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Use or Misuse? Addiction Care Practitioners’ Perceptions of Substance Use and Treatment
Eva Samuelsson
No. 30
Use or Misuse?

Addiction Care Practitioners’ Perceptions of Substance Use and Treatment

Eva Samuelsson
List of papers


IV. Samuelsson, E. Substance use and treatment needs: Constructions of gender in Swedish addiction care. (submitted)

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Abstract

The aim of this thesis has been to study boundary-making in addiction care practitioner’s perceptions of substance use and treatment. The four papers are based on three data collections in Swedish outpatient addiction care: a) a survey conducted in 2006 (n=655), b) a factorial survey using randomly constructed vignettes conducted in 2011 (n=474), and c) a focus group interview study from 2013 (n=30) with a sample of the respondents from the factorial survey.

The analyses show that practitioners tend to draw boundaries between various forms of substance use, with alcohol use being perceived as a less severe problem than narcotics use and requiring less extensive treatment measures. There are also partially varying perceptions in different parts of addiction care. By comparison with social services staff, regional healthcare staff generally see a greater need for treatment, recommend medical treatment to a greater extent, and display less confidence in the possibility of handling problematic use without professional treatment. Despite an ongoing medicalization at the policy level, psychosocial treatment interventions appear to have legitimacy in both regional healthcare and social services settings.

Boundary-making processes are also found in relation to the specific user’s age, family situation, socio-economic status and in some cases gender, with young women’s drinking being seen as more severe than young men’s drinking for example. The boundary-making between different substance users may be interpreted as a sign of an approach based on a professional consideration of the person’s socially exposed situation, which might require more comprehensive support. At the same time, it may be an expression of a stereotyped approach, involving a normative evaluation of women’s behaviour as being more deviant than men’s, thereby having a limiting effect on the conduct norms that regulate women’s behaviour and making the problems of men invisible. To avoid disparities in addiction care delivery, it is of major importance that practitioners are given room to reflect upon the assumptions and values that underlie the assessments they make in practice. Combining a factorial survey with focus group interviews is proposed as one means of facilitating this type of reflection.

Keywords: substance use, treatment, practitioners’ perceptions, social services, regional healthcare, factorial survey, multi-level analysis, focus group interviews, discourse analysis, Sweden
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### Abbreviations

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<tr>
<td>APA</td>
<td>American Psychiatric Association</td>
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<td>ASI</td>
<td>Addiction Severity Index</td>
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<td>AUDIT</td>
<td>Alcohol Use Disorder Identification Test</td>
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<tr>
<td>CAN</td>
<td>The Swedish Council for Information on Alcohol and Other Drugs</td>
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<tr>
<td>DSM</td>
<td>Diagnostic and Statistical Manual of Mental Disorders</td>
</tr>
<tr>
<td>DUDIT</td>
<td>Drug Use Disorders Identification Test</td>
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<tr>
<td>ICD</td>
<td>International Classification of Diseases</td>
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<tr>
<td>EBP</td>
<td>Evidence-based Practice</td>
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<td>FSA</td>
<td>Factorial Survey Approach</td>
</tr>
<tr>
<td>Forte</td>
<td>The Swedish Research Council for Health, Working Life and Welfare (former FAS)</td>
</tr>
<tr>
<td>HLM</td>
<td>Hierarchical Linear Modelling</td>
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<tr>
<td>NBHW</td>
<td>National Board of Health and Welfare</td>
</tr>
<tr>
<td>NPM</td>
<td>New Public Management</td>
</tr>
<tr>
<td>PHAS</td>
<td>Public Health Agency of Sweden</td>
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<tr>
<td>SBF</td>
<td>Swedish Drug Users’ Union</td>
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<tr>
<td>SBU</td>
<td>The Swedish Council on Health Technology Assessment</td>
</tr>
<tr>
<td>SoRAD</td>
<td>Centre for Social Research on Alcohol and Drugs</td>
</tr>
<tr>
<td>SOU</td>
<td>Swedish Government Official Report</td>
</tr>
<tr>
<td>SALAR</td>
<td>Swedish Association of Local Authorities and Regions</td>
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Introduction

An alcohol problem can be seen in any of a number of ways: as a sin, as a crime, as a disease, as a result of deprivation, as a failure of social planning, as a consequence of the social or economic system. Its handling will accordingly tend to be defined as a matter for priests, for lawyers, for doctors, for social workers, for social planners, for revolutionaries (Room 1978:18).

This thesis studies addiction care practitioners’ perceptions of substance use and treatment needs. The definitions, solutions and norms that regulate substance use are subject to historical and cultural variation. In the Anglo-Saxon countries, substance use problems are predominantly handled as a disease and as a medical problem. In countries such as Finland and Sweden, excessive alcohol consumption has traditionally been comprehended largely as a social problem and handled within the framework of the social legislation (Bruun, 1971; Takala & Lehto, 1992). Social workers have had a central role and psychosocial interventions have focused on integrating marginalised individuals with substance use problems into society (Stenius, 1999). At the beginning of the 20th century excessive use of narcotics was viewed from a medical perspective and was not regarded as a problem in the same way as alcohol. Today this situation has more or less been reversed. All use of narcotics is criminalized and drug use is viewed as a serious social problem. Alcohol consumption and intoxication are instead viewed as being normal, within certain limits (Billinger & Hübner, 2009).

As a result of the development of Swedish addiction care over the last century, the responsibility for handling substance use problems is divided between the social services and the regional healthcare system. Over the last decade, Swedish addiction care has been subjected to increasing demands to introduce evidence-based practice (EBP). This idea was first expressed in 2001 in a research review presented by the Swedish Council on Health Technology Assessment (SBU). In addition, the national guidelines for addiction care, which were issued in 2007 and are currently under review, include recommendations for effective treatment interventions directed at the main actors in the addiction care field, including the municipal social services and the regional healthcare system (National Board of Health and Welfare [NBHW], 2007; 2014). The call for evidence-based practice in addiction care is rooted in a medical approach and is based on an individualistic view of substance use problems, which assumes that having such prob-
lems may be regarded as a uniform state that can be correctly diagnosed and resolved by means of the best available interventions. In 2011, a governmental inquiry presented a report (SOU 2011:35) proposing a far-reaching remodelling of Swedish addiction care and arguing for a transfer of the responsibility for treatment from the social services to regional healthcare, thereby representing a break with the traditional non-medical model (Bergmark, 2012; Storbjörk, 2014). Even though the majority of the proposals in the report have not been implemented in practice, these initiatives indicate that addiction care is a highly contested field, and that there is substantial disagreement about how substance use problems should be understood and dealt with (Blomqvist, 2012; Storbjörk, 2014). It is therefore very relevant to pose the question of how and to what extent perceptions of substance use and treatment differ between practitioners in different parts of the contemporary Swedish addiction care system.

Definitions of a problem have practical consequences in terms of the way care provision is designed and what is prioritised and thus also for the interventions offered to people with substance use problems (cf. Sutton, 1998). Addiction care practitioners may be viewed as street-level bureaucrats (cf. Lipsky, 1980), whose perceptions are important determinants of their use of discretion when categorising individuals and assessing whether they are eligible or ineligible for the various interventions that may be provided (Keiser, 1999). The lack of consensus as to what constitute substance use problems and how they should be dealt with, together with the discretionary powers exercised by practitioners, thus make practitioners and their perceptions an interesting case for study.

Over recent years, a greater responsibility has been assigned to individuals to deal with their substance use themselves. This change can be seen as a result of an increasing availability of substances in society and the fact that the alcohol policy has become less restrictive (see e.g. Hellman, Roos & von Wright, 2012). In addition, more continental drinking patterns have developed alongside the weekend binge drinking that previously characterised Swedish alcohol culture (Tryggvesson, 2013). Further, tendencies towards a more liberal view of cannabis can be discerned among youths (CAN, 2012). At the official level, specific attention has been given to certain “risk groups”, such as women, young people and immigrants (SOU 2011:35). In times when consumption patterns are changing and a greater responsibility is being placed upon the individual, it is relevant to study how perceptions of substance use and treatment are influenced by who the user is in terms of social categories such as age, gender, ethnicity and socio-economic status (cf. Fahlgren & Sawyer, 2005).

The thesis employs the concept of boundary-making processes (Lamont & Molnár, 2002) in order to describe the distinctions made in addiction care practitioners’ perceptions and assumptions about substance use and treatment. These distinctions are contested and are used to categorise individuals
and behaviours and they are therefore crucial to be able to understand the social processes involved in the definition and handling of substance use problems.

Aim

The overall aim of the thesis is to study boundary-making processes in three respects: a) boundary-making in the form of differences in the ways substance use problems and their solutions are perceived between different parts of the addiction care system – the social services, regional healthcare and to some extent probation services, b) boundary-making in relation to different substances in terms of severity, the need for treatment and the possibility of recovery, and c) boundary-making based on social categories such as gender, age, socio-economic status and ethnicity. More specifically, the four papers included in the thesis answer the following questions:

I. How do practitioners perceive the severity of different forms of substance use problems as societal problems, the risk of becoming addicted, and the possibility of recovering with and without treatment?

II. To what extent and how are practitioners’ perceptions of the severity of substance use influenced by various factors related to the use, the user, the practitioner and the work organisation of the practitioner?

III. To what extent and how are practitioners’ perceptions of treatment needs influenced by various factors related to the use, the user, the practitioner and the work organisation of the practitioner?

IV. How do addiction care practitioners relate to a gender-specific approach and what are the central discourses and dilemmas that manifest themselves in practitioners’ approaches to substance use and treatment needs?

Data collection procedure

The material examined in the thesis is based on three data collections in which both quantitative and qualitative methods have been applied. The first study (Paper I) consists of a survey conducted in 2006 in the social services, regional healthcare and probation service-based addiction care in the region of Stockholm (n=655). Secondly, a web-based questionnaire was sent to social services and regional healthcare addiction care units in the three largest urban areas of Sweden, in which staff assessed a number of fictive cases
of substance use (n=474). The study involved randomly assigned vignettes constructed in accordance with the factorial survey approach (Rossi & Nock, 1982) and was conducted in 2011. This specific method, in combination with multi-level analysis, made it possible to disentangle how and to what extent perceptions were related to factors associated with the specific user, the practitioner and the work unit (Papers II & III). Thirdly, focus group interviews were conducted in 2013 in six of the work units that had participated in the vignette study (n=30) (Paper IV). As suggested by Wallander (2012), the results from the vignette study were presented as a stimulus material and the participants were asked to reflect on the meaning and implications of the results. The purpose of combining surveys and focus group interviews was to get complementary knowledge of complex issues. The ambition in combining the two research methods has also been to encourage professional development, since the discussions may provide the practitioners with room to reflect about the assumptions underlying their own approaches to addiction care practice.

Some clarifications

Substance use problems and their solutions are viewed in this thesis as heterogeneous and as manifesting themselves in a variety of ways. The meanings and definitions of concepts such as “misuse/misuser”, “abuse/abuser”, “addiction/addicted” and “dependency/dependent” are constantly disputed. They are what Christie and Bruun (1969) have labelled *fat words* in the sense that they serve a function by being vague and thus open to use for different purposes and interests. They may also have a stigmatizing influence on those designated with such a label. In an attempt to avoid such value-laden concepts, this thesis employs the terms “substance use” “substance user” and “substance use problems”. The term “narcotics” is used to refer to non-alcoholic psychoactive substances.

In Swedish, the term commonly used to denote the care offered to people with substance use problems is “misuse and dependency care”. However, for the sake of simplicity the thesis employs the term “addiction care” in a very broad sense to describe the institutions that provide care and treatment for alcohol and drug problems organised by the state, regional healthcare, the social services, the criminal justice system, non-governmental organisations and private actors (Babor, Stenius & Romelsjö; 2008:51). The focus of the thesis is directed however at the specialised outpatient services provided by the social services, regional healthcare and to some extent probation services. The term “clients” is applied widely to refer to people who come into contact with addiction care, although “patients” is the standard term used in healthcare settings.
This thesis takes as one point of departure various studies by the cross-national research consortium “Theories of Addiction and Images of Addictive Behaviours (Images)”, which involved researchers from Canada, Finland, France, Russia and Sweden. The term “perceptions” is used in the same way as in several of the reports from this consortium, where it has been used interchangeably with terms such as “views”, “images”, “conceptions” or “beliefs” to denote the ways in which respondents understand various substance use problems and their solutions (see e.g. Blomqvist, 2009c; Blomqvist, Koski-Jännnes & Cunningham, 2014; Cunningham, Blomqvist, Koski-Jännnes & Raitasalo, 2012; Holma et al., 2011; Koski-Jännnes, Hirschovits-Gerz & Pennonen, 2012a; Sulkunen, 2007). Similarly, Marton and Svensson (1978:20) refer to perceptions (or in Swedish “uppfattningar”) as relating to what is often understood to be implied, and does not need to be said out loud, since it is seldom subject to reflection. Perceptions constitute the frame of reference on which we build our reasoning (Marton & Svensson, 1978:20) and they involve an evaluation of the object or phenomenon in question (Uljen, 1989).

The focus of the thesis is not directed at the importance of the immediate context of the decision-making that takes place (see e.g. Gabbay & le May, 2004; Rapley, 2008; Smith, 2014) in addiction care practice, but rather at the general perceptions and assumptions about substance use and treatment that are held by practitioners. The clients who come into contact with addiction care are often both socially marginalised and have severe substance use problems (Storbjörk & Room, 2008). The focus of this thesis however involves a specific interest in the boundaries between use and misuse, and in the factors that are of importance when the “normal” becomes deviant and in the variations that characterise this boundary-making process. The thesis makes no clear distinction between professional and non-professional perceptions, since perceptions about social phenomena are viewed as being culturally shared and influenced by situational, individual and societal influences. As has been argued by Gabbay and le May (2004:1), practitioners rely on “collectively reinforced, internalised tacit guidelines” in their everyday practice. Substance users who come into contact with care are therefore directly affected by the constructions and reconstructions of “the problem” that constitute practitioners’ perceptions (cf. White & Stancombe, 2003).

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1 See http://blogs.helsinki.fi/imagesofaddiction/ for information about the research consortium.
2 In social psychology, the term “social perception” relates to how an individual “sees” others and how others perceive an individual. For example, judging someone on the basis of one’s perceptions of the group to which that person belongs is referred to as stereotyping (Pickens, 2005:60).
Outline of the thesis

In the previous sections, the relevance and aim of the thesis have been presented. The context briefly described will be further developed in the following sections. The next chapter presents a description of ways in which substance use problems are frequently conceptualised. The text then moves on to an organisational overview of the Swedish addiction care system, which is followed by a description of previous research conducted in this field and then a presentation of the theoretical points of departure and concepts employed in the thesis. The methods section then explains the mixed methods design and presents a number of methodological reflections. The four articles are summarized and this is followed by a discussion of the conclusions and their practical implications. The Appendix presents the translated questionnaires from the vignette study together with the interview guide and informed consent form used in the focus group study.
Perceptions of substance use problems and their solutions

In this chapter, common ways of comprehending substance use problems and their solutions are described and related to the Swedish context. A number of dimensions are relevant for the perceptions that are held in relation to substance use problems. One such dimension concerns the extent to which the individual substance user is perceived as being a victim of circumstances that s/he cannot control, e.g. an impersonal disease process (object), or as being capable of changing a potentially problematic situation (subject). Another dimension that may influence the social handling of a problem and the division of labour between various public actors is whether an individual is seen as primarily causing harm to her/himself or to her/his environment (Mäkelä, 1980). Moreover, as has been argued by Sahlin (1994), deviant groups have through history been categorised on the basis of who is regarded as being to blame for the origin of the problem, in terms of one of two polarised images; “wretches” or “villains” (Sahlin, 1994). People belonging to the first category are seen as weak and submissive victims, who have ended up in their predicament undeservedly, and who are therefore entitled to pity and charity. Those belonging to the second category are instead seen as shameless crooks, who have brought about their troubles by themselves, and who therefore only deserve to be despised and punished.³ In practice, however, punishment, coercion and control on the one hand, and treatment and support on the other, are difficult to separate, and they may be performed by means of the same actions (cf. Svensson, 2001).

Brickman and colleagues (1982) separate responsibility for the origin of the problem (“blame”) and responsibility for the solution to the problem (“control” or capacity) as a means of understanding approaches towards social problems and how they can be dealt with. Moreover, the perception of deviant behaviour is influenced by whether there are specific interventions available to deal with it and whether or not the condition is considered as curable (Freidson, 1965; Gusfield, 1981).

Another relevant dimension is that of whether substance use problems are viewed as a homogenous entity that can be defined on objective and unanimous grounds, thus implying that there may be an optimal solution (cf.

³A similar distinction is the one between the “deserving or undeserving poor” (cf. e.g. Katz, 1989; Will, 1993).
or whether phenomena such as substance abuse or addiction are viewed as being socially constructed, in the sense that they are given different meanings in different historical and socio-cultural settings (Fingarette, 1988; Room, 1985).

**Substance use problems as a disease**

The concept of “alcoholism” was first used by the Swedish doctor Magnus Huss to describe excessive drinking as an individual disease, with the drinker being depicted as a slave to his habits. The disease was seen to have been caused by the alcohol itself, which produced physiological and psychological effects on the individual (Blomqvist, 2012). Total prohibition was advocated by the temperance movement as a logical consequence of the early disease view, but by contrast with the situation in Finland and the US, it was never realized in Sweden (Blomqvist, 1998). In the 1930s, alcohol consumption increased sharply in the US with the end of prohibition. The “alcoholism movement” promoted the belief that alcohol problems were a result of a disease among a certain group of deviants (Gusfield, 1996). The cause of the problem was thus transferred from the alcohol itself to the specific disposition of certain individuals. This new disease model of addiction was based upon the idea that there are inborn differences between non-alcoholics and alcoholics, with the latter experiencing a strong craving to drink, an inability to stop drinking and a loss of control. Moreover, the process was seen as being inexorably progressive and as resulting in a chronic condition. Alcoholics should therefore not be blamed or punished, but rather helped to stop drinking (Pattison, 1976). These ideas were embraced by Alcoholics Anonymous and Narcotic Anonymous, were eventually incorporated in the WHO definition of alcoholism in 1952, and were given scientific status with the publication of the work of Jellinek (1960). In Sweden, a socio-medical approach was evident in policy reports during the 1940s and 1950s, but medical interventions and the role of doctors were limited at the practical level (cf. Blomqvist, 1998; Oscarsson, 2011). The ideas of Alcoholics Anonymous did not become strong until the 1980s when the Minnesota model became the dominant treatment model (Bergmark & Oscarsson, 1994a), but they have occupied a strong position in the context of care delivery since that time (Bodin, 2006).

Scholars such as Conrad and Schneider (1992) have questioned the medicalization of various forms of deviance. By transferring the character of the problem from “badness” to “sickness”, it was thought that the disease model would unburden people with substance use problems from the shame and the moral stigma associated with such problems. However, Conrad and Schneider (1992) argued that the notion of loss of control embedded in the disease concept portrays the drinker as a victim of an irreversible process (“once a
drunk, always a drunk”) impossible to cure, but manageable by professional treatment experts.

During recent decades, the idea of substance use problems as a “chronic brain disease” has been launched (cf. Vrećko, 2010) and has also achieved a dominant position at the official level in Sweden (cf. e.g. SOU 2011:35). This notion emphasises genetic factors that are perceived to make certain individuals more prone than others to developing substance use problems. In addition, this view focuses on the substance’s effect on the reward system in the brain, and can thus be seen as an integration of the old disease model (“the problem lies within the bottle”) and the new disease model (“the problem lies within the individual drinker”) (Blomqvist, 2012:22). There are however few advocates of the disease model today who totally deny the importance of social and psychological factors in understanding substance use problems (Blomqvist, 2012).

Substance use problems as social problems

While various forms of the disease notion have been and remain the dominant way of conceptualizing alcohol problems in the Anglo-Saxon world, the Nordic countries (and particularly Sweden and Finland) have traditionally applied a predominantly social perspective on substance use problems, with an emphasis on integrating socially marginalised individuals into society (Stenius, Witbrodt, Engdahl, & Weisner, 2010). Several factors have been important in the formation of the social model of Swedish addiction care. In the early days, the responsibility for dealing with people with alcohol problems was located within the municipal poverty relief system, where the main focus was directed at the citizen’s inability to support him-/herself, rather than at the alcohol consumption per se (Edman, 2012). The doctor Ivan Bratt, who was a powerful opponent of the disease model, had a central position in the early 20th century political discussion in this field. In 1922, a national referendum took place on prohibition, in which the prohibitionists lost by a narrow margin. Instead, as was proposed by Bratt, a rationing system was introduced as a way of limiting access to alcohol. Thus besides providing treatment for heavy drinkers, Swedish policy has been directed at limiting the substance use of all citizens, which may be related to the presence of an extensive welfare state with a focus on providing universal policy measures rather than residual programmes (Esping-Andersen, 1990; cf. Korpi & Palme (1998) on the encompassing welfare model covering the entire population).

In the 1970s, a social perspective was evident, which emphasized the relationship between the individual and the social context in which the substance use was taking place, with this including both socio-economic aspects and socio-cultural definitions of substance use (Bergmark & Oscarsson, 1988;
And critical voices were raised about how a medical approach overlooked the social and structural causes of alcohol problems. Social and psychological aspects of substance use problems were stressed and treatment interventions expanded, with all kinds of measures and methods being offered within a socio-environmental therapy frame (Bergmark & Oscarsson, 1988). A public health perspective towards alcohol emerged, focusing not only on the problems of individual drinkers, but also on problems such as crime, drunk-driving and work-absenteeism at the societal level (Gusfield, 1996). The single distribution theory advocated by Bruun et al. (1975) was of major importance to the development of the restrictive alcohol policy seen in Sweden. Stated briefly, the theory argues that there is a relationship between the total consumption of alcohol in the population as a whole and the total number of people with alcohol related problems and injuries in society at large (cf. Skog, 1985).

With Sweden’s accession to the European Union in 1995, the possibilities for restricting the sale and serving of alcohol became more limited. The state monopoly on the import, export and production of alcohol was removed and only its retail remained monopolized. The availability of alcohol increased and the control of alcohol consumption and alcohol-related harms, in parallel with an increasing liberalization of alcohol policy, has become the responsibility of the individual consumer rather than of society (Room, 1997). Alcohol policy interventions aimed at limiting the harms of alcohol use increasingly came to be focused on certain risk groups, rather than on the population as a whole (Abrahamson & Heimdahl, 2012).

The institutionalised position of narcotics

Since the end of the 1960s, narcotics have been described as a major problem in Sweden and as constituting a threat to society, irrespective of the low prevalence of drug use (Edman, 2012). The constitution of narcotics as a social problem followed a very different path to that followed by alcohol. Opiates were prescribed by doctors for medical reasons for a range of symptoms in the 19th century and were not conceptualized as problematic or as being associated with risks. The increasing number of reported negative consequences of opiate use were understood within a medical frame and were dealt with within the doctor-patient relationship. This was also the case for other substances such as cocaine, cannabis and amphetamines (Olsson, 1994). From the 1920s to the 1960s, cocaine shifted from being a medical to a suspect drug that was linked to crime, immorality and decay (Lindgren, 1993:90). It was not until the 1950s and 1960s, when young people and deviant groups started using narcotics, that it came to be conceptualized as a social problem (Olsson, 2011). However, this depiction has since achieved such a dominant position that it has been characterized by Bergmark and
Oscarsson (1988:190) as doxic in a Bourdieuan sense. The doxic character of the drug problem involves both its status as a major social problem – a notion that cannot be contested – and its dangerousness, with the user being viewed as a victim who should be offered care (Bergmark & Oscarsson, 1988:195ff).

