Locked Up and Locked Out: Client Perspectives on Personal Relationships While in Compulsory Drug Treatment

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Abstract
This qualitative study explores clients’ perspectives on their personal relationships while in compulsory drug treatment. Interviews with 31 participants (14 female and 17 male) were conducted at four compulsory treatment institutions for adults who use drugs in Sweden. Taken together, our study reveals that clients in general had to struggle to maintain social relationships due to strict restrictions on their interpersonal contact and communication. Feelings of isolation and anxiety characterized much of their relationships during the treatment period, with emotional withdrawal commonly described as a way to cope. Moreover, some participants expressed shame and guilt over the pain and suffering they had subjected their family members to through their drug use, feelings that put additional strain on the contact. The emotionally and socially significant relationships described by our interviewees provide links to other personal roles and settings than those prescribed by the institution. At the studied institutions, however, little attention was given to this relational dimension of the clients’ situation. Based on the results of the present study, possibilities for improvement of compulsory drug treatment are discussed.

Keywords
compulsory drug treatment, client perspective, substance use, social relationships, intimate relationships, qualitative research

Introduction
This article focuses on a specific field of drug treatment—compulsory drug treatment for adults in Sweden. More specifically, we explore detained clients’ perspectives on their personal social relationships while incarcerated, a field in drug treatment research that has been given little attention. We aim to investigate the character of the relationships between clients and their friends and family during

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ongoing compulsory care for drug use from the perspective of the clients, while also taking the institutional coercive setting into consideration. Specifically, this study addresses the following research questions: How are the institutional conditions regarding contact keeping with friends and family described? How do clients experience these institutional conditions (rules, regulations), and what are the consequences of these coercive elements for their management of intimate relationships?

The governing approach to drug treatment in Sweden is guided by the country’s strict drug policy, with a drug-free society as its ultimate goal. All use and possession of illicit drugs are criminal offences under the Penal Law on Narcotics (SFS 1968:64). Compulsory treatment has been practiced in Sweden since “the Alcoholism Act” of 1913 and is still an integrated part of the Swedish treatment system for substance use (Palm & Stenius, 2002). Compulsory drug treatment for adults is regulated by the Care of Substance Abusers Act (LVM 1988:840). It is an acute intervention, regardless of the individual’s will, and as such it has a “last resort” character in relation to voluntary treatment (cf. Svensson, 2010). The legal requirement for using coercion is if individuals, due to continuing drug use, (1) seriously risk their own physical or psychological health, (2) seriously risk to harm themselves or their family, or (3) risk destroying their lives—and the need for necessary care is judged not to be met on a voluntary basis (i.e., there is a lack of motivation to enter voluntary treatment). Thus, the Care of Substance Abusers Act (LVM 1988:870) shows a combination of paternalistic (coercion directed against persons capable of decision-making with reference to their best interest) and utilitarian (protection of the family and society) motives (Palm & Stenius, 2002; Runquist 2012). Compulsory treatment is initiated by municipal social services agencies, and the decision is made by regional Administrative Courts. Around 1,000 persons are forced into this kind of treatment each year, of which 30% are women (http://www.stat-inst.se).

Compulsory treatment due to substance use is coordinated through the National Board of Institutional Care (Statens Institutionsstyrelse, SiS), an independent Swedish government agency. SiS operates 11 gender-specific, compulsory treatment institutions (or “residential homes” as SiS refers to them on its webpage) for adults sentenced to treatment according to the Care of Substance Abusers Act (LVM 1988:870). These are the only treatment facilities that have the right to forcibly detain individuals who have been taken into compulsory care for substance use. The maximum time for clients at a compulsory treatment institution is 6 months. The stated purpose of this kind of compulsory treatment is to break a “life-threatening pattern of substance abuse”1 and to motivate clients to seek change and voluntary treatment,” enabling them to live a drug-free life (https://www.stat-inst.se). This purpose includes a long-term goal for the individual to permanently abandon their substance use, as well as a short-term goal for the person in question to be motivated to enter voluntary treatment. To reach these goals, the compulsory institutions first treat clients’ withdrawal symptoms. During this mandatory detox phase, which typically lasts 1–2 weeks, there is a very high level of security. No contact with people from the outside world is allowed, apart from authority figures such as social workers and lawyers. After that, the institutions’ work focuses on initiating a process of change, including drug cessation, as well as work with other presumably problematic behaviors. Treatment is organized in accordance with a “chain of care” (https://www.stat-inst.se), in which the links involve different kinds of support, control, and regulation. The idea is that during their time in compulsory treatment, the clients are moved from wards with a high level of security to wards with fewer restrictions (SOU, 2004:3). The offered treatment-related activities vary between and within institutions, but assessment (physical, psychological, and social), motivational work, social support, leisure activities, and treatment planning are meant to constitute main elements of the care, following the initial focus on creating conditions for the client to “settle down” and adapt to the forced situation. Lack of meaningful activities, however, is a coherent and recurring theme in previous Swedish studies of compulsory drug treatment (cf. Ekendahl, 2001; Svensson, 2010).

Generally, clients are moved from the detox ward to a placement in a closed facility. Here, the level of security is high. All doors and windows (with unbreakable glass) are locked. Clients are allowed out
only under the supervision of staff or in an exercise yard, which is sometimes topped with barbed wire or covered with nets. No leave of absence is allowed, and if visits from family and friends are granted, they are conducted under the direct supervision of staff. Many clients spend several months in these high-security wards, before being moved to a placement in a more open facility where the level of supervision decreases and the level of treatment-related activities increases (however, this transfer is only made if the individual passes the institution’s “risk assessment”). On these wards, doors are typically kept unlocked during the daytime. Clients can move more freely in the institution’s premises and receive unsupervised visits from family and friends. During this final treatment phase, the idea is that the client should be initiating some kind of voluntary treatment and prepare for a life of freedom.

Throughout the compulsory treatment period, staff are legally entitled to impose extensive and rigorous restrictions on the clients’ freedom of movement and personal privacy to keep the facilities drug-free, prevent escapes, and maintain rules and structure in everyday institutional life (Care of Substance Abusers Act, LVM 1988:870). For example, the clients’ right to receive visits, and use phones and the Internet may be circumscribed if staff assess that the individual client’s treatment or the order at the institution is negatively affected. Staff also have the right to search clients’ personal belongings or body without their permission if someone has been outside the facilities, or in the case of suspicion that the client may possess something that is not allowed at the institution.

In sum, even if coercion is present through all the treatment stages, there is a planned gradual movement toward greater freedom and increased room to maneuver, as the client accepts and takes advantage of what the institution has to offer. However, if clients do not use the space made available in a socially desirable way, for example by escaping or using drugs, the extended freedom is again limited.

