Addiction and recovery: perceptions among professionals in the Swedish treatment system

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ABSTRACT
AIMS – The objective of the study was to explore perceptions of different addictions among Swedish addiction care personnel. DATA – A survey was conducted with 655 addiction care professionals in the social services, health care and criminal care in Stockholm County. Respondents were asked to rate the severity of nine addictions as societal problems, the individual risk to getting addicted, the possibilities for self-change and the perceived significance of professional treatment in finding a solution. RESULTS – The images of addiction proved to vary greatly according to its object. At one end of the spectrum were addictions to hard drugs, which were judged to be very dangerous to society, highly addictive and very hard to quit. At the other end of the spectrum were smoking and snuff use, which were seen more as bad habits than real addictions. Some consistent differences were detected between respondents from different parts of the treatment system. The most obvious was a somewhat greater belief in self-change among social services personnel, a greater overall change pessimism among professionals in the criminal care system and a somewhat higher risk perception and stronger emphasis on the necessity of treatment among medical staff. CONCLUSION – Professionals’ views in this area largely coincide with the official governing images displayed in the media, and with lay peoples’ convictions.
KEY WORDS – treatment, addiction general, surveys, social work, health/social services administration, probation services, Sweden.

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Introduction
Concepts such as alcoholic, drug abuser, or addict have various definitions and meanings in different historical, cultural and situational contexts. These definitions and meanings can in many ways influence the life of those defined. Not only are they likely to govern the reactions these people may encounter, but they may also be internalised in their self-definitions and influence their options of finding a stable path out of their predicaments (Blomqvist, 1998). In a sense these concepts may therefore act as powerful and self-perpetuating interactive categories (Hacking, 1999).

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Disease models that depict addictions as inexorably progressive and almost impossible to stop, can have a negative influence on people’s faith in their own ability to quit (Peele, 1985) and may hamper the environment’s readiness to offer help (Klingemann, 1992). As discussed by Cunningham, Sobell and Sobell (1998; 1999), views that stigmatise the addict may prevent him/her from seeking help or evoke discrimination against former problem substance users in working life.

Nonetheless, relatively little is known about the governing images (Room, 1978) that shape the official and unofficial reactions that people with addiction problems are likely to encounter from various population groups. Even less is known about the prevailing images among those whose official duty it is to handle addiction problems. In Sweden, the classical disease notion of alcoholism has long been less influential than in many other countries. While Sweden prefers a more social model, the medical model has over the recent decades gained increasing influence, and more than half of all treatment units describe twelve-step ideology as at least one “bearing ingredient” in their programmes (National Board of Health and Welfare, 2004; Blomqvist, 2012). As concerns narcotic drugs, the Swedish official stance, notably influential, views narcotics as extremely dangerous, poisonous and impossible to quit, and endorses a policy of a drug-free society (Bergmark & Oscarsson, 1988). This has – until quite recently – informed media reporting, public policy as well as the design and character of officially preferred measures to handle addiction problems at the individual level (Blomqvist, 2004; 2012). At the same time, professional consensus about the proper handling of addiction problems is generally fairly low, at least in the social services sector (Wallander & Blomqvist, 2005). There are also indications that the prevailing images of addiction problems may vary considerably between various parts of addiction care (Palm, 2004). Little is known about how habits that have only recently started to be discussed in terms of addiction (such as gambling, illicit use of prescribed medical drugs and tobacco use) are perceived by treatment personnel. The overall aim of this study is therefore to provide a clearer picture of the governing images of addiction in the Swedish treatment system. The study is part of a larger project that has explored perceptions of addiction and recovery in a representative population sample in Sweden (Blomqvist, 2009; 2012), and connects to similar studies within the international IMAGES network.

Addiction care in Sweden
Addiction care in Sweden entails several main actors that fulfil partly differing functions and provide partly differing specialised services. The main legal responsibility for long-term care, treatment and potential cure lies with municipal social services (Blomqvist, Palm & Storbjörk, 2009; Christophs, 2009). The social services are obliged to provide misusers with the help and care they need to recover from their misuse and to promote the individuals’ economic and social safety, equal living conditions and active participation in social life. Each municipality or city district of large cities have social services offices which usually have specialised units for handling addiction problems. The support provided can,
after means tests, come in various forms, such as outpatient or inpatient treatment, or different kinds of housing and social or personal support. In severe cases there is also the possibility to refer a person with addiction problems to compulsory care.

Second, the regional health care organised at the county level provides detoxification and other emergency services, as well as medical and psychiatric care for alcohol and drug-related disorders. There are also specialised programmes for substitution treatment, for example, health care for homeless people and special interventions for certain groups such as pregnant women, drunk drivers or patients dependent on medical drugs. The third actor in this study is the probation services, since many people with addiction problems end up in the criminal justice system. There are various treatment facilities for misusers in prisons, and under certain circumstances people with addiction problems can serve part of their sentence in addiction treatment outside the penal system. During the last decades, the parole system has also built extensive evidence-based treatment programmes (National Council for Crime Prevention, 2008). Specialised services for misusers in Sweden are thus, with the exception of compulsory care, provided by the municipal social services, the regional health care system at the county level and the criminal justice system. Inpatient treatment in particular is to an increasing degree provided by private actors and voluntary organisations, although mainly paid for by the social services (National Board of Health and Welfare, 2004). However, our study is restricted to publicly run outpatient units.