Including illicit drugs, prescription drugs, alcohol, tobacco and caffeine in their analysis, Christie and Bruun (1985) highlighted the size of the discrepancy between the harms caused by illicit drug use and those caused by licit drug use. While the interests that support pharmaceuticals, tobacco, alcohol and caffeine are strong and influential and thus constitute unsuitable enemies for the state, illicit drugs constitute a much more suitable enemy. By comparison with the alcohol problem, the illicit drug problem occupies a position of being both irrefutably dangerous and linked to deviant individuals located at the very bottom of society. Despite the fact that only a minority of those who use narcotics develop problems, there is a dominant belief that those who use drugs will never be able to stop (cf. Bergmark & Oscarsson, 1988).

The high profile and doxic character of the drug issue in Sweden has created a specific political consensus, with drug policy rarely having been questioned (Hübner, 2001). The ambition of achieving a “drug free society” has shaped a restrictive drug policy focused on limiting the availability of drugs in society, culminating in the criminalization of the use of narcotics in 1988. No distinction is drawn between soft or hard drugs. Instead, drugs such as cannabis have been depicted as constituting a gateway drug to heavier use (Träskman, 2001). This has involved repressive measures towards the drug users, with high penalties, compulsory treatment and a restrictive stance towards maintenance treatment and needle exchange programmes. Having been available in southern Sweden since 1987, a needle exchange programme was opened in Stockholm in 2013 after a long period of political resistance. This harm reduction intervention, together with the increased provision of maintenance treatment, could be seen as indicating that Sweden’s restrictive drug policy may at least have undergone some form of loosening over recent years, or that a more pragmatic strain of drug policy has begun to emerge (cf. Blomqvist, Palm & Storbjörk, 2009).

**Multidimensional models of substance use problems**

Over recent decades, various researchers have presented comprehensive models of addictions, synthesizing biological, psychological and social explanations. For example, Skog (2000) has described the substance user as a rational individual, whose actions are based on behavioural-economical, decision-theoretical and neurobiological factors. The tendency to relapse is

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4 See Bourdieu (1977:164) for an elaboration of the concept of doxa.
explained by the fact that people tend to evaluate the choices made in relation to everyday actions on the basis of the expected rewards, and at the same time prioritize rewards that are expected sooner rather than later. Orford (2001) has described addiction as an excessive appetite. According to this view, potentially problematic behaviours such as drinking, smoking, eating, exercising, gambling, sex and drug taking, are in fact expressions of similar psychological principles. Focusing on emotional and cognitive processes, Orford argues that the social and moral context is crucial for the course of events when functional and sometimes vital habits become destructive. Universal characteristics of the change process are applied, irrespective of the problematic behaviour in question. Orford thus contends that the concept of addiction should be widened to not only include the consequences of excessive psychoactive substance use, but also other destructive behaviours.

West (2006; West & Brown, 2013) has developed a synthetic motivational theory of addiction. The main factors causing this malfunction are fundamental characteristics in the individual, factors caused by the activity itself, and also social and physical circumstances. West argues that an integrated theory of addiction must involve explanations of both underlying neurobiological mechanisms, the desire for the addictive experience and the tendency to repeat the behaviour against better judgement.

On the basis of multidimensional models, substance use problems can thus be understood as involving a complex interplay between the individual (constitutional and acquired) prerequisites and the environment (structural conditions and unexpected events). These problems are also of a highly heterogeneous character and manifest themselves in a variety of ways, which is also true for the ways in which people tend to recover from their predicaments (Blomqvist, 2009a). Societal reactions thus need to consist of a variety of measures, offering not only psychological and pharmacological treatment but also measures to change the social and physical environment of the individual. There is however no consensus concerning the ways in which substance use problems should be perceived and dealt with, either in Sweden or internationally, among researchers, professionals or the general public (Blomqvist, 2009b; 2009c). The dominant model for understanding and perceiving substance use problems in a particular society at a given time is however of importance for the organisation of care and for the interventions and methods applied (Bergmark & Oscarsson, 1988).
The handling of substance use problems in Sweden – current organisation and contemporary trends

In an international comparison, Swedish addiction care is probably one of the most extensive systems in terms of the number of treatment facilities and costs (Klingemann, Takala & Hunt, 1992; Klingemann & Hunt, 1998). Despite a development towards individualization and increased medicalization, responsibility for the treatment of substance users has primarily been located at the social services (Stenius & Edman, 2007). While Denmark and Iceland have a more medicalized care system, Finland and Sweden have applied a social model in relation to substance use problems (Stenius, 1999). Many people with substance use problems are in contact with different parts of the addiction care system simultaneously (social services, criminal justice, regional healthcare, self-help groups). A large proportion of treatment resources are used by clients who have severe social problems in addition to their substance use problems (Eriksson, Palm & Storbjörk, 2003), and social circumstances and previous treatment experiences have shown themselves to be stronger predictors of ending up in addiction care than the severity and frequency of substance use (Storbjörk & Room, 2008). By comparison with the American treatment system, for example, the Swedish system focuses to a greater extent on dealing with marginalised individuals with substance use problems rather than middle-class heavy drinkers (Stenius et al., 2010).

Over the course of the past century, the handling of substance use problems has largely been shaped by economic and political-ideological factors rather than by scientific and professional knowledge (Bergmark & Oscarsson, 1994b; Blomqvist, 1998; Edman, 2012; Oscarsson, 2011). Swedish addiction care has been characterised by integration and by collaboration between the state, the municipalities and non-governmental organisations (Stenius, 1999). This chapter describes the organisational handling of substance use problems with a specific focus on the two main actors discussed in this thesis, the specialised outpatient services delivered by the social services on the one hand and the regional healthcare system on the other. The role of probation services in providing substance use treatment is also described in brief (since they are included in the study described in Paper I), together with the overall prevalence of substance use and substance use
problems. The chapter concludes with a discussion of recent developments in the field of addiction care.

The present organisation of Swedish addiction care

In Sweden, substance use problems are dealt with by four organisations on three different levels; 1) the municipal social services, 2) the county-based regional healthcare system, and 3) the state organised correctional care (prison and probation services) and coercive care (run by the Swedish National Board of Institutional Care) systems. Eligibility for compulsory care is investigated by the social services and decided by the municipal boards for a maximum period of six months. The object is to interrupt a destructive substance use and to motivate clients into voluntary care (Blomqvist, Palm & Storbjörk, 2009). It is worth mentioning that there are substantial variations in how addiction care is organised throughout the country, in terms of both cooperation and the division of responsibility between municipalities and regional healthcare, and the degree of specialisation and the kinds of interventions offered. There is sometimes an overlap in the types of care and treatment offered between the various organisations involved, i.e. what in some quarters is treated as the responsibility of regional healthcare is in others treated as an issue to be handled by the social services. In some cases, but not very often, specialised regional healthcare and social services addiction care are located in the same building and provide common interventions (SOU 2011:35).

Social services

The municipal social services have the responsibility for long-term care and treatment for substance use problems. Based on the regulations contained in the Social Services Act (SFS 2001:453), the social services should provide the help and care that the individual needs to recover. The measures should be based on a concern for individual integrity and should be aimed at promoting the individual’s economic and social safety and active participation in society. The nature of the support provided is commonly determined by means of an investigation in which social workers assess the individual’s need for and right to assistance and which should be conducted in consultation with the client. Standardized instruments such as the Addiction Severity Index are used in this process. Some counselling services can be provided without the individual concerned undergoing an investigation. The support provided is aimed at stabilizing or maintaining a person’s life situation by means of e.g. housing support, a contact person, activation, social training and financial assistance, as well as psychosocial treatment interventions (SOU 2011:35). Examples of the type of treatment interventions offered
include motivational interviewing, cognitive behavioural therapy and 12-step programmes, which may take place in outpatient or residential care run by either the municipality or private actors. Decisions regarding interventions that involve more expensive residential treatment, placements outside of existing contractual agreements or compulsory care are made by the municipal social welfare board. In each municipality, or in urban areas in each city district, there is often a specialised work unit for handling substance use problems (Blomqvist, Storbjörk & Palm, 2009). Besides conducting investigations, the work assignments of the social workers also involve planning, coordinating and evaluating the interventions but not offering treatment as such. Their work often involves having contact with other actors, such as probation services, regional healthcare and other units within the municipality. Social services may also offer interventions for children and other relatives to individuals with substance use problems.

Regional healthcare
The regional healthcare system offers detoxification and other health-related emergency services, pharmacological treatment and also some therapeutic interventions. The measures are regulated by the Health and Medical Services Act (SFS 1982:763). To take one example, health-based addiction care in Stockholm County is organised by the Stockholm Centre for Dependency Disorders (Beroendecentrum) and the private actor Capio Maria. In addition to local outpatient units, there is inpatient emergency care provision and specialised treatment programmes for certain target groups such as pregnant women, relatives, the homeless, youths and patients with neuropsychiatric disorders or prescription drugs problems. Common interventions found in outpatient care include the on-site distribution of disulfiram, naltrexone, acamprosate to treat alcohol problems, maintenance treatment for opioid addiction, pharmacological treatment for neuropsychiatric disorders, urine or blood testing, psychiatric assessments, motivational interviewing and relapse prevention (SOU 2011:35). The work units cooperate with psychiatric and primary care facilities. More extensive psychological treatment can be offered if the patient can show stable abstinence for one year. In rural areas, the supply of measures is more limited (SOU 2011:35). Recent developments in regional healthcare include the introduction of a guarantee of specialist care within three months and the possibility of choosing a service provider within the county. In addition, outpatient facilities have recently opened which target socially integrated individuals or young adults; these facilities have controlled drinking as a treatment goal and view substance use problems as a lifestyle problem.
Probation services

The Swedish Prison and Probation Service has responsibility for providing care and treatment to prevent relapse in criminality at the national level. The probation service handles the supervision of clients on probation, and of those subject to electronic monitoring, or whose sentences involve contract care or community service orders. Substance use problems are common among clients (60-70 percent; SOU 2011:35). Resources have been increased over recent years in order to develop treatment interventions in prisons and the probation service. A number of manual-based treatment programmes are offered, whose contents are mainly based on cognitive behavioural or 12-step models. Persons with substance use problems sentenced to prison may serve their sentences in residential treatment in cooperation with the social services.

Substance use and problems – prevalence and recent trends

Alcohol consumption and problems

With the Sweden’s accession to the European Union, political opportunities to regulate access to alcohol became more limited. The increase in alcohol consumption that was witnessed up until 2004 and has now decreased and stabilized.\(^5\) There is a growing trend among young people towards decreasing alcohol consumption and complete abstinence from alcohol, which cannot be explained by young people exchanging alcohol for narcotics (Leifman, 2013).

Definitions of risk consumption, misuse, dependence or addiction are neither unambiguous nor based on scientific consensus (Andersson & Spak, 2012; Gmel, Kuntsche & Rehm, 2011; Room, 1985). One in five men and one in eight women are assessed to be risk consumers (Public Health Agency of Sweden [PHAS], 2014a). It has been argued that drinking guidelines should actually specify lower levels of drinking for men than for women (as is the case in e.g. Australia), considering the association between male drinking and fatal injuries (Rehm, Room & Taylor, 2008). The prevalence of alcohol dependence in the population based on a diagnosis in the last 12 months is estimated at 5.5 percent of men and 3 percent of women (ages 17-84), which is equivalent to 206,000 men and 112,000 women (Ramstedt, Sundin, Landberg & Raninen, 2014).

\(^5\) The amount of pure alcohol consumed per consumer (above 15 years of age) and year is now 9.9 litres, compared to 10.6 litres in 2004 (Leifman & Trolldal, 2014).
Narcotics consumption and problems

In an international comparison, narcotics use is infrequent in Sweden. About 4 percent of men and 2 percent of women have used narcotics in the last 12 months. Cannabis is the most commonly used drug, with an annual prevalence rate of 2.5 percent (Ramstedt et al., 2014). A tendency towards an increased use of cannabis can be seen among young boys over recent years (CAN, 2012). Besides cannabis, the most common substances are amphetamines, cocaine, hallucinogenic drugs, opiates and ecstasy. The use of prescription drugs is more common among women than among men. Polydrug use is frequent, particularly among recent users. The availability of narcotics has increased during recent years, as has the number of individuals in inpatient care for narcotics-related diagnoses and the number of narcotics-related deaths (PHAS, 2011). Doping is increasingly coming to be viewed as a problem, although little is known about the prevalence of such use. The number of frequent narcotics users has been estimated at 77,000 individuals (reporting some type of illicit drug use in the past 30 days; PHAS, 2010) and problematic narcotics users at 29,500 individuals (based upon diagnosis according to ICD; PHAS, 2014b), of whom one fourth are women (Misuse commission, 2008). The prognosis is for narcotics use and problems to increase in the coming years as a result of increasing availability, e.g. via the internet, and more liberal views among young people (Svensson, 2011).

Addiction care in the new millennium

The economic recession of the 1990s meant that higher demands were placed on the effectiveness of substance use treatment. Addiction care has been influenced by New Public Management (NPM) as expressed through greater demands for efficiency, market-inspired solutions and the contracting out of services in purchaser-provider models (Bergmark, 2010; Olsson, 2011). In 2001, a review of effective treatment interventions for alcohol and drug problems was presented by the Swedish Council on Health Technology Assessment (SBU, 2001). The Council called for evidence-based practice in addiction care based on evidence produced by means of randomized control trials. Client organisations such as the Swedish drug users’ union (SBF), established in 2002, have become stronger over the past decade. In 2005, the guidelines for maintenance treatment for opiate addicts were made more liberal and the number of drug users in these programmes increased rapidly (Ekendahl, 2009a; Johnson, 2007; Stenius & Edman, 2007). In 2007, the National Board of Health and Welfare published national guidelines, directed at the addiction care provision of both social services and the regional healthcare system. The guidelines included recommendations for “evidence-based” interventions and assessment instruments. The concept of treatment
was narrowed, with interventions having to have the ambition of producing behavioural change. The responsibility for implementing the guidelines was assigned to the Swedish Association of Local Authorities and Regions (SALAR), which launched a nation-wide programme entitled “Knowledge to Practice”. The campaign had what Karlsson and Bergmark (2012) have described as a “very unclear and broad use of the concept of evidence-based practice” which in practice undermined its own legitimacy. Many addiction care practitioners have undergone education and training in the use of assessment instruments and treatment methods recommended by the NBHW, particularly those working within the social services, but the degree to which this has changed practice and resulted in better outcomes for clients is still unclear (Blomqvist & Christophs, forthcoming).

In 2008, the Ministry of Health and Social Affairs initiated an inquiry with the intention of conducting a comprehensive revision of the Swedish addiction care system. The report presented in 2011 proposed far-reaching changes to the organisation of care (SOU 2011:35). It proposed that the responsibility for treatment should be transferred from the social services to the regional healthcare system, that compulsory care should be incorporated into psychiatric coercive care, and that substance use problems should be viewed as a disease rather than a social problem. Even though the majority of the proposals were not implemented in practice, the report has been described as constituting a break with the Swedish social model of addiction care (Bergmark, 2012; Edman, 2012; Storbjörk, 2014). There were several reasons for the failure to implement the inquiry’s central proposals, but the arguments against their implementation raised a social perspective, which highlighted the importance of social interventions and was critical of a medicalization of the addiction problem. Among those physicians specialised in addiction and other advocates who promoted a medicalization, it might have been expected that the arguments would follow organisational affiliations, as a means of protecting the professional boundaries between social work on the one side and medicine on the other. An analysis by Storbjörk (2014), however, showed that the lines of division between the social and medical approaches were far from clear-cut and did not follow organisational boundaries. Proponents of medicalization were also found among the municipalities and opponents were found within the regional healthcare system.

One of the main ambitions of the 2011 inquiry was to strengthen the position of the individual with substance use problems. However, despite the fact that the individual’s right to autonomy and integrity in contacts with the system care is regulated both in the Social Services Act (SFS 2001:453) and the Health and Medical Services Act (SFS 1982:763), these may in fact be more of a rhetorical construct than rights that are actually observed in practice (cf. Hultqvist & Salonen, 2011). Despite being redefined from client to service user or customer as a part of the NPM approach, the individual’s choice in relation to various treatment interventions may in practice be quite
limited (Storbjörk, 2007). The 2011 governmental inquiry stated that one of the main challenges for addiction care in the future is that of reaching those risk and problem users who are not currently in contact with the care system. The use of screening and brief interventions in a primary care setting were proposed as a means of also reaching more socially integrated substance users (Nordström & Andréasson, 2011). In 2014, preliminary revised national guidelines for addiction care were presented, which recommend the use of certain instruments and methods, and which increased both cooperation between the various actors in the field and also staff training and education measures (NBHW, 2014). The future of addiction care remains unclear, but recent developments indicate the presence of an ideological struggle in which the medical perspective appears to be gaining ground, along with a range of developments towards the implementation of NPM, harm reduction and increasing demands for evidence-based care provision.
Theoretical points of departure and central concepts

This section presents the theoretical points of departure and the central concepts employed in the thesis. The social constructionist orientation has made possible a deeper understanding of the implicit assumptions that underlie the boundary-making processes that frame the definition of social problems (Gusfield, 1996). The definitions of different types of deviance that dominate in a given cultural context at a certain time may be understood as interactive categories (Hacking, 1999) in the sense that what is categorised as “misuse”, “addiction” or “dependence” affects both the treatment of the “misuser” and his or her self-definitions. Ideas and behaviours are shaped by social interaction, and people who are regarded as having substance use problems may become aware of the way in which they are categorised by their environment and may adjust their perceptions of themselves and their behaviour accordingly. This process of reciprocity is reinforced within a larger framework of experts and treatment strategies. Once defined as “addicts”, “misusers” or “abusers”, individuals may carry this stigma with them. What makes it important to study these perceptions is thus the fact that they have both direct and indirect effects on those who are regarded as problem users.

As was mentioned in the introduction, the ambition in this thesis has not been to capture the judgements that are made in addiction care practice. Instead the focus is directed at the perceptions, discourses and underlying assumptions found among staff that may be influential in relation to the approaches employed in the meeting with clients. The relationship between perceptions and actions will not be discussed further in the current context. Rather the study is based upon the assumption, shared by a wide range of scholars (e.g. Berger & Luckmann, 1966, Edley, 2001; Elster, 1999; Sulkunen, 1998), that the ways people think and reason about phenomena are of significance to the way people behave, in interaction with personal values, experiences and contextual circumstances.

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6 Cf. the Thomas theorem: if we ”define situations as real, they are real in their consequences” (Merton, 1995:380).
7 Berger and Luckmann argue, for example, that “the reality of everyday life contains typificatory schemes in terms of which others are apprehended and ‘dealt with’ in face-to-face encounters” (Berger & Luckmann, 1966:45).
The discretion of the practitioner

Among professionals in the treatment system, there are a range of conflicting moral, medical and social perspectives on substance use problems and how they should be dealt with (Palm, 2006), and these different perspectives have different consequences for the people with whom these professionals come into contact. In human service organisations (Hasenfeld, 2000) such as the institutions that provide addiction care, the basic task is that of getting clients to change their behaviour by means of various interventions. In the context of the more or less explicit and formal work processes at these institutions, the staff make decisions on a daily basis that result in clients being categorised and diagnosed (Taylor, 2006). The categorisation of individuals is an inevitable part of social work practice (Svensson, Johnsson & Laanemets, 2008) and involves making moral assessments of individual behaviour and striking a balance between a supportive and a controlling function (cf. Payne, 1999; Svensson, 2008). By drawing boundaries (cf. Gieryn 1999), practitioners classify who falls within or outside the remit of a given organisation (Johansson, 1992). Described by Lipsky (1980: xiii) as street-level bureaucrats, practitioners work within a demanding context characterised by insufficient resources and vague policy goals. Street-level bureaucrats act within a space that is defined by both legislation and regulations, as well as by economic constraints. However, laws and regulations do not state exactly how a given practice should be conducted, which gives the practitioner a certain degree of autonomy. Lipsky calls this space of autonomy discretion, arguing that it is associated with the autonomous, flexible and arbitrary character of decision-making processes (1980:13f) in which practitioners have to deal with often contradictory demands and expectations (cf. Runqvist, 2012). This means that there is a discretionary space which allows for a degree of variation in the way decisions and categorisations are made, and in which the perceptions of individual practitioners are central to the assessments made (cf. Johnsson, Laanemets & Svensson, 2008; Svensson, 2008).8

Governing images

Dealing with complex social problems is subject to a constant negotiation that involves boundary-making both within and between actors. Certain types of understanding can become culturally dominant or hegemonic (Gramsci, 1971) in the sense that they are taken for granted or assume the

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8 Wallander and Molander (2014) distinguish between discretionary space and discretionary reasoning where the former relates to the degree to which practitioners are given room to make judgements based on their own considerations (space of autonomy), while the latter relates to the activity of deliberation, and to the norms and values that form the basis for the decisions that are made. In this thesis, the focus is directed at the process of discretionary reasoning, in which boundary-making, based on perceptions of deviance, need, and capability, is crucial.
status of facts. *Governing images* (Room, 1978:4) are suggested by moral and ideological entrepreneurs to constitute the accepted perceptions of problems and their solutions. A governing image summarises and characterises a problem and how it should be handled, both in individual cases and in social policy. The governing images concept acknowledges the complexity of people’s inconsistent and shifting ideas about societal phenomena, which are due to the fact that people’s perceptions are seldom strictly associated with only a single position but are rather linked in varying degrees to a range of different ideological currents (Room, 1978). In general, people’s perceptions bear traces of different governing images, which originate in the surrounding culture and are then applied to an individual’s own experiences in order to make sense of what is going on (Room, 1978). Thus by applying the concept of governing images, rather than treating perceptions about substance use and treatment needs as fixed, stable and coherent, this thesis instead views these perceptions as flexible, inconsistent and multifaceted.

**Interpretative repertoires**

Inspired by Durkheim’s theory of collective representations, Moscovici (1984) has developed a theory of social representations as a means of understanding everyday knowledge, i.e. how individuals and groups create a stable and predictable world with the help of their lay knowledge (cf. Chaib & Orfali, 1995; Moscovici, 1984). Social representations are the mental images by means of which people make sense of the world in order to communicate, and they provide a framework for understanding attitudes, beliefs and attributions (cf. Potter & Wetherell, 1987:138). In a critique of the emphasis placed on consensus in social representations, however, Potter and Wetherell (1987) have argued for the importance of looking at the variety and context of different accounts. For example, representations may be mentioned merely because they are an available explanation that is prevalent in the media, or they may be used to justify a specific behaviour in a certain practical situation. Potter and Wetherell instead suggest using the *interpretative repertoire* concept. Interpretative repertoires are “recurrently used systems of terms used for characterizing and evaluating actions, events and other phenomena” (Potter & Wetherell, 1987:149). The repertoires constituted by relatively coherent ways of talking about phenomena in everyday conversations form a basis for shared social understanding (Edley, 2001). The terms interpretative repertoires and discourses are commonly used interchangeably to address different ways of talking about objects and events. The ways in which we talk about something are also linked to the way we understand phenomena, which means that interpretative repertoires and discourses are linked to ideology. The difference between the concepts may lie in differences in the focus of the analyses in which the terms are used, with the discourse concept...
tending to be used in the context of analyses that adopt a Foucauldian focus on the exercise of power or to designate higher-level institutions. The interpretative repertoire concept is instead used to emphasise flexibility in the ways we talk about things and to acknowledge the agency of the speaker in the process being examined (Edley, 2001). Instead of perceiving discourses as abstract quantities, Potter and Wetherell (1987) wanted to accentuate the ways in which discourses are used in social interaction and how they thereby constitute social practice. This would lead to the analysis including a focus both on how the repertoires are used in the immediate context and on their wider social implications.

