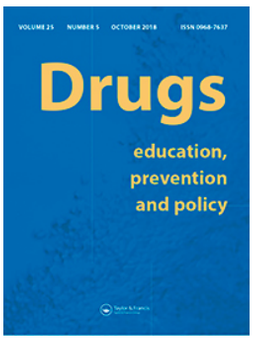

Drugs: Education, Prevention and Policy

ISSN: (Print) (Online) Journal homepage: https://www.tandfonline.com/loi/idep20

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To cite this article: Karin Berg, Frida Petersson & Anette Skårner (2021): Keeping concerned significant others at a distance in compulsory treatment for people with substance use in Sweden, Drugs: Education, Prevention and Policy, DOI: 10.1080/09687637.2021.1889466

To link to this article: https://doi.org/10.1080/09687637.2021.1889466

Published online: 18 Feb 2021.

DRUGS: EDUCATION, PREVENTION AND POLICY
https://doi.org/10.1080/09687637.2021.1889466

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RESEARCH ARTICLE

Keeping concerned significant others at a distance in compulsory treatment for people with substance use in Sweden

Karin Berg, Frida Petersson and Anette Skårner

Department of Social Work, University of Gothenburg, Gothenburg, Sweden

ABSTRACT

While previous drug treatment research has focused on the importance of supportive social relationships for recovery from alcohol and drugs, less is known about how this theme relates to compulsory drug treatment. This study analyzes how staff at four compulsory treatment institutions for adult drug users in Sweden rationalize the importance of maintaining contact with concerned significant others (CSOs) during the client's treatment. Four focus groups (22 participants) were carried out and analyzed thematically. This study shows that staff perceives the client's initial isolation as a necessity, primarily making CSOs a problem or distraction in relation to the recovery process. Moreover, staff position CSOs in two broad categories, as either 'problematic' or 'resourceful' in relation to a client's recovery. The two categories are used to justify individual regulation between clients and their CSOs, which varies between strictness and leniency. In addition, staff position themselves as guides, finding it necessary to help clients regulate problematic CSOs themselves and strengthen the link to those who are seen as resources. These two forms of regulatory work – setting rules and providing guidance – are analyzed in terms of disciplinary and pastoral power.

ARTICLE HISTORY
Received 2 June 2020
Revised 5 February 2021
Accepted 8 February 2021

KEYWORDS
Social networks; substance use; recovery; residential treatment; compulsory treatment

Introduction

Numerous empirical studies underline the importance of supportive social relationships to people with substance use problems in rehabilitating and rebuilding their lives without alcohol and drugs (Granfield & Cloud, 2001; Krishnan et al., 2001; Litt et al., 2009; Neale et al., 2014; Skogens & Von Greiff, 2014). However, the influence of personal relationships is complex, and access to a social network is not supportive per se (Veseth et al., 2019). Relationships may be strained or distant, which affects the availability of support (Skårner, 2001; Sun, 2007). Studies highlight the negative impact on family relationships and the health and quality of life of related persons; conflicts, mistrust, and feelings of guilt are recurring themes (Orford et al., 2013; Richert et al., 2018). A social network can be motivating and/or an additional emotional burden if concern about a network member's well-being becomes overwhelming (Tracy et al., 2010). Moreover, research shows that for a person who is trying to quit a problematic substance use, support from CSOs can have a positive impact on their willingness to seek professional help, and on the treatment outcome. Such support also tends to reduce the risk of relapse and early dropout (Dobkin et al., 2002; Kidorf et al., 2016; Orford et al., 2006).

Other research documents that barriers to involving CSOs in treatment are linked to organizational resources, such as lack of time, suitable premises, staffing, social network competence, and social network-oriented practices (Orford et al., 2010; Orr et al., 2014; Selbekk & Sagvaag, 2016). Also, prioritizing regular work, such as 'individual casework,' and 'waiting lists,' limits CSOs' involvement (Lee et al., 2012, p. 248). In addition, Orr et al. (2014) found that professionals viewed family members as generally part of the problem, and rarely part of the solution, which motivated their exclusion from care. Similarly, parents who blamed their child, or were overly engaged in treatment, were found to be largely disruptive to the work alliances between staff, clients, and their parents (Misouridou & Papadatou, 2017).

