DOCTORAL THESIS

Social Work Approaching Evidence-Based Practice

Rethinking Social Work

Benitha Eliasson

LULEÅ UNIVERSITY OF TECHNOLOGY

LULEÅ
UNIVERSITY
OF TECHNOLOGY

Social Work Approaching Evidence-Based Practice

Rethinking Social Work

Benitha Eliasson

Luleå University of Technology
Department of Business Administration, Technology and Social Sciences
Division of Human Work Science

Printed by Luleå University of Technology, Graphic Production 2014

ISSN 1402-1544
ISBN 978-91-7439-997-4 (print)
ISBN 978-91-7439-998-1 (pdf)

Luleå 2014

www.ltu.se

Said by one of the regional representatives about evidence-based practice:

It is not like that, if we did not have evidence-based practice then all development would stop. It is just some kind of idea that this is a good way to think about development.

Abstract

The Swedish public sector has undergone major changes over the last decades, with increased demands to be effective and perform their tasks with high quality, but also with the demand to increase the influence of users and citizens over the support given. This development has influenced how social services organise and how their work is perform, and is one motive given as to why evidence-based practice was introduced. This development can also be traced back to the manager philosophy new public management and neo-liberalism. Evidence-based practice has its origin in evidence-based medicine, which had a large impact internationally from the 1990s. Although there are different opinions concerning how evidence-based practice should be understood is often described on the basis of Sackett et al.'s (2000) definition which regards evidence-based practice as an integration of different knowledge sources – the best evidence, clinical or professional expertise and the values and preferences of users. The professional have the responsibility to use all these knowledge sources in the daily work.

The purpose of this thesis is to describe and analyse different processes of the introduction of evidence-based practice. One aspect is what these processes have contributed to in terms of organising ways of working and management within social services; another aspect concerns what this means for social work. With a combination of new institutional organisational theory and Berger and Luckmann's (1967) insights into the social construction of everyday life, it is possible to analyse the introduction of evidence-based practice as a process, moving between a macro, meso and micro perspective. The empirical base for this thesis is interviews with 33 personnel from different professions and organisations. Those interviewed from the social services include social workers within individual and family services and social services managers, as well as regional representatives from a Research and Development Unit. To understand the development of evidence-based practice and its proliferation into social services I also interviewed doctors from health care in a County Council.

New institutional organisational theory is useful for understanding how different ways of organising activities are spread between and within organisations. With concepts used in new institutional theory, the focus is on how evidence-based practice travels from medicine to social work, and from a national level to the local social services level, via the regional level. Giddens (1990) terms 'disemedding' and 'reembedding' are used. Different isomorphic processes are recognised in these processes, as well as strategies to decouple or loosely couple evidence-based practice from social services ordinary activities as a way to gain legitimacy.

The main findings in the thesis are that evidence-based practice has been introduced with evidence-based medicine as a role model, and that this has been done from different conditions. As is described in the interviews, the development of evidence-based practice has been controlled from national organisations such as the government, the National Board of Health and Welfare and in recent years also the Swedish Association of Local Authorities and Region, while the development within the

medical area was governed by national organisations but performed by the medical profession, which advocated the introduction of evidence-based practice within the profession. The regional representatives largely support the myth that is presented of evidence-based practice, and have a central responsibility in the national initiatives conducted; they are intermediary between the national initiatives on development work and the local practice. When evidence-based practice is introduced in social work this has entailed loosely coupling between the myth about evidence-based practice and the ordinary activities, this strategy is especially obvious among social services managers. Furthermore, when a medical model of evidence-based practice is used, although with a broader approach, the introduction of evidence-based practice does not reflect the social workers' education, profession and ways of working in the same way as evidence-based medicine reflects the doctors' education, profession and way of working.

The intention to analyse the introduction of evidence-based practice from a micro perspective is about understanding how evidence-based practice is received by the social worker and their managers. When the interviews with the doctors, social workers and managers are analysed there is less coherence between evidence-based practice and social workers' work than between evidence-based medicine and doctors' work. This means that social workers have to shape and construct their daily work anew through internalising the new habits and routines into everyday work, something that takes energy and time, which most interviewees feel does not exist. This thesis also highlights the need for social work to approach evidence-based practice both at an organisational and a structural level, and from the level where the daily work is performed by social workers. Finally, there exists among almost all interviewees a great interest in introducing evidence-based practice, especially among the social workers, but at the moment it is not re-embedded in social work.

Swedish abstract

Den svenska offentliga sektorn har genomgått stora förändringar de senaste decennierna med ökade krav på effektivitet och att uppgifterna utförs med hög kvalitet, men även att öka brukares och medborgares inflytande över det stöd som ges. Denna utveckling har haft en inverkan på hur socialtjänsten organiserar och utför sitt arbete, och är ett motiv som ges till varför evidensbaserad praktik introduceras. Utvecklingen kan även härledas till ledningsfilosofin new public management and till neoliberalism. Evidensbaserad praktik har sitt ursprung i evidensbaserad medicin och fick ett internationellt genomslag från 1990-talet. Det finns olika uppfattningar hur evidensbaserad praktik ska förstås, men beskrivs ofta från Sackett et al. (2000) definition där evidensbaserad praktik betraktas som en integrering av olika kunskapskällor – bästa evidens, klinisk eller professionell expertis och brukares värderingar och preferenser. Den professionella har ansvaret att använda alla dessa kunskapskällor i det dagliga arbetet.

Syftet med avhandlingen att beskriva och analysera olika processer av introduktionen av evidensbaserad praktik. En aspekt är vad dessa processer har inneburit i termer av sätt att organisera arbetet och ledningen inom socialtjänsten, och en annan aspekt är vad detta innebär för socialt arbete. Med en kombination av nyinstitutionell organisationsteori och Berger och Luckmann's (1967) insikter om social konstruktion av vardagslivet, är det möjligt att analysera introducerandet av evidensbaserad praktik som en process, som rör sig mellan makro-, meso- och mikroperspektiv. Den empiriska grunden för denna avhandling är intervjuer med 33 personer från olika professioner och organisationer. De intervjuade från socialtjänsten är socialarbetare (socionomer) som arbetar inom individ- och familjeomsorg och chefer inom socialtjänsten, samt regionala företrädare från en Forsknings- och Utvecklingsenhet. För att förstå utvecklingen av evidensbaserad praktik och dess spridning till socialtjänsten har jag dessutom intervjuat läkare från landstingets hälso- och sjukvård.

I avhandlingen har jag funnit nyinstitutionell organisationsteori användbar för att förstå hur olika sätt att organisera verksamheten sprids mellan och inom organisationer. Med begrepp som används i nyinstitutionell teori fokuseras hur evidensbaserad praktik reser från medicin till socialt arbete, och från nationell nivå till den lokala nivån där socialtjänsterna finns, via den regionala nivån. Giddens (1990) termer 'disemedding' och 'reembedding' används. Olika isomorfa processer identifieras i dessa processer, liksom strategier för att isärkoppla eller löst koppla evidensbaserad praktik från socialtjänstens ordinarie verksamhet som ett sätt att uppnå legitimitet.

Viktiga resultat i denna avhandling är att evidensbaserad praktik har introducerats med evidensbaserad medicin som en förebild men att det har gjorts från olika förutsättningar. Som beskrivs i intervjuerna har utvecklingen av evidensbaserad medicin kontrollerats från nationella organisationer som regeringen, Socialstyrelsen och under senare år även Sveriges Kommuner och landsting, medan utvecklingen inom det medicinska området styrdes av nationella organisationer med utfördes av den medicinska professionen. De regionala företrädarna stöder till stor del den presenterade myten av evidensbaserad praktik, och har ett centralt ansvar i de nationella initiativ

som genomförs; de är förmedlare mellan de nationella initiativen på utvecklingsarbeten och den lokala praktiken. När evidensbaserad praktik introduceras i socialt arbete har det medfört lösa kopplingar mellan myten om evidensbaserad praktik och den ordinarie verksamheten, speciellt tydligt är denna strategi bland socialtjänstens chefer. Vidare, när en medicinsk modell av evidensbaserad praktik används, även med ett bredare förhållningssätt, speglar inte introduktionen av evidensbaserad praktik socialarbetares utbildning, profession och arbetssätt, på samma sätt som evidensbaserad medicin speglar läkares utbildning, profession och arbetssätt.

Intentionen att analysera introduktionen av evidensbaserad praktik från ett mikroperspektiv handlar om att förstå hur evidensbaserad praktik tas emot av socialarbetarna och deras chefer. När intervjuerna med läkarna, socialarbetarna och cheferna analyseras är det mindre överensstämmelse mellan evidensbaserad praktik och socialarbetares arbete än mellan evidensbaserad medicin och läkares arbete. Detta innebär att socialarbetare har att forma och konstruera det dagliga arbetet på nytt genom att internalisera de nya vanorna och rutinerna in i det dagliga arbetet, något som tar energi och tid, vilket de flesta intervjupersoner upplever saknas. Avhandlingen belyser även behovet för socialt arbete att möta evidensbaserad praktik på en organisatorisk och strukturell nivå, samt från nivån där det dagliga arbetet utförs av socialarbetare. Slutligen, det finns bland nästan samtliga intervjupersoner ett stort intresse av att introducera evidensbaserad praktik, speciellt bland socialarbetarna som möter brukarna, men för tillfället är evidensbaserad praktik inte återinbäddat i socialt arbete.