Ideological dilemmas

When making assessments, practitioners draw on a number of potentially influential factors (including mood, beliefs and behaviours) (cf. Wilson & Hodges, 1992). Their beliefs and assumptions are also based on socially shared constructions of reality (cf. Hardin & Higgins, 1996). It is also important to note the ideological character of everyday thinking, as has been emphasized by Billig et al. (1988) in a description of ideological dilemmas of common sense. Different messages of a contradictory or dilemmatic nature are often a central feature of social interaction and constitute the seeds of argument when trying to make sense of a phenomenon. While both interpretative repertoires and ideological dilemmas provide the building blocks for conversation and are part of a culturally shared understanding, dilemmas are rhetorically structured as a result of an historical argumentation (Edley, 2001). Paper IV, for example, describes the ideal of treating everyone the same (universalism), which may be regarded as being in conflict with another ideal in social work, whereby special consideration should be given to each person’s special circumstances (particularism) (cf. Molander, 2011). These opposing ideals clash with each other and constitute an ideological dilemma in the everyday practice of practitioners.

Boundary-making processes

Definitions of substance use may be viewed as products of social and symbolic boundary-making processes (Lamont & Molnár, 2002) in which the boundaries separating acceptable from unacceptable actions are constructed

9 Osmo & Landau (2001) however describe this as an ethical rather than an ideological dilemma that is frequently part of the social work practice, and that involves conflicts of rights, responsibilities and interests. In order to emphasise the ideological characteristics of everyday conversations, however, the concept of the ideological dilemma has been employed in the analysis of the focus group interview data (see Paper IV).
in interaction with the prevailing culture and norms of society. Symbolic boundaries are created and contested by social actors in order to categorise objects, individuals and practices across contexts, groups and levels. When symbolic boundaries are widely agreed upon, they become social boundaries, where social differences are manifested in an unequal distribution of material and non-material resources and social opportunities (Lamont & Molnár, 2002). In the case of addiction care, the symbolic boundary-making process engaged in by practitioners to categorise “problematic” and “non-problematic” narcotics and alcohol consumers, “treatable” and “non-treatable” clients, “deserving” and ”non-deserving” clients may manifest themselves in the assessment process. Studying boundary-making processes involves investigating how different behaviours are perceived as deviant depending on who is engaging in the behaviour in question, in what context and on the basis of which normative position. When examining boundary-making processes, it is of some interest to scrutinize the way different social categories are used to create difference and sameness between various individuals and groups (cf. Lamont & Molnár, 2002).

Subject positions

The concept of subject positions refers to the positions or categories to which people are assigned as subjects on the basis of ideological constructs (Althusser, 1971:171). Edley (2001:210) defines subject positions as locations or identities that are made relevant in a conversation. In the analysis process, the researcher aims to focus on who is implied by a certain interpretative repertoire. Subject positions could thereby serve a symbolic boundary-making function in a process of identification that differentiates between us and them. One reason for analysing subject positions is the functions they serve in the conversation (for example how the participants want to position themselves in relation to others or how participants categorise others). Further, the very availability of certain subject positions may be seen as revealing for the ideology that is present in the context of the conversations (Edley, 2001).

Social categorisations

Fahlgren and Sawyer (2005) argue that more social work research should be conducted into how normalisation and deviance is shaped within power

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10 Lamont & Molnár (2002:186) argue that “symbolic boundaries are often used to enforce, maintain, normalize, or rationalize social boundaries as exemplified by the use of cultural markers in class distinctions or cognitive stereotyping in gender inequalities.”
structures and how different social categories intersect (intersectionality, cf. Crenshaw, 1991). Analysing only one aspect at a time, such as the influence of gender, is not sufficient for understanding practitioners’ perceptions, and instead several aspects must be taken into consideration simultaneously and analysed in relation to one another. For example, the alcohol consumption of an elderly unemployed man is probably perceived differently than the drinking of a young female student. When discussing social categories such as gender, class, ethnicity and age there is thus a need to highlight the importance of the interplay between various power structures. Social categories are linked to power by functioning as a basis for social stratification and thereby also for the allocation of various resources in society (de los Reyes, 2005). Including all possible categories makes the analysis difficult to handle, however, (cf. Staunæs, 2003) and the choice of the variables to be examined in the current thesis has been guided by theoretical interest. In Paper IV the main focus has been directed at the importance of gender for the practitioners’ perceptions, since gender may be described as the most fundamental basis of division in our society (Hirdman, 2001). The ambition, however, has been to take several power aspects into account in the analyses when these are of relevance for the boundary-making processes that are taking place.

The current study employs dichotomous categories such as man/woman, young/older, unemployed/middle class etc. and these are operationalized in vignettes that describe fictive situations involving people consuming alcohol or narcotics with different consequences. Using e.g. the categories “ethnicity” or “socio-economic status” in the way they are employed in this thesis involves a risk of reproducing stereotypes, since the operationalizations employed in the vignettes are simplified (cf. the method section; Gunaratnam, 2003; McCall, 2005). In reality, social categories such as gender, age, ethnicity, and socio-economic status are not fixed or stable but rather variable and are influenced by the social and discursive circumstances in which they are applied. For example, gender performances in everyday life are defined by our ideas about feminine and masculine features (cf. Butler, 1990; West & Zimmerman, 1987). Ethnicity is based on stereotypical perceptions of the cultural, racial, or skin-colour differences between one’s own group and other groups (Hylland Eriksen, 1993; de los Reyes, 2007). When categories are viewed as being non-stable and socially constructed, the question arises as to how researchers should handle such categories in the research process. McCall (2005) has formulated three methodological approaches, which she labels the anticategorical, intracategorical, and the intercategorical complexity. With an anticategorical approach, the researcher deconstructs categories and investigates the process in which categories such as gender and race are constructed. The intracategorical approach involves stressing the situation of individuals and social groups living on the boundaries of different intersections and focusing on the micro level and on identity processes. The intercategorical approach instead uses social categories as anchor points in
order to be able to analyse relations involving multiple inequalities between socially constructed groups. In this, often quantitative, approach the researcher selects in advance the social categories of interest and focuses on factors associated with structural inequalities (McCall, 2005). While acknowledging the discursive and anti-essentialist characteristics of social categories, the ambition in this thesis has been to follow the intercategorical approach and to employ the categories strategically in order to describe and investigate the importance of various social categories for understanding the process of boundary-making in addiction care practitioners’ perceptions.
Previous research

There are substantial variations across cultures and population groups with regard to how substance use and treatment needs are perceived and categorised. As an example of the importance of the cultural setting, Roizen (1988) has shown that what is perceived to be an acceptable amount of alcohol differs for men and women of different ages and in different countries. What is considered “dependency” in one culture may be seen as “normal” drinking in another (Bennett, Janca, Grant & Sartorius, 1993; Room, Janca, Bennett, Schmidt & Sartorius, 1996). As regards views on how excessive drinking should be dealt with, different cultures apply different norms in relation to gender, age and the responsibilities of the individual vis-à-vis the authorities (Roizen, 1988).

This chapter describes previous research on perceptions of substance use problems and their solutions. The review is not intended to be exhaustive in relation to the research conducted in this field, but rather draws on the international and Swedish literature that has served as an inspiration for this thesis and that is important for an understanding of its findings. The emphasis is placed on Swedish research on addiction care practice in order to contextualise the papers presented in the thesis. With reference to the separate prevailing views of alcohol and narcotics in Sweden, the chapter begins by presenting research concerning the range of lay and practitioners’ perceptions of different forms of substance use problems and how they should be handled. The presentation then moves on to consider the Swedish social model of handling substance use problems and the division of responsibility for addiction care by describing research on potential differences based upon organisation and practitioner characteristics. Thereafter comes a presentation of research focused on how various characteristics of the substance user such as age, gender, socio-economic status and ethnicity are of importance for per-

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11 The thresholds for normal drinking were found to be much higher in wet drinking cultures (Spain, Greece, Rumania) than in India and Nigeria. In Greece and Turkey, it was seen to be more acceptable for men to drink than for women. In India, social class was influential, with the drinking of rich individuals being viewed as a sign of social status, while poor individuals were viewed as drinking in order to escape difficult situations (Bennett al., 1993).

12 In Mexico, the tolerance for women’s drinking was lower than in Scotland and the US, while in Zambia age was a more important factor for the norms surrounding drinking behaviour. Relatives were given a central position in helping with and controlling drinking in Zambia, while in Scotland police interventions were recommended to a greater extent, particularly when the situation involved harm to others (Roizen, 1988).
Perceptions of various substance use problems

Swedish public opinion towards alcohol consumption became more permissive during the period between 1995 and 2003, which reflects an increase in the level of actual consumption during this period (Hübner, 2012). Similar findings have been reported in Norway, where views on what constitutes alcohol abuse have changed substantially, becoming more liberal and permissive in terms of the amount consumed. The more people drink, the more liberal their views become. The changes described are believed to have been influenced by globalisation processes, higher total consumption levels and more liberal views in general (Nordlund, 2008). Views of alcohol problems tend to vary with respondents’ age, gender, income and place of residence, with women, older people, people with lower incomes and those from rural areas being more negative towards alcohol and more likely to advocate restrictive alcohol policies than men and younger people, people with higher incomes and those from urban areas (Hübner, 2001; 2009). In a qualitative study of young people’s views of alcohol, participants with higher levels of alcohol consumption differentiated more between heavy consumers and alcoholics. Those with lower levels of consumption instead expressed more fluid and gradual definitions of heavy consumption and alcoholism (Abrahamson, 2004). The tendency towards finding a relationship between individuals’ own patterns of substance use and their perceptions of substance use, problems and policy has also been confirmed in other studies (e.g. Karlsson, 2006; O’Brien, Rossi & Tessler, 1982) indicating that there is a connection between the norms and values we hold and the actions we engage in (Hübner, 2009).

Views on narcotics in the Swedish population are more unitary and in line with Sweden’s official narcotics policy, and are dominated by a perception of narcotics as dependency-generating and highly dangerous (Hübner, 2001; Ekendahl, 2004). These views reflect the official stance of a restrictive drug policy with a focus on both control and care. A majority have been found to perceive cannabis as being more dangerous than alcohol and to hold the view that it is impossible to use narcotic drugs without becoming dependent. Narcotics use has thus become institutionalised as a phenomenon that is totally different from alcohol use in the sense that the use of narcotics represents a deviation from the norm whereas alcohol use is not only acceptable in many situations but also expected. The pleasures associated with alcohol use were not attributable in the case of narcotic use (Hübner, 2001). The view of narcotics use as a severe societal problem may be considered somewhat paradoxical, given that alcohol problems are more prevalent and cause...
more problems at both the individual and societal levels. As has been noted by the Independent Scientific Committee on Drugs in the UK, alcohol is generally the most harmful drug to individuals and to others, followed by heroin and crack cocaine (Nutt, King & Phillips, 2010). The fact that alcohol and tobacco are assigned a high position on harm-ranking scales indicates that legal drugs cause at least as much harm as illegal substances (van Amsterdam & van den Brink, 2010). The institutionalised position of narcotics as a severe social problem in Sweden was confirmed in the cross-national Images research consortium based at the University of Helsinki. The use of hard drugs was ranked as a very severe societal problem, despite the fact that the prevalence of such use is very low in Sweden. Smoking was ranked as the least severe societal problem, notwithstanding its much higher costs to society. Alcohol and cannabis were assigned intermediate positions, but drinking was perceived as somewhat less serious and dangerous than smoking cannabis (Blomqvist, 2009c). In Finland, alcohol was instead seen as the substance that generated the greatest problems at the societal level (Hirschovits-Gerz et al., 2011; Holma et al., 2011).

Views on cannabis tend to differ depending on the cultural context, the prevalence of cannabis use and the drug policy applied in a given country. For example, Canadian lay respondents are more likely to have tried cannabis and they perceive it as a less serious social problem than Finnish and Swedish lay respondents (Cunningham et al., 2012). Attitudes towards the dangers associated with cannabis have shifted towards a more liberal view among teenagers (Raninen, Dahlman & Raninen, 2012). In the public at large, however, no evident shift in perceptions towards cannabis could be discerned in a comparison of studies conducted in 2005 and 2014. Women and older respondents (over 30) tend to hold more positive views towards restrictive drug policies than men and younger respondents (CAN, 2014).

Research on addiction care practitioners’ views on substance use severity is relatively sparse, but in a Finnish context, Koski-Jännes, Hirschovits-Gerz, Pennonen and Nyvssönen (2012b) have shown that addiction care practitioners, clients and lay respondents differed in their views about different kinds of substances. Clients made less of a distinction between illegal and legal substances than practitioners and lay respondents, and they rated alcohol use and smoking as significantly more addictive than other respondents. Cannabis use caused more concern among lay respondents while practitioners instead emphasised the addictiveness of prescription drugs.

Research has shown that self-change – recovery from substance use problems without the help of professional treatment or self-help groups – constitutes the most common path to recovery (Blomqvist, 1996; 2002; Blomqvist, Cunningham, Wallander, & Collin; 2007; Cunningham, 1999; Klingemann & Sobell, 2007). In these recovery processes, the support offered, the demands made, and the perceptions held by those in the user’s environment are crucial to attempts to change a problematic substance use and to maintain
such changes (Bischof, Rumpf, Hapke, Meyer & John, 2001; Blomqvist, 1999; Granfield & Cloud, 1999). To discern a potential climate of a “self-change friendly society” (Klingemann & Klingemann, 2007) in various contexts, cross-cultural studies have been conducted. Swedish lay respondents are more pessimistic about the possibilities for self-change recovery from various substance use problems than would be expected on the basis of the prevalence of this recovery mode described in the research (Blomqvist, 2009c). Swedish and Finnish lay respondents appear to be more inclined to believe in the necessity and efficacy of formal treatment than Canadian and Russian respondents, which perhaps reflects the relatively extensive nature of the welfare states found in the Nordic countries (Hirschovits-Gerz et al., 2011). Compared to lay and client respondents, Finnish addiction care practitioners believe that there is a greater need for professional treatment in connection with prescription drug use but less need for treatment in connection with cannabis. In general, Finnish practitioners report high levels of confidence in treatment, reflecting their identities as treatment providers (Koski-Jännnes et al., 2012a).

In Sweden, Wallander and Blomqvist (2005) found that the user’s primary drug was influential for social services practitioners’ ideal treatment recommendations, with heroin users being regarded as eligible for compulsory care to a greater extent than users of alcohol or amphetamines. Also, heroin users were more often recommended inpatient instead of outpatient treatment when controlling for physical, psychological, social and other factors (Wallander & Blomqvist, 2008).

Differing views among addiction care practitioners depending on the substance used were also found by Palm (2004). People with narcotics problems were seen as being more responsible for the origins of their problem and less responsible for the solution than persons with alcohol problems. While the disease concept was relatively well-established in relation to alcohol problems, narcotics problems were perceived as social problems to a greater extent (Palm, 2004).

Perceptions in different parts of addiction care
Practitioners’ perceptions and assessments may be influenced by organisational factors, such as workplace cultures and routines, treatment availability and economic constraints (Lordan, Kelley, Peters & Siegfried, 1997; Breslin, Gladwin, Borsoi & Cunningham, 2000; NBHW, 2004; Wallander & Blomqvist, 2005; 2008). A review of the organisation of Swedish addiction care (Karlsson, 2009; SOU 2011:35) has revealed that there are substantial variations in the division of responsibilities between social services and regional healthcare, as well as in the level of specialization and the organisation of treatment and in the interventions offered in different parts of the
Certain municipalities are more inclined to prefer interventions such as residential and coercive care. Certain regional healthcare settings are more inclined to recommend maintenance treatment than others (NBHW, 2004). The degree of specialization seems to be of importance, with specialized units being less prone to advocate compulsory treatment than non-specialized units (Wallander & Blomqvist, 2005). The prevailing general ideological convictions at a given work unit also appear to be important, with work units influenced by the ideas of Alcoholics Anonymous, for example, having been found to be more likely to recommend residential care than outpatient care by comparison with other work units (Ekendahl, 1999).

There is no strong consensus among addiction care practitioners regarding the nature of the problems that they are assigned the task of handling (Blomqvist, 2009b). Palm (2004) has found support for moral, social and medical views in both social services and regional healthcare settings. Contradictions were present in the sense that there was evidence of support for the disease concept while at the same time a majority of the staff perceived substance use problems as social rather than medical problems. Moreover, staff did not agree with the statement that substance use problems should be treated by doctors (Palm, 2003; Storbjörk, 2003). It would be expected that a stronger commitment to a social view would be evident among social services staff and a greater agreement with the disease concept among regional healthcare staff. This has also been found to be the case, but the differences noted were not particularly distinct (Palm, 2004). Regional healthcare staff are more inclined to agree with the statement that people with substance use problems need professional help by comparison with social services and probation service staff (Blomqvist, 2009b). With regard to the use of differing models to handle substance use problems in different countries, Egerer (2014) found that Finnish addiction care practitioners were more inclined to employ a social model by comparison with French social workers, who instead applied an individual medical model, with these differences reflecting the traditional institutional framing of the problem in the respective countries.

With regard to the legitimacy of medical and psychosocial interventions among addiction care practitioners, it can be noted that Sweden has previously been dominated by a socio-political discourse on substance use problems and by zero-tolerance towards narcotics. In recent years, a medical-scientific discourse has become more evident in the professional discussion. Medical interventions such as maintenance treatment have achieved increas-

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13 The finding that the handling of addiction care takes different forms in different parts of the country is nothing new. Rosenqvist (1985:166) described substantial differences in the application of the legislation by local temperance boards. Coercive care was more often employed in urban areas and the less resource-demanding measure of suspending the individual’s rationing book was more often applied in rural areas. Practice differed depending on the strength of the temperance movement in a given area (Rosenqvist, 1985).
ing legitimacy among social services practitioners (Ekendahl, 2009a; 2009b). Healthcare and social services staff deal with the potential dispute between science and values in relation to the legitimacy of maintenance treatment by employing a decent-life discourse, in which psychosocial interventions are described as important supplementary measures (Ekendahl, 2011).

Swedish vignette studies have shown that social workers’ personal beliefs about substance use problems are of importance in relation to their choices of interventions for fictive clients (Wallander & Blomqvist, 2005; 2008). Staff adhering to a medical view of substance use problems (a view that the problems have been caused by factors outside the individual’s control and that they require professional treatment) were more inclined to recommend compulsory treatment than those who adhered to a compensatory view (which also sees the problems as having been caused by factors outside the individual’s control, but which views individuals as being capable of solving their problems themselves) (Wallander & Blomqvist, 2005). The more social workers believe in the importance of treatment, the more inclined they are to recommend inpatient treatment (Wallander & Blomqvist, 2008). Practitioners who regard substance use problems as a disease are more prone to recommend interventions in the regional healthcare system (NBHW, 2004). In the case of mental health providers’ attitudes towards persons with various mental health problems, Stoneking (1996) found that practitioners in the US saw limited possibilities for recovery. Stoneking (1996:94) contends that negative beliefs and stereotypes have a negative influence on the practitioners’ work with this target group with regard to creating an environment in which clients can have input, make choices and feel empowered. According to Nunes-Dinis (1996), US addiction care practitioners tend to select generic, social or multiple-cause models based on their personal beliefs. However, a medical model was predominant among the approaches employed towards pregnant women’s substance use problems.

Studies have also indicated that practitioners’ perceptions vary in line with their personal characteristics and experiences. In the field of income support work, practitioners with more work experience tended to recommend interventions towards alcohol problems at an earlier stage than less experience colleagues (Skogens, 2005). Practitioners without a social work degree made greater demands with regard to participation in treatment interventions than those who had a social work degree. Practitioners with a lower level of education and those working in inpatient care have been found to be more inclined towards a moral view of substance use problems (Palm, 2004) while practitioners with a social work degree tend to focus on the individual client’s own view of the situation to a greater extent (Blomqvist & Wallander, 2004). In a Finnish context, Pennonen & Koski-Jäntä (2010) found that Finnish addiction care practitioners with various forms of social work education supported the moral model less than professionals with a healthcare
oriented education. As has been argued by Skogens (2005), even though the relationship between attitudes and action is unclear, education and training may constitute a way to achieve the application of less judgemental approaches towards substance use problems.

The gender of the practitioner also seems to be of importance, with men tending to choose residential care more often for female clients and housing measures for male clients (NBHW, 2003). Kullberg and Fälldt (2008) investigated social workers assessments and help-provision strategies directed at single parents applying for income support. The results showed that the male and female social workers tended to adjust their judgements to expectations based on their own gender. For example, female respondents tended to rate situations as being more severe for clients who lacked social support and who had mental health problems, and saw clients’ needs for counselling as being more important in relation to the clients’ well-being. Male respondents on the other hand emphasised factors related to the clients’ self-promotion, independence and goal-orientation – traits generally associated with a traditional male gender role.

Gender differences have also been found in social workers’ assessments of clients’ needs for substance use treatment, with female social workers assessing clients to be in need of organised help to a greater extent than male social workers (Wallander & Blomqvist, 2005). A complementary view of gender has been applied in addiction care, with men and women being treated as one another’s opposites and being expected to complement one another by contributing with different forms of knowledge and personality traits in their role as treatment providers (Mattsson, 2005). Male practitioners are expected to contribute with a certain form of competence (setting firm limits as male role models, cf. Bäck-Wiklund, Franséhn & Johansson, 2003) and female practitioners with another (caring and listening).

The importance of the social characteristics of the user

Another essential question examined in this thesis relates to the importance of the social situation and the characteristics of the substance user for the perceived severity of substance use and for how it should be handled. While the international research has shown social categorisations based on age, gender, ethnicity and socio-economic position to be influential in relation to clinical assessments in the meeting between doctor and patient in healthcare settings (Clark, Potter & McKinlay, 1991; Raine et al., 2000; Tengelin, 2013; Wiggers & Sanson Fisher, 1997), not much research has been conducted on this issue in the field of Swedish addiction care. In the UK, Kaner, Heather, Brodie, Lock and McAvoy (2001) found that general practitioners tended towards bias when offering brief interventions for risky drinking to primary care patients. Risk drinkers were more likely to receive brief inter-
ventions if they were male, unemployed and technically trained. The risk drinkers who were least likely to receive brief interventions were female, students and university-educated. O’Brien, Rossi and Tessler (1982) employed a factorial survey approach to study US college students’ definitions of alcohol abuse. While neither the gender nor the social class of the users influenced the perceived severity of their alcohol use, higher tolerance was shown towards the alcohol use of older individuals. Social and potentially threatening consequences such as drunk driving and public fighting were seen as more severe than personal consequences such as dropping grades.