Our specific interest in CSOs stems from research within the context of Swedish compulsory drug treatment. The tension between managing both care and control is central to all social work (see, e.g. Juhila, 2009; Lilly et al., 1999) but was described as amplified in compulsory treatment (Billquist & Skårner, 2009; Ekendahl, 2011; Holmes, 2002; Petersson, 2013). For example, the paradox of enforcing internal motivation was highlighted in a study of professionals' motivational work with clients at a compulsory drug treatment institution (Billinger, 2005). The challenge of 'making' clients be motivated to abstinence in the context of compulsion compels staff to merely try 'sowing a seed of change' (Billinger, 2005, p. 63). To date, no study has explored how staff in compulsory drug treatment institutions understand the role of CSOs in the recovery process.

Research has highlighted numerous organizational barriers to the involvement of CSOs in treatment from a staff

CONTACT Karin Berg karin.berg.3@socwork.gu.se Department of Social Work, University of Gothenburg, Sprängkullsgatan 23–25, Göteborg 405 30, Sweden

perspective; this is despite CSOs' evident importance in clients' recovery. Treatment and motivational work in compulsory institutions may entail additional challenges due to its element of enforcement and high security. There is, therefore, a need to gain further insight into how CSOs are understood in the context of compulsion. This article aims to critically analyze how professionals at Swedish compulsory treatment institutions for adults with substance use problems view: (1) the significance of CSOs for clients; and (2) the involvement and regulation of contact between clients and their CSOs during treatment.

Background

Compulsory treatment institutions for persons with substance abuse are run by the Swedish National Board of Institutional Care (SiS) and provided under the Care of Substance Abusers (Special Provisions) Act (LVM). The treatment has two main aims: being an acute intervention to protect those with life-threatening patterns of substance use and motivating clients to seek change and voluntary treatment. The compulsory treatment has been described as paternalistic coercion, that is, directed against persons incapable of decision-making with reference to their interests (Tännsjö, 2002). SiS (https://www.stat-inst.se) describes their treatment approach as psychosocial; it involves an assessment of the individual client's physical, social and psychological needs. This assessment forms the basis for treatment and support offered after the stay has ended. The treatment provided mainly consists of physical/medical care, and brief interventions such as motivational interviewing and relapse prevention. Compulsory treatment is limited to a maximum of 6 months. According to LVM, (§ 33a) clients have the right to keep in contact with their CSOs during compulsory treatment, but this right can be retracted if staff assess that such contact can have a negative influence on their treatment or disrupt the treatment environment.

In recent years, the role of the CSOs has been highlighted in Swedish policy and guidelines regarding drug treatment. CSOs should be offered support and, with the client's permission, be considered important 'partakers' in treatment and care planning (National Board of Health and Welfare, 2013, 2015). There are no specific guidelines regarding the involvement of CSOs during compulsory treatment, other than that contact must be facilitated.

Materials and methods

This article is part of a larger study on the involvement of CSOs in compulsory treatment for adults with substance use in Sweden carried out in 2018–2020 in 4 of the 11, gender-specific, compulsory treatment institutions in Sweden: two for men and two for women.

Aside from seeking institutions for both men and women, the choice of institutions was guided by availability and geography; some institutions were too remotely located, and others could not, at the time, accommodate visiting researchers. All 11 institutions are, however, managed by the same organization and are therefore similar in structure, treatment-principles, and daily activities. Each institution hosts 20–40 clients with problematic, often long-term, substance use. Clients receive care behind locked doors; it is not unusual for clients to try to escape, which explains the treatment facilities' high level of security (Svensson, 2010). Treatment activities – motivational interviewing, group sessions and, in some cases, individual therapy – aim at motivating clients to engage in voluntary treatment. Within the 6 months of compulsory treatment, clients are to be moved to other forms of treatment. Clients are rarely allowed to leave the facilities; treatment-related activities and leisure activities mainly occur at the institution. The compulsory institutions are strict about allowing outside activities, which occur mostly under staff supervision.

Focus groups

The selected methodology was focus groups (Smithson, 2000), which served to bring out collective perspectives and reveal dominant and normative discourses as well as contradictions and confusions. The selection criteria aimed at capturing the variety of staff working at each institution, differing in gender and professional roles. Written information about the study, and an invitation to participate, were sent to staff before the focus groups. To ensure there was a sufficient number of staff to participate on the scheduled dates, the executives organized the focus groups in advance amongst those interested in participating. Details about participation, such as a participant's right to withdraw their participation, were further explained on the day of the interview. Four focus groups were conducted including 22 staff in total. Between three and seven service providers participated in each focus group; in one, only three professionals could participate due to unexpected events, reducing the workforce on the day of the researchers' visit. Despite being smaller and shorter (75 min) than the other focus groups, it provided rich empirical material and did not differ in content.

The variation in staff was similar within each institution (see Table 1).

