Check for updates

DE GRUYTER OPEN

NAD

Research report

Stakeholders' arguments for and against moving Swedish substance abuse treatment to the health care system: How a fat reform proposal became a thin government bill

JESSICA STORBJÖRK

ABSTRACT

BACKGROUND – Far-reaching changes in the Swedish substance abuse treatment system (SAT) were proposed by a state-commissioned inquiry in 2011. The proposal implied a break with the social tradition of SAT. It was suggested that the treatment responsibility should be transferred from the municipal social services to the regional-level health care system; and that compulsory treatment in its present form (assessed by/paid for by social services, run by the state) should be abolished and become incorporated into coercive psychiatric care provided by health care. A lively debate arose, and the vast majority of stakeholders sought to articulate their arguments. AIM – The study analysed the development of Swedish SAT by examining the policy process from reform proposal to government bill in 2013. METHOD – Content analysis was used to analyse written comments on the proposal submitted to the Ministry of Health and Social Affairs by close to 200 stakeholders. The goal was to empirically chart and examine the arguments for and against as well as advocates and opponents of the reform. With the government bill at hand, we retrospectively sorted out the winning arguments in the now highly contested SAT field and which actors were able to influence the process. CONCLUSIONS – The article discloses that the mixed response and rather critical voices in most groups, including social/medical professions and government bureaucracy, helped block the responsibility shifts, and that reformations of subsystems like SAT are difficult to carry out as freestanding projects within larger systems of social and health care.

KEYWORDS – substance abuse treatment systems, policy, medicalisation, social perspective, formative moment, path dependency

Submitted 05.05.2013 Final version accepted 26.08.2013

Introduction

This article analyses the political context and the development of the Swedish substance abuse treatment system (SAT) in recent years. Sweden has a long social tradition of treating alcohol and drug problems with the municipal social services holding the major treatment responsibility. In 2011 a state-commissioned inquiry (SOU, 2011) suggested responsibility shifts that would make the regional health care system responsible for the (compulsory) treatment of misuse and dependence. The proposal implies a break with the social tradition. *The article analyses the process from inquiry to government bill by examining written comments submitted to the Ministry of Health and Social Affairs by close to 200 stakeholders. The goal is to empiri-*

Unauthenticated
Download Date | 12/16/16 11:54 AM

cally chart and analyse arguments for and against the reforms as well as advocates and opponents of these changes. The article explores how systems change, or not, when extensive organisational reforms are proposed, and which arguments and forces obstruct and which lead to change. It focuses on the case of the Swedish substance abuse system, but it may also have practical and theoretical implications for analysing other complex systems of care and for the understanding of substance abuse treatment systems internationally.

In April 2008, the Ministry of Health and Social Affairs appointed an inquiry[1], named *Missbruksutredningen* (Misuse inquiry). It was led by a single investigator Gerard Larsson, who had previously led more than 20 such commissions within the field of social, health and employment policy. The inquiry's task, as requested by the Ministry, was to review the full substance abuse treatment system: consider treatment responsibilities; quality of care; evidence-based practices; and problems with pharmaceuticals and doping, etc. (Dir. 2008:48). Several interim reports were released before the 1000-page final report (SOU, 2011) was presented in April 2011. This report includes about 70 reforms and can be considered a massive investment. The most far-reaching and debated part was the proposal to transfer the treatment responsibility from social services to the health care system, while social services should keep the responsibility for providing social support. A split was thereby suggested between *treatment* and *support*. It was also suggested that compulsory substance abuse treatment in its present form should become incorporated into coercive psychiatric care, also provided by the health care system. This article focuses on these two shifts.

What does the system look like and how could this extensive shift be suggested? The legal prerequisites of Swedish substance abuse treatment have been stable since the early 1980s. It is organised and regulated at three levels: (1) the municipal (N=290) social services (SS) have held the major responsibility for long-term care, treatment and potential cure of alcohol and drug problems; (2) the regional county councils' (N=21) health care system has been responsible for medical/psychiatric care for substance-related disorders (detoxification, emergency services and pharmacological treatment); and (3) the state has held the responsibility for providing compulsory treatment (assessed by and paid for by social services), and for treatment in the criminal justice system (Blomqvist, Palm, & Storbjörk, 2009). However, the substance abuse treatment system has been subjected to many critical inquiries (SOU, 2004; SOU, 2005) and has shifted towards more outpatient services and expanded opioid-maintenance treatment (Blomqvist et al., 2009; Ekendahl, 2009; Storbjörk, 2010). Evidence-based treatment guidelines, compiled by the National Board of Health and Welfare (NBHW, 2007), have been launched and are implemented in a nationwide project called *Knowledge to Practice,* a collaboration between the government and the Swedish Association of Local Authorities and Regions (SALAR), led by SALAR. Compared to the latest big change of substance abuse treatment in the early 1980s when the Social Services Act and the Health and Medical Services Act came into force (after state-commissioned inquiries and a lively debate), the situa-

Unauthenticated
Download Date | 12/16/16 11:54 AM

tion today is somewhat different. New interest groups have arisen, and service user organisations have grown numerous and more specified – a fragmentation of voices (Sellerberg, 1999; Storbjörk, 2012).

The process of medicalisation by which problems and phenomena are defined and treated as medical problems has gained a stronger foothold at the expense of social professions and models (Conrad & Schneider, 1992; Conrad, 1992; Topor, 2010; Upmark, 2006). Even if it in the late nineteenth century was a Swedish physician, Magnus Huss, who coined the term *alcoholism,* and even if the first Swedish alcoholism institutions were established by physicians (Prestjan, 2007), and while the medical aspects of abuse have at times been highlighted, Swedish substance abuse treatment, which has its roots in poor relief and once cultivated close links to a strong temperance movement, has primarily been the responsibility of social services. This has entailed a dominance of social care, models and professions (Edman & Stenius, 2007; Rosenqvist & Kurube, 1992; Stenius & Edman, 2007). A disease or medical model has been present, especially since the emergence of Minnesota model treatment, but a critique of medicalisation and a symptom-theoretical model have also made themselves felt. In fact, support can be found for both moral, medical and social views among social and health care staff working in the contemporary substance abuse treatment system (Palm, 2004). A disease concept was quite prominent among staff, although a majority also agreed that alcohol and drug problems are social problems rather than medical issues and that doctors were not best suited to treat such problems. In other words, this was a "disease" that did not demand medical attention. Social services staff leaned somewhat more towards a social model.

However, the social perspective has been under considerable strain for slightly more than a decade. The expansion of maintenance treatment in the early 2000s coincided with a growing interest in evidence-based treatment. This promoted maintenance treatment and supported the influence of medical arguments more generally, in part because medical treatments are more easily tested in double-blind randomised controlled trials than are psychosocial interventions (Bergmark, 2012; Johnson, 2007). We are thus witnessing an expanded concept of medicalisation compared to the original versions (Conrad & Schneider, 1992; Conrad, 1992) that seeks to transform various phenomena into (medical) science (Bergmark, 2012). Social professions (social workers and academics) are repeatedly being reduced to a minority when knowledge is summarised and transformed into guidelines, also in social fields (Bergmark, 2012; Topor, 2010). State and governmental agencies constitute important driving forces in these processes. For example, the National Board of Health and Welfare led the compiling of guidelines, while the Swedish Association of Local Authorities and Regions (representing the governmental, professional and employer-related interests of municipalities and county councils) has been in charge of implementing the guidelines and improving the substance abuse treatment field. For its part, the National Public Health Institute is an important player in alcohol and drug policy. The opinions of these agencies regarding the

Unauthenticated
Download Date | 12/16/16 11:54 AM

suggested reforms are listed under Table 1. Thus, the development in recent years has by and large been driven by anonymous bureaucrats, and physicians, favouring medically-oriented problem formulations and solutions, whereas service users have typically played a rather modest role in the development of substance abuse treatment (Edman & Stenius, 2007; Storbjörk, 2012).We thereby have a strong social profession, whose power is grounded in a long history of dominance, but we also see growing medical argumentations from both physicians, with an overall strong legitimacy, and bureaucrats riding on evidence-based argumentation.

The Swedish substance abuse treatment system has been described as dysfunctional for quite a while by governmental inquiries, professionals and other stakeholders in the media, etc. For instance, the split responsibility between actors has been repeatedly problematised. Perhaps we could argue that the misuse inquiry (SOU, 2011) was preceded by a crisis of legitimacy that in theory might have facilitated a *formative moment* (Rothstein, 1988) or a *critical juncture* (Thelen, 1999; Torfing, 1999): it became possible to suggest a radical change of the substance abuse treatment system. The inquiry claims that split and unclear responsibilities have led to ineffective care and misusers falling through the cracks in the system; that the health care system has in practice gained a strong role in providing substance abuse treatment by the expansion of medically-assisted treatments; that dependence is a psychiatric diagnosis in diagnostic manuals and should therefore be treated in the health care system like other diseases; that compulsory treatment should therefore also be transferred to the realm of health care; that few hazardous/problem users are reached by treatment and that the health care system may attract more people to seek help compared with the stigmatised social services; that comorbidity is better handled in the health care system; that it is easier for bigger regions than local municipalities to provide good quality treatment; and that most countries have located substance abuse treatment in the health care system (SOU, 2011).

The proposal was, in accordance with Swedish procedures, referred for consideration to 186 stakeholders with vested interests in the field (see Endnote 1). Submitted comments shall be considered in the legislative process, i.e. stakeholders' opinions may influence reform proposals. A lively debate arose after the presentation of the inquiry, particularly about the responsibility shift(s). Most actors in the field mobilised their strengths and sought to articulate their arguments when such encompassing changes were proposed. This provides us with an unusually good opportunity to study the dynamics, complexity and policy of system change. Submitted comments can provide us with a good overview of actors, arguments and power in the substance abuse treatment system. With the government bill at hand (Prop. 2012/13:77, 2013), we can retrospectively sort out winning arguments in the now highly contested substance abuse treatment field and which actors were able to influence policy.