From having been characterized as either “mad, sad or bad”, women’s substance use is increasingly being framed as an expression of agency in the research literature (cf. Ettorre, 1992; Lander, 2003; Richert, 2014). If the norms of female drinking were previously based on abstinence and morality, these strict norms have now become weaker, without having completely dissolved, and in the new millennium they are based on health-related values rather than on morality (Helmersson Bergmark, 2004), and on moderation rather than abstinence (Abrahamsson, 2009). In an American context, Schmidt (2014) has argued that the norms regulating middle and upper class women’s drinking have dissolved over recent decades. However, women living in poverty have been “subject to even more restrictive norms and stigmatization for drinking and intoxication along with more punitive social controls” in the form of the surveillance of pregnant women and economic sanctions in the context of social assistance provision (Schmidt, 2014:582).

Lander (2003) studied the living conditions of eight women with narcotics use problems, focusing on constructions of gender and deviance. Women with substance use problems are commonly described as being different from men with substance use problems and different from “ordinary” women. The relationships between the studied women and social workers were moulded by the women’s positions as “female drug addicts”, with both the social workers and the women being restricted by the asymmetry of these relationships and by the associated images of the women as hopeless deviants. Their status as deviants was influenced by processes of stigmatisation, incapacitation and diagnosis in their contacts with the care system (Lander, 2003).

Similarly, Mattsson (2005) found that residential care treatment practice was gendered by a discourse of difference based on norms of sexuality, ethnicity and class. Women and men in treatment are constructed in accordance with traditional norms of femininity and masculinity, with gender being performed through separation and differentiation between clients and staff. Also, female clients are expected to adopt a more caring role and to assume responsibility for the home, whereas men are expected to be more aggressive and to assume responsibility for earning a living (Kullberg, 2002; 2004; Mattsson, 2005). Deviations from gender-based behavioural expectations are seen as being more serious, for example men suffering from depression or
women being unable to care for their children (Kullberg, 2002). Women are also perceived as being more vulnerable and exposed than men and treatment interventions tend to be oriented towards reinforcing traditional ideals of femininity (Laanemets, 2002). Men are not seen as being traumatized to the same extent and the contents of their treatment are therefore more oriented towards work and education (Mattsson, 2005).

The gender of the substance user has been shown to be influential in previous vignette studies of practitioners’ perceptions. Fictive cases describing patients with alcohol related problems were assessed differently by general practitioners depending on the gender of the patient described (Giersson, Hensing & Spak, 2009). Women were more often advised to abstain from alcohol than men, despite the fact that men on average have a higher prevalence of alcohol problems (Hensing & Spak, 2009). Social services and regional health addition care staff assessed fictitious female narcotic users as being more in need of therapeutic interventions, while more extensive assessments were more often recommended for men, perhaps reflecting a generally higher level of scepticism in relation to the information provided by men about their situation (NBHW, 2003). This indicates that conceptions of male and female substance use, and gender issues in general, affect perceptions of how substance use should be handled in the treatment system.

The gender of the fictive client was not however found to be influential in Wallander and Blomqvist’s (2005; 2008) factorial survey of social services practitioners’ treatment recommendations. Factors that were found to be influential for perceived eligibility for compulsory care were criteria specified in the compulsory care legislation regarding levels of motivation and the severity of physical and mental health problems, and also the fictive client’s age and social situation (Wallander & Blomqvist, 2005b). Similarly, the user’s age, family situation, treatment experiences and preferences were all found to be significant in relation to recommendations for outpatient or inpatient care (Wallander & Blomqvist, 2008). The socio-economic status of the client was also found to be of relevance in relation to the choice of care by Ekendahl (1999) and Skogens (2006), with clients assessed as being able to work having greater demands imposed on them for the receipt of social assistance by comparison with those assessed to be unable to work. The former group could thus be viewed as being capable of changing their situation, while the latter to a greater extent were left to fend for themselves. This tendency was also found by Järvinen (1998) in a Danish context, where socially marginalised clients were channelled out of the treatment system while socially integrated individuals were offered a broader spectrum of interventions. The clients’ status on the labour market was thus influential for the way their substance use was handled (Skogens, 2009). A moral dimension was also noted in the practitioners’ approach to clients, which emphasized that the alcohol consumption should never impede the person’s ability to be self-sufficient. The practitioners’ approach in relation to clients was guided
by two dimensions; firstly considerations relating to the client’s right to integ-


tegrity versus support and control, and secondly considerations relating to
the client’s right to equal treatment versus the right to have special consider-
ation given to the individual client’s unique circumstances (Skogens,


14 Similarly, Ekendahl (2004) found that social workers make use of both universalistic and particularistic
approaches in their complex considerations of voluntary versus compulsory care. The universalistic
considerations mean equality in relation to the legislation and the available resources. However, the
individual clients’ specific needs and characteristics are considered to a great extent and taken into ac-
count in the assessment process. Economic preconditions, the practitioners’ notions of the individual’s
needs, preferences and capacity as well as the treatment goals perceived as reasonable for different clients
are influential for the ways in which the compulsory care legislation is implemented.


The second dimension has also been described by Herz (2012) in a study
of social workers’ approaches to gender and ethnicity in child welfare cases.
There is an ideal among social workers of treating clients as individuals, and
gender and ethnicity are therefore treated as though these power relations do
not matter in the context of everyday work. Many practitioners are aware of
and able to reflect on their role in the production and reproduction of dis-
courses, but they are unable to transform this reflection into practice. Percep-
tions and practices are impregnated with categorisations based on gender and
ethnicity, which are taken for granted and unquestioned. Examples include
“bad mothers”, “absent fathers”, “cute girls” and “boys at risk”. Ethnicity is
exclusively related to “immigrants” as “the others”. These categories are
based on a notion of difference between men and women and are treated as
stable and static entities, which limits the possible positions available to the
clients. These categorisations are also reproduced in the use of various evi-
dence-based assessment tools (Herz, 2012).

Nordling (2011) has studied social services and regional healthcare prac-
titioners’ views on ethnicity in their work with substance use problems. On
the one hand, the practitioners argue that ethnicity should not be of im-
portance and that everybody should be treated the same in relation to the
rules and regulations that apply to the care being offered. On the other hand,
the care that is offered should be adapted to the specific individual, and in
this regard knowledge of ethnicity is crucial (Nordling, 2011). On the basis
of the concept of similarity, the focus is directed at the general rights of citi-
zens, which involves a risk of not taking into account the potentially discrim-
inatory structures that exist in society (Baianstovu, 2012). On the basis of the
concept of difference, potentially discriminatory structures are made visible,
which makes it possible to take cultural identities into account, but which
also involves a risk of reproducing stereotyped notions of culture as a stable
entity. These contradictory considerations of equal treatment versus the
acknowledgement of the specifics of a given case are essential elements in
the context of social work assessments. Both Herz (2012) and Nordling
(2011) propose a more dynamic view of gender and ethnicity, in which cli-
ents are allowed to do gender/ethnicity in different ways and which stresses
the importance of practitioners systematically reflecting on the relevance of social structures and the practitioners’ positions in relation to the clients they encounter in their everyday work.

Concluding remarks

To conclude, the literature indicates that a range of factors exert an influence in relation to perceptions of substance use problems and how they should be handled. The knowledge is limited, however, in relation to the issue of how and to what extent perceptions of substance use and treatment needs vary when characteristics related to the substance user and the substance use, as well as factors relating to the practitioner and his/her work place, are taken into consideration and controlled for simultaneously. The contribution of this thesis is thus to study addiction care practitioners’ perceptions of substance use and treatment needs with regard to factors that are located on different levels, and with a specific focus on the importance of the social characteristics of the user. It builds on the literature by focusing on perceived severity in general and on its relevance for the question of whether the appropriate solution is viewed as having a medical or psychosocial orientation. Further by including not only social services staff but also staff from the regional healthcare system (and to some extent probation services), the thesis also focuses on potential differences in the approaches employed in different parts of the addiction care system. By combining a factorial survey with focus group interviews, the ambition has been to develop a more detailed understanding of the assumptions that are of importance for the boundary-making processes found in Swedish addiction care.
Material and methods

A mixed methods approach

Several scholars have emphasised the potential of using multiple research methods when studying complex issues (e.g. Clarke & Yaros, 1988; Newman, Ridenour & Newman, 2003). Using mixed methods, i.e. combining different quantitative and qualitative methods in research (Johnson & Onwuegbuzie, 2004:17), is nothing new (Small, 2011), but the approach has not been very common in field of the alcohol and drugs research (Demant & Frank, 2011). Some researchers, referring to what has been described as the “incompatibility thesis” (Howe, 2004), question whether it is possible to mix different paradigms and traditions within the same research project (cf. Creswell, 2011). It can be claimed that social constructionism and experimental research designs, such as the factorial survey approach (derived from the field of social psychology, Rossi & Nock, 1982), are based on very different paradigmatic approaches to understanding the social world. While experimentalism presupposes the feasibility of empirically studying how different factors are influential in social processes and assumes that the methods applied will produce results that say something meaningful about the social world (cf. Campbell, 1993), the constructionist critique points to the relative and arbitrary characteristics of research representations and the unfeasibility of retrieving an objective truth about reality. As has been argued by Hammersley (1992), the distinction between qualitative and quantitative research is often exaggerated and tends towards oversimplification. Rather than being committed to one methodological paradigm over another, the researcher’s focus should be directed at the research questions to be examined and at the best ways to answer them. The distinction between quantitative survey research and qualitative studies of the meanings attributed to various phenomena is not particularly clear-cut, since both approaches need to relate to the meanings and context of the results (cf. Hammersley, 1992; Jost & Kruglanski, 2002). Qualitative studies may be used to help explain the factors that underlie the relationships among variables identified in quantitative research and can thus provide a deeper understanding of the findings (Bryman, 1992; Driscoll, Appiah-Yeboah, Salib & Rupert, 2007). Conversely, quantitative techniques can increase our understanding of the diversity that exists within categories in e.g. feminist research (Spierings, 2012). By using different methodological approaches to answer different questions in the same re-
search design, the findings can be corroborated (see Flick, Garmshomolová, Herrmann, Kuck & Röhnsch (2012) for a discussion on triangulation in mixed methods research), which contributes to the development of a more sophisticated understanding of complex social phenomena.

To take a clarifying example, the combination of a vignette survey and follow-up group interviews has been applied by Egelund and Thomsen (2002) in a study of child welfare social workers. The results of the vignette survey showed considerable variation in the respondents’ answers about how cases should be dealt with, and in the follow-up interviews the social workers were asked to motivate their choices. Despite the fact that all of the social workers who participated in the survey had been given the same information, they had created their own versions of this information, which in turn resulted in different consequences for the hypothetical clients. In the subsequent interviews, the social workers were able to explain their choices and discuss the relevance of the results for their everyday practice and could thus provide a more nuanced and complete picture (Egelund, 2008). For example, one result was that the social workers did not recommend an intervention as often, or recommended a less extensive intervention, if the fictive child came from an ethnic minority. In the interviews, the social workers were able to reflect on and discuss this issue, and expressed their uncertainty about the suitability of the available interventions for the needs of ethnic minority clients. The systematic differences in the assessments were thus anchored in a practical context. Egelund’s (2008) conclusion was that vignette studies combined with qualitative instruments not only allowed for the investigation of perceptions using the advantages offered by statistical measures (standardisation, statistical analysis of variability on different levels etc.) but also captured reflections regarding the factors (practitioner or organisational) that influence these perceptions. The use of the mixed methods approach applied in the current project thus provides a more nuanced picture of practitioners’ perceptions of substance use and treatment needs, and one that is larger than the sum of its parts (cf. Lieberman, 2005).

The thesis applied a partially sequential study design (see Table 1 for an overview of the data collection procedure) in which some of the data collected in one phase were used as a basis for the collection of data in the next (cf. Driscoll et al., 2007; Lieberman, 2005). Qualitative interviews were used firstly to develop the vignettes for the vignette survey in a preparatory study, and secondly to understand the meanings and assumptions that lay behind the patterns of assessments found in the vignette study. Rather than attempting to simply integrate the data (since the data cannot be expected to be consistent), the knowledge obtained by means of the respective methods can instead be seen as complementary.
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<td>Web-based survey about the size, orientation and target groups of the work units</td>
<td>77</td>
<td>Social services and regional healthcare executives from specialized outpatient units in the three largest counties of Sweden</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use or misuse – group interviews</td>
<td>Focus group interviews</td>
<td>30</td>
<td>Practitioners from six different work units that had participated in the vignette study (3 social services, 2 regional health care and 1 mixed unit)</td>
<td>2013</td>
<td>Discourse analysis</td>
<td>To analyse practitioners’ constructions of gender in discussions of substance use and treatment needs – the meaning and implications of the results from the vignette study (presented in Paper IV).</td>
</tr>
</tbody>
</table>
This chapter discusses the methodological procedures employed in the thesis. The design of the first survey is briefly explained. The main part of the chapter is dedicated to the vignette study, in order to describe the careful procedure employed to prepare, construct and test the vignettes. The follow-up focus group interview study is then described, and the chapter concludes with a number of methodological and ethical reflections.

The social context of recovery survey

In the context of the research project “The social context of recovery from addictions”, which was financed by the Swedish Research Council, a survey was sent to approximately 900 practitioners working in social services, regional healthcare and probation services in the region of Stockholm. The work units were strategically chosen to include city districts and municipalities with higher, middle and lower levels of income. Staff from the social services and regional healthcare outpatient units for addiction care were included, as well as staff from healthcare inpatient units providing emergency, detoxification and maintenance treatment services. Staff from the Stockholm region state run probation services were also included in the sample. Questionnaires were sent in 2006 to the executives and to all staff who came into contact with individuals with substance use problems in the course of their everyday work. The survey included questions on the respondents’ backgrounds and on the perceived severity of various societal problems (including e.g. poverty, environmental damage, prostitution, violent crime, hard drugs, alcohol, cannabis, medical drugs, gambling, and tobacco). The decision to study the respondents’ perceptions of various substance use problems in relation to other societal problems was inspired by Hübner (2001). The respondents were also asked to rate the perceived risk for developing misuse of/addiction to various substances and the possibility of recovery with and without treatment; these questions were based on the Images-project (cf. Blomqvist, 2009c; Blomqvist, Koski-Jännès & Cunningham, 2014; Cunningham et al., 2012; Hirschovits-Gerz et al., 2011; Holma et al., 2009; Ko-

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15 The classification of city districts and municipalities was based on information on income levels from the Stockholm Office of Research and Statistics (USK) and at the regional level from the Office of Regional Planning and Urban Transportation (RTK).

16 The exact wording of the question was (in translation): “How severe do you think that the following societal problems are on a scale from 0 (not severe at all) to 10 (very severe)?” The survey was oriented towards perceptions of substance use problems, which could have contributed to the respondents’ high ratings of such problems in comparison with other societal problems.

17 The wordings of the questions were (in translation): “How great do you rate the risk to be for developing a misuse or addiction if someone tests one of the following, on a scale from 1 (no or very low risk) to 4 (very high risk)?” and “How great do rate the likelihood to recover from various forms of misuse/addiction to be, without treatment/with treatment, on a scale from 1 (no or very small possibility) to 5 (very substantial possibility)?”
ski-Jännes et al., 2012a; 2012b) in order to facilitate international comparisons.

In all, 21 social services units (of a possible total of 43; 49% response rate), 25 regional healthcare units (of a possible total of 60; 42% response rate) and 6 probation services units (of 6 possible; 100% response rate) participated. Of the 894 possible respondents at these units, 655 valid responses were provided, which gives a response rate of 73%. No analysis of the potential bias among non-respondents could be conducted as a result of the respondents’ anonymity. However, the response rate was considered relatively satisfactory for a study of this kind. The quantitative analysis of the data consisted of ANOVA and linear regression analysis. For a more extensive description of the study design, see Christophs (2009). The results are presented and discussed in Paper I.

The vignette study

The research project “Use or misuse – practitioners’ perceptions of alcohol and drug consumption” was financed by the Swedish Research Council for Health, Working Life and Welfare (Forte 2006-1523) within the framework of SoRAD’s Centre of Excellence programme “Exclusion and Inclusion in the Late Welfare State: the Case of Alcohol and Drugs”. The ambition of the study was to explore practitioners’ perceptions of substance use and treatment needs on the basis of a more sophisticated approach than the one used in the above-described survey. The vignette study was able to take into account the fact that substance use can take various forms (and thereby be perceived quite differently), by including factors such as the social characteristics of the user and the frequency and character of various consequences of the use. By applying a specific vignette method (the factorial survey approach) it was possible to study consensus and variation in the respondents’ perceptions. In combination with multi-level analysis, it was further possible to take the hierarchical structure of the data into account and to model the unexplained variance on each level (see the data analysis section).

In vignette studies, the respondents are presented with short stories containing hypothetical descriptions of persons or social situations and are asked to respond to them (Alexander & Becker, 1978). Vignettes can be used to explore actions in context and to clarify people’s judgements, and they “provide a less personal and therefore less threatening way of exploring sensitive topics” (Barter & Renold, 1999:1). Vignettes have similarly been used in social work research and development settings to promote collegial reflection over assessment processes, where tacit knowledge can be made more explicit (cf. Lönnback & Östberg, 2007; Svensson, Ulmestig & Johnsson, 2008).
In this study, the respondents were presented with ten short situations describing persons using alcohol, cannabis or cocaine with various short-term consequences. They were further asked to rate, on a scale from 0-10, the perceived severity of the use and to what extent they thought that the person could handle the situation on his/her own, to what extent he/she needed psychosocial or medical treatment, and to what extent it was the person’s own business and the family’s responsibility to intervene\(^\text{18}\) (see Figure 1 for an example of a vignette and the response alternatives). A continuous eleven-point scale was chosen to allow greater variation in the ratings, thus making possible a more detailed statistical analysis (Dawes, 2002; Wallander & Molander, 2014). The response alternatives were selected to measure the perceived severity of the use and the practitioners’ perceptions about natural recovery, individual capability and the role of treatment provided by the two major actors in Swedish addiction care, the social services and regional healthcare.

Peter is 42 years old and works as a lawyer. He lives with his wife and children. A couple of times during the last year, after taking cocaine, he has ended up feeling so much anxiety that he wasn’t able to handle his ordinary commitments.

Mark with an X the box that corresponds best with your own opinion. (0 = No problem, 10 = A severe problem)

<table>
<thead>
<tr>
<th>How severe do you find this person’s alcohol or drug use?</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
</table>

Put an X in the box that best describes how much you agree with the statement to the left.

<table>
<thead>
<tr>
<th>This person has a good chance of dealing with his or her alcohol or drug problem on his/her own</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>This person needs psychosocial treatment/help from the social services</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td>The person’s family should intervene and help him/her</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td>The person’s substance use is his/her own business and there is no reason for anyone else to interfere</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td>This person needs medical treatment/help from regional healthcare</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10</td>
</tr>
</tbody>
</table>

Since all of the conclusions that can be drawn from a vignette study are based on the fictive descriptions, a great deal of attention must be devoted to

\(^{18}\) The two latter outcome variables have not yet been subject to analysis and are not included within the scope of this thesis. They are however described here because it is important to understand the context in which the data were collected.
the construction of the vignettes (Rossi, 1979; Wallander, 2008). A preparatory study was therefore conducted in which three group interviews were held to discuss various factors that might be of importance to the perceived severity of substance use and the perceived treatment needs of substance users, and also the design of the vignettes and the response alternatives. The first group consisted of five lay people in their thirties, the second group comprised six researchers, some of whom had experience of vignette studies, and the third group was comprised of six addiction care practitioners: social workers, treatment assistants and nurses working in addiction care work units. The results from this preparatory study, together with theoretical considerations, provided the foundation for the construction of the vignettes.

Construction of the vignettes

The specific characteristic of the factorial survey approach (Rossi & Nock, 1982) applied in this thesis is that the vignettes used are based upon descriptors that are randomly assigned. This means that each of the vignettes is uniquely constructed by selecting a value, or level, from a set of dimensions and then combining these into unique scenarios. Different dimensions included in this study, for example, are gender, age, and substance, whereas different levels refer to the values the dimensions can assume, namely man/woman, young/middle-aged/older, and alcohol/cannabis/cocaine (see Table 2 for a presentation of the dimensions, levels and wordings chosen). By allowing each of the dimensions to vary randomly, the variables become approximately independent in relation to one another, which makes it possible to disentangle the unique effects of each variable both separately and in interaction with the other variables (Wallander, 2008). The randomisation of the contents of the vignettes, combined with the randomisation of the sample of vignettes given to each respondent, thus allows for the investigation of multiple variables and gives the factorial survey the robustness of an experimental method (Taylor, 2006).

As regards construct validity, i.e. the degree to which the measures used are related to the concepts that they are intended to represent (operationalization) (Frankfort-Nachmias & Nachmias, 1996:168), the variables and measures employed in the survey were designed on the basis of theoretical interest, empirical knowledge of the relevance of these dimensions and the results generated in the preparatory study (cf. Jasso, 2006). The vignettes

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19 In the preparatory study, the participants were asked about what signals and signs they would react to if somebody close, such as a relative, friend or colleague, was on the borderline of having a problematic consumption of alcohol or narcotics. The interviews included questions about whether such boundaries would be drawn differently depending on the user’s age, gender, ethnicity or socio-economic status and the substance used. In addition, the participants were presented with a preliminary vignette to assess and discuss. The interviews lasted for 1-1½ hours, and were recorded and transcribed. The material was analysed using a simple form of content analysis, which sought to identify common themes and patterns in the participants’ discussions.
therefore described cases that were deliberately unclear as regards the dis-
tinction between use and misuse, and where the consequences of the use
were relatively mild.20 Another consideration was to make the vignettes re-
fect general situations that may be experienced by people using alcohol or
drugs, rather than situations based on clients that the practitioners meet in
their everyday practice, since the objective was to study perceptions of sub-
stance use and treatment needs in general, rather than professional judg-
ment processes.