Previous research

An increasing number of studies have recently investigated how lay people as well as professionals in the addiction field perceive the character and changeability of different addictions. The international, explorative study Societal Images of Natural Recovery (SINR) (Klingemann, 2003) indicates that confidence in the possibility of self-change from different addictions is rather low, despite ample scientific proof that untreated solutions are in fact the most common path out of many addictions (Klingemann & Sobell, 2007). Respondents’ perceptions are also shown to vary a great deal between countries and cities, as well as between professionals and lay people and various addictions. The Swedish sub-study in this project (Andersson, Florell & Samuelsson, 2004) found that representatives from the treatment sphere were relatively pessimistic towards the possibility of misusers quitting their misuse or addiction without professional treatment, whereas respondents from the media were the most optimistic. In a sequel to this study, Klingemann and Klingemann (2007) further mapped popular attitudes towards self-change in Switzerland, exploring what they described as the key elements of a self-change friendly society.

In a later Swedish survey, a representative population sample was asked to rate different psychoactive substances or potentially addictive activities in terms of their perceived severity as societal problems, the perceived risk for a user to develop an addiction to them, the extent to which an individual should be held responsible for acquiring such an addiction, as well as for solving it, and the chances of recovery from these addictions, with or without...
formal treatment (Blomqvist, 2009; 2012). As a complement, the key questions from this survey were also directed to a sample of units in the county of Stockholm from the three main providers of addiction care, that is, social services, addiction care in the health services system, and the probation services. This study is also the source of the data analysed in this paper. Further replications of the Swedish population study have since been conducted within the framework of the international IMAGES consortium in Finland, Canada, and Russia (Cunningham, 2009; Koski-Jännes, Hirschovits-Gerz, Pennonen & Nyyssönen, 2009; Holma et al., 2011; Hirschovits-Gerz et al., 2011; Koski-Jännes, Hirschovits-Gerz, Pennonen & Nyyssönen, 2012; Koski-Jännes, Hirschovits-Gerz & Pennonen, 2012). The two latter Finnish papers include data on professionals’ and clients’ views on addiction and recovery. Overall, these papers show that while different addictions are perceived in quite different ways, hard narcotic drugs are most often perceived as the most dangerous, both to the individual and to society. There are some interesting differences between countries: Finns rate alcohol as a more severe problem than other respondents, and Canadians rate cannabis as a less severe problem than do other respondents (Holma et al., 2011; Hirschovits-Gerz et al., 2011). However, lay respondents’ and professionals’ views seem to differ surprisingly little, at least in Finland (Koski-Jännes, Hirschovits-Gerz, Pennonen & Nyyssönen, 2012; Koski-Jännes, Hirschovits-Gerz & Pennonen, 2012).

Aims and research questions
The overall aim of this study is to explore how addiction professionals in Sweden perceive the severity to society and to the individual of various forms of substance use or other potentially addictive behaviours, as well as the chances for recovery from addictions to these substances/behaviours. Another aim is to examine to what extent and how these perceptions differ between staff in the three main organisations involved in addiction care in Sweden, namely the social services, health care and the probation services. The substances/behaviours analysed were the same as those in the population study, on which our study was modelled (Blomqvist, 2009; 2012), namely alcohol, cannabis, amphetamines, cocaine, heroin, snuff, cigarettes, (illicit use of) prescribed medical drugs and gambling. Comparisons are made with results from studies of perceptions among Swedish lay people and Finnish professionals and lay people.

More specifically, the research questions are
1) How do addiction treatment professionals perceive a) the severity of different forms of addictions as societal problems; b) the risk of becoming addicted to various substances/behaviours; c) the possibility of recovery from various addictions without treatment; and d) the importance or “added value” of treatment in recovery from these addictions;
2) Are there essential differences in these perceptions between addiction professionals in the social services, health care and the probation services, and how can such differences be understood?

Method
Study design and data collection
A survey was handed out in 2006 to ap-
proximately 900 professionals working with addiction problems in the municipal social services, county-based health care and the state criminal probation services in Stockholm County. The participating work units were strategically chosen to reflect socio-economic diversity in the catchment areas. On the municipal level, the respondents represented 12 of the 18 social services districts of the city of Stockholm, and 9 of the 25 other municipalities in Stockholm County. Regional health care respondents represented 24 of about sixty addiction care units in Stockholm County, while respondents from the probation services represented all of the nine probation offices in the former Stockholm Region. Approval to conduct the study was obtained from the executives in each organisation. A contact person at each unit helped in distributing the surveys and enabled reminders to be sent out without jeopardising the respondents’ anonymity. The criterion for inclusion in the study was that respondents should have contact with people with misuse problems in their daily work. The total response rate was 73%: 79% among social services, 79% among probation services and 61% in health care. The questionnaire contained a selection of questions taken from the population study (Blomqvist, 2009). The questions asked the respondents to rate the severity of various addictions and other problems on a scale from 1 to 10, and rate the addictiveness of various substances/behaviours and chances of recovery from various addictions (with or without professional treatment) on scales from 1 to 5. Their sex, age, work experience, and basic and professional education were also included among the questions.

