Review of treatment services for substance use disorders in Iceland

Commissioned by the Ministry of Health of Iceland

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Executive summary

Iceland has demonstrated significant progress in reducing substance use among young people, thanks to targeted prevention programs and increased community engagement. These efforts have successfully raised awareness and promoted healthier choices. However, to build on this success, further attention is needed to address certain systemic challenges within the treatment system for substance use disorders. By strengthening coordination, improving accessibility, and enhancing the quality of services, Iceland can continue to make progress in reducing substance use and its associated harms.

Key Findings

Opportunities for improvement: While stakeholders acknowledge the positive advancements in prevention efforts, there is broad consensus on the need for more structured coordination and clearer policy responses. The existing treatment system has many valuable components, but refining and expanding services could lead to more effective outcomes.

Need for a new policy framework: Iceland's national policy on alcohol and drug prevention, which expired in 2020, needs to be updated to reflect current trends in substance use. A new, comprehensive policy would enhance treatment accessibility, improve emergency services, and strengthen support systems for those affected by addiction.

Enhancing monitoring and data collection: The absence of systematic monitoring of treatment demand presents a significant challenge to understanding and addressing substance use. Improved data collection, particularly around treatment demand and regional disparities, would enable more responsive and informed policymaking.

Addressing resource limitations: The treatment system is facing resource constraints, including limited capacity and a shortage of specialized personnel. Long waiting times for treatment and assessment continue to be a concern. Addressing these issues through capacity planning and resource mobilization is key to meeting the growing demand.

Moving towards diversified care: There is a recognized need to shift from programme-centred to patient-centred care. Tailoring treatment plans to the unique needs of individuals, rather than fitting them into pre-existing models, would improve the effectiveness of interventions and support long-term recovery.

Expanding harm reduction initiatives: Iceland's existing harm reduction services have been a positive step forward. However, with the evolving opioid crisis, these services need to be expanded and adapted to meet current and emerging challenges, particularly for younger populations.

Strengthening Coordination and collaboration: Iceland's close-knit professional community has fostered informal collaboration, but there is a growing need for formalized cooperation. Establishing clear roles and responsibilities for all stakeholders would ensure more consistent and effective service delivery.

Recommendations

1. Improve access and capacity: Reducing waiting times and increasing access to treatment should be prioritized. This can be achieved by streamlining intake processes, expanding outpatient services, and leveraging telehealth solutions, particularly for those in remote areas.

2. Adopt a new drug and alcohol policy: Iceland would benefit from a renewed policy that clearly defines the goals and objectives of substance use treatment, focusing on a recovery-centred approach. Such a policy would guide resource allocation and ensure that services are tailored to meet the diverse needs of the population.

3. Elaborate a comprehensive action plan: An action plan outlining clear roles and responsibilities for stakeholders, supported by appropriate resources, would provide a structured approach to implementing the new policy. This would foster collaboration and enhance accountability across sectors.

4. Facilitate stakeholder communication and accountability: A formal steering group, facilitated by the Ministry of Health, would strengthen communication and coordination among stakeholders, ensuring alignment and facilitating more efficient and timely service delivery.

5. Establish treatment standards: The Ministry of Health, in collaboration with relevant stakeholders, should develop national treatment standards based on international best practices. This would ensure consistency, quality, and efficiency in service provision.

6. Increase capacity to train professionals: enhance existing qualifications, partner with other educational institutions in other countries, engage stakeholders for competence building, utilise distant and online learning formats.

7. Engage with international expertise: Iceland should consider collaborating with the European Union Drugs Agency (EUDA) to benefit from its expertise in addressing emerging drug-related challenges. Participation in EUDA's early warning systems would strengthen Iceland's ability to anticipate and respond to evolving trends.

8. Explore international funding opportunities: As a member of the European Economic Area (EEA), Iceland has access to various EU funding programs. Exploring these opportunities could provide additional resources to support public health initiatives, including substance use treatment and prevention.

Conclusion

Iceland has a strong foundation for addressing substance use disorders and there are important opportunities to build on this progress. By enhancing coordination, improving access to treatment, and adopting a more patient-led approach, Iceland can continue to reduce the harms associated with substance use. A new policy framework, supported by a comprehensive action plan and greater stakeholder collaboration, will be key to achieving better outcomes and ensuring a healthier future for all.

Introduction

Scope and purpose: This report presents the results of an ad hoc review of the treatment system for substance use disorders concerning illicit drugs and alcohol consumption, and the delivery of treatment and rehabilitation services in Iceland with respect to effectiveness in terms of reaching therapeutic results and coverage of existing needs. The review will be assessment based and can serve as basis for potential improvements of services.

Furthermore, the review is intended to provide guidance and recommendations for the development of a future policy document and the elaboration of quality standards. In this way it can facilitate a basis for discussions on the side of the relevant stakeholders aiming at developing policy principles, professional standards and quality control for the treatment of substance use disorders and addictions in Iceland.

The review was initiated and commissioned by the Ministry of Health and conducted by the consultant in consultation with key stakeholders in the period 1 September to 31 October 2024.

Beneficiaries: Policy makers, administrations, managers and professionals, media and public, people with substance use disorders, service users.

Methodology: The assessment is built around relevant policy documents, legal standards and treatment guidelines, in particular those established by WHO, UNODC, EMCDDA and the Council of Europe as Iceland is a member of these international organisations, and its standards are binding or applicable for governance.

Quantitative data were made available by the Icelandic Ministry of Health and other governmental institutions and non-governmental organisations. Qualitative data was obtained through interviews with *key stakeholders → Appendix I* in September 2024.

Limitations: The assessment was subject to limitations that may arise from availability of resource, time constraints and availability of cooperation with relevant sources.

Acknowledgements: the author wishes to thank the representatives of all different stakeholders within the Icelandic treatment system who collaborated and assisted in the preparation of this review. In particular I want to express my sincere gratitude for the invaluable support, Guidance and practical assistance I received from Helga Sif Friðjónsdóttir and Sigríður Jónsdóttir of the Ministry of Health without whom this review would not have been possible to be conducted so efficiently is such a short period of time.

Findings

There has been encouraging progress in Iceland in reducing substance use among young people, largely due to targeted approaches and comprehensive prevention programmes. These efforts have played a key role in raising awareness and promoting healthier choices among youth. Additionally, increased community involvement has fostered more localised and effective prevention strategies, demonstrating the power of collective action in addressing substance use. By up-dating and improving treatment services in terms of availability, accessibility, adequateness and quality, significant further progress can be achieved to reduce substance use and associated harms in the population at large.

In this context, it is particularly noteworthy that all interviewed stakeholders welcome the review undertaken and have expressed the need for improved coordination and clearly structured policy responses. This provides a unique momentum to move the policy agenda forward.

The current treatment system for substance use disorders in Iceland includes already many essential components, but certain aspects need to be recalibrated, strengthened, or rethought to improve effectiveness and achieve better outcomes. Additionally, there is a need to develop an overarching policy framework to ensure a well-integrated and cohesive service provision that maximises both effectiveness in reaching recovery and efficiency of resource use.

Iceland's national policy on alcohol and drug prevention expired in 2020. Given recent developments in substance use trends, there is a need for a new, comprehensive approach. Treatment for addiction should be made more accessible, with emergency clinics, specialised psychosocial services, and aftercare programmes. The health system should ensure the provision of evidence-based treatments grounded in human rights and dignity.

The absence of systematic monitoring of treatment demand for alcohol and drug addiction in Iceland creates significant gaps in understanding and addressing the issue. While there are efforts to track general trends and prevalence of substance use, current methods lack the depth and consistency required to capture real-time changes and regional disparities. This inadequate monitoring hinders the ability to respond effectively to emerging patterns of addiction, allocate resources efficiently and develop targeted interventions. Without comprehensive data on treatment demand, policymakers may overlook areas in need of support, leading to delayed or insufficient care for individuals struggling with addiction. Consequently, the lack of proper monitoring undermines prevention efforts, strains healthcare services, and exacerbates the long-term social and economic impact of substance abuse in Iceland.
More specifically, the following are aspects of key importance requiring attention:

While Iceland benefits from a close-knit professional community, there are significant challenges in delivering effective treatment, harm reduction and rehabilitation services. Resource constraints, a shortage of specialised care for marginalised groups and limited treatment options impact on access, availability and adequateness of treatment services. Thresholds limiting access and waiting lists along with systemic issues of coordination and cooperation within the healthcare system, contribute to delays and adverse outcomes, including preventable deaths. Additionally, the influence of ideology and political lobbying can impede necessary reforms. The lack of international connections and data collection further limits the ability to adopt and implement modern harm reduction practices. Addressing these challenges with a comprehensive and collaborative approach will enhance the effectiveness of the services provided.

Waiting times to access assessment and treatment remain a significant concern among stakeholders, largely attributed to the limited capacity of treatment centres in the face of growing demand. This issue has been exacerbated by the rapid increase in opioid use. However, it is important to acknowledge that service providers have already taken initial steps to address this challenge. To prevent serious consequences for the health and well-being of those awaiting treatment, providers have introduced prioritization criteria and interim services, such as counselling, to support individuals during the waiting period. These efforts must be systematically expanded to ensure that those on waiting lists are not unduly exposed to health risks. In addition, further measures in capacity planning and resourcing are essential to ensure that the rising demand for treatment is adequately met. Failure to address this issue, or any further increase in waiting times, could risk non-compliance with international human rights standards.

Given the increasing diversity available of drugs, special needs populations and demographic developments, the existing treatment offers cannot adequately cover all different needs and placement demands. This concerns among other children and adolescents and the fast-growing group of elderly people with substance use problems. Furthermore, expected population growth and immigration will require a greater **variety of treatment offers** to adequately meet care and treatment needs.

Cooperation and coordination between stakeholders functions mainly on an informal level owed to the comparatively small population size and close communities of the country. There are only few arrangements between different actors presently in place. However, while this tradition has been functional for a long time, evolution in population demographics as well as drug use and drug use patterns, show that the system of informality is reaching its limitations. Almost all interviewed stakeholders advocate for the establishment of formalized cooperation and coordination arrangements to clearly define roles and responsibilities.

There is a critical **shortage of trained personnel** in the addiction treatment sector, particularly among addiction counsellors, which is significantly affecting the capacity to meet the growing demand for treatment services. Furthermore, there is no formal training programme on addiction for medical doctors, nurses, psychologists and other healthcare workers in Iceland. This contributes to delays and long waiting lists, which impact patient care and hinder the overall effectiveness of addiction treatment in Iceland. In addition, there is presently **only one organisation offering licensed training** for addiction counsellors in Iceland. While this organisation plays a crucial role in providing specialised education, the placement of the training programme within hospital operations complicates both the organisation's management and the students' experience. The intense nature of the work environment, combined with the academic demands of the three-year training and salary levels programme, has led to a high dropout rate, particularly in the first year of study. This results in a limited number of graduates entering the labour market, further exacerbating the shortage of qualified addiction counsellors.

Dual diagnosis patients face waiting lists due to capacity limitations and high thresholds to access residential treatment and rehabilitation, uncoordinated care, and specific challenges for certain user groups. There is an expressed demand for integrated care, improved infrastructure, and structured coordination of different services to address these complex challenges. Measures are needed to ensure continuity of care for those transitioning between treatment and rehabilitation services. In particular, following-up after completing inpatient and residential care is a crucial necessity to avoid early relapse and those most in need falling under the radar of the care system.

There are notable systemic gaps in the provision of through care, which ensures the continuous support for individuals across all stages of treatment and recovery. At present, there are no established concepts or structures to ensure **continuity of care** following the completion of treatment or release from prison or detention. While local governments are responsible for providing vocational training and housing to support rehabilitation and recovery, existing resources are limited. Some transitional housing options, such as halfway houses of which most are run by NGOs and private operators, are available; however, the demand for these services exceeds current capacity, highlighting the need for expanded support to facilitate successful reintegration and ongoing recovery.

There appears to be no emphasis on **individualised care plans** tailored to the specific needs of each patient. Instead, individuals are often placed into pre-existing programmes, such as the 12-step model, regardless of whether these approaches are best suited to their unique circumstances. This reflects a programme-centred model, where the focus is on fitting service user or patient into available structures, rather than adopting a patient-centred or patient-led approach. A patient-centred or -led model, by contrast, would prioritise personalised care, adapting treatment strategies to the individual's needs, goals, and preferences, ensuring a more holistic and effective recovery journey. The absence of such a tailored approach may limit the success and long-term outcomes of the treatment process.

The **prison system** in Iceland faces both progress and challenges. While there are efforts to improve training for guards and care for prisoners, the school for prison guards is facing challenges in further enhancing the curriculum due to resource constraints and budget cuts. Staff members, many with decades of experience, rely on on-the-job training and trauma-informed care techniques introduced in recent years. Efforts are made to ensure the continuity of prisoners' education and healthcare, although there is no structured follow-up after release.

The **opioid issue** in Iceland has been escalating, with notable increases in usage and associated fatalities. The abuse of both legal and illegal opioids has surged in Iceland, with hospital admissions related to opioid addiction rising sharply. Younger individuals, especially those under 25, are increasingly affected. The number of people receiving treatment at addiction centres has also grown significantly. Deaths related to opioid abuse have been rising, though official statistics lag behind due to delays in receiving death certificates. Current treatment services may not be fully meeting the needs of all individuals affected, leaving those with severe multi-layered problems without the necessary care and support.

Harm reduction has been successfully introduced but given the evolution of substance use, in particular opioid consumption, an extension of these services seems necessary as a matter of priority. Under the leadership of the Ministry of Health, the Health Minister has established a working group to develop Iceland's first comprehensive policy and action plan on harm reduction. The goal is for this initiative to garner official support from both the government and parliament, further advancing harm reduction efforts in the country.

Setting out a clear **recovery paradigm** can reduce stigma, lower social and economic costs and apply evidence-based interventions to address associated causes of addiction such as trauma or poverty. By fostering long-term recovery, it promotes healthier individuals and communities, reduces the burden on the health, welfare and criminal justice systems, and ensures lasting societal benefits. Furthermore, recovery-based policy ensures the development of an integrated support system, common standards and cooperation structures.

Several stakeholders express concerns that the largest service provider in the addiction treatment sector may exert undue influence over funding and policy decisions, potentially disadvantaging other organisations. This provider also operates as the only one institution for training licensed addiction counsellors, raising the risk of an oligopoly in the field. The **market for treatment services should be more diversified** and less dominated by a single organisation. Rather than focusing on the expansion of the main provider, stakeholders suggest that opportunities should be created for other service providers to gain a greater share of the market. Diversifying the landscape of treatment services would promote competition, innovation, and improved access to care.

There are overall concerns that pose ongoing challenges. Ensuring **consistent funding** and resources continues to be a concern, which can affect the long-term sustainability of certain programmes. Furthermore, shifting **deeply rooted cultural attitudes** towards alcohol and drug use is a gradual process that requires sustained effort and commitment over time.

