

# Great expectations: The bureaucratic handling of Swedish residential rehabilitation in the 21st century

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## Abstract

**Background and aims:** Increasingly, efforts to counteract perceived problems in drug treatment at residential rehabilitation centres have come to rely on measures drawing on evidence-based practice (EBP). However, the Swedish media, government inquiries, and international research have identified a number of problems regarding both residential rehabilitation and EBP. This suggests that caution should be exercised when placing expectations on EBP. The aim of this study is to investigate how the responsible authorities have handled increasing demands for EBP with administrative control while facing critical evaluations of their steering and implementation efforts. The study examines the maturation of a widespread treatment ideology, which aims to be based on evidence, in a country known for its restrictive drug policy and its goal of becoming a drug-free society. **Methods:** Through a qualitative textual analysis of 17 years (2000–2016) of inquiries, directives, and authority archives we have traced the interplay between problem descriptions, intended goals, and implemented solutions. **Findings:** The analysis shows that the ambition to provide care and welfare based on EBP is still an ambition. Also, the authorities' control over the care actually provided still leaves room for improvement. Recurring criticism and the empirical material indicate that the expectations have not been met. **Conclusions:** We would like to suggest that continued frustration can be traced to the misconception that EBP is the opposite of

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values and ideology, and hence preferable. As drug treatment strives for scientific credibility to give it legitimacy, some types of “evidence” are preferred above others. We would like to suggest that we need to bring ideology to the fore, and openly discuss our restrictive policy goals and choices of “evidence”.

### Keywords

drug policy, drug treatment, evidence-based practice, residential rehabilitation, Sweden

News reports have lately drawn attention to several problems in Swedish residential rehabilitation centres: accessibility to drugs, shortage of competent personnel, insufficient supervision, and behind it all an ever-present disappointment with the lack of treatment results (DN, 2016; SVT, 2016). The reports refer to only a few centres in 2016, but they mirror concerns about this particular treatment approach – residential rehabilitation – examined in several public inquiries of the 21st century (SoS, 2015; SOU 2000:126; SOU 2011:35). The problems predate these inquiries (Edman, 2012, 2013).

An increasingly common way of trying to counteract perceived problems associated with drug treatment in the Western world has been to adopt a drug policy focusing on evidence-based practice (EBP) (Fraser, 2015; Lancaster, 2014, 2016; Månsson & Ekendahl, 2015; Monaghan, 2010; Stevens, 2007). This has also been the case in Sweden where EBP, with strong public funding and the implementation efforts of the National Board of Health and Welfare (NBHW), was introduced in the 1990s (Bergmark, Bergmark & Lundström, 2012; Edman, 2016). Whether, and how, the launch of EBP has improved the outcome of drug treatment is contested, and the approach has been criticised from a number of angles. Bergmark et al. (2012) even question whether it has made any difference at all (see also Lancaster, 2014). Other potential problems with EBP discussed in research include how people engaged in treatment fare in a system of standardised measures which often reflect narrow norms without

considering power and values when dealing with often marginalised people (valentine, 2009). In addition, those working in the policy development and the service provision of drug treatment are pressured by the strong emphasis on EBP. Frasier (2016) shows how EBP causes professionals to struggle when they, for strategic reasons, feel compelled to describe addiction in essentialist disease models, even if in reality they are convinced that addiction is a highly complex phenomenon (see also Bergmark et al., 2012; Nutley, Walter, & Davies, 2003). Still, perhaps the most fundamental criticism revolves around the popular and political assumption that EBP represents the opposite of, as well as the eradication of, treatment practices based on political convictions and values. This also involves the implicit assumption that EBP is better than previous treatment practices. Several researchers argue that the assumption is wrong: valentine (2009, p. 459), for example, maintains that “[t]here is nothing apolitical about ‘evidence-based’ approaches” (see also, e.g., Cairney, 2017; Fraser, 2015; Lancaster, 2016; Ritter, 2015).

Based on such research, there seems reason to be cautious when placing expectations on EBP. The Swedish National Board of Health and Welfare (NBHW) has made an attempt to counteract some of the potential problems by codifying their definition of “good care and welfare”. In 2009 the board specified six dimensions which together would capture the essence of good practice and safeguard the welfare of those engaged in treatment: (1) Care and welfare shall be based on best available

knowledge and build on both science and tested experience; (2) Care and welfare shall be based on legal certainty as well as being otherwise safe for the individual. This also includes that services provided shall be transparent and predictable for people engaged in treatment and that risk of violations, neglect, and physical or mental injury shall be prevented; (3) Care and welfare shall be individually adapted to the specific needs, expectations, and integrity of each person engaged in treatment as well as facilitating the individuals' participation. They shall also consider the individuals' complete life situation and coordinate services provided by different actors and professions when required; (4) Care and welfare shall be efficient inasmuch as the available resources shall be utilised in an optimal way in order to achieve the set goals; (5) Care and welfare shall be provided and distributed on the same conditions for everybody; (6) Care and welfare shall be easily accessible and be provided within reasonable time (SoS, 2009).

This study investigates how the responsible authorities in Sweden have handled increasing demands for what research has found to be rather ambiguous evidence-based practice and administrative control, while facing critical and discouraging evaluations of their steering and implementing efforts. The study examines the maturation of a treatment ideology that aims to be based on evidence in a country known for its restrictive drug policy and its goal of becoming a drug-free society. This is done through an analysis of the bureaucracy's intermediate role between political goals and the care and welfare in residential rehabilitation of people with a problematic use of drugs. In order to operationalise the aim, the following questions will guide the investigation: (a) In what way have the policy goals codified by the NBHW left their mark on the bureaucratic handling of residential rehabilitation? (b) How have the responsible authorities acted in order to implement the policy and to steer the working practices of residential rehabilitation? (c) Has the

ambiguous nature of EBP been addressed, and if so, in what way?