Acknowledgements

During the spring of 2007 the Research and Development Unit in North Bothnia offered to support me as a PhD student at Luleå University of Technology. Seven interesting years have passed since then, with some interesting projects and a licentiate thesis. Now, this journey is almost over, and a new one starts. I would like to thank the Research and Development Unit for their financial support, for their encouragement and for their patience. Especially Agneta Bygdell, the leader for the Research and Development Unit, individual and family services, who is now retired, as well as the newly appointed head of the Research and Development Innovation Unit, Ulf Hyvönen.

The topic of this thesis is evidence-based practice, which concerns those who work in the social services. The question, 'what are you writing about?' has led to numerous and sometimes long conversations, and it feels satisfying to get such responses from those the research affects. Therefore, I give my warmest thanks to all those who have offered their time and shared their experience of their daily work with me.

Then I want to show my deepest gratitude to those who have assisted me in my work at Luleå University of Technology. Of course Professor Elisabeth Berg, who with her warmth is always there when needed, and has led me through the thesis work with great knowledge about research. I also want to thank my assistant supervisor Lecturer Saila Piippola who has been a constant support during these years, for much good advice, for being a good travel companion and for all the valuable comments on the thesis. I also thank Doctor John Chandler from the University of East London for his extremely valuable comments as opponent at my final seminar; they have been with me in my writing since then. Furthermore, I want to give my PhD colleague Allen King my appreciation for all the help with the English text and the commentary of it. I really liked them. Your help has been invaluable. Thanks also for our conversations over a cup of tea; the understanding from another PhD student is sometimes needed.

Finally, to Stig, Gunnel my mother and Erik my father, this thesis if for you.

Luleå September 2014,

Benitha Eliasson

Abbreviations and Swedish words used in the thesis

Children's Needs in the Centre. *Barns Behov I Centrum*.

Random Controlled Trial, RCT. *Randomiserade kontrollerade studier.*

Research and Development Unit, R&D Unit. *Forsknings- och utvecklingsenhet, FoU-enhet*.

Governmental Official Report. *Statens Offentliga utredningar, SOU.*

The Government. *Regeringen.*

The Health Technology Assessment. HTA. *Medicinska utvärderingar.*

The Institute for Evidence-Based Social Work Practice. *Institutet för utveckling av metoder i socialt arbete, IMS.*

The Ministry of Health and Social Affairs. *Socialdepartementet.*

The National Board of Health and Welfare. *Socialstyrelsen.*

The Swedish Association of Local Authorities and Regions, SALAR. *Sveriges Kommuner och Landsting.s*

The Swedish Council on Health Technology Assessment. *Statens Beredning för medicinsk Utvärdering, SBU.*

The Swedish Parliament. *Sveriges Riksdag.*

Contents

1

Introduction

In recent decades the public sector has undergone major changes and the demand for organisations to be effective has increased (Holmberg, 2003; Johansson, 2008; Alexanderson et al., 2012; Harlow et al., 2013; Berg, Chandler and Barry, forthcoming). The requirement for efficiency is partly due to demographic changes, with an increasing proportion of elderly in the population, to globalisation, increased competition and a decline in economic growth (Holmberg, 2003; Schartau, 2003). While resources decrease, or at best remain unchanged, organisations must continue to perform their everyday activities. With the public sector facing competition the common reasoning is focused on how to use resources more effectively and how to create sensitivity to the citizens' needs. Consequently, the public sector has been challenged and there is an intention to introduce a more 'business-like climate' (Holmberg, 2003:9). These changes are consistent with the management philosophy known as new public management (ibid.) and with the introduction of evidence-based practice in public organisations that deals with such issues as health care, social work, probation services and education, (Trinder, 2000a; Hansen and Rieper, 2009; Alexanderson et al., 2012). Even in the Swedish social welfare sector there is a trend toward higher efficiency requirements, a development being characterised by three waves which concerns cost limitations, work quality and a 'knowledge-based or evidence-based practice (i.e. "what works")' (Alexanderson et al., 2012:158; Tengvald, 2008).

This development has significantly influenced the organisation of social services and has raised questions in Sweden, as in many other countries, about how work can be performed with positive results and with high quality for the organisation, but also for society and individuals in need of support (cf. Tengvald, 2008; Oscarsson, 2009). In this context, introducing evidence-based practice has become a focal point, because evidence-based practice is founded on the idea of the users receiving the best possible support in accordance with the needs they have (Oscarsson, 2009). Considerations about the effects and quality of interventions should be the basis for decisions and priorities that organisations need to make (ibid.). Actors at the national level, or state level, such as the National Board of Health and Welfare and in recent years The Swedish Association of Local Authorities and Regions (SALAR), have had a substantial responsibility to introduce evidence-based practice into social work. According to Bergmark and Lundström (2011), the profession or researchers have not been a strong driving force in the introduction of evidence-based practice, this has mainly been done

by representatives from central bureaucracy who have driven the development forward (ibid.).

In the Swedish public sector, the state has been and remains a strong actor with responsibility for the transference and alteration of ideas in relation to how welfare is organised, and thereby provides a framework for the practical execution of social work. The state (one of three welfare pillars) has traditionally held a strong position in relation to the other two pillars; the market and the family. This is an essential feature of what Esping-Andersen (1990) and Johansson (2008) call the social democratic welfare regime or the Scandinavian welfare model (Esping-Andersen, 2002). The Swedish state therefore has a strong position regarding organising welfare compared with countries which are categorised as conservative or liberal welfare models[1] (Esping-Andersen, 1990). According to Esping-Andersen's (1990) understanding, an essential feature of the social democratic welfare model is that the state is responsible for a large portion of welfare solutions, whereas the liberal welfare state models largely uses market solutions to organise welfare problems (Johansson, 2008). Dent (2003:171), who has studied the health care systems in different countries in Europe, explains that how different countries have organised the 'delivery of health care' varies. For example, Sweden and the Scandinavian countries have to a greater extent than many other countries in Europe a well-funded health care system (Dent, 2003.). Countries like the United Kingdom and the United States encourage private solutions and at the same time limit public responsibilities (Esping-Andersen, 2002).

How the three interdependent pillars – the family, the market and the public sector – cooperate has altered in Western Europe over the years. Generally, whilst the importance of the labour market and the public sector has increased, the importance of the family has reduced (Olofsson, 2009). Compared to 40-50 years ago the labour market and the public sector constitute an increasingly important part in enabling people to support themselves (ibid.). To retain a strong position when it comes to meeting the needs of people for welfare solutions it is essential that as large a part of the population as possible work, which is the case in the Scandinavian welfare model (Esping-Andersen, 1990, 2002; Johansson, 2010). As Esping-Andersen (1990:28) notes:

> Perhaps the most salient characteristic of the social democratic regime is its fusion of welfare and work.

In comparison to many other countries Sweden has a large public sector financed through taxation. The Swedish welfare model is founded on a high employment rate and sustained economic growth, which implies that the public sector receives a relatively large proportion of revenue. Organising social policies becomes more vulnerable when high employment and sustained economic growth cannot be achieved (Olofsson, 2009).

[1] Conservative welfare regimes exist in countries such as Belgium, France, Holland, Germany, Italy, Japan, Switzerland and Austria. Liberal welfare state regimes exist in countries such as the United Kingdom, the United States, Australia, New Zealand, Ireland and Canada. In Sweden, as in the other Nordic countries Norway, Denmark and Finland, exist the social democratic welfare state regime (Esping-Andersen, 1990). In a publication from 2002 Esping-Andersen uses the terms continental and liberal welfare models.

The development of social policy in Sweden from the 1930s led to an expanded local government sector in the 1960s. Today, municipalities have a major responsibility as 'producers or purchasers of services' *[author's translation]* in areas such as childcare, elderly care and education (Olofsson, 2009:175). This development in Sweden and other Scandinavian countries has not been the same as developments in other countries; the United Kingdom and the United States for example (ibid.). With strong political support and good economic conditions in Sweden the construction of the welfare state continue during the 1960s and 1970s and national agreements in relation to the continued improvement of national insurance and welfare services were made (Johansson, 2008).

However, the situation, mainly the international situation, altered during the oil crisis in the 1970s and the economic crisis years in the 1990s. The possibility of implementing social reforms decreased and whether the welfare state could continue to expand as it had done so far became subject to debate (Johansson, 2008). Economic growth became weaker, industries were exposed to international competition and the profitability of many companies decreased. These changes characterises the development in Sweden but, due to the previous substantial expansion of the welfare state, did not affect the local government sector to the same extent as in many other countries. It was not until the 1990s that the effects of these changes reached Sweden and full employment, which the state strived for, was no longer possible to achieve (Olofsson, 2009).

Thus, the development during the later decades of the 1900s is characterised by a 'calibration of existing welfare system' *[author's translation]*; meaning that the organisations neither expanded nor dismantled the welfare system (Johansson, 2008:32). This is acknowledged by Alexanderson et al. (2012) when writing about changes towards decreased costs, higher work quality, and the introduction of evidence-based practice within the social services. The question concerning how financial resources are spent was put on the political agenda because of the increased costs for the Swedish welfare state during the 1970s and thereafter. These changes, all applicable to social services, had the intention of using the money in a sustainable way in the long term. Available resources ought to be used the best possible way, which means that social work should be conducted with good results in relation to the resources invested (ibid.).

