:

> *For the regional health enterprises and many of the other specialized healthcare services, the treatment and rehabilitation system for substance abusers and the patient group itself constituted largely unknown parts of the healthcare and social-service systems, with their own peculiarities regarding organization, ideology, and treatment practices. … Many general practitioners and the somatic specialized health services had little knowledge or experience in working with substance abusers, and had to be followed up both by educational activities and development projects. (Nesvaag and Lie, 2010, p. 659)*

Funding for the treatment of SUD in Norway is now based on a combination of block grants, activity-based funding, and a small incentive for high-quality services. Activity rates are measured using the Nordic diagnosis-related groups system (Sperre Saunes *et al.*, 2020; Stenius and Storbjörk, 2020). General health services and mental health services are funded using separate systems, with drug and alcohol treatment services being included within the latter category, but with a special status, as already mentioned. In 2017, about one-half of Municipalities purchased mental health or addiction treatment services from third sector organisations (especially in the smaller Municipalities), and profit-making firms had only a small role in service provision in the main urban areas (Stenius and Storbjörk, 2020).

4.1.3 National coordination

In 2012, the Coordination Reform was introduced, which established network governance structures across the health service, including hospitals, specialised services, and Municipalities (Sperre Saunes *et al.*, 2020). This reform is generally viewed as intensifying the pressure to decentralise care to the lowest level possible, which is why multidisciplinary primary care teams have also been piloted (2018–2021), with the aim of creating community clinics that are responsible for working in a proactive manner to meet the needs of their patients. Quality monitoring and performance standards have been implemented by the central administration.

4.1.4 Clinical governance

Quality assurance is legally required for all institutions that provide health or care services. Under the Municipal Health and Care Act (2011), the Directorate of Health at national level has exclusive responsibility for the development and dissemination of clinical guidelines; there are currently about 400 guidelines covering various aspects of the health service. The Directorate is the main source of advice for the Government, and coordinates national prevention, ensuring that policies are implemented at local level in accordance with the Ministry's guidelines:

> *I was in the committee making the national guidelines for interdisciplinary drug treatment. And that was a very good thing, because when we became part of this Health Trust, they said "Okay, we need to have the same kind of guidelines as for other diseases". So the whole field was lifted up. And when they said that they wanted our research centre, it was because they said "Okay, we have research centres for very many different somatic diagnoses and we need the same when it comes to… [We just apply the same approach for substance use?] Yeah, we need the same here. We have to know what we are doing, what is working". (Interview with Espen Andreas Enoksen, Director of the Centre for Alcohol and Drug Research, Stavanger University Hospital, 17 October 2025)*

4.1.5 Monitoring and evaluation

The Norwegian Institute of Public Health produces annual overviews of population health, as well as health profiles for counties and Municipalities. A 2014 Act distinguishes between consent-based registries of health data and statutory registries, which do not require consent. Under the Statistics Act of 1989, it is possible to link health data with information from other databases for research purposes. Each RHA has a service user committee, and the level of participation in these bodies is very high.

4.2 Sweden

Sweden is a parliamentary, constitutional democracy with a proportional election system; elections for all three levels of government (central, regional, and municipal) are held on the same day every 4 years. The national level of the health service influences policy through legislation, regulations, supervision, and financial incentives. The central government, Regions, and Municipalities levy proportional income taxes, and regional/local tax revenue is supplemented by national grants and user charges.[11] There is no defined package of benefits, although the relevant authorities are expected to meet the health needs of their citizens. Recent reforms focus on person-centred care and the implementation of standardised clinical pathways. Patients can receive outpatient care at hospitals or by attending specialists located throughout the country, irrespective of where they live, and can also receive inpatient care in other regions (Janlöv *et al.*, 2023).

4.2.1 Regional structure of health service

In Sweden, responsibility for health care is delegated to 21 Regions and 290 Municipalities, and both are required to set priorities based on population needs and available resources. The population of the Municipalities varies from less than 3,000 in Bjurholm to almost 1 million in Stockholm, and the Regions vary between about 150,000 and 2.5 million inhabitants. The regions allocate resources to health care providers and monitor their activities.

The health care system is highly integrated within each region, and includes a varying mix of public and private outpatient service providers. Primary care centres, community emergency centres (in urban areas), and child and maternal services are entirely funded by the Regions. Due to the implementation of freedom of choice among providers, there is no longer a network of primary care centres with defined geographical catchment areas. The primary role of the Municipalities is to fund, organise, and provide care to elderly people and those with functional impairments (e.g. via nursing care in the home) and to provide preventive health care in schools (all of this accounts for about 25% of total health care expenditure). The Municipalities also have responsibility for the provision of primary and secondary education as well as childcare during the preschool years.

11. Fees are charged for almost all types of services, but the annual limit is low, at just over €100 for services and just over €200 for pharmaceuticals.

The use of contract-based governance is now the norm in primary care, with payments following the patient's choice of provider. Recent policy reforms have sought to reduce hospitalisation and length of stay by strengthening primary care. This has led to the development of primary care centres with 4–6 physicians, nurses, psychologists, occupational therapists, and other health care professionals working as part of a multidisciplinary team and increasingly relying on digital consultations. These centres are intended to act as the first point of contact for citizens. Most health workers are salaried employees in Sweden, and are represented by professional unions. At national level, the Public Health Agency of Sweden has overall responsibility for overseeing implementation of the alcohol, narcotics, doping, and tobacco strategy.

4.2.2 Drug and alcohol treatment system

In Sweden, the regions are responsible for providing detoxification facilities and OAT for problem drug use, as well as for the treatment of any comorbid psychiatric disorders. The Municipalities, by contrast, have responsibility for psychosocial therapy and long-term social rehabilitation (Swedish Focal Point on Drugs, 2019). Treatment for SUD is often managed autonomously by the social services offices of individual city districts (in Stockholm, for example). Notwithstanding the formal responsibilities of the regions, many of these city district or municipal services provide OAT, counselling, and psychological treatment within their own facilities (Blomqvist *et al.*, 2009; Storbjörk and Stenius, 2019a):

> *So in the Stockholm Region, for instance, our clinic is working with all of the local councils except a few: out of a total of 26 councils, we work with 23. Two of these have private health care providers for addiction care, as per procurement contracts. The City of Stockholm itself has 12 boroughs which are each run like a small city council. Interestingly, these have somewhat varying approaches to care and support for people with substance use disorders, in spite of being part of the same administration. (Interview with Johan Franck, Clinical Director of the Stockholm Centre for Dependency Disorders, 27 February 2026)*

The management of addiction services is highly centralised in this city, coming under the jurisdiction of the Stockholm Centre for Dependency Disorders, which has around 900 employees, a budget of roughly €95 million, and between 30 and 40 outpatient clinics, which collectively provide care to 25,000 patients each year, with an additional 18,000 people attending two specialised emergency rooms for SUD (interview with Johan Franck, Clinical Director of the Stockholm Centre for Dependency Disorders, 27 February 2026). The majority of people working in the clinics, providing and managing services, are psychiatrists. The development of a more sophisticated understanding of SUDs, the availability of relatively effective forms of treatment, and the fact that addiction is the most common psychiatric disorder has contributed to improvements in the profile and status of this field within the broader discipline of psychiatry. The need to provide integrated care for patients with dual diagnosis is also widely recognised:

> *Previously, people with alcohol problems and psychiatric comorbidities – for example, depression – might have been told to "go to the addiction clinic and then come back after six months of sobriety" before being admitted to a psychiatric treatment service. Not anymore! Psychiatric outpatient clinics are now encouraged to treat the alcohol problem within the context of a depression treatment programme, to a certain degree, but if treatment goals are not reached, then the addiction treatment service steps in and offers more intense interventions. Before, general psychiatry was like: "we don't do anything with addictions, that is your task". But patients with substance use disorders may also have bipolar disorder, they may have schizophrenia, they may have depression, and so forth, so they're psychiatric patients and they're our citizens, so they have the right to treatment, and treatments should be coordinated and provided simultaneously. That's a huge change in mentality, if you ask me, over the last 30 years. (Interview with Johan Franck, Clinical Director of the Stockholm Centre for Dependency Disorders, 27 February 2026)*

Mental health care is part of the Swedish health service, and is subject to the same laws and regulations as general health care. Mental health disorders are considered to include substance abuse and addiction issues, but for historical reasons, social workers also played a central role in the assessment of treatment needs and in the delivery of outpatient services (Stenius and Storbjörk, 2023). This is why parts of the mental health care system fall under the responsibility of the Municipalities, including some services for substance abuse and addiction (Janlöv *et al.*, 2023, p. 134). In February 2026, the Swedish Government passed legislation assigning full responsability for SUD treatment to the regions.[12] This decision was based on the results of a government report published in 2021 that highlighted the need for SUD treatment to be coordinated with treatment for other psychiatric conditions (Janlöv *et al.*, 2023, p. 135). Once implemented, this reform will yield a more uniform level of service provision, overcoming some of the ambiguities generated by the special status that was previously attributed to addiction services:

> *Sometimes it is suggested that patients with substance use disorders and other co-occurring mental illness need to be approached in a "special" way and need more intense collaborative interventions than other psychiatric patients, but many other comorbidities require that too. What isn't special? I mean, come on, this is the eternal argument: that substance use makes treatment especially difficult and sets it apart from other psychiatric disorders! Because if you have schizophrenia, it's very similar, I mean everyone concerned needs to be involved in the treatment of a patient with schizophrenia. If you are a geriatric patient and you can't walk and you can't eat, a lot of stakeholders need to be involved, and so on. So it's really not specific to substance use disorders, it's just stigma and prejudice. I'm sorry, but this is what it is all about! So we have to treat people with substance use disorders like everyone else: it's a health problem. And finally Sweden is taking the last step in that direction, by new legislation due in 2027 that puts the responsibility for substance use disorders treatment entirely on the health care services, which is a huge thing. (Interview with Johan Franck, Clinical Director of the Stockholm Centre for Dependency Disorders, 27 February 2026)*

12. See: https://www.regeringen.se/pressmeddelanden/2026/02/regeringen-starker-varden-for-personer-med-skadligt-bruk-och-beroende-och-andra-psykiatriska-tillstand/ (consulted in March 2026).

In contrast to Norway, where the outsourcing of addiction treatment services has tended to favour associations and non-profit-making foundations, Sweden relies more heavily on for-profit enterprises. Complex procurement processes have given rise to a shift from the local to the national level in some cases, counterbalancing the high level of decentralisation that has historically characterised the welfare system (Stenius and Storbjörk, 2020). At the same time, in Regions with stable left-wing majorities, direct provision of health care by state-run service providers tends to be more common. Because of the nature of the commissioning process, social care providers and service users have little or no influence over the design of services:

> *NPM is at first glance incompatible with a social democratic regime, with big government and a universalistic welfare state. … From the 1980s, the Right, in line with the Anglo-American trends, propagated market models and privatization in production as a new welfare vision to shrink the scope and size of the public welfare state. The social democrats, who lost the 1976 elections and came back in 1982, regarded the shrinking legitimacy of the welfare system as their core political problem. Reform seemed necessary. For the social democrats, municipal steering, with a separation of decisions about allocations and needs assessment from the production of services (purchasing-provider models), was an administrative reform to promote service diversity, citizens' choice, lower costs, and better quality… (Storbjörk and Stenius, 2019a, p. 777)*

As we mentioned previously, there are many similarities between the Nordic countries in terms of how welfare services are organised, the culture of drug and alcohol treatment, and the structure of the public administration. As in Norway and Sweden, the Finnish Government is also implementing a reform of its welfare system that incorporates elements of regionalisation. The Municipalities are responsible for public health care and primary care is delivered in local multidisciplinary centres, which include psychologists and psychiatric nurses (Pucci *et al.*, 2011). There are 18 new Regions, which are much larger than the 300 Municipalities that were previously charged with providing services (Hirschovits-Gerz *et al.*, 2019). This is a good example of how regionalisation can involve rationalising and aggregating care rather than necessarily decentralising decision-making:

> *In Finland, the whole system of health services is undergoing a phase transition from a decentralized municipality-based organization towards larger and more centralized basic units. In Nordic countries, there is a general trend towards greater centralization of health services in order to have better control over access to and quality of services. Decentralization of services has been an effort to increased local democracy, but this increase of democracy came with the price of increased variation in quality and access to health care. (Korkeila, 2009, p. 87)*

In the first draft of the Finnish reform law, mental health services and the addictions treatment system were included within the list of services to be organised within health districts. In subsequent years, the Ministry of Social Affairs and Health set up a work group to consider different aspects of this question, and it is now working on clinical models where cooperation between services is structured within the context of specific care programmes, rather than depending on generic rules.

4.2.3 National coordination

The Regions and Municipalities are collectively represented by the Swedish Association of Municipalities and Regions, which promotes local self-government and provides these bodies with a national platform. Government agencies, the National System for Knowledge-driven Management, and the aforementioned association all collaborate to analyse the current and future needs of the population and to develop plans to improve the health service.

Local self-government is intended to generate different solutions rather than similar services across all regions, although the most advanced and complex interventions have been centralised in an attempt to improve outcomes. Janlöv *et al.* (2023) provide the following overview of the current coordination mechanisms:

> *The 21 regions in Sweden collaborate in six larger geographical areas (collaborative health care regions) in which they work together in groups of two to seven regions to ensure full coverage of services for their citizens. Each collaborative health care region has at least one university hospital that serves all the regions in the area (seven university hospitals in total). In 2023, Sweden there are 59 additional regional emergency hospitals and a large number of specialized clinics operating outside emergency hospitals, around 1,100–1,200 PCCs [primary care centres] and approximately 4,430 dental clinics. (Janlöv et al., 2023, p. 24)*

In the late 1980s, cost inflation was blamed on regional autonomy and a lack of accountability, leading to reforms inspired by the NPM approach. The aim was to create a purchaser–provider split and to provide citizens with the possibility of choosing between competing service providers. However, many Regions returned to centrally planned services following the financial crisis of 1990–1994 (Janlöv *et al.*, 2023). After 2015, most Swedish Regions abandoned casemix reimbursements for hospitals, marking a shift away from NPM, although market mechanisms remain important within the primary care system. As Storbjörk and Stenius (2019b) observe, NPM-inspired policies tend to create a fragmented system which reduces scope for the coordination of services, while also undermining the continuity of care. The managers and professionals interviewed by Stenius and Storbjörk (2023) repeatedly referred to barriers to cooperation between municipally financed treatment services and the health care system: "The interview data show that social workers prefer everywhere an organization where statutory [social] work and outpatient treatment is handled within the same budget and under the same political board and administrative leadership, preferably even, according to several interviewees, sitting in the same building" (Stenius and Storbjörk, 2023, p. 43).

As far as health care is concerned, the Swedish Regions have a very high degree of autonomy, which reduces the scope for national coordination:

> *The State basically governs our health care by, how do you say, by normative laws and regulations and also by contributing with special targeted grants to these Regions. Some of these grants are linked to performance. For example, if a health care provider can shorten its waiting lists, then you get more money from the state and so on. But that money is really a fraction of the total cost, it's like one or two percent of their actual costs for a certain health care service so the impact is not always impressive. (Interview with Johan Franck, Clinical Director of the Stockholm Centre for Dependency Disorders, 27 February 2026)*

4.2.4 Clinical governance

During the early 1990s, attempts were made to improve services for people with functional impairments or mental illness through integration between regional health care and municipal social services. The health sector has been undergoing change in recent years:

> *Ongoing reforms have been directed at strengthening the primary care sector and emphasize quality, prevention and person-centred services. Specialist care reforms have focused on the implementation of evidence-based and standardized care processes and the concentration of services at both national and regional levels. … Further debates concern how governance and management can support collaboration across regions and municipalities, and the integration of the National System for Knowledge-driven Management into existing governance structures. (Janlöv et al., 2023, p. xvi)*

Growing interest in evidence-based policy-making has led the National Board of Health and Welfare to publish national guidelines for SUD care based on the results of evidence reviews carried out by expert groups, which includes social researchers and practitioners as well as physicians. Even though the experts were divided on this question, the Board has approved psychosocial interventions as a treatment for SUDs, even without OAT (Blomqvist *et al.*, 2009). There have also been initiatives to enhance clinical governance within this context:

> *Before, managers in psychiatric services had no idea what was going on behind the 'locked door' at the outpatient clinic because we had few agreed local processes for assessment and treatment of the various psychiatric conditions, except perhaps general national guidelines. Now, since 15 years, we have a system in place in Stockholm with process charts: they work like a flow chart, and describe – on a general level – the patients' pathways through screening, assessment and treatment for different types of psychiatric symptoms and disorders. This ascertains a minimum level of activities and interventions on a general level and helps the clinic to maintain quality in its health care provision. Now we can ensure that every clinic in our system follows the same process chart and delivers on the target clinical parameters. It means that we all offer the same evidence-based assessments, we take the same tests and so on and differences in quality can be monitored by the management. (Interview with Johan Franck, Clinical Director of the Stockholm Centre for Dependency Disorders, 27 February 2026)*

4.2.5 Monitoring and evaluation

There is no general accreditation system in Sweden for drug and alcohol treatment, although many service providers have their own quality assurance systems. It is mandatory for health care providers to report information from administrative records to more than 100 national registries for monitoring and research purposes. These registries are governed collaboratively and contain individual-level data on diagnoses, treatments received at all levels of the system, and outcomes. Individual data are transferred automatically to the Better Addiction Care registry, for example, based on a simple opt-out system which has a very high level of coverage. There are several frameworks for monitoring the performance of the system using standardised indicators, taking into account the overlap between different types of care.

