

## Ambiguous indifference: fatal overdoses following treatment for drug use

This is a translation of an article originally written in Norwegian and published in *Nordic Studies on Alcohol and Drugs* VOL 33 2016 2, 189-213

ELIN BERG

### ABSTRACT

Ambiguous indifference – fatal overdoses among marginalized drug users following in-patient treatment

**BACKGROUND** – In the European context, Norway has one of the highest overdose mortality rates. Research shows that the risk of overdose mortality among marginalized drug users is particularly high during the weeks immediately following in-patient treatment for drug use. **AIM** – It is therefore interesting to investigate whether there might be a connection between marginalization and treatment culture in order to understand the overdose mortality following discharge from in-patient treatment. **DESIGN & METHODS** – The case study is based on a previous field study combined with a registry link. The study focuses on a single individual, Sam, and his treatment process. Data is analysed in the light of a culture-analytical perspective. **RESULTS** – The results show how the treatment system can represent a social arena for institutional exclusion and marginalization, which can aggravate the person's self-esteem and life situation. One central aspect of the treatment process was that it generated indifference. Sam's treatment motivation developed into treatment indifference. In the last part of the article, the author discusses indifference as a risk aspect of overdose mortality after discharge from treatment. It is not possible to conclude whether Sam's fatal overdose was an accident or suicide. However, in the light of action theory, the case can show that indifference can be a central aspect of both unintentional and intentional fatal overdoses. Sam's death can be understood in the light of the concept ambiguous indifference. **CONCLUSION** – The case shows that there may be a relationship between marginality, treatment culture and overdose mortality. Cultural and structural aspects of the treatment system put Sam in a risky situation and left him in a void, which probably contributed to his death. A comparison of risk situations between this case history and recent research on the treatment system shows several worrying similarities in relation to overdose mortality after discharge from in-patient treatment. **KEYWORDS** – Fatal overdoses, drug treatment system, marginalization, indifference

Submitted 25.08 2015

Final version accepted 11.01 2016

### Introduction

For the tenth consecutive year, the United Nations Development Programme (UNDP) has named Norway the world's best country to live in, measured by gross national income, access to education and life expectancy.<sup>1</sup> However, there also appears to be greater social inequality linked to mortality in Norway than in, for example, South and Central Europe (Mackenbach, Kunst, Cavelaars, Groenhof & Geurts, 1997; Claussen & Bruusgaard, 2009). National research has shown that the disparities in health in Norway are greater than assumed, and in relation to the mortality disparities there is cause for concern (Westin, 2002; Dagens Medisin 2012<sup>ii</sup>). The

social inequality in mortality in Norway is most apparent in the lower social strata (Mæland, 2004, 56) and among marginalized groups such as drug users (Rognerud, Strand & Hesselberg, 2000; Naper & Dahl, 2007, 26). Norway has one of the highest overdose mortality rates per capita in Europe (EONN, 2009<sup>iii</sup>). The number of fatal overdoses rose in the 1990s and peaked in 2001 with more than 400 deaths. In the last ten years, 260 fatal overdoses have been registered annually, which means that five people die every week on average (Helsedirektoratet, 2014). According to Bretteville-Jensen (2011), Norwegian users have a greater risk pattern of use than that found in many other European countries, which is due to the fact that the majority of fatal overdoses in Norway are a result of using heroin (Steentoft, Teige, Ceder, Vuori, Kristinsson, Simonsen, Holmgren, Wethe & Kaa, 2001; Bønes & Waal, 2010; Bretteville-Jensen, 2011; Gjersing, Biong, Ravndal, Waal, Bramness & Clausen, 2011; Simonsen, Normann, Ceder, Vuori, Thordardottir, Thelander, Hansen, Teige & Rollmann, 2011; Waal & Gossop, 2014) and because a high proportion of the users inject the heroin, which multiplies the risk of death (Clausen, 2010; Bretteville-Jensen, 2011; Waal & Gossop, 2014). Autopsies of users have shown a cocktail of drugs in addition to heroin (Bretteville-Jensen, 1994; Rossow, 1996; Rossow & Lauritzen, 1999; Clausen, 2010; Simonsen et al, 2011; Sirius 2010<sup>iv</sup>; Bønes & Waal, 2010; Gjersing et al, 2011). The fact that a large proportion of drug users combine different drugs in their injections carries an extra high risk of overdose mortality (Clausen, 2010). Research also shows that a lower opiate tolerance after a prolonged period of abstinence from drugs is a common cause of overdoses (Bretteville-Jensen, 1994; McGregor, Dark, Ali & Christie, 1998; Johansen & Myhre, 2004; Ødegård, Amundsen, Kielland & Kristoffersen, 2010; Ravndal & Amundsen, 2010). In addition to these high-risk single factors and direct causes of overdoses, there are also underlying causes and motives that can lead to overdoses.

Studies have shown a relation between overdoses and suicide attempts and suicidal behaviour (Rossow, 1994; Rossow, 2001; Brådvik, Frank, Hulenvik, Medvedeo & Berglund, 2007; Dark, Degenhardt & Mattick, 2007; Biong & Ravndal, 2009; Herrestad & Biong, 2010; Biong, 2013). It is not sufficient to examine overdoses in terms of suicidal behaviour by referring to characteristics of the individual alone. According to Platt, Davis, Sharpe and O'May (2005), the interaction between individuals and contexts must also be recognized. One central context in this regard may be the housing market, because having a place to stay, according to the then Ministry of Local Government and Regional Development (Kommunal og regionaldepartementet, 2011, 15), is a determining factor in a person's health, education, employment and participation in society. Drug users that are clearly identifiable are, for various reasons, marginalized in the housing market (Rus & avhengighet, 2003) and thus have fewer opportunities for belonging to the majority population's living environments. The lack of housing for this group (Helse- og omsorgsdepartementet, 2012<sup>v</sup>) means that temporary shared living facilities are often offered to drug users, such as blocks of bedsits and hostels. In 2012, Norway had 6259 homeless persons, and drug addicts accounted for over half of these (Dyb, Johannessen, Lied, Kvinge, 2013). Periods of homelessness among drug users are common and are associated with an increased risk of premature death and suicide (Rossow & Lauritzen, 1999; Dark et al, 2007, 38). Single drug addicts are at greater risk of a fatal overdose due to the lack of social support and the absence of others who can help (Dark et al, 2007). This mostly relates to men, and there were more men in their mid-thirties<sup>vi vii</sup> who died of a drug-induced overdose in Norway than men below the age of 25 in 1997 and between 2006 and 2008 (Steentoft et al, 2001; Gjersing et al, 2011).

An extensive Italian study shows that admission to specialized drug treatment reduced the number of fatal overdoses, but that mortality in the first month after completing or discontinuing treatment was high (Davoli, Bargagli, Perucci, Schifano, Belleudi, Hickman, Salamina, Diecidue, Vigna-Taglianti & Faggiano, 2007). According to these authors, if heroin

users have a relapse in the first month, the risk of overdosing increases due to their reduced tolerance to heroin. The researchers have reservations about whether the risk of mortality was entirely due to an elevated degree of relapse in the first month after treatment or if there may also be other factors that constitute an increased overdose risk compared with drug users who relapse at a later point (Davoli et al., 2007). Results from a Norwegian study show that the risk of a fatal overdose is 16 times higher in the first four weeks after discharge from medication-free inpatient treatment (Ravndal & Amundsen, 2010). As in the Italian study, the cause of mortality is explained by the reduced tolerance to heroin, while Ravndal and Amundsen note that *resignation* caused by discontinuing treatment<sup>viii</sup> is likely to increase the overdose risk. According to Ravndal and Amundsen (2010)<sup>ix</sup>, the risk of a fatal overdose is so dramatic that further research is needed into similar inpatient programmes in order to gain more systematic knowledge about the reasons behind these deaths. As there is a general widespread belief that an effective treatment programme for serious drug problems must take into account the recipient's social situation, it is thought-provoking that the recipient is given a fragmented offer (Hanssen & Braut, 2010). Politicians report that many overdoses and deaths could be avoided if the waiting times for follow-up after, for example, detoxification were reduced (Representantforslag, 2007–2008). In other words, weaknesses in the treatment programmes and interruptions in the treatment chain can have serious consequences for marginalized heroin users. A Swedish study shows that heroin addicts, who for one reason or another are discharged against their will from medication-assisted treatment (MAT), find that the withdrawal of their treatment and the exclusion aggravate their circumstances. They return to the same lifestyle and drug use that they had before the treatment, in addition to being excluded from all MAT programmes for at least three months (Svensson & Andersson, 2012).

Studies therefore show that discontinuing treatment, whether at the behest of the client or the employee, may contribute to putting marginalized drug users in a vulnerable situation, and increase the risk of overdose mortality. Discontinuation of treatment can also be a sign that there are *factors in the treatment system* that may contribute to the overdose mortality. In this article, it will be interesting to examine whether there are risk factors in the treatment system that can lead to fatal overdoses. The author's ambition is to retrospectively evaluate whether there may be a relationship between marginality and treatment culture in order to understand overdose mortality following medication-free inpatient treatment. Research on fatal overdoses after discontinuing/completing treatment in the state treatment system is an unexplored context. The research question is therefore to be considered exploratory because it intends to investigate something we know little about. It is an interesting context, since according to Waal and Gossop (2014), the care and treatment services in most European countries with a high overdose mortality rate are provided by the welfare state, while in countries with a low overdose mortality rate the family's role is more central.<sup>x</sup> According to these researchers, it is possible that these cultural differences can impact on susceptibility to high-risk drug use.

