

Social worlds of person-centred, multi-sited ethnography

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Human services are conducted in a *place*, but places are not always separated entities with solid boundaries. Rather, places form and are part of cultural, social, political, economic and academic networks that depend on and/or conflict with each other. The place-bound understanding of human services is partially due to the dominant academic and political focus on professionals and institutions that deliver services and on their specific meetings with singular clients, users or patients. Usually, however, the service recipients move from one place to another as they must relate to multiple institutions. I argue that the study of human services must account for this physical and conceptual movement *between* places. In particular, the relations between these places need ethnographic attention.

One way to focus attention on the relations that shape human services and experiences with them is through *person-centred, multi-sited fieldwork*, terms I use to describe my research on addiction treatment in Norway (Bartoszko, 2018c). This type of ethnography emerged as I followed (not shadowed—a point I will return to later) one person I call ‘Siv’ through arenas of care (for example, the hospital, her general practitioner’s office, the social services office, her lawyer’s office and a patient ombudsman’s office) while she negotiated her right to individualized treatment and appropriate medication in opioid substitution treatment (OST).¹ The relationships and trajectories that I traced around Siv as she pursued her preferred treatment became my ‘field’, consisting of her family, friends, policymakers, health professionals, research institutions, patient and user organizations, professional organizations, pharmaceutical companies, the media and political parties. The OST patient’s social world mirrors the relations and dependencies in the realm of human services.

Doing Human Service Ethnography

Person-centred, multi-sited fieldwork offered me an ethnographic lens through which to view the multidisciplinary substitution treatment of opioid addiction *and* facilitated examination of patients' lived experiences of the pharmaceutical interventions through their political, epistemic, moral and clinical dimensions. The ethnographic focus on the relations between places of human service where decisions about this patient's life were made revealed the mutual constitution of the social, medical and legal in this particular form of therapeutics, and in human services in general. This chapter describes how my ethnographic approach allowed me to examine the state, the experts and the medical and legal reforms related to addiction treatment and policy.

The Norwegian context

My study emerged in the aftermath of the Substance Treatment Reform in 2004, under which the responsibility for all types of addiction and rehabilitation services (including health, psychosocial and social educational aspects) was transferred from the county level to state-owned regional healthcare enterprises. These enterprises were given the statutory responsibility to ensure that all people in their catchment areas have access to specialized healthcare services. In addition, responsibility for treatment shifted from social welfare services to specialized healthcare; therefore, drug treatment was defined as part of specialized health services along the same lines as somatic and psychiatric care. However, other services provided to substance users remained the responsibility of local municipalities.

The main goal of this reform was to improve the health of drug users through guaranteed access to multidisciplinary specialized treatment for substance addiction (Tverrfaglig spesialisert behandling av rusavhengighet, TSB), standardization of treatment and referrals to treatment through general practitioners (previously, only social services could make such referrals). TSB services focus on comprehensive and individual approaches, with equal importance given to social welfare and health perspectives. In addition, all interventions are meant to be knowledge-based (Helsedepartementet, 2004). Nevertheless, by moving the responsibility for treatment to the health service, the Norwegian government chose a 'medical' approach to addiction, which largely increased the role and influence of medicine and doctors in the treatment field (Skretting, 2005). What is more, persons diagnosed with dependence syndrome (avhengighetssyndrom) were granted patients' rights.

Meeting Siv

Initially, I planned to study how the Substance Treatment Reform unfolded in patients' lives, with these questions in mind: What does it mean to be a *patient* with substance addiction, and what does it mean to have patients' rights or, more precisely, *to receive* patients' rights? Do these rights matter to patients? How do patients understand, apply and negotiate their rights?

Before starting my fieldwork, I presented my project idea to a friend who suggested that I speak to someone she knew who was a 'heroin addicted' patient invoking her patients' rights to continue treatment with morphine.² In early November 2013, I was sitting on a train on my way to meet someone who would provide a direction for the rest of my fieldwork; I was on my way to meet Siv. Our first meeting was at Siv's mother's place, where Siv was living in order to help her mother recover from a broken hip. Siv met me at the train station and warned me that we would have to go into the kitchen or her bedroom to talk about 'these things' (drugs, her past and current situation) because her mother did not like to hear about them. After a nice chat with her mother over cinnamon rolls and a cup of tea, we went to Siv's little room where we talked so late that I had to run to catch the last train back to Oslo.