The majority of the participants were responsible for the everyday care of clients, and the contact with their CSOs. Social workers, with a university degree, were also responsible for managing the contact with the client's social services and documentation. Treatment assistants, with some education in nursing assistance and/or basic counselling, were more in charge of organizing individual activities and group activities. A few participants had managerial functions or medical responsibilities. Their ages spanned from the early twenties to early sixties, and their work experience in compulsory treatment varied between a few months to 30 years.

The focus groups were supported by a thematic interview guide to enhancing the potential for comparison and to moderate discussions. Themes covered were: (1) contact between clients and their CSOs; (2) involvement of CSOs in treatment; (3) contact between CSOs and staff; and (4) areas of development in relation to CSOs. The focus groups lasted between 75 and 120 min. All focus groups were conducted,

Table 1. Focus groups.

Focus group	Institution	Participants	Professional roles
FG1	Male	5 (4 females/1 male)	3 treatment assistants (TS), 2 social workers (SW)
FG2	Female	7 (6 females/1 male)	4 TS, 2 SW, 1 registered nurse
FG3	Male	7 (3 females/4 males)	4 TS, 2 SW, 1 manager
FG4	Female	3 (1 female/2 males)	2 TS, 1 SW
FG1–FG4			Most had training in methods such as motivational interviewing and relapse prevention.

recorded, and transcribed verbatim by the same two researchers. In subsequent excerpts, the data have been edited so that speech has been given conventional spelling. The original language for the focus groups was Swedish, but excerpts have been translated into English. Pseudonyms (P1, P2, etc.) have been used for all participants. The different focus groups are referred to at FG 1, 2, 3, 4. The study was approved by the Swedish Ethical Review Authority (ref.nr 1149-16).

Analysis

The focus groups were analyzed thematically from a social constructionist perspective overlapping with thematic discourse analysis (Braun & Clarke, 2006). We aimed to identify 'underlying ideas, assumptions and conceptualizations' (p. 84) in the participants' talk.

Participants' talk was seen as collective constructs of the topic, linked to broader discourses that hold power (Foucault, 1980). Discourses are defined as collective narratives, theories, and assumptions of reality (Foucault, 2002). In addition, the perspective of Potter and Wetherell (1987) was used, examining how people strategically employ discourses to make sense of their actions and make other people follow certain principles, which also places them in a different 'subject position.' The concept of subject positioning is used throughout the analysis to discover how staff position themselves and others in different social categories. Subject positioning was shortened to 'positioning' in the analysis. The meaning and function of discourse are situated in the context of the conversation (Wetherell, 1998). The accounts presented in the focus groups are therefore viewed as contextual constructs (Smithson, 2000). In this study, the researchers decided on conversation topics from the implicit perspective that CSOs are important. Any departure from these conversation topics might have triggered a sense that there was a need to account for the lack of involvement of CSOs.

The notion of accounts was defined by Scott and Lyman (1968) as 'a linguistic device employed whenever an action is subjected to valuative inquiry' (p. 46). In this study, accounts became a useful analytical tool to understand participants' statements that were interpreted as 'excuses' or 'justifications' for the lack of involvement of CSOs. The former refers to a person acknowledging an act as regrettable but defusing or mitigating responsibility; the latter refers to a person mitigating the negative impacts or justifying the act in itself (Scott & Lyman, 1968).

Our analytic procedure, as described below, followed Braun and Clarke's (2006) six steps of thematic analysis.

Firstly, all transcripts were read openly to broadly define the content of the discussions. Based on this, we identified a list of initial codes. Among them were: perspectives on CSOs; the lack of involvement/involvement of CSOs; the practical routines around phones and social media; and the staff's encouragement of clients to find new social contacts.

Since our specific interest was the staff's perspectives on clients' *existing* social networks, the number of codes was narrowed down in a second step. We then made the analytic decision to shift the focus from the whole data set to a detailed analysis of a few relevant themes. In a third step, the aim of the analysis was further specified, reducing the scope of the content. This part of the analysis resulted in six themes, divided into two sections to mark their overall difference in content: *Isolation as a Necessity* involves staff discussions of the *general* ideas of CSOs' presence in treatment as either important or problematic; *Approaches to CSOs: problems or resources* includes discussions on how staff approach CSOs in their everyday work, that is, concrete examples and general descriptions of how they assessed, interacted with, and regulated *specific* CSOs.

Results

The following six themes are presented in the two sections below: Protecting Clients: preventing negative influence and enabling self-reflection; Respecting the Clients' Will and Integrity; Ambivalence of CSOs as a Motivation; Assessing CSOs as Problems or Resources; Enforcing Rules and making Exceptions; Staff acting as Guides.

