Interviews with people currently in a heavy drug use about why they are not in treatment and their perception and attitudes towards treatment.

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Abstract

In Sweden there are approximately 45 000 people that show signs of being dependant on narcotics, and there are approximately 26 000 people who can be defined as heavy users. Heavy users is defined by Centralförbundet för alkohol- och narkotikaupplysning as persons who have injected narcotics of any kind in the last 12 months or persons who have had a daily or practically daily use of narcotics the last four weeks. The aim of this study was to understand why people with a current heavy drug use are not in treatment. Through interviews their perceptions and attitudes towards drug treatment were raised to create understanding as to why they are not in treatment. The information was collected through semi-structured interviews with ten people with a current heavy drug use. The interviews were transcribed and a content analysis was applied. The results indicated that there are mixed thoughts about treatment but also that most participants did want treatment. Even though all participants had experience of treatment not working for them, many were motivated to try something new or try the same treatment again. The conclusion was that the participants are searching for a more individual based treatment since they felt like the treatment that they had been offered did not work for them.

Key words: Heavy users, treatment, drugs, strain theory, general strain theory, social bonds

* Martina Abdalla and Alva Rydén has been equally responsible for the work surrounding this study.
Forewords:
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**Introduction**

This study aimed at understanding why people with a current pattern of a heavy drug use are not in treatment. Through interviews their perception and attitudes towards drug treatment were raised to create understanding as to why they are not in treatment. Heavy users is defined by Centralförbundet för alkohol- och narkotikaupplysning [CAN] as a person who has injected narcotics of any kind in the last 12 months or a person who has had a daily or practically daily use of narcotics the last four weeks (CAN, 2017). Narcotics is defined as any substance that alters the mood or frame of mind and that is illegal, for example amphetamine or heroin (Nationalencyklopedin [NE], 2017). Through Sweden's legislation, use, possession, distribution and production of illicit narcotics is illegal (SFS 1968:64).

**Previous research on drug users and treatment**

Previous research have been about life happenings that leads to treatment, what drug users are looking for when they go to treatment, the success of drug treatment, different barriers that makes it hard for drug users to seek to treatment and how heavy drug users claim to be occasional users (Bobrova et al., 2006; McKeganey, Morris, Neale & Robertson, 2004; Morral, McCaffrey & Iguchi, 2000; Pollini, McCall, Mehta, Vlahov & Strathdee, 2006; Stevens, Verdejo-García, Roevers, Goudriaan & Vanderplasschen, 2015; Storbjörk, 2009; Van der Poel, Barendregt & Van de Mheen, 2011). One study by Pollini et al., (2006) found that overdose was a leading cause of death among drug users and that the most common reasons for not seeking treatment was because they were not ready for it or because they did not perceive their drug use as a problem. One qualitative study was made in Russia on barriers to accessing drug treatment among drug users in two cities (Bobrova et al., 2006). The study's results showed that there was three barriers identified and those are financial constraints, perceived low efficacy and fear of registration as a drug user. One study found that more than 50% of the 84 participants that went to detoxification programs dropped out prematurely because of their low patience (Stevens et al., 2015).

Morral et al. (2000) examined the validity of self-reports from people using drugs in methadone maintenance treatment. The authors used 701 cases from 255 clients and compared their self-reports of drug use with urinalysis. Out of those 279 of the cases reported an occasional opiate use and more than half of them were found to be heavy users. Out of their participants 34% of the opiate users and 43% of the cocaine users had reported use
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Frequencies that were almost impossibly low. Among ongoing drug users the frequency average was calculated to 34% higher for opiates and 29% higher for cocaine than what they self-reported. Because of the frequency of underreporting, the validity of some treatment outcome evaluations can be threatened (Morral et al., 2000). The authors also found that drug users who were in treatment had lower rates of underreporting their drug use.

McKeganey et al. (2004) interviewed participants starting a new round of drug treatment in Scotland and had an aim to find out what the participants were looking for from treatment. 56.6% of the 1007 participants said that they hoped to ease their withdrawal but very few, 7.1%, wanted to reduce their drug use (McKeganey et al., 2004). Van der Poel et al. (2006) studied the differences and similarities in different treatment groups with drug users. They had 201 nearly daily users of heroin and/or crack which they categorised into four different groups depending on their treatment state, one group for those in treatment, a second for those in care, for example day or night shelters and drug consumption rooms. A third group for those in both treatment and care, and the last group with drug users who did not go to either. Results showed that the group with no treatment or care had reported good health (68%), and a fixed residence (79%) (Van der Poel et al., 2006). From the treatment group 31% expected addiction care to help them become drug free and 18% expected to have control over their drug use (Van der Poel et al., 2006). From the care group 52% stated that the addiction care had helped them with other issues than drug use and the people in this group are in the stage where they do not want to recognize their problems (Van der Poel et al., 2006). The last group where the participant went to both treatment and care group, 53% wanted addiction care to help them with other issues than drugs addiction but at the same time many of them did not have the energy to think about changing things in their life when they are just trying to survive (Van der Poel et al., 2006).

To find out if delay discounting, was predictive of poor treatment retention among 84 drug users a study was made by Stevens et al. (2015). Shortly after the participant entered the detoxification treatment a measure was made and the results was that delayed discounting was predictive of shorter treatment retention and higher odds of dropping out of treatment prematurely (Stevens et al., 2015). Other results in the study showed that the odds of dropping out of the detoxification program prematurely were 3.04 times higher than the odds

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1 To prefer smaller immediate rewards over waiting for a bigger reward (Richards, Zhang, Mitchell, & De Wit, 1999)
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Previous research from Sweden

In Sweden there are approximately 45,000 people that show signs of being dependant on narcotics, and there is approximately 26,000 people who can be defined as heavy users (CAN, 2014). In Sweden treatment is paid for by the government, so reasons like it is too expensive are not applicable in Sweden (SFS 2001:453). The social services in Sweden also have daily operations and one of those places is Slink In in Sundsvall which is a daily operation for people in social alienation (Sundsvalls kommun, 2016). Slink In is operated by socialtjänsten and offers coffee and some food, newspaper reading, phonecalls for other authorities and help or advice (Sundsvalls kommun, 2016).

Storbjörk (2009) made a study to find out the extent to which different negative incidents in the previous years lead to treatment entry for drug users in Sweden. The clients entering treatment reported that they had experienced many negative drug and alcohol related incidents (Storbjörk, 2009). The negative incidents related to family and health workers were found to be most influential and lead to treatment (Storbjörk, 2009). Another study was made to investigate the motivational factors for drug sobriety and differences in motivational factors between two groups of former addicts (Wallin, 2009). The two groups consisted of those that ended their abuse by themselves and those that ended after a treatment, the investigation was made through interviews (Wallin, 2009). In the results Wallin (2009) found both similarities and differences in the motivational factors between the groups. The results indicated that the important factors for sobriety is the participant's level of motivation at the occasions of successful trials and belief in their ability to successfully end their addiction (Wallin, 2009). The motivation for the group of people that had sobered without treatment was the belief in their own ability to successfully end the addiction while the group that went to treatment found motivation in a wish to stop hurting people close to them (Wallin, 2009).

Swedish studies have not only focused on motivation and life events that brings drug users to treatment but also about the experiences of treatment from both personnel and participants in treatment. Carlsson, Gustavsson and Söderholm (2006) made a study with basis in interviews with personnel and clients from Rällsögårdens drug use program to examine their experiences of the treatment and its implementation. The results indicated that all the client
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that participated in the study had the motivation for treatment, even if some felt split in the decision on whether they would stop using drugs or not (Carlsson et al., 2006). The clients also had different judgements on the treatment program, some experienced it as a treatment, others like it was more information than treatment and some did not feel it was treatment other than the group discussions (Carlsson et al., 2006). According to the personnel in the locked sections of the treatment, those clients were nuanced in their participation in treatment while the personnel in the open sections felt like those clients were more active and were participating more (Carlsson et al., 2006). The personnel also expressed that the motivation within the clients was important for the effect of the treatment and that clients in open treatment were more motivated to finish the treatment than those in the closed treatment (Carlsson et al., 2006).

Existing treatments in Sweden

In Sweden 12-step treatments are used for drug related problems and they are based off of the Alcoholics Anonymous [AA] and Narcotics Anonymous [NA] treatment programs (Socialstyrelsen, 2017a). The aim of the treatment is to give insight into the negative consequences that come from a drug and alcohol use. Detoxification is supposed to be included in the treatment according to the basic concept but it differs from treatment to treatment (Socialstyrelsen, 2017a). The treatment is mostly done in group with a drug and alcohol therapist. There is also outpatient care offered, for example through Sundsvall county, Sundsvalls Behandlingscentrum [SBC] which is Sundsvall’s treatment center and offers 12-step treatment, and work rehabilitation (Sundsvall kommun, 2017). An inpatient treatment last for about six weeks and contain daily group therapy and is followed by after treatment for about a year, in the participant’s hometown (Socialstyrelsen, 2017a). When it comes to relapse when in group treatment facilities where participant live and go to treatment together, the person that relapses might need to terminate the treatment and come back later (Riksförbundet för rättigheter, frigörelse, hälsa och likabehandling [RFHL], 2008). In Sweden addiction care is primarily voluntary, but compulsory care can be put in place in certain cases (SFS 1988:870).