Many of the reform packages which characterises the expansion of the welfare state have been challenged in recent years and today, the public sector is more exposed to competition (Olofsson, 2009). For example, the public cost of health care has increased across Europe and health care organisations need to find solutions to reduce costs (Dent, 2003). This is also the case in Sweden. The public sector changes have resulted in more market-oriented solutions and an increase of individual responsibilities. Olofsson (2009) points out that there has been a debate about deficiencies in the public sector and the increasing demand placed on the public sector. This has entailed a higher confidence in market efficiency, and individuals' own responsibilities for their social situation (ibid.). New public management is a process of reform initiated to make the public sector more efficient through management techniques that originate from the private sector (Hood et al., 1999; Dent, 2003; Holmberg, 2003; Pollitt and Bouckaert, 2004). Sweden adopted the reform of new public management relatively easily, as did the United Kingdom and New Zealand (Dent and Barry, 2004). Public organisations

now have tighter budgetary margins which, for many organisations, entail reorganisation of services through the introduction of purchaser and provider system and through outsourcing their services (Olofsson, 2009).

The fact that public services are exposed to competition is evident in areas such as social services and education; where private companies are becoming increasingly common. The development since the 1970s has been characterised, according to Harvey (2005:3), by '[d]eregulation, privatization, and withdrawal of the state from many areas of social provision.' Löfstrand (2008) explains from a Swedish perspective that private alternatives have been established within social services in the last 20-25 years. Today, municipalities have statutory ability to outsource social services and education to private companies. This is generally regulated by the Local Government Act (SFS 1991:900) and specifically by the Social Services Act (SFS 2001:453) and the Education Act (SFS 2010:800) (Sveriges Kommuner och Landsting, 2011).

An ideological aspect underlies the increased competition within the public sector, which is concerned with the right of individuals to choose a service provider in order to reduce their own vulnerability (Olofsson, 2009). Citizens are users of public services and they can become more involved when decision making is decentralised. Decentralised decision-making also help organisations to increase their legitimacy. An example where this was expressed is the initiative on knowledge development carried out by the National Board of Health and Welfare (cf. Socialstyrelsen, 2000, 2004). Citizens, or the users, are not only to be 'passive clients and receivers'. Instead they shall be 'active co-creators' *[author's translation]* and be involved in decisions as well as in the services provided (Johansson, 2008:125f). Individually adapted methods are increasingly used and different social policy reforms emphasise the establishment and use of treatment plans. Besides clarifying the responsibilities of organisations the plans are instruments with the intent to clarify the rights and responsibilities of individuals. The argument is that when support and services are tailored to the needs and circumstances of each individual then the public sector will become more efficient (Johansson, 2008).

Benefits for the individual with evidence-based practice in social work are described much the same way; the emphasis is on the right of individuals to choose, to be involved in their own treatment and support and to participate in planning with the organisation on an organisational level. In a broader context the changes within the Swedish welfare state correspond to the impact of individualisation in society. Neo-liberalism began to emerge the later 1970s and early 1980s (Harvey, 2005). Harvey (2005:2) writes about neo-liberalism:

> Neoliberalism is in the first instance a theory of political economic practices that proposes that human well-being can best be advanced by liberating individual entrepreneurial freedoms and skills within an institutional framework characterized by a strong private rights, free markets, and free trade. The role of the state is to create and preserve an institutional framework appropriate to such practices. The state has to guarantee, for example, the quality and integrity of money.

The demands of citizens, their attitudes toward welfare and the support given by social services have changed (Printz and Ljunggren, 2005). Although pursuing their own in-

terests remains difficult for some groups, an increasing number of individuals demand that those working in social services have the proper skills and that work practices are evaluated (ibid.).

Individualisation is related to individual freedom of choice. An increasing number of voices within social work talk about the citizen as a customer with the right to choose among different producers (Johansson, 2008) and products (support and interventions). For example, considering conditions in Iceland Jonsðottir (2005) writes about the increased demand for user participation and individual freedom of choice as well as the increased demands on a wide range of services (ibid.). The Act on System of Choice in the Public Sector (SFS 2008:962) was introduced to increase the opportunities for individual choices and determines when municipalities and county councils introduce systems of choice for social services and medical care (Sveriges Kommuner och Landsting, 2011). The state has the responsibility to use available resources in a sustainable way and that activities are conducted with high quality, as Harvey (2005) points out in the quotation above.

Changes towards evidence-based practice

Evidence-based practice has its origins in evidence-based medicine, and has been introduced in several areas and to several professions other than doctors since the beginning of 1990s. When evidence-based medicine was transferred from the medical field to other fields it engendered the development of evidence-based practice (Reynolds, 2000; Angel, 2003; Morago, 2006). During the early years of the 2000s, the Swedish government has undertaken extensive efforts to meet the demands placed on social services and to enhance the development of knowledge within them (Börjeson, 2005).

The development of evidence-based practice is, according to Trinder (2000a), one of the great success stories of the 1990s. Whilst being a controversial area for those who advocate evidence-based practice and those who oppose it, evidence-based practice is nonetheless associated with many values considered to be important. Because of its good intention it is almost impossible to have a negative attitude toward an approach that is described as giving users the best possible support, and it is perceived as unethical, for example, to expose children and their families to interventions that social services does not know the effects of (Trinder, 2000a; Pease, 2009; Vindegg, 2009). Oscarsson (2009) relates evidence-based practice to ethical considerations which both doctors and social workers must make in their daily work. For example, doctors and psychologists must act in accordance with science and proven experiences (see the Swedish Medical Association[2] and the Swedish Psychological Association[3]), while 'social work and social workers professional role shall "be related to" science and

[2] See also Swedish Medical Association, *Läkarförbundets etiska regler.* [Medical Association's code of ethics].

[3] See also Swedish Psychological Association, *Yrkesetiska principer för psykologer i Norden.* [Professional ethics for psychologists in Scandinavia].

proven experience' *[author's translation]* (see for instance The Union for Professionals[4]) (Oscarsson, 2009:20).

From the 1990's evidence-based practice has had a large impact on 'health and care policy' in many countries, not least in Great Britain:

> Over the last few years many other disciplines within and outside of medicine have adopted the 'evidence-based' tag and can therefore be considered under the generic title "evidence-based practice". (Trinder, 2000a:2).

With the spread of evidence-based practice to other areas, such as social work, evidence-based practice encounters new professionals and other scientific fields. This alters the initial perception of evidence-based medicine and it is given a somewhat different meaning as evidence-based practice (Bergmark and Lundström, 2011). When evidence-based practice is observed from a distance it appears as something uniform, as something that can be transferred easily to other areas in the medical field (Bohlin and Sager, 2011) as well as to other fields. There are basic ideas in literature that constitute the core of the concept but when examining more closely differences in how evidence-based practice can be applied are found to exist (ibid.). The social services have, as I describe in the next chapter other preconditions when evidence-based practice was introduced than those within the medical field. According to Svanevie (2011:1), the evidence-based practice model seems possible to reformulate; which means that the model 'over time has been moving back and forth – between different senders and receivers – and has thus not remained unchanged in relation to the intended practice'*[author's translation]*.

There are also different opinions in relation to how evidence-based practice should be understood and to the extent to which it is at all possible to use evidence-based practice in social work in accordance with the original idea (Vindegg, 2009; Bilson, 2005; Trinder, 2000) where problem-based learning and critical appraisal emphasised, in accordance with Sackett et al. (1996) definition. There are those arguing that this development goes hand in hand with new public management (Welbourne, 2011; Svenaeus, 2010; Vindegg, 2009) and with neo-liberalism (Welbourne, 2011; Berg, Chandler and Barry, forthcoming). As a 'rational' approach to ensure control of how work is performed, evidence-based practice is in line with the new public management agenda in both the Swedish and English public sectors (ibid.).

The development of 'evidence-based practice has come to legitimise a more quantitatively oriented model of knowledge about social work', consistent with new public management and neo-liberalism (Berg, Chandler and Barry, forthcoming). According to Berg, Chandler and Barry (forthcoming) and Bilson (2005) there is a clear ambition to introduce a more scientific approach in the formulation of policy in social work. Today, many public sector organisations strive to become more evidence-based (Bilson, 2005; Vindegg, 2009). This is part of an international trend that goes parallel with the developments within medicine, and especially in specialist medicine, as a role model. One example is the establishment of the international Campbell Collaboration which

[4] See also The Union for Professionals, *Etik*. [Ethics].

develops and publishes systematic reviews in areas such as social work and education. They are referred to as Campbell protocols (Ogden, 2006). A narrow approach to evidence-based practice is based primarily on an evidence hierarchy where systematic reviews, meta-analysis and random controlled trials are considered the best or the only way to work with evidence-based practice (cf., for instance Gray, Plath and Webb, 2009). Organisations that base their work on evidence hierarchy regard primary studies conducted with RCT design as a strong design that gives the most reliable results. Primary studies with a qualitative approach are considered by these organisations rather as a complement and support to experimental or quasi-experimental studies than the primary source of knowledge and evidence (Rieper and Hansen, 2007).