Recommendations

1. **Improving access to care and treatment** should be a priority as this is a key factor for treatment outcomes and recovery. Reducing waiting times plays a crucial factor as this can help prevent the deterioration of health, alleviate suffering, and lower death rates associated with delays in care. To achieve this, several measures can be implemented:
   Streamlining the intake process and employing efficient triage systems can expedite the initial assessment and placement of individuals into appropriate care programmes.
   Expanding outpatient services can reduce the demand for inpatient places. Setting up online tele-health services can provide interim solutions for those on waiting lists and provide an alternative for those living in remote areas.
   Planning capacity and resource mobilisation should involve analysing treatment demand while also considering projected trends and developments. This will lead to more targeted and needs oriented allocation of resources.
   Enhancing coordination between different levels of care and making referral systems more efficient can also minimise delays and contribute to improve the effectiveness and efficiency of the treatment system.

2. A new drug and alcohol policy should clearly define the goals and objectives for treatment, centred around a well-articulated **recovery paradigm**. By establishing this framework, the policy can provide a clear mission statement that guides resource allocation and outlines the roles and mandates of various professions and stakeholders involved in its implementation. For the policy to be both effective and efficient, it must emphasize rehabilitation and support, offering comprehensive services such as medical care, mental health treatment, and social reintegration. It is crucial to recognize that recovery from addiction is not a linear process, requiring sustained and adaptable support tailored to the diverse needs of different populations. This approach ensures that a wide range of care and support options are available, reflecting the complexity and individuality of the recovery journey. → *Appendix V – Elaborating a Recovery Paradigm, p.49*

3. Establish a **comprehensive action plan** setting out programmes and measures to implement the policy, including roles and responsibilities of stakeholders responsible for implementation, as well identification of needed resources and their mobilisation. Such a

plan ensures clarity in the division of tasks, roles, and responsibilities, providing a structured framework for those mandated to carry out the policy. By coordinating efforts across sectors, this approach fosters collaboration, minimises overlap, and addresses gaps in service delivery. A well-defined action plan also promotes accountability and ensures that each stakeholder is aware of their specific duties, ultimately leading to a more efficient and successful policy outcome.

4. Establish a **stakeholder-based steering group**, supported by a secretariat and a national coordinator facilitated by the Ministry of Health, with the aim to enhance communication, coordination and collaboration among various stakeholders in exercising their role in delivering services and actions under the new drug and alcohol policy in terms of its treatment pillar. Regular meetings, including informal discussions, significantly improve communication, foster common understanding and are a mechanism to resolve potential issues before they escalate into larger problems. It would ensure that all parties are aligned, enable quicker detection of emerging issues across different sectors allowing for swift responses. Ultimately, this would reduce tensions and misunderstandings that often hinder cooperation, helping to prevent delays and inefficiencies in service delivery. While establishing the group and defining roles are important, they do not equip members with the skills needed to work effectively together. It must be borne in mind that without proper training, these teams often face difficulties, conflicts, and inefficiencies that undermine their performance. *→ For details see section on training needs for collaboration, p. 39*

5. Mandate the Health Ministry to develop treatment **standards for substance use disorders treatment and guidelines** in consultation with the relevant service providers and concerned stakeholders. This should be based on international standards that are relevant to the Icelandic context, in particular those of the Council of Europe and the United Nations (UNODC, WHO) as Iceland is a member of these organisations and has certain obligations to adhere to their standards. This combined with cost-benefit analysis will contribute to improved treatment results and an increase in return of public investment→ *Sections: Defining Treatment Standards, p. 33 ; Ensuring Quality, p. 35; Cost-benefit Analysis, p. 36*.

6. Enable educational institutions to **increase capacity to train professionals** without requiring extensive financial investment, thereby enhancing their impact and reach in the community. Scaling up existing educational capacity quickly and with minimal investment can be achieved through several strategies:
   Develop certification programmes that build on existing qualifications, allowing professionals to upskill rapidly. Include specific modules on substance use disorder treatment in the curricula for the education of doctors, nurses, healthcare workers and social workers.
   Partner with other educational institutions in other countries, thereby broadening the reach without significant investment.
   Engage relevant stakeholders who have competences to provide short-term training programmes, workshops and seminars that focus on specific skills or topics, as well as traineeships in the context of their activities.
   Utilise existing online platforms to offer online and distant learning courses, which can accommodate a larger number of students without the need for physical attendance.

7. Consider **joining the European Union Drugs Agency (EUDA)** to take advantage of its expertise in forecasting and providing guidance on emerging and evolving drug-related challenges. By utilising EUDA's early warning systems and preparedness strategies, the country could better anticipate and respond to drug issues. Additionally, adopting

evidence-based policy options, rooted in reliable data on prevalence and trends, would support informed decision-making and the development of effective long-term strategies. Furthermore, EUDA membership could enhance the quality of national discourse, as experience shows that it promotes a more evidence-based and less ideological approach to discussions. In the absence of evidence, best practices and actionable guidance, policy debates risk becoming overly speculative, which can hinder or delay necessary interventions.

8. **Broaden resource mobilisation by accessing international funding**. Although not a member of the European Union (EU), Iceland can directly benefit from participation in various EU programmes through its membership in the European Economic Area (EEA). This allows Iceland to take part in EU initiatives and apply for funding, including those in the field of public health. → *Appendix VII – EU Programmes, p. 53*.

Policy context

In 2013 the government of Iceland adopted the Alcohol and drug prevention policy until 2020 to be implemented under the auspices of the Ministry of Welfare. The policy document outlines a holistic strategy for alcohol and drug prevention in Iceland until 2020, focusing on prevention, treatment, rehabilitation and legal frameworks. It emphasizes the government's main objectives, including reducing access to alcohol and drugs, protecting vulnerable groups and preventing youth from starting substance use.

The document addresses harmful effects of alcohol and drug use on public health, including premature deaths and chronic diseases. It further foresees the development of an action plan based on evidence-based methods, involving various stakeholders and aiming to reduce the negative impacts of substance use on individuals and society.

The policy, and subsequent strategic actions, is to be aligned with international guidelines and commitments, particularly from the World Health Organisation (WHO). It integrates the government's policy on alcohol, approved in 2010.

As a result of the Corona pandemic, the follow up work to the policy document was deferred and the recommendations to date mostly remain not implemented. → *For details refer to Appendix II, p. 41*. As the policy expired by 2020, it was extended until the adoption of a new one. An expert group is presently conducting preparatory work under the auspices of the Ministry of Health in close consultation with the Parliamentary Committee for Drug and Substance Abuse. It is expected that this working group will deliver its proposals for a new policy by the end of 2024.

At present, no overall standards, guidelines and quality control criteria specifically for the treatment of substance use disorders have been established in Iceland. In 2024 the Ministry of Health has commissioned this assessment of treatment services for substance use disorders in Iceland with a view to establishing standards for treatment and quality control.

It needs to be pointed out that recent comprehensive quantitative data on substance use prevalence, use patterns and trends is not available for Iceland. There is at present no mechanism and systematic data collection in place for monitoring drug and alcohol use prevalence and trends on a regular basis. Most available data on this issue comes from various surveys, studies, or reports that are conducted periodically by different organizations or

governmental bodies. However, these efforts are often limited in scope, frequency and the populations they cover.

The most recent comprehensive data typically cited comes from 2019, prior to the COVID-19 pandemic. This includes reports from institutions like the World Health Organisation (WHO) and the United Nations Office on Drugs and Crime (UNODC). The gap in recent data is significant because trends in drug and alcohol use can change rapidly due to social, economic, and health factors, as seen with the COVID-19 pandemic. Changes in accessibility, mental health trends and other pandemic-related factors likely influenced substance use in ways that are not fully captured by existing data. Therefore, there is a growing need for more up-to-date, consistent and systematic methods of data collection to accurately reflect current drug and alcohol use patterns.

The absence of regular data collection means that policymakers, public health experts and organisations are working with potentially outdated information when designing intervention strategies or policies aimed at addressing substance use. This can limit the effectiveness of those efforts.

Legal context

The following are the main national and international legal and policy instruments that are of key relevance to the development of drug and alcohol policies with respect to substance use disorder treatment systems.

National

- Act on Addictive Substances and Narcotic Substances, No. 65/1974,
- Alcohol Act, No. 75/1998,
- Regulation on Addictive and Narcotic Substances and Other Controlled Substances, No. 233/2001.
- Public Health Act 2007, No. 41/2007
- Health Services Act, No. 40/2007
- Act on the Integration of Services in the Interest of Children's Prosperity, No. 86/2021
- Act on Patients' Rights, No. 74/1997

International

- Article 3 of the Convention on Human Rights and Biomedicine requires that Contracting Parties provide for equitable access to health care of appropriate quality.
- Although there is no specific right to health in the European Convention on Human Rights, a wide range of issues relating to health have been dealt with by the European court. The court's case-law requires states to safeguard people's mental and physical well-being in different circumstances.
- Article 11 of the European Social Charter on the right to the protection of health.
- Recommendation No. R (97) 17 on the development and implementation of quality improvement systems (QIS) in health care, which requires waiting times policies to be based on transparent criteria.
- Recommendation No. R (99) 21 on criteria for the management of waiting lists and waiting times in healthcare

Treatment system and services

Iceland has a healthcare system that provides treatment for substance use disorders (SUD), primarily illicit drug and alcohol addiction through a mix of public, private and non-profit services. Treatment for SUD in Iceland is generally available to all residents through the coverage of the universal healthcare system. This public healthcare system offers basic services related to addiction treatment through the national health insurance scheme Sjúkratryggingar Íslands (Icelandic Health Insurance).

Treatment model: Iceland's addiction treatment and rehabilitation services are mainly based on an abstinence-oriented approach starting with detox prior to admission to long-term treatment and rehabilitation programme. Drug or alcohol use constitutes an immediate exclusion criterion from the programmes. The most widely used treatment model is still the 12-step programme based on the so-called Minnesota model. Elements of cognitive behavioural therapy and motivational interviewing start to be increasingly incorporated in the treatment plans

Primary Care Centres: Local authorities are mandated to provide initial counselling and assessment of addiction problems. General practitioners (GPs) refer patients to specialised services. There are no formal screening protocols in place at present.

Detoxification clinics: Different inpatient facilities provide medically supervised detox. Outpatient detox is currently only offered by Landspitali University Hospital.

Mental health services: The Landspitali Hospital in Reykjavik offers both inpatient and outpatient treatment for dual-diagnosis patients. Also, an assertive community treatment (ACT) team provides service in the communities. However, there appears to be a lack of adequate long-term care and collaboration with social services for this population, the same which applies to patients with drug use disorders and severe neurological conditions.

Residential treatment: There are several facilities that offer long-term residential rehabilitation and outpatient services most of which are located in or near Reykjavik.

Special needs populations: while most treatment facilities accept pregnant women, there is no structured treatment offer other than medication assisted treatment in prisons. People who do not speak Icelandic and English are not admitted to residential treatment. For those with severe substance use addiction disorders, dual diagnosis or additional severe neurological disorder, the threshold to enter residential treatment is high and admittance the exception. It is also noteworthy that specific addiction treatment services are, with a few exceptions, only available to adults. The health care system does not provide specialised treatment services for adolescents and children under 18 years.

Medication assisted treatment (MAT): MAT is available mainly with Buprenorphine and in a limited number of cases methadone. Only few treatment programmes include the availability of MAT for their clients. According to several stakeholders working community based, there appear to be the notable limitations to the availability of MAT medications due to restrictive prescription regulations.

Harm reduction: While treatment services mainly focus on abstinence, there are also needle exchange services available in Reykjavik, Akureyri and Reykjanesbae and a recently set up safe injection site in Reykjavik. Harm reduction has been established and propagated mainly by the NGO sector and civil society organisations and is not yet part of the national strategy to manage drug and alcohol addiction.

Overdose prevention: Since July 1, 2022, the Ministry of Health has made Nyxoid (naloxone) nasal spray available free of charge for harm reduction. The spray is intended for the immediate emergency treatment of known or suspected opioid overdoses. It provides opioid users, first responders and other related providers, such as services and outreach workers, with access to a medication that saves lives following overdosing. The Icelandic Red Cross provides online training on the application. So far, there are no concepts and structures in place that secure continuity of care after completion of treatment or release from prison or detention. Local government services provide vocational training and housing in support of rehabilitation and recovery. Some transitional housing, such as halfway houses, is available. However, the demand for transitional housing outweighs the existing capacities.

While the urban centres, in particular the capital Reykjavik have a wide coverage in terms of treatment services, there is limited availability and access in rural areas and smaller towns.

Funding

Addiction treatment services in Iceland, provided by NGOs such as SÁÁ (Samtök áhugafólks um áfengisog vímuefnavandann), Krýsuvík, and Hlaðgerðarkot, are funded through a combination of public and private sources.

A significant portion of the funding comes from the national Health Insurance System (Sjúkratryggingar Íslands, SÍ). Several organisations have service agreements so that treatment costs are partly covered by Iceland's national health insurance system. Treatment providers negotiate services agreements with SÍ for a number of treatment places based on previous treatment demand. In the absence of systematic national data on drug use and trends, it is exclusively this historical data that serves as a basis for future treatment demand projections.

While inpatient treatment for addiction is fully covered, outpatient treatment requires a financial contribution by the service user. While the contribution is quite minimal it is for certain service users, in particular those with the most severe problems, a deterrent. This leads to a situation where some service users for whom outpatient treatment would be suitable will choose to opt for inpatient treatment to avoid having to pay a financial contribution to the costs. However, these fees are often waived by the treatment services for those unable to pay. For example, SÁÁ operates on a model where those who can afford to contribute are asked to do so, but treatment is never denied due to inability to pay. This however can lead to complication with the conditions of the service agreement with SÍ.

Additionally, Iceland's Ministry of Health allocates funding decided by Alþingi aimed at specific programmes, operational costs or expanding services. Local and municipal governments sometimes provide additional funding to ensure access to addiction services in their respective regions. This includes both direct financial support and collaboration in providing housing or reintegration programs.

Organisations such as SÁÁ, Krýsuvík and Hlaðgerðarkot also rely to a significant extent on private donations and contributions from individuals, businesses, churches and charitable organisations. SÁÁ, in particular, has a strong tradition of community involvement, where individuals and families affected by addiction may contribute financially to support ongoing services. Some centres receive donations or sponsorships from private and corporate entities efforts.

Costs for housing during rehabilitation are mainly covered by municipal and local authorities respectively by the Ministry of Welfare. Training and other costs for reintegration into the labour market are to a great extent covered by the schemes of the Ministry of Labour

Stakeholder views

During the review a wide variety of stakeholders, including governmental institutions, nongovernmental service providers and civil society organisations have been reviewed to understand their views and perspectives on the functionality of the present treatment system. The list of consulted stakeholders is included in Appendix I. Stakeholder consultation is an ongoing practice in Iceland and explicitly referred to in the Alcohol and Drug Prevention Policy until 2020.

Directorate of Health

The Directorate of Health, operating under the guidance of the Medical Director of Health and in accordance with the Public Health Act No. 41/2007, plays a pivotal role in promoting public health and enhancing the quality of healthcare services. Its key responsibilities include advising the Minister of Health, government bodies, health professionals and the public on health promotion, disease prevention and the improvement of healthcare. Additionally, the Directorate organises and evaluates public health initiatives, ensuring their effectiveness while supervising healthcare professionals and services. The Directorate primarily serves in an advisory capacity, with ultimate decision-making authority resting with the Ministry of Health.