Isolation as a necessity

In this section, the staff's different and sometimes conflicting accounts of the general significance of CSOs for their clients' recovery will be presented in three themes.

Protecting clients: preventing negative influence and enabling self-reflection

A key justification for regulating contact with CSOs was the importance of *protecting clients from negative influence*: drugs, violence, and emotional distress, factors which could be impediments to the client's motivation to engage in abstinence and treatment.

> P3: We make risk assessments, both in terms of threats and violence, but also when it comes to negative and positive contacts. There are clients with only unhealthy contacts in their social networks. In these cases, it may not be so good that they have those contacts. Especially in the beginning, you're forced to come here, you're detained. You have cravings. You detox. (FG3)

To protect clients, all contact between clients and their CSOs is regulated by staff. CSOs deemed as 'unhealthy' or negative influences may be prevented from visiting the premises, especially at the beginning of treatment when the client is perceived as being extra vulnerable. Another key justification for limiting contact with CSOs was that *clients need to focus on themselves* and their treatment. By controlling clients' incoming and outgoing calls, staff can provide a calm space that gives time to 'stabilize.'

> P1: Even if we spend a lot of time transferring calls, and we moan about it; I actually think it's a good tool. We've only got two phones, and that really cuts down on contacts. I think this is important when clients arrive, because you need to stabilize, you may be detoxing, and you're somewhat trying to catch up with yourself, focus on yourself.
>
> P2: If we'd had mobiles phones then the institution wouldn't have been a calm place, because people would've called and interrupted all night. There would've been a danger in that.

Social contact with the outside world was described as a distraction from more important issues, mainly introspective reflection and participating in treatment activities. According to this rationale, all influence from the outside world could be an impediment to treatment and was generally believed to be invasive in the absence of regulation. Thus, in staff discussions, focusing on oneself and interacting with CSOs are seen as irreconcilable. Self-reflection, isolated from the outside world, is described as necessary to move forward in the rehabilitation process, making the CSOs redundant in this initial phase. In addition, many participants agreed that clients are already caught up in meetings, medical issues, and conflicting thoughts, diverting their attention away from their CSOs.

> P1: And as we talked about earlier, they are sicker. Many years ago, you could organize network meetings after three months, but it takes much longer now for them [the clients] to recover; it takes longer for them to be motivated, to stabilize, than it did before.
>
> P2 + P3: Yes. (FG3)

Here, everything, including the institutions' official care aims of 'recovery' and 'motivation,' is said to be postponed due to clients' poor mental and physical health, pushing work on relationships to the future. The two overlapping accounts of the restrictions and lack of involvement of CSOs presented in this theme suggest a protective approach, that is, social restrictions imposed 'for the good of the client.'

Respecting the clients' will and integrity

In another account, participants discussed clients who themselves wish to keep their CSOs at a distance. In such cases, staff unanimously account for restricting contact and the lack of involvement of CSOs in clients' treatment by referring to their integrity, and right to decide for themselves.

> When the client doesn't want any contact [with the CSO], then you have to respect that, even when family members call us screaming and arguing. Then, you've listened to the client. After all, they are the one deciding over their own life, their own contacts. (FG3)

This reasoning provides a contrasting picture of clients: rather than being persons in need of protection, they are presented as adults who set boundaries on the staff's rights to interfere in their decisions, leaving staff with no choice but to accept their decisions to limit contact with their CSOs.

Taken together, the two themes above show the staff's different explanations for the restricted contact with clients CSOs. According to the first theme, staff justifies such decisions as being for the good of the client, restricting their self-determination, whereas the second theme leaves the responsibility to clients to make their own decisions about the involvement of their CSOs during treatment. However, all accounts above are justifications for the restricted contact and exclusion of CSOs in compulsory treatment.

The ambivalence of CSOs as a motivation

As demonstrated above, participants seem to describe clients as individuals, who, due to harmful lifestyles, need a break from their everyday lives in favor of a strongly controlled and protected environment. On the other hand, participants argue that CSOs are *strong motivating factors* in the recovery process and key providers of 'security' and a 'lifeline' in relation to clients' abilities to establish a future sober life. This puts staff in an ambivalent position.

> P1: The focus for our work is very much the clients. But they have a social network, and without that, it would be harder to find the motivation, so …
>
> P2: Yes, it's a bit two-sided. Because we work with the client, and you want to help them develop and change. And our main mission is to motivate the client to seek voluntary treatment.
>
> P1: The question is if it wouldn't be in conflict to arrange couple's therapy while they work with their addiction.
>
> P2: It feels more natural that they can work on their relationships once they're finished with themselves.