Through a qualitative textual analysis of 17 years (2000–2016) of inquiries, directives, and authority archives we will unravel the interplay between problem descriptions, intended goals, and implemented solutions. We will start by presenting the material and method, and will then put Swedish residential rehabilitation into a national drug policy context. Before moving on to the analysis, we will present the analytical context. The analysis is twofold, first accounting for the administrative development and steering efforts with regard to rules, regulations, and mandatorship, and then addressing the steering efforts through the bureaucratic implementation as shown in the authorities' case handling of licensing, inspections, and complaints. The article concludes with a discussion of the results.

## Material and method

This analysis is mainly based on the authorities' documents concerning residential rehabilitation administered in the county of Stockholm. More than 20% of people in residential treatment in Sweden receive their treatment in Stockholm County. The rest are scattered among the other 20 counties, where the county of Västra Götaland, including the city of Gothenburg, is the second-largest residential treatment provider, catering for some 10%. The relatively large proportion of treatment provision in Stockholm County allows for a sample containing residential rehabilitation centres which represent a wide range of treatment ideologies and ownership arrangements, as well as a variety in target groups and numeral capacity. The analysis of the authorities' steering efforts should give a comprehensive picture of friction points, challenges, and communication in the relation between the authorities and the centres.

Some of the documents are available on the Health and Social Care Inspectorate register at <https://www.ivo.se/tillstand-och-register/register/> with the key words "care register"

(*omsorgsregistret*), “region east” (*öst*), “Stockholm county” (*Stockholms län*), “residential rehabilitation” (HVB), and “drugs” (*narkotika*). In October 2015, the search located some 20 residential rehabilitation centres in the county of Stockholm, and each centre is linked to a number of documents concerning the licensing and inspections. These data are not complete, nor do they contain documents relating to centres which have closed down, been complained about, been denied licensing, or which have undergone organisational changes. Further, some centres have no documentation attached at all or either lack the licensing approval or potential inspection reports.

The majority of data analysed in this article are therefore drawn from the archives of the three authorities who at different times were responsible for the authorisation and inspection of the initially 50 licensed residential rehabilitation centres during the investigated period. In 1983–2010, the Stockholm County Administrative Board/Länsstyrelsen (SCAB), a regional representative of the government, was responsible for the bureaucratic handling of residential treatment. Their archival material is deposited at Stockholm City Archives for the years 2000–2006 and in the SCAB archive for 2007–2010. In 2010 the National Board of Health and Welfare/Socialstyrelsen (NBHW), a government agency under the Ministry of Health and Social Affairs, assumed responsibility before another institutional change in 2013, when the Health and Social Care Inspectorate/Inspektionen för vård och omsorg (HSCI) took over. This was a new government agency responsible for supervising healthcare and social services. The two latter authorities’ records are kept in the HSCI archive. Due to the unlikely but possible occurrence of sensitive information about individuals existing in the application and inspection files, access to the records is restricted, but is available for research purposes through an application to the responsible archive. Each archive employs a different archival system, resulting in the same type of documents, such as applications, having different kinds of file

numbering. The lack of harmonisation caused some initial problems, which were overcome with the help of the archival staff.

The bulk of the source material is the 37 box files with dossiers of the centres and the 16 boxes with licensing approvals. In general each rehabilitation centre has a manila folder of its own, ideally containing every document produced in connection with the bureaucratic handling of the centre’s work. Depending on how long the centre has been in operation, and on how much friction there has been in its dealings with the authority, the folder can contain anything from 20 to about 100 documents. Even though the number of centres has kept fluctuating, there is a general downward trend: at the beginning of the study period, there were over 50 rehabilitation centres in the county of Stockholm, while only some 20 remained in 2015 after rounds of re-prioritising and financial cut-backs (SoS, 2003; SoS, 2014). In addition to the different centres’ individual case folders and licensing approvals, we have sorted through the complaints and inspections box files, which contain details of the complaints and inspections concerning every aspect of the authority’s work, exclusively focusing on cases related to the residential rehabilitation centres.

In applying a qualitative approach based on the responsible authority’s archived records, the textual analysis has covered a wealth of documents. While we have read every document connected to each rehabilitation centre, we have also gone through correspondence, authority documents, and annual reports concerning residential rehabilitation. The assessment of the material has focused on the authorities’ efforts to steer and handle the centres. Communication between the centres and the authority in conjunction with, for example, implementation efforts and follow-ups of discrepancies has been especially interesting. There is an inherent focus on friction points, since these are the main reason for communication with the bureaucracy. These documents illustrate differences in interpretation, lack of compliance, and measures taken to assure compliance. We have also

paid attention to claims of and references to EBP.

Since this is a study of the implementation of policy goals, we have turned to Deborah Stone (2002) for analytical inspiration. In her policy discourse, a community which tries to achieve something is dominated by four goals or values: equality, efficiency, security, and liberty. Even though these values are at times overlapping, conflicted, or contested, “they function as standards against which programs are assessed” (Stone, 2002, p. 57). And in this case, they also function as a categorisation template for the empirical material.

## **A residential rehabilitation context**

Swedish drug policy has, since the 1970s, rested on the vision of a drug-free society. Despite doctrinal deadlock, the motives behind and the methods within drug treatment have varied. From the very beginning the overall ambition within residential care was to “cure” people who used drugs, while the means of how to go about this was somewhat vaguer (Edman, 2012, 2013). In their report (SOU 1969:52), the Drug Addiction Treatment Committee humbly conceded that it was not realistic to expect to be able to solve the problem exclusively through either prevention or rehabilitation aimed at individuals. Such measures were, according to the currently favoured symptom theory, regarded as a mere treatment of symptoms caused by societal shortcomings. The Committee concluded nevertheless that since the causes behind drug addiction were many and various, the measures could be equally manifold (SOU 1969:52). This approach was parallel to an epidemiological interpretation that any occurrence of illicit drugs use could potentially contaminate the entire population.

