

# Negotiating Space in Confined Places – Co-Production of Public Services with Unwilling Users

Therese Reitan\*

Therese Reitan<sup>1, 2</sup>

<sup>1</sup> Department of Public  
Administration,  
Södertörn University  
therese.reitan@sh.se

<sup>2</sup> Department of Public  
Health Sciences,  
Stockholm University  
therese.reitan@su.se

## Abstract

An expanding body of research on co-production, participation, co-creation and other forms of user involvement in public services has not sufficiently reflected their coercive nature. Coercion, like persuasion, is a central dimension of public administration and a defining element of, for example, compulsory care. It is, however, seldom properly addressed in the literature on co-production. The aim of this study is twofold; to propose a broadened definition of co-production which more adequately reflects the complexities of human services by distinguishing between users (clients) and consumers (social services), and to investigate the relevance and practice of co-production in a non-voluntary setting. Examples of enhanced, participative, consumer, and user co-production were identified based on organizational and individual data from the Swedish government agency responsible for compulsory care for substance abusers. Forms of user co-production at the operational level were highlighted through client records and administrative data concerning transfers to community care – so called Care in Other Forms (COF). COF placements are intricate processes involving many different stakeholders and the analysis revealed how clients actively partake in negotiations on the terms and content of service delivery. The idiosyncrasies of involuntary human services should be considered in future research on co-production.

## Introduction

Service delivery, service provision, public services, and public administration for that matter, are all concepts based upon an underlying idea of one party (the public agency) providing a good or a service to an individual (citizen, user, patient, client, inmate – or customer as it were<sup>1</sup>) or groups of individuals (for example school children, senior citizens, asylum seekers). The relationship is usually distinctly asymmetrical in the sense that the agency has the mandate and resources to decide on the design, content, timing and outcome of this service provision.

Co-production, user and citizen involvement in the provision of public services attracted the attention of policy makers and scholars alike – albeit for different reasons – from the 1970s onward. The first surge of scholarly interest originated in urban studies where researchers were looking for theoretical and empirical foundations for predominant policies of massive centralization. Through empirical studies they found that multiple service providers were operating in single jurisdictions and that it was difficult to produce a service without the active participation of those receiving the service (Pestoff, 2006). It became increasingly evident that most services (and the successful outcome of those services) are highly dependent on the input from users or recipients and that a change of perspective from one-way service *delivery* to complex *co-production* of services involving multiple stakeholders was needed (Verschuere et al., 2012).

Co-production, or citizen involvement, became highly relevant not only in the field of public administration but also for political scientists interested in

Keywords:  
Co-production,  
Compulsory care,  
Human services,  
Users,  
Substance abuse

---

\***Therese Reitan** is associate professor in Public Administration at Södertörn University, Sweden. Her main research focus has been on interorganizational relations, legislation, policies and decision-making in health care and social services – particularly compulsory care for substance abuse – as well as on leadership and the role of public servants.

different forms of democratic participation or, for example, for economists looking for models of welfare state reform. For policy-makers, co-production offered a feasible solution to the fiscal and organizational challenges of a seemingly overgrown public sector. Co-production was a satisfactory option for those looking for a more active role for citizens in service provision and society overall, as a way of increasing the efficiency and effectiveness of government. It also offered promises of a less expansive public sector (Barber, 1984; Walzer, 1988).

In their seminal contribution to the field, Parks et al. (1981) define co-production as the mix of activities that both public service agents and citizens contribute to the provision of public services, albeit with different roles: The former are involved as professionals, or ‘regular producers’, while ‘citizen production’ is based on voluntary efforts by individuals and groups to enhance the quality and/or quantity of the services they use.

Leaving aside the issue of voluntariness, Ostrom (1996) directed attention towards the underlying organizational structure of co-production by defining it as a “process through which inputs used to provide a good or service are contributed by individuals who are not in the same organization” (p. 1073). In a similar vein, Brandsen and Honingh (2015) see co-production as a relationship between a paid employee of an organization and (groups of) individual citizens that requires a direct and active contribution from these citizens to the work of the organization. Many definitions of co-production go one step further and make a distinction between co-production at the individual, group, or collective level depending on the nature of benefits achieved and the degree of overlap between activities of regular producers and consumers (Brudney & England, 1983: 63). This approach focuses on *de facto* service provision at the organizational and managerial level, but co-production may also be studied at the policy level – for example, in terms of civil society’s role in the development of the welfare state (Brandsen & Pestoff, 2006; Johnson, 2006; Trägårdh, 2007) or as a policy in itself; enhancing co-production, or co-creation, is one of the most frequently suggested remedies against malfunctioning human services and a way of harnessing resources (Lund, 2018).

The traditional definitions of co-production do have their limitations though. First, the constraint on individuals who are not in the same organization (Ostrom, 1996) is problematic. It is true that service users are generally not employed or professionally affiliated and that they often have a temporary link to the service in question. However, as a category, service users are definitely part of the organization. Users and (potential) users are in fact the *raison d’être* of public organizations. Citizens obviously need public services, but public services also need clients in order to fulfil their own goals (Alford, 2009). Second, the view of Parks et al. (1981) that co-production is about efforts by individuals and groups to enhance the quality and/or quantity of the services they use seems to exclude co-production at the street level (Lipsky, 2010) as part of the interaction between service providers and service users and focuses more on *institutional arrangements* for user involvement. That is more or less permanent structures where individuals or groups outside the organization (Ostrom, 1996), voluntary associations (Parks et al., 1981) and users, in the sense that user *representatives* are engaged in service planning, design, development – and provision for that matter – on a continuous and general level, not primarily in

service provision in individual cases. A third limitation is the underlying presumption of voluntariness.

### Coercion – the missing link in co-production?

Coercion – like persuasion – does not only “[have] its place in government” (Whitaker, 1980: 244), but also *defines* the state through its legitimate use of physical force within a territory (Weber, 1948). Nevertheless, the extensive body of research on co-production, participation, co-creation and other variants of user involvement in public services has not reflected the fundamentally coercive nature of public administration given the Weberian definition of a state. Some would therefore argue that co-production is not really feasible in public services and that “the paradigm case of administrator-citizen interaction is not, as we would like, co-production; rather, being confronted by cops and other agents of behavioural coercion is the paradigm case” (Fox, 2003: 63). From this point of view, co-production cannot really exist in what Fox calls “the prosecutorial state”.