Theoretical frame

Research on substance abuse treatment system reforms and policies

We do not know what works in reducing

Unauthenticated
Download Date | 12/16/16 11:54 AM

problems on the population level through treatment organisation (Storbjörk, 2010). Reforms take place internationally, and countries seek to implement models that have been tried elsewhere. For example, large organisational reforms have been implemented in our neighbouring Nordic countries recently. Substance abuse treatment in Finland is being integrated with the mental health system even though the reform was met with resistance concerning the risk of medicalisation, neglect of social work, etc. (Kuussaari & Partanen, 2010; Wahlbeck, 2010). Substance abuse treatment was decentralised to municipalities in Denmark without much of a debate (Pedersen, 2005; Pedersen, 2007), while the trend in Norway has been towards a centralised and medically-oriented structure, i.e. treatment and rehabilitation responsibilities were transferred to state-owned regional health care enterprises. Concerns about the survival of social aspects of treatment were evident also in Norway (Skretting, 2005) and a conceptualisation of drug problems as a medical disease contributed to the reform (Skretting, 2007). Researchers have later criticised the reform for creating a fragmented, linear transfer of responsibilities from one agency to the next (Nesvåg & Lie, 2010). However, the rationale, process, promoting/hindering factors and outcomes of reforms are still neglected areas in research (Wahlbeck, 2010). System reforms are often made without considering the implications for the population or specific groups, there appears to be little scientific evidence behind reforms (Babor, Stenius, & Romelsjö, 2008), and such efforts seem to have little impact on treatment outcomes (Humphreys & Mclellan, 2011; Pedersen, Hesse, & Bloomfield, 2011).

Policy research and theory

The debate and reforms are rather guided by ideological, political and economic considerations – often claiming to be research-oriented. Policy processes and controversies may be more driven by overarching narratives and value differences than by technical deficiencies or scientific evidence, especially when it comes to social policy and sciences (Kübler, 2001; MacGregor, 2013; Tieberghien & Decorte, 2013; Weible, 2007; Weiss, 1979). For example, Tieberghien and Decorte (2013) used a conceptualisation by Weiss (1979) when analysing Belgian drug policy in 1996–2006. Research in policy-making may be used: a) conceptually/as an enlightenment model (science is involved in percolation of new ideas); b) instrumentally (science has direct bearing on policy); c) politically/symbolically (knowledge is used as ammunition for political sides, e.g. to silence the arguments of opposition, to support ideas that have already been adopted (Weiss, 1979). While the Belgian study found rather strong science utilisation, science was often subordinate to other types of information (such as simplified media representations), competing values, interests, electoral considerations, etc. In their analysis, Tieberghien and Decorte found conceptual and instrumental use, but most of the time, science was used for political-strategic (or symbolic) reasons, as a tool to help win the case. In addition, actors often used knowledge selectively depending on their values. The debate could be perceived as an ideological struggle based on power relations. The political discourse knowingly misrepresented the facts for political ends. In sum, drug policy is a complex social domain driven by emo-

Unauthenticated
Download Date | 12/16/16 11:54 AM

tional arguments (Tieberghien & Decorte, 2013). Similar conclusions were drawn by MacGregor (2013) regarding UK drug policy. Overarching narratives of drugs, and the media, play a dominant role in policymaking. Evaluation of evidence and policy solutions are derived from a distinctive way in which the problem is socially constructed or framed. Politicians are strongly influenced by such narratives. Competing narratives are used and promoted by stakeholders on "the drugs battle field" (p. 2) and science is used as ammunition. Politicians accept science but say it is their role to represent public interests and to link evidence to visions – a tension between science and values. Each issue is valued in terms of how it fits into their frames, and those in favour of change search for suitable evidence and seek to launch alternative narratives. However, "for a decisive shift to occur in the overall paradigm within which drug policy is set, other features as well as logic and evidence would also be needed, such as the opening of a window of opportunity through crisis, change in the balance of forces or exceptional leadership" (MacGregor, 2013: 8).

There is, according to the evolutionary analogy (Stevens, 2007), a tendency for attention in policy to be paid only to the evidence that is helpful to the interests of powerful social groups. It is highly rational for them to use research to further their own interests and to ignore evidence that does not corroborate their beliefs (political/tactical model). Different groups have different narratives of how a problem arises and should be solved (see MacGregor, 2013). The extent to which these groups can impose their frame depends on their legal, professional, financial and ideological power. Power is therefore relevant, and some groups have more power to determine the process than others.

The Advocacy Coalition Framework (Sabatier, 1998) provides a useful understanding of factors affecting policy processes in certain policy subsystems, such as substance abuse treatment (Kübler, 2001). This framework, like the evolutionary analogy, explains policy outcomes by the presence of powerful and competing advocacy groups consisting of members from various levels of government, public and private organisations, and NGOs (Sabatier, 1998). People in such coalitions share beliefs and problems perceptions, and co-ordinate their activities in order to promote their policy goals. So-called *deep core beliefs* include ontological and normative beliefs (e.g. individual freedom versus social equality, right/left scale) across all domains, whereas *policy core beliefs* represent (causal) perceptions of the problem and strategies for realising core values in the subsystem. (Policy) core beliefs also include value priorities regarding which groups' welfare is of greatest concern. Core beliefs are very resistant to change, while policy core beliefs are somewhat less rigidly held. Given the stability of (policy) core beliefs, disputes tend to be stable over time. The only way to change policy drastically is through an extensive change outside the subsystem, which alters power relations or beliefs. A policy area, like the substance abuse treatment system, will not be significantly revised as long as the group that instituted the policy remains in power, except when the change is imposed by a superior change or jurisdiction. Thus, there are exogenous parameters that influence the constraints and power of stake-

Unauthenticated
Download Date | 12/16/16 11:54 AM

holders and hence policy. Such external dynamic factors are critical prerequisites to policy changes (Sabatier, 1998). In accordance with MacGregor (2013) and Stevens (2007), the Advocacy Coalition Framework argues that actors' perceptions of evidence are strongly filtered by their pre-existing beliefs. Coalitions resist changing their beliefs, even in the light of new evidence. This is even truer for areas, like substance abuse treatment, in which data and theory are quite subjective or lacking. Likewise, the Advocacy Coalition Framework stresses the role of individual/organisational self-interests. Actors wish to maintain or increase their viability and welfare, which is why major changes are rarely the result of policy-oriented learning (alterations of beliefs as a result of new experiences/evidence). More commonly, changes in external factors alter the composition and the resources of coalitions and, in turn, policy. Turnover in personnel or the replacement of one dominant coalition by another, or more frequently, when a minority coalition increases in importance may also lead to change. Most rarely, all major coalitions view the status quo as unacceptable and search for a win-win solution.

Institutional theory

Similar world views are found in institutional theory. The concepts of path dependency, critical juncture and formative moment suggest the rarity of major reforms. Path dependency is a tendency towards preserving the status quo, which can be explained by the history of organisations (Pierson, 2000). Interests/conceivable options/decisions are limited by past decisions, even though previous circumstances no longer apply. Solutions may survive despite the fact that the original problem has faded away. Organisations find reasons to survive in a changing environment, and previous work models appear self-evident and reasonable to apply also to new problems. Critical junctures and formative moments may, however, appear when new conditions undermine existing institutions and solutions. An institutional crisis arises which enables actors to change existing institutions (Rothstein, 1988; Thelen, 1999). Such formative moments are characterised by uncertainty and unpredictability: many options become possible, new actors may become important, and unintended consequences may emerge. Norms may adapt to the new situation, which will facilitate a change: beliefs through which actors view the situation are crucial. Actors are competing to impose their interpretations on the agenda (Lagergren, 1999; Torfing, 1999). The far-reaching proposal regarding the Swedish substance abuse treatment system (SOU, 2011) indicated a critical juncture. However, the path is decided during the process and it is difficult to know in advance if a formative moment is at hand.

To conclude, substance abuse treatment and system change can be viewed as a battlefield where power influences definitions of problems and (organisational) solutions. Actors, competing for values and resources, have different means and goals depending on their position (Bourdieu, 1999; Johnson, 2003), and change occurs as an interplay between actors and beliefs in an economic, social and political context. Disputes spring from actors trying to defend or improve their position, gain more power or redefine substance abuse treatment. Such social fields are also char-

Unauthenticated
Download Date | 12/16/16 11:54 AM

acterised by deep-founded beliefs that are taken as self-evident. Such (policy) core beliefs (Sabatier, 1998), narratives (MacGregor, 2013) or doxa (Bourdieu, 1999) favour existing arrangements and those with strong positions. The social perspective in Swedish substance abuse treatment can be viewed as such a taken-for-granted belief that needs to be articulated and fought for when under attack, e.g. when a reform proposal claims that doctors are best suited to treat misusers. Powerful groups are important in major policy changes (Sabatier, 1998; Stevens, 2007), which are difficult to pursue.

Data and method

The data consists of written comments submitted to the Ministry of Health and Social Affairs when the proposal (SOU, 2011) was circulated for consideration to concerned stakeholders. A total of 159 invited and 38 unsolicited comments were submitted by October 15, 2011 (Prop. 2012/13:77, 2013). Some comments merely stated that the stakeholder refrains from commenting. These were excluded from the analysis. Other stakeholders submitted contradictory comments: one arm of an organisation supports the proposal whereas another opposes it. These were divided into separate comments in the analysis. The final set of texts analysed consists of 198 comments.

Stakeholders were grouped into types of agencies in order to enable an analysis of the types of actors advocating and opposing the shifts (Table 1). Agencies were also classified by whether they supported or opposed the shift(s), did not take a clear stand or did not mention the shift(s) in their comment (Table 2).

Arguments for and against change were analysed by content analysis focusing on arguments, values and suggestions expressed in the texts. A coding scheme was created through an iterative process. First, all arguments for the major treatment shift and compulsory treatment shift were compiled from 80 comments by various types of sender. Next, these arguments were categorised thematically in order to create theoretically valid and internally coherent codes (Bauer, 2000; Kvale, 1997). All comments were thereby read and coded in the light of the coding frame, that is, the texts were processed through a systematic application of categorisation rules (Bauer, 2000). Sections of texts that fitted the frame – where an argument was expressed – were tagged with the predefined codes in QSR NVivo 10. Frequency distributions for each code are given in the Appendix. The goal was to provide accounts of the arguments as well as how often they were invoked and by whom. The context of the statements was important, and whole paragraphs were read before coding single sections. For example, sections in which the senders summarised the inquiry's arguments were not coded unless they explicitly agreed or referred to the arguments in other sections in which they gave their opinions. Most often, stakeholders raised arguments both for and against changed responsibilities. Thus, arguments were used to advocate/oppose the shift; as hopes when opposing the reform; and as fears when advocating the reforms. In order to avoid sliding in the coding, the process was varied by coding 5 state agencies, followed by 10 municipalities, 5 county councils, 10 NGOs, etc. (Bergström & Boréus, 2000). Some revisions were made after completing the cod-

Unauthenticated
Download Date | 12/16/16 11:54 AM

Table 1. Opinions regarding shifts of responsibility of treatment and compulsory treatment, in total and by type of agency.