Literature Review

There is a scarcity of drug research focusing on client perspectives on compulsory treatment for adults using drugs. Swedish research shows that the negative effects of coercion are repeatedly highlighted when clients get their say (Ekendahl, 2009; Svensson, 2010), and that clients often regard the care they receive as meaningless (Billinger, 2000; Ekendahl, 2001; Svensson, 2001, 2003, 2010). Regarding relationships in compulsory treatment settings, previous research tends to focus on the professional relationship between client and staff, indicating that a respectful relationship is an important factor for a positive treatment outcome (Ljungberg et al., 2015a, 2015b; Skärner & Billquist, 2016). There are many similarities between compulsory psychiatric treatment and compulsory drug treatment. In particular, they both include mechanisms of control (rules and regulations) used to administer the physical and social environment at the treatment institutions. A Finnish study on patient satisfaction in psychiatric compulsory treatment has shown that patients tend to be most satisfied with staff-patient relationships and most dissatisfied in areas regarding information access, restrictions on personal freedom, and compulsory measures (Kuosmanen et al., 2006). This stands in contrast to what other studies in the mental health field have highlighted, namely that the power imbalance between staff and clients is a major contributing factor identified by people who have had negative experiences of compulsory detainment (Ford et al., 2015; Nytingnes et al., 2016; Ridley & Hunter, 2013). Considering the social relationships of people using drugs in general, previous Nordic research has mainly focused on affected family members’ experiences (Norvoll et al., 2018; Richert et al., 2018; Schanche Selbekk et al., 2018; Skogens & Von Greiff, 2014). Studies focusing on youth drug treatment suggest that social relationships are a key component in treatment engagement for adolescents (Best & Lubman, 2017), a finding that resonates with similar studies on adult populations (Dobkin et al., 2002; Kidorff et al., 2016; Orford et al., 2006; Storbjörk, 2009; Veseth et al., 2019). To sum up, while relations and their importance in drug treatment have been given some consideration, there is a lack
of studies giving attention to clients’ own views on their personal relationships, especially while in compulsory treatment.

It is worth mentioning that security is tighter at SiS’s coercive treatment facilities for people using drugs than in many prison facilities. Thus, when it comes to detainment of people in a Swedish compulsory treatment setting, the prison functions as a point of reference. A large body of prison research has shown the importance of maintaining family bonds while incarcerated, for a more positive post-release outcome (e.g., Berg & Huebner, 2011; Walker et al., 2018). While few studies focus on relationships outside of the family, they point out the importance of inmates keeping contact with the outside world while detained, for a more successful reentry into society (Eades, 2009). In a prison context, female prisoners’ family relations during incarceration have been studied through their own descriptions, indicating that inmates’ family practices are diverse and manifold (Enroos, 2011). Similarly to compulsory treatment, a prison sentence creates a forced distance within a person’s social network, and maintaining relationships is not easy while incarcerated (Casey-Acevedo et al., 2004; Harman et al., 2007). As pointed out by Eades (2009), developing interpersonal relations with a “significant other” and restoring social relationships provides a protective element for those detained, supporting future progress of reintegration back into society once they are released. Strengthened intimate relationships may also counter some of the negative impacts of isolation from the outside world (Taylor, 2016; Valera et al., 2015). Contesting Goffman’s classic theory of the “total institution,” Moran (2013, p. 348), in a study of prison visiting rooms, draws attention to their spatial permeability, with the visiting suites serving as positive “liminal spaces in which prisoners come face-to-face with persons and objects originating in and representing their lives on the ‘outside’ and which act as spaces of betweenness where a metaphorical threshold-crossing takes place between outside and inside.” From this perspective, contact between incarcerated persons and family members offers the possibility of strengthening bonds and having a strong relational impact. This is in line with what Hakimian (2009) suggests, that the incarcerated context—with its restricted movement and heightened stress levels—may serve as a fertile ground for emotional bonding between people (the confined situation making relationships more intense than the ones taking place in ordinary life). However, scant attention has been paid to clients’ personal relationships in the compulsory drug treatment system, and little is known about their experiences of relationships and contact with family and friends while incarcerated.

**Theoretical Approach**

Erving Goffman’s presentation of total institutions is the lens through which we view the compulsory institutions studied in this paper. Crucial to this kind of institution is that all aspects of the detained clients’ lives are “conducted in the same place and under the same single authority” (Goffman, 1961/1991, p. 17). This arrangement contrasts with ordinary modern society where individuals tend to “sleep, play, and work” in different places, and without being regulated according to one rational plan. The total institution, then, is a closed facility where a “large managed group” is being cut off from wider society for a considerable time, while being supervised and managed by a “small supervisory staff” (Goffman, 1961/1991, p. 18). According to Goffman, total institutions are characterized by the bureaucratic control of many human needs of groups of people, and they operate through “mortification processes” (1961/1991, p. 47). A person’s self is mortified through several processes, including role dispossession (past roles played out in the wider world are lost, and the individual instead becomes a client or patient), dispossession of identity markers (property, name, etc.), and restrictions of self-determination (refers to the institution’s control over individual autonomy and freedom of action). Goffman describes how these mechanisms of mortification aim to eliminate inmates’ past selves and create individuals who the system can work with and reshape. Personal agency is more or less eradicated as an effect of the institution’s way of organizing and regulating
every aspect of the inmates’ lives. Contacts with the prior outside world are mediated by the institution’s staff. Control and regulation are characterizing features of everyday life at this kind of institution, where the inmates’ days are governed in detail by sets of rules, sanctions, and privileges. Goffman listed five types of total institutions: orphanages, mental hospitals, prisons, army barracks/boarding schools, and monasteries. We argue that the compulsory institutions studied here may be perceived as examples of total institutions, and comparisons will be drawn in this article.

Research Methods

Study context. The context of this study is four compulsory treatment institutions situated across Sweden. Two of these accommodate women and two host men, and each institution has a capacity to hold between 20 and 40 clients. All four institutions are closed with a high level of security, but two (one for women and one for men) also comprise facilities with fewer restrictions (as described in the Introduction). The high level of security is motivated by an ambition to prevent escapes and attempts to bring drugs into the facilities. The client groups at each institution were heterogeneous in terms of factors such as age, substance use, social situation, etc. What they had in common was that they had been judged to meet the requirements for undergoing drug treatment without their own consent.