As has been shown in earlier research (Edman, 2013), the drug treatment approach up until the 1980s should be viewed as a quite openly ideological project rather than as a therapeutic one. Treatment philosophies cherishing

values such as anti-institutionalism, anti-authoritarianism, anti-modernism, anti-capitalism, and Swedishness were endorsed by the National Board of Health and Welfare. From a therapeutic point of view, the treatment solutions rested on rather loose scientific grounds. Still, if one examines drug treatment as an ideological project, the NBHW demonstrated both adequate methodology and good management in their supervision and in the handling of applications. The next phase, 1982–2000, was marked by a lack of ideological vision in terms of treatment. Traits such as de-centralisation and privatisation instead became the hallmark of the era. An ideologically driven orientation toward New Public Management (NPM) got free reign under the poor bureaucratic steering of the County Administrative Boards. This resulted in a drug treatment market measuring economic stability rather than the best treatment, aiming for measurable outputs within activities that produce services which are difficult to measure, and a streamlining of services (Edman, 2016). This development has been summarised as a “craze for evidence-based solutions” in need of an articulated ideological steering, and this is where we find ourselves when our study commences (Edman, 2016, p. 98).

In Sweden, residential rehabilitation constitutes a quite small proportion of the drug treatment sector. On average, during the last decade, some 10% of the adults (1904 individuals aged 21+ years in 2016) in treatment have attended residential rehabilitation, while almost 90% get outpatient treatment. Some 7150 individuals are, however, at some point enrolled in residential treatment during a year. Only about 2% receive coercive treatment (SoS, 2016b). As a comparison, in England in 2012 residential rehabilitation accounted for 2% of adults in drug treatment (SoS, 2016b; NTA, 2012).

In general, the treatment of people who use drugs is an important part of the Swedish drug policy ideology, stemming from the paternalistic alcohol treatment system of the early 1900s (Edman & Stenius, 2007). This ideology aims

at both prevention and curbing the demand for drugs. While the emphasis in Swedish drug policy has always been on limiting access to drugs, measures of treatment aimed at abstinence have at least rhetorically been a priority (SOU 2000:126; Richert, 2014). Residential rehabilitation has, however, been decreasing in numbers as a result of continuous demands for municipal savings. In 2015 there were in Sweden 183 residential rehabilitation centres aimed at adults perceived as misusing drugs. Out of these some 80% were private enterprises, and the rest were mainly run by foundations, municipalities, and authorities. The average number of people engaged in treatment at each centre was 20, and the total number of beds available was 3790. The usual clientele is a mix of people who use alcohol and those who use drugs. The clientele is also a mix of female and males; women make up on average 30% of the population (IVO, 2016; SoS, 2015). Residential rehabilitation is the only treatment arrangement, besides coercive treatment, that physically removes people who use drugs from the environment and from acquaintances connected to their problematic use.

The Swedish approach to residential treatment is not unique, even though the volume is unusually large. According to the National Guidelines (SoS, 2017), residential treatment is offered in therapeutic communities with different treatment philosophies, such as 12-step, Christian philosophy, combined/integrated treatment, cognitive-behavioural therapy and social learning, and personal skills and development (see also Edman, 2013; Mold, 2008; Mold & Berridge, 2010; Rehab Online, 2016). Residential rehabilitation centres are considered an important part of the drug treatment policy in several Western countries (Edman, 2016). They are appreciated for their focus on the social aspects of rehabilitating a problematic use of drugs, the varied treatment philosophies, and their goal of achieving abstinence (Edman, 2013; Mold, 2008; Mold & Berridge, 2010). However, they also seem to have their own set of problems. According to Mold (2008)

and Edman (2013), there is a persistent lack of evaluations as to what kind of treatment really works, they are expensive, and they make strong but rarely substantiated claims of building on EBP (see also NTA, 2012). Before we turn to the empirical analysis of the workings of residential rehabilitation, we will introduce the literature and theoretical reasoning that have inspired our analytical approach.

## **An analytical context**

In aiming to understand the workings of the authorities in their intermediate role between policy goals and implemented practice, we need to define the parameters of this authority and the relation to residential rehabilitation. Research has convincingly shown that ideology and values play a central role both in drug policy making and drug policy implementation (Edman, 2012; Eriksson & Edman, 2017; Monaghan, 2010, 2011; Ritter, 2009; Stevens, 2007; Tieberghein & Decorte, 2013). This research highlights how drug policy choices lead to emotional and value-laden responses. Stone (2002) suggests that policy choices entail a large component of struggle over ideas based on such values. Whether open or covert, ideologies and values shape how a political problem is defined, which goals we are to set, and what possible solutions we can see (Stone, 2002).

These ideologically based policy choices have, in Sweden, for example, resulted in a problem description of drugs focusing on security, viewing them as being dangerous, potentially epidemic, and of foreign origin. As a result, the general policy goal is freedom from drugs – a drug-free society. The preferred solutions are control, prevention, and treatment, all aiming at abstinence and with a strong emphasis on effective control. Another aspect of the drug issue's ideological nature is that, in the Swedish context, the problematic use of illicit drugs has been interpreted as an equality issue within a social framework, as a symptom of inequality, rather than in a medical frame (Edman, 2012).

As drug treatment facilities in Sweden are part of the social service system, they are financed through taxes. In order to gain and retain the taxpayers' support, rehabilitation needs to uphold a certain level of legitimacy. Perhaps more importantly, the referring municipalities as well as the people engaging in treatment and their families have to consider the time spent in residential rehabilitation as good value for money and as meaningful in order to legitimise residential rehabilitation as a treatment alternative (Rothstein, 2008). However, the stay at a residential rehabilitation centre is a service provided on the basis of the individuals' social rights, which, due to the need for a great level of individual adjustment, are quite complex to implement (Rothstein, 2008; valentine, 2009). The predominant way of dealing with this complexity has for a long time been to staff the administration of social services with individuals possessing genuine expertise and then trust the professionals (Hall, 2015; Lipsky, 1989/1969; Rothstein, 2008). Lately this trust seems to be wavering, or at least it needs additional support from rules, regulations, and guidelines usually referred to as EBP.