P1 underlines the need for CSOs to motivate clients, reasoning that could prompt the inclusion of CSOs in treatment. However, this notion is refuted by the more dominant idea: that clients are in a process of change in which individual work comes first. Here the exclusion of CSOs in care is justified despite their stated importance for clients' motivation. The discussion illustrates the complexity of clients' relationships with CSOs from a staff perspective.

Throughout the analysis, a logic emerges whereby it is deemed especially important to limit contact initially. Restricted contact with CSOs is understood to be an unfortunate but necessary 'evil' in relation to clients' personal development. However, contacts with the outside world are not easily controlled and their assumed influence on clients' motivation goes two ways. Therefore, staff describes strategies aimed at assessing and regulating the involvement of CSOs in the institutional context.

Staff's approaches to CSOs: problems or resources

This section demonstrates that an important task for staff is to find out if (and when) CSOs are beneficial to the client's treatment:

Assessing CSOs as problems or resources

A recurrent theme was the participants' need for an early assessment of the CSOs, as a baseline for how to regulate the client's contact with them. Firstly, conversations with clients about their CSOs are commonly initiated by making a 'network map,' followed up by informal conversations with, and observations of, clients at the institution. Secondly, information and recommendations about clients' CSOs are provided by social services. Thirdly, information is gathered through conversations with the CSOs themselves. These conversations are framed as a form of 'digging' and 'snooping' for the potential impact of CSOs on clients.

> You have to be perceptive to the clients when they talk to their relative, and after the conversation you need to watch how they react: Positive? Negative? Are they happy? Are they sad? Maybe snoop a little: "Was it difficult to talk?" or something like that. (FG3)

The following analysis examines the assessment of CSOs as being either problems or resources. These six positions are not to be understood as fixed categories but as fluid constructs, that is, the same person can be positioned in different categories during staff discussions.

The most dominant perspective on CSOs identified was that they were part of 'the problem' behind the client's substance use. However, this analysis shows a variety of 'problematic' positions of CSOs. *The Deviant CSO* was a position linked to persons who were presumed to have 'their own problems,' such as substance use, criminality, or mental illness.

> P1: If you ask them [clients]: "Does your girlfriend have a problem?" they'll answer: "No, she only parties, maybe takes cocaine sometimes, or maybe smokes a little weed in the evenings, but nothing else." But if you dig a little deeper … I still think many partners do have drug problems of their own.
>
> P2 – P4: Mm. (FG1)

The participants demonstrate a suspicious attitude towards CSOs. Even when clients insist that their partner strongly rejects drugs, it is in this context read as a sign of the opposite. Thus, drug-using CSOs are assessed as a serious risk from which clients need protection.

Another problematic position is *the blaming CSO,* who places all responsibility for the situation on the client. This, participants claimed, further reduced the client's self-esteem. As one participant put it: 'They already think they are pretty useless, so they are not helped by hearing that' (FG4).

The *overprotective CSOs* were those who prevent clients from developing and making decisions for themselves.

> Parents can have a tendency to let their grown-up children, very grown-up children, continue to be children. They must do what their parents tell them to do; they suffocate the children, so that their own will won't get through. (FG2)

An overlapping 'problematic' position is the *critic of the system*; CSOs who are is said to constantly criticize staff and interrupt with questions regarding compulsory treatment: 'Why is he locked up? Why hasn't he got this specific kind of medication? He needs it and he has it at home. What is he doing with all the money? Shall I send money *again*?' (FG3). Questions such as these could be interpreted as a sign of care and support; however, CSOs' critical questions about the treatment were presented as problematic and as having a negative impact on the client's willingness to cooperate:

> She was completely unresponsive to care and treatment from the staff's side of things. She was so focused on what her dad had said, "Dad told me this and he told me that." So, you could've wished for a bit of telephone silence for a couple of weeks. (FG4)

Strong alliances between clients and their CSOs were seen as a disadvantage and obstacle to care if the CSO did not share the staff's perspective on treatment. The term co-dependence, which typically describes someone who 'enables' dysfunctional behavior (Bacon et al., 2018), was used: on the one hand, to refer to a specific kind of dysfunctional and problematic CSO; and, on the other, to describe the behavior of all CSOs who were deemed problematic.

Less prominent, but appearing in all focus groups, are accounts of CSOs as a source of motivation and a potential resource for clients in their recovery processes. The first account portrays the function of a CSO as a *moral supporter* to 'push' the client to stick to the program:

> The ones they [clients] contact at times when their motivation is really flagging, and they cannot go on anymore; they cannot bear it, but after they have talked to this person, they say, "I have changed my mind, I am going to stay." (FG3)

This kind of positioning is depicted as the opposite of a 'problematic' CSO; rather it is someone who can 'stand up to' a client, and who has the ability to shape the client's thoughts and motivations to align with the institution, rather than question it.