In a meeting at the Directorate of Health the following issues were discussed:

Waiting lists: In the context of substance abuse treatment, there is no standardised approach to waiting times across Nordic countries. Ideally, contact with individuals should occur within 24 hours, with specialist appointments available within two weeks. While recommendations have been put forward to reduce waiting times for acute cases to 2-3 weeks, there is no formal mechanism for addressing these proposals. Ongoing dialogues with the Ministry emphasize the importance of establishing a more structured process for timely responses.

Opioid use: The increasing opioid use in Iceland is another area of concern. Recent data from law enforcement indicates a significant number of drug-related fatalities, with projections suggesting that this trend may continue to rise. In light of this, the Directorate has proposed the creation of a standing committee, "Substance Addiction Watch" (Fíknivaktin), to coordinate data collection and enhance cooperation among stakeholders, including healthcare providers and law enforcement.

Vulnerable groups: There are also concerns regarding access to care for vulnerable groups with severe multi-layered problems, who often face barriers in receiving the treatment they need. The establishment of consistent standards for care has been challenging, though there is recognition that collaboration with international bodies, such as the European Drug Agency (EUDA), could provide valuable guidance. Ultimately, decisions on these matters fall under the purview of the Ministry of Health.

Data collection: Efforts to gather comprehensive data on substance abuse services have encountered obstacles, particularly with the electronic medical records (EMRs) at institutions like SÁÁ and Vogur, which are currently not compatible with the Directorate's data systems.

Clarification is needed regarding who will be responsible for funding necessary upgrades. Additionally, discussions in Parliament are ongoing regarding the legal framework for collecting data from healthcare specialists, and it is anticipated that new agreements, such as the one between SÁÁ and National Health Insurance, will support further improvements.

Monitoring: There is a need to establish a comprehensive monitoring system, particularly real-time monitoring. This requires systematic data collection on addiction to allow swift policy responses. Establishing a specialised focal point that collects and analysis data is needed. Iceland joining the European Union Drugs Agency (EUDA) would be an important step in this respect. It can play a crucial role in developing short- and long-term solutions. The Health Directorate, provided adequate resources are allocated, would be ready to serve as the EUDA focal point for collecting and analysing data.

Quality control: Ensuring the quality of healthcare services remains a priority. The Directorate's Quality Improvement Plan, which spans from 2019 to 2030, focuses on areas such as process improvement, quality indicators, adverse event reporting, and user surveys. While implementation was delayed due to the COVID-19 pandemic, the Directorate remains committed to a risk-based supervision model to address concerns proactively, though limited resources pose a challenge. Currently, the Directorate has two quality inspectors overseeing more than 3,000 healthcare units, making collaboration with institutions essential. However, these two inspectors also have to deal with many other tasks.

The Directorate acknowledges the importance of collaboration across institutions and sectors to address these challenges effectively. As the body responsible for supervision and providing guidance on quality improvement, the Directorate is committed to supporting the Ministry in achieving its healthcare goals. Further dialogue with the Ministry regarding priorities and areas of focus would help ensure implementation, while maintaining strong international connections is key to ensuring that Iceland's healthcare system adheres to global best practices which again could be achieved through EUDA membership.

Ministry of Education and Children

The Ministry is dealing with a complex challenge in supporting children under 18 who are dealing with substance abuse disorders. Children facing substance abuse problems frequently encounter multiple barriers in accessing treatment. There are high expectations for the new Act on the Integration on Services in the Interest of Children's Prosperity (Farsældarlögin). The Act frames the overall approach of the Ministry and the therapeutic work is based primarily on the child protection law and relevant regulations, e.g. about the state's treatment centre's role following the sentencing of children.

Early intervention is crucial but not always successful in preventing further difficulties. When early intervention does not yield the desired results, the Child Protection Agency (CPA) becomes involved. The main role of the agency is to provide and support services for the benefit of children and to promote quality development in accordance with the best knowledge and experience at any given time. Municipalities have a variety of support resources, but there are also specialized treatment options under the auspices of the Directorate for Children and Families. However, Iceland faces unique challenges, particularly due to its smaller population, which limits the possibility of creating specialized institutions for children with singular addiction issues. Often, these cases involve more complex psychological or behavioural challenges.

Inpatient treatment: Studlar, a government-operated treatment centre, plays a central role in managing the care of children with drug-related issues, in collaboration with other facilities like Lækjarbakki and Bjargey. MST (multi systemic therapy) is used for out-patient treatment on behalf of the The National Agency for Children and Families (BOFS). Despite their efforts, challenges arise in coordinating with the healthcare system. For instance, the two detox beds at Landspítali are rarely used, primarily due to the children's reluctance to stay, great difficulties in getting children admitted and complicated work processes. Delays in mental health assessments from the Children and Adolescents Mental Health Department (BUGL) further complicate matters. Many children experiencing withdrawal or related symptoms are often directed to Studlar, where the staff, while dedicated, are not equipped to provide the level of medical care required.

Detoxification: Landspítali University Hospital provides two detox beds for minors, yet these resources are often underutilized due to various systemic challenges. While these beds are intended for short-term detoxification and medical monitoring, only a few children have been admitted, and the utilization rate has been lower than anticipated. This situation reflects broader issues within the system, which could be more responsive in addressing the needs of these vulnerable children.

Cooperation: Efforts have been underway for more than a decade to strengthen cooperation between Studlar and the mental health departments at Landspítali. One of the key challenges is addressing the needs of children who present with both mental health and substance abuse issues, as the healthcare system is not fully designed to manage dual diagnoses. The waiting lists for mental health services, particularly at the Children's Mental Health Centre, can be extensive, sometimes up to three years, leaving children without timely support. This situation is particularly concerning for high-risk children, including those with conditions such as undiagnosed autism or severe anxiety, who often need immediate assistance. While the Farsaeldarlög is aimed at improving coordination across sectors dealing with children's welfare, promoting a more collaborative approach, experts caution that the full impact of this legislation may take time to materialize, possibly up to 20 years.

Vulnerable groups: In the meantime, there remains an urgent need to address severe cases of vulnerable groups currently being managed by Studlar, including children involved in the justice system and those with self-harm or suicidal tendencies. The mixing of such diverse cases poses serious challenges to professionals and the institutional structure.

Integrated approach: A more integrated approach to care is essential. Children in crisis require not only medical attention but also social and psychological support, and the current infrastructure is not fully equipped to meet these diverse needs. School nurses have demonstrated success in early intervention and monitoring, offering a model for effective collaboration schools and primary health care. However, the healthcare system, particularly in terms of mental health services, could be more responsive to the needs of children who face both addiction and mental health challenges. Greater collaboration between social services, the justice system, and healthcare providers will be crucial in ensuring these children receive the comprehensive care they need.

Increasing capacities: Expanding capacity of treatment centres would also help alleviate some of the strain. Currently, the centres accommodate 20 children, but demand suggests that double this capacity may be necessary to meet the needs of the youth population. A more integrated system that combines medical, psychological, and social care will be vital for providing holistic support to children with substance abuse and related issues.

Landspitali University Hospital

The Department of Psychiatry and Addiction at the Mental Health Services focuses on treating patients with both severe mental illness (e.g. Schizophrenia, bipolar disorder, severe personality disorders) and severe addiction. Patience with other than psychiatric comorbidities are provided with additional treatment in other departments of the hospital.

Mental Health Department

The mental health department primarily treats patients with dual diagnoses and collaborates with other organisations like SÁÁ Vogur Hospital. However, there are challenges related to capacity, building infrastructure, funding, and proper distribution of care among different stakeholders. Discussions with senior staff brought about the following issues:

Treatment of Dual Diagnosis (mental illness and addiction): There is a need for specialised treatment that addresses both mental health and addiction, in particular for those patients who have severe and multilayered social and medical problems in addition to the addiction. While Mental Health Services provide a small assertive community team for patients with severe addiction and severe mental illness, behavioural problems, homelessness etc., the capacity by far does not match the existing need. Furthermore, collaboration with SÁÁ Vogur for patients with severe addiction problems is in place, but Vogur is not in the position to accept patients with severe mental health issues.

Lack of coordination and organisation among providers: Concern causes a noted absence of a well-structured, coordinated approach among the various organisations and NGOs involved in treating addiction and mental health issues. Many "satellites" and overlapping responsibilities among different stakeholders cause confusion.

Capacity and infrastructure constraints: The facility's limited capacity of 16 beds for treating patients with severe addiction and mental health issues does not meet the current demand. It is frequently at full capacity, resulting in long wait times for treatment, particularly for patients with less severe conditions. Due to the shortage of beds, the ward also admits many patients with general psychiatric issues rather than dual diagnoses, further reducing the availability for dual diagnosis patients.

Furthermore, the building's infrastructure (e.g. one entry/exit) limits expansion and hinders adequate, safe and efficient treatment. These issues are aggravated by a lack of resources, funding and staff shortages.

Specific patient populations: There is a low demand for inpatient detox services for individuals under 18, despite the establishment of a dedicated ward. Elderly people with addiction problems pose a growing challenge in nursing homes. People with severe neurological issues and addiction are a high-risk group, often with criminal records, addiction problems and no stable housing options, frequently causing public nuisance and problems in housing facilities. For the time being, there are no adequate responses and programmes in place that cater for the needs of this patient group.

Lack of adequate housing for non-severe mental health patients: The absence of a dedicated facility for individuals with severe addiction but without serious mental health issues is leading to inappropriate admissions and overcrowding in the hospital's emergency room.

Challenges with housing and homelessness: The most vulnerable patients, often with severe mental illness and addiction, are homeless or at risk of losing housing. These patients often exhibit violent behaviour, making it difficult to find stable housing.

Harm reduction and vocational rehabilitation: Vocational training and appropriate work placements should be increased. These constitute important measures, in addition to housing, complementing harm reduction in getting patients to adhere to medication regimens (e.g. antipsychotics) and are important elements of the treatment process.

Need for policy and structural changes: There is an urgent need for reorganisation of the treatment system to ensure proper distribution of care and responsibilities among healthcare and social service providers. The Ministry of Health and other entities need to allocate more resources for addiction and mental health services. The current system, with a split in healthcare between the Ministry of Health and the Ministry of Education and Children for under 18-year-olds, is deemed problematic and inefficient.

Emergency Department and Infectious Diseases Ward

Since 1993, efforts within the infectious diseases ward have focused on addressing the HIV and Hepatitis C (HepC) epidemics, particularly among drug users. Over time, the ward has developed programmes to destigmatize drug users, providing medical treatment for those actively using drugs. Collaboration with VOR-team, a counselling team from the city of Reykjavík has enabled patients to access healthcare without first needing rehabilitation, a change that has drawn criticism from traditional drug treatment programmes.

A significant HIV outbreak occurred in 2010-2011 and an additional cluster in 2015-2016 among drug users, alongside HepC outbreaks. Following this, the use of Contalgin, a medication for pain management that contains morphine, for HIV patients was initiated. This resulted in non-detected intravenous drug use (IVDU) related HIV cases subsequently. Additionally, safe injection rooms were established in 2023, marking a new governmental initiative to combat the opioid and fentanyl crisis.

Despite some successes, challenges remain, particularly in bridging the gap between drug detox programmes and mental health services, as well as the overall strain on hospital resources. Overcrowding and a lack of hospital beds contribute to the difficulty in managing patients, and there is still no clear quality indicator to measure progress. Efforts continue to ensure that drug users receive dignified treatment while addressing the rising opioid problem.

Specific issues discussed:

HIV and HepC epidemics among drug users: In 2015-2016, an HIV epidemic spread among drug users, even though clean equipment was provided. HepC persisted as well. A programme offering HIV and HepC treatment in exchange for Contalgin was implemented, upon the initiative of the Infectious Diseases Ward, helping contain the epidemic.

Collaboration: The infectious diseases ward partnered with Vor-team of the Reykjavik City Welfare Department to help drug users access healthcare without being forced into rehabilitation. Efforts have been made to destigmatize drug users and understand their lifestyles, though this approach has faced criticism from more traditional drug treatment programmes.

Safe injection sites and opioid crisis: In June 2023, safe injection rooms were established, including healthcare services, to reduce emergency room visits and address the opioid and fentanyl crisis. These facilities offer pathways for users to receive immediate medical care without the requirement to stop using drugs.

Overcrowded emergency room: Staff is overwhelmed, operating with 50 patients in a 36-bed facility, with no increase in the net number of hospital beds in the past seven years despite population growth. The ward has struggled to accommodate drug users alongside the aging population, contributing to overcrowding.

Dual diagnosis: Lack of integrated care for dual diagnosis patients. Moreover, there is a gap between detox and mental health services. Many patients, after drug detox, require mental health support but face barriers to accessing integrated care. The mental health department operates separately from the infectious diseases ward, complicating patient care coordination.

Challenges with measuring quality and success: There is no clear quality indicator for measuring progress, though some suggest tracking ambulance calls for drug overdoses. Establishing metrics for political and healthcare stakeholders remains a key challenge in evaluating the success of these initiatives.

Strained resources and hospital funding: The hospital faces resource constraints, including the need to fund antibiotic medication for drug users. Further, there is a lack of clarity regarding whether substance abuse diseases (recognized in ICD-10 and ICD-11) receive adequate funding for treatment complicates the situation further.

Ethical issues in care for people who use drugs: While the ward maintains a compassionate approach, there are limits; for instance, individuals committing crimes like robbery may be denied treatment. The balance between offering medical support and enforcing social responsibility continues to be a delicate issue.

Hlaðgerdarkot treatment facility

Hlaðgerdarkot set up in 1973 and is operated by Samhjálp, focuses on helping individuals lead balanced lives through recovery programmes. It provides residential treatment for an average of 12 weeks, with stays extending up to a year in some cases. The centre follows the Minnesota model with its 12-step programme and offers life skills training and cognitive behavioural therapy (CBT) alongside addiction treatment. Hlaðgerðarkot collaborates with other institutions such as hospitals, halfway houses, and mental health services but faces challenges due to a long waiting list and limited resources. While the facility aims to maintain high standards of care, it does not systematically follow WHO or EMCDDA guidelines. As an added treatment benefit, clients are offered incentives and rewards for improved outcomes, such as attending weekly meetings with a sponsor, as well as a town permit to foster relationships with children and families. Recent leadership changes and efforts to enhance staff professional development are ongoing.

Main points discussed with the management:

Long waiting list: 144 people are currently on the waiting list (100 men, 44 women). Wait times range from 1 month to 12 weeks, with no outpatient services offered during the wait. The facility would require more funding to reduce the waiting list by increasing its capacity and service availability.

Resource constraints: Limited resources hinder the ability to offer outpatient services or expand services to meet demand.

Client-centred approach: Emphasis is on rehabilitation based on the 12-step model and life skills training, with a focus on practical skills like tax management. Treatment supports individuals with dual diagnoses in collaboration with hospitals. The centre also partners with Bjarkahlíð, the Women's Refuge or Stígamótir

Collaboration with other institutions: Informal cooperation exists with prison authorities and halfway houses. Referrals from hospitals, particularly after detox, are common, and the facility often serves as a transition from other treatment centres such as Vogur and Vík.