Analyses
The answers were processed statistically with SPSS 19. Differences between the three organisations on the mean ratings of various addictions/behaviours were tested with F statistics (Means and Oneway ANOVA), and with Scheffé post hoc test to specify group differences. Differences in the respondents’ perceptions of various addictions were tested using paired samples t-tests. In the description of the respondent groups, \( \chi^2 \)-tests were used for category variables (sex and education). Finally, linear regression analyses were performed to test to what extent different ratings between the three organisations could be explained on the grounds of differences with regard to respondent characteristics.

Results
In the following, respondents’ ratings of the nine substances/behaviours in the four aspects are presented for each of the three respondent groups, and for the total sample. For each respondent group and each aspect, the mean ratings of each behaviour, substance or addiction are presented first, followed by the rank of each of them for each organisation. Effects of respondent characteristics on the ratings are not displayed in the tables, but are briefly commented on under each ranking.

Respondents
In all, 655 valid responses were delivered. One third of the responses came from the health care sector, slightly more than one third from the social services and slightly less than one third from the probation services. Table 1 displays some basic characteristics of the respondents, as well as some differences between respondents.
The vast majority of the respondents were middle-aged, university-educated women, with a fairly long work experience in the field. Respondents from the probation services were on average the youngest and the most educated, and had a longer experience in addiction care than other respondents, whereas health care respondents were the least educated and contained the largest proportion of women.

The perceived severity of different addictions as societal problems

Table 2 shows how respondents rated the severity as a societal problem of the six forms of addictions in relation to nine other commonly discussed societal problems. There were obvious differences in the rated severity of the 15 issues under scrutiny. Paired samples t-tests for the full sample (p-values not displayed) revealed that violent crimes were rated as significantly more severe than any other problem. Further, the use of hard drugs, drinking alcohol and environmental problems were rated as more severe than prostitution, poverty, ethnic discrimination and cannabis use, which were in turn deemed as more severe societal problems than property crimes, illicit use of medical drugs and financial crimes. Wage differences, gender inequality and gambling were rated as the next to least severe problems to society, and tobacco use was rated as less severe than any of the other problems, despite its big and well-known hazardous health consequences. The ranking of various problems was largely the same for the three organisations, but the F statistics and post hoc tests showed that respondents from the probation services rated the severity of violent crimes, prostitution, property crimes and tobacco use significantly lower than other respondents. They rated the severity of environmental problems and the use of medical drugs lower than respondents from the social services, and the severity of wage differences lower than did health care staff. In addition they provided lower severity ratings than other professions for cannabis use, although this difference was not cor-

Table 1. Respondent characteristics

| Organisation: Variables: | Social services (n= 250; 38.1%) | Health care (n= 216; 33.0%) | Probation services (n= 189; 28.9%) | All (N= 655) | p-values |
|---------------------------|-------------------------------|-------------------------------|----------------------------------|--------------|----------|
| Per cent women            | 72.3%                         | 75.8%                         | 70.9%                            | 72.4%        | < .001   |
| Age (M, sd)               | 47.6 (10.2)                   | 47.3 (10.2)                   | 44.7 (12.4)                      | 46.7 (10.9)  | < .051   |
| Per cent university educated | 83.2%                        | 65.3%                         | 87.3%                            | 78.5%        | < .001   |
| Years working with addictions (M, sd) | 13.1 (9.9)               | 13.4 (9.3)                    | 15.0 (11.5)                      | 13.8 (10.2)  | ns       |
| Years at present workplace (M, sd) | 6.4 (6.4)                   | 6.7 (6.5)                     | 9.2 (9.0)                        | 7.3 (7.4)    | < .0012 |

Post hoc tests (Scheffé; p < .05): 1probation services < social services, health care; 2probation services > social services, health care
robated by the post hoc tests. Their overall severity ratings were also lower than those of respondents from the two other organisations.

Respondent characteristics also played a part. Regression analyses (not displayed) revealed that women rated addiction problems as significantly more severe as societal problems than men did, and that university-educated respondents rated them as less severe than lower-educated respondents. However, this did not influence the differences between the three organisations.

The perceived risk of getting addicted

Table 3 displays respondents’ ratings of the addictiveness of, or risk of “getting hooked” on, the nine investigated substances/behaviours. There were large differences between the substances/behaviours. Heroin was rated as the most addictive drug, followed by cocaine and amphetamine. Paired samples t-tests (not displayed) showed that the differences between all these three substances were statistically significant. In a second group, without significant internal differences between them, followed cannabis use, smoking and (illicit) use of medical drugs. These substances were followed, with significant differences between consecutive pairs, by snuff, gambling and alcohol. Rankings by respondents from different parts of the treatment system were largely similar, but the health care staff and the probation service personnel ranked the addictiveness of cannabis and cigarettes, respectively.
as lower than other respondents. The post hoc tests show that respondents from the probation services on average rated the addictiveness of cigarettes and alcohol significantly lower than respondents from the health care system, and that social services staff had overall lower risk ratings than health care staff. However, separate analyses (not displayed) revealed that university-educated respondents rated the addictiveness of most substances/behaviours as lower than other respondents, and that the difference between probation services staff and health care professionals concerning the addictiveness of alcohol could be explained by the probation service staff’s higher educational level. The addictiveness of amphetamine was rated highest by health care staff and lowest by social services staff, although post hoc tests detected no significant differences here.