A second positioning of the resourceful CSO identified was of the *practical supporter*, providing valuable support, planning ahead, and being interested in future treatment.

> Sometimes, they [clients] hardly knew the name or face of the social worker who was managing their case. Then the family needs to be that control center, taking care of the practical things for them, not least taking care of their children. One person [family member] I have here has been really active in creating possibilities for aftercare with methadone maintenance treatment. It was the mother who made the call, not the social services. (FG4)

Here, the CSO is presented as indispensable in filling the gaps when support from social services was not forthcoming. The common link between all the accounts of resourceful CSOs was that they acted as providers of support in the background, and played an important role 'to be there' once compulsory treatment had come to an end.

Taken together, the staff's assessment of clients' social networks depicts the CSO in one of two ways: as a resource or as a problem in relation to the client's rehabilitation. Notable here is that the alleged behavior of overprotective CSOs, the critics of the system, overlaps with that of the moral and the practical supporter. The common link between these positions is that they are engaged CSOs who try to contribute to the care and wellbeing of their relatives. The main difference between them is the way staff interpret their actions in the context of a client's care: as either a resource

or a problem in relation to institutional rules and the staff's perspective on rehabilitation.

Following the assessment of CSOs, the analysis shows two ways of regulating the involvement and contact with CSOs.

Enforcing rules and making exceptions

One way of regulating clients' contact with their CSOs is by enforcing explicit rules. The rules are, within the limits of standard security, described as flexible, and vary depending on the particular client's needs. Here, the dichotomous nature of positioning CSOs as problems or resources is central to the way participants justify individual regulation of maintaining contact with a CSO. Preventing visits were sometimes framed as a necessity, for example when the CSOs' mental influence on the client was deemed too intense: 'In one case it was a dad; it was because he was completely against the care planning we had (FG3).' In this quotation, 'a critic of the system' created a barrier to the staff's endeavors to 'reach' a client; this justified a stricter regulation of contact. At the other end, the staff gave examples of exceptions when limits on contact could be attenuated depending on the outcome of previous supervised visits and the assessment of the clients and their CSOs:

> P1: Encourage visits [P2: Yes, we do] in every possible way. When there is uncertainty around a client's social contact, then the visit will be supervised [by two staff], and when we start to trust each other more, they can be alone for a limited time.
>
> P2: We even have those clients whose partners pick them up, and they spend a couple of hours in town, eating, and then they come back. So, there are all forms and varieties. (FG2)

In this case, the exception is described as being dependent on the level of 'trust' between the client, the staff, and the CSO, that is, trust that nothing prohibited would occur.

Staff also described exceptions to the lack of involvement of CSOs in treatment. When CSOs are deemed as trustworthy, as a 'moral supporter,' staff describe them as valuable allies and a source of information, notably in cases when a client is not considered reliable.

> I have sometimes said to a grandfather who comes to visit that "after the visit can you tell us how he [the client] is doing, because you've known him his whole life, and we've only known him for a few weeks." It is a bit hard to see how he is coping, and whether he's intoxicated by medication. But I added that while I couldn't give him information, that it would be really good to hear his opinion. (FG1)

Even if the importance of 'respecting the client's integrity' is partly accounted for in this quotation, the CSO's potential to bring valuable information to staff justified an exchange of information.

Staff acting as guides

The participants underscored a more implicit way of regulating the client's contact with their CSOs: to reason with the clients and make them 'understand' the difference between supportive, non-supportive, and/or harmful relationships.

In line with the idea that staff must respect the client's will and integrity, participants were unanimous that they wanted, as far as possible, to restrict contact with problematic CSOs *in agreement with the client*. In particular, staff underlined the importance of being a 'filter' against bad influences from the outside, but without causing too much offence:

> We can't always set boundaries by force, because then the fallout may be bad. We always try to anchor it with the client. Maybe say, "Yes, she called, but I didn't think it was a good idea that you talked, and asked her to call again tomorrow." Then, at least you've said what you think, and then you can let the client decide. I guess that's our job, to be that filter, and yet do it in such a way that you don't always offend the client. Because we do offend. (FG3)

The staff's dual functions in relation to the client's treatment – to control outside influences, and build relationships of trust – are positionings that, evidently in this quotation, are complicated to hold. 'Offending' clients may compromise their trust and impede a possible alliance with the client. Instead of using outright force, participants stressed the necessity of 'helping' clients understand the potential negative impact of their CSOs, and to subsequently support the restricted contact with their social network. In the following quotation, the client is positioned as a person who needs guidance from staff, to see the difference between a resourceful and problematic contact.