Data collection and material. Study participants were aged 22–72 years (mean \(\mu = 38\)). The sample included people with a variety of compulsory experiences, some (15) of whom had been detained in accordance with the Care of Substance Abusers Act (LVM 1988:870) for the first time, while others reported up to eight previous involuntary treatment episodes due to their substance use. Seventeen of the interviewees had children (11F; 6M), 10 of whom had children under the age of 18. The empirical data used in this article were obtained from a larger qualitative research project conducted in Sweden during 2018–2020. In this larger study, the aim was to explore the interaction between clients, their close relatives, and staff from three perspectives: how clients perceive the importance and functions of close relatives during ongoing treatment, how close relatives perceive their role in their next of kin’s treatment, and how staff understand the function of clients’ close relatives during ongoing treatment.

In this paper, the data consist of transcribed individual interviews conducted with clients. A combination of purposive and convenience recruitment of participants was used. Individual interviews were conducted across four institutions, totalling 31 clients (14 female and 17 male).

Each institution was visited on two consecutive days. Clients were approached at the institutions, with written and verbal information regarding the research project asking them to participate in interviews. We made clear that participation was voluntary and interviewees were granted full confidentiality. Written consent was obtained before each interview was conducted. When we arrived at the institution, we presented the study to clients at their regular morning meetings with staff on each ward. We were then available on the wards to answer questions about the study. We were given our own keys, and a condition for us to be able to walk around was that we wore the same alarm equipment as the staff. With the participants’ consent, the research team conducted all the individually held interviews, which were tape-recorded and lasted 20–90 minutes each. All the interviews were conducted in private places on the wards. Participants were not reimbursed for their participation.

The interviews were initially examined without pre-selected theoretical concepts, in accordance with grounded theory (Strauss & Corbin, 1998). All transcripts were read openly to define broadly the content. Following this open reading of the data, we carried out targeted readings with attention to the following questions: How do clients describe the institutional conditions (i.e. setting, rules and regulations) regarding contact keeping with friends and family? How do clients experience these institutional conditions, and what are the consequences of these coercive elements for their management of their intimate relationships? During these readings, three themes emerged: “The break-up—being immediately detained,” “maintaining contact while detained,” and “relationships on hold.” The first
theme revolves around experiences taking place during the first stages of treatment, when clients have been removed from their everyday life swiftly and with force and placed at high security facilities with very limited opportunities for contact with their families. The theme “managing contact while detained” comprises stories on how rules, regulations, and control at the studied facilities affect people’s social relationships, and how these dimensions of treatment are dealt with and managed by clients. The third and final theme—“relationships on hold”—encompasses clients choosing to refrain from or severely limiting contact keeping with families and friends during the compulsory treatment period, as well as next of kin choosing not to have any contact with their incarcerated family member. Subsequently, we compared our results with Goffman’s writing on total institutions and the effects of asylums.

In the following excerpts, the data have been edited to give the speech conventional spelling, and non-verbal communication has been left out. The original language in the interviews is Swedish, but for the purpose of this paper the language has been translated into English.

**Ethical considerations.** The project was reviewed and approved by the Swedish Ethical Review Authority (ref. no. 1149-16). To protect confidentiality, all the participants have been given pseudonyms and all identifying information has been removed or changed.

**Results**

**The Break-Up—Being Immediately Detained**

Like most people, people in compulsory treatment describe many different experiences of and perspectives on social relationships and their significance in relation to alcohol and other drug use. A 29-year-old man, who is in compulsory treatment for the fourth time, explains that his family is his main motivation for not escaping from the institution.

I’m as sad as you can be, just want to lie down and rest in peace, forever. Had I not had my family, I would have died a long time ago. I would had taken my own life. I’m here for them. I have to face up to this shit and do this for them. My mother, she has become sick with stress; she is terrified all the time. Now that I’m here, she can relax, and so can my brother.

One 46-year-old woman and mother of two, undergoing her eighth compulsory treatment episode at the time of the interview, noted:

Because I have been away as much as I have, my relationships have become very damaged. And in all treatments, especially compulsory treatment, they say that “you should think about yourself first,” and “it’s about yourself,” and “you need to prioritize yourself.” So, you have to put the children aside.

This participant highlights the problems that enrolling in drug treatment can entail for peoples’ intimate relationships, not least with regard to compulsory drug treatment. Compulsory treatment in accordance with the Care of Substance Abusers Act (LVM 1988:870) is most often initiated through an immediate custody order created by the social welfare board or the police. This measure is taken if the assessment is made that waiting for the administrative court decision would imply serious risk or acute danger for the individual in question. Several Swedish studies have reported that immediate custody, a measure that is effected by the police, is a dramatic and shocking experience for people subjected to it (Billquist & Skärmer, 2009; Johnson & Svensson, 2006; Runquist, 2012). However, it has been pointed out by Palm and Stenius (2002, p. 72) that “what was supposed to be an exception has become the norm.” Hence, for the absolute majority of clients, the initiation of their compulsory treatment period entails a very concrete, physical separation from their everyday life and social relationships. One
theme emerging from the data relates to this break-up and the period following the immediate detain-
ment. One 52-year-old woman described her experience of being immediately detained as follows:

I went to the hospital and asked for help, but they rejected me, so I went home and drank a little [alcohol].
And then I went back, because I wanted to talk to someone, but I got no help. Instead, they called social
services and then they [the police] came and picked me up.

The quote above illustrates that, for most clients, the initiation of compulsory treatment meant being
swiftly, sometimes unexpectedly, and with force removed from everyday life without the chance to
make plans or arrangements for their absence.

My dad turned 70 when I was here. We were going to go to France and celebrate it together with the whole
family, but that didn’t happen. There were quite a lot of phone calls during that week, since I felt that they
had expected me to be there with them. The kids were expecting me to join and everything had been
planned. (Male, 36 years)

As highlighted in the above quote, planned events need to be cancelled at short notice and existing
bonds with family and friends are immediately cut off as a consequence of the involuntary detainment.
It was not unusual for family members to be involved in the process of having participants detained.
Unlike Goffman’s (1961/1991) inmates, however, few of our interviewees expressed feelings of
disloyalty and embitterment toward these persons. However, they faced considerable difficulties in
maintaining, for example, partner and parental social roles while incarcerated. One young man became
a father just before he was detained and he described feelings of inadequacy and deficiency of not
being able to be there for his new family.