Thereafter, I spent many hours and days in Siv's little room—a room filled with smoke from Tiedemanns Rød 3 tobacco and the smell of instant coffee that we sometimes enjoyed with lemon zest biscotti Siv had baked or with sweets her mother brought us. Cold wind often blew through the window, rustling piles of documents from her treatment team, health reports, printed bills of rights, library books and tufts of dog fur. On that first evening, however, I had no guarantee I would ever meet Siv again. Uncertainty, waiting and sudden engagements and disengagements are a natural part of doing ethnography. A few days after our first meeting, Siv sent me a text message asking if I would join her at her next treatment team meeting. I did so, and thereafter I accompanied her to all these meetings.

Following Siv

Forty-nine-year-old Siv had been an OST patient for three years. One day, the OST doctors discontinued her morphine treatment despite acknowledging statements in her medical records that the 'patient functioned well during her treatment with morphine.' As an alternative, they offered her buprenorphine—a semi-synthetic, long-acting opioid

Doing Human Service Ethnography

recommended as a first choice by national OST guidelines. Siv had had negative experiences with buprenorphine; however, if she rejected the change, she would be excluded from the program. She invoked her patients' rights and filed a complaint with the relevant entities. Pending a decision, her doctors continued the morphine treatment. For over two years, through negotiations in the clinic, legal complaints and attempts at political pressure, she struggled for what she perceived to be a good quality of life.

While my overall research objective was to explore OST patients' experiences within the context of the Substance Treatment Reform and the granted patients' rights, after meeting Siv I narrowed my focus to patients' experiences with a change of treatment modalities that appeared to be contentious. Patients who wish to switch or keep their prescribed drugs must negotiate with OST staff. The length and intensity of the negotiations vary depending on the patient's situation, preferences, negotiating capital and relationship to the treatment team, as well as the prescribing physician's preferences. Informed and led by Siv's case, I became interested in how patients and practitioners interpret, understand and negotiate user involvement and patients' rights in the context of choosing a medication. By tracing these negotiations, I wanted to explore how local healthcare policies and technologies shape the experience of being a patient and a citizen with opioid drug dependence. Thus, the project moved between social analyses of the institutional practices that shape Norway's response to opiate addiction and of the stories and lives of those affected by those practices. As I was eager to understand Siv's experiences as well as the logics of addiction treatment in Norway, person-centred multi-sited fieldwork came in handy.

Siv was not only my first interlocutor but also the one with whom I spent most of my fieldwork time, and thus, a prominent guide in the field. Since she lived outside Oslo, where I was based, every visit with her substantially limited my other field activities and the possibility of meeting other interlocutors. For instance, to join her for 15-minute doctor's appointment meant four hours of travel time, which prohibited my attending meetings in Oslo the same day. As Siv's case genuinely triggered my interest, I prioritized time with her, and rather quickly decided to take these impractical round trips to get to know Siv and her world better. Another trade-off was that I was rarely able to join her as spontaneously as I could the interlocutors in Oslo or nearby. Nevertheless, I also quickly realized that Siv and her case were rich enough material for my study, and focusing on her story also had methodological and analytical advantages.

During the fieldwork, I witnessed the life Siv had organized for and around herself, particularly in the context of OST treatment. I closely followed her through her daily arenas of care from November 2013 to December 2014. I accompanied her to meetings with OST consultants and appointments with her general practitioner. I attended her meetings with the health and social services ombudsman, supporting doctors and patient organizations. I accompanied her on her weekly visits for urine sample deliveries and to the pharmacy to pick up medications.