As the idea of applying evidence-based practice has spread to more and more policy areas, a number of potential problems have been observed. According to some critical commentators, EBP tends to bring about a de-professionalisation of social workers, reducing them to executants of rules and guidelines, and leaving little room for individual client-related judgements (Bergmark & Lundström, 2006; Nutley et al., 2003; Rothstein, 2008). Another dilemma is the apparent lack of impact, which might threaten the sought-after legitimacy: "The legitimacy of EBP is largely characterized [...] through being a kind of normative projection of expectations for the future, a legitimacy based on a potential rather than actual results: Legitimacy through what might be the case" (Bergmark & Lundström, 2006, p. 110; see also Bergmark et al., 2012; Fraser, 2015; Storbjörk, 2006). Evidence-based practice is also

problematized for emphasising the ideological dimension of evidence (see, e.g., Monaghan, 2010; Stevens, 2007; Weiss, 2001). This critique questions the assumed dichotomy between science/evidence and politics, the objective nature of evidence referred to in EBP, and the common separation of the scientific field from the social field. Here we can only very briefly touch on the nuanced and rich research referred to. For example, according to Fraser (2015), science is only one of the many ways of knowing, and the fact that scientific knowledge is apparently preferred actually *is* a matter of politics. She further argues that we need to consider other ways of knowing, such as values and experience, and to leave room for values other than objectivity when shaping policy and providing services (Fraser, 2015; see also Cairney, 2017; Lancaster, 2016; Ritter, 2015). Especially at a time when "...naïve appeals to 'evidence-based' responses grow ever more common" (Fraser, 2016, p. 10; see also Bergmark et al., 2012; Lancaster, 2014; valentine, 2009). Lancaster (2016) has examined how "evidence" and "EBP" are constituted in drug policy processes, suggesting that other possible policy-guiding principles, such as values, emotions, and common sense, are being obscured by the politically decided singularity of evidence. Further questioning the fabric of "evidence" in EBP is valentine (2009), who also argues that "evidence-based" approaches indeed are political. Her objection is that EBP neglects to consider, for example, the people who use drugs, the ethics, the interests, and the social environment. She even claims that "... the values and ethics of treatment need to be considered as core rather than add-ons" (valentine, 2009, p. 459).

Media reports, public inquiries, and research have thus identified two sets of potential problems regarding drug treatment through residential rehabilitation: those connected to the treatment arrangement per se, and those connected to the EBP approach. Swedish inquiries and media coverage draw on reports of lacking

control of those engaged in treatment, insufficient bureaucratic supervision, inadequate staffing, and poor treatment results to claim that residential rehabilitation is not properly adjusted to the policy values of security and efficiency. The EBP approach is, mainly based on research, criticised for being inefficient and not promoting individual liberty; it is deemed to lack impact, to disregard the experiences of those engaged in treatment or the professionals, and to represent too narrow a take on evidence and knowledge. This critique is all the more relevant in light of the NBHW's six dimensions of good care and welfare, which can be interpreted as aiming to secure the policy values of safety, efficiency, and equality as based on both science and experience (SoS, 2009).

The literature referred to above suggests that in order to analyse the Swedish authorities' efforts to handle and steer the residential rehabilitation centres and implement the national drug policy, we need to consider the consequences of the ideological and value-based aspects of the restrictive and abstinence-focused drug policy, and its dependence on legitimacy while handling the complexity of implementing individual social rights. Nor should we forget the ideological and value-laden aspects, either, of an EBP approach often believed to be "objective".

## Analysis

In the following analysis we will first discuss the authorities' attempts to get to grips with the perceived problems attached to residential rehabilitation. Then we move on to the bureaucracies' attempts to implement the suggested solutions. These are subdivided according to the core policy values identified by Stone (2002): equality, efficiency, security, and liberty.

### *Administrative regulations*

Previously mainly run by volunteers and ex-clients in non-profit organisations, residential

treatment centres became increasingly privatised in the 1980s and 1990s, and were considered in need of better steering (Edman, 2012). Since then the quest for better steering and treatment quality has led to ever-sharpening application criteria and regulations. Also, the regulations and guidelines of the 21st century make it clear that there is no longer room for the idealistic volunteers of the centres of the past. For example, the management and staff are required to be ever better educated, and the required documentation is ever more demanding. The aim to provide treatment based on science and tested experience is resulting in increasingly detailed official manuals and guidelines. For example, managers are now expected to have an adequate college education, while members of staff are requested to have appropriate training of their own (SOSFS 2003:20). Managers are also required to check job applicants' criminal records before hiring them (SOSFS 2009:4). A few years after these changes were made the management system was in focus, demanding a systematic approach to quality improvement (SOSFS 2011:9). The latest issue of the guidelines recommends that managers have at least three years of college education and staff at least two years of post-secondary education (HSLF-FS 2016:55).

However, the constant changes aimed at creating a higher degree of efficiency and security have caused problems concerning equality. According to the HSCI regulation of 2013, a centre must contain a considerable element of treatment in order to receive a licence. As a result, depending on when the licence was approved, a differentiation concerning the content and quality among the operating centres has arisen. As long as a centre is operating in accordance with its approved application, the licence cannot be revoked. In addition, the NBHW states that the ever-stricter regulations and the resultant practices have led to new, non-licensed, and therefore non-supervised supported housing (SoS, 2015). At times, as will be demonstrated below, these have caused some confusion for the municipalities wishing

to refer someone to a residential rehabilitation centre.