A comparison of tables 2 and 3 shows that professionals to a large part rank the severity to society and the danger to the individual in a similar way. The obvious exception is alcohol, the use of which was seen as one of the most severe problems to society, while its addictiveness was ranked lower than for any other habit.

The perceived possibilities for self-change from addictions

Table 4 shows respondents’ ratings of the chances of recovery from addictions to the nine substances/behaviours without treatment, that is, the perceived possibility for self-change. These ratings, too, differed considerably between different addictions. Snuff use and smoking were perceived as the most easy to quit on one’s own, whereas heroin use and the illicit use of medical drugs were deemed to be the most difficult. Alcohol appeared towards the middle of these opposite ends. More specifically, paired samples t-tests (not displayed) revealed significant differences between every consecutive pair of addictions in the full sample, while no differences could be detected between gambling, alcohol and/or cannabis in the organisational sub-samples.

The ranking of the options for self-

### Table 3. Perceived addictiveness of various substances/behaviours (scale 1–5)

| Organisation: Addiction to | Social services | Health care | Probation services | All | p-values |
|----------------------------|-----------------|-------------|--------------------|-----|---------|
|                            | M (sd) Rank     | M (sd) Rank | M (sd) Rank        |     |         |
| Heroin                     | 3.24 (0.8) 1    | 3.38 (0.9) 1 | 3.38 (0.6) 1       | 3.33 (0.8) 1 | ns      |
| Cocaine                    | 2.94 (0.5) 2    | 3.11 (0.8) 2 | 3.07 (0.6) 2       | 3.04 (0.8) 2 | ns      |
| Amphetamines               | 2.68 (0.6) 3    | 2.86 (0.8) 3 | 2.78 (0.5) 3       | 2.77 (0.8) 3 | <.05    |
| Cannabis                   | 2.35 (0.8) 5    | 2.47 (0.8) 6 | 2.45 (0.5) 4       | 2.44 (0.8) 4 | ns      |
| Cigarettes                 | 2.40 (0.9) 4    | 2.56 (0.9) 4 | 2.32 (0.8) 6       | 2.43 (0.9) 5 | <.05^1  |
| Medical drugs              | 2.35 (0.8) 5    | 2.52 (0.8) 5 | 2.42 (0.7) 5       | 2.41 (0.8) 6 | ns      |
| Snuff                      | 2.10 (0.7) 7    | 2.17 (0.8) 7 | 2.02 (0.5) 7       | 2.10 (0.7) 7 | ns      |
| Gambling                   | 2.00 (0.6) 8    | 2.12 (0.7) 8 | 1.99 (0.5) 8       | 2.04 (0.7) 8 | ns      |
| Alcohol                    | 1.94 (0.6) 9    | 2.06 (0.7) 9 | 1.89 (0.6) 9       | 1.96 (0.6) 9 | <.05^1  |
| Grand mean                 | 2.44 (0.6) 2    | 2.59 (0.6) 2 | 2.48 (0.5) 2       | 2.50 (0.6) 2 | <.05^2  |

Post hoc tests (Scheffé; p < .05): 1 probation services < health care; 2 social services < health care
change from various addictions were largely similar in the three organisations. However, the post hoc tests showed that health care professionals rated the possibilities for self-change from alcohol addiction lower than social services professionals, that professionals in the probation services rated the possibilities for self-change from addiction to amphetamine and cocaine lower than other respondents, and the possibilities for self-change from heroin addiction, as well as the average possibilities for self-change, lower than social services professionals. Men, university-educated respondents and those with a longer work experience generally rated the options for self-change as higher than other respondents. However, none of these effects proved to alter the differences between the three organisations.

The perceived significance of treatment

In a final sub-analysis, respondents’ ratings of the relative importance or “added value” of formal treatment in recovery from each of the nine addictions were calculated. This was done by subtracting the rated possibilities of self-change from the rated chances of recovery with the help of treatment. As displayed by Table 5, the rank order was almost the same in all the three organisations, with treatment perceived to be most important in the case of addictions to heroin and illicit medical drugs, and least important in relation to addictions to snuff and cigarettes. The only difference was that health care staff ranked treatment for alcohol addiction as more important, and treatment for cocaine problems as less important, than others did.

Paired samples t-tests of the mean ratings (not displayed) indicated that formal treatment was rated to be most important in recovery from heroin addiction, followed by addiction to illicit medical drugs, cocaine, amphetamine, alcohol, cannabis and gambling. As for addiction to snuff and cigarettes, self-change was in fact perceived to be more probable than recovery with the help of treatment. Differences between all consecutive pairs were statistically signifi-