However, as anthropologist Todd Meyers (2013) has emphasized, *following* does not mean *shadowing*. I did not shadow Siv's every move. Following includes:

conversations with concerned family members, friends, parole officers, clinicians, and social workers—often in the absence of the 'study participant'. Rumour, too, was a form of *following*. ...*Follow* would include documenting the work of clinicians and the material administrative traces that remained after someone would disappear—a *file itself*. ...*Follow* would also need to account for and blend the moments of impaired and unimpaired interaction with [my interlocutors]. (Meyers, 2013, pp 5–6)

Anthropologists Eugene Raikhel and William Garriott have noted that this approach involves 'attending not only to lived experience but also to the material out of which lived experience is made: the relations, knowledges, technologies, and affects, as well as the recursive impact of subjectivity itself' (Raikhel and Garriott, 2013, p 10). In my understanding, this implies expanding the network of interlocutors continuously during the fieldwork without giving epistemological priority to any of them. As anthropologist Steffen Jöhncke wrote in his work about a methadone clinic in Copenhagen, 'If there are any "natives" in this account, it is not the users in particular, but all of the people in general who participate in this field' (Jöhncke, 2008, p 7).

Configurations of worlds and organizations

Theoretically and methodologically, I drew inspiration from Raikhel and Garriott's (2013) idea regarding trajectories. They combine the approaches of both interpretative and critical social science, focusing on individual experiences, historical processes and structural conditions. They suggest looking at addiction through the lens of movement: 'movement of people, substances, ideas, techniques, and

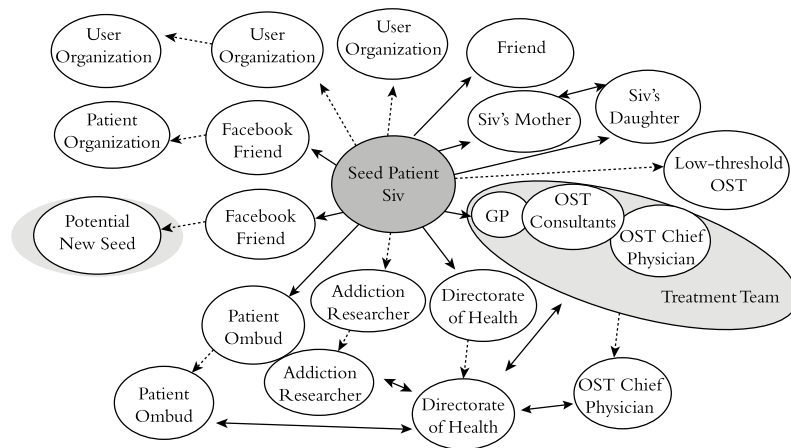
Doing Human Service Ethnography

institutions along spatial, temporal, social, and epistemic dimensions' (Raikhel and Garriott, 2013, p 2). In other words, the study of drug use and addiction should include objects, subjects and the process of meaning exchange between them in different social and cultural contexts. I have used these concepts as a way to approach the life of people with opioid addiction and dependence (and those others involved in their lives) while applying them as heuristic tools in my general analytical thinking.

In practice, to follow networks and study addiction and dependence as trajectories means visiting social worlds embedded in networks of people and organizations. Siv not only made these contacts but mentioned them in conversations with me or others. She frequently referred to patients, professionals and politicians to whom she had spoken by phone or sent emails, or who she simply had heard about. I followed these references conceptually and physically. Through her friendships, including those on the internet, I met other patients in similar situations who contributed comparative insights. These contacts broadened my understanding of Siv's network and the relations that influenced her knowledge of available human services and of herself as a patient, citizen and friend. The snowballing ethnography quickly revealed patients in substitution treatment to be a heterogeneous group that included those leading very 'stable' mainstream lives, those actively engaged in open drug scenes and those in between these two extremes. Siv's friends and acquaintances, and others I met while exploring Siv's world, belonged to all categories, fluctuating among them. Depending on their situation and geographical location, they used different combinations of medications. They also used and switched between different human services: pharmacies, low-threshold sites, specialized clinics, rehabs, detoxification units and urine collection sites, social welfare centres and child protections services, lawyers and dentists. In all these arenas, their status as former, current or future patients in addiction treatment dominated their experience with the services and revealed in more or less explicit ways the relations between these places.