Another response to some of the criticism has been to relocate the administrative responsibility for residential rehabilitation. At the beginning of the period, after the 1983 move from the NBHW, the administration was handled by the 21 County Administrative Boards. According to research, this shift resulted in a further bureaucratisation of the handling of residential rehabilitation. While the NBHW had acted as an ideological gatekeeper by administering a view of human beings through a mutual agreement as to what kind of society care should aim for, the counties rather evaluated whether the application forms were properly filled out (Edman, 2012). This development can, however, also be interpreted as a result of a general shift in public administration where expert opinions are considered more legitimate than political goals, and a focus on results through evaluations is taking over the role of policymaking (Hall, 2015; see also Bergmark et al., 2012). This arrangement lasted almost 30 years despite growing criticism.

In March 2009 the right-wing Alliance tabled a Government Bill (Government Bill [Proposition] 2008/09:160) in which one of the proposals was to reinstate the NBHW as administrative authority. The Committee on Social Affairs considered it “inappropriate to have several actors with similar functions to supervise private enterprises” (Parliamentary Records [PR] 2008/09: SoU22, p. 13). The Committee interpreted the bill as an effort to unify and simplify the supervision, to concentrate resources, and to facilitate the possibility for citizens to communicate any misgivings and/or complaints (PR 2008/09: SoU22). In addition, the left-wing opposition was positive towards the bill (PR, 2008/09:120, address [ad.] 52 & ad. 53). The bill passed in May 2009, and the NBHW regained authority over residential rehabilitation as of the beginning of 2010 (PR, 2008/09:122 § 5). However, an evaluation in 2012 by the Swedish Agency for Public Management (Statskontoret) found the reform not to

be as coordinated, structured, or efficient as expected. The agency proposed a pure inspection authority, which resulted in an Alliance Government Bill the same year (Statskontoret, 2012:11; Government Bill [Proposition] 2012/13:20). The bill was approved by parliament, and the new Health and Social Care Inspectorate (HSCI) was up and running on 1 June 2013.

These changes in mandatorship, qualification criteria, sharpening of rules and regulations, as well as a general focus on EBP, can be viewed as a response to public criticism and as a way of retaining legitimacy. Our review of governmental and departmental inquiries published since 2000 nevertheless reveals some recurring concerns throughout the period. At the beginning of the period the Narcotics Commission (SOU 2000:126) delivered an investigative report and declared its ambition to strengthen, renew, and develop the restrictive Swedish drug policy, stating that

There are serious deficiencies in the design of drug abuser care today, and the volume of such care falls short of actual needs. Long-term initiatives are called for, above all as regards interaction and the development of methods and competence . . . (SOU 2000:126, p. 42)

The report also mentioned a lack of effective treatment, insufficient evaluation and documentation routines, inconsistency in care measures taken by different municipalities, and fragmented care with no attention paid to the overall perspective. The knowledge dissemination was also deemed inadequate.

Some ten years later the Misuse Investigation (SOU 2011:35) presented its findings in April 2011. Its conclusions echoed those of the SOU 2000:126. For example:

The treatment of misuse and dependency is not sufficiently knowledge-based. For some misuse and dependency conditions, evidence-based measures are missing completely. [...] Also, the competence level is inadequate. The staff providing misuse and dependency treatment are often

very dedicated and experienced, but often lack formal education. (SOU 2011:35, p. 23)

The investigation also questioned the lack of emphasis on the demeanour of management and staff. The last major report came about as the government assigned the NBHW to produce a foundation for improving the quality of residential rehabilitation treatment. In the report (SoS, 2015), the same deficiencies were reported once again, with the added proposal of mandatory inspections and a critical remark about the centres' failure to provide those engaged in treatment with safety and predictability. As for the issue of education:

One condition for strengthening the quality of residential rehabilitation is that the staff have the proper education, competence, and suitability for their job assignments. [...] The Board believes that the staff as a rule should at least have an education corresponding to a two year post-secondary education oriented towards social care and treatment. (SoS, 2015, p. 33)

These are the recent developments and the different authorities connected to residential rehabilitation during the investigated period, which has seen several adaptations to policy changes, re-written rules and regulations, discouraging evaluations, fundamental criticism, and numerous confrontations. To investigate to what extent these conditions have affected the bureaucratic handling of residential rehabilitation we will now turn to the everyday work of the authorities.

### *Bureaucratic implementation*

The cases below are examples of occurrences triggering the response of the authorities. The empirical material is presented thematically even though three different authorities have been responsible for residential rehabilitation. After going over the entire material we can only conclude that as far as the administration of the residential rehabilitation is concerned, there is

no noticeable difference between the three authorities. Neither the authorities' centralisation nor specialisation seem to have had any effect on the implementation. There is, however, one important difference – the file numbering. Each file number usually contains information about the year of handling but in different ways, so we have highlighted the numbers (either a two- or four-number combination) identifying the year by italicising them. In three exceptional cases the file number indicates the year of the first licence approval instead of the year of handling.

### *Friction points related to equality*

Drug treatment is a targeted measure, and its legitimacy heavily depends on its being perceived as equally provided to those needing it. Failing to do so has been a recurrent issue within residential rehabilitation. In its annual report for 2000, the Stockholm County Administrative Board reported to the National Board of Health and Welfare a decrease in Social Services referrals to residential rehabilitation, claiming that financial cutbacks had put social workers and management in a difficult position. The cutbacks had forced them to choose between budget goals and the Social Service Act; they had often ended up choosing the budget, i.e., cheaper outpatient care (SCAB, Dnr. 2114-2000-62703). This problem persisted, as was evident on inspection of the drug treatment provided by the 26 Stockholm county municipalities. The SCAB concluded on several occasions that the municipalities failed to take individuals' needs into consideration (e.g., SCAB, Bet. 7012-03-36924; Bet. 7012-04-18834; Bet. 7012-04-6088; Bet. 7012-04-54786; Bet. 7012-04-20535; Bet. 7012-04-2076). The cutbacks also led to some centres closing down due to lack of referrals. One centre closed because "our referring clients, municipalities and the public sector, do not have the means or resources to send women to our facility" (SCAB, Bet. 7021-2009-085428, see also Bet. 7021-08-071046).