Staff development and leadership: Recent leadership changes include a change in management is expected to improve operations and fund-raising ability. A certified alcohol and drug counsellor recently joined the team, and all counsellors have undergone informal training including in motivational interviewing. Staff are participating in international seminars for the first time in 2024, which is expected to enhance the quality of care and practices.

Lack of Formal Standards: While Hlaðgerdarkot does so far not follow WHO or EMCDDA standards, efforts are being made to assess its professional framework. No formal data on remission or relapse rates is available, leaving room for improvement in outcome tracking and evaluation.

Special needs client groups: Services are available to pregnant women but limited to Icelandic and English-speaking individuals.

Krýsuvík treatment facility

Krýsuvík Treatment Facility was founded 38 years ago and offers a six-month onsite treatment programme based on the 12-step model, with strong ties to Highwatch in the USA, which trains its staff. The centre also provides legal and financial counselling to help residents become debt-free and stay away from crime. Three staff members are certified trauma therapists and provide individual and group therapy.

Admissions are primarily self-referrals, but social services and the mental health department also refer clients. Though there are no specific exclusion criteria beyond active substance use, the waiting list for admission can be long, often 4-6 months. The facility accommodates both men and women, with 21 beds for men and eight rooms for women, but faces ongoing challenges with securing licensed professionals, especially therapists.

Krýsuvík collaborates with the prison and probation administration to allow some residents to serve sentences during their treatment, and the facility does not offer extensive medication-assisted treatment. Aftercare is provided for three months post-treatment, with follow-up surveys showing a 55% sobriety rate after four years. However, financial and staffing constraints, along with broader systemic issues, pose ongoing challenges.

In discussions the management raised the following issues:

Staffing shortages and professional training: Krýsuvík struggles to recruit enough licensed therapists and addiction counsellors, as there are not enough trained professionals in Iceland. The SÁÁ training programme for addiction counsellors is demanding, and many drop out before completion. Also, there is a shortage of trauma therapists in Iceland.

Financial constraints: The facility relies on fixed government funding, which must be renegotiated annually, and client fees are often covered by government benefits. This funding basis limits Krýsuvík's ability to expand services or increase staff qualifications.

Long waiting lists: With around 100 people on the waiting list and an average wait time of 4-6 months, many individuals are delayed in receiving the care they need, despite efforts to manage the list.

Collaboration with the judiciary and prison system: Krýsuvík works with the prison and probation administration to negotiate treatment as an alternative to or in conjunction with serving sentences, which offers a potential lifeline to some residents but presents logistical challenges.

Medication-assisted treatment (MAT): While some residents use opioid agonist treatments through other facilities such as SÁÁ, Krýsuvík does not offer MAT directly, focusing instead on abstinence-based recovery, which may limit options for certain clients.

Aftercare and long-term recovery: The management follows up with residents for three months post-treatment. Long-term follow-up indicates that 55% remain sober after four years, highlighting a need for improved long-term support. In terms of aftercare, Krýsuvík offers a closed group once a week at Varðan treatment centre. The group is facilitated by their professionals plus one from Krýsuvík. This group has an attendance of average 20-25 clients weekly.

Stigma and systemic challenges: Although public stigma around addiction treatment has decreased, systemic issues, such as a lack of funding for addiction services and the outsourcing of care to nonprofits, create ongoing barriers to the facility's growth and effectiveness.

SÁÁ Treatment Centres

The SÁÁ treatment centres, comprised of three distinct locations—Vogur (hospital services), Vik (residential facility), and Von (outpatient clinic)—provide comprehensive care for addiction, with 68% (2023) being alcohol- and 21% opioid-related. A client service satisfaction survey collects feedback from service users at the point of discharge, and this information is used to improve services. The organisation ASAM (American Society of Addiction Medicine) guidelines focusing on ensuring that service users receive care tailored to their needs. Vik, the residential facility, offers intensive psycho-social treatment, with close collaboration with Landspítali's Mental Health Division from where patients can be admitted directly to Vogur for detoxification.

SÁÁ has a primarily abstinence-based approach but also offers medication assisted treatment for residents under certain conditions, during admission and residential treatment as well as part of outpatient services. The organisation is also the only educational institution in Iceland licenced to train addiction counsellors. Although the organisation does not handle court-mandated treatment anymore, it continues to work closely with various referral agencies to provide appropriate care.

Annual evaluation and service improvement: a two-week status study is conducted yearly to gather feedback from service users when they leave the SÁÁ clinics. The information is used to refine services. Comments have included concerns about phone usage, walking opportunities and food quality.

Treatment standards: SÁÁ recently introduced new criteria for treatment, based on the ASAM. standards, to better classify and treat service users at various stages of recovery. The Vik residential centre is focused on providing intensive psycho-social treatment, guided by DSM-5 classifications. WHO, UNODC standards are not applied.

Exclusion criteria: Certain physical or mental health conditions may exclude individuals from the Vik residential programme, particularly for those in need of more nursing care or who have unstable mental health conditions. Language barriers are also a potential reason for exclusion.

Collaboration: The treatment centres maintain close contact with Landspítali's Mental Health Department, especially for patients with dual diagnoses, ensuring comprehensive care for both mental health and addiction.

Admission and referral process: Vik has no waiting list, with patients typically referred from Vogur, although referrals from outpatient services are possible. Admissions are held twice a week, with a short waiting period of a few days. Non-participation in the programme or substance abuse may result in referral back to outpatient services.

Quality standards: SÁÁ complies with the Directorate of Health's Quality Action Plan and follows ASAM standards. It has introduced a new performance system (EOS) to assess staff performance, starting with top-level staff.

Training of addiction counsellors: SÁÁ is presently the only educational institution in Iceland to train licensed addiction counsellors. However, the organisation is facing a shortage of new graduates due to high drop-out rates in the first year of the course and recruitment from other organisations. Licensing for counsellors is government regulated, requiring extensive professional, supervisory, and teaching hours. A transition to a bachelor's degree programme at Reykjavik University is planned over the next five years in order to better labour market demand.

Outreach: SÁÁ currently does not conduct surveys on staffing needs and has limited outreach service capacity.

Court-mandated treatment: SÁÁ no longer offers court-mandated treatment, which was available up to a decade ago for individuals completing their sentences. However, they continue to provide voluntary and professional referrals for treatment.

Reykjavik Metropolitan Police

While police officers now receive training on addiction, the current system struggles with handling detainees who have serious substance abuse issues, as hospitals often refuse them. A new law on policing is being discussed to address some of these gaps.

In Reykjavík, the police approach to addressing substance abuse has shifted over time from dealing primarily with alcohol-related issues to focusing on drug abuse. Initially, alcoholics were detained overnight due to a lack of shelters, but cooperation between the police and the municipality led to the establishment of shelters and social services. This reduced the need for police detention, although new shelters still face challenges, such as being closed during the day, causing criminal activity to shift to downtown areas.

Key issues raised in discussions with a senior law enforcement officer:

Shelter availability and daytime crime shift: Initial cooperation between the police and Reykjavík municipality led to the establishment of shelters, reducing overnight detentions of alcoholics. However, shelters being closed during the day has led to a rise in daytime crime in the downtown area.

Transition from alcohol to drugs: Substance abuse has shifted from alcohol to a wide variety of drugs, including amphetamine, cocaine, oxycontin, ketamine, MDMA and cannabis. Local production exists, but imports are increasing due to growing demand.

Overdose emergencies: Overdose incidents are reportedly on the rise, though it is unclear whether this increase also includes suicide cases. The use of naloxone by police has saved lives, but logistical issues like frozen naloxone and limited medical support complicate the situation. Also, it is voluntary for police officers to carry naloxone.

Inadequate medical support for detainees: Hospitals often refuse to admit detainees with substance abuse issues, leading to a lack of proper medical care in detention. Frequently

police officers are left to manage health emergencies without dedicated medical professionals. An important improvement would be to set up a collaboration mechanism where the police can contact a doctor on call to come to the detention facility for assessment and initial medical response.

Lack of post-detention support: Individuals with drug problems are frequently released back onto the streets after short-term detentions. While some services are offered, there is minimal follow-up, leading many to return to criminal behaviour.

Training on addiction and substance abuse: Since 2007, police officers have received some education on addiction and substance abuse through training provided by the University of Akureyri. However, current protocols for handling these issues in detention remain limited.

Legislative Gaps: There is a need for new laws to address mental health and substance abuse issues within the police force's remit. A working group is in the process of drafting a new law on policing, but there is no existing mental health law to guide these procedures. However, the Ministry of Health has so far not been consulted in this process.

Prison system

Iceland has two main prisons, both accommodating wards for men and women. Hólmsheiði and Litla Hraun prisons offer different environments, with Hólmsheiði providing opportunity for the separation between inmates according to specific needs, the Litla Hraun facility offers conventional settings which make it difficult to create drug free spaces or wards. This difference in structure also affects the ability to manage prisoners and prevent conflicts. Inmates are encouraged to take responsibility, such as submitting CVs for job applications within the prison. Drug use is a significant issue, mostly within Litla Hraun, with many inmates having started using as young as 12. There are some elements from the therapeutic community model applied in prison settings. Though treatment instead of incarceration is an option for drug-related offenses, there are few facilities available to support this, and the system struggles with limited resources.

Key Issues raised in the discussion with senior staff from the prison system included:

Declining ambition for guard training: The school for prison guards in Iceland suffers from budget cuts and a lack of ambition, limiting its capacity to fully train new recruits. Training often takes place on the job, with limited formal educational resources despite the increasing use of trauma-informed approaches.

Inmate care and continuity of services: Efforts are made to ensure that prisoners continue their education and medical treatment while incarcerated, but there is no structured system for post-release follow-up. Medications for mental health and substance abuse treatment are available within the prison, but access to medical services outside regular hours is difficult.

Drug use and treatment: Drug addiction is a major issue, with prisoners often having a history of drug use from an early age. Judges can sentence offenders to treatment, but Iceland lacks adequate facilities to fully implement treatment programmes, leaving only a small number of inmates eligible for such options. Where needed, the mental health team for prisons also provides appropriate medication assisted treatment for individuals with opioid addiction who are serving a sentence. Everyone who begins maintenance treatment during incarceration is given an appointment at the Vogur outpatient clinic after the release to continue the maintenance treatment.

Therapeutic programmes and community models: There are some elements of therapeutic community practices, with prisoners engaging in group tasks and rehabilitation activities, although these programmes are not fully developed across the institutions.

Lack of formalised systems for accountability: Accountability within the prison staff is informal, relying on internal checks and regular meetings rather than a structured system. This informal system works to some extent, but it lacks the clarity and consistency of a more formal approach.

Limited Options for rehabilitation after leaving prison: After release, prisoners have some opportunities, such as halfway houses, jobs or schooling, but the lack of a structured follow-up system reduces the effectiveness of rehabilitation. Community service is a popular alternative to incarceration but lacks sufficient integration with therapy and rehabilitation services.

Gender imbalance and multinational population: Hólmsheiði prison houses inmates from 14 nationalities but has a stark gender imbalance, with only 4 women compared to 140 men, posing challenges for gender-specific care and rehabilitation programmes. Due to language barriers, there are little opportunities to engage with prisoners who do not speak Icelandic or English.

Local authorities

Representatives of local authorities discussed the need for a comprehensive and structured policy framework to address addiction treatment and rehabilitation. The conversation highlighted the importance of diverse treatment methods, long-term support, and holistic measures of success that go beyond mere abstinence. Participants emphasized the urgent need to reform the system, with some pointing out the delays in treatment and the lack of support post-rehabilitation, while others stressed the economic benefits of reintegration and trendspotting. The overarching goal is to meet individuals where they are in their recovery journey and ensure sustainable reintegration into society.

Comprehensive policy framework: The need for a clear, structured policy to ensure quality control across the phases of rehabilitation, from early intervention to long-term reintegration. The policy should consider three levels: early intervention, remission and reintegration and achieving a society free from debt, crime and drug use.

Diverse treatment approaches: Different individuals require different methods of treatment, from hospital beds to walk-in clinics and support for those not yet ready to stop substance use. The presently applied 'one-size-fits-all' approach does not work; there is a need for flexibility to meet people where they are in their recovery process.

Delays in access to treatment: A significant issue is the long wait times for individuals seeking treatment, often up to 10 months, which can lead to worsening conditions and, in some cases, death. This often concerns those that have been eight or more times in Vogur before as other groups are prioritised by SÁÁ. The lack of immediate and adequate care, particularly when individuals are ready for help, was described as a failure of the system.

Post-rehabilitation support: Once individuals complete rehab, there is often a lack of societal support, such as employment opportunities, housing, or family connections, making them vulnerable to relapse. Long-term, integrated support systems are needed to ensure recovery sustainability.

Indicators for measuring success: Treatment success should be measured by more than just abstinence rates. Indicators like employment, housing stability, and general health are more meaningful in assessing long-term recovery. The economic benefits of reintegration, such as reduced reliance on the prison system, were highlighted as critical outcomes of successful treatment.

Role of private healthcare: Concerns were raised about the influence of private rehabilitation operators without sufficient government oversight, which can result in resource misallocation. A more comprehensive government-led approach to treatment services is necessary for effective resource management.

Trendspotting and early warning systems: Identifying emerging trends in substance use and treatment needs is crucial for real-time policy adjustments, rather than waiting for crises to escalate. The need for proactive systems to track and address trends was emphasized as a more efficient approach than simply gathering retrospective data.

Economic and social benefits of Treatment: Effective rehabilitation should be viewed as an investment with the potential for significant long-term economic benefits, such as reduced costs in the prison and healthcare systems. Models from other countries like Portugal and the Netherlands demonstrate the benefits of reintegration into employment and housing for stabilizing individuals and reducing overall societal costs.

Civil society

In the view of consulted civils society organisations, despite advantages such as a close-knit professional community, Iceland faces major challenges in providing effective harm reduction and rehabilitation services. There are limited resources, a lack of specialised care for marginalised groups and inadequate treatment options, especially for complex drug problems. High thresholds for access, long waiting lists and systemic barriers in the healthcare system exacerbate the issue, leading to preventable deaths each year. The influence of ideology and political lobbying further hinders reform, while a lack of international connections and data collection prevents progress in adopting modern harm reduction practices.

The following are key issues raised in the different civil society organisations that participated in the consultations are summarised:

Limited rehabilitation resources: Only two centres offer short-term rehabilitation, and no treatment is provided in prisons. This leaves a significant gap in care for people in need of long-term or more specialised services.

Lack of specialised care for marginalised groups: Services are not equipped to meet the needs of queer individuals, disabled persons, non-native speakers, those with lower cognition and sex workers. Marginalised groups, particularly those with severe problems often face high barriers to accessing appropriate care.

Inadequate harm reduction policies: Traditional models focused on abstinence are inadequate for addressing complex drug problems. Suboxone, a more effective treatment option, is difficult to access due to restrictive regulations.

High thresholds and long waiting lists: Access to detox and treatment is delayed by high thresholds and long waiting times, leading to approximately 100 preventable deaths annually per year.