Table 4. Perceived possibilities for self-change from various addictions (scale 1–5)

| Organisation: Addiction to: | Social services | Health care | Probation services | All | p-values |
|-----------------------------|----------------|-------------|--------------------|-----|----------|
|                             | M (sd) Rank    | M (sd) Rank | M (sd) Rank        | M (sd) Rank |
| Snuff                       | 4.19 (1.0) 1   | 3.98 (0.9) 1 | 4.12 (0.9) 1       | 4.08 (1.0) 1 | ns       |
| Cigarettes                  | 3.97 (1.0) 2   | 3.84 (0.9) 2 | 3.99 (1.0) 2       | 3.94 (1.0) 2 | ns       |
| Gambling                    | 2.85 (0.6) 3   | 2.82 (0.9) 3 | 2.67 (0.9) 3       | 2.79 (1.0) 3 | ns       |
| Cannabis                    | 2.73 (1.0) 5   | 2.70 (1.0) 4 | 2.62 (1.0) 4       | 2.69 (1.0) 4 | ns       |
| Alcohol                     | 2.76 (0.7) 4   | 2.40 (0.9) 5 | 2.58 (0.9) 5       | 2.59 (1.0) 5 | < .001 |
| Amphetamine                 | 2.47 (1.0) 6   | 2.39 (1.1) 6 | 2.15 (0.9) 6       | 2.35 (1.0) 6 | < .005 |
| Cocaine                     | 2.30 (1.0) 7   | 2.28 (1.0) 7 | 1.97 (0.9) 8       | 2.20 (1.0) 7 | < .005 |
| Medical drugs               | 2.12 (0.9) 8   | 2.10 (0.9) 8 | 2.01 (0.9) 7       | 2.08 (0.9) 8 | ns       |
| Heroin                      | 1.74 (0.9) 9   | 1.70 (1.0) 9 | 1.49 (0.8) 9       | 1.66 (0.9) 9 | < .05  |
| **Grand mean**              | 2.78 (0.8)     | 2.70 (0.7)  | 2.63 (0.6)         | 2.71 (0.7) | < .05  |

Post hoc tests (Scheffé; p < .05): 1 health care < social services; 2 probation services < health care, social services; 3 probation services < social services
significant. Post hoc tests showed that probation officers rated the importance of treatment for addiction to cocaine, amphetamines and gambling higher than professionals in the social services and/or health care, and that social services staff rated the importance of treatment for alcohol addiction as lower than respondents from the health care and probation services. Further analyses (not displayed) indicated that these differences remained also when the influence of respondent characteristics – university-educated respondents rating the importance of formal treatment lower than other respondents – was controlled for. Overall, the fact that the rank orders in tables 4 and 5 are exactly the reversed indicates that professionals in Swedish addiction care, although they are sceptical towards the possibility of self-change from most addictions, have a strong confidence in the benefits of treatment, almost irrespective of the problem.

Comparisons with lay people’s perceptions

It may be interesting briefly to compare these results with lay people’s perceptions of the same issues (Blomqvist, 2009), and with results of a Finnish study of the perceptions of various stakeholder groups (Koski-Jännès, Hirschovits-Gerz, Pennonen & Nyyssönen, 2012). Overall, such comparisons reveal relatively few differences. In terms of the perceived social severity of various problems, Swedish lay respondents see cannabis problems as more severe than alcohol problems (Blomqvist, 2009), whereas the order is the opposite among Swedish professionals, who rate alcohol use as almost as severe to society as the use of hard drugs (see Table 2). A comparison of professionals’ perceptions of the addictiveness of various substances/behaviours (Table 3) with lay peoples’ perceptions (Blomqvist, 2009) shows that the ranking order between substances/behaviours is exactly the same in the two groups, although professionals’ ratings are somewhat lower in absolute terms. It may be noted in this context that Finnish lay respondents rated the addictiveness of cannabis significantly higher than

| Organisation: Addiction to: | Social services | Health care | Probation services | All | p-values |
|-----------------------------|-----------------|-------------|--------------------|-----|----------|
|                             | M (sd) Rank     | M (sd) Rank | M (sd) Rank        | M (sd) Rank |          |
| Heroin                      | 1.85 (1.3) 1    | 1.98 (1.3) 1 | 2.14 (1.2) 1       | 1.98 (1.3) 1 | ns       |
| Medical drugs               | 1.77 (1.2) 2    | 1.76 (1.2) 2 | 1.87 (1.2) 2       | 1.79 (1.2) 2 | ns       |
| Cocaine                     | 1.49 (1.4) 3    | 1.50 (1.3) 4 | 1.85 (1.2) 3       | 1.60 (1.3) 3 | < .01<sup>1</sup> |
| Amphetamines                | 1.41 (1.3) 4    | 1.40 (1.4) 5 | 1.79 (1.2) 4       | 1.52 (1.3) 4 | < .005<sup>1</sup> |
| Alcohol                     | 1.20 (1.2) 5    | 1.58 (1.2) 3 | 1.50 (1.1) 5       | 1.41 (1.2) 5 | < .001<sup>2</sup> |
| Cannabis                    | 1.16 (1.3) 6    | 1.18 (1.3) 6 | 1.39 (1.2) 6       | 1.24 (1.3) 6 | ns       |
| Gambling                    | 1.02 (1.3) 7    | 1.05 (1.3) 7 | 1.36 (1.19) 7      | 1.13 (1.3) 7 | < .05<sup>1</sup> |
| Cigarettes                  | -.21 (1.5) 8    | .01 (1.4) 8  | -.10 (1.4) 8       | -.12 (1.4) 8 | ns       |
| Snuff                       | -.46 (1.5) 9    | -.18 (1.2) 9 | -.31 (1.3) 9       | -.33 (1.4) 9 | ns       |
| Grand mean                  | 1.03 (1.0) 1    | 1.12 (0.9) 1 | 1.28 (0.9) 1       | 1.13 (0.9) 1 | < .05<sup>3</sup> |

Post hoc tests (Scheffé; p < .05): ‘probability services > social services, health care; “social services < probability services, health care; “probability services > social services.