The variables operationalized in the vignettes functioned as triggers in-
tended to give the respondents a sense or impression of the substance use
and to elicit a reaction. It may be difficult for practitioners to know what
assumptions underlie the assessments that they make. In contacts with a re-
searcher, there may be a tendency to present oneself in a positive light, and
thus to present a contrived representation of practice. It might be difficult to
talk about assumptions more or less consciously used based upon one’s own
experiences. As has been argued by Bergmark and Oscarsson (1991:140),
practitioners might not always “know what they do”, nor do they always “do
what they say they do”. By using fictitious descriptions of substance users,
the respondents were presented with and asked to assess tangible situations.
Rather than simply asking the practitioners what assumptions are influential
in relation to the ways in which they approach the issues of substance use
and treatment needs, creating a quasi-experimental simulation of a spontane-
ous assessment process could potentially stimulate a reaction that is less
influenced by social desirability bias. Since the respondents are not held
accountable for their assessments, the potential bias towards presenting their
assessment rationale in the best light may be considered as being less of an
issue (cf. Hübner, 2001). In addition, the systematic variation in the vignettes
may make it difficult for the respondents to grasp the full extent of the ma-
nipulation produced by the randomisation process (such as the impact of the
user’s age on their assessment of the severity of the use, for example) (Alex-

The nine dimensions chosen were gender, ethnicity, age, socio-economic
status, relationship, children, substance, frequency and character of negative
consequences. The process also involved deciding how the dimensions
should be varied, e.g. by allowing the age dimension to assume the levels
young (22-25 years), middle aged (41-44 years) and older (57-60 years).
Dimensions such as gender, age, ethnic background and socio-economic
status were included due to a theoretical interest in their independent and
interactive effects on perceptions of substance use and treatment needs (cf.
intersectionality; e.g. Crenshaw, 1991; McCall, 2005; Spierings, 2012).
Gender was operationalized through the use of common male or female

20 For example, including a consequence such as driving under the influence or substance use during
pregnancy would almost certainly provoke high severity ratings from most respondents.
names. Based on conclusions drawn in the preparatory study, the fictive persons were given names with different ethnic associations in order to trigger a sense of the user’s ethnic affiliation (it was argued that operationalizing ethnicity by means of the user’s country of birth would make the inclusion and manipulation of this variable in the vignettes more obvious). 21 Finnish and Middle Eastern (Iraqi, Iranian) ethnic backgrounds were chosen, since these are among the most common immigrant groups in Sweden and are the most common client groups with foreign backgrounds in addiction care. 22 Socio-economic status was represented by using different occupations to signal different class positions in society. The occupations were chosen on the basis of the Swedish Socio-economic Classification (SEI; Statistics Sweden, 1982). Using different occupations to operationalize socio-economic status might be seen as involving something of an over-simplification. Including e.g. the user’s educational level or income would have made the vignettes too complicated however. Occupations such as lawyer and engineer were used in the vignettes as markers of a more well-established position in society, while teacher and journalist were used to signal an intermediate position, and cleaner or nursing assistant a position with no university education and where career development opportunities are limited (a less privileged labour contract, cf. Goldthorpe, 2007). Unemployment was used to operationalize a marginalised position in society (cf. the discussion of social categorisation and the intercategorical approach described in the theory section). Relationship and children were chosen for inclusion as a result of findings from the group interviews, in which both addiction care practitioners and lay people claimed that a person’s family situation was of significance for perceptions of the severity of alcohol or narcotics use.

Different substances such as alcohol, cannabis and cocaine were included as a result of the findings in Paper I which showed that images of substance use problems vary greatly according to the specific substance involved (cf. Blomqvist, 2009c). Cannabis was chosen because of its status as the most widely used illegal drug in Sweden, and cocaine as a result of its being perceived as a hard drug and because it has recently been the subject of a substantial amount of attention in the Swedish media debate, where it has been described as “the new middle-class party drug” (e.g. Wierup & de la Reguera, 2010). 23 Alcohol was included as a reference point, representing the

21 The procedure was similar to that employed in a vignette study of social workers’ assessments of child welfare cases (Skytte, 2002) where the fictive children had a Danish (Erik) or an Arabic (Ali) name. Another example can be found in a study where foreign names were used in fictive job applications to study ethnic discrimination in the hiring process (Bursell, 2012).

22 This was also confirmed by the executives’ responses in this study.

23 The rationale for not including other “hard” drugs such as amphetamines or heroin, for example, which are more common in Sweden than cocaine, is that the inclusion of these drugs would almost certainly have provoked consistently high severity ratings. Cocaine was seen as more interesting to include, due to the social locus of the drug, which is historically associated with upper-class or middle-class use rather than working-class use and which therefore may not automatically be associated with perceptions of a highly problematic use per se.
traditional and most well-established type of substance. A simple measure of the frequency of negative consequences was also added. Since different substances are generally associated with different short-term effects on health, the dimension level “Health effects” was operationalized differently for each of the three substances. Choosing different negative short term consequences was somewhat complicated, but the material from the preparatory study formed the basis for the final alternatives, which became quite similar to those postulated for “abuse” in the DSM-IV. Other variables were also considered but excluded due to the fact that the vignettes would have become too long and complicated, with too many variables and combinations. To use as many as twelve dimensions or more might increase the risk of respondent inconsistency and fatigue in assessing the vignettes (cf. Sauer, Auspurg, Hinz & Liebig, 2011).

The wordings were combined into vignettes by means of a procedure in Excel. For each vignette that was constructed, one level was randomly selected from each of the dimensions of the vignette design. To avoid unrealistic combinations, if the vignette person was young (22-25 years old) and had been assigned one of the occupations requiring a longer education (teacher, journalist, lawyer, engineer), he or she was described as a student in one of these professional education programmes. A set of vignettes was then compiled to produce a unique web-based questionnaire for each of the respondents. This created a quasi-experimental situation, which allowed for the analysis of the influence that each and every one of the nine vignette variables had on the assessments, either alone or in interaction with one or more of the other variables. For example, this made it possible to establish whether the use of cocaine was generally seen as being more severe than the use of alcohol or whether the choice of substance interacted in the severity assessments with the consequences of the vignette person’s use and/or with personal characteristics, such as age and ethnicity.

24 The likelihood for the level “alcohol” to appear in the vignettes was twice that of the other substances. In the same vein, the likelihood for the vignette person to have a Swedish sounding name was twice that of the names signifying the other ethnic affiliations. The reason for this was to make the relevant sample proportions similar to the proportions found in the population.

25 In the earlier version of the DSM (IV) “substance abuse” was defined as “a maladaptive pattern of substance use leading to clinically significant impairment or distress as manifested by one (or more) of the following, occurring within a 12-month period: failure to fulfil major role obligations at work, school, or home, use in situations in which it is physically hazardous, legal problems, continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g. arguments with spouse about consequences of intoxication and physical fights)” (APA, 1994).

26 In the vignette universe used in the study, the number of theoretically possible combinations of vignette variables was 12,960 (2 (gender) x 3 (ethnicity) x 3 (age) x 4 (socio-economic status) x 2 (relationship) x 2 (children) x 3 (frequency) x 3 (substance) x 5 (consequence)). The total number of theoretical vignettes may be considerably larger than this in factorial surveys. For example, the vignette universe used by Jasso (1998) consisted of 1,047,259,295,424 possible combinations (cf. Wallander, 2009). In the current study, 474 respondents assessed 10 vignettes each, which gives a total of 4,740 assessed vignettes. Because of the randomisation process, however, it is possible to generalise the assessments made in relation to this sample of vignettes to the whole population of the vignette universe.
Table 2. Dimensions, levels, and wordings used in the vignettes

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Levels/classifications</th>
<th>Wordings/operationalization</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>Man</td>
<td>Martin/Johan/Peter/Björn/Anders/Kalle/Mats/Leif/Jonas/Bo/</td>
<td>51</td>
</tr>
<tr>
<td></td>
<td>Woman</td>
<td>Pekka/Arto/Jukka/Matti/Antti/</td>
<td>25</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mohammed/Reza/Ali/Ramin/Ahmed/</td>
<td>24</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>Swedish</td>
<td>Helen/Linda/Lena/Birgitta/Anna/Gun/Carina/Lotta/Nina/Barbro/</td>
<td>51</td>
</tr>
<tr>
<td></td>
<td>Finnish</td>
<td>Pirjo/Aino/Marja/Sirkka/Riika/</td>
<td>25</td>
</tr>
<tr>
<td></td>
<td>Middle Eastern</td>
<td>Fatima/Nahid/Soheila/Leila/Nadira is</td>
<td>24</td>
</tr>
<tr>
<td>Age</td>
<td>Young</td>
<td>22, 23, 24, 25 years old and</td>
<td>34</td>
</tr>
<tr>
<td></td>
<td>Middle aged</td>
<td>41, 42, 43, 44 years old and</td>
<td>33</td>
</tr>
<tr>
<td></td>
<td>Older</td>
<td>57, 58, 59, 60 years old and</td>
<td>33</td>
</tr>
<tr>
<td>Socio-economic</td>
<td>Unemployed</td>
<td>unemployed.</td>
<td>24</td>
</tr>
<tr>
<td>status</td>
<td>Working</td>
<td>works as a cleaner/ works as a nursing assistant.</td>
<td>26</td>
</tr>
<tr>
<td></td>
<td>Middle class</td>
<td>works as a teacher/journalist/studying to become a teacher/journalist.</td>
<td>24</td>
</tr>
<tr>
<td></td>
<td>Well-established</td>
<td>works as a lawyer/engineer/studying to become a lawyer/engineer.</td>
<td>26</td>
</tr>
<tr>
<td>Relationship</td>
<td>Single</td>
<td>He/she is single/a single parent.</td>
<td>47</td>
</tr>
<tr>
<td></td>
<td>Cohabitant</td>
<td>He/she lives with his/her partner/and children.</td>
<td>53</td>
</tr>
<tr>
<td>Children</td>
<td>No</td>
<td></td>
<td>51</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td></td>
<td>49</td>
</tr>
<tr>
<td>Substance</td>
<td>Alcohol</td>
<td>When drinking alcohol, he/she has</td>
<td>49</td>
</tr>
<tr>
<td></td>
<td>Cannabis</td>
<td>When smoking cannabis, he/she has</td>
<td>25</td>
</tr>
<tr>
<td></td>
<td>Cocaine</td>
<td>When taking cocaine, he/she has</td>
<td>26</td>
</tr>
<tr>
<td>Frequency</td>
<td>Once</td>
<td>recently, on one occasion</td>
<td>34</td>
</tr>
<tr>
<td></td>
<td>Two times</td>
<td>a couple of times during the last year</td>
<td>33</td>
</tr>
<tr>
<td></td>
<td>Several times</td>
<td>several times lately</td>
<td>33</td>
</tr>
<tr>
<td>Consequence</td>
<td>Relational problems</td>
<td>ended up in a quarrel with his/her partner/a friend.</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>Neglect of obligation</td>
<td>missed an important meeting the following day.</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>Health effects (Alcohol,</td>
<td>ended up not remembering what happened last night.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cannabis,</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cocaine)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Disorderly conduct</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Legal problems</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

To test the applicability of the vignettes and the questions, a pilot study was conducted among 35 students in the undergraduate social work programme at Stockholm University. A number of analyses were conducted in order to study whether the vignette descriptions were relevant and possible for the respondents to assess, and whether the dimensions and response alternatives were intelligible and sufficiently differentiated to answer the study’s research questions. Two different versions of the response alternatives were tested in order to specify the wordings, and interval scales were finally chosen to make it possible for the respondents to specify a degree of agreement,
rather than forcing them to categorise their reactions on the basis of a limited number of options.\textsuperscript{27}

Sampling procedure and data collection

The study population included all social services and regional healthcare outpatient addiction care units in the three largest counties of Sweden. The objective was to include units that provide specialised addition care services and to capture a variety of organisational solutions, rather than obtaining a representative sample of the treatment system as a whole. Thus only units in municipalities with 50,000 or more inhabitants were included. The reasons for excluding the smaller municipalities in rural areas were practical, since all units had to be contacted in person to retrieve e-mail addresses. In addition, it was desirable for each unit to have as many potential respondents as possible in order to enable multi-level analysis, which requires a certain number of respondents within each unit. The ambition was to obtain diversity in the socio-demographic characteristics of the catchment areas of the work units where the survey was conducted. The design also had a focus on including ‘front line’ services, where assessments and investigations are made, which is where clients and patients have their first contacts with the treatment system. Pure inpatient or residential care units were therefore excluded.

To begin with, contacts were established with the responsible section managers of the different work units for adult addiction care at the municipal and regional healthcare levels. These managers were then informed about the study via telephone or e-mail. If the managers agreed to participate, they were asked to provide the e-mail addresses of all the staff at the work units who had client/patient contacts and to inform their staff about the study. Unique web questionnaires were thereafter sent to each respondent’s e-mail address to begin the vignette study. One benefit of using a web survey was that it made it possible to ensure the anonymity of the answers while at the same having a record of who had completed the questionnaire and who needed to be sent a reminder. Another advantage was that it saved the work associated with the data entry process. All respondents were sent a lottery ticket worth 2.75 euro as a token of appreciation after completing the survey. The practitioners were asked to assess a unique set of ten short varied vignettes (see Appendix I for the staff questionnaire).\textsuperscript{28} The respondents were

\textsuperscript{27} In the pilot versions, an additional response alternative was tested which measured the respondents’ ratings of the described user’s “need for insight” (somebody ought to make him/her realize the consequences of his/her alcohol/narcotics use). Since this dimension was highly correlated (in version 1: r=0.801, p<0.01) with the problem severity measure, it was removed.

\textsuperscript{28} Four more detailed traditional vignettes presented to the respondents in the same manner functioned as a pedagogical introduction to the assessment process (cf. Blomqvist & Wallander, 2004), which was then conducted in the next step, and which involved the ten shorter factorial (varied) vignettes. For a description of the traditional vignettes and the questionnaire, see Appendix I. Two of the traditional vignettes,
asked not to spend too much time on their assessments, but rather to base their responses on their spontaneous impressions and to disregard the somewhat technical structure of the vignettes. Finally the questionnaire contained questions about the respondents’ age, gender, work experience and orientation, and education, and also questions about their own experience of substance use problems as well as their views on the role and responsibilities of the addiction care system.

In all, 91 work units were asked to participate in the study. Of these 11 (3 regional healthcare units and 8 social services units) refrained from answering or declined to participate due to e.g. re-organisation processes, lack of time or a limited number of staff. The work unit response rate was thus 88%. However, at three of the participating work units nobody, or only a single staff member, completed the survey, and these units were therefore excluded. Thus, 77 work units were included in the analysis, of which a substantial majority were social services units (51 work units) while about one third were regional healthcare units (23 work units) (see Table 3). Three of the work units were so-called cooperation units, since their executives described their organisation as constituting a collaboration between social services, correctional care or private actors.

Table 3. Numbers of participating work units and questionnaires distributed, and response rate

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Number of work units</th>
<th>Number of questionnaires distributed</th>
<th>Number of questionnaires returned</th>
<th>Response rate %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social services</td>
<td>51</td>
<td>505</td>
<td>333</td>
<td>66</td>
</tr>
<tr>
<td>Regional healthcare</td>
<td>23</td>
<td>212</td>
<td>129</td>
<td>61</td>
</tr>
<tr>
<td>Cooperation units</td>
<td>3</td>
<td>40</td>
<td>27</td>
<td>68</td>
</tr>
<tr>
<td>Total</td>
<td>77</td>
<td>757</td>
<td>489</td>
<td>65</td>
</tr>
</tbody>
</table>

The propensity to participate was somewhat lower among regional healthcare staff (61%) than among social services staff (66%) and among men (62%) than among women (66%). The same pattern has previously been found in similar staff surveys in Swedish addiction care (Palm, 2003; Storbjörk, 2003; Christophs, 2009). It was not possible to collect any other information about potential differences between respondents and non-respondents as a result of the respondents’ anonymity. As regards the significance of the specific context in which the research has been conducted, the question of external validity, i.e. the possibility of generalising the results to populations other than those studied, needs to be addressed. Since the study was not based on a probability sample but on a strategic sample, it is not possible to generalise the results to the national level. The study nonetheless

Johanna and Hans, were used as a stimulus material in the subsequent focus group interviews. The results of this analysis are not included within the scope of this thesis however.
involved large sample sizes and fairly high response rates, however, and the sampling frame accounts for a large proportion of the addiction care services delivered in Sweden.29

The respondent characteristics for those who participated in the survey are presented in Table 4. The staff information is based on the cases included in the analyses, following the filtering out of missing values (internal non-response). The samples included more women than men, which was particularly true of the regional healthcare sample, and this constitutes a reasonably good reflection of the actual gender composition of addiction care staff.30 Since the social services were represented to a greater extent than regional healthcare,31 the majority of the respondents had a social work degree. As many as 70 percent stated that they had experience of themselves or a significant other having had substance use problems.

Table 4. Respondent characteristics, n = 474

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>% of sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Men</td>
<td>119</td>
<td>25</td>
</tr>
<tr>
<td>Women</td>
<td>355</td>
<td>75</td>
</tr>
<tr>
<td>Organisation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social services</td>
<td>324</td>
<td>68</td>
</tr>
<tr>
<td>Regional healthcare</td>
<td>123</td>
<td>26</td>
</tr>
<tr>
<td>Cooperation</td>
<td>27</td>
<td>6</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social work education</td>
<td>258</td>
<td>54</td>
</tr>
<tr>
<td>Medical education</td>
<td>102</td>
<td>22</td>
</tr>
<tr>
<td>Other university education</td>
<td>58</td>
<td>12</td>
</tr>
<tr>
<td>No university education</td>
<td>56</td>
<td>12</td>
</tr>
<tr>
<td>Occupation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social worker</td>
<td>263</td>
<td>56</td>
</tr>
<tr>
<td>Nurse</td>
<td>72</td>
<td>15</td>
</tr>
<tr>
<td>Medical doctor</td>
<td>20</td>
<td>4</td>
</tr>
<tr>
<td>Therapist/Treatment assistant</td>
<td>119</td>
<td>25</td>
</tr>
<tr>
<td>Experience of own or relatives’ substance use problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes, during the last year</td>
<td>139</td>
<td>29</td>
</tr>
<tr>
<td>Yes, but not during the last year</td>
<td>194</td>
<td>41</td>
</tr>
<tr>
<td>No, never</td>
<td>125</td>
<td>26</td>
</tr>
<tr>
<td>Do not wish to answer</td>
<td>16</td>
<td>3</td>
</tr>
<tr>
<td>Mean age</td>
<td></td>
<td>46.3 (SD 10.9)</td>
</tr>
<tr>
<td>Mean years working with substance use problems</td>
<td></td>
<td>12.2 (SD 9.5)</td>
</tr>
</tbody>
</table>

29 The county of Stockholm accounts for approximately one third of the substance misuse treatment provided in Sweden (Wallander & Blomqvist, 2005). The care and treatment units in Sweden’s three largest counties, Stockholm, Västra Götaland and Skåne, represent 45% of the care services and 51 % of the treatment (outpatient) services provided for substance use problems in Sweden (NBHW, 2008; SOU 2011:35).
30 In an earlier study among addiction care staff in Stockholm County, 31% of the social services respondents and 23% of the regional healthcare sample were men (cf. Palm, 2003; Storbjörk, 2003). An analysis of the study’s non-response indicated that those answering the survey did not differ substantially differ from the non-participants.
31 Outpatient addiction care in Sweden is delivered by, in order of magnitude, social services (54%), regional healthcare (15%), private organisations (14%), social services and regional healthcare in cooperation (12%), NGOs (4%) and other (1%) (SOU 2011:35:582).
The section managers at the work units were also requested to complete a web survey containing questions about the size, orientation and target group of their respective work units, and this survey was completed by all 77 work unit managers (see Appendix II for a presentation of the executive questionnaire). The work unit characteristics are presented in Table 5. Socio-demographic information on the work units’ catchment areas was collected for each municipality (Statistics Sweden, 2010) and for the various city districts (statistics from the home pages of the city councils in the urban areas), and was used as an indicator of the socio-economic makeup of the catchment areas in which the work units were situated.

Table 5. Work unit characteristics, n = 77

<table>
<thead>
<tr>
<th>Organisation</th>
<th>N</th>
<th>% of sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social services</td>
<td>51</td>
<td>66</td>
</tr>
<tr>
<td>Regional healthcare</td>
<td>23</td>
<td>30</td>
</tr>
<tr>
<td>Cooperation</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Unit orientation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mainly assessment</td>
<td>31</td>
<td>40</td>
</tr>
<tr>
<td>Assessment and treatment</td>
<td>37</td>
<td>48</td>
</tr>
<tr>
<td>Mainly treatment</td>
<td>9</td>
<td>12</td>
</tr>
<tr>
<td>Substance orientation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol</td>
<td>33</td>
<td>43</td>
</tr>
<tr>
<td>Narcotics</td>
<td>12</td>
<td>16</td>
</tr>
<tr>
<td>Both alcohol and narcotics</td>
<td>32</td>
<td>41</td>
</tr>
<tr>
<td>Socio-demographics of catchment area</td>
<td>Mean 6.6 (SD 3.5)</td>
<td></td>
</tr>
<tr>
<td>Unemployment rate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social allowance rate</td>
<td>Mean 4.9 (SD 3.9)</td>
<td></td>
</tr>
<tr>
<td>Proportion of immigrants</td>
<td>Mean 31.4 (SD 17.4)</td>
<td></td>
</tr>
</tbody>
</table>

Analysis of the factorial survey data

The factorial survey procedure described above generated a data set structured at different levels based on three types of variability; the vignettes (Level 1, n=4740), the respondents (Level 2, n=474) and the respondents’ work places (Level 3, n=77). Hierarchic linear modelling (HLM; or multilevel analysis; Bryk & Raudenbush, 2002) was employed in order to take into account the grouped structure of the observations and to model the variation that was not explained by the independent variables on the different levels (Snijders, 2004). It is important to consider that the assessments made by practitioners might be correlated (intra-class correlation) as a result of e.g. the individual’s personal values and approaches (10 assessments each at the respondent level) and common local practices and work cultures (2 to 15 respondents per work unit at the work unit level). Failure to take this into account in the statistical analysis could lead to inadequate estimates of the standard errors (Bryk & Raudenbush, 2002).

A regression model in multilevel analysis consists of two parts; a fixed part involving estimates of the regression coefficients, their standard errors, t-values and p-values, and a randomised part which allows for the specifica-
tion of the variance at each level (Snijders, 2004). Since statistical power is to a large extent affected by the sample size and the number of observations, in this case based on level 1, even moderate effects at level 1 were associated with low p-values. The sample size on level 3 (77 units) may be considered as quite acceptable, since according to Snijders (2004) the smallest acceptable sample size at the highest level in multilevel regression analysis is 20 units. The analyses focused on the strength and direction of the unstandardised regression coefficients for each dimension. Since the dependent variable (ratings 0-10) was treated as interval-level data, linear multilevel regression analysis was conducted using the HLM statistical software (version 7; Raudenbush et al., 2011). The coefficients were interpreted as showing the amount of change in the dependent variable (Y) that was associated with a one-unit change in the independent variable (X). For example, Paper II shows that at the vignette level, if the described user had children (represented by the value 1), perceived severity increased by 0.65 units on the 0-10 scale, by comparison with a user described as not having children (represented by the value 0). Interaction effects were analysed to explore potential effect measure modification between variables on different levels (cross-level interaction) and between different vignette variables (see Figure 2 for a model of the factors examined in the vignette study). For example, in Paper II, it was found that doctors (Level 2) assessed the severity of women’s substance use (Level 1) as being more severe than did social workers.\(^{32}\) To avoid data dredging\(^{33}\) (cf. Martin & Roberts, 2010) the choices of vignette interaction and cross-level interaction analyses were guided by theoretical interest.

\(^{32}\) The results should however be interpreted with caution since only 20 doctors participated in the vignette study.