I wanted to get clean and all this before she was born. I didn’t trust myself at all. I understood that I couldn’t
manage to become sober on my own, so I asked for treatment, I did. But it took so long for them to fix it, and
then a week after my daughter was born [snaps his fingers] I was detained. It was tough. It doesn’t feel good
to sit here, completely locked up. I miss my girlfriend and my daughter so much. She says the baby wakes
up early so she hardly gets any sleep and it makes you feel even more that you need to go home to be able to
help. (Male, 23 years)

Considering the significant strain described by this young man when faced with his shortcomings as a
new father, the explicit goal of the studied institutions regarding this initial treatment phase—“settling
down” and accepting the new position of client—seems hard to implement. Enforced processes of
separation and isolation left participants feeling sad and lonely, especially those who had children. Of
our interviewees, 10 had children under the age of 18. One woman, who had only spent three weeks at
the institution at the time of our interview, was frustrated over not being able to communicate with her
4-year-old child, whom she had lost custody of previous to her incarceration.

She must be suffering so much. We had just started to build up confidence, her confidence in me. Since she
is so young, she needs close and regular contact. I have asked here [at the institution] if I can get video calls
with her, because she is so used to seeing me, she wants to see me when she talks, but they haven’t arranged
it yet. It’s been three weeks. I think that’s quite a long time for such a young child. (Woman, 31 years)

Despite asking staff every day for the chance to have video calls, no answer had been given so far. As
in all closed units in Sweden (i.e., prisons, psychiatric inpatient care), the clients have a legal right to
contact with their families during compulsory drug treatment, but this right can be retracted if staff
assess that such contact may have a negative influence on the clients or the institutions. Restrictions are
typically most strict during the initial phase, when staff deem clients as highly fragile, prone to
escaping, and in need of peace and calm (Svensson, 2010). Much relationally related anxiety and
tension was described by interviewees with minor children during this initial treatment phase.

When I was there [detox ward], it was a lot of hassle with taking and making calls. And you have lawyers
and people calling, and I know my boyfriend called several times and they haven’t even mentioned it. I
mean, those of us who have children, what if something happens to the children and their dad needs to call,
and we don’t get to know what’s happened. (Woman, 37 years)

This woman points out one important consequence of the institutional regulatory practices—when
the clients’ “normal” life is shut out, so are the roles connected to these external settings. While
life continues “on the outside”—with bills that need to be paid, cats that need feeding, and
children that need to be attended to—new clients are not allowed by the institutions to take
responsibility for these matters. Consequently, during the initial treatment period, clients’ families
and friends often have to “save” emergency everyday situations regarding payment of bills,
organizing child care, attending to animals, and other hands-on issues. Many participants
described how close relatives and friends played a crucial role in providing practical support
during this unexpected absence from ordinary life.

My mom has really been there now, when I had to go here. I have my own house, my job, and I was
supposed to pay my bills just before I came here. You can’t go home and get stuff, but you come here
without your credit cards, and everything is taken from you, from being a free person taking care of things
on your own. Now that I’m here, mom pays all the bills. (Male, 36 years)

As indicated by the quote above, the first stages of detainment involve sharp decreases in adult status,
not only in relation to the institution but also to the next of kin. In this context, rules and regulations
denying people of their ability to pursue basic adult duties (such as paying bills) conflicts with core
values within contemporary liberal Western culture, which emphasizes individualism, autonomy,
and freedom of action. According to Goffman (1961/1991, p. 47), this loss of adult self-
determination is likely to create “the terror of feeling radically demoted in the age grading system.”
This feeling is often mentioned by our interviewees when discussing their experiences of compul-
sory treatment institutions. One 49-year-old man relates his feelings about the strict regulations
regarding phone use during the initial treatment phase: “It’s a bit like, ‘little boy, you can’t make the
call yourself, but I can make the call and then hand over the phone to you. There you go—now you
can talk.’” In addition to the oftentimes strained pre-carceral situation, many clients find themselves
in a position toward their loved ones characterized by gratitude, guilt, and dependence, a potentially
negative situation given that personal relationships between adults are expected to be reciprocal
(Järvinen & Bloch, 2016). As pointed out by Veseth et al. (2019), there is a close connection between
developing and maintaining reciprocal relationships (in which people are able to switch roles and
both provide and receive help) and positive post-treatment processes. However, our interviewees had
few opportunities to develop relational reciprocity during their ongoing treatment, especially during
the initial stages.

In sum, the excerpts presented in this section reveal several effects of the sudden incarceration on
clients’ intimate relationships. The immediate detainment means that the person—irrevocably and
often abruptly—is removed from their everyday life, and thus also abandons those left at home. This
frequently engendered feelings of anxiety and guilt among the clients, many expressing worries over
the possibility that they had hurt their loved ones through their drug use. At the same time as the clients
are locked up, the outside world is locked out, thus eradicating clients’ contact with the most socially
and emotionally important people to them.
Maintaining Contact While Detained

This environment does not invite you to safeguard and maintain your relationships. Not at all. (Woman, 46 years)

Though strictly regulated, contact keeping while at the institution is possible in some ways. Our interviewees mentioned telephone calls, letters, and planned visits, as well as leave to meet family members outside the coercive facilities. The latter, however, was only mentioned by clients at the final stage of their treatment periods. As pointed out by Quirk et al. (2006), the negative consequences of permeability in institutions are unwanted people coming to cause trouble, and illicit drug use among clients. Hence, staff need to employ various methods to regulate their ward’s permeability. At the studied institutions, this could be observed in the form of strict admission procedures and rules for visits. Interviewees specifically mentioned difficulties having visits from friends accepted. Due to these constraints, many participants chose to keep in contact with friends and family over the phone.

My partner can call me any time and I can call her several times a day, which we do. The staff never gets tired of connecting calls. If you ask them to connect a call they do. I’ve never had any visits. It’s a long journey for her, with the dog and everything, so no visits. (Male, 53 years)

Like the man in the quote above, many clients have daily telephone contact with family members. At one of the four studied institutions, clients were even permitted to have personal mobile phones. However, the majority of our interviewees were not allowed the relative privilege of their own phones during their treatment period. Instead, they were subjected to the discretionary power of staff to transfer or reject incoming calls.

My sponsor called me, but they didn’t forward the call or even mentioned that someone had called. And I’ve heard several of the girls say that “Damn, they didn’t tell me that this person called,” or “They didn’t transfer that call,” even though the person in question doesn’t have a damn idea that someone is trying to reach her. And you don’t get any kind of motivation as to why it is like this. (Woman, 46 years)

As highlighted in the following quote, clients are aware that staff are interested in keeping a check on their personal relationships while at the institution.

They have very old rules regarding telephone use. They claim that you can order drugs if you have your own mobile phone. But you can do that on their phone as well. So, it feels more like they want to control who you may call. (Man, 25 years)

As another 25-year-old man points out, having calls approved may be hard when the caller is deemed by staff to be under the influence of drugs.