	Legal agencies	State agencies	County Administrative Boards	Universities, experts & education agencies	Municipalities	County Councils	Labour unions	Employers' organisations, business federations & for-profit treatment companies	NGO – service user organisations (incl. relatives/friends)	NGO – associations for social welfare staff	NGO – associations for health staff	NGO – non-for-profit care	NGO – others (temperance, social policy, etc.)	Total	
Treatment															
Advocate	-	6	5	5	13	9	4	2	4	-	4	4	1	57 (29%)	(34%)
Oppose	2	2	1	3	38	13	4	5	7	3	2	-	9	91 (46%)	(54%)
Do not take a stand	7	4	-	-	3	1	1	-	-	-	1	2	2	21 (11%)	(12%)
Do not mention	2	9	-	5	-	-	1	5	-	1	4	1	1	29 (15%)	(100%)
Total	11	21	6	13	54	23	10	14	11	4	11	7	13	198 (100%)	
Compulsory treatment															
Advocate	1	3	2	1	8	5	3	1	-	2	2	-	1	29 (15%)	(20%)
Oppose	9	4	1	5	35	15	4	3	11	1	2	5	8	103 (52%)	(72%)
Do not take a stand	1	2	-	-	5	2	-	-	-	-	2	-	-	12 (6%)	(8%)
Do not mention	-	12	3	7	6	1	3	10	-	1	5	2	4	54 (27%)	(100%)
Total	11	21	6	13	54	23	10	14	11	4	11	7	13	198 (100%)	
		[1]						[2]	[3]		[4]				

[1] Including the National Board of Health and Welfare (split opinion/two submitted comments: advocates and opposes treatment shift; opposes and does not mention compulsory care shift), National Board of Institutional Care (opposes; opposes), National Institute of Public Health (advocates; does not mention).
[2] Swedish Association of Local Authorities and Regions (opposes; opposes).
[3] Swedish Drug Users Union (advocates; opposes); National Association for Rights, Liberation, Health and Equality (opposes; opposes).
[4] Swedish Society of Addiction Medicine & Swedish Society of Medicine (advocates; advocates), Swedish Society of Nursing (opposes; opposes)

ing because the codes had some inconsistencies. These were re-coded. Some codes with thematically similar content but with few supporters were combined; and arguments with fewer than five agencies expressing it were omitted. The codes were transferred to SPSS to facilitate an exploration of the data.

The analysis focuses on the manifest content of the texts and on *what* is said rather than *how* it is said (Bauer, 2000; Bergström & Boréus, 2000). This underlines visible power that is openly expressed and is the equivalent of the first dimension of Lukes' conception of power (Lukes, 2005). Texts may mirror, repro-

Unauthenticated
Download Date | 12/16/16 11:54 AM

duce and question power, and can thereby be used to study relations between groups of actors outside the actual comments (Bergström & Boréus, 2000). Different strategies of interpretation can be applied when interpreting the texts. This interpretation seeks to reconstruct the sender's intent and understanding of substance abuse treatment and the inquiry – what it wanted the text to represent (Bergström & Boréus, 2000). The texts are thereby *mediums of expressions* (Bauer, 2000), representing the sender's values and arguments. We can thus re-construct such world views and compare these across actors.

It should be mentioned that our research centre wrote a comment on behalf of the University. We sought to express what could be expected of the reform based on research and tried not to take a clear stand. However, the Ministry listed us among those who were "negative" (but not rejecters) of the reform (S2011/4504/FST, 2012).

Results

More than half (54%) of the agencies which mention the major treatment responsibility shift oppose the reform, 34% advocate it and 12% do not take a clear stand but list a number of advantages and disadvantages. An even higher percentage opposes the compulsory treatment shift (72%); only one fifth advocates this reform (Table 1).

It could be hypothesised that municipalities, which run the social services, would oppose the changes since they would lose responsibilities and resources, whereas county councils, in charge of the health care system, would advocate the shifts. Table 1 reveals no clear patterns regarding such opinions by types of agencies. It is true that 38 municipalities were negative about the treatment reform, but a sizable 13 municipalities advocated the change. Also a majority of the county councils (n=13) opposed the shift; 8 wished to pursue the reform. The pattern was the same for compulsory treatment. The analysis thereby focuses on similarities and differences between advocates and opponents of change instead of separating between types of agencies. The opinion of some of the more powerful agencies is mentioned under Table 1 and some examples are presented in the text. We could also assume that those arguing for the treatment responsibility shift also would speak in favour of transferring compulsory treatment but that is not the case. Only a quarter of the treatment reform advocates supported the compulsory treatment shift, while 51% opposed this reform (Table 2). The stakeholders tend to put forward a higher mean number of counterarguments than arguments promoting the reforms: advocates formulate an average of 2.5 and 1.6 arguments for the treatment reform and compulsory treatment reform, respectively; rejecters report 6.2 (treatment) and 3.2 (compulsory treatment) counterarguments. Interestingly, advocates of the reforms also express a significant number of counterarguments or fears regarding the changes (2.7 and 1.1). Opponents also mention some, albeit fewer, advantages (0.9 and 0.4 for the treatment shift and the compulsory treatment shift, respectively). The next two sections present which arguments agencies use to promote their opinions, hopes and fears (See **Appendix** for an overview of arguments and counterarguments by advocates and opponents).

Unauthenticated
Download Date | 12/16/16 11:54 AM

Table 2. Association between advocates/opponents of shifts of responsibility of treatment and compulsory treatment, numbers and percentages.

	Treatment				
Compulsory treatment	Advocate	Oppose	Do not take a stand	Do not mention	Total
Advocate	14 (25%)	12 (13%)	2 (10%)	1 (3%)	29 (15%)
Oppose	29 (51%)	61 (67%)	10 (48%)	3 (10%)	103 (52%)
Do not take a stand	-	6 (7%)	5 (24%)	1 (3%)	12 (6%)
Do not mention	14 (25%)	12 (13%)	4 (19%)	24 (83%)	54 (27%)
Total	57 (100%)	91 (100%)	21 (100%)	29 (100%)	198 (100%)

Arguments for shifting treatment responsibility from social services to the health care system

The inquiry (SOU, 2011) suggested that the treatment responsibility should be transferred from the municipal social services (regulated by the Social Services Act, first enacted 1982) to the regional county councils that hold the responsibility for providing health and psychiatric services in accordance with the Health and Medical Services Act (1982). More specifically, the health care system should be responsible for counselling, sobering up stations, detoxification, medically-assisted treatments and psychosocial *treatments*. Social services should be in charge of psychosocial *support,* assistance with housing/occupation/financial support as well as counselling.

Starting with arguments for change, the National Institute of Public Health provides a good example of the advocates' voices:

> It has been a correct choice to prioritise the most severely affected group, which obviously requires a well-developed co-operation between treatment and support measures. The next step is partly about broadening the perspective to the whole group of people with alcohol and drug problems and partly about improving the quality of care. When we expand the perspective to the whole group with alcohol and drug problems, there is less need for collaboration between health care and social services. A large majority of Swedes now perceive alcohol and drug problems as health problems and primarily wish to receive help from health care, not from social services. Dependence should be treated like other health problems, such as asthma, diabetes, depression. The special solution chosen for dependence in Sweden is based on outdated views and misconceptions about the needs of the large group of people suffering from these problems. There is now a strong case for developing dependence care for the vast majority of "ordinary people" in the health care system. There should be special solutions for the smaller group with extensive social problems in which collaboration with social services is important.

The most commonly expressed argument (n=29 of 169 comments mentioning this

Unauthenticated
Download Date | 12/16/16 11:54 AM

shift; 14 advocates, 13 opponents; the rest among those that did not take a stand) is that treatment must be broadened to reach hazardous users and "ordinary people" who feel uncomfortable coming to social services and in practice do not turn up until they are facing eviction or money problems. Society would benefit financially if people got treatment at an earlier stage. Actors often referred to the inquiry's statement that treatment reaches only 1 out of 5 problem users and to the finding of a study, mentioned in the inquiry, that people prefer the health care system over social services. Almost equally important are the arguments that medically-assisted treatment is currently an underused treatment strategy (n=28, 13 advocates, 13 opponents) and that collaboration efforts have failed (n=28; 25 advocates, 2 opponents). They argue that more medicines are needed in the treatment of alcohol problems. Opioid-maintenance treatment should become more available, while medical assessments and interventions are necessary during detoxification. These are clearly the tasks of the health care system. The stakeholders note collaboration problems, due to unclear responsibilities, between social services and the health care system, and claim that the state's effort to improve collaboration in recent years has failed (including many references to *Knowledge to Practice*). It is better to gather responsibilities within the system of health care. Access and equality arguments are put forward by 26 agencies (16 advocates, 6 opponents). Unacceptable regional differences are also brought up: centralisation of treatment from municipalities to regions would guarantee access to good quality care for more people, as the system would become fairer for the citizens.

Twenty-five agencies (4 advocates, 21 opponents) are pleased to see that the proposal clarifies the health care system's responsibilities for early intervention, sobering up stations and detoxification. Their experiences are that health care, despite its current duty, has not shown adequate interest in these interventions. Twenty-one agencies claim that the current legislation is old-fashioned (10 advocates, 9 opponents) and that a holistic view is necessary (14 advocates, 5 opponents). It is stressed by both sides that current legislation is more than 30 years old and that the patterns of misuse, perceptions of dependence and available treatments have changed. Therefore, the system must be reformed and the special solution for misuse/dependence (with social services and not the health care system holding the treatment responsibility) must cease. The high prevalence of concomitant dependence and mental health problems (as well as somatic issues) is stressed by many actors, primarily advocates. They argue that dual diagnosis groups will benefit from the shift, as dependence and psychiatric/somatic care would then be under one organisation – an improved holistic perspective.