> You can start building a conversation with the client, compare pros and cons together, explore the client's ambivalence, and hopefully make the client realize that: "Maybe it's good that I don't speak with Mum when she has her bad periods." Because it triggers a lot of emotions if Mum or Dad caused them a lot of pain, which was the beginning of what would become a tough life, maybe battling PTSD and all that entails. (FG3)

The participant illustrates a potential situation with a 'deviant CSO,' who caused a client 'a lot of pain,' which serves as an explanation for the need for distancing from the CSO.

At the other end, staff stresses the importance of helping clients find new good contacts if they have none, or increasing contact with 'resourceful CSOs' if contact is limited. This work involves helping them 'get over' anger and contempt.

> P1: And that can be based on how their relationship has been through the years, but it can also be based on the parent having reported the substance abuse [to the social welfare authorities]. And then you can turn to the client and listen, and listen, but the client should make the decision himself, and come to the realization that: "Mum and Dad only want what's best for me. They didn't do it to punish me." Make them see it differently.
>
> P2: Yes. Make the anger go away. (FG1)

Two common sources of conflict are distinguished here: one caused by a troublesome history and one by a CSO reporting the client's substance use. The latter reflects the role of 'the moral supporter' who approves of compulsory treatment. The situation is framed by staff as a therapeutic conversation in which staff aim to change the client's thinking, feelings, and actions; in this case, to come to the realization that the CSO is a resource. Thus, this last theme has illustrated how the staff's understanding of their work on the client's internal perspectives not only involves their relationship with alcohol and drugs but also their CSOs.

Discussion

This analysis illustrates how staff understands the importance and involvement of the client's CSOs while detained in an institution for compulsory drug treatment. The first finding is that isolation is seen as a necessity in relation to the client's recovery process. While sustained contact with 'supportive' CSOs is understood as an essential motivation for clients during and after compulsory treatment, the dominant perception of CSOs' involvement in treatment is as a distraction in relation to the client's early-stage recovery. Similarly to Selbekk and Sagvaag (2016) study, staff justified the exclusion of CSOs in treatment by referring to the client's need to focus on their own recovery, and the client's right to refuse CSOs' involvement. In this study, isolating clients is also seen as positive, reasoning we have interpreted as based on the separation between the outside and the inside of the total institution (Goffman, 1961): primarily, the institution needs to stay clean from unwanted influences such as taking drugs; but on an individual level, staff describes the client's need for isolation as part of the recovery process. Not until clients have successfully gone through the first phase of treatment activities and self-reflection can contacts from the outside be involved. Thus, compulsory treatment can create an involuntary moratorium for clients. However, based on the rationality of isolation presented by staff, it can be seen as a possibility for asylum, that is, in line with Goffman (1961), isolation becomes the prerequisite for the development of new selves constituted by the institution. In all four institutions, the influence of the client's usual environment on the outside was treated as a potential threat to their ability to accept their situation and strive for change. As pointed out by and Billquist & Skårner Billquist and Skårner, Billquist and Skårner, (2009), care and control are intertwined in compulsory drug treatment: the repressive part of compulsory treatment is constructed as supportive, facilitating self-reflection. A consequence of this reasoning is that clients' CSOs are made irrelevant, a stance that is contradicted by a number of studies stressing the importance of social networks for client recoveries (Kidorf et al., 2016; Neale et al., 2014).

The second finding is that staff perceive the assessment of CSOs to be a necessary step in deciding the individual regulation of contact for each client, that is, enforcing more or fewer restrictions depending on the perceived risks of a specific CSO. In line with previous research, CSOs are constructed as 'problematic' (Lee et al., 2012; Misouridou & Papadatou, 2017; Orr et al., 2014) but also as 'resourceful' (Orr et al., 2014). Staff automatically categorized CSOs with 'their own problems' (deviant CSOs) as a risk, which motivated their exclusion from the care setting. In addition, CSOs being engaged but deemed too critical of treatment (the Critic), or overly concerned (the Overprotective CSO), were perceived as an equal risk to clients' abilities to change. Two categories of active CSOs with positive connotations were the Moral Supporter and the Practical Supporter, who encouraged clients to follow through with the program and supported staff in practical ways; these CSOs could be accepted as allies in the treatment. The problem with the Critic and the Overprotective CSO was linked to the possible disruptions that they could cause in treatment, rather than how they might impact the client's life post-treatment. Similarly, Misouridou and Papadatou (2017) found that demanding parents were especially stressful for therapists because they intruded on the therapist–client alliance. Overall, co-dependence stood out as a flexible concept used to explain many of the characteristics of active CSOs that staff found problematic. This analysis corresponds to Goffman's (1961) writing on the CSO as an important ally or problem for staff in the total institution. 'Kin as critics' (p. 75) is depicted as a special kind of problem, reminding staff of the client's civil rights – when many of these rights are taken from clients in the total institution – that is, they function as a counterweight to the mortification process (Goffman, 1961). However, CSOs can also help to induce the mortification process by contributing to, believing in, and supporting the staff's construction of the client's need for incarceration. None of these functions, however, entail their direct involvement in treatment. The staff's understanding of CSOs as problems may also be an expression of 'stigma by association:' in other words when stigma linked to some people is extended to their social networks (Goffman,1986; Van der Sanden et al., 2016), and this may create additional barriers to CSOs, engaging in the treatment.

