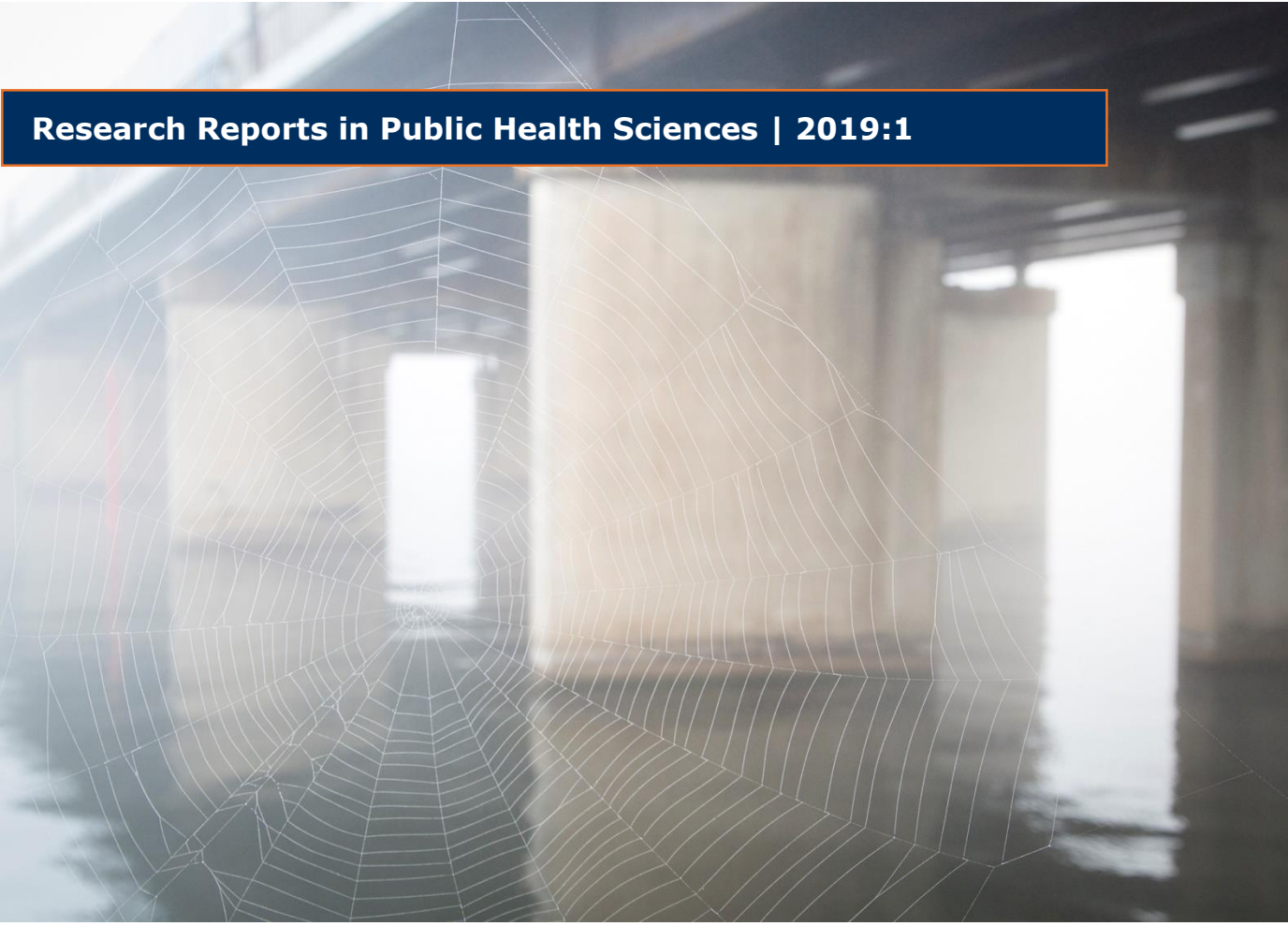
Research Reports in Public Health Sciences | 2019:1



The Swedish Addiction Treatment System: Government, Steering and Organisation

Technical Report

Jessica Storbjörk, Erik Antonsson & Kerstin Stenius

Stockholm University

Department of Public Health Sciences

The Swedish Addiction Treatment System: Government, Steering and Organisation

Technical Report

Jessica Storbjörk, Erik Antonsson & Kerstin Stenius

About the authors

Jessica Storbjörk, Associate Professor of Sociology, is a Senior Lecturer at the Department of Public Health Sciences, Stockholm University, and as of January 2019 the Director of the Centre for Social Research on Alcohol and Drugs (SoRAD). She was the PI of the current research project. Her research has focused on the addiction treatment system, its service users, professionals, and organisation, in Sweden and internationally.
Orchid: https://orcid.org/0000-0002-1757-9974
Email: jessica.storbjork@su.se

Erik Antonsson is a Master of Science of Sociology and served as a research assistant of the current research project in the spring of 2019.

Kerstin Stenius is an Associate Professor of Social Work and an experienced addiction treatment systems scientist. She worked as a researcher in the current research project and was involved in all phases of the study. Kerstin Stenius was the editor of the journal *Nordic Studies on Alcohol and Drugs* in 1983–2016.

Research Reports in Public Health Sciences (RRPHS) 2019:1

ISBN 978-91-7797-986-9

ISSN 2003-0142

Cite this report:
Storbjörk, J., Antonsson, E., Stenius, K. (2019). The Swedish addiction treatment system: Government, steering and organisation. Technical report. *Research Reports in Public Health Sciences*, Stockholm University, no:2019:1.

Abbreviations

Acronym	Explanation in English	In Swedish (if applicable)
Ds[1]	Ministry Publications Series.	*Departementsserien (Ds).*
EBP	Evidence-based practices.	*Evidensbaserade metoder och praktiker (EBP).*
HSL[1]	The Health and Medical Services Act (2017:30; replaced 1982:763).	*Hälso- och sjukvårdslag (2017:30), HSL, instiftad genom 1982:763.*
HSLF-FS[1]	Statutory instrument/provisions provided by government authorities involved with health, social services, pharmacotherapy, public health, etc. A joint series as of July 1, 2015.	*Gemensam författningssamling avseende hälso- och sjukvård, socialtjänst, läkemedel mm.* Föreskrifter från olika myndigheter sedan 1 juli 2015.
HVB; HVB homes[1]	Homes for care or residence; Institutional care facility with a permit issued by IVO.	*Hem för vård eller boende (HVB); Institutionsvård med tillstånd från IVO.*
IFO[1]	Individual and family care. The part of the social services generally responsible for addiction treatment.	*Individ- och familjeomsorgen (IFO). Del av socialtjänsten som vanligen ansvarar för missbruksvård.*
IVO[1]	Health and Social Care Inspectorate.	*Inspektionen för vård och omsorg (IVO).*
KL[1]	The Swedish Local Government Act (2017:725; replaced 1991:900).	*Kommunallag (2017:725), KL,* ersatte 1991:900.
LOB[1]	Act 1976:511 on the Disposal of Drunk People.	*Lagen (1976:511) om omhändertagande av berusade personer (LOB).*
LOU[1]	The Swedish Public Procurement Act (2016:1145). Replaced 2007:1091; and first enacted by 1992:1528.	*Lag (2016:1145) om offentlig upphandling*. LOU instiftades genom 1992:1528 som ersattes av 2007:1091.
LOV[1]	The Act on System of Choice in Public Sector (2008:962).	*Lag (2008:962) om valfrihetssystem (LOV).*
LVM; LVM homes[1]	The Care of Abusers (Special Provisions) Act (1988:870) [e.g., compulsory care]. Compulsory	*Lag (1988:870) om vård av missbrukare i vissa fall.* LVM, tvångsvård. *LVM-hem drivs av SiS.*

	treatment facilities run by SiS.	
NBHW[2]	The National Board of Health and Welfare (NBHW).	*Socialstyrelsen.*
NEP law[2]	The Act (2006:323) on Needle and Syringe Exchanges.	*Lag (2006:323) om utbyte av sprutor och kanyler.*
NGO	Non-governmental organisation, usually not-for-profit.	*Ideella eller idéburna organisationer, vanligen icke-vinstsyftande.*
NPM[2]	New Public Management.	*New Public Management (NPM).*
OMT[2]	Opioid Maintenance Treatment.	*Läkemedelsassisterad behandling vid opiatberoende (LARO).*
SBU	Swedish Agency for Health Technology Assessment and Assessment of Social Services.	*Statens beredning för medicinsk och social utvärdering (SBU).*
SIP[1]	Joint and coordinated Individual Plan. An individual-level treatment plan jointly written to specify the responsibility of different care providers.	*Samordnad individuell plan (SIP). Vårdplan för enskild som anger respektive vårdgivares ansvar.*
SiS[1]	The National Board of Institutional Care.	*Statens institutionsstyrelse (SiS).*
SALAR[2]	Swedish Association of Local Authorities and Regions (SALAR).	*Sveriges kommuner och landsting (SKL).*
SoF[1]	Social Services Ordinance.	*Socialtjänstförordningen (2001:937, SoF).*
SoL[1]	The Social Services Act (2001:453; replaced 1980:620).	*Socialtjänstlagen (2001:453), SoL,* ersatte 1980:620.
SOSFS[1]	Provisions and general advice issued by the NBHW. A statutory instrument. Provisions are binding regulations. General advice includes recommendations on how a provision can or should be applied.	Socialstyrelsens föreskrifter och allmänna råd. Föreskrifter är bindande. Allmänna råd ger exempel på hur föreskrifterna kan och bör appliceras.
SOU[1]	Swedish Government Official Reports (series).	*Statens offentliga utredningar (SOU).*

[1] Refers to abbreviations as commonly used in Swedish, such as abbreviations for laws and government agencies, in cases when no established abbreviation in English exists.

[2] Abbreviations commonly used in English.

Preface

This technical report presents the background, aims and research design of the research project *Benefits, tensions and inconsistencies in the health and welfare system: The case of New Public Management in Swedish substance abuse treatment* as specified in the research grant application. It describes the setting, methods, data sources and procedures used. It also provides information on the government and organisation of the Swedish addiction treatment system that is of importance for the interpretation and understanding of the analyses and findings presented in scientific journals and other short formats. *The aim is therefore twofold: to outline the setting of the study, primarily for an international audience, and to offer a comprehensive account of the study's background and methodology.*

The project received funding from the Swedish Foundation for Humanities and Social Sciences (*Riksbankens Jubileumsfond; RJ;* No. P14-0985:1). It started on January 1, 2016 at the Centre for Social Research on Alcohol and Drugs (SoRAD), Stockholm University. As of January 1, 2018, SoRAD was merged with the Centre for Health and Equity Studies (CHESS) into the new Department of Public Health Sciences within the Faculty of Social Sciences at Stockholm University. The research project ended on June 30, 2019.

Associate Professor of Sociology and Senior Lecturer Jessica Storbjörk served as the principal investigator (PI). She worked on the study with Associate Professor of Social Work Kerstin Stenius. Other involved scientists were Erik Antonsson (MA), Irja Christophs (MA), Filip Roumeliotis (PhD) and Eva Samuelsson (PhD). A reference group was also established in the planning phase of the project consisting of Associate Professor Eva Bejerot (Örebro University School of Business), Professor Björn Blom (Department of Social Work, Umeå University) and registered psychologist, supervisor and development consultant Sven-Eric Alborn (Centre for Education and Research on Addiction, CERA, and Region Halland).

We are deeply thankful to all the people involved in addiction treatment that have contributed to the study. It would not have been possible to carry out this research project if had they not participated in an interview, responded to the web survey or helped us in many other ways. Thank you!

Jessica Storbjörk

Stockholm, July 19, 2019

Summary

Welfare systems in Sweden and internationally have gone through major changes regarding modes of operation and means of government in New Public Management (NPM) reforms, which have sought to balance autonomy and control. There is a lively debate about NPM, but research is scarce. NPM indicates improved performances but also unintended consequences and inconsistencies concerning ideas, demands on the services and performance incentives – such as tensions between medical and social professional autonomy and knowledge on the one hand and administrative control, auditing and a growing bureaucracy (e.g., procurement, inspections, documentation) on the other. The research project used addiction treatment with different organisations and professions as a case for studying the impact of NPM on the daily work in regional health care and municipal social services organisations.

We charted the broad steering and organisation of addiction treatment. We analysed the extent to which tendencies of NPM have conveyed advantages or created conflicting logics by comparing addiction treatment in three regions and six municipalities with varying degrees of NPM. The study used official statistics, documents, interviews and a web survey. A total of 85 interviews were made with 93 individual state, regional and local policy-makers and officials (including the previously unstudied procurers) and public and private care providers (managers and treatment professionals) in 2017–2018. The interviews formed the basis for a web survey among professionals in Sweden in 2019. Purchasing addiction services was further examined by observing a large procurement process, by organising a workshop with Nordic procurement experts, and by interviewing civil servants in Finland, Denmark and Norway.

The study shows how addiction treatment is governed and organised, highlighting developments over time with special emphasis on various NPM features. The interviews addressed advantages and tensions in the daily work and if and how professionals seek to adapt to new, perhaps inconsistent, demands. The web survey allows for comparisons across organisations and professional groups. This technical report presents the background and aims of the study and describes in detail the Swedish study setting, and the study design, methods and data sources used.

Keywords

Addiction treatment, professionals, neoliberalism, NPM, marketisation, social services, medical care, government, steering, organisation, public procurement.

Sammanfattning

Välfärdssystemens organisation och styrning har förändrats genom New Public Management (NPM) och olika reformer som syftat till att balansera autonomi och kontroll. NPM-debatten är livlig men forskningen sparsam. Den indikerar förbättringar men även oavsiktliga konsekvenser och motsägelsefulla visioner, krav på utförarna och incitament: en spänning mellan medicinska och sociala professioners autonomi och kunskap å ena sidan och administrativ kontroll och växande byråkrati (upphandling, tillsyn, osv.) på den andra. Detta forskningsprojekt använde missbruks- och beroendevården med dess olika organisationer och professioner som fall för att studera hur NPM har påverkat den dagliga praktiken i den regionbaserade sjukvården och den kommunala socialtjänsten.

Forskningsprojektet kartlade den övergripande styrningen och organiseringen av missbruks- och beroendevården. Vi analyserade om och hur olika NPM-inslag medfört förbättringar eller skapat motsättningar genom att studera och jämföra missbruks- och beroendevården i tre regioner (fd. landsting) och sex kommuner med olika grad av NPM. Studien bygger på intervjuer, offentlig statistik, dokument och en webbenkät. Totalt gjordes 85 intervjuer med 93 enskilda politiker och tjänstemän på nationell, regional och lokal nivå, inklusive de tidigare ostuderade beställarna, samt med vårdgivare (ägare, chefer och professionella) i offentlig och privat regi år 2017-2018. Intervjustudien låg till grund för en webenkät riktad till professionella i Sverige 2019. Upphandling av missbruksvård studerades vidare genom en observation av en stor upphandling, genom arrangerandet av en workshop med Nordiska upphandlare och upphandlingsexperter samt genom intervjuer med tjänstemän i Danmark, Finland och Norge.

Studien visar hur missbruks- och beroendevården styrs och organiseras samt hur fältet utvecklats över tid med särskilt fokus på NPM. Intervjuerna behandlar fördelar och spänningar i den dagliga praktiken samt om och hur professionella anpassar arbetet efter nya och kanske motstridiga krav. Webbenkäten möjliggör jämförelser mellan olika organisationer och professioner. Denna tekniska rapport redogör för studiens bakgrund och målsättningar samt beskriver den svenska situationen och studieområdet, studiedesign, forskningsmetod och de datamaterial som används.

Nyckelord

Missbruks- och beroendevård, professionella, nyliberalism, NPM, marknadisering, socialtjänst, sjukvård, styrning, organisering, upphandling, sociologi.

Table of contents

Introduction

The rationale for the research project outlined in the grant application which was submitted to *Riksbankens Jubileumsfond (RJ)* was that the public administration, governance and production of health and welfare services in many Western countries in the last decades have gone through substantial changes regarding their organisation, modes of operation, models of funding, and means of government and control. These changes are usually summarised as New Public Management (NPM) (1–6). NPM has had a major impact in countries such as the United Kingdom (UK), the United States (US), Australia, and also in Sweden (7,8).

While NPM has no agreed definition, its tendencies usually comprise a move away from public monopolies and rules-based bureaucracy towards demands for greater efficiency and lowered costs; decentralisation of decision-making; introduction of market-inspired solutions such as purchaser–provider models, contracting, competition, competitive tendering processes including public procurement, and consumer orientation; performance measurement systems sometimes used in payment-by-results models; and the incorporation of private-sector managerial techniques into public services (9–12).

The changes have been accompanied by demands for re-politicisation, documentation and evaluation – often characterised by the concept of 'auditing' (13). Christensen and Laegreid (14) argue that increasingly complex 'hybrid' organisations develop out of such reform attempts to balance (institutional and professional) autonomy and (political and administrative) control. As a result, there are tensions between diverse structural and cultural elements in government. Such organisations have to work with inconsistent considerations which produce unstable trade-offs and lasting tensions.

The critical reportage in the national newspaper *Dagens Nyheter* by Zaremba in 2013 (15,16) started a highly polarised debate on NPM in welfare services in Sweden regarding the value and problems of competition, freedom of choice, privatisation, profiteering, auditing and administrative control (17–34). Other 'leading-edge' countries are on the other hand discussing the death of NPM or post-NPM (14,35–37) emerging out of reactions to the experienced negative effects.

The research project *Benefits, tensions and inconsistencies in the health and welfare system: The case of New Public Management in Swedish substance abuse treatment* used **addiction treatment**[1] as a case for studying the application and impact of NPM

[1] There have been different lables over the years on the treatment system involved in offering services to people experiencing alcohol or other drug problems, defined as problematic users,

and post-NPM tendencies on health and social services. It explored the broad government, perceptions of benefits and tensions, and experiences as concerns expectations for addiction treatment, demands on services and performance incentives among policy-makers, bureaucrats and management and staff within addiction treatment. The project examined how potential inconsistencies in such performance incentives and demands were handled by service providers and concerned actors, and how the service user level might be affected by NPM according to professionals.

Addiction treatment is an interesting case for the study of NPM. It comprises the local municipal social services dominated by social workers and the regional health care system with medical professions, as well as not-for-profit non-governmental-organisations (NGO) and for-profit private providers from whom the public administration may purchase services on behalf of the citizens. These types of organisations differ considerably in organisational structures, steering principles and work logics, and NPM may have different implications for the medical and social professions in terms of their historically different levels of professional authority – i.e., the medical professions have traditionally held greater prestige. In addition, people with addiction problems seldom live up to market ideas of self-managing customers (39,40), and it is seldom the individual service user that pays for the treatment. This produces a separation between customer (the service user) and purchaser (the local treatment administration). Legislation and goals regarding health and welfare services have remained fairly untouched over the last decades and the vast majority of services are still funded from tax revenues.

However, moves towards a quasi-market (41–43) have changed the delivery of services. The composition of care providers in the addiction treatment system has moved from public units and non-profit organisations toward for-profit private enterprises and incorporated companies (3,10,39,44). Internal purchaser–provider

or engaged in addictive behaviours (e.g., gambling). The currently most used Swedish term is 'missbruks- och beroendevården', which can be translated into 'misuse and dependency care'. 'Misuse' is rarely used internationally, but is the term used in Swedish social legislation (e.g., SoL and LVM). Dependency refers to dependence diagnoses that are important inclusion criteria in the health care system. Substance abuse treatment (SAT) – as used in the title of our research project – could be an alternative term, but 'abuse' has been criticised for covering only abuse as defined in diagnostic manuals. Substance use treatment (SUT) is yet another alternative but does not cover gambling that is also the responsibility of the Swedish treatment system. We have therefore chosen the term 'addiction treatment' in this report. The concept of 'addiction' is far from uncontested (38) and not that common in Sweden, perhaps because of its primarily medical connotations and the strong social roots of the Swedish treatment system (see below). It is, however, a broad concept that covers substances and behaviours, and it is also a shorter term than many of the other words used to characterise services involved in curing, caring or controlling these problems.

models have become innumerable, and addiction treatment is increasingly turning towards a situation where private enterprises and public units compete for contracts with public financiers in a contractual environment. The introduction of managerialism implies that health and welfare administrations are increasingly being run in the manner of business enterprises. This includes managerialist techniques such as strategic or operational plans, statistical reporting of activities and outcomes, and quality assurance frameworks (15,20,39,45). Care providers' budgets are guaranteed to a lesser extent than before, and contracts and negotiations are made by high-ranking bureaucrats, sometimes without proper medical or social work training, rather than by medical or social professionals (40).

Studies indicate that NPM may have brought about a de-professionalisation among social and medical professions (14,40,46–49), and may have increased the power of new actors, e.g., bureaucrats (care purchasers, experts, performance evaluators, inspectors). Also, high-ranking national-level policy-makers and bureaucrats increasingly seek to govern addiction treatment by means of evidence-based practices and other regulations. We may be witnessing a redistribution of power from health and welfare professionals to experts and bureaucrats, or perhaps a continued but different autonomy among professionals (4,50–53). The balance between autonomy and control is changing (14,53). NPM-driven fragmentation and a siloing of agencies through the contractual structure may also imply that no one has a good overview of services, which may increase the presence of inconsistent incentives (54) that, in turn, undermine the effectiveness of addiction treatment and similar organisations.

Theory and research also indicate the rise of unintended consequences, including cost-increasing effects (55,56), and inconsistencies in the goals of the organisations, conflicting demands on services and problematic performance incentives. NPM practices vary across time and space. A study comparing different organisations, with varying models and local practices, can provide knowledge about the benefits of NPM and problems related to conflicting logics. It can produce a picture of how widespread problems are. Better-functioning organisational models and concerned actors' suggestions for improvements may provide us with recommendations for improvements of addiction treatment and other health and welfare services. These services consume a large share of tax revenues, and the study of the functioning and potential flaws of such organisations and governance matters to all citizens.

Theory and previous research

NPM reforms were launched as a reaction to the problems of the 'old public administration' and the Weberian bureaucratic model. It seems obvious that health and welfare services must be able to demonstrate the delivery of desired outcomes, be

held accountable and deliver efficient services in a cost-efficient manner (57). It is valuable for many service users to be able to choose services, and studies have shown that concerned actors may report positive experiences after the introduction of NPM in addiction treatment (58). However, while the overall research base is thin, there is a vast body of research suggesting unintended consequences and problems with NPM, prompting a shift towards post-NPM reforms and calls for reintegration and needs-based holism (14,35–37).

Nordic research suggests that NPM reforms of addiction treatment have prevented fundamental preconditions for effective care (40,59); created a fragmented system with linear transfer of responsibility (59), and gaps between visions and everyday practice (40). Unintended consequences of a quantitative performance measurement system were also reported for addiction treatment in an Australian setting. NPM rewarded gaming/manipulating of the system [see also (40,60)]; encouraged fragmented care provision; undermined long-term support; and marginalised less profitable people with multiple needs (61) by selecting customers [see also (43,45)]. Such 'cream skimming' may have an impact on Swedish addiction treatment that has traditionally focused on socially marginalised treatment repeaters (62).

Studies indicate that service users often are forgotten stakeholders in addiction treatment reforms (41,63). The research base is also particularly thin when it comes to the field of addiction treatment organisation and outcomes at the service user level (12,43,64). The few existing reports show some improved process performances (12). For example, pay-for-performance model reformations in addiction treatment may improve process measures such as reduced waiting list times or increased capacity use (58,64). Nonetheless, such efforts often have little (positive) impact on outcomes for the treated (64–66). An early study, relying on performances as reported by treatment agencies in the US, reported some promising results following the introduction of performance contracting in the early 1990s (67). The study showed improvements in terms of 'efficiency' (minimum service delivery) and 'effectiveness indicators', such as abstinence, reduction in substance use, referral and self-help participation, and reductions in work problems, arrests and family problems. There was also an indication of reduced employment problems (67).

However, a recent study (68) did not find a clear link between the introduction of payment by results[2] into public drug treatment and treatment outcomes in England. Treatment commissioned on a payment-by-results basis had higher rates of abstinence

[2] Payment-for-performance models usually base a proportion of the payment to a unit on pre-selected achievement indicators either referring to processes or outcomes. The goal of such a remuneration system is usually to introduce incentives to improve client outcomes [for an overview, see Maynard et al. (69), West and McLellan (70,71)].

as measured at the latest assessment within treatment than services on other payment schemes when adjusting for client complexity. There was no sign of cherry-picking less complex client groups. However, payment-by-results services had lower rates of treatment initiation following the initial presentation; and waiting times went up, probably due to an additional layer of administration introduced that lowered access. The experimental areas had lower successful treatment completion without re-representation and higher unplanned discharges. There were no substantial changes in non-injection, nor were significant differences found across commissioning models in terms of mortality, reported crime or housing status two years after treatment as compared to the period two years prior to care (68).

West (71) has argued that the UK's National Health Service system had many essential features of efficient care in place until the 1980s when an 'internal market' was created and the system was run as a quasi-market. Likewise, Stenius (55) points out that there was a good mix of services for all groups of problem users in the centrally or locally planned addiction treatment system, with few financial restrictions, in the heyday of the universalistic welfare state in the 1980s. The introduction of market solutions may in fact have diminished consumer choice, when competition in many places has implied a streamlining and uniformity of services (55,72). There are signs that some groups continue to receive extensive interventions while others, often poor and chronic problem users, are the targets of less ambitious measures (73–75). Money and local traditions also matter when social workers choose an intervention for their client (76). Thus, recent changes may have far-reaching effects on treatment availability for those with the greatest needs.

There are potentially several inconsistencies caused by external and internal demands that addiction treatment staff must respond to. Competing logics may be found in NPM's ambition to pay attention to *customer preferences, local variations (decentralised decision-making), professional autonomy and judgement, customers' freedom of choice* on the one hand and *political, administrative and financial control (including procurement), standardisation and auditing* and *coercion* in addiction treatment on the other (39,40,46). The result may be a de-professionalisation of medical and social professions or perhaps changed professional autonomy (13,14,40,46,48,49,52,77), and a potential re-distribution of power (4,49). Skilled medical and social professions are assigned more *administrative tasks* that may steer the focus away from *time spent with service users* (17,26,47,48).

There is a risk that financial considerations or tariffs become more important than needs in treatment provision among professionals (45). Fragmented demands, when the payer is separated from the service user, are also present in a quasi-market, which raises the question of to whom service providers in a competitive market are supposed to respond – to payers or substance users (4,78)? Another suggested tension is that

between *quality of care* (which is difficult to measure) and *financial and statistically oriented incentives.* NPM tends to equate quality and accountability with documentation, and most performance measurement systems measure quantitative outputs. This may direct efforts towards easily defined interventions that show good results in statistics rather than towards work that produces good long-term client outcomes (39,61). A '*commodification*' of care is suggested when diagnoses and treatments become products on a price list (15,24,40), and purchasers' demands for measurable products may alter treatment content towards *unification* (40,48,55). Care providers may become governed by purchasers and statistics (45), i.e. a sharpened tension between professional values and bureaucratic accountability (48,49). NPM may have a formative role if care producers focus on meeting administrative criteria (61).

How do care providers (managers and professionals) seek to cope with experienced inconsistencies? One alternative is to seek to secure the autonomous position of the professions, gain legitimacy and expand the professions' jurisdiction through boundary demarcation and boundary work (79,80); another is to resort to 'organisational hypocrisy'. Brunsson (81,82) theorises about organisations' exposure to inconsistent demands. Internal processes are required to cope with tensions arising from inconsistent logics. One mechanism for reconciling inconsistencies between rhetoric and practice – as well as for winning legitimacy – is organisational hypocrisy. Managers may seek to balance control and autonomy, pretending to some audiences that the control side is important, while others will hear the autonomy message; or have certain parts of the organisation specialising in control, while others focus on autonomy [see also (83)].

Organisations may seek to isolate their technical cores from external demands by establishing boundary-spanning units to buffer external fluctuations (84). Similarly, Meyer and Rowans (83) argue that the act of 'decoupling [organizational structures/activities] enables organizations to maintain standardized, legitimating, formal structures while their activities vary in response to practical considerations' (p. 357). If organisations manage to control their boundaries and environments, less buffering takes place, raising interesting questions on power relations embedded in the relationship between organisations (service providers) and their environments (policy-makers, bureaucrats and service users).

Aims and research questions

The main aim of the study, as outlined in the grant application, was to explore the application, permeation and consequences of NPM and potentially post-NPM in health and welfare systems, by studying the case of Swedish addiction treatment. We

charted national developments, and mapped and compared organisations, modes of operation and funding, means of control, logics and incentives in health and social administrations in different areas with varying models, degrees of NPM and local practices. We analysed the extent to which different tendencies of NPM in various organisational models had conveyed benefits or created experiences of conflicting logics and incentives; explored potential effects on the service user level according to staff; and examined how inconsistencies were handled by managers and professionals.

The research project as a whole applied the following research questions:

A. How is health and social care-based addiction treatment organised, governed and controlled?
B. Which benefits and inconsistencies regarding goals, performance incentives and demands are experienced by the professionals and by other concerned actors (policy-makers and bureaucrats)? Which logics and working principles guide their actions? What are the perceived/experienced consequences for the service users?
C. Are logics and principles compatible? How do professionals handle inconsistencies in the daily work?
D. To whom do professionals primarily respond (to policy-makers, bureaucrats or service users)? How is power distributed in the addiction treatment system (professional autonomy vs control)?
E. How do applications and consequences of NPM vary between regions and organisations and what are the experienced consequences?
F. Which aspects of (post-)NPM may be utilised to benefit funders, providers and service users and which are not appropriate for sectors with characteristics similar to those of the addiction treatment system?

Report structure

Besides presenting the initial rationale for the research project (above), this report provides detailed information on the study and its methods that is crucial for interpreting further analyses of the data derived from the study. The next section outlines the study setting by describing the broad government (legislation, control agencies, etc.) and organisation (division of work, etc.) of the Swedish addiction treatment system. The system is very complex and differs significantly from other addiction treatment systems internationally, such as an insurance-based system in the US (85–87). This section thereby helps the reader understand the role of various stakeholders. Next, we will cover information on ethical approval and provide details on study design and outline the data sources: official statistics, documents and reports,

observation, and most importantly interviews and a web survey. We describe the sample design and characteristics, fieldwork procedures and recruitment strategies, preparation of interview guides, details of data processing in terms of transcription and initial interviews coding, and the preparation of the web survey, data collection and some results in frequency tables in **Appendix C**.

Setting: The Swedish addiction treatment system

As explained in the Introduction, we use the term addiction treatment system to refer to the services involved in tackling alcohol and other drug problems as well as gambling problems. Sweden has a long history of alcohol treatment that dates back to the late 19th century and which has in international comparisons (85,86) been found to spend much resources on various attempts to counter addiction problems. Illicit drug use was recognised as a problem when drugs spread to subgroups already considered marginal, such as criminal gangs (88). Drug treatment was thereby established in the 1960s, and expanded heavily in the 1980s following the detection of HIV/AIDS. This expansion slowed down with the economic recession in the early 1990s; since then, alcohol and drug treatment have merged (89). Polydrug use is very common, and most treatment facilities now treat *both* alcohol and other illicit or prescription drugs. Apart from opioid maintenance treatment (OMT) specifically targeting opioid users, we see an almost total fusion of the previously separate alcohol and drug treatment systems (90).

The Nordic countries, and Sweden in particular, have held a predominantly social perspective upon the nature and treatment of addiction problems (91–94) as opposed to more medical, psychiatric or criminal justice approaches. These Swedish features are evident also in the legislation and division of work of the addiction treatment system that have remained fairly untouched since the beginning of the 1980s when new social and health care legislations were enacted.

Addiction treatment is located within public administrations. Besides state-level government, Sweden is administratively divided into *21 regions* (each with a Regional Council assembly appointed by the county electorate and a County Administrative Board [*Länsstyrelse* in Swedish] appointed by the national government). The *290 local-level municipalities* have large variations in geography, population size and other characteristics. Such heterogeneity poses challenges in providing citizens in each administrative geographic area with health and welfare services, addiction treatment included.

With only ten million inhabitants, Sweden is nevertheless quite a large country (≈407 300 km^2) with a low population density (24.5 inhabitants/km^2). The population is unevenly scattered with most people living in urban areas and in the mid-southern parts of Sweden. A cross-county comparison demonstrates that the number of inhabitants per square kilometre ranges from 348 in Stockholm, 121 in Skåne and 70

in Västra Götaland; to 40–60 in counties such as Blekinge, Halland, Södermanland, Uppsala, Västmanland and Östergötland; to only 4.9 in Västerbotten and 2.6 in the Northern regions (Norrbotten, Jämtland) (95).

Addiction treatment is regulated by general health and welfare laws with an additional law on compulsory treatment. The organisation and provision of services are primarily delegated to the regional and local public administrations governed by elected representatives. Specialised addiction treatment services are provided by the municipalities (the social services), which hold the major treatment responsibility. The regions (health care and mental health system) provide medically assisted treatment for addiction problems and treat medical complications. These two organisations are the primary focus of our study. We will also discuss non-public providers contracted by the social services, and to some extent also by the regions, when services are purchased rather than delivered in-house – i.e., NGOs and for-profit care providers such as incorporated companies.

Due to the special powers and limited individual integrity involved, the state holds the responsibility for providing compulsory care – assessed and paid for by the social services, with some state support – and addiction treatment within the criminal justice system. These state matters are not addressed in this study.

Addiction treatment is primarily tax-funded and is free of charge for the individual user, besides small fees that are strictly regulated and can be paid for by the social services if the service user lacks financial resources. Detailed descriptions of the addiction treatment system and its different parts are also found elsewhere (75,96).

The roles and responsibilities of the major treatment providers (local/regional administrations and other, non-public providers) are clarified below followed by an overview of national agencies involved in steering addiction treatment. We start off by describing the rights and duties of the self-governed local municipalities and regions responsible for organising and providing services to their citizens.

Local and regional self-government and political decision-making bodies

Local self-government at municipal and regional levels is a long-standing Swedish tradition enshrined in the Constitution (The Instrument of Government [*Regeringsformen* in Swedish]). The Swedish Local Government Act (KL; 2017:725; introduced in 1991) specifies the powers, rights and duties of these administrations and elected representatives. Municipalities and regions may levy taxation for the discharge of their duties. They may attend to matters of general concern for their area of administration or citizens, provided that these matters are not to be addressed solely by the state or

another actor. Local administrations and policy-makers decide upon the organisation and provision of social and health services, addiction treatment included, as long as they comply with health and social legislations.

The terms of office for national and local-regional elected bodies and members are four years. The primary decision-making bodies at the local level are the *municipal assemblies*, with 21–101 representatives depending on population size, and the corresponding *regional council assemblies* [*fullmäktige* in Swedish]. The bodies are elected in elections with proportional representation. The assemblies decide upon matters involving questions of principle or of major importance. These tasks include: setting goals and guidelines of activities; budget and taxation; organisation and procedures of committees and the election of committee members; election of auditors, etc.

The assemblies appoint political *municipal* and *regional council executive committees* [*kommun-/landstingsstyrelse* in Swedish] that direct and coordinate the administration of affairs and supervise the activities of other *committees/boards* [*nämnder* in Swedish] consisting of elected representatives, i.e., laymen, appointed by the assembly for the discharge of duties. Such committees differ in scope and number between administrations. They specialise in various matters (including social and health matters). They shall ensure that: activities are conducted in accordance with the goals and guidelines resolved on by the assembly and with provisions applying to the activities; activities are carried in a satisfactory way; internal checks are in place, etc. Executive and other committees/boards have an elected representative serving as *chairperson* and one or more vice chairpersons also elected by the assembly among its members. Committee meetings are to be minuted. There shall be *auditors* to inspect the activities within the sphere of each committee, and committees may authorise a *select committee*, a member or a municipal or regional employee (e.g., a senior executive official), to decide in particular matters on behalf of the committee.

Certain areas may not be delegated, such as matters relating to the goal, focus, scope or quality of activities, and matters relating to the exercise of authority in relation to individual persons.

The assembly may entrust to a committee/board to decide in certain matters in the council's stead as long as these can be delegated – e.g., are not required by law or statutory instruments to be decided by the council itself. When the budget is being adopted or funding otherwise voted by the assembly, the council may charge a committee/board with the conduct of a certain activity subject to the guidelines or other general policy decisions adopted by the assembly for the activities, unless otherwise enacted by law. The duties of the committees/boards are to decide upon management and questions which they are required by law or other statutory

instrument to take charge of. The committees/boards also prepare business for the assembly – i.e., suggest target areas and expected expenses to the assemblies in the budget process – and are responsible for giving effect to council decisions.

In regard to addiction treatment, it is the municipal *social welfare committee/board* or assigned *select committee* [*utskott* in Swedish] that will decide, based on the assessment and recommendation of the social services, if an individual shall be committed to compulsory care (the final order is made by Administrative Court). The social welfare committee may either make decisions themselves regarding voluntary institutional care or have such decisions delegated to officers within the social services, usually trained social workers. *The social welfare committee/board, which consists of elected representatives, i.e., laymen and not treatment professionals, is thereby involved not only in the steering and control of addiction treatment but also, at least partly, in individual-level daily treatment practices and decision-making.*

Importantly, the number and structure of local committees/boards and their areas of responsibility vary across time and administrations. For example: Municipalities with a pronounced purchaser–provider split may choose to have a special provider committee/board. In such cases, treatment provision may belong to a provider committee, whereas needs assessment and treatment decisions (statutory social work) are assigned to the social welfare committee/board – i.e., the social services belong to one committee/board, whereas the actual services are organised within another handling the production of care. Some municipalities have a broad social welfare committee handling most welfare issues, while others opt for an eldercare committee, etc. Financial support often belongs to the social welfare committee, but such activities may also be assigned to a committee for work or employment.

Municipal and regional council assemblies may transfer the management of a local government concern, for the conduct of which no special procedure has been prescribed, to a limited company, incorporated association, a non-profit association, a foundation or a private individual. Concerns which include the exercise of authority, such as decisions regarding a person's right to addiction treatment following a needs assessment, may not be transferred to non-public providers. Local governments that enter into agreements with various providers shall ensure that the municipality or region is guaranteed an opportunity to follow up on the activities.