4.3 United Kingdom

The National Health Service (NHS) was established in 1948 and encouraged many other European countries to move towards a universalistic Beveridge-style system funded by general taxation, with free access to comprehensive care when this is needed. The constituent countries of the UK, unlike most countries in continental Europe, do not have a defined benefit package setting out the entitlements of citizens. The UK was highly influential during the shift towards NPM policies, with one of the key pieces of legislation being the National Health Service and Community Care Act 1990, which introduced the internal market and GP fund-holding, enabling GPs to purchase services for their patients. Hospitals and certain community health services were also reorganised into semi-independent NHS Trusts (Anderson *et al.*, 2022, p. 17).

Over time, major differences in policy have emerged between the historical countries, with Wales and Scotland moving earlier to reject NPM-inspired reforms and to develop systems based on collaboration. In recent years, England has also moved in this direction, following a post-NPM trajectory. This has led to the adoption of integrated care systems (ICSs), which involve partnerships between local councils and NHS organisations in planning and commissioning services (Anderson *et al.*, 2022, p. 18). Choice between alternative service providers is promoted as a way to improve the quality of care, although this is not the case in Scotland, Wales, or Northern Ireland. In 2002, the UK Government introduced a tariff system for hospitals, which has encouraged higher rates of hospitalisation and is increasingly viewed as an obstacle to integrated care (as in Italy).

4.3.1 Regional structure of health service

Following the 1999 devolution settlement, the UK Government reserved some areas of policy-making as its own exclusive responsibility, but responsibility for health and social care, education and training, agriculture, and transport were devolved (UK Focal Point on Drugs, 2019, p. 2). Local councils are responsible for the delivery of most public services, including social care and (in some cases) public health, although a different approach is adopted in England (McCambridge, 2009). Since 2022, 42 ICSs bring together providers and commissioners to plan services in England, with primary care networks having responsibility for providing community services for populations of about 30,000–50,000.

In Scotland, responsibility for providing local health services rests with 14 Health Boards. In Wales, by contrast, three NHS Trusts arrange ambulance, specialist cancer, and public health services, with seven Health Boards planning and delivering health care services at local level. In England and Northern Ireland, public hospitals are managed as Trusts, while those in Wales are generally managed by the Health Boards. In Scotland, the Health Boards plan and oversee the hospitals, although the latter have a local management team with a degree of autonomy.

Primary care in the UK serves as a gatekeeper to specialised care, but increasingly involves a whole team of doctors, nurses, midwives, health visitors, and other health care professionals, with involvement of third sector organisations in the provision of mental health care. GPs work under the General Medical Services (GMS) Contract, although many prefer to work as salaried employees of a practice or Trust (Oxtoby, 2019). GP practices are organised into primary care networks which can provide additional services to their patients, including mental health care.

Community mental health teams work in primary care centres to treat people with mental health problems. Current policy is to involve GPs in the care of people with SUDs, exploiting 'shared care' arrangements (Gerada, 2000). For example, a specialised community drug team may provide initial assessment and treatment planning, meeting patients at their GP's office. There is a mechanism that enables GPs to be paid for services that go beyond what they are expected to provide under the GMS Contract.

4.3.2 Drug and alcohol treatment system

Drug and alcohol treatment services in the UK (and particularly in England) are often subject to local commissioning, which raises complex issues in relation to coordination (National Treatment Agency for Substance Misuse, 2006; UK Focal Point on Drugs, 2019). The main actors in England are the local authorities, which have an average of about 150,000 people.[13] In Scotland this role is carried out by Health Boards, in Wales this is overseen by community safety partnerships; and in Northern Ireland this responsibility lies with the drug and alcohol coordination teams. In the early 2000s, coordination issues were addressed through the notion of 'shared care', where multidisciplinary teams work within a specific geographical catchment area to support GPs in the provision of long-term specialist support for SUDs.

The distinction between different 'Tiers' of drug and alcohol treatment was developed in this context, with Tier 1 broadly coinciding with primary care, Tier 2 mainly involving low-threshold services, Tier 3 denoting community-based specialised treatment services, and Tier 4 referring to residential treatment. The main responsibility for guiding patients within this complex institutional architecture falls on the shoulders of GPs, although in some cases the role of keyworker is assumed by an operator from a drugs project or voluntary body (National Treatment Agency for Substance Misuse, 2006). Since 1984, a booklet containing practical guidelines for GPs has been distributed to GPs, with the endorsement of the Chief Medical Officer (Kalk *et al.*, 2018). Attempts have also been made to develop practice networks within which more advanced models of care can circulate among GPs.

Community-based specialised drug treatment centres are the most common source of treatment, and OAT is generally offered to patients attending these centres through shared care arrangements with GPs (UK Focal Point on Drugs, 2019, p. 20). Kalk *et al.* (2018) observe that the doctors heading these treatment services are usually psychiatrists with accreditation in the area of addictions, or expert GPs with many years of experience in treating SUDs. They also describe the gradual shift that has taken place in service provision over the past 15–20 years towards third sector organisations:

> *Initially, commissioners funded statutory NHS services to provide pharmacological treatment, including in-patient detoxification, whilst third sector services provided advice and psychosocial interventions as well as residential rehabilitation (Turner 2005). Over time, and particularly from the late 2000s onwards, clinicians based in statutory services noticed a difference in the behaviour of third sector organisations. Instead of providing collaborative services, they began to bid, increasingly successfully, to take over existing NHS treatment services. … Third sector organisations were often more responsive to the needs of local commissioners, who were themselves performance managed by a central special health authority — the National Treatment Agency. (Kalk et al., 2018, p. 195)*

13. Responsibility for commissioning SUD treatment passed from the NHS to local authorities under the Health and Social Care Act 2012.

In this context, Integrated Care Pathways (ICPs) aim to overcome the boundaries between services provided by disjointed (and potentially self-interested) private providers. The National Treatment Agency for Substance Misuse (NTA) (2006) advised local commissioners to ensure that service providers were contractually obliged to assign an ICP to each drug and alcohol treatment intervention through service level agreements:

> *The integrated care pathways for each intervention should be designed in a way that ensures good links across a range of interventions can be made effectively to provide joined-up treatment for each client. Commissioners should ensure that the full range of these treatment interventions are available to clients in their DAT [Drug Action Team] partnership area, according to identified local need. These separate interventions need to fit together in a complementary way, as part of a local drug treatment system. (National Treatment Agency for Substance Misuse, 2006, p. 40)*

Starting in the early 2000s, the Substance Misuse Advisory Service and other national bodies focused on drawing up guidelines for local commissioning procedures for drug and alcohol treatment services. The ICPs play a key role in these guidelines, covering specific categories of service user and promoting uniformity and integration across a multiplicity of service providers (there are ICPs for pregnant women in OAT, drug-using parents of young children, etc.). For the purposes of commissioning, services are assigned to categories such as specialist prescribing, structured day programmes, structured psychosocial interventions, and specialist psychological treatment.

Partly due to the complexity of this system, but also due to the nature of the political system in the UK, the names and the nature of the bodies involved in setting policy, drawing up guidelines, carrying out assessments, and analysing data have been subject to frequent change. The National Treatment Agency became part of Public Health England in 2013, and the Substance Misuse Advisory Service no longer has an advisory role in relation to central government.[14] In policy terms, this shift led to greater decentralisation: "Now that the NTA has moved into Public Health England, and the ring fence funding removed, drug and alcohol services will have to be justified locally, and must compete alongside other health and social needs, in the wider competition for limited funding" (Roy and Buchanan, 2016, p. 400).

4.3.3 National coordination

The current national drugs strategy in England is entitled *From harm to hope: A 10-year drugs plan to cut crime and save lives* (HM Government, 2021); regional strategies were published by the decentralised governments of Scotland, Wales, and Northern Ireland at about the same time. The Home Office is responsible for coordinating the delivery of the Drug Strategy on behalf of the Government and is supported by the Drug Strategy Board, chaired by the Home Secretary (UK Focal Point on Drugs, 2019). The approach of the UK Government has changed as a result of the review carried out by Dame Carol Black, which concluded that greater national coordination and accountability were required within the drug treatment system. Promotion of a more coordinated approach to meeting the health, public health, and social care needs of the population is identified as a key priority:

14. The NTA had been established under the New Labour government as a special health authority within the NHS in 2001, with the mission to improve the availability and effectiveness of SUD treatment in England (MacGregor and Thickett, 2011).

> *We will improve consistency and transparency of service delivery in England, so that people everywhere can expect the same quality of service, and local areas can be held to account at a national level. By March 2022 we will have developed a new national commissioning quality standard to increase transparency, ensure consistency, promote effective joint-working, and enhance improvement support and accountability. (Black, 2021, pp. 33–34)*

At the core of government strategy are the ICSs, which include representatives of local government, NHS Trusts, primary care organisations, third sector organisations, social care providers, housing organisations, and private providers. One of the key tasks of the ICSs, in terms of SUD treatment, is to integrate general health care, mental health care, and specialised addiction services (HM Government, 2021). Because commissioning is decentralised, and services are often provided by private or third sector organisations that operate in different areas of the country, there are structural barriers to integrated service provision:

> *At the local level, in 2013, some parts of the public health function in England were re-located from the NHS to local authorities as part of widespread structural reforms triggered by the Health and Social Care Act 2012. Public health departments within local authorities became responsible for commissioning some sexual health services, smoking, alcohol and drug addiction services, and the early years healthy child programme. (Anderson et al., 2022, pp. 105–106)*

A key task of the ICSs in England is to conduct a joint needs assessment by reviewing data on local substance use partners and related harms, and to use these in order to develop a local strategy and action plan. One of the recommendations in the *Review of drugs part two: prevention, treatment and recovery* (Black, 2021) is that integrated commissioning of mental health and substance misuse services should be used to promote greater integration between these two sub-systems:

> *Addiction is a chronic condition experienced within the social environment. Clinical treatment on its own is rarely enough: many people will also need services to help them with family challenges, mental health, housing and employment support. These services must be coordinated at the local level, but now commonly exist in separate silos or are missing altogether. (Black, 2021, p. 19)*

4.3.4 Clinical governance

The Department of Health's *Standards for Better Health* (2004) contains core standards that are universal and mandatory, relating to safety, clinical effectiveness, cost-effectiveness, governance, patients' rights, accessibility, responsive care, care environment/amenities, and public health. Regular assessments are carried out in order to verify whether these standards are being met, and this information is central to the commissioning process. The same mechanisms employed across the health service are used to ensure appropriate clinical governance with drug and alcohol treatment services:

> *The NTA works in partnership with the Healthcare Commission, developing detailed criteria for reviewing drug and alcohol treatment services, and carrying out these reviews. These criteria are developed during the process of each themed annual Improvement Review of drug treatment systems. (National Treatment Agency for Substance Misuse, 2006, p. 34)*

In her 2021 report, Dame Carol Black also recommended that the Office for Health Promotion should have the resources needed in order to assess the performance of local authorities in relation to the Commissioning Quality Standard and the Local Outcomes Framework, reporting these results to the new centralised Drugs Unit in order to ensure accountability and improve national coordination.

4.3.5 Monitoring and evaluation

Providers of health care in all United Kingdom constituent countries are required to collect data on activity, workforce, and performance indicators, which are incorporated by Health Data Research UK into the Secure eResearch Platform, which contains linked individual-level data for monitoring and research. Data on drug treatment services are traced by the National Drug Treatment Monitoring System, which has a decentralised organisational structure. Under the current drugs strategy, a national outcomes framework will be developed based on a range of metrics for measuring progress towards key goals. These will be matched by a local outcomes framework, which will facilitate comparisons across areas.

4.4 Portugal

In 1976, Portugal adopted a new Constitution, which established a democratic republic. After the Second World War, the country had implemented a Bismarck-style social insurance system financed by compulsory contributions from employees and employers. After the revolution of 1974, however, a Beveridge-style National Health Service was created, with universal coverage funded via general taxation. Some special health insurance schemes for particular groups remain (covering about 16% of the population), and one-quarter of the population has voluntary health insurance, which speeds up access to elective procedures and specialist consultations. A relatively large proportion of health spending is private (around 35%), mostly due to out-of-pocket payments.

The 1990 Basic Law on Health promoted regionalisation and established the possibility of privatising certain sectors of health care provision. Portugal adopted a number of NPM-inspired policies during the early to mid-1990s, which led to a decentralisation of functional administration. There was a subsequent shift away from the NPM model in the late 1990s, which strengthened the role of the central administration. At the same time, a growing proportion of hospital funding was based on a prospective casemix payment system.

4.4.1 Regional structure of health service

Like Ireland, Portugal is a unitary state, although the Azores and Madeira islands have special status. The country is divided into Municipalities (*concelhos*) and parishes (*freguesias*). Political power is highly concentrated; although there are five administrative regions (the North, Centre, Lisbon and Tagus Valley, Alentejo, and Algarve), these have few decision-making powers and their governors are nominated by the central administration.

A system of five Regional Health Administrations (Administrações Regionais de Saúde; ARS) was introduced in 1993, with each ARS being run by a board responsible for implementing national policies and signing contracts with semi-autonomous hospitals, private providers, and voluntary organisations (like the Misericórdias, for example). The boundaries of the ARSs coincided with the smaller administrative regions mentioned in the previous paragraph. As hospital budgets were allocated directly by the Ministry of Health, the main responsibility of the ARSs was to organise primary care. In practice, responsibility for planning and expenditure remained centralised, and the ARS management boards were also appointed centrally by the Minister of Health (de Almeida Simões *et al.*, 2017).

Specialised health care in Portugal is mainly provided in hospitals, grouped into Hospital Centres, which are tasked with improving coordination between health care providers within a specific geographical area. Since 2003, most public hospitals have gained functional autonomy and these institutions are referred to as *Hospitais EPE*. A system of eight local health units (*unidades locais de saúde*) was introduced in 1989 to bring together hospitals and primary health care units. The boundaries of these local health units do not align with those of the ARSs, however, and it has been reported that their introduction did not lead to much improvement in coordination (de Almeida Simões *et al.*, 2017, p. 120). When the ARSs were dissolved in 2024, the local health units were assigned a greater role in the coordination of services, and they now form a network of 31 units.

Patients are expected to register with a GP, although many choose not to. Secondary care is subject to a gatekeeping process, with strict rules for referral by GPs. Choice of provider is greater for those covered by a health subsystem or those who have voluntary health insurance. People who are not registered with a GP, are not part of a special scheme, and do not have private insurance tend to go directly to the accident and emergency department of the nearest hospital when they experience acute symptoms. There are no formal arrangements to promote collaboration between the health care system and the social care system (de Almeida Simões *et al.*, 2017, p. 135).

Family Health Units (Unidades de Saúde Familiar) were created in 2007 and cover more than three-quarters of the population. They consist of small teams of 3–8 GPs, a similar number of family nurses, and a variable number of administrative professionals, with the goal of providing primary care to a population of between 4,000 and 14,000 people.

Primary Healthcare Centre Groups (Agrupamentos de Centros de Saúde) were introduced in 2008 in an effort to provide more effective integrated primary care (de Almeida Simões *et al.*, 2017). There were 459 Family Health Units in Portugal in October 2016 and 74 Primary Healthcare Centre Groups. The National Plan for Mental Health Services 2007–2016 indicates a need for multidisciplinary mental health teams for populations of about 80,000, supported by psychiatric hospitals. The role of the Municipalities continues to be marginal, limited to health promotion.