## **Method and sample**

In order to understand a social phenomenon, Grønmo (2011) believes that researchers need to understand and interpret the phenomena based on the intentions of the persons in question and on the specific contextual conditions. As it is methodologically impossible to get the opinions of those who have died of an overdose, researchers have often used extensive research design to examine the prevalence of mortality with many units and few variables, which are subsequently linked to the Cause of Death Registry. In this article, an intensive research design with few units is used in order to obtain more detailed and rich information from few informants. Earlier fieldwork and two links to the Cause of Death Registry will be used to illuminate the research question.

### *Fieldwork and sample*

During the field study in 1998, the dominant tradition for treatment in Norway was drug-free and medication-free treatment as opposed to medication-assisted treatment. The treatment initiatives were aimed at rehabilitating drug users, with a view to non-dependence on drugs and satisfactory functioning in relation to employment, education, housing and social networks (Bystyremelding 1997). The fieldwork, which was conducted over a six-month period and completed in 2000, was carried out in different parts of the treatment support system, from referral bodies and institutions for detoxification, assessment and treatment, which should be viewed as a continuous initiative and treatment chain. The purpose of the field study was to examine what happens in the interaction between employees and drug users with an immigrant background (Berg, 2001). The empirical material consisted of 20 men with an immigrant background from Africa and Asia, who were selected by staff involved in the treatment study (Berg, 2001<sup>xi</sup>). All 20 of the men, except for one, said they smoked, snorted or injected heroin.<sup>xii</sup> Participant observation and conversations in the field that were based on different interaction situations with the men and employees were used. Death and overdoses were not discussed in these conversations. The results of the field study showed that employees and clients strongly disagreed about what treatment meant, and that they tried to interact without a common definition of the situation. This was perhaps the reason that most of the clients dropped out of the treatment programme before it was completed in line with a plan or an agreement (Berg, 2001).

### *Register review and sample*

Based on the client sample of 20 men, links were made to the Cause of Death Registry in 2003 and 2009. In the first link, five of the 20 men were registered as having died of an overdose<sup>xiii</sup> in the period 1998–2001. Not all overdose deaths are included in official overdose statistics or in the European overdose statistics. The European Monitoring Centre for Drugs and Drug Addiction's (EMCDDA) definition of drug-induced death covers deaths that are directly caused by the consumption of one or more drugs (overdose), of which at least one is illegal (EONN 2009, 84). In order to decide whether a death falls under this definition, an autopsy must be performed, and the deceased's blood and/or urine samples must be analysed to determine which drugs they have taken (Bretteville-Jensen, 2011). Drug-induced death, which is the definition used in this article, is defined and classified according to international agreements and international codes, ICD.<sup>xiv</sup> In this classification system, categories such as underlying and contributory causes of death are used, where the underlying cause of death is considered the main cause of death. It is this cause of death that is represented in the statistics, as in this article. Contributory causes of death relate to complications or conditions that contribute to the fatal outcome (Amundsen & Bretteville-Jensen, 2010).

In the second register link, a further three of the 20 men were registered as having died<sup>xv</sup> in 2003 and 2004 respectively. In this registry link,<sup>xvi</sup> the underlying cause of death for two of the men was given as a heroin overdose.<sup>xvii</sup> This means that, as with the five men from the first register link, these two died of a heroin overdose. Of the seven drug-induced deaths, consumption of other addictive drugs,<sup>xviii</sup> alcohol<sup>xix</sup> or benzodiazepines<sup>xx</sup> was reported as a contributory cause of death for four of the men. The seven men who died of a heroin overdose were homeless and unemployed, and were registered as single.<sup>xxi</sup> Six of the deceased had an immigrant or refugee background, while one was born and raised in Norway. Those who had immigrated to Norway or were born and raised here had family in the country, while the three with refugee status had no relatives in Norway.

Today, 15 years later, I return to the fieldwork and the original field data in order to examine whether it can help shed light on overdose mortality. Paul Atkinson (1992) analysed his

field notes after a twenty-year period in two different ways, which shows that re-examining fieldwork is not limited to single use. While Berg's (2001) first analysis of meaning content summarized common features from many different informants, the analysis in this follow-up study entails following a single case over time. A horizontal analysis, as opposed to transverse, will provide a better basis for an in-depth analysis (Malterud, 2011, 94). The hallmark of a case study is that it collects detailed information about one or a few units, and the study can focus on a single individual (Fangen, 2010, 187). The case in the article is a course of treatment that extends over two months, with a focus on one of the deceased men with refugee status, Sam (35). He was the man the researcher observed the most often (21 times) in most drug treatment institutions (3), and had the most conversations with (15) during the fieldwork. In addition to these field observations and conversations, the researcher observed the employees while they discussed Sam. During the fieldwork, the researcher chose an independent researcher role, which meant not intervening in the clients' treatment process. By assuming this role, it was neither appropriate to discuss their cases in meetings with employees, or to discuss Sam's case, since following a conversation with Sam the employees asked the researcher about what Sam really wanted help with. Moreover, it was not appropriate to let Sam read the field notes referring to him or to help him when he on one occasion tried to draw the researcher into a helping role. The informant-researcher relationship was therefore never close. Nevertheless, Sam gave the impression that it was a relationship of trust, by communicating in various ways that *'it's very good for me to talk to you. You are from the outside, and it's very good for me'*. Sam died of a heroin overdose one and a half months after being admitted for treatment. Given his marginal life situation, with a lack of affiliations and high-risk drug use such as injecting heroin in combination with Rohypnol, Sam is a typical case among the group of drug users who are particularly susceptible to overdose mortality. However, he also represents a divergent case in a treatment context. Keeping in mind the high drop-out frequency from drug treatment in general (Brorson, Arnevik, Rand-Henriksen & Duckert, 2013) and drop-out rates among the 21 men in the field study in particular (Berg, 2002), Sam completed several different consecutive stays in institutions even though his expectations of help were not fulfilled. He also represents an atypical case in that he was unaware of what drug-free and medication-free treatment involved. It is the combination of Sam's inexperience and his staying power despite reduced hopes of help from the service providers that is the key to understanding his descriptions of various aspects of drug treatment. Deviating or atypical cases often provide more information than a typical case because the atypical involves several players and several basic mechanisms in the situation being studied (Flyvbjerg, 2006, 229). Sam's case can thus provide opportunities to examine whether there are *factors in the treatment system* that can lead to an overdose after discontinuing/completing treatment.

The article is about the individual story of Sam, as part of the big story of overdose deaths in Norway following treatment. The purpose of this article is to try to generate knowledge about a possible relation between a marginalization process and overdose mortality in light of a treatment context, with a view to reducing mortality among drug users. This follow-up study was approved by the Regional Committee for Medical and Health Research Ethics (REC) in 2009, and was previously granted a licence in 2003 and dispensation from the duty of confidentiality in 2002.

## Theory

The analysis takes a phenomenological and hermeneutical perspective, where the emphasis is placed on interpreting and understanding the intent and meaning of Sam's actions. In a phenomenological perspective, it is the actors' actions and perceptions of their everyday lives that are analysed. The researcher focuses on understanding and describing actions based on the

actors' own standpoints, and the perspective is based on the fundamental thinking that the reality is how the actors themselves perceive it to be (Grønmo, 2011, 372–3). The analysis in the article assumes such a first-person perspective, while the researcher's interpretation of the actors' interpretations is also a main focus, as in hermeneutical studies. The researcher's interpretations include her preconceptions, which are partly influenced by earlier research, professional concepts and a theoretical frame of reference.

In order to understand overdose mortality in light of a possible relation between marginality and treatment culture, a culture-analytical perspective is employed. According to Mary Douglas (1997, 53-), culture can be described as an expression of a society's public and standardized values, where anyone who does not fit into the standard created by society is defined as an anomaly. Anomaly can be viewed as marginality or deviation, and there are several ways to relate to those who do not fit into the established categories. They may be excluded through rejection or condemnation, because anomalous cases can be defined as dangerous (Douglas, 1997, 53–54). Notions of deviation or marginality are to be understood as cultural constructions that are actualized in their social consequences. Using a culture-analytical perspective, a systematic focus is placed on values and behaviours that are established and often taken for granted (Leseth & Solbrække, 2011). According to Leseth and Solbrække (2011), culture in the meaning of values and behaviours that shape people's notions, choices and practices, is not only related to what actors have and are, but also to what they are capable of and what they do. As values and behaviours will be understood and experienced differently, culture is also about how people construct and interpret realities in interactions with others. Culture is to be understood as a *pattern of meaning* that is constantly formed and recreated through people communicating with each other (Geertz, 1973). In order to illuminate the research question and give the culture-analytical perspective meaning, it is necessary to clarify how marginality and marginalization are to be understood in this article.

In Norwegian everyday language, marginalization is a term that refers to making someone marginal, i.e. defining someone as on the fringes and at the edge, or as unimportant and without much significance.<sup>xxiii</sup> Heavy drug users are perhaps the most marginalized group in our society.<sup>xxiii</sup> According to Svedberg (1995), the concept of marginalization is used to describe both states and processes. Marginalization as a process entails groups and individuals being pushed out of society's central arenas, such as livelihood, housing and social community (Piuva & Brodin, 2013). Marginalization as a state can be described as outsidersness, i.e. whether you are inside or outside the margin. The underlying process, however, and the contributing factors that have created outsidersness, are often shrouded in darkness (Davidsson, 2010 in Karlsson, Kuusela & Rantakeisu, 2013, 21). According to Philip Lalander (2005, 67), there are social and economic structures in society that help to create outsidersness, while the outsidersness also consists of individual experiences of not belonging to society. A distinction can be made between self-chosen and forced outsidersness (Lalander, 2005, 59). Forced outsidersness, which is relevant in this article, evolves through a process in which drug users are eventually seen as 'junkies', and labelled as inferior individuals by the outside world (Lalander, 2005, 59–60). There are several ways to deal with perceived outsidersness; one of these ways, according to Lalander (2005, 67), is to *resign* to their life situation. From a first-person perspective, resignation can be based on a process in which hope for the future is transformed into a feeling of hopelessness, which can lead to indifference to life and death.