Other centres were less understanding. A facility notified the SCAB that it was closing down due to lack of referrals after four years of successful treatment. The manager claimed, without referring to any evidence, to have an 87% recovery rate but still got no referrals. This led him to question both the issuing of a licence and the inspections: “The inspections have centred on following up routines. Nobody has shown any interest in our results” (SCAB, Bet. 7021-06-94349). The municipalities also referred to tougher financial times when advising against issuing new licences, declaring that they had to prioritise outpatient care over inpatient treatment (SCAB, Bet. 503-93-17735; Bet. 503-93-19844). Another argument for advising against either the establishment or expansion of a residential rehabilitation centre was the individuals’ tendency to stay in the vicinity of the centre after completing the treatment. The assumption was that those who had engaged in treatment would continue to be a financial burden to the social services. The SCAB, however, never paid any attention to the financial worries of the municipalities when granting and renewing licences (SCAB, Bet. 213-02-59154; Bet. 7021-08-07104; Bet. 213-02-17311; Bet. 7021-2009-010170). This placed the centres in an unstable financial situation and those engaged in treatment in an unstable treatment centre.

There are also a few cases where relatives of people who use drugs have communicated their grievances about their loved ones not getting equal access to the drug treatment system. Family members have lodged complaints about the municipal social services’ processing time and lack of interest in providing treatment. However, neither the SCAB nor the HSCI found upon investigation any reason to take action in these cases (SCAB, Bet. 7012-07-47702; Bet. 7012-07-56095; HSCI, Dnr. 10.2-29692/2013). For obvious reasons relatives and authorities have different opinions of what an equal treatment should contain.

The value of equality, i.e., distribution being regarded as fair, was thus compromised on

several occasions, reportedly mainly because of financial reasons. This could also be interpreted as a lack of service efficiency, since the authorities fail to meet the objective of providing equal care – one of the dimensions of the NBHW definition of good care and welfare. On the other hand, one might argue that meeting budget goals is a result of efficiency. The examples above illustrate that the different dimensions of good care and welfare encompass several values, which at times are at odds with each other, and at other times have different aims depending on the vantage point.

### *Friction points related to efficiency*

A dimension expected to promote efficiency is to provide treatment based on EBP. The general ambition to ground policies on research and tested experience (EBP) is of course a lot older than NPM and the EBP craze of the 1990s (Lundin, 2010; Weiss, 1979). What, however, is connected to this era is the ambition to fit services which need a great deal of situational adaptation into a rather inflexible format (Bergmark & Lundström, 2006). Research gives evidence on the importance of providing multiple solutions, treatments, and goals, which in extension means relying on the competence and perceptivity of the professionals (Bergmark & Lundström, 2006; Cameron, 2010; Lancaster, 2016; Stevens, Hallam, & Trace, 2006; Storbjörk, 2006). Nevertheless, when evaluating licensing applications the authorities are expected to follow the recommendations in the existing NBHW national guidelines supposedly based on research and tested experience – which in turn is ever shifting as new findings are published (Bergmark & Lundström, 2006; Fraser, 2015; Mold, 2008).

One such recommendation is that a residential rehabilitation centre should not be aimed at too many target groups: “[i]ndividuals with different basic problems or who differ substantially in age or maturity should as a rule not be cared for or treated together in a residential rehabilitation centre” (SOSFS 2003:20, p. 3).

So, when faced with applications that were considered too inclusive the SCAB would not issue a licence. This was the case when the proposed target group was deemed too wide and too problematic, containing diagnoses of both drug misuse and mental disease (SCAB, Bet. 7021-04-10077). In another instance, one facility did, however, get, and keep, its licence even though it welcomed a much wider range of people engaged in treatment. The application listed: men and women over 17 years of age with a problematic use of drugs and/or alcohol, individuals with a mild psychosis, abused women and children, youth with family problems, divorcées, immigrants, families in desperate need of housing, and addicts on maintenance (SCAB, Bet. 7021-08-94651). This inconsistency is problematic from an efficiency point of view since it becomes very hard for the centres to predict what is accepted and not.

More to the letter when it comes to the implementation of EBP are the applicants that seem to be aware of the expectations, at least to a certain degree. One facility informed the SCAB about a change of treatment method to the “evidence-based treatment CBT”, when moving away from providing 12-step therapy (which according to the NBHW is also considered evidence-based) (SCAB, Bet. 7021-08-13255). Another claimed to provide treatment, which “is evidence-based according to the NBHW”, while omitting to identify the method (SCAB, Bet. 7021-03-94904). On the rare occasions that the inspectors reflected on EBP they did not do it very consequently. In a case file one inspector remarked laconically in 2002: “My assessment is that the activities do not build on science and tested experience. This is however not unusual within the social services, but, when running such an activity it really should be well defined and possible to evaluate...” (SCAB, Dnr. 93/SN268 763). A few years later an inspection of the same facility, performed by another individual, stated that it was functioning well and that: “the treatment is carried out with lots of dedication, love and joy” (SCAB, Dnr. SN99/217 751). These

requirements are not found in the national guidelines.

The national guidelines, aimed at creating a uniform and efficient treatment through EBP at the centres, were not always met, at least not in terms of procedure and practice. What is perhaps more remarkable is that efficiency in terms of treatment outcome is never discussed.

### *Friction points related to security*

Security is another value that according to Stone (2002) is central when policy choices are made. One important aspect of security is how the people engaged in treatment fare in the context of residential rehabilitation. As shown above, several researchers have drawn attention to the risks of “losing” the users’ perspective in an EBP facility. The NBHW seemed to be aware of this: it aimed to provide care and welfare based on legal certainty as well as being otherwise safe for the individual. They were not always successful. A recurring issue in public inquiries is the lack of predictability and the vulnerability of people engaged in treatment.