They refused to transfer a call from my relative who wanted to talk to me. They said she sounded drunk. I can imagine she got pretty pissed off. She hasn’t called back as far as I know. I think that’s bad. After all, it doesn’t matter to me if she’s drunk. They could have asked me at least, if it was ok. It could have been something important that she wanted to tell me. And she has no problem with substance abuse. They didn’t even take her number or ask her what it was about.

These descriptions demonstrate the “total” character of the studied institutions, where staff regulate the passage of information and the clients are easily excluded from knowledge of decisions taken regarding their cases.
So far, we have focused on client accounts of institutional rules related to the use of phones. Other institutional rules targeting people’s social relationships are associated with visits. For instance, when a partner has a known background using drugs, this makes the relationship very hard to maintain physically.

My boyfriend isn’t allowed to visit at all, because social services have written that he used to be an active drug user. That he had a criminal background. “He had” they wrote, not that he has. But it’s like he said, they [the staff] are very anti him. They don’t understand. So, you get very bitter because they take what little you have. I am very bitter. (Woman, 40 years)

Consistent with previous research (Harman et al., 2007), the transition from “we” to “I” (i.e., from being a couple to separate individuals) was described as a difficult process by our interviewees. However, restricting physical contact between inmates and visitors to prevent trafficking of drugs in coercive settings (such as prisons and compulsory treatment institutions) is a usual intervention in Sweden as well as internationally (Walker et al., 2018). As illustrated by the case described above, removal of visitation rights on the basis of the visitor’s presumed drug use was common practice at the studied institutions.

At the facilities focused on here, the visiting process is initiated by the client who must apply for and book the appointment through a visiting order. The visitors must make their own travel arrangements, which can be expensive and extensive, given the fact that many clients are placed at institutions far away from their home towns. The most common type of visits mentioned by our interviewees were supervised and carried out inside the institutions in special visiting rooms, often with staff present for “security reasons.” On some visits, no physical contact is allowed, putting additional stress on the situation. One 40-year-old woman, who was undergoing her first compulsory treatment episode at the time of our interview, described her one monitored visit from her father and husband as follows:

We had to sit in front of each other and were not allowed to touch. For one and a half hours. If you needed to go to the toilet in the meantime, the visit ended. So, you had to make sure not to drink too much before the meeting.

Similar descriptions are given by male interviewees, sometimes with the prison functioning as a reference point.

Certain things get on your nerves. When you get supervised visits at the prison you don’t have to undress and everything, but that is mandatory here. Even when there are two staff members sitting and monitoring you all the time. That can be a bit annoying. (Male, 32 years)

The intimate control of the body carried out by staff is also mentioned as a negative dimension of visits.

My grandfather is coming here with my clothes and stuff. Then, I have to undress completely naked and everything like that. They make it so that you almost don’t want to bring people here. It becomes so cumbersome. And then two of the staff sit and stare when you’re talking to your relative. But, I need things and I also want him to see that I look healthier and healthier, so my family don’t have to worry. (Woman, 31 years)

Some, like the women in the quote above, chose to subject themselves to the humiliating rules linked to visits, while others refrained and chose to keep contact with family and friends strictly to phone calls. Previous studies have highlighted the potentially restorative function of personal relationships within visit venues in carceral spaces (e.g., Moran, 2013), and Eades (2009) suggests that “the personal bonds
formed [are] able to counter some of the impacts of isolation” (p. 40). However, the uneven character of the relationship—where the clients given their incarcerated everyday life do not feel they have much to contribute to the interaction—seems like an obstacle for some.

I had a visit from my dad and my brother a week ago. It was a bit forced. Like, it’s not so bloody fun to be stuck here. It was okay though. We sat up here in a room. And this time it was unmonitored. We sat and talked for an hour, something like that. But eventually it was like: What the hell, I want to go and lie down on the sofa on the ward again. You don’t have much to talk about here. You just sit and drink coffee all day long. Watching TV. So, there’s not so much to talk about. You don’t know what to say really. (Male, 25 years)

This experience seems far from the image of the visit venue as a “liminal space” opening up for emotional bonding as described by Moran (2013), despite the fact that the visit in question was unmonitored. It appears hard to distance oneself from the client role, even when given the opportunity to meet with family in private. From an interactionist point of view, visits bear the potential of easing “role carry over” from the outside world, something that could serve as an important contrast to the client role prescribed by the institution. The next statement, by a 46-year-old married woman, illustrates the importance for clients to keep roles other than that of client while incarcerated.

It’s very hard. You only have this to talk about and you don’t get much input. I’ve told my husband “talk about everything you do, and don’t forget to tell me everything, so I am involved.” Otherwise, I will lose the whole outside world.

As indicated by the above quote, visits from family and friends could also serve the function of making sure that the relationships remain when clients return home. Potentially, the enforced abstinence may also create openings for rebuilding or repairing strained or distanced relationships (Skärner, 2001). However, according to our interviewees, the institutional practices regulating visits make it difficult to maintain (not to mention establish new) relationships during ongoing treatment. Time restrictions typically limit the visitation time, which is mentioned as a problem.

I had a visit last weekend. My mom, my siblings, my stepdad and my dad, my girlfriend, and my daughter. It was monitored. One hour. I think it’s a little short. It went pretty fast when there where so many people, I didn’t get the chance to speak to everybody. I thought it was damn hard when they left. (Male, 23 years)

For our interviewees, visitors were most often family members, such as mothers or siblings, which resonates with the findings of Moran (2013). However, while the Russian prisoners interviewed by Moran had positive experiences of long-term visits in specific, domestic-like visiting facilities (often including a kitchen, shower, and toilet), clients in this study were critical of the carceral visiting environment. So much so that it made some interviewees hesitant to bring visitors to the facilities.

Obviously, it’s difficult for relatives to call here, or to come and visit. It feels like I’m in jail and in prison, and for my mom it’s painful, do you get it? She doesn’t like getting into these kinds of environments, behind barbed wire and fences and camcorders and everything like that. I noticed that. For her, coming here and it’s totally locked up and she thinks: “My son is sitting here. What have I done wrong?” (Male, 39 years)

This description demonstrates the nature of the visiting space as one in which identities are constructed, hence echoing “the implications for self of social settings” (Goffman, 1961/1991, p. 138). From this account, there is no sense in which a more “normal” relationship can be maintained in this context. The man quoted expresses guilt and shame over the situation on behalf of both himself and his
mother, raising questions regarding experiences of “stigma by association” (or “courtesy stigma” to speak as Goffman, 1963/1984, p. 4) among clients’ families (Van der Sanden et al., 2015).

Another difficulty highlighted by the interviewees relates to the physical monitoring of the actual visit by staff, a procedure that is a standard routine on the closed wards.

