The social ecology of alcohol and drug treatment

Client experiences in context

Jessica Storbjörk
To my mother and father, 
my sister and brother, 
mommo, and Johan.
List of papers

PAPER I  Storbjörk, Jessica & Room, Robin. The two worlds of alcohol problems: Who is in treatment and who is not? Submitted.

PAPER II  Storbjörk, Jessica. The interplay between perceived self-choice and reported informal, formal and legal pressures in treatment entry. Accepted for publication, Contemporary Drug Problems.


PAPER IV  Stenius, Kerstin & Storbjörk, Jessica. The dynamics underlying the story of a reform that redefined borders of the addiction treatment system: The rapid privatization of the Maria-unit. Published, Socialvetenskaplig tidskrift.


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## Abbreviations

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<th>Description</th>
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<tbody>
<tr>
<td>BC</td>
<td>Dependence Centre Stockholm <em>(Beroendecentrum Stockholm)</em>.</td>
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<tr>
<td>BCN</td>
<td>Dependence Centre North <em>(Beroendecentrum nord)</em>.</td>
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<tr>
<td>BCS</td>
<td>Dependence Centre South <em>(Beroendecentrum syd)</em>.</td>
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<tr>
<td>EBP/T</td>
<td>Evidence-based practices/treatment.</td>
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<tr>
<td>HSL</td>
<td>Health and Medical Services Act, 1982:763 <em>(Hälso- och sjukvårdslagen, SFS 1982:763)</em>.</td>
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<tr>
<td>HSN</td>
<td>The Health and Medical Services Board of Stockholm County Council <em>(Hälso- och sjukvårdsnämnden)</em>.</td>
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<tr>
<td>KvaL</td>
<td>Law on Care of Criminals in Institutions <em>(Lagen om kriminalvård i anstalt, SFS 1974:203)</em>.</td>
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<tr>
<td>LVM</td>
<td>Care of Alcoholics, Drug Abusers and Abusers of Volatile Solvents (Special Provision) Act, 1988:870 <em>(Lagen om vård av missbrukare i vissa fall, SFS 1988:870)</em>.</td>
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<tr>
<td>LVU</td>
<td>The Care of Young Persons Act <em>(Lagen med särskilda bestämmelser om vård av unga, SFS 1980:621)</em>.</td>
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<tr>
<td>MMT</td>
<td>Methadone maintenance treatment.</td>
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<tr>
<td>MT</td>
<td>Maintenance treatment <em>(refers to MMT and SMT)</em>.</td>
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<tr>
<td>ROSE</td>
<td>Risk Opiate Addicts Study – Europe.</td>
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<tr>
<td>SCC</td>
<td>Stockholm County Council <em>(Stockholms läns landsting)</em>.</td>
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<tr>
<td>SiS</td>
<td>The National Board for Institutional Care <em>(Statens Institutionsstyrelse)</em>.</td>
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<tr>
<td>SMT</td>
<td>Subutex® <em>(buprenorphine)</em> maintenance treatment.</td>
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<tr>
<td>SoS</td>
<td>The National Board of Health and Welfare <em>(Socialstyrelsen)</em>.</td>
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<tr>
<td>VKP</td>
<td>Treatment chain evaluation <em>(Utvärdering av Vårdkedjeprojektet)</em>.</td>
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INTRODUCTION

How can we sociologically understand alcohol and drug treatment? What is the goal and role of treatment according to different actor groups? How can we understand clients’ experiences in context?

“From all points of view – from that of those seeking help with their drinking, from that of the professional or paraprofessional seeking to provide compassionate and effective assistance, and from that of those seeking to build a just society within the constraints of available resources – there is an urgent need for a better understanding of how alcohol-related problems are defined, processed, and treated in alcohol treatment agencies,… and in the community at large” (Weisner 1986: 232).

This thesis deals with the Swedish treatment system, focussing on Stockholm County, and seeks to increase our knowledge of who comes to treatment and why. More broadly, it deals with the individual and societal response to alcohol and drug problems – the social ecology of treatment (Weisner 1986).

Across time and space, different groups of people have been in treatment because their behaviour or condition have been defined by the surrounding as unacceptable and as a problem, because a certain solution to the problem has been politically prioritized, etc. These factors influence how problems are handled and by whom – by the family, the correctional system, the social welfare system, etc. (Room 1980; Weisner 1987). It is not known to what extent new populations replace old ones or if treatment systems expand or shrink to include or exclude specific groups of people (Weisner 1986). For instance, the conceptual change in North America from viewing alcoholism as a unitary disease to seeing it as a multidimensional problem brought with it a different perspective on how the problem should be treated and by whom – envisaging a spread into other societal institutions (Rush 1996).

Thus, the goal and role of alcohol and drug treatment may shift and different actor groups may have different views on this topic. This thesis seeks to study treatment from a client perspective, and broadens the perspective by including views of other highly interested groups as well – by portraying the context in which treatment is provided.
Purpose of the thesis

The overall purpose of the thesis is to offer knowledge on how individuals with alcohol and drug problems come to treatment in Sweden. What are their reasons for entering treatment and who is in treatment, in relation to who is not? This is the concern of the first three papers. More specifically, the first paper (“two worlds”) explores different lines of explanation (demographics, marginalization, drinking, social response to drinking, and previous treatment experiences) for who is in treatment for alcohol problems, and who is not. The second paper (“interplay”) deals with reasons for coming to treatment. It studies how perceived self-choice in treatment entry is related to informal, formal and legal pressures to enter treatment among alcohol and drug (mis)users. The third paper (“events”) focuses on the role of different alcohol and drug related events in treatment entry. The impact of these events is studied in relation to the level of marginalization of interviewed clients. The fourth paper deals with the organizational level of the treatment system and analyses the motives for and conflicts surrounding changes in the treatment organization. In the thesis, the main focus is on the health-based and social welfare based treatment systems of Stockholm County, Sweden.

The introductory part has a broader perspective. The goal is to offer a better understanding of who is in treatment, and the experiences and views of clients, by portraying the context in which Swedish treatment is provided – by studying the social ecology of treatment. The main research questions are: How can we understand the clients’ experiences by turning to the context in which treatment occurs?

By analysing how treatment is used and by whom, we can gain knowledge on the role treatment fulfils in Swedish society. The first three papers give insight into this matter from the point of view of those treated by the system. Complementarily, the fourth paper sheds light on treatment on an organisational or system level. Finally, the introductory discussion helps provide a more comprehensive picture of how treatment is used by different actors. The main focus is on clients in alcohol and drug treatment. However, staff, managers and politicians also play an important role in the treatment system.

The introductory part discusses how these actors view and use treatment: What are the goals of treatment regarding aims at the social level and the corresponding aim regarding the individual client? How is treatment used?

The thesis is based on the comprehensive data of the Women and men in Swedish alcohol and drug treatment-study, with a representative sample of clients in the treatment system as well as complementary data on the views of staff and the general population. Some additional data is included from two other treatment studies, Risk Opiate Addicts Study (ROSE) and Treatment chain evaluation (VKP).
Treatment research

There is a rather persistent understanding among practitioners and treatment researchers that treatment is good for the individual and society. This view is often prominent in more clinically oriented treatment research, which usually applies a rather narrow definition of treatment.

In a chapter titled “Is ‘treatment’ the right way to think about it?”, on how to address alcohol and drug problems, William Miller (2002) questions traditional paradigms of what treatment is, how it could be conceptualized and how it should be evaluated. The paradigm he describes consists of four elements: 1) Addictions require formal treatment; 2) The problem lies within the individual and loss of control is fundamental to the problem; 3) Treatment works; and 4) The intensity of treatment is crucial for success.

Miller does not question that people who receive treatment typically fare better than those who do not (cf. SBU 2001), and that a longer stay in treatment usually is connected with better outcome (cf. Gossop et al. 1999; Simpson & Brown 1999). However, he points towards puzzling findings in treatment research that give a basis for rethinking the traditional paradigm.

First, Miller points toward the prevalence of natural recovery – people recover from addictions without treatment. In fact, a rather small percentage of those experiencing problems receive treatment. Instead people fall into and out of addiction problems rather independently of receiving formal treatment (cf. Blomqvist 1999 & 2002; Klingemann 1991 & 1992; Sobell et al. 1993). Second, control groups of clinical trials show about as much improvement as those who are randomly assigned to receive a special kind of treatment. There is also a lack of dose effect, meaning that more treatment is not better than less treatment in clinical trials. Better outcomes are seen among those who attend more sessions or stay longer in treatment. Importantly, there seems to be a lack of differences in treatment outcome. In fact, treatments differing in content yield similar outcomes. Neither has it been possible to confirm matching hypotheses, meaning that one could improve outcome by matching clients to the right treatment for them. Miller also points to a failure of causal chains, referring to the fact that it has not been possible to find the underlying mechanisms by which behaviour change occurs. What is it in treatment that works? This is often referred to as “the black box of treatment” (cf. Simpson 2001). He also points to the fact that the “same” treatment can have different outcomes when delivered by different therapists. “It appears that the therapist to whom one is assigned makes considerably more difference than the specific substance abuse treatment method employed” (Miller 2002:20). Finally, there are extra-treatment determinants, having little to do with treatment, that are of importance. For instance, attributes of the post-treatment environment to which the client returns is important – more important than the specific treatment received. Miller (2002) concludes that treatment usually is beneficial, but the
“puzzle is that treatment doesn’t seem to work in the way or for the reasons that we often expect. … How clients fare, in fact, may be less influenced by the technicalities of treatment than by the therapist who delivers it, or by the life circumstances that surround them outside of treatment, and a great deal of positive change happens without professional help” (Miller 2002: 20).

Miller advocates a reconceptualization away from viewing the problem in terms of an individual disorder. Instead, the problem should be viewed as residing in the individual’s environment. The solution offered, in the book edited by Miller and Weisner (2002), is not to rely on specialist treatment alone as a remedy for alcohol and drug problems. Instead, the societal response to these “complex societal problems” should be broadened and integrated into other systems like the health, mental, social welfare and/or criminal justice systems.

In sum, every type of treatment seems to work a little, but it doesn’t really matter what you do. Treatment doesn’t seem to change the prevalence rates of problems in the population. Miller points out that the prevalence of alcohol use disorders in the U.S. is roughly the same today as in the late 1960s. “The overall outcomes of alcohol treatment, as reflected in large multi-site studies, have not changed appreciably in three decades” (Miller 2002: 22, referring to a review by Miller, Walters & Bennett 2001). In addition, reviews show that only 20-40 percent of individuals who go through treatment are abstinent for one year after treatment (McLellan 2002). The solutions for the rather poor success rates lined up have usually dealt with educating the professionals; developing assessment tools for better matching of client problems to treatment; trying to figure out the “black box of treatment” and thereafter developing treatment models and services that better deal with the problem, etc.

Alcohol and drug research is largely driven by practical or political interests. For example, areas acknowledged as in need for further research by the U.S. National Institute on Alcohol Abuse and Alcoholism (NIAAA, 2000) are to study the effects of managed care on access, utilization, quality, costs, and outcomes of alcohol treatment services. Social treatment research is, due to difficulties in getting funding for basic social research (cf. Midanik 2006 on biomedicalization of research), primarily directed towards evaluations of treatment models, searching for evidence-based practices and treatment (EBP/T), etc., usually serving the interests of the service providers, the system’s funding agencies or the politicians.

Altogether, this implies that all the resources spent on further educating treatment providers, developing treatment methods and EBP/T, assessment tools and monitoring systems, followed by implementation efforts, evaluations and research, have not yielded better results over the last three decades.

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1 If addictions are viewed as chronic diseases, these success rates can be viewed as high.
Still, treatment persists and is “further developed” and exported to other parts of the world that do not yet have a developed treatment system.

This is important when considering the focus on developing EBP/T, which is also the case, in Sweden (see Socialstyrelsen 2006a). Swedish voices are raised against this trend and some researchers ask for a discussion of its weaknesses and of possible alternative strategies – not only a focus on its strengths. Bergmark (2006) asks whether or not the “Dodo bird verdict” is true also for the addiction treatment field. This verdict implies the general equivalence of outcomes from different modalities of treatment and has been a controversy in psychotherapy. He argues that the EBP focus on uncertainty follows from a general trend in modernity of an endless need for and production – and revision – of knowledge. The references to a Dodo bird within the addiction field are surprisingly few. As argued by Bergmark, the Swedish evidence-based review of alcohol and drug treatment (Berglund, Thelander & Jonsson 2003; SBU 2001) points towards a clear Dodo bird verdict by stating that no specific treatment is found to be superior to another. Bergmark asks if we shall just continue on the same old track – search for EBP – based on the hope that future research will identify factors important for outcome?

Are there other ways of trying to understand the treatment system? Instead of offering a potential solution for improving treatment outcome, this introductory section offers a sociological way of understanding the treatment system and the role it plays in society.

### Treatment system studies

This thesis and the *Women and men in Swedish alcohol and drug treatment* study it builds on belong to the treatment research field. More precisely, it can be positioned in the *treatment systems* research field.

This field has grown rapidly over the last two decades (Rush 1996). One explanation for the growing interest in entire systems instead of single modalities might just be the fact that research has proven it difficult to find a single superior treatment method or modality (cf. Berglund, Thelander & Jonsson 2003; SBU 2001). Instead, researchers’ attention is increasingly drawn towards looking at the functioning of the whole system (cf. Humphreys & Tucker 2002; Klingemann & Hunt 1998; Klingemann, Takala & Hunt 1992).

The concept of *treatment system* is still blurry, and it is somewhat unclear what types of studies should be included in this line of research. The field is characterized by varying emphases on system *research* – undertaken to test theory and generate knowledge – and system *development*. Brian Rush (1996) attempts to summarize what appear to be the main disciplinary and theoretical perspectives embodied in research in the treatment system area.
In his view, treatment system analysis “seeks to understand the individual and his interaction with the world around him for the purpose of making the most efficient use of public resources to assist the individual with health and other problems” (p. 633). He outlines five major origins of treatment systems research:

(1) **Systems theory** research is grounded in the belief that the interaction of the individuals with the full range of systems and institutions, including the family, must be analysed in order to understand the problems. Examples of studies: Model the movements of clients through the system; study utilisation and costs; and evaluate the impact of program and policy interventions.

(2) **Social ecology** studies overlap with system theory studies by focusing on people’s interaction with their environment. Important in social ecology studies “is the process by which the individual experiencing problems comes to acknowledge these problems and seek help for them. This process of problem definition and help-seeking occurs in the context of the family, community and institutional resources that may be available to provide assistance” (Rush 1996:631). Further, this line of research is concerned with the interaction between different service systems, and the relationship of informal and formal support networks. It deals with society’s responses to alcohol and drug problems. Examples: Comparisons of characteristics of treated and general populations; trends in the composition of treatment populations; studies of paths to treatment including the role of coercion; questions concerning the objectives of treatment; and treatment in the context of the broader societal response to alcohol and drug problems.

(3) **Health services research** has been concerned with the organization, financing, administration and effects of services. Examples: Studies of resources for treatment; estimates of need or demand for treatment; studies of costs or cost-effectiveness of treatment, and studies of possible strategies for financing and organizing treatment.

(4) **Studies of public policy processes and program evaluation.** Policy processes include defining problems, forging means to deal with them, implementation of solutions, and monitoring or evaluation of success or failure. This line of treatment system research deals with the last phase – program or policy evaluations. Nowadays, evaluation is often viewed as a feature of an ongoing management or improvement of services or policies. Following this line of argument, it is not only individual client outcome that is of importance. Funders and managers also expect economic evaluations and monitoring systems for providing information about the accomplishments of the treatment system. Examples: Development and evaluation of monitoring systems; outcome studies conducted in naturalistic settings.

(5) **Changed conceptualization of “alcoholism” and the matching hypothesis:** The changing conceptualization of “alcoholism” from a unitary disease entity to a multivariate syndrome brought with it a demand for thorough assessment of strengths and problems of the clients, treatment planning
and evaluations. This has been followed by an assumption that clients can and should be matched to the – for them – right treatment. In this way, treatment outcome could be optimized and treatment costs reduced. However, research has shown poor evidence for this matching hypothesis (cf. Babor & Del Boca 2003). Nevertheless, the hypothesis has brought with it a fast growing research field aiming at developing and implementing assessment tools etc. Other examples: Studies of the prevalence and identification of problematic alcohol and drug users in non-addiction specialist systems, such as work-places and the correctional system; assessments of availability of the full continuum of care; searches for gaps in the system (Rush 1996).

In Sweden, outcome studies and evaluations of single modalities and policies are fairly common (cf. Bodin & Romelsjö 2006; Dahlgren & Willander 1989; Gerdner 2004; Öjehagen et al. 1992), and work has been done in the field of health system research as well. Emphasis has been put on register studies of the composition of client loads of different agencies and systems (cf. Romelsjö & Diderichsen 1989; Romelsjö et al. 2005). Today, there is a fast growing research field around the development, implementation and evaluation of EBP/T, using different assessment tools and documentation systems in treatment settings (cf. Jenner & Segraeus 2005; Socialstyrelsen 2006a).

In general, treatment system studies have been rare. One comprehensive treatment study though, Swedish Drug Abuse Treatment Evaluation (BAK/SWEDATE), covering institutional treatment, originates from the beginning of the 1980s (cf. Berglund et al. 1991; Byqvist 1997). In the study, 1268 drug using clients were interviewed at the beginning of treatment, a one-year follow-up study was conducted, questionnaires were handed out to staff regarding organization and administration, and a register study (criminality, civil status, income, etc.) was conducted. This work was initiated in the context of a stated need, expressed by the Government, for developing methods and instruments for describing clients, treatment organization and content, as well as client outcome (Byqvist 1997).

The point of departure of the Women and men in Swedish alcohol and drug treatment-study 2 was somewhat different, in the social ecology line of treatment system research. There are no previous Swedish studies explicitly looking at the social ecology of treatment. The study’s starting point was the work of Constance Weisner (1986) and her colleagues in Berkeley. The social ecology approach is further developed in the Conceptual framework section. The study also has influences from the other strands outlined by Rush above, reflecting different interests and experiences of the research group. For instance, analyses of treatment outcome are performed, although they are not necessarily part of the social ecology of treatment. The study has mainly had a research ambition, but some development desires as well.

2 See the paper in Appendix I for a fuller description of the study and its background.
This section provides a conceptual framework for understanding the experiences of clients, and the treatment system, by looking at the social context in which treatment occurs. The framework starts from Constance Weisner’s (1986) concept of “social ecology” and lies more broadly in a soft social constructionist way of thinking.

Social ecology

Weisner (1986) argues that the social ecology of treatment concerns a view of treatment agencies as a system that exists alongside and in interaction with other parts of society that respond to defined problems.

“By ‘social ecology’ is meant the social environment of and processes surrounding treatment for alcohol-related problems, however carried out. The term calls attention to the general patterns of problem-handling and service provision in the community – how cases come into the systems and the interaction and referral processes between different community systems – with particular reference to the alcohol treatment system. The term refers also to the interaction between formal treatment represented by agencies and the informal processes that take place in the everyday life of the community. As Edwards (1973) put it, the problematic drinker provokes responses from many informal actors, including ‘his family, his neighbors, his employers, and the man at the bus-stop.’ Behind entry to treatment lie many informal and formal social processes; in the colorful image of treatment providers, clients are brought in by the four Ls (liver, lover, livelihood, and the law) (Roizen & Weisner 1979). In short, the study of the social ecology of alcohol treatment focuses attention on the community and asks questions about its responses to alcohol problems” (Weisner 1986: 204).

In Weisner’s (1986) view, two major areas of research are connected to the social ecology approach. The first refers to the characteristics of people in treatment, paths to treatment and the role of coercion, treatment utilization, beliefs, and the organization of services and its effect on the composition of the clinical population. The second concerns responses to addiction problems, which includes descriptions of treatment systems, studies of how problems are defined and how they are handled in society. What role do society and treatment play in who goes to treatment and where?
Weisner’s approach can be placed in the social constructionist paradigm, which was crystallized into a coherent theory in Berger and Luckmann’s *The Social Construction of Reality* (1966). This paradigm has been criticized and developed into several more and less hard or strict strands (cf. Gergen 1999; Holstein & Miller 1993; Sahlin 2002). Best (1995) argues that positions in social constructionism can be located on a continuum from vulgar to strict. Vulgar constructionism does not problematize truth or existence and treats constructions as prejudices which prevent us from finding the “true” representations (cf. Gusfield 1996). In strict constructionism, researchers avoid giving values to different definitions. Instead, different representations are compared (cf. Derrida 1998). The social ecology approach, and my view on reality, is closer to vulgar than strict constructionism, as defined by Best.

The social ecology approach stresses a social constructionist – relativist – ontology (there are multiple realities). Alcohol and drug problems do not exist *per se*, they are products of a process of collective definition, a process determining whether a condition or behaviour becomes legitimated or is defined as a problem. This process shapes how the problems are addressed in official policy (cf. Blumer 1971).

The definitions of problems and how they should be handled have an influence on individuals. Whether or not a “problem” is a “real” problem, it brings with it consequences. Problem definitions and the characteristics of the treatment system influence how people come to treatment. We can here refer to the line of arguments, which stresses that the socially constructed world is viewed by individuals as existing “out there” and constraining their actions (cf. Berger & Luckmann 1966). The social handling of alcohol and drug problems, and the effects it has on the individuals, can be understood in terms of the “knowledge” they have of it – how they understand and perceive treatment. These perceptions guide actions.

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3 Ontology refers to question such as: What’s the nature of reality? What kind of being is the human being? What exists?

4 Social constructionism has been criticized regarding its stance on “existence”. If a phenomenon is constructed, does the phenomenon exist? If something is explained by the context in which it occurs, is there a real context and something social that really happens? The general constructionist answer is that the question of existence is of less importance. More important is that we only can think of the phenomenon through constructions (cf. Sahlin 2002).

5 Reality is available to individuals as commonsense knowledge that guides everyday life. The world originates in and is maintained by thoughts and actions. The world consists of multiple realities. One of these is understood as the reality – it is taken to be normal/self-evident and appears as coherent. This world is experienced as external to individuals – coercive in its effects on them. It becomes experienced as existing over and beyond the individuals. Individuals’ knowledge about society is a realization in the double sense of the world – apprehending and ongoingly producing reality. Social reality is understood by individuals as a continuum of typifications. The social world is constructed in interaction between individuals. Over time, typifications/representations arise and become habitualized into roles. Institutions emerge through typification and are passed on to others. Institutions become experienced as exerting authority over the individuals (Berger & Luckmann 1966).
Studying the social ecology of treatment

The social ecology perspective has several implications for how to study and understand the treatment system, and more specifically, how individuals come to treatment – who is in treatment and who is not?

The context of treatment

The importance of the social context is often stressed in social constructionism. What is labelled as deviant and how it should be dealt with vary by context (Best, 1995; Conrad & Schneider 1980; Greene 2003; Gusfield 1996). The social ecology approach stresses that treatment is not an isolated phenomenon. Treatment plays a role in, and is responsive to the larger society. Therefore, we should study the context of problem handling. Alcohol and drug (mis)users’ paths to treatment are influenced by the social environment, by how these problems are viewed, and what solutions are offered – the general alcohol and drug problem handling in society.

The individual alcohol or drug (mis)user is influenced by the reactions of others – how family and societal institutions try to influence the individual to do something about consumption or other problems arising from drinking or drug use. The interaction between formal and informal actors is important for the characteristics of the context and individuals’ actions.

Interaction and interests of groups of actors

“The central interest of sociologists of social problems and deviance is the interaction between claims-making groups and others about the definition of social conditions and what should be done about them…. It would seek to explain how those definitions and assertions come to be made, the processes by which they are acted upon by institutions, and how those institutional responses do or do not produce socially legitimated categories of social problems” (Kitsuse & Spector 1975: 593).

The social ecology perspective stresses interaction between clients, treatment units, informal actors, etc. According to social constructionism, individuals belonging to a group, sharing a common biography and with common experiences, have similar knowledge of reality. Differences are also most likely found within these groups. The views, perspectives, and claims of actors, or groups of actors, are stressed. These actors have their own motives, intentions and interests – noble or otherwise, which may be grounded in their experiences, values, and possession of power (cf. Berger & Luckmann 1966; Greene 2003; Schwandt 1994:125).

The existence of problems depends on the existence of groups that define some condition as a problem and attempt to do something about it. Kitsuse
and Spector (1973) argue that we should study not only the emergence of claims-making and responding activities, but also the maintenance of these. Spector and Kitsuse (1973) present a four-stage “natural history model” of social problems. Stage one concerns how groups declare the existence and offensiveness of a condition; in stage two an official agency responds to the claims; in stage three claims and demands re-emerge, expressing dissatisfaction with the official response; in stage four alternative, parallel or counter-institutions are established.

Regarding Swedish alcohol and drug treatment, substance use problems have already been asserted and agencies have been created for responding to the claims. At the moment, groups have expressed dissatisfaction and complaints with the established treatment system (stage 3). The lack of satisfactory response of the system to these claims has led to the creation of alternative responses and solutions (stage 4), such as voluntary organizations taking care of those who fall through the safety net provided by the state. In the fourth stage, claims challenge the legitimacy of the treatment system.

What keeps these groups going? Moral concerns, a wish for alleviation of social, political, legal or economic disadvantages, or other considerations, may lead groups to act (Spector & Kitsuse 1973: 146). Kitsuse and Spector discuss two types of groups. *Interest groups* consist of people who complain and themselves are the victims of the condition. They have (dis)advantages or stakes of the outcome of a given line of activity – something to gain or lose. In Kitsuse and Spencer’s (1973) words, an interest “may be defined as any social arrangements upon which some individuals or groups claim to depend, rely, use, or need in the conduct of their daily activities” (p. 417). *Dis-interested or value-oriented groups*, “moral crusaders”, consist of actors who become annoyed or upset about a condition and call for its change. These actions are based on moral indignation and the actors are not themselves victims of the condition they set out to change – it seems wrong to them that the condition exists. From this point of view, the experiences, interpretations and intentions of actors in the treatment system, formal as well as informal, are important for understanding the treatment system.

In this thesis, the focus is on three main sets of actors arguably of greatest importance for understanding the treatment system. The main focus is on clients in alcohol and drug treatment. Treatment staff has a crucial role in the treatment system as well. These two groups can be viewed as *interest groups* – they are dependent on the treatment system and have something to gain or lose. There are also groups of *disinterested* actors. In the thesis, those acting on behalf of the broader society to set the terms of operation of the treatment system are included. This implies attention to policy statements by politicians and actions with respect to the treatment system, as policy affects priorities, planning and financing of the treatment system. Alongside these three groups, some views of the general population (another disinterested group) are included, reflecting the overall context of treatment. Single indi-
viduals in these disinterested groups may have personal interests at stake. However, as groups, they are acting on behalf of other individuals (with substance use problems) and their decisions or opinions may be based on moral indignation as well as pragmatic grounds.

Perceptions and claims may be competitive or in congruence. Clients can have their own interests and understanding of treatment as compared to that of treatment staff, etc. Clients are often viewed as a rather powerless group in relation to care providers, and in society in general (cf. Järvinen 2002). More powerful groups are often more successful in promoting their views (cf. Berger & Luckmann 1966; Spector & Kitsuse 1973):

“problems arise from the statement by groups that certain conditions are intolerable and must be changed. Such actions may provoke a reaction from other groups that prefer the existing arrangements or would stand to lose something if they were altered. Such groups may challenge the claims of the protesting group, … lobby against proposed changes, … [actions that] bring them into conflict with groups that do not share these values or with groups with vested interests in the condition in question” (Spector & Kitsuse 1973: 151).

These views and interactions make up the social context of treatment. Our knowledge of the treatment system can be enriched by contrasting views on and experiences of treatment between actors. Are their perspectives and experiences in agreement or conflict? It is not only the clients who are in focus, other actors which the treatment system interacts with are also important.

To sum up: The thesis concerns how a phenomenon, such as how and under what circumstances alcohol and drug users come to treatment, can be understood by portraying the context in which it occurs – “the social environment of treatment” (Weisner 1986:204). The context refers to how problems are viewed, but more specifically to how they are thought to be and are handled – “the general patterns of problem-handling” (Weisner 1986:204). It concerns if and how family and friends, as well as societal institutions, interact and influence an individual’s decision to seek treatment. The general way of handling alcohol and drug problems in treatment is apprehended as the way of dealing with this problem, and influences clients as well as other involved actors. The treatment system influences and constrains how individuals act in relation to the system.

In this thesis, in The social ecology of Swedish alcohol and drug treatment section, the communalities and divergences in the perspectives and purposes of three sets of actors (clients, staff, and policymakers) are discussed, and some views of the general population are included.
DATA MATERIAL AND STUDIES

In order to make sense of the discussion in this introductory part, the studies, the data materials and some methodological problems, as well as a description of the interviewed clients and summaries of the papers included in the thesis (Paper I-IV), are hereby presented. The goals, methods and data materials of the *Women and men in Swedish alcohol and drug treatment*-study have been described in detail in reports and articles (see Eriksson, Palm & Storbjörk 2003; Palm & Storbjörk 2003; Palm 2006a; Palm 2003; Storbjörk 2003a). A paper describing the study is also included in this thesis in Appendix I (Room *et al.* 2003). Therefore, the presentation here is kept short. Before turning to the methods, the concepts of “treatment” and “treatment system”, used in the study and thesis, are defined.

**Defining “treatment” and “treatment system”**

A broad definition of treatment was used. This definition was first formulated by the National Board of Health and Welfare and used in annual Swedish treatment statistics (Holmberg 1999). By this definition, alcohol and drug treatment refers to:

“medical, psychosocial and social measures or interventions aiming at initiating and maintaining individuals to stop or decrease abusing alcohol or drugs and to prevent relapse. Detoxification and interventions of more supportive and caring nature with the purpose to reintegrate the individual socially are also included.”

This definition was applied in the papers in this thesis. However, the concept of alcohol and drug treatment system was not initially defined in the *Women and men in Swedish alcohol and drug treatment*-study.

As stated by Rush (1996), it is unclear what is meant by this concept and there is no generally accepted definition of the word “system”. In an international comparison of alcohol treatment systems, Hunt, Klingemann and Takala (1992) defined “system” broadly and referred to “those social structures and processes that have the function of alcohol treatment, and, in a narrower sense, to the interconnection of different treatment units and agencies, chains of treatment, and referral channels” (p. 4).
Babor, Stenius and Romelsjö (2006) further expand the definition in an attempt to define a conceptual model of treatment systems. In their view, it is also necessary to include policy determinants of treatment systems since these are important for the structural resources available for treatment. Treatment policies made by governmental agencies and legislative bodies affect the planning, financing, and monitoring of services, as well as the development of a professional workforce to operate them.

The introductory section of the thesis falls within social constructionism. According to this line of arguing, the treatment system can be viewed as a constructed social system which is invented and maintained by (claims of) participants in society.

Guided by the definitions of treatment systems used by others and by considering the social constructionist and social ecology approaches, what is meant by alcohol and drug treatment system in this thesis is a system that is constructed by actors in society and the presence of the system shapes the action of individuals. The system consist of interacting informal and formal agencies and individuals intending to assist individual alcohol and drug (mis)users through alcohol and drug treatment (as defined above). The formulation and existence of treatment policies are crucial for the features of the system.

In the thesis, the main focus is on publicly funded treatment in (relation to) the social welfare and health-based systems, as in the Women and men in Swedish alcohol and drug treatment-study. The definition also includes other forms of treatment, e.g. treatment provided in the criminal justice system. Alcohol and drug problem screenings, for instance by district doctors, are not included in the thesis, apart from pressures from the doctor that the individual should start treatment for his or her assessed problems.

Main data

Women and men in Swedish alcohol and drug treatment

As stated, the study Women and men in Swedish alcohol and drug treatment was guided by the social ecology approach, with the aim to study the functioning of Swedish treatment at the level of systems, using services in Stockholm County as its study site. The focus was both at the level of treatment services and at the level of individual clients in treatment – and the general population. The study includes several data-sets:

1) Initial interviews (T1), in the beginning of a new treatment episode, with 1865 alcohol and drug users entering 24 sampled inpatient and outpatient treatment services in the health care system, and clients receiving an alcohol- or drug-specific intervention provided for and/or paid for by the social services in 11 sampled municipalities and Stockholm city districts,
including a unit for homeless people. Structured face-to-face interviews were conducted by trained interviewers and took place 14 November 2000 - 14 November 2002. Participants received 100 Swedish crowns for their contribution (Eriksson, Palm & Storbjörk 2003; Palm & Storbjörk 2003).

(2) Follow-up interviews (T2) after 12 months (up to 18 months was accepted) with 1210 of 1763 T1-respondents (69% were re-interviewed). In the main sample, 1644 individuals consented at the time of T1 to be contacted for a request for a follow-up interview, which gives a completion rate of 74 percent. The interviews were mainly conducted by telephone. The last interviews took place in April/May 2003. Respondents received 100 Swedish Crowns which was sent to them by post.

(3) 913 questionnaires were filled in by staff in the treatment system in 2001-2002: 344 by health services staff from 54 inpatient and outpatient services; and 569 by social service staff in the sampled municipalities, every district of Stockholm City, and inpatient facilities (HVB-hem) run by Stockholm city. Thus, the base was broader for the study among staff than among clients (point 1). The response rates were 56 and 58 percent respectively (Palm 2003; Storbjörk 2003a).

(4) A mapping of units and municipalities that took part in the study in 2001-2002. Twenty heads of units in the health system and 14 heads of the social services were interviewed by telephone or in person with a semi-structured questionnaire.

(5) Starting out from a representative sample of 6000 individuals, screening interviews were made with 3556 individuals in the adult (18-75 years) general population of Stockholm County (59% response rate). An extended interview was conducted with 367 individuals who were screened-in as “high-consumers”. Attitude items were asked of a probability sub-sample of 800 of those who were screened-out (see Paper I “two worlds” for further description of procedure and screening).

(6) Finally, register-linkage was conducted with respondents under point 1 and 5 who consented. Concerning the clients, this linkage comprises care registers from the health system, cause-of-death registers, registers regarding compulsory alcohol and drug treatment, and crime registers. For the general population sample, information from the care register and a register covering sick-listings are linked to the interview data.

The focus of this dissertation is on the initial interviews with clients (point 1). The general population sample (point 5) is included in Paper I and in the introductory part. Finally, some data from the staff questionnaires (point 3) is included in the introductory part.

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6 102 clients from T1 were not eligible for follow-up since they were derived from a sub-study organized by a research unit connected to the social services administration in the northwest region of Stockholm County (FoU-Nordväst).
Client weighting procedure

In the study, the aim of the sampling procedure was to represent the full range of people coming to treatment. Given the number of treatment agencies and services in the county, we drew a sample of services from which to recruit clients. Although substantial effort was made to minimize differences in fieldwork procedures between units, fieldwork continued longer in some services than others, due to such factors as the need of obtaining a sample size large enough. It was easier to recruit respondents from inpatient services than from outpatient units.

Therefore, the data sets have been weighted by known information from records and annual statistics. Data from the health system were weighted by the proportion of new patients in a one-year period entering different kinds of units (outpatient units; inpatient detoxification units; a clinic specializing in people with pharmaceutical drug problems; methadone maintenance; and a clinic treating people with infectious diseases and addition problems). The information was drawn from records kept by the treatment organization. Due to different statistical sources, the procedure for the social welfare data was slightly different. The data is gathered by the National Board of Health and Welfare and consist of yearly measures of interventions by the social services. The information used was the proportion of different interventions in 2001 (housing; assessments and outpatient treatment; institutional treatment including family homes and compulsory treatment). In addition, the distributions of different types of interventions in different types of municipalities and/or districts were incorporated into the weights. In order to take into account different types of areas in the county, the municipalities were grouped into seven area/income categories based on mean income among the adult population (bottom ¼, middle ½, and top ¼) and geography (Stockholm city, other parts of the county, and a unit for homeless people).

Finally, the two client data sets were merged together. The only comparable data available – across the two systems – were annual counts of the number of clients in treatment in units run by the two systems in Stockholm County on a given day, 2 April 2001 (unpublished data from Roger Holmberg). These data suggest that about half of the clients in Stockholm County are treated in the health system and the other half in the social service system (including treatment paid for by the social services performed by other care providers). Since this is in line with our sampling procedure of equal numbers of cases from each system, no further weighting was performed.

Some methodological issues

Methodological concerns are discussed in the papers. For example, Paper I (“two worlds”) deals with the representativity of the general population sample as well as general problems in measuring alcohol problems through surveys. Some important or additional aspects are brought up below as well.
Studying individuals’ problems include ethical considerations. The Women and men in Swedish alcohol and drug treatment-study and its procedures were approved by the regional board of Stockholm for vetting the ethics of research involving humans, 13 November 2000 (Dnr 00-319). The clients gave their informed consent for participating. In the end of the baseline and follow-up interviews, respondents were asked for permission to be contacted again with a request to participate in a follow-up. We had the clients’ consent for recording information and for approaching them again.

Constructionism implies that what we take to be truth is the result of perspective. This implies that “the researcher’s bias, experience, expertise, and insight are all part of the meanings constructed and inscribed” (Greene 2003: 598; Kitsuse & Spector 1975). In the case of this study, as well as more generally, the effects of a rather objectivist approach, with standardized questionnaires and fixed response categories, as well as researcher’s bias are discussed by Palm (2006a). Standardized and structured interviews suffer from several disadvantages. The respondents are asked to choose from predetermined sets of response categories. The wordings of the questions and the response categories are those of the researcher. The respondent may feel that the wordings are not suitable for his or her situation or view, which may lead to decreased validity and may lower the respondent’s motivation to respond honestly and continue the interview. In addition, response categories such as “moderately agree” may mean different things to different respondents, as well as the researcher.

Reliability concerns the consistency of measurements – do results remain consistent over repeated studies of the same subjects under identical conditions (cf. Frankfort-Nachmias & Nachmias 1996)? In naturalistic studies, reliability is very difficult to test – the conditions change constantly.

The characteristics of the general population sample were compared to the characteristics of those who were not reached or did not participate (based on register data), and to another general population sample also collected in 2002 (see Hradilova Selin 2004). These comparisons show that our sample suffers from often cited shortcomings concerning general population studies on alcohol and drugs (women, married and older people as well as those born in Sweden are most likely to take part). However, our study did not show more severe shortcomings than those which are often acknowledged (cf. Kühlhorn et al. 1999; see Paper I “two worlds”).

Sampling and representativity of the staff samples are discussed by Palm (2003) and Storbjörk (2003a). Staff working in the health system who took part in the questionnaire study was compared to registers on people working in the health-based system. As a group, participants did not differ from the whole staff group with regard to professions. An analysis of a subsample shows that the participating individuals’ sex and age correspond well to that of those working in that part of the treatment system (Storbjörk 2003a).
The reliability of the client data is most difficult to estimate. It is noted above that the data has been weighted to further represent the County. However, there are no really good figures on what the treatment population looks like (see Client weighting procedure).

A high number of interviewers worked on collecting the initial client interviews. In order to optimize reliability, they all received training and a handbook was produced and used which described the intentions of different questions, how to categorize certain responses, etc. This manual was updated repeatedly when new questions came up. Meetings were held every two weeks where questions and interview situations were discussed among interviewers and project co-ordinators. In addition, Storbjörk observed the interviewers under a number of interview situations. Differences between interviewers were thereafter discussed in the fieldwork group.

Validity concerns if we are measuring what we are supposed to measure. Reliability does not automatically imply validity. Validity implies reliability (cf. Frankfort-Nachmias & Nachmias 1996). The client questionnaire and the general population form included some questions from the Addiction Severity Index (ASI, McLellan et al. 1992), and the Composite International Diagnostic Instrument (CIDI, WHO 1994). These questions have been tested for validity in several settings and groups (cf. Joyner, Wright & Devine 1996; McLellan et al. 1985a, 1985b; Üstün et al. 1997). Most of the items on attitudes and reasons for coming, or not coming, to treatment (across samples) were new and have not been tested elsewhere. The questions on events that happened in the year prior to treatment and individuals or agencies that suggested treatment were used by Weisner (1987, 1990). Before starting the fieldwork, the interview form was tested on clients in order to estimate the time required as well as which questions were difficult to understand, etc. Likewise, the staff questionnaire was tested before it was applied. Heads of units got the chance to comment on the form, and staff from inpatient as well as outpatient units filled the questionnaire out and discussed the questions with project co-ordinators (see further Palm 2003; Storbjörk 2003a). Nevertheless, the difficulty to measure the validity of new questions remains. No special validity analyses have been conducted.

A classification of clients into alcohol and drug (mis)users

Sweden has different policies regarding alcohol and drugs, and it can be assumed that society’s way of handling alcohol and drug (mis)users differ. Alcohol and drug (mis)users may come to treatment for different reasons and perceive treatment differently. Therefore, a division between alcohol and

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7 Altogether 33 interviewers worked on T1. Each interviewer conducted on average 56 interviews. Twelve interviewers collected up to 10 interviews (these were mainly working in the FOU Nordväst substudy); 10 interviewers conducted 11-50 interviews; 3 interviewers 51-100 interviews; and 8 interviewers collected 101 or more interviews each.
drug users is necessary in the analysis. In the *Women and men in Swedish alcohol and drug treatment*-study, several ways of categorizing the clients and arranging the data have been used.8

In the thesis, and the papers, respondents were classified based upon three criteria for alcohol and/or drug problems: (1) consumption, (2) dependence (ICD-10) and/or (3) alcohol- or drug-related life-area problems. To fulfil the consumption criterion for alcohol the respondent had to drink at least five drinks three times a week or more often, or 12 drinks at least once a week. The consumption measure for drugs was to have used a drug at least once in the last thirty days. To fulfil the dependence criterion the respondent had to say “yes” to at least three of the six ICD-10 criteria. To fulfil the life-area problem criterion the respondent had to have experienced at least two of the following: That the respondent’s alcohol/drug use had had a harmful effect on their friendships or social life; physical health; home life or marriage/relation to partner; studies or possibilities at work or in their occupation; and finally their finances. In the analysis and the papers, respondents have been grouped into four categories: “neither alcohol nor drug problems”, “alcohol problems”, “drug problems”, or “both”, based on whether the respondent fulfilled at least one of the three criteria for alcohol or drug problems respectively (see Tables in Appendix II for the number of respondents in each group). In some of the analyses, this categorization is used as an additive score, ranging from 0 (no problem) to 3 (highest problem).

Additional data

Some additional data from two treatment studies is included in the introductory part of the thesis. Data regarding opiate users recruited from the streets of Stockholm (open drug scenes) are included from the first additional study, *ROSE*, as a complement and comparison group to clients in treatment (*Women and men in Swedish alcohol and drug treatment*-study), concerning reasons for *not* seeking treatment among people *not* in treatment. From this

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8 This is a question the research group has not been able to find a solid solution to. We have tried and advocated different ways of categorizing the interviewed clients: by their own rating of problems and need for help according to ASI; whether they said they came to treatment for their drug use or not; by dependence, etc. I have chosen a categorization that builds in both consumption and problem severity. The client rating from the ASI could be an alternative but these measures do not correspond well with the other ways of categorizing clients into alcohol and/or drug (mis)users in our sample.

9 This group is rather diverse. It consists mainly of respondents receiving some kind of housing intervention or general outpatient treatment. The mean number of days in treatment among these clients was high, 100 days in the last year, which might explain their present low alcohol and drug consumption. Sixteen percent of them reported that someone in the judicial system had suggested to them to seek treatment. It is likely that several of these individuals are in some kind of aftercare and are therefore sober/drug-free at the moment, but with a history of alcohol and/or drug problems.
study, quotes from qualitative interviews with opiate users are included to voice experiences and views on treatment of this group. The second additional study, *Treatment chain evaluation (VKP)*, is included for the same purpose – to present clients’ experiences and perspectives on treatment.

**Risk Opiate Addicts Study – Europe (ROSE)**

Data regarding treatment experiences and reasons for not seeking treatment are included in the introductory part of the thesis and in Appendix II (Table 5) from a European comparative study (Haasen *et al.*, 2004). This EU-funded study, Management of high risk opiate addicts in Europe (Risk Opiate Addicts Study – Europe), was initiated by Zentrum für Interdisziplinäre Suchtforschung der Universität Hamburg, Germany (EU contract no. QLG4-CT-2002-01681). It was a multi-centre study which took place in 2003-2004, with the aim to produce epidemiological data on high risk opiate users and evaluate the management of this group. Two target groups were included in the study:

Group 1 (“maintenance treatment failures”) included opiate users who were not adequately served in maintenance treatment, which meant that they had been in maintenance treatment for at least three months, had problematic use due to concomitant substance use, or other problematic behaviour such as delinquency or violent behaviour. In Stockholm, 77 respondents belonging to this group were interviewed. These were recruited from MMT and SMT services in Stockholm County.

Group 2 (“untreated”) referred to opiate users *not* in treatment (used opiates for at least four days a week during the last two months, and had not been in maintenance or abstinence-oriented treatment for the last six months). Short-term detoxification was not counted as treatment in this study. In Stockholm, 73 respondents were recruited from low-threshold services, such as day shelters, and from the open drug scenes of the city centre.

The data included in this thesis is derived from work-package 3 (WP). WP3a included quantitative interviews with the aim of assessing the situation, characteristics and treatment needs in European cities. As a complement to the ROSE interview form, the questions regarding reasons for not seeking treatment from the *Women and men in Swedish alcohol and drug treatment* study were added to the questionnaire and asked of people in the “untreated” group in Stockholm (Table 5, Appendix II). This was done with the purpose of complementing the views on reasons for not seeking treatment among those who actually started treatment with drug users inter-

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Centres/cities included were Amsterdam (The Netherlands); Athens (Greece); Bordeaux (France); Hamburg (Germany); Liege (Belgium); London (United Kingdom); Oslo (Norway); Stockholm (Sweden); Vienna (Austria); Zurich (Switzerland).
viewed on the streets (see Sand & Romelsjö 2005 for a description of inter-
viewed respondents).

In WP3b qualitative interviews were made with a sub-group of 10 partici-
pants from WP3a. Personal in-depth interviews were carried out to collect
the views of the respondents on their lives, drug use, treatment needs and
drug treatment. In Stockholm, these interviews were conducted and summa-
rized in 2003 by Jessica Storbjörk (“untreated group”) and Jenny Cisneros
Örnberg (“maintenance treatment failures”) (see Appendix A in Haasen et
al. 2004).

Treatment chain evaluation (VKP)

This study evaluated a trial named *Vårdkedjeprojektet* (VKP), which can be
translated as the treatment-chain project. The background of this trial is an
official governmental report looking at compulsory treatment (SOU
2004:3). The investigation gave rise to a project, initiated by the Ministry
of Health and Social Affairs, within the National Board of Institutional Care
(SiS), which emphasizes strengthening the aftercare for this group of clients.
The VKP project was initiated in April 2004.

The goal of the VKP project was “that the clients involved in the Treat-
manship project achieve positive and durable changes in their life situa-
tion; that the Treatment chain project contributes to the creation of working
models for collaboration between social services and the compulsory institu-
tions, and between compulsory treatment and the care provided with the
consent of the individual” (SiS, 2004a). In the project, each client who con-
sented was assigned a special case-manager who followed him or her over
one year. A treatment agreement was signed for each client, between the
client, SiS and the social services. The client had the right to receive treat-
ment, including coercive treatment and aftercare for one year. These agree-
ments should be regularly followed-up and revised.

The VKP project was a trial encompassing five municipalities/city parts
and three compulsory institutions. In the initial phase, the Ministry of Health
of Social Affairs stated that the trial should be evaluated. The trial is pres-
ently being evaluated by Kerstin Stenius, Jessica Palm and Jessica Storbjörk.
The evaluation started in March 2005 and runs till March 2007. The aim of
the evaluation was to evaluate the process of VKP, focusing on the imple-
mentation of VKP and the treatment provided as well as on the experiences
of the clients. The evaluation was divided into two main parts.

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11 It was concluded in the investigation that the treatment needs of the heaviest abusers were
not thoroughly filled. Another problem acknowledged and viewed as a shortcoming of the
treatment system (although already acknowledged at the end of the 1980s, SOU 1987:22) was
the lack of good aftercare for individuals committed to compulsory treatment.
In the client part, data was collected from assessments and follow-ups to describe clients at intake and one year later. The main focus, though, was on a qualitative study in which a group of clients were followed during their year in VKP. The researcher (Storbjörk) made observations at crucial meetings between different staff representatives and the client, and interviewed the client several times. The main questions in this part of the study were how the clients experience the treatment and their case manager, and how – if – their lives change.

In the implementation part of the study the researcher (Palm) followed the five case-managers for one to two weeks each and during this time also interviewed social workers and other actors. This part was qualitative and aimed at analyzing the processes behind local variations in the implementation (how the program is translated to different local settings) and the perspective on VKP of different actors. Interviews were made with civil servants behind the initiation of VKP and those implementing the project.

Background and current living situation of clients

Table 1a and Table 1b in Appendix II show the demographic characteristics, alcohol and drug use and treatment experiences of the client sample of the Women and men in Swedish alcohol and drug treatment-study by type of drug (according to the described classification, using weighted data).

The gender distribution is similar across type of drug (roughly 1/3 female). The mean age of the sample was 43 years. Individuals with alcohol problems were significantly older than individuals with drug problems.

Most of the patients recruited from the health system were treated in general outpatient treatment, with those from alcohol detoxification wards the next most numerous. A majority of the respondents that did not fulfil the alcohol or drug criteria were treated in general outpatient treatment. Thirty-one percent of the respondents from the social welfare system received some kind of housing assistance at the time of the interview. This category was broad and includes also different forms of care homes. Nearly as many received some kind of outpatient treatment. Institutional treatment, including compulsory treatment, was received by one quarter of the sample. Half of the non alcohol-non drug group received some kind of housing, and a higher proportion of the alcohol users got some kind of outpatient intervention.

Only one fourth of the sample was married or lived together with a partner. A significantly lower proportion of respondents with drug problems were married. Altogether, one third had children under the age of 18. A higher proportion of the drug users had children, reflecting at least in part the age differences between alcohol and drug users. About 50 percent of the sample had their own apartment or house. A higher proportion of the alcohol users had their own place to live. A higher percentage of the drug users were
homeless or had their housing arranged by the social services. Eighteen percent of the respondents reported work (part- or full time) as their main occupation in the last month. A lower proportion of the drug users had a job.

One third of the sample had not drunk twelve drinks on one occasion in the last year, but nearly one quarter of the sample drinks twelve drinks daily. On average, the interviewed sample had used a drug other than alcohol ten days out of 30. A comparison of the groups with regard to frequency of heavy drinking and number of drug-using days in the last month shows, as expected, considerable variation.

The sample’s mean number of days in treatment in the last year was 66 days. The mean was higher among drug users. One should also note that the respondents without alcohol or drug problems, according to the categorization used, had been in treatment on average 100 days in the year prior to this particular treatment entry and interview. In interpreting this, one should not forget that treatment is defined broadly in the present study.

The client group under study in this thesis is a rather marginalized group. In general, drug users have worse living situations, regarding housing and occupation, than alcohol users. Drug users have a more extensive treatment history. Likewise, the client groups of the ROSE and the VKP studies are marginalized as well (Sand & Romelsjö 2005; SiS 2006a). This should be kept in mind when the experiences and views of clients are discussed.

**Summaries of Papers**

**Paper I-III. Studies on the client level**

The first three papers deal with client level data. The first and third papers also include data from a sample of the general population.

**Paper I (The two worlds of alcohol problems: Who is in treatment and who is not?)** examines who is in treatment for alcohol problems in relation to who is not by an analysis of a combined sample of people in the general (n=3557) and the treated population (n=1202 alcohol misusers) of Stockholm County. It is acknowledged that drinking volumes and patterns differ significantly between problem drinkers in general and clinical populations, which has come to be labelled as the “two worlds” of alcohol problems.

As expected, the two samples were found to differ significantly. Clients are older, more marginalized, and report more severe alcohol problems. A high proportion has been in treatment before and has experienced pressures to cut down or seek treatment from people and agencies in the surrounding.

The aim of the paper was to study to what extent 1) demographics (sex and age); 2) level of marginalization (housing and work); 3) volume and frequency of drinking as well as alcohol dependence; 4) social response to
drinking such as suggestions to cut down or seek treatment by (in)formal actors; and 5) treatment history predict entering the clinical population.

For this purpose, the general population sample is weighted up and the clinical sample is weighted down to represent 0.5 percent of the total sample – the proportion hypothesized to be in treatment. This procedure is question-able methodologically. Therefore the analyses were run both with and without these rather extreme weights. Logistic regression analyses show that previous treatment experiences, unemployment and institutionalization, and having an unstable living situation are strong predictors of who is in treatment. Age, alcohol dependence and frequency of drinking are also found to be predictive. In addition, social pressures are important and males are more likely to be in treatment.

To conclude, alcohol use and problems are not the most prominent predictors of who is to be found in the treatment system compared to who is still a part of the general population. There are two worlds of alcohol problems and it is hypothesized that the Swedish treatment system is a place for repeatedly handling people on the margin, beyond and beside their extent of drinking.

In Paper II (The interplay between perceived self-choice and reported informal, formal and legal pressures in treatment entry) the experiences of the clients are studied. Reported reasons for coming to treatment and other events prior to treatment entry are divided into informal pressures (IP, from family and friends), formal pressures (FP, from work, authorities, etc.), and legal pressures (LP, by police, courts, etc.) to come to treatment. The prevalence of these pressures and their relation to clients’ reported self-choice in treatment entry are analyzed.

The paper shows that most clients claim that it was their own idea to come to treatment (81%). Pressures are also commonly reported. For instance, 75 percent of clients report some kind of informal pressure to come to treatment. Half of the respondents (48%) say that they got suggestions to do something about their substance use and/or seek treatment from the health system. Almost as many say that someone in the social services suggested treatment (44%, FP). Twenty-three percent reported police-related legal pressures. In the sample, one fifth (19%, FP) reported pressures from work. As a conclusion, self-choice in treatment entry and social pressures are not mutually exclusive. Clients report both as they enter treatment.

Multiple logistic regression analyses show that informal pressures tend to be positively correlated with reported self-choice in treatment entry; formal pressures, and especially legal pressures, tend to be negatively correlated with self-choice. There are some exceptions. Formal pressures concerning work and child-custody are not found to significantly predict self-choice. Drinking-driving arrests are, somewhat surprisingly, found to predict reporting self-choice (a positive correlation). More severe alcohol and drug problems are found to predict reporting self-choice in treatment entry.
**Paper III** (*Events in problematic alcohol and drug users’ lives: Contributions to treatment and the impact of marginalization*) studies different alcohol and drug related events\(^\text{12}\) that happened in the year prior to treatment entry. To what extent do alcohol and drug (mis)users entering treatment experience such events, in comparison to the frequency found in the general population? To what extent are the events said to contribute to treatment? The paper also studies if clients’ level of marginalization influences whether the events are found to contribute to treatment or not.

It is found that most clients had had events and these were also perceived as contributors to treatment. Events related to significant others and health workers are of greatest important ones for treatment entry. More marginalized (concerning housing; living situation; work; and treatment experiences) clients experience more types of events. Logistic regression models for each event and graphs showing partial correlations between level of marginalization and mean odds ratios that each event, when occurring, is said to contribute to treatment show non-linear correlations (mainly U-shaped). The least marginalized clients are found to most often say that an event contribute to treatment when it occurs; clients in the middle of the marginalization score are the least likely to report events as contributors; highly marginalized clients, on the other hand, are found to report that the events contribute to treatment to a high extent.

It is hypothesized that socially integrated clients find the events more frightening – a new experience that stands out in their lives. Highly marginalized clients, on the other hand, have had many events in their past and each event adds to the total burden of substance use. Finally, the individual wishes to seek help relieving the difficulties.

**Paper IV. A study of staff and the organizational level**

**Paper IV** (*The dynamics underlying the story of a reform that redefined borders of the addiction treatment system: The rapid privatization of the Maria-unit*) focuses on the organizational and treatment provision side of the treatment system. In the paper, the motives for and conflicts surrounding recent changes in the health-based treatment system (run by the Stockholm County Council, SCC) are analyzed – changes with implications for other parts of the treatment system as well. The paper deals with a quick privatization of a large treatment unit, previously run by the health system. In 2001, nearly 5,000 individuals were treated as in- and outpatients at the Maria-unit.

The paper builds on key-informant interviews (with treatment providers and politicians), interviews with staff at the treatment unit, and documents

\(^{12}\) Family arguments; warning regarding use by doctor/health worker; police troubles related to use; work complaints; arrest for drinking driving; public drunkenness or overdose; an alarming feeling due to heavy alcohol use; or an alarming feeling due to heavy drug use.
(protocols, agreements and letters) regarding the organizational changes, mainly collected from the Health and Medical Services Board of Stockholm County Council ("Hälso- och sjukvårdsnämnden", HSN).

In Sweden, there is a growing share of private companies involved in providing alcohol and drug treatment. In fact, there has been a political ambition in SCC to increase care choices through a diversity of care providers.

In 1997, health-based alcohol and drug treatment units were brought together into two organizations, Dependence Centre North (BCN) and Dependence Centre South (BCS). The fact that two centres were created instead of one was to a large extent the result of conflicts between the northern and southern part of the County – the latter known to be poorer. At the same time, a treatment policy agreement was set up between the County and the municipalities, with a focus on strong collaboration between these two establishments and decentralization of the treatment units. BCS did not follow the policy and continued to focus its work on hospitals instead of starting up integrated outpatient units, which led to dissatisfaction among municipalities and care buyers. The reform brought with it economic cuts and concerns among staff.

About three and a half years later – before the re-organization had settled down in BCS – BCN and BCS were merged into one organization, Dependence Centre Stockholm (BC). Staff was taken by surprise. In the south, staff were afraid that their units would be closed down due to new cuts and the push to finally carry through the decentralization. This led the south to investigate possible privatization of their treatment units – to break loose. Consequently, the Maria unit was privatized and became owned by (parts of) the staff. The health system continues to buy treatment from the Maria unit.

The paper shows that this privatization was brought about not only by the political care-diversity push. The course of events was influenced by other factors as well. The privatization followed after a decentralization trend and struggles between treatment ideologies (centralization vs. decentralization), as the result of abrupt and repetitive organizational changes, a feeling of disadvantage among staff in a complex treatment organization, struggles over resources between north and south which escalated during economic cuts, and weak political leadership. The left wing parties were against this privatization but did not oppose it since they wanted to keep the unit going and had no other alternatives, given the threat that the unit could be closed down in the new organization. As argued in the paper, these changes were not built on thorough knowledge of possible effects for the clients, and were not the effects of a well thought-through implementation process. Rather, the events can be viewed as the results of different factors that worked together and resulted in a privatized unit – retreating from threats in the health-based treatment provider organization.
The treatment system, its organization and responsibilities, are here described. Aspects described in this section will thereafter be discussed as features of the social ecology of the treatment system in the following section.

In an international perspective, researchers argue that Sweden has an extensive treatment system, which mainly builds on the social welfare system, rather than the health system (Klingemann & Hunt 1998; Klingemann, Takala & Hunt 1992). According to survey-based estimations (adjusted for drop-outs) from the National Board of Health and Welfare, close to 30,000 individuals were in treatment for alcohol and drug problems in Sweden on 1 April, 2003 (IKB 2003). This survey is wide in its coverage; treatment in the social services, in the health-based system, in the criminal justice system, and in compulsory treatment as well as in privately run treatment units is included. Treatment for alcohol problems is highly integrated with treatment for drug problems. In 2003, most of the units (84%) addressed both alcohol and drug problems: c. 7 percent treated alcohol but not drug problems; 9 percent treated drug but not alcohol problems. Most of the units (57 percent) are run by municipalities and/or counties. Twenty-three percent are run by private companies or private persons (this treatment is usually paid for by the social services). Eleven percent of the units are run by non-profit organizations or foundations (this too often paid for by the social services); seven percent by the criminal justice system; and two percent by the National Board of Institutional Care (SiS, Compulsory treatment) (IKB 2003).

The Swedish alcohol and drug treatment system is governed by three responsible administrations: municipalities (social welfare-based treatment), the counties (health-based treatment), and the state (treatment in the criminal justice system and compulsory treatment). The municipalities have the ultimate responsibility for addiction treatment (cf. SOU 2004:3; SOU 2005:82). Below, the responsibilities of the municipalities, counties and the state are summarized. The chapter deals mainly with national legislation and regulations. It also includes data specifically for Stockholm County. As noted in the Appendix paper, decentralization has led to local variations regarding treatment in the health-based and social welfare systems.
Responsibilities of involved actors

Municipalities: Social welfare-based treatment

The municipality shall, according to the Social Services Act (SoL, Socialtjänstlagen, 2001:453), provide the individual with the help and care he or she needs in order to overcome an addiction. If voluntary treatment is not enough, and the person is a danger to him/herself or others, the board shall apply for compulsory treatment (LVM). The social services provide the individual with treatment and psychosocial support. The responsibility of the municipality regarding substance misusers and the goal of municipal alcohol and drug treatment is regulated in legislation in SoL (chapter 5, § 9):

“The social welfare committee shall actively ensure that the individual substance abuser receives the assistance and care which he needs in order to overcome his abuse. The committee, acting in consensus with the individual, shall plan the assistance and care and closely monitor compliance with the plan.”

There are no definitions of abuse (“missbruk”) and who is a misuser (“missbrukare”) in the legislation (SOU 2005:82). This implies that the responsibility of the social services for providing misusers with care (SoL 5:9) is not connected to time or intensity of abuse, or time of abstention of a client.

Counties: Health-based treatment

The counties’ responsibilities lie in providing health care according to the Health and Medical Services Act (HSL, Hälso- och sjukvårdslagen 1982:763). With respect to alcohol and drug treatment, they are responsible for providing medical interventions for somatic and psychiatric problems (i.e., abstinence-oriented treatment and detoxification) as well as pharmaceutical treatment for alcohol and drug problems (i.e., Methadone and Subutex maintenance, Naltrexone treatment, etc.).

In a regional care document on alcohol problems from the Stockholm County health system, it is argued that the “goal of treatment must be individual and be built on the motivation level of the patient. The goal can be changed during treatment, which in the beginning can include motivational enhancement therapy. In the first place, treatment aims at limiting harmful alcohol consumption, regarding quantity and frequency. In the second place, it is desirable to attain enhanced mental and social functioning” (Regionalt vårdprogram..., p. 41). EBP/T, leaning on the SBU (2001) report, is recommended.

13 (In English: http://www.sweden.gov.se/content/1/c6/04/34/02/9d488738.pdf, viewed October 16, 2006)
Health-based treatment services in Stockholm are regulated by agreements between the financing organization and the care providers. One example of the more general tasks and goal of the health-based alcohol and drug treatment system is found in the *Women and men in Swedish alcohol and drug treatment*-study. According to the agreement regulating the work at the new Maria treatment unit (see Paper IV), the goal of the treatment unit is to:

“– provide for decreased morbidity and mortality due to substance abuse and dependence on alcohol, drugs and pharmaceuticals.
– together with the districts of the municipality, and the primary care and psychiatric sector, take responsibility for and develop the interventions for abusers (“missbrukare”) and mentally ill abusers.
– work toward the individual experiencing the dependence care’s treatment as an integrated part in an intact chain of treatment, *i.e.*, a whole regardless of type of care and responsible care provider…. The unit shall be organized to provide high patient security and good quality as well as to promote cost-effectiveness” (Appendix I of the Maria unit agreement; see Paper IV).

### Maintenance treatment for opiate-dependent individuals

The health-based treatment system is responsible for providing pharmaceutically assisted maintenance treatment for opiate dependence (substitution treatment): Methadone maintenance treatment (MMT) and Subutex® (buprenorphine) maintenance treatment (SMT).

This treatment is provided in accordance with HSL (1982:763), and as of January 1, 2005, there is a new special regulation in force (SOSFS 2004:8, Socialstyrelsen 2004) for maintenance treatment (MT). MT is viewed as a last resort and should only be given to individuals aged 20 or older with at least two years of documented opiate dependence. If it is judged that another type of treatment is enough, the patient should not be given MT.

According to the directions, “the goal shall be that the opiate dependent individual shall come to an end of his or her addiction and achieve an improved health and social situation” and MT “shall be carried on by taking the goals of the national drug policy into consideration” (Socialstyrelsen 2004:4). In order to achieve this, the doctor must do a thorough assessment of the patient’s full medical status and social situation. The regulation further states that a treatment plan shall be made for each patient. This plan shall include the goal of MT and its contents, by stating/including: an evaluation of medical needs and interventions; setting up (part)goals of MT; deciding upon/carrying through medical interventions; an evaluation of care needs (“omvårdnad”); a psychiatric assessment; an evaluation of social needs; deciding on goals and part goals for the social interventions; deciding upon and carrying through social interventions.

The regulation states how relapses during planned weaning from the substitute should be dealt with. If the patient relapses or is suffering from severe withdrawal symptoms, the weaning should be broken off. If two attempts to
cease MT fail, “the treatment plan shall be reconsidered and the goals of the treatment should be looked over” (Socialstyrelsen 2004:9).

A joint treatment policy: Stockholm County and the municipalities
As described in Paper IV, there is a treatment policy agreement between Stockholm County’s health service and the municipal social services system. According to the policy document from 1998, “the joint goal is to create requirements for the person who misuses to return to a life as normal as possible without misuse. And to be able to live with other people, be in good mental balance and have a good physical health” (Samverkan i... 1998:2).

The state: Criminal justice system and compulsory treatment
The state is responsible for running treatment in the criminal justice system in accordance with the Law on Care of Criminals in Institutions (KvaL, Lagen om kriminalvård i anstalt, 1974:203) and compulsory treatment in accordance with the Care of Alcoholics, Drug Abusers and Abusers of Volatile Solvents, Special Provision, Act (LVM, Lagen om vård av missbrukare i vissa fall, 1988:870). These types of treatment are, at least in part, funded by the Social services through payments for treatment of individual clients. In fact, the responsibility for the individual’s needs, including alcohol and drug treatment, rests with the municipality and the health system also when the person is in the criminal justice system (Prop. 2001/02:91, p. 47). In practice, it is often the criminal justice system that provides for this type of treatment.

Treatment in the criminal justice system
In 1994, Lehto concluded that prisons “seem to be big custodial ‘treatment’ institutions of alcoholics and drug users” (p. 22). In fact, a high proportion of the prison population has problems with alcohol and drugs, and is in prison due to crimes committed under the influence of alcohol or other drug-related crimes. In 2002, 62 percent (6,250 individuals) of the prison population were known drug users (cf. BRÅ 2003). In 2004, the Government estimated that 10,000 of the country’s heavy misusers (c. 27,000 individuals) pass through the criminal justice system and prison (Skr. 2004/05:152, p. 17).

In Sweden, a criminal offender with a drug problem sentenced to imprisonment has three treatment alternatives. According to article 34 of KvaL, an inmate can be placed outside prison if she or he can receive interventions that can help her or him reintegrate into society. In a §34-evaluation, the inmate’s need for alcohol or drug treatment shall be strongly considered (Prop. 2001/02:91, p. 55). Treatment is mainly intended for inmates with long-term sentences (at least two years).

The second alternative is “contract treatment” (“Kontraktvård – skydds- tillsyn med föreskrift om särskild behandlingsplan”), regulated by the Swedish penal code (28 chapter, 6a § BrB). The court can sentence a person
with substance problems to an alternative prison sentence – to treatment for alcohol or drug problems at an institution or in a private home (probational sentence). It is the probation officer who assesses and administers this treatment. This way the individual can avoid imprisonment. If the individual breaks the contract, the court can decide to send him or her to prison.

The third alternative, motivational efforts and treatment in prison, is becoming more widely used and involves more clients, as a result of an action plan against drugs by the Government, launched in 2002. In the starting phase of this action plan, aiming at improving drug treatment in prisons and adding 100 million Swedish Crowns to the criminal justice system, the Government set the goal that “every drug abuser shall be motivated to treatment” (Prop. 2001/02:91). The criminal justice system shall to a higher extent than before motivate and prepare drug-using inmates for treatment, and if possible, start treatment. Treatment shall be prioritized. Interventions in the criminal justice system have increased and been broadened due to this action against drugs (IKB 2003).

The goal of providing treatment in the criminal justice system, as stated by the Government, is that

“the criminal justice system fulfils an important function in society’s actions against drug abuse. Therefore, the time of an inmate in custody, prison and under probation, must be used to motivate the drug abuser to treatment…. Inmates as well as staff in prisons and custody have the right to a drug-free environment…. In order to achieve a drug-free environment, a combination of powerful motivation and treatment interventions, as well as well-balanced control measures, are required” (Prop. 2001/02:91, p. 47).

By referring to the fourth article of KvaL, the Government argues that “the treatment of offenders shall be tailored to promote the inmates’ adaptation to a life in society, and the harmful effects of imprisonment shall be counteracted…. Therefore, working with substance abuse problems is one of the most effective actions for improving the inmates’ re-adaptation to society” (Prop. 2001/02:91, p. 49). In fact, in the proposition, it is said that the criminal justice system is being developed to have “a new treatment role” (p. 51).

**Compulsory treatment according to LVM**

Sweden has a long history of compulsory treatment. This part of the system is not that extensive. In 2004, on 1 November, six percent of those receiving inpatient treatment care (c. 3,200 persons) were placed in compulsory treatment (Socialstyrelsen 2005). In a year, about 1000 individuals are in compulsory treatment (SiS 2006a).

The extensive rights of the state to intervene in the private lives of the individuals has been found to have a solid support in Swedish society. The Swedish use of compulsory treatment is quite unique with respect to its prevalence (cf. Lehto 1994; Palm & Stenius 2002). Most other countries
have abolished this form of civil commitment or let it fall into disuse, whereas it is a quite integrated part of the Swedish treatment system.

LVM requires the social services administration to take steps to force a person into treatment if he or she, due to ongoing misuse, is risking:

- her/his physical or psychological health on purpose or by helplessness (the health criterion); or
- destroys the prospect of her/his future, e.g., cannot live a life with human dignity and is severely risking her/his life (the social criterion); or
- risking the security of her/himself or intimate associates, e.g., by a high risk of committing suicide or domestic violence, but also by causing mental suffering of family members etc. (the violence criterion);\(^{14}\)
- and the necessary intervention is not possible on a voluntary basis (Palm & Stenius 2002; SOU 2004:3, p. 108-109).

The explicit goal of LVM is to:

- immediately stop a destructive way of life (immediate goal);
- motivate to further (voluntary) treatment (short-term goal); and
- overcome the addiction and achieve a better lifestyle (long-term goal).

The intention is that the client should be given possibilities to manage the problems himself or herself. However, the goal is not to provide treatment, but rather to motivate the individual to voluntary treatment.

When LVM was legislated, the intention of the legislature was that society is obliged to intervene when the misuser or his or her significant others are in such situations as the law states and his or her needs cannot be fulfilled by SoL or in any other ways, for instance by HSL (SOU 2004:3, p. 105). In addition, the goal must always be to achieve positive changes for the client, apart from the temporary and immediate improvement the LVM episode per se can provide (SOU 2004:3 p. 106).

The support for LVM in Swedish society is strong (Hübner 2001:166; Palm & Stenius 2002). In fact, when a large official governmental investigation of compulsory treatment was launched (SOU 2004:3), the investigators were not allowed to touch upon the issue of whether or not Sweden should have compulsory treatment. Instead, the focus was on why the use of this type of treatment had gone down and on how its use could be increased. The decline was actually viewed as an indicator that heavy users had not been given appropriate treatment. The investigator was directed to see if he could “contribute to the fulfilment of the most vulnerable abusers’ care needs and [ensure] their legal rights are strengthened” (Dir. 2002:10).

In the data of the *Women and men in Swedish alcohol and drug treatment*-study, compulsory treatment is favoured, at least for certain cases. Eighty-nine percent of staff in the social welfare system and 94 percent of

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\(^{14}\) Purely economic harms to intimate associates are not included in the violence criterion.
the staff in the health-based addiction treatment system agreed that it “sometimes is necessary to force someone into alcohol treatment for their own good”. The equivalent proportions for coercion regarding drug problems were higher (93% social welfare staff; 96% health system staff) (Palm 2003; Storbjörk 2003a). A majority in the general population also believe that (86% for alcohol; 92% for drugs) (see Table 2 and 10, Appendix II).

Swedish “treatment” definitions

Finally, some influential Swedish definitions of treatment are mentioned. These definitions give a good view of what treatment is thought to be and achieve. The definition adopted by the National Board of Health and Welfare has been mentioned (see Defining “treatment”…) but is repeated here. Treatment refers to:

“medical, psychosocial and social measures or interventions aiming at initiating and maintaining individuals to stop or decrease abusing alcohol or drugs and to prevent relapse. Detoxification and interventions of more supportive and caring nature with the purpose to reintegrate the individual socially are also included” (Referred to as the “earlier definition” in this thesis).

This definition reflects the Swedish treatment approach, which is social service-oriented. In this perspective, the reintegration of individuals into society is in focus, and not solely substance use. This might be one explanation for the fact that Sweden has a large treatment system in comparison to other countries (Klingemann & Hunt 1998; Klingemann, Takala & Hunt 1992).

The broadness of the definition has been criticised by Bergmark and Oscarsson (1994), who think that there should be a division between treatment and other types of interventions. They argue that the concept of treatment, instead of referring to everything that is called treatment or listing a wide range of different types of activities, should refer to

“activities on an individual which have a primarily therapeutic intention concerning identified alcohol problems, are acted out in a primarily therapeutic context, and are expected to give a therapeutic effect within this context” (p. 124).

Their line of arguing has recently been adopted in the extensive line of work, led by the National Board of Health and Welfare, aiming at providing practitioners with evidence-based treatment guidelines15 (Socialstyrelsen 2006a).

15 The work has included seven expert committees summarizing and presenting EBP/T: detection and prevention; assessment tools and documentation; psychosocial and pharmaceutical treatment of drug problems; psychosocial and pharmaceutical treatment of alcohol problems; treatment of pregnant women; co-morbidity (substance use and mental/somatic problems).
The Board expresses the wish “to take the first step towards developing a common terminology” (p. 14) to be used by different treatment actors. The Board defines treatment as “dependence care” (“beroendevård”) instead of addiction or substance abuse treatment. Dependence treatment includes actions that aid or provide services in the form of care or treatment to clients and patients with abuse (“missbruk”) or dependence (“beroende”) problems in the social services and health-based services. Treatment

“is systematically and theoretically grounded techniques or methods that are used to help individuals to overcome their abuse (“missbruk”) and prevent relapse. Medically assisted abstinence oriented treatment is also included” (Socialstyrelsen 2006a:16, referred to as the “later definition” in this thesis).

The Board argues that adequate competence and education is required in order to be able to perform these techniques or methods. Therefore, treatment includes the following criteria:

“– Evidence criterion (refers to systematic, theoretical methods supported by research)
– Intention criterion (intention to initiate that individuals overcome their abuse and do not return to it)
– Competence criterion (practitioners shall have adequate competence)
– Criterion of therapeutic context (a practice that is provided in a context suitable for therapeutic and treatment activities)” (Socialstyrelsen 2006a:16).

In addition, the Board rejects the term “psychosocial support” (“psykosocialt stöd”) and argues that this type of action is not treatment. This term is used for measures related to work and housing and the living situation of the client, including relationships etc. This term refers to actions aiming at improving the social situation of the individual. These measures can have treatment elements in them, but should not be labelled treatment per se. The difference is based on the lack of evidence-based methods or techniques in psychosocial support actions. However, this kind of support “can be viewed as a prerequisite for treatment interventions” (Socialstyrelsen 2006a: 18). These changes in the official definition of treatment will be discussed further on.
By looking at the varieties of reasons why people come to treatment and their treatment goals, in relation to the views on treatment of treatment staff and politicians, and the general population’s view on treatment, I will here discuss the social ecology of treatment. First, the official views on treatment, as reflected in policy, are discussed. Thereafter, treatment is discussed from the point of view of staff, and clients’ experiences and views are charted. In Discussion, these goals, interests and experiences are discussed in relation to each other. In this section, some views on treatment of the general population, as well as concepts and findings from research, are also included for broadening the portrayal offered. Researchers’ voices are mainly used in the latter part of the chapter, dealing with areas not often mentioned by officials.

### Treatment in society: Policy and goals

This section sets out to crystallize the officially perceived goals treatment is supposed to fulfil. What do responsible actors say that treatment is for – for individual clients as well as for society as a whole? What can be told from actions regarding treatment, actions with a rationale not explicitly spelled out?

The actors involved in defining the official goals are mainly civil servants and politicians at different levels – state, counties and municipalities. The goals of treatment are extracted from the perceptions of these actors – as stated in legislation and regulations, official documents and reports (*i.e.*, *SOU*, reports from the National Board of Health and Welfare, etc.), policies and local care agreements, and treatment goals of services.

This section is mainly limited to Swedish actors, legislation and arguments. In order to avoid getting caught in historical changes, the documents under study are limited to the last 5-10 year period. Special attention is paid to Stockholm County, since the empirical data is from that region.

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16 This is somewhat problematic, since a lot of the treatment literature and policy, due particularly to the strong influence of the United States, is becoming more and more international.
Curative and reformative goals: A vision of a drug-free society

Swedish drug policy aims at an illicit drug-free society (Tham 2003). Treatment provision is also a prominent feature of the policy (SOU 2000:126). The drug prohibition is also supported by people in the general population: about 90 percent think that cannabis and other narcotic drugs should be forbidden (Hübner 2001:158). This is not the case concerning alcohol. “The goal of Swedish alcohol policy is to lower the medical and social harms from alcohol” (Prop. 2000/01:20 p. 18). Alcohol consumption is allowed, though strongly regulated, and the policy puts its faith in the total consumption model (Olsson, Ólafsdóttir & Room 2002; Skog 1985). If the total consumption is kept low, the number of problem drinkers and harms from drinking will be low as well. Treatment is also viewed as part of the alcohol policy (Prop. 2000/01:20). In 1995, 42 percent of women and 57 percent of men in the general population thought that Sweden had too many restrictions regarding alcohol (Hübner 2001:165).

Today, Sweden is not a drug-free country. In a Nordic anthology on how control and treatment are applied in the Nordic countries in response to drug abuse, Ólafsdóttir claims that

“the extensive measures of control that have been introduced under the umbrella of drug policy in the Nordic countries have done little to prevent drug use; in fact all these countries have seen an increase in drug use and longterm abuse. This has thrown up a host of problems in society that has also affected the division between the police, social welfare authorities and health care services” (Ólafsdóttir 2001:232).

Joining the European Union (EU) in 1995 brought about a more liberal alcohol policy (cf. Holder et al. 1998). This might explain why a renewed political interest in treatment is arising (cf. SOU 2004:3; SOU 2005:82). Treatment is becoming a more important cure for alcohol and drug problems.

In Sweden, a rather optimistic official view on treatment is visible. For instance, the Government believes in alcohol and drug treatment and argues that “well suited and designed treatment interventions (“insatser”) contribute to decreased drug addiction and improve the life situation of the abuser” (Prop. 2005/06:30, p. 99).

Regarding individual alcohol and drug misusers coming to treatment, curing alcohol and drug problems and achieving abstention are the most often stated goals. As stated by the Swedish Drug Commission (SOU 2000:126), “measures of care shall be aimed at achieving a life free from substance abuse and illegal drugs” (p. 44). The influence of Alcoholics Anonymous (AA) and the quite prominent role of Minnesota model treatment in Sweden (Helmersson Bergmark 1998; Stenius 1991) may have buttressed or be explained by a norm of abstinence as the goal of treatment. Forty-five percent of the treatment units offer Minnesota or 12-step treatment. Twenty-five
percent of the units report that these types of treatment carry important weight in their treatment. The only treatment methods found to be reported by a higher proportion of the units are social skills training (32%) and psychotherapy or supportive therapy (31%) (IKB 2003).

A number of examples from the overview of Swedish alcohol and drug treatment (above) can also be cited here: 1) The earlier as well as later definition of treatment by the National Board of Health and Welfare say that treatment is aiming at “initiating and maintaining individuals to stop or decrease abusing alcohol or drugs”, or, as reformulated later, “to help individuals to overcome their abuse”; 2) SoL is aiming at the individual overcoming his abuse; and 3) even the goal of MMT is that the individual shall “come to an end of his or her addiction”.

Curing alcohol and drug problems also includes improving the physical and mental health of the clients. The major aim of treatment in the health system is to provide care for somatic and psychiatric problems and decrease morbidity (see Swedish alcohol and drug treatment, previous chapter). There is also the health criterion underlying LVM.

It is easy to conclude that one of the official purposes of treatment is to cure individuals’ alcohol and drug problems.

Social reintegration: A tradition of the welfare state

Sweden has a tradition of a strong, universal and rather successful welfare state (cf. Fritzell 2001; Kautto et al. 2001). This implies that those in need have been provided with a minimum standard of well-being. However, over the last three to four decades, reports have pointed out that there are marginal groups that do not benefit from the welfare system (cf. Inghe & Inghe 1970; SOU 2000:41; SOU 2001:79; Stenberg, Svanström & Åhs 1989). Nevertheless, the intention of the Swedish welfare state is to provide for basic needs for its citizens regarding economic resources, education, work, housing, social network, etc. This approach is present in the alcohol and drug treatment system as well.

In Sweden, alcohol and drug problems, as well as treatment of these problems, have been and are mainly viewed as social problems (cf. Rosenqvist & Kurube 1992). This is reflected in the way society has decided to deal with these problems: “the Government wishes to underline that addiction treatment always should be viewed from a social and social psychological perspective, even though medical interventions at times are extensive” (Prop. 2005/06:30, p. 66).

In Sweden, alcohol and drug treatment is closely integrated with other types of (social) interventions. IKB 2003 shows that only 38 percent of the treatment units who took part in the survey reported that they only provided “treatment”, defined as “services which are focused on initiating a break in the cycle of misuse and ensuring that this break is maintained and that indi-
Individuals do not return to substance misuse, including medically supervised detoxification” (p. 74). The rest of the units provided treatment plus sheltered housing and other measures. This is remarkable, considering the survey’s focus on the key services in treatment provision, i.e., units offering treatment – specific, targeted interventions with the aim of achieving a change in the misuse behaviour itself – as opposed to units solely offering other services such as sheltered housing, sobering up, emergency interventions, physical care, vocational training or employment (IKB 2003).

This welfare goal of treatment is also evident in other statistics from the National Board of Health and Welfare. Statistics on interventions provided to substance misusers aged 21 or older show that on 1 November 2004, among individuals receiving social services due to the abuse of alcohol, narcotics, or prescription drugs, over 6,100 were receiving housing assistance and slightly more than 11,900 were receiving individual needs-tested outpatient care (Socialstyrelsen 2005). The statistics present separate figures for the following services provided in accordance with the Social Services Act: housing assistance, individual needs-tested outpatient care, and round-the-clock care. Thus, it is not only specialized treatment techniques that are viewed as treatment. During 2004 a total of 23,600 people were registered for substance abuse interventions in accordance with the Social Services Act (SoL). Fifty-five percent of these (nearly 13,000 individuals) received housing assistance (Socialstyrelsen 2005).

The above statistics are all in accordance with the earlier treatment definition from the National Board of Health and Welfare, that “interventions of more supportive and caring nature with the purpose of reintegrating the individual socially are included”. As pointed out, in the later definition used for the treatment guidelines this goal has been dropped. Instead, the definition focuses solely on overcoming abuse. In fact, “psychosocial support” is not regarded as treatment, since it does not build on strong evidence. Nevertheless, it is believed that these types of interventions are of importance – as a base – for other “real” treatment interventions (see Swedish Alcohol...).

Most explicitly, providing social welfare and promoting social integration of the clients is the task of the social services. This view also exists in the health system, where it is stated, in the aims of alcohol treatment, that it is “desirable [that it be] with an enhanced ... social functioning”. In addition, when starting maintenance treatment in the health system, it is required that a thorough social assessment is done, goals are set and decisions made regarding social interventions (see Swedish Alcohol...).

In the criminal justice system, treatment aims at adapting or reintegrating the drug user into society. To repeat from above: “working with substance abuse problems is one of the most effective actions for improving the inmates’ re-adaptation to society” (Prop. 2001/02:91, p. 49). This can be interpreted as a strong re-integration goal. Treatment is used for the purpose of re-integrating the individual to society – the task of the welfare state.
The re-integration goal, or the importance of a functioning social life that is not ruined by alcohol or drug problems, is perceptible in the LVM-legislation as well. The social criterion is concerned with such severe social harms as when abuse is dominating the life of the individual – he or she can no longer keep up social relations. LVM can be considered as a last resort to help save what is left of the individual’s connection to the labour market, school system, housing and relation to significant others and to break a lifestyle of hanging out with other misusers (SOU 2004:3, p. 108-109).

In sum, alcohol and drug treatment is closely linked to other welfare services and treatment is used with the goal to re-integrate individuals socially.

Highly valued life saving allows soft harm reduction

In the welfare state, as well as in most modern societies, human lives are highly valued. Attempted suicide has sometimes in history been punished by a death sentence (Durkheim, 1979). A loss of life is generally viewed as a loss to society – alcohol or drug related deaths as well (cf. Jarl et al. 2006). Politicians aim at keeping people alive.

HSL, regarding treatment in the health system, states that persons in greatest need shall be given priority. Treatment of life-threatening diseases shall be prioritised above other conditions (SOU 1995:5; see Palm 2006b on priorities in alcohol and drug treatment).

Treatment serves a life-saving purpose. This purpose is most explicitly spelled out regarding LVM (social criterion: severely risking life). If a person is about to kill himself or herself by using alcohol or drugs, the state intervenes. If the person is about to destroy his or her future, the state intervenes. Another example comes from the Health system, where the Maria unit agreement states that the unit shall provide for decreased mortality due to substance use (see Swedish Alcohol...).

Alcohol and drug treatment fulfils a life saving role in society. It is possible that this is why harm reduction as an exception to curing substance problems quite often is used in practice.

Soft harm-reductionist goals and practices

Harm reduction is intended to be an alternative to the prohibition of certain lifestyle choices. It is recognized that some people always will engage in substance use. The main objective is to alleviate potential dangers and health risks associated with the behaviours, and to reduce harms associated with, or caused by the legal circumstances under which substances are used. Examples of harm-reducing actions are needle-exchange, heroin prescription, offering safe injecting rooms, or legalization. The International Harm Reduction Association (IHRA) recommends that the term harm reduction should be used as and understood to mean “policies and programs which attempt primarily to reduce the adverse health, social and economic consequences of
mood altering substances to individual drug users, their families and their communities”.

Rogers and Ruefli (2004) argue that by using a ‘low-threshold approach’, harm reduction does not require that clients abstain from drug use to gain access to services, nor expect adherence to one service to be eligible for another. Rather than having abstinence goals set, clients take part in goal-setting. No one should be excluded from benefits or services because they are unwilling or unable to abstain from alcohol or drugs.

In Swedish policy, harm reduction is officially not recognized. It is seen as incompatible with the official goal of a drug-free society and harm reduction is most often rejected in legislation.

Needle exchanges have been long discussed – with official actors mainly arguing against needle-exchanges. The Drug Commission (SOU 2000:126) argued that other interventions can be used in order to get in contact with drug users. The Commission did not, indeed, dissociate itself from needle exchanges, since “situations may arise when there are reasons to use this method” (p. 170). The commission claims that such an activity must be run in connection with active drug treatment.

The fact that needle exchange is justified, if at all, as a tool for getting in contact with drug users and must be run in conjunction with traditional treatment, instead of offering relief in drug users’ daily lives, implies a non-harm reduction approach. This is also observable in a recent proposition suggesting a law that is in force from July 1, 2006, which in fact allows needle exchanges (Prop. 2005/06:60). In the proposition, needle-exchange is framed as protection from contagious diseases (HIV/AIDS) instead of being part of drug policy legislation. One interpretation of this is that the idea of needle exchange is not in agreement with the official drug policy, but is implicitly accepted and has found its way around the obstacles through being framed as a contagious disease issue instead of a drug policy issue.

Another example of the non-harm reductionist approach is maintenance treatment. It has not been legislated about, but strongly regulated, and MMT was only allowed to a limited number of clients (cf. Johnson 2003). However, as stated, MMT and SMT have become more accepted in Sweden during recent years.

In official documents, a soft harm reduction approach is sometimes visible. For instance, as stated above (see Swedish Alcohol...), the Drug Commission proclaims abstinence as the goal of drug treatment (in line with vision of a drug-free society). Nevertheless, in the report, the Commission also critiques the description, often cited in national and international debate, of Swedish restrictive drug policy as opposed to “measures aiming at reducing

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suffering and harms of the individual abuser” (SOU 2000:126, p. 168). The Commission argues that such an opposition should not be exaggerated.

“The individual abuser can and shall, naturally, be offered caring interventions, medical care, care for infections, housing assistance and other socially supporting interventions without these interventions always being linked to demands for immediate and/or long-term drug abstention. In actual treatment, such measures frequently occur. For many of the heaviest and most harm-exposed abusers, an abstention goal or goal of severely reducing abuse is achieved only after long and coherent processes. To prevent abusers from entering supporting and helping interventions during these processes most likely implies that the harms from abuse increase for the individual and for society. Based on experience, we know that supporting interventions per se often bring with them a moderating of abuse, which is good for everyone involved” (SOU 2000:126, p. 168-9).

The Commission continues this argumentation by saying that these measures most often concern a group of heavy users, the group that often is the subject of needle-exchange programs and injection rooms in other countries. However, they state that interventions like heroin prescription and injecting rooms have never been considered, and should not be considered as interventions in Sweden (SOU 2000:126). The Commission implicitly approves some forms of soft harm reduction, but not approaches on the other end of a possible harm reduction continuum.

This acceptance of harm reduction is also detectable in a more recent official report concerning a care agreement in the addiction treatment system (SOU 2005:82), aiming at improving treatment for “heavy abusers”:

“the rehabilitation of heavy alcohol and drug abusers is a complicated and long-term work that has to take its starting point in the individual needs and conditions of the individual. For some persons with addiction problems, the goal of total rehabilitation in terms of total abstinence from alcohol and drugs, employment and housing is not realistic. The goal for these individuals must instead be a matter of improved quality of life in terms of longer sober/drug-free periods, housing with support/care or their own housing with housing support, access to functioning outpatient psychiatric care/addiction treatment and some kind of occupation” (SOU 2005:82, p. 16).

In fact, harm reduction thoughts are also noticeable in the LVM-legislation. In SOU 2004:3, it is stated that the goal of LVM could be different for older persons with a long history of addiction problems committed to compulsory treatment in compliance with the social criterion – when the usual drug-free goal is not realistic. “It can be a question of returning the abuser to a less risky lifestyle, mainly in the form of supportive interventions and humanitarian care, when compulsory treatment can be necessary to break an ongoing abuse that can lead to medical harms” (SOU 2004:3, p. 108).
In addition, in annual statistics from the National Board of Health and Welfare, adults with substance abuse problems are defined as persons who “receive individual needs-tested interventions by the social services aiming to rectify (“avhjälpa”) or relieve (“lindra”) these problems” (Socialstyrelsen 2005:21). Finally, there are also indications of acceptance of decreased use – and not abstention – in the health system. As stated in the regional care document for Stockholm County, the foremost goal of treatment aims at “limiting harmful alcohol consumption” (see Swedish Alcohol...).

Consequently, in spite of the fact that Sweden proclaims the goal of a drug-free society and that the main goal of treatment is to achieve abstinence, there is some support for a soft version of harm reduction. Research also shows that harm-reducing actions often are accepted and used in practice (cf. Lindström 1992).

Paternalism: Protect those who cannot manage themselves

Another feature of the welfare state is that the state seeks to protect the weakest and most vulnerable individuals of society. A paternalistic stance is visible, which means that there are laws for the safety of the citizens – the state claims to know what is best for the individual.

In Sweden, there is treatment for alcohol and drug problems which is justified by claiming that it promotes the well-being of the individual. In fact, Sweden has been categorized as a paternalistic and caring society with respect to compulsory alcohol and drug treatment (Lehto 1994).

The LVM-legislation demands paternalism by requiring authorities to take action if the person is risking his or her health or destroying the prospects of his or her future by substance use. In fact, in Lehto’s (1994) comparison between Nordic countries, Sweden came out as the most paternalistic system of dealing with misusers. This was inferred from the criminal justice system and the compulsory treatment system (LVM). The attempts to work for the best of the client even against his or her will were obvious (see Utilitarianism... below). In fact, as pointed out, the goal of LVM must always be to achieve positive changes for the client (see Swedish Alcohol...).

Even apart from the fact that the social services are obliged to initiate LVM if necessary, one can say, based on the overview of the treatment sys-

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18 Lindström (1992) conducted a functional analysis of how homeless alcoholics were handled in Sweden. In his view, “treatment” is not the best solution to the handling of this group. Care and provision of a better-adjusted living milieu are more realistic than reintegration into society. He argues that society has a responsibility to provide severely marginalized alcoholics, who cannot be reintegrated, with a decent life. In his view, the second-best alternative, harm reduction (my choice of word) instead of cure, is good enough and can help to include the homeless in the care apparatus by not scaring them away. To allow these views also decreases the sorting process of sorting out those who are difficult to treat (see also Järvinen 2002).

19 Sweden was categorized as paternalistic and caring; Finland as paternalistic but neglecting; Denmark as liberal but neglecting; and Norway as paternalistic/liberal and caring.
tem above, that the social services in general stand on a paternalistic ground. In SoL, it is stated that “the social welfare committee shall actively ensure that the individual client receives the assistance and care which he needs” (see Swedish Alcohol...), which implies that the administration cannot wait for the individual to enter their door. Under circumstances when the individual cannot seek help, the social services have to step in – for the good of the individual. On the other hand, this paternalism in alcohol and drug treatment was more obvious in the 1990s when the state launched an “offensive drug treatment” (cf. Blomqvist 1998; Socialstyrelsen 1993). More recently, researchers have argued that misusers more actively have to search and qualify for treatment – a more passive treatment system (Svensson & Kristiansen 2004).

Nevertheless, the individual can be placed in treatment if the social services think that he or she cannot take care of him or herself.

Treatment for enhancing order in society

In society, most individuals internalize and share some social norms on how to behave and interact, on what is right and what is wrong (cf. Mead 1934). Three related topics are here discussed: treatment for avoiding harms to others, treatment for cleaning up the streets, and social control – including stigmatization. The common denominator is that they are about social norms in society – rules that are socially enforced. Norms bring with them obligations and violations are punished with sanctions of different kinds. Violations are often viewed as deviant and are stigmatized.

Utilitarianism: Treatment for avoiding harms to others

"Utilitarianism” refers to actions aiming at achieving the maximization of good consequences (happiness, welfare etc.) for a population. In political actions, utilitarianism generally implies that power can only be used over citizens, against their will, in order to prevent harm to others.20

Lehto (1994) argues that “while justified in paternalistic terms, it is often argued that the ultimate goal of treatment is the good of others than the person treated. According to this claim, paternalistically motivated treatment involves a hidden non-paternalistic agenda” (p. 11). He further states that the non-paternalistic argument is more problematic in the treatment sector, because the sector’s legitimation derives from the benefit that it is claimed to give to the person treated. Although treatment often benefits others as well, treatment for the benefit of others cannot be the only purpose or the legitimation of a treatment institution.

Judging from the Swedish treatment overview (above), one can claim that a non-paternalistic, and even utilitarian, approach is observable – and explic-

itly spelled out. For instance, there’s the violence criterion in the LVM-legislation (see Swedish Alcohol...). Although controversial, the violence criterion implies that treatment is for protecting people in the environment (utilitarian motives) and not the misuser per se (paternalistic motives). In fact, in the work preceding the legislation, it was argued that it was easier for a significant other to report someone close for compulsory treatment instead of reporting the person to the police for a crime, for instance domestic violence, by motivating that this was done with the best interests of the misuser in mind (SOU 2004:3, p. 109).

Another example of utilitarianism comes from the policy document regulating alcohol and drug treatment in Stockholm County, where children of misusers are taken up as one special group that has to be protected and given proper care by societal institutions (Samverkan i…1998).

The utilitarian approach is especially prominent in the criminal justice system, the part of the treatment system that is expanding the most due to the drug action plan launched by the Government. As pointed out, treatment in the criminal justice system is viewed as an important part in society’s actions against drugs. Therefore, motivation and treatment are combined with control measures in prisons to offer a drug-free environment. Consequently, treatment in the criminal justice system fulfils not only paternalistic goals, but also utilitarian goals of protecting non-drug-using inmates and staff from drugs. The reason for treatment is a more general fight against drugs in society. As stated in a text from the Government, based on the argument that half of the inmates are drug users, “the criminal justice system is one of the most important arenas for fighting drugs” (Skr. 2004/05:152, p. 17).

Treatment for cleaning up the streets from “spare” people

Paper I ("two worlds") shows that those in alcohol and drug treatment in Stockholm County to a large extent are “marginal” or “spare” people, of which a high proportion is living an unstable life. How come the treatment population is marginalized to such an extent? And how come the police are involved in treatment entry (Paper II “interplay”; Paper III “events”)?

Putting forward this aspect points to the fact that treatment efforts sometimes are combined with the aim of cleaning up streets or closing open drug scenes in city centres. Christie (1994) claims that the crime control industry is for “cleaning up, removing unwanted elements from the social system” (p. 13). Similarly, in formulating the concepts of “discipline” and “border control” for controlling a territory or field of responsibility, Sahlin (2001) argues that “border control” aims at achieving a “clean” society. It operates through deciding who is allowed to come in and stay outside of a territory. Exclusion can be more or less explicit. An implicit form of exclusion is to remove the bench where the homeless alcoholic sits, or to ban alcohol in certain areas.

I will here offer two examples of how treatment is combined with mopping-up actions. In 2004 “Plata” (an open drug scene close to the central
train station in Oslo, Norway) was cleaned up in the “Plata aksjonen” (Plata action). In this effort, service centres or shelters providing food etc. were built up to attract misusers to go to these places instead of staying at Plata. At the same time, the police took part by clearing out Plata (Skretting 2006).

There is one recent Stockholm example of how treatment is used to clean up the streets from misusers. In 2005, an effort was launched in collaboration between the Swedish drugs coordinator (“Mobilisering mot narkotika”), Stockholm city, the health system in Stockholm County and the police. In the project, “Lots för livet”, which means a pilot for life, heavy drug users who were known by the police to regularly spend time at Stockholm’s open drug scenes, who were registered as living in Stockholm, who were not awaiting charges, and who were willing to receive treatment for their addiction, were asked to take part. “The aim is on the one hand to help abusers to receive treatment, on the other hand to close the open drug scenes” (MOB 2006). In the project, the police made sweeps at these drug scenes. On the spot, the police offered treatment and a ride to the nearest addiction clinic. Those who accepted this offer were assigned a case manager (“pilot”) who made an assessment of abuse and organized treatment planning.

An evaluation shows that 263 persons were approached by the police, of which 198 were eligible according to the inclusion criteria. Forty-four (22%) of these took the ride to hospital, and 42 of them accepted to be admitted to detoxification. Twenty-nine of these continued to other types of treatment after the detoxification. According to registers, 33 (75%) of the 44 participants had been in contact with the health-based addiction treatment system during the last year, and 130 (84%) of the 154 individuals who didn’t accept participation in the project had been in contact during the last year. Some of the reasons for refusing participation were that they did not think they had problems, that they had recently come out of prison, that they did not want to have contact with treatment and the social services, and that they had other things to do first (Palmstierna & Winerdal 2006).

The effort was “successful” (MOB 2006). The project did indeed offer a priority lane or treatment guarantee for this group of drug users and some individuals who had not been in treatment before were recruited. Most of the approached individuals, including those who participated in the project, were already known to different parts of the alcohol and drug treatment system (Palmstierna & Winerdal 2006).

These projects combine actions for mopping-up the streets with a wish to help alcohol and drug misusers. The neighbour or the tourist won’t find needles on the streets and the (mis)users may receive treatment they want.

**Social control**

The concept of social control is complex and refers to a range of social actions. Social control theories focus on strategies and techniques which help regulate human behaviour and lead to conformity and compliance to the
rules of society, including the influence of family, societal institutions, morals, values, beliefs, etc.\textsuperscript{21} Earlier theories referred to those aspects of social life contributing to the social order (cf. Mead 1934).\textsuperscript{22} Later theories have mainly focussed on how state institutions deal with deviants. In this line of reasoning, social control refers to coercion, manipulation, classification, incarceration and stigmatization. It is stated that these acts have consequences for the individual – they accelerate deviancy (cf. Becker 1963; Goffman 2001; Lemert 1996).

Social control in relation to treatment is here divided into two parts: Social control from informal sources and exercised by authorities.

**Social control by informal actors: Treatment as a respite and remedy for significant others**

To start with significant others around the alcohol or drug misuser – family, partner and friends: these informal actors were reported by clients to suggest and even force the individual to enter treatment (see Paper II, “interplay”). What explanations can be found for this? First and probably foremost, these people are concerned about the individual and wish that treatment will offer a remedy. Another explanation is that significant others, too, stress the norms in society, and pushes “deviants” into treatment – although they are pushing their own spouse, daughter or parent. A third explanation is that the responsibility of the significant others – worrying about the misuser – is relieved when the individual enters treatment. A fourth is that their own life may be in turmoil because of the misuser’s actions. Treatment offers a respite also to the significant others of the misuser.

This may be explained by the fact that “drug addiction” and “drunkenness and alcoholism” are viewed as serious problems by the general population. In a Swedish study, drug addiction is ranked as number three among problems; offences against people and family violence are viewed as more serious, and alcohol is placed as number seven. Drugs are viewed as more dangerous than alcohol (Hübner 2001: 122, 136). In addition, as shown in Table 10 (Appendix II), people in Sweden believes that there are treatments which are successful for people who want to cut down or quit drinking (96%) or using drugs (95%). They do also believe that it may be necessary to force someone into treatment for their own good (86% for alcohol problems; 92% for drug problems). Forty-four percent believes that compulsory treatment

\textsuperscript{21} In Berger and Luckmann’s (1966) view, institutions \textit{per se} imply social control. Institutions control human conduct by setting up predefined patterns of conduct, which channel it in one direction as against other alternative directions. This controlling character is inherent in institutionalization as such, prior to or apart from any mechanisms of sanctions set up to support the institution. The efficacy of this control is of a secondary or supplementary kind.

\textsuperscript{22} Mead discusses the “generalized other”. Values and norms in a culture are internalized during childhood through role-playing – through seeing things from another person’s perspective. The concept refers to the general notion that an individual has of the common expectations that others have about actions and thoughts in society – the standpoint of the group.
can help the misuser. A majority believes that alcohol or drug problems are not just the business of the individual misuser; they concern the community as well. The population have strong beliefs that self-help groups, such as Alcoholic Anonymous (AA), Narcotics Anonymous (NA) and the Links ("Länkarna"), can help people with their alcohol or drug problems (94% believe that). Treatment in the private sector (82%) and the health system (69%) are also thought to be effective. Treatment in the social services and the criminal justice system are thought to be less likely to help people with their addictions (44% and 25%) (Table 10, Appendix II).

Significant others around the misuser believe that these are serious problems that can be relieved by treatment. They try to influence the misuser to seek help.

Social control by authorities: Pushing towards conformity to norms
To what extent is treatment used for the purpose of controlling individuals in society? This topic is seldom discussed in official documents. Therefore, this section builds mainly on researchers’ opinion on treatment.

In an international perspective, Swedish alcohol and drug treatment is characterized as treatment-oriented rather than control-oriented (Klingemann, Takala & Hunt 1992). The history of treatment shows another picture. In the 19th century, Swedish temperance treatment ("nykterhetsvården") arose from legislation on poor relief. The legislation was tailored to maintain moral values regarding work, economy and family life. It was not only poverty, but also the social and moral environment the poor lived in, that the state wanted to control through legislation and social institutions (Bergmark & Oscarsson 1994). In theory, the introduction of SoL in 1980 ruptured the moral aspects of the legislation. However, as pointed out by Bergmark and Oscarsson (1994), “society’s possibilities to control the group of heavy alcohol abusers from lower social economic groups remained, in the frame of the special legislation on compulsory treatment” (p. 121). They argue that social control is still a part of treatment. There are interventions that are labelled treatment, but are not expected to yield more than care for the individual along with social control. Alcohol and drug (mis)users are often living a life outside the social values and norms of society regarding work, economy, family life and leisure life. Thus, marginalized misusers are somewhat immune to legislative threats or sanctions. The treatment system is a structural and socially legitimate way of dealing with and controlling the uncontrollable. Treatment “offers society a harmonizing function in relation to the abuser” (Bergmark & Oscarsson 1994:123).

Conrad and Schneider (1980:241) regard medical and psychological paradigms as the most powerful institutions of social control – apart from legal institutions. For instance, in the context of Australia, policy-makers and clinicians saw MMT not so much a treatment for addiction but as a tool for the control of addicts. “Methadone might not cure addiction but it was seen as
fulfilling the social objectives of limiting the need for junkies to hit ‘little old ladies’ over the head for their purses” (McArthur 1999: 13) – the explicit social control of heroin users was used as a strong argument for MMT. This experience is not far from what recently has taken place in Norway, where MMT was promoted by media and viewed as a simple and straightforward “solution” to the drug problem. Does this change reflect a treatment or control strategy (Skretting 2001)?

The highly regulated MMT programmes in Sweden require a very structured life of the client, which aims at introducing an ordered social life to individuals who have had addictive life styles – a push into societal norms.

As will be discussed below as well, clients in alcohol and drug treatment are not allowed not to want to change their consumption. Professional skills have been developed to motivate people to participate in treatment, for instance Motivational Interviewing (MI). In treatment, there is a push towards motivational efforts – to make the person want to change. The motivation of the client is viewed as important in just about every part of the treatment system – including in involuntary treatment, i.e., the goal of LVM is to motivate the client to treatment, rather than successful treatment itself. In the care document for Stockholm County (Samverkan i…1998), it is stated that the goal of treatment must be built on the motivation level of the patient. In addition, the goal of the recent effort to improve alcohol and drug treatment in prison is mainly to motivate misusers to treatment (Prop. 2005/06:30).

In the *Women and men in Swedish alcohol and drug treatment*-study, the general population, staff and clients believe that treatment for alcoholism and drug addiction only works if the individual (mis)user wants it to work (94-99%, Table 2, 9 and 10, Appendix II).

As stated, treatment includes explicit control tactics and threats. But involuntary treatment, such as legally mandated treatment

“is only one part of the control or the power exercised by the treatment system on the clients. There are also many other ‘technologies of power’ which are used to get people to enter treatment or to keep them in treatment. For instance, economic sanctions can be used, such as loss of job or apartment or social security benefits upon failure to enter treatment.…. Family members, friends and relatives or the employer can resort to many delicate methods in pushing a person into treatment” (Lehto 1994: 8).

Technologies of power in the treatment field can be seen as a development from traditional police, prison and involuntary treatment approaches to softer professional methods of persuasion, conditioning, or creating dependence. Softer technologies do not entirely end the use of traditional methods. Instead, we get layers of control which complement each other. Softer technologies can be said to work effectively if there remains the possibility of using more traditional technologies (Lehto 1994). For instance, in our study, as stated in Paper II (“interplay”), the threat of LVM in Sweden is widely
used in the treatment system, and the existence of LVM has further implications than what should be expected by its somewhat limited use.

Recently, researchers (cf. Sahlin 2001; Svensson 2001) have talked about this phenomenon in terms of discipline, by referring to Foucault. According to this view, it is the disciplinary power which controls the individuals and offers coherence in society. For instance, concerning Sahlin’s (2001) “discipline”, she argues that A can legitimate actions against B by defining the interests of B. For instance, when a social worker is intervening in the life of a client, it is legitimated by the fact that the social services have the right to define the problems and real needs of the client. She argues that discipline refers to social order in society which is achieved through controlling and improving the lives of “problematic” individuals. The measures against these individuals are legitimated by “taking care” of them.

“Discipline is a control strategy which conquers resistance through redefining it as incompetence, helplessness or lack of will, and escapes restrictions… through defining the interests of the objects as identical to the ones who exercises power” (Sahlin 2001: 127).

The extreme end of social control is punishment. Treatment and punishment are often viewed as contradictory. Another view is that treatment and punishment are two evils – treatment as the lesser of the two evils (cf. Lehto 1994). Treatment can also be viewed as punishment.

Christie (1981) argues that efforts in the last 100 years in the Nordic countries have been focused around controlling certain categories of people who cannot hold their liquor – in order to get rid of the problems, but not the alcohol. In particular, skid-row alcoholics have had to be controlled – drunkenness in the streets has been viewed as distasteful. Therefore drunkards had to be kept out of circulation: “what could not justly be done in the name of punishment could not be objected to if it were carried out as treatment”. The potential pain caused to the individual is legitimate since “it is not intended as pain. It is intended as a cure” (see also Utilitarianism...). Swedish research by Svensson (2001), based on interviews with substance misusers, shows how punishment and treatment are two sides of the same coin. In rhetoric, these concepts are typically discussed in terms of antitheses. In practice, as argued by Svensson, they work side by side and involve the same measures and actions. Which term is chosen depends on one’s expectations and point of view. These actions do not per se entail a certain meaning, it is the individual who attaches meaning to the action, and Svensson’s research shows that different individuals receiving the same kind of treatment (“contract treatment”) perceive it differently: for one person it is treatment,

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23 For instance, in Australia MMT advocates viewed MMT as better than imprisonment, since the heroin users either would be enslaved by the criminal system (i.e., the police and prisons) or by the medical system – the former far more expensive for society (McArthur 1999).
for the other it is punishment. “Punishment and treatment are both parts of a caring power which is exercised with the pronounced conception that it is possible to provide the individual with a better life, as long as the individual adjusts to the treatment on offer. The caring power is part of the disciplinary power [referring to Foucault]” (Svensson 2001:183).

Lehto (1994) concluded that the role of the criminal justice system is significant in the Swedish treatment system. “Contract treatment” is treatment undertaken with a clear and direct threat of imprisonment. As pointed out in above, the criminal justice system is applying a new “treatment role”, and the goal is set that treatment in this setting shall increase.

The role of the police in their contact with substance (mis)users is also blurred. In focus group interviews with policemen and social workers (Johansson & Skrinjar 2001), it was evident that the role of the police in working with drug users included both helping and controlling elements. Policemen stressed their supportive and caring role in their daily work with drug users almost as much as their role detecting and preventing crimes. Some policemen said that they work against drugs but with the drug users. The policemen thought it was important to get to know the drug users. In that way, it is easier for them to acknowledge treatment needs and act like a referral source to treatment or part of a treatment chain. The policemen saw their controlling function as a way to help the drug user.24

Ólafsdóttir (2001) argues that the adaptation of the police to take a more active role in providing help and support highlights the complexity of the relationship between treatment and control. This demonstrates either that a treatment ideology has gained ground at the expense of control, or implies an expansion of the control network. Either way, it is clear that the roles and boundaries between different controlling and caring authorities and agencies – between treatment and punishment – are still unclear.

**Stigmatization**

The labelling theory line of argument (cf. Becker 1963; Lemert 1996) stresses that treatment has a stigmatizing effect on the treated. As argued in paper I (“two worlds”), the perceived devaluation and discrimination experiences can continue to affect treated individuals negatively – even after successful treatment. The treatment system seems to treat the same individuals repeatedly – focuses on a relatively small group of marginalized (mis)users. This was also found by Wiseman (1970), who showed that the alcohol treatment system in “Pacific City”, U.S. focussed on a small proportion of Skid Row alcoholics – although intended to assist a broader population. In her wording, Skid Row drinkers “take the loop” around the service delivering stations – “stations of the lost”, as she terms them – as they move from institution to institution. For these people, with few ties to family and the

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24 This can be compared to Sahlin’s (2001) emphasis on discipline.
general society (as is most likely true also for “heavily treated” clients in alcohol and drug treatment in Stockholm), the treatment system makes up a new environment of rehabilitation agencies – serving the same clientele in rotation. In a way, the treatment system takes over the role of informal bonds. There is an institutional complex that has grown up to take care of the social problem constituted by marginalized alcohol and drug misusers.

Under these circumstances, it is difficult for the individual not to be stigmatized by treatment. As described by Goffman (1973), clients or inmates of “total institutions” such as inpatient treatment facilities are often totally deprived of the life they had outside and forced into the institutionalized life. Individuals in treatment are at high risk of internalizing an apprehension of themselves as at the margin of society. Consequently, the person with less severe problems may be less likely to enter treatment, since they would thereby become categorized as a person at the margin worth stigmatizing. In our study, a consistent understanding among staff and people in the general population is that anyone would be embarrassed to seek treatment for drinking or drug problems: 70-75 percent agrees that seeking help for alcohol problems is shameful, and 64-72 percent agree that treatment for drug problems is shameful (Table 2 and 10, Appendix II).

Staff in the treatment system

Many people are involved in the treatment business, which makes staff a highly interested set of actors in the treatment system (interest group as defined by Kitsuse & Spector 1973). At the turn of the year 1996/97, there were about 2,800 fulltime appointments in outpatient alcohol and drug treatment in the Social services in Sweden, including general social services for alcohol and drug misusers. Another 3,600 people were employed at institutions (Socialstyrelsen 1998). To these figures, staff from the health system and the criminal justice system working with alcohol and drug misusers can be added. These people are all part of organizations and have their own incentives for doing their work.

In this section, the views of care providers in the two dominating systems, the social-welfare and health-based systems, are reflected as responses to questionnaires in our Women and men in Swedish alcohol and drug treatment-study (for a thorough analysis of staff views see Palm 2006a; see also Palm 2003; Storbjörk 2003a). The section also builds on the fourth paper in the thesis, as well as some recent Swedish examples.

Optimistic staff views and controlling elements

The empirical data show that staff populating the treatment system of Stockholm County to a high extent believes in their work. Table 2 in Appendix II
indicates that nearly everyone, 97-98 percent, believes that there are treatments that work for alcohol and drug users who want to lower their consumption or stop altogether. They believe that clients’ lives always become better if they stop drinking or using drugs (93%) and they feel strong empathy with the clients (90-92%). Just about the same proportion report that they felt that in their work they get to help people and do something good (95% social services, 92% health system) (see also Palm 2003; Storbjörk 2003a).

The belief that treatment works, but only if the drinker or drug user want it to work (94-98% believe so), may explain why it is common among staff to report that they often have to motivate clients to want to do something about their alcohol or drug use (around 80%). In addition, 45-48 percent of the staff agrees that they often have to convince the clients that they have problems (Table 2, Appendix II).

This issue also points to social control over alcohol and drug misusers, as exercised by treatment staff. Letting an individual use alcohol or drugs to an extent that others regard it as a problem is not allowed. The treatment system intervenes.

In Sweden, individuals are expected by authorities (and the public) to be responsible, and deviation from moral values, where having an honourable job is viewed as important, is still condemned. This is especially true for youth (Johansson & Skrinjar 2001). In a study by Johansson and Skrinjar (2001), social workers were not willing to admit and talk about the fact that they also have a controlling function regarding drug using clients – not only a function as helpers. Instead, they stressed the social and supportive elements of their work. Still, the social workers have the power to set up conditions for social benefits, define treatment needs and choose a “proper” treatment unit, and in the end, the right to suggest compulsory treatment.

Excluded heavy misusers?

It has been argued that the traditional groups of homeless and substance misusers on the margin have been given low priority as hopeless cases. This group has also been excluded from the psychiatric sector, and is not wanted by treatment staff, who often prefers groups of clients that are “easier” to work with (Järvinen 1992, 2002; Kühlhorn & Gerdman 1983; Lindström 1992). However, there are indications that the group that is populating the treatment system to a high extent consists of heavy and marginalized misusers (cf. Paper I: “two worlds”; Blomqvist & Christophs 2005).

Our study shows that a low proportion of staff thinks that “persons whose misuse has been going on for a long time” or “heavy misusers” should be prioritized in treatment. Staff wish to prioritize “motivated misusers” and “persons who just started misusing” (Palm 2006b).

Järvinen (2002) argues that professional care providers in the welfare state have a strong power in relation to clients, who are categorized into
those who are or are not motivated to change – can or cannot be treated. Guided by Bourdieu’s concept of doxa, she argues:

“The treatment system’s view on addiction, how it arises and how it should be treated, which groups should be helped and which should not be helped, is not based on scientific research or collection of experiences. It is a mishmash created by struggles between professions, ideological currents, economic cuts and random, popularized research results” (Järvinen 2002: 266).

Staff in a treatment industry

The above is in correspondence with Paper IV (“Maria-unit”), which indicates that staff in the alcohol and drug treatment system act as professional and occupational actors. They have their own interests in their job, its continuance, their satisfaction in it, etc. As Christie puts it:

“Only rarely will those working in or for any industry say that now, just now, the size is about right. Now we are big enough, we are well established, we do not want any further growth” (1994: 13).

Gusfield (1996) argues that the concept of “deviance” seems to be coupled with the welfare state. The welfare profession serves to create entitlements in deviance and vested interests in their existence and continuation. The definition of alcohol problems as an illness – victims suffering from alcoholism – rather than crime gave rise to a new “troubled-persons” industry, which here can refer to the alcohol and drug treatment system. Following the precepts of the alcoholism movement, the drinker rather than the alcohol was viewed as the problem (Christie & Bruun, 1969). The solution to the problem was to provide services for this special group whose condition entitles them to consideration and help:

“Such professions are by no means in a static relationship to their existing or potential clientele. The development of problem-solving professionals has produced a body of people who possess the skills, interests, time, mission, and resources to articulate and organize the groups whom they serve or seek to serve… They … assume leading roles in reformist movements to alleviate the problems to their clientele or newly discovered clientele” (Gusfield 1996: 189-190).

Gusfield (1996) continues by arguing that this type of stigma “creates a demand for services that enhance the stigmatized, even if it maintains the stigma” (p. 190). Those who define others as having social problems are

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25 Each field has its own “doxa”, its own rules, routines and perceptions on what is right and what is wrong, normal and abnormal, natural and unnatural. Doxa refers to professional perceptions and behaviours and views that are taken for granted in the field.
simply “agents of social control.” Somebody’s trouble in a welfare state is somebody else’s job.

This implies that it is not only the best interest of the client that is in focus in organizing and developing the treatment system.

In a newsletter from the National Board of Health and Welfare on the new treatment guidelines (Socialstyrelsen 2006b), it is stated that these guidelines seek to rectify the situation that developments in the treatment system have not always been to the advantage of the clients. Paper IV (“Maria-unit”) shows that changes in the organization are not always initiated with the best interests of the clients in mind. Changes often occur due to general politics, resource problems or conflict-related issues. In the case of the privatization of the Maria-unit, this was brought about by a perceived threat that the unit would be closed down in the competition for resources between units.

In Stockholm County, treatment providers are satisfied with their work and workplace. As shown in the _Women and men in Swedish alcohol and drug treatment_-study, over 80 percent wanted to go on working in their workplace for a long time (86% social services, 81% health system) (Table 2, Appendix II). They have an interest in the continuance of their work, such as privatizing their treatment unit if there is a threat that it will be closed down (Paper IV, “Maria-unit”).

Another example of a somewhat self-adjusting system is from the compulsory treatment system. When the client load was dropping, the head of SiS was visible in media and articulated that the municipalities neglected the care needs of the heaviest misusers (cf. SvD 2004a, SvD 2004b). This might have contributed to the state investigation (SOU 2004:3), which in practice broadened the field of LVM. The LVM institutions have adapted to the drop in the number of clients by building aftercare units where clients can stay after the LVM-period. This was motivated as a step to strengthen aftercare (SiS 2004b). But it also helps the organization to survive. A high number of clients is viewed as positive by SiS: “The contract for life action has resulted in a positive development for LVM-treatment. The average number of occupied beds has increased from 359 clients in January this year (2005) to 449 in November” (SiS 2005).

The views of the clients are often neglected. There are a number of user organizations growing stronger in Sweden today. However, the user groups involved in policy issues are often in fact interest organizations acting on behalf of what they see as users’ interests, rather than being composed of treatment users themselves. It is difficult for the user organizations to stay in the game once they enter the field. For instance, as shown by Palm (in press) in an analysis of the Swedish Users Union (SBF) for drug users, the union has to balance between voicing users’ interests and not challenging too directly established beliefs and official drug policy, if they are to be taken seriously in the debate.
In sum, treatment staff believes in and are satisfied with their work. At an organizational level, the treatment system operates rather independently of the needs of the clients populating it. The treatment system also has the function of offering a workplace to treatment providers.

**Treatment from a client perspective**

Clients constitute a highly interesting interested group concerning alcohol and drug treatment (Spector & Kitsuse 1973). Where do their views and experiences fit into the social ecology of treatment? This section pictures clients’ experiences of treatment, by looking at the varieties of reasons why people come to treatment and their treatment goals. These reasons and experiences are grouped conceptually to correspond with the topics discussed above. The empirical data is mainly from the papers in this thesis, and additional data from the *Women and men in Swedish alcohol and drug treatment* study presented in Appendix II. Data from other studies (ROSE and VKP, see *Additional data*) are also included to provide a more comprehensive and colourful picture of clients’ and misusers’ views.

**Life saving and cure**

Clients, too, view treatment as a life-saving facility. For example, in the evaluation of the special action in the compulsory treatment system (“Vårdkedjeprojektet”, VKP), I interviewed people who said that they were close to dead when they came to treatment – they were saved by treatment. As one man states it:

“My liver has been in bad shape for many years. But now, this time, several doctors have taken tests, independently of each other, and they all show that it [his liver] is finished. … I am actually starting to believe them now. … If I’ll continue drinking, I may live for half a year, a couple of months, or I may die the same night, roughly speaking. That is why I consented to go to treatment…. Alcohol is a damn slow process, but in the end, it catches you…. Without X [a social worker], damned if I know if I would be alive at all…. X is very skilled and smart, and I am a rambling drunk, so I guess it isn’t difficult to figure out which of us two is right and which is wrong…. X has always managed to do the right things at the right time…. Right now, they [the social services] are chasing me like hell” (VKP-evaluation, man, August, 2006).

This view is also observable among those who were interviewed in the ROSE-study. One opiate user asked for LVM. She said the following about how and why she came to treatment at one point:
“then I reached an agreement with my social worker, because it was the only way to get help from the social services. Her boss should authorize that I should get help. Because I couldn’t get any volunteer help. She went in [to her managers] and said that I needed an LVM, even though it was she and I who agreed upon this. Because it was the only way for me. Because I said that I was scared to death for this. I really wanted to do it. Because I wanted to continue living. I didn’t want to die” (ROSE, Untreated opiate user, Haasen et al. 2004: Appendix A, p. 74).

As shown in Paper II and Table 3 and 6 in Appendix II, most clients say that they did want to come to treatment when entering the door to the treatment unit. At treatment entry, a majority (81%) say that their goal regarding their drug use is to stop using altogether. About half of the clients (53%) said that their goal regarding alcohol use is to stop altogether. Another twelve percent wish to lower their drug use, and 40 percent report that they want to cut down on their drinking.26 Thus, abstention is a prominent goal among clients.27 Some think that it is the only solution for them. A man with alcohol problems and a woman with drug problems interviewed in the VKP evaluation saw abstention as the current alternative:

Respondent: I do not really know what I want. I was about to say that I want to put my social life in order. However, I know, to be sure, that I am finished boozing.

Interviewer: How do you feel about that?

Respondent: Well…. Actually it feels pretty good. I do believe that, seriously speaking, I would not drink [if he left treatment]. I am pretty convinced about that.

Interviewer: How come? What is different this time?

Respondent: I feel so bad and worn out now (VKP-evaluation, man, August 2006).

“A mess! I got really sick. I had a long blackout that lasted over a whole week. That is the longest blackout I’ve ever had in my entire life.… I can feel, after the last relapse, after that relapse … it hit me very hard because I used so much, you know…. It is like I got psychological antabuse [she laughs]. I got DAMNED afraid because I have never ever had a six days-long blackout before. That was just too much. Therefore I realize that … there is no twaddling anymore. I am serious. I have … I have really longstanding plans to become drug-free” (VKP-evaluation, woman, August 2006).

A majority of the clients also reported that they wanted some kind of counselling regarding alcohol and drugs and relapse as they entered treatment.

26 Among those who were categorized as alcohol users, 58% wanted to stop altogether and 39% wanted to lower their consumption. Among drug users, 72% wanted to stop using drugs altogether and 8% wanted to lower their use.

27 Interestingly, staff think that the harm reducing goals of eliminating problems caused by alcohol or drugs and lowering one’s consumption are more prominent among clients (Table 3, Appendix II).
Over 90 percent of clients believe that there is treatment that works for alcohol and drug problems (Table 4 and 9, Appendix II).

Alcohol and drug misusers who seek treatment view treatment as a way of survival and a tool for curing their alcohol and drug problems.

Welfare and social (re-)integration

A lot of people enter treatment for alcohol and drug problems with the goal of achieving a better social situation in life. In fact, 59 percent of those entering the social welfare and health-based treatment system reported that they wanted some kind of practical help with their daily life, such as social allowances, clothes, housing, education or a job (Table 4 and 6, Appendix II).

This can be explained by turning to Paper I, which shows that the treatment population is highly marginalized as compared to people in the general population. This group has social needs that they hope will be fulfilled through entering treatment. In the ROSE-study, a respondent interviewed for the maintenance treatment failure group put it like this:

“there’s certainly been a lot of hopes that everything would be fine, that some of the different problems I have would be fixed, that I would get some kind of calm in my body so that I could maybe start to sleep at night, that I would get some peace so that I could start some kind of decent life, but all that is very much up to me.” (ROSE, Maintenance failure, Haasen et al. 2004: Appendix A, p. 74)

It is fairly common among clients that their only wish and the only thing they want to get help with is to get an apartment or financial help. In their view, their alcohol or drug use is not the main problem. In the VKP-evaluation, one man, after going through compulsory treatment, said the following, which reflects a feeling of frustration over not getting help with welfare issues but being sent to rehab for alcohol problems instead:

“When you really need help, then you get the brush-off. There is no logic in that. Okay, I can go to the institution [compulsory treatment] and then they [social services] have to pay. Then they’ll see how much it costs. They KNOW how much it costs. They have to pay. How come they cannot put the money on something else? If they have to pay that amount anyway? Can’t they help me get on to my feet at home instead? That’s where I’m going to be later on, not here. I am very unsatisfied…. Economically, my situation is worse now than when I was committed to treatment. That cannot be the goal of this. Then, why are they doing this?… If I call them, and do what I am supposed to do, and she [the social worker] thinks that I should be committed to compulsory treatment: Then I think she should help me with the problems I have too…. It is the practical stuff I need help with. The only thing they care about is whether I am sober or not. They don’t care a damn about the rest. They don’t care about whether I have food or not. They think it is good if I get to eat here at the institution. What reasoning!… My biggest concern is
that I cannot eat as a normal ... be like a normal person in my relations with others. My teeth! That is a big problem you know.... I need to get help with my teeth, my apartment and everything around that. Otherwise, this cannot work. But when I ask for help, I get turned down and sent to rehab. What reasoning is that?! I do not get it. They can pay 3700 crowns a day, but they cannot help me with my teeth.... You know, I call her about money. Then she says that I should talk to a counsellor. What am I going to do with the counsellor?... If everything was okay in my life, then I would not drink. I don’t think I would do that. I am not sure, but I think that I would not. Because I have not done that before when my finances and everything else was OK” (VKP-evaluation, man, June, 2006).

Respite and eased harm: A wish for a more peaceful life

Some of the most often endorsed reasons for coming to treatment, as shown in Table 6 in Appendix II and Paper II, were related to a wish to get a respite. Note the wordings were those of the questionnaire and not those of the respondents. A hectic lifestyle was also shown to prevent alcohol and drug misusers from seeking treatment, as half of the respondents in and out of treatment said so (Table 5, Appendix II). They do not have strength left to get it together to seek help. In the empirical sample, 89 percent said that they came to treatment because they “wanted help in making my life more rewarding or serene”; 69 percent reported that they wanted “a little respite; things just got too complicated”; and 41 percent said that they “wanted to recover from a long period of being ill and not feeling well”. Treatment does also serve a function of letting the alcohol or drug (mis)user rest. For example, one man who went to a treatment facility said the following:

*Interviewer:* Was it you or the social services who wanted you to go here?
*Respondent:* It was the social services.
*Interviewer:* What did you think about that?
*Respondent:* Well, I thought I could go here to rest. Get some orderliness in my life. But now, I guess I’ll go home soon again.
*Interviewer:* Do you feel that you got to rest here?
*Respondent:* Oh yes, yes, I do (VKP-evaluation, man, June, 2006).

There is also a downside to this from the fact that treatment often is viewed as storage rather than treatment – a storage good enough for a rest. For instance, a man interviewed in the VKP-evaluation says the following about the treatment unit where he was located:

“You see, they do not provide treatment here, LVM is the law on TREATMENT of abusers... However, this is not treatment, this is just storing” (VKP-evaluation, man, September, 2005).
This may in fact explain why clients (44%) say that they did not come to treatment earlier because they did not think treatment would help them – it is not viewed as treatment (Table 5, Appendix II).

Do clients ask for harm-reducing interventions? In our study, we asked whether the clients wanted methadone maintenance or other opiate substitution or not. Twelve percent of the total sample wanted this kind of treatment (Table 4, Appendix II). Among drug using clients, 39 percent reported that they wanted maintenance treatment. When this alternative was set as an alternative to other treatment goals, a lower proportion of the drug users (18%) stated that they wanted maintenance treatment over other alternatives. As can be seen in Table 3, Appendix II, only six percent report that they want to eliminate problems caused by drinking, whether or not the actual consumption changes. The corresponding percentage regarding drug use was four percent. In addition, the vast majority of the clients argue that an individual has to stop altogether in order to overcome alcohol and drug problems (Table 9, Appendix II).

However, there are client voices in Sweden asking for more harm reduction interventions – for instance the Swedish User Union (cf. Palm in press). In the ROSE-study, needle-exchange was also put forward by several respondents (Haasen et al. 2004: Appendix A).

Reasons for not seeking treatment

It is common among clients to report several reasons why they have not sought treatment earlier (Table 5, Appendix II; Storbjörk 2003b). Fifty-eight percent report that they did not want to stop drinking or using drugs; more than half (54%) report that they did not think their problems were that serious; 58 percent said that they thought they could handle their problems themselves; and 44 percent did not think treatment would help them. In the total sample, eleven percent reported that they had not sought treatment earlier because they were afraid that they would lose custody of their children if they did so. Among drug users, nearly one fifth reported that (see Utilitarianism...).

In a comparison with the views regarding reasons for not seeking treatment in a sample of opiate users not in treatment in ROSE-study (Table 5, Appendix II), it is shown that these reasons for not seeking treatment are less frequently endorsed by this group recruited from day shelters and open drug scenes in Stockholm. Only eleven percent report that they do not think their problem is serious, and about one fifth say that they don’t want to stop, and that they think they can handle their problems themselves.

One reason for not seeking treatment may also be that clients think or experience that they will be turned down. One opiate user who has failed in maintenance treatment says that he is no longer prioritized by the social services:
“I’d really like to go (to a treatment facility), but I can’t go there because it costs too much money. And then there’s also some who think that the older you get the less help is available because then all hope is lost. It’s a cynical thought but despite everything maybe it’s true. There’s something unspoken with the social workers” (ROSE, Maintenance failure, Haasen et al. 2004: Appendix A, p. 76).

Social pressures and control as experienced by clients

Alcohol and drug misusers are subjects of social control. Heavy alcohol use, and drug use in particular, are not accepted. As discussed earlier, one can claim that individuals are not allowed to not want to change their substance use – if they are considered to have a problem by someone else (family or authorities). They are pressured to cut down and enter treatment, and treatment staff tries to motivate them to want to do something about their “problems”. At the most extreme, the individual is committed to compulsory treatment. The tough response from society is stated by one opiate user as follows:

“I think that most heroin addicts have periods when they want to commit suicide. Physically you become totally exhausted, it might not be just that you destroy so much, but there are so many secondary effects. And then of course since it’s illegal it is pretty tough. You forget that it’s illegal and that you should stay away from the police. Socially it’s not acceptable, you don’t make yourself very popular with the family or in the apartment building or with your friends or in the city or whatever, so I mean, unfortunately it’s not good anywhere” (ROSE, Maintenance failure, Haasen et al. 2004: Appendix A, p. 70).

Pressures from significant others: Positive for the clients?

Seventy-five percent of clients had experienced pressures from informal actors, such as family or friends (Paper II “interplay”). Paper III (“events”) shows that pressures from significant others are influential for treatment seeking. About half of the clients had experienced arguments with family members or others who were close to them about their drinking or drug use, or the effect it is having on those around them. Among these, the majority (69%) said that this contributed to treatment entry in their case. Paper II (“interplay”) indicates that these informal pressures are correlated with an enhanced feeling of self-choice in treatment entry.

This type of social control is formulated by one of the respondents interviewed in the ROSE-study as follows:

“I’ve often gone into treatment for other people than myself, for my family’s sake. Since I suffer from their suffering over what I’m doing” (ROSE, Maintenance failure, Haasen et al. 2004: Appendix A, p. 74).
Formal and legal pressures: Experiences and consequences

Alcohol and drug misusers report experiencing control efforts by authorities. Our study shows that their entry into treatment is influenced by pressures from a wide range of actors – they are pushed into treatment (Paper II, Paper III and Appendix II).

As shown in Paper II and Table 6, 7 and 8 in Appendix II, most of the clients have experienced pressures from authorities to enter treatment. As an example, LVM may not be so extensive in practice, but its existence has wider implications in the system (see Paper II ”interplay”; Table 6, Appendix II). A fifth of the clients came to treatment “voluntarily” in order to avoid being committed to compulsory treatment. One respondent in the ROSE-study describes the LVM-threat this way:

“I haven’t always gone into voluntary treatment, but I have gotten alternatives from social services: ‘either go into treatment or we’ll put you on LVM somehow’, and those times it’s been almost doomed to fail, as long as I don’t have the motivation or desire myself…. Those times I’ve gone in myself I’ve always had great hopes and really given 100%” (ROSE, Maintenance failure, in Haasen et al. 2004: Appendix A, p. 74).

Clients stress the demands and the conditioning by the social services – these aspects are mainly viewed as unhelpful by the clients. Some quotes from the ROSE-study show examples of how the social services exercise power over their clients, in this case, opiate users:

“I have wanted to come back [to MMT] – but the only way is to get help from the social services and all that. But then they started demanding things that I couldn’t do” (ROSE, Untreated opiate user, Haasen et al. 2004: Appendix A, p. 75).

“Most often it’s of course that the social services demand that you should do certain things. It’s like a game between me on one side and the social services and the authorities on the other. Maybe in the beginning I want to use as much as possible but still take advantage of the social service benefits in terms of money and having the rent paid and all that. Then sometimes when it’s gone too far I have to accept certain drug treatments” (ROSE, Maintenance failure, Haasen et al. 2004: Appendix A, p. 74).

Methadone maintenance programs require a structured life. One woman, with along heroin addiction, did not want Methadone because of the effects of methadone, and because of the control of the social services:

“Those on Methadone have like a glass wall that you cannot break through. You die emotionally when you’re on Methadone. When I tried it myself, I could feel it, I turned into a fucking walking…. And you become radio controlled again, by the authorities. They become pissed off when you cannot do it. Because they want to keep us in check. They want to control us and keep
us the way they want us to be” (ROSE, untreated, see Haasen et al. 2004: Appendix A).

Paper II (“interplay”) shows that almost one third (23%) of the clients had experienced different police-related troubles and pressures to enter treatment. Paper III (“events”) tells us that such events are more common among more marginalized misusers than among less marginalized misusers.

It is stated above that the division between police-work and treatment or care is not that clear (Johansson & Skrinjar 2001; Svensson 2001). In fact, this phenomenon was also noticeable in a study among homeless alcohol and drug (mis)users visiting a shelter of a voluntary organization in Stockholm (Convictus Bryggan City). In the study, several of the homeless people had a fairly close relation to the police, who often chatted with them on the streets, offered encouragements, etc. The study showed that private security officers had taken over the role of controlling certain areas. No one reported a close relationship with the security officers – they were reported to be the “bad guys”. The police were seen as just doing their job (Storbjörk forthcoming).

Svensson’s (2001) study indicates that alcohol and drug misusers in contract treatment can perceive the treatment as punishment. In our study, as presented in Paper II (“interplay”), respondents under legal pressures to enter treatment were less likely to report self-choice in treatment entry. In addition, coerced treatment is often viewed as a punishment – a punishment for a crime the convicted did not commit. For instance, clients committed to compulsory treatment in the VKP-evaluation said the following about LVM:

“There is nothing positive about that. Incarceration and storage, that is what I think…. Many things you HAVE to attend. A bloody storage history. Surveillance and everything. I don’t think that is good. It is my life, not theirs” (VKP-evaluation, man, June 2006).

“I don’t like being locked up against my will. It is not like I have committed a crime or anything…. I have not chosen this. They have chosen this for me. No one likes coercive treatment. No one. That is why it is called COERCIVE treatment…. Go out for fresh air – you are not allowed to do that. You are locked up 24 hours a day. It is useless and unhealthy. Psychologically, no motivation. If you are motivated when you get here, you are guaranteed to be unmotivated when you leave. It is difficult to stay motivated. This is no treatment. This is incarceration. Like fish in a bowl. That is how it feels” (VKP-evaluation, man, September 2005).

One consequence of deviance and social control is stigma and feelings of shame. Table 5 in Appendix II shows that roughly half of the clients who entered treatment were concerned about what other people would think of them if they started treatment, which was considered a reason for not having sought treatment earlier. The proportion among the untreated ROSE-respondents was much lower, only 19 percent. This may be explained by the
fact that these people already were part of a “deviant” group at the margin, as they were recruited from day shelters for homeless people or from open drug scenes. Table 9 (Appendix II) indicates that a majority of clients, as well as staff and people in the general population, generally think it is embarrassing to seek treatment for drinking or drug problems (c. 70%). Consequently, there seems to be a shaming or stigmatizing consequence not only of alcohol and drug problems, but of treatment as well (see also Paper I, “two worlds”).

One man interviewed in the VKP-evaluation relates that his life is filled with drunkards and institutions. The only “sane” people he saw were staff of the treatment system:

“I am so tired of places like this [treatment]. It is... you are sitting here... what the hell... I’ve been doing that... for the last six or seven years. I’ve been sitting with old drunkards. Month after month. The same drinking stories [laughs]. It is not fun.... [deep sigh] I am becoming institutionalized, you see. The only sane people I hang out with are nurses, doctors, social workers. The rest are just tramps” (VKP-evaluation, Man, August 2006).

In sum, there is evidence in the research literature, as well as in the empirical data of the present thesis, that social control is still experienced by clients as an important feature of their handling.
Matching and incompatible goals and interests

In previous chapter, the views of interested and dis-interested actor groups in the alcohol and drug treatment system (Spector & Kitsuse 1973), their goals of treatment, etc., are discussed. Legislation, policy documents, official governmental reports and definitions of treatment, as well as views and experiences of staff and clients, are used to portray the social ecology of treatment. The context in which individual alcohol and drug misusers enter treatment and try to use treatment for their own purposes, is portrayed.

Glancing over the political and societal goals of treatment reveals that several of these are complementary and well-matched. For example, eradicating alcohol and drug problems is the ultimate goal. At the same time, in a welfare state, those suffering from these problems have to be kept alive and provided with a stable and adequate living situation – to be (re)integrated into society. Therefore, paternalistic actions may be used – society protects those who cannot manage themselves.

On the other hand, the goal of a drug-free society with abstinence-oriented treatment conflicts with harm reduction. The ambitious abstention goal is not always viewed as realistic, and the treatment system faces individuals who do not want to or cannot stop using altogether. In order to provide the individual with a decent life, harm reducing interventions are used. Harm reduction may also save the lives of those who do not comply with the goal of abstention. People cannot be left to die – even when they do not comply with the norms and policy of society.

Another difficult equation follows from the paternalistic and utilitarian goals of treatment. Treatment is good and justified in terms of paternalistic values. However, there are quite prominent utilitarian goals noticeable as well, mainly regarding involuntary treatment (LVM and the criminal justice system). A third problematic example is the combination of welfare or re-integration and harm reduction. In rhetoric, one can argue that the goal of re-integrating the clients into society does not go together well with harm reduction – with letting the clients continue using. In practice, on the other hand, an individual may need Methadone in order to function socially and thereby rebuild her or his social situation. In addition, treatment is not an
isolated phenomenon. The public annoyance of alcohol and drug misusers hanging out on the streets may lead to combined mopping-up and treatment actions. Cleaning up the streets for the good of the neighbours is not compatible with the paternalistic view of helping the individual. In sum, the treatment system faces difficult equations – policy actions in real life.

To these conflicting goals, we can add the interests of treatment staff. Wiseman’s (1970) study of Skid Row alcoholics, through taking into account both the perspective of agents of social control as they attempt to cope with the problems of the alcoholics and the perspective of the Skid Row individuals, shows that there is an inevitable collision resulting from cross-pressures between official objectives and the effects of operating a rehabilitation organization.

Staff providing treatment do indeed believe that they are doing something good – that they can help. On the other hand, they have their own interests and their own work satisfaction to fulfil. Sometimes, their interests do not match the interests of the broader treatment goals of politicians or of potential clients. For example, economic cuts forced on staff from above may, as shown, result in opposition and a privatized, and for the moment rescued, unit. This event may on the other hand lead to changes in the provision of treatment that may or may not benefit clients.

Staff interests are noticed by system managers and politicians. For instance, as presented below (see Swedish handling…), improvement efforts often include elements of improving collaboration and the work climate of those working in the system as well. The comfort of the staff is viewed as important and is considered.

What stands out from portraying clients’ views and experiences is that these correspond well with the official goals and views of staff as well as of the general population. Clients, too, believe in the capacity of treatment; think treatment is for saving lives; for helping them cure their problems; and for accessing social welfare interventions and thus improving their social situation in life.

On the other hand, clients often stress that treatment is merely a place for getting a respite – that is what they want and what they get. This usage of treatment is generally not acknowledged as acceptable in policy and by staff. On the other hand, offering a chance to rest and achieving a life with less harms is stressed in the soft harm reduction approach. In general, clients, in correspondence with the official goals, aim rather at eradicating their problems than asking for harm reducing actions such as methadone, needles, or help with getting rid of the problems related to substance use – regardless of whether the consumption changes.

Detectable from the clients’ point of view is a dissatisfaction with and problems arising from the social control exercised on the individual by surrounding actors. Clients stress problems with too high demands from the treatment system, stigma and sanctions. In official documents, efforts to
reduce stigma are usually not set as a goal. In the clients’ view, these control measures are not viewed as compatible with the goals of attaining abstinence, re-integration, etc. Control measures are seldom talked about by staff, and if mentioned, viewed as necessary means to motivate the client to want to change – as in the best interest of the client. It is often staff who decides what is best for the client (see Sahlin 2001).

The analysis also shows that clients report several and somewhat conflicting reasons for treatment. It is their own choice, but they are pushed, which is viewed as unhelpful. On the other hand, later on, the client may say that his or her social worker did what was best at the time. An ambivalence is noticeable among the clients, as well as among the political goals.

It is likely that staff, treatment managers, and politicians are aware of these views of clients, but they are deemphasized or disregarded for ideological or other reasons – not accepted as alternatives to the official ones. As an example, in an evaluation of the care of homeless alcoholics in Stockholm (Kühlhorn & Gerdman 1983), staff was aware of the fact that their care mainly provided the homeless with sheltered housing, rather than reintegrating them into society, which was the official goal. However, this was not recognized publicly as the goal of their work.

In sum, matching and competing interests and views surround alcohol and drug treatment. How do politicians and treatment managers manage in this system? In the next section, three recent examples from Stockholm are presented to illustrate this.

**Swedish handling of alcohol and drug problems:**

**Recent examples**

As presented above, the goals of treatment are ambitious. However, as argued, the treatment system is not an isolated island in society. It interacts with other parts of society, is constrained by economic resources, and suffers from competing goals and interests of *interest* and *dis-interested* groups. Conflicting interests may sometimes have an immobilizing effect and do, in fact, make the management of the system more difficult. As presented below, the attempt to decentralize the treatment system was turned back by staff at the Maria-unit (Paper IV “Maria-unit”). The political level is to some extent reduced to symbolic gestures and setting ambitious objectives that do not work out in practice.

Three examples are here provided of how Swedish politicians (a *dis-interested group*) act when pressured to do something about the problem of alcohol and drug use while living up to the vision of a drug-free society, but are faced with the realities of the treatment system.
Utopian goals: The Swedish Drug Commission

One example comes from the Swedish Drug Commission (SOU 2000:126). On the basis of national drug policy objectives, the Commission stated that the following “public measures of care and treatment for addiction to and abuse of narcotic drugs should be attained.

- All drug abusers shall be reached by an offer of help and, if necessary, care for the abuse.
- Advice, support and assistance shall reach people at an early stage of abuse.
- Measures of care shall be aimed at achieving a life free from substance abuse and illegal drugs.
- Care and other measures on behalf of substance abusers shall be of good quality.
- Measures to combat substance abuse shall be sustainable and long-term.” (p. 44).28

Not surprisingly, the Drug Commission states that more resources are needed for drug treatment. Considering that the budgets for alcohol and drug treatment have mainly been cut since the beginning of the 1990s, and in view of the ceaseless hunt for cost-effectiveness in treatment, it is most likely that the aims formulated above could never be fulfilled. The Swedish Government would most likely not be willing to take on the costs required for actually fulfilling these goals.

In order to show the magnitude of the above ambition, I will offer one rough example. In 1998, it was estimated that there were approximately 28,000 heavy drug users29 in Sweden (Lander et al. 2002). About 30,000 individuals are in alcohol and drug treatment on a given day (IKB 2003). Assuming that half of these (15,000 individuals) were in treatment for drug problems, there would be 13,000 individuals left who would be “untreated”. To this figure, we can add a number of users who are not yet categorized as “heavy”, who should be reached early. This implies that the drug treatment system would have to expand by about 100 percent – to double its present capacity.

Improve treatment in the criminal justice system: Data collection as a solution

Another, more recent example, comes from the criminal justice system. In 2002, the Government commissioned the National Prison and Probation Administration to initiate a three-year effort to combat drug abuse among prisoners. The earmarked money consisted of 100 million Swedish crowns

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28 These goals are still in force and are the same for alcohol treatment (Prop. 2005/06:30).
29 “Heavy drug user” referred to injection of illegal drugs in the past 12 months (regardless of frequency) or (almost) daily use of illegal drugs in the past four weeks.
(approximately 11 million Euro). The work involved identifying drug users, investigating their needs and providing motivation and treatment for their drug abuse. Depending on the degree of motivation, the clients are placed in one of three different types of units: a motivational unit; a treatment unit; or a unit for those whom it is difficult to motivate (BRÅ 2003).

This effort was evaluated by the National Council for Crime Prevention (BRÅ). The first report (BRÅ 2003) studies to what extent the effort has been implemented and how it was received by prison staff. The evaluation showed that 57 “drug units” at 28 institutions, offering 1300 places, had been created. A lot of the resources were put into training staff in Motivational interviewing, using the Addiction Severity Index (ASI) and Monitoring Area and Phase System (MAPS) instruments, etc. In addition, 23 percent of those serving a prison term of at least six months, and one fifth of those with shorter terms, were screened by ASI/MAPS. However, the evaluation concludes that there “does not appear to have been any increase in the proportion of drug-using clients participating in programmes in connection with the special anti-drug effort” (BRÅ 2003:65-65). Those responsible for placing the clients did not feel that the ASI effort gave them more information, since they already had access to such information. The evaluation further showed that there were not enough treatment units. Only 20 percent of the drug using prisoners on a given day could be provided a drug-free environment in prison.

To conclude, this special effort swallowed a lot of money, it certainly put treatment on the prisons’ agenda, and there are certainly drug users in prison who benefited from the effort and found it meaningful. On the other hand, one can ask if this was the best way to spend the state’s resources? The Government’s goal was that every convict at motivation or treatment units should be assessed with the ASI, and every individual placed in a unit for those who are difficult to motivate should be offered Motivational Interviewing (MI). Is it is useful to collect thousands of ASI interviews in the prison system without being able to handle the information in a productive way? For instance, the evaluation (BRÅ 2003) showed that many ASI interviews were not followed up by other interventions. Clients did not think that the assessment brought with it anything after the assessment (see also Prop. 2005/06:30, p. 110). The evaluation (BRÅ 2003) concludes that the stated goals are far from fulfilled. The evaluators argue that there might be reasons, based on these experiences, for reformulating the achievement measures and goals into more realistic and effective ones.

30 ASI is a structured interview measuring clients’ needs in different life areas regarding their present situation, problem history and need for assistance. MAPS gathers information regarding client, treatment and staff. It aims at picturing the client’s stage of change and helps the treatment provider direct the assistance, in accordance to problems assessed in the ASI.
Multiple and overlapping demonstration projects: LVM

A third, and recent series of examples, are found in the compulsory treatment system and in the state’s attempt to provide the heaviest users with good treatment.

Just a few months after the initiation of the “Vårdkedjeprojektet” (VKP, as described earlier) trial, another much bigger and more expensive program was launched. This project, “A contract for life” (“Kontrakt för livet”), brought with it huge resources from the Government (820 million Swedish crowns, of which 120 million was earmarked for the criminal justice system, as compared to 7 million a year over three years for VKP). This project, as well as VKP, offered aftercare to the municipalities for a significantly reduced cost (see Prop. 2005/06:30, p. 101-102).

The Contract for life effort had implications for the VKP-project, which makes it difficult to draw conclusions from the VKP trial to guide future efforts. Before the VKP-trial and evaluation was finished, a similar trial was launched in the LVU-based youth compulsory treatment system, also run by SiS. This trial was set to get started July 1, 2006 (cf. SiS 2006b; SiStone 2006).

How can these multiple efforts be interpreted? There are, indeed, difficulties and deficiencies in the treatment system which justify efforts to solve the problems. On the other hand, these projects are all run as trials or short-term actions. There is usually a quick rush to get projects started and clients recruited, even before there are project staff available able to inform and take care of the recruited clients. Additional trials and efforts are launched before experiences and evaluation results from previous ones can be used to guide the actions. This gives a picture of quite short-term thinking. One explanation for the rush in this case may be that there was an election coming in September, 2006.

Summing up the handling examples

Efforts aiming at improving how society treats alcohol and drug misusers can be valuable. Often they have positive effects also for the individual. As discussed above, the goals and assumed effects or consequences that are put forward in official governmental reports, in political programs, and by politicians are usually exaggerated, unrealistic and impossible to achieve. Considering the push to get started immediately, the projects appear less than fully thought through. These efforts are especially unrealistic given the short period of time usually offered for running a special project. In this regard, in a recent official governmental report (SOU 2005:82), there was a warning against the dangers of running improvement efforts in the addiction field in the form of short-term projects. The time issue is also problematic when
implementing treatment in the criminal justice system, where prisoners usually serve a short sentence.

Sometimes there is a stated goal that the actions or improvements must not increase the costs. For instance, in the recent official governmental report aiming at improving alcohol and drug treatment for “heavy abusers”, it was stated by the Government that the “suggestion shall not bring forth increased costs for the public sector”. In the final report from the investigation, the investigator points out that this “may not be realistic, at least not in a short-term perspective, given the strong ambitions in the directive that the social services, health system and other involved actors shall admit more people with heavy abuse to treatment, and that this group as a whole shall receive a better life situation” (SOU 2005:82, p. 71). The investigator concludes that the suggestions regarding an integrated addiction treatment, a guarantee for treatment and better treatment planning, will, if properly carried through, lower the costs for alcohol and drug treatment. She is “not certain that these savings will occur during the declared time period, 2006 and 2007. All previous experience shows that time and reflection is required for implementing new methods and ways of working in order for them to find a hold in the organization, survive and become successful” (p. 74).

In summary, these efforts – pushed forward in a hurry and seemingly impossible to achieve – mainly represent attempts to demonstrate an ability to take action against alcohol and drug problems. These examples do, in fact, show how the ambitions are shrunk by limits outside the actual goals, such as finances and competing interests.

Changes in the treatment system

Considering that treatment outcome has not been improved even though efforts have been made, as stated at the start, and with the case studies above in fresh memory: How can we understand the treatment system? This introductory part aimed at portraying the social ecology (Weisner 1986) of Swedish alcohol and drug treatment, and thereby offering a frame for understanding clients’ experiences and views regarding treatment. Obviously, as presented, the individual client, as well as the treatment system, are part of a broader society encompassing groups of actors with matching and conflicting motives and interests.

The thesis offers a cross-sectional portrayal of Swedish society, with few backward looks. Therefore, we offer here a short discussion on whether the treatment system appears to be changing at the moment.

How do societies change? In social constructionism, changes are not viewed as part of a natural order in a more biological sense (cf. Spector & Kitsuse 1973). As an example, Conrad and Schneider (1980) view the transformation of views of deviance in America, from moral to medical, as a col-
lective and political achievement rather than as inevitable products of society or the progress of medicine. They argue that changes can be traced through the actions of specific people, events, ideas, and techniques. They also stress that these changing views have political consequences.

Definitions of reality are embodied in concrete groups of individuals, and society changes through their actions. Treatment may change in what it represents, in how it appears, and in how and why it is used. As an example, with more complex forms of knowledge, experts claim jurisdiction over the knowledge. Experts may claim to know practitioners’ activity better than practitioners themselves, which can give rise to rival definitions of reality, and to the appearance of new experts in charge of new definitions. There can also be competition between staff views and the definitions of “official” legitimators of society. Variations may exist in one institution, depending upon the tasks assigned to different categories of personnel (Berger & Luckmann 1966). Power is important. Those who occupy decisive power positions can impose their own definitions of reality on people in society.

“Power in society includes the power to determine decisive socialization processes and, therefore, the power to produce reality. In any case, highly abstract symbolizations (that is, theories greatly removed from the concrete experience of everyday life) are validated by social rather than empirical support…. Theories may … be said to be convincing because they work – work, that is, in the sense of having become standard, taken-for-granted knowledge in the society” (Berger & Luckmann 1966: 110).

Legitimation is needed – ways by which things can be “explained” and justified. This legitimation implies that institutions are, at least to a certain extent, protected from cognitive and normative re-interpretations. Legitimation is put under threat if alternative or “deviant” perspectives become shared by a large number of people or groups and thus challenge the reality status of the reality as originally constituted. Deviant groups (staff, clients, etc.) carry an alternative definition of reality – a theoretical threat with practical implications. These threats are repressed by actors proclaiming the “official” definitions (Berger & Luckmann 1966).

Starting from these thoughts on changes, some trends regarding changes in the treatment system are noticeable in previous sections.

A growing treatment industry separated from the re-integration goal?

As announced by the National Board of Health and Welfare, there seems to be a changing view of treatment: social interventions are not to be included – not even in a country with a long history of a social model regarding addic-
tions and treatment; a more technical view is being adopted on what is treatment of good quality.

This change may be driven by a general medicalization, technicalization and search for knowledge in society (cf. Bergmark 2005). These changes give rise to new experts specialized in drawing research conclusions and tailoring and implementing guidelines, methods and tools, as well as training staff who become experts on special methods. The field of alcohol and drug treatment may grow, which is in the interest of staff populating the treatment system. Such a change may also satisfy disinterested groups, such as politicians, who think that something has to be done about alcohol and drug problems.

Clients may of course benefit from this change as well. On the other hand, one can assume that the client selecting process described earlier (heavier misusers are excluded from the treatment system, Järvinen 1992, 2002; Kühlhorn & Gerdman 1983; Lindström 1992) is accelerated with the advances towards EBP/T. It is possible that several of these methods are best suited for well-integrated and motivated client groups. As an example, Randomized controlled trials (RCT) are considered to be the most valid form of scientific evidence. RCT studies were also given the highest evidence value in working out the Swedish national treatment guidelines (Socialstyrelsen 2006a). However, such studies often have low external validity and suffer from generalizability problems. They are often performed on more integrated misusers. For studying how clinical trial samples differed from real-world samples regarding alcohol outcome studies, Humphreys and Weisner (2000) used eight of the most common exclusion criteria used in such studies and applied to a large representative clinical sample. For each of the criteria, between 11 and 75 percent of clients in the real-life sample were to be excluded – not eligible to participate. Vulnerable populations are excluded from studies used for promoting special treatment methods. This implies that we do not know how well suited these types of treatments are for more marginalized alcohol and drug misusers – the majority of clients in treatment.

However, Bergmark and Lundström (2002) have shown that social workers generally do not read about and use research results in their work. EBP/T and guidelines are most likely difficult to implement in practice.

Will the social re-integration goal diminish? As said, EBP/T are often more suitable for well-functioning individuals, and staff prefer to work with this group (cf. Järvinen 2002). Does the strengthened focus on technique imply that the more marginalized clients, who populate the treatment system at the moment, will be pushed out? The other alternative is that this trend is resisted by practitioners, who are faced with clients standing in the door, and

31 Psychiatric or emotional problems; noncompliance or lack of motivation; medical problems; drug dependence; unsuccessful prior treatment; residence distant from treatment facility; social instability; residential instability.
the gap between policy and practice will increase (cf. Klingemann & Berg-mark 2006).

More coercion and stronger utilitarianism?

In a Nordic comparison, in the beginning of the 1990s (Lehto 1994), Sweden was high on several measures of involuntary treatment: number of involuntary treatment periods in specialized institutions (LVM); maximum length of involuntary treatment in specialized institutions; alternative sentences for imprisonment for persons with substance problems; specific treatment of persons with substance problems during imprisonment; a great proportion of prisoners have substance problems. Sweden was not high on the average number of prisoners.

Recent changes in the treatment system imply that coercive parts of the treatment system are further expanding. The trials and efforts in the compulsory treatment system (LVM) as well as in the criminal justice system may change the proportion of clients treated under a clear threat of incarceration. As mentioned in the previous chapter, treatment in these sectors builds more on utilitarianism than is true in other parts of the treatment system. The driving forces have mainly been political. Clients are not the main advocates of such changes. Does this mean that the focus on treatment will shift from treatment for the sake of the individuals towards treatment for the sake of society and others?

Harm reduction when techniques and coercion are not enough?

There are tendencies that certain harm reducing actions become more accepted and available (maintenance treatment, needle-exchange, etc.). One explanation could be that it is acknowledged that treatment is not achieving total abstention among clients. The treatment system can, on the other hand, reduce the harms and provide the client with a more decent life. A shift towards harm-reducing interventions may also accelerate as an effect of the technicalization of treatment and treatment guidelines launched by the National Board of Health and Welfare (Socialstyrelsen 2006a). In the guidelines, cost effectiveness is promoted. It is suggested that:

“If the treatment facility cannot demonstrate a successful outcome, the treatment cannot be recommended. Care providers should specify and clarify
1. the goal of treatment (i.e., abstention, decreased abuse or consumption)
2. treatment target group
3. treatment duration
4. treatment frequency
5. treatment content
6. the number of staff and their education
7. which costs are included in the price or will come up [later]
What is suggested is that treatment that does not reach its stated goal should not be recommended. Many treatment units do not reach the most commonly stated goal of abstention. This may lead treatment managers to reduce the pronounced goals of treatment and to a higher extent accept and promote harm reducing interventions – in theory as well as in practice. Utopian visions do not correspond well with a strong reliance on evidence.

Recently, user unions have become more important and integrated in the management of the treatment system (cf. Palm in press). Klingemann and Bergmark (2006) claim that lobbying efforts and social movements influence the nature of the social response to problems far more than does scientific research. They further conclude that the political influence of treatment consumers is under-researched. It is difficult to foresee what these changes will bring with them.

* * *

In general, these trends are not compatible. For instance, the growth of coercion is difficult to understand when turning to the technicalization of treatment: coercion cannot be legitimated by pleading good outcome. Maintenance treatment, on the other hand, has evidence-based support (SBU 2001). We may be facing a more diversified treatment system with highly specialized therapeutic methods, with both needle exchanges and treatment in prison. By referring to Spector and Kitsuse’s (1973) stages of claims-making and change in society, we could say that actors in the treatment system presently are expressing dissatisfaction with the way treatment works (stage 3). This has led to the development of alternative responses (stage 4). Maintenance treatment and needle-exchanges become available when treatment is not successful in reducing drug use. At the same time, counter institutions are expanded for promoting alternative ways to go: Coercion becomes more widely used for pushing misusers to conform.

It is unclear what client groups will be found in which type of intervention. The future will tell.

The end: Is “treatment” the right way to think about it?

By returning to Miller’s (2002) question, if treatment is the right way to think about it? Considering that treatment outcome has not improved over decades, that interest and dis-interest groups struggle over how to handle the problem, and the fact of the social control experienced by clients, we can
question if treatment, in its present form, is mainly good – for society and the individual client. As a matter of fact, Berger and Luckmann (1966) equate therapy to social control. Therapy ensures that deviants stay in an institutionalized definition of reality by applying a legitimating apparatus to the status of individual deviants. The conceptual aspects of therapy are important, since it is concerned with the “official” definitions and has developed a conceptual machinery to account for deviations. This requires a theory of deviance, diagnostics, and a system for the “cure of souls” (p. 104). In therapy, under pressure, individuals come to accept subjectively the conceptualization of their condition with which the therapeutic practitioners confront them. They develop “insight” and the diagnoses become subjectively real to them. In order to deal with doubts regarding the therapy, the conceptual machinery elaborates a theory of resistance. However, there is also considerable subjective satisfaction for the individuals in such a return to “normality”. According to Berger and Luckmann (1966), institutions must and do claim authority over the individuals. Individuals have to be “kept in line”.

Apparently, deviance seems impossible to eradicate:

> “Deviance is a universal phenomenon. All societies have definitions of some behaviors or activities as deviant or morally reprehensible. The very notion that a society has social norms or rules ensures the existence of deviance” (Conrad & Schneider 1980:5).

Alcohol and drug problems, Skid Rows, and treatment (or at least institutionalized handling of problems) indeed appear as social facts. A social fact, according to Durkheim (1978), refers to ways of acting, fixed or not, capable of exercising on the individual an influence, or an external constraint. Social facts commonly exist in a given society, with an existence that is independent of each individual and of individual expressions. Gusfield (1996:185) challenges the common view that social problems are the results of disorganization, and argues that this perspective ignores the constant persistence of ills and troubles in society.

Wiseman (1970) argued that Skid Row areas seemed to exist in almost every town and seem to be impossible to get rid of. In terms of traditional specific characteristics, these areas may have become rarer in North America. On the other hand, we could say that they have become replaced with groups of homeless and highly marginalized people with and without addiction problems who are standing outside of the welfare state (cf. Storbjörk forthcoming).

> “No city has been successful in eradicating either the area or the inhabitants through social engineering alone. Some cities have resorted to the bulldozer – and the homeless male moves on geographically, but does not move up socially. … The area and its culture are strikingly similar from city to city and from time period to time period…. When the existence of a phenomenon is
apprehended by concerned groups as inherently bad for society at large, a
great deal of professional energy usually is expended on eradication and/or
prevention of the presumed problem. Skid Row has attracted its share of all
types of social reformers and they ... have, over the years, become an integral
part of the scene there. Thus, as Skid Row alcoholics view their world, they
must take into account these agents of social control who, in term, see the
area within a rehabilitation framework” (p. 3-4).

In the foreword of Wiseman’s book, Herbert Blumer writes:

“No one can ... fail to see the desultory and essentially fruitless character of
the official and semiofficial apparatus that has grown up to deal with the Skid
Row alcoholics. Arrest, detention, legal penalty, counseling, psychiatric
treatment, other kinds of therapy, and missionary endeavors, as they crystal-
lize into institutional forms, are alike in failing to provide an answer to the
problem of Skid Row alcoholics” (p. xiii).

In this light, treatment may best be viewed as a way of “controlling the un-
controllable”, returning to Bergmark and Oscarsson (1994). Treatment pro-
vides a structural and socially legitimate way of dealing with problematic
alcohol and drug users and “offers society a harmonizing function in relation
to the abuser” (Bergmark & Oscarsson 1994:123). Similarly, Kühlhorn ar-
gues that treatment provides a way for society to “live with its abusers”
(1983). Wiseman (1970) talks about the “dilemma of handling the socially
unattached” and keeping the peace (p. 65).

In summary, the present treatment system may not be the ultimate one re-
garding its outcome. Other alternatives, such as letting people die, are diffi-
cult to imagine in modern societies. However, one should not wink at the
downsides of treatment. In light of that, and the hope treatment offers to
individual clients who consider themselves to have problems, the approach
of today which includes putting a lot of professionals to the task of “treating”
and “reintegrating” alcohol and drug users – this keep-on-trying attitude –
still seems to be an acceptable choice. In my view, however, client choices
and wishes should be taken even more seriously.
How can we sociologically understand alcohol and drug treatment? What is the goal and role of treatment according to different actor groups? How can we understand clients’ experiences in a context? This thesis deals with the Swedish treatment system, focusing on Stockholm County, and seeks to increase our knowledge of who comes to treatment and why. More broadly, it deals with the individual and societal response to alcohol and drug problems – the social ecology of treatment.

The overall purpose of the thesis is to study how individuals with alcohol and drug problems come to treatment. What are their reasons for entering treatment and who is in treatment, in relation to who is not (client level)? The study also deals with the organizational level of the treatment system by analysing the motives for and conflicts surrounding changes in the system.

The introductory part takes a broader perspective and aims at offering a better understanding of the experiences and views of clients in alcohol and drug treatment by portraying the context in which treatment is provided – by studying the social ecology of treatment. What are the goals of treatment regarding aims at the social level and the corresponding aim regarding the individual client? What are the goals and purposes of treatment according to different actor groups – clients, staff and politicians?

The main data is from the comprehensive Women and men in Swedish alcohol and drug treatment-study, with a representative sample of clients in the treatment system as well as complementary data on the views of staff and the general population. Some additional data is included from two other treatment studies, Risk Opiate Addicts Study (ROSE) and Treatment chain evaluation (VKP).

Four papers
This thesis consists of four papers and one paper in Appendix I describing the study (design, data material, etc.). The first three papers deal with clients in treatment for alcohol and drug problems. The conclusion of Paper I, which compares clients in treatment with people in the general population regarding demographics and alcohol related problems, is that the treated population is marginal (regarding housing, work, family etc.) in comparison to the general population. Moreover, having been in treatment once predicts being treated again. It is hypothesized that the treatment system is serving the same population repeatedly.
The second and third papers study alcohol and drug users’ paths to treatment. Paper II studies to what extent clients report self-choice in treatment entry, and how self-choice is related to reported informal (i.e. family, friends), formal (i.e. authorities, work place) and legal (i.e. police, judicial system) pressures to enter treatment. It is shown that self-choice and pressures are not mutually exclusive. Informal pressures are especially common among those entering treatment. Such pressures tend to be positively correlated to reporting self-choice, whereas formal pressures as well as legal pressures to enter treatment tend to be negatively correlated to self-choice. On the other hand, those arrested for drinking-driving tend to report self-choice in treatment entry. The third paper focuses on what role different alcohol and drug related events (i.e. arguments with significant others, police contacts, alarmingly high alcohol or drug use) play in treatment entry. The paper shows that these events contribute to treatment entry. Individuals with a high and low level of marginalization are more likely to report that these events contributed to treatment in their case, in comparison to those in the middle of a marginalization score (a non-linear correlation).

The fourth paper studies motives behind organizational changes in the treatment system. It is concluded that these changes are driven by economic cuts, professional struggles and coincidences, rather than by research results, by implementation efforts, and with client interests in mind.

The social ecology of Swedish alcohol and drug treatment

In the introductory section, the views of treatment of different actors – politicians, staff and clients – are discussed. On a political level, alcohol and drug treatment mainly is about helping the individual misuser. The ultimate goals are a drug-free society and a society free from harms from alcohol. The main goal of treatment is abstention, but it is also about saving lives. Swedish society seeks to protect the weakest and a paternalistic stance is present in the treatment system, which is justified by claiming that it promotes the well-being of the individual client.

In general, an optimistic view is noticeable – politicians, staff, and the general population as well as clients believe that there are treatments which are successful. Sweden also has a history of a strong welfare state. This feature is prominent in alcohol and drug treatment, which is highly integrated with other social interventions. Re-integrative goals are evident in every part of the treatment system.

In Sweden, harm reduction is not officially recognized as an accepted alternative – it is not in agreement with official policy. However, in official documents, practice, and actually in legislation, a soft harm reduction approach is sometimes noticeable. Total abstention is not always seen as a realistic goal and reducing harms becomes an option.

From a sociological point of view, we could say that treatment enhances order in society. In fact, the treatment system does have utilitarian features –
treatment is justified by preventing harm to others. It is shown that treatment may be combined with other actions for cleaning up the streets from “spare” people. Social control refers to actions which help regulate behaviour and lead to compliance to the norms of society. Alcohol and drug problems are viewed as serious social issues, and significant others around the alcohol or drug misuser, as well as authorities, push the individual to conformity and treatment. Linked to this is the stigma which is still attached to treatment and the treated.

The discussion about staff in the treatment system shows that the personnel believe in their job and abilities to help individuals with alcohol and drug problems. Staff is also part of a “treatment industry”, which implies that they wish to continue their work. Staff have their own interests in their job, its continuance, their satisfaction, etc. In fact, staff may often manage to keep their units running, even when client load is dropping or economic cuts threaten their workplace.

Where do clients’ experiences fit in to the picture presented? It is shown that clients too view treatment as a life-saving as well as curative facility. However, often clients request welfare assistance and help in their practical life, rather than treatment for alcohol and drug problems. In other cases, they wish to get a respite and reduce alcohol and drug related consequences and harms. Nevertheless, generally, when asked to choose, clients wish to achieve abstinence over receiving harm reducing interventions.

It is shown that alcohol and drug misusers, whether presently in or out of treatment, experience social control and pressures to change their behaviour, go to treatment and follow the rules of society and of the treatment facilities. In this section, examples of how clients experience social control tactics and pressures from their environment are provided.

To what extent these views and interests are well-matched or incompatible is thereafter discussed. Several aspects are compatible. On the other hand, the goal of a drug-free society and the abstention goal are in conflict with harm reduction, which on the other hand may help save lives. Paternalism and utilitarianism are not well matched: Mopping up the streets for the good of the neighbours may not always be in correspondence with paternalistic goals, etc. In addition, staff interests are not always in agreement with the goals of politicians and clients. They have their own interests and their own work satisfaction to fulfil.

Noticeably, clients’ views and experiences often correspond well to the official views of staff, politicians and the general population. Clients believe in treatment and use it to stay alive and get cured, as well as to access welfare interventions. On the other hand, treatment is often used as and experienced as a place to get a rest – nothing else. Harm reduction is acknowledged by a few but is not the most important aim among clients. However, social control, demands, sanctions and stigma most often are experienced
negatively by clients, and are thought by them to counteract the goal of achieving abstention.

Consequently, the treatment system is a complex system with compatible and incompatible perceptions.

How is the system managed, then? Three recent examples are provided which show that policy often is about offering utopian goals regarding treatment, which are difficult to fulfil through short-term projects and with limited resources.

Finally, some noticeable changes in the treatment system are discussed: a growing “treatment” industry separated from the re-integration goal; more coercion and stronger utilitarianism; and harm reduction when techniques and coercion are not enough.
SAMMANFATTNING


Det huvudsakliga syftet med avhandlingen är att studera hur individer med alkohol- och drogproblem kommer till behandling. Vilka är deras skäl till att komma till behandling och vad skiljer de som är i vård från dem som inte är det (klientnivå)? Studien behandlar även behandlingssystemets organisatoriska nivå genom att analysera motiv och konflikter inom missbrukarvården som omger systemets förändringar.


Datamaterialet är huvudsakligen taget från den omfattande studien Kvinnor och män i svensk missbruksbehandling som består av ett representativt urval klienter i behandlingssystemet samt data om personalens och den allmänna befolkningens uppfattningar. Dessutom inkluderar data från två andra behandlingsstudier, Risk Opiate Addicts Study (ROSE) och Utvärdering av Vårdkedjeprojektet (V KP).

Fyra artiklar

Avhandlingen består av fyra artiklar plus en artikel i Bilaga I som beskriver studien (design, datamaterial mm.). I de tre första artiklarna studeras klienter i behandling för alkohol- och drogproblem. Slutsatsen i Artikel I, i vilken klienter i behandling jämförs med personer i den allmänna befolkningen avseende demografi och alkoholrelaterade problem, är att den population som befinner sig i behandling är marginaliserad (avseende boende, arbete,
familjesituation mm.) i jämförelse med befolkningen. Att ha varit i behandling tidigare predicerar dessutom att bli behandlad igen. Slutsatsen är att behandlingssystemet hjälper en grupp individer upprepande gånger.


I den fjärde artikeln studeras de motiv som ligger bakom organisatoriska förändringar i behandlingssystemet. Slutsatsen är att dessa förändringar drivas av ekonomiska nedskärningar, professionella strider och olika tillfälligheter, snarare än av forskningsresultat, implementeringsförsök eller med klienternas bästa i åtanke.

**Den svenska alkohol- och drogbehandlingens sociala ekologi**


Generellt sett är en optimistisk behandlingssyn märkbar – politiker, behandlingspersonal och personer i den allmänna befolkningen liksom klienter har tilltro till att det finns framgångsrika behandlingar. Sverige har även en historia med ett starkt välfärdssamhälle, vilket också är ett framträdande drag
i vården av alkohol- och drogproblem. Missbrukarvården är i hög grad integrerad med andra sociala insatser. Återanpassning till samhället som ett mål för behandling finns i varje del av behandlingssystemet.

I Sverige är skadelindrande insatser ("harm reduction") generellt inte officiellt erkända som accepterade alternativ – de är inte förenliga med den officiella politiken. I officiella dokument, i praktiken, och även i lagstiftningen, är en mjukare variant av skadelindring trots det skönjbar. Total avhållsamhet är inte alltid betraktat som ett realistiskt mål och skadelindrande insatser framstår då som ett alternativ.


Diskussionen kring behandlingssystemets personal visar att de anställda tror på sitt arbete och sina möjligheter att hjälpa individer med alkohol- och drogproblem. Personalen kan även sägas ingå i en "behandlingsindustri", vilket medför att de önskar fortsätta med sitt arbete. Personalen har således sina egna intressen att tänka på avseende sitt arbete, dess varaktighet, sin arbetstillfredsställelse osv. I verkligheten lyckas personalen ofta hålla sina enheter flytande och fungerande, även när clientbeläggningen sjunker eller ekonomiska nedskärningar hotar arbetsplatsen.


Slutligen diskuterar om och i vilken grad dessa uppfattningar och intressen matchar varandra eller är oförenliga. Flera aspekter är förenliga, andra inte. Målet om ett drogfritt samhälle strider till exempel mot skadelindring,

Det är beaktansvärt att klienternas uppfattningar och erfarenheter överensstämmer så väl med de officiella målsättningarna hos personal och politiker, samt hos den allmänna befolkningen. Klienterna använder behandling för att hålla sig vid liv och bli botade, liksom för att få tillgång till sociala insatser. Å andra sidan används och upplevs behandling ofta som ett ställe för vila – inget annat. Skadelindring erkänns som önskvärt av en del men är inte det viktigaste målet bland klienterna. Social kontroll, krav, sanktioner och stigma upplevs oftast som negativt av klienterna, och betraktas som att de motverkar målet om avhållsamhet.

Behandlingssystemet är således ett komplext system med förenliga och oförenliga uppfattningar.

Hur sköts då systemet? Tre nyligen inträffade händelser presenteras som exempel. Dessa visar att politiken ofta handlar om att sätta utopiska mål för behandlingssystemet, som är svåra att uppnå genom kortsiktiga projekt och med begränsade resurser.

Slutligen diskuteras några märkbara förändringar i behandlingssystemet: En växande "behandlingsindustri" som är separerad från målet om återintegration, mer tvång och ett tydligare förmyndarväxt, samt skadelindrande insatser när behandlingsteknik och tvång inte räcker till.
When I was admitted to the PhD program in sociology, I could not imagine that I would actually write a dissertation and it has been quite a journey to get to the point where I am today.

When I started to do alcohol and drug treatment research, six years ago, the field was new to me. A world opened up before my eyes with an inexhaustibly large number of services. It was difficult to grasp the variety of services and I had a hard time understanding that there were really enough people to fill these places. After I had been around for a while, my impression changed. When reading books on homelessness in Sweden in the 1960s, I was surprised, or rather disappointed. The texts, written more than a decade before I was born, mirrored what I saw in Stockholm in the beginning of the new century. I wondered how come a welfare state like Sweden cannot take better care of its citizens. How come Sweden has so many people with such an unfortunate living situation? This led me to go further into marginalization of those inhabiting the treatment system. My treatment-naive attitude was replaced by a more complex view on how society deals with alcohol and drug (mis)users. This forms the background to the questions asked in this thesis.

There are several people that I want to acknowledge. First, I would like to give my deepest gratitude to Robin Room, my supervisor, former boss and intellectual inspirational source. Your endless encouragements made me stay on track and prevented me from losing the ground under my feet.

I would like to thank everyone who has been involved in the *Women and men in Swedish alcohol and drug treatment*-study. I am especially grateful to Kerstin Stenius, Jessica Palm and Vera Segraeus for good work, collaboration, comments and support over these years. I would also like to thank Edle Ravndal (SIRUS); your comments on an earlier version of this manuscript helped me mobilize my strengths and finish this work.

I am delighted with all my co-workers at SoRAD, thank you for offering such a cheerful environment. I would especially like to thank Jenny Cisneros Örnberg and Klara Hradilova Selin for listening to my complaints and cheering me up during my path to a finished draft.

Others, which deserve to be mentioned, belonging to Young ARG, are Alexandra Bogren, Ninive von Greiff, Patrik Karlsson, Lisa Skogens, Kalle Tryggvesson and Lisa Wallander.
I am grateful to Turning Point Alcohol and Drug Centre in Melbourne, The Finnish Foundation for Alcohol Studies (Stakes), and the Nordic Council for Alcohol and Drug Research (NAD) in Helsinki for offering me a place to work on this thesis – away from home where I could concentrate.

Special thanks to my parents who have helped in so many ways during my extended time in school. I am grateful for that. Finally, to my mother and father, Camilla and Micki, my grandmother mommo, and Johan, I wish to thank you for putting up with me during this time, for allowing me space to work on this thesis, for always believing in my capabilities and for always being there for me.

Jessica Storbjörk
Stockholm,
October 16th, 2006
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The two worlds of alcohol problems: Who is in treatment and who is not? 32

By Jessica Storbjörk(a) & Robin Room(b)

(a) Centre for Social Research on Alcohol and Drugs (SoRAD), Stockholm University
(b) School of Population Health, University of Melbourne, and AER Centre for Alcohol Policy Research, Turning Point Alcohol and Drug Centre, Melbourne, Victoria, Australia

Abstract. In the study “Women and Men in Swedish Alcohol and Drug Treatment” it is possible to compare alcohol consumption and problems among respondents in the general population to clients entering alcohol treatment. The differences between these groups have led researchers to talk about the “two worlds” of alcohol problems – in general and clinical populations. Aim. The aim in this paper is to study the relative strength of factors (demographics and marginalization; volume and frequency of drinking, alcohol dependence; social response to drinking like suggestions to cut down or seek treatment by (in)formal actors/institutions; and treatment history) in predicting entering the clinical population. Methods. The client sample includes 1202 clients (71% men) interviewed face-to-face when entering inpatient and outpatient treatment facilities in Stockholm. In the general population survey, 3557 persons aged 18-75 were interviewed. Findings. The two samples differ significantly. As expected, clients were older, more marginalized, and reported more severe alcohol problems, and many reported previous treatment experiences and social responses. Logistic regression analyses show that previous treatment, unemployment/institutionalization and having an unstable living situation are the strongest predictors of who is in treatment, followed by age, alcohol dependence and frequency of drinking. Formal pressures to cut down or seek treatment are also important, and males are more likely to be in treatment. Conclusions. The results support a notion of the treatment system as a place for handling marginalized people, beyond and beside their extent of drinking.

Keywords: General and clinical populations, treatment, alcohol, marginalization

32 As Submitted to Addiction Research and Theory, 12 April, 2006.
PAPER II
The interplay between perceived self-choice and reported informal, formal and legal pressures in treatment entry

By Jessica Storbjörk

Centre for Social Research on Alcohol and Drugs (SoRAD), Stockholm University

Abstract. This paper focuses on the interplay between reported informal, formal and legal pressure and self-choice in treatment entry. The representative sample of those entering treatment for alcohol or drugs problems in Stockholm County, Sweden includes 1865 clients (71% men). Most respondents reported that it was their own idea to come to treatment (81%). It was also common to report reasons for entering treatment indicating different forms of perceived pressures, especially informal pressures (75%), but also formal and legal pressures. Informal pressure from someone close was a particularly important reason for treatment entry. Informal pressure was found to be positively associated with the feeling of self-choice in treatment entry, whereas perceptions of formal pressure (and particularly legal pressure) mainly were negatively related to self-choice. Most of those reporting self-choice in treatment entry also reported informal, formal or legal pressure as reasons for coming to treatment.

Keywords: Paths to treatment, Sweden, self-choice, informal, formal, legal pressures, alcohol, drugs.
Events in problematic alcohol and drug users’ lives: Contribution to treatment and the impact of marginalization

By Jessica Storbjörk

Centre for Social Research on Alcohol and Drugs (SoRAD), Stockholm University

Abstract. One aim of the study “Women and Men in Swedish Alcohol and Drug Treatment” is to study how people with alcohol and drug problems come to treatment. Aim. The focus in this paper is on different alcohol- and drug related life events in the year prior to treatment and whether or not these events contributed to treatment entry. The importance of these events is also studied in relation to level of marginalization. Methods. The representative cross-sectional sample includes 1865 clients (71% men) interviewed in-person when entering inpatient and outpatient treatment facilities. Findings. Most respondents had had events in the year prior to treatment and these were also perceived as contributors to treatment. Events related to significant others and health workers seem to be of greatest importance for treatment entry. These events happen to a lot of the problematic alcohol and drug users and they are viewed as strong contributing factors by the respondents. More marginalized people experience more events. There’s a curvilinear relationship (somewhat U-shaped) between level of marginalization and events as contributors to treatment: the least marginalized people are most likely to report events as contributors, people in between are the least likely and the most marginalized people are likely to report events as contributors to treatment.

Keywords: Substance abuse treatment; paths to treatment; Sweden; events; marginalization.

34 As Submitted to Journal of Substance Use, 13 March, 2006.
The dynamics underlying the story of a reform that redefined the boundaries of the addiction treatment system: The rapid privatization of the Maria-unit

By Kerstin Stenius & Jessica Storbjörk

Centre for Social Research on Alcohol and Drugs (SoRAD), Stockholm University

Abstract. The article analyses the motives and conflicts within a substance dependence care organization and its environment, which provided the background to the privatization of a county council, owned addiction unit in Stockholm.


36 We would like to thank all those we have interviewed for their willingness to share their information, and in particular Caroline Adamsson Wahren, Stefan Borg, Markus Heilig and Ulf Rydberg, for having also provided feedback on earlier drafts of this article.
APPENDIX I – Description of study
Women and men in alcohol and drug treatment: An overview of a Stockholm County Study

By Robin Room, Jessica Palm, Anders Romelsjö, Kerstin Stenius & Jessica Storbjörk

Centre for Social Research on Alcohol and Drugs (SoRAD), Stockholm University

Abstract. Sweden has a longstanding and well-developed addiction treatment system, about 2/3 in the social welfare system and 1/3 in the health system. Apart from a small separate system for compulsory treatment, treatment is more or less voluntary, driven by the welfare aim of getting the drinker of drug user back into the workforce. There has been little study of similarities and differences between clients in the health and the welfare treatment systems, and about the systems and their interaction. How and when those with problematic drinking and drug use enter the systems in Stockholm County, and what happens to them then, is being examined with a series of coordinated studies. Altogether, 942 cases have been interviewed at entry to the health-based system, and another 837 defined as alcohol or drug cases in the welfare system; these two cohorts are being followed up 12 months later. In addition to substance use and dependence, treatment history, and status on the composite-score parts of the Addiction Severity Index, clients are asked how they came to treatment, their expectations and perceptions of treatment, and their conceptualizations of alcohol and drug problems. Questionnaires to staff of the two systems ask the same questions on conceptualization, along with their views of the treatment process. A general-population sample of the County, over-representing heavy drinkers, drug users, and those with experiences of treatment, is also interviewed, giving a

38 Revised from a paper presented at the 28th Annual Alcohol Epidemiology Symposium of the Kettil Bruun Society for Social and Epidemiological Research on Alcohol, Paris, June 3-7, 2002. In the studies reported on here, Jessica Palm has served as study director and Jessica Storbjörk as assistant study director, with the fieldwork coordinated by Jenny Cisneros. The coordinating team for the studies also includes Caroline Adamsson Wahren, Anders Bergmark, Kajsa Billinger, Tom Palmstierna, and Vera Segraeus.
view both of problematic users who do not come to treatment, and of experience and concepts of alcohol and drug problems in the population at large.
APPENDIX II – Tables
<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Neither</th>
<th>Alcohol</th>
<th>Drugs</th>
<th>Alcohol + drugs</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1865</td>
<td>291</td>
<td>808</td>
<td>502</td>
<td>264</td>
<td></td>
</tr>
<tr>
<td><strong>Women</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean age (years)</td>
<td>43</td>
<td>43</td>
<td>50</td>
<td>35</td>
<td>39 ***</td>
<td></td>
</tr>
<tr>
<td><strong>Treatment, Health system</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol detoxification (inpatient)</td>
<td>22</td>
<td>10</td>
<td>30</td>
<td>2</td>
<td>27 ***</td>
<td></td>
</tr>
<tr>
<td>Drug detoxification (inpatient)</td>
<td>12</td>
<td>4</td>
<td>.5</td>
<td>34</td>
<td>17</td>
<td></td>
</tr>
<tr>
<td>Methadone maintenance (inpatient)</td>
<td>3</td>
<td>.5</td>
<td>8</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medications (inpatient/outpatient)</td>
<td>5</td>
<td>2</td>
<td>.5</td>
<td>14</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Infection clinic (inpatient)</td>
<td>2</td>
<td>2</td>
<td>.5</td>
<td>5</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Outpatient treatment</td>
<td>57</td>
<td>82</td>
<td>69</td>
<td>37</td>
<td>46</td>
<td></td>
</tr>
<tr>
<td><strong>Treatment, Social welfare</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assessment (outpatient)</td>
<td>14</td>
<td>16</td>
<td>13</td>
<td>13</td>
<td>18 ***</td>
<td></td>
</tr>
<tr>
<td>Housing (inpatient)</td>
<td>31</td>
<td>54</td>
<td>28</td>
<td>30</td>
<td>27</td>
<td></td>
</tr>
<tr>
<td>Treatment home or institution, and compulsory treatment (inpatient)</td>
<td>26</td>
<td>8</td>
<td>24</td>
<td>26</td>
<td>28</td>
<td></td>
</tr>
<tr>
<td>Outpatient treatment</td>
<td>28</td>
<td>22</td>
<td>35</td>
<td>22</td>
<td>28</td>
<td></td>
</tr>
<tr>
<td><strong>Marital status</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married/live together with partner</td>
<td>23</td>
<td>15</td>
<td>31</td>
<td>24</td>
<td>13 ***</td>
<td></td>
</tr>
</tbody>
</table>

*** p ≤ 0.001; ** p ≤ 0.01; * p ≤ 0.05; (*) p ≤ 0.10 (differences across client groups).

Alcohol and drug user categorization is based on consumption, dependence (ICD-10) and/or alcohol- or drug-related life area problems (see *A classification of clients*...).
Table 1b. Clients’ (n=1865) background and demographic characteristics, total and by alcohol and/or drug user, percentages/years/mean and significance levels based on ANOVA (weighted data).

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Neither</th>
<th>Alcohol</th>
<th>Drugs</th>
<th>Alcohol + drugs</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1865</td>
<td>291</td>
<td>808</td>
<td>502</td>
<td>264</td>
<td></td>
</tr>
<tr>
<td>Have children &lt; 18 years old</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>33</td>
<td>29</td>
<td>25</td>
<td>46</td>
<td>33</td>
<td>***</td>
</tr>
<tr>
<td>Main housing (30 days)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Own place to live</td>
<td>52</td>
<td>38</td>
<td>70</td>
<td>29</td>
<td>50</td>
<td>***</td>
</tr>
<tr>
<td>Subletting</td>
<td>4</td>
<td>3</td>
<td>4</td>
<td>6</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Stay at parents’ or relatives’ house, housing collective etc.</td>
<td>14</td>
<td>12</td>
<td>6</td>
<td>23</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>Arranged by authorities</td>
<td>13</td>
<td>38</td>
<td>11</td>
<td>11</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Homeless</td>
<td>15</td>
<td>7</td>
<td>9</td>
<td>28</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>Other alternative</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Occupation: work (30 days)</td>
<td>18</td>
<td>20</td>
<td>23</td>
<td>10</td>
<td>16</td>
<td>***</td>
</tr>
<tr>
<td>How often drank 12 drinks in one day (last year)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not at all</td>
<td>33</td>
<td>77</td>
<td>11</td>
<td>75</td>
<td>9</td>
<td>***</td>
</tr>
<tr>
<td>At least once a year</td>
<td>14</td>
<td>16</td>
<td>11</td>
<td>19</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>At least once a month</td>
<td>10</td>
<td>7</td>
<td>12</td>
<td>6</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>At least weekly</td>
<td>25</td>
<td>-</td>
<td>32</td>
<td>-</td>
<td>40</td>
<td></td>
</tr>
<tr>
<td>Daily</td>
<td>19</td>
<td>-</td>
<td>29</td>
<td>-</td>
<td>27</td>
<td></td>
</tr>
<tr>
<td>Mean no. of drug using days, last 30 days</td>
<td>10</td>
<td>.2</td>
<td>.1</td>
<td>25.1</td>
<td>15.5</td>
<td></td>
</tr>
<tr>
<td>Mean no. of days in treatment, last year</td>
<td>66</td>
<td>100</td>
<td>45</td>
<td>84</td>
<td>73</td>
<td></td>
</tr>
</tbody>
</table>

*** p ≤ 0.001; ** p ≤ 0.01; * p ≤ 0.05; (*) p ≤ 0.10 (differences across client groups).

Alcohol and drug user categorization is based on consumption, dependence (ICD-10) and/or alcohol- or drug-related life area problems (see A classification of clients…).
Table 2. Views of staff working with alcohol and drug users in the social services (n=574) and health-based (n=344) alcohol and drug treatment system in Stockholm County, percentages.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Social services</th>
<th>Health system</th>
</tr>
</thead>
<tbody>
<tr>
<td>There are treatments which are successful with people who want to cut down or quit drinking.</td>
<td>97</td>
<td>97</td>
</tr>
<tr>
<td>There are treatments which are successful with people who want to cut down or quit using drugs altogether.</td>
<td>97</td>
<td>98</td>
</tr>
<tr>
<td>Anyone would find it embarrassing to ask for help for a drinking problem.</td>
<td>71</td>
<td>70</td>
</tr>
<tr>
<td>Anyone would find it embarrassing to ask for help for a drug problem.</td>
<td>64</td>
<td>64</td>
</tr>
<tr>
<td>Treatment for alcoholism only works if the drinker wants it to work.</td>
<td>98</td>
<td>95</td>
</tr>
<tr>
<td>Treatment for drug addiction only works if the user wants it to work.</td>
<td>97</td>
<td>94</td>
</tr>
<tr>
<td>I often have to convince the clients/patients that they have a problem.</td>
<td>48</td>
<td>45</td>
</tr>
<tr>
<td>I often have to motivate the clients/patients to want to do something about their problems.</td>
<td>84</td>
<td>78</td>
</tr>
<tr>
<td>If clients/patients stop drinking or using drugs, their lives will always become better.</td>
<td>93</td>
<td>93</td>
</tr>
<tr>
<td>I feel strong empathy with our clients/patients; I can imagine what it is like to be in their shoes.</td>
<td>92</td>
<td>90</td>
</tr>
<tr>
<td>This is a work place where I want to stay for a long time.</td>
<td>86</td>
<td>81</td>
</tr>
<tr>
<td>In my work, I feel that I get to help people and do something good.</td>
<td>95</td>
<td>92</td>
</tr>
</tbody>
</table>

Table 3. Staff views on and clients’ stated treatment goals regarding alcohol and drug use, percentages and significance levels based on ANOVA (weighted client data).

<table>
<thead>
<tr>
<th></th>
<th>Treatment staff</th>
<th>Clients</th>
<th>Social services</th>
<th>Health System</th>
<th>Total</th>
<th>Neither</th>
<th>Alcohol</th>
<th>Drugs</th>
<th>Alcohol + drugs</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Staff: A typical client/patient...</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Clients: I...</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>...want to stop using alcohol altogether.</td>
<td>10</td>
<td>13</td>
<td>53</td>
<td>45</td>
<td>58</td>
<td>57</td>
<td>42</td>
<td></td>
<td></td>
<td>***</td>
</tr>
<tr>
<td>...want to cut down on my drinking, or get it under control.</td>
<td>59</td>
<td>65</td>
<td>40</td>
<td>43</td>
<td>39</td>
<td>30</td>
<td>45</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>...want to eliminate any problems caused by drinking, whether or not my drinking changes.</td>
<td>31</td>
<td>23</td>
<td>6</td>
<td>13</td>
<td>4</td>
<td>13</td>
<td>13</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drugs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>...want to stop using drugs altogether.</td>
<td>37</td>
<td>34</td>
<td>71</td>
<td>81</td>
<td>58</td>
<td>72</td>
<td>70</td>
<td></td>
<td></td>
<td>***</td>
</tr>
<tr>
<td>...want to cut down on my drug use, or get it under control.</td>
<td>38</td>
<td>22</td>
<td>12</td>
<td>8</td>
<td>20</td>
<td>8</td>
<td>23</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>...want to eliminate any problems caused by drug use, whether or not my drug use changes.</td>
<td>28</td>
<td>17</td>
<td>4</td>
<td>2</td>
<td>11</td>
<td>3</td>
<td>5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>...want to get methadone or other substitute medication.</td>
<td>7</td>
<td>28</td>
<td>13</td>
<td>8</td>
<td>11</td>
<td>18</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*** p ≤ 0,001; ** p ≤ 0,01; * p ≤ 0,05; (*) p ≤ 0.10 (differences across client groups).
Table 4. Kind of help clients (n=1865) wanted when entering treatment, total and by alcohol and/or drug user, percentages and significance levels based on ANOVA (weighted data).

<table>
<thead>
<tr>
<th>Proportion of clients who wanted…</th>
<th>Total</th>
<th>Neither</th>
<th>Alcohol</th>
<th>Drugs</th>
<th>Alcohol + drugs</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1865</td>
<td>291</td>
<td>808</td>
<td>502</td>
<td>264</td>
<td></td>
</tr>
<tr>
<td>… detoxification, getting “clean” from alcohol/drugs</td>
<td>32</td>
<td>11</td>
<td>31</td>
<td>43</td>
<td>39</td>
<td>***</td>
</tr>
<tr>
<td>… methadone maintenance or other opiate substitution</td>
<td>12</td>
<td>3</td>
<td>&lt;.5</td>
<td>39</td>
<td>9</td>
<td>***</td>
</tr>
<tr>
<td>… other alcohol/drug treatment with medications (e.g. sedatives, antabuse)</td>
<td>38</td>
<td>23</td>
<td>52</td>
<td>25</td>
<td>38</td>
<td>***</td>
</tr>
<tr>
<td>… counselling/talk therapy about alcohol and drugs, relapse and treatment</td>
<td>63</td>
<td>49</td>
<td>67</td>
<td>63</td>
<td>67</td>
<td>***</td>
</tr>
<tr>
<td>… counselling/talk therapy about conditions of life (relationship problems, aggression training, etc.)</td>
<td>64</td>
<td>56</td>
<td>61</td>
<td>67</td>
<td>76</td>
<td>***</td>
</tr>
<tr>
<td>… practical help with daily life (social allowances, clothes, housing, education, job, etc.)</td>
<td>59</td>
<td>53</td>
<td>48</td>
<td>76</td>
<td>71</td>
<td>***</td>
</tr>
<tr>
<td>… treatment for physical troubles (health problems)</td>
<td>31</td>
<td>18</td>
<td>32</td>
<td>38</td>
<td>34</td>
<td>***</td>
</tr>
<tr>
<td>Proportion who believe they will receive the help they want</td>
<td>70</td>
<td>67</td>
<td>77</td>
<td>65</td>
<td>63</td>
<td>***</td>
</tr>
</tbody>
</table>

*** p ≤ 0,001; ** p ≤ 0,01; * p ≤ 0,05; (*) p ≤ 0.10 (differences across client groups).
Table 5. Clients (n=1865) reasons for not coming to treatment (earlier), total and by alcohol and/or drug user, percentages and significance levels based on ANOVA (weighted client data); and reasons for not seeking treatment reported by drug (opiate) user not in treatment (ROSE), percentages.

<table>
<thead>
<tr>
<th>Proportion of clients/opiate users who did not come to treatment because…</th>
<th>Total</th>
<th>Neither</th>
<th>Alcohol</th>
<th>Drugs</th>
<th>Alcohol + drugs</th>
<th>Sig.</th>
<th>ROSE (not in treatment)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1865</td>
<td>291</td>
<td>808</td>
<td>502</td>
<td>264</td>
<td>73</td>
<td></td>
</tr>
<tr>
<td>I did not think my problem was that serious.</td>
<td>54</td>
<td>61</td>
<td>55</td>
<td>50</td>
<td>52</td>
<td>*</td>
<td>11</td>
</tr>
<tr>
<td>I did not want to stop drinking or using drugs.</td>
<td>58</td>
<td>53</td>
<td>59</td>
<td>58</td>
<td>57</td>
<td>ns.</td>
<td>21</td>
</tr>
<tr>
<td>I was concerned about what other people would think of me.</td>
<td>49</td>
<td>33</td>
<td>51</td>
<td>46</td>
<td>54</td>
<td>***</td>
<td>19</td>
</tr>
<tr>
<td>I did not think treatment would help me.</td>
<td>44</td>
<td>50</td>
<td>43</td>
<td>44</td>
<td>44</td>
<td>(*)</td>
<td>21</td>
</tr>
<tr>
<td>I felt I could handle my problem myself.</td>
<td>58</td>
<td>80</td>
<td>56</td>
<td>55</td>
<td>55</td>
<td>***</td>
<td>17</td>
</tr>
<tr>
<td>I felt I had too many responsibilities at home.</td>
<td>30</td>
<td>23</td>
<td>30</td>
<td>29</td>
<td>33</td>
<td>*</td>
<td>8</td>
</tr>
<tr>
<td>I felt I had too many responsibilities at work.</td>
<td>22</td>
<td>18</td>
<td>26</td>
<td>15</td>
<td>24</td>
<td>***</td>
<td>1</td>
</tr>
<tr>
<td>I was afraid I would lose custody of my children.</td>
<td>11</td>
<td>16</td>
<td>8</td>
<td>18</td>
<td>10</td>
<td>***</td>
<td>4</td>
</tr>
<tr>
<td>There was nobody to take care of my children.</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>4</td>
<td>4</td>
<td>ns.</td>
<td>1</td>
</tr>
<tr>
<td>My family or someone in my family did not want me to seek treatment. □</td>
<td>5</td>
<td>2</td>
<td>6</td>
<td>3</td>
<td>8</td>
<td>*</td>
<td>-</td>
</tr>
<tr>
<td>My living situation was such that I could not get it together to seek help. □</td>
<td>51</td>
<td>34</td>
<td>44</td>
<td>57</td>
<td>64</td>
<td>***</td>
<td>50</td>
</tr>
</tbody>
</table>

*** p ≤ 0.001; ** p ≤ 0.01; * p ≤ 0.05; (*) p ≤ 0.10 (differences across client groups).
□ Not asked of the health system sample.
Table 6. Clients (n=1865) reasons for coming to treatment, total and by alcohol and/or drug user, percentages and significance levels based on ANOVA (weighted data).

<table>
<thead>
<tr>
<th>Proportion of clients who came to treatment because…</th>
<th>Total</th>
<th>Neither</th>
<th>Alcohol</th>
<th>Drugs</th>
<th>Alcohol + Drugs</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1865</td>
<td>291</td>
<td>808</td>
<td>502</td>
<td>264</td>
<td></td>
</tr>
<tr>
<td>It was my own idea to come to treatment.</td>
<td>81</td>
<td>68</td>
<td>84</td>
<td>80</td>
<td>83</td>
<td>***</td>
</tr>
<tr>
<td>I wanted practical help with my daily life.</td>
<td>60</td>
<td>56</td>
<td>55</td>
<td>62</td>
<td>70</td>
<td></td>
</tr>
<tr>
<td>I wanted help in making my life more rewarding or serene.</td>
<td>89</td>
<td>73</td>
<td>90</td>
<td>88</td>
<td>93</td>
<td>***</td>
</tr>
<tr>
<td>I wanted to recover from a long period of being ill and not feeling well.</td>
<td>41</td>
<td>14</td>
<td>44</td>
<td>38</td>
<td>48</td>
<td>***</td>
</tr>
<tr>
<td>I wanted a little respite; things just got too complicated.</td>
<td>69</td>
<td>45</td>
<td>71</td>
<td>63</td>
<td>82</td>
<td>***</td>
</tr>
<tr>
<td>Someone I care about said I had to come if we were going to stay connected.</td>
<td>49</td>
<td>33</td>
<td>52</td>
<td>50</td>
<td>50</td>
<td>***</td>
</tr>
<tr>
<td>I was told to come if I wanted to keep my job.</td>
<td>5</td>
<td>-</td>
<td>7</td>
<td>2</td>
<td>4</td>
<td>***</td>
</tr>
<tr>
<td>I was told to come if I did not want to lose my social allowance.</td>
<td>9</td>
<td>3</td>
<td>7</td>
<td>11</td>
<td>11</td>
<td>***</td>
</tr>
<tr>
<td>I was told to come if I did not want to lose my place to live, unemployment benefit, temporary sickness allowance or other support.</td>
<td>10</td>
<td>19</td>
<td>10</td>
<td>10</td>
<td>6</td>
<td>***</td>
</tr>
<tr>
<td>I was warned that I would loose custody of my child(ren) if I did not come to treatment.</td>
<td>4</td>
<td>2</td>
<td>4</td>
<td>5</td>
<td>4</td>
<td>ns.</td>
</tr>
<tr>
<td>The police or some other authority brought me here.</td>
<td>12</td>
<td>9</td>
<td>7</td>
<td>21</td>
<td>12</td>
<td>***</td>
</tr>
<tr>
<td>I was told to come if I wanted to avoid jail or other consequences.</td>
<td>8</td>
<td>9</td>
<td>3</td>
<td>14</td>
<td>11</td>
<td>***</td>
</tr>
<tr>
<td>I wanted to avoid compulsory treatment.</td>
<td>18</td>
<td>6</td>
<td>16</td>
<td>20</td>
<td>22</td>
<td>***</td>
</tr>
<tr>
<td>I was committed to compulsory treatment.</td>
<td>10</td>
<td>6</td>
<td>6</td>
<td>21</td>
<td>4</td>
<td>***</td>
</tr>
<tr>
<td>Someone reported to the social services that I have a problem.</td>
<td>24</td>
<td>10</td>
<td>23</td>
<td>34</td>
<td>23</td>
<td>***</td>
</tr>
<tr>
<td>I was referred here or sent here from another unit.</td>
<td>62</td>
<td>64</td>
<td>62</td>
<td>59</td>
<td>64</td>
<td>ns.</td>
</tr>
<tr>
<td>I wanted to lower my tolerance for drugs so that my drug use would be less expensive.</td>
<td>3</td>
<td>3</td>
<td>&lt;.5</td>
<td>5</td>
<td>5</td>
<td>*</td>
</tr>
</tbody>
</table>

*** p ≤ 0.001; ** p ≤ 0.01; * p ≤ 0.05; (*) p ≤ 0.10 (differences across client groups).

Not asked of the health system sample.
Table 7. Clients (n=1865) who reported that the following people/agencies suggested to them to seek treatment prior to treatment entry, total and by alcohol and/or drug user, percentages and significance levels based on ANOVA (weighted data).

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Neither</th>
<th>Alcohol</th>
<th>Drugs</th>
<th>Alcohol + drugs</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1865</td>
<td>291</td>
<td>808</td>
<td>502</td>
<td>264</td>
<td></td>
</tr>
<tr>
<td>Your partner/spouse</td>
<td>35</td>
<td>26</td>
<td>33</td>
<td>38</td>
<td>38</td>
<td>*</td>
</tr>
<tr>
<td>Somebody else in your family</td>
<td>43</td>
<td>34</td>
<td>37</td>
<td>55</td>
<td>44</td>
<td>***</td>
</tr>
<tr>
<td>A friend</td>
<td>35</td>
<td>28</td>
<td>31</td>
<td>38</td>
<td>43</td>
<td>***</td>
</tr>
<tr>
<td>Your employer</td>
<td>8</td>
<td>4</td>
<td>10</td>
<td>4</td>
<td>8</td>
<td>***</td>
</tr>
<tr>
<td>Somebody else at work</td>
<td>8</td>
<td>12</td>
<td>8</td>
<td>5</td>
<td>8</td>
<td>*</td>
</tr>
<tr>
<td>Someone in the health system (incl. Dependence unit, psychiatry, primary care)</td>
<td>37</td>
<td>22</td>
<td>39</td>
<td>38</td>
<td>36</td>
<td>***</td>
</tr>
<tr>
<td>Someone in the social services</td>
<td>44</td>
<td>54</td>
<td>32</td>
<td>58</td>
<td>48</td>
<td>***</td>
</tr>
<tr>
<td>Probation officer</td>
<td>8</td>
<td>12</td>
<td>2</td>
<td>19</td>
<td>8</td>
<td>***</td>
</tr>
<tr>
<td>Court</td>
<td>7</td>
<td>7</td>
<td>3</td>
<td>16</td>
<td>6</td>
<td>***</td>
</tr>
<tr>
<td>Lawyer</td>
<td>5</td>
<td>7</td>
<td>2</td>
<td>12</td>
<td>4</td>
<td>***</td>
</tr>
<tr>
<td>Probation officer, court and/or lawyer</td>
<td>12</td>
<td>16</td>
<td>4</td>
<td>23</td>
<td>12</td>
<td>***</td>
</tr>
</tbody>
</table>

*** p ≤ 0,001; ** p ≤ 0,01; * p ≤ 0,05; (*) p ≤ 0.10 (differences across client groups).
Table 8. Events in the last year that contributed to treatment among clients (n=1865), total and by alcohol and/or drug user, percentages and significance levels based on ANOVA (weighted data).

<table>
<thead>
<tr>
<th>Event</th>
<th>Total</th>
<th>Neither</th>
<th>Alcohol</th>
<th>Drugs</th>
<th>Alcohol + drugs</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Had serious arguments with family members or others close to you about your drinking or drug use, or the effect it was having on those around you.</td>
<td>32</td>
<td>7</td>
<td>30</td>
<td>33</td>
<td>41</td>
<td>***</td>
</tr>
<tr>
<td>Your boss or supervisor (or teacher) made serious complaints about your work or attendance at work, related to your drinking or drug use?</td>
<td>9</td>
<td>1</td>
<td>12</td>
<td>5</td>
<td>12</td>
<td>***</td>
</tr>
<tr>
<td>A doctor or other health worker told you that you had serious problems connected to your drinking or drug use.</td>
<td>30</td>
<td>6</td>
<td>33</td>
<td>28</td>
<td>34</td>
<td>***</td>
</tr>
<tr>
<td>Were picked up and brought somewhere for public drunkenness or with a drug overdose.</td>
<td>10</td>
<td>-</td>
<td>6</td>
<td>13</td>
<td>19</td>
<td>***</td>
</tr>
<tr>
<td>Had trouble with the police about being involved in using, buying or selling drugs.</td>
<td>10</td>
<td>3</td>
<td>1</td>
<td>25</td>
<td>14</td>
<td>***</td>
</tr>
<tr>
<td>Were arrested for drinking-driving.</td>
<td>3</td>
<td>1</td>
<td>4</td>
<td>3</td>
<td>3</td>
<td>ns.</td>
</tr>
<tr>
<td>Had an overdose or an occasion of particularly heavy drug use that alarmed you.</td>
<td>13</td>
<td>1</td>
<td>&lt;.5</td>
<td>26</td>
<td>25</td>
<td>***</td>
</tr>
<tr>
<td>Had an alcoholic blackout, DTs (delirium tremens) or an occasion of particularly heavy drinking that alarmed you.</td>
<td>26</td>
<td>3</td>
<td>40</td>
<td>2</td>
<td>34</td>
<td>***</td>
</tr>
<tr>
<td>A friend of yours went into alcohol or drug treatment.</td>
<td>16</td>
<td>8</td>
<td>11</td>
<td>19</td>
<td>24</td>
<td>***</td>
</tr>
</tbody>
</table>

*** p ≤ 0.001; ** p ≤ 0.01; * p ≤ 0.05; (*) p ≤ 0.10 (differences across client groups).
Table 9. Views on alcohol and drug treatment among clients (n=1865), total and by alcohol and/or drug user, percentages and significance levels based on ANOVA (weighted data).

<table>
<thead>
<tr>
<th>Proportion of clients who agreed with the following statements</th>
<th>Total</th>
<th>Neither</th>
<th>Alcohol</th>
<th>Drugs</th>
<th>Alcohol + drugs</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1865</td>
<td>291</td>
<td>808</td>
<td>502</td>
<td>264</td>
<td></td>
</tr>
<tr>
<td>Alcohol</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcoholics must give up alcohol entirely in order to overcome</td>
<td>93</td>
<td>87</td>
<td>93</td>
<td>96</td>
<td>94</td>
<td>***</td>
</tr>
<tr>
<td>their misuse.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A person’s drinking is his own business, and no concern of</td>
<td>40</td>
<td>40</td>
<td>35</td>
<td>48</td>
<td>37</td>
<td>***</td>
</tr>
<tr>
<td>the community.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>There are treatments which are successful with people who</td>
<td>90</td>
<td>91</td>
<td>90</td>
<td>91</td>
<td>88</td>
<td>ns</td>
</tr>
<tr>
<td>want to cut down or quit drinking.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sometimes it is necessary to force someone into alcohol</td>
<td>82</td>
<td>78</td>
<td>82</td>
<td>80</td>
<td>87</td>
<td>*</td>
</tr>
<tr>
<td>treatment for their own good.</td>
<td></td>
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<tr>
<td>Anyone would find it embarrassing to ask for help for a</td>
<td>71</td>
<td>76</td>
<td>70</td>
<td>67</td>
<td>73</td>
<td>(*)</td>
</tr>
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<td>drinking problem.</td>
<td></td>
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</tr>
<tr>
<td>Treatment for alcoholism only works if the drinker wants it</td>
<td>99</td>
<td>99</td>
<td>99</td>
<td>97</td>
<td>99</td>
<td>ns</td>
</tr>
<tr>
<td>to work.</td>
<td></td>
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<tr>
<td>Drugs</td>
<td>95</td>
<td>96</td>
<td>97</td>
<td>95</td>
<td>92</td>
<td>**</td>
</tr>
<tr>
<td>Drug addicts must give up drug use entirely in order to</td>
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<tr>
<td>overcome their misuse.</td>
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<td></td>
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</tr>
<tr>
<td>Whether a person uses drugs is his own business, and no</td>
<td>35</td>
<td>33</td>
<td>28</td>
<td>43</td>
<td>40</td>
<td>***</td>
</tr>
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<td>concern of the community.</td>
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<td></td>
</tr>
<tr>
<td>There are treatments which are successful with people who</td>
<td>92</td>
<td>89</td>
<td>93</td>
<td>93</td>
<td>93</td>
<td>ns</td>
</tr>
<tr>
<td>want to cut down or quit using drugs altogether.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sometimes it is necessary to force someone into drug</td>
<td>85</td>
<td>88</td>
<td>88</td>
<td>79</td>
<td>86</td>
<td>***</td>
</tr>
<tr>
<td>treatment for their own good.</td>
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<tr>
<td>Anyone would find it embarrassing to ask for help for a</td>
<td>70</td>
<td>79</td>
<td>71</td>
<td>62</td>
<td>74</td>
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<td>drug problem.</td>
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<tr>
<td>Treatment for drug addiction only works if the user wants it</td>
<td>99</td>
<td>99</td>
<td>99</td>
<td>98</td>
<td>99</td>
<td>ns</td>
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<tr>
<td>to work.</td>
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</tbody>
</table>

*** p ≤ 0.001; ** p ≤ 0.01; * p ≤ 0.05; (*) p ≤ 0.10 (differences across client groups).
Table 10. Views on alcohol and drug treatment in the adult general population of Stockholm County, total percentages and by those screened in and out as high consumers (with high consumption, having experienced problems, etc.).

<table>
<thead>
<tr>
<th>Proportion of general population who agreed with the following statements</th>
<th>Total sample</th>
<th>Screened out</th>
<th>Screened in: high consumer</th>
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<tbody>
<tr>
<td><strong>Alcohol</strong></td>
<td></td>
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<tr>
<td>Alcoholics must give up alcohol entirely in order to overcome their misuse.</td>
<td>543</td>
<td>90</td>
<td>90</td>
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<tr>
<td>A person’s drinking is his own business, and no concern of the community.</td>
<td>561</td>
<td>35</td>
<td>30</td>
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<tr>
<td>There are treatments which are successful with people who want to cut down or quit drinking.</td>
<td>526</td>
<td>96</td>
<td>95</td>
</tr>
<tr>
<td>Sometimes it is necessary to force someone into alcohol treatment for their own good.</td>
<td>568</td>
<td>86</td>
<td>86</td>
</tr>
<tr>
<td>Anyone would find it embarrassing to ask for help for a drinking problem.</td>
<td>561</td>
<td>75</td>
<td>77</td>
</tr>
<tr>
<td>Treatment for alcoholism only works if the drinker wants it to work.</td>
<td>564</td>
<td>98</td>
<td>97</td>
</tr>
<tr>
<td><strong>Drugs</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drug addicts must give up drug use entirely in order to overcome their misuse.</td>
<td>572</td>
<td>94</td>
<td>96</td>
</tr>
<tr>
<td>Whether a person uses drugs is his own business, and no concern of the community.</td>
<td>570</td>
<td>26</td>
<td>25</td>
</tr>
<tr>
<td>There are treatments which are successful with people who want to cut down/quit using drugs altogether.</td>
<td>535</td>
<td>95</td>
<td>95</td>
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<tr>
<td>Sometimes it is necessary to force someone into drug treatment for their own good.</td>
<td>580</td>
<td>92</td>
<td>93</td>
</tr>
<tr>
<td>Anyone would find it embarrassing to ask for help for a drug problem.</td>
<td>560</td>
<td>72</td>
<td>74</td>
</tr>
<tr>
<td>Treatment for drug addiction only works if the user wants it to work.</td>
<td>567</td>
<td>96</td>
<td>95</td>
</tr>
<tr>
<td><strong>It is somewhat or very likely that treatment in...</strong></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>...self-help groups (AA, NA) helps those with alcohol or drug problems.</td>
<td>1093</td>
<td>94</td>
<td>95</td>
</tr>
<tr>
<td>...the private sector helps those with alcohol or drug problems.</td>
<td>991</td>
<td>82</td>
<td>81</td>
</tr>
<tr>
<td>...the health-based system helps those with alcohol or drug problems.</td>
<td>921</td>
<td>69</td>
<td>70</td>
</tr>
<tr>
<td>...the social services helps those with alcohol or drug problems.</td>
<td>978</td>
<td>44</td>
<td>44</td>
</tr>
<tr>
<td>...LVM helps those with alcohol or drug problems.</td>
<td>1017</td>
<td>49</td>
<td>49</td>
</tr>
<tr>
<td>...the criminal justice system helps those with alcohol or drug problems.</td>
<td>1004</td>
<td>25</td>
<td>27</td>
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</tbody>
</table>
Dissertations at the Centre for Social Research on Alcohol and Drugs (SoRAD), Stockholm University


2. BJÖRN TROLLDAL (2005) Availability and Sales of Alcohol: Experiences from Canada and the U.S. Stockholm University: Department of Sociology.


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