Marginalization in the article is considered to be a structured process. A process that, according to Marianne Gullestad (1999, 346–7), involves several parties, and not a state that only involves one party. Gullestad asserts that it is 'necessary to rethink the kind of social field of action that different marginalization processes are linked to' (Gullestad, 1999, 347). Such exploration can be important because marginalization that takes place in several key arenas

simultaneously may mean that the individual's latitude to act is severely limited, which according to Piuva and Brodin (2013), may be perceived as being robbed of human worth. If the person feels their dignity has been taken from them this may result in a feeling of shame. According to Ivar Frønes (2001), shame is about social categorization, in which shame is inflicted on a person by others. The person may even have done something shameful, but it is other people's gaze and sanctions that create shame (Frønes, 2001, 72). According to Frønes (2001), shame is associated with public situations.

Marginalization in this article is to be understood as rejection based on the categorization of groups on the outside and the inside, where the different contexts of this categorization bring about an indifference to whether one lives or dies. The social field of action in the article is connected to drug treatment, and is aimed at examining whether there may be a relation between marginality and treatment culture with a view to understanding overdose mortality.

## Results

*'Life for me is working on things that matter'*

I first met Sam in a detoxification unit. He was a tall, well groomed, slim man, with dark curly hair and smiling eyes, who had arrived in Norway in the 1990s as a refugee. In his late teens, Sam became a political activist, working for democracy in his homeland – something that he was imprisoned for. As the political work was the driving force in his life, he continued his work in prison despite signing an agreement not to. He said that he had read a lot in prison, and recommended books, and also stayed up to date with what was happening in the world. After several years in prison, he managed to escape in order to continue with his political work. In order to evade capture, he was constantly on the move, and found temporary jobs and places to stay. It was a risky situation, because *'if you get jail time and continue to be politically active after you're out, you get the death penalty'*. His political network eventually decided that it was too dangerous for him to stay, and at short notice and against his will he had to flee the country, leaving behind his girlfriend and family, in order to stay alive.

When he arrived in Norway, he had hopes of creating a new and meaningful life. He said that *'life for me is working on things that matter'*, and together with friends he tried to form a political organization. According to Sam, that was when things started to go wrong. He wanted to work on important issues and have a democratic form of cooperation. Problems arose in their working cooperation because, according to Sam, the others were mostly concerned about themselves and not about the issues. The working cooperation became dictatorial. *'At that point I lost the desire to work with them' (...)* *'I was doing a lot of thinking, and developed sleeping problems. I just let things continue in the same vein. Away from them, I isolated myself. I then slid into a new negative world. I just wanted peace, to sleep the time away'*. He said that he had an existential crisis, because he had a life without meaning in Norway, with no family and no possibility of returning to his homeland. He said he started taking sleeping pills given to him by friends. He subsequently experimented with snorting heroin, which brought him peace, and eventually became a daily habit. For the last three years, he had been injecting heroin combined with sleeping pills. He then lost touch with his friends and the organization. Sam said that taking the drugs helped him to forget his problems, but also had a devastating effect. He went from being active and believing he could influence the political situation in his homeland to being passive, emotionless and selfish. He told of a life with drugs that brought about indifference, because *'drug addicts have a bad life, destroying everything, you cannot choose. They don't think about love, sex, food, music, society or other people; they only think about drugs and themselves. A dead person who lives, so to speak'*, as he pretends to operate a wooden puppet. (...) *'I have to stop taking drugs or I'll die'*.

*'If you quit, [with drugs] there needs to be a good alternative, otherwise the situation is just devoid of any content'*

In other words, Sam's life when admitted for drug treatment consisted of two contrasting situations: one meaningful as a political activist and one indifferent and deadly as a drug user. He told with a smile in one of our early conversations at the detoxification unit that he had been asked to work in the organization again, and reiterated that *'life for me is working on things that matter. When I do something positive it makes me happy. When it's not positive I become sad'*. Sam was concerned that we must learn from our experiences, and stated *'I have made mistakes and have become passive'*. At this point, he had hopes of getting out of the difficult and passive life situation with drugs, he said, because *'I've now found a new way [drug treatment] to be active again and work with the organization'*. Sam, who had previously been admitted for detoxification, said that *'I thought it was enough, but I began using again'*. He explained that *'it's very difficult and very easy to quit. Easy, just look at it as a poison in order to stop. Difficult, because how do you find other alternatives. If you quit, there needs to be a good alternative, otherwise the situation is just devoid of content'*.

Sam, who had never been admitted for drug treatment, said he did not know what treatment entailed. He explained that he had a notion that it was staying at a drug-free place while receiving practical help to live a normal life in society. For Sam, the practical aspect of the treatment was fundamentally important to succeeding in life and with the treatment. He believed that the practice involved a process in which the person has a theory that is realized through a plan. According to Sam, it was *'only a practical approach that can change people and it is practice that gives me life'*. His plan was to stop taking drugs, learn to read and write Norwegian and find other work besides the voluntary work at the organization. It was part of his plan to re-establish contact with his ethnic network and friends, and nurture hobbies such as music, films and books. He told me he was totally addicted to reading newspapers and books. In other words, Sam was a content-oriented person. He communicated in various ways that he had high hopes of putting his plans into action quickly when he went directly from the detoxification unit to a recommended treatment institution.

### *Social categorization and shame*

Sam said that in various meetings with employees involved in the treatment system he was treated as if he was a 'drug addict', a social category he rejected because he did not see himself as an addict. *'I am a normal person.'* (...) *'I used drugs, but I'm not a drug addict,'* he said. According to the Norwegian online encyclopaedia *Store norske leksikon*, the term drug addict means: 'A person who abuses drugs or is dependent on medication'<sup>xxiv</sup> [Translation]. The extent to which employees in the initiatives and treatment chain intended such a literal meaning when they used the term drug addict about patients, as opposed to Sam whose frame of reference was the meaning and feelings that the term evoked for him, is uncertain. According to Sam, a drug addict was *'a person who has lost everything, dreams and determination'*. (...) *'Throughout the world, those who use drugs are viewed negatively.'* It is the notions and emotions that the term evoked for Sam that are important in the treatment context. He said that in his home country, drug addicts are punished with imprisonment and harsh prison conditions, and those who continue to take drugs on their release face the death penalty. *'Does your family know about your problems?'* I asked during one of our conversations. *'No! If they got to hear about my problems it would be a tragedy for them, like hearing that I was dead. Exactly the same.'* Sam, who had regular telephone contact with his family, said that he contacted them when he was doing well so that they wouldn't have to know when he was having problems. Showing sides of oneself that should really remain hidden, at least from the gaze of others, entails surpassing a threshold that



puts one in danger of losing one's dignity (Wyller, 2001). According to Wyller (2001, 9), many people experience shame as being stripped bare.

Sam is likely to have felt that he passed such a threshold when he described how he had to participate in compulsory excursions with employees and other patients in the various institutions. He said he tried to avoid taking part in such outings because he felt that the people outside the institutions looked at him as a drug addict. On one occasion, he described a trip to public swimming facilities, where he went into the sauna. *'Suddenly the door opened and an employee shouted in front of a bunch of other people that we had to tell them where we were going. But it's private'*, Sam said to me. (...) *'Another day they took us to a restaurant, and I didn't know it was a restaurant from my homeland. I felt awful while we were there'*.

It was not only Sam who conveyed a sense of acute shame in the face of others' gaze. One of the seven other men, Brian, who died of a heroin overdose 14 days after dropping out of the treatment institution, said in a conversation with the field worker that his stay there felt like 'mental rape'. He said that being there was not good for him, *'for example, I was sitting on the underground and felt that everyone was looking at me and thinking that I was not normal'*. *'What would they have been thinking about you?'* I asked. He looked seriously at me without answering. *'How did they see you?'* I repeated. *'A drug addict. That's what it's like when you've been in an institution, you carry it with you.'* According to Skårderud, the nature of shame relates to introspection, seeing oneself through the eyes of others. The shame arises in the tension between how one wants to be seen and how one feels that one is seen (Skårderud 2001a, 43).

#### *Loss of human worth and social exclusion*

For both Sam and Brian, an important distinction is made between being seen as a normal person or a 'drug addict'. While being a normal person entailed being regarded as a decent human being, it appears that being considered a 'drug addict' reduced them to something else in their own eyes and those of others. For Sam, who viewed himself as a normal person, being viewed as a 'drug addict' may represent an essential difference within society in terms of his self-esteem and circumstances. By viewing other people as essentially different, a divide is created between them and us, where those who do not fit into a given group or pattern – the drug addicts – are excluded from different areas of society. This forced outsidership can be understood as 'a wall of exclusion'; a socially constructed barrier that separates drug users from mainstream society (Buchanan 2005, 77). The barrier emerges when they are denied opportunities that the majority population has access to. Marginalization occurs when future possibilities are limited for those labelled as substance abusers. This can be interpreted as a cultural pattern associated with egalitarianism. According to Gullestad (2002, 82), Norwegian society (and that of the other Nordic countries) is characterized by an egalitarian mentality in which people in many informal contexts have to perceive themselves as alike in order to feel equal. Equality, in the sense of 'sameness', does not necessarily relate to an observable likeness, but to a manner that draws attention to the traits that are perceived to be alike. Gullestad (2002, 83) calls this 'imagined sameness'. According to Gullestad, sameness as a positive value often means it is problematic when people are perceived as different. 'Difference is commonly viewed as a deficiency: those who are different lack something essential', and it is not uncommon to avoid them (Gullestad, 2002, 83). The perspective thus focuses on the view that within different social contexts both equality and avoidance strategies are employed in order to confirm the individual human worth. Equality strategies employed vis-à-vis problem drug users in society at large and drug treatment are likely to be portrayed as different, while for Sam they seemed to have the same reinforcing effect.