4.4.2 Drug and alcohol treatment system

Portuguese drug policy is set out in the *National Strategy for the Fight Against Drugs* (1999), which promotes an integrated response to SUD involving GPs, health centres, and mental health departments (see van Beusekom *et al.*, 2002). The *National Plan for the Reduction of Addictive Behaviours and Dependencies 2013-20* was followed by the *National Plan for the Reduction of Addictive Behaviours and Dependencies 2030* (Serviço de Intervenção nos Comportamentos Aditivos e nas Dependências, 2023), which is referred to as PNRCAD 2030.

The Directorate-General for Intervention on Addictive Behaviours and Dependencies (Serviço de Intervenção nos Comportamentos Aditivos e nas Dependências; SICAD) was, until recently, in charge of coordinating prevention and treatment services, operating under the Ministry of Health. When the Health Regions were abolished in 2024, however, responsibility for organising treatment was assigned to the Institute for Addictive Behaviors and Addictions (Instituto para os Comportamentos Aditivos e as Dependências; ICAD), which took over the functions of SICAD: "And then we have the so-called integrated response centres, of which there are 24 around Portugal. … We call them CRI, and each CRI has a prevention, treatment, social reintegration, and harm reduction team. … The person in charge is always a psychiatrist" (interview with Kerstin Hoffmeister, Head of Referral and Integrated Care Unit, ICAD, 20 November 2025).

The relationship between specialised drug treatment services (which were previously referred to as Centros de Apoio a Toxicodependentes) and primary health care services is described in the following extract:

> *Researcher: How would you characterise those relationships with the primary health centres?*
>
> *Kerstin Hoffmeister: Generally they're very good. We work well together. … Our units have a platform that recently was integrated with the primary health care platform. So now every family doctor and family nurse can refer any client to our units through this platform, and we believe that this will be a big advance in making this relationship more fluid. (Interview with Kerstin Hoffmeister, Head of Referral and Integrated Care Unit, ICAD, 20 November 2025)*

4.4.3 National coordination

Planning and regulation are the responsibility of the Ministry of Health, whereas operational management is carried out at the regional level. The Directorate-General of Health is responsible for the national organisation of public health as well as the regulation of private health care providers. The Ministry of Health is responsible for defining the basic benefit package for the whole population and the National Health Council brings together a range of stakeholders (patients, municipalities, researchers, etc.) to commission research and to make policy recommendations.

The Interministerial Council for Drugs, Drug Addiction and Alcohol-Related Problems has overall responsibility for the endorsement, coordination, and evaluation of drug policy. It is chaired by the Prime Minister and consists of Ministers from all relevant areas, as well as the national drug coordinator. Since 2024, ICAD has a direct role in coordinating drug treatment services, as the following extract explains:

ICAD coordinates all these services nationally, but these services interact locally with the other health care responses, and not only with the health system, but also with the education system, with the Municipalities, with social security, with the justice system. So all this system is somehow linked. [Researcher: So it would be the responsibility of the CRI to set up relationships with the Municipalities for social care and so on?] Exactly. (Interview with Kerstin Hoffmeister, Head of Referral and Integrated Care Unit, ICAD, 20 November 2025)

4.4.4 Clinical governance

The Health Regulatory Agency, which is formally independent from the Ministry of Health, plays an important role in carrying out assessments. It monitors the quality of care and maintains a classification of health care providers, which is part of the National System of Healthcare Evaluation.

Within ICAD, there is a Clinical Council with responsibility for publishing guidelines for treatment, including OAT, screening for infectious diseases, distribution of methadone at community pharmacies, and other innovations. The Clinical Council is multidisciplinary, and includes not only a physician, but also a psychiatrist, a social worker, a clinical psychologist, and a nurse (interview with Kerstin Hoffmeister, Head of Referral and Integrated Care Unit, ICAD, 20 November 2025).

4.4.5 Monitoring and evaluation

Portugal has an extensive electronic information infrastructure for health that is used for monitoring as well as other purposes. A National Health Observatory was established in 1998 under the supervision of the National Institute of Health, with the aim of producing regular reports on the health of the population.

Like in Italy, the need to collect data on individual episodes of care for payment purposes has led to the creation of a better information system, covering both inpatient and outpatient care. These records populate the Portuguese Health Data Platform, which contains data on prescriptions, disease-specific registers, and other aspects of health care. The platform is managed by the Servicos Partilhados do Ministerio de Saude within the Ministry of Health and is facilitated by a Citizen Card, which links all relevant data (identity, tax, social security, health). Data on activity rates and waiting times are available in real time via a web portal. As in several other European countries, challenges remain regarding the use of personal data and linking data across different sources for research and analysis.

4.5 Spain

Spain is a parliamentary monarchy which, in administrative terms, is organised as a quasi-federal state with 17 Autonomous Communities (Comunidades Autónomas) and two Autonomous Cities (Ceuta and Melilla, which are Spanish enclaves in Morocco). Like in Portugal, legislation in 1986 transformed the health system from a Bismarck-style (social insurance) model to a Beveridge-style (national health) service. The national health system is moving towards universal coverage and is mainly funded by taxes; following recent reforms, services are free at the point of delivery, although there is some cost-sharing for pharmaceuticals and prostheses (Bernal-Delgado *et al.*, 2024). There are some mutual funds, and roughly one-fifth of the population has voluntary health insurance.

4.5.1 Regional structure of health service

After the end of the Franco dictatorship in 1975, responsibility for healthcare was gradually transferred to the Autonomous Communities, with the central State defining benefits and retaining an overall role in coordinating care, under the governance of the Inter-territorial Council (which includes the Health Ministers of the Autonomous Communities and Cities). The development of health information systems and the definition of mechanisms for reporting health data to the central State are agreed by a dedicated task force within the Inter-territorial Council (Bernal-Delgado *et al.*, 2024, p. 26). The Autonomous Communities can organise services in different ways, based on their preferences and taking local conditions into account:

> *Each autonomous community is entitled to organise and deliver health interventions in accordance with its own plans, budgets and personnel. Some have integrated treatment for drug use-related problems within primary care units or mental health services, and some have a separate treatment network that retains a connection with the general healthcare system. (Spanish Focal Point on Drugs, 2019, p. 20)*

Primary care is the cornerstone of the national health service, with GPs acting as gatekeepers for their public patients in terms of access to specialised services and hospital care. The primary care areas are nested within health care areas, which are used to coordinate the delivery of specialised health care (including hospital treatment). The boundaries of these areas are defined by the Autonomous Communities:

> *Typically, the primary care management structure of the health care area signs an annual framework contract with the regional health service, based on capitation criteria (with some elements of demographic structure and population dispersion) and including some specifications linked to the priorities of the regional Department of Health. These contract specifications cascade down, translating into contracts with each primary care team – that is, the group of specialized doctors and nurses in charge of primary care in each health care area. (Bernal-Delgado et al., 2024, p. 69)*

Each citizen is allocated to a health care area, and the latter are usually centred on a single large hospital, which has the effect of reducing choice, although urban health care areas can include more than one hospital.

4.5.2 Drug and alcohol treatment system

The first National Plan on Drugs (Plan Nacional Sobre Drogas) was published in Spain in 1985, and the most recent strategy covers the period 2017–2024. One of the aims of this plan was to improve care for people with dual diagnosis (Delegación del Gobierno para el Plan Nacional sobre Drogas, 2017). Drug and alcohol treatment services are organised across the full hierarchy of administrative units, with the primary care system playing a role in screening and early detection of SUDs, symptomatic treatment, and follow-up. Each Autonomous Community has its own drug strategy and coordination structure (e.g. Plan Andaluz sobre Drogas y Adicciones in Andalusia, Subdirecció General de Drogodependències in Catalonia):

> *There are funds, national funds, which are transferred to the Autonomous Communities independently of the economic transfers from the government [Researcher: Okay, so that funding is ring-fenced, you'd say?] Yeah, that's it. … Those funds are for activities related to the implementation of the National Drugs Strategy, and there are a lot of things that you can put in there. (Interview with Rosario Sendino Gómez, Deputy Director for Programme Coordination, Government Delegation for the National Plan on Drugs, 26 January 2026)*

In common with most other continental European countries, Spanish policies and services address illicit drugs, new psychoactive substances, alcohol, tobacco, prescription drugs, and behavioural addictions in an integrated fashion (Spanish Focal Point on Drugs, 2019). Treatment services are provided through a mixture of public addiction centres, primary care units, hospital outpatient clinics, non-governmental organisations (NGOs), and private providers via agreements or contracts that are negotiated at regional level, but in collaboration with the Municipalities as far as social support services are concerned. Although NGOs play an important role in providing services in many parts of the country, they frequently encounter difficulties in accessing ongoing funding. Integration between drug and alcohol treatment, primary care, and mental health services is promoted by national agencies, but the relationship between them varies:

> *The transfer of competences to the Autonomous Communities and Cities over the integrated care and treatment of people with addiction problems has meant that the therapeutic itineraries and dedicated resources in each one of the Autonomous Drugs Plans have developed differently over time. This diversity contributes to the richness of the Spanish health care model. Nonetheless, although a basic consensus does exist about the services to offer, in some cases this diversity may lead to some unevenness in the availability of and accessibility to treatment when the systems function differently with different reporting structures and management, information systems, health care and referral circuits, resources and intervention methodologies, or different service offerings. (Delegación del Gobierno para el Plan Nacional sobre Drogas, 2017, p. 32)*

Community care in Catalonia is organised through mental health care areas, each of which has a mental health centre for adults, a centre for children and young people, a drug addiction centre, a rehabilitation centre, and residential services. The relationship between SUD treatment and mental health care is highly variable, as the following extract indicates:

> *So another feature, a specific feature of our network for addiction services is that we've got a health care system for diabetes, for heart attacks, for whatever, but our addiction network was created as a parallel health care system from the beginning. So one of the problems is that for many years there was the addictions network and then the rest of the health service. So over time, the Autonomous Communities have evolved and some of them have located addictions under mental health, others have located addictions under primary care, and others still have parallel networks. (Interview with Rosario Sendino Gómez, Deputy Director for Programme Coordination, Government Delegation for the National Plan on Drugs, 26 January 2026)*

In specialised drug treatment centres across Spain, multidisciplinary teams provide psychosocial therapy, OAT, case management, and referral to other services as required (Spanish Focal Point on Drugs, 2019, p. 20). Where appropriate, community pharmacies dispense medication to patients. Improving the coordination of primary care and community mental health care is one of the current priorities of the Spanish Government, which has provided additional funding to set up coordination activities and initiatives (Pucci *et al.*, 2011, p. 3).

4.5.3 National coordination

The Government Delegation for the National Plan on Drugs within the Ministry of Health is the main coordinating body for drug and alcohol treatment. It is in charge of proposing a national strategy and hosts the Spanish Observatory on Drugs and Addictions. The system of national and regional governance is summarised by the Spanish Focal Point on Drugs in the following terms:

> *At the national level, the Spanish Council for Drug Addiction and Other Addictions is responsible for inter-sectoral collaboration. … The Government Delegation for the National Plan on Drugs is the national drug policy coordinator. … It coordinates the institutions involved in delivering the drug strategy at central administrative, autonomous community and local levels. The Sectoral Conference on Drugs facilitates cooperation between central government and the administrations of the autonomous communities and cities. … The Communities Commission on Drugs, chaired by the Government Delegate for the National Plan on Drugs, reports to the sector conference, which is made up of all the deputy directors-general of the Government Delegation and those responsible for the regional drug plans. (Spanish Focal Point on Drugs, 2019, p. 3)*

The following extract describes the tensions that can emerge between the responsabilities of the central State and those of the Autonomous Communities:

> *There are some national laws regarding alcohol, tobacco, but it's difficult sometimes to determine what is the competence of the central government and what other things are the competence of the Autonomous Communities. For instance, in relation to betting and gambling, the State has competence for online gambling, but other forms of gambling are in the field of the Autonomous Communities. (Interview with Rosario Sendino Gómez, Deputy Director for Programme Coordination, Government Delegation for the National Plan on Drugs, 26 January 2026)*

4.5.4 Clinical governance

Over the past two decades, the Autonomous Communities have put in place various initiatives to improve the quality of treatment services in Spain, including: (1) the Common Assessment Framework of the Government of Cantabria; (2) the set of standards implemented by the Institute for Addiction Research in Madrid; and (3) the quality and evaluation system deployed by the Catalonian Government (Hilarion *et al.*, 2010, p. 2).

4.5.5 Monitoring and evaluation

Drug treatment services in Spain are monitored via a decentralised system that combines epidemiological surveillance, administrative reporting, and programme evaluation. Most assessments are carried out internally by the Autonomous Communities themselves. Using the national identity card and electronic prescription systems, relevant clinical data can flow across regional borders and are used for central monitoring and research. The Spanish Observatory on Drugs and Addictions and the National Institute of Statistics collaborate to analyse standardised data on treatment demand and utilisation, which are also reported to the European Union Drugs Agency (EUDA).

The Government Delegation for the National Plan on Drugs determines the indicators and reporting frameworks to be used, and the Autonomous Communities are required to report the number of people attending each type of treatment service, as well as staffing levels and capacity:

> *Information systems have been developed in a different way depending on the Autonomous Community, so there's not a common link to our information system – we've been doing that almost manually for years and years. So now we have developed an internet system, a new system.... So if you start your process having in mind that you've got to start with a common information system to avoid this problem. That would be a very good idea. (Interview with Rosario Sendino Gómez, Deputy Director for Programme Coordination, Government Delegation for the National Plan on Drugs, 26 January 2026)*

These data are usually compiled into annual reports. Trinidad Requena *et al.* (2004) provide the following overview of the critical aspects of this process:

> *With regard to planning, we have found that most of the Autonomous Communities set out broad objectives, sometimes disconnected from reality; some do not even carry out needs assessments. Although we consider the drafting of these documents to be successful, we believe they should be understood as practical working tools, with measurable and assessable indicators and achievable objectives, linking them to the resources available and allowing these goals to be reviewed periodically and improved without having to wait for the plan to end and a new one to be drawn up. In addition, it is important that they be published in the same year in which they were produced and that their dissemination be improved so that citizens are aware of the priorities and can become involved in the programmes. As regards evaluation, it may be open to criticism that, in almost all the Autonomous Communities, those responsible are internal evaluators. (Trinidad Requena et al., 2004, p. 16; our translation)*

4.6 France

The French Republic includes mainland France and a number of overseas territories (French Guiana, Guadeloupe, Martinique, Mayotte, and Réunion), which are subject to the same laws and regulations. There are four levels of administration: (1) the central State; (2) 18 Regions (*Régions*); (3) 101 Departments (Départements); and (4) roughly 35,000 Municipalities (Communes). The regional and local levels include institutional propagations of the central State as well as forms of decentralised decision-making involving elected local assemblies.

The French health service shifted from a primarily Bismarck-style insurance system to a Beveridge-style health service in 1999, and the system is now funded by a tax on all revenues. As in the case of Spain, certain categories of public employees have separate insurance schemes. Services are provided by a mixture of private physicians, private hospitals, non-profit-making organisations, and public providers. Everyone living or working in France has access to a fairly comprehensive basket of services, and nearly everyone has complementary private health insurance to cover the (relatively low) co-payments which are charged for most services. France spends a higher proportion of its gross domestic product on health care (12.2% in 2020) than most other European Union countries, and it spends more on inpatient care than outpatient services.

4.6.1 Regional structure of health service

In overall terms, the jurisdiction of the Regions includes planning, development, economic development, health, vocational training, and upper secondary education, while the Departments have some authority in the areas of health, social care, and lower secondary education. Each Regional Health Agency is represented at the level of the Department by local delegates who ensure that they implement regional policies effectively when providing health care to the elderly, young children, and people with functional impairments. This division is also found in many other European countries, and is due to the need for an articulated network of services at local level for elderly people and others who are not self-sufficient.

The Regional Health Agencies monitor population health, provide health education and health prevention, and monitor health providers. They can authorise new services in coordination with the central State, representatives of the Departments, and the social insurance fund. The Directors of the Regional Health Agencies have a degree of autonomy, but operate under the umbrella of the Ministry of Health and related institutions. In overall terms, therefore, the French welfare system remains centralised, and this also applies to the drug and alcohol treatment system (see, for example, Mission interministérielle de lutte contre la drogue et la toxicomanie, 2023). Limited forms of administrative deconcentration are designed primarily to enable the Regional Health Agencies to implement national policies in ways that are appropriate to the local context.