Evidence-based practice in social work was launched internationally in the second half of the 1990's, about ten years after the launch of evidence-based medicine, but the process has been much the same. Campbell Collaboration is a sister organisation to Cochrane Collaboration that is focused on the medical field (Svanevie, 2011). Campbell has taken over the areas dealing with social and psychological issues as well as issues related to the probation service and education from the Cochrane Collaboration (ibid.). There are many similarities between the two networks in terms of organising and ways of working and they have influenced the direction and development of evidence-based medicine and evidence-based practice (Bhatti, Hansen and Rieper, 2006; Hansen and Rieper, 2011; Svanevie, 2011). Hansen and Rieper (2009a:147) emphasise that Campbell Collaboration had the same development process and organisational ideas as the Cochrane Collaboration:

> The development of methodology in the Campbell Collaboration can be characterized as a mimetic process where the practice of the Campbell Collaboration has been modelled on the practice of the Cochrane Collaboration.

The transition of evidence-based medicine to evidence-based practice is considered a mimetic process (Hansen and Rieper, 2009a, 2011). However, the spread of evidence-based practice within social work has instead been characterised by a process with a top-down approach (Bergmark and Lundström, 2011). For example, Svanevie (2011), Bhatti, Hansen and Rieper (2006), and authors in an anthology edited by Ljunggren (2006) describe the importance and influence of specific persons and organisations for promoting evidence-based practice in the Swedish social services as well as for building a structure supporting evidence-based practice at a national level.

Four key actors are identified by Alexanderson et al. (2012) as important for promoting evidence-based practice within the Swedish social services. These actors have different tasks in terms of conveying knowledge to and from the social services. The first organisation mentioned is The National Board of Health and Welfare, which is a government agency of the Ministry of Health and Social Affairs. The second key actor is the Swedish Association of Local Authorities and Regions which is an organisation representing all 290 municipalities and 21 county councils or regions. The universities, as is the third key actor, should be an important actor in educating social workers and conducting research within social work. Finally, Research and Development Units, which were established during the 1990s with financial support from the government,

is the fourth key actor. Today almost all municipalities in Sweden have access to some kind of Research and Development Units (ibid.). The government is also an important actor and is investing financial resources in certain areas of development in order to facilitate the introduction of evidence-based practice. Today, the government's extended arm is mainly the Swedish Association of Local Authorities and Regions, and the National Board of Health and Welfare.

Bergmark and Lundström (2011) argue that there are two strategies for introducing evidence-based practice. The strategy used primarily in Sweden is referred to as the guideline model. This is a top-down approach where guidelines and summaries of available knowledge are tools used to introduce evidence-based practice in social work. This top-down process can be considered a regulative and normative control through which the Swedish government direct and facilitate the introduction of evidence-based practice in municipalities (ibid.). The guideline model differs from what is often described as an original or initial model of evidence-based medicine, and evidence-based practice, defined by Sackett and colleagues (1996), where the professionals actively seek, evaluate and use knowledge. This approach to work, which is termed problem-based learning or critical appraisal, has been difficult to realise completely in social work. Nor has it been easy to use critical appraisal within the field of medicine; meta-analyses, systematic reviews and guidelines are used to communicate results from research to doctors, which imply a similar approach to disseminating knowledge as in social work (Bergmark and Lundström, 2011).

Over the years a broader approach to evidence-based practice has been launched and today it is not so much about methods and models as it was when it was first introduced. For example, Oscarsson (2009) emphasises the importance that evidence-based practice is understood as a broad approach to work. Based on the definition of evidence-based medicine offered by Sackett et al., Oscarsson (2009) explains that three sources of knowledge – research, professional experience and the patient's biology, values and life circumstances – is the basis for the professional's choice of action. In several countries the concept of evidence-informed practice gained a foothold because of a perceived need for a broader approach to evidence-based practice. Although this was not the case in Sweden, evidence-based practice can be understood in a Swedish context in a broad perspective, essentially the same way as evidence-informed practice often is described (cf. Alexanderson et al., 2012; Dill and Shera, 2012a). Because evidence-based practice is the concept used in Sweden I have chosen to use that concept in this thesis. All of the social workers, managers and regional representatives that provided the information presented in this thesis also use the concept evidence-based practice.

Studying organisations from inside

Although evidence-based practice is to a great extent introduced with a top-down perspective, evidence-based practice is changing the work within the social services. This is part of a continuous process of change which is present in social work today. Traditionally organisations often have been regarded as being founded on 'stability, routine, and order' (Tsoukas and Chia, 2002:567). When organisations are perceived as

stable it is assumed that organisational change only occurs in exceptional cases (ibid.). A classical way to consider organisations is to regard them as rational tools, where organisations make decisions based on different alternatives and that those decisions are then implemented in a linear process. Changes are perceived in the same way; the organisation is declared to be relatively stable, and changes occur only when different alternatives have been carefully considered (Eriksson-Zetterquist, 2009). Instead, Tsoukas and Chia (2002) reason, the norm is that organisations are continuously changing and that change inside (*in*) organisations is something going on in a continuous process.

In the process of introducing evidence-based practice social workers must deal with the changes that evidence-based practice implies. Ideas of evidence-based practice are not automatically transferred from the national level to the local level (Czarniawska, 2005; Czarniawska and Joerges, 1996). The original way of perceiving evidence-based practice will change, to some extent, when it travels between different actors. It is the people (the actors) who come into contact with the idea that alter it via a 'collective creation process' (Czarniawska, 2005:106). This entails that the people in the organisation become particularly important (ibid.). As Berger and Luckmann (1967) explain, the reality that people (social workers) perceive in their daily practice is constructed through interaction between individuals and society. According to Tsoukas and Chia (2002:580) it is essential to study 'microscopic changes' inside organisations. To study organisations from inside means to observe and pay attention to 'how organisational members reweave their webs of beliefs and habits of action in response to local circumstances and new experiences' (ibid:580).

In my licentiate thesis (Eliasson, 2010), I considered the cooperation between and within social services and health care. Although professionals have a positive attitude towards the benefits of cooperation (as with evidence-based practice) it is not always easy to improve cooperation, especially when changes are introduced with a top-down perspective (ibid.). On the basis of the results of the licentiate thesis, I argue that evidence-based practice can be understood similarly. National actors have taken a responsibility to convey ideas about how social work should be performed. Although there are differences between introducing cooperation and evidence-based practice, they are two examples of ways of organising work that, to a great extent, is introduced in a top and down process. In my licentiate thesis it is clear that the introduction of cooperation easily becomes dependent on the people who work in the organisation and their subjective interest of the cooperation (ibid.), or evidence-based practice.

The starting point for this thesis is the introduction of evidence-based practice, which can be understood in relation to other changes and trends in society and in social work such as new public management and neo-liberalism. These changes have been and still are significant when introducing evidence-based practice. Ideas about evidence-based practice are often mediated via organisations at a national level, and these ideas have an impact on how professionals act and how they think about evidence-based practice. For this reason I believe it is important to examine how social workers incorporate evidence-based practice in their daily work. It is, as Tsoukas and Chia (2002) claim, important to study organisations from the inside. The main focus is on how profession-

als[5] work to receive and manage the idea of evidence-based practice. I have therefore interviewed social workers, mainly social workers working within municipal social services and primarily those working in the area of children and families, about their daily work.

In addition to the introduction of evidence-based practice at an individual social worker level, managers and local politicians must organise and create structures for evidence-based practice within the social services. To create a better understanding of the context, what is important for introducing evidence-based practice in social services, I have also interviewed managers within social services, regional representatives from a Research and Development Unit and some doctors. The analysis is performed in relation to different levels important for the introduction of evidence-based practice (cf. for instance the discussion by Gray, Plath and Webb, 2009); at international, national, regional and municipal social service level. In addition, I also acknowledge the importance of analysing the introduction of evidence-based practice within the organisation from managerial and a social worker level.

The purpose and questions

The purpose of this thesis is to describe and analyse different processes of the introduction of evidence-based practice. One aspect is what these processes have contributed to in terms of organising ways of working and management within social services, the other aspect is what this means for social work.

The following research questions have been formulated:

- How is evidence-based practice introduced into social work and what changes is evidence-based practice expected to entail for social work?
- What organisations are involved in introducing evidence-based practice?
- How do professionals at different levels relate to evidence-based practice?
- In what way do the doctors perceive and relate to evidence-based medicine in their daily work?
- Is it possible to introduce evidence-based practice in social work in a similar way as in the area of medicine?
- In what way is social work shaped (and constructed), as it is increasingly based on evidence-based practice?

Disposition

In this chapter, *chapter one*, I have given an introduction of changes in society that have entailed the development of evidence-based practice in social work. The purpose and research question of this thesis have also been presented. In *chapter two* I describe the

[5] I use a very broad understanding of profession, where professions are occupations that perform services which are founded on theoretical knowledge acquired through specialised education. From this point of view social worker and doctor are two different professions (cf. Molander and Terum, 2008).

development of evidence-based practice and its development within medicine and the transference to other areas, as evidence-based practice. I also give an overall description of how evidence-based practice is understood and defined, and how evidence-based practice has been received in the Swedish context. The *third chapter* provides my methodological considerations, my approach and the method that I have used in this thesis. Further, the chapter contains how the empirical material has been collected and analysed, and what my reflections about the quality in my research.

The theoretical perspectives I have used are presented in *chapter four*. Primarily I have used new institutional theory in combination with Berger and Luckmann's (1967) theory about social constructionism. *Chapter five, six, seven and eight* contain the result from the interviews with the doctors, regional representatives, social services managers, and with social workers within individual and family service. In these chapters I present how the interviewees work with and perceive evidence-based medicine and evidence-based practice. Finally, a discussion about the thesis results follows in *chapter nine*.

