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# Practices of Government in Methadone Maintenance

## Summary

Addiction is a central issue in a liberal society of autonomous citizens, as the nodal point of addiction is self-control – or rather the lack of it. By looking at different ways of problematizing and working upon addiction, one might also get some idea of different ways of conceptualizing and practicing freedom. The point of departure for my paper is practices of methadone maintenance in different regimes of drug treatment. The article illustrates how treatment practices produce different forms of subjectification of drug addicts, depending on the discourses and technologies these practices articulate, and by implication, how they constitute different ways of problematizing freedom as something to be worked upon. My argument is based on interviews with managers of the drug treatment system in Copenhagen, documents concerning drug policy and drug treatment on a local and national level as well as addiction research. My analyses in this paper are tentative and a first report from a study currently under way.

## Addiction

The concept of addiction is closely related to conceptions of autonomy and freedom. Levine's (1979) analysis of 'the discovery of addiction' in American society shows a close relationship between the constitution of a liberal society of autonomous citizens, willing and able to practice their freedom in a productive and responsible manner, and the distinction between actions governed either by the

free will or by the passions of the individual. The free will of the individual is construed both as a reality and as something to be produced, thus, constituting the central problem of liberal government: How to provide security for the autonomous individual, defend his freedom, as well as how to help the not yet free individuals to develop and practice their freedom (Hindess, 1996, 2000). As shown by Valverde (1998), a particular kind of despotism and hermeneutics of suspicion is thus involved in liberal government in which the control of instincts, passions and bad habits of both oneself and particular groups are made into objects of surveillance and government. 'Addiction' serves as one of these kinds of lack of freedom in which an individual instead of conducting himself in a responsible manner is governed by his passion, instinct, or 'drug hunger'.

As shown by Foucault (1986a, b), freedom is practiced differently under different regimes of practice, that is, freedom is constituted differently under different discursive and technological conditions. The same goes for drug problems which regularly undergo re-conceptualizations according to, among other things, how freedom and a society of free subjects is conceptualized. Matza and Morgan (1995) identify three general conceptualizations of individual drug problems.

First, there is the medical discourse that is a conceptualization of addiction where excessive use of drugs is explained as a consequence of physical and/or psychic illness driving the person to use drugs against his will. The discourse of 'misuse' explains excessive drug use as a social and moral issue where the breach of the injunction not to use illegal drugs is seen as a lack of sociability, caused by e.g. a 'drug career' through which an individual learns to use illegal drugs as part of his or her involvement with a deviant sub-culture (Becker, 1963). The discourse of 'dependence' explains excessive drug use as a psychological problem. Ege (1997) uses these different kinds of explanations to construct a theory of drug addiction in which the initial use is seen as a 'misuse' which can or will lead to a physical and psychological dependence and in which the physical dependence is relatively easy to cure while the psychological dependence is much more difficult to treat. This conceptualization of addiction as a mix of medical, psychological and sociological discourses is common, if not uncontested, today. However, the form and content of this general conceptualization of drug addiction, which is the one concerning us here, varies with different conceptualizations of autonomy, society, integration and addiction as they are e.g. articulated in different regimes of practicing drug treatment. In what follows we will have a look at such different regimes of practices involving the use of methadone.

## Methadone maintenance treatment

Methadone can be given to drug addicts for different reasons and serve different purposes in treatment, thus, also involving different kinds of subjectifications of drug addicts.

In the model of methadone maintenance treatment developed by Dole and Nyswander in the 1960s, addiction was seen as a metabolic disease with psychological and social effects. Hence, the drug treatment consisted of a medical and a social treatment that could not be disentangled. The function of methadone was to 'block the drug hunger' of the addict, and this would minimize the importance of drugs in his or her everyday life, making it possible for him or her to focus upon other things, and hence – by means of rehabilitation – to engage in normal activities and become a normal citizen (Dole, Nyswander, Kreek 1966; Fernandez, 1998). What made methadone useful for treatment of addictions was that in a therapeutic context it could be contrasted to heroin, with the effect of stabilizing its user: Taken orally it did not have any euphoric effects, it could be taken only once a day, when stabilized it did not involve withdrawal symptoms for the addict, and at a sufficient tolerance it could block the effects of other opiates. As discussed by Gomart (2002), the therapeutic effect of methadone, that which made it a medication and different from other opiates, was its function as one element entangled in a regime of practices consisting of many other elements. It was this whole regime of practices that worked upon addiction, and it was difficult to point to what specifically caused the effects of treatment. Even the way in which methadone would block drug hunger could not be predetermined, but was an effect which had to be achieved by means of a host of different practices having to do with observation of the addicts, dosage, the setting etc. in