In France, patients have the right to choose between alternative health professionals and health providers, including GPs. In common with Sweden and other countries, the mental health care system was historically centred on the network of psychiatric hospitals, each with its own catchment area (*secteur psychiatrique*), as defined by the Département. Outpatient care is provided by roughly 3,100 outpatient care centres (*centres médico-psychologiques*) and psychiatric hospitals are increasingly integrated within networks of local health care providers, which are supervised by the Regional Health Agency. Each network has its own management structure, and has responsibility for the diagnosis, treatment, rehabilitation, and social integration of patients with mental health disorders who are referred for care. Apart from psychiatric hospitals and outpatient mental health centres, most care is provided by self-employed psychiatrists, most of whom operate in the larger cities.

Most primary care physicians are self-employed, work in solo practices, and are paid a fee for the services they provide. These payments mean that they have little incentive to provide health promotion services or to improve efficiency. Recent reforms, including the 2004 'gatekeeper' policy and the 2009 'payment-by-quality' policy, sought to improve this aspect of care (Or *et al.*, 2023). Partly because of a new set of incentives, younger GPs increasingly work in primary care centres as salaried employees (19% of GPs in 2021), and there are State incentives to encourage the spread of multidisciplinary primary care centres (*maisons de santé pluriprofessionnelles*), which are able to meet a wider range of needs, sustain longer opening hours, and play a more effective gatekeeping and health promotion role.

A system of local hospitals (*hôpitaux de proximité*) serves deprived urban areas with a low density of GPs (the latter can freely choose where to practise). These small hospitals have links with primary care providers, specialised hospitals, and social care providers, and can function as a single/first point of contact with the health service for people living within the local area.

4.6.2 Drug and alcohol treatment system

Drug policy is coordinated at the national level by the Interministerial Mission for Combating Drugs and Addictive Behaviours (Mission interministérielle de lutte contre les drogues et les conduites addictives) (French Focal Point on Drugs, 2019). It is funded by the social security system and implemented by regional and local authorities. The national drugs strategy for 2018–2022 addresses alcohol, tobacco, doping, gambling, and other behavioural addictions, as well as the use of illicit drugs. It focuses on strengthening GPs' ability to provide access to treatment services (Mission interministérielle de lutte contre les drogues et les conduites addictives, 2018). This is a distinctive feature of the French approach to SUD treatment, although 80% of patients in OAT are treated by just 5% of GPs.[15] The most recent strategy covers the period 2023–2027 (Mission interministérielle de lutte contre les drogues et les conduites addictives, 2023).

15. The French Focal Point on Drugs (2019; Mission interministérielle de lutte contre la drogue et la toxicomanie, 2018, p. 53) states that although methadone treatment can only be initiated in specialised centres, it can subsequently be prescribed by GPs (who can also prescribe other forms of OAT directly, and 59% of patients in treatment for SUD receive buprenorphine). OAT is frequently dispensed at community pharmacies. Dupouy *et al.* (2020) note that the coverage rate for OAT in France is particularly high.

The main aim of the French Government is to expand the model of multidisciplinary primary care centres (*maisons de santé pluriprofessionnelles and centres de santé*), and to improve their ability to identify people at risk and to accompany them through treatment. Since 2008, the national drugs strategy has emphasised the need to develop an integrated pathway that brings specialised treatment services into alignment with primary care, mental health services, and social care (Mission interministérielle de lutte contre les drogues et les conduites addictives, 2018, p. 55). This is identified as a crucial tool for overcoming unevenness across treatment providers.

Alongside primary care, the French treatment system includes 'microstructures', comprising a psychologist and a social worker, who can provide treatment and support through the primary care network in a flexible manner. Specialised treatment for SUD is also provided by addiction treatment, support and prevention centres (*centres de soins, d'accompagnement et de prévention en addictologie*), which are often managed by third sector organisations (such as Addictions France, for example):

> *Almost all of the 100 sub-regional administrative areas have at least one specialised drug treatment and prevention centre (CSAPA). These centres, managed mainly by non-governmental organisations, provide both outpatient and inpatient care as well as care for prison inmates. Care in CSAPAs is anonymous and free. Both pharmacologically assisted and psychosocial treatments are provided in the same centres. There are also nine 'drug-free' therapeutic communities and about 540 services for young drug users, which provide early intervention and psychological care on an outpatient basis. (French Focal Point on Drugs, 2019, p. 20)*

Third sector organisations also run the low-threshold Centres d'Accompagnement et de Réduction des Risques pour Usagers de Drogues (CAARUD), mainly located in large urban areas. Within the hospital system, there are *équipes de liaison et de soins en addictologie* (ELSA) which provide a bridge between inpatient and outpatient care for people with SUDs.

4.6.3 National coordination

The central State maintains a crucial coordinating role across all levels of the system, and the French civil service has a long tradition of centralism, with a marked reluctance to reduce central control over policy and finance. To the extent that this tradition has been moderated in recent years, regionalisation has taken the form of deconcentration, with local administrators operating under central direction and the Ministry of Health maintaining substantial control over key aspects of the system.

4.6.4 Clinical governance

The Regional Health Agencies are supervised by the National Steering Council, which includes delegates of the Ministry of Health and senior civil servants with responsibility for the public accounts, social security system, statutory health insurance, and National Solidarity Fund for Autonomy. The policy agenda is set by the Ministry of Health, although there is a complex institutional architecture which enables a range of actors to contribute to the definition of policies:

> *The CNS (Conférence nationale de santé) brings together representatives of the health professions, healthcare facilities, the Regional Conferences on Health and Autonomy (Conférence régionale de la santé et de l'autonomie, CRSA) and other experts to discuss and define healthcare priorities at the national level. The strategy is mainly implemented through the regional health projects (Projets régionaux de santé, PRS), through which the strategic regional plan for health (Plan stratégique régional de santé, PSRS) is developed by the ARS [Agences régionale de santé], in consultation with the stakeholders who participate in the CRSAs on health and autonomy. (Or et al., 2023, p. 22)*

Recent reforms aim to improve coordination and to implement standardised care pathways with a view to reducing inappropriate hospitalisation. The remaining critical issues relate to the integration of services:

> *The fact that most providers work independently – with little collaboration between hospital, primary and social care services – means that care is fragmented and patients need to navigate a complicated system. Moreover, uncoordinated care, coupled with the high degree of independence and choice both for providers and patients, has been identified as a key driver of healthcare costs. (Or et al., 2023, p. 125)*

4.6.5 Monitoring and evaluation

A large database containing information on the use of health services (both hospital and outpatient) was merged in 2016 with other information (pharmaceutical consumption, social care services, and cause of death). A national Health Data Hub was set up in 2019 to enable researchers to access these anonymised, linked individual data via a secure platform. This is similar to the approach adopted in the UK with its secure data environment.

The French National Health Authority is in charge of quality control activities for CSAPAs and CAARUDs, while the French National Focal Point for Drugs (the Observatoire français des drogues et des toxicomanies; OFDT) is charged with collecting and analysing drug-related data.

4.7 Germany

Germany is a federal parliamentary republic comprising 16 states (*Länder*). By contrast with the more unitary institutional architecture of Spain and Italy, which are often described as 'quasi-federal' countries, Germany is the result of a different kind of model where autonomous states delegate powers upwards to the Federal Government. Health care is a responsibility of all levels of administration, and states can fill gaps in federal legislation. The high level of cooperation and corporatist inspiration of the German model contrast with the sharper separation of responsibilities within American federalism.

The German system retains a strong Bismarck-type approach to welfare involving mandatory membership of a health insurance scheme, shared payment of contributions, and a complex system of corporatist self-government. Contributions to the 105 health funds are the main source of funding, although there are risk-adjustment mechanisms which compensate for the unequal distribution of health expenditure. All funds must cover a predefined package of benefits, although they are free to add other services in order to attract members.

Health systems based on the social insurance model incorporate competition by giving patients the possibility of choosing between different health funds (which has been possible since 1996 in Germany) and allowing them to select the provider that they prefer (which has always been possible). The latter tends to generate a fragmented system of provision where service integration and coordination are difficult. Germany has also introduced the possibility of substitutive private health insurance for employees with a relatively high income and those working in the public sector.

4.7.1 Regional structure of health service

The 16 state governments are in charge of planning new hospitals and public services and supervising the sickness funds and health care providers at state level. They come together within the Conference of Health Ministers (Gesundheitsministerkonferenz) to coordinate legislation, to build consensus, and to participate in working groups on various aspects of the health system.

Patients can generally choose their GP, as well as any accredited specialist physicians they wish to consult and any hospitals that have contracts with the health fund that they belong to. Most GPs work in solo practices, but they also participate in the provision of out-of-hours services, which are organised by regional associations. Most services have fixed charges which are determined jointly by corporatist bodies and insurance funds. Nearly all health care is provided in this way, and the result is a very costly system that is characterised by a number of rigidities:

> *In 1931 office-based physicians were granted a monopoly over outpatient care and were required to hold membership of their respective Regional Association of Statutory Health Insurance Physicians, which was charged with negotiating collective contracts with the sickness funds. This concession to physicians disconnected ambulatory care from both population-based and public health institutions and from hospitals that had to limit their scope of work to inpatient services. (Blümel et al., 2020, p. 17)*

4.7.2 Drug and alcohol treatment system

The Federal Government has legislative authority over laws relating to drugs, which enables it to define the overall framework for drug treatment, although the provision of services is the responsibility of other bodies (German Focal Point on Drugs, 2010). Historically, the German medical profession viewed abstinence as the main objective of drug treatment, with a preference for long-term inpatient care in closed institutions (Michels and Stöver, 2012). This situation has changed over the course of recent decades, in line with the trends observed in other European countries.

In common with Italy, Spain, and other countries, the national drugs strategy in Germany covers disorders relating to the use of legal and illegal substances, as well as compulsive gambling and other behavioural addictions (Drug Commissioner of the Federal Government, 2012). Because of the nature of the German welfare system, the provision of services for drug and alcohol disorders has a subsidiary structure in which responsibilities are distributed across different levels of the system and between different institutions:

> *Today, for example, counselling for problems with addictive substances or behaviours takes place in addiction counselling centres that are mainly funded by municipal governments. Detoxification or withdrawal treatment for addicts takes place in hospitals or in special wards of psychiatric hospitals, with the coverage of the costs negotiated with the health insurance funds. On the other hand, the German Federal Pension Insurance Fund is usually responsible for the costs of withdrawal treatment, which often follows withdrawal, i. e., the medical rehabilitation of addicts. Both the pension insurance fund and addiction counselling centres are responsible for immediate follow-up treatment as prophylaxis against a relapse. The office in charge of administering basic income support and the employment agencies are responsible for the integration of former addicts into some form of employment, the debt counselling centres are responsible for any debt, and psychiatric specialists, psychologists and psychological psychotherapists are to be contacted for the treatment of the psychological problems that often accompany addiction. (Drug Commissioner of the Federal Government, 2012, p. 14)*

The complexity of this system means that service providers spend a lot of time dealing with bureaucracy and coordinating interventions, and rely heavily on key workers. Voluntary organisations provide many services, including psychosocial therapy for drug users, typically with public funding (Michels *et al.*, 2007). Because of the way the principle of subsidiarity is applied, there are considerable regional differences in how SUD are treated in different parts of Germany (German Focal Point on Drugs, 2010; Michels *et al.*, 2007). Michels and Stöver (2012) provide the following summary:

> *The bodies responsible for providing social security benefits in Germany are as follows: the health insurance funds (for detoxification treatment up to 14–21 days), pension insurance funds (for medical, psychosocial in-patient treatment up to 6–9 months), institutions responsible for social assistance (for housing, reintegration programs, etc.), the municipalities (for counseling, drop-in centers, drug consumption rooms [DCRs], etc.) are obliged to finance such assistance. Together with service-providers and self-help groups, they have succeeded over the past decades in making a differentiated range of addiction assistance offers available, which provides addicts in need of assistance with a broad spectrum of targeted services. (Michels and Stöver, 2012, p. 912)*

There are roughly 1,300 specialised outpatient SUD treatment facilities in Germany, many of which are funded by the Municipalities (German Focal Point on Drugs, 2010). These are complemented by approximately 125 rehabilitation centres, which are nearly always residential, and more than 250 inpatient facilities. Psychiatric clinics frequently have wards for supervised withdrawal treatment, and generally provide counselling and therapy services on an outpatient basis (German Focal Point on Drugs, 2010, p. 108). OAT takes place in a different location.[16] The German Focal Point on Drugs (2019) summarises the role of these different services as follows:

16. In most cases, OAT is coordinated by physicians in private practices. However, as Michels *et al.* (2007) explain, these practices are mostly run by specialised teams that cater almost exclusively for drug addicts, integrated with other aspects of the treatment system.

> *Most drug treatment takes place in centres and institutions that deal with dependence in general, although there are some treatment units specifically for illicit drug users. Outpatient counselling centres provide psychosocial care and psychotherapy and are often an entry point for clients. These centres provide treatment either directly using their own resources or in collaboration with general practitioners who are specifically qualified in addiction medicine. Psychiatric facilities for dependency represent the second major pillar of drug treatment in Germany. A wide range of services are provided in these facilities, including low-threshold, detoxification treatment, crisis interventions, complex treatments for comorbidity and planning for reintegration. (German Focal Point on Drugs, 2019, p. 18)*

Further details were provided by Ingo Ilja Michels during the interview we carried out as part of the consultation phase of this project:

> *We have a treatment system where the basis is the counselling services, and they are run by social workers, not by medical doctors, and not by psychologists. They're also involved, but in this field, mostly social workers are involved … and these special services are financed by the municipalities. This is also a problem, because it's a voluntary payment. Detox is paid by the insurance, 100% … But rehabilitation in rehabilitation centres is paid for by the pension funds. And that's why: because the idea is that they should be reintegrated into work. … And it's very difficult sometimes to explain this to people outside Germany, but it's working quite well. (Interview with Ingo Ilja Michels, former Head of the Office of the Federal Drug Commissioner in Germany, 16 October 2025)*

Vogt (2009) describes how, over time, these treatment centres have developed in Frankfurt, acquiring new functions and integrating different kinds of services within the same location:

> *The centres have developed in the last 15 years into places which offer a multitude of services to drug users such as caring for basic needs (cheap meals and drinks) and hygienic services (showers, washing machines, cleaning services, etc.), needle exchange services, night shelters and – since 2000 – day shelters, emergency medical services and methadone dispensaries and, since 1994, consumption rooms. They offer jobs in employment projects and help drug users to find places in supervised housing projects. (Vogt, 2009, p. 518)*

4.7.3 National coordination

Governance of the German health service is carried out not only by the Federal Government (which establishes the legal framework and supervises other actors), but also by self-regulated (corporatist) organisations representing funding bodies and service providers. For example, physicians and psychotherapists who are accredited for reimbursement by the social health insurance funds participate in associations that organise independently in each state. The Federal Government delegates a range of tasks to these bodies, and they play a key role in governing the social health insurance system and providing clinical governance. This is described by Blümel *et al.* (2020, p. 29) as "the most striking aspect of the decentralized health care system in Germany".

The main responsibilities of the Federal Ministry of Health are: (1) proposing legislation; (2) prevention, health promotion, patient rights, registration, and distribution of pharmaceuticals and medical devices; (3) registration of health professionals; (4) international health politics; and (5) supervision of the main corporatist bodies. The federal Health Insurance Reform Act (2000) obliged corporatist organisations and self-governing bodies to adopt a prospective fee payment system based on diagnosis-related groups. This kind of reform is associated with the NPM model, and is designed to facilitate/intensify competitive pressures in order to improve hospital care.