Evidence and effective treatment methods are cited as an argument for change by 23 stakeholders, in particular by advocates (18 advocates, 5 opponents). It is first and foremost the evidence for brief interventions that is mentioned. Another argument, for example by the Swedish Society of Addiction Medicine, is that addiction medicine has developed rapidly and this is where we find future potential. A strong argument for locating treatment in the health care system is that it will provide the best conditions for the ongoing

Unauthenticated
Download Date | 12/16/16 11:54 AM

development of treatment methods such as medically-assisted treatments, opioid-maintenance treatment and treatment for problems with pharmaceuticals and anabolic steroids. The Swedish Drug Users Union notes that the health care system is obliged to use evidence-based methods whereas social services "may use methods in vogue and the worst case scenario is that the help seeker in need of dependence care and financial support must submit to 'treatment' that the social worker 'believes' in for the client to have a chance of receiving income support". Superior evidence for psychosocial treatments is not mentioned specifically. Six agencies claim that the inquiry has a solid evidence ground (5 advocates, 1 opponent). The number of supporters may be low but the argument is compellingly expressed by the Swedish Society of Addiction Medicine: the inquiry is "to be considered the most profound illumination of misuse/dependence from both scientific, medical, political and health perspectives during recent years" and is "well grounded in solid scientific evidence and in the profession".

Twenty-two agencies (16 advocates, 4 opponents) argue that abuse and dependence are psychiatric diagnoses (DSM-IV and ICD-10) that increasingly – by a large majority of Swedes – have become perceived as health or medical problems rather than social problems and they should therefore be treated as such in health care. This would signal a normalisation, as other medical concerns are handled by the health care system. Thirteen stakeholders (9 advocates, 3 opponents) express arguments about the moralising and stigmatising nature of social services. For example, "people with misuse or dependence do not have a particularly high status in treatment… They may prefer to be patients instead of clients... Being a patient rather than a social problem could also mean that it would be easier to demand their rights as patients" (Lund University).

Counterarguments and fears

One of the most frequently endorsed arguments (n=79; 20 advocates, 54 opponents, the rest among those that do not take a stand) against the reform is that the shift will introduce new boundaries in substance abuse treatment. The split between psychosocial treatment and support is thought to lead to new uncertainties and co-ordination problems. An equally important argument (n=79; 13 advocates, 60 opponents) is that the inquiry "is permeated by the medical perspective and that it implies an overconfidence in what the medical profession can manage" (Västmanland county council). It will lead to a pronounced medicalisation of the substance abuse treatment system:

> The proposal represents a paradigm shift, from a so-called bio-psychosocial model to one that sees abuse and dependence from a medical perspective (disease/medicalisation). The consequence of the inquiry's proposal is an increased use of pharmaceuticals and medically-assisted treatment. Örebro fears that the medicalisation of the substance abuse treatment system will lead to a neglect of social aspects of treatment (Örebro municipality).

These actors reject the argumentation that dependence is a psychiatric diagnosis that belongs to the health care system. They be-

Unauthenticated
Download Date | 12/16/16 11:54 AM

lieve that this oversimplified model leads to fewer treatment options and shorter treatment episodes, that is, generalisation instead of needs-based individualisation of substance abuse treatment. The medicalisation fear is often expressed in relation to four other arguments: problems regarding the most severe cases (n=55; 14 advocates, 40 opponents); the loss of a holistic perspective (including social services' ultimate responsibility, n=47; 4 advocates, 42 opponents); the need for cross-disciplinary competence, interventions and collaboration (n=71; 12 advocates, 54 opponents); and references to ongoing efforts (foremost *Knowledge to Practice*) that have shown promising improvements in collaboration and evidence-based practices (n=54; 6 advocates, 46 opponents).

The reform is believed to disfavour the socially exposed most severe cases, and it is stressed that socially integrated hazardous users already have the possibility to visit the health care system and they do not. The weaker group is sacrificed when the needs of the integrated and the marginalised are set against each other. Neither does the health care system do outreach work. People must themselves apply for health care, which the most severe cases do not. Social services, with outreach work and knowledge about the local neighbourhood, have better possibilities to reach and provide these groups with proper care. Rainbow Sweden (umbrella organisation for service user organisations/NGOs) writes:

> [The] broad perspective of the inquiry including measures for more than one million Swedes is impressive but it is also its Achilles heel. The will to grasp the whole 'piece' without a proper attempt of a thorough analysis of how misuse and dependence problems hit among social classes leads the inquiry into failure regarding critical parts. This is particularly evident in the case of misuse and dependence among the most socially excluded people.

Advocates argue that the reform brings with it an improved holistic perspective (comorbidity). Opponents claim the opposite: social services work holistically, viewing a person as an entity with many needs that must be handled simultaneously. This approach threatens to become eroded. Social services hold the "ultimate responsibility" for the wellbeing and care of citizens. Stakeholders ask what this will mean if the reform is pursued and fear that social services will be forced to provide treatment in order to fulfil this responsibility if/when the health care system fails to meet its responsibility and misusers are discharged. A common argument is that the inquiry ignores the need for cross-disciplinary competence and simultaneous interventions, i.e. equal weight for and synchronised measures regarding dependence, employment, housing and other psychological/somatic/social problems. Further development of collaboration between social services and the health care system and integrated treatment units are suggested. Some refer to research and a previous stage in the work of the inquiry that showed that the majority of treatment staff prefers continued shared responsibility. They also cite recent investments in the substance abuse treatment field aiming at improved collaboration and the implementation of evidence-based practices

Unauthenticated
Download Date | 12/16/16 11:54 AM

including education efforts. These are primarily references to the *Knowledge to Practice* project. They state that these efforts are successful and wish to continue down that track.

Sixty-eight stakeholders, including 12 county councils and 3 associations for medical staff, point out that the treatment competence (education/experiences with evidence-based practices and knowledge about the life conditions of misusers) is found within social services and that the health care system is not equipped for or prepared to take over these tasks (13 advocates, 52 opponents). The lack of specialised medical doctors and nurses in health care/psychiatry as well as staff interested in working with addiction are highlighted. County councils already have problems fulfilling their medical responsibility in the wake of financial and human resource problems. In addition, social services will be drained of competence when it is indefensible to keep well-trained staff for providing "support". The purchase and evaluation of institutional care as well as the follow-up of clients in long-term institutional treatments is also mentioned as a specialty of the social services (n=8; 2 advocates, 6 opponents).

Costs (n=62; 22 advocates, 36 opponents) and conversion losses (n=34; 9 advocates, 24 opponents) are central counterarguments. The inquiry states that costs will decrease when people receive treatment earlier. There is therefore no need for more resources, and the reform will primarily be funded through a tax shift (from social services to the health care system). Stakeholders argue that the proposal suggests a higher level of ambition, which requires *additional* resources. There is also the risk that social services also in the future will have to bear a large share of the financial burden for support and for those that the health care system throws out before they are well enough – the ultimate responsibility – but now without proper financing. The organisational change of building new units with properly skilled staff in the health care system and of winding up services provided by the social service sector will require a lot of time and money to carry through. Gaps may arise when services close down before new ones are established and money will be put into organisational changes instead of treatment. It is argued that such conversion losses will be devastating for the misusers for many years ahead.

Fifty-eight agencies (7 advocates, 47 opponents) stress that the reform will lead to impoverished legal rights for misusers:

> If there's a clash in your contacts with the health care system and they make decisions that are not in line with the wish of the patient, these decisions cannot be appealed against in court or elsewhere. The words of the attending physician are valid unless you find another doctor whose judgment contradicts the first doctor's assessment. This has proven to be difficult for most patients and is even more difficult for patients who have difficulties prompting their case and who lack knowledge about their (legal) rights. The Social Services Act allows clients to go to court and to appeal against the decision made by social services. Too few appeals are made today, which is problematic given that the Social Services Act is a rights-based law. There is rea-

Unauthenticated
Download Date | 12/16/16 11:54 AM

son to believe that this is due to a lack of knowledge of the legal status of service users, but the possibility to have the case reviewed exists. (The service user council for misuse and dependence issues in Stockholm County)

This means that citizens have a weaker legal position in the health care system, where the law regulates the responsibilities of medical staff instead of the rights of the patients as in the social services. Other problematic features of the health care system are also raised. Eighteen stakeholders (3 advocates, 15 opponents) fear that misusers cannot assert themselves in competition with other severely ill patients since the health care system, according to law, shall give priority to those with the greatest treatment need. They fear that the money from the tax shift will not get earmarked for misusers and will vanish into the overall budget of the health care system. Patient fees in health care are also found problematic for the socially exposed. The inquiry suggests a new law to regulate treatment responsibilities. Twenty-seven actors (5 advocates, 17 opponents) reject this solution, claiming that a special law will undermine and be problematic to interpret in relation to the current framework laws regulating social services and the health care system. Likewise, 11 stakeholders (2 advocates, 7 opponents) note current collaboration problems *within* the health care system today (bigger problems than between social services and health care): between dependence care, primary health and the psychiatric sector. This will not provide a good basis for misusers' effective care. Three agencies advocating and three opposing the change conclude that there are regional differences regarding access and quality of care also in the health care system. Today's inequalities would therefore not be solved by moving treatment to the regions (n=6). Advocates stress the advantages of centralisation, whereas disadvantages are endorsed by 21 stakeholders (1 advocate, 20 opponents) who claim that the reform will lead to longer distances to care and will limit the ability to choose between different care providers – impaired access to care.

Science, or rather lack of evidence, is present also in the counterarguments, regarding the scientific base for the proposal (n=18; 2 advocates, 14 opponents) and the lack of evidence for methods used in the health care system (n=17; 9 advocates, 8 opponents). Stakeholders are not convinced by the arguments and the evidence that is presented for the responsibility shift. The service user organisation the National Association for Social and Mental Health concludes that "the experts/researchers involved in the inquiry seem to have overlooked that there is scientific evidence for a broader treatment approach" than medical treatments. The Care Group for Collective Welfare, an NGO, bluntly notes that medicalisation is pursued "without new knowledge to support this". Stakeholders criticise the evidence base for treatments in health care. Some mention that it is only the medically-assisted treatments that have scientific support in the health care system, whereas Stockholm University asks whether medicines such as Campral/Akamprosat and Naltrexone really can set the world on fire when only one out of nine treated patients does not relapse and these treatments must be provided together with psychosocial treat-

Unauthenticated
Download Date | 12/16/16 11:54 AM

ment. Gothenburg and Ale municipalities, among others, argue that the health care system will not be able to provide evidence-based treatments to the same extent as the municipalities and that health care cannot provide treatment for several of social services' target groups, such as amphetamine and cannabis misusers.