Political and ideological barriers: The influence of large organisations like the SÁÁ and the lack of a human rights-based approach contribute to inadequate services. Many aspects of the system are shaped by political lobbying and religious ideologies rather than evidence-based care.

Lack of international connections and data: Iceland is not integrated into EUDA, limiting access to data and international guidelines that could push for reforms. The country lacks benchmarks and external support to modernise its harm reduction policies.

Gaps in primary healthcare and prison care: There is no screening for substance abuse in primary healthcare settings, and prisons do not address trauma or provide adequate detox services, despite 80% of inmates having drug problems.

Overreliance on abstinence models: A strong focus on abstinence rather than harm reduction, particularly in the prison system, creates barriers to more effective interventions.

Treatment demand and coverage

The AAAQ framework (Availability, Accessibility, Acceptability, Quality) developed by WHO provides the most widely accepted and applied conceptual basis for assessments of treatment systems in their alignment with international standards:

- *Availability and Accessibility:* Treatment services should be sustainably present, conveniently located, and accessible to all population groups.
- *Affordability:* Services should be affordable for those in need from different socioeconomic backgrounds and ideally provided free of charge.
- *Acceptability:* the treatment system must offer a variety of approaches to meet different needs and diverse backgrounds of clients.
- *Quality:* Treatment interventions must be based on scientific evidence, professional standards and require coordination between health, social, and community services to provide comprehensive care.

The AAAQ framework is also used as a benchmark standard by the Council of Europe and the European Court of Human Rights in terms of assessing human rights compliance in provision of health care. *→ Indicators for the AAAQ framework are included in Appendix III, p. 44.*

Based on the information available for this review the following observations can be made concerning the availability, access and adequateness of treatment services for substance use disorders in Iceland.

Availability

Iceland offers a variety of treatment services for substance use disorders, ranging from outpatient care to inpatient rehabilitation services offered by both the public healthcare system and through private, non-profit organisations (NGOs). Treatment modalities include typically a mix of approaches in inpatient and outpatient programmes, including detoxification, 12-step programmes, medication-assisted treatment (MAT) for opioid addiction (e.g. methadone or buprenorphine), counselling, cognitive-behavioural therapy (CBT). Self-help and support groups, such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA), are widely available in Iceland and are part of the support system for individuals with substance use disorders. Treatment providers negotiate services agreements with Sjúkratryggingar Íslands for a number of treatment places based on previous treatment demand. In the absence of systematic national data on drug use and trends, it is exclusively this historical data that serves as a basis for future treatment demand projections.

This has led to a situation where the demand has regularly exceeded the number of available places during the last years resulting in waiting lists and strains on staff and infrastructure of treatment service providers. To project and estimate treatment demand more adequately for the future, such as for the next financial year, funding calculations must be based on anticipated demand. The estimation should include not only historical data but also the following: epidemiological data, completion and relapse rates, capacity and resource evaluation as well as predictive modelling taking into account external factors such as policy changes and demographic developments.

Accessibility

Iceland's universal healthcare system ensures that most medical treatments are affordable and accessible to the population, including substance use disorder treatment. However, there are some limitations. Substance use treatments, especially detoxification and rehabilitation programs, are covered under Iceland's public healthcare system, making these services accessible to everyone regardless of income. However, outpatient services, such as therapy and counselling, may involve co-payments or private insurance coverage.

Given the country's small population and geographical isolation, most specialised services are concentrated in the capital, Reykjavik. People living in remote rural areas may face challenges in accessing inpatient services or ongoing therapy.

While Iceland has focused strongly on youth prevention through community programs, such as the Icelandic model for primary prevention, specific rehabilitation services for under 18-year-old or people with dual diagnoses (mental health and substance use disorders) however may be harder to access compared to general services.

The availability of immediate treatment can be affected by long wait times, particularly for inpatient rehabilitation services. While emergency detoxification services are generally accessible, rehabilitation programs can have waiting lists due to limited capacity. Nearly all consulted stakeholders underline that the demand has continuously exceeded the number of treatment places in the last years resulting in delays to access treatment. This has led to repeated high-profile discussions in the professional community, the political sphere, as well as in the media. While an assessment conducted by the Ministry of Health in 2020 highlighted the need to reduce waiting times, apparently no remedies came into place primarily due to managing the COVID pandemic and its consequences. The matter has already been tabled in parliament (Alþingi). In response to a question by a parliamentarian,

regarding treatment services during the 2023–2024 Alþingi session, the Minister of Health provided information about waiting lists at Vogur Hospital and the Vík Treatment Centre as follows:

On average, Vogur Hospital receives approximately 230 requests for admission each month, with around 500 to 700 individuals on the waiting list at any given time. In contrast, the Vík Treatment Centre typically does not have a waiting list.

The ministry is actively working to reduce waiting times. In recent months, SÁÁ has implemented measures to better manage access to inpatient treatment by establishing an outpatient treatment programme for individuals who do not require withdrawal care. These efforts have led to a decrease in admission requests to Vogur Hospital and have shortened waiting times, with most individuals now being admitted within the 90-day standard set by the Directorate of Health.

The ministry's priority remains to reduce waiting times across all levels of care, whether for emergency, urgent, inpatient, or outpatient services. Currently, a new comprehensive agreement is being developed between Icelandic Health Insurance and SÁÁ to replace the four existing agreements. This updated framework will allow SÁÁ greater flexibility in prioritizing tasks based on the needs of users and society at any given time.

Adequacy

Iceland's approach to treatment for substance use disorders is rooted in evidence-based methods but there are both strengths and challenges when it comes to adequacy.
The treatment system integrates medical detoxification, treatment and rehabilitation. Follow-up care is also emphasized, which is essential for relapse prevention. While the SÁÁ organisation, due to its size and resources, can provide a full range of integrated services including post-rehabilitation follow-up and social reintegration support, other service providers are not in the position to do so.

Although Iceland offers a range of services, the continuum of care could be improved, particularly for specialised populations such as people with co-occurring mental health issues, women and adolescents. The system sometimes lacks coordination between medical treatment, psychological care and social services, leading to gaps in treatment and care. The adequacy of treatment for chronic substance use often depends on the availability of ongoing support. Relapse rates remain a challenge and cause for concern about the effectiveness of the treatment system.

While Iceland’s healthcare system addresses substance use as a medical issue rather than a moral failing, social stigma still affects many individuals’ willingness to seek treatment. The small size of Icelandic communities can exacerbate this issue, as anonymity in treatment is harder to maintain.

As Iceland experiences rapid population growth and immigration, the treatment system struggles to adapt towards more diverse approaches meeting the specific needs of different populations. This includes particularly language, as well as sensitive cultural aspects that play a role in accessing treatment in the shaping and shaping of care and treatment concepts.

Quality

Currently, Iceland lacks comprehensive standards and quality control criteria specifically for the treatment of substance use disorders. The Health Directorate’s Quality Improvement

Plan aims to establish a system for quality control. To date, only SÁÁ has implemented systematic internal quality control.

Although the COVID-19 pandemic delayed implementation, the Directorate remains committed to developing an effective quality control system. This system will be based on service providers establishing and elaborating their quality standards and controls. However, limited resources pose a significant challenge. For example, the Directorate currently has only two quality inspectors responsible for overseeing 3,000 healthcare providers and units, in addition to other duties. This shortage of resources highlights the difficulties in establishing a robust quality control system.

Strengths, weaknesses, opportunities and threats

Based on the information generated in this review, the following strengths, opportunities and threats can be identified. These findings concern the treatment system at large and not the individual providers or institutions providing treatment and rehabilitation services. The aim of the review is an overall systemic analysis and not an evaluation of different stakeholders.

Strengths

Professionalism: Professionals working in the treatment field display a high degree of professionality commitment and dedication to the clients.

Closely knit society: The advantages of a comparatively small society together with closely knit communities allows for informal contacts and communication shortcuts.

Comprehensive treatment cost coverage by the public healthcare system: Iceland's universal healthcare system ensures that addiction treatment is accessible to everyone, regardless of socio-economic status. Treatment for alcohol and drug addiction is generally covered.

Prevention programmes and education: Iceland has invested in successful preventive programs, particularly those aimed at youth, such as the Icelandic Model for Preventing Adolescent Substance Use. These programs have been credited with drastically reducing teenage drug and alcohol use over recent decades.

Weaknesses

Structure: Informal communication channels and arrangements have led to only few formal structures being in place. Changing demands and demographic developments challenge the informal system.

Enforcement: Ensuring consistent and effective service delivery and adherence to standards are crucial but can be challenging, especially in remote areas.

Limited treatment capacity to cover demand: While the system provides access to basic treatment services, there is a limited number of treatment places for alcohol and drug addiction, particularly for long-term care or highly individualised treatment. People in need of treatment sometimes face waiting lists for inpatient rehabilitation programmes.

Understaffing and overburdening of services: The addiction treatment sector in Iceland is sometimes understaffed, which can lead to service delays and inadequate support. This is particularly true in rural areas where access to addiction specialists can be limited.

Insufficient aftercare and relapse prevention: There are significant gaps in long-term aftercare and relapse prevention. The absence of continuous, individualised follow-up can result in higher relapse rates.

Stigmatisation of addiction: Despite the public health focus, there remains some stigma attached to addiction in Iceland. Partly this can be attributed underlying philosophies and assumptions of the applied treatment models (12-step) as well of the treatment system (focusing on abstinence, detox and residential treatment). This stigma can prevent individuals from seeking help in the first place or from engaging fully with treatment services.

Cultural Factors: Changing demographics (population growth, ageing, migration influx) require systemic and service-related adaptation. This requires in turn changing longstanding cultural attitudes and behaviours which can be slow and complex.

Opportunities

Coordination: A structured coordination among various stakeholders, including government agencies, local organisations and the community, will lead to the more efficient use of resources which otherwise constitutes endless ground for disagreements between stakeholders.

Quality assessment: By setting clear objectives and following a detailed evaluation plan, addiction treatment services can be systematically assessed and improved, leading to better outcomes for service users and more efficient use of resources. Channels for ongoing service user and staff feedback are the basis to refine and improve services.

Data collection and regular Reporting:

E-health and artificial intelligence (AI): Advances in digital health offers more accessible forms of treatment, particularly for individuals in rural areas. Telemedicine, online counselling, including the use of Wobot AI where feasible, and digital relapse-prevention tools can greatly enhance the reach of addiction services without greatly increasing costs.

Mental health integration: With the growing understanding of the relationship between mental health, addiction as well as the socio-economic and cultural context, Iceland has the opportunity to strengthen integration between health, welfare services and civil society organisations. This would reduce stigma and foster rehabilitation and social re-integration.

International collaboration: Iceland can benefit from increased collaboration with international bodies, such as professional networks, agencies as EUDA, research institutions, and other bi-laterally with countries to enhance its addiction treatment methods. International partnerships can bring cutting-edge therapies, new methodologies and more evidence-based treatments.

Rehabilitation services for specific target groups: Tailoring more services for people under 18 years of age, the growing number of elderly with addiction problems, marginalised groups, such

as immigrants, LGBTQ+ individuals or those with dual diagnoses, would ensure that no population is left behind in receiving adequate treatment and support.

Data collection and regular Reporting: Data collection and regular reporting to enhance both effectiveness and efficiency by providing real-time insights treatment progress, treatment outcomes and programme success. It enables healthcare providers to identify trends, adjust interventions as needed and allocate resources more effectively. It also supports better forecasting and planning, allowing to anticipate future needs, optimise staffing and target services where they are most needed.

Threats

Relapse following treatment: A lack of robust long-term support structures increases the risk of relapse among individuals after they complete primary treatment. Without a strong focus on aftercare, Iceland's addiction system may see diminishing effectiveness over time

Change and rise in substance use trends: Iceland, like other countries, is not immune to global shifts in substance use patterns, such as the increasing prevalence of synthetic drugs and opioids. The system may struggle to keep up with new and emerging drug challenges if it does not act with a concept of foresight, risk assessment, early warning system and systemic preparedness.

Economic pressures on healthcare funding:
Economic downturns or budget constraints could threaten the funding available for addiction treatment services. This could result in cuts to service funding, fewer resources for service users or reduced capacity in treatment centres.

Challenges in addressing co-occurring disorders: Treating individuals with both addiction and mental health issues, as well as other medical conditions, in an integrated manner remains a challenge. Without adequate integration of services, service users with co-occurring disorders may not receive the holistic care they need, leading to poorer outcomes.

Demographic developments: Iceland's population is aging and at the same time the population increases rapidly with more diversity due to migration. These demographic trends may require more specialised treatment approaches, creating additional pressure on the treatment system.

Observing human rights obligations

International human rights standards require states to ensure that individuals with addiction issues have access to appropriate and effective treatment options. The European Convention on Human Rights (ECHR) and the case law on health of the European Court of Human Rights (ECtHR) bring about binding obligations for signatory states.

Waiting times for medical treatment can violate human rights when they lead to unnecessary suffering, deterioration of health or when they disproportionately affect vulnerable populations. According to international human rights standards, everyone has the right to the highest attainable standard of health. Long waiting times can hinder access to necessary medical care, thus violating this right. This is in particular the case:

- If waiting times are longer for specific groups (e.g. based on race, gender, socioeconomic status, or disability), this can constitute discrimination and a violation of human rights.
- In cases where delays in treatment can lead to severe health consequences or death, long waiting periods can be seen as a violation of the right to life and the right to health care.
- Where prolonged waiting times can also affect mental health, leading to increased anxiety and stress, which may constitute a violation of the right to mental health care.

The ECtHR has addressed issues related to waiting times for medical treatment in several judgements under *Article 2 - Right to Life* and *Article 3 - Prohibition of Inhuman or Degrading Treatment* of the ECHR:

- *Article 2 ECHR- Right to Life:* The court has ruled that excessive waiting times for urgent medical treatment can be a violation of the right to life. For example, if a person suffers severe consequences due to delays in receiving necessary medical care, it may be interpreted as a failure of the state to protect the right to life.
- *Article 3 ECHR - Prohibition of Inhuman or Degrading Treatment:* The ECtHR has also considered waiting times in the context of Article 3, particularly when delays result in significant pain or suffering. If the waiting times lead to a deterioration of health or prolonged suffering, the court may find that such circumstances violate this article.

In its rulings the court has emphasized the importance of timely access to healthcare as part of states' obligations under the ECHR. While some waiting times are inevitable in healthcare systems, excessive delays that compromise well-being and violate fundamental rights are a serious concern. Exceeding these limits can constitute human rights violations and lead to legal claims. These rulings highlight the necessity for states to ensure that their healthcare systems are efficient and accessible. The ECtHR's decisions highlight the need for governments to prioritise healthcare access and address systemic issues that lead to long waiting times. This is to implement reforms where necessary, allocate resources effectively, and assess waiting times regularly to comply with human rights obligations.

Defining treatment standards

One important step in addressing shortcomings in availability, accessibility, adequateness is the establishment of treatment standards and quality control. At present, no overall standards, guidelines and quality control criteria specifically for the treatment of substance use disorders have been established in Iceland. The Quality Improvement Plan of the Health Directorate foresees the establishment of quality indicators. So far, only SÁÁ has established systematic internal quality control.