Various professional societies (such as the Association of the Scientific Medical Societies in Germany) and multidisciplinary expert groups have worked in recent years to develop guidelines for the treatment of SUD in Germany (including illegal drugs, alcohol, tobacco, etc.), with cooperation between social workers, psychologists, psychiatrists, and other disciplines. Ingo Ilja Michels provided the following overview of this aspect of the treatment system:

> *For treatment, there are special guidelines, and they are discussed and developed by both of the associations of those working in the field: the Medical Association, but also the Association of Social Workers, because social work has a very important role in Germany. It plays a very important role, because they're involved in treatment, and they should also be involved. It's part of these guidelines, that psychologists and social workers must be involved in treatment for people with addiction problems. (Interview with Ingo Ilja Michels, former Head of the Office of the Federal Drug Commissioner in Germany, 16 October 2025)*

4.7.4 Clinical governance

Some areas of the German health care system are monopolised by private providers (such as specialised outpatient care, dentists, and pharmacies), while third sector organisations play an important role in others (such as the long-term care sector). Hospitals – which are typically owned privately or by non-profit organisations – sign contracts with the sickness funds at regional level, rather than participating in corporatist governance arrangements. Patients can choose accredited specialists directly, without requesting a referral from their GP, so there is no obligatory gatekeeping system.

Disease Management Programs are used to deliver coordinated treatment via the formalisation of evidence-based guidelines and the implementation of individual treatment plans, with GPs playing a key role. However, it is important to note the existence of relevant differences between regions: "Despite the fact that the SHI [social health insurance] guidelines are effective nationwide there are variations among the federal states with respect to the organization and delivery of substitution treatment and accompanying psychosocial care" (Michels *et al.*, 2007, p. 3).

These variations extend to non-medical care, as the same authors observe:

> *Psychosocial care is a collective name for a number of different services. These may include, for example, legal advice, managing financial problems (e.g. debts, rents), recreational activities, crisis intervention, (psychotherapeutic) group sessions, assistance with finding accommodation and jobs, and qualifying for school and vocational training. … There are great variations in psychosocial provision between different states and communities, and variations in quality and funding. (Michels et al., 2007, pp. 6–7)*

4.7.5 Monitoring and evaluation

Responsibility for quality assurance is shared between the Federal Government, the *Länder*, and the municipalities, with no uniform criteria (German Focal Point on Drugs, 2019). Data collected within the German welfare system are comprehensive and generally of high quality, but information is stored in a wide range of different databases at different levels, with limited integration. The multitude of initiatives, institutions, and programmes translates into a lack of systematic evaluation across the whole country.

The German Statistical Report on Treatment Centres for Substance Use Disorders was created in order to coordinate data collection, and there is a working group entitled Interface Problems in the Care of Addicts that also deals with coordination issues at national level (German Focal Point on Drugs, 2010).

4.8 Italy

The Italian national health service was established in 1978, following a Beveridge-style model of universal coverage that replaced the previous social insurance model. The central government was formally responsible for providing funding and publishing three-year national health plans, but the spending limits imposed by the State were never respected and the first health plan was published in 1994, with a delay of 14 years.

Italy is the largest unitary state in Europe to have decentralised its health system. It has 20 Regions, and one of these (Trentino Alto Adige) also has two Autonomous Provinces (Trento and Bolzano). Five of the Regions have special status, which means that they have more autonomy and additional powers, ostensibly to protect cultural and linguistic minorities in historically contested areas of the country. There are several similarities between Spain and Italy in terms of regionalisation, and both have adopted a 'system of regions' approach (Costa-Font and Turati, 2018):

> *The Region is relevant because it knows its own territory, and many of these services have a clear spatial dimension. Take Piedmont, for example: this Region is able to design the network of services drawing on a knowledge of the regional territory that [the central government in] Rome just doesn't have, in my opinion. It knows where people live, it knows what the topography is like, which roads you have to take to reach a certain area, what kinds of problems arise in terms of logistics. (Interview with Professor Gilberto Turati, Università Cattolica del Sacro Cuore, 2 December 2025)*

Each Region is governed by a Regional Council and has an elected President. The Regions have exclusive legislative power over certain issues, while in other areas of policy-making their authority overlaps with that of the central government. Their financial autonomy is quite modest, as they collect just one-fifth of all taxes, using these revenues mainly to finance the health care system. At the lowest level of governance, there are about 8,100 Municipalities, each with an elected Mayor and Council.

4.8.1 Regional structure of health service

During the 1980s, the regional authorities planned and managed health care through a network of about 100 local health units (*Unità Sanitarie Locali*) and health care providers, such as hospitals and local health centres. As de Belvis *et al.* (2022) observe, lack of clarity about responsibilities, combined with weak control over spending at local level, led to rapid increases in expenditure. The reaction was a series of laws in the 1990s (502/1992, 517/1993, and 229/1999) that were inspired by NPM (and influenced by the financial crisis of 1992). These laws devolved power, enhanced competition, and introduced a new managerialised form of governance. In 1995, a prospective casemix system was introduced and began to influence how hospitals were funded.

Following these reforms, the local health units were referred to as *Aziende Sanitarie Locali* and were subdivided into health districts, each with responsibility for primary care, outpatient care, and some inpatient treatment provided by smaller, directly managed hospitals. Professor Gilberto Turati views the 1990s as a key stage in the regionalisation process:

> *That period was, in my opinion, the real moment in which you could start to see the effects of decentralisation – and fiscal decentralisation above all – because there was a shock at a certain point to the expectations of the Regions. Now they had to use their own resources if they exceeded the regional health budget, because those funds had been distributed by the central government, which was less willing to give them more money because it was facing its own spending constraints, imposed by Europe. So in this situation the Regions acquired the 'freedom' to decide how to implement the managerial reform of the health service. The decision they had to take was the following: "should I really separate the local health units, which are responsible for the health of the population, from the public hospitals, which provide services?" And certain regions went down this route - like Lombardy, which had been pushing for that very reform. (Interview with Professor Gilberto Turati, Università Cattolica del Sacro Cuore, 2 December 2025)*

This process culminated in 2001 with a constitutional reform that altered the division of responsibilities between the central government and the Regions. The former retains responsibility for setting priorities, defining the package of fundamental benefits (Livelli Essenziali di Assistenza), providing funding, and coordinating the provision of care through regulations and guidelines. The Regions were tasked with financing, regulating, organising, and delivering care, and consolidated their far-reaching powers over subsequent years. Most treat the local health units as both service providers and purchasers of services. The Italian Focal Point on Drugs (2019) provides the following summary:

> *In Italy, health services are accredited through the National Health System, which is delegated to the individual regions/autonomous provinces; services for drug users are part of this system. The regions/autonomous provinces maintain their complete independence in formulating local policies and strategies, as well as planning, accrediting and organising the treatment services. The local health authorities (ASL) carry out a planning and operational role: they define and implement the evidence-based operational procedures with the aim of implementing homogeneous and coordinated interventions in their territories. ... So fiscal decentralisation was seen as a way of giving the right incentive to regional governments to improve their efficiency in terms of resource allocation. (Italian Focal Point on Drugs, 2019, p. 3)*

4.8.2 Drug and alcohol treatment system

Starting in the late 1960s, abstinence-based therapeutic communities with their roots in the Catholic subculture emerged in Italy as a response to problem substance use, particularly heroin addiction. Italy's first dedicated drug legislation (Law no. 685, 1975) distinguished addiction treatment from psychiatric care and provided a legal basis for the development of specialised centres that recognised addiction as a condition influenced by biological, psychological, and social factors (Besana *et al.*, 2025). Unfortunately, from the late 1970s, just as heroin use was surging and the stigmatisation of drug users was reaching its height, there was a gradual withdrawal of the health care system from direct involvement in the provision of addiction treatment. It was not until 1990 that an effective intervention strategy emerged.

Law no. 162 (1990), together with DPR no. 309 (1990), established a network of specialised addiction treatment centres. These were initially known as Servizi per le Tossicodipendenze (SerTs). Run by the regional administration, these centres formed a separate network of public services dedicated to alcohol and substance use disorders, including prevention, treatment, psychosocial therapy, and social reintegration. The services on offer included opioid agonist maintenance therapy with methadone (and, later, buprenorphine). All OAT was managed by SerTs, with little or no role for GPs, which remains the case today (Rupasinghe *et al.*, 2018).

In the 1990s, the SerT clinics recognised the underlying social and economic issues contributing to addiction and aimed to provide a holistic response to this condition. As well as pharmacological therapies, they provided counselling, education, and social support services, collaborating with third sector organisations to provide access to housing, training, and employment opportunities:

> *This integrated, multidisciplinary approach sought to address the multifaceted needs of individuals struggling with addiction, recognizing that effective treatment required addressing not only the physiological but also the emotional, cognitive, and social dimensions of addiction. In SerT clinics, medical treatment was provided not only by psychiatrists, but also by infectious disease specialists, internal medicine doctors, as well as pharmacologists, ensuring a comprehensive approach to care. This differed from Mental Health Centers, where only psychiatrists are present, highlighting the distinct focus of addiction treatment. (Besana et al., 2025, p. 4)*

Nevertheless, several tensions remained in relation to the relationship between SerD[17] clinics and the wider national health service. These included a rather conflictual relationship with mental health services, the existence of marked inter-regional disparities, and a degree of entanglement with the judicial system (Besana *et al.*, 2025). In the mid-1990s, a nationwide reform led to the creation of Departments of Mental Health across the whole country, each with responsibility for a catchment area with a population of roughly 35,000 (including community centres, semi-residential units, and residential units), and a specific mandate to participate in cross-sectoral networks, including third sector organisations, statutory social care, and addiction services. However, they have tended to view the 574 SerD centres as competitors, and have often been reluctant to collaborate with them, underlining the fact that SerD centres are not run by psychiatrists (Compagni *et al.*, 2011).

17. After their remit was widened to include behavioural addictions, these bodies were renamed, with the T (for *tossicodipendenze*) at the end of the acronym becoming a D (for *dipendenze*).

Over the course of the last decade, the multidisciplinary nature of the SerD clinics has been enhanced to include nurses, social workers, and educators, as well as physicians and psychologists. They work actively to promote a more compassionate approach to addiction and SUD treatment based on the provision of comprehensive, personalised care for this chronic condition.

Although addiction services in Italy developed independently over the course of the 1990s as a specialised branch of the health service, and despite the aforementioned obstacles, one of the most important aspects of their work is now the coordination of patient care with GPs, mental health services, the wider health service, and social care providers:

> *Many individuals with substance use disorders also experience co-occurring psychiatric conditions, such as anxiety, depression, or schizophrenia (Subodh et al. 2018). Treating these comorbidities effectively demands a multidisciplinary approach that bridges the gap between mental health services and addiction clinics. In this area, much progress has been made in recent decades, as the SerDs are integrated within a network that involves close cooperation with the Mental Health Centers (where non-substance-related psychiatric conditions are treated), psychiatric departments, and infectious disease and hepatology outpatient clinics. (Besana et al., 2025, p. 7)*

4.8.3 National coordination

The coordination of activities between the central government and the Regions is achieved through the Standing Conference of the State, Regions and Autonomous Provinces. The most important tool for national coordination is the identification of a package of essential services (cf. Ferrario *et al.*, 2023). This was introduced in 2001 and includes treatment for SUDs. This reform strengthened the integration of private and third sector providers within the treatment system via a system of accreditation and public payments, although (like in Spain) this does not always provide voluntary organisations with a continuous flow of funding. The Department for Anti-Drug Policies (Dipartimento delle Politiche Contro la Droga e le altre Dipendenze) is responsible for coordinating policy at national level. It is directly accountable to the Presidency of the Council of Ministers and its responsibilities include improving coordination across ministries and between central, regional, and local authorities (Italian Focal Point on Drugs, 2019).

Following a new national agreement with GPs in 2009, incentives were introduced to encourage group practices within multidisciplinary primary care units (Unità Complesse di Cure Primarie, UCCP). Some Regions (Emilia-Romagna, Tuscany, and Marche) have used this reform to set up community health centres (Casa della Comunità) with responsibility for providing primary care and coordinating social care and health prevention (de Belvis *et al.*, 2022, p. 119). The aim is for these structures to function as a single point of access for a range of services. However, GPs in most cases have resisted the implementation of this model, and some policy-makers are in favour of a more radical reform where GPs would work within this kind of integrated, multidisciplinary context (de Belvis *et al.*, 2022, p. 148). This is one of the current priorities for the Italian health service:

> *And one of the things that would facilitate this process is that whole architecture of services linked with the Case della Comunità and community hospitals which they are trying to set up under the National Recovery and Resilience Plan. … At least in theory, they provide a single point of access to a whole range of health and social services near where you live, open 24/7 to reduce the pressure on A&E Departments, with a multidisciplinary team … I don't think you need much more than some [regional] autonomy in the management of this kind of system. … The shared physical location becomes a way of saying "and now you have to talk to each other", because all you have to do is go across the corridor, or up the stairs to talk to your colleague to resolve a problem. (Interview with Professor Gilberto Turati, Università Cattolica del Sacro Cuore, 2 December 2025)*

4.8.4 Clinical governance

Italian citizens have the right to receive health care from any public or accredited private provider, and can choose a GP and/or paediatrician from a local list. When attending specialised services, they can choose the facility but not the individual doctor, unless they pay privately. GPs are nearly always self-employed professionals in solo practice, who are paid a per capita fee by the relevant local health unit. They act as gatekeepers by referring patients to specialised services, which accounts for a large proportion of their time. Patients can bypass their GP by booking and paying for a private appointment directly, and out-of-pocket payments account for about one-quarter of total health expenditure.

Based on Ministerial Decree 70/2015, the Italian Government has developed a detailed and centralised system of hospital planning, with a view to improving clinical effectiveness and efficiency. This system comprises such parameters as bed numbers right down to ward level and includes the required staffing levels and range of specialists that must be present. These criteria place considerable limits on regional autonomy in the implementation of health policy.

In 2022, the central government adopted a National Action Plan on Addictions (Piano di Azione Nazionale Dipendenze) based on a wide-ranging consultation with experts from the drug treatment sector (Ministro per le politiche giovanili, 2022). The Plan comprises 143 actions and 11 objectives, distributed across 3 strategic axes relating to demand reduction, supply reduction, and harm reduction. The Regions are encouraged to develop their own action plans, which should guide the interventions of the local health units and Municipalities, involving the third sector as an important partner at all stages of policy-making and service provision within a specific local context. At the heart of this document is the implementation of evidence-based, integrated clinical pathways that can meet the needs of service users:

> *From an advanced clinical and organisational perspective, the need to meet the complex needs of service users requires the construction of new treatment processes that are based on the development of Diagnostic/Therapeutic/ Treatment Pathways (Percorsi Diagnostico Terapeutico Assistenziali) that are integrated across social care and health care, including employment, education, and housing services. The goal is to identify tools for clinical management that help us to define an appropriate process of treatment that addresses specific health needs, based on the available scientific evidence, considering the local context, the available resources, and linking together access, evaluation, treatment and care. (Ministro per le politiche giovanili, 2022, p. 33, our translation)*

The aforementioned Diagnostic/Therapeutic/Treatment Pathways provide a tool for creating multidisciplinary care teams and integrating services across organisational boundaries. The National Action Plan refers to the need to institute a Department for Addictions within each local health unit in order to organise a diversified and ambitious range of interventions with the aim of improving population health within a specific geographical area (Il Dipartimento delle Dipendenze, 2011). The National Government states in the National Action Plan that it will coordinate the development of these local plans, in conjunction with the Regions and Municipalities, in order to ensure their alignment and uniformity.

One of the problems that is inherent in the current system, from the perspective of clinical governance, is that the director of each service is appointed by the director of the local health unit, who is typically nominated based on their political affiliations (Ministro per le politiche giovanili, 2022, p. 90). This undermines the goal of developing efficient clinical governance, as managerial, technical, and clinical objectives tend to become subordinate to political goals and priorities. The division between health services (organised by the local health units) and social care (provided by the Municipalities) continues to impede the integration of services, as is the case in many European countries.

4.8.5 Monitoring and evaluation

A new system (referred to as the Nuovo Sistema Informativo Sanitario) was introduced in 2003 in order to monitor the quality, efficiency, and appropriateness of care across all Regions. This system is used to monitor expenditure and to ensure the uniform provision of the national benefits package. It is managed by an intergovernmental body under the auspices of the State-Regions Conference. The system now covers 85% of services (de Belvis *et al.*, 2022, p. 26) due to a national system of health cards and electronic prescriptions. There is also a monitoring system called the Nuovo Sistema di Garanzia which consists of 88 indicators. The equivalent system for drug and alcohol treatment, the National Addiction Information System (Sistema Informativo Nazionale delle Dipendenze; SIND), contains a wealth of information on treatment and service users, but is not (and cannot be) integrated with other datasets:

> *The Government Regulation no. 679 (2016), taken together with recent decisions by the Data Protection Commission, excludes the possibility of linking data from SIND with information from other sources, and individual-level data cannot now be used for research purposes, rendering this valuable dataset, to all intents and purposes, worthless. (Ministro per le politiche giovanili, 2022, p. 349, our translation)*

5 Research questions

In this section of the report, we bring together the available evidence for the countries included in this review in order to answer the research questions posed by the Health Research Board. As we have seen, policies and procedures for the administration and governance of regionalised drug and alcohol treatment services vary greatly across European countries. It is useful to identify the models that emerge most frequently within these different contexts, although they also have some specific characteristics.