Without subscribing to the view that co-production and, in turn, much of public administration research at large, contributes to “legitimizing status quo stateism” (Fox, 2003: 71), it is evident that traditional definitions of co-production implicitly or explicitly depart from a paradigm image of service provision to those demanding such services. That is, the presumption is one of voluntariness and reciprocity as suggested by the prefix “co-“. In their overview of main definitions of co-production Nabatchi et al. (2017) point out how some specify voluntary engagement among actors, while others do not (p. 768). In the Parks et al. (1981) definition (see above), ‘citizen production’ is based on *voluntary* efforts by individuals and groups to enhance the quality and/or quantity of the services they use. Nabatchi and colleagues themselves argue that co-production is an “umbrella concept that captures a wide variety of activities that can occur in any phase of the public service cycle and in which state actors and lay actors work together to produce benefits” (p. 769). Lay actors are here understood as citizens (members of a geographic or political community), as clients (recipients of public services for which he/she is not required to pay directly, or as customers (recipients of public services for which he/she must pay the provider directly). More importantly, though, they exclude “activities that are not voluntary for the layperson”, i.e. that voluntary participation of lay actors is a *requisite* for co-production (p. 770).

Osborne et al. (2016), however, define co-production as the “voluntary or *involuntary* [my emphasis] involvement of public service users in any of the design, management, delivery and/or evaluation of public services” (p. 640). Co-production is, then, an inalienable component of service delivery – whether the public service encounter is coerced or not. “Indeed, resistance to service delivery, especially in the more coercive areas of public services such as the criminal justice system or mental health, is as much a form of co-production as a voluntary and conscious willingness to co-produce” (p. 641).

Part of the contradictory stands in the field is semantic and related to varying notions of *what* is being produced, *how* it is produced and *under what circumstances*. This is part of the reason we seem to be wandering aimlessly between concepts such as “stakeholders”, “citizens”, “users”, “clients”, “customers”, “co-producers” – or even “captives” (Jung, 2010). Each term carries different connotations concerning the degree of involvement and actual

scope for choice and influence; even “consumers” are varyingly depicted as empowered individuals who are free to choose or as victims of manipulation and exploitation (Jung, 2010: 441). “Participation” signals empowerment of individuals or groups. “Co-creation” and “co-production” are generally used interchangeably, but the former is usually associated with social innovation and value creation while the latter is linked to service production and cost reduction (Lund, 2018).

Participation, involvement, collaborative governance, inclusion and empowerment of individuals and groups – beyond participation in formal political processes and bodies through for example elections – are generally an explicit aim in most democratic welfare states. At the international level the Convention of the Rights of the Child, for example, also gives children the right to be heard and included in decisions that affect them. The forms such participation takes, the extent to which user involvement and empowerment is feasible and practiced is of course an empirical question which has spurred extensive research, professional and policy debates – in voluntary and coercive settings alike (Michels & De Graaf, 2010; Newman et al., 2004; Hill et al., 2004; Vis et al., 2012). Within medicine and human services there has been a strong movement towards evidence-based practice in recent decades based on the triangulation of scientific evidence, professional judgment, and user preferences. Consequently, user involvement, empowerment and participation has become not only an aim but also a requirement for access to public funding, a criterion in follow-ups and audits of service delivery. This form of dialogue- based governance has also spurred the creation of new “dialogic intermediary organizations” in the space between government and other stakeholders (Davis, 2007).

Although the literature on co-production does acknowledge that coercion in some form is an inherent part of public services (Whitaker, 1980), the field has gravitated around the voluntary end of public service provision. It has, moreover, largely failed to consider the idiosyncrasies of human services such as the distinction and co-existence of users and consumers. This study therefore sets out to

- investigate the relevance and practice of co-production in manifestly coercive public services
- propose a broadened definition of co-production based on the particularities of human services.

## Conceptualizing co-production in coercive human services

Unlike much current public administration and management literature, the service management literature emphasizes the interaction between the service producer and service user and the interdependence between them at the operational level. However, the service management theory has little room for or understanding of the policy context of public services, involuntary service delivery, or services where the desired outcomes are multiple and contested. Osborne and Strokosch (2013) therefore suggest a combination of the public administration and the service management perspectives to enhance our understanding of the nature, process and limitations of co-production at the operational, strategic, and service levels. Osborne and Strokosch call them the “consumer”, “participative”, and “enhanced” modes of co-production. The concepts are advertised as “powerful conceptual tools to assist with the

description, analysis and evaluation of different forms of co-production in public services” (p. S32). Their main features are described in further detail below, as well as in Table 1.

### Modes of co-production

Consumer co-production results from the inseparability of production and consumption during the service encounter and focuses upon the engagement of the consumers at the operational stage of the service production process. Co-production is not an add-on to the delivery of public services but rather a core element of it. In this mode, experience and outcomes are negotiated between the service user and the service delivery professional rather than one dominated by the latter. The aim of consumer co-production is *user empowerment*. What consumer co-production does not do, however, is to consider the needs of service users as a collective, to affect public services at the strategic planning level or to consider the needs of future service users and to ensure for example rule of law or equal treatment across geographical and economic boundaries.

Participative co-production results from the intention to improve the quality of existing public services through participative mechanisms at the strategic planning and design stages of the service production process. These mechanisms include user consultation and participative planning instruments. The aim is *user participation*.

Lastly, enhanced co-production results from combining the operational and strategic modes of co-production to challenge the existing paradigm of service delivery. The aim is *user-led innovation* of new forms of public service and could as such therefore just as easily be termed co-creation (Lund, 2018).

As Osborne and Strokosch (2013) point out, these categories do have their limitations. For example, they do not sufficiently reflect the coercive nature of many public services. Most of the work in the field still departs from a fundamental perception of public services as driven by user demand. In a typology of user identities between hierarchies and markets, Fotaki (2010) describes the least empowered users as “responsibilized”, i.e. users who may be forced into co-production arrangements when public services are cut down and not replaced by the market. “In an absence of options to choose from, such a user has little control of their destiny despite the freedom of choice. Moreover, the choices open to users may also be restricted if they perceive themselves to be involuntary service users” (p. 939). The underlying understanding of involuntariness is, however, the lack of choice, and the *perception* of being involuntary service users, rather than public services based on explicit coercion. The typology therefore needs to be developed in this direction.

### Human services

Human services, or human service organizations, are ubiquitous in most developed societies. Their primary role is to influence the welfare and well-being of individuals and as such they also epitomize the contradictory role of the (welfare) state; they are varyingly viewed as wasteful, fostering dependency, obtrusive and controlling (Offe, 1984), and as expressions of modernization and societal obligations towards the well-being of its citizens (Hasenfeld, 1992). Human services, as opposed to public services in general, are characterized by humans being the raw material, the production technology, and output – they are about people “doing something with or to” other people. Inherent in this kind of

people work is the fact that it is also moral work. Actions taken on behalf of the client is not only a concrete service but also a moral judgment and a statement of the worthiness of their needs. The centrality of client-worker relations and consequently of client compliance – or co-production, as it were – is another significant aspect of human services. Service delivery itself and the successful outcome of the same is highly dependent on the interaction between providers and recipients.