On no occasion did inspections that resulted in criticism concerning general procedures, fire safety, insufficient documentation, lacking individual treatment plans, and problematic staff demeanour cause any further disturbance in the centres’ practice than a request for correction (SCAB, Bet. 7021-05-25994; Bet. 7021-09-16223; Bet. 7021-04-25239; Bet. 7021-05-33756; Bet. 7012-05-30544, Bet. 7012-03-78131; HSCI, Dnr. 8.5-8040/2015-5). When a medical doctor sounded the alarm on discovering that an individual who was not addicted to opioids had been put on maintenance treatment, the Inspectorate only issued a critical note and closed the case (HSCI, Dnr.9.1-5852/2012). In the Inspectorate archive under the headline “Complaints” and in SCAB’s correspondence there are several cases concerning neglect, abuse, chaotic conditions as well as two cases of deaths. In no case did the authorities take any decisive action (HSCI, Dnr. 9.2.-341123/2012-3; Dnr. 8.2-6423/2013; Dnr.

8.1.2-31087/2015 -1; Dnr. 8.2-25739/2013-9; Dnr. 10.2-29692/2013; Dnr. 8.2-33753/2013; Dnr. 8.2-9435/2014; Dnr. 8.2-39537/2015; Dnr. 8.1.2-33729/2014-5; Dnr. 8.2-7712/2014; Dnr. 8.1.2-19318/2015 -1; SCAB, Bet. 7012-07-85587; Bet. 7012-07-94399; Bet. 7012-03-16133; Bet. 2121-01-41654; Bet. 2121-01-39649; Bet. 2121-02-51899).

One rather peripheral, but potentially very important area of unpredictability is whether the municipalities made referrals to a treatment facility needing licensing or not. On one occasion the police were called to a facility and found intoxicated staff, convicted robbers, filth, and drugs on the premises. A very concerned police officer, stressing that this was a facility admitting vulnerable young adults, contacted the SCAB and urged them to inspect. On inspection, the centre's management admitted that their activity was aimed at young adults with a problematic use of drugs and a criminal background. However, they did not claim to provide any element of treatment. According to the staff they only offered practical support as buddies, or as adult role models. The facility was deemed not to need a licence, and could continue to receive young adults. Apparently the only authority that supervised the place was the police (SCAB, 11/12-17/12 2001). Another borderline case in the eyes of the SCAB was a facility called Treatment 12-step Stockholm. They caught the attention of the Board through a newspaper advertisement claiming extensive experience of treatment and to provide those engaged in treatment with individual care plans. In a meeting with the centre management, the SCAB case manager accepted the management claims that no treatment was provided (SCAB, Bet. 7021-04-19343). Hence, the facility needed no licence, but was advised to change the advertisement, and could continue unchecked (see also cases SCAB, Bet. 7012-05-38701; Bet. 7012-07-94399; Bet. 7021-09-30380; Bet. 7012-07-53217; Bet. 7012-06-104328).

There were, however, a few cases where safety issues led to licensing being withheld.

These are worth mentioning in order to illustrate the level of problems leading to an unsuccessful application. One such application was filed by a company called Swedish Sign Service and Electrical Fittings Ltd. The application was deemed to show unclear ownership, and it turned out that the members of the management group all had lengthy criminal records and substantial debts. The decision also mentioned doubts regarding the ability to deliver care and treatment of sufficient quality and safety. One of the applicants was the manager of the previously mentioned treatment 12-step facility, which was not mentioned in the records, nor were any questions posed about the peculiar name of the aspiring drug treatment centre (SCAB, Dnr. 213-02-43260).

In another case, the SCAB found the applicant company too unstable in terms of staff, management, and finances. The applicant wanted to add another facility to the already existing three centres. When asked for their view, both the local social services and the police advised against granting a licence, based on reports of continuous problematic use of drugs and criminality at the existing centres. The SCAB records confirmed this picture, adding their own experiences of management shortcomings on the list of grievances. Inspections, too, had been cancelled because the facilities were allegedly about to shut down. Regardless, the Board closed the file, stating that few signs of abuse had been brought to their attention and that lately no formal complaints reports had been received. The applicant got to keep the licence for the existing three facilities, but was not granted a fourth one (SCAB, Dnr. 213-02-64615). This and the case of Swedish Sign Service and Electrical Fittings Ltd. are the only instances of centres having been denied a licence since the turn of the millennium. There were, however, several refusals for changes of management, increases in numbers, and changes in target groups (e.g., SCAB, Bet. 7021-04-10077; Bet. 7021-07-5274; Bet. 7021-07-58792).

While the security aspect can be related to several facets of drug treatment, here we have focused on the security of those engaged in treatment and the predictability of treatment efforts. The examples presented here are not an outcome of accidents, but of failure to follow the existing guidelines.

### *Friction points related to liberty*

The value of liberty is mainly manifested through the overarching goal of drug treatment: to become drug free. References to drug freedom are frequent when centres identify the ultimate outcome of a stay at a residential rehabilitation centre (SCAB, Dnr. 702-5212-09; Dnr. 702-35141-09; Dnr. 702-2993-09; HSCI, Dnr. 6.3.1-5538/2010; Dnr. 6.3.1-32424/2010; Dnr. 6.3.2-20708/2014). With this goal in mind, it is quite surprising that no attempts are made to evaluate to what extent those who are engaged in treatment do become drug free, and for how long. In the national survey Open Comparisons of Misuse and Addiction Care (SoS, 2016a), compiled by the NBHW on an annual basis, none of the items refers to the outcome of treatment. Website design, various routines, staff conduct, and the level of individual influence are some of the topics covered in the questionnaire to be filled out by every drug treatment centre in Sweden. No questions are asked about the outcome of treatment, nor are there any questions about whether people engaged in treatment share this view of freedom.