While implementation was delayed due to the COVID-19 pandemic, the Directorate continues to be committed to establishing an effective system of quality control that is based on service providers elaborating their quality standards and controls. Limited resources however pose a serious obstacle in the pursuit of this aim. To illustrate this, presently the Directorate has only two quality inspectors overseeing 3000 health care providers and units, as well as having other tasks to perform. This illustrates how resource shortages stand in the way of establishing a quality control system.

In setting treatment standards for substance use disorders it is advisable to use international standards that are relevant to the Icelandic policy context as a starting point.

The Alcohol and Drug Prevention Policy until 2020 explicitly refers to the UNODC/WHO International Standards for the Treatment of Drug Use Disorders. This set of standards stipulates that treatment should be accessible, ethical, evidence-based, and tailored to individual needs, with a focus on coordination between health and social services. Furthermore, it sets out that treatment systems require organised service provision, planning, funding and integration of various service models like community-based networks and sustained recovery management. In terms of delivery of services specific treatment needs for groups such as pregnant women, children, adolescents and those in contact with the criminal justice system shall be taken into account.

The WHO/UNODC treatment guidelines frame overall treatment systems around the following principles:

- Treatment should be accessible, ethical, evidence-based and tailored to individual needs, with a focus on coordination between health and social services.
- Effective treatment systems require organised service provision, planning, funding and integration of various service models like community-based networks and sustained recovery management.
- Specific treatment needs for groups such as pregnant women, children, adolescents and those in contact with the criminal justice system are highlighted.

This requires a reassessment of the waiting times. The Council of Europe Recommendation No. R (99) 21 on criteria for the management of waiting lists and waiting times in healthcare provides further guidance and addresses the following aspects:

Equitable access:
- Principle: Health care access should be based on need, not ability to pay.
- Legal Framework: Aligns with the European Social Charter and the Convention on Human Rights and Biomedicine.
- Non-Discrimination: Ensures no discrimination based on race, sex, religion, or socio-economic status.

Management of waiting lists:
- Strategies: Member states should develop comprehensive strategies to manage waiting lists and waiting times.
- Efficiency: Aim to improve the efficiency of health care systems.
- Monitoring: Regular monitoring and evaluation of waiting lists are essential.

Transparency and criteria:
- Admission criteria: Transparent criteria for admission and prioritisation are crucial.
- Clinical need: Decisions should be based on clinical need rather than socio-economic status.
- Standardisation: Standardised data collection methods should be implemented.

Client information:
- Communication: Service users should be informed about their waiting times and admission dates.
- Support: Provide individualised information and support to patients.
- Access to Information: Ensure patients have access to their position on waiting lists and relevant updates.

The Addiction Severity Index can provide a further important guidance tool in prioritising and managing waiting lists.

Ensuring quality

The Policy for Iceland's Health Services until 2030 states that treatment providers should have core indicators that demonstrate the outcomes of treatment. To ensure high standards, quality benchmarks, indicators and targets should be established in collaboration with healthcare professionals, along with strategies to achieve them. Funding should be conditional upon the production of these core indicators, demonstrating compliance with the required standards. Allocation of funds will then reflect these defined quality standards, with service outcomes made transparent.

In complementarity, the Alcohol and Drug Prevention Policy until 2020 sets out that interventions should be based on evidence and action plans be followed up annually covering activities of the state and municipalities, health care, social services, the education system, NGOs, law enforcement and customs authorities. Furthermore, the Council of Europe Recommendation No. R (97) 17 on the development and implementation of quality improvement systems (QIS) in health care, which requires waiting time policies to be based on transparent criteria, focuses on:

- *Practice Guidelines:* Guidelines should be systematically developed, effectively disseminated and their effects monitored to assist in clinical decision-making.
- *Technology Assessment:* Evidence-based medicine and technology assessment should be applied to improve health care quality.
- *Quality Indicators:* Health-care information systems should use relevant quality indicators to produce timely feedback and reliable data comparisons.
- *Service user's Perspective:* Needs, priorities and experiences should be actively gathered and considered in care provision.
- *Managing Change:* Effective mechanisms and strategies should be in place to manage necessary changes in a planned and inclusive manner.

These policy prerogatives set a starting point for defining quality standards and assessments.

Benchmarks

Benchmarks can be developed on the basis of policy prerogatives, regulatory provisions, professional standards and guidelines. The development of benchmarks should be an integrated part of the process developing national treatment guidelines and standards. As a starting point for these discussions by the concerned stakeholders it is suggested to apply basic principles contained in UNODC/WHO International Standards for the Treatment of Drug Use Disorders:

1. *Comprehensive Assessment:* Conduct thorough assessments to understand the individual's needs, including physical, psychological, and social aspects.
2. *Individual treatment plans:* Require individualised treatment plans that consider the unique circumstances and needs of each person.

3. *Evidence-based interventions*: Utilise treatments that are supported by scientific evidence, such as cognitive behavioural therapy, medication assisted treatment, and contingency management.
4. *Integrated Services:* Ensure coordination between different service providers, including health, social, and criminal justice systems, to provide holistic care.
5. *Continuity of care:* Provide ongoing support and follow-up to maintain recovery and prevent relapse.
6. *Specialised programmes:* Offer tailored programmes for specific populations, such as pregnant women, adolescents and individuals in the criminal justice system.
7. *Family Involvement:* Engage family members in the treatment process to provide additional support and improve outcomes.

Cost–benefit analysis

Financial constraints, rapid developments and fluctuations in economic dynamics requires cost-benefit analysis (CBA) in regular intervals. Cost-benefit ratios of different drug treatment models vary *→ for details see Appendix IV, p. 46*, but studies consistently show that the benefits of treatment exceed the costs.

These ratios highlight the overall economic value of investing in drug treatment programmes by reducing healthcare costs, crime, and lost productivity.

The cost-benefit ratio of addiction treatment varies depending on the type of programme, but studies consistently show that the financial investment in addiction treatment yields significant returns in terms of reduced healthcare costs, lower criminal justice expenses and increased economic productivity. Studies show that programmes like MAT, residential treatment, CBT and contingency management often show returns of € 4 to 7 for every € 1 invested, making addiction treatment not only a critical healthcare intervention but also a sound economic decision.

Conducting CBA

For conducting a detailed CBA, methods used in cost-benefit analysis to ensure consistency and comparability across studies need to be standardised across services and programmes in place. The natural history of addiction and treatment careers can be long, requiring repeated measures that increase the difficulty and cost of the analysis. Conducting a cost-benefit analysis (CBA) for addiction treatment models is an essential but challenging task in healthcare. Addiction treatment varies widely in approach, costs and effectiveness, making it critical to evaluate these models systematically. The aim is to determine the overall cost of treatment (e.g. per treatment day) and the individual or public benefits (e.g. in terms of reduction in health costs, unemployment, law enforcement costs). In cost-effectiveness evaluation, effectiveness is expressed in terms of costs per unit of outcome. Cost–utility evaluation determines the gains in years and quality of life in relation to costs. Cost evaluation and economic evaluation each have their dedicated volume in the WHO/UNDCP/EMCDDA Workbook Cost Evaluation. On a more practical level of applying CBA, the EUDA provides the Drug Abuse Treatment Cost Analysis Program (DATCAP) which is a data collection instrument and cost interview guide designed to be used for all types of treatment providers.

When evaluating addiction treatment models, there are several key cost elements to consider. Direct costs include treatment expenses such as inpatient or outpatient programs, medication, counselling, and non-medical support services like housing or vocational assistance. Indirect costs focus on the broader economic impact, such as lost productivity due to addiction or the costs associated with legal and criminal justice involvement. Opportunity costs—resources used for addiction treatment that could otherwise be allocated elsewhere in the healthcare system—are also relevant.

On the benefits side, healthcare providers must consider various health outcomes. These include improvements in quality of life and reduced mortality rates, often measured through Quality-Adjusted Life Years (QALYs) or Disability-Adjusted Life Years (DALYs). There are also economic benefits, such as lower long-term healthcare expenses due to fewer emergency visits or hospital stays and increased workforce productivity as individuals recover and rejoin society. Social benefits are equally important, including the alleviation of the burden on families, reduced crime rates and enhanced social stability as individuals reintegrate into their communities.

Comparing different addiction treatment models adds further complexity. For example, inpatient treatment programs offer intensive care but come with high upfront costs, while outpatient treatments may be more affordable but require longer commitments. Medication-Assisted Treatment (MAT) combines medication with behavioural therapies, offering a hybrid approach, and harm reduction programs aim to minimize harm (e.g., through needle exchange programs) without necessarily achieving abstinence.

Challenges in conducting a CBA for addiction treatment

One of the main challenges in conducting a CBA for addiction treatment models is quantifying long-term benefits. While many addiction treatments lead to improved outcomes over time, these benefits often materialize years later, making it difficult to assign them a precise monetary value. Additionally, measuring health outcomes—such as QALYs or DALYs—is particularly complicated due to the chronic nature of addiction and the potential for relapse.

Another issue is the availability and quality of data. Incomplete or inconsistent data tracking addiction-related outcomes, such as employment status, legal involvement, or long-term health, can make accurate analysis difficult. Since addiction affects different populations in diverse ways, generalizing results is also challenging.

A major concern in addiction treatment is the inclusion of externalities, or the broader social impact, in the analysis. The societal costs and benefits of treating addiction go beyond the immediate health improvements; they include reduced crime rates, improved public safety and the lessened emotional and financial burden on families. Capturing these indirect effects within a CBA framework is inherently difficult but necessary to fully appreciate the value of addiction treatment programs.

Lastly, the choice of time horizon and discount rate can significantly influence the results. The long-term nature of addiction recovery makes it critical to consider an appropriate time frame, but this also increases the uncertainty of the analysis. Deciding how to discount future benefits and costs to their present value is an additional layer of complexity.

An alternative: CBA ‘Light’ for health care providers

Given the complexities of a full-scale CBA, healthcare providers can use a simplified or ‘light’ version to evaluate addiction treatment models. This approach focuses on key, easily measurable, indicators allowing for a more practical and manageable analysis.

A simplified CBA would start with a basic cost breakdown that includes direct treatment expenses and easily estimated indirect costs, such as the loss of working hours during treatment. Instead of using detailed long-term projections for productivity losses, providers can rely on simple proxy measures. On the benefits side, basic health outcome metrics, such as QALYs or DALYs, can be estimated from existing research, focusing on average recovery and relapse rates. Providers can also track short-term benefits like reduced healthcare utilization by monitoring changes in emergency room visits or hospitalizations post-treatment.

Healthcare providers can also focus on short-term economic gains by tracking employment data—such as s return to work or improvements in job stability after completing treatment. Reduced criminal justice involvement can be measured using straightforward statistics on lower arrest rates or fewer legal costs for those who successfully complete treatment programs. The social impact of addiction treatment can be assessed through brief surveys or qualitative assessments, asking families or communities about improvements in social functioning, community safety or general well-being.

Lastly, a simplified benefit-cost ratio can be calculated using a straightforward comparison of estimated benefits (e.g. reduced healthcare and legal costs) against the direct costs of treatment. This avoids the need for complex, long-term projections while still providing valuable insights into the relative value of different treatment approaches. By focusing on key metrics and reducing the complexity of the analysis, this ‘light’ approach to CBA offers healthcare providers a practical tool for evaluating the cost-effectiveness of addiction treatment models without sacrificing the quality of insights gained.

Fostering client orientation

It is today widely acknowledged that the level and type of client orientation constitute crucial factors in achieving successful treatment and rehabilitation outcome.

Client/patient-led and client/patient-centred care are both approaches that emphasise the role of patients in healthcare, but they differ in terms of the level of control and involvement that patients have in their care.

In client/patient-led care, the service user takes a central role in leading their healthcare decisions and managing their care. This approach is often seen in chronic illness management, where patients become experts in their own condition and make informed decisions about their treatment and lifestyle. Healthcare providers act more as facilitators or partners, providing the necessary information, tools and support to help the patient manage their own care. The patient’s preferences, goals and choices drive the care process. This approach heavily emphasizes patient empowerment, autonomy and self-management. It assumes that the patient has the knowledge and capability to take charge of their health.

Patient-centred care focuses on providing care that is respectful of, and responsive to, individual preferences, needs and values. The goal is to ensure that the clients values guide all clinical decisions. While the healthcare provider may still lead the technical and clinical aspects of care, client/patient-centred care involves the service user in decisions and tailors the care to their preferences and circumstances. There is a strong emphasis on collaboration and communication between the service user and healthcare providers. Client/patient-centred care also tends to consider the whole person, including their physical, emotional, social, and spiritual needs, rather than just focusing on the illness or condition.

In summary, client/patient-centred care ensures that the service user's preferences and needs are central to the care process, with healthcare providers guiding the treatment while involving the service user in decisions. Client/patient-led care on the other hand emphasizes autonomy and self-management, while client/patient-centred care focuses on collaboration and respect for the service user's needs and values.

When developing a client/patient centred or treatment concept, the aims of a drug and addiction policy and the recovery paradigm included therein need to be taken into account together with the views of patients and clients that should be obtained from regular surveys. Appendix V provides examples of recovery paradigms and the structural components of recovery.

Training needs for collaboration

The is a necessity to train professionals from different institutions and professional backgrounds who come together in steering or working groups collaboration cooperation and collaboration skills and competences.

Experience shows that bringing together professionals from different institutions into a multidisciplinary stakeholder group, with the mandate to cooperate and collaborate on a shared goal, is not enough to guarantee success. While setting up such groups and defining terms of reference are important first steps, they do not inherently equip members with the necessary skills to work effectively as a team. Without proper training in collaboration, these groups are likely to encounter difficulties, conflicts, and inefficiencies that hinder their overall performance.

One key reason for this is the diversity of professional cultures within these groups. Healthcare providers, social workers, law enforcement officers, and policymakers often approach problems differently. Their institutional priorities, methods of decision-making, and communication styles vary widely. This can lead to misunderstandings, misaligned expectations, and even friction within the group. Training is essential to bridge these gaps, fostering mutual respect and understanding of each stakeholder's role. It helps professionals learn how to integrate their unique approaches into a coordinated effort, ensuring that the group works as a cohesive unit rather than as disparate individuals.

Another challenge is that stakeholders often come to the table with differing goals and expectations. For example, a health professional may prioritize patient-centred care, while law enforcement might focus on public safety. These competing priorities can pull the group in conflicting directions, making it difficult to achieve shared objectives. Training plays a critical role in aligning these divergent perspectives, helping the group to find common ground and work towards collective goals. It also provides the tools needed to navigate and negotiate competing priorities in a way that strengthens, rather than weakens, the group's efforts.

Effective communication is another area where training is crucial. Professionals in multidisciplinary groups are accustomed to different languages, jargon, and ways of sharing information. These communication barriers can lead to misunderstandings, missed opportunities, and duplicated efforts, all of which reduce the group's efficiency. Training helps team members develop clear communication strategies, ensuring that information flows smoothly and that everyone is on the same page.

Collaborative decision-making is also a common stumbling block for groups that have not received training. The diverse perspectives within a multidisciplinary team can make it difficult to reach consensus or make timely decisions. Without training, decision-making processes can become gridlocked or dominated by a single institution's perspective, leaving other members feeling disempowered or disengaged. Collaborative training equips team members with the skills to make joint decisions in an inclusive and effective manner, ensuring that every voice is heard and that decisions reflect the collective wisdom of the group.

In addition to communication and decision-making, managing conflict is a critical skill that training can provide. Conflict is inevitable in any group setting, especially when members come from different professional backgrounds with varying interests and priorities. Unresolved conflicts can disrupt progress or even lead to the group falling apart. Training in conflict resolution helps team members address disagreements constructively, maintain a positive working environment, and ensure that conflicts are resolved in a way that benefits the group as a whole.

Accountability and coordination are also key elements that can be overlooked when a multidisciplinary group is formed without proper training. Without clear accountability mechanisms, it can be difficult to ensure that everyone is fulfilling their responsibilities or that actions are coordinated effectively. Training helps clarify roles and responsibilities, setting up processes to track progress and hold members accountable for their contributions.
Lastly, multidisciplinary groups often need to adapt to changing circumstances, such as shifts in policies or emerging challenges related to drug and alcohol trends. Without the flexibility to adjust their approaches, these groups can become ineffective over time. Training teaches group members how to work together in a dynamic environment, ensuring that they can quickly respond to new situations and continue to function effectively, regardless of external changes.

In conclusion, setting up a multidisciplinary stakeholder group with a clear mandate is only the first step towards achieving effective cooperation and collaboration. Without training in the essential skills of teamwork, communication, conflict resolution, and adaptability, these groups are likely to encounter significant difficulties that limit their ability to deliver results. Training is not an optional extra but a necessary foundation for building the competence and agility required to navigate the complexities of working together in a multidisciplinary context. Without it, the group's effectiveness and long-term sustainability are at risk. → *Appendix VIII – Training course outline, p. 56*

Appendix I – Stakeholder consultations

List of stakeholders consultations consulted in the context of this review:

Ministry of Health

Health Directorate

Ministry of Education and Children

Hladgerdarkot treatment facility

Krýsuvík treatment facility

Samtök áhugafólks um áfengisog vímuefnavandann (SÁÁ)

Landspitali University Hospital

Parliamentary focus group on drug policy

Reykjavik Welfare Dept

Reykjavik Metropolitan Police

Prison and Probation Administration

Civil society organisations

Appendix II – Follow-up to the alcohol and drug prevention policy until 2020

- *Excerpts from the policy document in italics.*
  - Follow-up information was supplied by the Ministry of Health.

Based on this information, it can be concluded that the scope of alcohol and drug-related problems is significant. Therefore, it is important to strengthen prevention, early intervention, health and social services, rehabilitation, and harm reduction measures concerning the harm caused by consumption to users, their families, and society as a whole. In this way, health can be improved, and the substantial societal costs associated with consumption can be reduced.

Given the scale of alcohol and drug-related problems, it is essential that all procedures related to healthcare services be defined and harmonized. The conditions for success include active collaboration among service providers and a clear division of roles. Therefore, it is suggested that the Ministry of Health appoint a working group with representatives from key stakeholders in the field; from the Ministry of Health, Landspítali, SAk, SÁÁ, the Development Centre for Primary Healthcare in Iceland, the Icelandic Health Insurance, social services, and possibly other parties.

  - A working group like this has not been appointed to date.

- *It is proposed that Iceland collect relevant data using the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) Treatment Demand Indicator (TDI) method or comparable criteria to better assess the need for services at any given time.*

  - This step has not yet been implemented. Iceland is not a member of the European Union Drugs Agency (formerly EMCDDA), and data collection is neither systematic nor standardized. While Icelandic Health Insurance (SÍ) and the Directorate of Health (DH) are legally mandated by the Act on Health Records and the Act on Health Insurance to maintain databases on provided services and agreed-upon quality indicators, the SÁÁ has only recently begun supplying SÍ and DH with the required data.

- *The procedure for assessing individuals' need for services through a diagnostic interview shall be standardized.*

  - This step has not been taken.

- *The criteria and procedures for registering individuals on a centralized waiting list for services shall be standardized. Furthermore, access to services must remain good, and the complexity of seeking services should not increase.*

  - A centralized waiting list for treatment services related to addiction does not exist neither have criteria and procedures for registering individuals on a waiting list for different treatment providers been adopted.

- *The status of waiting lists, along with statistics on services provided, shall be assessed twice a year.*

  - There is no formal procedure in place for conducting such assessments, and it remains unclear which institution holds the responsibility for requesting data from treatment providers. This issue is frequently raised in Parliament through questions directed at the Minister of Health. In response, the ministry typically requests the necessary data from

treatment providers and compiles a formal answer, which is then submitted to Parliament (Althingi).

- *Quality indicators shall be defined so that the quality and effectiveness of treatment can be evaluated (cf. Quality Development Plan for Healthcare Services 2019-2030).*
  - Standardized and centralized quality indicators for treatment services have not yet been established. However, within the framework of an agreement between Icelandic Health Insurance and a service provider, certain quality indicators have been identified, which will be monitored throughout the duration of the agreement.

- *Minimum waiting time standards from the time an individual requests treatment shall be established. Examples could include:*
  - *Contact with a primary healthcare centre on the same day*
  - *Consultation with an alcohol and drug treatment specialist within 14 days*
  - *Access to appropriate treatment within 30 days*
  - *Shorter and different criteria shall apply when children are involved*
  - This has not been established. The general standards that are currently valid for all health care services equally apply for addiction treatment.

- *The implementation of the ASSIST tool, or a comparable tool, in primary care and healthcare institutions shall be pursued to ensure that individuals who only need conversation and support to reduce or quit using alcohol can receive that service, thereby reducing the number of people who need other forms of treatment.*
  - Guidelines for screening alcohol and substance use in primary care have been developed but have not yet been fully implemented across all primary care services. Currently, it is left to the discretion of individual healthcare providers to decide whether or not to conduct such screenings. However, the Development Center for Primary Healthcare in Iceland, in collaboration with the Directorate of Health, is working on expanding health promotion services for elderly individuals in primary care clinics, which will include screening measures for alcohol and substance use/abuse as part of these efforts.

- *The purchase of healthcare services in the field of alcohol and drug treatment shall be based on a service specification outlining the criteria and standards, as well as how to ensure quality and equal access to services regardless of residence, social, and economic factors.*
  - A specification outline was developed based on established criteria and international standards, and Icelandic Health Insurance is currently negotiating a new contract with the SÁÁ for inpatient, outpatient, and rehabilitation services. The criteria are based on the 2020 WHO international standards for the treatment of drug use disorders and the 2021 quality assurance guidelines. Additionally, the Ministry of Health had initiated an evaluation of available healthcare services for individuals with substance use needs. However, due to the COVID-19 pandemic, the ministry's specialists were redirected to more urgent matters for nearly two years, and the assessment was not completed. It was subsequently decided to alter the approach and engage an independent evaluator, preferably from outside Iceland, to carry out the assessment.

Appendix III – Indicators: availability, accessibility and acceptability

The following is a sample list of indicators that can be put to use to assess availability, accessibility and acceptability of treatment offers.

Availability

1. Number of Treatment Facilities
Indicator: Total number of addiction treatment centres within a specified area.
Rationale: Measures the capacity of the system to provide services.

2. Bed Capacity and Utilisation Rates
Indicator: Number of available treatment beds and their occupancy rates.
Rationale: Indicates whether the available resources are sufficient to meet demand.

3. Types of Services Offered
Indicator: Range of services provided (e.g. inpatient, outpatient, detoxification, counselling, medication assisted treatment).
Rationale: Ensures a comprehensive array of treatment options to address various needs.

4. Staff/service user ratios
Indicator: Ratio of healthcare providers (e.g. therapists, doctors) to clients/patients.
Rationale: Ensures adequate staffing to deliver effective care.

Accessibility

1. Geographic Distribution
Indicator: Distribution of treatment services and facilities relative to population numbers in areas.
Rationale: Ensures services are available in locations where there is demand and treatment need.

2. Wait Times for Services
Indicator: Average wait time from initial contact to receiving treatment.
Rationale: Shorter wait times improve access and timeliness of care.

3. Operational Hours
Indicator: Availability of services during nontraditional hours (e.g. evenings, weekends).
Rationale: Increases access for individuals who cannot attend during regular business hours.

4. Transport Accessibility
Indicator: Availability of transportation assistance or proximity to public transport.
Rationale: Reduces transportation barriers to accessing treatment.

5. Use of E-health Services
Indicator: Availability of online treatment offers and percentage of clients/patients using these for consultations and follow-up.
Rationale: Enhances access, especially for remote communities or mobility impaired patients.

Acceptability

1. Service user satisfaction scores
Indicator: Satisfaction levels from service user surveys regarding their treatment experience.
Rationale: Reflects how well the services meet service user expectations and needs.

2. Cultural competency
Indicator: Availability of culturally sensitive and language appropriate staff/services.
Rationale: Ensures that services are respectful and responsive to cultural and linguistic needs.

3. Stigma and discrimination levels
Indicator: Reports of stigma or discrimination experienced by service users.
Rationale: Measures the inclusivity and respectfulness of the treatment environment.

4. Service user Engagement and Retention Rates
Indicator: Rates of engagement and retention in treatment programmes.
Rationale: Higher engagement and retention indicate that services are acceptable and valued by patients.

5. Complaint procedures
Indicator: Number and nature of patient complaints and how they are resolved.
Rationale: Reflects the system's responsiveness to patient concerns and its commitment to continuous improvement.

Appendix IV - Evidence-based treatment models and their cost benefit ratios

The cost-benefit ratio of addiction treatment programmes refers to the economic value gained from treating substance use disorders compared to the costs of the treatment itself. Effective addiction treatment not only helps the individual but also reduces healthcare costs, criminal justice expenditures and lost productivity. Below are examples of cost-benefit ratios for various addiction treatment programmes, based on research and available data.

The figures for cost are based on studies from Europe and North America between 2019 and 2022.

The Drug Abuse Treatment Cost Analysis Program (DATCAP) developed by the EUDA is a data collection tool designed for use by various treatment providers to gather resource use and cost information for specific programs. It supports both self-evaluation by treatment programs and cost-effectiveness or benefit-cost analyses by researchers. DATCAP can be customized for different types of programs, including mental health clinics and outpatient drug abuse centres. After collecting the necessary data, DATCAP generates total annual cost estimates for individual categories, the overall program, and the average client.

Medication assisted treatment (MAT)

Programmes using medications like methadone, buprenorphine (Suboxone), or naltrexone for opioid addiction.

Cost of Treatment: On average, € 4,000 to 6,000 per year for outpatient MAT services.

Benefits:

- Reduces crime related to opioid addiction.
- Prevents overdose deaths.
- Lowers healthcare costs, particularly emergency care and hospitalisation costs.
- Increases productivity by reducing relapse and improving employment rates.

Cost-benefit ratio: For every € 1 spent on MAT, estimates suggest a return of € 4 to 7 in reduced healthcare costs and increased productivity.

Cognitive behavioural therapy (CBT)

CBT programmes for alcohol and drug addiction typically involve short-term, structured counselling aimed at behaviour change.

Cost of Treatment: average between € 1,500 to 3,000 for a 12-week outpatient programme.

Benefits:

- Reduced healthcare visits and hospitalisations.
- Decreased accidents, including motor vehicle crashes.
- Increased productivity by improving workplace performance and reducing absenteeism.

Cost-benefit ratio: For every € 1 spent on CBT for alcohol addiction, studies show a return of € 6 to7 in reduced healthcare costs, decreased legal costs, and increased work productivity.

12-step Programmes (outpatient)

12-step programmes, as used by Alcoholics Anonymous (AA) and Narcotics Anonymous (NA), are free or low-cost as they are run by support groups.

Cost of Treatment: free when delivered outside inpatient rehabilitation.

Benefits:

- Reduced relapse rates.
- Enhanced social support, which is crucial for long-term recovery.
- Decreased criminal activity and costs related to the legal system.

Cost-benefit ratio: On outpatient level 12-step programmes can lead long-term recovery outcomes, potentially saving € 5 to7 for every Euro spent on support services.

Residential care / Inpatient rehabilitation

Residential rehabilitation programmes involve long-term stays in a facility that provides intensive treatment and therapy for substance use disorders.

Cost of treatment: € 10,000 to 30,000 per month, depending on the facility and level of care.

Benefits:

- Significant reduction in relapse rates, especially for severe addictions.
- Decreased healthcare costs associated with emergency room visits and long-term medical care.
- Minimised criminal activity and increases long-term productivity.

Cost-benefit Ratio: For every €1 spent on residential treatment, studies estimate a return of € 4 to7 in reduced healthcare costs and increased societal benefits such as lower criminal justice expenses.

Contingency Management (CM)

CM uses rewards or incentives (e.g. vouchers, cash prizes) to encourage drugfree behaviour in individuals recovering from stimulant addiction (e.g. methamphetamine or cocaine).

Cost of Treatment: The cost of the incentives can range from €500 to 1,500 over a 12-week programme.

Benefits:

- Reduces relapse rates and increases the likelihood of continued abstinence.
- Lowers the cost of emergency room visits and healthcare for drug-related issues.
- Increases the individual's ability to maintain employment and contribute to the economy.

Cost-benefit Ratio: For every €1 spent on contingency management, the return on investment is estimated to be €3 to 5 in reduced healthcare costs and increased productivity.

Outpatient Treatment Programmes (Intensive Outpatient Programmes IOP)

IOPs offer structured treatment while allowing the individual to live at home and continue working or attending school.

Cost of Treatment: €3,000 to 10,000 for a typical programme lasting 8 to 12 weeks.

Benefits:

- Reduces the need for more expensive inpatient treatment.
- Improves overall health outcomes by providing flexible yet structured care.
- Allows individuals to maintain employment and family responsibilities.

Cost-benefit ratio: For every €1 spent on outpatient treatment, the return is approximately €2 to 5 in reduced healthcare costs and improved employment outcomes.

Therapeutic Communities (TCs)

Long-term residential programmes (6 to 12 months) that focus on behaviour modification, social reintegration and the development of life skills.

Cost of treatment: €20,000 to 40,000 per year.

Benefits:

- Reduces relapse rates significantly for individuals with chronic or severe addiction.
- Lowers criminal activity and incarceration costs, as many therapeutic communities work with individuals coming out of the criminal justice system.
- Improves long-term employment and social reintegration.

Cost-benefit ratio: For every €1 spent on therapeutic communities, the return is estimated to be €4 to 8 in terms of reduced legal system costs, healthcare savings and improved productivity.

Brief Interventions and referral to treatment (SBIRT)

A cost effective, early intervention approach where healthcare professionals screen individuals for risky substance use and provide brief counselling and referral to treatment if necessary.

Cost of treatment: Approximately €200 to 400 per session.

Benefits:

- Prevents the development of more severe substance use disorders.
- Reduces future healthcare costs by addressing substance use issues early.
- Decreases alcohol and drug-related accidents and injuries.

Cost-benefit ratio: For every €1 spent on SBIRT, the return is estimated at €3 to 4 in reduced healthcare costs and increased productivity by preventing future addiction-related issues.

Appendix V – Elaborating a recovery paradigm

A defined recovery paradigm in an alcohol and drug policy is essential as it provides clarity, structure and direction for addressing substance use and its impact. It establishes a clear vision for how addiction and recovery are understood and managed, ensuring all stakeholders have well-defined roles and responsibilities. This clarity helps align efforts across different sectors, promoting collaboration between medical, psychological, social and legal entities. A cohesive recovery framework ensures consistent policy implementation, prevents ad hoc decisions and supports the holistic recovery of individuals by addressing their physical, emotional and social needs.

An agreed understanding of recovery also sets ethical and legal guidelines for treatment, confidentiality and individual rights, providing a basis for fairness and legal compliance. By defining stakeholder responsibilities, the recovery paradigm enhances coordination, minimizes conflicts or misunderstandings and ensures that interventions are tailored to specific populations. Furthermore, it creates supportive environments, especially in workplaces, where employers are encouraged to assist in reintegrating recovering individuals. Finally, it aids in the efficient allocation of resources, ensuring that funding, personnel and time are effectively distributed across healthcare services, rehabilitation and community support, leading to better recovery outcomes.

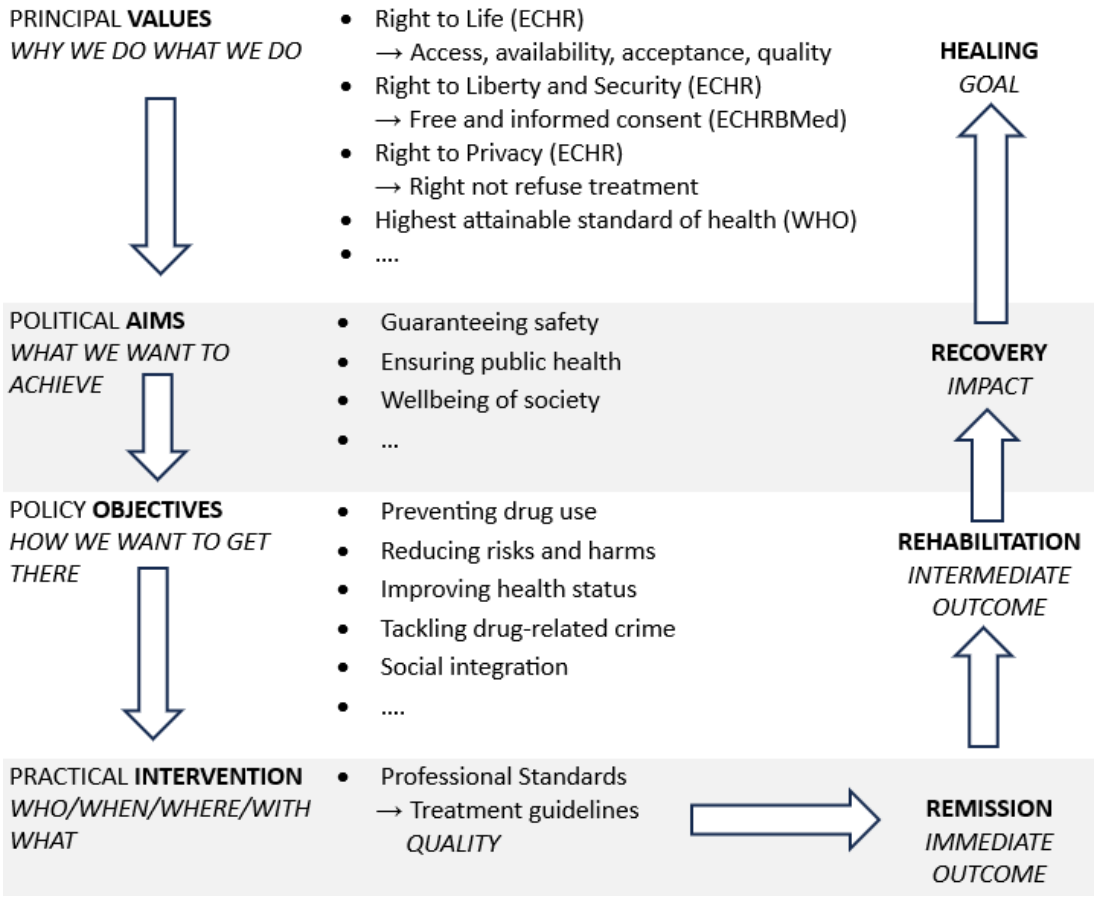
In addiction treatment, ‘recovery’, ‘remission’ and ‘rehabilitation’ are terms used to describe different stages or aspects of the process individuals go through to overcome substance abuse disorders. These are frequently interchangeably used. The following is suggested as workable explanation of each:

Recovery: Recovery refers to the ongoing process of change through which individuals strive to improve their overall well-being and live a fulfilling life without substance abuse. It involves not only abstaining from substance use but also addressing underlying issues that may have contributed to addiction, such as mental health disorders, trauma or social challenges. Recovery is often seen as a lifelong journey characterized by personal growth, self-awareness and maintaining a healthy lifestyle.

Remission: Remission typically refers to a period during which symptoms of addiction are significantly reduced or absent. It's often used in the context of clinical diagnosis to describe a state where the individual no longer meets the criteria for a substance use disorder. Remission can be partial or complete. Partial remission indicates that some symptoms are still present but not as severe as before, while complete remission suggests the absence of all symptoms. It is important to note that remission doesn't necessarily mean the individual is fully recovered, as the risk of relapse or recurrence of symptoms remains.

Rehabilitation: Rehabilitation focuses on helping individuals recover from the effects of substance abuse and regain functioning in various areas of life, such as social, occupational and personal domains. It involves a structured programme of therapy, counselling, education and support services tailored to the individual's needs. The goal of rehabilitation is to equip individuals with the tools and coping strategies necessary to maintain abstinence, manage cravings and rebuild their lives after addiction.

Systematic pathway in development of a recovery paradigm:



Examples of recovery paradigms:

United States: The Substance Abuse and Mental Health Services Administration (SAMHSA) in the United States defines recovery as 'a process of change through which individuals improve their health and wellness, live self-directed lives and strive to reach their full potential.'

United Kingdom: The UK's National Institute for Health and Care Excellence (NICE) describes recovery as 'a process of sustained action that addresses the biological, psychological, social, and spiritual disturbances inherent in addiction.'

Australia: The Australian National Council on Drugs (ANCD) emphasizes the importance of recovery-oriented systems of care, which focus on 'supporting and facilitating an individual's journey towards recovery, acknowledging that recovery is a deeply personal experience.'

Canada: The Canadian Centre on Substance Use and Addiction (CCSA) defines recovery as 'a process of change through which individuals improve their health and wellness, live self-directed lives and strive to reach their full potential, often while working towards overcoming the effects of addiction.'

Netherlands: Trimbos Institute, the leading Dutch centre for mental health and addiction research, defines recovery as 'a personalized process of learning to live a meaningful life beyond the limitations imposed by addiction, which may involve shifts in identity, values and relationships.'

New Zealand: The New Zealand Drug Foundation emphasizes the importance of holistic recovery, which involves 'addressing not only the symptoms of addiction but also the

underlying causes and broader social determinants, such as housing, employment and community support.'

Sweden: In Sweden, the Swedish Council for Information on Alcohol and Other Drugs (CAN) promotes a vision of recovery that focuses on 'empowering individuals to take control of their lives, build meaningful connections with others and contribute positively to society.'

These examples illustrate how the concept of recovery from addiction is understood and defined in different societies with common themes of empowerment, personal growth, holistic well-being, and social integration. However, the specific language and emphasis varies based on cultural, social, and policy contexts.

Appendix VI – Resources and tools

Council of Europe criteria on the development and implementation of quality improvement systems (QIS) in health care

Council of Europe criteria for the management of waiting lists and waiting times in healthcare

EUDA Guidelines for the evaluation of treatment in the field of problem drug use

EUDA Handbook on quality standards for interventions aimed at drug experienced young people in contact with criminal justice systems (EPPIC)

EUDA Problem drug use indicator (DDU)

EUDA Rapid Assessment and Response Methods

EUDA Treatment Demand Indicator (TDI) standard protocol 3.0

EUDA Treatment Costs Analysis Program (DATCAP)

EUDA Treatment Perceptions Questionnaire

European Court of Human Rights (ECtHR) Case law on health

SAMHSA EBT kit - Evaluating integrated treatment for co-occurring disorders

Pompidou Group self-assessment on human rights in drug policy (pdf)

Pompidou Group online tool for self-assessment of drug policy compliance with human rights standards

Pompidou Group drug risk test for substance users
UNODC/WHO International Standards for the Treatment of Drug Use Disorders

WHO/UNDCP/EMCDDA Workbook Cost Evaluation

Appendix VII – EU programmes

Iceland, being a member of the European Economic Area (EEA) can engage in and directly benefit in terms of funding from the following EU initiatives related to public health:

EU4Health Programme (2021-2027)
Iceland can benefit from the EU4Health programme, the EU's largest public health initiative, designed to strengthen health systems, promote innovation in healthcare, and improve health outcomes across Europe. The programme provides funding for projects aimed at disease prevention, health promotion, access to healthcare, and crisis preparedness, such as during the COVID-19 pandemic.

Horizon Europe (2021-2027)
This programme supports health research and innovation, providing funding for medical research, development of new health technologies, and addressing major health challenges such as pandemics, chronic diseases, and digital health innovations.

European Social Fund Plus (ESF+)
Although primarily focused on employment and social inclusion, the ESF+ includes components relevant to public health, such as improving access to healthcare and social services, reducing health inequalities, and promoting social inclusion for vulnerable groups. Icelandic organisations working in these areas can participate in relevant projects funded by ESF+.

Digital Europe Programme
This programme aims to promote digital transformation, including in healthcare. Iceland can benefit from initiatives related to health data, digital health services, and digital innovation in the health sector, such as telemedicine, AI in healthcare, and cross-border health data sharing.

European Innovation Council (EIC)
Under Horizon Europe, the EIC supports innovative health startups and small businesses, allowing Icelandic companies or researchers to receive funding for projects that advance healthcare solutions, medical technologies, and treatments.

EU Health Security Framework
Through EEA membership, Iceland can also participate in the EU Health Security Committee, benefiting from initiatives to improve cross-border health crisis preparedness, such as pandemic response coordination, early warning systems, and stockpiling of medical supplies.

Joint Action Programmes on Health
Iceland can take part in Joint Actions, which are initiatives co-funded by the EU and participating countries to tackle specific health challenges. Topics may include rare diseases, vaccination, antimicrobial resistance, and mental health.

Appendix VIII – Training course outline

This outline balances theoretical learning, practical exercises, and teambuilding activities to create a holistic approach to enhancing collaboration in drug and alcohol addiction treatment.

Title: Building collaborative competencies for effective substance use disorder treatment services

Training duration: 4 Days (residential)

Target audience: Professionals from various institutions (healthcare providers, social services, law enforcement, NGOs, policymakers) involved in drug and alcohol addiction treatment rehabilitation.

Overall aim: To build and enhance skills for interinstitutional collaboration in delivering effective and coordinated treatment responses to drug and alcohol addiction, while ensuring flexibility, adaptability, and accountability in dynamic sociopolitical environments.

Day 1: Introduction to collaborative addiction treatment frameworks

Morning: Setting the context and foundations

1. Welcome, course objectives, and expectations
   Introduction to course structure and aims
   Understanding participant expectations
2. Introduction to drug and alcohol addiction treatment landscape
   Overview of addiction trends and key challenges
   Importance of interagency collaboration in addressing addiction holistically
3. Understanding policy structures and levels
   International political and legal instruments (e.g., UN, Council of Europe)
   National policies and frameworks
   Institutional approaches and organisation of service provision

Afternoon: Policy analysis and stakeholder mapping

1. Force-field analysis in drug policy
   Understanding how policies respond to changing trends
   Case study analysis: Force-field analysis of a national drug policy
   Group exercise: Develop and present forcefield analyses of selected policies.
2. Stakeholder analysis for service delivery
   Understanding stakeholders (role, mission, contribution, limitations)
   Assessing stakeholders' influence, interests, and involvement
   Practical group work: Mapping stakeholders for the national treatment system.

Evening Session: Informal networking

Interactive networking session to build rapport among participants.

Day 2: Operational challenges and cooperation

Morning: Addressing resource constraints

1. Working under resource and capacity constraints
   Best practices for resource allocation, quality assurance, and sustainability.
   Case study: Resource constrained environments and how services were adapted to ensure

access and quality.
Group discussion: Strategies for managing limited resources.

2. Dealing with unintended consequences in service delivery
Identifying and managing unintended and adverse effects emerging in the work (e.g., criminalisation, stigma, displacement of addiction)
Roleplay exercise: Resolving policy induced problems in hypothetical cases.

Afternoon: Building collaborative skills

1. Cooperation, collaboration, cocreation: Frameworks and Practices
Introduction to different models of cooperation and their effectiveness in addiction treatment.
Practical activity: Simulated cocreation session on designing an intervention plan

2. Collaborative Management
Tools and techniques for leading and managing multidisciplinary teams.
Discussion: Leadership styles that foster collaboration.

Evening Reflection: Group debriefing
Participants reflect on key insights and takeaways from the day's activities.
Open floor discussion on real world examples from participants' experiences.

Day 3: Conflict management and communication

Morning: Conflict prevention and resolution

1. Understanding and anticipating conflicts in collaborative settings
Common sources of conflict (resource competition, organizational culture clashes)
Conflict prevention strategies: Building trust, fostering transparency
Group exercise: Conflict resolution roleplays based on real world scenarios.

2. Collaborative Problem Solving and Decision Making
Tools for joint problem solving and decision making
Case study: Resolving conflicts within a collaborative drug treatment project.

Afternoon: Communication strategies for effective collaboration

1. Communication in Formal and Informal Formats
Techniques for effective communication across different stakeholder groups
Managing meetings, reporting, and conveying feedback
Practical exercise: Designing a communication strategy for a collaborative team.

2. Agile and Adaptive Communication in Changing Situations
Handling communication during emergencies or changes in policy or social context
Case study analysis: Communication breakdowns in collaborative responses and lessons learned.

Evening Activity: Team building activity

Day 4: Managing change and ensuring accountability

Morning: Managing change in addiction treatment services

1. Understanding and leading organisational change
Theories of change management in healthcare and social services.
How to ensure service continuity during transitions.
Workshop: Developing change management plans for hypothetical changes (e.g., funding cuts, policy shifts).

2. Ensuring accountability in collaborative projects
Monitoring and evaluation frameworks for joint programs.

Tools for tracking progress and accountability in multiagency projects.
Case study: Reviewing accountability mechanisms in past collaborative projects.

Afternoon: Practical application and wrap up

1. Group Simulation Exercise: Developing a Collaborative Action Plan
   Participants will be divided into groups to simulate the design and implementation of a comprehensive, collaborative drug and alcohol addiction treatment response for a hypothetical community.
   Emphasis on stakeholder engagement, resource management, conflict resolution, and accountability.
2. Course Conclusion and Certification
   Summary of key learnings and takeaways.
   Open discussion: Participants share their personal action plans for applying the lessons learned in their own work environments.
   Distribution of certificates.

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