Substitution treatment is also an option, but only for opioid users (Socialstyrelsen, 2015a). Through substitution treatment, in Sweden called läkemedelsassisterad rehabilitering vid opiatberoende [LARO], people with opioid addiction receives methadone or other medicine
approved for opioid treatment to be able to manage their addiction. Substitution treatment is prescribed together with psychosocial treatment (Socialstyrelsen, 2015a). Sweden also offers cognitive behaviour therapy [CBT] and psychotherapy in different forms, like recidivism prevention which is based of off CBT, and psychodynamic therapy (Carlsson & Fahlke, 2012; Socialstyrelsen, 2017b, 2017c). CBT is therapy based in people's feelings, thoughts and behaviours and how they affect them. Certain types of CBT, like dialectal behaviour therapy, have shown to work well with co-morbidity, for example addiction in combination with some personality disorders, but there is very little support for this in research (Balldin & Berggren, 2012; Socialstyrelsen, 2017b, 2017d). In Sweden drug abuse treatment is paid for by Socialtjänsten, so money is not a restriction for participating in drug treatment (SFS 2001:453).

Social bonds theory
Social bonds theory is a criminological theory by Travis Hirschi (2009) that focus on four kinds of bonds a person has to society (Hirschi 2009; Sarnecki, 2009). The first bonds is called attachment which is the connection a person has to conventional people or activities, such as school, friends, family and alike (Hirschi 2009; Sarnecki, 2009). The Commitment bond is about the connection a person has to the conventional social order, such as education or employment. Involvement is the third bond to conventional activities, engagement to school or association activities (Hirschi 2009; Sarnecki, 2009). The last bond is belief, which is positive or negative attitude towards the law enforcement agencies, legislation and also towards addiction (Hirschi 2009; Sarnecki, 2009). If a person has all four bonds, according to social bonds theory, they will abstain from any criminal activity such as illicit drug use. Relationships to people who differ from society, can increase the risk for the person themselves to also deviate from society, as for example through drug use.

Strain theory and general strain theory
Robert K. Merton (1938) developed the theory called Strain theory. Strain theory is based on the notion that society puts people under pressure to reach goals accepted by the society (Merton, 1938; Sarnecki, 2009). If the person lacks the means to reach these goals this might cause strain, which can lead a person to commit crimes. Strain theory focuses both on a structural and a individual level (Merton, 1938; Sarnecki, 2009). Structurally, strain refers to the society's effect on the individual's perception of his or her needs. Individually the strain
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refers to the individual's attempt to reach his or her needs, and the friction it may cause. Merton elaborated on the theory by expressing that when an individual is faced by obstacles on their way to their goals strain occurs. When this happens, adaption can come about in five ways, *conformity, innovation, ritualism, retreatism and rebellion* (Merton, 1938; Sarnecki, 2009).

1. *Conformity*, when a person tries to reach their goals by means accepted by society.
2. *Innovation*, when a person uses unapproved means to reach their goals, for example dealing drugs.
3. *Ritualism*, using approved means to reach more humble goals.
4. *Retreatism*, when a person rejects the society’s goals and the means to reach them, for example through addiction.
5. *Rebellion*, when a person rejects both goals and the means, and then work towards replacing them.

General strain theory is a development of the strain theory by the criminologist Robert Agnew (1985). The general strain theory aims at expanding the focus that strain theory has, to include all types of negative relationship between both individuals and others. General strain theory also aimed at explaining why some people under strain do not turn to delinquency (Agnew, 1985; Agnew, 1992).

General strain theory brought up three categories of strain, the first category being the actual or expected failure to achieve goals (Agnew, 1985; Agnew, 1992). The second being, the actual or expected removal of positive stimuli (Agnew, 1985; Agnew, 1992). This might cause a person to commit some kind of delinquency as a mean to stop this loss from happening, to find a substitute stimuli or to seek revenge on those who caused the loss or to manage this loss by using drugs. The third category being, actual or expected presentation of negative stimuli (Agnew, 1985; Agnew, 1992). Negative stimuli may lead a person to commit some kind of delinquency. The negative stimuli that has occurred or is expected might lead a person to escape or avoid it, terminate it seek revenge at the cause of the negative stimuli or to manage it by using drugs. As there are different types of sources of strain that may cause a person to expect or actually fail at reaching their goals it is unclear which of these strains that lead to delinquency, which might mean that all types of strain might be relevant for this
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The study aimed at understanding why some heavy users were not in treatment. Through interviews their perceptions and attitudes towards drug treatment were raised to create that understanding. Three objectives for the study was formed, objective 1 what are the heavy users perception of treatment programs, objective 2, what do they want from treatment and objective 3 life-areas requiring care attention. To answer the aim this thesis also found out the characteristics treatment programs should have in order to have successful results from the participants perspective.

Method

Participants
The participants in this study were people with a current pattern of heavy drug use. That meant that the participants who state that they had used some kind of narcotics recently or had used for a longer time were included in the study. Narcotics includes substances such as amphetamine, opioids, benzodiazepines, and alike. Since previous research has shown that people not in treatment tend to underreport, people who stated that they had not used much narcotics are still included in the study (Morral et al., 2000). The people were contacted through Slink In personnel at first but after the first two interviews people who visited Slink In and did seem to have a drug use were asked if they wanted to participate. The heavy drug use was checked through verbal self reported drug use during the interviews.

The participants were both male and female with a heavy drug use. People who did not disclose any usage of narcotics were excluded. Those who voluntarily decided to participate were users of drugs such as amphetamine, heroin, cocaine, alcohol etcetera. The study consists of interviews with ten people who frequent Slink In in Sundsvall. The participant are between the ages of 21 and 40. Four females and six males participated. Other people were interviewed, but were excluded later on because they did not meet the inclusion criteria.

Design
For this study a qualitative design was used. Information was collected cross-sectionally to give a description of the circumstances at the moment of the performed study (Flick, 2014). The information was collected through semi-structured interviews and the questions were
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carefully chosen and written to an interview guide (see appendix A). By choosing the semi-structured interviews it was possible to ask questions during the interviews that was suitable and met the topics defined on the interview guide (Braun & Clarke, 2013).

**Sampling method**
Since the study had a qualitative design the concern of sampling was related with having people of different ages and gender that could have different perceptions and attitudes towards treatment. This was made through purposive sampling (Flick, 2014). Therefore potential participants were chosen through convenience with a primary selection with people who could answer the questions with knowledge about the area in question (Flick, 2014). The participants were chosen through help from personnel at Slink In, but also by asking if people at Slink In wanted to participate.

**Procedure**
The interviews were held in a meeting room at Slink In, where the participants felt comfortable. The participants were informed about all the ethical aspects the study entailed before the interviews were held and an information sheet with the same information was given to them. The information sheet also contained contact information in case they would want to withdraw their participation or had any further questions. Since not everyone wants to participate in a study like this, finding people willing to participate was not the easiest. This is also why the study was later expanded to include the EFS church in Sundsvall. One interview was held there one wednesday since they serve free lunches for people in need. The amount of time spent on waiting and searching for people who were willing to participate took about ten hours per week the first two weeks and the last two weeks about twenty hours per week. This time was spent at Slink In trying to meet people willing to participate.

Participation very much depended on the daily form of the participants, were they feeling fine, would they be able to concentrate for 30 minutes up to an hour and so on. Some of the people who were booked for an interview did not show up or backed out. This is something to consider while doing a qualitative study with interviews. 16 people were interviewed for this study, but six of the participants did not have the kind of heavy use that fit the criterias of this study. Because of that, those interviews could not be used for this study. Out of the ten participants in the study, six was men and four women, all participant were between the ages
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From the start the aim of the study was to understand why heavy drug users were not in treatment, but as the interviews were held, the aim had to be modified as there were very few who did not want to participate in treatment. The aim then became to understand why they are not in treatment through their perception and attitudes towards treatment. As the study continued a third objective was formed concerning what happens after treatment, the objective was called life areas requiring care attention.

Data collection
The questions for the interview guide were carefully chosen before the interviewing started. The interviews were held in Swedish and were supposed to be approximately one hour long, some were shorter and some went on for longer. The interviews were audio-recorded and later transcribed in Swedish. Transcription were made by writing all words that were said during the interviews but without the non-semantic signs, which means only the words were transcribed and not the sounds between the words. In the transcripts it was identified who said what, for example when the participant spoke and when the researcher spoke. Irrelevant information was not transcribed and all names and places mentioned during the interviews were removed. With consent from the participant all interviews were recorded with a dictaphone, and the audio from the interviews were only used for study purposes, and will not be heard by anyone unauthorized (Flick, 2014).

Ethical concerns
Since this was a qualitative research containing interviews in which people disclose sensitive information related with their patterns of drug use and their daily life to frame their perceptions and attitudes and motivation toward treatment, there had to be clear statement of the ethics surrounding the interviews. Ethical concerns are the confidentiality of the subjects participating in the study and that they know that their participation is voluntary (Flick, 2014). Each participant was informed that their participation can be terminated if and whenever they want, without any reason needed. All participants were informed that the material will only be used for study purposes and no names or descriptions of the participants will be published. To ensure that all ethical issues are covered we followed the ethical concerns proposed by the regional ethical committee boards in Sweden and An introduction
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*to qualitative research* by Flick (2014).

Particular attention was paid to (1) confidentiality, (2) voluntary, (3) possibility to withdraw consent at any time and (4) informed consent (Flick, 2014). The checklist on the webpage of the Central ethical committee board was used as a support for the ethical concerns for the handling of the personal information of the participants (Centrala etikprövningsnämnden, 2013). Those concerns was (1) Are there any personal data that will be handled in the project? (2) Is the handling allowed according to laws concerning personal data (SFS 1998:204). (3) What information should be left to the researchers? (4) Is there a consent to treatment according to personuppgiftslagen? (5) Request of data to be put out shall be done to every concerned authority. (6) If there is an attorney for personal data, he or she shall be informed of the treatment of personal data. If there is not the treatment shall be registered to the data inspection.

The interviewees were informed about the study and consent for participation. This information was given verbally and through an information sheet (see appendix B), with contact information, information about the aim of the study and how consent was given. Everyone was informed that their participation was voluntary and that their participation could be withdrawn whenever during the study if that was something they asked for. The aim of the study was to understand why heavy users are not in treatment. This was done through interviews about their perceptions and attitudes towards treatment. The study also focused on gathering information about if there was anything they wanted changed and if something is missing from treatment.

By consenting to participate in this study, the participant also consent to being recorded. As stated before no one will be able to identify the participants through the study, and the material will only be used for studies and nothing else. All participants were given a nickname that were chosen together with the participant. The nickname was used to keep their identity confidential also for if they want to withdraw their participation, they only have to state their nickname and their information would be removed from the study. Through the nicknames the participants will not be able to be identified and the answers they give will not expose their identity. In the study the participants will only be mentioned by numbers, this is because there might be a risk that someone has chosen a nickname that they commonly use in their daily life. Personal information that was disclosed during the interviews was also
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removed (Centrala etikprövningsnämnden, 2013; Flick, 2014). When the transcriptions of the recorded interviews were made, all names of people, cities and addresses were censored to ensure confidentiality. Individuals should be treated as autonomous agents and should be met with respect, this comprised how questions were stated so that the participant could feel comfortable to answer (Henriksen & Vetlesen, 2013).

Data analysis - Content analysis

Content analysis was applied to the data to find themes of perception and attitudes towards treatment. Questions that were asked to help answering the aim was for example, what is good with treatment, what could be changed and if there is anything else that is important for treatment to include. The transcribed interviews were read several times to comprehend its content, to make it easier to find categories later on (Flick, 2014). The important information from the transcriptions was summarized and then also coded and later put into categories which is part of the content analysis process (Flick, 2014). The transcriptions were in Swedish but were translated to English when used for the results. Quotes were also directly translated into English. From the codes, categories were formed, each category answering to the three objectives of the thesis. Some data was used for a description of each participant, their background, relationship to drugs and history of treatment, to give context to their opinions.

The first step in the process was to code data into categories, which gave a higher abstraction level and formed the groundwork of the analysis. While making the categories both the treatments mentioned throughout the study were treatments mentioned by participants during interviews. Categories that emerged from the coding that were made and stated under objective 1 were positive aspects of 12-step treatment, negative aspects of 12-step treatment, positive aspects of substitution treatment and negative aspects of substitution treatment. Cognitive behaviour treatment was made into one category as there were little information about the treatment from the participants. More categories were other information about treatment that collected information that could not be placed under a specific treatment category, motivation for treatment and after treatment care. Combination of treatment and participants in treatment were collected under the heading objective 2. Under objective 3 the categories were living and work situation which were combined into one as they were closely related and diagnostics. After the data was coded into categories, the categories and data was
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interpreted and patterns were analyzed.

The study will be organized with headings for objective and subheadings based of off the categories. For objective 1; 12-step treatment, substitution treatment for opioid users, cognitive behaviour treatment, other information about treatment in general, motivation for treatment, after treatment care. For objective 2; combination of treatment, participants in treatment and for objective 3; living and work situation, diagnostics and psychological, physical issues and self medication.

Results

The results are based of off the interviews with the heavy users. The results are organized under the objectives, and sub headings are based on the categories that were found through content analysis as stated in the method.

Descriptives

What follows are descriptions of each of the ten participant, when they started using drugs, how many and which treatments they have participated in. Also some of the drugs they stated that they had used are mentioned in their descriptives. The different drugs that the participants mentions are described in appendix C.

Participant 1.

Male, 35 years of age who started using drugs at the age of 14. He comes from a good family where no one had ever used drugs before, but they had some financial issues. He started to hang out with a friend, when he wanted to escape his home, which was when he was introduced to drugs and more specifically Stesolid (Valium)\(^2\). He has been using drugs since then, for example he has used, Benzodiazepines\(^3\), Subutex\(^4\), Lyrica\(^5\). He is still using Lyrica, Tramadol\(^6\) and Subutex, but said that he is using less than before, and he wants to quit. At the moment he uses drugs to get through the day. It was unclear if he had undergone any treatment before, but he was now looking to start treatment soon. He said that participating in treatment would be like a dream. He is at the moment homeless, and he is currently unemployed. The relationship to his family is not good but he wishes to get a good relation to

\(^2\) Valium (Stesolid)  
\(^3\) Benzodiazepines  
\(^4\) Subutex  
\(^5\) Lyrica  
\(^6\) Tramadol
them because he said they are getting older and we do not know for how long we live.

**Participant 2.**

40 year old female. Started using drugs at the age of 30, when she was younger she only drank alcohol and had tried Hash\(^7\). She had separated from her ex-partner because he had problems with alcohol but later she got the same problems. She started using Hash at first and later stated using Morphine\(^8\) and Subutex, because she felt she had too much responsibility and wanted to escape from reality. She is injecting drugs with syringes, and wants to stop doing that. She has been through two 12-steps treatments and she is trying to get into LARO. Participant 2 has now recently moved into a place to live, before she was homeless. Her relationship to her family is starting to get better. At the moment she is unemployed.

**Participant 3.**

35 year old male. He tried drugs the first time at the age of 12, hash and alcohol, and he started using Amphetamine in the 9th grade when he was 14 or 15 years old. He had a good life growing up with a stable family but started to hang with older friends who introduced him to drugs, he started taking Amphetamine and he said he loved it and it made him feel better about himself. He said that he also have used syringes and that the past year he has not used Amphetamine, Heroin or other drugs every day. Currently he uses alcohol more than other drugs. His parents separated and his father, which he lived with, did not notice that he was using drugs the first years. He went to his first treatment at the age of 20, and has been to nine 12-step treatments since, three of them were nine months long. One of the treatments offered CBT once in the week. He tells that he has a addiction personality, and suffers from many different kinds of addictions, like sex, food, and drugs. At the moment he is unemployed and also homeless. His relationship to his parents are good, he talks to his mother almost everyday. He is the only one in the family with a drug addiction.

**Participant 4.**

Male, 35 years of age. He started drinking alcohol at the age of 12 and started using drugs at the age of 18. He met a girl and they had a child, but when they broke up he did not get to see his child. At this time he was introduced to drugs. His main drugs have been, and still are,
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Amphetamine and Hash, but tells that he has tried most kinds of drugs, without specifying what kinds. He started using drugs to calm and numb his feelings of missing his son. He stopped using drugs for 1,5 year when he met a new girlfriend, she was an ex-addict, who he married. But when she had a relapse he also started to use drugs again. He has been through four to five 12-step treatments. At the moment he is unemployed and has been homeless for about four years. His relationship to his family he said was good, he is in contact with his eldest son, mother and brother.

**Participant 5.**

42 years old, male. In second grade in school, when he was 8 years old, he used to sniff glue and later tried some drugs at the age of 14-15. But he said that his so called real drug use started after the age of 18. He started with smoking Hash and later started using Heroin. He recently stopped using syringes and heroin, but still has a Benzodiazepines problem. He tried to stop, but relapsed after a few months. He has been through 12-step treatments, cognitive behaviour treatment and has also participated in substitution treatment, LARO, for his opioid use. He is at the moment homeless, and is unemployed since two years back.

**Participant 6.**

Female, 26 years old. Started drinking alcohol at 15, a year or two later she started with taking medication prescribed by a doctor, Benzodiazepines, but she said that her, as she calls it, real drug use started at 18 when she started using Subutex. She has used opioids since then and is starting LARO in the near future. Has been to a treatment facility with a 12-step treatment, and tried outpatient care. She has lost contact with many old friend and some family, but is still in contact with her mother and some other family members and she also has a boyfriend. She does not have any work at the moment, but she has worked before. Has a bright look upon the future, hopes for treatment and to go on with further education. She currently lives with her boyfriend.

**Participant 7.**

Male, 39 years old. Started with drugs at 13 years of age, alcohol, non-specified pills and Hash. Continued at 14 with other drugs, such as Amphetamine and later Heroin. Entered first

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9 Heroin
10 Opioids
Interviews with heavy drug users about drug treatment.

12-step treatment at 17-18 and has been through at least seven 12-step treatments both in outpatient care and at treatment facilities. Has also been through LARO treatment for 10 years until 3 years ago. Was free from drugs for 10 years, had work and a house. Now lives in a house, and is working towards entering LARO treatment again. Limited contact with family, mostly in contact with his mother. Has been through several resurrections after heroin overdoses at the hospital as a consequence of drug use.

**Participant 8.**
Female, 37 years old. Started using drugs as a 12 year old, started drinking alcohol and using Hash. She has only started using unspecified pills for her anxiety, panic attacks and sleeping problems in the later years, she has also used Subutex and Benzodiazepines. She mainly uses alcohol, Hash and pills for her psychological issues. She has taken part in several 12-step treatments, but she does not disclose how many. She is currently homeless and sleeps at shelters, the train station or in the public restrooms in town. She is still in contact with her children, her mother and a couple of siblings, and she is engaged to be married with her fiance. She is not able to work because of a serious physical injury to her back.

**Participant 9.**
Male 29 years old. Started using drugs at 12 or 13 years of age. Started using alcohol and Hash but later moved on to other types of drugs like Morphine, Benzodiazepines and other unspecified pills. Later he also started using Ecstasy\(^{11}\). He started with injections at the age of 17. He uses a lot of different drugs, but now mostly uses opioids. He is currently homeless and sleeps at the train station or in the public bathrooms around town. He has taken part in 12-step treatments before and outpatient treatment, but is now hoping for the substitution treatment from LARO. He has a long criminal record, and has been to prison once before. He has almost no contact with family other than his girlfriend and his brother. At the moment he has no job, but is hoping for some kind of employment in the future.

**Participant 10.**
Female, age 21. She started using drugs at approximately 12 years of age. She started using Amphetamine and has some other usage in the past of other drugs, but she said that her real drug use started at the age of 12. Wants to escape reality through the usage of drugs. Now

\(^{11}\) Ecstasy
Interviews with heavy drug users about drug treatment.

uses a lot of different drugs, Opioids, painkillers, Benzodiazepines and such. Has been through many 12-step treatments, though she never specified how many, and told that she was close to participating in other types of treatment than 12-step treatments but she opted out before the treatment started. The participant did not disclose any information about her family. She is also homeless at the time of the study.

Objective 1. What are the heavy users perception of treatment programs?


Five participants said that 12-step treatments helped them with insight into their addiction, and also into themselves. Participant 5 said that he learned from 12-step treatment that it is not his fault that he is using drugs, that it is an illness that he suffers from which has helped him to not feel bad about himself. Participant 3 said similar things, like it helped him realise he was an addict, and that the treatment was not completely wasted on him; “But it has given me a hell of lot of other things, I have gotten to know myself in a different way, and such.”. The same was said by participant 4; “(...) It has helped a little bit to get knowledge in myself and my own behaviour (...)”.

Participant 9 said that 12-step treatment was good and that he got good insight to himself and his addiction. The group he was in worked well together, but after that one time when he tried to get back into treatment he felt it was hard, he said; he later said, “I have been in a couple of times at SBC and a treatment facility but it only lasted a couple of weeks then i could not manage to finish it. It has like not been possible to come back.”. Participant 6 said that she felt that it was good that there is an option for couples to participate in treatment together. Participant 2 said she had tried couple treatment, this did not work for her, and separate treatment worked better. Participant 9 felt like he could recognize something in all the different participants even though some things were hard to go through. It was whole life stories that they had to tell but that is how it is in all 12-steps treatment and it worked well when in treatment, he continues; ”(...) no matter how different you were you could see yourself in everyone, it was a really good group and I thought the treatment (...) it nevertheless worked well there at the treatment (...)”. Three of the participants mentioned the religious aspects of 12-step treatment, participant 2 stood positive towards it and said that she did not mind the religious aspects.
Interviews with heavy drug users about drug treatment.

**Negative aspects of 12-step treatment.**

“It is good, I think that it works for some but it is far from something that works for everybody. Because it entails somehow that you need to have some kind of faith in something, (...)”

- Participant 6.

Seven of the participants said that 12-step treatment had not helped them with their addiction. Participant 9 said that 12-step treatment aimed at tough love but this did not work for him, this is also said by participant 6, who said they wanted to break you down to later be able to build you up again, this did not resonate with her, and neither of participant 9 or 6 thought this was a good way to go about treatment. Participant 6 said; “(...) Broke one down to later be able to build one up again, that i do not think is really fitting anyway. And i think that many have a bit hard for the 12- step way of thinking like.”.

Many participants have taken part in several 12-step treatments, like participant 5 who said that none of the treatments worked, he also said that if it did not work the first couple of times it would not work the next time either. Participant 8 said that right after the treatment was finished, she started drinking again, and like participant 3 who has had a continuous drug addiction since he was 14-15 years old and only stopped using drugs while he was in treatment but right after treatment finished he started using again.

"Like if I go to treatment, I get into the way of thinking. Yes but what the hell, it has given me a lot and all, just to realise that I am an addict and that I have this illness. (...) (...) but (...) it has not made me drug free."

- Participant 3.

Two participants saw the religious aspects of 12-step treatment as something negative, participant 6 and 9 felt like you had to have some kind of faith for it to work, and participant 9 said that he thought that it felt like a sect. Participant 4 mentioned that they had spoken about some kind of miracle with him; “That miracle they are talking about that would come when I was done I have still not found it (...)”
Interviews with heavy drug users about drug treatment.

In 12-step treatment talking in groups are a large part of the treatment, this was a problem for some, for example participant 10 who said that it depended on the group if she felt comfortable or not. Participant 8 said something similar, that she thought it would work better for her if the group was the same age as herself, and not older or younger. She thought it would have worked better if she was with the right people. Participant 2 said that she thought it was hard to open up in front of a group of people, since you have to tell your whole life story with both the good and bad. Participant 10 said that she did not like the part of 12-steps where they were supposed to go through their life story because her life story is stuck so deep inside her that she will not let it out, she has buried it inside her for years. She said; “(...) I have still not managed to do it, because i don’t do it. I can’t manage to do it. Because I have something i should tell, but you know they will never get it out of me.”.

Two of the participants said that the treatment leaders were somewhat important for the treatment to work. Participant 6 said she had been yelled at by her supervisor and participant 10 told that she did not feel comfortable with some of the treatment leaders. As participant 6 said; “(...) So I had a supervisor that was unbelievable mean. He started to yell at me at two different occasions (...)

Two participants talked about their experiences from outpatient care, which they had a negative experience of. Participant 7 mentioned that when he was in outpatient care, at a younger age, it was like going to a youth center because there was no treatment. He said; “There it was like an outpatient treatment you could go to. Like this every day for younger, younger people. (...). There were no therapy or like that but it was more like going to a youth center and then you went home.”. Participant 6 said that she changed her treatment for outpatient care, she said that she did not manage for long. She said; “(...) So I started to go to outpatient treatment instead (...) and leave drug tests there. (...). So it did not work for very long so but then I started taking drugs again (...).”.

**Summarization of 12-step treatment.**

12-step treatment seemed to be good at creating insight into the illness that addiction is. The religious aspects can divide people in what they think, as seen with three of the participants who mentioned this. The treatment leaders and the groups seem to affect the way people feel towards 12-step treatment. The other participants in the treatment can both help and do
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damage to how the treatment is perceived.

**Substitution treatment for opioid users.**

*Positive aspects of substitution treatment.*

There seems to be mostly positive thoughts about LARO treatment among the participants that mentioned it. Through substitution treatment two participants said that they could be able to get back to a normal life with family, work and a better living situation. Three of the participants were at the moment trying to get into LARO, participant 2, participant 9 and participant 7. One of them, participant 7, said that the drugs he got from the LARO treatment made the need for drugs go away which made room for other thoughts that were not about drugs. He was able to have a normal life, he said:

> “Because I know that then when I had it, during the 10 years I had it then, then I was drug free. I had a job, I had a house, I had a house in the middle of the city and had cleared with really, really good. so...”.
> - Participant 7.

But he also said that Subutex and Methadone are not miracle medicines that make everything fine.

Participant 6 said that she has realized that she will not be able to quit using drugs on her own so with the help of substitution treatment she would at least be using in controlled forms with doctors taking tests, doing drug analysis and controls. She said that out of two bad worlds this would be the least bad, and she thought that the program gets a lot of negativity, she said that if there was no substitution treatment there would be even more people using heroin in this town.

> “But at the same time I have realized that now that I do not quit anyway so and if I start at LARO it is for the first under controlled forms, you have doctors, you give tests, supervision, welfare officers, drug test, therefore there is control on things and you do not walk around and mix things but you stay like, clean and sober from everything else.”
> - Participant 6.
Interviews with heavy drug users about drug treatment.

**Negative aspects of substitution treatment.**

For substitution treatment to be prescribed there has to be documentation about previous opioid use, and participant 5 was put into substitution treatment but later had his treatment terminated because they realised there was no or not enough documentation. Participant 9 who also mentioned this said that “Otherwise you just have to get some more documentation, make sure to get caught for more opioids”. He shortly after said that he did not want to say too much. Participant 2 hoped that she had enough documentation, she said; “(...) otherwise I will quit anyways. (...). Quit using drugs. I will quit if I can't get in. I don’t have the energy to continue. But I have enough years so that I should get in.”.

Participant 5 said that LARO is good when it works, but he said that it felt like there were no doctors there who were specialised on addiction, which he would like, at least to have a contact person who maybe had a background in drug use.

“No one is really trained on addicts. They might be trained in psychology but (...) for example none of them have ever taken any drugs. It would be good to have someone like that as a contact person”.

- Participant 5.

He felt that they were playing with people’s lives. Two of the participants felt like LARO was the wrong kind of treatment for them. Participant 3 said that he did not feel good using opioid and that he has tried to stay away from it. He said that from LARO you get drugs that you get to bring with you. Participant 6 said that she never wanted to start with LARO to begin with because she felt that if she started, she would never be able to quit. But after a while she felt that she would not quit anyway and she said that at least LARO was use under control.

“(...) LARO, firstly it is under controlled conditions, you have a doctor, you take samples, supervision, curators, they are drug tests, like they are in control of things and you do not get around and mix lots of things, but you are just as clean and sober from everything else.”

- Participant 6.

Participant 4 thinks that they, at LARO, give too high doses of a drug that he is already using and if he would misbehave and get kicked out, he would be left in the streets with an
addiction worse than when he started there.

“(…) I denied that [LARO] because I, to start, I’m already on one of the drugs they supply so that feels all kinds of wrong (…). In addition to that I am on a much lower dosage than what they put you on. So if i were to mess up and get kicked out, then I am on the street with three times the addiction than what I had before.”

- Participant 4.

Not all participants think that LARO is a program for everyone. Participant 5 and 7 both said that young people should not go to LARO. Participant 7 said that young people have not ruined their brains yet and that some other treatment would be better for them. Participant 5 said that “(…) the health care in Sundsvall is crap”, he continued with that the people who need it do not get it and the ones who get it do not need it. Participant 5 was critical because young people who had an addiction to opioids get subutex instead, which is a similar drug. He said that “(…) it is a substitution for us that has had a problem for thirty years, so that we can get a normal life.”.

One of the few setbacks for LARO seems to be that it does not work for polydrug users. The participants that are trying to get into LARO have said that they were trying to only use Methadone and Subutex. One participant had been told that it could be dangerous for him to partake in substitution treatment when he was using other drugs than opioids. Participant 5’s treatment was terminated after he confessed to have used other drugs than opioids during treatment. Many drug users in Sundsvall are polydrug users as seen in the description of each participant’s, which means they use several kinds of drugs.

Before people are accepted into the substitution treatment they have to leave tests that should show that the person is only using opioids. Participant 6 said that she was in the phase of leaving tests and was using opioids only, during this time she did not get the opioids with a recipe from the hospital and she need to find it on her own, which could be a problem if the police caught her. She needed to have the opioids in her system to be able to get the treatment but if the police would find out that she had drugs in her blood or with her when they caught her she would get sentenced for a crime. That would make it complicated for her since she had to have opioids in her blood but still have to get them in an illegal way.
“But I will have it in me so it is like a collision there like. It should be some form of a certificate or some form av something, that says that -that it is okay that I have those substances in me. Then if it is something else of course it is a crime but... you should not need to walk around and worry about that thing during the time you are trying to come in”.

- Participant 6.

**Summarization of substitution treatment.**

Substitution treatment enables the people who participate to live a normal life, with employment, driver's license and such. A better living situation. What seems to be a flaw from what the participants told, was that it is not for everyone. For example polydrug users are not allowed to participate, since mixing other drugs with the medicine can be dangerous. Another problem that was brought up was that when trying to get into the treatment you still had to buy drugs illegally which could cause problems with the law, while you are trying to make your life better.

**Cognitive Behaviour Treatment.**

For CBT treatment there is a wait between one to two years, said Participant 9. He said that he felt like having someone to talk to was important. He said that this person did not have to be a psychologist.

“If you look through the county council for CBT treatment there is a wait for between one to two years, for a couple of conversations and I feel that I have not really had the patience for that. (...). Things that help me is finding someone good to talk to, someone you trust (...).”

- Participant 9.

Participant 10 said that she would like to receive CBT treatment but that she was instead put into 12-step treatment while being put under compulsory care. Participant 5 said that at one treatment facility he received CBT treatment, which he felt was good, he said; “(...) there they had CBT and I like that, because then you really get to work with yourself and your problems and find solutions to... how I should manage my anxiety.”.

**Other information about treatment in general.**

Three participants were sent directly to treatment without any real detoxification and all three
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Participants said that they started to feel bad while in the treatment. Participant 2 said that it is a must to go through a detoxification, as she uses Subutex, because a detox from Subutex is about 67 weeks long. Participant 6 said she did not understand how they could send her to treatment without a detoxification first. Participant 7 said that after a few weeks after being kicked out of substitution treatment, and trying to detoxify from methadone, he broke down and started using alcohol and drugs again and later he got back into Heroin.

“(…) Methadone takes about, well you have to feel like that for a year and after a couple of weeks, a month then you’re broken so… you think well i’ll just keep going. Then I started using alcohol and pills. A lot of alcohol and pills, but then that did not work so I had to go back to heroin (...)”

- Participant 7.

De-escalation of drugs was one of participant 6 request when going to treatment, she did not receive adequate detoxification and no de-escalation at all, but was sent into treatment right away.

“(…) sent directly to women’s treatment instead. (…) I was still not detoxified, I was not clean in any way. So i came there and stayed for two days at the women’s treatment, at that house, later I became really ill (…).”

- Participant 6.

This ended with her leaving treatment and trying outpatient care instead. Participant 5 also told about a de-escalation of drugs that he thought was all too short, he got a de-escalation of four days when he felt he needed more.

**Motivation for treatment.**

Many of the participants spoke about motivation, participant 1 said that his motivation for treatment was that he later might be able to find somewhere to live and also get a better relationship with his parents, he said “(...) If i go to treatment, so okay yeah it is good but, okay i will get an apartment (...)”. This was also similar to participant 6’s motivation, she wanted to be a rolemodel for her sibling and that they would have a better relationship. She also felt like she had different ambitions now than she had before, and that the support she
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had from family and friends were helping her a lot. Other participants also had similar motivations, a better living situation, better relationship with family. Participant 2 said that she did not have the strength to go on with her drug use anymore, she wanted to quit now. Participant 10 and 8 said that they did not want to quit. Participant 10 said that she did not have the motivation to quit either. "(...) I feel that I am not going to stop using drugs, I do not want to stop using drugs (..)", Participant 10.

Three of the participants felt that they had a good support from their families. Participant 3 said that; "I have the world's greatest mom and dad too, and so yeah. And so it is that yeah, I shape up a bit. (...) They shine like the sun even if, just if I stick to drinking (...)". Participant 6 said that she has a good boyfriend who wants her to be sober and is trying to support her and bring her up instead of down.

**After treatment care.**

Three participants have experience of lacking after treatment care. Participant 9 said that he was let out into the streets without any after treatment care; "(...) I was released here in Sundsvall, without after treatment care (...), just released right out, the only thing I had was community service (...)". Participant 5 said that a diabetes patient who would not be able to handle his or her medicine would get help from a nurse that would come to the patient's home and check their blood etcetera, they do not tell that person that they can not get their medicine because they can not handle it. That happened to participant 5 when he told the doctor that he took other drugs than opioids, after that he got kicked out of the treatment program.

**Summarization of objective 1.**

The participants in this study have divided thought about all three types of treatments that they have mentioned. Both positive and negative aspects of the treatment was brought up by the participants. Most participants were still motivated and positive towards going into treatment. There was some who stated that they needed more aftercare.

**Objective 2. What do they want from treatment**

**Combination of treatment.**

The participants were asked what they would like treatment to be like, some wanted a
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combination of different things. Participant 7 wanted a combination of substitution treatment and 12-step treatment. This was similar to what participant 5 stated, a combination of medication and treatment. He thought that AA and NA were a good thing but he also said that they had not helped with his addiction but that a combination of treatment and medication might work. Participant 5 also said that he once stayed at a treatment facility where he received both medication and CBT which he felt was a good combination. Participant 3 felt like there were not many options for treatment and that he wanted to try something other than 12-step treatment. In connection to treatment, participant 2 said that there should be better collaboration between treatment and different authorities.

Participants in treatment.
Two participant said that there should be separate groups in treatment for younger and older people. Participant 8 said that she felt like she was in the wrong group when she was placed with two elderly women and the rest were at the age of 18 and focused more on their make up and about meeting boys. Mixing older and younger people was also an issue for participant 7 who said that if a young guy would come to treatment with a group of older people, he would learn so much that he would be a full-fledged drug addict when he leaves the treatment. “(...) In treatment then it can be when a young guy comes... has barely done anything, and when he leaves there, then he knows everything he needs to be a full fledged narcoman.”.
Participants 6 also stated that having separate treatments for women and men would be better than mixing them.

Participant 7 felt that young addicts should not partake in LARO treatment since he felt that the drugs had not affected their brains as much as a person who had used for a longer time. Participant 5 also felt that LARO should be aimed more towards older drug addicts, that it should be for people who have had an addiction for several years who are trying to get back to a normal life.

Summarization of objective 2.
Most of the participants in this study wanted treatment, but some were not in treatment at the moment because they wanted some other treatment that they did not receive. As said some participants they are looking for combinations of treatment, such as substitution with 12-step like treatment and one mentioned better collaboration between authorities and the different
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treatments. There were also some participants looking for treatment with people that were like themselves as in age, gender and alike. This was some things that the participants to make treatment more attractive for them.

Objective 3. Life-areas requiring care attention

Living and work situation.

Seven of the participants were currently homeless and they were hoping to somehow be able to find some kind of living situation. Participant 1 is currently homeless, but the treatment he was going to start is at a treatment facility where you live during treatment. Participant 2 said that work and a living situation was important after treatment.

“(…), if the person has been to prison for example, (…) try to put that person to work then, and make sure they have a place to live then they might not end up there again. The risk is overwhelming, and to end up with your old friends, when you do not have that safety.”, Participant 2.

Participant 9 thought that there should be more focus on making sure people had somewhere to stay during the nights; “I think that they should help people who are homeless to a greater extent. It does not have to be real housings, but they can expand the shelters (…)”, participant 7 also felt that there should be more shelters.

For some of the participant, working was also important. Participant 9 told that the longest time he was free from drugs was during a two year period when he worked. After losing his job he slowly drifted back into using drugs. Participant 5 said that work was essential for him, he wanted to combine substitution treatment with work so that he was occupied during the days, to not be restless at home. Participant 2 said similar things that as soon as she got into LARO she would find a job and participant 7 also said that he needed to have some kind of occupation, so that he could keep himself busy during the days. Though participant 3 said that before starting to work he would need somewhere to live, since at the moment he stays at the train station during the night and that would not work out. “Come to a job, “Where do you live?”. Well I am homeless… No one wants a homeless person, like what are they thinking?”, Participant 3. Participant 4 also felt that it was important to have some kind of work and somewhere to stay; “Home and work are a prerequisite for being able to stop, it's
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just that. No one can manage to stop on the street.”.

Diagnostics and psychological, physical issues and self medication.

During the interviews many of the participants spoke about diagnoses. Participant 1, 3 and 7 were all diagnosed when they were adults. Participant 5 thinks that he has got ADHD but he had not been diagnosed yet. He said that the wait for an evaluation for a ADHD/ADD diagnosis is two years. He said that he had to wait, wait and wait, since it is about people's lives this was not good, he said that people waiting for evaluations might turn to self medication which is dangerous and may lead to a person’s death.

“But so I think it’s a shame this with care, (...) I had got the diagnose ADHD and ADD mix and i got a diagnose (...) They are really slow with those things. It is not good. But i am happy that it is not like that when it comes to children. They check children really well.”

- Participant 1.

Participant 5 also said that people die before they get any help; "(...) it is human lives, they self medicate, they die. Yes you almost die every time before you get any help in this town.”. Participant 8 spoke about her psychological issues for which she has been taking medicine for for about 12 years, anxiety, sleeping issues and panic attacks, she does not know what these issues stem from since she said she never received any kind of investigation into these problems. Participant 4 said he was only 15 years old when he got diagnosed with psychopathy, he felt like he already knew that he could not be a psychopath because he could feel empathy, so after that he felt like he could not trust psychiatry anymore.

“I find it really hard to trust the psychiatry and psychology and so. Since they gave me the classification Psychopath already when I was 15, and I knew then already that I am not. I am not empathyless at all. (...) For a long time I thought i was and then I acted after that”

- Participant 4.

Eight participants told about their psychological issues, 6 of these were suffering from anxiety or anxiety attacks, some also told that they were depressed and did not want to live anymore. Participant 10 said that; “(...) It is a bad psychological feeling like, should we take
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our life, should we go and die, but it is just destructive like and it is like - you feel like it will not last for long. Because you do not have the energy forever, you are just human.". Some of them had these issues before they started using drugs and some have them as a consequence of their drug use. One of the participants had issues with sleeping when he was not taking drugs. Participant 4 also told that he was using drugs because they help him focus "(...)it becomes quiet in my head (...)."

Many of the participants have had some physical consequences. Five participants suffer from Hepatitis C. One of the participants said that he did not receive any treatment for his Hepatitis C since he was an active drug user. But he could not quit using drugs without help, which he felt he did not get. That a person's body takes damage is one of the reasons for why participant 6 would like to stop using drugs. Participant 4 said that his kidneys do not work as they should and that he had injured a blood vein so the blood supply was not as it should have been.

Seven participants said that they use drugs to, in some ways, self medicate. Participant 9 and 10 said that they have chronic pains that the drugs help to relieve. Participant 9 even said that since he started using painkillers he became a straight through opioid user. Others said that they suffer from anxiety and other psychological issues which the drugs help with. Participant 4 said that he uses Subutex to help get rid of the feeling of need for other drugs. Two participant said that they use illegal drugs to cope with ADHD or ADD. Participant 10 also said that she uses some drugs because of her mental and physical health; "(...) I take Subutex to get well, Benzo for my bad mental health, but they are not helping anymore, because i have such a heavy mental health and the pills are too weak for me (...)"

Summarization of objective 3.
The participants said that they feel like there is more than just a good treatment that is necessary for them to be able to leave the life of heavy drug use behind. A place to live in, a work or some kind of daily activity and care for their diagnoses or bad health was some of the things they thought would help.

Discussion
The result of this study are findings on why the participants of this study are not in treatment
and what their perceptions and attitudes towards treatment were and how they would want treatment for drug users to be like. The findings in this study indicated that all people are different and have different needs going into treatment. There are both positive and negative aspects to all the treatments mentioned by the participants but most participants felt motivated to try treatment again. There were some thing they felt was needed to succeed in being drug free after treatment. The discussion is based of off the results from the content analysis and is put in context with the help of the theories and previous research stated in the introduction.

**Objective 1. What are the heavy users perception of treatment programs?**

Similar to the findings from an earlier Swedish study by Carlsson et al. (2009) some participants said that they felt like the 12-step treatment was only a kind of group discussion while others felt like it was actually a type of treatment. 12-steps treatment are used for drug and alcohol related problem and is one of the most common form of treatment in Sweden with the aim to give insight into the negative consequences that come with drug or alcohol use (Sivertsson, 2015; Ekeroth, 2014; Rundgren 2016; Socialstyrelsen, 2017a). 12-steps treatment lead to some people having more insight into their problems and a realization that what they have is an illness, but none of the participants in this study has been able to leave their drug addiction behind with the help of 12-steps treatment. A need for more than just 12-step treatment alone is evident, and many started to use drugs and alcohol not long after they left the treatment. The 12-steps treatment is mostly done in groups and with a drug and alcohol therapist, the treatment is based of off AA and NA treatment (Socialstyrelsen, 2017a). One thing that was found through this study, was that some felt it was hard to open up in front of a group of people they did not know, and if they can not open up and participate in the group treatment it could be hard for the treatment to work at all. The therapists in the treatments are important for people to feel comfortable and for the treatment to work well. If the participants in treatment feel that the therapists are not treating the participants well or if a participant is not comfortable with the therapist, this could lead to people dropping out before the treatment is finished, as some participants in this study stated. It could be an important factor that lead to poor effects from treatment.

Pollini et al. (2006) found that the most common reason for drug users not to seek treatment was because they were not ready or that they did not see their drug use as a problem which is
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similar to the results in this study. Some of the participants did not want to go to treatment or stop using drugs while others found it hard to open up in front a group of unknown people, which can mean they felt that they were not ready for treatment but also that they were looking for other options of treatments. Six of the participants had at some point dropped out of treatment prematurely and that is similar to the study of Stevens et al. (2015) where they found that participants dropped out prematurely of detoxification programs because of low patience. The reason for these participants dropping out of treatment prematurely could also be because of low patience. It could also be a combination with lack of motivation and low patience which is what Wallin (2009) found in her study. A feeling of being under pressure and that the society has expectations on a person to become drug free could make people want to drop out. As said while in treatment the expectations was raised from parents and close friends, because they had hope for the person to live a drug free life.

The fear of disappointing people close to them could cause pressure, which might lead to dropping out early, as seen in the results. This is something that also could be explained with the strain theory that Robert Merton (1938) developed, when a person feels the pressure from society, and they do not have the means to reach that goal, they react (Robert Merton, 1983; Sarnecki, 2009). Some cases could be explained with retreatism, that the person rejects society's goals and the means to reach them, and that the person then turns to drugs as an escape from that pressure (Robert Merton, 1983; Sarnecki, 2009). Drug use can be a way of coping with the situation a person is in and to relieve the strain that society puts on them. It can also be explained through the general strain theory (Agnew, 1985; Agnew, 1992). When a person is met by the expectation of negative stimuli, the disappointment from family or friends could make a person want to escape before the negative stimuli actually happens, which could lead to a return to drugs as a mean to cope with this strain (Agnew, 1985). This can explain why some of the participants are not in treatment but also why some drop out of treatment before finishing it.

Participants who had or wanted to try LARO were mostly positive towards it, and believed in the treatment. Faith in treatment can make people more willing to go into that kind of treatment which connects back to Bobrova et al., (2006) who stated that people did not go into treatment because they thought it was not effective. Wallin (2009) found in her study that important factors for soberness are the level of motivation and belief in their ability to end
Interviews with heavy drug users about drug treatment.

their addiction. Similar to that, this study found that those participant who were positive to a life with substitution treatment had goals that they wanted to start working towards, some had a place to stay and just wanted to live a normal life. As stated in the results one participant had substitution treatment for ten years and was during that time able to have a job, a house and lived a normal life.

Since the treatment made the need for drugs go away it leaves room for other things not concerning drugs. According to Socialstyrelsen (2015a) that is exactly what the treatment is meant for, people with opioid addiction receive medicine in order to be able to handle their drug addiction and are supposed to be able to live a normal life. Even though starting LARO might feel like it would lead to a harder time quitting drugs, some might feel that they would never quit anyway. That might make LARO a better choice of treatment, since it is under controlled forms. Going into LARO treatment could be a help to connect back with conventional society, since people in the treatment are able to work while in treatment. This might help relieving strain that was caused by being alienated by conventional society (Merton, 1938; Sarnecki, 2009). Also it gives a person greater opportunity to create new social bonds through commitment and attachment through work and people living conventional lives (Hirschi 2009; Sarnecki, 2009).

When using other drugs than opioids during the substitution treatment, the participants treatment is terminated. Polydrug use, mixing opioids with other drugs, for example amphetamine or hash, is dangerous and could get a person killed which seemed to be the biggest reason for people having their treatment terminated. Both by confessing to using other drugs, that might not appear on a urine analysis, and getting back a positive test can lead to termination of treatment.

After a relapse it is not uncommon to terminate treatment, as a relapse during treatment might disrupt treatment for others participating (RFHL, 2008). When the treatment is terminated, because of a relapse, the idea is that the treatment should be resumed later. The participants that relapse need help and the right help is not to exclude the participants from treatment but to find the reasons for the relapse and try to solve them (RFHL, 2008). This is a problem that seems to occur in both 12-steps treatment and LARO. The risk of getting kicked out with a bigger addiction than before was one of the reasons behind not going into LARO treatment. The doses that LARO gives are higher than the doses some of the participants use of Subutex.
As the detoxification for Subutex is about 67 weeks it might be intimidating for some drug users especially if they think that they will not handle detoxification on their own. In a study by McKeganey et al. (2004) 56.6% of their participants wanted the treatment to ease their withdrawal, this strengthens the results of this study. Some drug users might not want to go to substitution treatment because they are afraid that their addiction would become bigger after terminated treatment, which could cause worse withdrawal than before.

Only one participant had ever received CBT treatment but several wanted to try it as they had some faith that CBT would work for them. As stated before perceived low efficiency has been a factor in not seeking treatment, CBT seemed to be perceived as something that might work which made the participants willing to try it (Bobrova et al., 2006). But among these participants it seems as though not many had been offered CBT as an option. One participant said that she was going to receive CBT at one point and one participant said that CBT was a weekly element of his treatment, which he appreciated. Being able to work with your issues other than drug use, could be important in the recovery. As one participant stated that it was good being able to work with yourself. As stated one negative aspect of 12-steps treatment, is that it included group therapy which could mean that CBT could be a better option for those who have issues with treatments in group. One problem is that the wait for CBT treatment is between one to two years and for people with low patience and/or a poor life situation, with a destructive personality it might be hard to wait for that long. Especially with a heavy drug use and a situation where they do not have a place to live, which is common for people with a drug use who live for the day and do not know if they will survive until the next.

Not being offered proper detoxification while trying to stop using drugs might be a problem, as some of the participants stated that they felt that this was important. This seemed to be something of huge importance for three of the participants who mentioned that they had been sent to treatment without a detoxification. Being sent to treatment without detoxification could be a reason for people not being able to complete treatment, they felt sick and feel that they did not receive the help they needed. In Sweden there are approximately 26 000 people who can be defined as heavy drug users according to CAN (2014) and according to Folkhälsomyndigheten (2017) there is detoxification treatment in Sweden, but there is very little information about it to be found. Because of that it is hard to know if there is enough detoxification facilities and if there is enough help for the people who need it.
Interventions with heavy drug users about drug treatment.

Even though many negative things were brought up about treatment, most of the participants were motivated to try again. Some wanted to try a new kind of treatment and some wanted to go back to something they had tried before. From these results motivation to re-enter or start treatment seemed to be reconnecting with family, support from a partner and having a more decent quality of life. This is in part supported by previous research by Storbjörk (2009), and by Wallin (2009) who said that negative incidents related to family was a big factor leading up to treatment and that people in treatment found their motivation in a wish to stop hurting the people close to them. In a study by Carlsson et al. (2006) personnel from an open and a closed 12-step treatment expressed the importance of motivation of the clients for better results from treatment. Also through social bonds theory, the bonds to family is important when trying to stay away from delinquency (Hirschi 2009; Sarnecki, 2009). The bond, attachment, to family is very important as strong family ties can help with choosing a good path in life, and maybe help to turn away from illicit drugs (Hirschi, 2009). Even though 12-step treatment is one of the most used treatments, it does not seem to have especially much faith among drug users, even though it can help create some insight into drug addiction as an illness and such, it did not seem to attract these participants anymore. For the people that it works for, it is good, but the ones that it does not work for need something else. As one participant said, if it did not work the first couple of times how would it work any other time. Bobrova et al. (2006) brings forth the issue of people perceiving treatment as to having low efficiency as a factor for people not entering treatment, which is also shown in this study's results.

After treatment care and drug users not being offered it was an issue raised in this study but also by Socialstyrelsen (2015b) that wrote in a report, that there is room for improvement when it comes to after treatment. Socialstyrelsen (2015b) wrote in their report that 40-80% of those who try to get sober had a decreased risk for relapse within the first 12 months after finished treatment. Those numbers should be a reason for persons to get after treatment care.

The different attitudes and thoughts towards treatment can come from different needs for each participant, some felt like they needed medicine to help them out of their addiction and some felt like other ways may work better for them. This is similar to what Van der Poel et al., (2006) found in their study. Different people need different things, some need treatment,
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some need care, others need both and some do not want either one. It may also come from different motivations and belief in the person's own ability to end their addiction as shown in a study by Wallin (2009). Some have more belief in themselves to be able to end their addiction and they may not feel the need for treatment as much as others. While some find their motivation in a wish to not hurt the people close to them, and these people may find themselves turning to treatment.

Objective 2. What do they want from treatment?

As stated by one participant, who felt that the doctors in substitution treatment lacked knowledge, “(...) they do not have the competence (...)”, surrounding drug users and that is something that Socialstyrelsen (2015b) also wrote in a report. Socialstyrelsen (2015b) have found that there is a problem, the knowledge in the area of addiction is only a small part of many educations among professionals that work with people with heavy drug use, those professions are for example, doctors and psychologists (Socialstyrelsen, 2015b). This is similar to what Van der Poel et al. (2006) found in their study which was that in order to help drug users, qualified staff in addiction care is needed. Also having better collaboration between different treatments and authorities is important as stated by one participant.

Combining different treatments was something that was brought up during the study and one participant wanted there to be a combination of 12-step treatment with medicine, since he liked AA and NA, but felt like there was a need for something more. Another participant mentioned that he would like to combine CBT with medication. Also as there seems to be a problem with polydrug use and getting LARO treatment terminated and then not getting any other help after that. Also as seen in the descriptives many participants use both narcotics and alcohol and it was unclear if they were treated for both types of drugs at the same time. Those who had undergone LARO did not get any treatment for alcohol through LARO, but they also never stated if they had other treatments at the same time for their alcohol use.

Treatments efficiency seemed to be affected by the other participants in the 12-step treatment group, not feeling comfortable might lower motivation to stay in treatment. Being able to relate to and understand the other participants could help keep motivation up to be able to complete treatment, just as one participant stated. Also having the participants close in age could both help the participants to relate to and understand each other. Having younger
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People in separate groups could prevent them from learning new things and from making them more fully-fledged in their addiction, as one participant stated. There was also some critique surrounding young people going into LARO. As one participant stated, who felt that LARO should be for people who have had a problem for several years and wants to have a normal life. Another participant also stated that the young participants in LARO should try some other drug treatment first, since he felt they had not harmed their brains as much yet.

Feeling a connection to the people in treatment may help the effectiveness of the treatment. This may be connected to social bonds theory where you have an attachment to other people and activities where for example treatment could be a type of involvement, the participants in treatment are trying to leave addiction behind. By having the connection to the treatment as an engagement, this may be a part of getting a more conventional lifestyle (Hirschi 2009; Sarnecki, 2009). This could also be connected to the attachment bond, people in treatment, working towards the same goal, leaving drugs behind, may be a good support during treatment, where everyone in the treatment are trying to reach sobriety (Hirschi 2009; Sarnecki, 2009).

What the participants are looking for in treatment is more competence, which also is what Socialstyrelsen (2015b) states. A lack in competence and lack in co-operation between different treatments were something that was brought up in this study. As some participant stated they wanted a combination of treatments, CBT with medicine, medicine with a 12-step like treatment. Some of the participants said that the groups in treatment affected them, as one participant stated in a good way, that the group made him feel comfortable. Others said that it was not a good idea to mix participants of different ages, since it was hard to relate to each other and that the young ones learned tricks from the older addicts, which did not help them leave their addiction behind. Attachment to other people in treatment working towards being drug free and having the involvement in treatment may help when trying to reach the goal of being drug free (Hirschi 2009; Sarnecki, 2009). As one participant mentioned that one group that he felt he could relate to was a good group in treatment.

**Objective 3. Life-areas requiring care attention.**

Several participants said that they mostly wanted somewhere to stay, a roof over their head. Having somewhere their children could stay and visit and an expansion of the shelters so they
had somewhere to stay during night. Through treatment some hoped to have somewhere to stay, during and after treatment, like an apartment. The participants wanted help in other areas than just drug addiction which is also shown in a study by Van der Poel et al., (2006). With a place to live they thought that they could also start working, but without a place to stay the thought of working was hard. Feeling like no one would hire a homeless person and using drugs to cope with being homeless becomes a vicious cycle. One participant said that he would never be able to live like he does now, homeless and without some kind of work, without using the drugs. Without connections to conventional society it is hard to live conformative life. According to social bonds theory these people are living without a current connection to the commitment bond, which involves employment (Hirschi, 2009; Sarnecki, 2009).

As explained in social bonds theory this might make it harder when wanting to come back into conventional society, as some felt like without a place to live there was no way they would be able to have or get an employment, which makes the commitment bond hard to attain without somewhere to stay (Hirschi, 2009; Sarnecki, 2009). Which also makes a living and work situation important, as sated by the participants. People with a heavy drug use, without a home or a job, may connect with or feel attachment to people they feel comfortable with, which could be other people in similar situations. They become each others social network and they involve in activities together to make money for example or to find drugs, as stated by one participant. Their life experiences can give them negative attitudes toward the society and authorities as in the belief bond. This type of living can be explained, but also supported by the social bond theory (Hirschi, 2009; Sarnecki, 2009). With housing it would be easier to get back into society, be able to keep a job and live a normal life. Obstacles also lead to strain as mentioned in strain theory, by not being able to reach the goals of the society a person is put under strain (Merton, 1938; Sarnecki, 2009). Some have rejected the society’s goals, for example retreatism, and use drugs as a way to cope, others are trying to reach more humble goals as in ritualism, they just want somewhere to stay and to have something to do during the days, as a way to keep busy (Merton, 1938; Sarnecki, 2009).

Psychological issues and diagnoses were common among the participants. Being diagnosed earlier and get help earlier, might relieve issues that arise during the younger years, as one participant who was diagnosed with dyslexia quite late, could have benefited from being
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diagnosed earlier. Another felt that since he was an adult they did not diagnose him in time with ADHD/ADD, but he felt that they worked quicker when it comes to children which he was positive to. Diagnosing people and giving them the help they need is important, since without the help those people might turn to self medication and risk their lives. Receiving proper evaluation of the causes behind conditions like panic attacks, anxiety and depression are important. As one participant who suffered from both anxiety and panic attacks, which she treated through medication, never received any kind of evaluation into why she was suffering from these conditions. Many others were suffering from similar issues like anxiety and depression, suicidal thoughts and self harm. For these issues several of the participants self medicated. If the participants would get help with all these issues in drug treatment it might be easier for them to stop using drugs and reach their goals.

Other issues were physical, like their bodies taking damage, like the bloodstream not working correctly, kidneys being injured and hepatitis C. These issues all come from drug use and people who continue using drugs will keep getting worse if they do not get the help they need. As stated before one participant said that he did not receive help or treatment for his Hepatitis C since he was in an active drug use. This is also a big issue since many participants felt that they did not get the help or treatment that they needed to become drug free, which means that other treatment and care is lost because of that. That a person has to stop using drugs while in treatment for hepatitis C is also stated in Vårdguiden (2015).

As seen several of the participants use drugs as some sort of self medication, some use it for pain, and some use it for psychological issues and alike. Self medication, for some started after getting a prescription and that they later continued to use substances alike to continue their medication and others are using it to relieve anxiety. Just as general strain theory drug use can be a way to manage a negative stimuli, which anxiety, depression and such issues could be interpreted as (Agnew, 1985; Agnew, 1992).

That the people want help with more than just drug addiction is also reported in previous studies by Van der Poel et al. (2006), some drug users, people who are in both treatment and addiction care, want help in other areas not connected to drug addiction. Which might be needed as seen in these results, addiction might only be a symptom of something else, a way of coping with other issues that need care and attention.
Conclusion

The results showed that not being in treatment was something two of the participants chose, they did not believe it would help them, but other participants were motivated to try again and seemed to be inbetween treatment when interviewed. Mixed feelings about treatment is found throughout this study, even though most participants still were motivated to try treatment again. The participants showed that they are searching for a more individual based treatment since they did not feel like the treatment that they were offered worked for them. 12-step treatment being one of the most common treatments for addiction got mixed reviews, some felt like it was good for the people it worked for, but that it did not work for them (Sivertsson 2015; Ekeroth, 2014; Rundgren, 2016). Many of the participants had been through several 12-step treatments and felt like they did nothing for them, except give them insight into their addiction and that addiction is an illness.

Motivation was found to be important for the participants and even though some of them had bad experiences from treatment they seemed to have motivation to keep trying to reach for a drug free life or at least try other types of treatment that could help them to become drug free. That is similar to what other studies have found, that motivation is necessary to become drug free (Carlsson et al., 2006; Wallin, 2009). So even though there were mixed feelings about the treatment that exist today, most were still motivated to try again.

Getting more than just help with drug use was important for the people in this study. This was an important finding, showing that many felt like they needed somewhere to stay and some kind of employment both during and after treatment. As after treatment care should be a part of treatment this is important to bring up in this study. More individualised treatment for the individual was also something that came up during the study. Also a need for more co-operation between authorities was sought for.

Strengths

This study raises the opinions of people who have participated in drug treatment, their concerns and thoughts. This study shows there should be some evaluation surrounding the addiction care, both in treatment, aftercare and other sections like housing and employment.
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This study can be used as groundwork for future research in the area.

**Limitations**

Limitations of this study were that not many of the participant have been through CBT, so some statements about CBT is assumptions from the participants themselves. Also there might be differences in selection of treatment depending on locations in Sweden. This study only shows one side in this area, which could make it angled. This study is also a small qualitative research which makes it not generalizable (Flick, 2014). As this study is focused on the participant's perception and attitudes towards different drug treatments, they are only speaking on treatments they have heard of and participated in. The General Strain theory is a broader and the latest version of the strain theory and even though it is applicable to the results of this study it is important to have in mind that the theory is still evolving and needs to be realized and further research. The theories chosen for the study can not explain the attitudes that the participants had towards treatment, the theories were used to support the need for some parts of treatment that the participants mentioned.

When the context of the interview situation is removed, the meaning of what is stated may be interpreted differently by the reader (Edvardsson, 2013). As the interviews were made in Swedish all quotes have been translated to English, which can create some involuntary alterations from the original statement (Cassinger, 2014). As this study is recounting statements from people who have been interviewed, and then transferred into text, there might occur some errors in the recounting and interpretation of statements (Edvardsson, 2013). Even though it has all been directly translated from transcriptions from the interviews, it is important to address this risk.

**Future research**

Further research in the area of addiction treatment is needed. There should be more research into what people with addiction feel about treatment and surrounding areas to help drug users get back on their feet. There should also be some research in the effects of each treatment and research into how well these bigger treatments like LARO, CBT and 12-step treatments collaborates to make the addiction care as good as possible, and also co-operation between different authorities to help with better care.
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Interviews with heavy drug users about drug treatment.


Interviews with heavy drug users about drug treatment.


Appendices

Appendix A.

Interview guide

Interview guide

GUIDE FOR SLINK IN INTERVIEWS

- When and how did you start to use drugs?
- Since you started until now, have you been using drugs all the time or have there been periods in your life in which you were not using drugs?
- At the beginning, when you started, what type of drugs did you use?
- Are you still using the same type of drugs today? (If not...) What drugs do you use today?
- Where in the town do you usually buy these drugs? And how do you do it, I mean do you buy once per day for the whole day or do you go and buy several times in the day?
- Tell us about how a normal day for you is, from when you wake up in the morning until you go to sleep...
  - Morning
  - Lunch
  - Afternoon
  - Dinner
  - Night
- Do you have people with you or do you do everything alone?
- What would you say are the good things in your life; And the bad things in your life?
- Have you ever considered to stop using drugs?
- What type of information have you gotten about treatment? Where did you get this information?
- Have you ever participated in treatment or rehabilitation?
  (If yes...)
  - What kind of treatment or program did you participate in?
  - Did you complete the treatment/program?
  - What did you get from the treatment? Did you learn anything? Did it change anything in your life?
  (If no...)
  - Have you ever considered participating in treatment? (If no...) Why not?
  - What would you like to see changed in the treatment/rehabilitation programs that would make it more attractive for you?
This study is about you and others who use drugs. How you live, how you feel and what thoughts you have. When we finish we want to tell this to people who do not take drugs. Would you like to tell them something? Do you want to add something?

***

If the interview went well and the interviewee seems willing to participate in more interviews...

Do you live with your family or have any contact with your family?... Some of our colleagues are doing a study interviewing families (parents, siblings or other relatives) of persons who use drugs. Do you think that anyone in your family would like to talk with our colleagues? It is not to talk about you but to talk about them and how they feel in relation with you.
INTERRORATIONSBLAD OCH SAMTYCKE

Mittuniversitetet har ett projekt om narkotikaproblematiken i Sundsvalls innerstad. Tidigare forskning har visat att många deltagare i avgiftningsprogram eller behandling hoppar av i förhållandevis kort tid, och det är av intresse att undersöka om det övergripande problemet är att de inte återvänder till rehab- eller behandlingsprogrammen. Denna studie är till för att få reda på informationen från personer som använder narkotika. Du ska med egna ord få berätta vad du tycker kring din behandling eller varför du inte deltar i behandling just nu.

Intervjuerna kommer att genomföras när Slikn In har öppet. Om Du känner någon som använder narkotika som du tror vill delta i studien får du gärna tipsa dem om oss.

Deltagandet i denna studie är helt frivilligt. Intervjuerna kommer att spelas in på ljudfil. Under intervjun kommer du ges ett smeknamn som vi kommer överens om tillsammans. All information som samlas in kommer behandlas konfidentiellt vilket innebär att ingen utomstående person kommer kunna identifiera dig. Resultaten kan komma att publiceras i vetenskapliga tidskrifter och i vetenskapliga databaser. Genom att låta dig intervjuas samtycker du till ditt deltagande i studien. Du kan när som helst dra tillbaka ditt deltagande utan att uppgive någon anledning till detta. Informationen som samlas in kommer endast användas i vetenskapliga ändamål.

Ditt smeknamn i studien är: ____________________________

Avdelningen för Samhällsvetenskap vid Mittuniversitetet i Sundsvall ansvarar för studien och Teresa Silva är huvudansvarig forskare. Om du efterfrågar ytterligare information eller om du har några frågor kan du kontakta Ellen Fjellborg (ellen.fjellborg@mitun.se) eller Teresa Silva (010-142 85 06; endast engelska).

Tack för din medverkan!
Appendix C.

**Drug appendix**

1. Stesolid (Valium) is a kind of benzodiazepines, works to soothe anxiety (FASS, 2015).
2. Benzodiazepines, is an umbrella term for different kinds of narcotics, for example, Stesolid, Diazepam (Vårdguiden, 2017a; FASS, 2015).
3. Subutex, also known as Buprenorphine, is a drug used in substitution treatment for opioid users (Läkemedelsverket, 2017).
4. Lyrica, a type of medicine used for epilepsy and anxiety (FASS, 2017).
5. Tramadol, a type of opioid used for soothing pain (FASS, 2014).
6. Hash, a form of cannabis which makes a person feel intoxicated (Cannabishjälpen, 2017).
7. Morphine, used for longstanding pain from for example cancer (Vårdguiden, 2016).
9. Opioids, an umbrella term used for different narcotics like heroin, morphine and codeine (Beroendecentrum Stockholm, 2015).
10. Ecstasy, amphetamine like drug, a central stimulant which disturbs emotions (Drogportalen, 2017).