Integrity, paternalism and a top-down perspective in the inquiry as well as in treatment are mentioned by 14 stakeholders (6 advocates, 8 opponents), including representatives of the health care system and medical professions. These concepts refer to the proposal that the health care system shall regularly screen for problem users whenever they seek health care. It is argued that those "detected" will not regard themselves as problem users in need of treatment. Thus, society is forced to intervene and the interventions will violate the integrity of the citizens and damage their trust in substance abuse treatment and health care.

Six agencies (1 advocate, 5 opponents) reject the notion that social services would be stigmatising: "We do not recognise ourselves in the analysis of social services as having had 'a moralistic approach' and that this would still characterise the perception of misusers. Such an approach is far from modern social services" (Botkyrka municipality). Also questioned is the study, referred to in the inquiry, which argues that most people prefer the health care system over social services. It is noted that the study had targeted the general population and does not represent the views of those in need of substance abuse treatment. It is finally acknowledged, by 9 stakeholders (2 advocates, 4 opponents), that the overall consequences of the reform are very unclear. We do not know what the effects will be.

Compulsory treatment arguments: compulsory care for substance misusers into psychiatric compulsory care

The inquiry suggested that compulsory care for substance misusers, called LVM and regulated by the Care of Misusers (Special Provisions) Act (first enacted 1982; a complement to the Social Services Act), should be revoked. Instead, the inquiry proposed the broadening of psychiatric compulsory care (called LPT) in accordance with the Compulsory Medical Care Act from 1991 (a complement to the Health and Medical Services Act) to cover also the need for coercive care of misusers. "[S]erious mental disturbances" (LPT criterion) should be equated with the condition that a person as a result of abuse/dependence on alcohol, drugs or other addictive drugs has a vital need of psychiatric care. The compulsory treatment shift is most often mentioned after the major treatment shift in the comments. These sections are often shorter and may refer to what had already been written on the major reform. Many of the arguments are alike.

Stakeholders (n=19 of 144 comments mentioning this shift; 5 advocates, 12 opponents, the rest among those that did not take a stand) agree that there are (efficiency) problems regarding LVM that call for changes. Advocates see a solution in LPT that is perceived by some as more effective, whereas opponents believe in other reforms. Psychiatric and somatic comorbidity is an argument used by 11 actors (7 advocates, 4 opponents): "Extensive comorbidity problems, psychiatric disturbances

Unauthenticated
Download Date | 12/16/16 11:54 AM

and abuse/dependence, are best handled in a psychiatric organisation and call for an integrated and well-defined legislation for psychiatric conditions including dependence" (Swedish Society of Medicine, interest organisation). Both advocates (n=5) and opponents (n=6) argue that psychiatric compulsory care is an emergency law, focusing on life-saving instead of long-term care, and allows quicker interventions (n=11). These features of LPT (compared with LVM) are perceived positively. Access and equality are also mentioned by advocates and opponents (n=10; 4 advocates, 5 opponents). They refer to variations between municipalities regarding the use of compulsory care for substance misusers and argue that centralisation provides a remedy for these inequalities. One law/organisation instead of two is also perceived to be a positive solution by 10 agencies on both sides (4 advocates, 4 opponents), as it would limit the risk of misusers falling through the cracks in the system. Ten stakeholders (7 advocates, 2 opponents) claim that the legal rights of the patients are better in LPT due to more assessments and shorter episodes. It is also argued by 7 stakeholders (5 advocates, 2 opponents) that medical assessments, expertise and interventions are needed in compulsory care and that these are more easily provided within the health care system. Outpatient compulsory care, part of LPT, is pointed out by 6 agencies (4 advocates, 0 opponents) as a flexible and good option that would benefit misusers. Five stakeholders believe that moving compulsory care from social services/the state to the health care system is a logical consequence if treatment responsibility is moved to health care (4 advocates, 1 opponent).

Counterarguments and fears

Resistance to medicalisation is an obvious counterargument (n=56; 3 advocates, 50 opponents, the rest among those that did not take a stand). Stakeholders reject the argument that dependence is a psychiatric diagnosis and find it reprehensible to perceive misusers as mentally ill. They argue that there is a considerable group of misusers who do not consider themselves in need of psychiatric care. They need other types of (social) interventions and more individualised care than can be provided through LPT. It is therefore unfortunate to incorporate compulsory care for substance misusers (LVM) with psychiatric compulsory care (LPT). It is claimed that the inquiry performs "a simplified and partly confusing and biased play with numbers" (Rainbow Sweden) when concluding that the vast majority of LVM clients have comorbidity problems. Related to this, 25 agencies (1 advocate, 24 opponents; primarily legal agencies) argue that dependence is not a mental disorder and that the proposal complicates the criterion in the LPT law. It makes the concept "serious mental disturbances" very unclear. They also note (n=11; 2 advocates, 9 opponents; mainly legal agencies) that the revision of "serious mental disturbances" has unprocessed implications for other laws and influences the possibilities to sentence people to prison, forensic care, etc.

Thirty-nine agencies find it problematic that fewer will get compulsory care and thereby not get the treatment they need (2 advocates, 35 opponents). This is due to the narrower criteria in LPT compared to LVM. The most important restriction is the lack of a so-called "social criterion" that can be used to provide young misusers

Unauthenticated
Download Date | 12/16/16 11:54 AM

with care. Also, misusers cannot get care for somatic problems and their families are not protected by LPT. Paradoxically, nine agencies fear that *more* people will get compulsory care since LPT does not state that misuse must be "continuous" and because care providers might find the option of outpatient compulsory care as a "light model" that can be used more often than coerced inpatient care (0 advocates, 8 opponents).

A few advocates claim that the reform would improve the legal rights of patients (above). Thirty-eight opponents disagree (4 advocates, 32 opponents). They state that the reform implies impoverished legal rights and increased legal uncertainty. Compulsory care for substance misusers (LVM) has a maximum length of six months in coerced treatment, whereas outpatient compulsory care (LPT) has no upper time limit. A misuser could stay in coerced treatment for years. During this time, several restrictions may apply such as the demand to visit treatment services, avoid certain places or people, etc. It is also considered problematic that doctors make decisions about LPT, instead of a court decision for LVM, and that it is more difficult to appeal against LPT. Integrity problems of psychiatric compulsory care are brought up by 13 agencies (0 advocates, 12 opponents). It is primarily outpatient compulsory care that is called into question with the possibility of forced medication, for years, and the fact that coerced care in the misuser's residence may be experienced as a more severe violation of integrity than inpatient care.

Thirty-seven stakeholders cite the lack of competence in the health care system in general and in the psychiatric sector in particular (5 advocates, 32 opponents). The health care system is not, due to the lack of skilled/interested staff and financial resources, prepared to accommodate the large group of misusers. Collaboration problems in health care are also raised.

Important counterarguments refer to unclear consequences and the lack of scientific evidence in the inquiry and in LPT. Twenty-nine agencies state, more generally, that the consequences of the reform are unclear (4 advocates, 20 opponents). The proposal is poorly investigated and lacks a solid evidence base (n=19; 2 advocates, 16 opponents). There are so many uncertainties that many actors find it difficult to take a stand. Another eleven question the evidence for LPT as treatment method and argue that LVM is highly researched in comparison with psychiatric compulsory care (0 advocates, 11 opponents). Therefore, as many as 33 stakeholders (6 advocates, 24 opponents) call for further investigations before any changes are made. They agree that there are problems today in all compulsory laws and suggest an inquiry commissioned to investigate all types of coerced care.

The fact that psychiatric compulsory care LPT is considered an emergency law, at least by some, is viewed as problematic, for many misusers need long-term care (n=21; 1 advocate, 20 opponents). The misusers' chaotic life situation at intake makes it impossible to plan for the future. It is therefore good for the misuser to be forced to a long period of sobriety to facilitate motivation work and treatment.

Centralisation advantages also get a mention (n=12; 1 advocate, 11 opponents). The nationwide system of compulsory care for substance misusers LVM is better

Unauthenticated
Download Date | 12/16/16 11:54 AM

at meeting the demands and providing differentiated good quality care than are the regions. The regional differences in the health care system are noted and so is the fact that the state took over the responsibility for LVM in 1994 after it had been acknowledged that the regions were not best suited for the task.

It is argued that the municipalities need LVM as a tool to perform their ultimate responsibility for the citizens (n=11; 0 advocates, 11 opponents). It is also considered problematic that the health care system does not do outreach work (n=6; 0 advocates, 6 opponents) and will not reach those in need of care. Neither is there any forced notification in psychiatric compulsory care: the staff has no duty to report people in need of LPT unlike in LVM. Ten agencies raise the collaboration and cross-disciplinary argument (0 advocates, 9 opponents). They express the importance of competence and interventions of both health care and social services also in compulsory care and find it problematic to locate coerced treatment solely in the health care system.

The government bill

The bill (Prop. 2012/13:77, 2013) that was finally presented after two years is narrow in its scope. It suggests (1) the introduction of an obligation for the health care system and social services to settle local agreements on responsibilities and collaboration on the treatment of alcohol, drugs, pharmaceuticals and doping (as of July 1, 2013); and that (2) no change is made regarding compulsory treatment. The agreement requirement is inscribed in current laws. Thus, the government does not move forward with the inquiry's responsibility shifts. The starting point of the bill is that substance abuse treatment has developed positively with the implementation of treatment guidelines and *Knowledge to Practice* that has contributed to increased competence and collaboration. The end result is also in agreement with the government's national action plan for alcohol, drugs, doping and tobacco (Prop. 2010/11:47, 2011). It is stressed that the problem group is heterogeneous and has varying needs; some are socially well off, others live in an exposed environment. We therefore need a range of interventions from both social services and the health care system. These interventions "shall be valued equally and be co-ordinated in a well-functioning care and support system with the point of departure in the different needs and requests of the individuals" (p. 8 of the bill). The government considers it desirable that both health care and social services also in the future can provide psychosocial treatment, and find it difficult to separate such treatment from support. It claims that *Knowledge to Practice* has proved that agreements are valuable tools for improved local collaboration and clarification of responsibilities. While a responsibility shift "has some advantages, … the government does not consider it suitable to pursue this reform considering, among other things, the mixed outcome of the submitted comments" (p. 11).