5.1 Question 1

What arrangements are made for the clinical governance of drug services that are administered at a regional level?

Clinical governance refers to aspects of services that encourage better outcomes, such as their adherence to evidence-based standards and their ability to involve service users in decisions about their care. Most of the countries analysed in the course of this project adopt a similar approach to this issue. National governments set out a list of treatment services that are funded by the State and provided to all members of the eligible population through the public welfare system. Regional administrations are bound by this list of essential services, although they may be able to provide additional services. National governments also specify a set of guidelines or principles to be followed by service providers. These guidelines are generally defined by the Ministry of Health or by a national institute, which may also be involved in monitoring and assessing outcomes. In most European countries, guidelines for drug and alcohol treatment services are subsumed within the broader system of clinical governance for health care. From the perspective of clinical governance, this is one of the benefits of integrating drug and alcohol treatment services within the public health service.

We will now provide a brief summary of the different institutional forms that these arrangements assume in European countries. In Norway, the Directorate of Health is responsible for developing clinical guidelines, which is done exclusively at national level. In Sweden, the National Board of Health and Welfare publishes guidelines for SUD care based on the results of evidence reviews carried out by multidisciplinary expert groups. In Germany, there are national social health insurance guidelines, and the corporatist bodies also play a role in clinical governance by defining models of good practice. In France, the Conférence Nationale de Santé defines health care priorities and related guidelines. In Portugal, the Institute for Addictive Behaviours and Addictions has a multidisciplinary Clinical Council with responsibility for publishing guidelines for SUD treatment. Best practice at European level thus involves the definition of clinical guidelines at national level by a prestigious multidisciplinary body that is formally independent of the Government and is well-integrated within clinical governance systems for the health service as a whole.

Many European countries have developed pathways for SUD treatment, such as Integrated Care Pathways in the UK, Disease Management Programs in Germany, and Percorsi Diagnostico Terapeutici Assistenziali in Italy. This is a clinical governance tool to improve the coordination and integration of care and may be considered a good practice. In contrast with clinical guidelines – which comprise a set of abstract principles that service providers are expected to adhere to – care pathways indicate in more concrete terms who is responsible for specific elements of care, how practitioners should intervene, how patients should be informed and consulted, and how different services should collaborate in order to ensure that all aspects of the care process are integrated.

In most European countries, regional administrations are expected to apply these national guidelines and care pathways, to assign responsibility for their implementation, and to provide training in order to support practitioners and managers to carry out their clinical roles. National governments and regional administrations often use certification processes to determine whether service providers can operate in specific areas of the welfare system. In Norway, for example, quality assurance is legally required for all institutions that provide health care services. In Portugal, the independent Health Regulatory Agency plays an important role in monitoring the quality of services. However, cultural and political disparities at regional level often lead to heterogeneity in treatment practices and service organisation. In countries like Spain and Italy, responsibility for clinical governance tends to be shared between the central and the regional administrations, and distinct approaches have emerged over time. Experts and top administrators typically view this unevenness as an obstacle to the improvement of services. Certification is considered important in countries where a significant part of service delivery is commissioned from private companies or third sector organisations.

All actors in the treatment system are typically obliged by the national government to collect standardised data on key aspects of treatment provision and to share individual-level data with regional and national databases. These data are used in order to calculate payments and performance incentives at various levels of the system, to ascertain whether service providers are meeting their obligations, and to conduct research. Service users are typically identified by a univocal identity number, which is determined at national level and can be used to join data from different databases for research and monitoring purposes.

Auditing and assessment procedures are sometimes carried out at local level to provide more detailed information on treatment. These assessments may be systematic or periodic and are generally used in order to ascertain whether national or regional guidelines are being respected, and to monitor service level agreements with private providers. The assessment of outcomes through data analysis and auditing focuses on two main elements: (1) whether services are in line with national and regional guidelines, and (2) whether they are achieving the expected results.

To conclude, as far as clinical governance is concerned, there is a degree of convergence between European countries in terms of the institutional structures that they have adopted over recent decades. Regardless of the degree to which responsibility for treatment services is decentralised, and the specific model of regionalisation adopted, clinical governance tends to have a national dimension. In fact, the national definition of essential services, the centralised development of guidelines and standardised pathways, and the evaluation of outcomes has become more important in the presence of decentralised decision-making.

This suggests that clinical governance is used by central governments to counterbalance the decentralising effects of regionalisation, based on an awareness that the latter has the potential to generate disparities. There is evidence of heterogeneity in service provision and clinical outcomes in all countries where responsibility for treatment provision has been decentralised. It can therefore be argued that an effective national system of clinical governance is an important centralising component of these systems. As the degree of regionalisation increases, we expect to observe a simultaneous strengthening of nationally coordinated clinical governance structures.

5.2 Question 2

In what manner do regionally administered drug services demonstrate adherence to national policy as articulated in drugs strategies or similar documentation?

Most of the European countries that we discuss in this report have a national drugs strategy, and many have national action plans that set out national recommendations and objectives, in line with European Union Drugs Agency (EUDA) recommendations. Where regions (or states) have at least some responsibility for decision-making, they are typically expected to develop a regional drugs strategy and perhaps even a regional action plan where they indicate how they propose to achieve their aims. For example, regions like Piedmont and Trentino-Alto Adige in Italy must consider how to provide access to treatment services in the relatively isolated and sparsely populated mountain valleys that form an important part of their territory.

National policies typically place an obligation on regional administrations to report their progress towards the goals specified in the national drugs strategy, as well as sharing data on services and their use. In Spain, for example, treatment services are monitored via a decentralised system combining epidemiological data, administrative reporting, and programme evaluation. These activities are carried out within the national framework, but are designed, managed, and implemented by the Autonomous Communities. The data available in this country on drug and alcohol treatment services are much less detailed than those that are routinely available in countries with a more centralised health service.

As we noted at the beginning of this report, there are different forms and dimensions of regionalisation based on, for example, decentralised funding, decentralised policy-making, and decentralised administration. Where funding is distributed by the central government to a system of regions, a key concern of the administration relates to efficiency. Centralised monitoring systems are used in order to ascertain whether regions are making good use of public funding, whether they provide essential services, whether the quality of services is satisfactory, and whether outcomes are in line with national targets. These assessments generally require the same kind of data and institutional arrangements as the clinical governance system. As mentioned in relation to Question 1, standardised forms of reporting are typically used in order to evaluate services from a financial and managerial perspective as well as from a clinical viewpoint.

The ongoing monitoring and evaluation of regional treatment systems poses a number of challenges, which are at the centre of recent reforms. With the appropriate data, it is relatively straightforward to estimate the number of treatment centres, practitioners providing services, and people attending these services, and this is largely what regional administrations concentrate on when drafting their reports. At national level, the information and assessments carried out at regional level are analysed in a comparative fashion, in collaboration with the decentralised administrations, with a view to identifying underserved areas.

It is a lot more complicated to evaluate quality and outcomes, and this is the domain of clinical governance. This challenge is at the centre of attention in systems where policy-making and administration are decentralised. If regions are free to implement different kinds of treatment systems, then it is no longer sufficient to estimate activity rates, and it becomes important to assess whether systems are associated with more or less favourable outcomes for service users. In countries like Germany, Spain, and Italy, where the structure and organisation of treatment systems can vary quite substantially at regional level, the question of clinical efficacy is receiving more attention from researchers. At present, outcomes are typically measured in procedural terms using indicators that measure adherence to standardised, evidence-based treatment pathways, an issue that we discuss further when we address Question 5.

5.3 Question 3

How are relations between regional health authorities and non-governmental organisations charged with implementing policy managed?

As we have seen, the European countries included in this review have drug and alcohol treatment systems with a complex, multilevel administrative structure, involving a combination of public, voluntary (non-profit), and private (for-profit) organisations. In the Scandinavian countries, drug and alcohol treatment services are often commissioned from voluntary organisations (which is common in Norway, for example) or private corporations (in Sweden). A similar situation is observed in the UK, albeit with variations between the historic nations. Initially, third sector services were viewed as complementary to statutory services in England, but these organisations are now more likely to compete with the National Health Service.

In France, Germany, Portugal, Spain, and Italy, third sector organisations are also involved in the provision of drug and alcohol treatment services within the institutional framework of the public welfare system. In France, treatment services are provided in centres that are often managed by third sector organisations and provide both outpatient and inpatient care, pharmacologically assisted and psychosocial treatment for SUDs, and low-threshold services. In Portugal, non-governmental organisations (NGOs) often run needle exchange programmes, safe consumption facilities, outreach projects, and centres providing psychosocial support to people with SUDs. These services are financed through competitive tenders or service level agreements with public authorities.

In Spain, NGOs are also involved in providing services within the framework of the public system, often via contracts negotiated at regional level. The local treatment centres in Italy rely heavily on third sector organisations for counselling, education, and social support services, again with public funding based on contracts. Italy's most recent national drugs strategy emphasises the role of the third sector as a key stakeholder.

It is clear, therefore, that private firms and voluntary organisations have come to play an important role in the delivery of treatment services for SUD in Europe. Third sector organisations have demonstrated an ability to collaborate with statutory services, to adapt to local conditions, to meet the needs of service users, and to promote user involvement. This is one of the positive results of the decentralising tendencies that characterised NPM-inspired policies during the 1990s and early 2000s. By providing local actors with greater autonomy in relation to how they used their budget, the central State cleared the way for the greater involvement of voluntary organisations within the public welfare system. In recent years, about one-half of Norwegian Municipalities have purchased mental health or addiction treatment services from these organisations. The task of negotiating with non-State organisations and commissioning services is handled at different levels, from the treatment centre to the national government, based on the scale of the contract.

Third sector organisations have expanded their role in the delivery of SUD treatment services in practically all jurisdictions, but particularly where drug and alcohol treatment services are subject to commissioning procedures. In continental Europe, the integration of third sector organisations within statutory public services is premised more strongly on the realisation that they can play a complementary role with respect to the State, integrating, extending, and improving treatment services at a modest cost. This post-NPM approach seeks to combine aspects of the universalistic social democratic model and aspects of the market-based neoliberal model, with the hope of identifying a point of equilibrium. Of course, there are also European countries (such as Sweden and the UK) where policy continues to be influenced by the NPM model and non-State organisations compete directly with public providers. However, even in this case, policy-makers appear to be aware of the need to counterbalance centralism and fragmentation, competition and coordination.

5.4 Question 4

What is the nature of the relationship between regionally administered drug services and primary care services?

This is a complex but important aspect of processes involving the deconcentration of treatment service administration, and is currently at the centre of the policy agenda in European countries. Simplifying somewhat, regionalisation aims to find a point of equilibrium between the micro-level dynamics of the primary care system, on the one hand, and the macro-level objectives of national strategies, on the other. If a government wishes to improve population health, to control spending, or to boost satisfaction with services, it must understand how people flow into and through the health care system, and primary care is particularly influential in this respect. All elements of the health system are connected, so if a government wishes to reduce unnecessary use of hospital services, for example, it must enhance the capacity of primary care and specialised outpatient services to diagnose and resolve health conditions in the community.

The Norwegian reforms of the early 2000s provide a number of insights into the ways in which these different elements of health and drug treatment systems are related. The Norwegian Government initially focused on containing the costs of hospital care by implementing health service regionalisation. It quickly realised that in order to achieve its goals, the administrative geography of each area would have to be aligned. In order to enhance the ability of the primary care system to treat SUD and other mental health issues, it was considered necessary to pursue integration between the general health, mental health, addiction treatment, and social care systems. Drug and alcohol treatment in Norway thus involves a three-way collaboration between a specialised treatment centre, a primary care provider, and municipal social services. In this formulation, primary care is one of the key nodes in a triangular structure of service delivery for SUDs.

In countries where drug and alcohol treatment services are managed at the regional level, there are typically pressures to maintain quality and to improve population health while controlling costs. These pressures encourage regional managers to pursue efficiencies by integrating and coordinating the delivery of services. This process has followed two broad models: (1) strengthening collaboration between GPs and a network of specialised services; and (2) the construction of multidisciplinary primary health care centres that can provide some specialised services. Norway, the UK, Ireland, and Germany are examples of the first model, while Portugal and Spain fall into the second. Sweden, France, and Italy combine elements of both. It is interesting to note, however, that Norway and France have also experimented with hybrid forms of primary care that do not rely on inter-organisational cooperation, but bring several disciplines together within a single structure. This shows that a mixed strategy is possible, based on the introduction of innovative forms of integrated multidisciplinary care at the periphery of the existing health service, perhaps by encouraging younger professionals to adopt new ways of working.

In Norway, the UK, Ireland, Germany, France, and Italy, GPs generally operate as self-employed practitioners with a service contract that is agreed at national level. This reduces the ability of regional health managers to influence the primary care system and to develop an approach that is centred on improving population health within a specific territory. In these countries, GPs have little incentive to engage in health promotion or to promote the efficiency of the wider health service. In Sweden, Portugal, and Spain, by contrast, GPs are generally health service employees, which facilitates the reorganisation of primary care. People in Sweden can freely choose their primary care provider, and government policy promotes multidisciplinary primary care centres that can act as a first point of contact for the population.

In a similar way, it is possible to identify two different models for the organisation of SUD treatment: (1) the separate provision of medical, mental health, psychosocial support, and care services; and (2) multidisciplinary treatment centres that bring at least some of these services under one roof. Norway, the UK, Ireland, and Germany adopt the first model, while Sweden, Portugal, Spain, France, and Italy adopt the second, albeit with some limitations and exceptions. In the first model, physicians operate independently, with a minority choosing to specialise in addiction medicine. In Norway, the UK, and Germany, considerable efforts have been made to overcome the obstacles created by the separate provision of medical, mental health, addiction, and social care, mainly by strengthening collaboration. Under the second model, by contrast, physicians form a stable part of the multidisciplinary addiction treatment centre, with the task of meeting the needs of patients. For example, this is the case in Spain and Italy, and is often the case in Sweden. In Spain and Italy, the development of multidisciplinary addiction treatment centres has reproduced a sharp separation between the way in which treatment for SUD and treatment for other health conditions is provided. It is evidently inefficient and stigmatising to develop a separate health service for people with SUDs, implying that these multidisciplinary centres must be closely integrated within the broader health service if they are to function as intended.

These differences in the organisation of primary care and drug treatment services have a number of consequences for service delivery, as people with SUD tend to have complex needs that can only be met by integrating different forms of care. In theory, this can be achieved under both models: through inter-institutional collaboration in one case, and through multidisciplinary teamwork in the other. The evidence suggests that in both cases it can take a considerable amount of time and resources to break down institutional and disciplinary boundaries, particularly where service users are marginalised and stigmatised. It also suggests that some combination of these two models is required in order to combine efficiency and effectiveness.

Some European countries have sought to develop treatment services for SUD that are based on concepts like ‘shared care’ (the UK), or seek to develop integrated pathways that bring specialised treatment services for SUD into closer alignment with primary care, mental health services, and social care (Norway, France, and Germany). Others – including Portugal, Spain, and Italy – have adopted a more multidisciplinary and territorial approach to the provision of services which poses different challenges. Although the resulting services are only partially integrated with the wider health service (with GPs and psychiatrists often resisting incorporation within these multidisciplinary teams), drug and alcohol treatment centres have nevertheless developed a culture that values integration between services and disciplines. As they have gradually adopted a more holistic approach, these multidisciplinary service providers have become better at involving service users and articulating the needs of the sector as a whole, which has enabled them to exert an influence on public policy and to pursue a closer relationship with other services.

This holistic approach resonates with recent health research, which emphasises the role of primary care and the importance of integrated service delivery when seeking to improve efficiency and effectiveness. In short, policies for health service regionalisation must produce a roadmap for the integration of treatment services for SUD that embraces the primary care system and sets up a dynamic institutional configuration that actively encourages closer collaboration between services and more interdisciplinary integration as time goes by.

5.5 Question 5

What indicators/metrics have been used to monitor the regionalisation of drug services?