As concerns local economic administration, the Swedish Local Government Act (KL) stipulates that municipalities and regional councils shall exercise good economic management in their activities. Municipalities and regions shall administer their funds in such a way that requirements of a good return and adequate security can be catered for. This implies that budgets shall be drawn up so that incomes exceed expenditures. The annual budget must contain a plan for activities and economic management

during the fiscal year. If expenditures exceed income, the deficit must be adjusted and the net equity as entered in the balance sheet restored during the two succeeding years.

Organisational diversity

The local government reform and the establishment of the KL in 1991 implied that local/regional public administrations were given greater freedom to organise political and administrative functions – e.g., organisation of committees and the delegation of affairs to committees/boards, elected representatives, and officials. The municipalities and regions were also imposed requirements of good economic administration (97). A less detailed central regulation had been initiated already in the 1960s while Management by results in state activities was legislated in the late 1980s (8).

The government shall determine objectives and main directions as well as available resources for state activities, and responsible agencies are to be given increased responsibility to fulfil these tasks. *What* to do is decided by the government, who also shifted focus from budgeting towards follow-ups and evaluations of results. *How* to do it – the means – are chosen by the responsible agencies. Accordingly, one of the goals of the local government reform was to enhance such target and performance management.

Local/regional administrations have since the 1990s shown great enthusiasm in experimenting and reforming their organisations for ideological or cost-saving reasons grounded in local conditions (98,99). Many municipalities/regions reduced the number of political committees. The diversity is now so vast that basically every municipality/region has a unique organisation, uses various hybrid forms and continues to change. It is therefore not meaningful to outline exactly which models are applied at a certain moment. However, most municipalities/regions still adhere to a traditional model of appointing a number of specialised committees responsible for certain matters. Other main alternatives are to divide responsibilities in accordance with geographic areas, concentrate power to the assembly or executive committee with just a few mandatory committees/boards or to adhere to a purchaser–provider split (99).

Many reforms sought inspiration from NPM. Some of the most important choices for public administration became whether to produce services in-house or transfer such activities to the market, how to organise the relations with the producers and how to arrange the internal structure (degree of decentralisation or disaggregation) to facilitate discretion and monitoring. Mattisson (98) explains some of the most common variations in expressions found in terms of management techniques: purchaser–provider models (with competition), entrepreneur providers, results units, corporatisation, public and private partnerships, increased local autonomy, systematic

comparisons (benchmarking) across providers, privatisation, quality and management systems, systems of choice and vouchers, models of target and performance management, reward systems, key figures and operational measures in monitoring systems, units specialised in auditing, and accrual accounting as opposed to general cash flows.

The purchaser–provider model and contract government – emphasising competition between providers and creating internal markets – is of great interest to our study and is therefore further explained [see also p. 287 onwards in SOU 2013:53 (99)]. Such splits were first introduced for goods in the 1980s and have since spread to health care and social service sectors. The arrangements and terms in applying such a model differ but the basic idea is a separation between policy-making and service delivery: purchasers and policy-makers focus on strategic government, goalsetting, guidelines, terms, budgeting, whereas contracted providers are to realise the order and deliver the agreed outputs as they choose, and are reimbursed accordingly by means of the chosen reimbursement model (block grants, payment-by-results, etc.). Generally, a political committee/board and its administration order and buy services internally from their own public sector providers within the administration (belonging to another part of the organisation or another committee) or buy externally from non-public providers or sign agreements with a certain provider committee in charge of production of care within the public administration.

The idea behind this system is that both purchasers and providers can focus on their area of responsibility (*what* versus *how*), citizens' may be able to choose between different providers, the division of labour and thus accountability can improve, and awarding contracts for public services on the basis of competitive tenders can drive down costs and lead to more efficient services. Commonly occurring organisational reforms obstruct proper monitoring, but SOU 2013:53 states that about 30 percent of the municipalities applied purchaser–provider models within some public matters in the early 2000s (99).

Social services-based addiction treatment: local municipal administrations

The social services are populated by officials (social workers and other social or behavioural professions) and located within the municipal public administration governed by the elected representatives and bodies described above. Ultimately, it is the municipal assembly that is responsible for addiction treatment. The assembly usually delegates this activity to a political *social welfare committee/board*, to which officials and social workers in the social services administration report.

Notably, there is little available statistics on the composition and competence of addiction treatment staff in Sweden. Statistics from 2008 by the National Board of Health and Welfare (NBHW) regarding municipal outpatient addiction treatment conclude that 28 percent of the staff had social work training, 22 percent had some post-high school relevant training for addiction treatment (e.g., treatment assistants), and 12 percent were nurses. Three percent were medical doctors, 3 percent psychologists and 4 percent mental health or other nurses (quoted in Table 30.1 on p. 926 in the '*Misuse inquiry*' (100)). For inpatient treatment there was no exact information (apart from compulsory treatment excluded in our study). Many positions in such facilities as well as in HVB homes, e.g., mental health nurses and treatment assistants, do not require a university education. There are no minimum *requirements* for a HVB home in terms of staff competence other than that the director must have a relevant university degree. Other staff shall have the competence required for the tasks; the NBHW *advises* at least two years of post-high school studies (101) (see below). Lundström et al. (102) estimated the number of staff in both public and private out-patient and inpatient addiction treatment in 2015 to about 5000 employees. Our guess is that the composition of the staff has not much changed since 2008.

Needs-based voluntary care, 'free utility' and coercion

The general rules are that addiction treatment is voluntary and based on a proper needs assessment. In some cases, compulsory care may apply, but models of 'free utility' without needs assessment challenge current legislation.

The Social Services Act (2001:453 [*Socialtjänstlagen (SoL),* in Swedish]), first enacted 1982, regulates social work duties and activities funded by local taxation. The law stipulates that the basic responsibility for (long-term) treatment and potential cure of addiction problems lies with the municipal social services. The law establishes that the social services shall provide individual citizens with the help and care they need to recover from alcohol and other illicit drug problems (as of January 2018 also gambling problems). Society has to promote every citizen's right to economic and social safety, equality in living circumstances and active participation in societal matters. A reasonable standard of living is guaranteed. The law claims the importance of self-determination and user involvement, but it also stresses the responsibility of each individual for his/her and others' situation. Treatment shall be designed, chosen and implemented together with the service user, who has the right to appeal against municipal treatment decisions in their own case. Administrative appeals are determined by the County Administrative Court that can annul a municipal decision and force the municipality to implement a new decision.

Individual problem users may present themselves or be referred to the social services by various authorities or significant others. The service user first meets with a social

worker/officer for a needs assessment and service decision, or return to this officer for follow-up and assessment of additional interventions. According to SoL and related statutory instruments (103), the social services must properly assess the service user's needs, make a treatment decision (or rejection), write a plan for the services to be provided, follow up the treatment and properly document all procedures, preferably in a well-structured way that is easy to track and inspect. The records must be updated continuously and include information that is deemed important, sufficient and appropriate in relation to the assessment, application and treatment. These procedures are essential for the rule of law and the legal rights of the individual (103).

Needs assessments may take a long time and be considered too bureaucratic. Following the lead of Linköping municipality in the 2000s, some municipalities have chosen to offer *free utility services* [*serviceinsatser, fri nytta* or similar terms in Swedish] without formal registration or assessment. Some municipalities allow for three counselling sessions while other municipalities allow for many more. The arguments for such free utility models are that easily accessible services and confidentiality will bring more people into treatment when they are motivated to change, strengthen their agency and offer greater services to the citizens (104).

However, the national control agency (first the County Administrative Board [*Länsstyrelsen*, in Swedish], later the National Board of Health and Welfare (NBHW), and as of 1 June 2013 the Health and Social Care Inspectorate (IVO)) now rejects the free utility model. In 2009 the County Administrative Board criticised an addiction treatment unit in Linköping and claimed that the activities must be subject to proper individual-level needs assessment and decision-making in accordance with the SoL. The municipal outreach obligation, motivation efforts and possibility to appeal decisions have been highlighted in the debate – values and activities that are downplayed in these models. The NBHW took judicial proceedings against Linköping by filing an application to Administrative Court in 2013. The verdict of 2014 decided that Linköping did not have to pay a fine but the court did not take a stand in regard to municipalities' right to offer free utility services. The case of the legality of such welfare services has therefore been carried to higher court. In 2016 the final court of appeal declared that the Supreme Administrative Court will not consider this case to provide any further guidance for how these cases shall be considered. The legality of free utility remains unclear. Some municipalities apply it until a final declaration is made by the legislator or court.

If deemed necessary according to *the Care of Abusers (Special Provisions) Act (1988:870)* [*Lagen om vård av missbrukare i vissa fall (LVM),* in Swedish], the social services shall assess addiction problems and report the service user to the Administrative Court that decides upon civil compulsory care commitments for a maximum of six months. Such treatment applies if an individual due to proceeding

misuse is in need of treatment and does not consent to voluntary measures; and there is an obvious risk that s/he might endanger his or her physical or psychological health, or destroy his/her life, or seriously harm her/himself or someone close to them. It is the social welfare committee that applies for such coercive care based on the recommendation and assessment made by the social services' officials.

Compulsory care usually starts with institutional care at special LVM homes run by the independent Swedish government agency the National Board of Institutional Care (SiS)(105). The state provides this kind of treatment because of the coercion and special powers involved. Compulsory care is therefore purchased from the state but is paid for by the social services administration responsible for the service user. It is expensive and fairly seldom used in practice (around 1000 service users annually) but the law has broad implications in daily practice, as it may be used to urge people into voluntary treatment (106).

In-house or purchased care

Disregarding free utility models and compulsory care, the general rules are that a service user with a treatment decision from the social services shall be provided with care that meets the needs – e.g., personal and/or material support, or advice. This can be made directly in-house if the municipality has chosen to provide services run by the municipality. In a generalist approach, the treatment may be provided by the same social worker that exercised authority in regard to the service application. Alternatively, and by now more commonly, the actual treatment intervention is provided by specialised in-house service providers, e.g., at outpatient treatment or housing facilities run by the municipality (specialisation). Some municipalities have chosen a very clear specialisation or division of labour in which the needs-assessing and decision-making social worker orders the services from or refer the service user to the in-house units providing the intervention. Such specialisation may occur with and without an overarching purchaser–provider model (see above). Either the social services hold a budget covering both decision-making and in-house specialised treatment, or the municipal purchasers have ordered and contracted a certain annual amount of treatment to be delivered by each in-house unit, or the referred service user is accompanied with a voucher or pre-decided payment in a more clear-cut purchaser–provider model or internal market. In other cases, a service user with a treatment decision may be referred to a service run by a non-public provider, contracted and payed for by the social services – if an administration with in-house services does not offer the required service that will meet the need of the individual or if the administration has made a more general decision to purchase services. Different forms of inpatient or residential care, outpatient treatment and various forms of housing services, are thereby purchased in accordance with LOU or LOV from non-public

providers such as NGOs and for-profit enterprises. LOU and LOV are further outlined below (see Central government control and supervision).

Unknown mix of addiction treatment organisational models

As mentioned, the exercise of authority in formal service decision-making according to SoL and LVM must be part of the public administration and cannot be delegated to another provider. In addition, compulsory care must be purchased from the state (LVM homes run by SiS) if a person is committed to such care.

Municipalities may also apply a mix of organisational models and service provision as indicated above. They may provide most types of services themselves, in-house, and only occasionally purchase services in cases when they cannot respond to the needs of individual service users themselves. Municipalities may choose to purchase most services and provide very little or no treatment in-house. It is also possible for municipalities to introduce competition between the in-house public providers and other providers, either by means of Systems of choice (LOV) or procurement processes (LOU) in which municipal in-house units are invited to submit tenders and compete with other applicants about running treatment. The municipality may thereby hand over a unit previously run in-house if another provider assures that it can produce the same treatment at a lower cost. These choices regarding organisational models may relate to the population basis (size, problem level, income/wealth, etc.) and ideology, because the administrations are governed by political parties (90).

The general trend within the in-house organisation of social services' *Individual and family care* [*Individ- och familjeomsorgen (IFO)* in Swedish] since the 1980s has been a move away from integrated generalist models of work based on holistic views towards specialised groups with high competence in specific tasks dominated by evidence-based methods (EBP). The specialisation may be based on types of problems if working groups are organised to meet certain problems (e.g., addiction problems, economic or family problems) and on tasks such as intake, needs assessment and provision of services (107,108). In 2005, Bergmark and Lundström (109) concluded that the social services presented far more diversity in local organisation than before. Organisational changes frequently occurred as responses to political change, professional influence, economic restraints or other demands. Whereas specialisation appeared like a tangible and stable development, other organisational changes were rather short-lived fashions or trends.

There is no good overview of local-level organisation of addiction treatment. All of the above point to vast variations. We can add the varying and changing divisions of labour across local committees and accompanying official levels – i.e., whether addiction treatment is politically and practically coorganised with disability care,

social psychiatry, eldercare, etc.; if the dividing lines focus on purchasers or providers; or if all addiction-related activities (assessment, decision and provision) belong to one committee and to one single organisation.

A comprehensive SOU report – the '*Misuse inquiry*' (110) – sought to review the organisation of the municipalities, institutional care (HVB), compulsory care (LVM homes) and regional dependence care (see the next section for the organisation of health care) in 2009. As expected, the review showed large variations in the supply of services, how the municipalities organised addiction services internally as well as the local-level divisions of labour and the division between the municipalities and the regions. In general, areas with large population sizes often had units specialised in addiction problems, whereas less populated areas often did not. In such small municipalities, social workers were more often generalists handling all sorts of social problems and often also providing services themselves, besides exercising authority in assessments and treatment decisions. Addiction care usually belonged to the municipalities' IFO section. Larger municipalities often offered a range of in-house services with emphasis on psychosocial treatment (EBP like Motivational Interviewing and Cognitive Behavioural Therapy) and support (housing, occupation, financial support and employment). The municipalities had different strategies regarding the use of institutional care (HVB) and compulsory care (LVM) (110). The IVO (111) has criticised the use of in-house services, such as a municipality's own outpatient unit, in cases where municipal policy-makers, managers or local guidelines state that the internal services shall be given priority, that the municipal unit is generally to be tested before other measures or providers can be considered in individual cases [*hemmaplanslösningar* in Swedish]. IVO stresses that the individual needs assessment always shall be given priority over such general guidelines, that the services shall always meet the needs of the individual and be grounded in best available evidence, and that political goals must match legislation.

The inquiry (110) divided the municipalities into areas with more or less than 40 000 inhabitants and noticed that 65 percent of the larger areas had specialised units in 2003 compared to 41 percent of the smaller municipalities that more often had integrated units (41 vs. 14%). The inquiry further summarised (pp. 572, 578–580, Tables 15.5 and 15.6) the NBHW's inventories of outpatient addiction treatment: most of the outpatient units in 2008 were in larger municipalities (70 000+ people). Municipalities with smaller populations had a lower share of the units.

A more recent mapping of ten municipalities in the southern part of Stockholm county (112) shows large variations in outpatient addiction services. The municipalities differed significantly in terms of organisational models (purchaser–provider models, focus on in-house services, etc.) and if and how they used a free utility model. Municipalities with larger population sizes offered a wider range of services. Most of

them reported using widespread evidence-based methods (relapse prevention, twelve-step programmes, motivational interviewing), but other interventions were also reported.

Health care-based addiction treatment: regional administrations

The Health and Medical Services Act (2017:30, first enacted in 1982) [*Hälso- och sjukvårdslagen (HSL),* in Swedish] and the additional *Patient law* (2014:821) [*Patientlag* in Swedish] guide addiction treatment, usually labelled as the treatment of dependency in a health care setting. The regional council's elected assembly and its health care system are responsible for providing medically assisted detoxification and other emergency services; medical and psychiatric care for alcohol- and drug-related disorders (and as of January 2018 also gambling); and pharmacological treatment including opioid maintenance treatment (OMT) that is further regulated by the NBHW (113). Treatment is usually provided at outpatient units, but detoxification and emergency care are often initiated at inpatient hospital wards. A regional council assembly may decide to implement needle exchange programmes as regulated by a special *Law (2006:323) on needle exchange programmes* (NEP) and statutory instruments by the NBHW (114–116). For long, the Swedish drug policy, which aimed for and continue to aim for a drug-free society, opposed harm-reducing efforts such as NEP (117). Two programmes were opened in Lund and Malmö in the late 1980s and run as trials. It was not until the enactment of the NEP law of 2006 that other regions were allowed to provide such programmes. They did, however, need municipal approval, and no new programmes were established in practice. This municipal 'veto' was abandoned in 2017 (118). NEP is up for debate in many regions, and new programmes are established (119).

HSL and the Patient law stress good-quality evidence-based treatment on equal terms. Care shall be provided with respect for the equal dignity of all people, for the dignity of the individual and shall be founded on respect for the patients' self-determination and privacy. As opposed to SoL, HSL spells out priorities and stipulates that priority be given those whose needs of health and medical care are the greatest. Costs must be considered justifiable in treatment decisions. An individual patient cannot, according to law, require a specific treatment. It is the medical doctor who is in charge of the treatment decisions. The treatment is often carried out by other professions, such as nurses. Also, health care decisions cannot be the subject of appeal unlike decisions in the social services. Dissatisfied patients can complain to IVO, which supervises both health care and social services.

The organisation of dependence treatment varies across regions. Some advanced

regions have set up specialised dependence care sectors, either as independent organisations or subsections within the mental health organisation. Less specialised regions may have some specialised wards or have most patients with addiction problems treated within general psychiatry. Primary care serves varying and different purposes in terms of dependence care in these regionally planned systems.

It is mandatory within general primary care to establish a System of choice, as described above and regulated by LOV. This may also apply to outpatient dependence care, and it appears that such a system of choice may offer more options to some patient groups but not to other patient groups such as the more socially marginalised service users in need of services from multiple providers (72). The only specialised dependence treatment activity specifically subject to System of choice according to LOV, and thereby announced in the national System of choice database (120,121), is OMT in the southern region of Skåne. Patients have been able to choose their OMT provider since 2014, and a recent evaluation concluded that the number or units increased from seven public and one private unit in 2014 to 18 in mid-2017 (of which eleven were run by private providers). Access was significantly improved and waiting lists disappeared. Most of the newly established units operated in areas that already had existing OMT units – hence increasing choice in some areas whereas geographic inequalities remained; the outspoken goal to differentiate OMT care was not reached; and opioid-related mortality did not decrease but increased (122).

Regions may, like municipalities, choose if they prefer to provide in-house treatment or open up for competition and non-public providers, either by means of LOV or LOU. Reimbursement models for internal as well as external providers, as specified by the regional-level purchasers, also vary greatly across medical sectors and regions. Some models are primarily based on block grants, some parts may be adjusted to population parameters in the catchment area (capitation), and parts of the reimbursement may be based on a payment-by-results scheme in terms of various process outcomes such as number of visits or days in inpatient care, etc. (123,124). Reimbursement models also vary across medical specialties and treatment forms *within* a region. There is no compilation of reimbursement and funding models applied in terms of dependence care in Sweden.

The *Misuse inquiry* (110), cited above, reviewed the organisation of dependence care in five regions in 2009: Jönköping, Västerbotten, Uppsala, Halland and Jämtland. It is evident that also these parts of the addiction treatment system presented vast variation in regional-level organisation of addiction treatment, local-regional divisions of labour and the supply of services. Some regions had specialised dependence care units. Treatment was most specialised in regions that had set up dependence centres. Other regions had specialised units within psychiatry. Some regions did not have any specialised care for dependence. Some regions provided a

range of treatments, including psychosocial care, whereas others only provided detoxification in inpatient wards and referred patients to the municipality for other types of care (110). Table 15.2 in the inquiry showed that 13 out of 20 regions had specialised dependence care to some extent: Stockholm, Uppsala, Sörmland, Jönköping, Kronoberg, Kalmar, Skåne, Västra Götaland, Värmland, Örebro, Västmanland and Dalarna. Seven had units integrated with psychiatric care: Östergötland, Blekinge, Halland, Gävleborg, Västernorrland, Jämtland and Skåne. Jämtland also had another organisation. In 2003, Stockholm, Örebro, Uppsala, Skåne and Västra Götaland had the highest staff resources. Kalmar, Värmland and Östergötland had the fewest staff resources. Variations were huge in inpatient care (summarised in the inquiry's Table 15.3) regarding resources and organisation across regions.

Legislated collaboration: broad and individual-level agreements

The sections above have sought to specify the responsibilities of the municipalities relative to the regions concerning addiction problems. It is clear that these two administrations have a joint responsibility to deal with people suffering from substance use within their joint geographic areas.

Collaboration problems between (and within) health care and social services, and between other organisations involved such as SiS and other non-public providers, have been discussed for decades – both in more general terms (125) and regarding substance users (126,127). Reports have frequently been published about service users falling through the cracks in this system with unclear boundaries and split budgets. The critique culminated in a proposal by the *Misuse inquiry* (110) that in 2011 sought to remedy the collaboration problem by transferring the main addiction treatment responsibility from the social services to the health care system so that one principal administration would be in charge instead of two.

Few question that the health care system is responsible for medically assisted detoxification and other pharmacotherapies whereas the social services shall provide individuals with general support (financial and other supporting interventions to help people with housing, occupation, etc.). However, laws and local-level experiences speak of uncertainties in regard to who is responsible for early detection and interventions, lighter sobering up or detoxification stations (without pharmacotherapies) and the handling of those brought into custody or emergency ward by the police to sober up (LOB). In addition, the revised national addiction treatment guidelines issued by the NBHW (128) states that psychosocial treatment methods that until now are more widely used in the social services shall be applied by

both regions and municipalities. The guidelines further stress collaboration between the social services, mental health care, dependence care, and primary health care.

The opposition against moving the treatment responsibility from a social to a medical setting was quite solid (93). The Government therefore decided on a middle-ground alternative (129,130) with legislative changes in HSL (Chapter 16) and SoL (Chapter 2) that implied continued shared but clearer responsibilities and demands for enhanced collaboration. As of July 2013, regions and municipalities are obliged to enter locally designed agreements that are grounded in a holistic approach, account for local conditions and regulate the responsibilities and tasks of both administrations regarding services for people suffering from problems with alcohol, illicit drugs, prescription drugs and doping. The goals were to improve treatment availability and to safeguard good-quality interventions. It was stressed that medically assisted treatments and psychiatric interventions were more effective when provided together with psychosocial treatment and support offered by the social services. The agreements shall include joint goals, division of resources and responsibilities, and overarching collaboration efforts.

SoL (Chapter 2 Section 7) and HSL (Chapter 16 Section 4) further state that the two administrations must draw up a joint and coordinated individual plan [*Samordnad individuell plan (SIP)*, in Swedish] for each service user in need of assistance from both the health care and social services systems – i.e., in cases when either the region, the municipality or the individual think a SIP is necessary in order to meet the needs of the individual. The plan shall preferably be established together with the service user. It regulates the responsibilities of each provider, and a SIP shall state what interventions that are needed, which actions are to be taken by each care provider (region, municipality and other providers) and which of the principal administrations have the overall responsibility for the plan.

In late 2017, the NBHW (131) presented the first report based on open comparisons data collected jointly from addiction services within both the health care system and the social services. The report concluded that collaboration – according to the indicators – was improving but pointed out that more than half of the municipalities still lacked a joint agreement with the health care system and that there were big variations across regions. Besides a slow implementation of the overarching agreements, committees and officials have been found to be unaware of existing general agreements between administrations, and individual-level SIPs may not be drawn up in practice (111,127,132,133).

Non-public providers of addiction services

As outlined above, addiction services funded by local or regional public administrations may according to KL be *provided* by another legal entity if such a decision has been taken by the municipal/regional council assembly. These legal entities include non-public providers such as not-for-profit foundations and associations (NGOs) and for-profit enterprises of various sizes (ranging from single entrepreneurs to venture capital companies). The public administration is responsible for following up the purchased care to safeguard that it meets the required quality criteria and the assembly's goals and guidelines. Such monitoring has been problematic when services are scattered across actors. The government has therefore sought to improve transparency by establishing a provider register [*utförarregistret*, in Swedish] and has made revisions of KL in force as of 2015. Public administrations must receive enough information regarding contracted-out services be able to provide citizens with a reasonable level of transparency; they must monitor activities of private enterprises; and have goals and guidelines for activities and services provided by private actors (134,135). Notably, follow-up or any registers covering aggregate or individual-level addiction treatment outcomes are missing in Sweden (133).

The general picture is that for-profit providers are becoming more common in the provision of social services (32,44,90). Information on private provision of addiction treatment in health care settings is missing. We will not discuss LVM homes run by SiS in this section, as SiS is as a public provider only offering compulsory care.

Outpatient care: primarily run by public providers but with increasing presence of private provision

Data is scarce on producers of outpatient addiction treatment. Table 15.7 of the *Misuse inquiry* (110) with information on providers of outpatient care in 2007 found that 81 percent of the 321 outpatient treatment units were publicly run, 14 percent were run by private enterprises, four by NGOs and one percent by other providers. It was clear in terms of the public units that the municipalities dominated the service provision with 54 percent of the 321 units, followed by 15 percent run by regions and 12 in collaboration between these two public administrations (110). More recent studies of the development, based on the municipalities' annual accounts, indicated that since 2009, outpatient care has been more often purchased than produced in-house and that for-profit enterprises are increasing their share of purchased outpatient care at the expense of outpatient care provided by NGOs (90).

Institutional care: primarily run by private providers

Non-public providers have primarily been a matter for institutional addiction

treatment and support[3]. The most typical form of treatment is institutional care at a HVB home. HVB is regulated by SoF and refers to *homes for care and living*: treatment is provided in an institutional setting and should, as stated by SoF, be carried out professionally. An intervention at a HVB home shall be adapted to the needs, wishes and circumstances of the individual service user, and the activities must be run in continued collaboration with the social services administration responsible for providing the individual with care.

A permit issued by IVO is required for non-public providers[4] who wish to run a HVB home. The permit safeguards good quality and safety. It includes information on: type of activity; provider type; how the activity is run; target groups; funding; director and who has the right to represent the association, foundation or company; and information on the facilities, staffing, and the skills and experience of the staff. Blueprints and information on fire protection are to be attached.

Certain requirements for the HVB homes are decided by the general SoL, SoF, IVO and special provisions (101). Included are demands regarding the qualifications of the director and the staff, and proper staffing across all hours that suits the needs of the service users staying at the facility. The director must be qualified to lead, develop and follow up on the activities; have a relevant university degree (e.g., social work, behavioural sciences); have experience of similar work; and be judged suitable for the position. Other staff shall have the education and skills required and be suitable for the job in accordance with the unit's operations. It is suggested (101) that staff have at least two years of post-high school studies and that most of the staff be educated in social work, behavioural sciences or pedagogics.

A management system for systematic quality work, as stated by special provisions (137), must be in place to determine the principles for the management of operations. Quality refers to an activity meeting the requirements and objectives relating to activities in accordance with the laws and other provisions on social services and health and medical care. For example, systematic self-monitoring must be in place that monitors and evaluates a unit's activities together with verifications that they are

[3] Voluntary care in private homes, as specified by SoF, has a long history in addiction treatment. There is no inventory of the number of available families or private homes. Such interventions are however marginal and decreasing in importance following the quest for EBP [see Chapter 15 of the *Misuse inquiry* (110)]. Families that receive a person for stable housing or care are usually non-professionals and only granted a small emolument paid by the social services in return for offering the person with a meaningful environment. Voluntary care in private homes is not in focus in our study.

[4] The legislator has not expressed a need to require a permit issued by IVO for publicly run HVB homes, because such a public legal entity is expected to be well aware of requirements and quality issues (136).

carried out according to the processes and procedures in the unit's management system. The general advice issued by the NBHW (101) lays down that self-monitoring includes assessments of whether the methods applied are evidence-based and carried out correctly, if and how the service users are involved in the treatment, if the goals of the responsible social welfare committee are fulfilled, etc. Collaboration must be made possible with other activities, other public or non-public providers, and authorities. There must also be procedures for keeping the HVB home free from misuse and for assessing whether to admit a certain service user or not, i.e., if the HVB home has the proper qualifications to meet the needs of the individual and whether he/she fits the target group of the facility.

In summary, a HVB home may choose which target groups it wishes to treat and how as long as it adheres to legislation and provisions. The NBHW (136) reviewed the quality of HVB homes for adults with addiction problems in 2015. The board concluded that there were about 200 HVB homes providing round-the-clock institutional care and targeting adults with addiction problems. About 80 percent of these were run by non-public providers. A longer time perspective reveals that for-profit providers have increased their share over time in this treatment sector (44,90).

Official statistics for the social services on adults with addiction problems collected as an electronic survey to the municipalities by the NBHW (138) on November 1, 2016 indicated a total of 745 556 days in voluntary institutional care in 2016. The majority of these (N=540 146; 72%) were delivered by a non-public care provider, 23 percent (N=172 803) by a public provider, while a small part (N=32 607; 4%) was delivered in collaboration between a public and a private provider (**Table 1**). The percentages for single municipalities range from 0 to 100 percent as produced by public and non-public providers, respectively. As shown in **Table 1**, the average percentages of institutional days produced by public providers in municipalities within the different counties of Sweden ranged from only four percent in Gotland to 41 percent in municipalities in Blekinge and in Gävleborg.

Table 1. Percentage of total number of days (N=745 556) granted in voluntary institutional care for adults with addiction problems during 2016 by type of provider. [a]

	Public provider	Non-public provider	Jointly (public & non-public provider)
Sweden in total	**23**	**72**	**55**
Municipalities in the following regions			
Stockholm	33	64	3
Uppsala	12	86	2
Södermanland	28	67	5
Östergötland	9	91	0
Jönköping	19	80	1
Kronoberg	19	80	2
Kalmar	37	55	8
Gotland	4	96	0
Blekinge	41	30	29
Skåne	29	66	6
Halland	22	78	0
Västa Götaland	15	82	4
Värmland	29	67	4
Örebro	7	81	12
Västmanland	15	85	0
Dalarna	5	85	11
Gävleborg	41	59	0
Västernorrland	7	93	0
Jämtland	23	72	5
Västerbotten	9	91	0
Norrbotten	19	63	17

[a] Based on numbers presented in Table 6b in NBHW's official social services statistics (138).

Despite the gaps in the information on various providers and particularly so for the health care system, the *Misuse inquiry* (110) sought to provide an estimate of providers of round-the-clock services for people with addiction problems during 2010. The conclusion was that around 42 percent of the inpatient units were run by private legal entities, followed by 18 percent run by NGOs, 18 percent by municipalities, 15 percent by the regions, one percent jointly between municipalities and regions, and six percent by the state (i.e., LVM homes). Private legal entities and NGOs had primarily HVB homes, while the regions focused on inpatient wards within mental health, and municipalities offered HVB and voluntary care in private homes. It remains unclear what is included in this comparison, based on unpublished data, as it only covers 223 inpatient units and it is estimated that there are about 200 HVB homes.

Prevalence and addiction treatment statistics

There are no reliable statistics on the number of adults with addiction problems in Sweden (with about 10 million inhabitants). However, the *Misuse inquiry* (110) and the addiction treatment guidelines issued by the NBHW (128) have established widely accepted estimates. As concerns alcohol, 780 000 adults are estimated to have alcohol problems, of whom 330 000 would qualify as dependent (139,140). Other estimates based on those treated with an alcohol-related diagnosis within the health care system suggest that 80 0000 Swedes have severe alcohol problems (100).

In terms of illicit drugs, case-finding studies suggested that Sweden in 1979 had 15 000 'heavy illicit drug users' reporting any injection use in the last twelve months or (almost) daily use of illicit drug in the last month. This estimate increased to 19 000 in 1992, and to 26 000 in 1998 (141). The *Misuse inquiry* further suggested that the number of Swedes with drug addiction or dependence amounted to 55 000, and 8 000 of these were estimated to have intravenous use (110,140). Another NBHW estimate (128) suggested that the total number amounted to 29 5000 persons (based on those with a drug-related diagnosis in the health care system and the number of people with heavy drug use in the criminal justice system). In addition, 45 000–65 000 people may have problems with prescription drugs (110,140).

It is often repeated in the public debate that only one in five people with addiction problems enters treatment (100). However, there is also a lack of proper statistics on the number of people treated due to the lack of a joint national register covering all interventions provided by all administrations and providers (71). The NBHW (136) recently concluded that 'There is a lack of an updated picture of the treatment landscape in terms of the content of institutional care and the development and scope of the content of outpatient care' (p. 8). The board intends to start a proper mapping. As noted above, follow-up of treatment outcomes is basically missing (133). Despite these shortcomings, the various registers and statistical series may be used to provide an overview.

Official statistics for the social services on adults in addiction treatment according to SoL and LVM collected[5] by the NBHW (138) on November 1, 2016, showed that *individual means-tested outpatient care* was the most common form of intervention with 10 627 people (31% female) in such care during that day, followed by 6247 in *housing assistance* (25% female)[6], and 2450 people (26% female) in round-the-clock

[5] Data is gathered by means of an electronic survey to all municipalities, which are obliged to reply, and by gathering data from the County Administrative Courts and SiS on LVM. There is no statistics on interventions offered as free utility services.

[6] Of the housing assistance measures, 47 percent were long-term interventions, 34 percent referred to transitional housing and 19 percent were emergency interventions.

care, of whom 1904 (25% female) were in voluntary institutional care (SoL; HVB), 384 (29% female) in compulsory care (LVM), and 162 (32% female) in care in private homes (SoL or LVM aftercare). Notably, a single service user may have several means-tested interventions approved during one single day. All municipalities reported their interventions but accuracy may vary.

Somewhat less reliable calculations for the entire year of 2016 indicated that about 10 977 people received housing assistance, 7147 got voluntary institutional care, and 368 were in voluntary care in private homes. The average number of days in such round-the-clock care per service user was 104 days in institutional care, 146 days in private homes and 209 days in housing assistance (138).

Long-term, voluntary institutional treatment (SoL) decreased by about 30 percent between 2006 and 2016, whereas the number of people in compulsory care increased by 33 percent and the median age among those committed to LVM decreased from 40 years in 1994 to 34 years in 2016 (138). The expansion of outpatient care started already in the 1940s, and the number of units remained quite stable during the 1990s through 2007 with around 300 units. Most of the outpatient units are located in big cities and in bigger municipalities (110).

The above-mentioned report by the NBHW (131) concluded that 180 000 persons (31% female) with an alcohol diagnosis and 131 000 (33% female) with a drug diagnosis (prescription drugs included) were found in specialised addiction treatment in the health care system in Sweden during 2011–2015.

The *Misuse inquiry* (110) may again provide some examples. Stockholm County has the most advanced dependence centre with about 22 000 patients in 2008 (with 240 000 outpatient visits and 22 500 inpatient days). The Örebro dependence centre had 2400 patients in 2009 (31 000 outpatient visits and 900 inpatient admissions). Another indicator provided by the *Misuse inquiry* (Tables 15.9, 15.10) refers to the costs of handling addiction-related conditions within the two public administrations. It is estimated that the social services spent about SEK 5.5 billion on addiction problems in 2009 based on the annual accounts. The costs are increasing over time, but treatment of addiction problems within the social services is increasing less than other municipal service areas. The costs for the regions are less exact, because dependence care is not registered separate from other psychiatric care in annual accounts, budgeting, etc. It was, however, estimated in the inquiry that the total costs amounted to SEK 2.8 billion for specialised inpatient care, and to 3.1 billion for specialised outpatient care in 2010.

Central government control and supervision

As pointed out in *Local and regional self-government and decision-making bodies* (above), Sweden has far-reaching local self-government, and the addiction treatment *system* is increasingly re-conceptualised into an addiction treatment *market* that, at least in theory, is regulated only by 'an invisible hand' (142). However, the field of addiction treatment, like most other administrative areas, is also subject to extensive national-level steering by the government and its government agencies.

In practice, as articulated by Bergmark (143), 'markets often tend to be the target of different attempts by actors other than sellers and buyers to organize or re-shape markets. Such attempts may involve setting standards for the goods or services exchanged and supervising that the rules of standards are adhered to … activities that contribute to establish guidelines for how a market should be (re)shaped or work according to some (group of) actor(s)' (p. 568–9). Furusten (144) stressed the involvement of central government in implementing and shaping public procurement. Likewise, the discussion on how to balance local autonomy and national-level interests and values, like equality in access and services, has a long history and was, for example, much debated in the 1980s with the establishment of the framework laws SoL and HSL.

Montin (145,146) argues that while the 1980s was characterised by 'trust-based steering' in the central government–local administration relationship, government in the 1990s already started to turn towards 'mistrust-based steering'. This development coincided with the shift from a decentralisation focus with weakened central government and authorities towards marketisation and buzzwords like competition and choice. Many claim that Sweden has been unusually keen to adopt competition as the overarching steering principle – a shift grounded in beliefs in accompanied efficiency and quality improvements in products and services (8,145,147). Montin (146) states that the steering in the 2000s has mostly been about market regulations, auditing and agreements, and that local/regional administrations since the 1990s, from the point of view of central government, have mostly been viewed as obstacles to promoting competition, freedom of choice and equal services.

Market regulations and the implementation of public procurement laws can thus be seen as means to promote the competition idea and to curtail the discretion of local policy-makers and administrations (144,146–148). In addition, with the expansion of different service providers and more cluttered systems rose the experienced need not only to follow up on performances but to control and inspect municipal and other legal entities (146).

Voices have been heard that the central-level steering has become too strong and detailed. In 2016, the Government therefore commissioned an investigation on the

government of local administrations (149). Among the rationales were the facts that reforms since the 1990s on performance management, decentralisation, financial framework steering, delegated budget responsibility, etc., have been paralleled with demands for increased monitoring in order to meet rising demands for information and control. The Government claimed that several reforms had led to more efficient administrations. It also acknowledged that these reforms have conveyed some negative effects, e.g., increased administration and distorted incentives. Therefore, performance management of authorities and services must be characterised by trust and confidence. Detailed control shall be reduced and allow for strategic control and steering in which the professionals' knowledge, experiences and ethics are utilised, as suggested by the Government (149,150). The steering was further said to have become too complicated and divided across sectors – a siloing. This has conveyed negative consequences for the local level: resources may be used inefficiently, goals may not be met, local administrations may be forced to take resources from core tasks such as welfare services in order to meet monitoring, reporting and inspection requirements (149).

The requested overview of the central government's steering of the municipalities (151) concluded that the steering efforts have increased in scope, complexity and degree of detail in recent decades. Many agencies are involved in steering efforts directed towards many different levels in the municipalities. New forms of steering have emerged or become more widely applied, such as agreements, action plans and knowledge management. Central steering was found to be most tangible in social care (and schools) with an exceptional large number of regulations, special supervisory agencies and state subsidies (151). We thereby see the increasing critique of such steering and auditing, and especially so a critique against focusing too much on processes that are more easily measured by numbers than actual effects and outcomes, conflicting steering efforts, and, as a result, the administrative work load (13,17,133,146,151,152).