*'They [the employees] think all drug addicts are the same'*

Sam had a surprising encounter with this sameness mentality in the treatment institution he went to after detoxification. After a few weeks at the institution, he asked staff for help to find another treatment institution because the treatment was harmful to him. *'I have boundaries, which is why I had to leave my homeland. I have a problem now; I can't leave here and I can't stay.'* He told of a compulsory treatment programme where everyone was treated the same because *'they [the employees] think all addicts are the same'*. According to Sam, the treatment programme consisted of cleaning, sleeping and yelling. He described how they had to clean from 7.30 in the morning until 9 o'clock at night. They even had to clean the same room twice in an hour. *'They say crush a person's personality in order to build it anew' (...)* *'I can't be a normal person after I've been here.'* (...) *'We are all different, and I need a different kind of treatment.'* *'Being here makes me feel like a drug addict.'* (...) *'I'm completely exhausted by 9.30 pm. I'm addicted to reading books, but need to ask permission here.'* He said there was no time to realize any of his own plans as part of the institution's programme, which he felt consisted of pointless labour. *'I need to treat myself, read, write and think. I'm not allowed to do that in here. This is fundamentalism. I want to work eight hours, have leisure time and read for 2–3 hours every day' (...)* *'When, for example, we want to use the toilet, we must stand upright with our arms by our side and say: Excuse me, can I interrupt. May I use the bathroom? Then we have to notify the supervisor when we get back, they need to know everything we're doing (...)* *I don't like the yelling. It's psychological terror. (...)* *I was going to make a call and was standing less than two metres from the supervisor. He shouted, and I became angry. They cannot shout at me, I lose control.'* *'What's going on?'* I asked. *'Then I went and sat by myself, just like this.'* He stooped forward in the chair and started to shake.

Not long afterwards, Sam was transferred for a three-week stay in another institution for further treatment assessment. After he was more than halfway through his stay in the new institution, he was frustrated that nothing was happening. *'I'm wasting time in institutions just like when I used drugs, and I don't have time to waste'*, he said, and his once smiling eyes looked sad. As with the previous institution, this one also had a compulsory programme. He said that the new institution's programme was different from the previous one with all the cleaning, but in principle was the same, because it was compulsory and everyone was treated the same. He described how the staff at both institutions believed that all patients only thought about drugs, *'but I'm done with drugs, I've forgotten about them and don't want to think about them'*.

According to Sam, the programme in the new institution consisted of talking, where all subjects were drug-related. He told how *'they [the employees] talk about problems and substance abuse all the time'*, which the staff confirmed, because *'we are, after all, an institution for [people with] drug-related problems'* (Berg, 2001, 77). *'Being here'*, explained Sam, *'makes me feel sick and abnormal. (...)* *I hate myself because I live here and am in such a situation.'* As part of the inpatient programme, he had to take part in various compulsory groups where *'they talk about how we became drug addicts and how we can stop being addicts'*. *'It's not interesting. I have decided. I take part in the groups out of respect for the others, but it's not interesting for me to be there.'* Sam expressed in different ways that it was incomprehensible to him why they had to talk about substance abuse when he was no longer using. He also said that the groups' discussion topics were thematically uninteresting. He said he did not talk in the groups, and only attended because they were compulsory. According to Skårderud (2001a), substance abuse is a shame-based syndrome, and shame is the perception of one's own unworthiness, which one would rather not discuss (Skårderud, 2001b). It was important to Sam that he was considered a normal person, so participating in the groups along with the other patients and employees could bring about a conflict in him between how he wanted to be perceived and how he felt that he was perceived. According to Skårderud (2001a, 38–39), shame, whether conscious or subconscious,

is an emotion that is fed by a discrepancy between who one is and who one wants to be. For Sam, who viewed himself as an active and important person, seeing himself as the group saw him may have reduced him to something he did not want to be. The higher the self-ideals one has, the greater the likelihood of a large discrepancy, and the greater the need for self-loathing and self-reproach (Skårderud, 2001a, 39). Sam therefore probably tried in different ways to protect his own self-image and dignity by withdrawing. As with the compulsory excursions, he physically tried to avoid being with people he did not want to be compared with. This was probably why he kept himself to himself in the institution and spent much of his time in his room. He said he preferred being in his room and reading newspapers and books, because *‘when I sit alone in the room and read, I feel completely normal’*.

After participating in various individual and group conversations on drug-related topics, reading brochures about different institutions and taking part in compulsory information meetings with representatives from various institutions, Sam no longer wanted treatment in an institution because *‘institutions are all the same. Programmes, phases, periods of leave.’* Sam was concerned with the fact that everyone who is admitted to drug treatment institutions is different, and said *‘I need different treatment to others. (...) I need to be normal in a normal society and an active person who is concerned about normal things. (...) Father in his 70s still work. It’s not good to sit at home, a tragedy. We need to go out and work. We need to be active. That’s our culture’*. The fact that Sam no longer wanted to be treated at an institution may be because he felt that staying in an institution, with the compulsory programmes and sameness mentality, was a paradoxical way to become active and be able to cooperate with the organization again. He probably felt that the employees’ sameness mentality reduced his affiliations to one single affiliation, the socially stigmatized identity from which he distanced himself. The treatment programmes at the two institutions with their cleaning and talking practices respectively, were no doubt viewed as empty situations by Sam, because nothing happened in relation to his self-defined plans. The convergence of empty situations and stigmatizing categorization in the drug treatment may have caused Sam to feel he was treated with an imagined sameness, which simultaneously included him in the drug institutions and excluded him from society. This sameness mentality probably played a role in reproducing the marginality in that no attempts were made to stop his marginalization process; a process that Sam not only perceived as social exclusion in society, but also what Martin Kronauer defines as institutional exclusion when *‘The institutions which administer unemployment and poverty very often act vis-a-vis their clientele in the paradoxical way of simultaneously including and excluding them from society. The less they are able to help people out of unemployment and poverty, the more they participate in reproducing the status quo’* (Kronauer, 1998, 67).

### *Indifference*

According to Sam, the staff were concerned that patients should change, and should stop taking drugs, while at the same time he was offered a compulsory treatment programme that was devoid of any content. For Sam, the key to change consisted of working on important issues. When he was offered the opportunity to resume his work with the organization and re-establish contact with his ethnic network, he regained hope of having a worthwhile life. Continuing his institutional stay and a treatment programme devoid of content probably represented for Sam losing the opportunity to have an active, worthwhile life and therefore hope of changing his life circumstances. In order to get support to realize his plans, he told his field worker with a smile that he had invited his case worker from social welfare office to attend a meeting at the drug treatment institution.

Prior to the meeting with the case worker, Sam and his contact person had a one-to-one conversation in which they ‘agreed’, according to the contact person, that Sam should apply for a

place in a specific drug treatment institution. When they were about to write the application in the presence of the field worker, Sam said *'I'm thinking of living in a block of bedsits, then I would feel like an ordinary person. If I stay in an institution for a long time, I'll be changed and will feel like an outsider my whole life.'* Sam said that his first priority was drug-free housing in a block of bedsits, and an institution was the second alternative, provided that it was possible to go to work during his stay there. The contact person asked loudly if they were going to write an application or not, and Sam answered *'Yes, that might be an alternative. I don't have to choose an alternative'*. Later the same day, the application was reviewed at the meeting with the case worker, and Sam was asked what had gone wrong at the previous institution. He described the programme there, saying *'It's best for me to start an ordinary life on the outside'*. The case worker was focused on the differences between institutions, and turned to Sam's contact person and asked *'Have you tried to tell him about that?'* *'Yes, many times'*, the contact person answered. Sam looked from one to the other with big, sad eyes, wiping the sweat from his face with his hand. The case worker said gravely that Sam had tried to manage without treatment previously but had not succeeded. *'I won't make that mistake again,'* said Sam, *'and I have a plan and I'm asking for a new chance'*. He said he had invited her to the meeting because *'I have friends who're drug free, and I've been invited to work in the organization again'*. He smiled, then continued *'That's why I need help to get a start'*. The case worker looked at the contact person and answered: *'You're impatient, in a rush and things can go wrong. You must give us time to plan and make arrangements.'* *'How long?'* asked Sam, who felt he had no time to lose. The case worker and the contact person laughed. *'You want a flat?'* asked the case worker. *'No, a bedsit in drug-free housing.'* *'There may be a waiting time of 2–3 months,'* answered the case worker. The two employees were preoccupied with the fact he had tried housing accommodation previously without success. *'What's the difference between now and a year ago? You were using drugs then when you had a place of your own,'* said the case worker. *'I lost the flat because the rent went up,'* answered Sam. *'I'm in a different situation now. At that time I wanted a break, now I want to stop.'* The contact person cut short the discussion and said *'If you want housing, we won't extend the time; if you want treatment, we're positive to prolonging your time here.'* Sam looked seriously from one to the other. *'What about local authority housing?'* he asked. *'Your application will be rejected. You have to show papers to confirm that your treatment has been completed,'* answered the case worker. *'As a drug addict? I'm an ordinary person.'* Case worker: *'They don't think like that when you have drug problems.'* *'Punishment,'* said Sam. *'That's what I think. I'm not satisfied. I have to pay the price for a new life. I'll pay. (...). I'm not satisfied with an institution, but I have to be.'* Contact person: *'When you attend the admission session at the institution, I don't think that's the motivation they're looking for.'* The two laugh. *'If that's where you want to go, you can't say that's the price you have to pay.'* They agreed on a follow-up meeting at which the case worker would write an application for bedsit housing. When the field worker met Sam in the corridor after the meeting, Sam said sadly that the case worker and the social welfare office thought inside the box, making a box shape with his hands. *'They think once an addict, always an addict.'* He shook his head and continued with a look of resignation towards his room.