Stakeholder arguments that are referred to in the bill are medicalisation fears; loss of holistic perspective; the most severe cases; problems regarding priorities in the health care system; impoverished legal rights; new boundaries; conversion losses; competence drain in social services; problems with special law; good development

Unauthenticated
Download Date | 12/16/16 11:54 AM

following *Knowledge to Practice* and similar efforts; and that municipalities/regions need more collaboration, joint social and medical interventions. The most frequently suggested alternative is to stimulate collaboration between the health care system and social services. It is argued that causes and consequences of hazardous use, misuse and dependence may be social, psychological and somatic. Some advantages are mentioned by the government: the ability to reach socially integrated hazardous users earlier than is managed by the stigmatising social services; misuse/dependence is increasingly perceived as a health problem/psychiatric diagnosis; good development of addiction medicine; and equality and access.

It is acknowledged that the vast majority of stakeholders oppose the compulsory treatment reform. Counterarguments referred to in the bill include the uncertain and problematic criterion in the law on psychiatric compulsory care LPT; poorly investigated proposal with unclear consequences; doubtfulness of regarding dependence as a psychiatric diagnosis that must be handled by the health care system; influence on other laws; continued regional differences; fewer will get treatment (young people/social criterion); social services' ultimate responsibility; need for a broader compulsory treatment inquiry; and impoverished legal rights. Arguments for change that are raised, by referring to the Swedish Society of Addiction Medicine and the Swedish Society of Medicine, are the adequacy of LPT regarding emergency care; the benefits of just one law; and comorbidity. The conclusion is that the proposal "is too unclear and difficult to interpret. Neither have the consequences of the proposal been properly investigated. The government's judgment is that there is no adequate basis for the reform" (p. 48).

Discussion

There was no formative moment in the Swedish substance abuse treatment system. Explanations for the lack of policy change can be sought in the Advocacy Coalition Framework (Sabatier, 1998), the Evolutionary Analogy (Stevens, 2007), values/narratives (MacGregor, 2013) or doxa (Bourdieu, 1999) and the concept of path dependency (Pierson, 2000). These are all theoretical concepts that favour existing arrangements and those with strong positions, and stress the infrequent event of major change.

There are traces of path dependency in stakeholder arguments and in the government bill, such as references to advantages of the existing system (improved collaboration between the health care system and social services, collaboration problems within health care, etc.); the success of collaboration efforts such as *Knowledge to Practice;* and by choosing a final solution that is in line with ongoing efforts and the Government's national action plan. Historical decisions influence new ones. It is difficult to break up with the past.

Considering that major substance abuse treatment system reforms have been carried out in our neighbouring countries, and that the Nordic countries historically have made constant comparisons among themselves (Edman & Stenius, 2007), the Nordic reforms, particularly those in Norway and Finland, could have promoted the centralisation and medicalisation of Swedish substance abuse treatment. Fears

Unauthenticated
Download Date | 12/16/16 11:54 AM

of medicalisation and implementation problems as well as notes about lack of scientific evidence were evident also in Norway and Finland, and these reforms were carried through. However, theories stress the importance of the context of potential policy change and external changes that may facilitate change (MacGregor, 2013; Sabatier, 1998). While substance abuse treatment is just a minor part of national health or social systems, the reforms in Norway, Finland and Denmark were all imposed by larger structural reforms in those overarching systems (Pedersen, 2007; Skretting, 2007). The substance abuse treatment system reforms can be viewed as by-products of these superior changes. No big shifts in the general health or social care occurred in close relation to Swedish substance abuse treatment. The reform proposal stood alone, which discouraged change and allowed core beliefs/narratives/doxa and struggles within the policy field of substance abuse treatment to blossom. The social perspective, which highlights the importance of social interventions, is evident in the counterarguments on medicalisation and the most severe cases raised by many opponents at various organisations. It is also referred to by the government in the bill. The inquiry, physicians (specialised in addictions) and some other advocates sought to promote an alternative narrative (MacGregor, 2013), that of a medical (and evidence-based) perspective contesting the dominant social belief. The power of doxa, path dependency and resistance groups managed to block these narratives and the reform.

The resistance to medicalisation, and the role of social work in Finland, is said to have its origin in needs to defend professional boundaries (Wahlbeck, 2010). This could have been expected also in Sweden – that social workers would fight against the reforms and medical professions would promote them. However and interestingly, the division lines were not that clear cut. A significant number of the municipalities promoted the reforms, while many county councils opposed the shifts. Interesting differences were also found within medical professions: the Swedish Society of Addiction Medicine and the Swedish Society of Medicine advocated the shifts, whereas the Swedish Society of Nursing was found among the opponents. Perhaps we can conclude that there is some confusion in the substance abuse treatment field regarding traditional division lines between stakeholders, i.e. a confusion on who supports a social versus a medical perspective. Yet, the confusion was not strong or articulated enough to pave the way for a formative moment.

The government's reference to the mixed responses by stakeholders (Prop. 2012/13:77, 2013) and critical voices in most groups suggests that their opinions made a difference in this process. It was clear from the presentation of the government's intentions (Larsson, 2013) that the government had consulted experts in the field and that the voice of the Swedish Association of Local Authorities and Regions, who opposed the changes, had a bearing on the decision. The Advocacy Coalition Framework suggests that major reforms cannot be carried through as long as the group that instituted established institutions remains in power. The Swedish Association of Local Authorities and Regions is an organisation for municipalities

Unauthenticated
Download Date | 12/16/16 11:54 AM

and county councils, a powerful agency with vested interests in the current system, and is deeply involved with *Knowledge to Practice*. The municipalities, with social services and a social perspective, have until now been the owner of the overarching narrative in the field of substance abuse treatment. It is clear that a medical perspective is growing and is particularly promoted by physicians specialised in addiction medicine. Apparently, Sweden was not yet ready to let go of the social perspective by giving the treatment responsibility to medical doctors. Considering the many counterarguments and the many opponents among the stakeholders, we could also argue that it would have been undemocratic to pursue the reforms in the face of resistance within the field.

Historical studies of institutional structures and actors involved in the development of Nordic substance abuse treatment systems reveal that politically acceptable causes and solutions to the problems and suitable treatments have been rather vague and have changed constantly for more than 120 years (Edman & Stenius, 2007). There have been several political battles in this highly ideological field, and expert knowledge has mainly been used to back up pre-formulated problem descriptions (ibid.; see MacGregor, 2013; Stevens, 2007; Tieberghien & Decorte, 2013). The temperance movement, the state bureaucracy and special interests groups have been strong players. Today, the temperance movement has lost much of its power, and there have been few party-political disputes at a national level. Politicians have been anonymous actors in reforming substance abuse treatment. Actors behind reforms are rather anonymous bureaucrats, which leads to accountability problems. Other groups – physicians, social workers, academics – have managed to leave their mark at different times, but the service users have played a rather modest role in developing Nordic substance abuse treatment systems (Edman & Stenius, 2007). These features are primarily valid also in this reform. There has been no noticeable political debate. We are rather witnessing the rise of a new coalition of medical doctors, academics and representatives of various interest/service user organisations. They have turned against the responsible minister Maria Larsson, written debate articles and requested more prompt decisions regarding the inquiry and the realisation of at least some of the inquiry's proposals. However, considering the various core beliefs that can be found among actors and organisations in this coalition, it is not likely to survive in the long run due to self-interests and disputes over beliefs (Sabatier, 1998).

An interesting feature of the analysis, perhaps reflecting the uncertainties surrounding social policies, is that similar arguments could be used by both sides. It was possible for advocates to claim that collaboration efforts had failed whereas opponents stressed good experiences of such efforts. Centralisation as well as the evidence base for the proposal were both good and bad; the reforms were argued to lead to both impoverished and improved legal rights and holistic perspectives, etc. This uncertainty is also reflected by the poor usage of science in the comments, even among opponents. In agreement with the evolutionary analogy, advocates stressed the sufficiency of evidence whereas opponents stressed the lack of

Unauthenticated
Download Date | 12/16/16 11:54 AM

evidence. Interestingly, stakeholders rarely provided additional or alternative evidence that could strengthen or overthrow the inquiry. The debate was instead dominated by beliefs, personal experiences and self-interests of the organisations.

The analysis mainly focused on visible power (first dimension of Lukes, 2005) but the arguments also acknowledge Lukes' second dimension of power: one important form of the exercise of power is to be able to decide which topics are put on the agenda and which topics are left out of the discussion (Lukes, 2005). Social aspects and researchers were largely left out from the inquiry (see also Topor, 2010). Topics that were important to social workers were blocked. This was also pointed at by many of the referral organisations. This blocking of the social perspective was not successful. The government acknowledged opposition to this framing and did not follow the advice of the inquiry. According to Conrad and Schneider, medicalisation can appear at three levels: on *the conceptual* level, abuse is defined in medical terms; on *the institutional* level, medical arguments are the basis for administrative or political decisions and practices; and on *the interactive* level, abuse is diagnosed and treated by physicians with medical treatments (Conrad, 1992). Medicalisation appears at all three levels as well as in the evidence-based rhetoric regarding Swedish substance abuse treatment. There are, however, competing definitions, also among strong interest groups, including the Swedish Association of Local Authorities and Regions, which probably affect the total degree of medicalisation of substance abuse treatment in Sweden (ibid.).

To conclude, this study contributes to our knowledge on policy processes in the substance abuse treatment field as well as other systems regulated by (social) policy and legislation. It sheds light on the functioning of power in democratic processes – how stakeholders may block a reform despite years of investment in an inquiry when the response is mixed or rather quite critical in most groups. It was confirmed that major subsystem reforms are difficult to carry out as freestanding projects. External superior changes may help promote such change. However, the future of Swedish substance abuse treatment, in a longer perspective, is still unclear. There seems to be a loosening of traditional dividing lines in the substance abuse treatment field. The debate continues. This can easily be understood by the Advocacy Coalition Framework, which argues that actors' (policy) core beliefs – medical versus social perspectives/solutions – are resistant to change and that disputes and coalitions will remain active for years. New coalitions appear to be rising, but it is unclear if they will survive, and the inquiry symbolises an increased loosening of the social perspective. Instead of reforming the system radically, it may be fair to say that the inquiry, with its radical proposal that trickled out early in the process, created a deadlock in the field of substance abuse treatment for many years. Many care providers refrained from larger investments in light of the unknown future of treatment responsibilities. It will be interesting to follow what lies in store for the field of Swedish substance abuse treatment.