each single case (ibid.). The central governable substance<sup>1</sup> in this treatment program was the 'drug hunger' of the addict since it was the control of this hunger that was a precondition for successful treatment, i.e., made it possible for the addict to engage in normal activities instead of the drug sub-culture. This, however, had to be done in a particular context in which the addict was subjectified as a patient and where the control of the drug hunger was not just a medical issue but also a social and psychological issue.

Another model for methadone maintenance is known as 'the British model' where methadone serves quite a different function than in the program discussed above. In this model methadone serves as a medicine equivalent with other kinds of medicine where the pharmacological effects of the substance itself are central, and not the effects of the drug as a part of a complex regime of treatment practices. In some versions of this model, the drug addicts are given a drug of their own choice by general practitioners or at special clinics while in other versions the choice of drugs is restricted to methadone. Here the drug hunger is the object of government and not its psychological and social effects, at least not in any direct way (though, of course, a rationale for this model is to reduce the prevalence of drug scenes and crime).

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1 I use the four aspects of ethical practices put forward by Foucault (1986) and developed further by Dean (e.g. 1996), as an instrument to analyse and compare different practices of drug treatment. Foucault originally described these aspects as: 1) 'The ethical substance' (that which is isolated to be worked upon to become a moral subject). 2) 'The mode of subjectification' (the discourses, norms, values etc. which are made or taken to be authoritative and to which one subjectifies oneself in attempting to become a moral subject). 3) 'The ethical work' (the means by which one works upon oneself in the form of the ethical substance in order to become a moral subject). 4) 'The telos' (that mode of being, way of life, form of conduct one attempts to achieve by working upon oneself)

Methadone is not only used for maintenance or for what is called an 'adaptive treatment' (Goode, 1999) in which the goal is to adapt the client to his or her problem, making it possible for him or her to live a normal life as an addict. It is also used for a 'change' or 'abstinence-oriented treatment'. Here the goal is to make the client abstinent and change his or her personality, lifestyle or social conditions, and methadone serves as a means of detoxification. As we shall see, the rationality of a treatment program is not always clear to the treatment staff and/or their clients.

## Disciplining addiction

When the Danish treatment system for drug addiction was developed in the late 1960s and early 1970s, drug addiction was seen as a youth problem explained in sociological and psychological terms as a symptom of social change (Villadsen, 2000; Pedersen, 2001). The dominant model for drug treatment came to rest upon sociological theories of deviance as something which is learned through interaction with deviant sub-cultures and hence something which can be treated by means of re-socialization. The treatment goal was normalization and social integration by means of an almost universally applied treatment program consisting of three phases: 1) detoxification, 2) social, psychological and possibly psychiatric treatment, 3) social rehabilitation. The rationality of drug treatment was that drug addiction could and should be cured. The primary governable substance was seen to be the sociability of the drug user with the addict's physical dependence as a substance to be worked upon and dealt with in advance. The primary technologies for working on these substances were medical and psycho-social expertise. The drug user was subjectified to discourses of physical and psychological dependence and to discourses of deviance.

When the population of drug addicts grew older, both in age and in terms of the duration of their addiction, the question of what to do with 'the old drug addicts' was raised. This meant that by the late 1970ies the treatment system for the drug problem among the youth was increasingly problematized as being irrelevant for an increasing number of drug addicts. It also meant that addiction as a more or less chronic or at least long-term state was put on the agenda as a problem to be dealt with, and, in line with this, the use of methadone maintenance treatment was brought into discussion (Pedersen 2001). In 1979 'The Alcohol and Drug Council' issued a white paper advocating a more flexible use of methadone for the treatment of old drug addicts, and measures were taken to implement this policy. However, employing a methadone maintenance treatment did not fit well with the dominating epistemology and technologies of treatment, and it was widely criticized from within the treatment system for not dealing with the fundamental causes of the problem. It was claimed merely to provide a drug solution to a drug problem and, hence, not to be a solution at all but a way to gloss over the fundamental social, economic and psychological causes of drug addiction (Bengtson, 1981). Methadone maintenance treatment, it was also claimed, would reproduce the social identity of the drug addicts as drug addicts and not provide them with a new identity. Finally, it would institutionalize the drug addicts since they would become extremely dependent on the treatment system for providing drugs (*ibid.*).