2

Evidence-based practice

This chapter has the intention of giving an overall understanding of evidence-based practice, its development within medicine and the transference to other areas as evidence-based practice, and how it has been received in Sweden. My primary focus is the development of evidence-based practice within social work. There are four main sections in the chapter. This *first main section* contains two subsections which describe the development of evidence-based medicine and evidence-based practice, and two subsections discussing the two different ways of understanding evidence-based practice, a narrow and a wider perspective. At times these perspectives are set against one another. In the *second main section* I want to give an understanding that there are different ways to approach evidence-based practice and that those approaches are used in different ways when introducing evidence-based practice.

The *third main section* begins with a brief review over the need to structure the introduction of evidence-based practice at an organisational level, and then I continue to describe important actors in a Swedish context for introducing evidence-based practice. There are other important actors but I choose those actors that are relevant for this thesis, and who work at a national, a regional or a local level. In the *fourth main section* I will move on to Swedish national actors, what they have done in the development towards an introduction of evidence-based practice. Here, I want to show how national initiatives have launched evidence-based practice and how the efforts have developed during the years. However, this chapter covers far from all events and perspectives with evidence-based practice. My intent is instead to create an understanding of how different stages in the development are connected to each other and affect one another, which will give a context to what the interviewed individuals are saying.

Evidence-based practice began to emerge within the medical field in the early 1990s, and became a role model for dissemination and introduction of evidence-based practice in areas such as social work, education and the probation service. The evidence-based practice movement has gradually started to transform the work in these fields (Bhatti, Hansen and Rieper, 2006; Bohlin, 2011; Svanevie, 2011). How evidence-based practice has been shaped depends on 'which professional reality' *[author's translation]* evidence-based practice has encountered (Bergmark and Lundström, 2011:163). In Sweden, evidence-based medicine spread to social work in the late 1990s under the name of evidence-based social work, and later evidence-based practice. This occurred a

few years after it was launched in journals about social work in the United Kingdom and the United States (Bergmark, Bergmark and Lundström, 2011).

As explained in the introduction, evidence-based practice is the term used in a Swedish context (cf. Alexanderson et al., 2012), and therefore in this thesis. The concept evidence-informed practice has never been used in Sweden (ibid.). There are arguments about whether to use the concept evidence-based practice or not, and what benefits there are with both concepts. The choice to maintain the concept evidence-based practice in Sweden has two main reasons, the first is the standpoint that not 'all knowledge gives evidence', and the second is that 'it is not only scientific knowledge that is important' (Jergeby and Sundell, 2008:12; see also Socialstyrelsen, 2011). Evidence informed practice as a concept is used by several researchers and in several countries, such as the United Kingdom, Canada and the United States, and emphasises the practitioner as an expert, using scientific information in work (cf. Chaffin and Friedrich, 2004; Epstein, 2009; Nevo and Slonim-Nevo, 2011; Dill and Shera, 2012; Shlonsky and Ballan, 2012). Evidence informed practice is, briefly, an approach which entails that the professional is informed by evidence and theory, and where there is an on-going interaction between the professionals and users (Nevo and Slonim-Nevo, 2011). Regardless of if one calls it evidence-based practice or evidence informed practice, it differs from the original version of evidence-based medicine. For example, both evidence-based practice (as used in Sweden) and evidence-informed practice emphasise the responsibility that the professionals have for using different knowledge source (cf. Haynes et al., 2002; Mullen et al., 2005; Oscarsson, 2009).

A historical review of the development within the field of medicine

Within the medical field the development is characterised by organisations that produce reviews and those where reviews are a part of their products, namely Health Technology Assessment (HTA) (Bhatti, Hansen and Rieper, 2006). Cochrane Collaboration is the largest organisation that produces reviews and is influential in this field. The development of these two types of organisations progressed in parallel in many ways, but they have different origins. Those who produce reviews developed foremost in Europe during the 1980s and those who form HTA developed in the United States around 1970 (ibid.).

The tradition to produce reviews is long within the medical field (Bhatti, Hansen and Rieper, 2006). The development of experimental studies in which experiments were carried out with comparative groups began back in the 1700s in the United Kingdom, with James Lind as a prominent person (Thröler, 2000; Chalmers, 2001). Lind performed experiments within the Navy, on sailors suffering from scurvy (Peile, 2004). The need for quantitative data increased until the 1800s, as Chalmers (2001:1159) explains:

> Over this period, there was increasing recognition of the need for quantitative data to describe progress following treatment, the need to report disappointing as well as heartening results, the inadequacy of small samples, and the need to organize prospective, concurrent comparison of alternative therapeutic strategies.

Around the year 1780 this trend reached its peak. Thereafter, doctors began to take the methods that had developed for granted, as 'standard techniques', and the methods were not used in their entirety (ibid.). During the following centuries the medical field was characterised by 'experimental learning' (Peile, 2004:102f).

During the 1930s and 1940s random controlled trials (RCT) began to be used within the medical field (Scocozza, 2000; see also Bhatti, Hansen and Rieper, 2006). Two central persons during these years were Austin Bradford Hill and Ronald Fisher. For example, Bradford Hill conducted the first modern RCT-studies about medical treatment during the second half of the 1940s, and Fisher contributed to the design of RCT-studies (Scocozza, 2000; Chalmers, 2003; Sherman, 2003). However, it was not until the 1960s and 1970s as RCT-studies seriously began to be used in medical research (Bhatti, Hansen and Rieper, 2006).

As the knowledge base grew during the 1970s the interest in systematisation and summaries of knowledge became larger. The British epidemiologist Archie Cochrane is regarded in this respect as a central person, whose ideas about clinical learning gained great influence in the development of evidence-based medicine and the creation of Cochrane Collaboration (Petrosino et al., 2000; Bhatti, Hansen and Rieper, 2006). According to Petrosino et al. (2001) Cochrane claimed that practitioners did not fully incorporate information about which practices that had been proven effective and which were harmful and, that there was a need to consider the scientific evidence in the work. The problem was that doctors tended to 'rely on intuition, expert or peer opinion, tradition and anecdotal experience rather than on the most updated research findings' in their daily work (Morago, 2006:463).

Cochrane, who advocated RCT-studies, considered however that this method would be used when it was practicable, and when it was possible from an ethical perspective (Peile, 2004; Svanevie, 2011). Cochrane was also interested by questions about the importance that sectors such as health care are effective and that available resources are used in the best way possible (Bhatti, Hansen and Rieper, 2006; Morago, 2006). There was, according to Cochrane, a necessity to act in the light of what had been proven most effective because the 'resources would always be limited' (Peile, 2004:103f). Cochrane was also involved in knowledge compilations, and at the end of the 1980s became the British National Health Service interested in Cochrane's work and contributed with funds to the English Cochrane Collaboration, which formed in 1992 (Petrosino et al., 2000; Svanevie, 2011). Two key persons in the formation of Cochrane Collaboration became Iain Chalmers and David Sackett. Chalmers became later also involved in the formation of Campbell Collaboration (Svanevie, 2011).

The international Cochrane Collaboration was formed the following year with financial support from, among others, the European Union and Swedish Council on Health Technlogy Assessment, SBU (Petrosino et al., 2001; Peile, 2004; Svanevie, 2011). According to the Cochrane Collaborations website, the purpose with the network is to:

> Work together to help health care providers, policy-makers, patients, their advocates and carers, make well-informed decisions about health care, based on the best available research evidence, by preparing, updating

> and promoting the accessibility of Cochrane Reviews. (The Cochrane Collaboration, *About us*).

An important part of the Cochrane Collaboration's work is to compile knowledge into systematic reviews (Trinder, 2000a; Svanevie, 2011). The intention is that policy makers, practitioners, and citizens get access to 'updated and relevant results from research of high scientific quality' *[author's translation]* (Svanevie, 2011:27). The Cochrane Collaboration is regarded as one of the most important producers of reviews and many organisations follow or refer to the Cochrane Handbook, which is a comprehensive document where the methodology adopted and advocated is described in detail (Bhatti, Hansen and Rieper, 2006). The systematic reviews and the use of meta-analyses is the most desirable and are considered the most ideal methods in the evidence hierarchy (Hansen and Rieper, 2009). The development with making reviews can to a great extent be traced to the United Kingdom; most organisations that have been and still are important for the evidence-movement are British, for example the Centre for Reviews and Dissemination, CRD, (Centre for Reviews and Dissemination) and The Evidence for Policy and Practice Information and Coordinating Centre, EPPI, (EPPI-Centre).

Those organisations working with Health Technology Assessments, HTA, developed mainly in the United States during the late 1960s and early 1970s, which is a little earlier than the development of the organisations conducting reviews. The development of HTA began within other areas but came to influence the medical field (Bhatti, Hansen and Rieper, 2006). Internationally there was a spread of HTA in the 1980s, for example the international network International Society for Technology Assessments in Health Care (ISTACH), which later became Health Technology Assessment International (HTAi) (Sundhedsstyrelsen, 2003; Bhatti, Hansen and Rieper, 2006; HTAi, *Mission*), and the Swedish Council on Health Technlogy Assessment (SBU) which was one of the first national organisations in the world for HTA were created (Bhatti, Hansen and Rieper, 2006).