Limitations

Content analysis and the current analysis have the advantage of dealing with large

Unauthenticated
Download Date | 12/16/16 11:54 AM

amounts of data. They provide a good overview of the submitted comments (Bauer, 2000; Bergström & Boréus, 2000). However, the study uses public and naturally occurring data only. The analysis is based on texts, manifest content and visible power. It does not, for example, take into account what has been said in other forums and how stakeholders have tried to influence the policy process in other ways (Bauer, 2000; Bergström & Boréus, 2000). There may also be problems regarding the sequence of arguments in texts. The moment at which something is said may be more important than what is said. However, the analysis has sought to take the context into account in the coding process and generally, there was no given sequence of arguments apart from some arguments that often were presented simultaneously. This was also mentioned in the results section.

Declaration of interest None.

Jessica Storbjörk, Associate professor
Centre for Social Research on Alcohol and Drugs (SoRAD)
Stockholm University, Sweden
E-mail: jessica.storbjork@sorad.su.se

ENDNOTE

1. The extensive use of designated state commissions together with the circulation of a proposal for comments (*remiss* in Swedish) has for long been a unique feature of governmental policy-making in Sweden. Invited stakeholders and anyone with an interest in commenting on a proposal will send their statements, i.e. the comments analysed in this article, to the appropriate ministry, which then analyses them in a subsequent government bill. Nearly every important piece of legislation is prepared through such a commission specially appointed by the responsible minister. Most often a commission has up to five members (typically civil servants, MPs and established interest groups, seldom scientific researchers); sometimes it is a single-member commission; and some very large commissions have up to 30 members. The commissions have been important arenas for political negotiations, and the major goal is to formulate a proposal that stands a chance of being adopted by the Riksdag and implemented, which most proposals are in one way or another. A suggested latent function is that a commission is appointed in order to postpone action. Commissions are thought to provide good knowledge of public policy issues; constitute a mechanism for consensus building; and are viewed as instruments for governmental policy planning. However, the notion of these commissions as instruments of objective inquiry is increasingly being rejected. They are rather described as an integral part of an often highly politicised process of policy-making with partisan use of the commissions' end products, and research knowledge is typically used as political ammunition. As commissions have become more controlled by the Government, there are increasing difficulties in reaching consensus (Johansson, 1992; Premfors, 1983).

Unauthenticated
Download Date | 12/16/16 11:54 AM

REFERENCES

Babor, T. F., Stenius, K., & Romelsjö, A. (2008). Alcohol and drug treatment systems in public health perspective: Mediators and moderators of population effects. *International Journal of Methods in Psychiatric Research, 17*(SUPPL. 1), S50–S59.

Bauer, M. W. (2000). Classical content analysis: A review. In M. W. Bauer, & G. Gaskell (Eds.), Qualitative researching with text, image and sound: A practical handbook (pp. 131–151). London: Sage.

Bergmark, A. (2012). Om medikaliseringen av svensk missbrukarvård [On the medicalisation of Swedish substance abuse treatment]. *Socialvetenskaplig tidskrift, 20*(3–4), 232–242.

Bergström, G., & Boréus, K. (2000). *Textens mening och makt. Metodbok i samhällsvetenskaplig textanalys* [The meaning and power of the text. A methods book in text analysis in the social sciences]. Lund: Studentlitteratur.

Blomqvist, J., Palm, J., & Storbjörk, J. (2009). "More cure and less control" or "more care and lower costs"? Recent changes in services for problem drug users in Stockholm and Sweden. *Drugs: Education, Prevention & Policy, 16*(6), 479–496.

Bourdieu, P. (1999). *Praktiskt förnuft: Bidrag till en handlingsteori*. Göteborg: Daidalos.

Conrad, P. (1992). Medicalization and social control. *Annual Review of Sociology, 18*, 209–232.

Conrad, P., & Schneider, J. (1992). *Deviance and medicalization: From badness to sickness*. Philadelphia: Temple University Press.

Dir. 2008:48. Kommittédirektiv. Översyn av missbruks- och beroendevården [Committee directive: overview of misuse and dependence treatment]. Stockholm: Socialdepartementet.

Edman, J., & Stenius, K. (2007). From sanatoriums to public injection rooms: Actors, ideas and institutions in the Nordic treatment systems. In J. Edman, & K. Stenius (Eds.), *On the margins: Nordic alcohol and drug treatment 1885–2007* (pp. 314–337). Helsinki: Nordic Council for Alcohol and Drug Research (NAD).

Ekendahl, M. (2009). The construction of maintenance treatment legitimacy: A discourse analysis of a policy shift. *The Policy Press, 5*(3), 247–265.

Humphreys, K., & Mclellan, A. T. (2011). A policy-oriented review of strategies for improving the outcomes of services for substance use disorder patients. *Addiction, 106*(12), 2058–2066.

Johansson, J. (1992). *Det statliga kommittéväsendet: Kunskap, kontroll, konsensus* [Governmental commissions: knowledge, control, consensus]. Stockholm: Stockholms universitet, Statsvetenskapliga institutionen.

Johnson, B. (2003). Policyspridning som översättning. Den politiska översättningen av metadonbehandling och husläkare i Sverige [Diffusion of policy as translation: the political translation of methadone treatment and general practitioners in Sweden]. Lund: Lund University.

Johnson, B. (2007). After the storm: Developments in maintenance treatment policy and practice in Sweden 1987–2006. In J. Edman, & K. Stenius (Eds.), *On the margins: Nordic alcohol and drug treatment 1885–2007* (pp. 259–287). Helsinki: Nordic Centre for Alcohol and Drug Research (NAD).

Kübler, D. (2001). Understanding policy change with the advocacy coalition framework: An application to Swiss drug policy. *Journal of European Public Policy, 8*(4), 623–641.

Kuussaari, K., & Partanen, A. (2010). Administrative challenges in the Finnish alcohol and drug treatment system. *Nordic Studies on Alcohol and Drugs, 27*(6), 667–684.

Kvale, S. (1997). *Den kvalitativa forskningsintervjun* [The qualitative research interview]. Lund: Studentlitteratur.

Lagergren, F. (1999). På andra sidan välfärdsstaten. En studie i politiska idéers betydelse [On the flip side of the welfare

Unauthenticated
Download Date | 12/16/16 11:54 AM

state: a study on the significance of political ideas]. Stockholm: Symposion.
Larsson, M. (2013). Webbutsändning: Lagrådsremiss för missbruks- och beroendevården presenteras 30 januari 2013 av barn- och äldreminister Maria Larsson, Socialdepartementet [WebCast: Presentation of report to legislative council about misuse and dependence treatment, January 30, 2013, by Maria Larsson, Minister of children and the elderly, Ministry of Health and Social Affairs]. Retrieved March 6, 2013, from http://www.regeringen.se/sb/d/3209/a/208082
Lukes, S. (2005). *Power: A radical view* (2nd ed.). Basingstoke: Palgrave Macmillan.
MacGregor, S. (2013). Barriers to the influence of evidence on policy: Are politicians the problem? *Drugs: Education, Prevention & Policy*, 1–9. doi:10.3109/09687637.2012.754403
NBHW (2007). Nationella riktlinjer för missbruks- och beroendevård. Vägledning för socialtjänstens och hälso- och sjukvårdens verksamhet för personer med missbruks- och beroendeproblem [National guidelines for addiction and dependence care: guidance for the social services' and the health care system's treatment of people with addiction and dependence problems]. Stockholm: National Board of Health and Welfare.
Nesvåg, S., & Lie, T. (2010). The Norwegian substance treatment reform: Between new public management and conditions for good practice. *Nordic Studies on Alcohol and Drugs, 27*(6), 655–666.
Palm, J. (2004). The nature of and responsibility for alcohol and drug problems: Views among treatment staff. *Addiction Research & Theory, 12*(5), 413–431.
Pedersen, M. U. (2005). A Danish perspective on the treatment of substance users in Norway. *Nordisk alkohol- och narkotikatidskrift, 22*(English Supplement), 174–178.
Pedersen, M. U. (2007). Professional expertise versus market mechanisms in contemporary Denmark. In J. Edman, & K. Stenius (Eds.), *On the margins: Nordic alcohol and drug treatment 1885–2007* (pp. 292–314). Helsinki: Nordic Council for Alcohol and Drug Research (NAD).
Pedersen, M. U., Hesse, M., & Bloomfield, K. (2011). Abstinence-orientated residential rehabilitation of opioid users in Denmark: Do changes in national treatment policies affect treatment outcome? *Scandinavian Journal of Public Health, 39*(6), 582–589.
Pierson, P. (2000). Path dependence, increasing returns, and the study of politics. *American Political Science Review, 94*(2), 251–267.
Premfors, R. (1983). Governmental commissions in Sweden. *American Behavioral Scientist, 26*(5), 623–642.
Prestjan, A. (2007). Idealistic doctors: Alcoholism treatment institutions in Sweden 1885–1916. In J. Edman, & K. Stenius (Eds.), *On the margins: Nordic alcohol and drug treatment 1885–2007* (pp. 25–49). Helsinki: Nordic Centre for Alcohol and Drug Research (NAD).
Prop. 2010/11:47 Regeringens proposition: En samlad strategi för alkohol-, narkotika-, dopnings-, och tobakspolitiken [Government bill. A joint strategy for alcohol, drug, doping and tobacco policy]. Stockholm: Socialdepartementet, Prop. 2010/11:47 (2011).
Prop. 2012/13:77 Regeringens proposition: God kvalitet och ökad tillgänglighet inom missbruks- och beroendevården [Government bill. Good quality and better access in substance abuse treatment]. Stockholm: Socialdepartementet, Prop. 2012/13:77 (2013).
Rosenqvist, P., & Kurube, N. (1992). Dissolving the Swedish alcohol-treatment system. In H. Klingemann, & Takala, J-K., Hunt, G. (Eds.), *Cure, care or control: Alcoholism treatment in sixteen countries* (pp. 65–86). Albany: State University of New York Press, cop.
Rothstein, B. (1988). Aktör–strukturansatsen: Ett metodiskt dilemma. *Statsvetenskaplig tidskrift, 9*(1), 27–40.
S2011/4504/FST. (2012). Remissammanställning över betänkandet Bättre insatser vid missbruk och beroende (SOU2011:35) i de delar som rör

Unauthenticated
Download Date | 12/16/16 11:54 AM

kommunernas och landstingens ansvar för missbruks- och beroendevården [Compilation of comments concerning the inquiry on Better interventions for misuse and dependence (SOU2011:35), sections on the responsibility of the municipalities and the county councils for substance abuse treatment]. Stockholm: Regeringskansliet, Socialdepartementet.