The regionalisation of drug and alcohol treatment services takes many forms and usually comprises a combination of decentralising and centralising tendencies. Regionalising reforms are under-theorised and their rationale is rarely stated in policy documents. This is true in the case of Ireland, as we showed earlier, but it is also true of the other countries we discuss in this report. Change tends to involve an ongoing, incremental process, marked by unexpected changes of direction and corrections that are rarely based on evidence. With regionalisation, different solutions may be adopted at local level, which further complicates the task of monitoring and assessing services.

Although concepts like the identification of problem substance use, service integration, evidence-based treatment models, and user involvement are often referred to in policy documents, robust ways of measuring their implementation have generally not been identified or implemented. Scientific research often relies on qualitative methods when studying treatment systems, and these studies typically do not use standardised indicators and metrics to capture important aspects of service development within the context of institutional reforms.

Nevertheless, most European countries have systems for gathering and sharing data, with Norway and Sweden having national registries that contain comprehensive information on diagnoses, treatment, and outcomes. It is possible to link these data with information from other databases, and in Sweden there is a framework for monitoring the performance of the drug and alcohol treatment system using standardised indicators (Blomqvist *et al.*, 2009). Drug and alcohol treatment services are treated in a similar way to other health services, with SUD patients being identified in databases by diagnostic category.

Providers in the UK are also obliged to collect and share data, and treatment services are monitored through the National Drug Treatment Monitoring System. The current aim is to develop metrics for measuring progress at both the national and local level. In France, like the UK, there is a national Health Data Hub that enables researchers to access anonymised and linked individual-level data via a secure online platform. In these countries, comprehensive individual-level data on drug and alcohol treatment services are collected more or less in real time within the framework provided by the national health data infrastructure. The data can be linked with information from other sources for research purposes, and can be accessed by researchers via secure online platforms. This coincides with the current state of the art and facilitates the dynamic measurement of progress as national, regional, and local goals change and evolve over time.

In other countries, the situation is less favourable. In Portugal, data on drug treatment service utilisation are stored on the Health Data Platform, which has disease-specific registers and contains information on different aspects of the health care system. The information collected is shaped by the requirements of the payment system, and there are limitations on the use of personal data. Drug treatment services in Spain are largely monitored at regional level, although there is a national framework that permits the Spanish Observatory on Drugs and Addictions to produce annual reports on treatment demand, essentially by integrating data from the Autonomous Communities. In Italy, individual data on drug and alcohol treatment are recorded in a national database that contains a wealth of information, although these data cannot be linked with other datasets due to recent regulations regarding the use of personal data. In what is undoubtedly the most fragmented system in Europe, data on drug treatment services in Germany are stored in a range of different databases at different levels, which restricts the ability of the central administration to monitor the situation in a flexible and up-to-date manner.

The development of effective monitoring systems for drug and alcohol treatment services was not treated as a strategic priority in European countries until recent years. In many cases, the goals that are set at national level are rather broad and aspirational, and are not based on a rigorous assessment of the available evidence, which makes it difficult to identify appropriate indicators and targets. At the same time, there are signs of a growing emphasis on the importance of evidence-based policy-making and building a culture of performance assessment.

Once powerful databases have been developed, the construction of a flexible monitoring framework represents an obvious way to add value to these systems. One reason why monitoring frameworks are weak in European countries is that the sectoral research infrastructure is still rather weak. Independent national research institutions with a focus on addictions and drug and alcohol treatment arguably need to be better funded if monitoring systems and activities are to improve. In the absence of a body that is capable of implementing a sophisticated research agenda in this area, and is allowed to access and analyse individual-level data on treatment, it is difficult to imagine significant progress taking place. As treatment pathways become more complex, individualised, and integrated across services, systems for data collection and analysis must also move in the same direction, following the example of the Scandinavian countries. The use of individual-level administrative data to develop indicators that capture different aspects of performance within treatment systems, and which can be compared across regions, represents a strategic goal. Without this kind of system, it is difficult to monitor the process of regionalisation, to identify good practices, and to measure progress towards regional and national goals.

5.6 Recommendations for future research

As we have shown in this report, research on the regionalisation of drug and alcohol treatment services in Europe is in its infancy, and many of the policies described in this review are still being implemented. This topic seems destined to receive greater attention in the coming years, as regionalisation will have far-reaching effects on the organisation, management, and delivery of drug and alcohol treatment services. One of the goals of this evidence review is to identify the issues that policy-makers, administrators, and service providers will need to tackle in the coming years, and to indicate the role of research in relation to regionalisation.

The first challenge that researchers face when seeking to make sense of regionalisation is of a theoretical nature, involving the development of a framework that can help to distinguish between different models of service provision. As we have seen, there are many different forms of regionalisation in European countries as far as drug and alcohol treatment services are concerned, and a theoretically grounded explanatory framework could support empirical research and guide comparative research. It will be necessary to compare different national and regional contexts so that we can gain a better understanding of how the processes of decentralisation and recentralisation unfold in different areas of Europe.

Within the broad area of regionalisation, as we have seen, different types of deconcentration and decentralisation are observed: decisions about the distribution of funds may be decentralised, the power to legislate may be devolved to a lower level, authority to implement policies may be shifted from the centre to the local level, or the distribution of power to carry out evaluations may be altered. Each national system is characterised by a combination of different centralising and decentralising pressures that cut across these different spheres. A theoretical framework is needed which can help researchers to track this complex, multidimensional process across time and space.

The second recommendation relates to empirical research on the effects of regionalisation. Research is needed on the organisational implications of regionalisation (what happens within treatment systems) and how this process affects local populations (the impact of treatment systems). It is both difficult and important to measure treatment outcomes in systems where policy-making and administration are decentralised. Where regions are free to implement different policies and to introduce new organisational forms, it is no longer sufficient to measure activity rates or adherence to national standards. In this context, it becomes important to assess whether systems are associated with more or less favourable outcomes for local populations, in terms of their health and well-being.

In short, it is important to focus not only on the nature of regionalisation processes but also on their impact on treatment outcomes and population health. This means that appropriate ways of measuring these crucial outcome variables must be identified, and baseline measurements obtained, so that the impact of regionalisation reforms can be monitored and assessed. Researchers have, for several years, emphasised the need to shift away from organisational outputs and activity rates and towards the measurement of outcomes at the population level. This paradigm shift is particularly important in the field of drug treatment, where the objectives of services are increasingly framed in terms of the health and well-being of a specific population.

The third recommendation is of a methodological nature, and rests on the importance of exploiting mixed methods research. As well as measuring impacts in terms of health and well-being, it is important to listen to the voices of service users, their families, service providers, and third sector operators. Qualitative and quantitative research can reinforce each other and provide greater insights into the generative mechanisms that are active within the treatment context. Research is needed in order to assess whether regionalisation policies encourage inter- and trans-disciplinary collaboration, for example, and to understand the role of different groups. Administrators are often portrayed as mediating between centralising and decentralising tendencies, and research is needed on how their role evolves over time under the influence of regionalising policies.

Finally, we believe that routine administrative data can play a valuable role in the monitoring and assessment of outcomes in this field, and across the whole health care system, in the future. In jurisdictions where it is possible to access joined individual-level datasets in order to carry out research, scientists are able to complete more ambitious studies and to implement more powerful research designs. They can look at how drug and alcohol treatment services relate to other forms of service use, for example, and explore the role of individual characteristics, the local context, and the different types of treatment that were available and effectively utilised. This is the only type of research design that is currently powerful enough to identify how treatment access and outcomes change over time, against the backdrop of regionalisation processes.

In the Nordic countries, for example, this type of research design has enabled researchers to understand how the development of drug and alcohol treatment services and their integration within the health service can influence treatment use and population health. Because SUD are frequently underdiagnosed, improving the capacity of the primary care system to identify and treat this condition is an essential step towards improving population health. Paradoxically, effective services are likely to attract more service users and to require more resources, in the short term, in order to produce their mid- to long-term benefits for population health. This was one of the principal lessons of the Norwegian reforms in the mid-2000s, and deserves further research attention.

Appendix A: Studies retained after title and abstract screening (bibliographical databases)

For each record, we indicate the judgement reached after full-text screening, using the following four categories: (1) eligible; (2) does not deal with drug or alcohol treatment services; (3) does not relate to regionalisation; and (4) does not meet the formal criteria.

1. Blomqvist J, Palm J and Storbjörk J (2009) 'More cure and less control' or 'more care and lower costs'? Recent changes in services for problem drug users in Stockholm and Sweden. *Drugs: Education, Prevention and Policy*, 16(6): 479–496. Available from: https://doi.org/10.3109/09687630802640305 [Decision: eligible]

2. Butler S (2016) Coolmine Therapeutic Community, Dublin: A 40-year history of Ireland's first voluntary drug treatment service. *Addiction*, 111(2): 197–203. Available from: https://doi.org/10.1111/add.13157 [Decision: does not relate to regionalisation]

3. Comiskey CM, O'Sullivan K and Milnes J (2012) Regional drug user services in times of scarce financial resources: Using a rapid assessment response approach to evaluate, plan, and prioritize essential services. *Subst Use Misuse*, 47(3): 254–264. Available from: https://doi.org/10.3109/10826084.2011.633958 [Decision: does not relate to regionalisation]

4. Compagni A, Gerzeli S and Bergamaschi M (2011) The interplay between policy guidelines and local dynamics in shaping the scope of networks: The experience of the Italian Departments of Mental Health. *Health Serv Manage Res*, 24(1): 45–54. Available from: https://doi.org/10.1258/hsmr.2010.010013 [Decision: eligible]

5. Cullen OJ and Norton MJ (2024) Mental Health, Addiction and Dual Diagnosis: National and International Policy Context. In Cullen OJ and Norton MJ (eds) *Different Diagnoses, Similar Experiences: Narratives of Mental Health, Addiction Recovery and Dual Diagnosis*. Emerald Publishing Limited. 19–33. Available from: https://doi.org/10.1108/978-1-80455-848-520241002 [Decision: does not relate to regionalisation]

6. Dar K, Ashby F, Dhandayudham A, *et al.* (2015) Challenges and recommendations for the UK drug treatment system: Findings from a UK expert meeting. *J Subst Use*, 20(2): 151–153. Available from: https://doi.org/10.3109/14659891.2014.920053 [Decision: does not relate to regionalisation]

7. De Ruysscher C, Magerman J, Goethals I, *et al.* (2024) Islands in the stream: A qualitative study on the accessibility of mental health care for persons with substance use disorders in Belgium. *Front Psychiatry*, 15: 1344020. Available from: https://doi.org/10.3389/fpsyt.2024.1344020 [Decision: does not relate to regionalisation]

8. Drake RE and Bond GR (2010) Implementing integrated mental health and substance abuse services. *J Dual Diagn*, 6(3–4): 251–262. Available from: https://doi.org/10.1080/15504263.2010.540772 [Decision: does not relate to regionalisation]

9. Duopah YA, Moran L, Elmusharaf K and Kelly D (2025) Illicit drug use in Limerick City: A stakeholder and policy analysis using multiple streams model. *Int J Health Plann Manage*, 40(1): 86–107. Available from: https://doi.org/10.1002/hpm.3856 [Decision: does not relate to regionalisation]

10. Ettorre B (1987) A study of voluntary drug agencies: Their roles in the treatment and rehabilitation field. *Br J Addict*, 82(6): 681–689. [Decision: does not relate to regionalisation]

11. Gerada C (2000) Drug misuse and primary care in the new NHS. *Drugs: Education, Prevention and Policy*, 7(3): 213–221. Available from: https://doi.org/10.1080/09687630050109907 [Decision: does not relate to regionalisation]

12. Gerada C, Barrett C, Betterton J and Tighe J (2000) The Consultancy Liaison Addiction Service—The first 5 years of an integrated, primary care-based community drug and alcohol team. *Drugs: Education, Prevention and Policy*, 7(3): 251–256. Available from: https://doi.org/10.1080/09687630050109934 [Decision: does not relate to regionalisation]

13. Gjersing L, Waal H, Røislien J, Gossop M and Clausen T (2011) Variations in treatment organisation, practices and outcomes within the Norwegian Opioid Maintenance Treatment Programme. *Nor Epidemiol*, 21(1): 113–118. [Decision: eligible]

14. Häkkinen U and Lehto J (2005) Reform, Change, and Continuity in Finnish Health Care. *J Health Polit Policy Law*, 30(1–2): 79–96. Available from: https://doi.org/10.1215/03616878-30-1-2-79 [Decision: eligible]

15. Herrero Yuste MN (1999) La intervención en drogodependencias desde el ámbito municipal. *Adicciones*, 11(2): 87–90. Available from: https://doi.org/10.20882/adicciones.597 [Decision: does not relate to regionalisation]

16. Hilarion P, Groene O, Colom J, Lopez RM and Suñol R (2010) Results of a sector-wide quality improvement initiative for substance-abuse care: An uncontrolled before-after study in Catalonia, Spain. *Subst Abuse Treat Prev Policy*, 5: 26. Available from: https://doi.org/10.1186/1747-597x-5-26 [Decision: does not relate to regionalisation]

17. Hirschovits-Gerz T, Kuussaari K, Stenius K and Tammi T (2019) Estimating the Needs of Substance Problem Use Services: An Exercise in Seven Finnish Municipalities Using Nationally Collected, Municipal-Level Survey and Register Data. *J Stud Alcohol Drugs Suppl*, 18(18): 76–86. [Decision: does not relate to regionalisation]

18. Johansen KA, Feryn N, Vandevelde S and Vandenbroeck M (2024) The man with a plan: A genealogical study of the medicalisation and individualisation of the 2004 Norwegian drug treatment reforms. *Crit Radic Soc Work*, 14(1): 59–75. Available from: https://doi.org/10.1332/20498608Y2024D000000035 [Decision: does not relate to regionalisation]

19. Kalk NJ, Robertson JR, Kidd B, *et al.* (2018) Treatment and Intervention for Opiate Dependence in the United Kingdom: Lessons from Triumph and Failure. *Eur J Crim Policy Res*, 24(2): 183–200. Available from: https://doi.org/10.1007/s10610-017-9364-z [Decision: does not relate to regionalisation]

20. Klingemann HK (1996) Drug treatment in Switzerland: Harm reduction, decentralization and community response. *Addiction*, 91(5): 723–736. Available from: https://doi.org/10.1046/j.1360-0443.1996.9157238.x [Decision: does not relate to regionalisation]

21. Korkeila J and Fink-Jensen A (2009) Current trends in psychiatry care in Finland with special focus on private practice psychiatry and psychotherapy. *Nord J Psychiatry*, 63(1): 87–91. Available from: https://doi.org/10.1080/08039480802699886 [Decision: does not relate to regionalisation]

22. Kunnes R, Niven R, Gustafson T, *et al.* (1993) Financing and payment reform for primary health care and substance abuse treatment. *J Addict Dis*, 12(2): 23–42. [Decision: does not relate to regionalisation]

23. MacGregor S and Thickett A (2011) Partnerships and communities in English drug policy: The challenge of deprivation. *Int J Drug Policy*, 22(6): 478–490. Available from: https://doi.org/10.1016/j.drugpo.2011.06.003 [Decision: eligible]

24. McCambridge J (2009) Devolution and British drug policies: Natural experiments in need of evaluation. *Drugs: Education, Prevention and Policy*, 16(1): 1–6. Available from: https://doi.org/10.1080/09687630802530720 [Decision: does not meet the formal criteria as this is just a short comment]

25. Michels II, Stöver H and Gerlach R (2007) Substitution treatment for opioid addicts in Germany. *Harm Reduct J*, 4: 5. Available from: https://doi.org/10.1186/1477-7517-4-5 [Decision: does not relate to regionalisation]

26. Nesvaag S and Lie T (2010) The Norwegian substance treatment reform: Between New Public Management and conditions for good practice. *Nordic Studies on Alcohol and Drugs*, 27(6): 655–666. Available from: https://doi.org/10.1177/145507251002700610 [Decision: eligible]

27. Oldeide O, Fosse E and Holsen I (2019) Collaboration for drug prevention: Is it possible in a "siloed" governmental structure? *Int J Health Plann Manage*, 34(4): e1556–e1568. Available from: https://doi.org/10.1002/hpm.2846 [Decision: does not relate to regionalisation]