\(^{33}\) Data dredging or data fishing is used to describe repeated data analysis with no a priori hypothesis of interest, which can result in significant findings that are artefacts of the repeated analysis of the data (cf. Martin & Roberts, 2010).
The analyses of the vignette data (Papers II and III) showed that a high proportion of the variance remained unexplained on the vignette and practitioner levels, indicating that factors not included in the survey were influential. On the vignette level, for example, factors such as the user’s own view of the substance use, the age of possible children, previous experience of substance use problems or treatment etc. could have been included, but might also have made the vignettes too complicated. Selecting certain variables at the expense of others is part of the research process, and it is therefore important to provide a detailed description of the rationale for the choices made (cf. Becker, 1998). At the practitioner level, some of the unexplained variance might, for example, be attributed to perceptions based on personal values and experiences (cf. Skogens, 2007) or on locally developed work unit practices (Smith, 2014). Earlier research has shown that individuals’ patterns of consumption are related to their attitudes and values towards alcohol and alcohol problems (Hübner, 2001; 2009; 2012; Karlsson, 2006). For reasons of integrity, the presence of substance use problems among the respondents themselves and/or relatives was measured using a single, combined question (yes/no/unwilling to answer). Since this variable was not influential in the multilevel analyses, it was not included in the analyses. It is possible that with a more specific measure of the respondents’ own consumption, the analysis might have explained more of the variance at the respondent level. Factors such as the current mood of the respondent, the situation at the workplace, or fatigue after filling out eight out of ten vignettes (cf. Sauer et al., 2011) may also be of influence. The point of using the factorial survey ap-
proach, however, is that the standardisation of the assessments and the ran-
donisation procedure employed introduces a control for the various inde-
pendent effects of the variables, which produces high internal validity (con-
fidence about the validity of the results within the context of the study). Bearing in mind the relatively coherent results of the vignette study, which are very much in line with those reported in previous research, the findings may be regarded as being fairly robust. The analyses were conducted several times and using different software packages (HLM, MLwiN, SPSS, Stata) in order to ensure the accuracy of the results produced, a procedure which produced similar findings.

The questionnaire asked the respondents for their comments on the design and topic of the study. About 100 respondents provided comments and about half of these related to the difficulty of making assessments based on the limited information contained in the vignettes. The respondents thought that important factors were missing, such as information regarding a history of problematic consumption and the users’ own views on their consumption. Occasional comments noted that the statements regarding how the substance use should be dealt with were too crude and should also have included primary care measures, since the use described in the vignettes took the form of risk consumption rather than misuse or addiction. The other half of the comments were for the most part positive, stating that the respondents found the topic interesting and relevant. Studying staff perceptions was viewed as being important in order to contribute to a more coherent view in addiction care. It was suggested that similar studies could be conducted on a regular basis in work places, increasing the opportunities for reflection. The results of the vignette study are presented in Papers II and III.

The focus group interview study

In order to understand the thoughts and processes that lay behind the patterns of assessments made in the “frozen moments” of the vignette study (cf. Wallander & Blomqvist, 2005) among Swedish addiction care practitioners, a follow up qualitative group interview study was conducted with a sample of the respondents from the vignette survey. The study was financed by the Swedish Research Council on Health, Working Life and Welfare (Forte) within the “Women, health and substance use” programme at SoRAD (Dnr 2007-2131). Focus group interviews are considered to have special advantages in providing information about people’s views or understandings, but they also provide information about how these views and understandings are produced (Morgan, 1996). Other strengths are that the participants both question and explain themselves to one another, which produces more than the sum of a number of separate individual interviews. The interviewer, by observing the interactions within the group, can also assess the extent of
consensus or diversity among the participants. In addition, the researcher can ask the participants themselves to make comparisons or to describe their own experiences (Morgan & Krueger, 1993). By using focus groups, the researcher can obtain an understanding of public discourses on a social matter (Kitzinger, 1994) as opposed to the beliefs expressed in individual interviews. It is important to note that the accounts obtained in the discussions should not be treated as being “wrong or right” or “accurate or inaccurate” but rather as representations generated in a specific group context (Smithson, 2000). The knowledge obtained is shaped by the situation in which the interview takes place. The discussions may be understood as constituting the representations that the practitioners are willing to share, and that thus reveal the discourses that are dominant in their social practice. One problem associated with focus groups may be that the discussion is dominated by one or a number of participants, making it more difficult for others to express their opinion. However, the dominance of one or a number of participants may also be viewed as an expression of the power relations taking place within the group, and thereby as being constitutive of the existing norms (cf. Bernhardsson, 2014; Demant & Järvinen, 2006). Using pre-existing social groups in which the respondents know each other and that are relatively homogeneous in their composition facilitates the study of group norms (cf. Bauer & Gaskell, 1999; Bloor, Frankland, Thomas & Robson, 2001) by reflecting the thought-styles (Fleck, 1997) or local discourses (Sahlin, 2003) that are prevalent in, for example, an addiction care work unit.34

Sampling procedure and data collection

The focus group interviews were preceded by careful preparations, in which the interview guide was discussed with experienced qualitative researchers. The recruitment process was determined by the fact that the respondents in the vignette study had been asked whether they would be interested in participating in follow-up group interviews to discuss the results. Of the 469 respondents answering this question, 295 stated such an interest (63%). The executives of six work units with the largest number of interested participants were contacted and all of the contacted work units agreed to participate. Three of these were social services work units, two were regional healthcare units and one was a cooperation unit with representatives from both social services and regional healthcare. The time and location of the interview was agreed with the executives and individual practitioners were invited to participate in good time prior to the scheduled session. The execu-

34 Börjesson and Palmblad (2007) distinguish between dominant (large) and local (small) discourses, where dominant discourses are used in the media, in public reports and are found in public opinion (cf. the Swedish doxa of narcotics, Bergmark & Oscarsson, 1988). Local discourses are formed within certain organisations and social groups, e.g. by the workplace culture at an addiction care work unit. See also Petersson (2013).
tives were asked not to participate in the interviews in order to increase the chances of a relaxed discussion climate in the interview groups. Six focus groups were conducted with 3 to 7 participants. In total, 30 individuals participated (see Table 6 for a presentation of the participant characteristics). Participation in the preceding vignette study was not a precondition, since the participants were not going to be presented with their own assessments, but rather asked to reflect on the meaning of the results and their implications for practice in general. The participants were informed of the fact that their participation was voluntary and anonymous. In the categorisation presented in Table 6, participants are described either as social workers (working mainly with assessments), nurses or treatment providers. Unfortunately, no doctors participated in the focus groups, despite efforts to include them.

Table 6. Participant characteristics in the focus group study, n=30

<table>
<thead>
<tr>
<th>Category</th>
<th>Variables</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>Female</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>10</td>
</tr>
<tr>
<td>Occupation</td>
<td>Social workers</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>Nurses</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Treatment providers</td>
<td>11</td>
</tr>
<tr>
<td>Age</td>
<td>18 – 29</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>30 – 39</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>40 – 49</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>50 – 59</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>60 –</td>
<td>7</td>
</tr>
<tr>
<td>Organisation</td>
<td>Social services</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Regional healthcare</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Cooperation</td>
<td>1</td>
</tr>
</tbody>
</table>

The same moderator (the author) was used in all six interviews, which lasted between 73 and 82 minutes. The interviews were relatively structured in the sense that they were divided into five different stages. First, practical information was provided about the content and structure of the interview, with the participants being told that the subject of the interview was perceptions and assessments of substance use (see Appendix III for the interview guide). They were informed that there were no right or wrong answers on the topic, but rather they were encouraged to engage in a discussion about the difficult issues associated with their complex work and to express divergent opinions and experiences. Second, after a brief presentation, the participants were asked to reflect on their first meeting with a client/patient, on how a spontaneous assessment is made and on which factors determine whether or not a given person is in need of treatment. Third, two vignettes were presented and the participants were asked to discuss the severity of the substance use described and the need for treatment. Fourth, some of the results from the vignette study were presented and the participants were asked to reflect on the meaning and implications of the results. The participants were asked for
their spontaneous comments on the results and were thereafter requested to discuss to what extent and how the results confirmed or contradicted their experiences of practice. Finally, the participants were asked for any concluding remarks and whether they felt that something important had been missed in the discussion. In Paper IV, the analysis was based on the discussions generated in the fourth part of the interviews. In the interviews, the moderator tried to adopt a reserved position, allowing and encouraging the participants to talk among themselves, which sometimes led to the discussion moving away from the topic. However, the topics sometimes came up without the moderator having to ask about them. The moderator used open ended questions, and occasionally asked the participants to develop their ideas and to express conflicting views by asking for examples or for them to elaborate on things they had said. The practitioners were given a cinema ticket as a token of appreciation for their participation.

Discourse analysis of the focus group interviews

Discourses are socially produced representations that set limits on how the world (and aspects of it) can be thought about (Bacchi, 2009). They may often be so widespread that their claims – their representations of the world – become taken-for-granted ways of thinking about given subjects. Discourse analysis involves focusing on the function of language (Potter & Wetherell, 1987). People use language to construct versions of the social world, by trying to make sense of a phenomenon or by unconsciously assigning blame for or justifying a situation or behaviour. Potter and Wetherell (1987) criticise traditional attitudes research for the simplistic assumption that attitudes are something enduring that it is possible to measure on a scale, separately from the “object of thought”. One important aspect described by Potter and Wetherell (1987) is the variability of the accounts expressed. From a discourse analytic view, the “attitude” expressed depends on the context, and the same person can produce quite different stereotypical categorisations depending on the situation. It is thus of interest for the researcher to analyse the construction of the accounts and categorisations and the function they serve in the context.

The analysis process was cyclical in the sense that it moved between coding, reading and analysing the material in several stages. Immediately following the conclusion of the interviews, quick summaries of impressions were written. Since the interviews were not transcribed by the author, the recordings were listened to carefully several times to get a sense of the material and to supplement the transcripts with pauses, laughter, irony etc. (in total the transcripts accounted for approximately 100 pages of text). Thereafter, all of the various discussions relating to gender that occurred during the discussions of the vignette results were compiled in a separate document, which then contained approximately 200 excerpts. In the third step, these
excerpts were coded based upon a simple form of content analysis in order to discern recurring themes and meanings. No semantic or conversational analysis was conducted, since the focus of the analysis was directed at the meanings and assumptions embedded in the discussions. Patterns of shared and varying accounts were searched for in the material, focusing on contradictions and nuances. Fourthly, these excerpts were analysed in depth in accordance with the discourse analytic approach suggested by Edley (2001), applying the concepts of interpretative repertoires, ideological dilemmas and subject positions (cf. the Theory chapter and Paper IV). The choice of this critical discursive psychological approach (cf. Edley, 2001) was based on an ambition to emphasise the variation in the accounts expressed, which included differing and sometimes contradictory components. Also, a more agency-oriented discourse analytical approach was considered to be suitable, since the participants were reflecting on the topics discussed, not only reproducing but also questioning the prevailing discourses.

During the analysis it became apparent that the participants sometimes tried to avoid expressing generalisations in their discussions about substance use and treatment needs (cf. Hertzberg, 2005). Talking about the importance of gender, ethnicity and class in relation to the application of care is a value-laden issue, with the participants wanting to avoid being perceived as engaging in discrimination. At the same time, they made use of stereotypes based on social categorisations both in their own accounts and in references to societal discourses and practice. Simplified descriptions were used in the vignette study that formed the basis of the discussions. The social categories were thus used as anchor points to construct tangible descriptions for the practitioner to form an opinion about, thereby enabling an analysis of the importance of the categories for the perceptions in question (see the Theory section for an elaboration of this intercategorical approach; McCall, 2005).

The material obtained from the interviews may be regarded as a product of what is experienced as being possible to express in the interview context and thereby as constituting interesting and revealing discourses on the construction of gender in addiction care. In qualitative research, the question of generalizability is of importance with regard to the extent to which the findings are relevant for other situations than those directly studied (Becker, 1990:240; Maxwell, 1992:293). In discourse analysis, the participants’ accounts are approached in their own right, with the focus of the analysis being directed at looking at the construction and function of the discourse in question (Potter & Wetherell, 1987:160). Sample size is thus less of an issue. Similar accounts or discourses appeared in different contexts, however, sometimes without the moderator having to ask about them, which points to

35 Content analysis could be defined as a “careful, detailed, systematic examination and interpretation of a particular body of material in an effort to identify patterns, themes, biases and meanings” (Berg & Lune, 2011:349)
a certain amount of consistency in the practitioners’ accounts and thus sug-
gests that it may be possible to generalise the findings theoretically to other
similar contexts (Vicsek, 2010). The focus group interviews are not however
viewed as being able to reveal an unbiased set of opinions but are instead
treated as conversational encounters (cf. Potter & Wetherell, 1987) that are
shaped by the constitution of the groups, the stimulus material and the inter-
view questions. In reporting the findings, efforts were made both to describe
the analysis process as thoroughly as possible in order to increase transpar-
ency (cf. Golafshani, 2003) and to provide lengthy quotations from the inter-
views in order to give the reader the opportunity to follow the conversations.
The results from the focus groups interviews are presented in Paper IV.

Concluding methodological reflections

In this thesis, social constructionism is expressed, for example, in the way
the results are interpreted and in the discussion of the knowledge claims that
it is possible to make. It is acknowledged that the methods employed are by
no means objective or neutral. The formulation of the vignettes, questions
and response alternatives in the surveys, as well as the settings for the focus
group interviews and the role played by the moderator, have shaped the re-
sults obtained, and for this reason the research was preceded by careful con-
sideration and preparation. It is impossible for the researcher to escape as-
sumptions about the world, and it may be argued that the assumptions under-
lying the current project are relatively explicit in the form of the variables
tested in the vignette study.

The material obtained by means of the factorial survey may be regarded
as abstract “representations” rather than as true “replicas” of the practitio-
ers’ assessments (cf. Benbenishty, 1992). The assumptions on which the practitioners based their assessments could not be accounted for however.
With subsequent group interviews it was also possible to distinguish some of
the assumptions underlying these assessments, which in turn improved the
understanding of the results from the vignette study (cf. Wallander, 2008).
The question of whether research can actually uncover a true or accurate
representation of reality is complex, but the ambition in this project has been
to study both abstract representations of perceptions (the surveys) and disc-
cursive formations (group interviews) of substance use and treatment needs.
This combination contributes to existing knowledge about the prevailing
governing images and boundary-making processes in contemporary addiction
care.
Ethical reflections

Since the described situations (vignettes) used in Papers II, III and IV were based on fictive cases, no ethical complications for individual clients/patients were involved. The participation of work units and staff was voluntary. Informed consent forms were signed by all practitioners in the focus group study (see Appendix IV). From an ethical point of view, contributing to the clarification of practitioners’ values regarding the subject of the study, and giving them an opportunity to reflect on these values, might be considered positive. One issue that might have constituted a problem is that the focus group interviews could have provoked discussions about potentially sensitive personal experiences or beliefs among the participants. The discussion climate in the groups was relaxed and in order to limit the risk of participants talking to other colleagues about what was said in the interviews, the moderator began by asking everybody to agree that what was said in the group would stay among the participants. At the final stage of the interview, the moderator also asked the participants about their thoughts and feelings about the interview, in order to give them the opportunity to express any discomfort. Following the completion of the interviews, several participants said that it had been rewarding to have been given the opportunity to discuss and reflect on categorisations of substance use and treatment needs. They also said that they were rarely given time or the opportunity to do so in their everyday work practice. Participation in the interviews was not considered to involve any risk for harm to the respondents, who were free to break off their participation in the study at any time. No information that would make it possible to identify any individual respondents or work units has been published. The participants were informed that the results would be presented in peer-reviewed articles. The material was stored on Stockholm University’s secure server and personal respondent records were kept separate and were only accessible to the project’s team members. The project was approved by the Stockholm Regional Ethical Review Board (2010-01-14, registration no. 2009/2101-31/5).
Summary of papers

Paper I

The first paper presents results from a survey conducted in 2006 among staff from different parts of the Swedish addiction care system. Participating work units were included from the social services, regional healthcare and the probation service in the Stockholm region. The 655 respondents rated the severity of various forms of substances as societal problems, the risk of becoming addicted and the possibility of recovery with or without treatment. By analysing means and using linear regression, the study examines differences in perceptions between practitioners based on their organisational affiliation, education, gender and work experience.

Despite the fact that many people recover from alcohol and drug problems without the help of professional treatment (e.g. Klingemann & Sobell, 2007), staff felt there were only limited possibilities for individuals to handle problematic substance use on their own. Confidence in the effectiveness of treatment was high, particularly in the regional healthcare system. Perceptions of different forms of addictive behaviours varied substantially in the sense that hard drugs such as heroin, amphetamines and cocaine were viewed as being very dangerous to society, highly addictive and difficult to quit. Tobacco was located at the other end of the spectrum, and was viewed as being easy to quit and as only constituting a minor problem in society. Gambling, alcohol, cannabis and medical drugs were located between these two extremes. This is in line with the official doxa in Sweden, which describes narcotic drugs as a major threat to society, despite the fact that alcohol causes more problems at both the individual and societal levels. The differences that were found among practitioners in different parts of the addiction care system took the form of a somewhat stronger belief in self-change among social services staff, a general tendency to rate the addictiveness of various substances higher in regional healthcare and an inclination to rate the need for treatment higher among probation service staff. These differences are seen as reflecting variations in the practitioners’ roles across different parts of addiction care. In general, however, perceptions were similar across different parts of the addiction care system, and were also similar
to images of substance use problems and recovery found among lay people. One conclusion was therefore that practitioners’ perceptions of various substance use problems are linked to the governing images of substance use problems and recovery that are prevalent in society as a whole.

Paper II

The second paper aimed to explore the importance of characteristics of both the substance user and the practitioner making the assessment, and also of the practitioner’s workplace, for the perceived severity of substance use. The study employed a special survey method, the factorial survey approach (Rossi & Nock, 1982), which has lately attracted a great deal of attention as a result of the special advantages it offers in the study of social norms. 474 practitioners from 77 outpatient units located in the largest counties of Sweden each evaluated ten short fictive scenarios of people using alcohol or narcotics with various consequences. The scenarios, or vignettes, combined values from relevant dimensions such as gender, age, ethnicity, socio-economic status, family situation, substance, frequency and character of negative consequences, to produce unique, concrete situations for the respondents to assess. Each of the variables included in the vignettes was randomly assigned, which made it possible to disentangle the importance of each variable on the assessment made. In combination with multilevel analysis, it was furthermore possible to specify the importance of variables at different levels of the analysis, taking into account the grouped structure of the data (Hox, 2010).

The results showed that perceptions differed not only depending on the type of substance and the frequency and character of the negative consequences, but also depending on the age, socio-economic status and family situation of the user. Older age, unemployment and having children were all associated with higher severity ratings. Although the gender or ethnicity of the user were not significant in the main analyses, a number of interaction analyses showed that doctors assessed the use of women as being more severe, irrespective of the circumstances or the consequences of the use. In general, the alcohol use of young men was perceived as being less severe by comparison with that of young women. Alcohol consumption was seen as being considerably less problematic than narcotics use, which indicates that the illegal status of the substance, rather than the social circumstances in which the use takes place, is of major importance for how substance use is perceived by addiction care staff. The tendency to make a distinction between alcohol and narcotics was somewhat less marked among staff from work units specialised in narcotics, which may be viewed as a logical consequence of this group’s more extensive experience of working with poly drug
use. There were no major differences in the assessments made by social services and regional healthcare staff respectively, but medically trained practitioners tended to assess substance use as being more severe than others. In addition, older female practitioners with longer work experience viewed the described substance use as being more problematic than younger, male practitioners with less work experience. The implications of the findings may be that people seeking help from the addiction care system may be met in different ways depending on who they are and which practitioner they meet.

**Paper III**

The third paper studies addiction care practitioners’ perceptions of how substance use problems should be handled. In a factorial survey (as described above in the summary of Paper II), regional healthcare and social services staff (n=447) were presented with fictitious cases of alcohol, cannabis and cocaine use and asked to rate the need for psychosocial and medical treatment and the possibility for the users to handle the situation on their own. Multilevel analysis was employed in order to take the significance of user, practitioner, and work unit characteristics into account and to model the unexplained variance at different levels. The perceived severity of the use was treated as a control variable.

Regional healthcare staff in general perceived the possibilities for the individuals to handle the situation on their own to be lower and assessed the need for medical treatment to be greater by comparison with social services staff, which may be a reflection of the nature of the two groups’ different work assignments. The relatively low level of confidence in self-change solutions and the perceived necessity for treatment is linked to a disease perspective on substance use problems. The images conveyed by the staff in their contacts with clients may signal that it is not possible for individuals to affect their own substance use problems. Psychosocial treatment interventions were recommended to a similar extent in both social services and regional healthcare settings however. Irrespective of the prevailing medical discourse at the official policy level, psychosocial interventions are thus still seen as constituting a central part of treatment by staff in different parts of addiction care. If the described use was related to cannabis or cocaine rather than alcohol, the user was perceived as being in more need of psychosocial treatment and as being less capable of handling the situation on his/her own, which might be attributed to the illegal status of the drug signalling a more socially marginalised position. No distinction was made between cannabis and cocaine in these respects. Older users were perceived to have less chance of handling the situation on their own and to be in greater need of medical treatment than younger users. By comparison with unemployed users, those who studied or worked were seen as being more likely to self-change and...
less in need of psychosocial interventions. The importance assigned to the various user variables by the respondents in social services and regional healthcare were strikingly similar. Some differences did however emerge which indicated a somewhat greater degree of consensus and more socially oriented perceptions among social services staff. The specific orientation of the work unit had some importance, with practitioners in units oriented towards assessing alcohol problems being more inclined to recommend medical solutions. One conclusion was that perceptions of substance users’ conditions and treatment needs cannot simply be ascribed to either a social or a medical perspective and that practitioners’ images of substance use and treatment are instead complex and ambiguous.

Paper IV

The aim of this paper was to analyse boundary-making in addiction care practitioners’ constructions of substance use and treatment needs, with a specific focus on the importance of gender. Six focus group interviews were conducted with a total of 30 participants from both social services and regional healthcare addiction services. Results from the preceding vignette study (Papers II and III) relating to women and men using substances with various consequences were presented as a stimulus material. The discussion shifted between explanations of the results of the vignette study, the practitioners’ own views and experiences, and the gender norms on substance use and treatment needs that are prevalent in addiction care and in society in general.

The discourse analytic approach revealed an interpretative repertoire based on a construction of women’s substance use as being essentially different to men’s in psychological, social and biological respects. Subject positions of young vulnerable girls and macho immigrant men emerged, with the former being used to assign a specific, exposed position and the latter representing a machismo involving an inability to talk about sensitive issues and which required concrete resources. The practitioners related to the issue of gender in addiction care as an intractable ideological dilemma resulting from the contradictory ideals of treating everybody alike (universalism) and of focusing special attention on the specific needs of women (particularism). This dilemma also contributes to an improved understanding of the findings of the vignette studies, where social categories such as age, socio-economic status and gender were of significance for the assessments made. On the one hand, the assessment of a woman’s substance use as being more severe may be viewed as representing an approach that takes the more exposed situation of women into account, and which could involve more comprehensive professional support. On the other hand, it might be the result of a normative
evaluation of women’s behaviour whereby women are labelled as deviants to a greater extent than men, thereby limiting the space available to them for action. In the discussions, reflections on the importance of being aware of one’s own stereotyped assumptions emerged, as did reflections on the importance of also focusing attention on problems that are specific to men, together constituting a reflective repertoire. Focusing single-mindedly on women’s needs in addiction care could result in an underestimation of men’s problems and needs. The application of a gender-responsive approach should therefore acknowledge the variety of forms in which femininity and masculinity may be performed in order to avoid potentially stereotyped treatment and the reproduction of traditional gender norms. Another conclusion is that the combination of vignette data and focus group interviews provided both a basis for complementary understandings of boundary-making processes in contemporary addiction care and a space for the practitioners to reflect on the beliefs and assumptions that are often hidden and taken for granted in practice.
Concluding discussion

The overall aim of this thesis has been to study boundary-making in Swedish addiction care practitioners’ perceptions of substance use and treatment needs. More specifically, the thesis has examined perceptions of the severity of various kinds of substance use, of the possibility of recovery without treatment, and the need for various types of treatment. Further, the thesis has also studied the extent to which these perceptions were influenced by factors related to the user, the practitioners and the practitioners’ work organisations. Boundary-making processes in addiction care have been studied in three respects: boundary-making based on substance use problems and their solutions in different parts of addiction care; boundary-making between various substances, and boundary-making based on social categorisations such as gender, age, socio-economic status and ethnicity. In this section the central findings are discussed in relation to previous research, the theoretical concepts employed in the thesis and the practical implications of the results. The section concludes with suggestions for future research.