As [Figure 7.1](#) outlines, I travelled to the places where the people to whom Siv referred lived or worked. I sought to have conversations with them and to get a sense of the relationships they shared with Siv. Sometimes these relationships were direct; sometimes not but were important to Siv's understanding of her situation. For instance, I visited representatives of the Directorate of Health not only because she had mentioned them several times but also because these officials were responsible for making and disseminating the national guidelines central to her case. I wanted to understand the logic and process

Figure 7.1: Siv's social world. The arrows indicate types of relations significant for Siv's case. Solid lines indicate relations with direct contact (physical, digital or by phone). Dotted lines indicate relations with actors or institutions that Siv mentioned, for example through reading an article in an addiction journal and referring to a researcher from a Norwegian institution. Double arrows indicate relations which the various actors mentioned and which impacted Siv's case, for example a physician in opioid substitution treatment (OST) referring to the directorate guidelines, or bureaucrats from the directorate mentioning scientific experts they collaborate with.



behind the creation of the guidelines and to discuss relevant issues and challenges. I travelled to other cities to speak to doctors who had helped Siv's case by tapping relevant contacts and institutions or by advising on medical issues. I interviewed representatives of the office of the health and social services ombudsman where Siv had filed her complaint. All these persons shaped how Siv understood her situation and how she organized her life at that point in time. In turn, they shaped my understanding of and sharpened my focus on the social relations constituting the field of addiction treatment in Norway.

During discussions and negotiations with her treatment team, Siv frequently mentioned 'current research'. Following the thread, I spoke to addiction researchers, quite a few of whom happened to be OST clinicians serving also as policy advisers, and I gained insight into the linkages between research, clinical practice and policy. With this knowledge, I was in a better position to identify Siv's place in among all these arenas as well as to map the consequences of various connections and relations. When speaking with researchers, clinicians and state bureaucrats, I paid particular attention to the language they used and how they positioned OST patients in relation to other patients and

Doing Human Service Ethnography

the dependence diagnosis in relation to other diagnoses. I asked OST doctors and consultants how they perceived and defined their work, and I questioned them about the cases I was working on or reading about in the public texts. I was interested in how they navigated the complex landscape of addiction medicine, the challenges they confronted and the possible solutions they had identified. To understand the language of the OST staff and clinical researchers, I took courses in addiction medicine at the Oslo University Hospital (OUS), arranged by the Norwegian Centre for Addiction Research (SERAF), a course that many OST consultants have taken. I participated in OST conferences, workshops and seminars organized by the Norwegian Institute for Alcohol and Drug Research (SIRUS), SERAF and OUS, to mention a few.

Through Siv's relationships, including those with the health and social services ombudsman, patient interest organizations and the county medical officer, I enhanced my understanding of the social world of OST patients. I came to realize that this world is composed of families, friends, policymakers, health providers, research institutions, patient and user organizations, professional organizations, pharmaceutical companies, media and political parties. The network of encounters, relations and trajectories, which I traced around Siv, became my 'field'. Through this multi-sited fieldwork, focusing on the logic of relations, associations and translations between all these actors, places and arenas, I acquired a broad insight into 'emergent discourses' or oppositional practices, not just those that were dominant (Marcus, 1998, p 53). Nevertheless, the important focus was on the person herself. I do not assign any analytical privilege to the networks, as opposed to the human beings, with whom I interacted.

Connecting artefacts, times and spaces

In the early stage of my research, I contacted various user and patient organizations in order to accelerate my fieldwork and identify project participants. I spoke to people with the Norwegian Association for Human Drug Policy (Foreningen for Human Narkotikapolitikk, FHN), local divisions of FHN and the Interest Organization for Substance Misusers (Rusmisbrukernes Interesseorganisasjon, RiO) along with OST patient organizations, such as LAR-NETT and Pro-LAR. I also visited numerous low-threshold organizations and institutions including drug injection rooms (Sprøyterommet), day centres and food distribution facilities. I travelled west to Bergen for a user-initiated protest action, and north to Trondheim to participate in establishing a new patient organization.

Person-centred, multi-sited ethnography

These arenas and engagements gave me insights into the complex worlds of people with opioid addiction and dependence in Norway. For instance, as I accompanied Lasse (pseudonym), a fieldworker from the FHN, which distributes sterile equipment to users on the streets in Oslo, I became familiar with the city's 'drug scene', its rituals, people and services. I learned about the life that Siv and my other 'patient interlocutors' had left behind and I could better understand their stories. Lasse became my conversation partner, and these walks facilitated my meeting people who had either 'dropped out' of treatment or who had never applied to it. Even after establishing my own network of patients, I continued to accompany Lasse and to visit the organizations regularly to follow their work.

This multi-sited, multi-temporal approach led me to collect various material cultural productions including texts, pictures and movies. I used this diversity of sources to show how they spoke to each other. For instance, my interlocutors often read and actively used texts that had significant political and social power. I observed how my interlocutors, both patients and professionals, used OST guidelines to negotiate treatment. I wondered: How does Siv read these guidelines? What significance do they have for my interlocutors' lives? What exactly are the guidelines?

As many of my interlocutors, including Siv, spent much of their time online, *netnography* (see Caliendo, 2014; Kozinets, 2015) became an important part of my fieldwork. I followed social media debates and the relations established through them. How did Siv use social media to share her story, and with whom? How did she use social media to learn about patients' rights and treatment possibilities? I read posts in Facebook groups that Siv and other interlocutors joined, participated in through discussions, or simply followed.

I also read medical records and archival files that Siv had collected. They helped me to fill 'gaps of knowledge' and gaps in Siv's memory. I looked at how Siv's life was defined in these records. How did she read and react to these professional and clinical stories? All these texts helped me to understand Siv's life from different angles and perspectives.

I followed the news and read newspaper articles. I looked at the public atmosphere around drug-related issues. Which articles did my interlocutors read and comment on? How did they react? What sense were they making of these readings? Studies within the OST field in Norway often present patients as if they exist on a desert island (for example, Havnes et al, 2014; Nordbø, 2014; Granerud and Toff, 2015; Grønnestad and Sagvaag, 2016), isolated from society, neither reading nor meeting other people beyond the clinics. After one of

my interlocutors had read a newspaper article on an action conducted against an open drug scene in Bergen, she exclaimed, “Look what they do with us in Bergen!” I realized then that her attitude and experience with the treatment could not be limited to happenings at the OST office. She filtered her experience through things that were happening to people with whom she identified. This situation illustrates ‘the inadequacy of conceptualizing worlds or spaces—such as those of the clinic or of the “street”—as separate from one another’ (Raikhel and Garriott, 2013, p 10; see also Meyers, 2013).

Challenges of dissemination

Focusing research presentations on one person brought challenges related to the anonymity of interlocutors (Bartoszko, 2018a, 2018b, 2018c). Some of my interlocutors were well known among other patients, therapists and health agencies because of their diagnoses, non-traditional medication or public disclosures of their histories. Siv was one of these, and the ‘uniqueness’ of her story was what had triggered my research interest. To use radical anonymization and alter the details of her struggle would mean losing much of the point of her story and our cooperation. Additionally, I would have to construct the research data and risk not meeting the requirements of material reliability and credibility. Researchers who avoid ‘unique cases’ get standard responses and standard stories from standard patients, rarely gaining insights into nuanced experiences and unconventional choices. Therefore, I weighed the value of anonymity against the value of the knowledge that extensive person-centred fieldwork could create. Since my objective was to explore the significance of the unique, the idiosyncratic and the sometimes provocative in the treatment of addiction in Norway, I decided to anonymize Siv’s story only partially. I changed her name, family relations, places and times, and I altered clinical relations and identities of third parties. Nevertheless, some people in the OST field may recognize parts of her story. Siv agreed to my choice and she is familiar with my writing style and the closeness of my presentation to her story.

Another challenge of studying and writing through the lens of one person is the accusation—particular from OST professionals—of being ‘partial’. Opioid substitution treatment is part of a charged social and political landscape that links diverse actors and stakeholders, including researchers, health professionals, regulators, policymakers, police, patients, consumers and private industry investors. It is a landscape of hopes, losses, benefits, profits, risks, trust, suspicion and of life and

death. My gradual involvement in patients' lives, particularly Siv's life, following their struggles, enabled me to share their frustrations, impatience and feelings of unreasonability on the part of clinicians and of systemic injustice. This kind of involvement and empathy with interlocutors is both a professional blessing and a curse. To detach completely from these feelings is an impossible task and an undesirable one. Yet, it is possible to transform such feelings into analytical creativity, and thus, in my publications I have tried to write with care about all the actors I have met during my fieldwork. Therefore, even if my work critically explores the OST and the Norwegian response to opioid addiction, it is not 'anti-OST', nor is my intention to undercut the social value of the treatment program, medicine or social policy. Rather, I address the various meanings produced by and around these institutions as I explore the unintended consequences met with at the various crossroads that make up a singular human life. Throughout my project, I explored the perspectives of patients, doctors, consultants, researchers and state agents. Nevertheless, my primary goal was to understand patients, their situations and experiences. What challenges do they encounter, and how do they cope with the complex issues of addiction treatment and the polyphony of clinical and political voices?

Conclusion

According to the methodological literature, Siv could be described as my 'key informant' (see Lavrakas, 2008). Nevertheless, I choose not to use that term because doing so would imply, in some ways, that Siv's expertise was more valid than that of others I met during my fieldwork. That is not the case, and in fact, none of my interlocutors fit this category. Although I spent more time with some, I believe it is impossible to create any hierarchy of my interlocutors in relation to their knowledge of local conditions. I did not approach Siv, or others, as an 'expert witness' or as someone 'knowledgeable about local custom and behaviours' but rather as 'an object of systematic study and observation in herself' (Hollan, 2005, p 463). I considered Siv to be my flashlight in the field of addiction (treatment) and related human services in Norway. In the diagram (Figure 7.1) I label her the 'seed' from which the field emerged.

That being said, in publications I often chose to emphasize Siv's subjectivities and the significance of her experience in the field my research had created. I argue that by focusing on her lived experience we get a sense of what was at stake for her in the local, moral and social world that she inhabited. That kind of approach facilitates an

Doing Human Service Ethnography

experience-near level of analysis. Despite some great person-centred ethnographies having been published and widely recognized as valid scholarship (for example Wadel, 1973; Crapanzano, 1980; Biehl, 2005; Wikan, 2008), many scholarly colleagues still ask what we can learn from the study of a singular person. What is the significance of Siv's story? Pondering his own work, Meyers has written, 'Does *one* symptomatic body—its physiology and psychology, the registers upon which healing and cure are mutually judged, the status and placement of local moral worlds on the individual, and so on—hold meaning for others?' (Meyers, 2013, p 13). I find an answer in his own words as well:

The focus on the individual is essential not because it privileges singularity over collectivity, nor because it affords—however strangely—uncertainty, but because such a focus simply has the ability to show that generalizations are sometimes unrecognizable when held up against the individual experience of disorder. (Meyers, 2013, p 13)

In other words, complexities are hidden in the larger numbers. My project's methodological and analytical focus aimed to contribute, thus, to the current field of addiction treatment, particularly in Norway, which privileges generalizations over individual experience, certainty over uncertainty and being over becoming.

At the same time, however, by following one patient, my project shapes the field through significant insights into how addiction treatment in Norway works, as I have shown. Person-centred, multi-sited fieldwork gave me access to relations in the field that were based on empirical experiences, not theory. I was able to trace how care happens and how institutions interrelate based on the lived lives of people who must navigate between them all in search of better living. What is more, I was able to explore the specific relations between the state, the research field, the clinic and the law that *matter to the individual*. Such insights are, I argue, crucial for developing policies that account for the lived experiences they aim to address.

Notes

- ¹ In opioid substitution treatment (OST), an opiate-dependent patient receives a (preferably) long-lasting opioid under controlled conditions as a substitute for illegal opiates. In Norway, the treatment is organized as a multidisciplinary programme, which includes social service centres, general practitioners and specialized healthcare, in which the latter has authority to assess the need for treatment and is responsible for medications. OST national guidelines emphasize user involvement

Person-centred, multi-sited ethnography

in treatment and choice of medication. Three medications are recommended for treatment, but guidelines allow others if soundness of treatment is documented.

- ² A short-acting morphine sulphate is usually prescribed to patients in Norway undergoing pain. For treating opiate addiction, morphine is used in countries like Austria, Denmark or Switzerland. It is, however, administered as an exception in Norway, where the most commonly prescribed medications for treating opiate addiction are buprenorphine (Suboxone or Subutex) and methadone.

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Doing Human Service Ethnography

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