In 1984 the council issued another white paper which this time criticized the treatment system for its lack of ability and willingness to take care of the old drug addicts. It recommended normalizing methadone as an instrument alongside other instruments in the treatment of drug addicts. It also recommended that the treatment system should work with different goals, from stabilizing the addiction

to improving the personal and social functioning of the addicts while still using drugs to achieve abstinence and normalization. The council won the support of the social minister, and gradually the treatment system accepted methadone treatment, especially as the HIV problem entered into the agenda a few years later (author's interview with Ege, 2000). Despite this, or perhaps because the acceptance was slow, the 1970s and 1980s saw a number of drug addicts having methadone prescribed by general practitioners (that is, a kind of slipping the British model of medicalization in through the backdoor) where the prescription of methadone was not accompanied by psychological or social treatment. This, finally, led to a centralization of methadone treatment in 1996 when legislation turned the regional authorities into the only authority to write long-term prescriptions.

Methadone treatment was introduced into a system based on a sociologically inspired phase program, as described above, where methadone was primarily seen as an instrument of detoxification. This meant that despite intentions to reproduce the regime of practices for methadone treatment developed by Dole and Nyswander, systems emerged which involved peculiar mixes of adaptive and abstinence oriented models. Their rationale has been described as 'methadone until further notice' (Jöhncke, 1997). This, of course, meant that quite a different regime emerged – for some addicts at least – where methadone treatment became, to use the words of Bourgois (2000), a system for 'disciplining addiction'. In this system the drugs came to be a central issue because historically detoxification had been a precondition for social rehabilitation (Smidt, 1999). The result was a subjectification of the clients under an abstinence-oriented regime mixing medical, psychological and social discourses and with an ambiguous telos in which the compliance of the client was the central issue.

Whether or not this was experienced as help or as social control, depends, of course, on the individual clients and, among other things, on the role played by methadone in their own drug-management (Graapendal, 1995; Jøhncke, 1997). The ultimate sanction (and failure) of the system was the so-called administrative detoxification (as opposed to a therapeutic detoxification) where clients were detoxified because of non-compliance. The health authority guidelines state that administrative detoxification can be executed in case of:

1. Lack of benefit from treatment, meaning the drug addict does not follow the treatment plan but regularly uses other opiates, appears irregularly (at the clinic), etc. In these cases the treatment should be adjusted and the addict moved to a treatment without methadone.
2. Behavioral problems to such a degree that it is unacceptable for the treatment facility. This mainly concerns violence or threats against other drug addicts and/or staff and drug-use or -sale at the facility. (Sundhedsstyrelsen, 1995, p. 18).

Criticism has increasingly been voiced against the attempts to discipline addiction (when it was not possible to cure it) for being unethical, ineffective, costly and even harmful. It has been said, among other things, that despite continued use of illegal drugs, the methadone maintenance treatment has beneficial effects with regard to minimizing harm, reaching hard-to-reach drug addicts and normalizing or integrating drug addicts as citizens.

### **The methadone maintenance clinic as a treatment modality**

As a consequence of the centralization of the methadone maintenance treatment in 1996, the city of Copenhagen set up four metha-

done maintenance clinics in order to accommodate the demand for treatment when drug addicts could no longer get maintenance treatment through general practitioners. In the guidelines for these clinics it was stated that they should be run in accordance with the original concept of methadone treatment developed by Dole and Nyswander, that is, the adaptive model mentioned above where methadone serves as an instrument (medicine) to improve the social functioning of the client. It should be much more 'entangled' with psychological and social aspects of treatment which were to play a much more central role (Smidt, 1999). The guidelines for the clinics stated that the methadone treatment should be considered equal to other kinds of treatment (restating the goal of turning methadone treatment into a normal instrument from the 1984 white paper). In other words, the methadone treatment should not be residual. The clinics should, therefore, not be places to 'dump' drug addicts who were considered to be without any potential for change. Because the demand for methadone treatment has been high, the clinics have in practice partly come to serve as such places anyhow although they do attempt to, and do succeed in, producing changes in the lives of their clients.