National-level policy-making and priorities in the field of public health and alcohol and other drugs, addiction treatment included, are also influenced by international treaties such as the WHO European health policy framework Health 2020 (153) and various global actions – within the EU, the United Nations, and the WHO – specifically targeting addictive substances (100,154,155)). These are not further elaborated in this report, which outlines Swedish conditions.

Steering means

Swedish central government has several possibilities to steer local administrations and operations – by means of rule rather than only by management by objectives – to guarantee that national goals are achieved [for overviews of such steering, see

(149,151), and Chapter 14 of the *Misuse inquiry* that outlines the State's government of addiction treatment (100)].

Enforcing modes of steering

The strongest tool is *legislation* through which detailed rules regarding local and regional matters handled by municipalities or regions are laid down. Such steering shall be proportionate – i.e., restrictions in local self-government should not exceed what is necessary with regard to the restriction's purpose. Sweden has, in line with this, a tradition of using framework legislation, such as SoL and HSL, instead of detailed legislation in the social and health care fields, as outlined above. Other central legislation areas for the addiction treatment system are the laws on public procurement and system of choice (LOU and LOV, outlined below).

Some legislative tasks are delegated to government agencies that may issue mandatory *regulations and statutory instruments or provisions*. In our field of study, many provisions have been issued by the NBHW in their earlier SOSFS series. Provisions are binding regulations, often complemented with general advice and implementation recommendations. All health, social services, pharmacotherapy, public health-related and similar statutory instruments are as of July 1, 2015, incorporated into one joint HSLF-FS series covering regulations issued by all relevant government authorities. For addiction treatment, these include important regulations on documentation practices (103), OMT (113), needle exchange services (114–116), HVB homes (101), and quality and management systems (137).

The state further exerts its control through *inspection, supervision and licensing*. IVO and NBHW are crucial for our study. Private residential institutions undergo control before they can be established and granted a permit by IVO. It is also IVO that inspects these HVB homes as well as other health and social services, and complaints may be raised to IVO (156). IVO was established in June 2013 in an attempt to gather these assignments that had previously been spread out across different agencies. Addiction treatment had previously been handled by the NBHW and before that by the County Administrative Boards [*Länsstyrelserna,* in Swedish]. The NBHW also awards licences or professional certification for those educated in Sweden or abroad that wish to work as health care practitioners, e.g., doctors, psychologists, psychotherapists and nurses.

Miscellaneous modes of steering

There has previously been no good compilation or overview of the steering tools used by the state across sectors (134). It is clear, though, that the Government steers local/regional matters also by means of less coercive 'soft laws'. New methods have emerged and others become more prevalent (151): Action plans, national

coordinators, agreements, state subsidies, knowledge managements and national guidelines. The state also exerts its control through monitoring and evaluation of local administrations and services, e.g., by means of statistics.

The most important *action plan*, in our case, is the Government's joint strategy for alcohol, drugs, doping and tobacco policy 2016–2020 (157), which builds on a previously decided cohesive ANDT strategy (158,159) and is located within one of the previously set eleven (160) but now eight (161) overarching public health goals [see (162)]. The broad ANDT objective is 'a society free from illegal drugs and doping, with reduced alcohol-related medical and social harm, and reduced tobacco use.' Six subgoals refer to desirable decreases in availability and initiation to substance use among children and adolescents, decreased harmful use, misuse and dependence, decrease in substance-related harms and mortality, and a public health-based approach to ANDT within the EU and globally.

The fourth goal is important for our study. It declares that 'Women and men, and girls and boys, with misuse or dependence shall be given improved access to care and support of good quality in accordance with their preconditions, capabilities, and needs.' Suggested measures include improved collaboration between the health care and social services systems for a coherent treatment system and continuity in services, equality in services and access across social groups, early detection and outreach activities, low-threshold facilities and continued development of quality and access to services. The County Administrative Boards are responsible for coordinating the ANDT policy, while the Public Health Agency is the primary government agency in charge of the ANDT strategy and its national coordination.

Reaching consensus on a certain matter specified in a joint *agreement* with set priorities has become especially common in the health and welfare sectors (151). For example, the Swedish Association of Local Authorities and Regions (SALAR) [*SKL* in Swedish] has recently entered a range of formal agreements with the Government on certain care-related issues such as re-allocation in health care towards primary care, support to national quality registers, standardised procedures in health care (equal and effective good quality care), and mental health interventions (163). SALAR previously had agreements with the Government regarding the implementation of the first edition of the national addiction treatment guidelines (164,165).

Steering has also increased by means of specially allocated *state subsidies*, which goes against the earlier development when earmarked government grants were replaced by general state grants in the *Riksdag's* move towards performance management in the 1990s (134). Different government agencies handle the applications and follow-ups of state subsidies. Such grants have been common in the ANDTG field. In July 2019, The Public Health Agency listed 15 different subsidies either running or possible to

apply for, targeting county councils, municipalities, NGOs and other authorities. Several of these subsidies may be applicable in the substance use field, such as the prevention of mental health problems and suicide; preventive and health-promoting ANDT interventions; HIV prevention; tobacco prevention; gambling prevention; telephone and web-based support in the case of alcohol, tobacco and gambling (166). The NBHW also lists a range of relevant ongoing or recent state subsidies including the development of methods targeting domestic violence; municipalities' interventions towards homelessness; improved youth care staffing; the prevention and treatment of unhealthy lifestyle choices in primary-level mental health services; and civil society organisations' work in regard to people in vulnerable social positions (167). Financial contributions like these may be regarded as strong policy instruments. They have been criticised for causing short-term and re-active priorities and interventions that may not best suit local needs. In other cases, local administrations may miss out on the opportunity to apply for such subsidies if they do not have time to plan for the suggested type of activity (100,151).

Knowledge-based steering has become increasingly important – perhaps as a response to the strong local self-government and marketisation? In the area of health and welfare, the central government has sought to strengthen the coordination of this steering by forming a *Council for knowledge-based governance* [*Rådet för styrning med kunskap* in Swedish] (151). This council gathers nine government agencies, including the NBHW, IVO, SBU and Forte (Swedish Research Council for Health, Working Life [*Forskningsrådet för arbetsliv, hälsa och välfärd*, in Swedish]). Its work is decided by special ordinances (168) on how the state shall govern health and welfare activities and professionals by means of knowledge in a useful way. Such government uses and provides non-binding knowledge-based support to contribute to EBP in health and social services, user involvement, the needs of different professions and administrations, etc. (169).

EBP and knowledge-based steering has expanded significantly in regard to addiction treatment since the first launch of national treatment guidelines (170–173). The national treatment guidelines for alcohol and drug treatment were first launched by the NBHW (165) in 2007, grounded in an extensive meta-analysis by SBU (174,175). They have since been updated (176). Such guidelines may be viewed as inherent in a general worldwide trend towards EBP, 'but they can also be seen as an attempt to standardise the types of treatment that can be sold on the treatment market', according to Bergmark (143) (p. 570). Interestingly, the subtitle of the 2007 guidelines – 'guidance for the social services and the health care system's treatment of people with

addiction and dependence problems'[7] – was replaced with 'support for governance and management'[8] in the 2015 version. Was this a result of visualising a tendency towards management and a steering of resources to recommended treatment options? As further argued by Bergmark (143), such guidelines may be viewed 'as an attempt to bring order into the alcohol and drug treatment market by providing specifications on the quality (in terms of effectiveness) of different treatment modalities' (p. 571). However, the guidelines remain diffuse in this regard, as the mere listing of different treatment methods – with some shared features such as clear definitions and structures of the interventions; being manual-based; and focusing on the addiction – is not very useful in determining the quality in purchasing processes (ibid.).

Other important evidence-based guidance for addiction treatment relate to OMT (177), support to children affected by addiction in their families (178) and general information on addiction problems to practitioners on Kunskapsguiden.se (179). The central government also provides a wide range of knowledge on varying topics by commissioning different state inquiries, like the *Misuse inquiry* (100) and other evaluations or reports by government agencies such as the Swedish NAO [*Riksrevisionen,* in Swedish], the Swedish Agency for Health and Care Services Analysis [Vårdanalys] (125,127,133) and The Swedish Agency for Public Management [*Statskontoret*].

Moving on to *statistics and registers used in the government of local administrations through monitoring and evaluation* (134), the following sources of information are commonly used.

Official statistics: Sweden's official statistics[9] are provided by a range of responsible government agencies and are primarily handled by Statistics Sweden [*Statistiska centralbyrån (SCB)* in Swedish] but also by the NBHW in regard to health and welfare statistics. Our current research project did, for example, analyse the local administrations' annual accounts (SCB-RS, see below), which were recently complemented with a provider register on all the companies that municipalities and regions purchase services from (180). Another source of information is the Kolada database that is owned and run by a non-profit association [*Rådet för främjande av kommunala analyser (RKA)* in Swedish] formed in collaboration between SALAR and the State (181). The purpose is to facilitate the monitoring and analysis of local

[7] 'Vägledning för socialtjänstens och hälso- och sjukvårdens verksamhet för personer med missbruks- och beroendeproblem'.

[8] 'Stöd för styrning och ledning'.

[9] Local and regional-level administrations are obliged by law to provide the state with information. It is, however, a matter of proportionality: the workload must be justified by the needs of those using the statistics (134).

and regional matters, such as IFO and health care, addiction treatment included, and thereby enabling comparisons and offering a tool for internal local steering and management by offering follow-up information on goals fulfilment and the use of resources (134,182,183).

National quality registers: The Swedish National Quality Registers (184) hold about 100 registers that provide the health care system with the possibility to monitor the treatment quality, and some results by the compilation of individualised data on problems, interventions and outcomes. One important register within psychiatry is the Swedish dependence register [*Svenskt Beroenderegister (SBR)* in Swedish], established in 2009 and merged with the OMT register in 2015. SBR (185) includes treatment for alcohol, drugs and pharmaceutical problems in the health care system.

Open comparisons: Another important source of information in the central government of local administrations is the indicator-based register *Open comparisons* [*Öppna jämförelser: missbruks- och beroendevård* in Swedish] for municipal health and social services that also covers addiction treatment (private HVB homes are excluded). This performance assessment system, administered by the NBHW, measures quality and the use of resources. It targets managers and decision-makers of local services and seeks to facilitate monitoring and comparisons that will encourage providers and managements to develop the work and improve their performance. It may improve transparency and the overall insight into publicly funded services. The data is collected by surveys sent out to local administrations. In 2019, most (92%) municipalities and city districts in Stockholm and Gothenburg responded to the survey underlying the data on addiction treatment (186). Among the indicators measured for addiction treatment are routines to offer service users to bring another person as support to meetings with the social services; offering at least one manual-based treatment intervention; offering at least one support programme to significant others affected by addition problems; systematic follow-up by the use of standardised assessment methods; waiting lists; revisions made by service users; and using these revisions in the development work; routines in place for collaboration with other units in the administration; collaboration agreement with the regional health care system, etc. The information is presented by administrations in Excel files where a positive response is marked in green and a negative response is marked in red – thus visualising good or poor performances of each administration (187–191).

Public procurement (LOU) and system of choice (LOV)

Public procurement and system of choice legislations have become strong steering means also in the field of addiction treatment and are therefore outlined here. If a municipality or a region decides that some services shall be produced by and purchased from other providers – as opposed to offered in-house – they will have to

consider the *Swedish Public Procurement Act* [*Lag om offentlig upphandling (LOU)*, in Swedish] or *The Act on System of Choice in Public Sector* [*Lag om valfrihetssystem (LOV)*, in Swedish], as these apply to purchases of health and social services.

The LOU (first enacted in 1994 [1992:1528], replaced by 2007:1091 and most recently by 2016:1145), in particular, is largely based on EU procurement directives. As of 2004, these directives also included the procurement of services and aimed at increasing the free movement within EU, not only of goods but also of services. However, public procurement of social and health care services became common in Sweden before this, in the late 1990s, influenced by ideologies that stressed competition on a (quasi)market as a road to better and cost-efficient services. By now, Sweden is clearly the Nordic country, and possibly also the European country where public procurement is most commonly used in social services (192).

Social and health care services are regarded as being of limited (economic) cross-border interest, and have thus a higher financial threshold for stricter procurement rules and more room for special procurement forms under the threshold (usually 750 000 euro). The purchaser can therefore choose a *direct award* of a single intervention, when there is need for a specially tailored intervention in an individual case. Other possibilities are *competitive procurement with negotiation* during the contract period and *innovative partnership*, or *reserved contracts*, which are not based on competition. In all cases, however, procurement shall be guided by transparency and fairness in the process.

Providers may also be accredited and approved after competition on a *framework agreement* following competitive tendering in accordance with LOU. This procurement form is today especially important in Swedish addiction treatment. Service providers are invited to submit tenders that are evaluated against pre-specified tender documents listing qualification criteria and other requirements. Tenderers describe their qualifications and list their price for offering the demanded service. Approved tenderers may thereby be ranked on a framework agreement based on, for example, *lowest price* or the *most economically advantageous tender* if quality criteria are built into the ranking order. Such framework agreements generally run for two years with the possibility for a one- plus one-year renewal. The social services thereby award providers contracts in individual cases based on the individual needs and wishes, and the providers' ranking in the framework agreement. The agreement shall guide the purchasers in the choice of provider, but gives no guarantee to the provider of a specific number of purchased services.

There is no previous research on public procurement practices in Swedish addiction treatment. Research originating from child and youth care shows that most municipalities have framework agreements for such care, but the agreements are quite

often neglected – e.g., if beds are occupied or a certain treatment method is requested (193,194). Similarly, addiction treatment service users and providers have witnessed that framework agreements often curtail professional discretion and user involvement by limiting the range of possible alternatives. Sometimes, such agreements are therefore neglected in practice (72). It is possible that the revised LOU, in force as of 2017, may better take into account special features of certain markets. Perhaps we are approaching a greater understanding of the different logics inherent in different types of markets (144)?

Another alternative for the local political assembly in terms of how to provide citizens with services is to adhere to the *Act on System of Choice in Public Sector* (LOV; 2008:962) (195–197). The contracting authority thereby opens up an activity for competition by the establishment of a system of choice for a certain type of services. Guiding principles in such a system are non-discrimination of providers, equal treatment, proportionality, transparency and mutual recognition. This may mean, for example, that the contracting authority must provide citizens with information about all suppliers and may not favour one or the other in discussions with potential service users. The contracting authority must decide upon a no-choice alternative for those service users that do not wish to choose. LOV is first and foremost a voluntary option. It is only mandatory for regional primary health care. An assembly thereby decides to apply a *system of choice* within one or several social or health services. As a contracting authority, it specifies contract documents or specifications in terms of quality requirements, financial remuneration, etc. These are made available on a national website for ongoing System of choice activities [*Valfrihetswebben,* in Swedish] (120,121), and applications are continuously requested from suppliers of services. Providers that submit an application and fulfil the specifications are awarded a contract. The public administration thereby allows citizens to choose among the contracted suppliers. An individual service user that has been granted an addiction treatment decision, by an official with the right to exercise such authority, is thus entitled to choose which of the contracted suppliers they wishes to deliver the service.

Compared to LOU, where the providers usually compete in terms of offered price for the requested service, LOV implies that the reimbursement for a service user receiving a service is pre-set by the contracting authority and the providers compete in terms of the quality they can offer for that price. It is assumed that service users will choose good-quality providers and reject poor providers that eventually will run out of business. A search on the System of choice website (198) demonstrates that LOV is rare in regard to addiction services but somewhat more frequent in regard to housing assistance also targeting substance users.

It is probably fair to say that LOV is best suited for markets with standard offers and

many possible providers, as argued by Furusten (144). The problem for addiction treatment is that the local demand for specific services is rarely big enough to attract so many providers that a choice system is feasible.

Furusten (144) argues that LOU may be considered an attempt by the state to govern markets and public purchasers by stressing the hierarchical system and that all public administrations must adhere to parliamentary decisions that have sought to facilitate markets. However, there is a conflict between the market ideals inherent in LOU and a policy debate grounded in a certain type of market with standard products and many available producers on the one hand, and the demand on the public sector to deliver good quality services to the citizens on the other. This is particularly true when certain markets – such as addiction treatment – are characterised by unique products (difficult to define and evaluate) and few producers, rather than a variety of producers competing to produce a standard product of the best quality for the lowest price – such as light bulbs.

The mandatory nature of LOU forces public administrations to adhere to procurement, yet there is often poor agreement as to how services producers are chosen and what is stipulated by LOU. Furusten concludes that decoupling activities are applied in order to both follow LOU and make good service provider choices based on previous knowledge and trustful relationships. This points to a failure in the implementation and government of LOU. However, this may according to Furusten in fact explain why such markets function satisfactorily despite a possible mismatch between LOU and some types of markets. The public administrations tend to aim for good business and satisfy the needs of all parties but without following LOU too strictly in cases where LOU is considered inappropriate and the administration is running a risk of getting providers that do not match the needs. Yet, the market ideals as expressed by LOU have become so institutionalised that an administration cannot openly violate the law and at the same time appear as a serious and credible actor – thus this separation, or decoupling, between theory and practice (144).

Central-level government agencies

Important central-level government agencies involved in addiction treatment government are briefly described here.[10]

[10] The Public Health Agency [*Folkhälsomyndigheten* in Swedish], under the Ministry of Health and Welfare, promotes public health issues at a national level. Among its duties, this agency is responsible for the coordination and monitoring of ANDTG matters and policies, such as the Government's ANDT strategy. It compiles, analyses and disseminates knowledge on these topics in order to prevent such substance- and behaviour-related illness. However, the agency is not particularly involved in addiction *treatment* and

The National Board of Health and Welfare (NBHW)

The National Board of Health and Welfare (NBHW) [*Socialstyrelsen* in Swedish] is a government agency under the Ministry of Health and Social Affairs, which is responsible for issues related to the population's health and welfare (including social insurance and the pension system) and issues directives to its subordinate agencies. The NBHW seeks to 'ensure good health, social welfare and high-quality health and social care on equal terms for the whole Swedish population. The activities concern social services, health and medical care, and communicable disease prevention' (199). It is a supervisory body for all health and welfare services, including addiction treatment. It gives support to staff, managers and decision-makers, and exerts influences in the health and welfare area. Central aspects in the development of services include EBP, equal and good-quality services, staff competence, quality and management systems, patient security, user involvement and service user-centred care.

The NBHW has a range of duties. It collects and analyses information on health and social matters. It maintains several register databases, is responsible for official statistics and publishes statistics on health care and social services. Aggregate-level statistics is viewable online, and individual-based register data – e.g., on cause of death, inpatient care and compulsory care – can be made available for research purposes following a special review. Recent relevant statistical factsheets cover voluntary and compulsory interventions within the social services for adults with addiction problems, and on licensed health care personnel (200,201). The *open comparisons*, also covering addiction treatment and described above, are central to the duty of offering information. All the statistics are, together with legislation, used by the agency to develop standards. Statutory instruments and regulations – e.g., on documentation, OMT, NEP, HVB and quality and management systems (99,101,113–116,137) – have been outlined above.

The NBHW handles the licensing of health care personnel such as medical doctors, psychologists, psychotherapists, nurses and pharmacists. It also handles and evaluates state subsidies (see above) and other government grants. One recent activity was the evaluation and distribution of Government money to municipalities that wanted to investigate the possibility to implement or further develop LOV within health and welfare services (202).

A central activity of the NBHW is the duty to facilitate knowledge-based policies of health care and of social services. This includes treatment guidelines, knowledge

therefore declined participation in an interview for our research project by referring to the NBHW and other agencies.

application, health care and social services guidance, and patient safety. In regard to addiction problems, the NBHW offers support to professionals working with alcohol, illicit drugs, doping, tobacco and gambling by providing knowledge, guidance and support on how to offer good quality services; information on laws, regulations and rules of the running of addiction services; statistics on national developments, and support for systematic follow-ups (203). The NBHW compiles and updates guidelines for the treatment and screening of addiction problems (165,176); keeps registers on interventions and on quality in terms of *Open comparisons* (see above); manages and develops screening by use of the Addiction Severity Index (ASI); follows the development on homelessness and offers guidance on how the social services may counteract evictions; and offers newly developed guidance on overdose prevention (204,205).

Another recent activity, commissioned by the Government, was to investigate and offer advice on how to improve the quality of care in HVB homes, as there is little information on the around 200 facilities, even if more than 7000 people were offered such care in 2014 (136). In terms of governance, the report (136) suggested a minimum level of staff competence, that national treatment guidelines should be applied, documentation must be developed and that HVB homes should be included in the *Open comparisons*. Also, there should be strengthened quality controls when permits are issued and more continuous and active inspection by IVO of HVB for adults. Guidance on continuity of care and service user involvement should be developed, and there should be further analyses of needs and access to HVB. A joint register for addiction treatment services is suggested.

Besides permits and inspections, the section on Safe treatment also includes procurement and the follow-up on such contracts. It is acknowledged that municipalities may list their demands when purchasing services, but they often find these procurement practices demanding – something that has also been confirmed by The Swedish Competition Authority [*Konkurrensverket* in Swedish]. Municipalities may strongly influence the HVB market if they join forces in procurement – e.g., by means of national-level procurements and contract follow-ups (136).

The Health and Social Care Inspectorate (IVO)

The Health and Social Care inspectorate [*Inspektionen för vård och omsorg (IVO)* in Swedish] is a government agency under the Ministry of Health and Social Affairs. It is responsible for considering and issuing permits and supervising the areas of health and social services. IVO took over these licensing and supervisory activities from the NBHW when it was established on June 1, 2013 (156,206,207). Permits are handled in Stockholm, while supervision activities are split across six regional offices.

Permits of relevance for our study are the permits for *private* providers offering services under SoL (i.e., HVB), and for NEP services in the health care system. HVB homes are regulated by SoF, SoL, special provisions (101,137) and by IVO. The agency assesses whether units that wish to establish themselves as a HVB can be run safely and with good quality before a permit is issued. Features that are examined are, for example, the competence of staff, premises, and the quality and the management system. IVO thereby also maintains the National HVB register (208).

Supervision includes inspections of care providers offering health and social services, the processing of complaints by individual, supervision of licensed professionals (including withdrawal of licenses) and the handling of the municipal obligation to report non-enforced decisions.

IVO's inspections of health care and the social services, HVB included, assess if the activities meet legislation (SoL, HSL, etc.) and required demands and special provisions – i.e., rules concerning processing, safety, equal treatment and the right to a particular service. Inspections may be pre-announced or unannounced and initiated by IVO or in connection with a report of complaint. The supervision specifically focuses upon low quality or poor safety services that may endanger individuals or populations, the lack of a functioning management system for systematic quality work, and licensed health care professionals that do not practice their work in a satisfactory way. It is not only individual services that are inspected, but entire care chain functions and the extent to which collaboration between providers is satisfactory (206). IVO may issue orders to remedy any misconduct of significance for the service users and their entitlements. Severe misconduct and endangerment of individuals' life, health and safety, and failure to meet orders may cause IVO to withdraw a treatment permit or close down a facility.

IVO present their findings from supervision activities to promote systematic learning. The major take-home messages from such reports on addiction treatment (111,132,209) are that: collaboration between and across providers must continue to be improved, and especially so in regard to co-occurring mental health problems, SIP, and overarching agreements that regulate the responsibilities between different actors; assessments and the time required to reach a treatment decision must be quickened; compulsory measures *shall* be considered if necessary; treatment shall be grounded in individual needs and wishes (a general routine to try in-house units first is not acceptable); EBP shall be applied; treatment must be systematic and structured; and documentation must be satisfactory but not too far-reaching (ibid.).

SoF determines that HVB homes for children and youth must be subject to regular – yearly – inspections. There is no such rule for regularity set for HVB for adults. This has been criticised by the NBHW (136), which stresses the necessity of proper and

holistic inspection of providers handling people in exposed and weak positions.

Complaints regarding irregularities, errors or deficiencies may be submitted by individuals or other parties, either as an anonymous tip-off or a formal complaint. A registered complaint must be preceded by a contact with the deficient unit or professional that made the error that thereby are offered the chance to explain the situation and/or correct the problem or decision. The complaint can, if the response is deemed unsatisfactory, thereafter be forwarded to IVO. It becomes a public document, and IVO assesses which complaints to investigate further. Social services decisions may be appealed against in court (see above). Complaints may also be submitted to IVO in cases of experienced inadequacy or deficiency.

The processing of complaints includes the handling of reported irregularities by accountable health care and social services managers (so-called lex Maria and lex Sarah reports) (210). The care providers must investigate situations that caused or could have caused severe care injuries and report these to the IVO, which decides if measures taken to avoid such situations in the future are satisfactory.

The supervision of licensed professionals may include the withdrawal of the right to prescribe narcotic substances, demands for further training or delicensing and the loss of the right to practise a profession in cases where professional practice deficiencies are found to be severe enough. Such authorisation matters concerning health care licensing are decided by the Medical Responsibility Board (HSAN).

The Swedish Association of Local Authorities and Regions (SALAR)

The Swedish Association of Local Authorities and Regions (SALAR) [*Sveriges Kommuner och Landsting (SKL)* in Swedish] is not a government agency but of great importance for the government of public administrations and addiction treatment. SALAR is both an employers' organisation and an actor that advocates for and represents all local and regional governments. SALAR acts on the initiative of the member administrations, work for their interests by raising important issues and offers them support and advice. SALAR has continuous dialogue with the Government and has entered several agreements with the Government on behalf of its administrations.

SALAR is involved in and supports various registers and databases, such as Kolada and *Open comparisons* (see above), and the voluntary KKiK [*Kommunens kvalitet i korthet* in Swedish], entailing annual compilations regarding quality and effectiveness for internal steering and development, and *Kommunkompassen*, which is an annual evaluation tool that illustrates local-level activities from a citizen and service user perspective (134).

SALAR gives priority to addiction problems and treatment (211). Previous activities of great importance involve agreements with the Government to implement the first

edition of the national treatment guidelines (165) in a project called Knowledge to practice [*Kunskap till praktik* in Swedish] (164), to develop and support children's and parenting perspectives in addiction treatment, and to broadly implement EBP into the social services (212,213). Regional platforms with coordinators for addiction treatment across the country were established during the Knowledge to practice project. This MILK network remains active, even if funding has been cut. Another SALAR priority has been service user involvement (214).

An important task of SALAR at the time of this research project was a problem inventory and the drafting of an action plan targeting decision-makers and dealing with early detection, interventions and treatment of 13–29-year-olds (215) – a group often emphasised in recent years. The plan stresses responsibility issues and collaboration between care providers, accessibility, continuity of care, user involvement, knowledge-based services, and stigma and attitudes to addiction. Interestingly, the last point involved a call for an evaluation of the prohibitionist Swedish drug policy that would investigate whether treatment entry would be better facilitated by a softening of the current Penal law on narcotics (1968:64) [*Narkotikastrafflagen* in Swedish] and a de-criminalisation of drug use.

Government agencies for competition and procurement

Two government agencies handling procurement practices are important also for addiction treatment: The Swedish Competition Authority [*Konkurrensverket (KKV)* in Swedish] under the Ministry of Enterprise, and the National Agency for Public Procurement [*Upphandlingsmyndigheten* in Swedish] under the Ministry of Finance.

The Swedish Competition Authority (KKV) enforces public procurement and competition rules (216,217). It supervises public procurement, can make supervisory decisions or bring court actions regarding procurement fines – e.g., in the prioritised case of an illegal direct award of contracts (218). In its strive for uniform application of the rules, KKV investigates if contracting authorities, like municipalities, observe LOU and LOV regulations in their practices. It also seeks to combat cartels and private or public participants who abuse their position on the market. The overarching mission is to work 'for effective and efficient competition in the private and public sectors for the benefit of consumers, and effective and efficient public procurement for the benefit of the public and market actors … [It] works on the application of the law, supervision, improvement measures, knowledge, research, international work and cooperation in its areas' (219).

KKV has not specifically targeted addiction treatment in its activities. However, as pointed out above, the NBHW argued that municipalities often find public procurement of HVB difficult and time-consuming (136). The NBHW referred to a

KKV report, later transferred to the National Agency for Public Procurement (220), that argued that the problem lies in the lack of proper follow-up of the contracts. This problem may be explained by a lack of resources and skills. In addition, the balancing act of managing the requirements of both LOU and SoL in purchasing HVB has also been acknowledged (221). In 2013, 221 of the 290 municipalities stated that they had framework agreements for HVB for children and youth, but 40 percent reported that they did not make call-offs from these agreements. The municipalities found it difficult to formulate clear tender documents, evaluate quality and call off services that would satisfy an individual's needs (ibid.). Such problems escalated with the heavy influx of refugees in 2015 that led to a rapid increase in the number of HVB homes for unaccompanied minors, including the entry of some deceptive actors seeking profits on a very profitable market (222). HVB for other service user groups shows a more stable development.

The National Agency for Public Procurement [*Upphandlingsmyndigheten* in Swedish] was established in September 2015 to take over public procurement (LOU and LOV) related support and guidance activities targeting contracting authorities and units. These were previously handled by the Swedish Competition Authority, which retained inspection activities (223). The agency provides support to contracting authorities and suppliers, and works for 'effective and socially and environmentally sustainable public procurement to the benefit of the society and the participants in the markets' (224). It aims to contribute to the Government's goals for procurement, namely that such procedures 'must be efficient and legally certain, and make use of market competition. It must also promote innovative solutions and take environmental and social considerations into account. The procurement law framework must also help realise the internal market and facilitate the free movement of goods and services in the European Union. Opening purchases made by public authorities and public bodies to competition can mean better deals for the public sector and a more efficient use of public funds.' (225).

The National Agency for Public Procurement is responsible for the national System of Choice Website [*Valfrihetswebben* in Swedish] that makes easily accessible and searchable information available about services advertised within a municipality's or region's (as well as The Public Employment Agency's) system of choice according to LOV. All continuous requests for applications and the corresponding relevant contract documents shall be listed on this website. All providers that apply for an assignment and qualify in accordance with the listed documents may conclude a contract with the contracting authority, e.g., a municipality that offers housing assistance according to LOV (198).

Government agencies for the analysis of government and services

Two government agencies focusing on analyses are of interest to our study: The Swedish Agency for Public Management [*Statskontoret* in Swedish] and the Swedish Agency for Health and Care Services Analysis [*Myndigheten för vård- och omsorgsanalys (Vårdanalys)* in Swedish].

The Swedish Agency for Public Management analyses and evaluates state-funded and related activities such as the organisation, governance and development of public administrations. For example, the agency follows up on the governmental steering of local government. It provides the Government and Ministries with knowledge-based information that may guide their decisions in making the public sector more efficient. The organisation has five topics departments of which one focuses on the Labour market, social welfare and health care. Several of its reports, some of them cited in this report, are summarised in English on their website (226).

The Swedish Agency for Health and Care Services Analysis is required to strengthen the position of the service users through analysing health and social services from a service user or citizen perspective; to analyse the functioning of such services; to review the effectiveness of activities in these areas; and to provide the Government with advisory support and recommendations for making state-run institutions more effective (227). The agency does not issue guidelines or regulations and is thereby an independent evaluation agency. It was established in 2011 and has since published some reports on addiction treatment (127,133,228) and more general reports on service systems (125). These have stressed the importance of a coordinated, as opposed to a fragmented, treatment system; user involvement and what coordination and collaboration means from the point of view of the service user; and factors of importance to service users and thereby important to use as outcome indicators in systematic follow-ups: substance use, health, relationships, criminality, social (housing, income) and psychosocial issues, including a sense of security, independence and coherence that together form an overall good situation in life.

Data and methods of the study

This section outlines the research design of the study with three different substudies, sampling strategies and recruitment procedures, characteristics of the sampled and participating administrations, organisations and interviewees, as well as ethical and methodological considerations.

Original research design

The research project was, as originally planned in the research grant application, divided into three highly linked substudies. Question A, 'How is health and social care-based addiction treatment organised, governed and controlled' was examined in Study 1 that focused on politicians and bureaucrats and served as a frame to Study 2 and 3 that scrutinised the work of service providers and sought to answer questions B–E regarding the logics and working principles, their compatibility and perceived effects on the work, how conflicting goals and incentives are handled by staff, autonomy versus control among professionals and the local variations in these aspects (B was also covered in Study 1 by analysing views and experiences among policy-makers and bureaucrats). It was particularly Study 3 that provided answers to the question about local variations (E). Knowledge from the entire project can provide suggestions for improvements and problems that should be avoided (Question F).

Study 1: Background and key-informant interviews with politicians and officials (nationally and in selected areas)

Study 1 used statistics, public documents and key-informant interviews to map the organisation, funding environment and means of control of health care-based addiction treatment in three selected counties in Sweden and in six municipal social services administrations and contracted (private) providers. Urban and rural areas, with varying degrees of NPM (43), were included and are further elaborated below. The goal was to represent different modes of operation and elements of NPM or post-NPM. Key-informant interviews involved national, regional and local-level policy-makers and bureaucrats. Special attention was paid to purchasers and procurers – previously unstudied actors with growing influence on addiction treatment. Local and regional-level addiction treatment is influenced by national-level central governance, expectations and incentives that our study covered by reviewing central governments'

web pages, reports and by interviewing high-ranking bureaucrats in charge of national addiction treatment policy, management, auditing, inspection and procurement (at the NBHW, IVO, SALAR, etc.). Respondents, in selected areas and at the national level, were selected based on an inventory of actors of influence and who might possess the necessary information. Selected regions and organisations were classified in terms of NPM permeation. National-level expectations, incentives and means of control were charted.

Study 2: Service providers' experiences within selected administrations and contracted providers

This part consisted of semi-structured interviews with managers and treatment professionals (doctors, nurses, social workers and other treatment staff) in public units and contracted private enterprises. Apart from representing varying professions and organisations with varying degrees of NPM, respondents were also selected based on an inventory of influence and possession of varying experiences. These interviews identified experienced benefits from (post)-NPM reforms but also experienced central inconsistencies as concerns visions, objectives, demands and incentives. Experienced effects on the service user level were collected. We explored ways of handling tensions in the daily work, i.e., to what extent providers changed their practice in accordance with incentives, ceded to boundary demarcation (79,80), took on organisational hypocrisy (81,82), etc.

Study 3: Web survey among service providers

Study 3 used data from Studies 1 and 2 in the preparation of a web survey targeting addiction treatment professionals nationwide. They were recruited via a targeted recruitment campaign that collected email addresses to treatment units across Sweden, and by advertising the survey through appropriate list serves (profession membership registers), professional associations, and in union and other branch journals, newsletters and websites. This procedure gave us access to addiction treatment workers in Sweden without the time-consuming process of gaining access and getting permissions from managers.

The web survey contained questions on the respondents and their organisations, questions derived from the qualitative Studies 1 and 2, open-ended questions on other benefits and problems, and suggestions for improvements. Responses to the open-ended questions can inform us whether there are other benefits and tensions in Swedish addiction treatment than those identified and thoroughly studied in the sampled municipalities and regions. They can thereby assist reliability and validity judgments. A web survey has low costs in terms of money and time (including elimination of data entry stage) compared to other forms of surveys (229), and

response rates may even be higher for web surveys than for postal surveys (230). Thus, Study 3 may provide us with knowledge about the proliferation of benefits, inconsistencies and ways of handling such tensions. It also allows for comparisons across professions, organisations and areas.

Ethical clearance

The research followed the existing ethical guidelines for the social sciences. Ethical approval for the entire study was granted by the Ethical Review Board of Stockholm (EPN 2016/446-31/5) before the fieldwork was undertaken. The study applied informed consent (see **Appendix A**), and we received signed consent (and audio-recorded consent in telephone interviews) from the interviewed research participants. We guaranteed that we would not share the research participants' information with unauthorised parties. This included our obligation to observe silence also towards the respondents' colleagues. The interview data and the characteristics of local administrations (municipalities and regions) and service providers are therefore anonymised. We only present information by type of respondent, organisation or other feature important for the findings to avoid that the readers recognise respondents. If deemed necessary, we have changed some features of presented stories or personal characteristics, or lump cases together to further aid confidentiality.

The General Data Protection Regulation (GDPR) came into force before the web survey was launched. The information provided to research participants was thereby altered in this part of the research project to match the revised privacy regulations. We do not have access to the IP addresses of the respondents and can thereby not offer research participants that they can access their information. See **Appendix A**.

Fieldwork and data (Study 1 and 2)

In the fieldwork and in the analyses, the research project separated between national-level data, reports, key-informant interviews with national-level officials and a substudy of public procurement on the one hand, and documents and interviews in the sampled local and regional recruitment areas on the other. This section describes the national-level data (register data and interviews at government and other state-level agencies), the interview and document study performed in selected municipalities and regions, and the additional study of public procurement. Studies 1 and 2 applied a qualitative research approach, except the quantitative analyses performed on official national statistics.

National-level official statistics: charting trends in purchases of care and providers of institutional care

Official statistics of Sweden were used to gain some insight into the permeation of NPM in the Swedish addiction treatment system. Public administrations are obliged to submit information to national-level registers such as information on different types of interventions offered to substance users that is sent to the NBHW. There is, however, basically no available information on the local and regional organisation of health and social services and particularly on the organisation of addiction treatment.

Two registers were identified as useful and were analysed for the research project (90): SCB-RS and providers of institutional care (HVB register).

Statistics Sweden (SCB) holds information on municipalities and regions' annual accounts [*Räkenskapssammandrag (RS)* in Swedish]. SCB-RS provides annual statistics on each administration's income statements and balance sheets. The information is broken down by different activities and informs about money spent per sector and how much was spent on purchases from various types of care providers (134,231). SCB-RS is a total study, and information is provided by all municipalities and regions. SCB states that the information is highly reliable, but there may be more errors in sections on health and other services, as these pieces of information are broken down into detailed categories. Health and care was included in the register as of 1998 (232). We collected information from 1999 and every fifth year: 1999, 2004, 2009 and 2014.

We used data on the municipalities' total expenditures for 'treatment for adults with addiction problems', which has been subdivided into inpatient and outpatient care since 2004. We also used monetary values for how much each municipality purchased services from different types of providers: private companies, associations, other municipalities/regions/municipal associations or companies, the state, and private households or individuals (i.e., family homes). We charted expenditures over time, calculated the percentage of purchased care in relation to how much was spent on in-house public activities and analysed purchases from different types of providers (90).