28. Oldeide O, Fosse E and Holsen I (2021) Local drug prevention strategies through the eyes of policy-makers and outreach social workers in Norway. *Health Soc Care Community*, 29(2): 376–384. Available from: https://doi.org/10.1111/hsc.13096 [Decision: does not relate to regionalisation]

29. Poldrugo F, Lenassi P, Fiore A and Spazzapan B (2005) Italy: A profile of treatment facilities for drug users. *Addiction*, 100(6): 879–880. Available from: https://doi.org/10.1111/j.1360-0443.2005.01167_3.x [Decision: does not relate to regionalisation]

30. Pucci D, Amaddeo F, Rossi A, *et al.* (2011) A comparison between two community-based mental health services, Northern Italy and Northern Norway. *Psychiatr Prax*, 38. Available from: https://doi.org/10.1055/s-0031-1277917 [Decision: does not deal with drug or alcohol treatment services]

31. Robles G (2000) Estrategia Nacional sobre Drogas. *Adicciones*, 12(2): 157–159. Available from: https://doi.org/10.20882/adicciones.629 [Decision: does not relate to regionalisation]

32. Rohrer JE and Westermann J (1998) Definition of service areas for substance abuse treatment agencies. *Adm Policy Ment Health*, 25(4): 449–454. Available from: https://doi.org/10.1023/A:1022200809685 [Decision: does not relate to regionalisation]

33. Roy A and Buchanan J (2016) The Paradoxes of Recovery Policy: Exploring the Impact of Austerity and Responsibilisation for the Citizenship Claims of People with Drug Problems. *Soc Policy Adm*, 50(3): 398–413. Available from: https://doi.org/10.1111/spol.12139 [Decision: eligible]

34. Rupasinghe B, Georgitseas N, Madaan P, Digiacomo F, Olid Gonzalez A and Walsh K (2018) PMH50 - Treatment of Opioid Use Disorder in Italy: Is there scope for policy change? *Value Health*, 21(S3): S283. Available from: https://doi.org/10.1016/j.jval.2018.09.1685 [Decision: does not relate to regionalisation]

35. Schmidt M, Cranach MV and Egger S (2006) Anforderungen an ein regionalisiertes medizinisches Versorgungssystem für Drogenabhängige [Requirements of a regional medical service for drug addicted patients]. *Wien Med Wochenschr*, 156(3–4): 102–110. Available from: https://doi.org/10.1007/s10354-005-0256-3 [Decision: does not relate to regionalisation]

36. Sosin MR (2012) Decentralization, Devolution, Financial Shortfalls, and State Priorities in Service Programs in the Early 2000s. *J Public Adm Res Theory*, 22(4): 701–730. Available from: https://doi.org/10.1093/jopart/mur067 [Decision: does not meet the formal criteria as it relates to the USA]

37. Stallvik M, Flemmen G, Salthammer JA and Nordfjærn T (2019) Assessing health service satisfaction among users with substance use disorders within the municipalities in Norway. *Subst Abuse Treat Prev Policy*, 14(1): 18. Available from: https://doi.org/10.1186/s13011-019-0207-4 [Decision: does not relate to regionalisation]

38. Storbjörk J and Stenius K (2019a) The new privatized market: A question of ideology or pragmatism within the Swedish addiction treatment system? *Soc Policy Adm*, 53(5): 776–792. Available from: https://doi.org/10.1111/spol.12414 [Decision: eligible]

39. Trinidad Requena A, Martín-Lagos López MD and Fernández Alonso M (2004) La atención institucional a las toxicomanías en España: evaluación diagnóstico de los planes autonómicos sobre drogas [Institutional attention for drug-addiction in Spain: A diagnostic evaluation of regional drug plans]. *Adicciones*, 16(2): 123–141. Available from: https://doi.org/10.20882/adicciones.411 [Decision: eligible]

40. Vogt I (2009) Drug problems, community reactions and policy changes in Frankfurt/Main. *Drugs: Education, Prevention and Policy*, 16(6): 512–526. Available from: https://doi.org/10.3109/09687630802640297 [Decision: eligible]

41. Wälti S and Kübler D (2003) "New Governance" and Associative Pluralism: The Case of Drug Policy in Swiss Cities. *Policy Stud J*, 31(4): 499–525. Available from: https://doi.org/10.1111/1541-0072.00040 [Decision: does not relate to regionalisation]

42. Weaver T, Stimson G, Tyrer P, Barnes T and Renton A (2004) What are the implications for clinical management and service development of prevalent comorbidity in UK mental health and substance misuse treatment populations? *Drugs: Education, Prevention and Policy*, 11(4): 329–348. Available from: https://doi.org/10.1080/09687630410001687851 [Decision: does not relate to regionalisation]

43. Yates R (2003) A brief moment of glory: The impact of the therapeutic community movement on the drug treatment systems in the UK. *Int J Soc Welf*, 12(3): 239–243. Available from: https://doi.org/10.1111/1468-2397.00499 [Decision: does not relate to regionalisation]

Appendix B: Studies retained after title and abstract screening (targeted web searches)

For each record, we indicate the judgement reached after full-text screening, using the following four categories: (1) eligible; (2) does not deal with drug or alcohol treatment services; (3) does not relate to regionalisation; and (4) does not meet the formal criteria.

International organisations

1. Athanasiadis A, Kostopoulou S and Philalithis A (2015) Regional Decentralisation in the Greek Health Care System: Rhetoric and Reality. *Glob Health Sci*, 7(6): 55–67. Available from: https://doi.org/10.5539/gjhs.v7n6p55 [Decision: does not deal with drug or alcohol treatment services]

2. Babor TF, Stenius K and Romelsjo A (2008) Alcohol and drug treatment systems in public health perspective: Mediators and moderators of population effects. *Int J Methods Psychiatr Res*, 17(S1): S50–S59. Available from: https://doi.org/10.1002/mpr.249 [Decision: does not relate to regionalisation]

3. Christensen T and Lægreid P (2009) *Democracy and administrative policy: Contrasting elements of NPM and post-NPM*. Stein Rokkan Centre for Social Studies - Working Paper No 11. [Decision: does not deal with drug or alcohol treatment services]

4. Colson R and Bergeron H (eds) (2017) *European drug policies: The ways of reform*. 1st edn. London: Routledge. Available from: https://doi.org/10.4324/9781315690384 [Decision: does not relate to regionalisation]

5. European Monitoring Centre for Drugs and Drug Addiction (2017) *EMCDDA strategy 2025*. Luxembourg: Publications Office of the European Union. Available from: https://doi.org/10.2810/1751 [Decision: does not relate to regionalisation]

6. Exworthy M, Frosini F, Jones L, *et al.* (2010) *Decentralisation, Centralisation and Devolution in Publicly Funded Health Services: Decentralisation as an Organisational Model for Health Care in England*. National Institute for Health Research Service Delivery and Organisation. [Decision: does not deal with drug or alcohol treatment services]

7. Gilchrist G, Moskalewicz J, Nutt R, *et al.* (2014) Understanding access to drug and alcohol treatment services in Europe: A multi-country service users' perspective. *Drugs: Education, Prevention and Policy*, 21(2): 120–130. Available from: https://doi.org/10.3109/09687637.2013.848841 [Decision: does not relate to regionalisation]

8. Harnett PJ, Kennelly S and Williams P (2020) A 10 Step Framework to Implement Integrated Care for Older Persons. *Ageing Int*, 45(3): 288–304. Available from: https://doi.org/10.1007/s12126-019-09349-7 [Decision: does not relate to regionalisation]

9. Holt DH, Carey G and Rod MH (2018) Time to dismiss the idea of a structural fix within government? An analysis of intersectoral action for health in Danish municipalities. *Scand J Public Health*, 46(22_suppl): 48–57. Available from: https://doi.org/10.1177/1403494818765705 [Decision: does not deal with drug or alcohol treatment services]

10. Jacqueson C (2019) Administering social security and health in Denmark: Between centralisation and decentralisation. *Eur J Soc Secur*, 21(2): 183–191. Available from: https://doi.org/10.1177/1388262719847807 [Decision: does not deal with drug or alcohol treatment services]

11. Marchildon G (2019) The integration challenge in Canadian regionalization. *Cad Saúde Pública*, 35(suppl 2): e00084418. Available from: https://doi.org/10.1590/0102-311x00084418 [Decision: does not meet the formal criteria]

12. Montero-Granados R, de Dios Jiménez J and Martín J (2007) Decentralisation and convergence in health among the provinces of Spain (1980–2001). *Soc Sci Med*, 64(6): 1253–1264. Available from: https://doi.org/10.1016/j.socscimed.2006.10.016 [Decision: does not deal with drug or alcohol treatment services]

13. Muscat R and Pompidou Group Treatment Platform Members (2009) *Draft Treatment Systems Overview*. Pompidou Group. [Decision: does not relate to regionalisation]

14. Nielsen AS and Nielsen B (2015) Implementation of a clinical pathway may improve alcohol treatment outcome. *Addict Sci Clin Pract*, 10(1): 7. Available from: https://doi.org/10.1186/s13722-015-0031-8 [Decision: does not relate to regionalisation]

15. Ramos MC, Barreto JOM, Shimizu HE, de Moraes APG and da Silva EN (2020) Regionalization for health improvement: A systematic review. *PLoS One*, 15(12): e0244078. Available from: https://doi.org/10.1371/journal.pone.0244078 [Decision: does not deal with drug or alcohol treatment services]

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Appendix C: Health service reviews

1. Anderson M, Pitchforth E, Edwards N, Alderwick H, McGuire A and Mossialos E (2022) The United Kingdom: Health System Review. *Health Systems in Transition*, 24(1): i–192.

2. Bernal-Delgado E, Angulo-Pueyo E, Ridao-López M, *et al.* (2024) Spain: Health system review. *Health Systems in Transition*, 26(3): i–187. Copenhagen: WHO Regional Office for Europe.

3. Blümel M, Spranger A, Achstetter K, Maresso A and Busse R (2020) Germany: Health System Review. *Health Systems in Transition*, 22(6): i–273.

4. de Almeida Simões J, Figueiredo Augusto G, Fronteira I and Hernández-Quevedo C (2017) Portugal: Health System Review. *Health Systems in Transition*, 19(2): 1–184.

5. de Belvis AG, Meregaglia M, Morsella A, *et al.* (2022) Italy: Health system review. *Health Systems in Transition*, 24(4): i–203.

6. Janlöv N, Blume S, Glenngård AH, Hanspers K, Anell A and Merkur S (2023) Sweden: Health system review. *Health Systems in Transition*, 25(4): i–198.

7. Or Z, Gandré C, Seppänen AV, *et al.* (2023) France: Health system review. *Health Systems in Transition*, 25(3): i–241.

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Appendix D: Focal Point reports

1. French Focal Point on Drugs (2019) *France Country Drug Report 2019*. EMCDDA.
2. German Focal Point on Drugs (2010) *2010 National Report*. EMCDDA.
3. German Focal Point on Drugs (2019) *Germany Country Drug Report 2019*. EMCDDA.
4. Italian Focal Point on Drugs (2019) *Italy Country Drug Report 2019*. EMCDDA.
5. Norwegian Focal Point on Drugs (2019) *Norway Country Drug Report 2019*. EMCDDA.
6. Portuguese Focal Point on Drugs (2019) *Portugal Country Drug Report 2019*. EMCDDA.
7. Spanish Focal Point on Drugs (2019) *Spain Country Drug Report 2019*. EMCDDA.
8. Swedish Focal Point on Drugs (2019) *Sweden Country Drug Report 2019*. EMCDDA.
9. UK Focal Point on Drugs (2019) *United Kingdom Country Drug Report 2019*. EMCDDA.

Appendix E: Terms used in targeted web searches

Table E.1 English terms[18]

Search terms	Notes
regionalisation	Check whether search engine can truncate (if it can, then truncate at "regionali"). Sometimes the truncation is automatic.
regionalization	
regionalise	
regionalize	
regionalised	
Search terms	**Notes**
regionalized	
Regional	This may be a very noisy so only use if volume is low. If phrase searching is possible try: "regional plan" "regional plans" "regional planning" "regional structure" "regional structures" "regional administration" "regional administrations" "regional organisation" "regional organization" "regional role" "regional roles" "regional mandate" "regional mandates" "regional responsibility" "regional responsibilities" "regional management" "regional coordination" "regional reorganisation" "regional reorganization" "regional funding" "regional decision" "regional decisions" "regional authority"

18. These were translated into Norwegian, Swedish, German, French, Portuguese, Spanish, and Italian for use during the targeted web searches.

Search terms	Notes
Regionally	This may be very noisy so use only if volume is low. If phrase searching is possible try: “regionally planned” “structured regionally” “regionally administered” “administered regionally” “regionally organised” “organised regionally” “regionally organized” “organized regionally” “regionally mandated” “mandated regionally” “regionally managed” “managed regionally” “regionally coordinated” “coordinated regionally” “regionally reorganised” “reorganised regionally” “regionally reorganized” “reorganized regionally” “regionally funded” “funded regionally” “decided regionally” “delegated regionally”
centralisation	Check out whether search engine can truncate – if so, then use “centrali”
centralisation	
centralization	
centralise	
centralize	
centralised	
centralized	

Search terms	Notes
Centrally	This may be a very noisy and non-specific term, use if volume is low. If phrase searching is possible try: “centrally planned” “structured centrally” “centrally administered” “administered centrally” “centrally organised” “organised centrally” “centrally organized” “organized centrally” “centrally mandated” “mandated centrally” “centrally responsible” “centrally managed” “managed centrally” “coordinated centrally” “centrally reorganised” “reorganised centrally” “centrally reorganized” “reorganized centrally” “centrally funded” “funded centrally” “decided centrally”
Central	This will likely be a noisy term so only use if volume is low. If phrase searching is possible try: “central planning” “central administration” “central organisation” “central organization” “central mandate” “central responsibility” “central responsibilities” “central management” “central coordination” “central reorganisation” “central reorganization” “central funding” “central decision” “central decisions” “central authority”

Search terms	Notes
decentralisation	Check whether search engine can truncate – if so, use “decentrali”
decentralisation	
decentralization	
decentralise	
decentralize	
decentralised	
decentralized	
De-centralisation	Often search engines will ignore hyphens, so the previous searches for “centrali” etc. may find this term
De-centralisation	
De-centralization	
De-centralise	
De-centralize	
De-centralised	
De-centralized	
localise	
localize	
localised	
localized	
local	This may be a noisy term, so only use if volume is low. If phrases are possible then try: “local responsibility” “local responsibilities” “local administration” “local administrations” “local government” “local governments” “local administration” “local administrations” “local management” “local managements” “local coordination” “local reorganisation” “local reorganization” “local funding” “local decision” “local decisions” “local authority”

Search terms	Notes
Locally	This may be a noisy term, so only use if volume is low. If phrase searching is possible try: “locally planned” “structured locally” “locally administered” “administered locally” “locally organised” “organised locally” “locally organized” “organized locally” “locally mandated” “mandated locally” “responsible locally” “locally responsible” “locally managed” “managed locally” “coordinated locally” “locally reorganised” “reorganised locally” “locally reorganized” “reorganized locally” “locally funded” “funded locally” “decided locally”
areawide	
Area-wide	Often search engines will ignore hyphens. If hypens are ignored then this search is likely to be very noisy, use only if volume is low.
autonomy	
autonomous	
devolution	
devolve	Check out whether search engine can truncate – if so, then next row is not required
devolved	Not required if the search engine used is able to truncate

Search terms	Notes
institutional	This may be a noisy term, so only use if volume is low. If phrases are possible then try: “institutional structure” “institutional structures” “institutional form” “institutional forms” “institutional architecture” “institutional architectures” “institutional role” “institutional roles” “institutional mandate” “institutional mandates” “institutional responsibility” “institutional responsibilities” “institutional management” “institutional coordination” “institutional reorganisation” “institutional reorganization” “institutional funding” “institutional decision” “institutional decisions” “institutional authority”
administrative	This may be a noisy term, so only use if volume is low. If phrases are possible then try: “administrative structure” “administrative structures” “administrative form” “administrative forms” “administrative architecture” “administrative architectures” “administrative role” “administrative roles” “administrative mandate” “administrative mandates” “administrative unit” “administrative units” “administrative responsibility” “administrative responsibilities” “administrative coordination” “administrative reorganisation” “administrative reorganization” “administrative funding” “administrative decision” “administrative decisions” “administrative authority”

Search terms	Notes
autonomy	
autonomous	
governance	
integration	
integrate	
integrated	

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