In addition to the above there is another trait with direct relevance for co-production in coercive contexts: In the private sector, expressing preferences and receiving goods or services are usually performed by the same party – the customer. In the public sector, where the large bulk of human services are found, these functions are asymmetrically divided between the citizenry and clients. The function of expressing preferences about what value should be produced (and how they are to be paid for) is primarily carried out by the citizenry through democratic institutions. The citizenry, through its elected representatives and the public administration through which decisions are implemented, has the dominant say about what is to be consumed, how, and by whom. In this way the value delivered by government is “consumed” both by citizens, who receive public value and by individual recipients who receive private value (Alford, 2002: 338).

Given the inherent asymmetrical relationship between users and providers in (public) human services, and the importance of distinguishing between consumers in the form of citizens (as represented by the political-administrative system) and individual clients, we propose an expansion of the Osborne and Strokosch (2013) typology by adding a fourth category. Starting at the system-level, *four* modes of co-production may be identified; enhanced, participative, customer, and user co-production. See Table 1.

*Table 1. Modes of co-production in coercive human services.*

	Enhanced co-production	Participative co-production	Customer co-production	User co-production
Type of stakeholder(s) involved	Stakeholder representatives, of which some may have previous experience of service utilization (indirect users)	User representatives with previous or present experience of services in question (direct, but not necessarily current, user)	Service commissioner, no experience of service utilization (indirect user)	Present service recipient (direct and current user)
Aim	Developing services at the organizational and policy level	Developing services at the production level	Solving particular problems and catering to specific needs of individual clients	Client empowerment
Forms of evaluation, salient issues	User perspective in all services	Rate of staff with necessary level of education, share of clients offered qualified treatment measures. Developing relevant programs, increased inter-agency cooperation.	Providing a bed in due time (no queue). Service commissioner’s satisfaction with procured services.	Surveys among individual clients Share of clients who go on to voluntary care. Follow-up studies focusing on improvement in quality of life.

The second aim of this paper is to study relevance of this typology by applying it to a manifestly coercive human service was chosen, in which co-production (participation) is also a stated formal policy aim. The next sections will, however, first describe the system of compulsory care for substance abuse in Sweden, as well the data and methodology on which the study is based.

## Compulsory care for substance abuse

Health care and social services in Sweden are to be provided according to the basic principle of voluntariness and patient/client participation<sup>2</sup>. An individual may, however, be placed in care without his/her consent if this is deemed necessary to protect the person and/or others from physical, mental, or social harm. Compulsory care on the grounds of health or social conditions is regulated in the Care of Young Persons (Special Provisions) Act, the Care of Substance Abusers (Special Provisions) Act, and the Compulsory Psychiatric Care Act. The first two are part of the social welfare legislation and are administered by the municipal social services. The latter is a supplement to the general health and medical services act and administered by the health care system.

The empirical focus in this study is compulsory care for substance abuse, according to the Care of Substance Abusers (Special Provisions) Act. According to this act a person may be committed to care for *a maximum of six months* if he/she a) has an ongoing abuse of alcohol, drugs or volatile solvents, b) is in need of care in order to come clear of this abuse, and c) voluntary measures have proved to be insufficient. Moreover, it must be proved that he/she is at great risk of severely harming his/her health, or destroying his/her life, or that it can be feared that he/she will inflict serious harm to him-/herself or to a next of kin. It is the municipal social welfare board's responsibility to apply for such care if it is reasonable to believe that the individual meets the requirements in the law and the application is tried in an administrative court. Every year approximately 1,000 persons committed to compulsory care and placed in one of presently 11 closed facilities run by a government agency, the National Board of Institutional Care (NBIC)<sup>3</sup>.

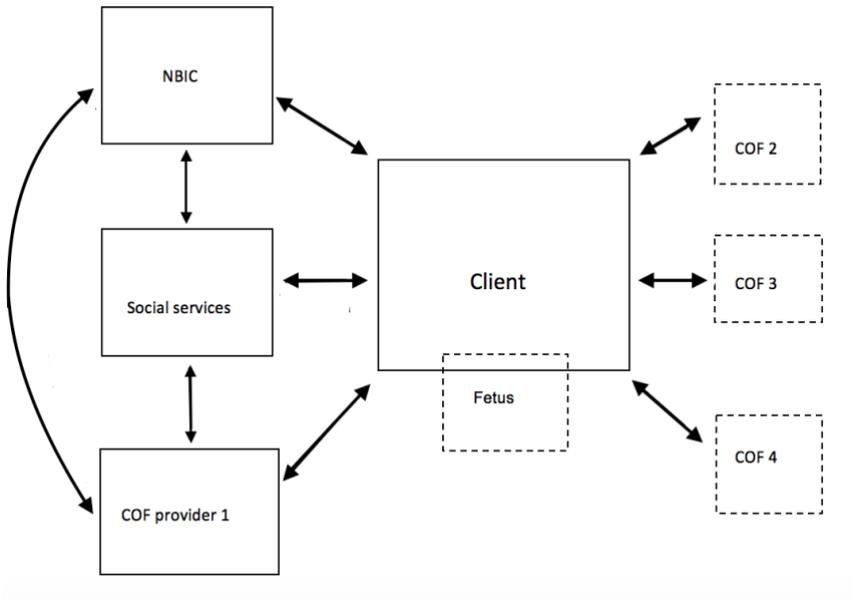
Being committed to compulsory care does not, however, necessarily imply that the client is confined to a closed facility throughout the placement period. The avowed aim of the legislation is to motivate clients for voluntary treatment and clients are therefore to be provided with an opportunity to reside outside the NBIC facility and receive care in community programs during their period of commitment. This arrangement is formalized in section 27 of the Act and is referred to as Care in Other Forms (COF)<sup>4</sup>. Similar arrangements are also found in mental health care, in Sweden as well as other countries (Maughan et al., 2014; Reitan, 2016).

In general, clients are eager to be placed in COF as soon as possible after arriving at an NBIC facility. This is a way of escaping the confinement of a closed facility and the most obtrusive effects of an involuntary placement. Despite the threat of being brought back to the NBIC facility if they fail to comply with rules and plans, being able to reside in an open institution or even in their own homes while participating in outpatient treatment programs, is clearly more attractive than remaining in an NBIC facility for up to six months. Some clients do not, however, wish to be placed in COF at all and just wish to "serve their time". Other clients are not placed in COF because it is not possible to make the necessary arrangements. On average around 75-80 percent of

eligible clients are placed in COF at least once during their commitment (National Board of Institutional Care, 2018).

Placing clients in COF is an exceedingly complex process involving several parties with potentially conflicting judgments and interests, in addition to structural and practical obstacles. An overview over actual and potential stakeholders in the COF process is presented in Figure 1.

Figure 1. Overview over stakeholders in co-production of COF placements within compulsory care



For a COF-placement to come about four parties must come to an agreement; the client, the NBIC, the social services, and the COF provider. This is illustrated in the left side of the figure. The NBIC (in practice the manager of the facility in which the client is placed) has the formal right to decide that the client be transferred to COF – and to retract this decision if for example the client relapses or fails to comply with regulations. The decision to place the client in COF is, however, in practice taken jointly by the NBIC and the social services in the client’s home municipality, who are responsible for making the arrangements and contracting a COF-provider outside the NBIC.