McMaster University, in Canada had an important part in the development of evidence-based medicine (Morago, 2006). In 1991 evidence-based medicine was launched as a concept. Evidence-based medicine was used to describe a new method for the doctors' practical work with patients, where the use of knowledge should be founded in research (Vandvik, 2009). David Sackett, professor of clinical epidemiology and biostatistics, is regarded as a prominent person in the evidence movement. During the time Sackett worked at McMaster University Sackett and colleagues developed new working methods for education of doctors, which is known as problem-based learning (Gray, 2000; Reynolds, 2000; Svanevie, 2011). Sackett was recruited in 1994 to Oxford in Great Britain where he became the head of the institute 'the Centre for Evidence-based Medicine' (Gray, 2000:97; Morago, 2006; Svanevie, 2011). The work at the institute became important for the further development of evidence-based medicine and for its spread to fields other than the medical in the United Kingdom and other countries (Morago, 2006). The research team with Sackett designed a definition of evidence-based medicine that is well known and used in many contexts (Sackett et al., 1996). For further description of problem-based learning and the definition of evidence-based medicine, see the section about Evidence-based practice from a wider perspective.

A historical review of the development within the social work field

Although randomised experiments are often associated with research within the medical field there is a history of experimental research also within the sphere of social science (Oakley, 2000; Petrosino et al., 2000, see also Bhatti, Hansen and Rieper, 2006) that can be followed back in time at least to the early 1930s when the experimental sociology emerged in North America:

> In the early years of the 20th century, social sciences in North America developed an established tradition of quantitative sociology that included experimental studies. This was followed by a number of experiments from the 1960s to the 1980s. (Oakley, 2000:315).

The need for effective interventions to improve the conditions of people's lives became especially evident during the big depression in the 1930s and the following years. Then, these issues became a serious aspect on the political agenda, driven mainly by American researchers (Oakley, 1998). Ernest Greenwood's publication from 1945 'Experimental Sociology' outlined as a theoretical foundation how to use experimental methods when social issues were studied (ibid:1240). Greenwood shared Fisher's interest in RCT-studies but advocated also the importance of a combination with case studies. However, Greenwood regarded case studies as an introduction, before RCT-studies are conducted. In the United States there was at this time a need to make social science more scientific, unlike many other countries who regarded social science as a non-academic subject, for example the United Kingdom (Oakley, 2000, see also Bhatti, Hansen and Rieper, 2006).

The progress in the United States between the 1960s and 1980s described as 'the golden age of evaluation' when the use of controlled trials in evaluation of social interventions was supported by both the academy and by the politics (Oakley, 1998; 2000:322). The interest that existed for evaluations in the United States was due to the welfare sector in the country that was in disarray and that government spending had increased dramatically while the government had not come to grips with the problems of poverty and inequality. This development in the United States coinciding with the American psychologist and social scientist Donald Campbell's work with experimental methods and their use in social sciences (Shadish, Cook and Leviton, 1991; Oakley, 2000).

Although Campbell stressed RCT studies, Campbell felt that RCT studies were not always feasible and even that 'the experimental society was somewhat Utopian' (Davies, 2004:25). In an article from 1969 Campbell argues that 'where randomized treatments are not possible, a self-critical use of quasi-experimental designs is advocated' and continues to explain that 'we must do the best we can with what is available to us' (Campbell, 1969:411). According to Davies (2004) Campbell considered that these difficulties to be due to the political and social context and that there was a need for different approaches in research, as the quasi-experimental design. Qualitative research could be needed to understand what is stated in quantitative studies (Davies, 2004; Svanevie, 2011).

In line with Campbell's work was the work of Robert F. Boruch, published in 1997, decades after Campbell. At the same time people in senior positions within the Cochrane Collaboration argued that a new independent organisation focusing on the social sector should be created. Given the success of the Cochrane Collaboration the need for a similar organisation for conducting reviews within social work and education were expressed (Petrosino et al., 2001; Chalmers, 2003a). This development took place in the United States (Chalmers, 2003a) and can be traced to Campbell's work (Davies, 2004).

Outside the United States a number of organisations, who conduct reviews, became important from the early 1990s (Bhatti, Hansen and Rieper, 2006). It was mainly British organisations such as the Science Research Unit (SSRU), the Evidence for Policy and Practice Information and Coordinating Centre (EPPI), and the Centre for Reviews and Dissemination (CRD), which focuses primarily on the medical field but has also developed systematic reviews relevant to the social sector. In the mid-1990s additional organisations working with reviews within the social sector were formed, for example Research in Practice (RiP) and Centre for Evidence-Based Social Services (CEBSS), both formally organised under the charity organisation The Dartington Hall Trust. The Centre for Evaluation of Social Services (CUS) started their activity in 1993, on the initiative of the Swedish Ministry of Health and Social Affairs (ibid.).

Efforts to create Campbell Collaboration began with exploratory meetings in 1999 and 2000 (Boruch et al., 2004). In a review of literature from these meetings, as Svanevie (2011:43) does in her thesis, it appears that an issue that was discussed at the meetings was 'how the medical model would help with problem solving in other fields' *[author's translation]*. Also discussed at the meetings was the importance of creating an own organisation, and that it would be secluded from the Cochrane Collaboration, because the Cochrane Collaboration was so strongly associated with the field of medicine and healthcare. This would give the social and educational fields its own identity (ibid.). Karin Tengvald from the Swedish National Board of Health and Welfare was invited to the meetings. Tengvald became very significant for the introduction of evidence-based practice in Sweden. A few weeks before the formation of Campbell Collaboration, a conference was held in Sweden for Swedish researchers, policy makers and practitioners (Mullen, 2006) to present the new collaboration.

The Campbell Collaboration was formed in the early 2000, as a sister organisation to the Cochrane Collaboration (Petrosino et al., 2000, 2001; Boruch et al., 2004). Campbell Collaboration's intention is, according to Davies (2004:21), to 'help policy-makers, practitioners and the public make well-informed decisions about policy interventions by preparing, maintaining and disseminating systematic reviews of the effectiveness of social and behavioural interventions in education, crime and justice, and social welfare'. The international activities of the Campbell Collaboration have over the years become 'increasingly important as a guide for what counts as reliable knowledge, as evidence' *[author's translation]* (Eriksson, 2006:10).

When Campbell Collaboration had been formed the number of organisations working with evidence-based social work increased significantly, especially in the United Kingdom. One of the most important organisations is the Social Care Institute for Excel-

lence (SCIE) (Bhatti, Hansen and Rieper, 2006), which was established in 2001 by the English government. SCIE is a charitable organisation who produces reviews and products that will facilitate the use of the practice, including practical guides to collect information on specific issues (Social Care Institute for Excellence, *About SCIE*). In 2002 a Nordic Campbell Centre was established in Denmark, at the initiative of the Danish Government, but with the support of the Swedish and Norwegian government (Petrosino et al, 2001; Bhatti, Hansen and Rieper, 2006). Erstwhile the Centre for Evaluation of Social Services (CUS) was the Swedish node in the Nordic Campbell (Mullen, 2006). Nordic Campbell directed primarily to the social field (Boruch et al., 2004) and has responsibility for the reviews prepared in any of the Nordic countries in the social field (Bhatti, Hansen and Rieper, 2006).

The use of evidence in a narrow perspective

Work according to evidence-based practice, understood in a narrow perspective, is built on the notion of what gives the best evidence and the best quality in practical work. As described in the historical review above, the Cochrane Collaboration and the Campbell Collaboration have advocated a narrow view on the use of evidence as the most desirable, especially the Cochrane Collaboration.

Evidence-based work is founded on general results from research and well documented studies which determine ways of working and the interventions given (Sohlberg and Sohlberg, 2013). Work is thus not based on the professional's own limited experience. Evidence-based knowledge can in some ways be described as opposite to practice knowledge. The core idea is that support and interventions are given after careful considerations and decisions of what is most effective. In the strictest version of evidence-based work the effects of the methods or interventions used are tested through a thorough experimental design.

Within medicine this means to start with a diagnosis or a problem and then treat the patient with proven treatments (ibid.). Sackett et al. (2000) and Thyer (2006:36) define five steps that are important when working according to evidence-based practice:

1. Convert one's need for information into an answerable question.
2. Track down the best clinical evidence to answer that question.
3. Critically appraise that evidence in terms of its validity, clinical significance, and usefulness.
4. Integrate this critical appraisal of research evidence with one's clinical expertise and the patient's values and circumstances.
5. Evaluate one's effectiveness and efficiency in undertaking the four previous steps, and strive for self-improvement.

The practitioners have a responsibility to keep themselves informed of developments within research and to use the knowledge from research in the daily work (Thyer, 2006). These five steps are a guide for the work, but at the same time there are several methods possible to use (Gray, Plath and Webb, 2009). In the second step methods with an experimental design are considered to be the best choice, random controlled

trials (RCT-studies) are the very best if they are available. In the third step the practitioner needs to critically appraise the evidence. Systematic reviews, meta-analysis, and/or research literature are useful for this step (ibid.).