When the case worker failed to support Sam's plans but instead supported Sam's contact person regarding his need for institutional treatment, a radical change occurred in Sam. He had invited the case worker to the meeting and had expected an alliance and a positive response to his plans from the latter. When they did not see him as he saw himself, and was instead ridiculed, rejected and criticized, because in their eyes he was a permanent drug addict, he probably experienced a feeling of shame, and his plans for the future collapsed. 'Shame is not being recognized', Skårderud (2001a) writes, and we turn the lack of acceptance on ourselves as if we do not deserve to be recognized. 'Few other emotions feel equally dramatic. It descends on us

swiftly and recedes slowly' (Skårderud, 2001a, 42). According to Skårderud (2001a), a reaction of shame is an implosion or a sudden 'destruction' and shrinkage. In Sam's case, it appears as if he expresses shame through increased resignation and withdrawal. Withdrawal can be understood as protection against greater invasion of oneself, thus helping to preserve relationships and a perception of one's own identity (Skårderud, 2001a, 38).

From being an active and engaged person who tried to contribute to his own treatment process, Sam became more and more passive and uninterested in conversations with the staff as well as the field worker. He had fewer conversations with the latter and he spoke less about matters that engaged him. He said he had a headache and that he had no appetite, and he missed his mother who used to comfort him as a child when he was feeling bad. He could not bring himself to call her, he said, because she would be able to tell that he was not feeling good, and then he would have to lie to her, which he felt unable to do. Meanwhile, the staff discussed Sam's opposition to institutional treatment at departmental meetings, and the contact person brought up the fact that Sam vacillated about the treatment and had become uncommunicative. They discussed whether he was a reflective person and whether he realized that he needed treatment without reaching any conclusion.

Two to three days before Sam's contract with the institution expired, Sam, now thin and wan, had his last two meetings with the case worker and one of his two contact persons. At the meeting, the contact person was concerned about his need for supervision, but Sam insisted '*I want to be an ordinary person*'. '*Do you see yourself as a drug addict?*' '*No.*' The contact person smiled, but did not say anything. '*Housing isn't enough,*' said the contact person. '*But it's your choice, you decide, you know what's best for you.*' Sam brought up what the case worker had said about it taking roughly two months to get a place in drug-free bedsit housing. '*What are you going to do when your contract expires in three days' time? The social welfare office can help you with accommodation.*' '*Then I'll be sent to a hostel,*' Sam answered, adding that he did not want to live in a place like that. '*It's dangerous. There's only 100% drug addicts there. They knock on the walls and doors. Has anyone got a spoon? Does anyone want drugs? It's a dangerous place for someone like me who has tasted heroin.*' His contact person looked at him gravely and said that his contract could *maybe* be extended until he was notified about whether he would get a place for treatment or not, but Sam answered that he would not do anything to pursue the housing, and would just consider the institution. '*I have no other alternatives,*' he said resignedly. '*You can work on housing from there,*' his contact person said with a smile. '*Yes, that's what I'm thinking,*' said Sam in a low and serious voice, before adding that he wanted to go directly to the institution he had applied to. '*I can't promise that. I'm not the one who decides whether there's a place available. I would also prefer you to go directly there, but it's possible you may have to leave and wait for a place.*' Sam shook his head dejectedly. After the meeting, he turned to his field worker and said '*They say you need supervision, an institution. I would prefer bedsit accommodation. I agree to an institution. They say that maybe I must leave here, that means I won't go directly from here to an institution.*' He shook his head as if to indicate that such a break in the treatment was a totally incomprehensible way of providing successful drug treatment. The following day the case worker informed him that it was difficult to find an available place in a block of bedsits, and when the case worker suggested bedsit housing that was not drug free, Sam became despondent '*I just want a place that's drug free,*' he said. '*If the institution says no, what then?*' asked Sam. The case worker said she had two days to find bedsit housing. '*I don't control them. It won't be a hostel,*' she said. Sam stared off into space. His eyes, once lively and radiant, were dead, showing only indifference.

In our last conversation, Sam appeared to be indifferent to treatment, saying that he had given up hope of getting the help he needed to lead an ordinary life from the state treatment system. He said: '*When you've first tried heroin, if you're sad, if you have lots of thoughts or*

*problems, then it's easy to start taking heroin again. Then you feel nothing, you don't think about anything, you're dead.'* In his eyes, both the case worker and the staff at drug treatment institutions want change, but based the change on *'formalities stemming from experiences with drug addicts who don't want to stop taking drugs'*. He justified his way of thinking by their offers of hostels and bedsit housing that were not drug free, and a compulsory treatment programme. *'But when it's obligatory, you won't be changed, by supervision, for example. You can't solve drug problems in an institution (...) It's my life, but it's just a job for them.'*

Sam did not get a place immediately in the new treatment institution. He was discharged and placed on a waiting list, and no place in bedsit accommodation was available. Consequently, staff could apparently only refer Sam to empty situations, which meant that his treatment programme had no content. During the course of his treatment at different drug treatment institutions, nothing halted the process of marginalization, perhaps even the contrary. His motivation changed during the course of treatment from hope for the future to a feeling of hopelessness and indifference to treatment. The feeling of indifference was probably related to a wish to protect himself against being divested of his human dignity and to his loss of trust in receiving help from the treatment system.

The case shows that the treatment programme may be part of a marginalizing and stigmatizing process that can reduce a person's self-esteem and worsen their life circumstances, thus entailing a greater vulnerability to a fatal overdose. Sam died of a heroin overdose in a room in a hostel approximately six weeks after his treatment programme had been discontinued by the system from which he expected help. His encounter with the treatment system and his death from an overdose can be interpreted in various ways, including as a narrative of the risk situations and problems that the treatment system may contribute to, or how indifference can develop and manifest itself, and what the outcome may be. It is also conceivable that this does not represent two independent narratives, but rather a single narrative about complex risk situations vis-à-vis overdose fatalities in the wake of discharge from drug treatment institutions.

## **Discussion**

In his encounter with the state treatment system, Sam met a treatment culture that led to institutional exclusion generating a feeling of indifference to treatment. Like the social exclusion Sam experienced, institutional exclusion was anchored in a cultural practice of imagined sameness. Unlike institutional exclusion, which was based on sameness, social exclusion was based on a perception of difference. For Sam, who was categorized as a drug addict in both social and treatment contexts, institutional exclusion resulted in a greater risk of social and economic exclusion, together with an individual experience of outsidership. Since the staff did not manage to interact with Sam in terms of what he considered important and meaningful, this probably meant that they played a contributory role in creating the marginalization process he experienced. When he was discharged from the drug treatment institution to a life devoid of any content, his options were so limited that continued high-risk drug use seemed to be the only alternative, increasing the risk of a fatal overdose. Thus the treatment system helped to put Sam in a vulnerable and high-risk situation, which probably contributed to his death. It is unclear when Sam started using heroin again, but at some point, he probably contacted the social welfare office for a referral to a hostel, a type of shared accommodation where there is a widespread culture of heroin injection and a risk of fatal overdose (Wright, Oldham, & Jones, 2005). During the period 2006–2008, a few dozen people were found dead in this type of accommodation in Oslo as a result of overdoses (Gjersing et al., 2011, 45).

When Sam conveyed that he had given up trying to get the help he needed from the state treatment system to live an ordinary life, he had probably also lost hope of working in the organization again. Hope is considered to be an important requisite for change, and as stated by

Herrestad and Biong, 'Clinicians should be aware that sometimes maintaining hope may be more important to the patient than seeing hope fulfilled' (Herrestad & Biong, 2010, 8). During the course of Sam's treatment, faced with the problematic practices and transition phases of the treatment system, he developed an indifference which can be regarded as contrasting with hope. Despite not knowing whether Sam's overdose was an accident or suicide, in the discussion going forward it may be of interest to study indifference as a risk factor in understanding overdose mortality.

Studies on mortality among drug addicts have shown that the main causes of mortality are overdoses resulting from an accident or suicide. Some of the studies have indicated that approximately 50 per cent of the overdoses can be attributed to these two causes (Rossow & Lauritzen, 1999). It has been demonstrated that in light of their lifestyle and living conditions, the heaviest and most marginalized drug users can develop a feeling of hopelessness that may lead to indifference about whether they live or die (Rossow & Lauritzen, 1999; Gjersing et al., 2011). According to Vingoe, Welch, Farrell and Strang (1999), the relation between unintentional overdoses and intentional overdoses or suicides is unclear. If we examine non-fatal overdoses, which are common among heroin users, research shows that the largest proportion of overdoses are regarded as unintended/accidental as opposed to a suicide attempt (Brådvik et al., 2007). Non-fatal overdoses and suicide attempts are both common among heroin users, and overlap each other – some overdoses are deliberate and some suicide attempts are heroin overdoses (Brådvik et al., 2007). According to Brådvik, distinguishing between intentional overdoses and suicide attempts is difficult, because some may constitute suicide attempts while others do not (Brådvik et al., 2007, 479). Brådvik also states that knowledge of the relation between them is limited. In a Norwegian study of 2051 women and men admitted for drug treatment, 45.5 per cent had experienced life-threatening overdoses, and 32.7 per cent had tried to end their lives one or more times through a self-inflicted overdose (Rossow & Lauritzen, 1999). The researchers conclude that there is considerable covariation between suicide attempts and overdoses in which common underlying causal factors relate to heavy drug use and poor social integration. Brådvik (2007) is of the opinion that Rossow and Lauritzen do not take intention into account when an overdose is taken.

Based on a relation between unintentional overdoses (accidents) and intentional overdoses (suicides), in the following discussion it will be expedient to go beyond this dichotomization. In order to transcend intentions that differ initially, we require an explanatory model. Such an approach might be to describe overdoses along a continuum, focusing on the grey zone between suicide-related behaviour, indifference and risky drug-related behaviour (Miller, 2006; Richert & Svensson, 2008). Richert and Svensson's (2008) study showed that overdoses are most often the result of conscious risk-taking behaviour, sometimes in combination with indifference to the potential consequences of the risk taking, without an expressed wish to commit suicide (Richert & Svensson, 2008). On the other hand, Peter Miller (2006) classifies indifference as suicide-related behaviour and not risk taking as suggested by Richert and Svensson. These findings show that overdoses should not solely be attributed to pure accident or to suicide, but to something in between. This grey zone means that overdosing is understood as an ambiguous action.

Finding empirical evidence of whether Sam's fatal overdose was an accident, suicide or something in between is a challenge. However, it may be useful to consider his death by overdose as an ambiguous action. When the intention of an action is something in between what is intended and what is unintended, Dag Østerberg (1993, 100) describes this as amphibious. An amphibious interaction is understood as a type of action Østerberg (2012, 69) refers to as the '*unfolding* of an intention'. According to Østerberg (1993, 98), the concept of amphibious interaction contains two important distinctions. Firstly, there is the distinction between

immediate (pre-reflexive) and mediate (reflexive) actions. Immediate actions reveal an intention that is initially quite indeterminate in content, and is decided as the action is being executed. As an act of self-delusion, the final action can retrospectively appear to be a pre-determined intention (Østerberg, 1993, 98; 2012, 69). In Sam's case, when he was discharged as someone who was indifferent to treatment and who faced an empty life situation, an ambivalence developed in relation to stopping or continuing with heroin. While performing the action, something, for example a temptation, changed his intention and therefore the course of action, and he started to inject heroin again, thus adopting a lifestyle with drug use that also created indifference. Moreover, Østerberg distinguishes between direct intention and oblique intention. 'The surprising aspect of oblique intention is that by doing something that appears to be different from what we intend, we succeed' (Østerberg, 1993, 99). If we cast a glance at Sam's final action – the fatal overdose – the intention was perhaps to take a dose of heroin to change his state of awareness to indifference, and perhaps in this indifferent state he succeeded in fulfilling a different intention – taking his own life. By applying Østerberg's interpretation of action to the unfolding of intention, Sam's overdose can be understood as an action where the intention was double-edged or ambiguous in that it shifts between the unintended and the intended. This means that we can never reach a conclusion on whether his overdose was an accident or suicide. However, in light of Østerberg's theory of action, the case can elucidate indifference as a central aspect of both unintentional and intentional fatal overdoses.

Indifference can therefore be ambiguous. It can express hopelessness, i.e. the absence of hope, which according to Herrestad and Biong (2010) represents vital protection against intentional life-threatening behaviour. It can also be an aspect of resignation caused by a break in treatment, which according to Ravndal and Amundsen (2010) can increase the risk of overdose mortality. Indifference can also be a sign that one is seriously depressed or devastated. Indifference to treatment, as generated by Sam's encounter with the treatment system, may have developed into the ambiguity of indifference, with its many faces.

Those who consider that Sam's background is very special among drug users in Norway would do well to remember that each and every drug user is special. 'Drug addicts are like other people, they are all different and they must be helped differently', (Stoltenberg 2015<sup>xxv</sup>). To examine more closely whether Sam's treatment context is typical of the contexts in which drug users receive treatment today, we must consider whether more recent research in the field of drugs provides any indications. During the last 15 years, various reforms, including drugs policy reform, social welfare reform (Norwegian Labour and Welfare Administration – NAV) and the Coordination Reform (Helse- og omsorgsdepartementet, 2012), have been carried out. According to the Coordination Reform (2012), we shall 'receive the right treatment at the right place and right time through a comprehensive and coordinated health and welfare service adapted to the individual user'.<sup>xxvi</sup> The NAV reform (2006) is the most sweeping welfare reform in recent times, whereby municipality and state collaborate to provide services for the population. One of the four main objectives of the reform is to adapt services to the needs of users.<sup>xxvii</sup> The drugs policy reform (2004) transferred the responsibility for county authority initiatives for the specialist treatment of drug and alcohol users to the state, represented by the regional health authorities and the specialized healthcare services. The services, referred to as 'interdisciplinary specialized drug/alcohol treatment' (TSB) 'include specialized treatment such as detoxification, emergency treatment, assessment and specialized treatment (out-or inpatient)'.<sup>xxviii</sup> Expectations have been high regarding the goal of the reform to provide better and more coordinated services for drug users with complex problems (Johansen, 2007). An evaluation shows that the coordination between the administrative levels, TSB and the municipal services is not functioning well. The treatment chain is fragmented, with constant interruptions in the transition between services, and users who need 24-hour accommodation are referred to TSB, frequently



experiencing long waiting lists (Beyer, Enoksen, Lie, & Nesvåg, 2010). If we consider experience gleaned from inspections of the services provided for drug users, reports show that despite the high rate of mortality that is characteristic of heavy drug users, the emergency medical services of the specialized health services and long-term treatment programmes are often found to be deficient (Hanssen & Braut, 2010). These authors refer, for example, to failures in coordination among service providers, and a lack of individual adaptation and user involvement. A mapping of the housing situation for those with drug problems on completion of TSB treatment reveals that those who are homeless when they are admitted to an institution are most likely to be homeless when they complete the treatment (Dyb & Holm, 2015, 8). ‘In other words, over 4000 patients annually are discharged to their ‘home’, without having an address’ (Pedersen, 2015). Patients who have not been offered accommodation on completion of their treatment are referred to hostels by the municipality, and shortly afterwards they resume drug use, with a new round of applications for treatment: ‘A reality that can shed light on some of the excuses for why we ended up with a growing drug user environment in Nygårdsparken and an extremely high overdose rate in Bergen and in Norway’ (Pedersen, 2015).

The findings of this field study revealed a drug treatment system with little adaptation to individual users. There was a lack of procedures and routines to prevent breaks in the course of treatment and the risk of an overdose following discharge, in addition to an indifferent attitude to the importance of access to drug-free accommodation. These findings appear to indicate a number of timeless and typical features rather than an isolated course of treatment that took place 15 years ago. When comparing the risk factors in this case history with more recent research on the drug treatment system following the major reforms, several worrying similarities can be observed in terms of overdose mortality after discharge from a treatment institution.

This article points to high-risk factors in the drug treatment system that can turn motivation for treatment into indifference, which in turn can increase overdose mortality in the wake of discontinued or completed drug treatment. The case shows that there may be a relation between marginalization, the treatment culture and overdose mortality. The findings show that Sam’s case is a case involving rejection that helped to place him in an empty, indifferent, high-risk life situation. The findings of the article demonstrate that there is need for more knowledge about possible relation between indifference and overdose mortality from the perspective of the user, and more focus on how the treatment system can avoid systemic failure that can contribute to and bring about additional high-risk life situations for drug users.

#### **Declaration of Interest** None

**Elin Berg**, Assistant Professor

Faculty of Social Sciences

Oslo and Akershus University College of Applied Sciences

Email: [elin.berg@hioa.no](mailto:elin.berg@hioa.no)

I wish to thank Professor Emeritus Tian Sørhaug, Associate Professor Per Arne Tufte and two anonymous referees for their sound professional input to the text of this article.

## REFERENCES

- Amundsen, E. & Bretteville- Jensen, A.L. (2010). 263 narkotikadødsfall i Norge i 2008. Sirius-oppsummering.  
[http://www.sirus.no/263+narkotikad%C3%B8dsfall+i+Norge+i+2008.E2x322-8\\_Bp77BFv3TR9D6CJ1K0Aow7VPL28nMhPLZB9MtlY05hRHG1w.ips](http://www.sirus.no/263+narkotikad%C3%B8dsfall+i+Norge+i+2008.E2x322-8_Bp77BFv3TR9D6CJ1K0Aow7VPL28nMhPLZB9MtlY05hRHG1w.ips), lastet ned 07.07.14.
- Atkinson, P. (1992). “The ethnography of a medical setting. Reading, writing and rhetoric”. *Quality Health Research* 2(4), 451-471.
- Berg, E. (2001). *Jeg har fortalt. En studie av interaksjon mellom klienter med innvandrerbakgrunn og ansatte i rusmiddelomsorgen*. Hovedfagsoppgave i sosialantropologi. Universitetet i Oslo.
- Berg, E. (2002). Terapeutisk offentlighet - en kompleks hybrid. Hvorfor avbryter (en del) innvandrere behandlingen? *Nordisk alkohol- og narkotikatidskrift*, 19, 171–185.
- Beyer, S., Enoksen, E., Lie T., & Nesvåg, S. (2010). *Stortingsmelding om den nasjonale rusmiddelpolitikken. Oppdatering av rusreform-evalueringen (2006-2010)*. Korfor, Regionalt kompetansesenter for rusmiddelforskning i Helse Vest.
- Biong, S. & Ravndal, E. (2009). Living in a maze: Health, well-being and coping in young non-western men in Scandinavia experiencing substance abuse and suicidal behaviour. *International Journal of Qualitative Studies on Health and Well-being*, 4, 4–16.
- Biong, S. (2013). Overdoser som selvmord: en fenomenologisk case studie. *Sucidologi*, 18(3), 36–40.
- Bretteville-Jensen, A. L. (1994). *Narkotikadødsfall i Norge. En analyse av utviklingen fra 1976-1993*. Statens institutt for alkohol- og narkotikaforskning, Sifa rapport 4/94.
- Bretteville-Jensen, A. L. (2011). Hvorfor har Norge så mange overdosedødsfall?  
<http://www.sirus.no/Hvorfor+har+Norge+s%C3%A5+mange+overdosed%C3%B8dsfall%3F.d25-SMRfU1q.ips>, lastet ned 07.07.14.
- Brorson H., Arnevik, E.A., Rand-Henriksen, K., & Duckert, F. (2013). Drop-out from addiction treatment: A systematic review of risk factors. *Clinical Psychology Review* 33, 1010–1024.
- Brådvik, L., Frank, A., Hulenvik, P., Medvedeo, A., & Berglund, M. (2007). Heroin Addicts Reporting Previous Heroin Overdoses Also Report Suicide Attempts. *Suicide Life-Threatening Behavior*, 37, 475–481.
- Buchanan, J. (2005). Problem Drug Use in the 21st century: A Social Model of Intervention. I T. Heinonen & A. Metteri (Ed.), *Social Work in Health and Mental Health. Issues, Developments, and Actions*. Toronto: Canadian Scholar’s Press.
- Bystyremelding (1997). *Tiltak mot alkohol- og narkotikamisbruk i Oslo*. 1997, nr.1:24. Oslo kommune.
- Bønes, T. & Waal, H. (2010). *Hvor mange dør av hva? SERAF-rapport 2010 nr. 2*. Universitetet i Oslo.
- Clausen, T., Havnes, A. & Waal, H. (2009). Overdosestatistikk – et komplisert regnskap. *Tidsskrift for Den norske legeforening*, 21/5, 2009.
- Clausen, T. (2010). Norge på Europatoppen med overdosedødsfall! Senter for rus – og avhengighet. <http://www.seraf.uio.no/nyheter/2010/norge-paa-europatoppen-med-overdosedodsfall>, lastet ned 20.01.11.

- Claussen, B. & Bruusgaard, D. (2009). Fortsatt stor sosial ulikhet i dødelighet i Norge. *Tidsskrift for Den norske legeforening*, 129, 1230–1232.
- Dark, S., Degenhardt, L., & Mattick, R. (2007). *Mortality amongst illicit Drug Users. Epidemiology, causes and intervention*. New York: Cambridge University Press.
- Davoli, M., Bargagli, A.M., Perucci, C.A., Schifano, P., Belleudi, V., Hickman, M., Salamina, G., Diecidue, R., Vigna-Taglianti, F., & Faggiano, F. (2007). Risk of fatal overdose during and after specialist drug treatment: the VEdeTTE study, a national multi-site prospective cohort study. *Addiction*, 102, 1954–1959.
- Douglas, M. (1997). *Rent og urent. En analyse av forestillinger omkring urenhhet og tabu*. Pax Forlag.
- Dyb, E., Johannessen, K., Lied, C., Kvinge, T. (2013). Bostedsløshet i Norge 2012. Omfang, kjennetegn og forklaringer. Oslo. Notat 2013:112. NIBR Norsk institutt for by- og regionforskning.
- Dyb, E. & Holm, A. (2015). Rus og bolig. Kartlegging av boligsituasjonen til personer med rusmiddelproblemer. NIBR Norsk institutt for by- og regionforskning.
- EONN, Europeisk overvåkingscenter for Narkotika og Narkotikamisbruk (2009). Narkotikasituasjonen i Europa - Årsrapport 2009.
- Fangen, K. (2010). *Deltagende observasjon*. 2. utgave. Bergen: Fagbokforlaget.
- Flyvbjerg, B. (2006). Five Misunderstandings About Case-Study Research. *Qualitative Inquiry*, 12(2).
- Frønes, I. (2001). Skam, skyld og ære i det moderne. I T. Wyller (red), *Skam. Perspektiver på skam, ære og skamløshet i det moderne*. Bergen: Fagbokforlaget.
- Geertz C. (1973). *The Interpretation of Cultures*. New York: Basic Books.
- Gjersing, L., Biong, S., Ravndal, E., Waal, H., Bramness, J. & Clausen, T. (2011). *Dødelige overdoser i Oslo 2006 til 2008. En helhetlig gjennomgang*. Rapport 2/2011. Senter for rus- og avhengighetsforskning (SERAF). Oslo.
- Grønmo, S. (2011). *Samfunnsvitenskapelig metoder*. Bergen: Fagbokforlaget.
- Gullestad, M. (1999). Kunnskap sett «nedenfra». *Nytt Norsk tidsskrift* 4/1999.
- Gullestad, M. (2002). *Det norske sett med nye øyne*. Oslo: Universitetsforlaget.
- Hanssen, L. E. & Braut, G. S. (2010). Sårbarhet i tjenestetilbudet til rusmiddebrukere – erfaringer fra tilsyn. I J. G. Bramness (red.), *Følelser og fornuft*. Festskrift til Helge Waal. Oslo. SERAF.
- Helsedirektoratet (2014). *Nasjonale overdosestrategi 2014 -2017*. “Ja visst kan du bli rusfri - men først må du overleve”. Oslo: Helsedirektoratet.
- Helse- og omsorgsdepartementet (2012). Meld. St.30. (2011-2012). *Se meg! En helhetlig rusmiddelpolitikk, alkohol-narkotika-doping*. Bergen: Fagbokforlaget.
- Herrestad, H. & Biong, S. (2010). Relational hopes: A study of the lived experience of hope in some patients hospitalized for intentional self-harm. *International Journal of Qualitative Studies on Health and Well-being*, 2010(5), 4651.
- Johansen, J. A. (2007). Tverrfaglig spesialisert rusbehandling: et nytt tjenesteområde i spesialisthelsetjenesten. *Tidsskrift for norsk psykologforening*, 44(3), 269–272
- Johansen N. B. & Myhre, H. (2004). *Skadereduksjon i praksis, del 1*. Oslo kommune Rusmiddelstaten. Kompetansesenteret.

- Karlsson, L. B., Kuusela, K., & Rantakeisu, U. (red.) (2013). *Utsatthet, marginalisering og utanförskap*. Lund: Studentlitteratur.
- Kommunal- og regionaldepartementet (2011). *Rom for alle. En sosial boligpolitikk for fremtiden*. (NOU 2011:15). Oslo: Departementenes servicesenter, Informasjonsforvaltningen.
- Kronauer, M. (1998). 'Social exclusion' and 'underclass' – new concepts for the analysis of poverty. I H-J Andress (Ed.), *Empirical poverty Research in a comparative Perspective*. Aldershot: Ashgate.
- Lalander, P. (2005). *Mellan självmalt och påtvingat utanförskap. En analys av sju kvalitativa studier om unge narkotikaerfarne människors tanker om narkotika*. Rapport 10, 2005.
- Leseth, A. & Solbrekke, K. N. (2011). *Profesjon, kjønn og etnisitet*. Oslo: Cappelen Damm Akademiske.
- Mackenbach, J. P., Kunst, A. E., Cavelaars, A.E.J.M., Groenhouf, F., Geurts, J.J.M., & the EU Working Group on Socioeconomic Inequalities in Health (1997). Socioeconomic inequalities in morbidity and mortality in western Europe. *The Lancet*, 349, 1655–1659.
- Malterud, K. (2011). *Kvalitative metoder i medisinsk forskning*. En innføring. 3.utgave. Oslo: Universitetsforlaget.
- McGregor, C., Dark, S., Ali, R., & Christie, P. (1998). Experience of non-fatal overdose among heroin users in Adelaide, Australia: circumstances and risk perceptions. *Addiction*, 93, 701–711.
- Miller, P.G. (2006). Dancing with death: the grey area between suicide related behavior, indifference and risk behaviors of heroin users. *Contemporary Drug Problems*, 33, 427–450.
- Mæland, J.G. (2004). Sosial faktorerers betydning for sykdom og helse. I J. G. Mæland, P. Fugelli, G. Høyer og S. Westin. (red), *Sosialmedisin – teori og praksis*. Oslo: Gyldendal Akademiske.
- Naper, S. & Dahl, E. (2007). Sosialhjelpsmottakeres dødelighet: I hvilken grad kan overdødeligheten tilskrives deres sosiale status? *Norsk Epidemiologi*, 17(1), 21–28.
- Pedersen, A. G. (2000). Notater. *Oversikt over Dødsårsaksregisterets koderegler 1996-1997*. Statisk sentralbyrå. 2000/51. Avd. for personstatistikk/Seksjon for helsestatistikk.
- Pedersen, E. (2015). *4.000 pasienter sendes årlig «hjem» uten å ha en adresse*. Bergensavisen. <http://www.ba.no/debatt/4-000-pasienter-sendes-arlig-hjem-uten-a-ha-en-adresse/o/5-8-125706>, lastet ned 30.12.15.
- Piiva, K. & Brodin, H. (2013). En familj som alla andra - samtal med mödrar til vuxna barn med psykisk funktionsnedsättning. I L.B. Karlsson, K. Kuusela & U. Rantakeisu (red.), *Utsatthet, marginalisering og utanförskap*. Lund: Studentlitteratur.
- Platt, S., Davis, S., Sharpe, M., & O'May, F. (2005). Contextual effects in suicidal behaviour: evidence, explanation, and implications. I K. Hawton (Ed.), *Prevention and treatment of suicidal behaviour. From science to practice*. Oxford: Oxford University Press.
- Ravndal, E. & Amundsen, E. J. (2010). Mortality among drug users after discharge from inpatient treatment: An 8-year prospective study. *Drug and Alcohol Dependence*, 108, 65–69.
- Representantforslag (2007-2008). *Representantforslag nr.75 fra stortingsrepresentantene G. Ludvigsen, T. Skei Grande, O. E. Dørum og A. N. Skjelstad*. Dokument nr. 8:75 (2007-2008).

- Richert, T. & Svensson, B. (2008). Med livet som insats – injeksjonsmissbruk, risktagande och överdoser. *Nordisk alkohol- & narkotikatidsskrift*, 25, 355–376.
- Rognerud, M., Strand, B.H. & Hesselberg, Ø. (2000). *The health of Disadvantaged Groups in Norway*. Statens institutt for folkehelse, rapport 2000:2. Oslo.
- Rossow, I. (1994). Suicide among drug addicts in Norway. *Addiction*, 89, 1667–1673.
- Rossow, I. (1996). Rusmiddelbruk og dødelighet. *Norsk Epidemiologi* 6(1), 37–44.
- Rossow, I. (2001). Rusmiddelbruk og suicidal atferd. *Suicidologi*, 6(3).
- Rossow, I. & Lauritzen, G. (1999). Balancing on the edge of death: suicide attempts and life-threatening overdoses among drug addicts. *Addiction*, 94(2), 209–219.
- Rus & avhengighet (2003). Ja, takk, et sted å bo (men ikke i mitt nabolag). *Rus og avhengighet* 6, 2003.
- Simonsen, K. W., Normann, P. T., Ceder, G., Vuori, E., Thordardottir, S., Thelander, G., Hansen, A.C., Teige, B. & Rollmann, D. (2011). Fatal poisoning in drug addicts in the Nordic countries in 2007. *Forensic Science International*, 207(1), 170–176.
- Skårderud, F. (2001a). Tapte ansikter. I T. Wyller (red), *Skam. Perspektiver på skam, ære og skamløshet i det moderne*. Bergen: Fagbokforlaget.
- Skårderud, F. (2001b). Skammens stemmer - om taushet, veltalenhet og raseri i behandlingsrommet. *Tidsskrift for Den norske legeforening* (13), 1613–1617.
- Steentoft, A., Teige, B., Ceder, G., Vuori, E., Kristinsson, J., Simonsen, K. W., Holmgren, P., Wethe, G. & Kaa, E. (2001). Fatal poisoning in drug addicts in the Nordic countries. *Forensic Science International*, 123(1), 63–69.
- Svedberg, L. (1995). *Marginalitet*. Lund: Studentlitteratur.
- Svensson, B. & Andersson, M. (2012). Involuntary discharge from medication-assisted treatment for people with heroin addiction-patients' experiences and interpretations. *Nordic studies on Alcohol and Drugs*, 29(2), 173–193.
- Vingoe, L., Welch, S., Farrell, M. & Strang, J. (1999). Heroin overdose among a treatment sample of injecting drug misusers: accident or suicidal behaviour? *Journal of Substance Use*, 4, 88–91.
- WHO (1996). *ICD-10. International Statistical Classification of Diseases and Related Health Problems*. Geneva: World Health Organization.
- Waal, H., & Gossop, M. (2014). Making sense of Differing Overdose Mortality: Contributions to Improved Understanding of European Patterns. *European Addiction Research*, 20(1), 8–15.
- Westin, S. (2002). Sosiale gradienter i helse. *Tidsskrift for Den norske legeforening*, 122, 1861.
- Wright, N., Oldham, N., & Jones, L. (2005). Exploring the relationship between homelessness and risk factors for heroin-related death – a qualitative study. *Drug and Alcohol Review*, 24, 245–251.
- Wyller, T. (2001). Skam, verdighet, grenser. I T. Wyller (red), *Skam. Perspektiver på skam, ære og skamløshet i det moderne*. Bergen: Fagbokforlaget.
- Ødegård, E., Amundsen, E.J., Kielland, K.B., & Kristoffersen, R. (2010). The contribution of imprisonment and release to fatal overdose among a cohort of Norwegian drug abusers. *Addiction Research and Theory*, 18(1), 51–58.
- Østerberg, D. (1993). Latent funksjon og amfibisk samkvem. I *Fortolkende sosiologi 1*. Oslo: Universitetsforlaget.

Østerberg, D. (2012). *Sosiologiens nøkkelbegreper*. 7. Utgave. Cappelen Damm Akademiske.

<sup>i</sup> <http://www.tv2.no/a/5838147>, downloaded 1 December 2014.

<sup>ii</sup> Interview with Secretary General Bjørn-Inge Larsen in the Ministry of Health and Care Services; <http://www.dagensmedisin.no/Pages/PrintNewsArticle.aspx?printPageId=114657>, downloaded 1 March 2012.

<sup>iii</sup> Comparisons of the number of deaths in Norway with other European countries should be viewed with caution since different code traditions are applicable. Professor Clausen at Seraf says this does not affect the Norway's high ranking in the European overdose statistics.

[http://www.rop.no/Artikler/Nasjonalt/Problematisk\\_aa\\_sammenligne\\_overdosedoedsfall](http://www.rop.no/Artikler/Nasjonalt/Problematisk_aa_sammenligne_overdosedoedsfall), downloaded 27 June 2013.

<sup>iv</sup> <http://www.sirus.no/263+narkotikad%C3%B8dsfall+i+Norge+i+2008.d25-SMJrY3L.ips>, downloaded 7 June 2011.

<sup>v</sup> <https://www.regjeringen.no/globalassets/upload/hod/dokumenter-fha/opptr.plan.pdf>, downloaded 19 August 2015.

<sup>vi</sup> A Nordic study of forensic autopsies in Norway in 2007 shows that ca. 80 per cent of 236 deaths caused by poison were men, mostly between the ages of 25 and 34 (Simonsen et al. 2010).

<sup>vii</sup> The age of people dying from drugs-related problems is increasing. In 2012, most were in their 30s, 40s and 50s. (<http://statistikk.sirus.no/sirus/>), downloaded 22 August 2015.

<sup>viii</sup> The six persons who died of an overdose were dropouts (Ravndal and Amundsen 2010).

<sup>ix</sup> <http://www.sirus.no/Stor+risiko+for+overdose+etter+behandling.d25-SMJvO3W.ips>, downloaded 18 August 2014.

<sup>x</sup> The exception here is the Netherlands.

<sup>xi</sup> The original sample was made up of 23 persons; 2 women and 21 men. One of the men had a European background.

<sup>xii</sup> One of the men said he only used amphetamines. Mortality is lower for use dominated by psychostimulants and drugs taken orally than for the injection of heroin (Clausen, Havnes & Waal, 2009).

<sup>xiii</sup> The code for underlying cause of death was F110 for four out of five men, i.e. death due to acute intoxication, heroin overdose (Pedersen, 2000). A fifth death was registered without an ICD code. An enquiry to the Norwegian Institute of Public Health revealed that the cause of death was poison by heroin, and a degradation product from the sedative Flunipam/Rohypnol was also in evidence.

<sup>xiv</sup> International Statistical Classification of Diseases and Related Health Problems (WHO, 1996).

<sup>xv</sup> One of the deaths was HIV related, ICD code B201.

<sup>xvi</sup> Statistics Norway implemented a change to the codes in 2003 in connection with death from poisoning. WHO recommended that all deaths from poisoning should be coded as accidents. Prior to this change, deaths from poisoning among drug users were coded as psychological issues and behaviour disorders (<http://www.ssb.no/dodsarsak/>, downloaded 14 April 2012).

<sup>xvii</sup> The deaths were registered with the code X42, supplemented with code T401.

<sup>xviii</sup> ICD code R784.

<sup>xix</sup> ICD code T510.

<sup>xx</sup> ICD code T424.

<sup>xxi</sup> Five were single and two were divorced with children.

<sup>xxii</sup> <http://snl.no/marginal>, downloaded 2 April 2013.

<sup>xxiii</sup> <http://www.forebygging.no/Ordbok/L-P/Marginalisering/>, downloaded 12 January 2015.

<sup>xxiv</sup> <https://snl.no/narkoman>, downloaded 25 April 2015.

<sup>xxv</sup> <http://www.dagsavisen.no/oslo/thorvalds-jul-1.666626>, downloaded 28 December 2015.

<sup>xxvi</sup> <https://helsedirektoratet.no/samhandlingsreformen>, downloaded 29 December 2015.

<sup>xxvii</sup> <https://www.regjeringen.no/no/tema/pensjon-trygd-og-sosiale-tjenester/nav-reformen/id604957/>, downloaded 29 December 2015.

<sup>xxviii</sup> <https://www.regjeringen.no/no/tema/helse-og-omsorg/psykisk-helse/rus/rusbehandling-i-spesialisthelsetjenesten/id439355/>, downloaded 28 December 2015.