Mom has been here and visited me once. It’s not much fun to have visits here on the locked ward, because there is always a staff member present. So, I don’t like to have visits. I mean, it’s fun to see mom, but it’s hard because they’re sitting there staring at you. Even though she doesn’t suffer substance abuse. So, mom left after 45 minutes. I kind of wanted her to go because I thought it was too hard. And after the visit, they search you and you have to change clothes before going back to the ward. And I was really sad after she had gone. (Woman, 26 years)

This description of the supervised visit demonstrates how the watchful eye of the institution seems to prevent clients from re-engaging with their family members in the visiting space. In addition, many interviewees—like the woman quoted above—reflected on what happened after the visitor had left. Going back to the ward and the everyday institutional life was not an easy transition, but a situation many interviewees found profoundly distressing. This echoes what Moran (2013, p. 347) has pointed out, namely that “[r]ather than representing a stage in a linear transformation, the liminal space of the visiting room is (…) a space which can be repeatedly entered and left, but from which there is no immediate progression to another status.” In line with this reasoning, several interviewees who had experienced visits described feelings of loneliness and isolation.

We’re locked up in here after all, so everything becomes artificial. My parents would’ve liked to drive up here and talk to me once a week, but I just think it feels so artificial. Yes, you get two hours and you’re supposed to sit here and talk as if everything was business as usual, but it isn’t as usual. And then you go back in here and your thoughts keep spinning around at what’s happening back home and the family, after all, they’re the ones I want to be with. But then you have to enter this world again. (Male, 36 years)

As this man points out, the contrast between life at home versus life at the institution is hard to manage emotionally. Previous prison studies have shown that the visiting experience is typically filled with mixed emotions, and it has been described as “a double-edged sword” (de Motte et al., 2012). While a visit may be a positive experience for both the client and the visitor, as it allows time to see loved ones, maintain contact, and share stories, it may also evoke more negative, “bittersweet” emotions (Casey-Acevedo et al., 2004). Our participants experienced a variety of feelings following a visit, ranging from gratefulness to sadness and anxiety. For some, even contact on the telephone was challenging, since it stirred up a multitude of negative emotions.

Somehow you turn yourself off when you’re in here. It’s a completely different world. You turn everything off. At least I do. And I know many others do too. So, every time mom calls, I almost feel worse afterwards, because then you are reminded of everything at home, how it is at home now. Life continues there after all. It doesn’t stand still as it does when you are here. (Male, 36 years)

Consistent with other research (e.g., Harman et al., 2007), several interviewees acknowledged withdrawing emotionally as a means of coping. While this may be understandable, given that what Goffman (1961/1991, p. 61) called “situation withdrawal” is a common line of adaptation to institutional conditions, it may be detrimental to relationships in the outside world. Harman et al. (2007) have found that such tactics while incarcerated put a strain on personal relationships that is significant and hard to repair. However, not all participants describe negative experiences of visits. Some clients at the final stages of their compulsory treatment had been given the opportunity to leave the institution together with visiting family members, and they shared more positive stories.
My visits are always unmonitored, because I behave well here. Sometimes you go to a certain house here at the facilities, then the staff will join shortly after to see that the right people are coming. Then you sit there and drink coffee and talk for two hours. At other times, we’ve been out eating at restaurants, without staff. They just drive you into town and you have a couple of hours to walk around, eat, and socialize. Then the staff come and pick you up. My mum and my sister have been here a lot. They come and visit at least every two weeks. (Woman, 31 years)

This interviewee seems to be speaking from the position of the “ideal client,” presenting a view of her current situation as a consequence of her favorable personal qualities (“I behave well here”). Although not a common statement, this woman’s “success story” (Goffman, 1961/1991, p. 140) reveals the permeability of the studied institutions. Hence, for clients who align with the institution, there are possibilities to nurture intimate relationships during treatment. For most participants, however, the intrusion into their personal sphere and integrity that the described restrictions (surveillance, control of body, etc.) entail means that visits do not become the positive liminal zone they might have been. Instead, many interviewees strive to keep their personal worlds and the world of the institution apart, and if too much contamination occurs (i.e., that family members get an insight into the conditions under which they live), they would rather refrain from visits than be forced to reveal themselves in the inferior, humiliated client position provided by the institution.

Relationships on Hold

Due to the constraints related to contact keeping with family and friends presented in the previous section, some participants chose to completely refrain from visits during their treatment period.

I don’t consider visits an option. I think it’s so offensive that the staff need to be involved. It has to do with your integrity and your own freedom. They will stop at nothing to keep this a drug-free zone. But they can’t do that at the expense of your own integrity. (Man, 42 years)

I don’t want to receive visits. I don’t want anyone to see this place. I didn’t know myself what kind of place this was before I arrived. I might have thought it was some kind of treatment, but it clearly isn’t. (Woman, 52 years)

My boyfriend has been here one time and visited, but I’ve said no after that, because of the strict rules. I want it to be natural, so I would rather wait. I think the visiting rules are bad. I can’t give him a hug, even once. That’s part of your life too. (Woman, 28 years)

Intimacy is often seen as crucial for healthy relationship maintenance, but incarceration limits the contact necessary to sustain such intimacy (see also Harman et al., 2007). In the cases above, intimate relationships were in essence put on hold until after the completion of treatment. Others expressed that they experienced difficulties maintaining relationships related to restrictions due to suspicions regarding drug use on behalf of family members. Hence, in these cases, participants’ relationships were put on hold against their own will. Not being able to keep contact with drug-using partners created great strain and worries, of how the partner was doing and also regarding whether the relationship would last.

The relationship gets very damaged when you are here. You can have no physical contact. You only have telephone contact. And they often place you at an institution as far away from home as possible, to make visits impossible. Me and my fiancé are very tight. We hang out all the time. So, when you come here, after all, it’s a question of whether your relationship will last or not really. (Woman, 46 years)
From this woman’s description it becomes clear that contact keeping while detained at the studied institutions is conditioned and challenged by regulation of time, space, and privacy. In addition, problems of having visits approved clearly leads to negative consequences for the clients. Difficulties were also linked to complicated family relationships. For example, one female interviewee described conflicts between her parents and her partner as highly problematic, ripping her family apart.

My dad doesn’t even answer my calls. And my mother only screams at me when I call her. So, I don’t call them anymore. I’ve always had good contact with them before this happened. The situation with my husband is hard, because they blame him a lot for me using drugs. They think he’s bad for me. But I chose to take drugs myself. I was using drugs before I met him. But they consider him to be a bad person for me. (Woman, 40 years)

Due to the high level of conflict, this participant has chosen to refrain from contact with her mother and father during the remaining treatment period. In contrast, another woman explained how her dead husband’s alcohol addiction served as a “sympathy account” (Järvinen & Bloch, 2016) in relation to her parents’ conception of her drug use as caused by circumstances outside her own control: “My parents are very supportive. They know that my problem is rooted in my husband’s alcoholism.” This way of placing responsibility for clients’ drug problems on their partners was clearly gendered in our data, meaning that no male interviewee with a drug-using partner shared similar stories. Most clients recognized the efforts made by their family members to keep contact and come to visit. At the same time, there is not always that much to talk about. Many interviewees describe the routine, everyday life at the institution as mind-numbing and extremely dull (cf. Ekendahl, 2001; Svensson, 2001, 2003, 2010). A female participant in her mid-40s explain that “I do not have the energy to keep in contact with my friends. I have nothing to contribute [to the discussion]. What I do during the days and such kinds of things, no, I don’t want to talk about that.” Hence, this woman chose not to keep in touch with her friends during her time at the institution.

According to some of our interviewees, certain family members found the coercive situation too hard to handle and preferred putting the relationship on hold throughout the treatment period.

Sometimes it is difficult to talk to the family about certain things. You have done a lot; you have hurt them. I’ve destroyed a lot for my mother; she’s been so worried. It’s a bit difficult now, being locked up here, to apologize from out of nowhere. To really get in touch is difficult. (Male, 32 years)

The account above points out that contact may be available, but real connection seems out of reach within the walls of the institution. In a similar manner, many participants expressed shame and guilt over the pain and suffering they had subjected their families to through their drug use. These feelings put additional strain on the contact and, in some cases, served as an explanation as to why family members had chosen to put their intimate relationships on hold during treatment.

My oldest daughter, she prefers not to have any contact at all. She thinks it’s that hard. Especially the first weeks after you’ve arrived and you’re not allowed even to use the phone by yourself. Then, staff make the calls for you, and my kids think that’s really tough. My 20-year-old daughter, she thinks it’s very tough, even now when I’m allowed to use the phone by myself. She says “No, it’s better we keep contact after you’re back home, or when you’ve moved to some other place.” (Woman, 46 years)

For this woman’s daughter, even telephone contact with the compulsory institution was too traumatic, leading to the decision not to have any contact at all. To sum up, regardless of whether relationships are put on hold or maintained (in the circumscribed way enabled by the institutions), many interviewees say that they are set on that the “real” relational job begins when they leave the institution.
I haven’t had any contact with my family [during treatment]; I chose that myself. Now that’s starting to change, when they see that I’m sober. I want to spend time with them, especially with my brothers, in a different way. To be involved in their lives. That’s a big motivation right now. So, I’m rebuilding that. It’s hard now when you can’t meet them. I’m not very good at talking on the phone; I need to hang out with them to get to know them. But that will change soon, I hope. (Male, 25 years)

However, even if they express a need for support to rebuild intimate relationships post-treatment, far from everyone knows what kind of help they actually need.

I need help, but I don’t know what that help should look like. I wish we were a whole and healthy family. I wish that, but at the same time, I don’t know what to do to get it together. (Male, 42 years)

**Discussion**

The current study sought to explore the character of relationships between clients and their friends and family during ongoing compulsory care from the perspective of the clients, while also taking the institutional coercive setting into consideration. Compulsory drug treatment means that people are placed in a secluded environment where they have very limited opportunity to influence their everyday lives. Our findings show that most clients had limited opportunities to maintain intimate relationships during their ongoing treatment. Like at Goffman’s (1961/1991, p. 15) asylums, the studied institutions’ encompassing character clearly appears by the barriers to the outside, symbolized by locked doors and sometimes high walls and barbed wire. At the studied institutions, a central division is created between inside and outside, where the communication between these poles is constantly mediated and filtered through the staff. This has a number of consequences for the clients’ abilities to maintain and develop social relationships. First, a basic positioning takes place where the client is primarily defined as a person using drugs and the relationship to the drug is seen as more important than social relationships. This means a shift from a person’s other roles, such as partner, parent, child, spouse, friend, etc. to the institutional role of client. In addition, this positioning leads to both clients and institutions being considered in great need of protection (against the intake of drugs and toward the possibilities of escape), which justifies the coercive measures taken to safeguard the institution and its clients. Second, the division between inside and outside leads to a loss of opportunities for control and management of everyday affairs (such as paying bills, taking care of children, feeding pets, etc.), as well as intimate relationships. Clients are deprived of their autonomy, and the heavily circumscribed possibilities of action and maneuvering space that is a consequence of the detained situation prevents clients from arranging their lives and taking responsibility for the everyday duties that belong to ordinary adulthood. Instead, this is passed on to their significant others, which appears paradoxical when a basic idea of this kind of compulsory treatment is that clients should be fostered to take responsibility for their own lives (Billquist & Skärner, 2009). For clients who are parents, the detained situation becomes a substantial obstacle to them exercising responsible parenting (as much as this is possible given the incarcerated situation). Furthermore, the fact that there is someone at home taking control over practical matters that need to be attended to means that clients are relieved of some worry and stress. Practical support also has an emotional dimension in that it signals concern and care. At the same time, having to ask for help with basic everyday chores creates dependence and risks undermining self-esteem and confidence in the person’s own competence (Vaux, 1988). Simultaneously, the unevenness in the relationships appears to create feelings of guilt among the clients for burdening their family members. Perhaps, there is also a concern that they put too much pressure on the relationship. Thus, the situation described above entails threats to clients’ autonomy, integrity, and reciprocity in their relationships.
In general, the strict institutional restrictions on interpersonal contact and communication forced clients to struggle to maintain intimate relationships. An important finding is that the regulation of phone calls and visits at the studied institutions was not only limiting in terms of time and space but also had consequences for the quality of the communication. Participants pointed to real connections with loved ones remaining hard to achieve in the locked environment, despite opportunities to meet, and conversations rarely went beyond small talk. Such more superficial conversations appeared pointless for some interviewees in the context of the radical changes in their lives. This suggests that short, restricted meetings and limited phone contact are not enough to maintain intimate relationships, and for several of the clients they were not worth the confusion and emotional turmoil that often followed. The way that visits are currently organized and managed at the studied institutions seems to lead to a loss of the closeness and intimacy that participants identified as important for their relationships. This in turn leads to an intensification of worries and concerns. Clients had seen their loved ones, but not really met with them. They had communicated, but not talked. Questions that participants would have liked to talk about were not possible to address. Consequently, after visits or phone calls, the number of problematic issues had sometimes grown, and the worries were greater. This, however, stands in striking contrast to accounts given by participants who had been given the opportunity of more private visits, inside as well as outside the institutions.

As research has consistently shown, prominent features of client life at compulsory treatment institutions are emptiness and eventlessness (Ekendahl, 2009; Svensson, 2010). Our findings also highlight the uneventful, secluded existence at the institutions. It seems like the short-term goal of treatment (motivation to enter voluntary treatment) cannot get start-up help from external supportive relationships, but instead must start as an inner, individual journey. This resonates with Goffman’s (1961/1991) writing on the mortification process in total institutions: isolation, especially in the beginning, is important to ensure a complete break from past roles. Moreover, our interviewees’ accounts link to a dominant theme among Goffman’s inmates—“that time spent in the establishment is time wasted or destroyed or taken from one’s life” (1961/1991, p. 66). This enforced interim period has been referred to as an involuntary moratorium: a structured suspension of responsibility—a deadline, a time to search for a new platform, or a locked and meaningless transport route while waiting for the right to regain control over one’s life (Billquist & Skärner, 2009). While detained, the clients in this study experienced a moratorium with very limited opportunities to participate in what happens on the outside: a disconnection. Separating the client role from other roles (such as partner, parent, or child), although desirable, seems challenging in this context. In all, this means that the private and intimate side of social relationships is subjected to the conditions and rationality of the confinement. On the inside, as one of our interviewees so nicely puts it, there is a completely artificial situation. This stands in stark contrast to the authenticity that is typically associated with close relationships within a family (but which, of course, do not always exist in reality). The opportunities for clients to actively change and develop their social relationships during compulsory treatment are very limited. Likewise, there is little room to engage family members to participate constructively in the client’s treatment. On the contrary, our findings indicate that the relationship between clients and their families needs to be engaged in repair work after the end of compulsory treatment.

The compulsory treatment institutions studied in this paper are “total” in the sense that all aspects of the detained clients’ lives are “conducted in the same place and under the same single authority” (Goffman, 1961/1991, p. 17). While there has been much academic criticism aimed at Goffman’s total institution model, some arguing that it is out date and in need of remodeling (Scott, 2010), this is not our view. Many of the features of the total institution remain at the studied facilities. For example, like Goffman’s (1961/1991) inmates, clients within Swedish compulsory treatment for adults using drugs enter a setting in which they are “subjected to a rather full set of mortifying experiences” (p. 137): They are separated from the wider community and disconnected from their previous home life. Initially, they are placed on locked wards, stripped of their personal belongings, and forced to wear
standard issue clothing. They spend their days in communal living where their movement is greatly restricted. According to Goffman, procedures such as these aim to create a distance to roles founded in contexts and relationships outside the institution, to create a person that the total institution can work with. Nevertheless, we agree with Quirk et al. (2006) in that “permeable institution” may correspond better to the everyday reality of the studied institutions. The permeability lies first and foremost in that it is possible to maintain some contact with the outside world. Clients maintain contact with outside professionals, typically social workers, as well as their families (if they choose to). Second, the time at the institution is limited to a maximum of six months, something that is beyond the control of staff.

The findings of this study contribute to the literature by providing a deeper examination of the social relationships available to incarcerated clients. For the clients, significant and positive relationships can comprise an important connection to other roles than the one constructed inside the institution (Goffman, 1961/1991). For many of them, better contact and communication with family and friends would have functioned as important sources of emotional and practical support (see also Krishnan et al., 2001; Neale et al., 2012; Taylor, 2016; Valera et al., 2015). However, clients also described some relationships as characterized by ambivalence, conflicts, and guilt. Emotional strain and distance can be consequences of substance use (cf. Tracy et al., 2010) or caused by other conflicts that go back further (Neale et al., 2014). However, according to the participants in this study, little attention was given to these relational dimensions of their situation. Instead, staff seem to prioritize a gate-keeping function, assessing family members as potential threats, both toward the treatment system and to the wellbeing of the inmates.

Finally, there is the issue of potential for improvement. Taken together, our findings suggest that there are few opportunities to receive backup and input from family and friends that support the goals of the treatment (motivation to seek change and enter voluntary treatment), given the current situation at the studied institutions. Prior research has shown that efforts to maintain relationships with family, primarily through visits during incarceration, are associated with better post-release outcomes (Berg & Huebner, 2011; Eades, 2009; Taylor, 2016; Walker et al., 2018). We argue that opportunities for improvement may lie in a higher degree of permeability within compulsory treatment settings. The acute life-saving goal of treatment may be reached (through the high levels of control and security measures), but given the length of the involuntary treatment period, the strict control measures may counteract the long-term goals. Compulsory institutions should implement strategies to decrease the physical, financial, and emotional barriers that now separate clients from their families. Increasing the use of videophone calls (to complement and not replace visits) and offering assistance to visiting family members travelling long distances may help people to keep in contact in a better way (as also suggested by Taylor, 2016). Furthermore, specific facilities for visits, like visiting hostels, could be provided, visiting hours extended, and restrictions on visitors reduced. In addition, staff need to develop methods to work together with clients and their families to increase the possibility for supportive relationships to be in place upon exit from treatment (cf. Neale & Stevenson, 2015). Our findings suggest that Swedish compulsory drug treatment is flawed in its current form and potentially harmful in and of itself. It is our contention that the limitations regarding possibilities for contact keeping while incarcerated identified in this paper should be taken seriously by policymakers and treatment providers.

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Notes
1. In this article, we aim to use non-judgmental, respectful language to describe individuals using drugs. However, the term “substance abuse” is used consistently in Swedish legislation, so when making direct references to the law, or to the treatment providers’ official statement, this term will be used.
2. During the period 2013–2018, 90% of all compulsory treatment episodes regarding substance use were initiated through immediate custody (National Board of Health and Welfare, 2019).

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Karin E. Berg is lecturer in social work at the University of Gothenburg, Sweden. Her main research interests are peer support and social networks in relation to both domestic violence and substance use. Her PhD thesis, Online Support and Domestic Violence – Negotiating Discourses, Emotions, and Actions (London Metropolitan University, 2015), explored online support by and to women who were currently experiencing domestic violence, or were in the recovery process.

Anette Skårner is PhD and associate professor of social work at the University of Gothenburg, Sweden. She has worked as a social worker in the field of drug treatment and psychiatric care. Anette has conducted several research projects in the area of drug use and applies an interactionist perspective in her research. Common for her research is an ambition to highlight the role of the social relationships for people on their way into or out of drug use. Some of the themes focused on are the following: Social networks and social support, young people and drugs, affected family members, compulsory treatment and the client-counsellor relationship. A particular research interest in recent years is sexuality, intimate relationships and drug use in the context of long-term recovery from problematic drug use.