Sabatier, P. A. (1998). The advocacy coalition framework: Revisions and relevance for Europe. *Journal of European Public Policy, 5*(1), 98–130.

Sellerberg, A. (1999). Soon there'll be a society for every bit of the intestine: The complexities of positioning disability in Sweden today. *Scandinavian Journal of Disability Research, 1*(2), 86–98.

Skretting, A. (2005). From client to patient: Will the Norwegian substance abuse treatment reform mean better access to treatment? *Nordisk alkohol- och narkotikatidskrift, 22*(English Supplement), 167–173.

Skretting, A. (2007). Medicalisation with a focus on injecting drug users: Changes in the Norwegian treatment system from the 1990s. In J. Edman, & K. Stenius (Eds.), *On the margins: Nordic alcohol and drug treatment 1885–2007* (pp. 267–291). Helsinki: Nordic Council for Alcohol and Drug Research (NAD).

SOU (2004). Tvång och förändring – rättssäkerhet, vårdens innehåll och eftervård [Coercion and change: legal security, treatment contents and follow-up care]. (SOU 2004:3). Stockholm: Fritzes.

SOU (2005). Personer med tungt missbruk – stimulans till bättre vård och behandling [Persons with heavy abuse: stimulus for better care and treatment]. (SOU 2005:82). Stockholm: Fritzes.

SOU (2011). Bättre insatser vid missbruk och beroende. Individen, kunskapen och ansvaret. Slutbetänkande av missbruksutredningen [Better interventions for misuse and dependence: individual, knowledge and responsibility. Final report of misuse commission]. (SOU 2011:35). Stockholm: Fritzes.

Stenius, K., & Edman, J. (2007). A frame. In J. Edman, & K. Stenius (Eds.), *On the margins: Nordic alcohol and drug treatment 1885–2007* (pp. 5–23). Helsinki: Nordic Centre for Alcohol and Drug Research (NAD).

Stevens, A. (2007). Survival of the ideas that fit: An evolutionary analogy for the use of evidence in policy. *Social Policy and Society, 6*(01), 25–35.

Storbjörk, J. (2010). Alcohol and drug treatment systems research: A question of money, professionals, and democracy. *Nordic Studies on Alcohol and Drugs, 27*(6), 543–548.

Storbjörk, J. (2012). Drug users as social change agents: Increasing but limited possibilities in Sweden. *Substance Use & Misuse, 47*(5), 606–609.

Thelen, K. (1999). Historical institutionalism in comparative politics. *Annual Review of Political Science, 2*(1), 369–404.

Tieberghien, J., & Decorte, T. (2013). Understanding the science–policy nexus in Belgium: An analysis of the drug policy debate (1996–2003). *Drugs: Education, Prevention & Policy, 20(3)*, 241–248.

Topor, A. (2010). Medikaliseringen av det psykosociala fältet. Om en kunskapssammanställning från socialstyrelsen [The medicalisation of the psychosocial field: about an evidence-based review by the National Board of Health and Welfare], IMS. Socialvetenskaplig tidskrift, 17(1), 67–81.

Torfing, J. (1999). Towards a Schumpeterian workfare postnational regime: Path-shaping and path-dependency in Danish welfare state reform. *Economy and Society, 28*(3), 369–402.

Upmark, M. (2006). Medikalisering – en orsak till ökad sjukfrånvaro [Medicalisation: a reason for increased sick leave]. In C. Edlund, & M. Upmark (Eds.), *Den komplexa sjukfrånvaron* (pp. 161–181). Lund: Studentlitteratur.

Wahlbeck, K. (2010). Moving towards integrated addiction treatment systems. *Nordic Studies on Alcohol and Drugs, 27*(6), 699–702.

Weible, C. M. (2007). An advocacy coalition framework approach to stakeholder

Unauthenticated
Download Date | 12/16/16 11:54 AM

analysis: Understanding the political context of California marine protected area policy. *Journal of Public Administration Research and Theory, 17*(1), 95–117.

Weiss, C. H. (1979). The many meanings of research utilization. *Public Administration Review, 39*(5), 426–431.

APPENDIX

NUMBER OF AGENCIES THAT ENDORSE EACH ARGUMENT FOR TREATMENT RESPONSIBILITY SHIFT

Total n=198 of which n=169 mention responsibility shift	Advocates (n=57)	Opponents (n=91)	Do not take a stand (n=21)	Total (n=169)
Old-fashioned/out-of-date legislation, changed drug situation	10	9	2	21
Collaboration efforts have failed: better with one provider	25	2	1	28
Dependence=health problem/psychiatric diagnosis=health system (normalisation)	16	4	2	22
More pills: under-used treatment strategy	13	13	2	28
Reach socially integrated hazardous users	14	13	2	29
Patient rights, prefer health system over stigmatising/moralising social services	9	3	1	13
Evidence-based and effective (medical) treatment	18	5	-	23
Equality and access (centralisation)	16	6	4	26
Holistic view of service users and problems, e.g. psychiatric/somatic comorbidity	14	5	2	21
Good clarification of responsibilities within health system	4	21	-	25
Convincing evidence for change in inquiry	5	1	-	6

NUMBER OF AGENCIES THAT ENDORSE EACH COUNTERARGUMENT FOR TREATMENT RESPONSIBILITY SHIFT

New boundaries – new problems	20	54	5	79
Medicalisation, simplistic perspective → fewer social interventions	13	60	6	79
The most severe cases will be left out: favours socially integrated hazardous users	14	40	1	55
Loss of holistic perspective and ultimate responsibility	4	42	1	47
Cross-disciplinary competence and interventions are needed → collaboration between health and social services and/or integrated units	12	54	5	71
Good experiences of recent efforts to improve collaboration between health and social care and implementation of evidence-based treatment: continue down that road	6	46	2	54
Competence and interest is found in social services, not in health care system	13	53	2	68
HVB: institutional care specialty of social services	2	6	-	8
Costs	22	36	4	62
Conversion losses	9	24	1	34
Increased legal uncertainty/impoverished legal rights	7	47	4	58
Problems with the character of Health and Medical Services Act: priorities, misusers cannot compete for resources, patient fees	3	15	-	18
No need for/problems with special law: undermines current framework laws	5	17	5	27
Collaboration problems WITHIN the health system (poor basis for effective care)	2	7	2	11
Unequal care and regional differences also in health system	3	3	-	6
Disadvantages of centralisation and poor access/choice/long distances	1	20	-	21
Lack of evidence for inquiry's proposal	2	14	2	18
Lack of evidence for methods used in health system or no evidence-based methods available for certain groups, e.g. will be left without treatment	9	8	-	17
Integrity problems, paternalism and top-down perspective: forces society to intervene, everybody does not need/want treatment	6	8	-	14
Social services are not stigmatising any more, new work models	1	5	-	6
Unclear consequences/effects of reform, generally	2	4	3	9

Unauthenticated
Download Date | 12/16/16 11:54 AM

NUMBER OF AGENCIES THAT ENDORSE EACH ARGUMENT FOR COMPULSORY TREATMENT RESPONSIBILITY SHIFT

Total n=198 of which n=144 mention responsibility shift	Advocates (n=29)	Opponents (n=103)	Do not take a stand (n=12)	Total (n=144)
Logic consequence if treatment responsibility is transferred	4	1	0	5
(Efficacy) problems in current system/LVM, better effect in LPT	5	12	2	19
Better with one law/organisation instead of two	4	4	2	10
Comorbidity, psychiatric/somatic	7	4	-	11
Better legal security in psychiatric law/LPT	7	2	1	10
LPT is emergency law, good, can intervene more easily/quicker	5	6	-	11
Outpatient coercive care in LPT is flexible and good	4	-	2	6
Equality and access	4	5	1	10
Medical competence/assessments are needed in coercive care	5	2	-	7

NUMBER OF AGENCIES THAT ENDORSE EACH COUNTER-ARGUMENT FOR COMPULSORY TREATMENT RESPONSIBILITY SHIFT

Medicalisation: not all misusers have mental problems, need other (individualised/ social) treatments	3	50	3	56
Dependence is not a mental disorder → uncertain concepts/criteria in LPT law	1	24	-	25
Influence other legislation in an unfortunate way	2	9	-	11
Fewer will get coerced treatment: narrower criteria, no social criteria for youth, no protection for family/relatives	2	35	2	39
More people will get coerced treatment	-	8	1	9
Increased legal uncertainty/impoverished legal rights	4	32	2	38
Integrity problems and forced medication in LPT (outpatient compulsory treatment)	-	12	1	13
Lack of competence/capacity/interest for these groups in LPT/health care and collaboration problems within the health care system	5	32	-	37
Poorly investigated/supported proposal, e.g. lack of evidence	2	16	1	19
Lack of evidence for methods in psychiatry/LPT	-	11	-	11
Unclear consequences	4	20	5	29
Calls for inquiry on all coercive treatment. Problems in all laws, one law will not solve problems	6	24	3	33
Need for long-term treatments (instead of emergency law)	1	20	-	21
Benefits of today's nationwide system (centralisation vs. regional differences in LPT)	1	11	-	12
Ultimate responsibility, social services will lose important tool	-	11	-	11
Lack of outreach work in health care: no duty to report people to LPT	-	6	-	6
Cross-disciplinary competence/interventions needed → collaboration social services and health care needed	-	9	1	10



Unauthenticated
Download Date | 12/16/16 11:54 AM