Table 5. Rated “added value” of treatment in recovery from various addictions (scale -4 – +4)
did Finnish professionals (Koski-Jännes, Hirschovits-Gerz, Pennonen & Nyyssönen, 2012). Turning to the perceived options of self-change from various addictions (Table 4), a comparison with the results of the Swedish population study (Blomqvist, 2009) indicates that lay people are more optimistic than addiction professionals about self-change from addictions to alcohol and medical drugs, whereas the opposite is true for cannabis, and, less clearly, cigarettes, amphetamines, cocaine and gambling. Notably, in the Finnish study, too (Koski-Jännes, Hirschovits-Gerz, Pennonen & Nyyssönen, 2012), professionals were more optimistic than lay people about the possibilities of self-change from cannabis addiction, and less optimistic than lay people about the possibilities for self-change from an addiction to medical drugs. As regards the role of treatment (Table 5), a comparison with lay people’s ratings (Blomqvist, 2009) shows that professionals put more emphasis on the importance of treatment in recovery from addiction to medical drugs, and somewhat less emphasis on the importance of treatment in recovery from cannabis addiction. These results also mirror fairly well results from the Finnish study (Koski-Jännes, Hirschovits-Gerz, Pennonen & Nyyssönen, 2012).

Discussion
This paper has studied Swedish treatment professionals’ perceptions of various aspects of addiction and recovery. The analyses show that professionals’ perceptions differ substantially with regard to the societal and individual danger of various substances/behaviours, the chances for self-change from various addictions, and the relative importance of professional treatment in recovery from these addictions. At one end of the spectrum are the hard narcotic drugs, that is, heroin, amphetamine and cocaine, which are judged to be very dangerous to society, highly addictive and very difficult to quit. Treatment is seen as an important vehicle of recovery for the users of these substances. At the other end of the spectrum are cigarettes and snuff, the use of which is rather seen as a bad habit, of minor concern to society and as easy to quit. In between these two extremes come addictions to gambling, alcohol, cannabis and medical drugs. Interestingly, these results are surprisingly similar to lay people’s images of addiction and recovery (Blomqvist, 2009).

It might have been expected that professionals should display less variation in their perceptions of addiction to narcotic drugs and other addictions, and that they should have a more consistent attitude towards addiction problems as phenomena, irrespective of the drug or behaviour, at least in comparison with lay people. The reason for such an expectation could be that clients in treatment are often addicted to several different substances, and that clinical experience would lead professionals to attribute problem severity and possibilities for change more to such factors as clients’ personal and social resources, and the strength of their social networks, than to which specific substance they use. A reason for the lack of nuances may be that the questionnaire did not specifically invite such reflections. That addiction to narcotic drugs is seen as more dangerous and much harder to quit than other addictions could depend on the fact that Swedes – whether addiction profession-
als or not – are still strongly influenced by the traditional official policy that has more or less demonised narcotic drugs (Bergmark & Oscarsson, 1988). Tobacco use and gambling are perceived to be easy to quit and cause relatively little harm to society, which seems surprising considering the well-known health consequences of at least tobacco. However, in official discussions, tobacco has traditionally been treated more in terms of a health issue than in terms of addiction, and gambling has only recently started to be discussed in such terms.

Professionals’ relative scepticism towards the possibility of self-change and strong confidence in the benefits of treatment is not very surprising, but perhaps slightly discouraging in the face of recent research that has shown self-change solutions to be very common (Klingemann & Sobell, 2007; Blomqvist, Cunningham, Wallander & Collin, 2007; Blomqvist, 2012). One of the few obvious differences between lay people’s and professionals’ ratings is that the professionals are more pessimistic about the chances of self-change, and more convinced about the necessity of treatment in recovery from an addiction to medical drugs. One reason may be that this problem is much more visible inside than outside the treatment system (Koski-Jännes, Hirschovits-Gerz, Pennonen & Nyüssönen, 2012).

Another result of the study was that professionals’ perceptions were rather similar between respondents from different parts of the treatment system. Overall, this can be interpreted in the same way as the relative agreement between professionals’ and lay respondents’ perceptions. However, there were also some interesting differences. Social services staff showed a somewhat stronger belief in self-change, whereas general change pessimism was found among personnel in the criminal care system, particularly concerning addiction to hard narcotic drugs. Among health care professionals there was a general tendency to rate the addictiveness of various substances and behaviours higher than among social services colleagues. Particularly, the risk of getting addicted to cigarettes, amphetamine and alcohol was perceived as higher among medical staff than among other respondents. These differences – even if to some extent explained by differences of educational level between the organisations – seem to fit rather well with the partly differing tasks of the three organisations. Thus, the probation officers’ more sceptical view of the possibility of self-change could have to do with the fact that the clients they meet have been convicted of criminal acts and may have more severe and complex problems than clients from other parts of the system. The probation officers’ self-change pessimism and rather strong confidence in treatment could further be related to the extensive development of various treatment programmes taking place in the criminal care system during the last decade (National Council for Crime Prevention, 2008). Twelve-step programmes have had a prominent role in this development, with the basic idea that the addict needs to admit being sick, powerless and in need of help of others to be able to recover.