It is a distinguishing feature of the methadone clinics that they function as drop-in centers for their clients. In the 1990s drop-in centers have become instruments in a strategy of social politics dealing with social exclusion. In this strategy drop-in centers are seen as an instrument to get into contact with socially excluded or 'hidden' populations as well as an instrument for producing changes in their lives. This last issue of producing change, is related to discussions about what constitutes care, what constitutes treatment as well discussions about the function of professional expertise and about the personal qualities of the people working with the socially excluded persons (Villadsen, 2000;

Bømler, 2001). Drop-in centers are imagined as 'places to be' and places to receive care and support for persons who cannot or will not live a normal life and take care of themselves in a proper way. In these places no demands are to be raised at them to change their way of life. They are to be met by people who do not conduct themselves as experts, but as persons who want to give care and support without asking for any kind of compliance in return. In developing this kind of 'personal relations' and constructing 'a symbolic order of everyday life' the drop-in centers are seen as places which socially excluded people can identify with and which can bring some kind of normality into what is seen as their otherwise chaotic lives (Larsen, 2001). It is crucial in constructing such 'homely places' and the 'caring relations' associated with them that the drop-in centers are places where no normalizing or moral judgments are passed on how the clients live their lives. Hence, in describing the centers the staff recurrently uses expressions such as 'neutral place' or 'treatment free zone' (Hansen, 1996; my interview materials). There is no expectation that the clients are to change their way of life, and no pressure is brought to bear on them to do so. Change is seen as a result of the sense of trust, self-respect and self-esteem that the clients are able to develop in a caring, respectful, accepting and non-judgmental environment (Villadsen, 2000). Change is seen to arise from the ability and possibility for the clients to express their needs and wishes that such an environment may produce. And the ultimate goal is not primarily normalization but to 'empower' the clients, that is to develop and improve their ability to improve their quality of life as they themselves define it. Since the possibilities of social workers to speak for the clients (Philp, 1979) are minimized, the problem of 'the voice' of the clients, their ability to articulate needs and wishes, becomes a central issue in social

work. This means that the primary governable substance is the ethics of the clients: the way in which they develop relations to themselves and work upon themselves and hence construct themselves as subjects performing their freedom in particular ways. The social workers and the environment of the drop-in center are to help them develop and perform this ethics.

The stated goal of the methadone maintenance clinics is to improve the social functioning of their clients. Working with addiction as a part of the social functioning of the clients to a large extent incorporates elements of the governmental-ethical practices (Dean, 1999) of the drop-in center in attempting to govern addiction by developing particular ethical practices on behalf of the clients or, in the term used above, to help them practice their freedom in particular ways. This means that the clients are to some extent construed as 'normal governmental subjects' (O'Malley, 1999) as opposed to persons lacking self-control and social control.

Stabilizing addiction or achieving abstinence is not abandoned as goals but to be accomplished by developing and improving the clients' possibilities for handling their own lives in a competent and responsible manner – even if this means taking illegal drugs. Instead of excluding clients taking illegal drugs, attempts are made to make the clients themselves stop using them or use them in as safe a manner as possible.

However, the clinics are different from the drop-in centers because the 'caring relation' and 'the symbolic order of everyday life' are explicitly instrumentalized as means of treatment. For instance, the clinics work with a system of contact persons. Building trustful relations with the clients is the main task of these contact persons because, along with the general environment of the clinic, they are seen as the principal instruments for producing change. Even though so-called 'action

plans' are used (or intended to be used), few work in any systematic way with producing change by means of specific therapeutic or pedagogical interventions. Change is to grow from the trust and empowerment of the client produced by the relation with the contact person in particular and by the environment of the clinic in general. Again change is not caused by some particular intervention but by the regime of practices in general. Important is not so much the kind of change the client wants as the fact that the client takes upon himself to conduct himself and his life in a manner that improves his social functioning. In this context change can mean all sorts of things such as getting a place to live, getting one's apartment cleaned up, giving up or minimizing illegal drug use and going to school.

These kinds of relations between care and treatment can produce dilemmas in the methadone clinics. The staff may feel that they are service providers rather than treatment personnel because they are being crowded with a multitude of small day-to-day problems of the clients.

"The immediate satisfaction of needs has dominated the treatment and made the weakness of the kind of treatment-contact of the system of contact-persons obvious. There is not enough room for reflection and prioritizing." (Manager of a methadone maintenance clinic # 1)

Another manager says:

"If we do not pull ourselves together, it is going to be the users who prioritize our time with all their small odd things. We are not to ignore all this. They live lives so dramatic that we would be falling apart (...) My mantra is that it is us, not the clients, who shout most loudly and who should prioritize our time." (Manager of a methadone maintenance clinic # 2)

Methadone is, of course, the cornerstone of the activities at the clinics. Control with the

purpose of ensuring that the clients do not sell their drugs and of ensuring that they get the correct dosage still plays an important part. This means that many clients have to come to the clinic every day to take their methadone under supervision. However, no sanctions are ever made with regard to the methadone, e.g., by administrative detoxification. Use of illegal drugs is accepted as a fact of life. Therefore, no urine or needle-mark controls are carried out. Urine-tests are only used as a kind of self-technologies for the clients themselves to become better able to control their use of drugs, or to make an anonymous screening of the population of clients.

In order to change the clinical relation constituted when giving the clients drugs, the clinics have developed procedures for dispensing the drugs in as flexible, informal and relaxed ways as possible. With regard to the issue of governing illegal drug use, it is interesting that some of the staff describe the drug-dispensing situation as a kind of confessional situation where they can use the social relations constructed at the clinic and their ability to 'see illegal drug use' to get the clients to talk about their use of drugs. This provides the basis for the staff to inform the clients of the risk involved and to try to make them reflect on their actions in order to make them take better care of themselves.

The central issue is not just the use or non-use of illegal drug, but how to regulate the use of drugs in a manner that is as beneficial to the client's quality of life as possible. In the clinics the primary way to work upon the symptoms of addiction is indirectly through the ethical practices of the clients, by incorporating aspects of the drop-in center in terms of an environment and of relations between the staff and the clients. In this context drug addicts are subjectified to rationalities of social policies and social work which often constitute a peculiar mix of human re-

source or empowerment and cultural or anthropological discourses with the telos that you are to become an autonomous subject in terms of your lifestyle or a particular kind of community<sup>2</sup>.

For the staff methadone is still seen as a means to control the symptoms of addiction, that is, as a medicine. Still, the methadone clinics are not a medical or treatment regime but a regime primarily concerning care. And when one looks at the treatment of which methadone is a part, it seems more to function as a *drug* than as a therapeutic instrument. This concerns especially the way in which the issue of use of illegal drugs is handled where the acceptance that drug users use these drugs and the more or less active measures to promote safe drug use situate the methadone in a regime in which it performs the function of just being one drug in the drug household of the addicts (Graapendal, Leuw & Nelen, 1995). Some clients even define themselves positively as drug addicts or dope fiends where methadone is not seen as part of a therapeutic contexts but as a drug and hence as a possible means of pleasure. In an evaluation of the clinic from this year one client says:

“We are drug addicts. We are not content with feeling well. We also want to get high.” (Petersen, 2001, p. 148))

As a further example of this discourse, consider this statement from the Union of Active Drug Users in response to a white paper by the governmental advisory committee on drug issues in 1999:

“When a drug is evaluated from a medical point of view for the medicine-cabinet of substitution-drugs, the following criteria are often mentioned: Slowly working, stable concentration, cheap and easy to administer. These criteria are not very user-friendly or user-oriented. The truth is, as

<sup>2</sup> For a further discussion of these issues see Rose (1996).

mentioned above, that many of us do not want a ‘stable concentration’. The fluctuations are a part of using drugs and drug addiction. The methadone treatment attempts to enforce stability. Research shows that more than 89% of methadone users have a secondary misuse. Part of the explanation should perhaps be found in the enforced stability (...) We know that taking drugs with ‘needle and thread’ is not without risks, but for some of us this is inextricably linked to the addiction (however ‘foolish’ this fact might appear to the medical profession and the treatment staff, it is the reality in which many users find themselves...)” (Narkotikarådet, 1999, p. 84)

In accordance with this, one of the clinics is experimenting with injectable methadone. In that way it is incorporating the pleasurable aspects of drug use into the treatment.

It is interesting that, in the project mentioned above as well as in the discussions about conducting a heroin trial in Denmark, getting high has been put on the agenda and is instrumentalized as a part of governing addiction. It illustrates how the issue of addiction, and hence what constitutes an autonomous subject, is continuously rearticulated by the way social work and treatment practices mix different discourses and governmental technologies. What is particularly interesting is that issues concerning desire, passions and pleasure are finding their way into some of the regimes of practices which constitute an important part of the social organization of drug addiction, namely the treatment system.

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