## **Discussion**

We are making great efforts for addicts and misusers, and the treatment we are offering is among the best in the world. (Gabriel Wikström, Social Democratic Minister of Public Health, SVT, 2016-04-19)

The Minister of Public Health also said in this 2016 interview that treatment was becoming an

increasingly bigger part of Swedish drug policy. The journalist reported further that science and tested experience were challenging the zero-tolerance ideology that had been the foundation of Swedish drug policy (Wikström, SVT, 2016-04-19). After investigating one segment of the drug treatment sector we can conclude that the image conveyed by the Minister should perhaps be understood as a declaration of ambition and as a quest for legitimacy rather than as a description of the current state – or rather, as basing the legitimacy achieved through EBP on what might be the case (Bergmark & Lundström, 2006). This is intriguingly paralleled by the way in which the NBHW dimensions of good care and welfare do not exactly correspond with the residential care administered through the responsible authorities and received by people engaged in treatment.

So, how have these NBHW dimensions influenced residential rehabilitation and what has emerged from our examination of the authorities' attempts at policy implementation and steering? In short, the overall goal to provide care and welfare based on science and tested experience, or EBP, has not quite been reached yet, possibly because there is a lack of evidence for specific treatment methods. Nor have the authorities quite succeeded in exerting control over the care actually provided at the individual centres. The NBHW has set ambitious goals for residential treatment – equality, efficiency, security, and liberty – which are to apply to every aspect of the centres' work, including general rules and regulations, changes in mandatorship, and the fierce scrutiny before licensing. Yet the workings of the residential rehabilitation centres still appear to be quite chaotic. Supervision is complicated in a treatment system with no real accountability. Social politicians, procurement bureaucrats, local social services, service providers, and supervisory authorities can all blame each other for offering inadequate services. The relentless criticism of the system may also indicate that the treatment approach is a reform-resistant institution. Or perhaps more problematically,

it might indicate that the implementing authority is a reform-resistant bureaucracy – hence the repeated changes in mandatorship. When bureaucratic efforts to reach policy goals centre on formalities rather than on observance, the results are far from satisfactory. Judging by news reports and various inquiries, residential rehabilitation centres still lack legitimacy.

A number of policy paradoxes (Stone, 2002) complicate the handling of drug treatment, which becomes obvious from our study of the bureaucracies' attempts to steer residential rehabilitation and implement policy. The most obvious policy paradoxes are: demands for an individualised treatment plan clash with EBP templates and thus curtail the policy value of liberty – of both those engaged in treatment and of management and staff. The value of efficiency is compromised by demands for professionalised and effective care and simultaneous demands for economic efficiency. This often leads to financial cutbacks and NPM ideals where the lowest bidder gets the job. Efficiency is further challenged when demands for EBP clash with poorly educated staff and lack of unambiguous research. The value of security calls for increased control and monitoring, hampered by the centralisation of administration and financial down-prioritisation. One has to meet strict criteria to open a residential treatment centre – promoting the values codified in the six NBHW dimensions – but the criteria clash with the almost non-existent follow-ups. We have also assessed the policy values of residential treatment from the point of view of those who are engaged in treatment. This is a position also taken by the National Board of Health and Welfare but rarely seen among politicians. Their point of view is influenced by that of the voters (Eriksson & Edman, 2017).

Crucially, we also need to ask how the ambiguous nature of EBP has been addressed. The fact that the NBHW has codified a set of aims and regulations shows that they seek to counteract some of the potential risks that research has found are connected to a fully implemented EBP. In addition, the application

form that the aspiring centres are required to fill out poses several questions regarding the possibility for those who are engaged in treatment to participate in matters concerning their stay at the centre. However, upon rarely performed inspections these issues are seldom addressed. If the application form is filled out properly and no formal complaints are filed, several years can pass between inspections. Also, the NBHW regulations and aims do not address the problems highlighted by research, such as ignoring the professionals' experience and full potential as experts. But perhaps such problems are addressed in the implementation of the treatment? The lack of follow-ups and inspections, as well as the hesitance to take decisive action, leaves the management and staff of centres plenty of room for manoeuvre. This could be interpreted as one set of professionals, the bureaucrats, cutting another set, the treatment providers, some slack.

In summing up the bureaucratic handling of great expectations and harsh criticism we would like to suggest that the discrepancy is a result of a misunderstanding. The ideologically based drug and treatment policies aim to be perceived as legitimate in order to get public and financial support. Legitimacy is achieved through practices backed by a comprehensive ideology, in this case a drug-free society, and by a just and proper operationalisation and implementation. The implementation, in turn, needs a legitimate reason to be administered, and the implementation today reaches for EBP in order to gain legitimacy through scientific credibility. But practice which is reportedly evidence based still does not seem to deliver.

Perhaps the policy makers, the NBHW, and the authorities have underestimated the value of values (Eriksson & Edman, 2017)? This is an especially relevant question in a policy field positioned within a social framework and in a treatment field based on individual motivation. Could it be that the value of evidence has been overestimated, given that there is a lack of unambiguous research regarding treatment methods? Do we have here a case of two

misjudgements adding to the frustration and constant criticism of the bureaucratic steering and implementation? There are several references in Swedish drug policy debate which suggest a conviction that evidence is the opposite of values, and is preferable to values. Ideology and values are defined as that which gets in the way of a good and rational policy (Parliamentary Bill [PB] [Motion] 2001/02: So35; SOU 2011:35). Hence, ideology is defined as the problem in drug policy, as if evidence is intrinsically good and ideology is intrinsically evil. In reality, when evidence-based practice becomes the treatment approach of choice, values and ideology which cherish rigid treatment models, quantifiable results, and cost-effectiveness are hidden in plain sight. The dictionary Merriam-Webster.com defines ideology as “the integrated assertions, theories and aims that constitute a sociopolitical program”, and EBP is just as ideologically based as any other political agenda (Eagleton, 1991; Freeden, 2003; Moore, Fraser, Törrönen, & Eriksson Tinghög, 2015). Therefore we would like to suggest that what we need is more and openly declared ideology when discussing, administering, and implementing drug policy (Edman, 2016).

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