The corresponding data was also ordered for the regions. Unfortunately, information on the health care systems' expenditures and purchases is not that detailed; this piece of data only presents numbers for the entire psychiatric sector, in which addiction treatment is located. Because the organisation and funding may differ significantly across different health specialities in regions (124) and addiction treatment makes up only a small section of mental health care, we decided not to analyse this data further.

IVO currently holds the register on all HVB offering residential care (208). Stenius and Storbjörk (10,233) had previously gone through the registers manually for 1976,

1984, 1990, 1997 and 2003. In those earlier years, the information was published in catalogues describing all approved institutions for adults, adolescents and families. Units that in their descriptions reported that they treated adults with alcohol problems were singled out and information was gathered on the ownership and number of beds for each facility. For the current research project we collected information on all units in 2016. The information extracted from the HVB register was received as an Excel file from IVO on March 2, 2016, and we, again, manually went through all the descriptions to extract the corresponding information for 2016 – i.e., units with at least five beds treating adults with alcohol problems. Alcohol and drug treatment have been merged over time in Sweden, and by 2016 basically all units claimed that they treated all sorts of addictions. We used the information to analyse the development over time in regard to ownership, number of facilities and number of beds nationally (90).

Interviews with national-level officials involved in the government of addiction treatment

We started this substudy by reviewing the web pages of government agencies dealing with health and social care. Relevant reports were collected to offer an overview of activities related to the development and government of addiction treatment and to provide background information to the interviews conducted with officials and to the in-depth study of selected administrations.

The government agencies that were found most important were The Ministry of Health and Social Affairs, The Ministry of Finance, The Swedish Agency for Public Management, The National Board of Health and Welfare, The Health and Social Care Inspectorate (IVO) and The Swedish Competition Authority. We also included the Swedish Association of Local Authorities and Regions (SALAR), as it is highly involved with the development and government of health and social services (see above). Sixteen interviews were made with a total of 16 officials (one interview had two interviewees, and one person was interviewed twice) from these government offices and agencies. We also included officials involved with procurement in Sweden as well as in Finland and Denmark. The interviews took place between August 2016 and May 2017. Information on the interviewees is outlined under *Characteristics of 85 interviews and 93 research participants* below.

These interviews provided a backdrop to the in-depth studies in selected regions and municipalities by portraying the overarching government and control of local/regional-level addiction treatment.

Public procurement in Sweden and in the Nordic countries

Study 1 stated that ‘special attention will be paid to purchasers – previously unstudied actors with growing influence’ on addiction treatment. In the early phases of the

research project, it became increasingly clear that purchases have become highly regulated by procurement laws and that local and regional administrations, addiction treatment professionals and non-public treatment providers have grown highly governed by such legislation (72). Yet this has remained an understudied area. One explanation may be that we noted that the government agencies dealing with health and social care are not dealing with such organisational and financial matters that, instead, are decided by the Ministry of Finance, the EU and by local/regional politicians in accordance with the local self-government tradition. This led us to pay special attention to the public procurement of addiction treatment in our interviews, and in two substudies that evolved and are described below.

Observation of procurement of addiction treatment

At the beginning of the research it came to our attention that a big procurement effort had started in which a procurement firm gathered a large number of municipalities to conclude framework agreements with providers of addiction treatment for adults in a competitive tendering process. We seized the opportunity and reached out with a request to study this procurement process. We were met with a positive response, and Storbjörk, after signing a strict confidentiality agreement, was allowed participate and to observe three meetings in which the procurers met with representatives of participating municipalities (primarily social work professionals and procurers) to formulate and agree upon the type of procurement and the procurement documents that specify what the municipalities want to buy, decide the requirements that providers that submit tenders must fulfil in order to be accepted, and outline the contract that will be used when approved providers are signed. Drafts of the procurement documents were circulated prior to the first meeting, thoroughly discussed at the meeting, revised and further discussed at the following meetings.

We were not allowed to audio record the sessions. Instead, observational notes were written down in an almost 50 pages' long document including our analytical thoughts and memos on interesting features and questions that arose. This substudy was very informative in clarifying that procurement happens in an intersection between different vocabularies, legislations and logics (234–236). Considerations and discussions on how to formulate the procurement documents revealed the municipalities' previous experiences with purchasing services and with different types of providers offering good- or poor-quality services. The difficulties in defining treatment quality in a measurable were evident. This substudy significantly increased our knowledge and understanding of procurement of health and social services. It was primarily used as a background to the overarching research project, the formulation of interview guides, analyses of various data materials and the arrangement of a Nordic workshop on procurement.

Nordic workshop on procurement practices

Stenius had previously been involved in a comparative study and a report comparing procurement regulations in regard to addiction treatment in the Nordic countries (148). This report was followed up in a workshop funded and arranged by the Nordic Welfare Centre (NVC) and run in collaboration with our research project.

The workshop was held in Stockholm on December 8–9, 2016. It was chaired and hosted by Stenius and 11 procurers, jurists, procurement experts and scientists working on procurement of addiction services from Sweden, Denmark, Finland and Norway.[11] The point of departure was the previous report (148), and the aim was to further discuss procurement practices in addiction treatment in the Nordic countries. The discussions during the two full days were arranged around ten themes: Legal regulations and guidelines; New overarching conditions and efforts to re-regulate procurement; Proliferation of procurement and procurement models used; Political government and local/regional procurement strategies; Collaboration with treatment producers in procurement; Quality versus price and other selection criteria in procurement; User involvement as rhetoric or practice; Follow-ups of procurement, contracts and contracted providers; Summing up; and Conclusions to be drawn and suggestions for future work.

The meeting was documented in a 26-page report by Storbjörk and circulated to the participants for their convenience and comments. The conclusions were that all four countries relied upon and grounded their procurement legislation in the same EU directives, but national legislations and practices differed significantly and historical trails and institutional roots became visible in this practice. The role of the service users in procurement differed across the countries. While service users appeared invisible in Sweden, we noted that Denmark relied upon extended customer choice and treatment guarantees and that users were commonly included in the Norwegian procurement processes. Finland and Sweden witnessed a consolidation of providers and processes in which big company groups purchased smaller providers. Transnational actors and investment firms were present and increasingly entering these markets. Denmark had a very strict legislated control of private providers and

[11] Sweden: Kerstin Stenius and Jessica Storbjörk, Berit Johansson (procurer, Västerås municipality), Jenny Åberg and Christina Öhlund (procurers, SKL Kommentus). Finland: Vilma Jussila (procurer of health and social services, Helsinki municipality), Jonna Törnroos (lawyer, Finnish Association of Local and Regional Authorities). Denmark: Alberte Bryld Burgaard (responsible for addiction treatment development, Københavns municipality). Norway: Unni Aker (procurer, Helse Sør-Øst, one of the four regions responsible for offering specialised addiction treatment), Hanne Bogen (sociologist, Fagbevegelsen senter for forskning, utredning og dokumentasjon, Fafo), Christian Sohlberg (thematic director, Helse- og omsorgsdepartementet).

their finances, which appeared to have prevented large for-profit actors from entering Danish addiction treatment. Norway fostered not-for-profit organisations by means of a negotiated exception with the EU on procurement laws and did not report the same decline in the role of NGOs as did Sweden. The discussions in Sweden were found to be highly influenced by a recent welfare inquiry (32) and focused at the time upon profit making in tax-funded health and welfare services.

All participants stressed the need for better follow-ups of procurements, contracts and contracted providers. Knowledge, procedures and resources appeared to be lacking for such follow-ups despite good intentions. Denmark has a good register that could be used for these purposes. Norway also has data available in electronic systems on the regional-level providers of specialised addiction services. In Sweden, *SKL Kommentus* (procurement unit owned by SALAR) had taken steps to develop and implement a follow-up model to ease this time-consuming work for the purchasing administrations, i.e., municipalities. No one systematically measured the outcomes of the service users treated by contracted providers.

The discovery of these striking differences across the Nordic countries pointed to the need for a systematic comparison. A first draft was presented at the 43rd Annual Alcohol Epidemiology Symposium of the Kettil Bruun Society (KBS) in Sheffield, United Kingdom, on June 5–9, 2017, and was revised into a journal article (192).

One important finding of this comparative sub study with implications for the overarching research project is that Sweden seems to have gone the most far of the Nordic countries with marketisation and offering a prominent position to private service producers. Norway and Denmark appear as antipoles and Finland somewhere in between (192). This signals a quite high overall NPM permeation in the-market oriented Sweden, with early and strong procurement legislation, strong stakeholders in for-profit multinational treatment providers, few and weak opponents of NPM, legislated management by result (8), etc. A consequence is that local and regional-level variations in NPM permeation are likely to be quite small.

Selection and characteristics of local and regional administrations

Several pieces of information were used to inform the selection of areas for the in-depth, cross-sectional, comparative study of the daily practices and local/regional policymaking in administrations with varying degrees of NPM permeation.

Official statistics available at Statistics Sweden's and SALAR's websites were used on population sizes, geography (rural/urban areas), political majority of local and regional political assemblies, income levels as well as the annual accounts previously analysed in the research project (90). We further used different reports on, for

example, different payment models in different regions (124) to increase our understanding of various organisations. As pointed out, there is no satisfactory data on local and regional use of different organisational models in general and particularly not for various NPM features in addiction treatment. We therefore also sought information on potential areas from fellow scientists in Sweden (108,112,237), and important dimensions and possible areas were discussed at the first reference group meeting in 2016.

In summary, we sought to use a sampling procedure that would provide areas from different parts of Sweden and *variation* in terms of population size, geography, wealth and political majority – factors that may be decisive for which organisational models are possible to implement (e.g., very small or poor municipalities may not be able to run a specialised treatment facility, while a right-wing area may be more prone to implement market-oriented solutions). The NPM features that we initially tried to cover were private (vs public) production of services as reflected in the share of purchased addiction treatment or outspoken goals of the administration, purchaser–provider splits (vs traditional holistic administration), competition in the public administration (public providers competing with private providers for the contract to operate addiction treatment as a whole or a certain unit), performance-based funding (vs block grants) and the use of different procurement models such as framework agreements (LOU) and system of choice (LOV). We desired both right-wing and left-wing areas.

The characteristics of the areas are presented below. The information provided is quite crude to help protect the anonymity of participating administrations.

Three regions (health care system)

Official statistics by Statistics Sweden online (and previously analysed for the research project (90)) show that the population base differs significantly across regions (**Table 2**). The smallest one had only 57 000 inhabitants (rounded numbers) in 2015. The majority of regions had between 127 000 and 445 00 inhabitants, and the three biggest regions had more than 1.3 million with Stockholm County in the lead with 2.2 million people. The median income among inhabitants was more evenly distributed: In 2014, those aged 20 or older had an annual income between SEK 228 000 and 282 000 (mean=247 000; median 244 000).

Table 2. Population and median income in Sweden's 21 regions, numbers.

	Min—max	Mean	Standard deviation	Percentiles		
				25	50 (md)	75
Population 2015	57 391–2 231 439	469 096	553 072	240 788	281 028	351 000
Median income (age 20+) 2014	227 597–281 925	246 563	11 918	237 974	244 380	254 305

Twelve of the 21 regions got a left-wing regional government after the 2014 general election[12], followed by five with a right-wing government and four with a coalition government (**Table 3**).

Table 3. Regional political majority following general elections in the 21 regions of Sweden.

	Frequency (n=21)	Percent
Political majority following the 2014 regional election		
Left-wing	12	57
Coalition	4	19
Right-wing	5	24
Political majority over three regional elections (2006–2014)		
Left-wing	7	33
Shifting left- and right-wing majorities	9	43
Coalition or right-wing	5	24

Two of our three *sampled regions* were found above the median population size and one below. All three were found above the median regarding income. Two had left-wing governments and one had a right-wing government following the 2014 general election. In a longer time perspective, we see differences also in terms of changing political government from 2006 to the 2014 election: one had continuous left-wing government, one had shifting majorities and one had a coalition or right-wing government over all three general elections. The sample thereby covers different political majorities; have a fair variation regarding population size; but is biased towards higher income regions.

One of the sampled regions had a highly specialised dependence care organisation within the health care system. Two regions offered dependence care within the psychiatric sector – one of them had a longer history of offering such treatment and both were in the process of further expanding these specialties. Two regions primarily

[12] The 2018 election took place after the fieldwork had been conducted and is omitted.

relied on block grants, whereas the third one had a purchaser–provider model and used also performance-based payment. All administrations offered in-house treatment. One used public procurement and had contracted private providers to run addiction treatment. One was geographically located in a primarily urban area, one in a rural and one in between.

Region 1 was rural, smaller and had few NPM features. *Region 2* was more mid-sized and had had private actors but was primarily running addiction treatment in-house. *Region 3* was the biggest one, had a purchaser–provider split, contracted private providers (internal competition) and used performance-based funding. Overall, NPM permeation was the lowest in *Region 1* and highest in *Region 3*.

Six municipalities (the social services)

This section presents corresponding information for the municipalities, based on official statistics by Statistics Sweden and previously analysed for the research project (90), as for the regions above.

Starting off with different types of municipalities, four selected municipalities (two characterised as low and two as high on NPM) were categorised as belonging to the B type of municipalities (**Table 4**). One was a C area, and one was an A type of municipality. Correspondingly, the rural area was close to the 25th centile in terms of population size, one had a population size around the median, and the rest fell between the 25th centile and the median (**Table 5**). One municipality had a low median income below the 25th centile, one was found just below and another just above the median, and three could be characterised as rich (above the 75th centile). Our sample included all three types of political government following the 2014 general election, with three right-wing municipalities, two coalition municipalities and one right-wing governed area. All five types of political majority following the elections between 1994 and 2014 (**Table 4)** were represented in our selected municipalities.

The percentages of purchased addiction treatment in 2014 (relative to in-house public production, as previously analysed (90)) reveal that one of the studied municipalities was very low in its purchases, below the 25th centile on both measures, and this area was also characterised as low on NPM (**Table 5**). The two most NPM-like municipalities fell above the 75th centile on both measures; the last NPM municipality was close to the median on both purchasing measures. The last two municipalities, lower on NPM in general, fell between this one and the lowest.

Table 4. Type of municipality and local political majority following general elections in 290 municipalities.

	Frequency (n=290)	Percent
Type of municipality 2017		
A Large cities & municipalities near large cities:		
A1 Large city	3	1
A2 Commuting municipality near large city	43	15
B Medium-sized towns & municipalities near medium-sized towns:		
B3 Medium-sized town	21	7
B4 Commuting municipality near medium-sized town	52	18
B5 Commuting municipality with a low commuting rate near medium-sized town	35	12
C Smaller towns/urban areas & rural municipalities:		
C6 Small town	29	10
C7 Commuting municipality near small town	52	18
C8 Rural municipality	40	14
C9 Rural municipality with a visitor industry	15	5
Political majority following the 2014 regional election		
Left-wing	99	34
Coalition	101	34
Right-wing	89	31
Political majority in several local elections (1994–2014)		
Left-wing	40	14
Left-wing and/or coalition	46	16
Shifting left- and right-wing majorities	123	42
Right-wing and/or coalition	57	20
Right-wing	24	8

Table 5. Population, median income and percent purchased addiction treatment in 2014 in the 290 municipalities.

	Min–max	Mean	Standard deviation	Percentiles		
				25	**50 (md)**	**75**
Population	2451–911989	33612	69275	9765	15325	33943
Median income (age 20+)	196872–343500	244697	25577	228188	240473	253313
Purchased care, total	0–100	46	20	33	45	59
Purchased care, outpatient	0–100	25	30	1	12	36

Municipality 1 was rural, smaller and poorer, and had few NPM features (besides an outspoken broad and somewhat market-oriented vision of the development of the municipality in the locally and politically set Goals and budget document that governs public activities). *Municipalities 2* and 3 were mid-sized, one rich and one around the median income, and both relied primarily upon public treatment provision with, for example, a strong reliance on their own public outpatient units. One had a long history of formalised public procurement, also in institutional addiction treatment, whereas the other was just at the beginning of such a process. One municipality had a highly integrated management system in place in addiction treatment. Both municipalities experienced signals within their administrations that called for more measurable interventions, higher treatment volumes and more cost-effective services. While one of the municipalities had a very comprehensive and visionary overarching plan for the municipality and its citizens, the other presented quite a short and basic Goals and budgets document.

Municipalities 4 and 5 had histories of purchaser–provider splits, internal competition and contracted private providers, and were elaborating with different procurement models. Market-oriented principles were visible in their Goals and budgets documents, yet both were currently searching for more coherent administrations, and were, for example, merging the political boards from a previous separation between purchasing and provider/social boards. One was rich, the other was found around the median income. *Municipality 6* was rich and had several political boards involved in the services offered to people with addiction problems, contracted private providers, emphasised market-oriented values and models in their Goals and budget document, and was in favour of using customer choice also in addiction treatment. *Municipalities 2–6* were all discussing or had just undergone organisational changes that also affected addiction treatment.

Overall, NPM permeation was the lowest in *Municipality 1*, which also purchased the least. The permeation was low, but some NPM features were present in *Municipalities 2–3* (which bought somewhat more relative to their own in-house production of addiction services). High permeation was found in *Municipalities 4–5*, but with signs of post-NPM, and continuously high in *Municipality 6*. The 5th and 6th municipalities purchased the most, both outpatient services and in total; municipality 4 was somewhat lower on this measure.

Fieldwork, recruitment procedures and interviews in selected administrations

Gaining access

Appropriate holders of information on organisational features and addiction treatment

gatekeepers were identified in each area by the use of Internet (primarily the websites of the public administrations), fellow scientists, officials involved in the government and organisation of addiction treatment, and other available sources.

Contacts were made by an informative email and succeeding phone calls targeting the person in each administration identified as the most suitable for our purposes: a manager, someone who was known to have worked with addiction treatment in the administration for a very long time, or someone involved with development work. These initial contacts proved to be time-consuming. Firstly, the contact persons – or gatekeepers – appeared very busy and often did not respond, neither to our emails, phone calls nor voice messages. One manager later explained that s/he spends all days in meetings and has to reply to emails after hours. Secondly, due to an overall high staff turnover, some were quite new on their posts or had just received a new manager, which meant that they did not feel they had the experience or authority to make any decisions regarding research participation. Thirdly, some areas were undergoing re-organisations, were understaffed or were otherwise experiencing high work load and were reluctant to take on research.

Several and adjusted approaches were thereby applied by the research group in order to gain access, such as explaining that the research project would not require much time on their behalf, repeated contact attempts (yet trying not to annoy potential research participants) and waiting for a better and more suitable time for contact attempts and fieldwork. It usually took months to gain access, but eventually all selected administrations agreed to participate. We may mention the two most extreme examples in terms of the time required to gain access: In one region almost six months passed between initial contact and the first interview due to high work load. One municipality was re-organising the administration, which meant that our identified contact person, in favour of our research project, changed jobs to another unit. S/he referred to a temporary manager of addiction treatment that did not think the administration was suited to assist our research project. New contacts were taken when a new permanent manager was in place, and the fieldwork could start. Eight months passed between initial contact and an agreement. The interviewing started one month later.

It is clearly a delicate task to identify the right person to contact and to gain access in addiction treatment research. We have in previous research projects (238,239) experienced great differences across the health care and social services sectors in this respect. The health care system is usually more hierarchical and demands approval from chief executives and managers at different levels before access may be granted, whereas access to municipal organisations is usually more easily granted. Local cultures and influential professionals – some more in favour of research than others – are also decisive. The experiences from this research project, as well as from other

more recent efforts, do however inform us that getting in touch with and gaining access to – perhaps more streamlined – treatment organisations is becoming more difficult. One explanation may lie in a widespread 'research fatigue', as treatment facilities, especially in areas with universities or other big research organisations, are involved in a range of research or development-related projects, and are demanded to report information to a range of government agencies and registers – some of it in line with NPM.

Scrutinising public documents

The websites of the selected administrations (i.e., website of each region and municipality and if necessary also local federations or other development units that could be in charge of collaboration agreements or development work) were investigated to help characterise the administrations and inform the interview study in each area.

Sweden has robustly safeguarded the openness and availability of information concerning government, public documents and activities at various administrative levels. A *principle of public access to official documents* [*Offentlighetsprincipen* in Swedish] is incorporated into one of the fundamental laws, the Freedom of the Press Act (1949:105) [*Tryckfrihetsförordningen* in Swedish]. This transparency rule also implies that those working in public administrations – municipalities, regions and state government agencies – have a general right to tell media and others about matters related to their activities. Handing out information on individuals, such as addiction treatment patients and clients, is not allowed due to legislated confidentiality obligations. Some working documents may be out of reach if classified as unofficial (240,241). The research project was thereby guaranteed access not only to official statistics (above) but also to local/regional-level minutes of various political bodies, strategy documents, agreements, local guidelines and other documents submitted to, drawn up by or kept by local, regional and central governments. Most of the information is usually readily available online. Other information can be – and was – requested from each administration.

This procedure differed somewhat across selected administrations depending on the characteristics of the organisations. The annual Goals and budgets documents of each municipal and regional council assembly turned out to be a good – and comparable – source of information in regard to the administrations' organisational models, overarching visions, priorities and the position of addiction treatment in the organisation. These documents outline the experienced state of affairs, achievements, challenges ahead, balancing of the books and the next year's budget, and outlines the politically decided overarching goals for the municipality/region, often broken down into subgoals by each sector or political committee, e.g., by the social committee

regarding the activities of the social services. These documents expressed the degree of marketisation in the administrations. They could, for example, include market-oriented values, such as competition, as an overarching steering mechanism in the organisational model, and use market-oriented language. Another important source of information in the research project was the minutes of the social welfare committees or other relevant political bodies handling addiction treatment issues. Our general procedure included a screening of the lists of contents of the minutes from the last year and to further extract those articles and attached appendices, usually an official letter or investigation authored by a local/regional official, of relevance for our study. Based on the matters dealt with and our knowledge of previous matters, we further looked for older pieces of information on the websites. It could be an internal investigation, audit report or collaboration agreement that had been drafted a few years back but still was decisive for the everyday activities. We usually found information and documents related to the overarching organisational model (in case the administration had such a model), politically decided visions that guided the work, financial issues, budget cuts, the development and drafting of collaboration agreements between municipalities and regions, problems in regard to SIP, the implementation of EBP, the development or re-organisation of addiction treatment, overarching re-organisations that also affected addiction treatment, inspections and other matters and contacts with IVO, internal audit reports by the regional/municipal auditors, the application for and handling of state subsidies, procurement processes, documentation issues, the drafting of local guidelines and routines, and comments on different government inquiries relevant for addiction treatment or marketisation of health and welfare organisations.

Local and regional-level matters, available online, and important for the study subject were summarised, used in the description of each selected administration and incorporated into the interview guidelines used in each area. This proved to be important, for many matters were not automatically brought up by the interviewees, but interesting accounts usually followed when we posed a specific question about, for example, the last IVO inspection and how they experience such activities. It was equally interesting in cases when the interviewee had no idea about what was going on higher up the chain or in terms of the government of the administration.

Interestingly, the overarching Goals and budget documents and visions of the local/regional administrations often signalled a more marketised organisation than did the documents derived from the social services or health care sections. Such documents, e.g., internal guidelines for addiction treatment, more often used a language that referred to concepts in health (HSL) and social (SoL) legislations. While higher-level documents in an administration could use the term ‘customer’ also in regard to health and other welfare services, treatment-related documents – as well as

interviewed professionals and managers – typically used the concepts of 'patient' or 'client'. A municipality labelled as low on NPM could have some documents that reflected a more business-like management style, and a municipality high on NPM could have treatment-related documents that basically copied the values and concepts inherent in HSL and SoL. This illustrates that public administrations are complex and host a range of orientations.

Fieldwork periods

The dates of the fieldwork are specified in **Table 6**, in total and by different levels (national, regional, local) and selected area. The first interview, at national level, was conducted in August 2016, and the last interview took place in June 2018.

Table 6. Fieldwork initiated and terminated, in total and by recruitment area.

	Initiated	Terminated
Total sample	Aug 2016	June 2018
Central and Nordic level	Aug 2016	Feb 2018
Regional level (sampled regions)	Sep 2017	Apr 2018
Region 1	Sep 2017	Sep 2017
Region 2	Mar 2018	Apr 2018
Region 3	Mar 2018	Apr 2018
Local level (sampled municipalities)	Mar 2017	June 2018
Municipality 1	April 2017	June 2017
Municipality 2	April 2017	Oct 2017
Municipality 3	Mar 2017	Dec 2017
Municipality 4	Jan 2018	Jan 2018
Municipality 5	Mar 2018	Mar 2018
Municipality 6	Dec 2017	Jun 2018

In order to keep travel costs down, the initial plan was to travel to each selected area once and conduct all the interviews in a few days or in a week. Given the sometimes stressful work environments, difficulties of getting hold of potential research subjects (managers but also policy-makers and treatment professionals; see above), and cross-checking full calendars, this proved difficult. The fieldwork of some selected areas was therefore quite spread out over time. One advantage of keeping the fieldwork in an area together was that it helped the researcher remember the details from the scrutinised documents on the organisation and addiction treatment in mind, as well as remembering what other interviewees in the area had already shared that was potentially worthwhile bringing up in the next interview. The researcher kept notes following every interview and continuously wrote initial analysis thoughts as well as questions to pose to a certain research participant. These notes were read and repeated

at the return to a recruitment area to make sure we did not forget important features or experiences that had been brought up in an organisation. These difficulties in practically managing the fieldwork did, however, complicate the fieldwork and demanded more resources and working hours for travelling and preparations than originally planned for.

Recruitment procedures in sampled areas

As outlined in Study 1 above, we sought to interview key-informants involved in regional and local level-policy making – elected representatives as well as officials such as procurers. For Study 2, which made up most of the interview study, our goal was to interview service providers in public and contracted services. Ideally, respondents would represent varying professions, roles (treatment professionals and managers), experiences of addiction treatment and different types of organisations and providers. We wanted a heterogeneous sample that covered different experiences and administrative and organisational levels of addiction treatment. We also sought for a somewhat representative distribution across types of professions involved in addiction treatment (doctors, nurses, social workers, etc.). We used both strategic sampling and snowballing in the recruitment of informants in order to reach such heterogeneity that could match our research aims and questions (242).

The people bearing different kinds of knowledge and experiences that were most suitable to interview for our study had to be individually identified and approached in every selected organisation. A procurer was, for example, only interviewed in an administration with pronounced purchasing activities, such as internal competition. The sampling was guided by the studied documents (that often named people of importance for the addiction treatment organisation) and by our initial mapping of each organisation. Usually we started off with an interview with a higher-level manager in charge of addiction treatment. This person explained the organisation and its history, and units and people of interest to the study were brought to our attention. In some cases this initial contact asked lower-level managers to participate and to name some professionals that could be interviewed. In other cases we got suggestions and contacted potential research participants ourselves. During an interview we could also become aware of others that we wanted to approach.

For municipalities we wanted to interview both people involved with statutory social work and people primarily providing the granted services, for example at the municipality's own outpatient treatment unit. For the regions we wanted to interview people both in inpatient and outpatient units. For both types of administrations, we also tried to include managers or professionals at contracted private units if these played an important role in the administration's treatment offer – e.g., were running a unit (entrepreneurship) or offered treatment in a system of choice.

Qualitative work is an ongoing process, and the recruitment strategy was somewhat revised during the fieldwork. Early interviews made us aware of differences in experiences of professional autonomy across more and less experienced staff. This led us to ask for names also of more newly hired and graduated professionals. They were not always suggested to us, because they did not yet know the organisation that well. We also noticed that some managers and professionals had quite narrow knowledge of the organisation, which in many cases made us reach out for yet another person that could tell us more about important features. We thereby ended up doing more interviews per area than initially intended. Otherwise we would not have reached a good understanding of the organisation and would not have had such a saturated image of the experiences of the politicians, managers and treatment professionals that we were aiming for.

Characteristics of 85 interviews and 93 research participants

The 85 semi-structured interviews

A total of *85 semi-structured interviews were made with 93* research participants.[13] *Sixteen officials participated in 16 interviews* at government agencies involved in the steering of addiction treatment (e.g., at Ministries, NBHW, IVO, SALAR and procurement agencies). *Seventy-seven people participated in 69 interviews* with local and regional-level policy-makers, officials, treatment managers and treatment professionals in public in-house units and in contracted private (not-for-profit and for-profit) treatment organisations across Sweden.

As reported in **Table 7**, most of the 85 interviews (n=76; 89%) were conducted with one interviewee, seven interviews included two interviewees, and two of the interviews involved three research participants interviewed jointly.[14] The participation of more than one person was usually suggested and requested by the respondents who wanted to involve a colleague in a similar work role – e.g., the manager and deputy manager, two mid-level managers, or two social workers doing statutory social work.

[13] Three of the 93 interviewees were interviewed twice: a treatment manager was first included in a group interview and thereafter interviewed individually; a treatment professional was interviewed twice: s/he was re-interviewed over the phone four months after the initial interview to follow up on the implementation of a certain management technique in the municipality; and a national-level procurer was interviewed twice to follow up on the developments within public procurement legislation and processes.

[14] Broken down by government level (not shown in the table): All but one central-level interviews had one interviewee, one had two; 36 out of 43 local-level interviews had one participant, five had two, and two interviews had three interviewees; 25 out of 26 regional-level interviews had one participant, and one interview had two interviewees.

The interviews were conducted face-to-face, except for four that for practical reasons were made by telephone (one was a long-distance follow-up, one due to a sudden flu, one shorter central-level interview and one cross-border interview). In most cases, the interviews took place in a private room at the interviewee's workplace or in another private facility, based upon practicalities and the interviewee's preferred choice. Three interviews were conducted more openly in a public space when no private room was available. Most of the interviews (n=79; 93%) were made by the study PI Jessica Storbjörk, five were conducted by Kerstin Stenius, and one was made jointly.

Table 7. Characteristics of the 85 interviews.

	Frequency (n=85)	**Percent**
Total number of interviews	85	100
Number of interviewees per interview		
One	76	89
Two	7	7
Three	2	2
Form of interview		
Face-to-face	81	95
Per telephone	4	5
Place and type of interview (in-person or by telephone)		
In private at the interviewee's workplace	62	73
In private in a public space or at the interviewee's home	15	18
In a public space at the interviewee's workplace	3	4
In private at the research centre	1	1
By telephone (in private)	4	5
Interviewer		
Storbjörk	79	93
Stenius	5	6
Storbjörk & Stenius	1	1
Sample setting/level		
Central government (3 Nordic officials included)	16	19
Regional (contracted providers included)	26	31
Local (municipalities; contracted providers included)	43	51

Table 8. Length of interviews (minutes).

	Min–max	Mean	Median	Standard deviation
Total sample (n=81) [a]	25–98	67	68	14
Central level (n=12)	51–98	77	75	16
Regional level (n=26)	25–84	61	63	15
Local level (n=43)	46–92	67	70	10

[a] Four central-level interviews with officials abroad, with note-taking only, excluded.

The interviews lasted between 25 and 98 minutes, with an average of over an hour (mean=67; median=68). Central-level interviews were the longest, followed by interviews in selected municipalities. Regional-level interviews were the shortest.

Research participants received a symbolic reimbursement as a token of our appreciation – a *Triss* fortune scratch card (SEK 30). One interviewee declined the offered scratch card due to previous dependence problems and another declined because s/he was afraid it would be considered as corruption.

The 93 individual interviewees

This section portraits the characteristics of the interviewed 93 officials, managers, professionals and politicians, in total and by level of recruitment (local, regional and central level). As pointed out above, three research participants were interviewed twice. In this section, each research participant is counted only once.

The majority of the 93 interviewed research participants were female (**Table 9**). Fifty interviewees were recruited from selected municipalities, 27 from sampled regions, and 16 were recruited from the central/national level. Most of the respondents belonged to a public administration or government, but private operators are also present. Twelve were local- and regional-level elected politicians involved with addiction treatment or its steering. Twenty served as officials (experts, strategists, procurers, etc.), and most of them were interviewed at the central level at various government agencies. Fifty-nine were involved in actual treatment work. Nineteen of them had some form of lower- or higher-level coordination or management role. We also interviewed four high-ranking officials within the social services such as heads of IFO. Higher-ranking managers in the health care systems were found to be too distant from dependence care and appeared irrelevant for the interview study. The treatment professions reflect those found in municipal and health care-based addiction treatment. Thirty worked s social workers, ten worked as nurses, five were medical doctors, three were psychologists and the fourteen other professions covered, among other things, school welfare officers and occupational therapists.

Table 9. Characteristics of 93 individual research participants from sampled municipalities and regions, and from central-level government, numbers.

	Local	Region	Central	Total
Sex				
Women	41	14	5	60
Men	9	13	11	33
Type of provider/organisation				
National-level agency abroad	-	-	3	3
National-level agency in Sweden	-	-	11	11
Public service or administration	44	23	-	67
For-profit company	2	-	2	4
Not-for-profit organisation	4	4	-	8
Type of unit				
Outpatient	30	8	-	38
Inpatient/residential	5	10	-	15
In- and outpatient	6	3	-	9
Other (public administration, government agency, political body)	9	6	16	31
Work assignments/duties/roles				
Politician	8	4	-	12
Procurers or purchasers [a]	2	1	2	5
Officials: experts, strategists, etc.	-	-	14	14
Statutory social work (incl. managers) [b]	17	-	-	17
Treatment managers/coordinators (of whom the majority also did treatment work) [c]	13	11	-	24
Treatment providers	10	9	-	19
User organisation representatives	-	2	-	2
Profession *(12 politicians excluded)*				
Social worker	25	1	-	26
Doctor/psychiatrist	-	5	-	5
Nurses [d]	1	9	-	10
Psychologists	0	3	-	3
Misc. treatment professions: curator, occupational therapists, psychotherapist, behavioural scientist, etc.	14	2	-	16
Other (officials, procurers, user representatives)	2	3	16	21
Total number of individuals (n)	**50**	**27**	**16**	**93**

[a] Three officials now involved in procurement had a previous background in social work.

[b] Seven managers (sometimes involved in decision-making) and 10 social workers.

[c] Four higher-ranking social services managers such as heads of IFO, 8 that only did lower-level management, 12 that served both as managers/coordinators and treatment providers.

[d] Including two auxiliary psychiatric nurses.

Most of the research participants were directly associated with addiction treatment. Some higher-ranking managers were responsible for addiction treatment matters as well as a range of other service areas. Likewise, the local and regional-level officials (procurers and strategist) worked with addiction treatment as well as other service areas of the administration.

Elected representatives were identified and interviewed in all selected areas. For the municipalities, the chair (or former chair if a new chair had just been elected) of the social committee in charge of addiction treatment turned out to be best suited for the interview. There is often no political board particularly focusing on addiction treatment in the health care system. For the regions we therefore had to identify politicians that had a special interest in psychiatry, had been involved in developing dependence care or were formally in charge as a member of the executive committee, etc. A politician that served as a member of a municipal purchasing board was also interviewed in a municipality with a prominent purchaser–provider split. It turned out that most of the interviewed politicians had long careers within local and regional-level policy-making. Some of them were active both at the regional and municipal levels, and several of them had had many different kinds of assignments in different development projects and on both the purchaser and the provider side of the political body.

Likewise, but invisible from **Table 9**, the interviews informed us that a large share of the interviewees had previously worked at other units with other tasks than the position in which they were interviewed for this study. Most managers had previously worked primarily with the service users, some managers still had their own caseload, and some interviewees had moved between making treatment decisions and performing the actual treatment. Some of the staff now working primarily with service users had previously held management positions. Many had also moved between organisations: between private and public providers, between municipalities and regions, between eldercare or general psychiatry and addiction treatment, between municipalities with or without a market-oriented model, etc. Thus, the experiences covered in the interviews are richer than appears in **Table 9**. Many informants offered comparative accounts and could specify the importance of different features of the organisation in which they currently worked.

Interview guides, interview material and organisation of the textual data

Interview guides and interview situation

The interview study applied a qualitative research approach. It used semi-structured interviews to ensure that central and applicable topics were covered and to

simultaneously allow for variations based on organisational belonging or individual differences grounded in the informant's professional role and experiences (243,244).

Interview guides were drafted based on the study aims and research questions, and further developed by relevant research literature. The guides had thematic headings and lists of possible questions and useful wordings to use in the interview situation, if applicable. The guides were further developed along the fieldwork: They were complemented for every recruitment area or government agency to safeguard that important topics revealed in the investigation of online documents and reports were covered. The interview guides – in their basic form – are presented, in **Appendix B**.

The guide was primarily used as a checklist to ensure the coverage of important topics. The order of questions usually varied. Sometimes an informant automatically started to talk about a certain topic, at other times it was the interviewer who had to raise questions on that particular topic. The interviewer allowed such variations and made notes during the interview on which topics that had already been dealt with, which ones to return to or otherwise follow up upon later on in the interview. The interview situation was thereby context-specific and treated as a relational and iterative process. The interviewer often sought to confirm and further encourage the interviewee to continue sharing his or her experiences by interposing small words such as 'aha' and to repeat what the informant just said, like 'hm, many re-organisations'. Interpretive and summarising questions were posed by the interviewer to further validate the interview data – e.g., 'So what you're saying is that you think that you have enough freedom in your work, but that the routines in place may require too much time to keep up with and may be difficult to adapt to the clients. Do I understand you correctly? ', or 'You've been talking about all the detailed guidelines, does that mean that you think there is too much of that or are they useful to you?' (243). The interviewer also expressed in words, for the audio recording, what the interviewees silently expressed by body language, like showing a downward movement with their hands or demonstrating an angry face – i.e., 'it went down' and 'they got upset'. Most importantly, the interviewer endeavoured to be present in the moment, listen actively and be attentive to the interviewee.

Naturally, single interviews took different forms and turns depending on the interviewee. It was, for example, very clear that treatment professional working daily with service users devoted a lot time speaking about the service users, whereas higher-ranking officials spoke much less about the service users and automatically devoted more time to talk about organisational and strategic matters. It was up to the interviewer to seek for a balance in the interviews and to firmly draw the interviewee towards the research questions and the interview guide topics. Most of the informants were talkative, and the interviewer had to judge when a topic had been exhausted and it was time to move to another question or back to the issues of relevance for the

research project. This did include, perhaps not always beneficially for the interaction, interrupting the informants in their accounts.