There is an ambition with evidence-based practice that interventions given should be 'validated by research evidence through randomised controlled trials' (Pease, 2009:46). Two methods within the evidence-movement are more in focus than others, namely RCT-studies and systematic reviews (Bergmark, Bergmark and Lundström, 2011). RCT-studies are considered as the 'gold standard' method used to assess if a treatment or intervention is effective or not (Reynolds, 2000; Grimen, 2009). The arguments for these methods are that they give the best possibilities to produce reliable evidence. With RCT-studies it is the randomised selection with experiment groups and control groups that is the most important factor for producing reliable results (Reynolds, 2000; Grimen, 2009). In theory, this creates groups that in average are similar to each other, and what differentiates them is which intervention the test persons will get in the different groups (Reynolds, 2000; Sundell and Ogden, 2012).

Systematic review is a structured method for how to 'identify, select, assess and compile research' about a defined question, usually about effects of interventions (Bodin, 2012:574). Research results from different primary studies are weighed together in systematic reviews. Work is conducted according to a protocol containing a determined way of working. The Cochrane Collaboration and the Campbell Collaboration use such protocols (ibid.). Systematic reviews are essential in the introduction of evidence-based practice because individual research results are not enough if an evidence-based assessment shall be possible (Bergmark, Bergmark and Lundström, 2011). Systematic reviews make research results more available (ibid.). Meta-analysis, as a statistical method, is often a component in systematic reviews (Trinder, 2000; Bodin, 2012).

This perception of what gives the best evidence is usually formulated as an evidence-hierarchy. This hierarchy of methods is built up after how well it determines the quality of the evidence, and is an essential feature within medical evidence-based practice (Gray, Plath and Webb, 2009). Both within the Cochrane Collaboration and the Campbell Collaboration 'the hierarchy and levels of evidence is well established and institutionalized in the work' (ibid:31). The Campbell Collaboration has, according to Gray, Plath and Webb (2009), had more difficulties in getting the same driving force and support as the Cochrane Collaboration has had. Within the medical field RCT studies are accepted as a method that gives the best evidence for the interventions given (Pease, 2009); more so than in social work.

A method's place in the evidence hierarchy clarifies which criteria shall be used in the quality control of knowledge (Grimen, 2009). This is essential for evidence-based practice; evidence hierarchy is the core of the reasoning about working evidence-based and it is important because it determine if knowledge is reliable or not, and it specifies how practitioners make appropriate clinical decisions. Therefore, evidence-based work can be understood as a theory for making clinical decisions, and as a theory of 'information searching' *[author's translation]* (ibid:212). The best evidence is at the top, and that is where one should begin when searching for evidence. The lowest level in the hierarchy is used when there is nothing better available. RCT-studies or systematic reviews and

meta-analyses are, according to Grimen (2009), at the top of the hierarchy because they give the most reliable knowledge. Expert opinions are at the lower end of the hierarchy (ibid.), such as cross-sectional studies and case reports (Reynolds, 2000). This lowest level includes, for example, experience that is not systemised, such as expert committees and expert valuations (Grimen, 2009).

Before moving on to a section where a broader perception of evidence-based practice is presented I will briefly address some challenges with RCT studies in social work that are expressed every now and then. These challenges are not specific for social work and are also apparent within medicine (Gray, Plath and Webb, 2009). However, research within medicine usually suits the experimental research design better than research within social work (ibid). Grimen (2009) perceives that evidence-based work suits medicine but questions if it suits all areas, such as social work. For example, RCT-studies may not be used in social work because of its controlled research design, which entails that the design itself risks simplifying an amount of different relationships, or omit dimensions of social life (Gray, Plath and Webb, 2009). This also limits the possibility to generalise the results. Another challenge is the fact that RCT-studies shall be standardised and possible to replicate. This means that in an experimental group the same intervention must be given in exactly the same way to all individuals. This is often described as a challenge within social work because of its variation regarding for example context, individual conditions, the social worker's skill and competence as well as organisational conditions. A third challenge that is mentioned by Gray, Plath and Webb (2009:32) is that the outcome of research must be possible to measure, which is difficult within social work because the results are 'open to interpretation and dispute'.

Also the evidence-hierarchy, as a hierarchy with a golden standard containing RCT-studies, is questioned (Gray, Plath and Webb, 2009). They argue that 'the evidence-based practice movement has ... created and institutionalized notions of good and bad evidence in the decision-making process' and that there are limitations to which method one chooses (ibid:38). Qualitative research gives merely another type of evidence than that which is produced with RCT study design (ibid.). Bergmark, Bergmark and Lundström (2011) argue for an alternative approach for evidence-based practice in social work. One of the things emphasised is the need for another scientific paradigm, because the discussion about what science is has been reduced to a question of different research designs and to the use of different instruments for systematic assessments. Instead, Bergmark, Bergmark and Lundström (2011) argue that one should take into account different types of knowledge claims.

Evidence-based practice from a wider perspective

Influential for the development of evidence-based medicine was Archie Cochrane and the work conducted in the medical education at McMaster University in Canada (Reynolds, 2000). An important step in the development of evidence-based medicine and evidence-based practice is the work that David Sackett and his colleagues did at McMaster University (the McMaster group). The medical education started in the 1960s and during the late 1980s and early 1990s Sackett and colleagues developed 'pioneered teaching methods based on problem-based, self-directed learning' (Reynolds,

2000:21). The problem was that doctors did not use the best available knowledge in their work, instead the context doctors worked in had a great influence and they were dependent on authority figures (cf. McColl et al., 1998; Upshur and Tracy, 2004; Bergmark, Bergmark and Lundström, 2011). One illustration is given by Ekeland (2009) when writing about lobotomy as an example of a scientifically based treatment with good effect that medicine has later distanced itself from.

However, when evidence-based medicine was first introduced in the education of doctors a scientific approach was nothing new. The medical practice uses a scientific approach and doctors received scientific training in their education (Bohlin and Sager, 2011). But the need for developing problem-based learning was the experience that doctors did not use the best available knowledge in their work. Instead, the context they worked in had a great influence and they were dependent on authority figures (Bohlin, 2011). Furthermore, those clinicians who would use research in practice were significantly more in number than those who conducted research, and the results of research published in scientific journals were primarily written for and by other researchers. It was hard for the clinicians to keep up with current research. There was hence a need for medical students to learn 'the skills of critical appraisal' during their education (Gray, 2000:94).

The central idea with problem-based learning is that the clinical practice is integrated with research and that research principles are used 'to inform decisions about diagnosis treatment and its side-effects, and prognosis' (Reynolds, 2000:21). This was named 'clinical epidemiology' and the essential is thus that instead of conducting research doctors use the result from research on the clinical problems they encounter (ibid; Morago, 2006). The intention with the new way of educating doctors was to, according to Bergmark, Bergmark and Lundström (2011), educate them so they would not be authority bound, instead they should themselves have the ability to search and critically appraise research findings that are relevant in their work. Critical appraisal is a concept often used to describe this approach (Gray, 2000; Bergmark, Bergmark and Lundström, 2011; Bohlin, 2011), and is associated with this anti-authoritarian approach, with 'a pronounced scepticism against time-honoured tenets and established experts' recommendations' *[author's translation]* (Bohlin, 2011:39).

During the 1990s Sackett and his colleagues formulated a definition of evidence-based medicine that since then has become commonly used to define evidence-based medicine in several contexts, also in social work (Morago, 2006; Bergmark, Bergmark and Lundström, 2011). Sackett et al. (1996:71) defined evidence-based medicine as follow:

> Evidence based medicine is the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients.

This definition is often considered to be the original version of evidence-based medicine, and was later used to define evidence-based practice (Bergmark, Bergmark and Lundström, 2011). Sackett et al. (1996:71) explain that it is the professional who integrates 'individual clinical expertise with the best available external clinical evidence from systematic research'. All skilled doctors must, in their work, combine these

knowledge sources. Sackett et al. (1996:72) highlights the responsibility of the professionals' responsibility:

> Without clinical expertise, practice risks becoming tyrannised by evidence, for even excellent external evidence may be inapplicable to or inappropriate for an individual patient. Without current best evidence, practice risks becoming rapidly out of date, to the detriment of patients.

According to Oscarsson (2009:15) evidence-based medicine is to the initiators both 'an approach and a method that emphasises the reflective practitioner that in their choice of interventions in an autonomous way take into account and value different knowledge sources and types of evidence from the individual patient's needs and values'.

Since evidence-based medicine was launched in the mid-1990s the definition has developed and been adapted to other circumstances (Gambrill, 2003; Morago, 2006). In the year 2000, Sackett et al. (2000:1) defines evidence-based practice as decision-making process informed by three sources, which means 'the integration of best research evidence with clinical expertise and patient values'. Gambrill (2003:6) explains that this is a changed approach that entails a process where professional judgment is used effectively and integrates 'information regarding each client's unique characteristics and circumstances, including their preferences and actions, and external research findings'.

To illustrate the decision making process as professionals do in their daily work when working with evidence-based practice a model has been developed that consist of the three different elements mentioned by Sackett et al. (2000). A commonly used model in which these parts are included that descends from Haynes, Devereaux and Guyatt (2002) illustrates the process of evidence-based decision making (see Figure 1, below).

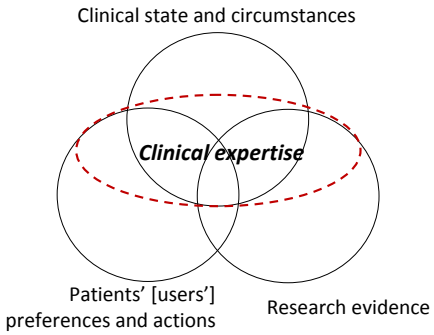


Figure 1: The evidence-based decision process, after Haynes, Devereaux and Guyatt (2002:1350).