The potential COF-provider may often be a private or non-governmental service with a long-term contract with the municipality following a procurement process – as in the case of COF 1 (see Figure 1). The social services are usually not willing to make use of COF providers outside the list of procured services (COF 2-4), although the client may have very specific preferences that do not coincide with the list of procured providers – for example COF 2 or COF 3. Furthermore, all COF-providers are free to accept or deny individual clients. There may simply not be any vacancies, they may deem the client as unsuitable for their services or may for example want to avoid mixing certain clients.

## Data and method

The modes of co-production described in Table 1 take place at different levels, and therefore data have been sought from several levels and sources within the NBIC. Enhanced and participative co-production involves stakeholders that are not directly or currently involved in the actual service delivery, where the institutional arrangements are at the fore.

To illustrate modes of co-production at the organizational and facility level documents and statistics such as annual reports, protocols, guidelines were retrieved from the NBIC web page as well as personal communication from key informants.

The main focus of the analysis is, however, placed on the operational level and user co-production – because this is where the distinction between consumer and user become most visible and where the tension between voluntariness vs involuntariness in co-production concept is most salient. For this purpose, client records from a previous study of pregnant women in compulsory care (Reitan & Weding, 2012) were analysed. The fact that these clients were pregnant puts an added demand on COF placements and adds a “fourth” party to the list of stakeholders (see Figure 1). Data were retrieved from the NBIC client administrative system and consisted of fixed variables concerning dates of admission and discharge, legal statutes for placement, leaves of absence and deflections, transfers between wards and in or out of COF, etc., as well as daily or weekly staff reports as free text entries. The texts were available in pdf-format and references to COF<sup>6</sup> were therefore sought throughout the documents, leading to accounts of negotiations and events in connection with COF-placements.

Fixed information was organized in a spreadsheet to enable a descriptive overview of COF placements in the entire group. To illustrate the complexity of user co-production in an involuntary setting, the most “pronounced” cases were chosen to scrutinize user co-production in COF-placements – that is, cases in which clients had been placed in COF on more than two occasions during the same placement. This approach is comparable to what Seawright and Gerring (2008) term the “diverse case method”.

## Modes of co-production in compulsory care for substance abusers

### Enhanced co-production

Although NBIC clients are, by definition, involuntary users, the agency’s operations are to be guided by a user perspective – as are most other public services in the health and welfare areas. The agency must, then, report back to the government in what way a user perspective has influenced the provision of care<sup>7</sup>. One of the NBIC’s main tasks is to implement the intentions of the Care for Substance Abusers Act, namely, to motivate clients to enter voluntary treatment. COF-placements are an important tool in that regard and the percentage of clients who are in fact placed in COF is an important measure of goal attainment and is presented in annual reports. Increasing the rate of COF placements was also a central aim in government initiative during the mid-2000s (Hajjighasemi, 2008). The main aim of this project was not to increase COF placement rates as such but rather to advance cooperation between the NBIC, the social services, and other caregivers and stakeholders to improve continuity of

care (Ministry of Social Affairs, 2004). In recent years, around 75-80 percent of clients have been placed in COF (National Board of Institutional Care, 2018).

An important element of enhanced co-production is user-led innovation, or perhaps more adequately described as “traditional professional service provision with user-community consultation on service planning and design issues” (Bovaird, 2007: 849). User consultation committees and expert groups are commonplace in public services, not least in human services. So is also the case at the NBIC, in the shape of an agency level user committee consisting of representatives from client-related organizations. The committee provides an arena for discussions and consultations about the content and development of NBIC care in general and how to develop a user perspective in particulars. According to an NBIC annual report the Central User Committee is an arena for consultations with user representatives from civil society about the content and development of NBIC services. The NBIC and the User Committee have jointly prepared a description of the aims, conditions, and forms of dialogue between NBIC and the User Committee (National Board of Institutional Care, 2018).

### Participative co-production

In Osborne’s and Strokosch’s terminology (2013) participative co-production takes place at the strategic planning and design stages of the service production process, including user consultation and participative planning instruments aimed at user participation. The distinction between participative co-production and enhanced co-production is not clear-cut but participative co-production takes place in near proximity to the service delivery and the actual user, while enhanced co-production takes place at an arm’s length’s distance. In this sense, participative co-production is analogous to Bovaird’s “user codelivery of professionally designed services” (2007: 849). In Bovaird’s case “users” broadly includes individual users of a service as well as ex-users, community services, volunteers, families, self-help groups etc. In both cases, though, the participation takes place primarily through institutional arrangements designed to improve clients as a group, more than individual clients, and to influence services over time – i.e. not only for the clients who happen to be admitted at the time but also for clients to come.

Enhancing participative co-production in substance abuse services has been a policy aim and the object of interest among both government agencies and in research (Motion 2014/15:710; Socialstyrelsen, 2012). In a coerced care environment participative co-production is limited, or at least of another nature, compared to a voluntary setting. It must therefore be adapted to the context but is nonetheless an important part of service provision. As in the case of the user committee at the central agency level each institution within the NBIC has a “user forum”. These groups are led by a member of staff and consist of representatives from clients presently in care. They are meant to be an arena for discussions about conditions at the specific facility (for example rules about smoking, problems related to the physical environment, leisure activities, menu and food preferences).

Another example of participative co-production is the involvement of for example self-help groups or voluntary organizations in the provision of care at the facility level. Clients may for example attend self-help groups outside the premises of the facility or make use of leisure activities run by private, public and voluntary organizations.

Lastly, specific projects at the facility level aimed at developing services and working methods may also be included in this form of co-production. They often evolve from specific cases and work with individual clients but also exist independently and form separate institutional arrangements that are relevant regardless of whether the individual client is part of the efforts or not. One facility aimed at working with the client's network, and within the scope of the project the network groups continued to meet even if the client discontinued participation (Wärmegård, 2005). Even research project involving for example focus groups should be included in this category (Billquist & Skårner, 2009).

### Customer co-production

According to Osborne and Strokoč (2013) the aim of consumer co-production is user empowerment. However, this definition does not distinguish between consumer (customer) and user, and in human services such as this one the municipal social welfare board is the customer – or the citizenry, as it were (Alford, 2002). The social services define the need, make the demand on the NBIC, and pay the costs. One of the NBIC's main tasks vis-à-vis the customer, the municipal social welfare board is to provide a placement for clients who have been taken into custody by the social welfare board or who have been court ordered<sup>10</sup>. The inflow of clients is not foreseeable in full detail and so a certain delay may occur before an actual placement can come about. But, if the queue becomes too long the agency's reputation and legitimacy is put at risk if customer discontent becomes an issue and finds its way from the general director's office to the political and media<sup>11</sup>.

In addition, one of the factors that influences the influx of clients is how the municipal social services deem the adequacy of compulsory care in general, and the quality of NBIC services specifically. According to present legislation, the social services are obliged to apply for compulsory care if the requisites of the law are in place, but it is nonetheless evident that some municipalities are less prone to apply for compulsory care than others. Be that as it may, the municipalities are important stakeholders as customers of NBIC services. Therefore, the NBIC has throughout many years followed up both users (clients) as well as social services. The client's social worker is asked to fill in a survey after the client has been discharged, including questions about level of satisfaction with the treatment, communication and cooperation, and other aspects of the placement<sup>12</sup>. Some of these results are presented in NBIC annual reports as a measure of service quality (National Board of Institutional Care, 2018).

### User co-production in compulsory care

As illustrated in Figure 1, a placement in COF is an event that potentially involves many parties and where there is ample space for user co-production. The process associated with placements in COF are, then, potentially an arena where co-production may materialize in its most distinct form.

Table 2 provides an overview of COF-placements among the clients included in this study and shows that the vast number of clients were placed in COF on one occasion and most of these women were also in COF at the time of their discharge. The second largest category consists of women who were placed in COF on two occasions (16 in all) and the likelihood that the client is in a COF-placement when she was discharged from compulsory care seems to

decrease with an increase in number of COF-placements. Several COF placements indicates an unplanned disruption – or a “breakdown” (Sallnäs et al., 2004). The client may then be brought back to the closed facility and potentially stay there till the maximum period of commitment has been reached.

Table 2. COF-placements during the same court order for women who were pregnant at the time of the first COF-placement, 2000-2009 (n= 79).

	Placement in COF at the time of discharge?		
	Yes	No	Total
<i>Number of placements</i>			
1	55 (90%)	6 (10%)	61
2	12 (75%)	4 (25%)	16
3	0	2	2

*Negotiating COF placements on several occasions within one court order*

Every COF placement is potentially complex with various negotiation processes. It is, nonetheless, likely that cases with more COF-placements are particularly intricate and demanding in terms of merging the will of different stakeholders. Two cases were chosen to illustrate this potential complexity on the grounds that they had been placed in COF on three occasions during the same placement in compulsory care. Table 3 gives a timeline of these events (number of days between) as well as an overview of agencies and actors who are mentioned or play some part in the planning, realization, and breakdown of the COF-placements.

In the following condensed accounts of events surrounding these COF-placements are presented for the two clients with the three COF-placements during their commitment to care. Names and details have been altered to secure anonymity.

Table 3. Timeline of cases with three COF placements during same court order

	Anna	Bella
Days from admission to 1st COF placement a).	48	57
Days in 1st COF placement	20	102
Days between end of COF1 and start of COF2	13	1
Days in COF2	3	19
Days between end of COF2 and beginning of COF3	38	1
Days in COF3	62	5
Days from end of COF3 to discharge	9	26

Agencies and actors referred to in client record	Primary and other social service officers, foster parents for older child, Anna's fiancé, two maternity clinics, a specialist maternity clinic, several police units, two NBIC facilities (several members of staff), Anna's mother and partner, maternity ward.	Midwife, (adult) social services, child protection services, the Swedish Social Insurance Agency, three boyfriends (of which one is child's father, the child's grandmother, Bella's mother, maternity clinic, staff from another NBIC facility, the prosecutor's office (summon to trial regarding an attempted assault), Bella's lawyer, previous foster parents, specialist maternity clinic, maternity ward at hospital, two COF homes, child health care centre, emergency foster home for baby, psychiatric emergency ward.
Child born	In period between COF1 and COF2, 116 days after arriving at NBIC.	Before COF1, 53 days after arriving at NBIC.

a) A client may be formally registered as admitted without physically present at the facility till some later (due to absconction, residing in jail or hospital before being transferred to the NBIC facility etc). The number of days in this table equals the time between physical admittance at NBIC and the first formally registered decision to place the client in COF.

### *Anna – expecting her second child*

Anna has a ten-month old child who is now placed in foster care, which means the COF placement must be close enough to allow for regular contact with her child and the foster family. Already one week after arriving at the NBIC facility the COF-issue arises in her client record:

Anna loudly expresses her concern about her situation and the future, about being at NBIC, about keeping contact with her son Harry etc. Most of all she wants to go to a home for mothers or a home for families. Anna's mentor, Amanda, calls Anna's social worker Lilly Smith about this. Anna has been offered various treatment alternatives but has turned all of them down. As far as visiting rights with her son, Lilly Smith will check if the foster parents can bring her son for a visit to the NBIC facility.

Within the next few days Anna has a check-up at the maternity clinic and visits a specialist for further examination. She is interrogated by the police after having threatened her fiancé with a knife. Negotiations about the terms of her contact with her son and future COF placement continue:

Anna wants Amanda to talk to Lilly Smith to get answers to some questions, particularly concerning the right to see her son. After booking a meeting, the social services promise to talk to the foster mother and have her come to NBIC with the boy. Moreover, Anna wants to go to a mother-child care facility, at least one month before her due date. The social services will try to find an adequate facility somewhere closer to Anna's hometown. They hope to have a proposal at the planning meeting in ten days. Anna also wants leave of absence over a whole weekend because so much time is lost travelling back and forth.

As if to strengthen her position in this negotiation Anna absconds from the NBIC facility. She returns after a few days on her own hand, accompanied by her fiancé, but vanishes once again the day after. Anna is brought back and is soon

transferred to another, more secured, NBIC facility. The COF issue is brought up again shortly after soon returns on the agenda. Anna and staff from the NBIC visit a home for mothers and children in a nearby town and 48 days after arriving at the first NBIC facility she is placed in COF, at Greenville home for mothers and children. Some 20 days later the placement is discontinued:

Staff from Greenville inform us that Anna has brought in wine bottles and appeared in a drunken state. Anna was driven back to NBIC by Greenville staff and police officers who met up halfway. Further plans will be made when regular staff and the manager at Greenville are back at work.

The following days consist of meetings and contacts between various staff at the NBIC and Greenville. A near fortnight after the first COF-placement was disrupted Anna is again placed at Greenville. Three days later the NBIC receive a phone call from the manager who informs them that Anna is in a pub, that she is drunk and refuses to leave the premises. The police will not drive her back so staff from Greenville escort her themselves. "Anna arrives at 02 am. She is heavily intoxicated and very loud".

After this incident Anna wants to stay on at NBIC till the baby is born. Her case managers at NBIC and Greenville agree that this is the best solution. Greenville staff will, however, keep in touch with both Anna and the social services. Discussions also continue between the NBIC, Anna, and the child protection worker responsible for her older son.

Four days before giving birth Anna is informed that she has been appointed a new social worker. After Anna's child is born the NBIC, the social services, Greenfield and the maternity ward agree that Anna, the baby and the child's father are to be placed at Greenfield after she had recovered in hospital.

While Anna and the baby are on their way to Greenville, child protection services call the NBIC to inform them that the chair of the municipal social welfare board has decided that, if Anna returns to Greenville, her newly born baby will be placed in a foster home. There are clear traces of friction about Anna not being informed about the board's decision before being offered a placement at Greenville.

She ends up returning to NBIC and her period of commitment expires a few days later. After being discharged she calls the NBIC on several occasions. She wants to come back. Anna agrees that NBIC may send her records to her mother, who is helping her with practical issues – for example preparing an appeal in a court case.

### *Bella – first commitment to care and expecting her first child*

Bella is 7-8 months pregnant when she arrives at NBIC. During her first week there are discussions about possible COF placements and Bella wants to enter a treatment program for couples with her boyfriend. A few weeks later Bella and her mentor sit searching for options for COF placements on the internet and "find a couple of alternatives".

Bella and her mentor Karen visited a potential home in the next town. It went well but both Bella and Karen agreed that there was a lack of structure at Midhill - "I would be allowed to do exactly as I wanted". Bella will talk to her social worker again about this other place –

Longside. Bella definitely does not want to go Midhill. She has tried to contact her social worker to arrange a visit at Longside instead.

The coming days several alternatives are aired and discussed by Bella, Karen, and her social worker. Bella's first alternatives are rejected by the social services because they are located too closely to Bella's home environment and her destructive social circles. Instead of going for another study visit, staff from another facility – Freemont – come to see Bella at NBIC to inform her about *their* program. After a few days, the social services send over an assessment of the various alternatives, and a treatment plan which they want Bella to sign. However, Bella declines – “there are several strange phrases in it”. For example, they suggest a facility she had not visited yet. Karen promises to get back to Bella's social worker about this.

The meeting between Bella and Freemont at the NBIC went well: “Bella opened up and talked about herself, substance abuse, criminality, boyfriends, previous treatment etc. in a way that she has not done before.” Karen thinks the structured treatment program and competence at Freemont would benefit Bella, and Bella almost instantly decided that she would like to go to Freemont. The social services are informed about the latest developments.

Bella's mentor informs Midhill that Bella has chosen another COF home. Thereafter she calls Freemont to tell them that Bella wishes to be placed there. “Have also faxed a signed treatment plan, in accordance with the social services' wishes”.

Almost 60 days after being admitted to the NBIC, Bella is placed in COF at Freemont. Ten days later she calls “home” to NBIC and is unhappy about being moved to another building. Bella also finds it too lax at Freemont, with no proper structure. Karen tries to reach Bella's social worker, without succeeding. The day after she talks to Bella again, who has calmed down a little, but says she cannot stay at Freemont. The previous day an older child hit Bella's baby in the head. Discussions proceed between social services, the NBIC, Freemont, and Bella:

Bella's social worker Sandra says she has talked to the manager and that they have decided that he should be responsible for the structure around Bella and her baby. Ongoing discussions about how Bella can feel safe at Freemont. Karen tries to get hold of the manager, but he will be away for the next few days. Karen speaks with Bella again, who has talked to Jason and the manager and who is now under the impression that they are working with her safety issue and improving the structure.

Some months later Bella does not return as planned from a weekend visit to the baby's grandmother. She returns to Freemont in the night, after leaving the baby with a friend. She was upset after breaking up with her boyfriend, ended up at a party, got drunk, and someone put drugs in her drink. Her placement in COF is formally terminated and the next day there are numerous contacts between Bella's mentor at NBIC, her social worker, and staff at Freemont. Bella calls the NBIC to ask what will happen now.

The plan was that after the period of commitment expires, she and the baby and the baby's father were to be placed in some form of

supported housing, but these plans will probably be altered now.

Karen speaks with Bella, who realizes that things are a bit messy.

All parties agree it is better for Bella to continue her treatment at Freemont and the placement in COF is formally resumed the day after, without Bella ever physically returning to NBIC. She is, however, denied leave of absence and the NBIC and social services will meet in a few weeks to discuss further plans.

A few weeks later Bella does not return as agreed after being allowed to go to shop with her new boyfriend. Bella contacts staff at Freemont the day after and explains that she has taken drugs but wants to come back. The staff at NBIC urge her to return to Freemont immediately. Bella arrives in the late evening but runs off again the next day. She left the baby with a member of staff and said she was going to take a shower and was instead picked up by a man waiting in a car outside. The staff at Freemont manage to get hold of her on the phone. She will not reveal her whereabouts but admits having taken drugs.

Bella says she was unhappy because the social services wanted her to stay on at Freemont. Bella calls the NBIC a few days later asking how many days are left of her commitment. She was told four days.

Bella finds it unnecessary to travel all that way for so few days and says she will contact her social worker to “settle” the matter.

Towards the end of her period of commitment she is escorted to the psychiatric emergency ward, before returning to NBIC again. Child protection services are arranging for foster care for the baby, while Bella wants to be placed in family therapy with her child and boyfriend. She awaits further notice from the social services as she is discharged from NBIC when the commitment period expires.

## Discussion

Perhaps more than in other public services, human service agencies need cooperation, compliance – and co-production – to fulfil organizational goals and policy aims (Alford, 2002). At the street-level teachers, social workers, therapists, health workers and so on are trained to balance between persuasion and coercion (Evans & Harris, 2004; Hasenfeld, 2009). The co-production literature does acknowledge that involuntariness is inherent in most public services, albeit to a larger or lesser degree. However, co-production in manifestly coercive contexts has largely been ignored – perhaps because it seems antithetical to the concept of co-production.

The purpose of this study was to elaborate on the typology of Osborne and Strokosch (2013) to accommodate the particularities of human services, and to incorporate services that are manifestly coercive. The introduction of a fourth mode of co-production, by separating consumer co-production from user co-production, proved to be fruitful. Compulsory care for substance abusers is an example of a human service based on a fundamental involuntariness from the client, where society can lawfully incarcerate a person for a given period. The customer is, in this case, the citizenry through their legitimate political and administrative institutions (Alford, 2002).

Based on the suggested typology and the chosen case it is possible to identify different forms of co-production at the agency, facility, and operational levels. Enhanced and participative co-production are typically found in user councils, regular monitoring of share of clients placed in COF (a policy aim), in recurring surveys and feedback systems at the group level. User compliance and

cooperation are important also in this respect when clients participate in client interviews, user groups, participating in program activities and research studies (thereby contributing to the agency's "performance"), and so forth. Also, the customer – in this case the municipal social welfare board – is important for fulfilling organizational goals by placing demand on the NBIC services and providing feedback on the quality of services through for example surveys to the social services in charge of placements.

The main emphasis of the study was, however, co-production at the operational level – where service delivery takes place. By focusing on the COF-institution within compulsory care – which is basically obligatory for the service provider, but not for the client – the negotiation between different interests in relation to what service is to be delivered, when, and under what terms, was visualized. The two cases in this study illuminated the relevance and importance of user participation and user power resources in this fundamentally coercive setting. Both Bella and Anna are quite categorical about their preferences for COF placements and are active in suggesting options and taking own initiatives in this regard. Bella and her mentor sit together searching for suitable options on the internet, and after a study visit to a facility Bella and her mentor both agree that there was a lack of structure which would not be beneficial for her. Even under coercive circumstances, clients and professionals are able to deliberate on how care should be provided to optimize outcome.

In the case of pregnant service recipients, such as in this study, it is even necessary to complicate the notion of "client". Although not formally defined as a legal subject or a formal recipient as such, the unborn child does influence the use of coercion in the first place, the procurement of within-coercion services, as well as the involvement of additional stakeholders. These stakeholders may be child protection services, midwives, health services at the operational level, as well as service planners and even policy makers at the national level). As such this study also highlights the complexity of "user".

### Generalizability and limitations

Compulsory care for substance abusers is used as a case to exemplify the relevance and possible application of the elaborated typology. Every form of public service has its institutional particularities which defines the power resources and rules of interaction between stakeholders and thereby how co-production is operationalized. It is reasonable to assume that similar structures and processes are present in other service delivery systems. The degree of voluntariness is questionable for many public services (for example paying tax), but a significant part service delivery does take place in a manifestly coercive manner – as in prisons, psychiatric institutions, child protection services, the army, or the police.

Pregnant substance abusers challenge the notion of "user" by introducing the unborn child into the equation. This is of course a very limited group and a highly specific issue, but there are definite parallels to other human services – coercive or not. In social work, treatment systems, policing, etc., next of kin, networks, and those somehow affected by the client's behaviour and needs are central stakeholders and often actively involved in service delivery. In Bella's and Anna's client records there was, for example. mention of parents, grandparents, children, partners, and ex-partners. The typology could, then, be

developed even in this direction to include the co-production of “auxiliary” users<sup>13</sup>.

There are some limitations which should be mentioned. It is important to keep in mind that this study cannot enlighten us about the actual scope of co-production in compulsory care, assess the relative impact of different forms of co-production, or least of all evaluate its organizational and individual impact. Identifying different forms of co-production cannot – and should not – divert attention from the fundamental coercive character of compulsory care or similar interventions.

The client records also convey *the staff's* account of events and represent their perception of client moods, feelings and responses. They are, then, secondary sources of information about user co-production. They may as such both underestimate and exaggerate the relevance of co-production from the clients' perspective.

Moreover, it is not possible to assess the actual impact of for example user committees at the agency or facility levels. Annual reports and official reports from the agency are likely to be biased towards communicating “success” in different ways.

## Conclusion

Although the co-production literature does acknowledge that many public service users are not consumers in the private market sense of the word, it has been based on a presumption of voluntariness. Moreover, the idiosyncrasies of human services – where users and customers are typically not the same – have generally not been addressed specifically in theoretical and empirical research on co-production.

There has been a call for more empirical studies in the co-production field using experimental, administrative, and ethnographic data, as well as “exploring the implications of unwilling, coerced and multiple service users for this framework” (Andrews et al., 2011). This study is a contribution in this direction and illustrates how co-production can be conceptualized in a human service characterized by manifest coercion. Based on a typology of modes of co-production, as presented by Osborne and Strokosch (2013), a distinction was made between enhanced and participative co-production, and consumer and user participation. The first two are primarily found at the agency and facility levels, through representative institutions and consultation processes. The two latter primarily take place at the operational level, within the actual service delivery involving individual clients.

Using a variety of data sources, including register data and client records, the study was able to show how co-production may take place in subtle, but powerful, ways at the client level. Clients who are committed to compulsory care are to be offered care outside the closed facility at the earliest possible convenience. To fulfil this policy aim the agency, the social services in the client's home municipality, the alternative care provider – and the client – must engage in an intricate negotiation process regarding the how, when, and were of continued service delivery. Co-production is an essential part of service delivery in involuntary, as well as voluntary, settings.

## References

- Alford, J. (2002) Defining the client in the public sector: A social-exchange perspective. *Public Administration Review*, 62, 337–346.
- Alford, J. (2009) *Engaging Public Sector Clients: From Service-Delivery to Co-Production*. Basingstoke: Palgrave Macmillan.
- Andrews, R., Boyne, G., & Walker, R. M. (2011) The impact of management on administrative and survey measures of organizational performance. *Public Management Review*, 13, 227–255.
- Barber, B. (1984) *Strong democracy: Participatory politics for a new age*. Berkeley, CA: University of California Press.
- Billquist, L., & Skårner, A. (2009) *En påtvingad relation. Kontaktmannaskapets utövande och villkor inom LVM-vården*. Stockholm: Statens institutionsstyrelse.
- Bovaird, T. (2007) Beyond engagement and participation: User and community coproduction of public services. *Public Administration Review*, 67, 846–860.
- Brandsen, T., & Honingh, M. (2015) Distinguishing different types of coproduction: a conceptual analysis based on the classical definitions. *Public Administration Review*, 76, 427–435.
- Brandsen, T., & Pestoff, V. (2006) Co-production, the third sector and the delivery of public services. *Public Management Review*, 8, 493–501.
- Brudney, J.L., & England, R.E. (1983) Toward a definition of the coproduction concept. *Public Administration Review*, 43, 59–65.
- Davies, C. (2007) Grounding governance in dialogue? Discourse, practice and the potential for a new public sector organizational form in Britain. *Public Administration*, 85: 47–66.
- Evans, T., & Harris, J. (2004) Street-level bureaucracy, social work and the (exaggerated) death of discretion. *The British Journal of Social Work*, 34, 871–895.
- Fotaki, M. (2010) Towards developing new partnerships in public services: users as consumers, citizens and/or co-producers in health and social care in England and Sweden. *Public Administration*, 89, 933–955.
- Fox, C. J. (2003) The prosecutorial state. *Administrative Theory & Praxis*, 25, 63–90.
- Hajjghasemi, A. (2008) *Ett kontrakt för livet. Utvärdering av en särskild satsning på missbrukarvården*. Stockholm: Statens institutionsstyrelse.
- Hasenfeld, Y. (1992) The nature of human service organizations. In: Hasenfeld, Y. (ed.), *Human services as complex organizations*. Los Angeles: Sage Publications.
- Hill, M. , Davis, J. , Prout, A., & Tisdall, K. (2004) Moving the participation agenda forward. *Children & Society*, 18: 77–96.
- Johnson, B. (2006) Brukarinflyandets utveckling i den svenska narkotikapolitiken 1965–2004. *Statsvetenskaplig tidskrift*, 108, 39–60.
- Jung, T. (2010) Citizens, co-producers, customers, clients, captives? A critical review of consumerism and public services. *Public Management Review*, 12, 439–446.
- Lipsky, M. (2010) *Street-level bureaucracy: Dilemmas of the individual in public services*. New York: Russell Sage Foundation.
- Lund, D.H. (2018) Co-creation in urban governance: From inclusion to innovation. *Scandinavian Journal of Public Administration*, 22, 3–17.

- Maughan, D., Molodynski, A., Rugkåsa, J., & Burns, T. (2014) A systematic review of the effect of community treatment orders on service use. *Social Psychiatry and Psychiatric Epidemiology*, 49, 651–663.
- McLaughlin, H. (2009) What's in a name: 'client', 'patient', 'customer', 'consumer', 'expert by experience', 'service user'—what's next? *The British Journal of Social Work*, 39, 1101–1117.
- Michels, A., & De Graaf, L. (2010) Examining citizen participation: Local participatory policy making and democracy. *Local Government Studies*, 36, 477–491.
- Ministry of Social Affairs (2004) SOU 2004:3 Tvång och förändring. Rättssäkerhet, vårdens innehåll och eftervård.
- Motion 2014/15:710. Lagstadgat brukarinflytande inom missbruksvården. Riksdagen.
- Nabatchi, T., Sancino, A., & Sicilia, M. (2017) Varieties of participation in public services: The who, when, and what of coproduction. *Public Administration Review*, 77: 766–776.
- National Board of Institutional Care. (2018) Årsredovisning 2017. Stockholm.
- Newman, J., Barnes, M., Sullivan, H., & Knops, A. (2004) Public participation and collaborative governance. *Journal of Social Policy*, 33: 203–223.
- Offe, C. (1984) *Contradictions of the welfare state*. Cambridge: MIT Press.
- Osborne, S. P., Radnor, Z., & Strokosch, K. (2016) Co-production and the co-creation of value in public services: A suitable case for treatment? *Public Management Review*, 18, 639–653.
- Osborne, S. P., & Strokosch, K. (2013) It takes two to tango? Understanding the co-production of public services by integrating the services management and public administration perspectives. *British Journal of Management*, 24, S31–S47.
- Ostrom, E. (1996) Crossing the great divide: Coproduction, synergy, and development. *World Development*, 24, 1073–1087.
- Parks, R.B., Baker, P.C., Kiser, L., Oakerson, R., Ostrom, E., Ostrom, V., Percy, S.L., Vandivort, M.B., Whitaker, G.P., Wilson, R. (1981) Consumers as co-producers of public services: Some economic and institutional considerations. *Policy Studies Journal*, 9, 1001–1011.
- Pestoff, V. (2006) Citizens and co-production of welfare services. *Public Management Review*, 8, 503–519.
- Reitan, T. (2016) Commitment without confinement. Outpatient compulsory care for substance abuse, and severe mental disorder in Sweden. *International Journal of Law and Psychiatry*, 45, 60–69.
- Reitan, T., & Weding, L. (2012). *Gravida missbrukare i LVM-vården*. Stockholm: Statens institutionsstyrelse.
- Sallnäs, M., Vinnerljung, B., & Kyhle Westermark, P. (2004) Breakdown of teenage placements in Swedish foster and residential care. *Child & Family Social Work*, 9, 141–152.
- Seawright, J., & Gerring, J. (2008) Case selection techniques in case study research: a menu of qualitative and quantitative options. *Political Research Quarterly*, 61, 294–308.
- Socialstyrelsen. (2012) *Metoder för brukarinflytande och medverkan inom socialtjänst och psykiatri*. Stockholm: National Board of Health and Welfare.

- Trägårdh, L. (2007) *State and civil society in northern Europe: The Swedish model reconsidered*. New York; Berghahn Books.
- Verschuere, B., Brandsen, T., & Pestoff, V. (2012) Co-production: The state of the art in research and the future agenda. *Voluntas: International Journal of Voluntary and Nonprofit Organizations*, 23, 1083–1101.
- Vis, S. A., Holtan, A., & Thomas, N. (2012) Obstacles for child participation in care and protection cases—why Norwegian social workers find it difficult. *Child Abuse Review*, 21, 7-23.
- Walzer, M. (1988) *Socializing the welfare state*. In: Gutmann, A. (ed.), *Democracy and the welfare state*. Princeton, NJ: Princeton University Press.
- Wärmegård, E.-M. (2005) *Del av ett sammanhang. Att arbeta med klienters nätverk under och efter LVM*. Stockholm: Statens institutionsstyrelse.
- Weber, M. (1948) *Politics as vocation*. In: Gerth, H. H. & Mills, C. W. (eds.) *From Max Weber: Essays in Sociology*. New York: Oxford University Press.
- Whitaker, G. P. (1980) Coproduction: Citizen participation in service delivery. *Public Administration Review*, 40, 240–246.

## Notes

<sup>1</sup> The choice of concepts is highly contentious and worth considering in further depth (McLaughlin, 2009). However, “user” and “client” are – unless otherwise stated – used interchangeably when referring to (groups of) individuals who are the end recipients of the services in question.

<sup>2</sup> Health and Medical Services Act (2017:30) 5§1, and Social Services Act (2001:453) 1§1. The Swedish term is “delaktighet”, which is best translated into participation, involvement or empowerment.

<sup>3</sup> Statens institutionsstyrelse.

<sup>4</sup> In Swedish: “vård i annan form”.

<sup>5</sup> The study group consisted of 79 cases involving women who were pregnant at the time of the first placement in COF during a commitment in compulsory care between 2000 and 2009. In 8 cases the same woman was placed in compulsory care on two separate occasions (while pregnant both times), so the study consists of 71 individuals. The study was approved by the Ethical Vetting Committee in Stockholm.

<sup>6</sup> The search terms were “vård i annan form”, “§27”, “27 §” or “P27” (the relevant section in the legislation).

<sup>7</sup> See appropriation directions for 2008-2010 at [www.esv.se](http://www.esv.se)

<sup>8</sup> See <https://www.stat-inst.se/om-sis/sis-brukarrad/>

<sup>9</sup> See for example <https://www.stat-inst.se/var-verksamhet/missbruksvard/vara-lvm-hem/hessleby/>

<sup>10</sup> Förordning (2007:1132) med instruktion för Statens institutionsstyrelse [Regulation for National Board of Institutional Care].

<sup>11</sup> In 2017, the minister of social affairs was called to parliament to answer for the “queue situation” at the NBIC. At the time, the situation was most problematic within youth facilities, but the minister could just as easily have been held accountable for queues in compulsory care for substance abusers (“Svar på fråga 2016/17:799 av Elisabeth Svantesson (M), Kösituationen på SiS”, Dnr S2017/00711/FST).

<sup>12</sup> <https://www.stat-inst.se/for-socialtjansten/socialtjanstenkat/>

<sup>13</sup> It is not uncommon that parents of substance abusers are the driving force behind a commitment process. In 2009 the social services in Gothenburg were taken to court by the parents of a young substance abuser who died from an overdose after social services failed to initiate compulsory care. Two officials were fined for misconduct (see case number B4761-09 at the Gothenburg Court of Appeal).