Sometimes the interviewer had already been in contact with the interviewee who was well aware of the research project. At other times, the informant had only little previous knowledge of the research project when the interview was about to start. The interviewer made sure that the informant understood the study purpose, how we were about to handle their information, the right to break off the interview or leave questions unanswered, etc. We clarified that we would not share their information or their interview accounts with unauthorised parties, including their colleagues and managers, and that the name of their administration or organisation would not be disclosed anywhere. Some interviewees also pointed out, during the interview, if there were certain passages that they did not want us to write about – hence stressing the importance of confidentiality also in studies where interviewees talk about their work. The interviewee signed the consent form (see **Appendix A**) and got a copy of the form, unless it had already been sent by email and s/he did not wish a copy. The consent form was emailed to the research participant, and his/her approval was audio-recorded when the interview was conducted over the phone.

The interviews were audio-recorded digitally into MP3 files by using a small Dictaphone device. The interviewer signalled to the interviewee when it was turned on. [15] The audio files were transferred via a secure FTP server to the company Transkribering.nu that transcribed the interviews[16] verbatim but in accordance with the company's standard transcription style (explained in a 16 pages long document known to their transcribers). They do not edit nor influence the text but try to 'make your text as readable as the spoken language allows'. They do, for example, leave out filler words such as 'like' or 'sort of' and leave out half sentences and faltering (and immediately write the entire sentence formulated), if those words or sections do not add meaning to what is said. They leave out sounds such as 'hm' or 'eh'. They do not, however, correct grammatical errors or a faulty word order and they write in sounds like laughter and notations for doubtfulness or other apparent emotions not expressed in words (245). Transcribering.nu signed a confidentiality form on how they were allowed to handle our research data – i.e., not share the information with anyone. They deleted their copies of the audio files after they had returned the word documents, via the FTP server, and we had confirmed that we had received the texts.

[15] Four central-level interviews by Stenius were documented by taking notes: one shorter Swedish central-level interview by telephone and three interviews with Nordic officials.

[16] Storbjörk transcribed five interviews due to financial reasons or low quality sound (recorded over the phone or with several participating interviewees).

Coding, organisation and initial analysis of interview data

The data comprises a highly comprehensive interview material of 1916 transcribed A4 pages (1030 pages for local-level interviews, 564 for regional level and 322 for the central level). The mean length of a transcribed interview was 23 pages (md=24, sd=5). More details are presented in **Table 10**.

Table 10. Number of words in transcripts.

	Min–max	Mean	Median	Standard deviation
Total (N=81)*	335–16190	10466	10626	2650
Central level (N=13)*	335–16190	10768	11269	3901
Regional level (N=26)	4104–13791	9636	9316	2640
Local level (N=43)	7255–15445	10877	10934	2101

* Four central-level interviews with officials abroad, with note-taking only, excluded.

The transcribed interviews were imported into the QSR NVivo software version 11 that was used to organise the data (246). The interviews were set in the following order for the reading, analysis and coding: from the municipality with the lowest to the highest level of NPM, followed by regions from the lowest to the highest on NPM, and within each selected area organised top-down from policy-makers, via higher-level managers and officials, to professionals (managers and providers within the same unit were grouped together). Central-level interviews were kept together.

Memos were continuously written down in an electronic research diary throughout the fieldwork to memorise initial thoughts and impressions regarding single interviews, entire organisations, differences across levels or organisations, and theoretical constructs.

All interviews were coded by the same scientist (Storbjörk). Both deductive and inductive procedures – i.e., an abductive approach – were applied to the coding of the textual data. We developed initial codes based on theory and our research questions. These were further inductively developed (with new nodes) and organised (separated, merged or moved in the code tree) during the coding process to safeguard that important aspects expressed by the interviewees would be covered. During this close reading, the meaning of each interview was condensed and summarised, but held closely to the original expressions and words used by the interviewees (243), into significantly shorter texts for each interview. The purpose of this step was to offer an overview of the material and to help facilitate comparisons across organisations and respondents by narrowing the textual data down. The research diary notes, previously organised around each interview occasion, were pasted below its corresponding summary and complemented during the coding process. Initial memos were thereby built into the continued analysis.

The descriptive or conceptual codes were primarily created and processed to allow for thematic analyses with the aim to categorise and condense the data into meaningful themes and subthemes, to allow for explorations of patterns in the data and relationships between different parts of the data, and to make comparisons across different types of organisations and professionals (247–249). In the coding process, Storbjörk read each interview line-by-line and considered each phrase and paragraph in order to assign codes to excerpts of the text that reflected the content of that passage. A section usually addressed several topics and thereby assigned all applicable codes. The text sections marked and coded under each code were broad enough to help the analyst to understand the context of the excerpts.

The *parent nodes* (with several underlying child nodes) covered content and meanings such as: *Tensions and logics* (autonomy–control, administration–treatment, treatment needs–budget, quality–costs, quality–volumes, professional ethics–economic/laboratory logic, rules and structure–gut feeling and experience, continuity–fragmentation, flexibility–market lock-in effects, who to respond to, national rules–local practices, etc.); *Boundaries* (keep one's boundaries, expand one's boundaries); *Strategies* (liberty-taking, deserting/exit, protesting/voice, negotiate, ignorance, coping with one's frustration, adherence/adjustment, trust capital, service user focus, organisational hypocrisy, etc.); *NPM* (marketisation, models of payment, economisation, purchaser–provider split, management by results, accountability, etc.); *Auditing* (documentation, measurable numbers, inspections, systematic follow-up, etc.); *Procurement* (competition, contracts, competence/skills, good/poor providers, practices, system of choice, etc.); *Government* (steering by politicians, by officials, by the state, etc.); *Service users* (effects on the service user-level, outcomes, user involvement); *Background* (characteristics of the respondent, of the organisation, etc.); *Buzzwords* (EBP, collaboration, trust, inequality, etc.); *Extras* (lobbying, development over time, power dislocation/shifts, etc.).

The coding process can be visualised by a slightly shortened excerpt that exemplifies how an interview section could be assigned several applicable codes. This is a quote by a worker engaged in statutory social work:

> There must be room for professional judgements. I'm thinking that social legislations are quite open for negotiations and judgements but it is all tightened up by local municipal routines, internal organisation and arrangements: 'This is how we do it here.' That removes the perspective of the individual user and his/her needs, if everything must be dealt with in the same way. Then it ends up like a control system. Quality should not only be on paper, in our indicators. We measure collaboration, whether we have addressed this or that in the assessment, and so on. But this can be done in many ways. And the more issues you must address on your checklist, the more time it will take. You must try to become even more effective and somewhere along the way, quality will suffer. You can't get the same quality. You can't have too many

> checklists – I already carry a thick pile to my client encounters. What kind of answers will I get from the client? In practice, I must adapt my work depending on the client, his/her ability and our relation – it may not be possible to dig into a certain issue during our first meeting. So that's the danger in adding more and more into the routines – ask this, ask that. That you actually lose information if the client chooses just to say no to everything. Clients must trust me, and that may require that we meet more often and that I don't ask all the questions in the recommended order, I adapt to make it work. So I guess that's what I can control – the order of things.

This dense section dealing with both autonomy–control, quality, professional ethics–administrative rules, structure–gut feeling, who to respond to, management/steering, accountability, documentation/administration, national rules–local practice, adjustment strategy, service user focus, measurable numbers, effects on the service user, process outcome as well as some other assigned nodes.

As a tool of analysis, the research participants or transcripts, were also assigned attributes reflecting the interviewees and their organisation (municipality, region or non-public; degree of NPM; professional role as policy-maker, manager or treatment provider, etc.). These attributes allow us to retrieve nodes with relevant text passages from different groups of respondents or organisations in the analyses.

Ensuring data quality of the qualitative study

Qualitative studies can be evaluated against three main criteria: a) significance of the data set; b) sufficiency of the data and coverage of the analysis, and c) transparency and repeatability of the analysis (250):

a) *Significance*. In this case we based the focus of the Studies 1 and 2 on previous literature, further nuanced before we performed the interview studies in regions and municipalities on national key person interviews and a Nordic seminar. The selection of regions and municipalities was theoretically grounded to produce a significant data set of staff interviews with experiences covering organisational, political and regional variations, and the selection of staff ensuring a variation in terms of staff position within organisations and length of work experiences;
b) regarding the *sufficiency* of the data, the extent of the material (almost 2000 pages of transcribed interviews as presented above, and the amount of work needed to recruit interviewees) was such that it would not have been feasible to extend the data collection any further. The analysis covered the entire transcribed text material;
c) to ensure the *transparency and repeatability* of the analysis, we have motivated the focus and concepts of the analysis and provided an example of how the text was coded (see above).

Based on literature, we made a first draft of the interview. It was slightly revised

during the fieldwork. Several actors were involved in helping us understand and term the area, and thereby draft a good-quality interview guide. The research team attended several conferences and seminars arranged by and targeting practitioners on NPM and on the organisation of health and welfare services. This helped us learn the language used and which features were considered important or problematic. Secondly, we were invited to a researchers' network on *Privatisation and competition in the social services,* coordinated by Marie Sallnäs and Stefan Wiklund at the Department of Social Work, Stockholm University (as of 2019 led by Emelie Shanks and David Pålsson). A group of Swedish scientists had just started to work on an anthology on the subject, and their expertise and the discussions in this network were very valuable to us. Our research project contributed with a book chapter on NPM in relation to service user involvement and professional discretion in health and social services-based addiction treatment (72). Thirdly, two additional exploratory interviews were made in March and June 2016, with people involved in addiction treatment and the NPM debate. The first 80- minute interview was made with a social worker with experiences from both health care and social services-based addition treatment, and from evaluation work. This interview helped us understand how certain NPM features may be implemented and shaped in addiction treatment and how treatment professionals may comprehend NPM. One immediate insight was that it is very difficult to translate NPM and its practices into everyday language commonly understood by treatment professionals. The second interview (130 minutes) was conducted with four representatives of the network *Gemensam Välfärd* [*Common Welfare* in Swedish], established in 2005 and protesting marketisation, de-regulation and privatisations in the health and welfare sectors. Their knowledge on such market-oriented features in Swedish health and welfare, and how they are implemented in practice, was very useful.

A study strength is that it was the same scientist (Storbjörk) that did basically all the fieldwork and interviews at both national level and in the selected administrations. The same scientist also coded all the interviews. This enables a more coherent treatment of the data, but we can, of course, not rule out gliding in the understanding of the study object and interpretations and thereby also in the interviewing and in the coding of the interviews. The scientist was supported by Stenius in this work. Stenius read many of the interviews along the fieldwork, which facilitated fruitful discussions in the research group on the content of the interviews and how to interpret our findings.

Methodological problems and limitations

Studies like this one naturally run into methodological problems along all stages of the research process. Some of these refer to quite common considerations and

problems in empirical research involving humans and service organisations. One example from our study is the workload of the treatment staff working at the recruitment units, which may lead to their de-prioritising the research project or tiredness with research due to other ongoing or recent research projects at the unit. This could have implied a certain biased selection of interviewees to those who had more control over their workload. In our case, and as outlined above, such problems could at least in part be counteracted by postponing the time of the fieldwork, by repeated reminders and encouragement, and by adding as few tasks as possible on treatment staff, i.e., to do most of the recruitment work ourselves – a choice which also helps to avoid research bias.

One problem, as acknowledged already in the first exploratory interviews, was that NPM was and remains a rather unknown concept and phenomenon in some quarters, and especially so among street-level bureaucrats working in a more traditional organisation. Some were not at all familiar with concepts like NPM, competition, market-oriented solutions, purchaser–provider splits, etc. This is very interesting as such, but it also caused some problems in how to phrase the questions.

Another difficulty is the problem of separating whether experienced and expressed problems originate in NPM – which remains difficult to define in practice – or other contemporary phenomenon, such as EBP and specialisation, which may or may not be linked to NPM in theory and practice. Including recruitment areas that, on average, are lower on NPM will help us in these interpretations, i.e., to understand which problems appear everywhere and which ones are more prominent in more or less NPM-oriented administrations. Also, some staff had long experiences from different organisational frames and could provide us with comparative experiences.

The research project primarily relies upon interviews and the research participants' own stories of what they experience and how they handle certain problems. We do not know how they actually behave and how this translates into their accounts.

Web survey (Study 3)

Construction of the web survey

The previous Studies 1 and 2 of the research project formed the basis for this web survey among professionals. The intention was to more thoroughly catch the proliferation of various NPM and related organisational features (such as EBP and the specialisation of services) and experienced advantages and problems thereof. We further sought to allow for comparisons across different types of organisations and professional groups.

Constructing a web survey whose purpose was to measure NPM and implications in everyday work within the addiction treatment system proved to be challenging. Firstly, NPM as a concept had to be untangled. This was done with the help of theory (5,6,251) and the empirical findings in the interview studies prior to this survey in the research project. The survey questions were thereby created partly from what was found out from the interviewed persons working in addiction treatment and the characteristics of the organisations in the six selected municipalities and three regions, including contracted companies and NGOs.

One thing we had experienced during the fieldwork in the previous substudies was that the knowledge about NPM and its components – as well as general knowledge of organisational matters – varies a lot among addiction treatment professionals and stakeholders. Staff in more marketised organisations may be well aware of concepts like purchaser–provider models and system of choice, whereas staff in more traditional organisations may be unaware of such phenomenon and concepts. It was thereby a challenge to choose the NPM features that appeared most important for addiction treatment and to phrase them in such a way that they would be comprehensible for potential respondents.

Further, the questions had to be adapted to whether the respondent was working in a municipality, region or working at a contracted agency. This applied, for example, to questions on public procurement and various agreements – whether the respondent was likely to be a buyer or a seller. A mandatory filter question was thereby built into the web survey in which the respondent stated whether s/he was working for a region, municipality, private company or NGO (ownership). Those that said they were employed by the state were taken to the end of the questionnaire, as the survey did not target staff within compulsory care and the criminal justice system. One challenge in our web survey was also that it targets different professional groups in different organisations usually studied apart. This implied, for example, that many response categories were needed in the section about the respondents and their workplaces to cover potential variations. Words and concepts had also to be considered, because the language differs across the medical and the social part of the addiction treatment system. These matters were also, in part, eased by the use of filter questions.

A first draft was discussed at a reference group meeting in Stockholm on November 15, 2018. We searched for existing surveys to guide us in our operationalisations of organisational features and professionals' experiences thereof. Previous research on the subject was basically lacking. There were however some surveys that had used some questions that were potentially relevant to this study. We thereby scanned the work and surveys used in previous research (107,108,252–259). These studies were primarily used for inspirational purposes, and only one question was used in its original format, namely the left–right political self-placement question on political

views as used by the SOM Institute (258,259).

Most of the main questions in the web survey, namely the blocks on autonomy and control, and pros and cons of organisational features and attitudes, were based on the interview material that was collected prior to the web survey study. Storbjörk, Stenius and Antonsson read the summaries of the interviews (see *Coding, organisation and initial analysis*… above) and used an inductive approach to thematise and formulate important questions and experiences shared by the interviewees in different types of organisations. This work required an iterative process and repeated discussions in the group to reach consensus on which questions to include and how to word them. This work continued during the pilot study.

Web survey tool: Survey & Report

The web survey was created with the help of the Survey & Report survey software provided to employees and students at Stockholm University. The programme allows the user to construct surveys that can be used to collect information for research projects. The logotype as well as the colour profile of Stockholm University are available in the tool, which may increase the respondents' trust in the study. The survey construction began with creating a general outline containing all the different sections that were going to be included in the web survey. The first page of the survey included some general information regarding the purpose of the research project, practical information about how to fill out the survey and ethical information (a selection of the most important issues fully presented to research participants in the informed consent form). A consent question followed this information section: the respondent was able to consent to participating in the survey or to not consent (mandatory question). Those that did not give their consent to participate were sent to the end of the survey and were instructed that they could close the webpage. Those that answered that they had received the information about the research project and how their information would be handled, and wanted to participate thereafter entered the actual web survey.

The sections reflected the following themes:

1. *Background questions*, which contained survey questions on background characteristics of the respondents such as sex, age, work experience and type of employer (ownership);
2. *Questions about the workplace*. This section contained questions about the respondent's workplace both with regard to the unit and the umbrella organisation they were working in and the presence of various NPM features;
3. *Questions about the everyday practice in addiction treatment*. This section contained several, rather large, question matrices that contained questions

measuring the respondent's experiences of autonomy and control, pros and cons about their unit and organisation as well as coping strategies. And finally,

4. *General attitude questions*, which contained items on the respondent's attitudes towards, e.g., private actors in publicly financed addiction treatment. There were also three open-ended questions, where the respondents were given the opportunity to write about what they felt was working particularly well or badly in addiction treatment as well as what could be improved in terms of organisation, steering and financing.

As the web survey was directed toward different types of addiction treatment workers in terms of employer and organisation, some questions were directed towards specific respondents through filters. Regions, for example, do not generally use framework agreements, making this question irrelevant to any respondent employed by a region. Adding filters was relatively intuitive and easy to do in this software. Several questions had an overarching question followed by several sub-items.

This was a structured survey and most questions had closed response categories. Several questions did, however, involve an 'other' alternative and/or allowed the respondent to write a specification or comment in their own words.

The risk was considered for internal missing values due to mistakes or initial hesitation about a certain question. We decided that questions with several items, where the respondent easily can miss one item, were going to be mandatory to allow the software to point out if the respondent had missed a question. However, the ethical approval allowed respondents to choose not to answer individual questions. In these cases, response options 'Don't know', 'Don't want to answer' and 'Not applicable' were therefore initially hidden from respondents in order to encourage them to try to answer every item. If a respondent skipped one item and tried to move to the next page, the software would perform a check to see whether every mandatory item was answered correctly. If not, a red text would appear as well as the option to choose 'don't know / don't want to answer'. Only a few questions that were mandatory had no such option; the consent question at the beginning of the survey (necessary for ethical purposes) and type of employer (needed for the filter questions). The latter was mandatory with no 'don't know / don't want to answer' option because the variable, as explained above, was vital for important filter questions and for the analyses and the addition of macro variables (such as population size, wealth and political government in different areas) that would help us categorise organisations.

The software was for the most part user-friendly and allowed us to create a sufficient number of different types of questions, i.e. multi-choice, single-choice, scales, etc., which would mostly fit the questions that we wanted to ask the respondents. Filters were for the most part easy and intuitive to create. Sometimes questions had to be

hidden in order to be able to use a filter where they would appear.

Filters would, however, sometimes fail to work as intended. The web survey had initially filter items within a question that would be mandatory. These items would be invisible for the respondents, who would in turn be prompted to answer the hidden question, even if it was invisible. No solution to this problem was found, and the number of within-question filter items had to be removed.

All the data entered into the web survey after launch were saved in a database provided by the company Artologik contracted by Stockholm University to offer the Survey & Report software. Data could easily be extracted both as Excel and SPSS files at any time. Responses could thereby be closely monitored during the whole duration of the data collection period. This proved to be useful when determining the efficiency of, e.g., reminder emails.

As concerns data protection, the research group initially investigated the handling of data by Artologik. A support ticket was opened up with a question regarding data protection and security, i.e. what kind of data, other than the survey response were collected and how data was stored by the provider. A question was posed about whether it was possible to track and identify individual respondents through, e.g., IP addresses. The IT security section at Stockholm University investigated the matter further, concluding that time and IP addresses were logged in addition to survey answers. This data is stored in a perimeter-protected server hall in southern Sweden, and only few people with strong disclosure contracts had physical access to the site. It was technically possible but far-fetched to track respondents, as the survey answers alongside the time stamp and the IP addresses were stored in separate data files. The company said it was theoretically possible to identify respondents if someone with access cross-referenced both data files with the time stamp as an ID, i.e., connecting IP addresses to survey answers. Because this appeared basically impossible in practice, however possible in theory, and because the research group never gets any IP addresses, our conclusion was that we cannot extract and hand out data to single respondents, as we cannot know for sure know who is who in the data material. This matter and our decision to rely upon GDPR2 was thoroughly discussed with Jenny Cisneros Örnberg, member of the Regional ethical review board of Stockholm.

Pilot study

A first final draft of the web survey was sent out to colleagues doing research in this field and the study's reference group for comments. Their[17] input was very helpful to

[17] We want to thank Björn Blom (Department of Social Work, Umeå University), Eva Samuelsson (Department of Social Work/Department of Public Health Sciences), and

help sort out important features and how to word question in the best way.

Revisions were made and the second final draft of the web survey was pilot tested. We used our network and knowledge of people working in addiction treatment to recruit six pilot respondents of whom three worked in municipal addiction treatment (both statutory social work/exercise of official authority and outpatient treatment), one in the private sector and two who worked in health care based-addiction treatment. The pilot selection managed to cover most of the different types of providers (i.e. public and private); the private sector respondent worked for a company that in turn is owned by a NGO – i.e., we had no pilot respondents that worked in a private company or a NGO directly.

The pilot study was conducted in the pilot respondents' workplaces after agreements made with them about a suitable time. Meetings began with a brief introduction of the purpose of the pilot study and the main study. Pilot respondents were then asked to fill in the pilot web survey on their computer, and the time to fully answer the web survey was measured for each pilot respondent. After the respondents submitted their answers we conducted short interviews. We asked about their general thoughts on the web survey and if there were any specific questions that were found unclear, difficult or irrelevant and if the web survey was of reasonable length. Pilot respondents were also asked if they thought the web survey was relevant given the purpose of the study. The web survey was generally positively perceived by the pilot respondents, but some of the feedback was almost unanimous regarding some parts and questions that were perceived as unclear or irrelevant. We received useful suggestions for how to improve these sections or have items cut out. Furthermore, the questions and topics of the web survey were generally perceived as relevant and important for those who work in addiction treatment.

With the results from the pilot study, this second draft version of the web survey was revised into the final web survey. Specific items were reformulated to increase clarity, some response categories were added, some questions were merged while others were dropped entirely as they were seen as not relevant for certain types of providers. One overarching goal was to shorten the questionnaire at this point, even if length generally was not raised as a problem in the pilot phase. The final web survey can in terms of number of questions/items be located somewhere in the middle in regard to the previous surveys we used for inspiration (see above).

Sampling strategies

The population or target group for the web survey was staff working with addiction

Emelie Shanks and David Pålsson (Department of Social Work) for their valuable comments on the draft.

treatment in both public and private sectors in Sweden, with the exception of staff working for state government agencies such as The Swedish Prison and Probation Service [*Kriminalvården* in Swedish] and The Swedish National Board of Institutional Care [*Statens institutionsstyrelse* (SiS), in Swedish]. We specified in the complete information to respondents that the web survey targeted staff working directly with service users in treatment or assessment as well as those working more indirectly with service users, such as lower-level managers involved in the daily practice and decision-making in individual cases. The web survey was not adapted for higher-level managers primarily involved with strategic or monetary work and with low involvement in treatment and daily practices.

The sampling method was a mix between snowball sampling, strategic sampling and total sampling (242). In theory, the web survey was targeted toward *all* staff in municipal, regional and private (for-profit companies and not-for-profit NGOs) addiction treatment services in Sweden. However, there are no complete registries over addiction treatment services or staff as opposed to typical population registries. We initially contacted the National Board of Health and Welfare (NBHW) to see if they had updated lists of services. They referred to SALAR, which in turn referred to a research and development unit that, in turn, said that they no longer had funding to maintain that list. No list was thereby received. SALAR (260) did however, estimate that 16 000 people working in addiction treatment (in the social services, health care system, criminal justice system, and other) received training in the Knoweldge to practice implementation of national treatment guidelines in 2009–2014. More narrowly defined, Lundström, Sallnäs and Wiklund (102) have analysed the development of the composition of staff working in organisations (institutional HVB homes and outpatient care) offering addiction services as part of Family and individual care of the social services. These figures (p. 70) indicate that there were about 5000 employees in 2015, of whom about 45 percent were employed by a private provider (vs public); the vast majority of these were for-profit providers (<10% not-for profit; p. 72).

As a consequence of the lack of oversight and lists of units, we did not know how many in total worked within addiction treatment in Sweden. Several different sampling and distributions strategies were used to get as broad a selection of respondents as possible. The focus of this study was addiction treatment directed toward adults, i.e., staff solely working with adolescent addiction treatment were not selected for the survey.

We strategically searched for different types of units. Snowball sampling was used by gathering contact information, which is disclosed further below, for managers, for example. These were contact persons to whom we sent an invitation to participate (if relevant) and asked them to circulate the questionnaire to relevant staff. Another

example of snowball sampling was the distribution of the web survey in different Facebook groups that were likely to have members working in addiction treatment.

Overarching strategies were applied to, hopefully, reach out to all units providing addiction treatment: through Facebook, advertising in relevant media[18], and through the use of general contact persons (at Research and development units across the country and SALAR's contact persons for addiction treatment). In addition, several strategic methods were used to further ensure that the information and invitation reached out to the various camps. A description of the different selection and distributions methods is given below.

Institutional care at homes for Care and living (HVB)

A list of HVB facilities was compiled from different sources, mainly; the Health and Social Care Inspectorate's (IVO)[19] list of publicly and privately run HVB facilities from 2016 that had been previously analysed and used in the research project (90); the SALAR company SKL Kommentus' list of HVB services that recently concluded framework agreements with close to 80 municipalities in a national procurement process initiated in 2016 and published in early 2018 (261,262); and other online search engines for information on treatment providers and companies.

Both IVO's and SKL Kommentus' lists were somewhat old (both established 2016): some facilities no longer existed; some had changed owners; or changed target group or direction of the operation between 2016 and the spring of 2019. For example, many units switched to target refugees and unaccompanied minors following the high rate of immigrants entering Sweden in 2015 (102). These lists did, however, provide us with initial information regarding most of the then existing HVB facilities, which helped us to collect contact information.

Several websites were used to collect information regarding the current status and contact information of the HVB facilities. Some operations were liquidated or had gone bankrupt during the period between 2016 and 2019, and websites which list information about companies (solidinfo.se and allabolag.se) were used to control whether companies that owned HVB facilities were still in business. Websites that

[18] As discussed at the reference group meeting on November 15, 2018, we decided that ads in very general media such as daily newspapers were not useful, especially not in relation to the price for such advertisement. As our target group runs across several organisations and professions, we could also conclude that few more targeted media forms appeared relevant or available for our purposes. Only a few paid ads were thereby used, and we decided to put most of our efforts into contacting units and professionals directly.

[19] IVO manages permits and registries over HVB facilities run by various public and private actors.

list, at least to our knowledge, most of the intuitional care facilities in Sweden were used (HVBguiden.se and SSIL.se). The purpose of these websites was to facilitate matching of service users and providers and to serve as a 'meeting ground' between buyers and sellers in addiction treatment. Sometimes news articles were found which contained information regarding, e.g., shutdowns of individual institutional care facilities. These facilities were excluded from the contact list, as they were no longer operational. A fairly large number of small institutional care providers had been purchased by larger companies in 2016–2019. Thirty-seven (18 percent) of the 211 units from the 2016 HVB list previously analysed by the research team (90) had, according to changes in the organisational numbers and checks in the online databases, been purchased by other providers, usually acquisitioned by larger companies or becoming incorporated into a large company group together with big multinational firms.

No HVB facilities that focused solely on adolescents (e.g. <18 or <20 years of age for the client) were selected, as the web survey was directed toward staff working with adult addiction treatment. As a minimum, facilities needed to at least to some extent provide care or accommodation for substance users. Institutional care facilities also operate in other fields than addiction treatment, such as dealing with general mental health or behavioural problems. For example, it was relatively common that facilities handled clients with mental illnesses in which substance use problems were common, i.e., comorbidity.

Contact information for every HVB facility was mainly drawn from the care provider's homepage, but when such information was not available directly, it could be found in the SKL Kommentus list or other websites that list these facilities. Contact information was collected to enable us to send the questionnaire via email, although phone numbers and the names of the supervisors were also collected if contact had to be made via telephone.

Assisted living facilities and outpatient facilities

Assisted living facilities [*stödboenden*, in Swedish] and outpatient facilities were mainly found through the providers' own homepages and lists. There is no public registry of this type of facilities, as they do not require permits to be able to operate, unlike HVB facilities. The operators could be public or private. The provider or municipal homepages could sometimes have their facilities listed with contact information for managers or other relevant contact persons. In addition, most of these facilities are publicly run within the local municipal social services administrations. We sought to reach these through invitations sent out to single municipalities, where we stated that we wanted to include staff at all services, including outpatient and housing facilities targeting people with substance use problems. Notably, single

administrations may, depending on their way of arranging addiction services, have somewhat different views upon which services include addiction treatment and which do not. One typical example are units for financial assistance that may be a separated unit in a large municipality or be run jointly with addiction services in a smaller and more integrated administration.

Addiction treatment within the municipal social services

Three major strategies were applied for the social services in the Swedish municipalities. Municipal social services include the assessments and decision-making branch (statutory social work/exercise of official authority), outpatient care, and institutional and assisted living facilities. Any part of the social services administration that had some direct or indirect responsibilities in addiction treatment was relevant for the study, be it treatment, assessment or other relevant activity as defined by the municipality.

Firstly, the six municipalities that were studied in the interview study prior to the web survey were specifically targeted and invited by individual emails to those that had participated in an interview and to central persons in each administration for further distribution. Secondly, the 24 largest municipalities in Sweden were selected, including Stockholm, Gothenburg and Malmö as well as all municipalities which have between 40 000 and 200 000 inhabitants and where a considerable amount of the inhabitants (less than 40 percent) does not commute to Stockholm, Gothenburg or Malmö. The third selection consisted of all other municipalities in Sweden: every remaining municipality after selection one and two were assigned a random number, and a selection of an additional 100 municipalities was made. Further, a few municipalities that based on our earlier analysis (90) of purchases of care were known to buy a considerable amount of addiction treatment and to also buy outpatient care (more than 50% of the outpatient care and/or more than 60–70% of all addiction services were purchased in 2015) were selected in case they had not already been picked up in earlier procedures. This was to ensure that municipalities that are likely to be more NPM-inspired were present in the material. Contact information was not collected for all Swedish municipalities because of the sheer number of municipalities and the time-consuming effort of finding contact information (apart from a general info email address) and sending out individual invitations. The survey was, however, directed toward all municipalities.

In total, 138 municipalities were selected for special targeting. These, as well as other organisations, could of course also be reached by other means: our invitations online, advertisement or forwarded invitations by contact persons in different regions.

Contact information[20] to relevant managers was collected where it was available. Some municipalities had contact information readily available on their homepages, whereas others did not. If possible, contact information of heads of units was collected, but if not, information regarding operational managers was collected. The primary contact information were email addresses, but if these were not listed on the homepage, a phone number was collected instead.

In sum, the following sampling strategies were applied:

1. The 24 largest Swedish municipalities.
2. A randomised selection of 100 Swedish municipalities (24 of these had no satisfactory contact information, in the form of email addresses to managers, listed on their homepages).
3. The six municipalities that were studied in previous part studies in this research project.
4. An additional 15 municipalities that to a large degree bought care from private providers (including voluntary actors).
5. Not all of the selected municipalities had sufficient contact information, so these were left out.

Addiction treatment within the healthcare system

Addiction treatment is also provided at the regional levels and is usually part of the psychiatric sector or organised in a specialised dependence care clinic or centre. The selection was based on psychiatry and health care units that in any way dealt with substance abusers. Lists of different units were made through searches on *1177 vårdguiden*, an online service intended for health care users. This site lists units tied to health care and is a service provided by the Swedish regions. Some regions (three and all of them fairly small in size) had no addiction treatment listed on the website. Addiction treatment is most likely part of the general psychiatry and was hence hard to come in contact with.

Addiction treatment units were divided into regions, and contact information was collected for each individual unit. This information was sometimes easily available at the individual region's homepage, whereas most of the time it was not. Whether contact information was available depended on the region itself. Some regions had their own search engines, where contact information to individual units could be found. Some regions have a special webpage for dependence care.

Certain regions did not list any information regarding their addiction treatment or even

[20] Email addresses to managers were deemed satisfactory as opposed to common addresses (e.g. an email address to the reception and/or the office with no specific person tied to the address).

the operational manager in charge. In these cases we called the telephone exchange and asked for the name and email address to the operational manager in order to be able to send information about the web survey with a request to circulate the survey to their staff. Eighteen out of 21 regions were eventually directly contacted; the three regions that were not contacted at least directly had little to no information regarding operational managers and whether they had dedicated addiction treatment units. Potential contact persons within some regions could be found through job adverts where usually the full name, the email address and their title were listed.

Circulating the web survey through central contact persons: Research and development units and MILK

Several municipalities, or groups of municipalities, and regions either have their own Research and development unit or share such a unit with other municipalities and/or regions (through, e.g., local federations [*Kommunalförbund*, in Swedish]). Their purpose is to perform evaluations and to develop and support the social services and the healthcare system. It was assumed that these units had good knowledge of services and actors in their catchment area and had a network of managers and staff working in addiction treatment to whom they could forward the web survey. In addition, they could be expected to be interested in research. An email with information regarding the web survey and the study with a request for this information to be circulated was sent out to all Research and development units across Sweden that were deemed relevant. Units that directly mentioned addiction treatment on their homepages were selected. In total, 24 such units received an invitation for further circulation. If possible, the invitation was sent to a person that, according to the web pages, focused on addiction treatment or the alike.

SALAR listed several contact persons for addiction treatment. This list, called MILK, was set up during the implementation of the first edition of the national treatment guidelines (165) and has thereafter been upheld to serve as a platform for information exchange. These persons were listed by the region they worked in. Similar to the Research and development units, it was assumed that these persons could circulate the information regarding the study and the web survey to relevant staff working with addiction treatment in municipalities and regions. Contact information was collected for a total of 49 persons that were on this list.

Of these contact persons, some were on sick leave or were found to have an invalid email address. Some had changed their jobs and referred, in an autoreply, to a successor. As a general rule during the fieldwork, we sought to forward the invitation to known successors. Autoreplies about holidays or sick leave were ignored in cases where the person was about to return to the office while the data collection was still ongoing.

Circulating the web survey on Facebook

Information and web link to the survey were also distributed through several Facebook groups. These groups were likely to have at least to some extent members whom worked in addiction treatment whereas some groups were specifically targeted towards workers in addiction treatment. In total, the web survey was distributed in eight such groups.[21] Users were also asked to circulate the survey further if they knew others who worked in addiction treatment.

Conferences

Attempts at recruitment of respondents were also made at two conferences which had a fairly large amount of addiction treatment staff attending. The first conference was arranged by the National Organisation against alcohol and narcotic abuse (RFMA),[22] an independent organisation which seeks to form opinion within the realm of problematic substance use. However, the main focus of the organisation is to be a place for discussion and knowledge exchange among its members, mainly through conferences and courses. Several members are either addiction treatment workers, researchers, companies or former addiction treatment workers. The conference was hence likely to have a significant number of attendees working within addiction treatment in Swedish municipalities and regions. We were allowed to hand out flyers with brief information about the study and with a link to the web survey homepage. This conference took place just before the web survey was launched.

The second conference was the REGAPS gambling conference arranged by our Department of Public Health Sciences in the end of April 2019. Like the RFMA conference, several attendees were addiction treatment staff in municipalities and regions, as gambling addiction is typically handled within regular addiction treatment. Attendee lists were public to all attendees, with full names, work titles and the name of the organisation they represented. A selection of conference attendees was made based on the relevance of their work titles and organisation (e.g., officials from state government agencies were excluded). Information and an invitation to participate in the web survey were sent out to those on the list deemed relevant for the study.

Miscellaneous

Requests were also sent out to relevant researchers and research networks (CERA, Privatiseringsnätverket, SAD, Sonad) that were assumed to be able to circulate the web survey to potential respondents. Advertisements were sent out in the newsletter

[21] 'Addiction treatment systems', 'ANDTS-psykologerna', 'HVB-gruppen', 'Institutionen för folkhälsovetenskap', 'Nätverket för beteendevetare', 'Socionom', 'Svenska nätverket dubbeldiagnoser', 'Yrkesverksamma och blivande socionomer'.

[22] Author's translation of 'Riksförbundet mot alkohol and narkotikamissbruk (RFMA)'.

to heads of the social services (Föreningen Sveriges socialchefer) and on the webpage of the journal *Alcohol & Narkotika* (run by CAN). We also intended to place an advertisement in a newsletter by the trade union SSR, but this was not realised due to high information load. Previous research participants involved in studies at the department were also emailed. Phone contacts were made with a list of private providers as well as umbrella organisations such as FAMNA in an effort to increase the number of responses from such agencies.

Survey launch (April 5–June 2, 2019)

The web survey was launched on April 5, 2019, and could be accessed on a subpage of the department's homepage (www.su.se/publichealth/websurvey2019). The webpage contained detailed information regarding the study, to whom the web survey was directed, information about ethics and informed consent as well as an additional link that directed toward the web survey. A Facebook event was created as part of the Department of Public Health Sciences Facebook account, and the web survey was advertised in the Facebook groups we had access to in conjunction to the launch. Both the event and advertisement contained a banner, some short information regarding the study and the web survey as well as a link to the web survey homepage.

Figure 1. Web survey banner attached to the survey invitation emails, used in advertisements, and attached to Facebook updates and events.

In the weeks following the launch, emails were sent out to all email addresses that had been collected prior to the launch date. This included the HVB facilities, assisted living homes, outpatient care, municipalities, regions and other contact persons. The email contained an invitation to participate, a link to the web survey homepage, a request to circulate the information to relevant units and staff as well as information regarding the study and the web survey. Reminder emails were sent out approximately two weeks after the initial invitation email.

Progress in terms of number of respondents was monitored during the data collection period. This enabled us to analyse the current situation and direct work toward target

groups that seemed to be underrepresented. It also gave us indications as to what specific action seemed to increase the response rate, e.g., when emails were sent out to the MILK list, the number of responses increased dramatically. The same could be observed when reminder emails were sent out.

The overall strategy was to start off by making the web survey visible by a broad dissemination online: Facebook events and banners in relevant Facebook groups, advertisement on *Alkohol & Narkotika*'s homepage, and early on an ad in the newsletter to the heads of social services across Sweden [*Föreningen Sveriges socialchefer* in Swedish] that was repeated after two weeks. We then invited all research participants that had been interviewed in the study and asked them and central actors in their administration to distribute the invitation to all staff working with addiction treatment in our sampled areas. We continued by sending out invitations to known HVB homes and to different research and development units that could distribute the invitation to units in their catchment area. We thereafter sent out invitations to other municipalities and regions, followed by the MILK network, whose forwarded message hopefully would reach new units and serve as a reminder to units that had already received the invitation. Special efforts were given to reach private providers and NGOs by contacting several agencies by phone. The Union for Professionals (Akademikerförbundet, SSR) offered to send out an invitation in their newsletter, for members working with addiction treatment were impossible to retrieve from their membership databases. This was not realised due to a high information burden and too frequent newsletters during the data collection period.