Boundary-making in different parts of addiction care

The thesis has examined the extent to which substance use problems and treatment needs are perceived differently, first and foremost by staff working in the two main addiction care organisations – the social services and regional healthcare. Differing perceptions were found but these differences were not found to be particularly distinct.

Both confidence in medical solutions and the belief that professional treatment is needed to recover from substance use problems are stronger among practitioners in regional healthcare, which probably is related to the presence of a disease perspective and to the assignments that are central to their clinical practice, which have a focus on the biological aspects of substance use problems. But the results also indicate that psychosocial treatment solutions have legitimacy among both regional healthcare and social services staff. This could imply that the practitioners, irrespective of whether they belong to a social work or medical profession, adhere to the notion that substance use problems are bio-psycho-social in character and that both psychosocial and medical interventions are needed, even if the emphasis on one of these dimensions is stronger in the one profession than in the other. At the
same time, the results showed that social services staff felt that the possibilities for self-change were greater. This could indicate that they have a better knowledge of the occurrence of this phenomenon, since their work assignments allow them to follow their clients for a longer period of time and to have a broader insight into the clients’ overall situation.

Different perceptions also emerged depending on the education and professional role of the practitioner and on the orientation of the work unit at which the practitioner works. For example, staff in work units oriented towards assessing rather than treating substance use problems, the majority of which were social services units, were more inclined to recommend medical solutions. One possible interpretation of this finding is that social workers oriented towards assessing substance use problems have been more apt to adopt the medicalisation arguments advocated in the EBP paradigm, whereas practitioners oriented towards treating substance use problems are more inclined towards a psychosocial approach. A somewhat higher level of consensus was evident in social services practitioners’ perceptions, which might be a reflection of the fact that regional healthcare includes a larger number of different professions (doctors, nurses and treatment providers) by comparison with the social services (mainly social workers).

People’s perceptions of social phenomena are rarely strictly tied to a single position but are rather associated to a varying extent with different ideological currents that are drawn from popular culture and applied to our own experiences in order to make sense of what is going on (Room, 1978). On the basis of results from studies conducted in 2001 and 2002, Palm (2004) argued that there were a range of conflicting moral, medical and social perspectives on substance use problems and recovery processes coexisting in addiction care. The same addiction care practitioners both agreed with statements stating that “alcoholism/drug addiction is a disease” and that “drinking/drug problems are social problems” (Palm, 2004:422). The results from the studies conducted in 2011 and 2013 for the purposes of this thesis suggest that Palm’s findings still hold.

Contemporary Swedish addiction care can be described as a contested field between the medical and social paradigms, in which the medical stance is gaining ground at the policy level. On the basis of the results obtained in this thesis, however, a social perspective in which psychosocial treatment is still perceived as central and which takes the social situation of the user into consideration is still present, not only in the social services, but also in the regional healthcare. The degree to which the ongoing process of medicalisation has had an impact at the practical level is therefore unclear.

The results from the four papers however point to the conclusion that addiction care practitioners’ perceptions of substance use problems and treatment needs are in line with the governing images that are prevalent in society as a whole (Blomqvist, 2009c). One such governing image relates to the social rubric of narcotics, which depicts narcotics use as a severe and dan-
gerous social problem. Another governing image relates to the necessity of undergoing professional treatment in order to overcome substance use problems. There is a relatively high degree of scepticism, particularly in regional healthcare and the probation service, about the possibility of handling a problematic substance use on one’s own, despite the fact that the phenomenon of self-recovery is well-established in the research. The implication of this could be that the approaches that clients meet with in their contacts with the care system send the signal that problem substance users are unable to change their situation on their own without the help of professional experts, which may have negative effects on self-efficacy.

Boundary-making between alcohol and narcotics

The governing images of substance use are related to the boundary-making between alcohol and narcotics. Alcohol use and narcotics use were conceptualized by the practitioners as distinct phenomena, which required separate solutions to some extent. Use of narcotics was seen as being more severe and as involving a greater need for treatment than alcohol use, irrespective of the circumstances of the use. Substance use problems are thus not entirely viewed as bio-psycho-social processes in which the substance use itself is only a symptom; instead the type of substance itself seems to be of substantial importance for the perceptions that are held. Where alcohol consumption is perceived as being socially acceptable, using narcotics is seen as problematic per se (cf. Grella, Karno, Warda, Moore & Niv, 2009). The restrictive Swedish drug policy and the illegal status of narcotics are reflected in the practitioners’ perceptions, a finding which is in line with previous research (Bergmark & Oscarsson, 1988; Ekendahl, 2004; Hübner, 2001; Palm, 2007). The boundary-making between alcohol and narcotics use can also be related to the governing image of hard drugs perceived as being highly deviant and linked to social marginalisation (Ekendahl, 2004). In their assessments of narcotics versus alcohol, the practitioners might take this social marginalisation into consideration. No definitive distinction was made between cocaine and cannabis, which implies that practitioners make no distinction between “hard” and “soft” narcotics. Cannabis use is thereby neither subject to more liberal views than other narcotics, nor regarded as normal by addiction care practitioners. Gassman and Weisner (2005) argue that the stigma associated with narcotics use may encourage a punitive rather than a helpful response towards the client. Perceiving drug use as more severe than alcohol use may be unfortunate, since alcohol problems are more prevalent in society and these perceptions may lead to these problems not receiving timely attention when it comes to identification and response processes. Focusing on the type of substance rather than the circumstances of the use could therefore be misleading in relation to the identification of appropriate solutions for the client.
While the separation of alcohol use from narcotics use has been questioned in the research field (e.g. Courtwright, 2005; Roizen, 1993), in part as a result of the common occurrence of poly drug use, this separation is still very much alive in the form of a governing image in Swedish society. Psychosocial treatment was more often recommended for narcotics use than for alcohol use, which indicates that the former is to a greater extent comprehended as a social problem and the latter to a greater extent comprehended as a medical problem. The boundary-making between alcohol and narcotics was somewhat less marked among staff at work units specialised in narcotics, which may be viewed as a logical consequence of this group’s more extensive experience of working with poly drug use.

Boundary-making based on social categorisations

Lamont and Molnár (2002) argue that studying how boundaries are drawn will generate new insights into social processes. Symbolic boundaries are defined as distinctions used in categorisation processes in which individuals or groups are classified based on notions of e.g. class, gender and ethnicity. When symbolic boundaries have practical implications, by resulting in unequal access to and the unequal distribution of resources and social opportunities, they become social boundaries. Only when symbolic boundaries are widely agreed upon can they be manifested in social boundaries. The results of this thesis indicate that symbolic boundaries emerged in the addiction care practitioners’ perceptions of gender, age, socio-economic status and to some extent ethnicity. The analyses showed that the socio-economic status of the user was important in relation to both the perceived severity of the use and perceptions of the need for treatment, with unemployment signalling a more severe situation. The use of younger persons was seen as being less severe than that of middle-aged persons. Interaction analyses revealed that the substance use of men living with children was assessed as being less severe if the man in question had a partner than if he was single, which was not the case for women. Also, a young man’s drinking was viewed as being less severe than a young woman’s. Unlike social workers, doctors were inclined to rate the substance use of women as being more severe than that of men. With regard to the perceptions of treatment needs, the socio-economic status of the user was found to be of relevance, with unemployed users being assessed as having less chance of handling the situation without treatment and as being more in need of psychosocial support by comparison with users who were in employment or studies. It was not possible in the quantitative studies presented in the thesis to examine whether this should be conceptualized as a sign of an approach based on a professional consideration of the situation of marginalised groups or one based on a normative stereotyping of these groups. This also means that it has not been possible to specify the
extent to which this symbolic boundary-making in fact manifests itself in social boundaries.

The focus group interviews provided another form of understanding of the boundary-making processes, with more complex images of the importance and interplay of the social categorisations. With a focus on the importance of gender in perceptions of substance use and treatment needs, the interviews contained discussions of the results from the vignette study, which were presented as a stimulus material, and also reflections on the practitioners’ own views regarding the prevailing norms relating to substance use, treatment and gender in both the addiction care system and society at large. A *repertoire of difference* was evident in the discussions, which emphasised the distinctive characteristics of men’s and women’s substance use and treatment needs in terms of biology, psychology and social vulnerability. As a counter discourse, a *repertoire of reflection* emerged, in which assumptions were re-evaluated during the ongoing discussions. It emerged that there is a need to develop addiction care in order to problematize prevailing hegemonic masculinity ideals by focusing on men’s parenthood, questioning destructive behaviours and encouraging men to talk about mental problems. It was further contended that men’s substance use problems are seldom comprehended in psychological terms as is the case with women’s substance use problems. A non-stereotyped approach was thus advocated, in which men and women who do not fit within the accepted frames in terms of being victims are also acknowledged. An additional component in the reflective repertoire concerned the need to also focus on men’s specific problems in assessment and treatment contexts.

The repertoires of difference and reflection were interrelated, internally multifaceted and were revealing of the boundary-making processes taking place in addiction care. They represented a process of shifts that took place within the discussions between a *universalistic approach* emphasising the importance of treating everyone the same (to ensure equal rights without considering the oppressive structures that exist in society) and a *particularistic approach* emphasising the importance of taking into account the specific situation of each individual (based upon social categorisations such as gender, ethnicity, socio-economic status, age etc.), but which also involved a risk of reproducing differences based upon stereotyped assumptions (cf. Baianstovu, 2012). This classic dilemma in social work is illustrated in the matrix below (Figure 3), and involves both potential advantages and disadvantages. Applying a universalistic approach could mean that clients are treated according to similar standards, but also that certain individuals are not assured the same rights as others, as a result of processes of social exclusion based on e.g. gender, class and ethnified/racified power structures (e.g. colour blindness; cf. Dominelli, 1988). Applying a particularistic approach means taking these power structures into account, but at the same time involves a risk of being based on stereotyped assumptions of difference. The
opposing ideals of treating everybody the same and of considering the specific circumstances of each individual constitute an intractable ideological dilemma (Billig et al., 1988) in the practitioners’ everyday practice.

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<thead>
<tr>
<th></th>
<th>Potential advantages</th>
<th>Potential disadvantages</th>
</tr>
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<tbody>
<tr>
<td>Universalism</td>
<td>Democratic rights equally distributed to all</td>
<td>Assumptions based on similarities</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“Blindness” resulting in neglect of existing power structures</td>
</tr>
<tr>
<td>Particularism</td>
<td>Considerate approach – taking into account the specific situation of the individual</td>
<td>Assumptions based on differences (essentialism)</td>
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<tr>
<td></td>
<td></td>
<td>Stereotyped and discriminatory treatment, neglect of certain needs</td>
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</tbody>
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Figure 3. Matrix of potential consequences of universalism and particularism

This ideological dilemma also contributes to the understanding of the results obtained in the vignette study, where social categories such as socio-economic status, age, and to some extent gender were of significance to the assessments made. On the one hand, the assessment of an unemployed person’s substance use as being more severe could be seen as a particularistic approach, in which the social vulnerability associated with unemployment is taken into account, producing a need for more comprehensive professional support. On the other hand, it could be viewed as a normative evaluation whereby the behaviour of unemployed persons is more strictly regulated. As has been noted by Skogens (2007), norms relating to substance use problems may be influenced by the user’s ability to earn a living. In terms of gender, a particularistic (i.e. women-specific) approach based on the biological, psychological and social vulnerability of women could result in the provision of more differentiated and well-adapted help and support. On the other hand, however, it could involve a normative evaluation of women’s substance use as being more deviant than men’s, thereby having a limiting effect in relation to the rules of conduct that frame the behaviour of women. Perceiving women as more vulnerable and sensitive than men, together with the fact that their substance use attracts more attention and criticism in policy and media reports (cf. Bogren, 2011; Courtenay, 2000; Storbjörk, 2011), may involve a risk that the problems of male clients will be neglected. As has been argued by Storbjörk (2011), in spite of the fact that men in Swedish addiction care are more socially marginalised than women in the same situation, more attention and more interventions are directed at women’s problems. This disproportionate focus on women could lead to stereotyped gender norms and an unequal allocation of care. One conclusion is that there is a need to acknowledge the specific needs of both women and men and also the multiple and varied ways in which femininity and masculinity can be expressed.
There is no simple or unequivocal solution to the dilemma between universalism versus particularism, but it is of crucial importance that the perceptions and approaches held by practitioners are discussed regularly, and that practitioners are aware of their own assumptions and of the images that they convey in their meetings with clients.

If there is a normative dimension according to which people are assessed and treated, how should this be dealt with? Increased use of standardized assessment instruments such as the Addiction Severity Index (ASI) and AUDIT/DUDIT could mean that clients are given a more objective assessment since they ensure that important questions are asked and that the assessment is based on a validated instrument. This presupposes however that the assessment instruments themselves are not based on stereotyped assumptions and that they are not applied differently in relation to different groups of clients. The use of assessment instruments such as the ASI involves a rating made by the practitioner which is largely based on his/her own perceptions of the problem. The same applies to screening and brief interventions, where there may be a suspicion that some people are subject to screening to a greater extent than others. This was the case in the UK, where offers of brief interventions were found to be biased in terms of gender and class irrespective of levels of risk consumption (Kaner et al., 2001). In a Swedish context, Herz (2012) found that the evidence-based assessment tools used in youth welfare cases, reproduced stereotyped categorisations based on gender and ethnicity.

The assessments made in practice are influenced by laws, regulations, local practices and resources and by the interaction between client and practitioner. Social work in general and addiction care in particular involve a certain space of autonomy, where the clients’ own wishes and preferences are taken into consideration (Evans & Harris, 2004). This constitutes one of three components in what is commonly referred to as evidence-based practice. The first component relates to the external scientific knowledge on the effects of various treatment methods, the second relates to the clinical expertise of the practitioner and the third the clients’ own values and preferences regarding what should be done (cf. Oscarsson, 2009; Sackett, Rosenberg, Gray, Haynes & Richardson, 1996). However, the current EBP initiatives expressed at the policy level via e.g. national guidelines mainly focus on the effects of various treatment methods (based on a top-down guideline model rather than critical appraisal model of EBP, cf. Karlsson & Bergmark, 2012). In combination with greater demands for increased user involvement in the process, this constitutes a dilemma for the practitioner, which emphasises the need for reflection and deliberation in contacts with clients. Inevitably there needs to be space for both negotiation and variation for the client and practitioner to find the best solutions. Practitioners’ perceptions of clients are shaped by the opposing ideals of offering help and support to people in exposed situations and of ensuring equal treatment. To limit the risks for addic-
tion care disparities based on the clients’ social characteristics it is of major importance that practitioners are given the opportunity to reflect critically on the assumptions underlying their work and on the images conveyed in their meetings with clients. These assumptions and beliefs should be the subject of both self-reflection and regular discussions with colleagues. Practitioners are seldom given the opportunity to reflect in their everyday practice however. There are different ways in which opportunities for such reflection could be provided in the context of education and training, and the use of a method such as the factorial survey in combination with group discussions might constitute a fruitful first step.

One conclusion that can be drawn from this thesis relates to the value of combining quantitative surveys with qualitative group interviews in order to develop an improved understanding of the results. With the mixed methods approach employed, it was possible to answer different kinds of questions. The focus group interviews showed that survey results need not have a single unequivocal meaning, but rather that the assessments made in the practitioner surveys could both be based on a social consideration of the unique situations of the substance users, and at the same time reflect a stereotyped approach based on social categorisations. This ambivalence reflects the diffuse and inconsistent nature of perceptions about substance use problems and their solutions, which are not unequivocally associated with a single perspective but are rather constructed using different components drawn from a range of ideological origins and common sense dilemmas.

Future research

The perspective of the user is absent in this thesis. It would have been interesting to study substance users’ own views on substance use severity and treatment needs. With reference to the changed role of the welfare apparatus over recent decades, with more responsibility having been assigned to individuals and their families to adapt to and deal with their problems (e.g. Hellman, Roos & von Wright, 2012; Jegermalm & Grassman, 2012), it would be of substantial interest to study how people with more or less problematic forms of substance use reason about their use, their rationales for whether to seek help and also the considerations underlying the choice not to seek help (e.g. fear of stigma) or where to do so (self-help options, primary care, regional healthcare or social services). Also, it would have been desirable to go into more detail in the analyses of the importance of ethnicity and class for the practitioners’ perceptions, which was not possible within the scope of the current thesis. Moreover, studies that focus on the needs of men with substance use problems, and on the risk-taking behaviour associated with a traditional masculinity, would be fruitful for the development of a less stereotyped addiction care. Further, it would be of interest to apply the facto-
rial survey approach in combination with group interviews in order to compare perceptions of substance use problems in a cross-national context, where the importance of various cultural values and organisational solutions could be examined.
Sammanfattning


I den första artikeln undersökt praktiker uppfattningar av olika typer av missbruk med avseende på dess allvarlighet som samhällsproblem, risken för att bli beroende samt möjligheten att ta sig ur ett problem med och utan be-
handling. En postenkät fylldes i av praktiker inom socialtjänstens missbruksvård, landstingets beroendevård och kriminalvårdens frivård i Stockholms län (n=655). Genom analys av medelvärdén och linjära regressioner undersöktes hur uppfattningarna skiljde sig åt mellan olika praktiker beroende på deras organisatoriska hemvist, utbildning, kön och arbetserfarenhet. Resultaten visade på stora skillnader i synen på bruk av olika substanser, där snus och rökning sågs som relativt oproblematiskt både för samhället och för individen, medan droger såsom heroin, amfetamin och kokain sågs som allvarliga samhällsproblem, lätta att bli beroende av och mycket svåra att ta sig från. I en mellanposition placerades alkohol, cannabis, läkemedel och spel om pengar. Behandling sågs som avgörande för att lyckas ta sig ur eventuella problem, och tilltron till människors förmåga att hantera problemen på egen hand var genomgående låg, vilket troligen hänger samman med praktikernas yrkesroll som förmedlare av behandlingsinterventioner. Uppfattningarna var relativt likartade inom olika delar av behandlingssystemet och även i jämförelse med den allmänna befolkningen. En slutsats är därför att praktikernas uppfattningar om olika former av missbruk hänger samman med de styrande bilder av missbruksproblematik och dess lösningar som är rådande i samhället i stort.

I artikel två undersöktes betydelsen av vem alkohol- eller narkotikaanvändaren är för praktikernas uppfattningar om substansbrukets allvarlighet. Praktiker i socialtjänstens missbruksvård och landstingets beroendevård (n=474) fick i en webbaserad undersökning ta ställning till ett antal fiktiva beskrivningar av personer som använder alkohol, cannabis eller amfetamin. Med hjälp av en specifik vinjettmetod kallad den faktoriella survey-metoden i kombination med multilevelanalyss kunde betydelsen av faktorer förrädpade med både den specifika brukaren, bedömaren och dess arbetsplats undersökas. Resultaten visade att den uppfattade allvarligheten i en viss situation inte bara påverkades av vilken typ av substans som användes samt karaktären och frekvensen av olika negativa konsekvenser, utan även av faktorer såsom användarens ålder, socioekonomiska status och familjesituation. Det framgår dock tydligt att cannabis- och kokainkonsumtion uppfattas som avsevärt mer allvarlig än alkoholkonsumtion, oberoende av brukets omständigheter, vilket skulle kunna ses som anmärkningsvärt med tanke på de mer omfattande konsekvenser som alkoholproblem har i samhället på både individ- och samhällsnivå. Den svenska narkotikapolitikens restriktiva karaktär och narkotikans illegala status avspeglas sig i praktikernas uppfattningar även gällande cannabis, som inte var föremål för en mer liberal syn bland praktikerna. Yngre personers bruk sågs också som mindre allvarligt än medelålders och äldre personers bruk, och att ha ansvar för barn innebar att bruket bedömdes som mer allvarligt än om brukaren var ensamstående och/eller barnlösh. Dessutom tenderade bruket att ses som mindre allvarligt om personen i fråga hade ett arbete eller studerade än om hen var arbetslös. Det fanns inga avgörande skillnader mellan socialtjänstens och beroendevår-
dens uppfattningar, men medicinskt utbildade bedömare tenderade generellt att bedöma substansbruket som allvarligare än bedömare med annan utbildning. Äldre, kvinnliga praktiker och de med längre yrkeserfarenhet såg också bruket som allvarligare än yngre, manliga och mindre erfarna praktiker. Även om användarens kön och etniska tillhörighet inte var avgörande i huvudanalyserna, visade interaktionsanalyser t ex att läkare bedömde kvinnors bruk som mer problematiskt än mäns, oavsett brukets omständigheter. En slutsats var att det bemötande som en person som använder alkohol eller narkotika får i kontakt med missbruks- och beroendevården inte bara kan påverkas av brukets karakter och personens sociala situation, utan också av vem personen möter. Detta innebär att det är viktigt att praktiker är medvetna om vilka antaganden som ligger till grund för de uppfattningar de har och de bedömningar som görs.

I den tredje artikeln tillämpades samma metodologiska tillvägagångssätt som i artikel två för att studera praktikers uppfattningar av behovet av psykosocial och medicinsk behandling samt möjligheten till att hantera situationen på egen hand (n=447). Resultaten visade att beroendevårdens personal, i jämförelse med praktiker inom socialtjänsten, generellt var mer skeptiska till vinjettpersonernas möjlighet att hantera situationen på egen hand och mer benägna att rekommendera medicinsk behandling. Detta reflekterar sannolikt de två organisationernas delvis skilda arbetsuppgifter där beroendevården är mer inriktad på att erbjuda interventioner direkt riktade mot substansbruket som sådant, medan socialtjänstens missbruksvård även syftar till att integrera individen i samhället genom stöd i form av boende, sysselsättning och för- sörjning. Faktumet att möjligheten till självläkning sågs som relativt låg bland praktikerna och att tilltron till behandling var hög, ett synsätt som hänger samman med ett medicinskt förhållningssätt till missbruksproblem- tik, kan också innebära att de uppfattningar som klienter och patienter möts av när de har kontakt med missbruks- och beroendevården signalerar att alkohol- och narkotikaproblematik är något som individen själv inte kan förändra. Psykosocial behandling rekommenderades dock i lika hög utsträckning av de båda respondentgrupperna. Trots en alltmer dominerande medikaliseringdiskurs på policynivå kan detta tyda på att psykosociala interventioner fortfarande uppfattas som en viktig del av den svenska missbruks- och beroendevården bland både medicinskt och socialt inriktade praktiker. Personer som använde narkotika snarare än alkohol bedömdes som mer i behov av psykosocial behandling och mindre kapabla att hantera situationen själva, vilket kan hänga samman med narkotikans illegala status. De fiktiva personernas ålder och sociala status spelade en motsatt roll för bedömningarna. Yngre och personer med högre socio-ekonomisk status bedömdes ha mindre behov av medicinsk behandling och större möjligheter att hantera sin situation utan professionell hjälp än äldre och personer med lägre socioekonomisk status. Några skillnader framkom som indikerade mer socialt inriktade och sammanhållna uppfattningar bland socialtjänstpersonalen i
jämförelse med landstingspersonalen. Dessutom visade sig den specifika inriktningen vid de enheter där respondenterna arbetade i vissa fall spela en viss roll där t ex enheter med utredande fokus snarare än behandlande var mer benågna att rekommendera medicinska lösningar. Totalt sett spelade dock de olika faktorerna som beskrev brukets och användarens olika karakteristika en förvånansvärt likartad roll bland praktiker inom socialtjänsten och beroendevården. Sammantaget kan sägas att de uppfattningar om alkohol- och narkotikakonsumenters förutsättningar och behandlingsbehov som är rådande i missbruks- och beroendevården inte entydigt kan hänföras till antingen ett socialt eller medicinskt perspektiv utan snarare att bilderna av missbruk och behandling är komplexa och mångtydiga.


De skillnadsgörande och reflektande tolkningsreperatoarna var sinsemellan sammankopplade, inbördes mångfasetterade och avspeglade de gränsdragningsprocesser som äger rum inom missbruks- och beroendevården. De representerade en pendling i diskussionen mellan ett universalistiskt förhållningssätt med tonvikt på att alla klienter ska behandlas lika (för att försäkras jämliga rättigheter men utan att ta hänsyn till förtryckande strukturer i samhället) och ett partikularistiskt förhållningssätt med tonvikt på att
ta hänsyn till varje clients specifika situation (utifrån kön, etnicitet, socioekonomisk status etc.), men med risk för att reproduceras skillnader baserade på stereotypa uppfattningar. Denna pendling kan ses som uttryck för ett svårlost ideologiskt dilemma som praktikerna ständigt behöver förhålla sig till i sin kontakt med sina klienter. Detta bidrar också till förståelsen av de resultat som framkommit i vinjettstudien, där sociala kategorier som socioekonomisk status, ålder och i viss mån även kön spelar roll för de bedömningar som gjordes. Å ena sidan kan således en bedömning av en arbetslös persons substansbruk som mer allvarligt ses som ett hänsynstagande till dennes utsatthet som utgör grund för ett mer omfattande professionellt stöd, medan å andra sidan kan det ses som uttryck för moralisering, där arbetslösa personers beteende döms hårdare än andras, eftersom de inte bidrar till samhället på samma sätt. I termes av kön, kan ett skillnadgörande baserat på kvinnors biologiska, psykologiska och sociala sårbarhet innebära att kvinnor erbjuds mer hjälp och stöd. Det kan å andra sidan innebära att kvinnors bruk värderas olika än mäns och därmed stämplas som avvikande i högre grad, ett normativt förhållningssätt som är begränsande för kvinnors handlingsutrymme och kan innebära att mäns problem osynliggörs.

En slutsats är att det behövs ett förhållningssätt inom missbruks- och beroendevården som erkänner den variation genom vilken feminitet och maskulinitet kan ta sig olika uttryck och där både mäns och kvinnors specifika behov uppmärkassas. Det finns ingen enhetlig och enkel lösning på detta dilemma, men det är av avgörande betydelse att de ständigt diskuteras och att praktikerna håller sig medvetna om sina egna uppfattningar och vilka bilder de förmedlar i mötet med klienterna.

Metodologiskt framstår avhandlingens sätt att kombinera den kvasiexperimentella faktoriella surveymetodiken med kvalitativa fokusgruppstrender som en fruktlig modell för att undersöka olika aktörers uppfattningar. De olika datamaterialen har på olika sätt bidragit till förståelse av ämnet som sådant och deras sammanförande har således varit större än sina delar. En slutsats blir att olika metoder kan ge komplementära bilder av komplexa fenomen, där det är viktigt att genom kvalitativa ansatser sätta kvantitativa resultat i ett sammanhang för att öka förståelsen om dess betydelse. Kombinationen av vinjetter och gruppintervjuer framstår också som en möjlig modell för att främja professionell utveckling, genom att praktiker får ta ställning till ett antal konkreta fall och därefter diskutera resultaten med sina kollegor, detta för att öka medvetenheten om vilka antaganden som ligger till grund för de bedömningar som görs och identifiera eventuella förutfattade meningar eller utvecklingsbehov.

En begränsning i de redovisade studierna är att respondenterna i huvudsak kommit från storstadsområden, vilket innebär att det är tveksamt huruvida resultaten kan sägas vara generaliserbara till svensk missbruks- och beroendevård som helhet. Snarare är det den specialiserade öppenvårdsbaserade missbruks- och beroendevård som finns i storstadsområden som finns repre-
senterad i undersökningarna. Dessutom bör det understrykas att de uppfattningar som respondenterna gett uttryck för i undersökningarna inte nödvändigtvis speglar de bedömningar de gör i sin praktiska vardag, där hänsyn också måste tas till en mängd ekonomiska, organisatoriska och andra förhållanden. Ambitionen har inte varit att undersöka bedömningar i praktiken, utan snarare att studera de antaganden och uppfattningar som ligger till grund för praktikers bedömningar av missbruksproblematik och dess lösningar. Dessutom hade det varit önskvärt att ytterligare fördjupa sig i betydelsen av etnicitet och klass för praktikernas uppfattningar, något som det dock inte funnits utrymme för inom ramen för denna sammanläggningsavhandling.

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Appendix I Staff questionnaire

This survey is intended for people working at [name of unit], whose work includes client/patient contacts. The aim is to study different perceptions about what constitutes an acceptable use of alcohol and other drugs in various situations and what constitutes misuse that should be addressed. We would be very grateful if you would consider participating.

The survey is estimated to take 15-20 minutes. Your participation is completely voluntary and your answers will be treated with confidentiality. All results will be presented at the group level and no information will be published that would enable the identification of individual participants. The research project is financed by the Swedish Council for Working Life and Social Research (FAS) and has been approved by a research ethics committee.

When you fill in the questionnaire, please try to ensure that you have a quiet moment by yourself, without interruptions from phone calls or visitors. If you have to leave the questionnaire before completing it, you will be able to restart from the last question that you have answered, so you won’t have to start over. But we would really appreciate it if you could fill in the questionnaire in one go, and if you could avoid discussing the survey with your colleagues until everybody has completed it. Please check that you have answered all the questions. If there is a problem with the link, please get in touch with us as soon as possible.

Click on the link below to proceed to the web survey:

If you would like more information or have any comments, please do not hesitate to contact us. Thank you for your participation!

Eva Samuelsson
PhD student/Social worker
Centre for Social Research on Alcohol and Drugs (SoRAD)/
Department of Social Work
Stockholm University
E-mail: eva.samuelsson@sorad.su.se
Phone: 08-16 17 54

Welcome to the web survey for the research project Use or misuse!

The questionnaire is organised in three sections. Please read the instructions carefully.

In the first section you will be presented with four different vignettes; descriptions of fictive persons using alcohol or drugs in different ways. The idea is that you should make an overall assessment and give your responses to a number of statements based on the information available.

In the second section you will be asked to consider ten shorter vignettes that we would like you to answer without taking as much time to consider them first. For methodological reasons the shorter vignettes may be perceived as being somewhat technical. We would like to ask you to disregard this and to instead make a spontaneous overall assessment.

In the third section we will ask you a few questions about you as a person and about your work and your perceptions about addiction care. All your answers are confidential and will be treated with the same confidentiality.
It is possible to move backwards and forwards through the questionnaire without your answers being erased. We ask that you check that you have answered all the questions before closing the questionnaire.

To move forward, click “Next”.

**Part 1.**

There now follow four vignettes; descriptions of fictive persons using alcohol or drugs in different ways. First read the vignette and then consider to what extent the use described constitutes a problem, and what (if anything) you think should be done to deal with the situation.

Answer the questions in turn, one vignette at a time. Mark one alternative on each row, doing this a total of six times per vignette.

1. Andreas is 25 years old and lives in a small apartment in a suburb of a large city. After high school he worked as a salesman, but decided to continue his studies after a few years. He is now studying business at the local university. He used to live with his girlfriend but they recently split up. They have no children. In his spare time, Andreas goes to the gym and to pubs and clubs with his friends. Sometimes they use cocaine. Several times during the last year when Andreas has used cocaine in a club, he has lost control and spent much more money than he had planned to.

[Response alternatives below presented after each vignette]

2. Johanna is 55 years old and works as a librarian. She lives in a three room apartment close to the city centre in a medium sized town. She is divorced and has two grown-up children. In the evenings she enjoys going to the cinema, the theatre and concerts. Often she does this with a couple of her female colleagues and they usually finish their evening out having dinner at a restaurant. Last year Johanna was promoted to head of department, which meant more administrative work and overtime, and forced her to take work home to finish it. Her new work situation has also forced her to cancel her evening activities with her colleagues more often. Instead she has recently started to have a few glasses of wine by herself in order to be able to relax and fall asleep at night. One night she had so much to drink that she overslept and was late for work.

3. Karin is 43 years old and works as a nursing assistant in a service home for elderly people. She lives in a terraced house in a small town with her husband, who works as a salesman. They have two children together, who are 8 and 11 years old. Occasionally at parties, they and their friends smoke marijuana. Since Karin works shifts, she is sometimes free in the daytime. She used to devote much of this time to physical exercise and reading, but during the last year she has become bored. She has started to smoke marijuana to relieve her boredom and nowadays makes sure she has a small stash of marijuana hidden at home. A month ago Karin smoked marijuana on one of her afternoons off and forgot to pick up the kids from their recreational activities.

4. Hans is 58 years old and a former manager at a large industrial company in a small city. He lives with his wife in a co-operative apartment and they have no children. Three years ago, the company was closed down and both Hans and his wife were made redundant. He has been discharged from unemployment benefit and has to live on social security. One condition for receiving these benefits is that he participates in the vocational training organised by the municipality, which he perceives as being degrading. Lately Hans has started drinking more often at the local pub, in the afternoon and evenings, with others who are in a similar situation. On several occasions lately he has arrived at the vocational training centre smelling of alcohol and on one occasion the staff suspected that he was drunk, something that he himself denied.

Mark with an X the box that corresponds best with your own opinion.

(0 = No problem, 10 = A severe problem)

**How severe do you find this person’s alcohol or drug use?**

0 1 2 3 4 5 6 7 8 9 10

Put an X in the box that best describes how much you agree with the statement to the left.

This person has a good chance of dealing with his or her alcohol or

0 1 2 3 4 5 6 7 8 9 10
Part 2.
There now follow ten shorter vignettes about people using alcohol or narcotics in different ways. We ask you to read each description and, in the same way as with the introductory vignettes, to give your own assessment of a number of statements concerning the described person’s alcohol or drug use. The difference is that we now want you to give a spontaneous assessment without considering your answer for too long.

The vignettes in this part of the survey are constructed in a way that makes them somewhat unrealistic and sometimes similar to one another, something that is unavoidable for methodological reasons. We would ask you to try to disregard this and to make a quick overall assessment of each vignette.

Answer the questions in turn, one vignette at a time. Mark one box on each row, making a total of six crosses per vignette.

Example of vignettes (ten randomized vignettes for each respondent):

Example 1. Johan is 59 years old and works as a teacher. He lives with his wife. Several times lately, when drinking alcohol, he has ended up not remembering what happened the night before.

Example 2. Nahid is 25 years old and works as a nursing assistant. She is a single parent. A couple of times during the last year, when smoking cannabis, she has missed an important meeting the following day.

Mark with an X the box that corresponds best with your own opinion.
(0 = No problem, 10 = A severe problem)

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<td>How severe do you find this person’s alcohol or drug use?</td>
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Put an X in the box that best describes how well your opinion fits with the statement to the left.

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<tr>
<td>This person has a good chance of dealing with his or her alcohol or drug problem on his/her own</td>
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<td>This person needs psychosocial treatment/help from the social services</td>
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<tr>
<td>The person’s family should intervene and help him/her</td>
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<tr>
<td>The person’s substance use is his/her own business and there is no reason for anyone else to interfere</td>
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<td>This person needs medical treatment/help from regional healthcare</td>
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Part 3.
Finally, we would like to ask a few questions about you as a person and about your work and your views about addiction care. All answers are confidential.
Woman
Man
Year of birth:

Which is your most advanced completed education?
- Social work degree
- Nursing degree
- Psychology degree
- Medical degree or PhD
- Other university degree, state which:
  - Nursing school
  - Other upper secondary education
  - Elementary school
  - Vocational school, please state orientation:
  - Other education, please state which:

What is your formal professional title?
- Social worker
- Nurse
- Treatment assistant
- Psychologist
- Doctor
- Behavioural scientist
- Mental carer
- Alcohol or drug therapist
- Other title, please state which:

Do you have any further vocational training for working with misuse problems?
- No
- Yes, short training program (maximum 2 weeks). State which:
- Yes, longer education (not university level). State which:
- Yes, longer education at university level. State which:

How long have you been working with people with misuse/addiction problems? (State number of years):

How long have you been working at your current unit? (State number of years):

Have you or has anyone close to you (family or friends) had problems with alcohol or narcotics in your opinion?
- Yes, during the last year.
- Yes, but not during the last year.
- No, never.
- Do not wish to answer.

Which are the three most important signs that a person has alcohol problems?
Which are the three most important signs that a person has narcotics problems?

There now follow a few statements about the organisation of addiction care. Please consider them and state the degree to which they correspond with your opinion.

It is an important task for addiction care to:
(0 = Do not at all agree, 10 = Totally agree)

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<td>help the individual to create a life situation that counteracts the addiction problem</td>
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treat addiction problems

get the client/patient to completely desist from his/her misuse

cater to/look after the interests of the client/patient

improve the client/patient’s quality of life irrespective of abstinence/ sobriety

counteract behaviours that harm society

Other suggestion regarding important tasks:

Who do you think should have the main responsibility for addiction care?
Regional healthcare
Social services
Both social services and regional healthcare (as today)
Other solution, state which:

Please state the degree to which the following statements correspond with your opinion.
(0 = Do not at all agree, 10 = Totally agree)

Non-governmental organisations should have more responsibility in addiction care today
Friends and family should have a greater responsibility for helping those close to them with addiction problems
Private actors should have more responsibility in addiction care today

Try to estimate the proportion of clients/patients you meet who are primarily (state in percent, sum up to 100):
People with addiction problems:
People with addiction problems and other problems:
People with other problems:

Try to state the proportion of your current work that primarily involves (state in percent, sum up to 100):
Investigation/assessments:
Counselling/support/treatment:
Managing tasks:
Administrative work (documentation, planning etc.):
Other assignments:

Do you have a specific target-group orientation in your work?
No
Yes
If yes, what?
Name of work unit and location (municipality, city district etc.):

In about one year from now, a follow up study will be conducted in which the results from this study will be presented and discussed in a group setting. As a token of appreciation a cinema ticket will be given to each participant. Would you be interested in participating?
No
Yes
If yes, please state your e-mail address:
(The contact information given here will be treated with confidentiality and kept separate from your other answers)

What other comments do you have about the design or topic of the study?
Please check that you have answered all the questions. You can move backwards and forwards through the questionnaire without erasing your answers. Please avoid altering your assessments. We would also like to ask you to avoid discussing the survey with your colleagues until everyone has completed the survey. When you click on the “Close” button, your answers will be sent in.

Thank you very much for your participation!
Appendix II Executive questionnaire

This survey is intended for you as a work unit manager, either in regional healthcare or social services addiction care. Among other things we will ask you to describe your work unit and the client/patient groups you meet. Note that the answers you give do not have to be exact numbers but rather approximate estimations. These questions are estimated to take 5 to 10 minutes to answer.

Your answers will be treated with confidentiality. All results will be presented at the group level and no information will be published that would enable the identification of individual participants or work units. The research project is financed by the Swedish Council for Working Life and Social Research (FAS) and has been approved by a research ethics committee.

It is possible to move backwards and forwards through the questionnaire. If you have to leave the questionnaire before completing it, you will be able to restart from the last question that you have answered, so you won’t have to start over. We would appreciate if you could complete the questionnaire in one go. Please check that you have answered all the questions.

Click on the link below to proceed to the web survey:

Your help is greatly appreciated.

If you would like information or have any comments, please do not hesitate to contact us.

Eva Samuelsson
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Phone: 08-16 17 54

Approximately how many clients/patients visit your work unit per year?

Approximately how many clients/patients are open cases at the moment?

How many staff members do you have who have client/patient contacts (excluding receptionists, including possible executives with client/patient contacts)?

Which organisation is responsible for your work unit/section?
Regional healthcare only
Social services only
Both municipal and regional healthcare
Private actor, state which:
Other solution, state which:

Please put an X in the box that best describes how much you agree with the statement to the left.

I agree with the statement
We have a close and well-functioning cooperation with regional healthcare/ the social services in client/patient cases
Totally
Partly
To some extent
Not at all
Does your unit/section cooperate with another organisation and if so in what way and to what extent (for example being located in the same premises, joint intake, continuous coordination meetings etc.)?

What is the unit/section’s primary orientation?

- Investigation/assessment
- Treatment
- Assessment and treatment
- Other, state which:

Do you have a specific target group orientation?

- No
- Yes

If yes, what?

How would you briefly describe the activities/interventions conducted at your unit/section?

Please try to estimate the proportion of clients/patients in care during the last year (state in percent; figures do not need to sum to 100) who have been:

- Homeless:
- Unemployed:
- Women:
- Born abroad:
- With parents born abroad:
- Younger than 25 years old:
- With apparent psychiatric problems:
- Previously in treatment for alcohol or drug problems:
- Parents:
- Single:

What are the three most common countries of origin (besides Sweden) among your clients/patients?

Try to estimate the proportion of clients/patients with substance use problems who have been in contact with your work unit/section during the last year who have primarily had problems with (state in percent):

- Alcohol
- Narcotics
- Both alcohol and narcotics
- Other problems

Do you offer any kind of support to relatives of individuals with substance use problems?

- No
- Yes

If yes, in what way?

Name of work unit and location (municipality, city district etc.):

What other comments do you have on the design or topic of the study?

Please check that you have answered all the questions. You can move backwards and forwards through the questionnaire without altering your answers. When you click on the “Close” button, your answers will be sent in.

Thank you for your help!
Appendix III Interview guide

Introduction
Thank you for coming here today. It means a lot to us. The subject of this interview is perceptions and assessments of people who use alcohol or drugs, and how to decide how this should be handled. This is part of my PhD thesis, which focuses on differences between social services and regional healthcare. I am a PhD student at the Department of Social Work and SoRAD at Stockholm University. The study has been reviewed by an ethics committee and is financed by FAS.

The discussion will be recorded and transcribed. The audio files and the transcripts will be kept secure so that they cannot be accessed by unauthorised persons. Your participation is voluntary. You can terminate your participation at any time without giving a reason. You are anonymous. No information will be published that reveals who you are or where you work. The results will be presented in articles and you will be given information about them when they have been completed. Each of you will receive a cinema ticket when we are finished here today. I would also like to you sign this consent form. It is required in order to ensure that you have received this information. You can keep a copy. Do you have any questions?

The plan is to first talk about practicalities and we will present ourselves briefly. We will discuss the subject in general, and thereafter on the basis of a couple of case descriptions. Then we will talk about some of the results from the vignette study that some of you participated in in 2011. Finally I will try to summarize briefly and you will have the opportunity to consider whether we have missed anything important. We have a pretty tight schedule, a maximum of one and a half hours, so we might have to move on from interesting discussions to be able to cover all the topics. I will monitor the time. Does this sound ok to you?

About the interview. I would appreciate it if we could agree on not talking to others about what is said in this room, in order to make everyone feel comfortable to express their views. Can we agree on that? Also, there are no right or wrong answers. I would really like to have a discussion about difficult issues in your work. You do not have to agree on a subject, you may express different opinions, and I would really like you to discuss them among yourselves. This topic is really complex, and you possess valuable knowledge and experiences. I would like to shed light on these and to hear about different opinions and experiences.

Presentation
Name, age, occupation and work experience.

Introductory questions
What influences the first impression you get of a client/patient. How is the initial assessment made?

What are the spontaneous thoughts about a person that arise when you first meet them?

If you were to imagine a person whom you would consider as not being in need of help from you – what would that person be like?

If you were to imagine a person whom you would consider to be definitely in need of help from you – what would that person be like?

Key questions 1. Discussion about vignettes
You are now about to read a short fictitious story about a person. The information given here is of course much more limited than when you meet people in reality. I would however like you to consider the concrete situation and the limited information given.

What do you think about Johanna’s drinking? How severe is it? Does she need any help and if so, what kind of help?
What do you think about Hans’s drinking? How severe is it? Does he need any help and if so, what kind of help?

If you compare Johanna’s and Hans’s situations, what importance does their social situation have for the severity of their drinking situation and their treatment needs? What importance does their gender have?

**Key questions 2. Discussion based on the results of the vignette study**

Some of you participated in a vignette study in 2011, where you were presented with a number of fictitious cases and asked to assess the severity of the situation and how it should be handled. 480 people from 80 work units in different parts of the country participated. The ratings made in the study cannot be treated as evidence of the assessments that are made in practice – when one meets clients/patients in reality, the process is much more complicated. The vignette study may reveal assumptions that underlie perceptions of substance use. I would like to give you some examples of results from the study.

The use of unemployed individuals was considered as being more severe, irrespective of the frequency or nature of the consequences, compared to the use of people who were working or studying.

Is it considered worse if a socially marginalised person uses alcohol or drugs?
Are socially marginalised individuals less capable of dealing with their problems?
Are socially marginalised individuals more eligible to receive help from society?
What importance does the social situation of the person coming to addiction care have for the help he or she is given and the response that he or she is met with?

One of the results of the study was that doctors saw women’s alcohol or drug use as being more severe than men’s. What are your thoughts about that?

Another result was that the drinking of young women was considered to be worse than the drinking of young men. What are your thoughts about that?

Do you think that men and women meet with a different response in their contacts with addiction care? In what way?

Female practitioners more often stressed the severity of a situation if there was a child present in the situation.

What difference does it make if a client is in contact with a male or female staff member in addiction care?

Different attitudes or approaches seem to be present in the social services versus regional healthcare. What effects might this have for patients/clients?

**Concluding discussion**

Is there something that we have forgotten or missed that is important in this context? Would you like to add anything?

How did you find this interview? How were the questions? Should anything be changed?

Thank you so much for your participation.
Appendix IV Informed consent form

Informed consent for participation in focus group for the study “Practitioners’ perceptions of alcohol and drug consumption”

The aim of this study is to explore various perceptions of and assessments of persons drinking alcohol or using drugs in different ways and how their use should be handled. The study is part of Eva Samuelsson’s doctoral thesis at Stockholm University.

You are invited to participate in a group interview, a so-called focus group. The interview takes about 90 minutes and is recorded with a digital recorder.

Your participation is entirely voluntary. You can terminate your participation at any time without giving a reason. The audio files will be handled in a way that ensures that no unauthorised person can access them. The content of the interview will be treated with confidentiality and it will not be possible to identify any individuals or workplaces when the results are presented in scientific journals. After the interview you will receive a cinema ticket as a token of gratitude.

I have verbally been informed about the study and have been given the information above. I am aware of the fact that my participation is voluntary and that I can terminate my participation at any time without giving an explanation.

I hereby give my informed consent to participate in the above described study:

Date: ………………………………………………………………………

Signature: …………………………………………………………………
Original papers I-IV