Respondents from the social services placed relatively little emphasis on the importance of formal treatment in recovery from addictions to alcohol and narcot-
ic drugs in particular, which could partly be explained by the fact that social workers deal not only with addiction problems as such. They are also more inclined to see themselves as responsible for maintaining long-term solutions by trying to improve individuals’ living conditions in terms of, for example, housing, employment, economic safety and decent social resources (Christophs, 2009). As for the somewhat higher addictiveness ratings among health care professionals, one explanation may be that the medical context of their work makes them more aware of the physical harms that often follow addiction. Their greater emphasis on the importance of formal treatment in recovery fits with their self-image: more than professionals from other parts of the care system, health care professionals see themselves as treatment specialists rather than as responsible for the long-term welfare of their clients (Christophs, 2009). The fact that university-educated respondents in general tended to be more optimistic about self-change and stressed the importance of treatment less, may suggest education as a way of reaching more versatile or less judgemental views of these matters.

In summary, the results indicate that there is no truly professional image of addiction problems among personnel in the Swedish treatment system, and that the views endorsed to a large degree seem to reflect traditional and media-conveyed stereotypes which are seldom questioned. This is unfortunate, considering that addiction problems are complex and heterogeneous, and require a broad range of diverse and flexible help options to be solved (Humphreys & Tucker, 2002; Blomqvist et al., 2007).

However, these conclusions need to be treated with caution, since the results may in certain respects be artefacts of the study design. The generalisability of the study is likely to be restricted by the fact that it was conducted in Stockholm County. However, this area is estimated to account for at least one fifth of the total Swedish addiction care, and the participating units were fairly representative with regard to the socio-demographic variation in the catchment areas. In addition, the response rate was high compared to most similar studies. Another limitation is that participants were asked to respond to rather complex issues, using mostly fixed response alternatives with relatively little room for more in-depth consideration or exhaustive answers. Yet, the stability of the ratings of various addictions and the fact that the results largely agree with those of a comparable Finnish study (Koski-Jännes, Hirschovits-Gerz, Pennonen & Nyyssönen, 2012) can be claimed to increase the confidence that the study gives at least a rather reliable “aerial photo” (Blomqvist, 2009) of prevailing perceptions and images of addiction and recovery in the Swedish treatment system. This photo can be used as a benchmark for future qualitative analysis and more in-depth inquiries which aim to capture more nuanced aspects of the images of addiction and recovery held by professionals, as well as various groups of clients (cf. Koski-Jännes, Hirschovits-Gerz, Pennonen & Nyyssönen, 2009).
NOTES

1 http://blogs.helsinki.fi/imagesofaddiction/publications-2/
2 A means test is a process where an individual’s or family’s eligibility for help from the government is determined based on the available needs and resources.
3 It should be noted that compulsory care, conducted at a number of state institutions, was not included in the present study.
4 For example, information campaigns picturing self-change as a viable option and underlining the importance of the environment’s support, as well as making various self-help vehicles available, for example on the Internet.
5 After a political shift in the City council in 2007, the number of social services districts (or city districts) was cut to 14.
6 These nine units today, after a reorganisation of the prison and probation services system, constitute the Stockholm Region and the Middle Region.
7 Corresponding response rates were also present in another study (Christophs, 2009): 81% in the social services, 80% in the probation services and 62% in the regional health care. The figures may reflect different working conditions as well as traditions and interests in social research issues in these organisations.
8 To be able to make valid comparisons, the design and wording of this question was based on a similar question in a previous Nordic study on substances and control policies, carried out in 1995 (cf. Hübner, 2001). In Table 2, heroin, amphetamine, and cocaine were collapsed into the category of hard drugs, and cigarettes and snuff into the category of tobacco.
REFERENCES

Andersson, B., Florell, L., & Samuelsson, E. (2004). Inställningar till självläckning – en studie av diskurser kring beroendeproblem[Perceptions of natural recovery – a study of discourses of addiction problems]. (Report no. 6). Stockholm: Social Services Administration Research and Development Unit.

Bergmark, A., & Oscarsson, L. (1988). Drug misuse and treatment: A study of social conditions and contextual strategies. Stockholm: Almqvist & Wiksell International.

Blomqvist, J. (1998). Beyond treatment? Widening the approach to alcohol problems and solutions. Stockholm: Stockholm University.

Blomqvist, J. (2004). Sweden’s “war on drugs” in the light of addicts’ own experiences. In P. Rosenqvist, J. Blomqvist, A. Koski-Jännes & L. Öjesjö (Eds.), Addiction and Life Course (pp. 139–172). Helsinki: NAD Publication.

Blomqvist, J. (2009). What is the worst thing you could get hooked on? Popular images of addiction problems in contemporary Sweden. Nordic Studies on Alcohol and Drugs, 26(4), 373–398.

Blomqvist, J. (2012). Perceptions of addiction and recovery in Sweden: The influence of respondent characteristics. Addiction Research and Theory, 20(5), 435–446.