Early on during the fieldwork, we noticed that a quite high proportion of the people that entered the online web survey just opened the survey without submitting it. We thereby did one more revision of the web survey and cut some more questions out in an attempt to increase the submission rate, which did increase. However, around a quarter that entered the survey did not submit it. Perhaps the recipients of the invitation wanted to check the survey out before forwarding it to people in our target group, some may have started to fill it out and came back to finish it at another time, and others may be dropouts that for some reason chose not to participate after they had started to fill out the survey.

The survey was closed on June 2 after it had been open for eight weeks.

Respondents

A total of 632 entries were made, of which 3 were working at a state agency and 23 marked that they did not want to participate. After excluding these, 606 valid respondents were included in the final dataset.

Most of the respondents were females and older than 40 years (**Table 11**). Nearly 75

percent of the respondents were female, and more than 50 percent reported that they were older than 40. The 51–60-year-olds were the most common age group. Most of the respondents were social workers (24%), other (20%) and treatment providers/therapists (16%). Those who answered ‘other’ tended to further specify their work role in the comments section as having some kind of supervisor or coordinator roles. The least common work role among the respondents was medical doctor: fewer than one percent of the respondents reported this as their work role.

A clear majority of the respondents (66%) reported that they worked with some kind of counselling, support, treatment and care for the clients/patients. Working with statutory social work (25%), collaboration (25%) and administration and documentation (22%) were also common tasks among the respondents. The least common task was ‘other tasks’ (4%) and neuropsychiatric assessments (5%). The comments section regarding the ‘other’ category showed that these respondents performed tasks such as teaching or supporting relatives to clients/patients.

It was fairly common among respondents to have worked for more than three years in their current position and unit; around 60 percent reported this. The remaining 40 percent reported that they had worked less than three years in their current position and unit. Among those, 1–2 years of work experience were most common. The majority of respondents were quite experienced in addiction treatment, as 66 percent had six or more years of addiction treatment experience. Less than one year of overall work experience in addiction treatment was the least common category among the respondents, at three percent.

The most common type of employer was municipalities; a total of 64 percent of the respondents worked for a municipality. These workers were further divided into two subcategories: statutory social work/exercise of official authority and other. The latter category reflects social work that mainly has to do with treatment and therapy. Twenty-five percent of the respondents worked within municipalities with statutory social work tasks, whereas 40 percent worked within a municipality with other social work tasks. Further, 23 percent of the respondents had a region as their employer, 9 percent worked for a private company, and only four percent worked for a NGO. In sum, the most common employer in the material is the public sector, whereas the private sector is significantly less common.

Table 11. Background characteristics of the web survey respondents, valid percent.

Characteristics of respondents and their workplace	Percent	n
		606
Sex		595
Male	26	
Female	74	
Non-binary	<0.5	
Age (years)		603
21–30	10	
31–40	25	
41–50	24	
51–60	29	
61–65	11	
66+	2	
Respondent work as a…. (Profession/work role)		602
Occupational therapist	1	
Alcohol and drug therapist	7	
Treatment assistant	9	
Treatment provider/therapist (with bachelor degree)	16	
Social work counsellor	5	
Medical doctor: psychiatrist and/or specialised in addiction medicine	1	
Medical doctor: other specialisation	<0.5	
Auxiliary nurse (psychiatry)	4	
Psychologist	4	
Nurse	9	
Social worker	24	
Assistant nurse	1	
Other	20	
Work with… (several 'yes' responses possible)		
…Counselling, support, treatment and care	66	604
…Statutory social work/exercise of official authority	25	604
…Neuropsychiatric assessments	5	604
…Other assessments	17	604
…Management and leadership	19	604
…Supervision	9	604
…Collaboration	25	604
…Administration and documentation	22	604
…Developmental, planning and educational work	15	604
…Other	4	604

Continued.	*%*	*n*
Work experience: years in current unit		591
<1 yr	16	
1–2 yrs	23	
3–5 yrs	27	
6–15 yrs	24	
16–30 yrs	7	
30+ yrs	2	
Work experience: years with people with addiction problems		564
<1 yr	3	
1–2 yrs	12	
3–5 yrs	19	
6–15 yrs	35	
16–30 yrs	24	
30+ yrs	7	
Type of employer		606
Public: Municipal – Statutory social work/exercise of official authority	25	
Public: Municipal – Other (outpatient, housing facility, etc.)	40	
Public: Regional	23	
Private: For-profit company	9	
Private: Not-for-profit (NGO)	4	
Number of employees working at the unit		595
1–5	13	
6–10	25	
11–20	32	
21–30	18	
31–50	8	
51–70	1	
71–100	1	
101+	1	
Type of municipality [a]		468
Big city or municipality in close proximity of a big city	38	
Large city or municipality in close proximity of a large city	42	
Smaller city or town and rural municipalities	20	
Type of region [b]		138
Large region (>70 pop/km^2)	46	
Medium region (41–70 pop/km^2)	36	
Small region (<41 pop/km^2)	19	

[a] Only applicable to respondents employed by municipalities or private companies/NGO:s.

[b] Only applicable to respondents employed by a region.

A majority of the respondents worked in units with 6–20 employees, where the most common category was 11–20 employees at 32 percent, followed by 6–10 employees at 25 percent. It was less common to work in very large units. In terms of the number of employees, around 10 percent worked in a unit with more than 31 employees. It is, however, possible that this question could have been misinterpreted by some respondents for being the number of employees in the organisation as a whole.

Forty-two percent of the respondents worked within municipalities which were either a large city or in close proximity to a large city. Working in a big city or close to a big city was fairly common as well (38%). The least common type of municipality in the data is smaller cities/towns or rural municipalities; 20 percent of the respondents worked within this type of municipality. Respondents that either had a municipality, private for-profit company or not-for-profit NGO as their employer are valid cases in this variable.

Among the respondents employed by a region, the most common type of region was large regions at 46 percent. The type of region was determined by population density. The least common type of region was small regions at 19 percent.

Limitations and problems

This section elaborates further on some methodological problems, fieldwork experiences and other possible limitations in regard to sampling bias in our web survey.

The results from analyses conducted on this web survey data material are most likely not generalisable for the entire staff working with addiction treatment in municipalities, regions, private and third-sector organisations. As mentioned above, a probability sample of all addiction treatment workers – across administrations and different types of owners – in Sweden is hard if not impossible to achieve due to the lack of registries or lists over addiction treatment staff. The absolute majority of administrations and treatment organisations do not list the name of their employees on their websites. It is not possible to conduct a meaningful response analysis as the full population is unknown. One implication of this is that the probability for a person to receive and answer the web survey probably differed with regard to employer, municipality/region and company, to name a few. However, as our sample of respondents in many ways resembles what we do know about the Swedish addiction treatment system, it appears that most of the treatment professionals are female, that the municipalities and the social services hold the major treatment responsibility and thereby may host most of the professionals, followed by the health care system, and private providers.

Staff in municipal addiction treatment seemed more inclined to participate in the web

survey, which is backed up by the number of web survey respondents employed by a municipality (see **Table 11**). Regional staff was, in contrast to municipal staff, much harder to get hold of. This is reflected in the number of responses and resembles our data collection experiences. Several regions did not list any information regarding managers of addiction treatment and some did not even list available addiction treatment units in the health care system on their homepages. This study has, in line with previous research projects (238,239), also indicated that health care organisations are more hierarchical in comparison to most municipalities and social services administrations. It was, for example, quite common that lower-level medical professionals as well as supervisors and listed contact persons replied that they needed approval from the operational manager to engage with a researcher, while professionals in the social services more often seem to be able to make their own decisions about such participation.

We did, in our contact attempts, experience catch 22 situations where heads of units in the health care system said that they needed the approval from their superior manager before they could forward our invitation to the staff, and this person was impossible to reach (did not respond or reply to our messages) or stated that s/he did not think it was appropriate that a higher-ranking manager sent out such an invitation in case the staff would feel forced to participate. Obviously, we had, to a large extent, to rely upon supervisors to circulate the information about the study and the web survey. Therefore, we could see no way around such gatekeepers besides stressing confidentiality, the fact that it is up to each and every one to decide if they wish to participate, and hope that these staff groups would see the invitation online or elsewhere. However, they were most likely not reached. In addition, we do not know if potential respondents trusted our confidentiality promise. For example, a municipal employee contacted us to get a copy of the submitted responses, because all surveys must be filed in the municipality. As pointed out above, we had already informed that we could not hand out any responses due to the impossibility of identifying single individuals.

Unfortunately, we received few responses from the third sector and from private treatment providers. However, there are not that many third sector providers left in this field that have not been corporatised. We may mention two encounters with these organisations that potentially explain this shortage. The first one that may also apply to other recipients was the misunderstanding, despite our information of target groups and request that the invitation was forwarded to the entire staff, that we requested only one response from each unit. In most cases, we received no replies to our email invitations sent out to various types of organisations and contact persons. At one point, though, a person from a HVB home replied to our reminder that a certain member of the staff group had already participated. The second event is derived from our

correspondence, per email and phone, with a large private company that had recently been awarded several new contracts within addiction treatment. The experiences of staff of this organisation were therefore of great interest to our study. Contact persons first appeared interested in our survey but came back with a message from the board that the company was going through changes with the new contracts, the work had not yet settled and therefore they did not find it appropriate to forward our invitation to their employees.

It would, indeed, have been better to be able to reach addiction treatment staff directly by means of list serves of other membership registers as opposed to having to rely upon higher-ranking gatekeepers. As pointed out above, there is no such register. Other problems with membership registers, such as the one of the trade union SSR mentioned above, is that most available registers cover, for example, all social workers and not only those working with addiction treatment. We were also restricted by GDPR and other regulations on the purpose of existing contact lists. Some actors do have list serves that would reach our target group, but we were, in these cases, informed that they were not allowed to send out third-party information to the recipients.

We may mention some potential individual-level reasons for choosing not to participate in the web survey also in cases when it did reach people in our target group. Contact persons in two of the sampled municipalities were reluctant to forward our invitation due to the high work load of the professionals and other recent surveys with low response rates and a widespread 'survey fatigue' – all in line also with the findings from Studies 1 and 2. The high work load may also explain why some of the contact persons we approached, e.g., representatives of Research and development units and the MILK list, responded to our invitation when the web survey was about to close and it was too late to forward the invitation.

Finally, as pointed out above and is evident from the responses to our web survey, many employees are unaware and perhaps uninterested in organisational features of their workplace. This will most likely keep them from opening the web survey in the first place and may lead them to drop out and refrain from submitting their responses if they started to fill it out but felt frustrated or ashamed when they did not 'know' the answers to our questions. It was a delicate task to ask about NPM and organisational matters. Many respondents, and much more so from the health care system, left many questions on these matters unanswered or clicked 'don't know' (see **Appendix C**) – which is a very interesting finding per se.

The purpose of the research project was to study the impact of organisational features. This made it impossible to leave such questions out. We sought to formulate friendly instructions to these sections, stressing that we were going to ask about organisational

features that may be uncommon and that it is therefore perfectly fine to reply that one does not know if one has never heard of it. We do know, though, from the pilot study that many respondents may jump straight to the questions and may not read the introduction. It is also possible that these explanations were not enough to keep the respondents interested in the survey.

Despite these limitations and problems, we believe that the questions were relevant, understandable and useful, and hopefully they can be used in future studies. We can with this data give a more general background to the qualitative interview data from municipal staff. We can make some comparisons in terms of experiences and attitudes between staff in statutory versus treatment-oriented municipal addiction treatment, between such staff in different age groups and different regions and with longer or shorter works experience. Regarding differences between regions and municipalities, we can look at differences and formulate hypotheses that can be studied in future research.

Closure and contributions

Swedish addiction treatment is regulated by national regulations but primarily organised, provided and paid for by local and regional public administrations. The municipal (N=290) social services hold the major treatment responsibility, together with the regions' (N=21) health care systems providing medical treatment. Individual needs are assessed in-house in the social services, because such exercise of authority cannot be delegated to another provider. About forty percent of the actual treatment provided (in terms of costs) is, however, purchased and provided by another provider – at the moment primarily by for-profit enterprises (90). A market perspective is thereby vital for understanding addiction treatment, as such purchasing must adhere to binding procurement laws (LOU or LOV).

Market ideas underpinning the formalised process of public procurement may be incompatible with the notion of a rational and well-coordinated treatment system – e.g., because a tendering process may be 'destructive for the linkage between different treatment units since it evaluates each tender separately' (p. 570). The market aspects as linking mechanisms have, according to Bergmark, been more important for the actual staging of the treatment system since the 1990s than its system properties usually defined as a whole constituted of interrelated parts (143). It is therefore crucially important to empirically study the permeation and impact of such market ideas and other features associated with NPM to establish potential benefits and problems arising from such models. That is the goal of our study.

This is one of the first Swedish studies to research NPM in addiction treatment. By exploring the ways that NPM has been applied across contrasting locations and the associated benefits and problems of the approaches taken, we will arrive at conclusions regarding the suitability and limitations of NPM for addiction treatment as well as other health and welfare services. The project provides us with new information on benefits, experienced outcomes and inconsistencies across elements of NPM, health and social administrations, professions and regions. It reveals the extent to which concerned actors have a shared image of the expectations and functioning of addiction treatment or pull in opposite directions. Suggestions for improvements can be provided.

Storbjörk is the primary *contributor* to the current technical report. Antonsson drafted the sections on the web survey and the corresponding **Appendix C** tables. Stenius commented on and edited the entire report prior to publication. The authors wish to thank Pirkko Hautamäki for the professional English editing.

References

1. Hasselbladh H, Bejerot E, Gustafsson RÅ. Bortom New Public Management: Institutionell transformation i svensk sjukvård. Lund: Academia Adacta; 2008.
2. Pollitt C, Bouckaert G. Public management reform: a comparative analysis: New Public Management, governance and the neo-Weberian state. Oxford: Oxford University Press; 2011.
3. Dellgran P, Höjer S. Mellan offentligt och privat, politik och profession – en introduktion. Socialvetenskaplig tidskrift. 2005;2–3:98–107.
4. Gingrich JR. Making markets in the welfare state: the politics of varying market reforms. Cambridge: Cambridge University Press; 2011.
5. Hood C. A public management for all seasons? Public administration. 1991;69(1):3–19.
6. Pollitt C. Justification by works or by faith? Evaluating the new public management. Evaluation. 1995;1(2):133–54.
7. Hood C. The "New Public Management" in the 1980s: variations on a theme. Accounting, organizations and society. 1995;20(2):93–109.
8. Sundström G. Management by results: its origin and development in the case of the Swedish state. International Public Management Journal. 2006;9(4):399–427.
9. Larsson B, Letell M, Thörn H. Transformations of the Swedish Welfare State: Social Engineering, Governance and Governmentality. In: Larsson B, Letell M, Thörn H, editors. Transformations of the Swedish Welfare State. London: Palgrave Macmillan UK; 2012. p. 3– 22. [cited 2019 Apr 4]. Available from: http://link.springer.com/10.1057/9780230363953_1
10. Stenius K. Privat och offentligt i svensk alkoholistvård: arbetsfördelning, samverkan och styrning under 1900-talet. Lund: Arkiv; 1999.
11. Bertling U. Om den banala managementfilosofin... Psykoterapi. 2013;22(4):15–22.
12. Pollitt C, Sorin D. The impacts of the New Public Management in Europe: a meta-analysis. European Commission; 2011 [cited 2019 Jul 8]. Available from: http://www.cocops.eu/wp-content/uploads/2012/03/WP1_Deliverable1_Meta-analysis_Final.pdf
13. Power M. Audit society: rituals of verification. Oxford: Oxford University Press; 1997.
14. Christensen T, Lægreid P. Complexity and hybrid public administration—theoretical and empirical challenges. Public Organization Review.

2011;11(4):407–23.

15. Zaremba M. Patientens pris. Ett reportage om den svenska sjukvården och marknaden. Stockholm: Weyler; 2013.
16. Zaremba M. Patienten och prislappen 1. Vad var det som dödade Herr B? Dagens Nyheter. 2013; 17 februari.
17. Alvesson M, Gudmundsson K, Sandberg P. Byråkratiseringen av socialtjänsten tar tid från brukarna: Granskningssamhällets glittersprayade organisationer (Debatt). Sociala nätet. 2013 [cited 2013 Nov 28]; Available from: http://www.socialanatet.se/byrakratiseringen-av-socialtjansten-tar-tid-fran-brukarna/
18. Brulin G, Svensson L. På väg utför med mätbara resultat. Svenska Dagbladet. 2014; 20 januari.
19. Strömberg A-M, Lindén E, Westergren E, Öjerhag K, Tillema M, Svan S. Samhällets skyddsnät är på väg åt helt fel håll. SVT Debatt: Socialpolitik. 2011 [cited 2013 Nov 11]; Available from: http://debatt.svt.se/2013/11/11/samhallets-skyddsnat-ar-pa-vag-at-helt-fel-hall/
20. Tiselius H-G. Reflektioner över den offentliga sjukvårdens ekonomiska system. Läkartidningen. 2012;109(38):1683–1683.
21. Alvehus J, Ahlbäck S, Englund T, Hasselberg Y, Jonnergård K, Kastberg G, et al. All kvalitet kan inte mätas. Dagens Nyheter. 2013; 20 november.
22. Ankarloo D. Du följer väl avtalet, lille vän? Tiden. 2012 [cited 2012 Mar 13]; Available from: http://tidenmagasin.se/artiklar/du-foljer-val-avtalet-lille-van/ downloaded 120322
23. Berggren H. Fastna inte i ideologistrid. Axess. 2013;1(1).
24. Malmgren K, Augustin J, Blume E. Läkarna i protest mot vårdsystemet. Dagens Nyheter. 2013 [cited 2013 Jun 20]; Available from: http://www.dn.se/nyheter/sverige/lakarna-i-protest-mot-vardsystemet/?print=true
25. Jansson B, Nitz L, Wedin M. Våra modeller har kidnappats av ekonomernas modeller. Dagens Nyheter. 2013; 24 juni.
26. Mattsson M, Pintea R, Lindh Å, Olofsdotter M, Jacobson A, Glammer T, et al. Den ekonomiska styrningen kan drabba våra patienter. Dagens Nyheter. 2013; 13 juni.
27. Wahlroos B, Georgiadou A, Riese B, Bohman C, Spendrup F, Burenstam Linder M, et al. Debatt: Björn Wahlroos m.fl: Marknad gynnar välfärd. Dagens industri. 2017 [cited 2017 Aug 22]; Available from: https://www.di.se/debatt/bjorn-wahlroos-mfl-marknad-gynnar-valfard/
28. Nilsson L. Nej till vinstutdelning – ja till valfrihet i välfärden. In: Bergström A,

Oscarsson H, redaktörer. Mittfåra & marginal. Göteborg: Göteborgs universitet, SOM-institutet; 2014. p. 309–324. Available from: https://som.gu.se/digitalAssets/1487/1487690_309-324-lennart-nilsson---vinstutdelning.pdf

29. Eldh K, Ryd G. Debatt: NPM har skapat ett tjänstemannavälde. ETC. 2016 [cited 2016 Feb 14]; Available from: https://www.etc.se/debatt/npm-har-skapat-ett-tjanstemannavalde
30. Ahlbäck Öberg S. Välfärden – en ödesfråga inför valet 2018. SVT Nyheter Opinion. 2018 [cited 2018 Jan 11]; Available from: https://www.svt.se/opinion/shirin-ahlback-oberg-om-valfarden
31. af Ugglas C, Morin A. Debatt: Valfriheten ett minne blott för nio av tio i välfärden. Dagens samhälle. 2018 [cited 2018 Mar 1]; Available from: https://www.dagenssamhalle.se/debatt/valfriheten-ett-minne-blott-nio-av-tio-i-valfarden-20953
32. SOU 2016:78. Ordning och reda i välfärden: Betänkande av välfärdsutredningen. Stockholm: Wolters Kluwer; 2016. Available from: http://www.regeringen.se/rattsdokument/statens-offentliga-utredningar/2016/11/sou-201678/
33. Ratio. Marknadsdriven kvalitet i välfärden. 2017. Available from: http://ratio.se/app/uploads/2017/08/marknadsdriven-kvalitetssa%CC%88kring-av-va%CC%88lfa%CC%88rden-web.pdf
34. Andersson G, Vilkkavaara P, Pålsson Syll L. Debatt: Låt svenskarna folkomrösta om vinst i välfärden. ETC. 2018 [cited 2018 Mar 5]; Available from: https://www.etc.se/debatt/lat-svenskarna-folkomrosta-om-vinst-i-valfarden
35. Drechsler W. The Re-emergence of “Weberian” public administration after the fall of New Public Management: The Central and Eastern European perspective. Administrative Culture. 2005;6:94–108.
36. Pollitt C, van Thiel S, Homburg V. New Public Management in Europe. Management Online Review. 2007;1–6.
37. Dunleavy P, Margetts H, Bastow S, Tinkler J. New public management is dead—long live digital-era governance. Journal of public administration research and theory. 2006;16(3):467–94.
38. Kardefelt-Winther D, Heeren A, Schimmenti A, van Rooij A, Maurage P, Carras M, et al. How can we conceptualize behavioural addiction without pathologizing common behaviours? Addiction. 2017;112(10):1709–15.
39. Wiklund S. Individ- och familjeomsorgens välfärdstjänster. In: Hartman L, redaktör. Konkurrensens konsekvenser: Vad händer med svensk välfärd? Stockholm: SNS Förlag; 2011. p. 111–145. Available from: http://www.sns.se/sites/default/files/konkurrensens_konsekvenser_pod_2.pdf;

40. Bjerge B. Structural reforms as new public management policy: Three dilemmas in Danish substance misuse treatment. In: Hellman M, Roos G, von Wright J, editors. A welfare policy patchwork: Negotiating the public good in times of transition. Helsinki: Nordic Centre for Welfare and Social Issues (NVC); 2012. p. 181–201
41. Stenius K, Storbjörk J. Dynamiken bakom en gränsomdragande reform. Den snabba avknoppningen av Maria-enheten. Socialvetenskaplig tidskrift. 2003;10(4):366–87.
42. LeGrand J, Bartlett W. The theory of quasi-markets. In: LeGrand J, Bartlett W, editors. Quasi-markets and social policy. Basingstoke, UK: Macmillian Press; 1993.
43. Hartman L. Konkurrensens konsekvenser: Vad händer med svensk välfärd? Stockholm: SNS Förlag; 2011.
44. Sallnäs M, Wiklund S. Socialtjänstmarknaden – om marknadsorientering och konkurrensutsättning av individ- och familjeomsorgen. Stockholm: Liber; 2018.
45. Hansen Löfstrand C. Homelessness as politics and market. In: Larsson B, Letell M, Thörn,M., editors. Transformations of the Swedish welfare state: From social engineering to governance? New York: Palgrave Macmillian; 2012. p. 247–61.
46. Bejerot E, Hasselbladh H. Nya kontroll- och maktrelationer i sjukvården. Arbetsmarknad & Arbetsliv. 2003;9(2):107–27.
47. Aronsson G, Bejerot E, Härenstam A. Onödiga och oskäliga arbetsuppgifter bland läkare. Samband mellan illegitima arbetsuppgifter och stress kartlagt i enkätstudie. Läkartidningen. 2012;109(48):2216–9.
48. Burton J, van den Broek D. Accountable and countable: information management systems and the bureaucratization of social work. British Journal of Social Work. 2009;39(7):1326–42.
49. Evetts J. New professionalism and New Public Management: Changes, continuities and consequences. Comparative Sociology. 2009;8(2):247–66.
50. Edman J, Blomqvist J. Jakten på den verksamma vården. Kunskapssträvanden och målsättningar inom den svenska missbruksvården under ett sekel. In: Olsson B, editor. Narkotika Om problem och politik. Stockholm: Norstedts Juridik; 2011.
51. Bejerot E, Hasselbladh H. Forms of interventions in public sector organizations: generic traits in public sector reforms. Organization studies. 2013;34(9):1357–80.
52. Jessen J. Mindre frihet og skjønn i forvaltning av velferd? Tidsskrift for Velferdsforskning. 2007;10(4):246–61.

53. Svensson LG. Profession, organisation, kollegialitet och ansvar. Socialvetenskaplig tidskrift. 2011;18(4):301–19.

54. Sulkunen P. Re-inventing the social contract. Acta Sociologica. 2007;50:325–33.

55. Stenius K. Market forces do not solve the problems. Addiction. 2011;106(2):2067–71.

56. Axelsson I. Vinstkrav försämrar och fördyrar vården. Läkartidningen. 2012;109:165–6.

57. Willis E, Young S, Stanton P. Health sector and industrial reform in Australia. In: Stanton P, Willis E, Young S, editors. Workplace reform in the healthcare industry The Australian experience. New York: Palgrave Macmillan; 2005. p. 13–29.

58. McLellan T, Kemp J, Brooks A, Carise D. Improving public addiction treatment through performance contracting: The Delaware experiment. Health Policy. 2008;87(3):296–308.

59. Nesvåg S, Lie T. The Norwegian substance treatment reform: Between New Public Management and conditions for good practice. Nordic Studies on Alcohol and Drugs. 2010;27(6):655–66.

60. Lu M, Ma CT. Financial incentives and gaming in alcohol treatment. Inquiry. 2006;43(1):34–53.

61. Moore D, Fraser S. Producing the “problem” of addiction in drug treatment. Qualitative Health Research. 2013;23(7):916–23.

62. Storbjörk J, Room R. The two worlds of alcohol problems: Who is in treatment and who is not? Addiction Research and Theory. 2008;16(1):67–84.

63. Moskalewicz J. The forgotten stakeholders in the drug treatment system: its addicted clients. Nordic Studies on Alcohol and Drugs. 2010;27(6):613–6.

64. Hull P, Ritter A. The potential role of pay-for-performance in alcohol and other drug treatment funding: A literature review (14 Feb 2014). Sydney: Drug Policy Modelling Program, National Drug and Alcohol Research Centre, University of New South Wales; 2014. Available from: http://dpmp.unsw.edu.au/content/WP5 (Retrieved 22 March 2014)

65. Humphreys K, Mclellan AT. A policy-oriented review of strategies for improving the outcomes of services for substance use disorder patients. Addiction. 2011;106(12):2058–66.

66. Pedersen MU, Hesse M, Bloomfield K. Abstinence-orientated residential rehabilitation of opioid users in Denmark: Do changes in national treatment policies affect treatment outcome? ScandJPublic Health. 2011;39(6):582–9.

67. Commons M, McGuire TG, Riordan MH. Performance contracting for substance abuse treatment. Health Services Research. 1997;32(5):631–50.

68. Jones A, Pierce M, Sutton M, Mason T, Millar T. Does paying service providers by results improve recovery outcomes for drug misusers in treatment in England? Addiction. 2018;113(2):279–86.

69. Maynard A, Street A, Hunter R. Using 'payment by results' to fund the treatment of dependent drug users—proceed with care! Addiction. 2011;106(10):1725–9.

70. Mclellan AT. Commentary on Maynard et al 2011, Considerations on performance contracting: A purchaser's perspective. Addiction. 2011;106(10):1731–2.

71. West R. Commentary on Maynard et al. 2011, 'Payment by results' and smoking cessation support. Addiction. 2011;106(10):1730–1.

72. Storbjörk J, Samuelsson E. Brukarinflytande på vårdmarknaden – en paradox i missbruks- och beroendevården? In: Sallnäs M, Wiklund S, redaktörer. Socialtjänstmarknaden – om marknadsorientering och konkurrensutsättning av individ- och familjeomsorgen. Stockholm: Liber; 2018. p. 85–115.

73. Kaukonen O, Stenius K. Universalism under re-construction: from administrative coercion to professional subordination of substance abusers. In: Kildal N, Kuhnle S, editors. Normative foundation of the welfare state: The Nordic experience. London & New York: Routledge; 2005. p. 130–48.

74. Järvinen M. Hjälpens universum – ett maktperspektiv på motet mellan klient och system. In: Meeuwisse A, Swärd H, redaktörer. Perspektiv på sociala problem. Lund: Natur och Kultur; 2002. p. 253–73.

75. Blomqvist J, Palm J, Storbjörk J. "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. 2009;16(6):479–96.

76. Blomqvist J, Wallander L. Åt var och en vad hon behöver? En vinjettstudie av socialarbetares bedömningar och val av insats vid missbruksproblem. Stockholm: Stockholms stad, FoU-enheten.; 2004.

77. Blom B. Marknadsorientering av socialtjänstens individ- och familjeomsorg: Om villkor, processer och konsekvenser. Umeå: Umeå universitet; 1998.

78. Holgersson S. Sättet att bygga fasader inom svensk polis – En analys av presenterad bild jämfört med verkligt utfall. Nordisk tidskrift for Kriminalvidenskab. 2013;(1):112–30.

79. Lamont M, Molnár V. The study of boundaries in the social sciences. Annual Review of Sociology. 2002;28(1):167–95.

80. Mizrachi N, Shuval J, Gross S. Boundary at work: alternative medicine in biomedical settings. Sociology of Health & Illness. 2005;27(1):20–43.

81. Brunsson N. Ideas and actions. Justification and hypocrisy as an alternative to

control. Accounting, Organizations and Society. 1993;18(6):489–506.

82. Brunsson N. The organization of hypocrisy. Talk, decisions and actions in organizations. 2nd ed. Malmö: Liber ekonomi; 2002.

83. Meyer JW, Rowan B. Institutionalized Organizations: Formal Structure as Myth and Ceremony. American Journal of Sociology. 1977;83(2):340–63.

84. Thompson JD. Organizations in Action. Social Science Bases of Administrative Theory. New Brunswick/London: Transaction Publishers; 1967.

85. Klingemann H, Hunt G. Drug treatment systems in an international perspective: Drugs, demons and delinquents. Thousand Oaks, CA: Sage Publications; 1998.

86. Klingemann H, Takala J-K, Hunt G. Cure, care or control: Alcoholism treatment in sixteen countries. Albany: State University of New York Press, cop.; 1992.

87. Klingemann H, Storbjörk J. The treatment response: Systemic features, paradigms and socio-cultural frameworks. In: Kolind T, Thom B, Hunt G, editors. The SAGE Handbook of drug and alcohol studies – social science approaches (Vol 1). London: SAGE; 2016. p. 260–86.

88. Olsson B. Narkotikaproblemets bakgrund. Användning av och uppfattningar om narkotika inom svensk medicin 1839-1965. Stockholm: Stockholm: Stockholms universitet, Sociologiska institutionen & Centralförbundet för alkohol- och narkotikaupplysning (CAN); 1994.

89. Bergmark A. Expansion and implosion: the story of drug treatment in Sweden. In: Klingemann H, Hunt G, editors. Drug Treatment in an International Perspective. Thousand Oaks, Calif.: SAGE; 1998. p. 33–47.

90. Storbjörk J, Stenius K. The New Privatized Market – a question of ideology or pragmatism within the Swedish addiction treatment system? Social Policy & Administration. 2018:1–17.

91. Blomqvist J. The "Swedish model" of dealing with alcohol problems: historical trends and future challenges. Contemporary Drug Problems. 1998;25(2):253–320.

92. Bruun K. Finland: The non-medical approach. In: Kiloch LG, Bell DS, editors. 29th International Congress on Alcoholism and Drug Dependence. Australia, Chatswood: Butterworths; 1971. p. 545–59.

93. Storbjörk J. 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. Nordic Studies on Alcohol and Drugs. 2014;31(1):81–110.

94. Storbjörk J. One model to rule them all? Governing images in the shadow of the disease model of addiction. Drug & Alcohol Review. 2018;37(6):726–728.

95. SCB. Statistics Sweden's Statistical database. [cited 2019 Sep 25]. Available

from: http://www.statistikdatabasen.scb.se/pxweb/en/ssd/?rxid=a8c3f37c-acbf-47cf-a98c-fafcff1bc3db

96. Storbjörk J. Skyldigheterna bakom rättigheterna i svensk välfärdslagstiftning. In: Storbjörk J, redaktör. Samhället, alkoholen och drogerna: Politik, konstruktioner och dilemman. Stockholm: Stockholms universitets förlag; 2012. p. 184–215. Available from: http://su.diva-portal.org/smash/get/diva2:515004/FULLTEXT01.pdf
97. Prop. 1990/91:117. Regeringens proposition 1990/91:117 om en ny kommunallag. Stockholm: Civildepartementet; 1991.
98. Mattisson O. Organisation och styrning på den lokala samhällsnivån – en forskningsöversikt om förändringar och utvecklingstendenser. Underlag till Fi 2012:07 Utredningen om en kommunallag för framtiden. Stockholm: Finansdepartementet; 2013. [cited 2019 Sep 25]. Available from: http://www.sou.gov.se/wp-content/uploads/2014/11/df28f8ec.pdf
99. SOU 2013:53. Privata utförare - kontroll och insyn: delbetänkande av Utredningen om en kommunallag för framtiden. Stockholm: Fritze; 2013.
100. SOU 2011:35. Bättre insatser vid missbruk och beroende. Individen, kunskapen och ansvaret. Slutbetänkande av Missbruksutredningen. Volym 2. Stockholm: Fritzes; 2011.
101. HSLF-FS 2016:55. Socialstyrelsens föreskrifter och allmänna råd om hem för vård eller boende. Stockholm: Socialstyrelsen; 2016 [cited 2019 Jul 15]. Available from: https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/artikelkatalog/foreskrifter-och-allmanna-rad/2016-6-14.pdf
102. Lundström T, Sallnäs M, Wiklund S. Marknadsutrymme för privata utförare inom social barn- och ungdomsvård och missbruksvård – förändringar och drivkrafter. In: Sallnäs M, Wiklund S, editors. Socialtjänstmarknaden – om marknadsorientering och konkurrensutsättning av individ- och familjeomsorgen. Stockholm: Liber; 2017. p. 61–84.
103. SOSFS 2014:5. Dokumentation i verksamheter som bedrivs med stöd av SoL, LVU, LVM och LSS. Socialstyrelsens föreskrifter (SOSFS) 2014:5. Föreskrifter och allmänna råd. Stockholm: Socialstyrelsen; 2014. [cited 2019 Sep 25]. Available from: http://www.socialstyrelsen.se/publikationer2014/2014-5-19
104. Börjeson M. Hur bör sociala insatser tillhandahållas? En studie av Linköpings kommuns arbete med servicetjänster inom socialtjänsten. Linköping University Electronic Press; 2017. [cited 2019 Sep 25]. Available from: https://liu.diva-portal.org/smash/get/diva2:1079460/FULLTEXT01.pdf
105. SiS. Statens institutionsstyrelse [The Swedish National Board of Institutional Care homepage]. [cited 2019 Sep 25]. Available from: https://www.stat-inst.se/
106. Storbjörk J. The social ecology of alcohol and drug treatment: client

experiences in context (Doctoral dissertation). Stockholm: Stockholm University, Centre for Social Research on Alcohol and Drugs (SoRAD); 2006 [cited 2019 Sep 20]. Available from: http://su.diva-portal.org/smash/record.jsf?pid=diva2:189858

107. Lundgren M, Blom B, Morén S, Perlinski M. Från integrering till specialisering– om organisering av socialtjänstens individ-och familjeomsorg 1988-2008. Socialvetenskaplig tidskrift. 2009;16(2):162–83.

108. Morén S, Blom B, Lundgren M, Perlinski M. Specialisering eller integration? En studie av socialarbetares syn på arbetsvillkor och insatser i tre organisationsformer. Socialvetenskaplig tidskrift. 2010;(2):189–209.

109. Bergmark Å, Lundström T. En sak i taget? Om specialisering inom socialtjänstens individ-och familjeomsorg. Socialvetenskaplig tidskrift. 2005;12(2–3).

110. SOU 2011:35. Bättre insatser vid missbruk och beroende. Individen, kunskapen och ansvaret. Slutbetänkande av Missbruksutredningen. Volym 1. Stockholm: Fritzes; 2011.

111. IVO. Med missbruksvården i fokus: Socialtjänstens planering och uppföljning av insatser till vuxna med missbruksproblem [Elektronisk resurs]. Inspektionen för vård och omsorg (IVO); 2015 [cited 2019 Jul 15]. Available from: https://www.ivo.se/publicerat-material/rapporter/med-missbruksvarden-i-fokus/

112. Samuelsson E, Christophs I. Öppenvårdslandskap med variationer – insatser i Södertörns missbruksvård (No. 158/17). Stockholm: FoU Södertörn; 2017. [cited 2019 Sep 25]. Available from: https://fou-sodertorn.se/wp-content/uploads/2017/11/Rapport-nr-158.pdf

113. HSLF-FS 2016:1. Socialstyrelsens föreskrifter och allmänna råd om läkemedelsassisterad behandling vid opioidberoende. Stockholm: Socialstyrelsen; 2016 [cited 2019 Jul 15]. Available from: https://www.socialstyrelsen.se/regler-och-riktlinjer/foreskrifter-och-allmanna-rad/konsoliderade-foreskrifter/20161-om-lakemedelsassisterad-behandling-vid-opioidberoende/

114. SOSFS 2013:23. Ändring i föreskrifterna (SOSFS 2007:2) om utbyte av sprutor och kanyler till personer som missbrukar narkotika. Socialstyrelsens föreskrifter (SOSFS) 2013:23. Föreskrifter. Stockholm: Socialstyrelsen; 2013 [cited 2019 Jul 15]. Available from: https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/artikelkatalog/foreskrifter-och-allmanna-rad/2013-5-48.pdf

115. SOSFS 2007:2. Utbyte av sprutor och kanyler till personer som missbrukar narkotika. Socialstyrelsens föreskrifter (SOSFS) 2007:2. Föreskrifter. Stockholm: Socialstyrelsen; 2007 [cited 2019 Jul 15]. Available from: https://www.socialstyrelsen.se/regler-och-riktlinjer/foreskrifter-och-

allmanna-rad/konsoliderade-foreskrifter/20072-om-utbyte-av-sprutor-och-kanyler-till-personer-som-missbrukar-narkotika/

116. HSLF-FS 2017:2. Socialstyrelsens föreskrifter om ändring i föreskrifterna (SOSFS 2007:2) om utbyte av sprutor och kanyler till personer som missbrukar narkotika; beslutade den 24 januari 2017. Stockholm: Socialstyrelsen; 2017 [cited 2019 Jul 15]. Available from: https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/artikelkatalog/foreskrifter-och-allmanna-rad/2017-2-12.pdf
117. Eriksson L, Edman J. Knowledge, Values, and Needle Exchange Programs in Sweden. Contemporary Drug Problems. 2017;44(2):105–24.
118. Prop. 2016/17:15. Regeringens proposition 2016/17:15. Ökad tillgänglighet till sprututbytesverksamheter i Sverige. Stockholm: Socialdepartementet; 2016.
119. Kåberg M. Hepatitis C in people who inject drugs in the Stockholm needle exchange program: incidence, spontaneous clearance and change in risk behaviour. Stockholm: Karolinska institutet; 2019 [cited 2019 Jun 18]. Available from: https://openarchive.ki.se/xmlui/handle/10616/46687
120. Upphandlingsmyndigheten. Välkommen till Valfrihetswebben. 2016 [cited 2019 Sep 2]. Available from: https://www.valfrihetswebben.se/
121. Upphandlingsmyndigheten. Valfrihetswebben – The System of Choice Web. [cited 2019 Sep 2]. Available from: https://www.valfrihetswebben.se/in-english/about-valfrihetswebben/
122. Andersson L, Johnson B. Vårdval LARO: En målorienterad intressentutvärdering. Malmö: Malmö University, Faculty of Health and Society; 2017. [cited 2019 Sep 25]. Available from: http://muep.mau.se/bitstream/handle/2043/23350/V%C3%A5rdval%20LARO%20utv%C3%A4rdering.pdf?sequence=2&isAllowed=y
123. SOU 2017:56. Jakten på den perfekta ersättningsmodellen – Vad händer med medarbetarnas handlingsutrymme? Delbetänkande av Tillitsdelegationen. Stockholm: Wolters Kluwer; 2017. [cited 2019 Sep 25]. Available from: http://tillitsdelegationen.se/wp-content/uploads/2017/06/jakten-p-den-perfekta-ersttningsmodellen.pdf
124. Lindgren P. Ersättning i sjukvården. Modeller, effekter, rekommendationer. Stockholm: SNS förlag; 2014.
125. Vårdanalys. Coordinated health and care services: An analysis of the coordination challenges in a fragmented system for health and are services. Stockholm: Vårdanalys [Swedish Agency for Health and Care Services Analysis]; 2016 [cited 2019 Jul 15]. Report 2016:1. Available from: https://www.vardanalys.se/in-english/reports/coordinated-health-and-care-services/

126. SOU 2005:82. Personer med tungt missbruk – stimulans till bättre vård och behandling. Stockholm: Fritzes; 2005. [cited 2019 Sep 25]. Available from: https://data.riksdagen.se/fil/CB0E9639-9A6D-40A8-91B5-ABC159B3EA2B
127. Vårdanalys. Att komma överens: En uppföljning av överenskommelser inom missbruks- och beroendevården. Stockholm: Vårdanalys [Swedish Agency for Health and Care Services Analysis]; 2017 [cited 2019 Jul 15]. Report 2017:1. Available from: https://www.vardanalys.se/rapporter/att-komma-overens/
128. Socialstyrelsen. Nationella riktlinjer för vård och stöd vid missbruk och beroende: stöd för styrning och ledning. Stockholm: Socialstyrelsen; 2015.
129. Prop. 2012/13:77. Regeringens proposition 2012/13:77 God kvalitet och ökad tillgänglighet inom missbruks- och beroendevården. Stockholm: Socialdepartementet; 2013. [cited 2019 Sep 25]. Available from: http://www.riksdagen.se/sv/Dokument-Lagar/Forslag/Propositioner-och-skrivelser/prop-20121377-God-kvalitet-o_H00377/
130. Socialutskottet. Socialutskottets betänkande 2012/13:SoU18: God kvalitet och ökad tillgänglighet inom missbruks- och beroendevården. Stockholm: Socialdepartementet; 2012.
131. Socialstyrelsen. Vård och omsorg till personer med en riskfylld konsumtion eller beroende av olika substanser: öppna jämförelser av socialtjänstens och hälso- och sjukvårdens insatser. Stockholm: Socialstyrelsen [National Board of Health and Welfare, NBHW]; 2017.
132. IVO. Samverkan för patienter och brukares välbefinnande: Missbruks- och beroendevården [Elektronisk resurs]. Inspektionen för vård och omsorg (IVO); 2016 [cited 2019 Jul 15]. Available from: https://www.ivo.se/publicerat-material/rapporter/samverkan-for-patienter-och-brukares-valbefinnande---missbruks--och-beroendevarden/
133. Vårdanalys. Missar vi målen med missbruks- och beroendevården? Om uppföljning av resultat ur ett patient- och brukarperspektiv. Stockholm: Vårdanays [The Swedish Agency for Health and Care Services Analysis]; 2016 [cited 2019 Jul 15]. Report 2016:2. Available from: https://www.vardanalys.se/rapporter/missar-vi-malen-med-missbruks-och-beroendevarden/
134. Statskontoret. Informationsförsörjning om kommuner. Stockholm: Statskontoret; 2014.
135. Prop. 2013/14:118. Regeringens proposition 2013/14:118 Privata utförare av kommunal verksamhet. Stockholm: Finansdepartementet; 2014.
136. Socialstyrelsen. Att stärka kvaliteten i hem för vård eller boende (HVB) för personer med missbruks- och beroendeproblem. Stockholm: Socialstyrelsen [National Board of Health and Welfare, NBHW]; 2015 [cited 2019 Jul 15]. Available from: https://www.socialstyrelsen.se/globalassets/sharepoint-

dokument/artikelkatalog/ovrigt/2015-9-11.pdf

137. SOSFS 2011:9. Ledningssystem för systematiskt kvalitetsarbete. Socialstyrelsens föreskrifter (SOSFS) 2011:9. Föreskrifter och allmänna råd. Stockholm: Socialstyrelsen; 2011 [cited 2019 Jul 15]. Available from: https://www.socialstyrelsen.se/regler-och-riktlinjer/foreskrifter-och-allmanna-rad/konsoliderade-foreskrifter/20119-om-ledningssystem-for-systematiskt-kvalitetsarbete/
138. NBHW. Statistics on adults with substance abuse and addiction 2016. Stockholm: National Board of Health and Welfare; 2017. [cited 2018 Feb 5]. Available from: http://www.socialstyrelsen.se/publikationer2017/2017-9-24
139. SOU 2011:6. Missbruket, kunskapen, vården: Missbruksutredningens forskningsbilaga, delbetänkande av Missbruksutredningen. Stockholm: Fritze; 2011. [cited 2019 Sep 25]. Available from: http://www.regeringen.se/rattsdokument/statens-offentliga-utredningar/2011/01/sou-20116/
140. Ramstedt M, Sundin E, Landberg J, Raninen J. ANDT-bruket och dess negativa konsekvenser i den svenska befolkningen 2013. Stockholm: STAD; 2014.
141. Lander I, Olsson B, Rönneling A, Skrinjar M. Narkotikamissbruk och marginalisering: MAX-projektet, slutrapport. Stockholm: Centralförbundet för alkohol-och narkotikaupplysning (CAN); 2002.
142. Smith A. An Inquiry into the Nature and Causes of the Wealth of Nations. Indianapolis: Liberty Classics; 1981.
143. Bergmark A. On the idea of treatment systems. Nordic Studies on Alcohol and Drugs. 2010;27(6):565–73.
144. Furusten S. Dåliga kunder gör bra affärer! Ett dilemma i offentlig upphandling. Stockholm: Liber; 2015.
145. Montin S. Från tilltrobaserad till misstrobaserad styrning. Relationen mellan stat och kommun och styrning av äldreomsorg. Nordisk Administrativt Tidsskrift. 2015;92(1):58–75.
146. Montin S. Statens styrning av kommuner, en historisk översikt. Bilaga 2 till rapport Statens styrning av kommunerna (2016:24). Stockholm: Statskontoret; 2016. [cited 2019 Sep 25]. Available from: http://www.statskontoret.se/publicerat/publikationer/2016/statens-styrning-av-kommunerna/
147. Nyberg L. Politikens handlingsutrymme och konkurrensens lagar. Nyliberala föreställningar om stat och marknad i tre konkurrensregelverk. Statsvetenskaplig tidskrift. 2015;117(4):505–30.
148. Schneider T, Karlsson N, Stenius K. Upphandling av missbruksvård i Norden. Helsingfors/Stockholm: Nordens välfärdscenter (NVC); 2016. [cited 2019 Sep 25]. Available from: https://nordicwelfare.org/publikationer/upphandling-av-

missbruksvard-i-norden/

149. Regeringen. Uppdrag till Statskontoret om statlig styrning av offentlig sektor (Regeringsbeslut 2016-02-04, Fi2016/00372/SFÖ). Stockholm: Regeringen: Finansdepartementet; 2016. [cited 2019 Sep 25]. Available from: http://www.regeringen.se/regeringsuppdrag/2016/02/uppdrag-till-statskontoret-om-statlig-styrning-av-offentlig-sektor/

150. Prop. 2015/16:1. Regeringens proposition 2015/16:1 Budgetpropositionen för 2016.. Stockholm: Finansdepartementet; 2015. [cited 2019 Sep 25]. Available from: http://www.regeringen.se/rattsdokument/proposition/2015/09/prop.-2015161/

151. Statskontoret. Statens styrning av kommunerna. Stockholm: Statskontoret [For a summary in English see: http://www.statskontoret.se/In-English/publications/2016---summaries-of-publications/central-governments-steering-of-municipalities-201624/; last accessed 25 Sep 2019]; 2016. Available in Swedish from: http://www.statskontoret.se/publicerat/publikationer/2016/statens-styrning-av-kommunerna/

152. Forssell A, Westerberg AI. Administrationssamhället. Lund: Studentlitteratur; 2014.

153. World Health Organization (WHO) Regional Office for Europe. Health 2020: the European policy for health and well-being. [cited 2019 Jul 11]. Available from: http://www.euro.who.int/en/health-topics/health-policy/health-2020-the-european-policy-for-health-and-well-being

154. Pellmer Wramner K, Wramner B, Wramner H. Grundläggande folkhälsovetenskap. 4th ed. Stockholm: Liber; 2017.

155. Hellman M. Mainstreaming concepts, discounting variations? Global policies of alcohol, drugs and tobacco. In: Kananen J, Bergenheim S, Wessel M, editors. Conceptualising Public Health: Historical and contemporary struggles over key concepts. Routledge; 2018. p. 156–73.

156. Pålsson D. The prerequisites and practices of auditing residential care: On the licensing and inspection of residential homes for children in Sweden. Department of Social Work, Stockholm University; 2018. [cited 2019 Sep 25]. Available from: http://urn.kb.se/resolve?urn=urn:nbn:se:su:diva-151624

157. Skr. 2015/16:86. Regeringens skrivelse 2015/16:86. En samlad strategi för alkohol-, narkotika-, dopnings- och tobakspolitiken 2016–2020. Stockholm: Socialdepartementet; 2015 [cited 2019 Jul 11]. Available from: https://www.regeringen.se/rattsliga-dokument/skrivelse/2016/02/skr.20151686/

158. Bet. 2010/11:SoU8. Socialutskottets betänkande 2010/11:SoU8: En samlad strategi för alkohol-, narkotika-, dopnings- och tobakspolitiken m.m.

Stockholm: Socialutskottet; 2011. [cited 2019 Sep 25]; Available from: https://data.riksdagen.se/fil/F99126AE-CA58-40CA-A0FC-09C1313A426C

159. Regeringskansliet. Regeringens åtgärdsprogram för alkohol-, narkotika-, dopnings- och tobakspolitiken 2010. Stockholm: ANDT-sekretariatet; [cited 2019 Sep 25]. Available from: https://www.regeringen.se/rapporter/2010/02/s.2010.001/
160. Prop. 2002/03:35. Regeringens proposition 2002/03:35: Mål för folkhälsan. Stockholm: Socialdepartementet; 2002 [cited 2019 Jul 11]. Available from: https://www.riksdagen.se/sv/dokument-lagar/dokument/proposition/mal-for-folkhalsan_GQ0335
161. Prop. 2017/18:249. Regeringens proposition 2017/18:249. God och jämlik hälsa – en utvecklad folkhälsopolitik. Stockholm: Socialdepartementet; 2018. [cited 2019 Jul 11]. Available from: https://www.regeringen.se/498282/contentassets/8d6fca158ec0498491f21f7c1cb2fe6d/prop.-2017_18_249-god-och-jamlik-halsa--en-utvecklad-folkhalsopolitik.pdf
162. Regeringskansliet. A cohesive strategy for alcohol, narcotic drugs, doping and tobacco (ANDT) policy: a summarised version of government bill 2010/11:47. Stockholm: Ministry of Health and Social Affairs; 2011. [cited 2019 Jul 11]. Available from: https://www.government.se/information-material/2011/05/a-cohesive-strategy-for-alcohol-narcotic-drugs-doping-and-tobacco-andt-policy/
163. SKL. Överenskommelser mellan SKL och regeringen inom vård och omsorg. Sveriges kommuner och landsting [SALAR]. 2019 [cited 2019 Jul 11]. Available from: https://skl.se/halsasjukvard/overenskommelsermellansklochregeringen.1463.html
164. Fridell M, Holmberg R, Billsten J, Benderix Y. Implementeringen av Socialstyrelsens riktlinjer för missbruks- och beroendevården: Utvärdering av det nationella utvecklingsarbetet Kunskap till Praktik. Lund: Lunds universitet; 2015. [cited 2019 Sep 25]. Available from: https://lup.lub.lu.se/search/ws/files/3896654/5276300.pdf
165. Socialstyrelsen. Nationella riktlinjer för missbruks- och beroendevård. Vägledning för socialtjänstens och hälso- och sjukvårdens verksamhet för personer med missbruks- och beroendeproblem. Stockholm: Socialstyrelsen [NBHW]; 2007.
166. Folkhälsomyndigheten. Statsbidrag. Folkhälsomyndigheten. 2018 [cited 2019 Jul 11]. Available from: https://www.folkhalsomyndigheten.se/om-folkhalsomyndigheten/statsbidrag/
167. Socialstyrelsen. Statsbidrag. Socialstyrelsen [NBHW]. 2019 [cited 2019 Jul 11]. Available from: https://statsbidrag.socialstyrelsen.se/

168. Förordning 2015:155. Förordning (2015:155) om statlig styrning med kunskap avseende hälso- och sjukvård och socialtjänst. Stockholm: Regeringskansliet; 2015. [cited 2019 Sep 25]. Available from: https://www.riksdagen.se/sv/dokument-lagar/dokument/svensk-forfattningssamling/forordning-2015155-om-statlig-styrning-med_sfs-2015-155
169. Socialstyrelsen. Rådet för styrning med kunskap. Socialstyrelsen [NBHW]. [cited 2019 Jul 11]. Available from: https://www.socialstyrelsen.se/om-socialstyrelsen/organisation/rad-och-namnder/radet-for-styrning-med-kunskap/
170. Eriksson L, Edman J. Great expectations: The bureaucratic handling of Swedish residential rehabilitation in the 21st century. Nordic Studies on Alcohol and Drugs. 2018;35(4):257–74.
171. Bergmark A, Lundström T. Mot en evidensbaserad praktik? Om färdriktningen i socialt arbete. Socialvetenskaplig tidskrift. 2006;13(2):99–113.
172. Christophs I. Mot en bättre missbrukarvård? En undersökning om förutsättningar för att evidensbasera missbrukarvården i fyra organisationer. Stockholm: Stockholms universitet, SoRAD.; 2009. [cited 2019 Sep 25]. Available from: http://su.diva-portal.org/smash/record.jsf?pid=diva2:287289
173. SOU 2008:18. Evidensbaserad praktik inom socialtjänsten – till nytta för brukaren. Betänkande av Utredningen för en kunskapsbaserad socialtjänst. Stockholm: Fritzes; 2008.
174. SBU. Behandling av alkohol- och narkotikaproblem: en evidensbaserad kunskapssammanställning. Stockholm: Statens beredning för medicinsk utvärdering (SBU); 2001.
175. Berglund M, Thelander S, Salaspuro M, Franck J, Andréasson S, Öjehagen A. Treatment of Alcohol Abuse: An Evidence-Based Review. Alcoholism: Clinical and Experimental Research. 2003;27(10):1645–56.
176. Socialstyrelsen. Nationella riktlinjer för vård och stöd vid missbruk och beroende: stöd för styrning och ledning. Stockholm: Socialstyrelsen [NBHW]; 2015.
177. Socialstyrelsen. Läkemedelsassisterad behandling vid opioidberoende: Kunskapsstöd – i hälso- och sjukvård och socialtjänst. Remissversion. Stockholm: Socialstyrelsen [NBHW]; 2019 [cited 2019 Jul 11]. Available from: https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/artikelkatalog/kunskapsstod/2019-6-14.pdf
178. Socialstyrelsen. Ändamålsenligt stöd till barn i familjer med missbruk och andra allvarliga svårigheter. Delrapport från ett regeringsuppdrag. Stockholm: Stocialstyrelsen; 2015. [cited 2019 Sep 25]. Available from: https://www.socialstyrelsen.se/globalassets/sharepoint-

dokument/dokument-webb/ovrigt/missbruk-och-beroende-andamalsenligt-stod-till-barn-i-familjer-med-missbruk-och-andra-allvarliga-svarigheter.pdf

179. Socialstyrelsen. Missbruk och beroende. Kunskapsguiden.se. [cited 2019 Jul 11]. Available from: https://www.kunskapsguiden.se/missbruk/Sidor/default.aspx
180. SCB. Utförarregistret. [cited 2019 Jul 11]. Available from: http://www.scb.se/ufreg
181. Rådet för främjande av kommunala analyser (RKA). Kolada. [cited 2019 Jul 11]. Available from: https://www.kolada.se/?_p=index#
182. RKA. Nyckeltal som spelar roll. Förbättra styrningen med hjälp av nyckeltal. RKA (Rådet för främjande av kommunala analyser); 2013. [cited 2019 Sep 25]. Available from: http://rka.nu/download/18.4b2bd6f9148a6b349f4650b/1411646030648/rka-nyckeltal-som-spelar-roll.pdf.pdf
183. RKA. Kvalitetsnyckeltal för individ- och familjeomsorgen 2012. Resultat för brukarnära indikatorer inom försörjningsstöd, barn och unga samt vuxna med missbruksproblem. RKA (Rådet för främjande av kommunala analyser); 2013. [cited 2019 Sep 25]. Available from: http://rka.nu/download/18.2064a667148a7e3a2b6332db/1412341224496/rka-IFO-kvalitetsnyckeltal-2012.pdf
184. SKL. Nationella kvalitetsregister: Kunskap för bättre vård och omsorg. 2019 [cited 2019 Jul 11]. Available from: http://www.kvalitetsregister.se/
185. SBR. Svenskt beroenderegister. 2019 [cited 2019 Jul 11]. Available from: https://sbr.registercentrum.se/
186. Socialstyrelsen. Öppna jämförelser 2019: Missbruks- och beroendevård. 2019 Jun [cited 2019 Jul 11]. Report: Art.nr: 2019-6-6. Available from: https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/artikelkatalog/oppna-jamforelser/2019-6-6.pdf
187. Socialstyrelsen. Öppna jämförelser 2014. Missbruks- och beroendevården. Resultat, metod och indikatorer. Stockholm: Socialstyrelsen [NBHW]; 2014.
188. Socialstyrelsen. Öppna jämförelser av missbruks- och beroendevården. Öppna jämförelser. 2019 [cited 2019 Jul 11]. Available from: https://www.socialstyrelsen.se/statistik-och-data/oppna-jamforelser/socialtjanst/missbruk-och-beroendevard/
189. Socialstyrelsen. Indikatorer - öppna jämförelser 2019: Socialtjänst och kommunal hälso- och sjukvård. Stockholm: Socialstyrelsen [NBHW]; 2019 [cited 2019 Jul 11]. Available from: https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/dokument-webb/oppna-jamforelser/oppna-jamforelser-socialtjanst-2019-indikatorer.pdf

190. Socialstyrelsen. Metod - öppna jämförelser 2019: Socialtjänst och kommunal hälso- och sjukvård. Stockholm: Socialstyrelsen [NBHW]; 2019 [cited 2019 Jul 11]. Available from: https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/dokument-webb/oppna-jamforelser/oppna-jamforelser-socialtjanst-2019-metod.pdf
191. Socialstyrelsen. Öppna jämförelser 2017: Missbruks- och beroendevården. Guide för att tolka resultaten. Stockholm: Socialstyrelsen [NBHW]; 2017 [cited 2019 Jul 11]. Available from: https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/dokument-webb/oppna-jamforelser/oppna-jamforelser-2017-missbruk-och-beroende-anvandarguide.pdf
192. Stenius K, Storbjörk J. Balancing welfare and market logics: Procurement regulations for social and health services in four Nordic countries. Nordic Studies on Alcohol and Drugs. In press.
193. Forkby T, Höjer S. Ritual eller strategi – upphandlingar och ramavtal inom den sociala ungdomsvården. Socialvetenskaplig tidskrift. 2008;15(2):115–34.
194. Forkby T, Höjer S. Placeringar i köpt vård – om rationell styrning och kontraktsproblem på den sociala barnavårdsmarknaden. In: Sallnäs M, Wiklund S, redaktörer. Socialtjänstmarknaden – om marknadsorientering och konkurrensutsättning av individ- och familjeomsorgen. Stockholm: Liber; 2018. p. 160–82.
195. Prop. 2008/09:29. Regeringens proposition 2008/9:29 Lag om valfrihetssystem. Stockholm: Socialdepartementet; 2008.
196. Socialutskottet. Socialutskottets betänkande 2008/09:SoU5 Valfrihetssystem. Stockholm: Socialdepartementet, Socialutskottet; 2008. [cited 2019 Sep 25]. Available from: http://www.riksdagen.se/sv/dokument-lagar/arende/betankande/valfrihetssystem_GW01SoU5
197. SOU 2008:15. LOV att välja - Lag om valfrihetssystem. Stockholm: Fritzes; 2008. [cited 2019 Sep 25]. Available from: https://www.regeringen.se/rattsligadokument/statens-offentliga-utredningar/2008/02/sou-200815/
198. Upphandlingsmyndigheten. About Valfrihetswebben. Valfrihetswebben. [cited 2019 Jul 15]. Available from: https://www.valfrihetswebben.se/in-english/about-valfrihetswebben/
199. Regeringskansliet. National Board of Health and Welfare (Socialstyrelsen). Government Offices of Sweden. [cited 2019 Jul 15]. Available from: https://www.government.se/government-agencies/national-board-of-health-and-welfare--socialstyrelsen/
200. The National Board of Health and Welfare. Statistics on social service for adults with addiction and dependence in 2018 (Factsheet). Stockholm:

Socialstyrelsen; 2019 May [cited 2019 Jul 15]. Available from: https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/artikelkatalog/statistik/2019-5-20.pdf

201. The National Board of Health and Welfare. Statistics on licensed healthcare personnel 2017 and workforce status 2016 (factsheet). Stockholm: Socialstyrelsen; 2019 Jan [cited 2019 Jul 15]. Available from: https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/artikelkatalog/statistik/2019-1-17.pdf
202. Socialstyrelsen. Stimulansbidrag LOV: Slutrapport 2011–2014. Stockholm: Socialstyrelsen; 2015 [cited 2019 Jul 15]. Available from: https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/artikelkatalog/ovrigt/2015-6-51.pdf
203. Socialstyrelsen. ANDTS – riskbruk, missbruk och beroende. Socialstyrelsen [NBHW]. 2019 [cited 2019 Jul 15]. Available from: https://www.socialstyrelsen.se/stod-i-arbetet/missbruk-och-beroende/
204. Socialstyrelsen. Du kan minska din risk för överdos och rädda liv: Samtalsstöd för att informera om överdosriser med opioider. Stockholm: Socialstyrelsen [NBHW]; 2019 Jan [cited 2019 Jul 15]. Available from: https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/dokument-webb/ovrigt/opioider-samtalsstod-overdosrisker-for-utskrivning-asiintervjuer.pdf
205. Socialstyrelsen. Lär dig rädda liv med naloxon: Samtalsstöd för att informera om opioid-motgiftet naloxon. Stockholm: Socialstyrelsen [NBHW]; 2019 Jan [cited 2019 Jul 15]. Available from: https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/dokument-webb/ovrigt/missbruk-och-beroende-samtalsstod-naloxonforskrivning-utbildning.pdf
206. IVO. About the Health and Social Care Inspectorate. IVO. 2015 [cited 2019 Jul 15]. Available from: https://www.ivo.se/om-ivo/other-languages/english/about-ivo/
207. Statskontoret. Inrättandet av Inspektionen för vård och omsorg. Slutrapport. Stockholm: Statskontoret; 2015 [cited 2019 Jul 15]. Report 2015:8. Available from: http://www.statskontoret.se/publicerat/publikationer/2015/inrattandet-av-inspektionen-for-vard-och-omsorg.-slutrapport
208. IVO. Nationella HVB-registret. [cited 2019 Jul 4]. Available from: http://85.119.131.165/hvb-registret/default.aspx
209. IVO. Unga personer inom missbruksoch beroendevården: Nationell tillsyn av samverkan mellan olika aktörer samt socialtjänstens myndighetsutövning. Inspektionen för vård och omsorg (IVO); 2017 [cited 2019 Jul 15]. Available from: https://www.ivo.se/publicerat-material/rapporter/unga-personer-

inom-missbruks--och-beroendevarden/

210. HSLF-FS 2017:41. Inspektionen för vård och omsorgs föreskrifter om anmälan av händelser som har medfört eller hade kunnat medföra en allvarlig vårdskada (lex Maria). Socialstyrelsen. [cited 2019 Jul 15]. Available from: https://www.ivo.se/globalassets/dokument/publicerat/foreskrifter/hslf-fs-2017-41-webb2.pdf

211. SKL. Missbruk och beroende. SKL [SALAR]. 2019 [cited 2019 Jul 15]. Available from: https://skl.se/integrationsocialomsorg/socialomsorg/missbrukochberoende.1165.html

212. Statskontoret. Evidensbaserad praktik inom socialtjänsten. Utvärdering av överenskommelsen mellan regeringen och SKL. Slutrapport. Stockholm: Statskontoret; 2014 [cited 2019 Jul 15]. Report 2014:18. Available from: http://www.statskontoret.se/publicerat/publikationer/2014/evidensbaserad-praktik-inom-socialtjansten.-utvardering-av-overenskommelsen-mellan-regeringen-och-skl.-slutrapport

213. SKL. Förstärkt barn- och föräldraperspektiv i missbruks- och beroendevården: Bilaga 3. Redovisning av 2016-års arbete. Stockholm: Sveriges Kommuner och Landsting (SKL); 2017 [cited 2019 Jul 15]. Available from: https://skl.se/download/18.4863503915b5e41750af1259/1492842413248/F%C3%B6rst%C3%A4rkt%20barn-%20och%20f%C3%B6r%C3%A4ldraperspektiv%20i%20missbruks-%20och%20beroendev%C3%A5rden.pdf

214. SKL. När brukare och patienter blir medskapare - en lönsam historia. Stockholm: Sveriges kommuner och landsting [SALAR]; 2015 [cited 2019 Jul 15]. Available from: https://webbutik.skl.se/sv/artiklar/nar-brukare-och-patienter-blir-medskapare-en-lonsam-historia.html

215. SKL. Handlingsplan mot missbruk och beroende: Tidig upptäckt, tidiga insatser, stöd och behandling för personer i åldern 13-29 år. Stockholm: Sveriges Kommuner och Landsting [SALRA]; 2018 [cited 2019 Jul 11]. Available from: https://webbutik.skl.se/bilder/artiklar/pdf/7585-664-3.pdf

216. Konkurrensverket. Konkurrensverkets konkurrenstillsyn 2017. Stockholm: Konkurrensverket; [cited 2019 Jul 15]. Report 2018:3. Available from: http://www.konkurrensverket.se/globalassets/publikationer/rapporter/rapport_2018-3.pdf

217. Konkurrensverket. Konkurrensverkets upphandlingstillsyn 2017. Stockholm: Konkurrensverket; [cited 2019 Jul 15]. Report 2018:2. Available from: http://www.konkurrensverket.se/globalassets/publikationer/rapporter/rapport_2018-2.pdf

218. The Swedish Competition Authority. Public Procurement. Konkurrensverket. [cited 2019 Jul 15]. Available from:

http://www.konkurrensverket.se/en/publicprocurement/

219. Regeringskansliet. Swedish Competition Authority. Government Offices of Sweden. [cited 2019 Jul 15]. Available from: https://www.government.se/government-agencies/swedish-competition-authority/

220. Upphandlingsmyndigheten. Avtalsuppföljning av vård och omsorg. Stockholm: Upphandlingsmyndigheten; 2017 [cited 2019 Jul 15]. Vägledning nr 2. Available from: https://www.upphandlingsmyndigheten.se/globalassets/publikationer/vagledningar/upphandlingsmyndigheten_vagledning_avtalsuppfoljningvardomsorg a4_low_170214.pdf

221. Konkurrensverket. Hem för vård eller boende för barn och unga: En kartläggning av kommunernas ramavtalsupphandlingar. Stockholm: Konkurrensverket; 2015 [cited 2019 Jul 15]. Report 2015:3. Available from: http://www.konkurrensverket.se/globalassets/publikationer/rapporter/rapport_2015-3.pdf

222. Konkurrensverket. Marknaden för hem för vård eller boende för ensamkommande och andra barn och unga. Stockholm: Konkurrensverket; 2017 [cited 2019 Jul 15]. Report 2017:8. Available from: http://www.konkurrensverket.se/globalassets/publikationer/rapporter/rapport_2017-8.pdf

223. Inrättandet av Upphandlingsmyndigheten. Slutrapport. Stockholm: Statskontoret; 2017 [cited 2019 Jul 15]. Report 2017:17. Available from: http://www.statskontoret.se/publicerat/publikationer/2017/inrattandet-av-upphandlingsmyndigheten.-slutrapport

224. Upphandlingsmyndigheten. The National Agency for Public Procurement. Upphandlingsmyndigheten. [cited 2019 Jul 15]. Available from: https://www.upphandlingsmyndigheten.se/en

225. Regeringskansliet. Public procurement – How it works in Sweden. Government Offices of Sweden. 2018 [cited 2019 Jul 15]. Available from: https://www.government.se/government-policy/central-government-adminstration/public-procurement---how-it-works-in-sweden/

226. Statskontoret. Publications: English summaries of all our publications from 2013 and forward. Statskontoret. 2019 [cited 2019 Jul 15]. Available from: http://www.statskontoret.se/In-English/publications/

227. Vårdanalys. English: The Swedish Agency for Health and Care Services Analysis. Vårdanalys. [cited 2019 Jul 15]. Available from: https://www.vardanalys.se/in-english/

228. Vårdanalys. En LOB i mål? Uppföljning av satsningen för ett förbättrat omhändertagande av berusade personer. Stockholm: Vårdanalys [The

Swedish Agency for Health and Care Services Analysis]; 2018 [cited 2019 Jul 15]. Report 2018:1. Available from: https://www.vardanalys.se/rapporter/en-lob-i-mal/

229. Schmidt WC. World-Wide Web survey research: Benefits, potential problems, and solutions. Behavior Research Methods, Instruments & Computers. 1997;29(2):274–9.
230. Cobanoglu C, Warde B, Moreo PJ. A comparison of mail, fax and web-based survey methods. International Journal of Market Research. 2001;43(4):441–52.
231. Statistics Sweden. Annual accounts for municipalities and county councils [Räkenskapssammandrag (RS)]. 2016. Available from: http://www.scb.se/oe0107-en
232. SCB. Räkenskapssammandrag för kommuner och landsting OE0107: Beskrivning av statistiken OE0107 2015-09-15. Örebro: Statistiska centralbyrån (SCB); 2015.
233. SOU 2004:3. Tvång och förändring – rättssäkerhet, vårdens innehåll och eftervård. Stockholm: Fritzes; 2004.
234. Thornton PH, Ocasio W. Institutional logics. The Sage handbook of organizational institutionalism. 2008;840:99–128.
235. Freidson E. Professionalism: The Third Logic. Cambridge: Polity; 2001.
236. Scott RW. Institutions and organizations: ideas and interests. 3rd ed. Thousand Oaks, California: Sage; 2008.
237. Bejerot E, Astwik W. Professioner i fokus: fakta om professioners arbetsvillkor. [cited 2019 Jul 8]. Available from: http://www.pifokus.se/
238. Room R, Palm J, Romelsjö A, Stenius K, Storbjörk J. Kvinnor och män i svensk missbruksbehandling. Beskrivning av en studie i Stockholms län. [Available in English: www.robinroom.net/womenmen.doc]. Nordisk Alkohol & Narkotikatidskrift. 2003;20(2–3):91–100.
239. Storbjörk J, Christophs I, Samuelsson E, Milander Yazdanpanah S. A study of service user involvement in practice in the Swedish substance abuse treatment system: Methods, participants, and outcomes. Stockholm: Stockholm University, Centre for Social Research on Alcohol and Drugs (SoRAD); 2016. [cited 2019 Sep 25]. Available from: http://su.diva-portal.org/smash/record.jsf?pid=diva2:971588
240. Sveriges domstolar. Introducing the Swedish courts [last updated 8 November 2017]. 2017. Available from: http://www.domstol.se/Funktioner/English/
241. Government Offices of Sweden. The principle of public access to official documents [last updated 11 April 2016]. 2016. Available from: https://www.government.se/how-sweden-is-governed/the-principle-of-

public-access-to-official-documents/

242. Bryman A. Samhällsvetenskapliga metoder. 2 rev. uppl. Malmö: Liber; 2011.
243. Kvale S, Brinkmann S. Den kvalitativa forskningsintervjun. 2 uppl. Lund: Studentlitteratur; 2009.
244. Galletta A. Mastering the semi-structured interview and beyond: From research design to analysis and publication. New York: New York University Press; 2013. (Qualitative Studies in Psychology; vol. 18).
245. Transkribering.nu. How we transcribe. Transkribering.nu. 2019 [cited 2019 Jul 10]. Available from: https://transkribering.nu/en/how-we-transcribe/
246. QSR International Pty Ltd. NVivo qualitative data analysis software; version 11. Melbourne: QSR International; Available from: https://www.qsrinternational.com/
247. Braun V, Clarke V. Using thematic analysis in psychology. Qualitative Research in Psychology. 2006 Jan;3(2):77–101.
248. Gale NK, Heath G, Cameron E, Rashid S, Redwood S. Using the framework method for the analysis of qualitative data in multi-disciplinary health reserach. BMC Medical Research Methodology. 2013;13(1):117.
249. Smith J, Firth J. Qualitative data analysis: the framework approach. Nurse researcher. 2011;18(2):52–62.
250. Stenius K, Mäkelä K, Miovský M, Gabrhelík R. How to write publishable qualitative research. In: Babor TF, Stenius K, Pates R, Miovský M, O'Reilly J, Candon P, editors. Publishing Addiction Science: A Guide for the Perplexed. 3rd ed. London: Ubiquity Press; 2017 [cited 2019 Sep 2]. p. 155–72. Available from: https://www.ubiquitypress.com/site/books/10.5334/bbd/
251. Ivarsson Westerberg A. New Public Management och den offentliga sektorn. In: Ivarsson Westerberg A, Waldemarson Y, Östberg K, redaktörer. Det långa 1990-talet: när Sverige förändrades. Umeå: Boréa Bokförlag; 2014. p. 85–119.
252. Astvik W, Welander J, Isaksson K. Sorti, tystnad och lojalitet bland medarbetare och chefer i socialtjänsten. Arbetsmarknad & Arbetsliv. 2017;23(3):41–61.
253. Dallner M, Lindström K, Elo A-L, Skogstad A, Gamberale F, Hottinen V, et al. Användarmanual för QPS Nordic: Frågeformular om psykologiska och sociala faktorer i arbetslivet utprovat i Danmark, Finland, Norge och Sverige. Stockholm: Arbetslivsinstitutet; 2000. (Arbetslivsrapport). Report 2000:19. Available from: http://www.ammuppsala.se/sites/default/files/fhv-metoder/QPSnordic%20manual.pdf
254. Shanks E. Managing social work: Organisational conditions and everyday work for managers in the Swedish social services. [Stockholm]: Department of social work, Stockholm University; 2016 [cited 2019 Sep 2]. Available from:

https://su.diva-portal.org/smash/get/diva2:920490/FULLTEXT01.pdf

255. Ordell S, Söderfeldt B, Hjalmers K, Berthelsen H, Bergström K. Organization and overall job satisfaction among publicly employed, salaried dentists in Sweden and Denmark. Acta Odontologica Scandinavica. 2013;71(6):1443–52.

256. Berthelsen H, Westerlund H, Kristensen TS. COPSOQ II: en uppdatering och språklig validering av den svenska versionen av en enkät för kartläggning av den psykosociala arbetsmiljön på arbetsplatser. Stockholm: Stockholms universitet, Stressforskningsinstitutet; 2014 [cited 2019 Sep 2]. Available from: https://copsoq.se/wp-content/uploads/2015/10/Stressforskningsrapport-nr-326-stressforskningsinstitutet-20141.pdf

257. Verhoest K, Verschuere B. Common data in the COBRA-research: An outline. Leuven: Public Management Institute, Katholieke Universiteit Leuven; 2010 [cited 2019 Sep 2]. Available from: https://soc.kuleuven.be/io/cost/act/pdf/20081014_PhD%20Training%20School/Dag%201/Common%20data%20COBRA.pdf

258. SOM-institutet. SOM-undersökningen 2017: Sverige 1. Göteborg: Göteborgs universitet, SOM institutet; [cited 2019 Sep 2]. Available from: https://som.gu.se/digitalAssets/1688/1688232_riks-1-2017.pdf

259. Martinsson J, Andersson U. Swedish trends 1986-2018. Göteborg: Göteborgs universitet, SOM institutet; 2019 [cited 2019 Sep 2]. (SOM-rapport). Report 2019:07. Available from: https://som.gu.se/publicerat/rapporter

260. SKL. Utveckling av missbruks- och beroendevården. Tillbakablickar och framtidsutsikter [The development of substance abuse treatment: flashbacks and prospects]. Stockholm: Sveriges kommuner och landsting (SKL); 2014.