Those adhering to Sacketts et al. (1996, 2000) definition claim that all these elements – best scientific evidence, users' preferences and actions, and the professionals' knowledge and clinical expertise – must be taken into account and combined in the work for it to count as evidence-based practice (Haynes et al., 2002; Mullen et al., 2005; Bergmark, Bergmark and Lundström, 2011). All these knowledge sources are important in

evidence-based practice, but in encounters with a user it is the professional's responsibility to, in different ways, weigh together these sources (Haynes et al., 2002; Jergeby and Sundell, 2008; Oscarsson, 2009). Sometimes the results of research get high importance while users' experiences and preferences may be more important in other cases. How these sources of knowledge are weighed together also depends on the national and the local context, it also depends on legislation, guidelines and other available resources (ibid.). This weighing together of different knowledge is not that easy for the professionals to do on a daily basis (Haynes et al., 2002).

Working with evidence-based practice is often characterised as a working process (Svanevie, 2013) that contains the different knowledge sources as described here above. The same five steps as described in the former section, *The use of evidence in a narrow perspective*, can also be used to understand this working process. Thyer (2006:36) explains the five steps (see also Sackett et al., 2000; Shlonsky and McLuckie, 2008; Oscarsson, 2009; Svanevie, 2013):

1. Convert one's need for information into an answerable question.
2. Track down the best clinical evidence to answer that question.
3. Critically appraise that evidence in terms of its validity, clinical significance, and usefulness.
4. Integrate this critical appraisal of research evidence with one's clinical expertise and the patient's values and circumstances.
5. Evaluate one's effectiveness and efficiency in undertaking the four previous steps, and strive for self-improvement.

Evidence-based practice is, according to Shlonsky and McLuckie (2008), a dynamic process where the support is customised for the individual user. The professionals' expertise is most prominent in step four (Shlonsky and McLuckie, 2008). The professionals have to learn to critically appraise the information and knowledge they gained during their education. This is an approach that has to be integrated into theory and into practice (Shlonsky and Stern, 2007; Shlonsky and McLuckie, 2008).

One aspect in the evidence-based decision making process, which has become more important in recent years, is the preferences of the user (Bergmark, Bergmark and Lundström, 2011). Besides being an approach and method for the professionals, evidence-based practice is a part in increasing individuals' influence and participation when they have contact with social services (Oscarsson, 2009). The individuals own perception about their problems and needs is one key element in an evidence-based practice, as well as individual's values and circumstances. Evidence-based practice is thus a method which increases the influence of the individuals own situation (ibid.). The preferences of the users are a form of an 'ethical point of view' *[author's translation]* in which the user has the right to choose (Bergmark, Bergmark and Lundström, 2011:23). User influence in individual cases is not completely alien to social work. At least it has been a part of the work as long as the Social Services Act has existed, in the beginning of 1982 (ibid.). In evidence-based practice the importance of users' participation is also emphasised by user organisations, users contribute with information and

knowledge of the group, but they can also participate in evaluations and in planning the activities (Freij, 2012; Svanevie, 2013).

This model and approach, described in this section, has been embraced by national actors in Sweden. Oscarsson (2009), for example, stresses in a book published by the Swedish Association of Local Authorities and Regions (SALAR) that three knowledge sources is the base in the professionals' decisions about interventions. Oscarsson (2009:17) writes that evidence-based practice in a social services perspective can be understood as 'the integration of the best support from research with professional practical experiences and client's values expectations and conditions' *[author's translation]*. This approach to evidence-based practice was also confirmed in 2008 by the Institute for Evidence-based Social Work Practice, IMS (cf. Jergeby and Sundell, 2008).

When the National Board of Health and Welfare uses this model they have named the circles the person's situation and contextual circumstances, scientific evidence and the person's experiences and wishes (Socialstyrelsen, 2011). The National Board of Health and Welfare accedes to Sackett et al.'s (1996) definition from 1996 and note that evidence-based practice 'involves a deliberate and systematic effort to build health care and caring on the best possible scientific ground (evidence) to increase the possibility to help' *[author's translation]* (Socialstyrelsen, 2011:2). Furthermore, the National Board of Health and Welfare, states that in an individual case there may be need for other knowledge because it is not certain that a specific intervention works for every individual. This entails that scientific knowledge is important but it is not enough if the best possible support shall be given. Scientific knowledge has to be complemented with users' preferences and wishes, with knowledge of the specific context for each individual, and with the professional's own competence (ibid.). SALAR is, at least since 2008, an influential organisation for introducing evidence-based practice. SALAR has the same approach to evidence-based practice, and states their direction in a document where evidence-based practice is considered to be 'a result of constant, systematic learning where knowledge from the user/patient, practitioners and from research are weighed together and used' *[author's translation]* (Sveriges Kommuner och Landsting, 2012:5).

Introducing evidence-based practice in social work

This main section describes different approaches to evidence-based practice. Those approaches affect the introduction of evidence-based practice. Since the mid-1990s there has been a growing interest in evidence-based practice within the field of medicine. Thereafter, evidence-based medicine has spread to other fields, such as social work (Morago, 2006). Evidence-based practice developed during the transference of evidence-based medicine to other areas (Trinder, 2000a). What impact evidence-based practice has depends among other things on the proximity between disciplines; how close the different recipient areas are to the centre of evidence-based medicine. If they are physically close to, culturally similar to, use the same language as or share similar research questions then the more likely it is that evidence-based practice is introduced in line with the original model for evidence-based medicine (ibid.).

Trinder (2000a:13) explains that 'evidence based practice has had its most receptive audience when that audience is one where there are considerable educational, occupational and organizational overlaps with the originating discipline or specialism'. The areas and disciplines located near this centre have introduced evidence-based practice without redefining it in any significant way. Acute medicine constitutes this 'epicentre' for evidence-based practice and specialist medicine and to some extent primary care and mental health has several factors in common with acute medicine. Disciplines such as social work and education do not share this closeness. In the outer edges, where social work and education are, other cultural expressions and other research traditions have evolved:

> The methodological centre of gravity of these disciplines falls largely within the social sciences and qualitative or non-experimental quantitative research, in contrast to medical research where the balance is tilted strongly towards models of research practice and cumulativeness drawn from the natural sciences (Trinder, 2000a:14).

The greater the distance is between a discipline and the epicentre then the less it corresponds with the original model of evidence-based medicine. And the risk that evidence-based practice is redefined and becomes an impoverished concept increases. This may result in ambivalence and scepticism in relation to evidence-based practice that can create a resistance to using it (ibid.).

Transferring evidence-based medicine to other areas has not been without problems, especially when 'underlying principles of the profession differ from the underlying principles of evidence-based medicine' (Reynolds, 2000:33), as is the case with social work. There is, according to Bergmark, Bergmark and Lundström (2011), a perception that it is hardly possible to reach full compliance with Sackett et al.'s (1996, 2000) definition and the ambition to educate so-called evidence practitioners with the skill to critically appraise research. At least there is a long way to go before this is achieved. It is explained that today's social workers probably do not have the skills needed to search for and critically appraise relevant research in their area. They need knowledge about how to search literature systematically, about scientific methods and knowledge of how to assess the quality of research (ibid.).

Studies have shown that even doctors generally deviate from the model the McMaster group formed. Doctors rely to the larger part on assessments that others have done than to do their own critical appraisal of scientific evidence (McColl et al., 1998; Guyatt et al., 2000). Guyatt et al. (2000) advocated an approach where clinicians are evidence based practitioners. But being an evidence-based practitioner is nevertheless a time consuming work. There are limitations with this approach and therefore an alternative strategy where the practitioners become evidence users is described. Even evidence-users can 'become highly competent, up to date practitioners who deliver evidence based care' (ibid:955). McColl et al. (1998) sent out a questionnaire to 452 general practitioners in England, of which 302 answered. They concluded that just over half of the general practitioners felt that the development from an opinion based to an evidence based medicine should be done by using evidence-based guidelines and protocols developed by other doctors, by colleagues. A slightly smaller proportion (37 per

cent) felt that the shift to evidence based medicine could be done through 'seeking and applying evidence based summaries'. Only five per cent of the doctors assume that this shift could be done by 'identifying and appraising the primary literature or systematic reviews' (ibid:363).

Upshur and Tracy (2004) have also studied doctors and conclude that the medical profession could not be considered evidence-based. They discuss four challenges with the basic assumptions which exist with evidence based medicine. One of these challenges is called 'the authority challenge'. A central element of evidence based medicine is that doctors become less dependent on authority figures, that they are looking for and assesses the evidence and various options available. Upshur and Tracy (2004) argue that doctors do not comply with these criteria, and within the medical profession there are two groups of professionals; those who are evidence users and those who are evidence practitioners.

Åke Bergmark, Anders Bergmark and Tommy Lundström, Swedish researchers within social work, have since the end of 1990s conducted a series of questionnaires which were sent to social workers, mainly within individual and family service (see Bergmark Å and Lundström, 2002, 2007; Bergmark A and Lundström, 2008, 2011a). The overall purpose with those questionnaires was to investigate how social workers perceive knowledge, use knowledge and evidence-based practice, and this has been done over time. In summary, