Knowledge in practice

The feasibility of recovery capital in Swedish alcohol and other drug treatment

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Abstract
The recovery model, endorsed by various governmental bodies, emphasises the integration of a recovery perspective into alcohol and drug policy, with a focus on post-treatment interventions such as housing, employment and education needs. In an effort to enhance the utility of the recovery perspective in treatment, the concept of recovery capital (RC) has been used as a foundation for operationalisations used to measure treatment needs and progress. While other countries have embraced the recovery model and RC in alcohol and other drug (AOD)-related policy and treatment, the treatment setting in Sweden has not undergone a comparable transformation. This dissertation aims to explore the feasibility of implementing RC in Swedish AOD treatment. It examines the transferability and applicability of assessment tools and considers the challenges of translating research into practice. This involves delving into the complexities of knowledge transfers, production and use in order to bridge the gap between research findings and practical implementation.

The feasibility study involved qualitative interviews with AOD treatment professionals to gather their perspectives on the applicability of an RC-based assessment tool (Papers II and III). Insights into feasibility were also obtained from a quantitative study assessing treatment progress in individuals residing in a recovery residence in Florida, USA, using an established RC-based assessment tool (Paper I). To further evaluate the target setting for the feasibility study, the use of a locally developed assessment tool was explored through a deviant case analysis (Paper IV). The dissertation’s theoretical framework is built upon conceptualisations of standardisations and professions that emphasise their interconnected nature and thereby underscore the significance of their relationship in the analysis of knowledge production and use, thus situating the study within a broader theoretical discourse on the interplay between standardisation and professionalism.

The findings confirm the applicability of the RC concept in Swedish AOD treatment by highlighting its unique benefits in exploring diverse recovery pathways to address individual challenges and strengths. However, it is evident that certain elements of its conceptual framework are already implemented in the treatment facilities visited in the study. Furthermore, whether or not to use standardised assessment tools to implement RC in Swedish AOD treatment remains unclear. The dissertation also emphasises the importance of collaborating with professionals during the development of assessment tools as a way of ensuring that these tools align with the cultures and structures of the social work profession, presenting this collaboration as an approach to bridging the gap between research and practice. It also identifies a significant knowledge gap in locally produced knowledge, urging further research to map its extent and evaluate its impact on current and future knowledge production and use in social work. Lastly, the absence of client participation is acknowledged. The need for future research to explore the client perspective is emphasised, given the potential adverse effects of recovery-oriented interventions on clients.

Keywords: the recovery model, recovery capital, alcohol and other drug treatment, assessment tools, feasibility study, transferability, applicability, jurisdiction, social work practice.
KNOWLEDGE IN PRACTICE

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Sofia Härd
Till mamma och pappa
Förord


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List of publications


IV. Härd, S. Methodological lucidity or relevance? A deviant case analysis of a locally developed assessment tool used in a psychiatric and addiction clinic in Stockholm, Sweden. (Submitted).
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Introduction

The recovery model, increasingly advocated by various governmental bodies (HM Government, 2010; Inter-Ministerial Group on Drugs, 2012; Scottish Government, 2018; Substance Abuse and Mental Health Services Administration [SAMHSA], 2023), prioritises the adoption of a recovery perspective in alcohol and other drug (AOD) policy, with the goal of integrating it into treatment practices. In response to findings suggesting that treatment effects tend to diminish over time (Miller & Miller, 2009), the recovery perspective in policymaking places great emphasis on post-treatment interventions. Consequently, it has underscored the importance of addressing housing, employment, and education needs. Furthermore, the recognition of the role played by family and social surroundings has resulted in the inclusion of broader societal resources in the treatment process (SAMHSA, 2023).

One approach aimed at operationalising the recovery perspective in AOD treatment is the concept of recovery capital (Cloud & Granfield, 2008), hereafter RC, which has proven to be analytically useful in assessing treatment needs and evaluating treatment progress. This approach has given rise to the development of several assessment tools based on RC, designed for measuring treatment progress and outcome. The current body of evidence on RC in practice primarily revolves around these assessment tools, with limited observations of experiences of using them in treatment (Best & Hennessy, 2022). Unlike other countries where there have been advancements in the integration of the recovery model and RC in AOD treatment, Sweden has not seen similar developments or changes in policy or practice in this regard. Yet although a medical perspective on AOD-related problems has recently influenced Swedish policy in the AOD field, a broad perspective rooted in social work and bearing implicit similarities to the concept of RC has dominated the treatment system for decades (Stenius, 2017). Therefore, this dissertation aims to explore the feasibility of both the concept of RC and its operationalisations in Swedish AOD treatment.

Studying the preconditions for using RC both conceptually and operationally in Swedish AOD treatment involves assessing the applicability of an assessment tool. Assessment tools constitute a category of knowledge that can be transferred to various contexts: a process that can be denoted as knowledge transfer. The knowledge transfer process, particularly when involving a pre-established assessment tool, raises questions of transferability, applicability
and feasibility. An existing body of research dedicated to the examination of transferability and applicability gives rise to two key ideas. Firstly, alongside psychometric properties and validity, it is important to consider the cultural and contextual conditions in which a given method or tool is applied (Bergmark et al., 2018; Greenhalgh et al., 2004; Guberman et al., 2007). Secondly, the exploration of cultural and contextual conditions is most effectively undertaken through consultations with professionals and other stakeholders (Burton & van den Broek, 2009; Smith & Collin-Jacques, 2005; Strydom & Schiller, 2019).

In essence, this issue revolves around the challenge of translating research into practice, a discourse inherently intertwined with the concept of evidence-based practice (EBP). EBP is characterised by the overarching goal of increasing the impact of research in practice through the utilisation of research-based standardised methods and tools. Nevertheless, the effort to improve practice-related outcomes through policy and research has shown itself to be a complex and intricate project. For instance, the implementation of standardisations is sometimes motivated by the idea that they can increase the professional status of the social work profession (Gambrill, 2011). This type of reasoning has also been observed among practitioners themselves (Cumming et al., 2007; Nilsson & Sunesson, 1988). Yet research has found that standardisations, by disturbing the conversation between client and professional, reduce discretion, something which negatively impacts the legitimacy of the profession (Falkenström & Hjärpe, 2017; Martinell Barfoed, 2014).

Consequently, and partly due to this inherent dilemma, research-based tools and methods do not always align with practical contexts, and are at times employed in ways that deviate from their original intent (Bergmark & Lundström, 2008; Bergmark et al., 2018; Björk, 2016; Høybye-Mortensen, 2015; Karlsson & Bergmark, 2012; Nordesjö et al., 2020). Some are concerned that this type of tinkering may reduce the effect of research-based standardisations (Bond & Drake, 2020; Corbière et al., 2010; Sundell et al., 2016), while others argue that it is a way to ensure that a method or tool remains applicable and relevant when travelling between different local contexts (Damschroder et al., 2009; Durlak & DuPre, 2008; Mol, 2006; Sletten & Bjorkquist, 2020; Timmermans & Epstein, 2010).

Transferring research into practice, therefore, extends beyond looking at evidence of what works and the outcomes of psychometric tests. To be effective in practical settings, an evaluation that considers practical and contextual factors, along with professional insights, is imperative. But it is also vital to contemplate how these tools are developed, as the development process influences their applicability in practice. Because of this influence, it is essential not only to evaluate knowledge use but also to consider knowledge production when examining the translation of research into practice.

The process of transferring research into practice can be broken down into two key components: knowledge production and knowledge use. This division
lies at the core of an ongoing scholarly discussion that explores how research-based tools are created and how they are practically and contextually applied. This ongoing debate encompasses diverse perspectives and sheds light on the complexities inherent in bridging the gap between research findings and their application in practice.

Research suggests that the concept of RC may be conductive to AOD treatment, primarily relying on observations regarding quantifications of RC. Nevertheless, RC in practice and policy requires both conceptual and empirical development (Best & Hennessy, 2022). In addition, it remains unclear whether RC can be deemed applicable in Swedish AOD treatment. To investigate this question, consideration must be given to the challenges associated with the transfer of knowledge between different geographical and political domains, as well as the challenges linked to the translation of research into practice.

Aim and research questions

The aim of this dissertation is to explore the feasibility of implementing both RC as a concept and operationalisations of RC in Swedish AOD treatment. The dissertation also seeks to contribute to the ongoing debate on knowledge production and use in social work. Exploring feasibility requires a deeper understanding of both the concept of RC and its operationalisations. This is achieved by analysing recovery progress in a sample of individuals in residential treatment using an established RC-based assessment tool. To further explore feasibility, the preconditions for using an RC-based assessment tool in a Swedish treatment context are examined from the perspective of social work professionals. Local knowledge production is also explored in order to gain a deeper understanding of the target setting. The research questions of this dissertation are:

1. As assessed by a recovery capital-based tool, which recovery capital factors are associated with treatment progress? (Paper I)
2. What are the preconditions for using a recovery capital-based assessment tool in a Swedish alcohol and drug treatment context, from the perspective of social work professionals? (Papers II and II)
3. How do professionals working with a locally produced assessment tool describe the use of the tool in relation to the tension between evidence and relevance? (Paper IV)
Delineations

Knowledge production in social work ultimately aims to enhance the services provided by social work professionals, with the underlying ambition of improving conditions and outcomes for their clients. While acknowledging the significance of incorporating the client’s voice, the focus in this dissertation was on studying the perspective of social work professionals. Therefore, the research design and methodology were primarily focused on contributing to an understanding of social work professionals’ practices and knowledge use.

Disposition

This dissertation is divided into six main chapters. Following the introductory chapter, the second chapter outlines a comprehensive background to the aim and research questions of the dissertation. This involves reviewing progress made in the recovery perspective since the turn of the century, with a particular focus on the emergence of RC operationalisations. This chapter also explores previous research on transferability and applicability and outlines different perspectives on knowledge production and use in social work.

The third chapter provides an overview of the theoretical framework that underlies this dissertation. It outlines the dissertation’s core concepts and how they are understood within this context. The fourth chapter describes, the research design, method and materials employed in each study. The fifth chapter summarises the findings and contributions of the papers written within the framework of this dissertation.

Lastly, the sixth chapter analyses and interprets the research findings in relation to previous research and the core concepts. This chapter also highlights the key contributions made and addresses some practical implications of the dissertation’s findings.
Background and previous research

This chapter introduces the scholarly contributions that underpin the rationale for this dissertation. The first sections explore the concepts of recovery in the AOD field and of RC, shedding light on their current practical applications. Next, the chapter presents perspectives and previous research on transferability and applicability. An underlying objective of this dissertation is to engage in the contentious discussion surrounding knowledge production and use in social work. Therefore, it is crucial to provide a comprehensive review of prior research and explore the diverse perspectives that have contributed to this ongoing discussion. The final section, therefore, delves into perspectives and previous research concerning knowledge production and use in social work practice.

Recovery and recovery capital

Defining recovery

As the recovery perspective gained prominence in AOD policy, growing need arose to define the concept of recovery. One thing that all definitions share is the notion that recovery goes beyond mere sobriety or substance use control to encompass aspects pertaining to physical and emotional health, well-being and active social engagement.

The Betty Ford Institute Consensus Panel (BFICP) (2007) argues that it is not primarily clients who require a unanimous definition, but rather, that a shared definition is important for practitioners, politicians and scholars in the recovery field. In collaboration with recovery scholars, advocates for recovery, and politicians in the AOD area, the BFICP suggests that recovery amounts to ‘a voluntarily maintained lifestyle characterised by sobriety, personal health, and citizenship’ (Betty Ford Institute Consensus Panel, 2007, p. 222).

Sobriety, health and citizenship also feature in another much-used definition by White (2007), who describes AOD recovery as ‘sobriety (abstinence from alcohol, tobacco and unprescribed drugs), improvements in global health (physical, emotional, relational and ontological – life meaning and purpose)
and citizenship (positive participation in and contributing to communal life)’ (White, 2007, p. 16).

One key distinction between the aforementioned definitions lies in their approach to voluntariness, which can, to some extent, be thought of as motivation – a critical factor for both initiating and maintaining a recovery process (Timpson et al., 2016). A comparable definition, emphasising the significance of voluntariness, is offered by the UK Drug Policy Commission (UKDPC) (2008). It defines AOD recovery as ‘voluntary sustained control over substance use which maximizes health and well-being and participation in the rights, roles and responsibilities of society’ (UK Drug Policy Commission, 2008, p.6). This definition diverges from those already mentioned in its approach to the meaning of sobriety. Both White and the BFICP imply that recovery necessitates strict abstinence from alcohol and drugs, while the UKDPC suggests that recovery involves exercising control over substance use.

In recent years, there has been a shift in the way AOD recovery is defined. Unlike earlier definitions that primarily focused on achieving sobriety, more recent contributions emphasise a broader perspective that centres on overall well-being. Ashford et al. (2019) encapsulate this viewpoint by defining recovery as ‘an individualised, intentional, and relational process involving sustained efforts to improve wellness’ (p. 183). Similarly, the Substance Abuse and Mental Health Services Administration (SAMHSA) (2023) characterises 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’ (p. 7).

Finally, it is important to note that the concept of recovery varies in its interpretation and definition across different scientific fields. For instance, distinctions exist between the field of mental illness and that of AOD (e.g., Corrigan et al., 2019).

Recovery capital

In the field of AOD, recovery capital – RC – is a term used to describe and understand recovery. RC aims to highlight resources, or capital, that can be utilised to ‘initiate and maintain a successful recovery’ (Cloud & Granfield, 2008, p. 1973). While different understandings of the term have emerged since it was first introduced, it was initially conceived as comprising social capital, cultural capital, physical capital and human capital. Social capital means not just emotional support but the social relations that create expectations from and obligations towards the social surrounding of an individual. Physical capital includes money, and thus resources such as insurance and the ability to finance professional treatment, but also the ability to relocate and change the physical environment if necessary to support recovery. Human capital in-
cludes resources that in various ways support and promote the client as a member of society, such as knowledge, education, mental health and vocational abilities. Cultural capital consists of resources that can be used in relation to an individual’s social surroundings and thus includes cultural norms as well as the ability to act according to them. The underlying assumption is that individuals in recovery need to go through substantial changes, and those changes are only possible if allowed and encouraged by their surroundings. Accordingly, cultural capital depends on the characteristics of an individual’s social environment (Cloud & Granfield, 2008).

Since Cloud and Granfield presented their concept of RC, other conceptualisations have emerged. White and Cloud (2008), for example, argued that RC should be divided into three types of capital: personal capital, social capital and community capital. Personal capital aligns with Cloud and Granfield’s (2008) physical capital and human capital. Community capital has to do with degree of integration in society and can thus be compared to cultural capital. Social capital includes, besides family and other relationships, relationships with conventional institutions such as schools and workplaces (White & Cloud, 2008).

The recovery model in policy

The expansion of a recovery perspective in the area of AOD has led to less focus being directed towards reducing symptoms of problems (Sterling et al., 2008). Motivated by the argument that treatment effects seem to decrease over time (Miller & Miller, 2009), the recovery perspective in policy involves post-treatment interventions, which, in turn, has highlighted the need for housing, employment and education. Further, the recognition of the importance of the family and social environment has resulted in the inclusion of additional societal resources in the treatment process. This means that in policy, the recovery perspective has meant the need for a broader spectrum of welfare resources such as aftercare, housing and education (Best et al., 2017).

Researchers have observed that translations of the recovery perspective between different geographical domains have produced different outcomes for different treatment systems (Best et al., 2017). That is, political and social aspects influence how the recovery perspective is translated. The recovery perspective has not been as widely adopted in Sweden and the other Nordic countries as it has been in the US and the UK (Stenius, 2017). Differences also exist between the US and the UK in how recovery is enacted in policy. More specifically, the US has a more embracing stance towards the recovery perspective compared to the UK (Best et al., 2017). This suggests that a number of factors lie behind the different levels of adoption of the recovery perspective.
Recovery capital in treatment settings

Because of its emphasis on resources, RC in practice entails a strength-based treatment model and is believed to influence attitudes among those undergoing treatment by cultivating more hope and positive expectations for the future (Best et al., 2017). White and Cloud (2008) argue that RC in practice also entails more individually adjustable AOD-related treatment and support, compared to more traditional treatment methods and strategies. Accordingly, treatment resources should be directed towards those with lower levels of RC, while those with higher levels of RC should be encouraged to use those resources to initiate and maintain a recovery process. Further, in evaluating treatment needs, the focus should be on mapping out an individual’s strengths rather than barriers. It has also been argued that, in addition to helping evaluate treatment needs, operationalisations of RC also possess therapeutic qualities, allowing the client to gain an understanding of treatment progress (Best et al., 2016).

Some gender-based differences concerning the applicability of RC have also been noted. For example, concerning cultural capital, one study showed that women were more likely to worry about aspects such as appearance to an extent that would affect mental health and act as a barrier to recovery. One could argue, therefore, that for women, higher levels of cultural capital would not necessarily entail a resource for initiating and maintaining a recovery process, but on the contrary could act as negative RC. These observable gender-based differences argue for a definition of RC that includes a gender perspective (Neale et al., 2014). Age-related differences have also been acknowledged, suggesting that RC can be expressed and described in various ways depending on age (Hennessy et al., 2019).

Operationalisations

Many of the attempts to administer RC in a practical treatment environment have resulted in the development of standardised assessment tools designed to evaluate treatment needs, progress and outcome (Best & Hennessy, 2022). One of the earlier attempts at quantifying RC was published in 2008 by Sterling et al. (2008). This particular assessment tool included, besides characteristics usually associated with RC, items designed to measure spirituality and faith. In 2012, Groshkova et al. published an assessment tool called the Assessment of Recovery Capital (ARC). In line with the concept of RC, the ARC is a method of quantifying and thereby illuminating resources and support, thereby reducing the medical focus (Best et al., 2011; Groshkova et al., 2013).

The ARC includes 50 items divided among the categories of social and personal capital. By looking at individuals’ strengths and resources, it is supposed to evaluate treatment needs and progress more accurately than more problem-focused assessments (Groshkova et al., 2013). The idea that a resource-focused approach is more accurate at predicting treatment needs and
outcomes, compared to problem-focused approaches, relies on the assumption that resources, such as social and personal capital, are stronger predictors of long-term recovery (Cloud & Granfield, 2008). In 2013, Burns and Marks published the Recovery Capital Questionnaire (RCQ), but argued that assessment tools based on RC, including the RCQ as well as the ARC, should not replace problem-focused tools and should work as a complement to other tools.

In 2016, Best et al. developed the REC-CAP. This assessment tool includes, in addition to demographic variables, questions about mental health, physical health, life quality and social support. Unlike the previously mentioned RC-based assessments, the REC-CAP includes items designed to measure negative RC: that is, barriers and obstacles to recovery. Negative RC is operationalised by including items designed to measure housing situation, substance use, risk-taking, criminality and occupation (Best et al., 2016). The REC-CAP includes a combination of already established assessments, such as the ARC to measure social and personal resources, the Recovery Group Participation Scale (RGPS) (Groshkova et al., 2011) to measure aspects defined as community capital, and the Social Support Scale (SSS) (Haslam et al., 2005) to measure social support. It also includes the Commitment to Sobriety Scale (CSS) (Kelly & Greene, 2014) to measure recovery motivation and dedication.

A recently published overview of RC in practice suggests that there are still conceptual and empirical contributions to be made to develop both the theory and the quantification of RC. As of now, the existing evidence surrounding RC in practice mainly involves quantification in terms of assessment tools. In addition, the translation of RC is described as unsystematic (Best & Hennessy, 2022).

Critiques and concerns
The changing views of recovery in the area of AOD have brought about a discussion in which recovery as a concept is problematised. Advocates of a harm-reduction perspective argue that the recovery perspective considers the individual solely responsible, and question whether sobriety should be seen as the preferred outcome of treatment and other interventions (e.g., Lancaster et al., 2015).

The increased focus on the individual that is associated with the recovery perspective has also been questioned on ethical grounds. Zschau et al. (2016) argue that recovery-influenced concepts, such as RC, should be more network-based, thereby reducing individual focus. The individual focus is said to stigmatise a ‘user identity’, and in doing so also stigmatises clients’ relationships, lifestyle and overall surroundings. The stigmatisation process occurs in interactions between clients and practitioners and can act as another barrier to recovery (Lancaster et al., 2015; Zschau et al., 2016, p. 35). Fomiatti et al.
(2017) have also, from a sociological perspective, argued that the recovery perspective, along with its associated treatments and interventions, can have negative effects on clients. A user identity is constructed in therapeutic environments, where the client is encouraged to go through an extensive identity change and replace current social relationships. This is further believed to cause feelings of inadequacy, reduced self-esteem and anxiety (Fomiatti et al., 2017, p. 181ff).

**AOD policy and treatment in Sweden**

The recovery perspective is not prominently integrated into either policy or practice in Sweden. Sweden has a longstanding strict policy towards drugs with goals such as achieving a drug-free society. This strict policy persists even though some changes in the direction of harm reduction have been made, such as substitution and syringe exchange programs (Tham, 2023). The lack of recovery-oriented policy development in the Nordic countries has been attributed to the fact that AOD-related treatment falls under the jurisdiction of social services rather than the health care system (Stenius, 2017). More specifically, placing AOD-related treatment in the hands of the social services inherently promotes a holistic approach that encompasses social and environmental aspects, emphasising the relationship between the individual and society (e.g., Prop. 1979/80:1 Del A s. 125). This argument assumes that the holistic approach aligns with the principles of recovery-oriented policy, suggesting that there may be no need to advocate for a recovery movement in the Nordic countries (Stenius, 2017).

In Sweden, AOD treatment typically occurs through outpatient care, employing treatment methods such as twelve-step treatment and relapse prevention. Social services are responsible for non-medical treatment as well as employment and housing support, while health care oversees medical treatment (Johnsson et al., 2017). Historically, there has been a principle of shared responsibility within this arrangement, but this is on the verge of changing due to recommendations presented in the Co-Morbidity Inquiry (2023).

**Knowledge production and use in Sweden**

Although the use of standardisations in social work practice is universal, a note on the Swedish context is needed to understand the setting of this dissertation. For example, Hood (1995) has described Sweden as an early adopter of New Public Management (NPM). To explore the perception that patterns associated with NPM have implications for various professional groups, Weiss-Gal and Welbourne (2008) compared the status of the social work profession in different countries. They noted that, unlike some of the other coun-
tries in the study, Sweden does not impose restrictions on licensing for individuals using the title of social worker. Nevertheless, the majority of individuals employed in the field of social work in Sweden hold a bachelor’s degree, granting them the professional title of ‘socionom’, which is a title that is often required for employment in social services or as a counsellor.

Another distinctive feature of Sweden is its implementation of evidence-based practice (EBP). Unlike many other countries, Sweden has primarily pursued EBP using a top-down approach, essentially relying on guidelines. In contrast to some other countries, such as the UK, where guidelines are produced at an organisational level, Sweden’s guidelines are generated at the state level (Bergmark & Lundström, 2011). Consequently, in Sweden there exists a greater disconnect between the source of the guidelines and their practical application, compared to other nations. As a result, the Swedish version of EBP has been characterised as radical, leaning more towards evidence-based policy rather than practice (Jacobsson & Meeuwisse, 2018).

Requirements and recommendations
The Swedish National Board of Health and Welfare (NBHW) guidelines encourage the use of assessment tools to determine treatment need and to measure treatment progress and outcomes (National Board of Health and Welfare, 2019). The Addiction Severity Index (ASI) (McLellan et al., 1992) and the DOC system (Jenner & Segraeus, 2005) are two examples.

To increase transparency, enable comparison, and as a means of quality assurance, all organisations connected to the social services are required to systematically evaluate client-level progress and outcome (National Board of Health and Welfare, 2014). This documentation requirement is also emphasised in the NBHW’s regulations and general advice on management systems for systematic quality work (SOSFS 2011:9), as well as in the Social Services Act (Chapter 3, § 3 SSA), which states that social services should be of high quality and that the quality of services should be systematically and continuously secured. Assessment tools such as the Addiction Severity Index (ASI) and the DOC system are suggested not only for assessing client-level treatment progress and outcomes but also for systematically evaluating organisations by generating aggregated data (National Board of Health and Welfare, 2019).

Transferability and applicability
A frequent challenge in EBP is applying standardisations in an area in which measured conditions tend to vary based on multiple factors, as is often the case in more than one domain of social work (Bergmark et al., 2011). This challenge has prompted the rise of perspectives on knowledge production that
acknowledge the equal or even greater influence of the practical context, compared to factors such as psychometric properties and validity (Björk, 2017; Guberman et al., 2007; Skillmark & Denvall, 2018; Spies et al., 2015).

In social work, knowledge production involving an already-established assessment tool raises questions of transferability, applicability and feasibility. Transferability, in one definition, is ‘the extent to which the measured effectiveness of an applicable intervention could be achieved in another setting’ (Cambon et al., 2012, p. 11). This means that the process of evaluating transferability entails looking at more aspects than psychometric properties and validity. It includes considering cultural and contextual factors in the area where the tool or intervention is to be applied (Fraser & Galinsky, 2010; Wells et al., 2012). Context here can be defined as including ‘anything external to the intervention that may act as a barrier or facilitator to its implementation, or its effect.’ (Moore et al., 2015, p. 2). There are also arguments for promoting qualitative research contributions (Cambon et al., 2012) as well as for viewing the process of adopting cultural and contextual aspects as a collective process, rather than a process in the hands of individual practitioners (Fraser & Galinsky, 2010).

A related question is that of applicability. This dissertation follows the approach taken by Cambon et al. (2012), who explain applicability as ‘the extent to which an intervention process could be implemented in another setting’ (p. 11). Another approach goes beyond lists of set criteria, which subsequently illuminates applicability as a non-binary concept (Burchett et al., 2018).

In assessing applicability, contextual variation once again becomes a crucial element of the implementation outcome (Burchett et al., 2018; Hawe, 2015; Moore et al., 2015). Therefore, to assess contextual conditions, scholarly contributions have accentuated stressed the importance of consulting practitioners and other stakeholders when assessing contextual conditions (Atkins et al., 2011; Strydom & Schiller, 2019). On the relationship between evidence quality and applicability, however, differing viewpoints do emerge. Some argue that applicability should factor into the assessment of evidence quality (Guyatt et al., 2008), while others argue for a separate evaluation. Those holding the latter view suggest using assessments of applicability to help guide the use of evidence (Atkins et al., 2011; Owens et al., 2010).

The evaluation of transferability and applicability can be carried out using feasibility studies, which can ‘enable researchers to assess whether or not the ideas and findings can be shaped to be relevant and sustainable’ (Bowen et al., 2009, p. 453). Feasibility studies, in this broad interpretation, can aim to address aspects such as acceptability, which involves reviewing the initial reaction to a tool or intervention in the context in which it is intended to be applied. Feasibility studies can also be used to make estimations of how the tool or intervention will be used, and whether or not it will be used as intended. This further implies a practice-focused approach where the question of ‘can it work?’ is explored with focus on the target population (Bowen et al., 2009).
The fact that evidence-based interventions and tools sometimes fail to be applicable in practice, and are sometimes used in other ways than intended, can also be interpreted as a question of implementation. Research suggests that implementation procedures must consider already existing interventions and tools (Guberman et al., 2007), as well as the compatibility of the intervention or tool with existing norms and values (Bergmark et al., 2018; Greenhalgh et al., 2004; Guberman et al., 2007). Further, if the intended users of the tool are included in its development and implementation, they are more likely to be invested in using the tool (Burton & van den Broek, 2009; Strydom & Schiller, 2019). Consulting with the professionals who will be using the tool is thus described as crucial (Burton & van den Broek, 2009; SaPey, 1997; Smith & Collin-Jacques, 2005; Spies et al., 2015). This means that professionals, once again, are described as a core component in the knowledge production process.

Transferring research and policy into practice

The standardisation movement in the managerial paradigm

This dissertation aims to explore the feasibility of implementing the concept of RC and operationalisations of RC within the Swedish AOD treatment context. To do so, it is crucial to understand the broader context of EBP and how knowledge is generated and valued within social work. When discussing evidence in social work, it is essential to acknowledge the influence of NPM. The introduction of NPM, sometimes referred to as a managerial paradigm, has influenced the public sector in various dimensions (Hood, 1995). One of these dimensions involves the implementation of standards and rules, such as documentation requirements for work that is carried out (Lauri, 2016) and standardised assessments (Hjärpe, 2017; Lauri, 2016). The rise in standardisation and rules that is associated with NPM has, however, been described as a ‘breach in the contract between the state and the professions’ (Ahlbäck Öberg et al., 2016, p. 120), reducing the power of professionals to define the content of quality work. Ultimately, the managerialism commonly attributed to NPM is associated with a reduction in professional autonomy (Ahlbäck Öberg et al., 2016; Hood, 1995; Rogowski, 2012).

In the field of public administration, two concepts that are distinct from NPM, yet similarly permeated by visions of quality enhancement, are EBP and evidence-based medicine (EBM). The emergence of EBM and EBP, which has been referred to as a ‘massive standardisation movement’ (Timmermans & Epstein, 2010, p. 80), is predicated on the assumption that restricting potential local variation based on individual judgement results in a greater ability to provide quality-assured, equal care (Bohlin & Sager, 2011).
The increasing role played by EBP in the field of social work reflects a similar ambition to increase the influence of research (Petersén & Olsson, 2015; Timmermans & Epstein, 2010). The EBP framework operates by offering a model that integrates the best available evidence with professional experience and expertise and the values and preferences of the individuals being served. Thus, the EBP process comprises three essential components: the best available evidence, clinical expertise, and patient values and preferences (Shlonsky & Gibbs, 2004).

Transferring research into practice can follow one of two models – a guideline model or a model of critical appraisal. The critical appraisal model stems from the ambition to create an ‘enlightened practitioner’ (Bergmark & Lundström, 2006, p. 103), where the responsibility of reviewing the current evidence base is placed in the hands of the practitioner. Ideally, this is done through a five-step procedure first outlined by Sackett et al. (2000). The guideline model places less emphasis on the ability of practitioners to critically review and apply scientific findings. Instead, guidelines are formulated based on the best available knowledge and made accessible through government agencies in various areas of social services. The national guidelines on substance abuse and dependence from the Swedish National Board of Health and Welfare (National Board of Health and Welfare, 2019) are an example.

The two models differ in terms of where the responsibility for reviewing the evidence lies. EBP enacted through a model of critical appraisal is referred to as a bottom-up structure, while the guidelines model is considered an example of a top-down procedure (Bergmark et al., 2011, p. 168) or an authoritarian model (Bohlin, 2011). In Sweden, therefore, where the production of guidelines is centralised (Bergmark & Lundström, 2011), the enactment of EBP is sometimes referred to as state governing of knowledge (Jacobsson & Meeuwisse, 2018).

Understanding and experiencing EBP

The concept of EBP has received criticism for its perceived vagueness (Avby et al., 2014; Karlsson & Bergmark, 2012), leading to different opinions among scholars. One area of contention revolves around the evidence hierarchy it relies on, which assigns high status to systematic reviews and randomised controlled trials (RCT) (Knaapen, 2014). Some argue that this hierarchical approach limits the attention given to qualitative scholarly contributions (Jacobsson & Meeuwisse, 2018), while others are concerned that the general lack of outcome research based on randomised controlled trials has implications for the EBP procedure (Olsson & Sundell, 2016). The exclusive reliance on research methods, as reflected in evidence hierarchies, has also been criticised, resulting in the emergence of evidence typologies (e.g., Bohlin, 2011).

Discussion of EBP has addressed not only the type of research it promotes but also the characteristics associated with its top-down nature. Some argue
that EBP is permeated by a binary image of practice as good or bad and knowledge as valid or invalid (Jacobsson & Meeuwisse, 2018), as well as the belief that the knowledge produced has general relevance (Pistone et al., 2022). Part of this binary image is a reduction of professional expertise and experience to ‘gut feelings’ (Barfoed & Jacobsson, 2012) and opinions (Sundell et al., 2010). The relationship between EBP and practice-related expertise and experience has thus been much debated (Martinell Barfoed, 2018; Petersén & Olsson, 2015; Pistone et al., 2022), with some arguing that standardised methods and tools can become oppressive and constrain practice-related expertise (Høybye-Mortensen, 2015; Martinell Barfoed, 2018), and others arguing that they can act as fluid support for (Pistone et al., 2022) and ultimately strengthen the status of professionals (Ponnert & Svensson, 2016; Skillmark & Denvall, 2018).

Regardless of whether EBP is enacted through guidelines or critical appraisal, a recurring dilemma is that the knowledge produced sometimes fails to be applicable and is sometimes used in other ways than it is intended (Bergmark & Lundström, 2008; Bergmark et al., 2018; Björk, 2016; Høybye-Mortensen, 2015; Karlsson & Bergmark, 2012; Nordesjö et al., 2020). It is known that professionals therefore sometimes adjust or tinker evidence-based standards to adapt them for a particular context. There is no consensus, however, on whether these types of adjustments should be part of EBP procedures. Some are concerned that local adaptations and tinkering can alter the effect of the evidence-based standard and, accordingly, advocate for method and intervention fidelity (Bond & Drake, 2020; Corbière et al., 2010; Sundell et al., 2016). Others argue that adjustments and tinkering are ways to ensure that a method or tool remains applicable and relevant when travelling between different local contexts (Damschroder et al., 2009; Durlak & DuPre, 2008; Mol, 2006; Sletten & Bjorkquist, 2020; Timmermans & Epstein, 2010).

The discussion of how standards and standardisations operate in health care can be traced back to the initial systematisation of patient medical records. This entailed moving from an administrative procedure where the doctors kept personal notebooks to a standardised medical record system. Not only was there discontent with the increased administrative burden, the standardisation was also perceived as a threat to the relationship between doctor and patient (Timmermans & Berg, 2003). Although this is an example of concerns that arose a century ago in the field of medicine, the influence of standardisations on client work remains an object of debate, with some arguing that standardisations affect the conversation between client and social work professional (e.g., Martinell Barfoed, 2014).

**Experiencing standardised tools**

In recent decades, professional experiences of using standardised tools and methods within the framework of EBP have received some scholarly attention. In the area of child welfare in Sweden, Tham (2018) reported a decrease in
work tasks that involved giving advice and support – indicating a decrease in time spent with clients – between 2003 and 2014. This reduction was further interpreted as a decrease in the exercise of professional discretion. In the area of substance use and dependence, many researchers have studied the use of the Addiction Severity Index (ASI), an assessment tool imbued with the core values of the EBP movement. According to Skogens (2012), social workers find the structure and legal certainty provided by the ASI to be appealing, but describe other aspects, such as time duration, as negative. While some suggest that the ASI disturbs the conversation between professional and client (Martinnell Barfoed, 2014), Skogens (2012) reports a somewhat mixed picture: although observations were made of the ASI interfering with the conversation between the client and professional, there were also observations of social workers finding the ASI to benefit the conversation in different ways. Some respondents argued that the ASI improved communication and created a feeling of security for the professional. Still, although observations exist of ASI acting to contribute to the client conversation, testimonies to the opposite are more common. By disturbing the client conversation, standardised assessment tools such as the ASI are reduce discretion – and subsequently negatively impact the legitimacy of the social work profession (Falkenström & Hjärpe, 2017; Martinell Barfoed, 2014).

Assessment tools are an example of standardisation in social work (Bergmark & Lundström, 2006), and not infrequently, their implementation is motivated by the notion that doing so might actually increase the professional status of social workers (Gambrill, 2011). This is not just a theory. The fact that standardisations such as documentation increase legitimacy has been expressed by social workers themselves (Cumming et al., 2007). The ASI and its influence on the legitimacy of the social work profession can be considered one building block in the somewhat discordant scholarly debate about whether standardisation increases or decreases the status of the social work profession. A related issue is the relationship between standardisations and discretion, which, it has been argued, is more complex than simply thinking that standardisations reduce discretion (e.g., Evans & Harris, 2004). On the one hand, standardisations have been described to reduce social workers’ discretion and autonomy (Timmermans & Berg, 2003). On the other hand, there is research suggesting that standardisations can increase discretion by forcing social workers to manage contradictory logics (Evans & Harris, 2004; Ponnert & Svensson, 2016) and that social workers can occupy a variation of discretion-ary positions concerning standardisations that do not necessarily reduce their professional status (Skillmark & Denvall, 2018). Some research, drawing on influences from science and technology studies (STS), illustrates a similar perspective on standardisations, where standardisations and interventions in a practical treatment environment are ‘fluid objects’ (de Laet & Mol, 2000; Ekendahl & Karlsson, 2021; Law & Mol, 2001; Law & Singleton, 2005). This perspective does not necessarily see standardisations and autonomy as a threat.
to one another; rather, it emphasises the adjustable characteristics of standardisations (Björk, 2016; Knaapen, 2014; Timmermans & Berg, 2003). The relation between professional status and standardisations will be further explored in the chapter on the theoretical framework of the dissertation, below.

Knowledge production and use in social work

Efforts to apply the concept of RC and its operationalisations in practice ultimately become a question of knowledge production and use in social work. As touched on above, the use of knowledge and knowledge production has been described as the most fundamental problem in social work (Munro, 2004). Numerous examples exist of science-produced knowledge lacking practical applicability. This has been described as being the result of opposing ‘practical ontologies’ (Young & Borland, 2011), where practitioners have been reported to request interventions based on ‘real-world settings’ rather than internal validity and generalisability (Bowen et al., 2009). The proposed solutions to this problem are many and multifaceted.

Some of those solutions concern how systematic reviews are conducted and come from a perspective in which the evidence hierarchy is still highly regarded. One proposal is that systematic reviews should include aspects such as applicability, not only validity and generalisability (Atkins et al., 2011). Another similar proposal, one that pays to the evidence hierarchy less consideration, is that systematic reviews should include a wider range of evidence and guidelines should include instructions for best to apply the evidence (Green & Glasgow, 2006).

Other suggestions for managing the elusive challenge of knowledge production in social work also exist. Guideline production and practical adoption need to be improved (Karlsson & Bergmark, 2012) and evidence-based standards should allow flexibility at all levels of the social work organisation (Nordesjö et al., 2020), so that they consider the ‘logic of care’ rather than a ‘laboratory logic’ (Björk, 2016; Mol, 2008). This further entails that there is a range of solutions that involve research conducted while considering the practice in which it is supposed to be applied (Björk, 2016; Brante, 2014; Sletten & Bjorkquist, 2020). Björk (2017) has proposed the idea of ‘situated standardisations’ (Zuiderent-Jerak, 2015) to enable the development of evaluation and monitoring while taking in-practice adjustments into consideration. Another, similar, solution involves taking a bottom-up approach to knowledge production, where the ambition is to utilise practical expertise (Petersén & Olsson, 2015). This solution would also entail questioning whether research-associated knowledge is the most valid source of knowledge (Jacobsson & Meeuwisse, 2018), and prioritise non-accredited or experiential knowledge (Young & Borland, 2011).
Summary of previous research

Previous research has highlighted the practical and theoretical usefulness of RC in Swedish treatment settings, although limited evidence of its application in practice exists. Furthermore, in the context of knowledge production and use in social work, previous research illustrates a dilemma involving the relationship between evidence and relevance, with some knowledge that is produced failing to find practical application. This chapter has emphasised the crucial role played by professionals in assessing transferability, applicability and implementation of knowledge.

Research thus suggests the necessity of consulting practice. This underscores the need for scholarly contributions addressing knowledge production in social work, particularly concerning standardisations such as assessment tools and the professionals who are meant to use them.
Theoretical framework and concepts

The preceding chapter gave an overview of diverse perspectives within the scholarly discourse on evidence and knowledge production in social work, covering theoretical viewpoints as well as previous research. The present chapter describes the theoretical approach that underpins this dissertation. In contrast to the overview presented in the previous chapter, the focus of this chapter is to elaborate on the core concepts as they are understood in the context of this dissertation.

What constitutes a profession?

Regardless of the criteria used to distinguish between a profession and an occupation, the relationship between social work professionals and standardisations is a question of professionalism. There are different ways to make this distinction, but it is evident that knowledge is at the core of any profession. Thus, knowledge production and use from the perspective of professionalism is a key theme in this dissertation.

Jurisdiction and science as a foundation

Power, control, jurisdiction and autonomy are recurring terms in attempts to define what constitutes a profession. All concepts of what a profession is have in common the ambition to describe the characteristics of the relation between the professional and the work carried out by the professional. Abbott (1988, 2010) suggests that the core of a profession is its jurisdiction, which is composed of both cultural and structural aspects, and the status of a profession ultimately amounts to its members’ ability to protect its jurisdiction. A profession is thus constituted relative to its surroundings. This means that the status of a profession is dependent on the extent to which its members constitute and define its work culture and structures (Abbott, 1988). Thus, the status of a profession is at risk when external forces are allowed to constitute these cultural and structural aspects – in other words, its jurisdiction.

Brante (2011), much like Abbott (1988, 2010), rejects conceptualisations of professions that are based on lists of attributes (e.g., Greenwood, 1957) and stresses the importance of a profession’s epistemic dimension. In simpler
terms, professions act as enablers of or ‘asset points’ (Brante, 2011, p. 9) to the highest knowledge within a given area. Throughout history, the definition of what qualifies as the highest knowledge has evolved. Today, science is considered the highest form of knowledge, and modern professions are described as science-based. This also means that the status of a profession is legitimised by science. Taken together, and considering social work to be a modern profession, this means that the professionalisation of social work takes place somewhere else than where it is practised. This amounts to the notion that social work entails a continuous process of conflict and change (Abbott, 1995).

Practice-based knowledge
This thesis is built on a theoretical foundation that emphasises the significance of knowledge as the cornerstone of a profession. It is important to note that knowledge encompasses a broader spectrum than merely scientific knowledge. Although Brante describes modern professions such as social work as science-based occupations, professional status relies on the ability to apply research in practice. Along those lines, other scholars suggest that skills, knowledge and expertise are important, and particularly how they are expressed and put into action in daily work (Dellgran & Höjer, 2001, 2003b, 2003a; Erat, 1994; Schön, 2017). According to Freidson, skill is ‘the capacity to accomplish a task, which may be kept analytically separate from the substantive knowledge connected to the task itself’ (2001, p. 25). This theoretic approach also suggest that skills encompass problem-solving abilities necessary for applying the available knowledge.

Within this context, formalisable skills may be distinguished from tacit knowledge. Formalisable skills can be described systematically and therefore they are associated with a level of transparency. In contrast, tacit knowledge is challenging to communicate explicitly; it is knowledge that cannot be easily articulated (Polanyi, 1983). Tacit knowledge, acquired through experience and practice, becomes ingrained in a professional’s capacity to navigate intricate situations (Brante, 2011; Freidson, 2001). The social work profession is considered a modern profession whose foundation is composed of science (Brante, 2011). Science is transferred into social work practice by different types of formalisations. Due to its unformalisable characteristics, tacit knowledge is likely to be left out of the knowledge production process.

Standardisations
The implementation of standardisations is driven by their purported capacity to achieve ‘legitimate coordination’ across diverse practices shaped by varying contextual factors. In the sociology of standards, standards are seen as a
collective act that involves not only the creators of the standardisations but also other actors. Both the emergence and the utilisation of standardisations are closely associated with notions of legitimacy, and the involvement of science accords particular significance in this context due to the legitimacy it holds. Supporting the theoretical contributions made by Abbott (1988, 2010), Timmermans and Berg (2003) argue that standardisations can be used to protect and maintain jurisdiction. Standardisations such as clinical guidelines and assessment tools are thereby classified as professional tools and represent a shared view of a profession. According to Timmermans and Berg (2003), clinical guidelines are a prime example of standardisation. Their use may not be uniform across all contexts, but they indirectly influence behaviour by compelling practitioners to contemplate when to adhere to or deviate from them. This inevitably raises the issue of discretion.

Disputed impact on discretion
Timmermans and Berg (2003), who prefer the term ‘autonomy’ over ‘discretion’, argue that standardisations in the form of top-down imposed guidelines are an external regulation that can risk interfering with the autonomy of a profession. They explain this phenomenon through the concept of accountability, which they consider a significant factor in understanding how standardisation affects a profession. Applied to the field of social work, accountability involves holding social work professionals responsible for their actions, and while it ensures quality and financial support, it also increases the risk of reduced autonomy for professionals. Consequently, accountability is viewed as a process wherein professionals are answerable for adhering to standards, potentially prioritising conformity over their ability to exercise independent judgement (Timmermans & Berg, 2003).

Discretion is, however, a multifaceted concept (e.g., Skillmark, 2018), and opinions differ on whether or not discretion is restricted by standardisations. Sosin (2010) has developed a typology to illustrate how discretion manifests in different institutional settings. This typology is based on the idea that discretion arises where two institutionalised standards intersect and that the level of discretion varies depending on the institutional environment. The typology also makes a distinction between interpretive and rigid standards. According to Sosin, the interpretative standard is optional and ‘workers are almost always choosing when to follow a standard’ (2010, p. 596). This is similar to the understanding of the impact of clinical guidelines mentioned just above, where the guidelines do not necessarily lead to uniform behaviour (Timmermans & Berg, 2003, p. 495). One of Sosin’s main conclusions is that the act of choosing when to follow a standard is an exercise of discretion. Other advocates for this perspective suggest that not only do standardisations not limit discretion, they might even increase discretion by forcing social workers to manage contradictory logics (Evans & Harris, 2004; Ponnert & Svensson, 2016).
Summary

The theoretical framework of this dissertation is constructed around the conceptualisations of standardisations and professions outlined in this chapter. It also includes the understanding that these concepts are interconnected and that their relationship is crucial to consider when examining knowledge production and use in social work. Consequently, this dissertation is positioned within a theoretical discourse on the relationship between standardisation and professionalism. It draws on scholarly contributions that stress that standardisations do not inevitably restrict discretion. An open, exploratory approach towards standardisations and discretion makes it possible to consider the diverse ways that standardisations operate in practice.

Viewed as an example of knowledge production and use, this dissertation explores the feasibility of implementing both the concept of RC and its operationalisations in Swedish AOD treatment. Consequently, the idea that the social work profession is considered a modern, science-based profession plays a pivotal role. This dissertation acknowledges that social work professionals utilise a knowledge base encompassing scientific knowledge, skills and tacit knowledge. Scientific knowledge is integrated into social work practice through various formalisations, such as the use of standardised assessment tools. However, due to its inherently unformalisable nature, the role of tacit knowledge in the knowledge production process is often overlooked.

The concept of jurisdiction is significant, as it underscores the imperative for social work professionals to have control over their own work and the knowledge that informs it. This concept becomes particularly important in understanding how knowledge is produced and used and to shed light on the continuous process of conflict and change that the social work profession entails.
Methods and materials

This chapter discusses the methodological approaches and underpinnings that are relevant to the dissertation as a whole. More detailed descriptions are provided in the respective papers.

Study design

As noted in the chapter on previous research, transferring research into practice is challenging – not least when transferring tools between different cultural and geographical domains. Methodologically, the challenge of knowledge transfer has been described as resulting from an extensive focus on internal rather than external validity. Furthermore, the evidence for interventions is often based on their effects in optimal rather than in typical conditions. Practice-based research is a proposed solution to this challenge (Green & Glasgow, 2006). Feasibility studies are particularly important in practice-based research, as they allow for the incorporation of the crucial component of consulting professionals in the intended area of operation of the intervention (Bowen, 2009).

The dissertation set out to explore the feasibility of implementing the concept of RC and its operationalisations in Swedish AOD treatment by deploying a feasibility study as outlined by Bowen. This methodological approach involves focusing on several areas when addressing the feasibility of a tool: namely, acceptability, demand, integration and expansion. Together, these areas of focus cover the initial reaction of the members of the setting when faced with the tool, estimations of tool use and the perceived demand for the tool, as well as the potential applicability of a tool that is already successfully implemented in another cultural and geographical setting. This approach carefully considers the organisational culture in which the tool is thought to operate, without necessarily exploring its actual use in that context. Performing a feasibility study further calls for defining the target setting. Although it is hoped that the findings will contribute to the scholarly and practical development of RC across different geographical and cultural domains, the primary focus here has been to explore feasibility in Swedish AOD treatment.

The feasibility was studied by qualitatively interviewing social work professionals working in AOD treatment about their opinions on the applicability
of an RC-based assessment tool (Papers II and III). Feasibility was also explored via observations made in a quantitative study that measured treatment progress using an established RC-based assessment tool in a group of individuals living in a recovery residence in Florida in the United States (Paper I). To further assess feasibility and to contribute to the discussion on knowledge production and use, overall aspects of developing tools and using assessment tools in Swedish AOD treatment were explored through a case study of the use of a locally developed assessment tool (Paper IV).

Transferring findings between settings

Observations from different settings were used to explore feasibility in a specific setting. This calls for a brief description of how the findings from each setting are used to explore the feasibility of the target setting. Firstly, the longitudinal quantitative data was retrieved from a residential treatment setting in Florida, which differs in many ways from the target setting of the dissertation. In the Swedish AOD treatment setting, treatment typically occurs via outpatient care, employing treatment methods such as twelve-step treatment and relapse prevention. Further, social services are responsible for providing non-medical treatment and also provide support in terms of employment and housing. In the qualitative sample, all but one treatment facility provided only outpatient care and they were all familiar with and/or used the twelve-step approach in treatment.

This means that the setting from which the quantitative data was derived differed from the setting in which its findings are applied. Drawing on findings from a different setting than the target setting was deemed necessary since data from the target setting was not available. The quantitative contribution thus gives no direct indication of RC’s applicability in Swedish AOD treatment. It does, however, contribute to the overall scholarly development of RC-based assessment tools. It also illustrates the use of an RC-based tool in practice and can thereby provide insights into the benefits and challenges of using the tool. All in all, the quantitative data managed in Paper I provided a better understanding of the assessment tool, which was found imperative for exploring feasibility in other settings.

Secondly, in Paper IV, a case study was carried out to explore the use of a locally developed tool to measure treatment progress on an aggregate level. This means that investigation into a different tool was used to help explore the feasibility of an RC-based tool. This was seen as a help in exploring the feasibility because it provided a greater understanding of the target setting in which an RC-based tool would potentially be implemented.
Data

Quantitative longitudinal REC-CAP data

The quantitative longitudinal data was derived from an implementation project using the REC-CAP tool (see Appendix 1) to measure recovery progress among clients living in recovery residences in Florida in the United States. The REC-CAP is designed to measure recovery progress and recovery capital through a self-completion interview schedule including 94 variables. The sample included individuals enrolled in a recovery house post-treatment or post-prison and clients who continued to attend intensive outpatient treatment in Florida during the period 2016–2019.

A first analysis of the dataset revealed a large number of missing values, which called for certain compensatory measures in the subsequent steps of the analytical procedure. The number of missing values did not motivate a complete case analysis to consider the issue of biased estimates and reduction in power (Graham, 2009). To manage the incomplete data (Enders, 2022), a multivariate imputation by chained equations (MICE) was used (Azur et al., 2011). The dataset managed in the MICE procedure was analysed using logistic regression to examine factors associated with retention. The dependent variable was retention: a binary variable that indicated whether individuals stayed in the residence for six months or not. In addition, the study used a linear mixed model to examine factors associated with changes in total ARC score, accounting for both time variation and covariance between observations on the same individual at different points in time (Brown & Prescott, 2006; Little et al., 2000). The sample and the analyses undertaken in this study are described in more detail in Paper I.

Qualitative interview data

The qualitative interviews were carried out in two phases with staff from different AOD treatment facilities. The recruited sample of treatment facilities was a convenience sample, where the ambition was to attain variation in type of client group. The first interview phase yielded a sample of five treatment facilities with three to six staff members from each facility, which ultimately yielded a sample of 22 interviewed professionals. In the first interview phase, an interview guide was designed to examine the preconditions for an RC-based assessment tool (see Appendix 2). At the beginning of the interviews, the interviewees were presented with a brief introduction to RC: both its conceptual aspects as well as a verbal description of operationalisations made based on the concept of RC. This means that the interviewees were introduced to and asked to review the concept of RC along with an outlined idea of an
assessment tool. A more detailed outline of the first interview phase is presented in Paper II.

By the time of the second phase of group interviews, almost two years had passed. With one treatment facility declining to participate, the second interview phase included four treatment facilities with three to seven staff members from each facility, which ultimately yielded a sample of 18 interviewed professionals. In the second interview phase, the interviewees were asked to review an actual RC-based assessment tool. The RC-based assessment tool used as discussion material (see Appendix 4) was the ARC (Groshkova et al., 2013). The ARC was chosen because it is one of the most used RC-based assessment tools (Best & Hennessy, 2022). It is also included in the REC-CAP to measure social and personal recovery capital. During the interviews, the ARC was used as a foundation for discussion, and, to begin with, the respondents were asked to reflect on the applicability of the specific items in the ARC. The interview guide used in the second interview phase can be found in Appendix 3 and a more detailed outline of the second interview phase is presented in Paper III.

Case analysis data

To explore experiences of using a locally developed assessment tool, a deviant case analysis was carried out. As outlined by Flyvbjerg (2011), a deviant case analysis involves studying a deviant or extreme case in order to explain a phenomenon, or domain (Swanborn, 2010). It is crucial to discuss and clearly define the selected case as well as the domain. One of the more important distinctions made is between cases that are randomly selected and cases that are information-oriented selected. Random selection is associated with aspects such as representativity and generalisability, while information-orientation selection attempts to maximise information by prioritising information content over aspects such as representativity (Flyvbjerg, 2011, p. 307). The case study in this dissertation used an information-oriented approach. In such an approach, a case can be selected based on different factors – one of them being that the case is deviant or extreme. To further motivate the case analysis approach, it is important to describe the extreme or deviant characteristics of the case in question.

In this study, the case represented an example of knowledge production and use in AOD treatment. More specifically, the case involved the use of an assessment tool that had been developed locally at a specific psychiatric and addiction clinic that participated in the interview studies carried out in paper II and III. The assessment tool was referred to by the employees at the clinic as the Smiley (see Appendix 6). In Sweden, EBP is mostly carried out via a guidelines model. Regardless of whether a guidelines or critical appraisal model is used, however, treatment methods and assessment tools are usually derived from recommendations coming from agencies such as the National
Board of Health and Welfare. This means that social work professionals normally encounter knowledge produced somewhere else than where it is utilised. Consequently, the production and use of the Smiley tool can be described as a deviant case of knowledge production and use. Considering Swedish enactments of the EBP model, the assumption of the deviant nature of using locally produced knowledge holds true. Nevertheless, limited research exists on the utilisation of such knowledge, and it is plausible that its prevalence exceeds the current awareness within the scholarly knowledge base.

Given that the case was the use of a specific assessment tool in a specific psychiatric and addiction clinic, the recruitment of study participants was limited to members of staff at this particular unit. Besides working at the unit, the other criterion for recruitment was that the professional had to either have taken part in the development and/or implementation of the assessment tool and/or used the tool in their daily work. A total of 15 staff members were contacted and asked if they were willing to participate in an interview and a total of 12 agreed to participate. Interviews were carried out using an interview guide (see Appendix 5). A more detailed outline of the case analysis is presented in Paper IV.

Analyses

To capture important elements while preserving a flexible approach to the interview data, a reflexive thematic analysis (TA) (Braun & Clarke, 2020) was used to process the data in both the first and the second interview phase. The same analytical approach was used to process the interview data derived from the deviant case analysis. It is important to clarify that TA includes a variation of approaches and orientations. Here, an inductive approach was used, meaning that the analysis was mainly data-driven. This inductive approach relied on a perception of the relationship between deduction and induction as more like a scale than a dichotomy (Braun & Clarke, 2020), with the analysis in this paper positioned on the inductive side of the scale.

Thematic analysis of qualitative data also entails an approach to the analytical process wherein the researcher is active in constructing patterns and themes. The active participation of the researcher means that the researcher, including the researcher’s subjective understanding, becomes part of the analytical process. Within the frame of reflexive TA, research subjectivity is considered a resource for creating themes (Braun & Clarke, 2019), where the addition of ‘reflexive’ denotes the subjective contribution (Braun & Clarke, 2020). With a few minor deviations, the analytical process here followed Braun and Clarke’s step-by-step guide (Braun & Clarke, 2006). After the interviews were transcribed, the data was coded and summarised under different topics. Next, these topics were reviewed and investigated for potential themes.
The analytical process, including a few re-categorisations of themes, continued throughout the entire writing process.

Methodological discussion and limitations

Incomplete data
Some limitations related to data availability were observed in the quantitative longitudinal data. Longitudinal data were only available for individuals who continued living in the residential service during the time of the data collection. Furthermore, the retention rate in the sample was relatively low. These limitations have implications for two main reasons. Firstly, the underlying assumption is that retention is a positive indicator of recovery outcome, even though there are no observations of the progress made among those who left the residences. Given that the reasons for discharge reflect a heterogeneous group, it is likely that the group comprises various recovery trajectories. Secondly, without observations of progress among those who left the residences, the observed increase in RC must be viewed with caution. While it is clear that those who continued living in the residences experienced increased levels of RC, it is not safe to say that those who left did not. This ultimately means that any conclusions regarding the effect of residential services should be approached with care.

As mentioned, the survey suffered from a large degree of non-completion. This was addressed by a statistical method (MICE) to impute missing values which made it possible to use all the cases. Additionally, there was a variation in the timing of the baseline assessment, with some participants assessed within the first week of their residence and others after a month. This variability is likely to have influenced the analysis of change, since unobserved progress may have occurred during the first month for some participants. Although incomplete data was statistically addressed, questions remain regarding the reasons for the substantial number of missing values, as well as the time variation in the baseline assessment. The ramifications of this matter are addressed in the discussion chapter, below.

Non-representativeness of clients
The methodological approach of using a feasibility study places particular emphasis on the environment in which the RC concept and its operationalisations are intended to function. In this dissertation, that environment is the Swedish AOD treatment setting, and the dissertation relies solely on the insights of social work professionals to delineate the environment’s unique characteris-
tics. It is crucial to recognise, however, that the AOD treatment setting, regardless of its geographical or cultural context, also encompasses the viewpoints and experiences of clients. The absence of a client perspective raises concerns regarding the internal generalisation, i.e. whether the sample is representative of the setting studied (Maxwell & Chmiel, 2014). The omission of the client perspective raises the risk of failing to uncover critical challenges and barriers associated with implementing both RC as a concept and its operationalisations. Particularly in light of research suggesting that the practical application of the recovery perspective can have adverse effects on clients (e.g., Lancaster et al., 2015; Zschau et al., 2016, p. 35), the non-representation of clients constitutes a significant limitation.

The lack of a client perspective also has ethical implications. Ethical research principles emphasise that research should aim to grant access to all groups to participate in research (World Medical Association, 2013). Consequently, the present findings may overlook potential consequences of implementing the concept of RC, given that it does not consider how RC may be experienced by clients in practice.

The dynamics of group interviews
The qualitative data comes from group interviews, and it is important to highlight some potential disadvantages of group interviews compared to individual interviews. Group interviews inherently present the risk that individual participants may adjust their opinions to align with the group’s view. The pressure to conform within a group setting may have limited the way that individuals expressed themselves. Furthermore, the presence of the treatment facility manager in a majority of the group interviews may have reinforced the pressure to conform. Participants might have tailored their responses to align with what they believed was expected from them as social work professionals, potentially exaggerating or modifying their descriptions of how they would utilise the tool. However, group interviews are preferred in cases where capturing the natural setting is crucial (Frey & Fontana, 1991; Kitzinger, 1994), and pre-existing group dynamics can help facilitate discussions of contextual aspects (Frey & Fontana, 1991; Strydom & Schiller, 2019).

Another limitation has to do with the discrepancy in the sample between the first (Paper II) and second interview phases (Paper III). This discrepancy arose due to one treatment facility declining participation in the second interview phase, and due to staff turnover between the two phases. One possible solution for the treatment facility that declined to participate could have been to substitute employees from a different treatment facility. However, this idea was rejected because the groups from the first interview phase were already familiar with the conceptual framework of the assessment tool. Moreover, no suitable solution was found to address the inclusion of newly hired profession-
als in the treatment facilities. Nevertheless, it is important to note the vast majority of those who participated in the second interview phase also participated in the first.

Observations of the unobserved
Another limitation is that this study explores feasibility without any observations of actual use. While quantitative data on treatment progress, measured using the REC-CAP, is available, there are no observations regarding professional experiences of utilising this instrument. When it comes to professional opinions about the applicability of an RC-based assessment tool in Swedish AOD treatment, observations of actual usage are also lacking. The evaluation of feasibility is thus based on data derived from using an established RC-based assessment tool in a setting different than the target setting of this dissertation. Further, the evaluation of feasibility rests on perceptions regarding the use of an RC-based assessment tool in Swedish AOD treatment, instead of observations of actual use. Similar limitations can be found in the case study, which relies on depictions by professionals of how a tool is employed, rather than direct observations of its use in practice. Nevertheless, under the broad definition of feasibility studies outlined by Bowen (2009), a feasibility study can be carried out without necessarily observing actual use.

Trustworthiness and the role of the researcher
Despite drawing on both quantitative and qualitative data, the feasibility study design of this dissertation positions it within the field of qualitative research. Assessing validity in qualitative research commonly involves evaluating whether the findings could also be explained by alternative interpretations and arguments. Related to this is the role of the researcher. The dissertation and its accompanying papers are written in the passive voice and have limited discussion on the role of the researcher. This is a limitation in terms of reflexivity and transparency (Thornberg & Feijes, 2015). Additionally, one underlying assumption of this dissertation is that the relationship between research and the social work practice is an intricate one. However, in the qualitative interviews conducted in paper II and III, the interviewees were presented with a tool they knew was supported by research, and at least one researcher was present during the interviews. It is likely that the researcher’s presence influenced the interviewees to mention the positive attributes of the tool. Without the presence of the researcher, the outcomes of the discussions might have been different. There is little way of knowing whether the findings would have pointed in another direction had researchers not been present at the interviews. Nonetheless, the interviewer was aware of the potential interview bias and took steps to mitigate it by explicitly stating that all opinions regarding the
applicability of the assessment tool were encouraged. Additionally, recognising the potential for interviewer bias, the interviewer continuously asked follow-up questions.

Ethics
All the individuals included in the quantitative longitudinal data signed full consent forms. Consent to participate included the client’s permission to use the data for research purposes, along with information that ensured that the data files would be de-identified if ever used for such purposes. Further, the study was conducted in adherence with the ethical considerations stated in World Medical Association (2013) Declaration of Helsinki. Parts of the data management were conducted at Stockholm University in Sweden in a procedure approved by the Swedish Ethical Review Authority (No. 2020-00802). The qualitative interviews were approved by the Swedish Ethical Review Authority (No. 2018/923-31/2). The research plan for the case study presented in Paper III was sent to the Swedish Ethical Review Agency, which ruled that the study did not fall under the jurisdiction of the Ethics Review Act, since no intervention with a research person or other intervention was to be carried out in the manner specified in § 4 of the Ethics Review Act (Dnr. 2021-03574).
Main findings

Paper I

The growth of recovery capital in clients of recovery residences in Florida, USA: A quantitative pilot study of changes in REC-CAP profile scores.

Setting

RC is an example of the theoretical and conceptual developments that have taken place in the field of recovery. RC is considered analytically valuable and believed to possess the ability to predict future needs; hence, several assessment tools have been constructed to measure it. Recovery housing is recognised as an evidenced area of recovery interventions. The aim of Paper I was to quantitatively assess RC in a sample of recovery residence clients. To assess RC, the study used repeated measures of self-completion of a standardised RC instrument (REC-CAP) for clients of recovery residences in Florida, USA. A total of 823 clients participated in the baseline assessment, and a sample of 267 clients remained in the residence and participated in the six-month follow-up assessment. A logistic regression model examined factors associated with retention and a repeated measures marginal mixed model evaluated the factors associated with changes in RC between the baseline and the follow-up assessment.

Findings and implications

The findings of the study indicate that RC increased during the residents’ stays in the recovery residences, although this increase was not consistently observed across all sample populations. Furthermore, significant differences were identified between the retained and drop-out samples, with the retained group consisting of older individuals who actively participated in recovery groups. Younger residents, female residents and those with an identified housing need were more likely to drop out. For the retained group, greater RC growth was associated with factors such as employment, higher level of social support, and higher quality of life. It is noteworthy that despite being more likely to drop out before the first follow-up, the younger residents who were
retained reported a larger increase in RC during their initial six months of residence. 

This implies that individuals enrolled in these types of residences might require different types of support services. Specifically, while younger people and female residents should be supported to remain in the residence, older male residents may require interventions that focus on promoting growth in recovery capital. It is important to note that the underlying assumption is that retention is a positive indicator of recovery outcome, even though there are no observations of the progress made among those who left the residences. Ultimately, the findings display a variation in recovery trajectories that is difficult to evaluate by relying solely on standardised outcome measures.

While efforts were made to address incomplete data statistically, lingering questions remain regarding the substantial number of missing values and the time variation in the baseline assessment. The inconsistent use of the assessment tool raises concerns about its practical operation in a treatment environment and how clients and practitioners can benefit from its implementation.

Paper II

*Balancing standards and flexibilities: Preconditions for a recovery-based tool in a Swedish alcohol and drug treatment context.*

**Setting**

Considering the body of evidence supporting the practical and theoretical value of RC, the primary objective of Paper II was to present the outcome of the initial phase in exploring the preconditions for using an assessment tool based on RC in a Swedish AOD-treatment context. In the process of studying the potential usefulness of such a tool, other aspects besides its psychometric properties and validity were considered important to examine. To achieve this, five key informant group interviews were conducted, involving employees from various AOD treatment facilities. These interviews aimed to elicit discussions on the applicability and relevance of an RC-based assessment tool. The collected data was transcribed and were then subjected to thematic analysis (TA) to facilitate data processing.

**Findings and implications**

The findings of the study revealed generally positive attitudes among the respondents towards the conceptual framework of RC, particularly the strength-based approach and the ability to identify resources. Remarkably, the respond-
ents often justified the tool’s applicability by referring to methods and strategies they were already utilising. Surprisingly, despite the successful implementation and positive reception of the existing tool by both clients and practitioners, the respondents expressed a greater interest in using the tool presented during the interviews. This was further interpreted as a recognition of the importance of employing evidence-based methods and strategies rather than solely focusing on what has proven effect.

Furthermore, the discussion highlighted a range of perspectives regarding assessment tools and standards. While some respondents expressed a desire for a systematic and standardised approach, others emphasised the potential drawbacks of such tools and standards in general.

Paper II ultimately underscored a tension between adherence to standards and flexibility. This suggests that any potential implementation would necessitate careful consideration of trade-offs between adherence to standards and flexibility, thus advocating for the development of solutions that takes these trade-offs into account.

**Paper III**

_A qualitative study of a recovery capital assessment tool in alcohol and drug treatment facilities: Perspectives from social work professionals._

**Setting**

The findings from Paper II revealed positive attitudes towards the conceptual frames of recovery capital. Additionally, a diverse range of opinions on assessment tools emerged, with some professionals advocating for systematisation and standardisation, while others highlighted the importance of professional discretion. This raised the question of whether these perspectives could coexist cohesively. The objective of Paper III was to investigate the potential combination of standards and professionalism in the context of AOD treatment facilities.

To study this, the AOD treatment facilities from Paper II were revisited. The respondents were introduced to the Assessment of Recovery Capital (ARC) tool and were asked to review each item and reflect on its usability in their daily work. TA was employed to process and analyse the interviews conducted with the AOD treatment facility respondents. The analytical process, including re-categorisation of themes, continued through the entire writing process and ultimately yielded three themes: the assessment tool, the clients and the social work practice.
Findings and implications

Within the discussions surrounding the assessment tool and its constituent parts, a central theme emerged – the respondents’ approach to the tool within their work environment and, notably, their interpretation of the extent of their professional discretion. While the concept of discretion was seldom explicitly addressed, the advantages and disadvantages of the tool prompted respondents to offer their perspectives on the interplay between professionalism and standardisation.

Perspectives on social work professionalism highlight the ability to modify and adjust standards to be at the core of the social work profession. The majority of the interviewees found the tool to be useful but indicated a preference for using it in a manner different from its intended purpose. Surprisingly, the desire to modify the tool was never reflected in their conclusions regarding its potential contribution to their work. These findings shed light on the intricate process of applying research in practice and demonstrate that a tool or intervention does not necessarily have to be deemed either entirely applicable or inapplicable. The respondents’ perspectives revealed a complex dynamic between professional discretion and the standardised nature of the tool. The findings emphasise the importance of considering individual contexts and the need for flexibility within social work practice.

Paper IV

*Methodological lucidity or relevance? A deviant case analysis of a locally developed monitoring tool used in a psychiatric and addiction clinic in Stockholm, Sweden.*

Setting

Paper IV aimed to address the challenging issue of applying research in practice by examining local knowledge production in the context of a psychiatric and addiction clinic in the Stockholm area, Sweden. Specifically, the focus was on a locally developed assessment tool called the Smiley, designed to generate aggregated data for evaluating clinic performance. By employing a deviant case analysis approach, the study explored the tension between evidence and relevance inherent in the use of this assessment tool. Twelve semi-structured individual interviews were conducted with employees from the targeted treatment unit. The interviews were transcribed and analysed using TA to identify key findings.
Findings and implications

The findings could be summarised in three arguments. First, it was observed that tinkering with and modifying tools and interventions was not necessarily associated with limitations in practice applicability or relevance. This raised the question of whether tinkering with interventions or tools should be allowed, or if intervention fidelity should be prioritised. Regardless of the stance taken on fidelity, local knowledge production alone does not appear to provide a definitive solution.

Secondly, professionals seemed more likely to systematically use a tool if the tool was designed with a treatment and conversation rationality in mind, indicating the importance of aligning the tool with their professional context. Lastly, the study found that knowledge recommended by the NBHW was not perceived as more valid than other types of knowledge. Instead, it was associated with a specific detailed and comprehensive style of knowledge that carried a sense of legitimacy.

The findings thereby challenge the assumption that tinkering with tools provides a solution to limited practice relevance. Moreover, the study underlines the importance of designing tools that align with a treatment and conversation rationality. Finally, knowledge recommended by the NBHW is perceived as characterised by a particular style and legitimacy, rather than inherent superiority. These insights contribute to the ongoing discussion on the interplay between evidence and relevance, ultimately providing insights into the development and implementation of assessment tools in clinical settings.
Discussion

This chapter first outlines the findings of this dissertation regarding the preconditions for RC in Swedish AOD treatment. Next, it analyses these findings in a more detailed examination of the intricate relationship between professionalism and standardised approaches. This discussion critically examines different types of intervention attributes, offering a brief comparison of the REC-CAP and the Smiley tools. The chapter also briefly discusses the importance of managing practice-related knowledge. Finally, the implications of the findings for AOD treatment are outlined, accompanied by some concluding remarks.

The conditions for RC in Swedish AOD treatment

Research concerning RC is still in its early stages, and the question of how to effectively utilise RC in Swedish AOD treatment remains unresolved. Papers II and III investigated the attitudes of professionals towards RC and its operationalisations, which can be summarised along two dimensions. The first dimension encompasses the conceptual aspects of RC, including its theoretical foundation regarding recovery progress. The second dimension focuses on the specific operationalisations developed to assess RC in treatment. Based on the findings, several key points regarding these two dimensions emerge. Conceptually, the majority of study participants found RC a relevant tool for measuring treatment progress. They particularly emphasised the strength-based and resource-focused perspective of RC, as well as its potential impact on client progress. This finding is consistent with current research on the effectiveness of RC. However, as demonstrated in Paper II, the professionals largely motivated RC’s conceptual applicability by arguing that it was consistent with their existing work methods and approaches. This finding is in line with a point made by Stenius (2017): namely, that when AOD-related problems are the responsibility of social services, not the health care system, these treatment settings promote a holistic approach similar to the core characteristics of the recovery perspective.

Regarding the second dimension, that of specific operationalisations of RC, Paper I demonstrated that REC-CAP effectively captured the changes that oc-
curred during residence stays, highlighting the analytical value of RC and underscoring its potential for operationalisation. Furthermore, the use of standardised measures presents challenges in terms of identifying a single outcome metric applicable to all trajectories. While specified and comprehensive data are often seen as desirable, it is essential to question whether such data truly capture the complexities of individual experiences and treatment outcomes in the area of AOD. Nevertheless, it is evident that utilising RC to assess treatment progress offers distinct advantages, enabling an exploration of diverse trajectories that, in turn, can effectively address individual barriers and strengths.

Findings from Paper III indicate that when implementing an RC operationalisation, such as the REC-CAP in Swedish AOD treatment, it is likely that the operationalisation will undergo modifications during client interactions. This finding is aligned with previous research indicating that methods and tools are sometimes used in ways that differ from their original intention (Bergmark & Lundström, 2008; Bergmark et al., 2018; Björk, 2016; Høybye-Mortensen, 2015; Karlsson & Bergmark, 2012; Nordesjö et al., 2020). Previous research also shows that lack of program fidelity is not always regarded as a problem, but rather can be regarded as a means of ensuring the method or tool’s applicability and relevance across different local contexts (Damschroder et al., 2009; Durlak & DuPre, 2008; Mol, 2006; Sletten & Bjorkquist, 2020; Timmermans & Epstein, 2010). This suggests that the desire to modify the tool does not necessarily constitute a barrier to implementing an RC-based assessment tool in Swedish AOD treatment.

A different potential barrier for the usability of RC can, however, be traced to another intervention characteristic. Papers II and III revealed that professionals found the conceptual dimensions of RC to be the most appealing for application in their daily work. When asked to elaborate on this preference, they said that RC as a concept was aligned with their existing work methods. Essentially, this implies that the conceptual parts of RC are already integrated into practice. This finding can be viewed in the context of relative advantage, which is recognised as the most significant attribute influencing the adoption of a tool (Greenhalgh et al., 2004). The concept of relative advantage encompasses the benefits gained from implementing a tool in comparison to alternative solutions (Damschroder et al., 2009; Greenhalgh et al., 2004).

At first glance, the desire to modify the tool could easily be understood as the primary obstacle for implementation. Previous research, however, suggests that this concern might not pose a substantial issue. Instead, the absence of relative advantage emerges as a more prominent challenge, particularly in light of the findings in this dissertation, which indicate that the conceptual components of RC are already integrated into current practice. The Smiley tool, for instance, covers areas similar to the key areas assessed in more comprehensive operationalisations derived from RC’s conceptual components.
This raises questions about the potential benefits that professionals could derive from adopting a formalised version of RC, and consequently raises doubts about the value of such a formalisation.

Navigating standardisations in social work
According to Abbott (1988), a core component of what constitutes a profession is its relative nature in relation to other professions. Members of a profession are thus occupied with controlling the culture and structure of their jurisdiction and protecting it from interference from other professions. The first example in this dissertation of what might be interpreted as professionals protecting their jurisdiction was observed in Papers II and III, where social work professionals were asked to review the applicability of RC both conceptually and as an assessment tool. When introduced only to the concept of RC, a majority were convinced that the practice would benefit from its implementation, because it bore similarities to the work methods and overall approaches to recovery they were already using.

In Paper III, the professionals were faced with an actual RC assessment tool, which prompted other reactions. For example, the professionals talked about how they would tinker with the tool if they were to apply it in their daily work. The tinkering was explained as a solution for its non-applicable standardised aspects – ultimately suggesting that social work cannot be standardised. One interpretation of this finding is that while the conceptual aspects of RC were found to be in line with cultural conditions already in place at the treatment facilities, the standardised aspects were not. Drawing on Abbot’s concept of jurisdiction, this could further be interpreted as professionals safeguarding their professional autonomy and expertise. From the perspective of the professionals, tinkering would be required in order for the assessment tool to fit their cultures and structures.

Another similar example was observed in Paper IV, which examined the use of a locally developed tool. When talking about non-local knowledge production, such as tools recommended by the National Board of Health and Welfare (NBHW), professionals described these tools as a distinct type of knowledge. They emphasised that these tools were highly specified and comprehensive, while avoiding saying that they had greater validity compared to locally produced knowledge. Instead, they emphasised the applicability of the locally produced tool, which they regarded as more valid in the context of their daily work. In doing so, they implied that the locally produced tool was permeated by practice-related knowledge and that this practice-related knowledge is a type of knowledge that the NBHW tools lack. This finding can be interpreted as social work professionals protecting their jurisdiction by perceiving NBHW-recommended tools as relatively invalid, compared to locally
produced tools. Abbot’s theory suggests that these conflicts and disputes over cultures and structures are inherent to the social work profession.

These types of disputes can also be viewed in the light of the scholarly debate regarding the impact of standardisations on discretion. While some argue that increased standardisation associated with NPM can lead to a reduction in professional autonomy, viewed as a form of de-professionalisation (Ahlbäck Öberg et al., 2016; Hood, 1995; Rogowski, 2012), others contend that standardisations can actually enhance discretion by necessitating the management of contradictory logics (Evans & Harris, 2004; Ponnert & Svensson, 2016). The latter perspective suggests that social workers may hold varying discretionary positions in relation to standardisations that do not necessarily diminish their professional standing (Skillmark & Denvall, 2018).

Viewed through the lens of Abbot’s concept of jurisdiction, the findings of this dissertation align with the theoretical framework positing that standardisations do not inherently limit discretion, but rather represent a process inherent to the social work profession.

A brief comparison of intervention attributes

The practical adoption of a tool relies heavily on its attributes and characteristics (Damschroder et al., 2009; Greenhalgh et al., 2004). While the empirical data in this dissertation do not allow for direct comparisons between the Smiley and REC-CAP tools, a few observations on the characteristics of these two interventions can be made. The REC-CAP has undergone rigorous psychometric testing and has accumulated a body of evidence supporting its effectiveness in measuring recovery progress and outcomes among individuals with AOD-related problems. Currently, the REC-CAP is widely utilised in multiple countries. In contrast, the Smiley, although it is inspired by other more established assessment tools, has not received any scholarly attention and is exclusively implemented in one treatment unit in Sweden. Nevertheless, both assessment tools share the common goal of systematically measuring treatment progress.

Another notable difference lies in the scopes of the tools. For instance, the REC-CAP consist of 98 items, while the Smiley comprises only seven questions answered using a smiley scale ranging from happy to sad. It is reasonable to assume that the REC-CAP can generate higher-quality and more specific data, compared to the Smiley. However, the scope of an assessment tool influences other aspects beyond data quality. In the field of implementation and intervention research, one key attribute that influences the adaptation of an intervention is its complexity, referring to how easily an innovation can be used (Greenhalgh et al., 2004).

Paper I indicate some challenges associated with the use of REC-CAP, leading to incomplete data and time-varying baseline assessments. Although
evidence clarifying the association between complexity and adoption is currently limited, some findings suggest that interventions are more likely to be used if they are simpler rather than complex (Dewar & Dutton, 1986). Accordingly, one interpretation of the inconsistencies observed in the REC-CAP data is that the tool’s complexity poses a challenge for systematic use. Paper IV examined the characteristics and use of another intervention, the Smiley. According to the study participants, the Smiley was systematically used to assess the progress made between the first and the last treatment occasion. When reflecting on the usability of the Smiley, many of the interviewed professionals highlighted its clear advantage of simplicity. One conclusion is that use of the Smiley is motivated by the expectation of increased systematic use, while use of the REC-CAP is driven by the underlying assumption that it produces data of higher quality and specificity. This further illustrates a clear trade-off between systematic use and data quality. One key concluding argument of this dissertation is that focus on data quality should not overshadow the significance of systematic use in monitoring and evaluating treatment progress. By prioritising systematic use over data quality, social work professionals can adapt and refine assessment tools to better align with the complex needs of their clients, ultimately promoting an emphasis on individualised recovery trajectories as inherent in the concept of RC.

Making practice-related knowledge explicit

This dissertation posits that knowledge is the foundation of a profession. The social work profession is considered a modern profession, and as such science-based. Science-based knowledge is transferred into social work practice through various formalisations. Another fundamental part of social work comprises what are described as skills and tacit knowledge (e.g., Brante, 2011; Polanyi, 1983), which are gained through direct experience and occur ‘in the wild’ (Bohlin & Sager, 2011, p. 116). Due to its unformalisable characteristics, practice-related knowledge is likely to be left out of the knowledge production process, and tacit knowledge and skills may be undervalued. Previous scholarly suggestions for managing knowledge production and use in social work involve the production of guidelines and interventions that consider the ‘logic of care’ rather than a ‘laboratory logic’ (Mol, 2008).

In line with previous research, this dissertation argues that practice-based knowledge is a fundamental part of social work and that expertise and experience rooted in practice must be taken care of. Additionally, local knowledge production provides a mechanism for capturing practice-based knowledge. Locally produced tools are inherently shaped by their local preconditions, and it follows that they will prioritise local needs and prerequisites. Furthermore, usability and applicability are not compromised in locally produced tools, providing favourable conditions for systematic use. Overall, enhancing the
conditions for and promoting the development of locally produced tools holds potential for involving practice-related knowledge in knowledge production, which ultimately is likely to benefit knowledge use.

This conclusion does not mean that science-produced knowledge should be abandoned. It does highlight the importance of incorporating professionals into the research process. Here, participatory research is a potential solution to effectively harness practice-related knowledge. Despite potential challenges in achieving higher levels of participation (Cornwall & Jewkes, 1995), the participatory approach allows for the utilisation of practice-related knowledge in science-based knowledge. All in all, promoting locally produced knowledge and participatory research does not reduce the importance of science-based knowledge; rather, it forms a basis for practice-related knowledge and science-based knowledge to coexist on equal terms.

**Final remarks and implications**

The findings demonstrate that the concept of RC is applicable in a Swedish AOD treatment context. Despite challenges, using RC to assess treatment progress has unique benefits. It allows for exploration of different pathways to recovery, which can effectively address individual challenges and strengths. However, the utilisation of standardised assessment tools as a strategy to implement RC in Swedish AOD treatment remains unclear. Furthermore, it is unclear whether RC should be incorporated into a knowledge production process with the ambition of improving Swedish AOD treatment, given that certain elements of its conceptual framework are already implemented in the treatment facilities visited in this study.

This dissertation’s contributions to social work practice also centre on the overall question of translating research into practice and improving conditions for knowledge production and use in social work. Consistent with existing research, the dissertation emphasises the importance of consulting professionals in the development of tools. If tools are designed in alignment with the expertise and preferences of the professionals who use them in their daily work, they are more likely to gain approval and be used systematically. Here, the promotion of locally produced knowledge is presented as a solution along with research designs that aim to incorporate practice-based knowledge. In this dissertation, this is understood as a matter of allowing social work professionals to remain in control of their jurisdiction.

The dissertation also reveals a significant knowledge gap regarding locally produced knowledge. Future research to map out the extent of local knowledge production is essential. The assessment of local knowledge products is paramount in comprehending both current and future knowledge requirements in social work practice. As such, the evaluation of locally produced knowledge is
integral to understanding knowledge production and knowledge use in social work.

In concluding the insights of this dissertation, the client perspective must once again be recognised. One limitation of the dissertation lies in the absence of direct client participation, so that client representation relies on the voices of professionals. The conclusion that emphasises the role of professionals in tool development does not imply that clients are or should be excluded from this process. Instead, the findings underscore the importance of client viewpoints and needs, even if their perspective remains unexplored within the scope of this dissertation. These findings only underscore the imperative for future research to delve into the client perspective, particularly in light of research indicating that recovery-oriented interventions and tools may have adverse effects on clients (Lancaster et al., 2015; Fomiatti et al., 2017; Zschau et al., 2016).
Sammanfattning på svenska


nomen. Detta perspektiv betoner betydelsen av relationen mellan dessa fenomen för kunskapsproduktion och användning, och placerar därmed avhändlingen inom den bredare teoretiska diskussionen om samspelet mellan standardisering och professionalism.

Delstudie ett visar att RC ökade under behandlingstiden, men att den observerade förändringen varierade i olika grupper. En större ökning av RC under behandlingstiden var associerad med faktorer som låg ålder, sysselsättning, högre nivå av socialt stöd samt högre livskvalité. Även betydande skillnader observerades mellan de som stannade och de som avbröt behandlingen. De som stannade var äldre och deltog aktivt i stödgrupper, medan yngre, kvinnor och de med i behov av bostad eller utan bostad var mer benägna att avbryta. Resultaten indikerar därmed att olika typer av insatser kan krävas för att stödja olika typer av grupper. Specifikt bör yngre personer och kvinnor stödjas för att stanna kvar i behandling, medan äldre män kan behöva interventioner som fokuserar på att främja ökningen av RC. Trots utmaningar med systematisk användning visade delstudie ett att operationaliseringar av RC har unika fördelar vad gäller att kartlägga olika typer av förändringsprocesser.


Resultatet från delstudie fyra tyder på att justeringar av verktyg inte nödvändigtvis är relaterat till begränsningar i praktisk relevans och ifrågasätter därmed antagandet att justeringar är en lösning på bristande praktisk applicbarhet. Ytterligare en observation var att professionella tycks vara mer benägna att använda ett verktyg systematiskt om det är utformat med hänsyn till mötet mellan klient och professionell. Det framkom även reflektioner kring


Kitzinger, J. (1994). The methodology of Focus Groups: the importance of interaction between research participants. *Sociology of Health & Illness, 16*(1), 103–121. https://doi.org/10.1111/1467-9566.ep11347023


Appendixes
Appendix 1. REC-CAP

REC-CAP
RECOVERY CAPITAL, RECOVERY ENABLERS
AND BARRIERS AND SUPPORT NEEDS

Section 1: Demographic characteristics

1.1 Gender?
   - Agender □
   - Demi-queer □
   - Non-Binary □
   - Trans-Femme □
   - Trans-Man □
   - Trans-Masculine □
   - Trans-Woman □
   - Trans-Gender □
   - Two-Spirit □
   - Male □
   - Female □
   - None of These Describe Me □
   - Prefer Not to Answer □

1.1 Age: ________ years

1.2 Ethnicity: ___________________________

1.3 Education:
   - Never attended school or only attended kindergarten □
   - Grades 1 through 4 (Primary) □
   - Grades 5 through 8 (Middle school) □
   - Grades 9 through 11 (Some high school) □
   - Grade 12 or GED (High school graduate) □
   - 1 to 3 years after high school (Some college, Associate’s degree, or technical school) □
   - College 4 years or more (College graduate) □
   - Advanced degree (Master’s, Doctorate, etc.) □
   - Prefer not to answer □
Section 2: Quality of life and satisfaction

For each of the questions below, please give a rating on the scale for how you are feeling today, where higher scores mean you are feeling better and lower scores that you are not so satisfied with this part of your life. Indicate your score by marking on the “rulers.”

1.1 How good is your psychological health?
- Poor
- Acceptable
- Good

1.2 How good is your physical health?
- Poor
- Acceptable
- Good

1.3 How would you rate your overall quality of life?
- Poor
- Acceptable
- Good

1.4 How would you rate the quality of your housing?
- Poor
- Acceptable
- Good

1.5 How would you rate your support network?
- Poor
- Acceptable
- Good

Section 3: Barriers to recovery

3.1 Housing

3.1.1 At any point in the last month have you been:
- At risk of eviction: No [ ] Yes [ ]
- Having acute housing problems: No [ ] Yes [ ]

3.1.2 Number of days in last 3 months (90 days) you have been living in:

<table>
<thead>
<tr>
<th>Days</th>
<th>Days</th>
<th>Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Own home</td>
<td>Supported Accommodation</td>
<td>Hospital or Detox</td>
</tr>
<tr>
<td>With family</td>
<td>Hostel (Shelter)</td>
<td>Treatment center</td>
</tr>
<tr>
<td>With friends</td>
<td>On streets/rough sleeping</td>
<td>Prison</td>
</tr>
<tr>
<td>Recovery residence</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
3.1.3 Do you have problems securing housing because of bad credit or other debt issues?  

No □ Yes □

3.2 Substance use

Have you used any legal or illegal substances in the last 90 days?  No □ Yes □

If 'No' please respond to the first column below then move to section 3.4.  
If 'Yes' please review the table below and record information as indicated.

<table>
<thead>
<tr>
<th>Substance</th>
<th>Ever been problem?</th>
<th>Used in the last 90 days</th>
<th>Days used in the last 90 days</th>
<th>Avg daily amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>□ NO □ Yes □</td>
<td>□ NO □ Yes □</td>
<td>□ NO □ Yes □</td>
<td>units/day</td>
</tr>
<tr>
<td>Heroin</td>
<td>□ NO □ Yes □</td>
<td>□ NO □ Yes □</td>
<td>□ NO □ Yes □</td>
<td>g/day</td>
</tr>
<tr>
<td>Crack cocaine</td>
<td>□ NO □ Yes □</td>
<td>□ NO □ Yes □</td>
<td>□ NO □ Yes □</td>
<td>g/day</td>
</tr>
<tr>
<td>Cocaine powder</td>
<td>□ NO □ Yes □</td>
<td>□ NO □ Yes □</td>
<td>□ NO □ Yes □</td>
<td>g/day</td>
</tr>
<tr>
<td>Amphetamines</td>
<td>□ NO □ Yes □</td>
<td>□ NO □ Yes □</td>
<td>□ NO □ Yes □</td>
<td>g/day</td>
</tr>
<tr>
<td>(Cannabis)</td>
<td>□ NO □ Yes □</td>
<td>□ NO □ Yes □</td>
<td>□ NO □ Yes □</td>
<td>spill/day</td>
</tr>
<tr>
<td>Fentanyl (prescribed)</td>
<td>□ NO □ Yes □</td>
<td>□ NO □ Yes □</td>
<td>□ NO □ Yes □</td>
<td>g/day</td>
</tr>
<tr>
<td>Fentanyl (street)</td>
<td>□ NO □ Yes □</td>
<td>□ NO □ Yes □</td>
<td>□ NO □ Yes □</td>
<td>g/day</td>
</tr>
<tr>
<td>Methadone (prescribed)</td>
<td>□ NO □ Yes □</td>
<td>□ NO □ Yes □</td>
<td>□ NO □ Yes □</td>
<td>mg/day</td>
</tr>
<tr>
<td>Methadone (street)</td>
<td>□ NO □ Yes □</td>
<td>□ NO □ Yes □</td>
<td>□ NO □ Yes □</td>
<td>mg/day</td>
</tr>
<tr>
<td>Methamphetamine (street)</td>
<td>□ NO □ Yes □</td>
<td>□ NO □ Yes □</td>
<td>□ NO □ Yes □</td>
<td>g/day</td>
</tr>
<tr>
<td>NPS (Synthetics)</td>
<td>□ NO □ Yes □</td>
<td>□ NO □ Yes □</td>
<td>□ NO □ Yes □</td>
<td>tab/day</td>
</tr>
<tr>
<td>Opioid Pain Medications (prescribed)</td>
<td>□ NO □ Yes □</td>
<td>□ NO □ Yes □</td>
<td>□ NO □ Yes □</td>
<td>mg/day</td>
</tr>
<tr>
<td>Opioid Pain Medications (street)</td>
<td>□ NO □ Yes □</td>
<td>□ NO □ Yes □</td>
<td>□ NO □ Yes □</td>
<td>mg/day</td>
</tr>
<tr>
<td>Buprenorphine (prescribed) (Subcut)</td>
<td>□ NO □ Yes □</td>
<td>□ NO □ Yes □</td>
<td>□ NO □ Yes □</td>
<td>mg/day</td>
</tr>
<tr>
<td>Buprenorphine (street) (Subcut)</td>
<td>□ NO □ Yes □</td>
<td>□ NO □ Yes □</td>
<td>□ NO □ Yes □</td>
<td>mg/day</td>
</tr>
<tr>
<td>Benzos (prescribed)</td>
<td>□ NO □ Yes □</td>
<td>□ NO □ Yes □</td>
<td>□ NO □ Yes □</td>
<td>mg/day</td>
</tr>
<tr>
<td>Benzos (street)</td>
<td>□ NO □ Yes □</td>
<td>□ NO □ Yes □</td>
<td>□ NO □ Yes □</td>
<td>mg/day</td>
</tr>
<tr>
<td>Tobacco</td>
<td>□ NO □ Yes □</td>
<td>□ NO □ Yes □</td>
<td>□ NO □ Yes □</td>
<td>cigarettes/day</td>
</tr>
</tbody>
</table>

Other problem substance?  [specify]

□ NO □ Yes □ □ NO □ Yes □ □ NO □ Yes □

3.3 Risk taking

Have you injected drugs in the last 90 days?  No □ Yes □  

(If No, skip to 3.4)

If yes, how many days have you injected on? 0-50 days or since last REC-CAP evaluation? ___________

Have you injected with a needle or syringe used by someone else, or have you been injected by someone else, within the last 50 days or since last REC-CAP evaluation?  No □ Yes □

Have you injected using a spoon, water or filter used by someone else within the last 90 days or since last REC-CAP Evaluation?  No □ Yes □
3.4 Involvement with the Criminal Justice System

Have you been involved in offending within the last 90 days or since last REC-CAP Evaluation? No □ Yes □

Have you been involved with the police at any time within the last 90 days or since last REC-CAP Evaluation? No □ Yes □

Were you on probation at any time within the last 90 days or since last REC-CAP Evaluation? No □ Yes □

Were you on parole at any time within the last 90 days or since last REC-CAP Evaluation? No □ Yes □

Have you had any other form of involvement with the criminal justice system within the last 90 days or since last REC-CAP Evaluation? No □ Yes □

If yes, please specify:

__________________________________________________________________________

3.5 Work, training, and volunteering

Are you currently working full-time? No □ Yes □

Are you currently working part-time? No □ Yes □

Are you currently attending school, including on-line course work? No □ Yes □

Are you currently volunteering? No □ Yes □

Section 4: Services involvement and needs

The following table assesses what services you are engaged with and whether your current level of service involvement is meeting your needs:

<table>
<thead>
<tr>
<th>Service</th>
<th>Are you currently engaged with this kind of service?</th>
<th>If you are, are you satisfied with the service you are getting?</th>
<th>Do you need help or additional help in this area?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug treatment services</td>
<td>□ No □ Yes</td>
<td>□ No □ Yes</td>
<td>□ No □ Yes</td>
</tr>
<tr>
<td>Alcohol treatment services</td>
<td>□ No □ Yes</td>
<td>□ No □ Yes</td>
<td>□ No □ Yes</td>
</tr>
<tr>
<td>Mental health services</td>
<td>□ No □ Yes</td>
<td>□ No □ Yes</td>
<td>□ No □ Yes</td>
</tr>
<tr>
<td>Housing support</td>
<td>□ No □ Yes</td>
<td>□ No □ Yes</td>
<td>□ No □ Yes</td>
</tr>
<tr>
<td>Employment services</td>
<td>□ No □ Yes</td>
<td>□ No □ Yes</td>
<td>□ No □ Yes</td>
</tr>
<tr>
<td>Primary healthcare services (GP, medical services)</td>
<td>□ No □ Yes</td>
<td>□ No □ Yes</td>
<td>□ No □ Yes</td>
</tr>
<tr>
<td>Family relationships</td>
<td>□ No □ Yes</td>
<td>□ No □ Yes</td>
<td>□ No □ Yes</td>
</tr>
<tr>
<td>Other specialist help or support (please specify)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Section 5: Personal recovery capital

Please read the following statements and check a statement only if you agree with it entirely and unreservedly. Do not linger over the question but give your initial feeling at this moment. If you disagree or are unsure, leave it blank. These should reflect how you currently feel about things that have happened to you in the last 3 months (90 days).

<table>
<thead>
<tr>
<th>Having a sense of purpose in life is important to my recovery journey</th>
<th>Check if you agree with this statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am able to concentrate when I need to</td>
<td></td>
</tr>
<tr>
<td>I am coping with the stresses in my life</td>
<td></td>
</tr>
<tr>
<td>I am free from worries about money</td>
<td></td>
</tr>
<tr>
<td>I am happy dealing with a range of professional people</td>
<td></td>
</tr>
<tr>
<td>I am making good progress on my recovery journey</td>
<td></td>
</tr>
<tr>
<td>I cope well with everyday tasks</td>
<td></td>
</tr>
<tr>
<td>I do not let other people down</td>
<td></td>
</tr>
<tr>
<td>I am happy with my appearance</td>
<td></td>
</tr>
<tr>
<td>I engage in activities and events that support my recovery</td>
<td></td>
</tr>
<tr>
<td>I eat regularly and have a balanced diet</td>
<td></td>
</tr>
<tr>
<td>I feel physically well enough to work</td>
<td></td>
</tr>
<tr>
<td>I have enough energy to complete the tasks I set myself</td>
<td></td>
</tr>
<tr>
<td>I have no problems with transportation</td>
<td></td>
</tr>
<tr>
<td>I have the personal resources I need to make decisions about my future</td>
<td></td>
</tr>
<tr>
<td>I have the privacy I need</td>
<td></td>
</tr>
<tr>
<td>I look after my health</td>
<td></td>
</tr>
<tr>
<td>I make sure I do nothing that hurts or damages other people</td>
<td></td>
</tr>
<tr>
<td>I meet all my obligations promptly (things you have made a commitment to do)</td>
<td></td>
</tr>
<tr>
<td>I sleep well most nights</td>
<td></td>
</tr>
<tr>
<td>I take full responsibility for my actions</td>
<td></td>
</tr>
<tr>
<td>In general I am happy with my life</td>
<td></td>
</tr>
<tr>
<td>What happens to me in the future mostly depends on me</td>
<td></td>
</tr>
<tr>
<td>I have a network of people I can rely on to support my recovery</td>
<td></td>
</tr>
<tr>
<td>When I think of the future I feel optimistic</td>
<td></td>
</tr>
</tbody>
</table>
## Section 6: Social recovery capital

Please read the following statements and check a statement only if you agree with it completely. Do not linger over the question but give your initial feeling at this moment. If you disagree or are unsure, leave it blank. These statements are about how you currently feel and about things that have happened to you in the last 3 months (90 days).

<table>
<thead>
<tr>
<th>Statement</th>
<th>Check if you agree with this statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am actively involved in leisure and sport activities</td>
<td></td>
</tr>
<tr>
<td>I am currently completely sober from drug use</td>
<td></td>
</tr>
<tr>
<td>I am actively engaged in efforts to improve myself (training, education and/or self-awareness)</td>
<td></td>
</tr>
<tr>
<td>I am happy with my personal life</td>
<td></td>
</tr>
<tr>
<td>I am proud of my home</td>
<td></td>
</tr>
<tr>
<td>I am proud of the community I live in and feel a part of it — sense of belonging</td>
<td></td>
</tr>
<tr>
<td>I am satisfied with my involvement with my family</td>
<td></td>
</tr>
<tr>
<td>I am free of threat or harm when I am at home</td>
<td></td>
</tr>
<tr>
<td>I engage in activities that I find enjoyable and fulfilling</td>
<td></td>
</tr>
<tr>
<td>I feel safe and protected where I live</td>
<td></td>
</tr>
<tr>
<td>I feel that I am in control of my substance use</td>
<td></td>
</tr>
<tr>
<td>I feel that I am free to shape my own destiny</td>
<td></td>
</tr>
<tr>
<td>I get lots of support from friends</td>
<td></td>
</tr>
<tr>
<td>I get the emotional help and support I need from my family</td>
<td></td>
</tr>
<tr>
<td>I have a special person that I can share my joys and sorrows with</td>
<td></td>
</tr>
<tr>
<td>I have access to opportunities for career development (job opportunities, volunteering or internships)</td>
<td></td>
</tr>
<tr>
<td>I have had no lapses or relapses regarding substance abuse</td>
<td></td>
</tr>
<tr>
<td>I have had no recent periods of intoxication</td>
<td></td>
</tr>
<tr>
<td>I regard my life as challenging and fulfilling without the need for using drugs or alcohol</td>
<td></td>
</tr>
<tr>
<td>It is important for me to contribute to society and be involved in activities that contribute to my community</td>
<td></td>
</tr>
<tr>
<td>It is important for me to do what I can to help other people</td>
<td></td>
</tr>
<tr>
<td>It is important for me that I make a contribution to society</td>
<td></td>
</tr>
<tr>
<td>My living space has helped to encourage my recovery journey</td>
<td></td>
</tr>
<tr>
<td>My personal identity does not revolve around drug use or drinking</td>
<td></td>
</tr>
<tr>
<td>There are more important things to me in life than using substances</td>
<td></td>
</tr>
</tbody>
</table>
Section 7: Involvement with recovery groups and your local community

7.1 Please check if you agree with any of the following statements about any group you have attended in the community in the last month to support your recovery. These questions refer to any group — formal or informal — that you attend that supports your recovery, including AA, NA, SMART Recovery, local peer groups, aftercare groups and any other types of recovery group you belong to:

<table>
<thead>
<tr>
<th>Statement</th>
<th>Check if you agree with this statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>I attend recovery group meetings on a weekly basis or more frequently</td>
<td></td>
</tr>
<tr>
<td>If I did not make a meeting at my group for two weeks, people would call to see if I was okay</td>
<td></td>
</tr>
<tr>
<td>I speak at recovery meetings</td>
<td></td>
</tr>
<tr>
<td>I perform service at recovery meetings</td>
<td></td>
</tr>
<tr>
<td>I carry a message of hope to others (and openly talk about my own recovery)</td>
<td></td>
</tr>
<tr>
<td>I socialize before and/or after meetings</td>
<td></td>
</tr>
<tr>
<td>I attend recovery social events</td>
<td></td>
</tr>
<tr>
<td>I visit a recovery center</td>
<td></td>
</tr>
<tr>
<td>I read recovery supportive literature</td>
<td></td>
</tr>
<tr>
<td>I carry a recovery object (something that reminds me of my ongoing recovery)</td>
<td></td>
</tr>
<tr>
<td>I have people from my recovery group who support my recovery</td>
<td></td>
</tr>
<tr>
<td>I use daily recovery rituals (things I do every day to support my recovery journey)</td>
<td></td>
</tr>
<tr>
<td>I do voluntary service to help my recovery group</td>
<td></td>
</tr>
<tr>
<td>I encourage others to attend my recovery group</td>
<td></td>
</tr>
</tbody>
</table>

7.2 Please specify what recovery groups you have attended in the last month:

7.3 Please specify what online recovery groups you have accessed in the last month:

7.4 Whether or not you are currently using any of the following, do you feel that you need additional support from:

- 7.5.1 Peer support
- 7.5.2 12-step mutual aid program
- 7.5.3 Other community recovery groups
- 7.5.4 Online recovery groups

[ ] No [ ] Yes
Section 7, Part 3: Support

7.5 How much support do you get from other people?

For each of the questions below, please give a rating on the scale for how you are feeling about the question today, where higher scores mean you receive more support, and lower scores mean you receive less support. Indicate your score by circling the number that best describes your feeling.

7.6 Do you get the emotional support you need from other people?

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at All</td>
<td>Completey</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

7.7 Do you get the help you need from other people?

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at All</td>
<td>Completey</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

7.8 Do you get the resources you need from other people?

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at All</td>
<td>Completey</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

7.9 Do you get the advice you need from other people?

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at All</td>
<td>Completey</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Section 8: Commitment

For each of the questions below, please give a rating on the scale for how you are feeling about the question today, where higher scores mean you strongly agree and lower scores mean you strongly disagree with this statement. Indicate your score by circling the number that best describes your feeling.

8.1. Staying sober/clean is the most important thing in my life.

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Strongly Agree</td>
</tr>
</tbody>
</table>

8.2. I am totally committed to staying off of alcohol/drugs.

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Strongly Agree</td>
</tr>
</tbody>
</table>

8.3. I will do whatever it takes to recover from my addiction.

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Strongly Agree</td>
</tr>
</tbody>
</table>

8.4. I never want to return to alcohol/drug use again.

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Strongly Agree</td>
</tr>
</tbody>
</table>

8.5. I have had enough alcohol and drugs.

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Strongly Agree</td>
</tr>
</tbody>
</table>
Section 9: What do you see as your needs?

Please respond to the following questions as fully as you want to, including using the back of the page if you need more space.

9.1 Where do you see yourself in your recovery journey?

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

9.2 What are your current life goals?

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

9.3 What do you need to help you get to the next goal in your life journey?

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

9.4 Who do you rely on to help you with your recovery?

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________
Appendix 2. Interview guide (first interview phase).

**Koncept**
- Är kategoriseringen av resurser rimlig även i en svensk kontext?
- Är resurserna som framhävs som viktiga relevanta?
- Finns det någon viktig resurs som ni tycker saknas?
- Finns det någon resurs som inte känns relevant?
- Tror ni att olika resurser har olika betydelse för olika klientgrupper?
- Vad tycker ni om definitionen? Är alla faktorer/resurser lika viktiga? Vilka faktorer är viktiga/mindre viktiga?

**Instrument**
- Är det viktigt att synliggöra dessa typer av resurser?
- Om ja, varför är det viktigt att synliggöra dessa typer av resurser?
- Om nej, varför inte?
- Kan det användas för att bedöma hjälpbehov/behandlingsbehov?
- Finns det ett behov av ett sånt här instrument (som REC-CAP)?
- Om ja (eller kanske), behandlingsverktyg eller bedömningsverktyg?
- Om bedömningsverktyg, komplement till redan etablerade instrument eller kan det stå för sig själv?
- Om nej, varför inte?
- Hur skulle det kunna användas?
- Används redan liknande instrument?
- Kan resurserna synliggöras utan ett instrument? Om ja (eller kanske), hur skulle det gå till?
- Kan begreppet och resurserna användas på något annat sätt?
- Är instrumentet mer applucerbart i vissa klientgrupper? Inom vissa behandlingar?

**Övergripande**
- Vad kan ett brukarperspektiv i de här frågorna bidra med?
- Har ni några frågor?
- Övriga kommentarer
Appendix 3. Interview guide (second interview phase).

**Frågor om specifika items**

- Är det något ni tycker känns lämpligt att fråga era klienter? Varför/vari för inte?
- Tycker ni att den fångar upp något som är viktigt att synliggöra? Varför/vari för inte?

**Övergripande**

- Är det något ni skulle kunna tänka er att använda er av? Skulle det på något sätt gynna er verksamhet att ha såna här formulerade frågor/påståenden eller ett annat liknande verktyg?
  - På vilket sätt?
  - I vilka situationer?
- Är det någon fråga/något område ni tycker saknas?
- Om ni fick välja två frågor, eller två typer av frågor, som ni tycker är bra respektive dåliga, vilka skulle det vara?
- Tror ni att frågorna är mer eller mindre lämpliga beroende på vem klienten är? Varför/vari för inte?
- När ni nu har kollat på det här instrumentet nu, vad har ni för reflektioner gällande instrumentet som helhet?
- Är det något ni skulle ha nytta av i ert arbete? Varför/vari för inte?
- Vad finns det för fördelar med specifika påståenden/frågor som dessa?
  - Vad finns det för nackdelar?
- När skulle det vara användbart med den här typen av frågor?
  - Kan det användas som stöd i samtal? Varför? Varför inte?
- Är det några frågor/påståenden som ni känner att ni skulle vilja använda er av?
- Använder ni er av något liknande instrument eller verktyg idag? I så fall vad?
- Är det något ni något ni skulle vilja tillägga?
Appendix 4. Instructions and discussion material (second interview phase).

Instruktioner
Recovery capital är ett begrepp som används för att beskriva resurser en individ kan använda sig av för att påbörja och upprätthålla en positiv förändringsprocess. För att använda recovery capital i praktiken har ett antal mätinstrument skapats baserat på begreppet. Förra gången vi träffades pratade vi om recovery capital och framförallt, utifrån era erfarenheter, behovet av dessa typer av mätinstrument i en svensk behandlingskontext.

Nedan hittar ni delar av ett av dessa mätinstrument som heter REC-CAP. De delar vi har valt ut är de delar som är utformade för att mäta just recovery capital. Första delen mäter personliga resurser, andra delen mäter sociala resurser och den tredje delen mäter något som kallas recovery group participation. Dessa tre delar av instrumentet består av påståenden där klienten ska sätta ett kryss i rutan om de anser att påståendet stämmer, och lämna blankt om de anser att det inte stämmer.

I det här steget av processen är vi nyfikna på hur överförbara såna här typer av instrument är, och framförallt de specifika frågorna. Instrumentet har tidigare inte översatts till andra språk, och det är möjligt att de specifika påståendena är applicerbara eller användbara i en svensk kontext. Därför skulle vi vilja att ni individuellt går igenom påståendena och reflekterar över hur applicerbara de upplevs för er i ert arbete. Är det frågor ni anser vara relevanta att ställa? Tycker ni att de fångar upp viktiga aspekter av era klienters förändringsprocesser?

Gå igenom varje påstående och fundera på hur applicerbart/relevant det skulle kunna vara att använda i er verksamhet. Försök att hitta ett par/tre stycken som ni tycker är bra och ett par/tre stycken som ni tycker är dåliga. Tanken är att varje person som deltar i intervjun gör den här ”uppgiften” på egen hand. Alltså, att alla som deltar i intervjun kommer dit med ett eget dokument och egna reflektioner kring påståendena. Självklart kan ni ha diskussioner med varandra redan innan, men helst vill vi att ni sparar så mycket som möjligt till intervjuut tillfället.

Instrumentet har uteslutande använts i engelsktalande länder, och finns därför bara tillgänglig i en engelsk version. Under varje påstående har vi gjort en godtycklig översättning, men kom ihåg att vissa av de engelska begreppen är svåra att direkt översätta till svenska och att påståendet därför kan få lite annan betydelse.

Vi uppskattar verkligen om ni har möjligheten att göra det här innan vi ses, men förstår samtidigt att det kan finnas tidsbegränsningar. Vi förstår om ni inte hinner gå igenom alla påståenden innan intervjun. Under intervjun kommer vi att gå igenom instrumentet och diskutera vad ni tycker funkar och inte funkar, och framförallt varför.
<table>
<thead>
<tr>
<th>Personliga resurser</th>
<th>Dina reflektioner</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Having a sense of purpose in life is important to my recovery journey</td>
<td>Att ha mål med livet är viktigt för min återhämtning</td>
</tr>
<tr>
<td>2 I am able to concentrate when I need to</td>
<td>Jag kan koncentrera mig när jag behöver det</td>
</tr>
<tr>
<td>3 I am coping with the stresses in my life</td>
<td>Jag kan hantera stress i mitt liv</td>
</tr>
<tr>
<td>4 I am free from worries about money</td>
<td>Jag oroar mig inte över pengar</td>
</tr>
<tr>
<td>5 I am happy dealing with a range of professional people</td>
<td>Jag har inga problem med professionella aktörer</td>
</tr>
<tr>
<td>6 I am making good progress on my recovery journey</td>
<td>Jag gör framsteg i min återhämtningsprocess</td>
</tr>
<tr>
<td>7 I cope well with everyday tasks</td>
<td>Jag kan hantera vardagliga sysslor</td>
</tr>
<tr>
<td>8 I do not let other people down</td>
<td>Jag gör inte andra människor besvikna</td>
</tr>
<tr>
<td>9 I am happy with my appearance</td>
<td>Jag är nöjd med mitt utseende</td>
</tr>
<tr>
<td>10 I engage in activities and events that support my recovery journey</td>
<td>Jag deltar i aktiviteter och event som gynnar min återhämtning</td>
</tr>
<tr>
<td>11 I eat regularly and have a balanced diet</td>
<td>Jag åter regelbundet och har en balanserad diet</td>
</tr>
<tr>
<td>12 I feel physically well enough to work</td>
<td>Jag mår fysiskt bra nog för att arbeta</td>
</tr>
<tr>
<td>13 I have enough energy to complete the tasks I set myself</td>
<td>Jag har tillräckligt mycket energi för att slutföra mina uppgifter</td>
</tr>
<tr>
<td>14 I have no problems getting around</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>72</td>
<td>Jag har inga problem med att “ta mig fram”</td>
</tr>
</tbody>
</table>
| 15 | I have the personal resources I need to make decisions about my future  
Jag har de personliga resurserna jag behöver för att ta beslut om min framtid |
| 16 | I have the privacy I need  
Jag har det privatliv jag behöver |
| 17 | I look after my health and wellbeing  
Jag tar hand om min hälsa och mitt välbefinnande |
| 18 | I make sure I do nothing that hurts or damages other people  
Jag försöker se till att jag inte gör illa eller skadar andra personer |
| 19 | I meet all my obligations promptly (things you have made a commitment to)  
Jag gör saker jag har lovat att jag ska göra |
| 20 | I sleep well most nights  
Jag sover mestadels bra |
| 21 | I take responsibility for my actions  
Jag tar ansvar för mina handlingar |
| 22 | I am happy with my life in general  
Jag är överlag nöjd med mitt liv |
| 23 | What happens to me in the future mostly depends on me  
Jag ansvarar för vad som händer mig i framtiden |
| 24 | I have a network of people I can rely on to support my recovery  
Jag har ett nätverk av personer som jag kan lita på stödjer mig |
| 25 | When I think of the future I feel optimistic  
Jag känner mig optimistisk när jag tänker på framtiden |
<table>
<thead>
<tr>
<th>Sociala resurser</th>
<th>Dina reflektioner</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 I am actively involved in leisure and sport activities&lt;br&gt; <em>Jag deltar i sport- och fritidsaktiviteter</em></td>
<td></td>
</tr>
<tr>
<td>2 I am currently completely sober and/or clean from drug use&lt;br&gt; <em>Jag är just nu nykter (avser alkohol och andra droger)</em></td>
<td></td>
</tr>
<tr>
<td>3 I am actively engaged in efforts to improve myself (training, education and/or self-awareness)&lt;br&gt; <em>Jag försöker aktivt förbättra mig själv avseende träning, utbildning och/eller självmedvetenhet</em></td>
<td></td>
</tr>
<tr>
<td>4 I am happy with my personal life&lt;br&gt; <em>Jag är nöjd med mitt privatliv/personliga liv</em></td>
<td></td>
</tr>
<tr>
<td>5 I am proud of my home&lt;br&gt; <em>Jag är stolt över mitt hem</em></td>
<td></td>
</tr>
<tr>
<td>6 I am proud of the community I live in and feel a part of it – sense of belonging&lt;br&gt; <em>Jag är stolt över det samhälle/lokalssamhälle jag befinner mig i och känner mig som en del av det – en känsla av samhörighet</em></td>
<td></td>
</tr>
<tr>
<td>7 I am satisfied with my involvement with my family&lt;br&gt; <em>Jag är nöjd med mitt engagemang i min familj</em></td>
<td></td>
</tr>
<tr>
<td>8 I am free of threat or harm when I am at home&lt;br&gt; <em>Jag känner mig trygg när jag är hemma</em></td>
<td></td>
</tr>
<tr>
<td>9 I engage in activities that I find enjoyable and fulfilling&lt;br&gt; <em>Jag deltar i aktiviteter jag tycker är kul</em></td>
<td></td>
</tr>
<tr>
<td>10 I feel safe and protected where I live&lt;br&gt; <em>Jag känner mig trygg och säker där jag bor</em></td>
<td></td>
</tr>
<tr>
<td>11 I feel that I am in control of my substance use&lt;br&gt; <em>Jag känner att jag har kontroll över mitt substansbruk</em></td>
<td></td>
</tr>
<tr>
<td>12 I feel that I am free to shape my own destiny</td>
<td></td>
</tr>
</tbody>
</table>
| 13  | I get lots of support from friends  
    | Jag får mycket stöd från mina vänner  |
| 14  | I get the emotional help and support I need from my family  
    | Jag får det känslomässiga stödet och hjälp jag behöver från min familj  |
| 15  | I have a special person that I can share my joys and sorrows with  
    | Jag har en speciell person som jag kan dela glädje och sorg med  |
| 16  | I have access to opportunities for career development (job opportunities, volunteering or apprenticeships)  
    | Jag har tillgång till möjligheter som kan gynna min karriär (jobbmöjligheter, volontärarbete eller praktik)  |
| 17  | I have had no lapses or relapses  
    | Jag har inte tagit några återfall  |
| 18  | I have had no recent periods of substance intoxication  
    | Jag har den senaste tiden inte haft några perioder av substansbruk  |
| 19  | I regard my life as challenging and fulfilling without the need for using drugs or alcohol  
    | Jag betraktar mitt liv som utmanande och uppfyllande utan att behöva använda alkohol eller andra droger  |
| 20  | It is important for me to contribute to society and or be involved in activities that contribute to my community  
    | Det är viktigt för mig att jag bidrar till samhället och är involverad i aktiviteter som bidrar till samhället/lokalsamhället  |
| 21  | It is important for me to do what I can to help other people  
    | Det är viktigt för mig att jag gör vad jag kan för att hjälpa andra människor  |
| 22  | It is important for me to make a contribution to society  
<pre><code>| Det är viktigt för mig att jag bidrar till samhället  |
</code></pre>
<table>
<thead>
<tr>
<th></th>
<th>My living space has helped to encourage my recovery journey</th>
<th>Mitt boende har hjälpt mig i min återhämtningsprocess</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>My personal identity does not revolve around drug use or drinking</td>
<td>Alkohol och droger är inte en del av min identitet</td>
</tr>
<tr>
<td></td>
<td>There are more important things to me in life than using substances</td>
<td>Det finns viktigare saker i livet än att använda substanser</td>
</tr>
</tbody>
</table>
Appendix 5: Interview guide (case study)

Bakgrund
- Vad har du för utbildning?
- Yrkeserfarenhet
  - Hur många års yrkeserfarenhet inom socialt arbete har du?
  - Vad har du arbetat med tidigare?
  - Vad har du för (yrkes)roll nu?
  - Hur länge har du arbetat med det här verktyget?

Utveckling och implementering (endast för intervjupersoner som deltagit i utvecklandet av verktyget)
- Varför skapades verktyget?
- Hur såg förutsättningarna ut för att skapa verktyget?
- Hur gick det till när verktyget togs fram?
- Hur gick det till när verktyget började användas?
- Ersatte verktyget något annat verktyg eller någon annan arbetsmetod?

Användning
- Varför används det?
- När används det?
- Hur arbetar ni med det?
  - Hur gör ni när ni går igenom respektive område?
  - Verktyget innehåller olika områden, är det något som är lättare/svårare att fänga upp/prata om?
  - Relation till andra verktyg?

Användning i relation till professionell
- Hur ser du på din roll i relation till verktyget?
- Vad fyller verktyget för funktion?
- Vad genererar det för information?
- Finns det några nackdelar med verktyget i relation till det praktiska arbetet?
- Hur kan det bli bättre?
- Använder ni andra uppföljningsverktyg?
  - Hur relaterar de till detta verktyg?
  - Andra verktyg som rekommenderas av Socialstyrelsen?
# Appendix 6. The Smiley

This is how I feel when I think about:

<table>
<thead>
<tr>
<th>Category</th>
<th>Feeling</th>
</tr>
</thead>
<tbody>
<tr>
<td>Myself</td>
<td>☹️</td>
</tr>
<tr>
<td>My family</td>
<td>☹️</td>
</tr>
<tr>
<td>Other important</td>
<td>☹️</td>
</tr>
<tr>
<td>My home</td>
<td>☹️</td>
</tr>
<tr>
<td>My leisure time</td>
<td>☹️</td>
</tr>
<tr>
<td>School/Employment</td>
<td>☹️</td>
</tr>
<tr>
<td>Future</td>
<td>☺️</td>
</tr>
</tbody>
</table>

[Smiley face scale]

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