261. SKL Kommentus. SKL Kommentus. [cited 2019 Sep 2]. Available from: https://www.sklkommentus.se/

262. SKL Kommentus. HVB vuxna med missbruk 2016. SKL Kommentus. 2018 [cited 2019 Sep 2]. Available from: https://www.sklkommentus.se/upphandling-och-ramavtal/vara-ramavtal-och-upphandlingar/ramavtal-och-avtalskategorier/sociala-tjanster/hvb-vuxna-med-missbruk/

Appendices

A. Information and consent form (in Swedish)

Stockholms universitet

2018-02-22

Jessica Storbjörk
Docent, universitetslektor och projektledare

Information och samtycke – ***Organiseringens, finansieringens och styrningens betydelse för missbruks- och beroendevården***

Forskningsprojektet *Fördelar, spänningar och motsägelsefulla incitament i välfärdssystemet: New Public Management (NPM) i svensk missbruks- och beroendevård* syftar till att studera hur olika modeller för organisering, finansiering och styrning påverkar missbruks- och beroendevården, vilka för- och nackdelar som finns med olika modeller och hur personal och berörda tjänstemän och politiker hanterar eventuella målkonflikter och problem. Projektet finansieras av Riksbankens jubileumsfond (RJ), har godkänts av Regionala etikprövningsnämnden i Stockholm och genomförs av Centrum för socialvetenskaplig alkohol- och drogforskning (SoRAD), på Institutionen för folkhälsovetenskap vid Stockholms universitet (forskningshuvudman).

Anställda i missbruks- och beroendevården samt politiker och tjänstemän på lokal, regional och nationell nivå intervjuas i studien för att studera olika aktörers uppfattningar, erfarenheter och förslag på förbättringar. Totalt görs ca 90 intervjuer. Studien vänder sig dels till tjänstemän och politiker i centraladministrationen, dels till anställda, tjänstemän och politiker i ett urval kommuner/stadsdelar (6 stycken) och landsting (3 stycken). Områdena utgör exempel på olika sätt att organisera vården, t.ex. genom beställar-utförarmodell. *Anställda med olika arbetsuppgifter i eller kopplade till missbruks- och beroendevården i centraladministrationen och i de utvalda områdena tillfrågas om deltagande i en intervju. Den tar ca 45 minuter, det är frivilligt att delta och du kan när som helst avbryta din medverkan utan att ange någon förklaring.* I ett senare skede i studien vänder vi oss till alla anställda inom missbruks- och beroendevården för att med hjälp av en webenkät kartlägga erfarenheterna i hela Sverige.

Stockholms universitet är ansvarigt för dina personuppgifter som används för att besvara forskningsfrågorna och i forskningsarbetet följs aktuella forskningsetiska regler. Detta innebär bland annat att dina svar kommer att behandlas så att obehöriga inte kan ta del av dem. Inte heller din arbetsgivare eller andra på din arbetsplats kommer att få veta vad du sagt i intervjun. Intervjun spelas in elektroniskt, skrivs ut och analyseras därefter i ett dataprogram. Inga personuppgifter antecknas i utskriften. Denna blankett förvaras inlåst på SoRAD och åtskild från dina intervjusvar. Inspelningen och utskriften förvaras elektroniskt på Stockholms universitets skyddade server. Det är bara personer knutna till forskningsprojektet som har tillgång till blanketten och intervjusvaren. Deltagare får en trisslott efter intervjun. Resultatet presenteras givetvis så att din identitet inte avslöjas. Du kan senare ta del av studiens resultat på www.su.se/publichealth/.

Du har rätt att ansöka om att få information om vilka uppgifter som behandlas och hur dessa hanteras samt rätt till rättelse (26 och 28 § Personuppgiftslagen 1998:204).

Centrum för socialvetenskaplig alkohol- och drogforskning (SoRAD)

Stockholms universitet
Institutionen för folkhälsovetenskap
106 91 Stockholm

Besöksadress:
Sveavägen 160, 3 tr.
Sveaplan, Stockholm

Telefon/mobil: 08-16 14 68
www.su.se/publichealth
E-post: jessica.storbjork@su.se

Stockholms universitet

Jag har tagit del av informationen och vill delta i en personlig intervju.

Datum: .....

Namnteckning: .....

Om du har frågor eller synpunkter om ditt deltagande och studien är du välkommen att när som helst under studiens gång kontakta projektledaren Jessica Storbjörk (telefon/mobil 08-16 14 68, e-post jessica.storbjork@su.se).

Stockholms universitet

2019-04-01

Information till forskningspersoner

Webbenkät om organiseringens, finansieringens och styrningens betydelse för missbruks- och beroendevårdens praktik

Om forskningsprojektet och enkäten

Forskningsprojektet *Fördelar, spänningar och motsägelsefulla incitament i välfärdssystemet: New Public Management (NPM) i svensk missbruks- och beroendevård* syftar till att studera hur olika modeller för organisering, finansiering och styrning påverkar missbruks- och beroendevården, vilka för- och nackdelar som finns med olika modeller och hur personal och berörda tjänstemän och politiker hanterar eventuella målkonflikter och problem.

Projektet finansieras av Riksbankens jubileumsfond (RJ), har godkänts av Regionala etikprövningsnämnden i Stockholm (Dnr 2016/446-31/5) och genomförs 2016-2019 av Centrum för socialvetenskaplig alkohol- och drogforskning (SoRAD) på Institutionen för folkhälsovetenskap vid Stockholms universitet (forskningshuvudman).

Anställda i missbruks- och beroendevården samt politiker och tjänstemän på lokal, regional och nationell nivå har redan intervjuas i studien för att studera olika aktörers uppfattningar, erfarenheter och förslag på förbättringar.

Vi tillfrågar nu alla anställda inom missbruks- och beroendevården i Sverige (dels i de kommuner och landsting som ingick i intervjustudien, dels i övriga landet) om att delta i denna webenkät. Den tar ca 25 minuter att fylla i. Deltagandet i enkäten är frivilligt. Du kan när som helst avbryta ditt deltagande genom att stänga ner webbläsaren.

Enkätsvaren används för att sammanställa för- och nackdelar med olika sätt att organisera vården och möjliggör jämförelser mellan olika regioner, delar av vården och professioner.

Dina svar är skyddade

Studien är godkänd av etikprövningsnämnden. Då du skickar in din enkät omvandlas svaren till sifferformat. De analyseras av forskargruppen med hjälp av ett statistikprogram. Stockholms universitet är ansvarigt för säkerheten för dina personuppgifter (personuppgiftsansvarig). Svaren används bara för att besvara forskningsfrågor. I forskningsarbetet följs de forskningsetiska reglerna. Det innebär bland annat att inga obehöriga kan ta del av dina svar och ingen kan se att de är just dina. Datafilen förvaras elektroniskt på en skyddad server. Resultatet presenteras gruppvis. Det kommer inte framgå vad just du har svarat varken när undersökningens resultat analyseras eller redovisas. Dataskyddsförordningen (General Data Protection Regulation – GDPR) innehåller regler om hur man får behandla personuppgifter och gäller i alla EU:s medlemsländer. Förordningen började gälla den

Institutionen för folkhälsovetenskap
CHESS | SoRAD
CHESS är ett samarbete med Karolinska Institutet

Stockholms universitet
106 91 Stockholm

Besöksadress
Sveavägen 160
www.su.se/publichealth

Telefon: +46 (0)8-16 14 68
E-post: jessica.storbjork@su.se

Stockholms universitet

25 maj 2018 och ersatte då personuppgiftslagen (PuL). Stockholms universitets dataskyddsombud nås per e-post på dso@su.se. Om du är missnöjd med hur dina personuppgifter behandlas har du rätt att ge in klagomål till Datainspektionen, som är tillsynsmyndighet.

Resultat och kontakt

Resultaten publiceras i artiklar och rapporter och redovisas på vår hemsida. Du kan senare ta del av studiens resultat på www.su.se/publichealth/ eller genom att följa vår forskning om missbruks- och beroendevården på Facebook: www.facebook.com/addiction.treatment.systems.

Om du har frågor eller synpunkter om ditt deltagande och studien är du välkommen att när som helst under studiens gång kontakta projektledare docent Jessica Storbjörk som är ansvarig för studien.

Webbenkäten finns på http://www.su.se/publichealth/websurvey2019 under datainsamlingsperioden 5 april – 2 juni 2019.

Jessica Storbjörk

Docent, projektledare

08-161468, jessica.storbjork@su.se

B. Semi-structured interview guide

The overarching themes covered in the semi-structured interview guide are outlined below. The focus and the interviews varied depending on the respondent and his or her background, knowledge and role in the steering or organisation of addiction treatment. We sought to cover the following points if applicable:

- Information on the respondent: Education; work experience; previous and current work roles; etc.
- Degree of marketization or NPM in the broad organisation (municipality, region, company or NGO) and in addiction treatment or their unit: The presence of purchase–provider splits or a more traditional organisation; private production of care; competition in the public sector; procurement and agreements; funding regime (performance-based funding, block grants, etc.); market oriented goals; managerialism; NPM inspired rhetoric (e.g., speak of units as businesses); measurable units of care or treatment volumes; auditing; delegation of responsibilities; customer choice, etc.
- Development of the organisation and re-organisations: Motives, driving forces, fears and hopes.
- Pros and cons of the current organisation and various NPM features: Effects on various groups (staff, service users); in comparison with other or previous organisational models; quality of care; the performance of different types of care providers.
- Government, steering and administrative control: Knowledge and experience of central government control and supervision (NBHW, IVO, etc.); documentation practices and demands; interests, goals, and steering by local/regional policy-makers (including budgeting); internal steering in the form of internal guidelines, etc.
- Professional autonomy: Own experience; changes over time; goal conflicts or other inconsistencies; strategies to handle problems; balance autonomy-control, etc.
- Daily work: needs-assessments; decision-making; standardisation; how choose an intervention or care provider for a service user; available treatment options and providers; collaboration; time spent on various tasks, etc.

C. Web survey frequency tables and means (in Swedish)

Tables C1–C5 present frequency distributions and **Tables C6–C10** present means by type of provider for respondents' experiences of professional autonomy and control, pros and cons with their treatment unit, pros and cons with their broad organisaiton (the municipality, region, company or NGO), strategies for handling problems, and attitudes. 'R' in the items refer to the respondent.

Tabell C1. Autonomi och kontroll; den svarande får stöd av följande, frekvenser, radprocent, antal valida svar (n) samt antal 'vet ej', 'ej relevant'.

	Mer hinder än stöd	Varken eller	Lite stöd	Ganska stort stöd	Mycket stort stöd	Totalt (n)	Vet ej (n)	Ej relevant (n)
Närmaste chef	4	8	15	35	38	583	1	22
Höga tjänstemän och chefer inom organisationen	10	35	26	22	8	558	2	46
Rs professionella kunskap och erfarenhet	<0,5	1	6	40	53	592	14	-
Kollegornas professionella kunskap och erfarenhet	1	2	8	38	51	593	13	-
Klienternas/patienternas kunskaper och erfarenheter	<0,5	5	20	47	28	589	17	-
Vård- och sociallagarna	1	16	24	44	16	573	1	32
Tvångslagarna	2	19	29	35	16	542	1	63
Nationella riktlinjer för missbruks- och beroendevården	2	9	21	42	27	577	29	-
Interna riktlinjer	3	23	27	33	14	521	1	84
Tillgången till vård- och insatsalternativ inom den egna organisationen	3	15	33	33	16	561	45	-
Tillgången till externa vård- och insatsalternativ	3	23	36	30	8	530	2	74
Processer och rutiner för att säkra verksamhetens kvalitet	3	35	29	24	10	528	3	75
IVO:s granskningar och krav	2	35	31	24	8	554	52	-
Uppföljningsarbete av vårdresultat	3	31	34	25	7	559	47	-
Samverkan inom organisationen	4	7	32	40	17	585	21	-
Samverkan med andra vård- och insatsgivare	4	10	39	37	11	585	21	-
Dokumentation och journalföring	2	8	22	49	20	578	28	-
Annan dokumentation	6	44	31	15	5	469	1	136
Managementmodeller	13	54	24	8	1	329	4	273
Hemmaplanslösningar i den egna organisationen (socialtjänsten)	15	23	16	28	18	546	60	-
Författningar, föreskrifter o. allmänna råd från statliga myndigheter.	2	29	32	28	10	547	59	-
Upphandlade ramavtal mellan kommuner och utförare.	6	37	25	22	11	475	131	-
Skala för autonomi–kontroll i klient/patientarbetet [a]	***14***	***11***	***22***	***30***	***24***	***503***	***103***	-

[a] Kan du utföra arbetet utifrån din professionella kunskap o. erfarenhet eller känner du dig styrd o. kontrollerad? Reglage:(0) Mycket fri, till (10) mycket kontrollerad. Anger här procent för 10-8, 7-6, 5-4, 3-2, 1-0.

Tabell C2. För- och nackdelar på enheten, frekvenser, radprocent samt antal svarande (n) av totalt 606 personer.

	Instämmer inte alls	Instämmer delvis inte	Varken eller	Insätmmer delvis	Instämmer helt	Totalt (n)
R vet exakt vad hen ska göra och vad som förväntas av hen	1	6	3	41	49	606
R är motiverad och engagerad i sitt arbete	<0,5	1	2	20	76	606
Enheten fokuserar på stora volymer, genomströmning och korta insatser	28	19	27	20	6	605
R har goda möjligheter att påverka inflödet av klienter/patienter	16	17	12	37	18	605
Rs arbetsuppgifter är alltför begränsade	44	28	12	13	3	605
Enheten fokuserar på att verksamheten ser bra ut snarare än att göra ett bra arbete på riktigt	57	18	9	12	5	604
Arbetet är förenligt med Rs värderingar	1	4	6	35	55	606
Enheten tar tillräckligt stor hänsyn till klienternas/patienternas behov	2	9	8	48	33	606
R måste göra saker som hen tycker är onödiga	17	25	20	30	9	606
Enhetens budget motsvarar vårdbehoven	27	26	20	21	6	604
Den dagliga praktiken drar stor nytta av indikatorer och register	31	19	36	11	3	603
R har goda möjligheter att påverka innehållet i sitt arbete	2	7	6	47	39	606
Arbetet på enheten styrs mycket av rörliga ersättningar, såsom pinnar	61	14	12	11	3	602
R har stor frihet att använda sin professionella kunskap	2	2	4	32	60	606
R har tillräckligt med tid för klienterna/patienterna	6	16	10	38	30	605
Arbetet upptas i för hög grad av dokumentation	14	17	21	36	13	605
R är nöjd med sitt nuvarande arbete	2	5	7	34	53	606
R måste göra sådant som hen tycker borde gjorts annorlunda	19	24	19	30	8	604
Ledningen har god förståelse för den dagliga praktiken	10	18	15	34	23	606
Ledningen litar på att det görs ett bra jobb i den dagliga praktiken	2	6	12	35	45	606
Det krav som strider mot varandra	19	19	21	33	9	604
Enheten ger god vård-/insatskvalitet till klienterna/patienterna	2	5	7	43	43	606
Externa vård-/insatsgivare ger god vårdkvalitet	4	11	27	47	11	605
Enheten har sammantaget god kompetens inom missbruks- o. beroendevård	1	3	5	36	55	606

Tabell C3. För- och nackdelar i organisationen, frekvenser, radprocent samt antal svarande (n) av totalt 606 personer.

	Instämmer inte alls	Instämmer delvis inte	Varken eller	Insätmmer delvis	Instämmer helt	Totalt (n)
R och hens kollegor får gehör för framförda synpunkter	6	16	14	46	19	605
Personalen har god kommunikation med ledningen	3	15	15	41	19	605
Missbruks- och beroendevården är organiserad på ett sätt som inte passar klienterna/patienterna	20	20	15	35	12	605
Ledningen har god kunskap om missbruks- och beroendevård	9	18	20	33	20	605
Medarbetarna har låg tillit till varandra	40	28	13	15	4	604
Besluten tas på för hög nivå inom organisationen	18	17	23	32	10	604
Ekonomer och jurister har för stort inflytande över klient-/patientarbetet	31	16	27	18	8	604
R vill arbeta kvar länge i organisationen	5	9	13	35	38	605
Organisationen är flexibel och kan anpassa vård/insatser efter behov	6	18	19	40	18	605
Organisationen sätter klientens/patientens behov före budgeten	16	23	19	30	12	605
Organisationen har en god helhetssyn i klient-/patientarbetet	8	17	14	37	24	605
Organisationen är alltför splittrad	21	23	23	22	11	605
Det finns för många chefer i organisationen	26	18	27	20	10	604
Politiker är intresserad av missbruks- och beroendevården	21	23	30	23	3	605
Styrningen inom organisationen är alltför hård och detaljerad	23	23	34	17	4	605

Tabell C4. Strategier, frekvenser, radprocent samt antal svarande (n), antal som svarade 'ej relevant' av totalt 606 personer. [a]

	Aldrig	Sällan	Ibland	Ofta	Mycket ofta	Totalt (n)	Ej relevant (n)
Gör det som R tycker är bäst för klienten/patienten, oavsett	11	30	37	15	7	571	34
R säger nej till att ta på sig mer arbetsuppgifter än vad hen hinner med	6	31	48	13	3	578	26
R utför arbetsuppgifter som egentligen är någon annans ansvar	4	20	44	24	9	599	6
R anstränger sig för att utförare, beställare och andra ska göra arbetet på ett sätt som R tycker är bra	5	9	36	36	15	553	51
R betonar att vård-/social- eller tvångslagarna måste följas när R inte får gehör	12	25	39	16	8	533	71
R säger att hen utför arbetet såsom enheten bestämt, fastän R egentligen gör något annat	61	30	8	2	<0,5	587	17
R låter inte kostnader hindra valet av vård/insats/medicin/provtagning om R anser att det är bäst för klienten/patienten	14	24	29	20	13	471	133
R minskar sitt engagemang i arbetet och klienterna/patienterna för att orka med	28	38	27	5	2	586	19
R utför arbetet som enheten kräver, fastän R tycker det är fel eller kan göras på ett bättre sätt	13	32	38	14	4	576	29
R försöker hitta sätt att hantera sin frustration	12	21	30	25	12	569	36
R sänker sina kvalitetskrav	24	37	27	10	3	595	10
R prioriterar bort arbetsuppgifter eller klienter/patienter fastän R inte vill	18	39	30	9	4	588	16
R arbetar övertid eller mer intensivt för att hinna med	17	27	28	17	11	596	9
R försöker övertyga klienten/patienten att acceptera enhetens arbetssätt och insatser även om R själv inte instämmer	18	27	37	13	5	572	33
R försöker rättfärdiga för sig själv varför arbetet ser ut som det gör	19	26	37	14	5	580	25
R undviker att göra dokumentation eller andra uppgifter som enheten tilldelats, som R tycker är onödiga	55	29	12	3	<0,5	591	14

(fortsättning)	Aldrig	Sällan	Ibland	Ofta	Mycket ofta	Totalt (n)	Ej relevant (n)
R påtalar problem eller ger förslag på möjliga lösningar till ledningen	1	9	38	34	18	593	11
R påtalar problem eller ger förslag på möjliga lösningar till politiker	51	23	16	6	3	586	19
R ser sig om efter andra jobb	31	27	31	6	5	593	12
R och Rs kollegor stödjer och hjälper varandra när de tycker att arbetssituationen är svår	3	3	16	31	47	590	14
R anstränger sig mycket hårt för att hitta bra lösningar och vård/insatser för klienten/patienten trots dåliga förutsättningar	4	7	27	36	27	564	41
R försöker övertyga ledningen eller beställare att de på enheten gör ett bra jobb	15	25	31	21	8	539	64
Rs enhet säger nej till klienter/patienter som inte direkt hör hemma hos dem	14	33	34	13	6	575	29
Rs enhet anpassar sig till avtal och beställares/uppdragsgivares krav fastän vi tycker arbetet borde utföras på annat sätt	9	26	42	15	8	503	102
R kringgår ramavtal eller rangordning vid placering om hen tycker det motsvarar vårdbehovet eller klientens önskan [b]	8	32	44	15	1	157	12

[a] Det fåtal personer som svarade ’vet ej / vill ej uppge’ är ej inräknade i tabellen.
[b] Enbart frågat av dem som arbetade med myndighetsutövning eller var chef på en sådan enhet.

Tabell C5. Attityder, frekvenser, radprocent, antal svarande (n) samt antal som svarade ’vet ej / vill ej uppge’. [a]

	Instämmer inte alls						Instämmer helt		
	0	**1**	**2**	**3**	**4**	**5**	**6**	**Totalt (n)**	**Vet ej / vill ej uppge (n)**
Privata aktörer borde ha en större roll i missbruks- och beroendevården (MBV)	36	19	10	14	8	6	7	570	30
Ideella organisationer borde ha en större roll i MBV	12	12	15	23	15	13	11	575	22
Den offentliga MBV förbättras om den konkurrensutsätts	34	16	9	15	9	9	8	555	40
Vinstutdelning ska inte tillåtas i skattefinansierad MBV	10	5	4	8	7	13	53	572	28
Ramavtal hindrar i alltför stor grad klienternas/patienternas valfrihet	8	11	10	20	20	16	16	502	94
Fördelarna överväger problemen med offentlig upphandling	11	13	10	28	16	14	10	455	145
Byte av utförare vid offentlig upphandling är skadligt för klienterna/patienterna	6	9	8	30	19	16	12	438	157
Större hänsyn borde tas till kvalitet istället för pris vid upphandling av vård/insatser idag	0	1	1	7	8	23	61	572	26
Valfrihetssystem enligt lag om valfrihet (LOV) borde tillämpas mer i MBV	9	7	6	18	18	15	28	480	119
Vinstsyftande vårdgivare missgynnar klienter/patienter med stor problemtyngd	5	7	5	14	15	21	33	514	83
Klienter/patienter gynnas av att betraktas som kunder i MBV	24	13	11	18	12	12	11	502	91
Chefen/ledningen på en enhet är viktigare för en god vårdkvalitet än om den är vinstsyftande eller inte	6	5	5	13	12	23	36	522	76
Offentlig upphandling har pressat priserna på köpt missbruks- och beroendevård för långt	10	5	8	26	19	14	18	351	239
Offentlig upphandling bidrar till bättre vårdkvalitet	17	14	16	26	13	10	5	422	173
Konkurrensutsättning ger ett fragmenterat behandlingsystem som inte passar MBV	6	6	7	24	15	20	23	417	177
Rs politiska åsikter på en vänster-högerskala [b]	-	28	37	17	14	4	-	514	88

[a] Det fåtal personer som svarade ’Ej svar’ är ej inräknade i tabellen.

[b] Svarsalternativ: (1) Klart till vänster, (2) något till vänster, (3) mitten, (4) något till höger, (5) klart till höger. ’Vet ej’ och ’Ej svar’ är bortfall.

Tabell C6. Autonomi och kontroll; den svarande får stöd av följande, efter huvudman, medelvärden, ANOVA-test. [a]

	Kommun, myndighets-utövning	Kommun, övriga	Region	Privat/ Ideell	Total	Sig.	N
Närmaste chef	2,92	2,90	2,81	2,83	2,87	0,843	605
Höga tjänstemän och chefer inom organisationen	1,78	1,84	1,43	2,15	1,77	0,000	604
Rs professionella kunskap och erfarenhet	3,41	3,41	3,24	3,50	3,38	0,074	606
Kollegornas professionella kunskap och erfarenhet	3,43	3,34	3,18	3,29	3,32	0,096	606
Klienternas/patienternas kunskaper och erfarenheter	2,97	2,95	2,81	2,83	2,91	0,329	606
Vård- och sociallagarna	2,90	2,34	2,41	2,32	2,49	0,000	605
Tvångslagarna	2,79	2,11	2,23	1,91	2,28	0,000	605
Nationella riktlinjer	3,01	2,73	2,59	2,49	2,74	0,000	606
Interna riktlinjer	2,16	1,98	2,25	2,52	2,15	0,001	605
Tillgången till vård- och insatsalternativ inom den egna organisationen	2,46	2,32	2,09	2,54	2,33	0,007	606
Tillgången till externa vård- och insatsalternativ	2,42	1,94	1,74	1,96	2,01	0,000	604
Processer och rutiner för att säkra verksamhetens kvalitet	1,89	1,92	1,59	2,29	1,89	0,000	603
IVO:s granskningar och krav	1,99	1,98	1,61	2,12	1,91	0,000	606
Uppföljningsarbete av vårdresultat	1,77	1,97	1,80	2,40	1,94	0,000	606
Samverkan inom organisationen	2,58	2,58	2,39	2,50	2,53	0,298	606
Samverkan med andra vård- och insatsgivare	2,43	2,24	2,49	2,37	2,36	0,064	606
Dokumentation och journalföring	2,69	2,59	2,73	2,82	2,67	0,246	606
Annan dokumentation	1,52	1,46	1,72	1,38	1,53	0,015	605
Managementmodeller	1,15	1,20	1,10	1,18	1,16	0,527	602
Hemmaplanslösningar i den egna organisationen	2,21	2,37	1,57	1,09	1,98	0,000	606
Författningar, föreskrifter och allmänna råd från statliga myndigheter.	2,28	1,96	1,98	1,87	2,03	0,006	606
Upphandlade ramavtal mellan kommuner och utförare.	2,23	1,57	1,34	2,03	1,74	0,000	606
På det stora hela, skala autonomi–kontroll i klient-/patientarbetet [b]	4,93	3,12	4,23	2,73	3,80	0,000	503

[a] Svarsalternativ: (4) Mycket stort stöd, (3) ganska stort stöd, (2) lite stöd, (1) varken eller, (0) mer hinder än stöd. ’Ej relevant’ är kodat som ’varken stöd eller hinder’. ’Vet ej’ och ’Ej svar’ är bortfall.

[b] Kan du utföra arbetet utifrån din professionella kunskap o. erfarenhet eller känner du dig styrd o. kontrollerad? Reglage:(0) Mycket fri, till (10) mycket kontrollerad.

Tabell C7. För- och nackdelar på enheten, efter huvudman, medelvärden, ANOVA-test. [a]

	Kommun, myndighets-utövning	Kommun, övriga	Region	Privat/ Ideell	Total	Sig.	N
R vet exakt vad hen ska göra och vad som förväntas av hen	3,17	3,41	3,15	3,46	3,30	0,003	606
R är motiverad och engagerad i sitt arbete	3,61	3,75	3,69	3,82	3,71	0,046	606
Enheten fokuserar på stora volymer, genomströmning och korta insatser	1,63	1,47	1,92	0,96	1,55	0,000	605
R har goda möjligheter att påverka inflödet av klienter/patienter	1,46	2,60	2,23	2,50	2,22	0,000	605
Rs arbetsuppgifter är alltför begränsade	1,16	0,98	1,17	0,65	1,02	0,006	605
Enheten fokuserar på att verksamheten ser bra ut snarare än att göra ett bra arbete på riktigt	1,28	0,74	1,05	0,47	0,91	0,000	604
Arbetet är förenligt med Rs värderingar	3,15	3,49	3,27	3,67	3,38	0,000	606
Enheten tar tillräckligt stor hänsyn till klienternas/patienternas behov	2,70	3,19	2,88	3,36	3,02	0,000	606
R måste göra saker som hen tycker är onödiga	2,38	1,68	2,04	1,40	1,90	0,000	606
Enhetens budget motsvarar vårdbehoven	0,93	1,55	1,70	2,37	1,54	0,000	604
Den dagliga praktiken drar stor nytta av indikatorer och register	1,15	1,37	1,60	1,23	1,35	0,006	603
R har goda möjligheter att påverka innehållet i sitt arbete	2,71	3,33	3,03	3,47	3,13	0,000	606
Arbetet på enheten styrs mycket av rörliga ersättningar, såsom pinnar	0,48	0,61	1,58	0,74	0,82	0,000	602
R har stor frihet att använda sin professionella kunskap	3,27	3,57	3,44	3,65	3,48	0,001	606
R har tillräckligt med tid för klienterna/patienterna	2,05	2,98	2,79	2,95	2,70	0,000	605
Arbetet upptas i för hög grad av dokumentation	2,82	1,67	2,45	2,01	2,18	0,000	605
R är nöjd med sitt nuvarande arbete	2,95	3,44	3,30	3,47	3,29	0,000	606
R måste göra sådant som hen tycker borde gjorts annorlunda	2,28	1,67	2,03	1,30	1,85	0,000	604
Ledningen har god förståelse för den dagliga praktiken	2,18	2,57	2,14	2,88	2,42	0,000	606
Ledningen litar på att det görs ett bra jobb i den dagliga praktiken	3,01	3,24	2,92	3,42	3,13	0,000	606
Det krav som strider mot varandra	2,42	1,79	2,04	1,34	1,94	0,000	604
Enheten ger god vård-/insatskvalitet till klienterna/patienterna	2,89	3,37	3,10	3,58	3,21	0,000	606
Externa vård-/insatsgivare ger god vårdkvalitet	2,67	2,42	2,45	2,51	2,50	0,072	605
Enheten har sammantaget god kompetens inom missbruks- o. beroendevård	3,25	3,57	3,26	3,47	3,41	0,000	606

[a] Svarsalternativ: (4) Instämmer helt, (3) instämmer delvis, (2) varken eller, (1) instämmer delvis inte, (0) instämmer inte alls, 'vet ej', ej svar'.

Tabell C8. För- och nackdelar i organisationen, efter huvudman, medelvärden, ANOVA-test. [a]

	Kommun, myndighets-utövning	Kommun, övriga	Region	Privat/ Ideell	Total	Sig.	N
R och hens kollegor får gehör för framförda synpunkter	2,38	2,59	2,40	3,15	2,57	0,000	605
Personalen har god kommunikation med ledningen	2,19	2,55	2,26	3,09	2,46	0,000	605
Missbruks- och beroendevården är organiserad på ett sätt som inte passar klienterna/patienterna	2,23	1,91	2,07	1,65	1,99	0,012	605
Ledningen har god kunskap om missbruks- och beroendevård	2,10	2,42	2,20	3,09	2,38	0,000	605
Medarbetarna har låg tillit till varandra	1,11	1,26	1,21	0,72	1,14	0,005	604
Besluten tas på för hög nivå inom organisationen	1,95	2,06	2,38	1,18	1,99	0,000	604
Ekonomer och jurister har för stort inflytande över klient-/patientarbetet	1,53	1,64	1,86	0,82	1,56	0,000	604
R vill arbeta kvar länge i organisationen	2,58	3,05	2,87	3,27	2,92	0,000	605
Organisationen är flexibel och kan anpassa vård/insatser efter behov	2,17	2,51	2,20	3,33	2,46	0,000	605
Organisationen sätter klientens/patientens behov före budgeten	1,89	1,90	1,77	2,83	1,99	0,000	605
Organisationen har en god helhetssyn i klient-/patientarbetet	2,27	2,52	2,31	3,35	2,52	0,000	605
Organisationen är alltför splittrad	1,93	1,83	1,95	1,09	1,79	0,000	605
Det finns för många chefer i organisationen	1,56	1,77	2,11	1,08	1,71	0,000	604
Politiker är intresserad av missbruks- och beroendevården	1,31	1,85	1,57	1,69	1,63	0,000	605
Styrningen inom organisationen är alltför hård och detaljerad	1,59	1,58	1,87	0,83	1,55	0,000	605

[a] Svarsalternativ: (4) Instämmer helt, (3) instämmer delvis, (2) varken eller, (1) instämmer delvis inte, (0) instämmer inte alls, 'vet ej', ej svar'.

Tabell C9. Strategier, efter huvudman, medelvärden, ANOVA-test. [a]

	Kommun, myndighets-utövning	Kommun, övriga	Region	Privat/ Ideell	Total	Sig.	N
Gör det som R tycker är bäst för klienten/patienten, oavsett	1,62	1,71	1,77	1,56	1,68	0,483	605
R säger nej till att ta på sig mer arbetsuppgifter än vad hen hinner med	1,66	1,69	1,79	1,53	1,68	0,227	604
R utför arbetsuppgifter som egentligen är någon annans ansvar	2,33	2,01	2,32	1,81	2,13	0,000	605
R anstränger sig för att utförare, beställare och andra ska göra arbetet på ett sätt som R tycker är bra	2,56	2,17	2,11	2,24	2,26	0,004	604
R betonar att vård-/social- eller tvångslagarna måste följas när R inte får gehör	1,91	1,57	1,56	1,29	1,61	0,001	604
R säger att hen utför arbetet såsom enheten bestämt, fastän R egentligen gör något annat	0,56	0,56	0,42	0,40	0,51	0,158	604
R låter inte kostnader hindra valet av vård/insats/medicin/provtagning om R anser att det är bäst för klienten/patienten	2,03	1,03	1,77	1,58	1,52	0,000	604
R minskar sitt engagemang i arbetet och klienterna/patienterna för att orka med	1,50	0,89	1,21	0,99	1,13	0,000	605
R utför arbetet som enheten kräver, fastän R tycker det är fel eller kan göras på ett bättre sätt	1,93	1,41	1,65	1,04	1,54	0,000	605
R försöker hitta sätt att hantera sin frustration	2,29	1,92	1,97	1,14	1,92	0,000	605
R sänker sina kvalitetskrav	1,77	1,10	1,31	0,92	1,29	0,000	605
R prioriterar bort arbetsuppgifter eller klienter/patienter fastän R inte vill	1,85	1,18	1,38	1,04	1,37	0,000	604
R arbetar övertid eller mer intensivt för att hinna med	2,13	1,44	1,82	1,87	1,75	0,000	605
R försöker övertyga klienten/patienten att acceptera enhetens arbetssätt och insatser även om R själv inte instämmer	1,79	1,32	1,85	1,19	1,54	0,000	605
R försöker rättfärdiga för sig själv varför arbetet ser ut som det gör	1,99	1,38	1,63	1,06	1,55	0,000	605
R undviker att göra dokumentation eller andra uppgifter som enheten tilldelats, som R tycker är onödiga	0,69	0,57	0,77	0,56	0,64	0,134	605

(fortsättning)	Kommun, myndighets-utövning	Kommun, övriga	Region	Privat/ Ideell	Total	Sig.	N
R påtalar problem eller ger förslag på möjliga lösningar till ledningen	2,55	2,54	2,53	2,44	2,52	0,861	604
R påtalar problem eller ger förslag på möjliga lösningar till politiker	0,91	0,87	0,64	1,00	0,84	0,075	605
R ser sig om efter andra jobb	1,55	1,22	1,19	0,82	1,24	0,000	605
R och Rs kollegor stödjer och hjälper varandra när de tycker att arbetssituationen är svår	3,13	3,08	3,07	3,08	3,09	0,963	604
R anstränger sig mycket hårt för att hitta bra lösningar och vård/insatser för klienten/patienten trots dåliga förutsättningar	2,77	2,52	2,52	2,47	2,57	0,163	605
R försöker övertyga ledningen eller beställare att de på enheten gör ett bra jobb	1,56	1,66	1,66	1,49	1,61	0,692	603
Rs enhet säger nej till klienter/patienter som inte direkt hör hemma hos dem	1,33	1,56	1,57	1,96	1,56	0,001	604
Rs enhet anpassar sig till avtal och beställares/uppdragsgivares krav fastän vi tycker arbetet borde utföras på annat sätt	1,49	1,56	1,65	1,58	1,56	0,710	605

[a] Svarsalternativ: (0) Aldrig, (1) sällan, (2) ibland, (3) ofta, (04 mycket ofta. ’Ej relevant’ är kodat som ’aldrig’. ’Vet ej’ och ’Ej svar’ är bortfall.

Tabell C10. Attityder, efter huvudman, medelvärden, ANOVA-test. [a]

	Kommun, myndighets-utövning	Kommun, övriga	Region	Privat/ Ideell	Total	Sig.	N
Privata aktörer borde ha en större roll i missbruks- och beroendevården (MBV)	1,85	1,48	1,45	3,75	1,84	0,000	570
Ideella organisationer borde ha en större roll i MBV	2,80	2,86	3,02	3,65	2,98	0,008	575
Den offentliga MBV förbättras om den konkurrensutsätts	1,96	1,80	1,57	3,84	2,04	0,000	555
Vinstutdelning ska inte tillåtas i skattefinansierad MBV	4,47	4,76	4,70	3,23	4,48	0,000	572
Ramavtal hindrar i alltför stor grad klienternas/patienternas valfrihet	3,22	3,75	3,01	3,56	3,43	0,004	502
Fördelarna överväger problemen med offentlig upphandling	3,09	3,05	2,90	3,11	3,04	0,848	455
Byte av utförare vid offentlig upphandling är skadligt för klienterna/patienterna	3,19	3,13	3,84	3,81	3,41	0,001	438
Större hänsyn borde tas till kvalitet istället för pris vid upphandling av vård/insatser idag	5,14	5,41	5,34	5,57	5,34	0,012	572
Valfrihetssystem enligt lag om valfrihet (LOV) borde tillämpas mer i MBV	3,35	3,99	3,71	4,59	3,85	0,000	480
Vinstsyftande vårdgivare missgynnar klienter/patienter med stor problemtyngd	3,91	4,44	4,80	3,27	4,24	0,000	514
Klienter/patienter gynnas av att betraktas som kunder i MBV	2,56	2,67	2,31	2,78	2,58	0,388	502
Chefen/ledningen på en enhet är viktigare för en god vårdkvalitet än om den är vinstsyftande eller inte	4,22	4,33	4,09	4,71	4,30	0,137	522
Offentlig upphandling har pressat priserna på köpt missbruks- och beroendevård för långt	2,89	3,65	3,50	4,28	3,52	0,000	351
Offentlig upphandling bidrar till bättre vårdkvalitet	2,68	2,48	2,49	2,44	2,53	0,778	422
Konkurrensutsättning ger ett fragmenterat behandlingsystem som inte passar MBV	3,29	4,16	4,32	3,40	3,85	0,000	417
Rs politiska åsikter på en vänster-högerskala [b]	2,14	2,26	2,36	2,56	2,29	0,082	514

[a] Svarsalternativ: Från (6) instämmer helt till (0) instämmer inte alls. ’Vet ej’ och ’Ej svar’ är bortfall.

[b] Svarsalternativ: (1) Klart till vänster, (2) något till vänster, (3) mitten, (4) något till höger, (5) klart till höger. ’Vet ej’ och ’Ej svar’ är bortfall.

Research Reports in Public Health Sciences

Stockholm University, 106 91 Stockholm
www.su.se/publichealth | ISSN 2003-0142

Stockholm University