Blomqvist, J., Cunningham, J., Wallander, L., & Collin, L. (2007). Att förbättra sina alkoholvervänor. Om olika mönster för förändring och om vad vården betyder [Improving one’s drinking habits. On various change patterns and the significance of treatment]. (SoRAD research report no. 42). Stockholm: Stockholm University.

Blomqvist, J., Palm, J., & Storbjörk, J. (2009). “More cure and less control” or “more care and lower costs”? Recent changes in services for problem drug users in Stockholm and Sweden. Drugs: Education, Prevention & Policy, 14(6), 479–496.

Christophs, I. (2009) (Ed.). Mot en bättre missbrukarvård? [Towards better addiction care?] (SoRAD research report no. 57). Stockholm: Stockholm University.

Cunningham, J.A. (2009, June). Societal images of addiction – first results from a Canadian representative survey. Paper presented at the 35th Annual Alcohol Epidemiology Symposium of the Kettin Bruun Society, Copenhagen.

Cunningham J.A., Sobell, L.C., & Sobell, M.B. (1998). Awareness of self-change as a pathway to recovery from alcohol problems: Results from five different groups. Addictive Behaviours, 23(3), 399–404.

Cunningham, J.A., Sobell, L.C., & Sobell, M.B. (1999). Changing perceptions about self-change and moderate-drinking recoveries from alcohol problems: What can and should be done? Journal of Applied Social Psychology, 29(2), 291–299.

Hacking, I. (1999). The social construction of what? London: Harvard University Press.

Hirschovits-Gerz, T., Holma, K., Koski-Jännes, A., Raitasalo, K., Blomqvist, J., Cunningham, J.A., & Pervova, I. (2011). Is there something peculiar about Finnish views on alcohol addiction? – A cross-cultural comparison between four northern populations. Research on Finnish Society, 4, 41–54.

Holma, K., Koski-Jännes, A., Raitasalo, K., Blomqvist, J., Pervova, I., & Cunningham, J.A. (2012). Perceptions of addictions as societal problems in Canada, Sweden, Finland and St. Petersburg, Russia. European Addiction Research, 17, 106–112.

Hübner, L. (2001). Narkotika och alkohol i den allmänna opinionen. [Drugs and alcohol in the public opinion]. (Doctoral dissertation). Stockholm: Stockholm University.

Humphreys, K., & Tucker, J. A. (2002). Toward more responsive and effective intervention systems for alcohol-related problems. Addiction, 97(2),126–132.

Klingemann, H. (1992). Coping and maintenance strategies of spontaneous remitters from problem use of alcohol and heroin in Switzerland. International Journal of the Addictions, 27, 1359–88.

Klingemann, H. (2003, August–September). How optimistic are the hairdresser and the lawyer about addicts ’kicking their habit’ on their own? Public images on natural
recovery from addiction in Switzerland, Columbia and Germany. The Societal Images of Natural Recovery from Addiction (SINR). Paper presented at the Summer Academy, Social Work and Society, St. Petersburg.

Klingemann, H., & Klingemann, J. (2007). Hostile and favourale societal climates for self-change: some lessons for policymakers. In H. Klingemann & L. C. Sobell (Eds.), Promoting self-change from addictive behaviors (pp. 187–212). New York: Springer.

Klingemann, H., & Sobell, L. (2007) (Eds.). Promoting self-change from addictive behaviors. New York: Springer.

Koski-Jännes, A., Hirschovits-Gerz, T., Pen nonen, M. (2012). Population, professional, and client support for different models of managing addictive behaviors. Substance Use and Misuse, 47, 296–308.

Koski-Jännes, A., Hirschovits-Gerz, T., Pennonen, M., & Nyysönen, M. (2009, June). Representations of addictions from inside and outside. The case of Finland. Paper presented at the 35th Annual Alcohol Epidemiology Symposium of the Kettil Bruun Society, Copenhagen.

Koski-Jännes, A., Hirschovits-Gerz, T., Pennonen, M., & Nyysönen, M. (2012). Population, professional and client views on the dangerousness of addictions: testing the familiarity hypothesis. Nordic Studies on Alcohol and Drugs, 29(2), 139–154.

National Board of Health and Welfare (2004). Insatser och klienter i behandlingsenheter inom missbrukarvården den 1 april 2003 – “IKB 2003” [Services and clients in substance misuse treatment units]. Stockholm: National Board of Health and Welfare.

National Council for Crime Prevention (2008). Behandling av narkotikamissbrukare i fängelse [Treatment of narcotic misusers in prison] (Rapport 2008:18). Stockholm: Fritzes.

Palm, J. (2004). The nature of and responsibility for alcohol and drug problems: Views among treatment staff. Addiction Research and Theory, 12(5), 413–431.

Peele, S. (1985). The meaning of addiction. Compulsive experience and its interpretation. Toronto: Lexington Books.

Room, R. (1978). Governing images of alcohol and drug problems: Structure, sources and sequels of conceptualizations of intractable problems. (Doctoral dissertation). Berkeley: University of California.

Wallander, L., & Blomqvist, J. (2005). Who “needs” compulsory care? A factorial survey of Swedish social workers’ assessments of clients in relation to the care of abusers (Special Provisions) act. Nordic Studies on Alcohol and Drugs, 22 (English supplement), 63–85.