In addition, the narrow categorization of CSOs' impact as a problem or a resource for ongoing treatment may be problematic in relation to research showing the complex function of clients' social networks over time (Tracy et al., 2010). A recent study by Veseth et al. (2019) highlights that all social contacts can have 'stabilizing' and 'destabilizing potential' depending on the situation, and, in relation to the changing self and needs of the client, that relationships can be meaningful in themselves because they offer belonging and connection, which is key to recovery. Thus, even if social contacts appear problematic for staff during the short period of compulsory treatment, they may still serve important functions in the broader context of the client's relationships and over time.

Moreover, the CSOs, in general, were presented as exercising a strong, negative or positive influence on their relatives, whereas clients were positioned as vulnerable, and susceptible subjects in need of protection. Such reasoning ignores the client's agency in their relationships and the importance of reciprocal relationships for people in recovery; having responsibilities towards other people can be motivating in itself (Veseth et al., 2019). This protective approach, which Tännsjö (2002) frames as paternalistic, is also what motivates compulsory treatment in the first place: the staff's role is to protect clients by force from their own self-destructive actions. Secondly, it is to initiate their motivation to change voluntarily (Billinger, 2005).

A third finding shows that work with clients' substance use, both disciplinary and motivational, also involves work on their social networks. Firstly, staff position themselves as a filter not only against drugs and excessive drinking but also against interference from the client's CSOs. The enforcement of contact rules was described as a flexible tool. If trust between staff, clients, and their CSOs is established, it can be rewarded with more freedom during visits and the CSOs being permitted more influence. In contrast, stricter

regulation can be applied in response to problematic behavior on previous visits. Such disciplinary acts can be understood as the enactment of disciplinary power (Foucault, 1977), aiming to influence a client's journey toward sobriety. Secondly, staff positions themselves as guides, finding it necessary to actively help clients change how they think and feel about their CSOs. Such enactment of pastoral power (Foucault, 1982) seeks to induce clients' 'self-governing' (Dean, 2010), that is, make clients regulate problematic CSOs themselves and strengthen their links to those who are seen as valuable resources. Thus, rather than staff describing their work with CSOs as generally collaborative (National Board of Health and Welfare, 2013, 2015), it is presented as promoting relationships that are assessed as being constructive and demoting others. Billquist and Skårner (2009) present compulsory drug treatment as a manifestation of sovereign power: clients are captured and treated by force under the presumption that they are incapable of being in charge of their own lives. The ultimate goal of compulsory care is to motivate clients to take responsibility for their own recovery process but in line with the perspectives of the institution (Billinger, 2005). This resonates with the analysis in this study. However, in the present case, the staff's understanding of the impact of their work on the client's perspectives not only involves their relationship with alcohol and drugs but also their social network. This form of governing (Dean, 2010) may leave clients little room to decide for themselves who may be a resource in the long term.

In summary, staff acknowledge supportive CSOs as vital for the client's recovery process, and facilitate contact with them; however, they find the presence of CSOs as most functional in the background, and at a distance from their work with clients. Compulsory drug treatment is a radical intervention enforced against a person's will, and this brings forward a discussion on which areas of clients' lives that should be governed. In addition, it highlights the extent to which the collective constructions of CSOs among staff may impact clients' access to and relationships with their social networks, and vice versa.

Disclosure statement

No potential conflict of interest was reported by the author(s).

Funding

This work was supported by The Swedish National Board of Institutional Care [Statens institutionsstyrelse] (2.6.1-1142-2016).

ORCID

Karin Berg http://orcid.org/0000-0003-2914-7500
Frida Petersson http://orcid.org/0000-0001-8512-7892

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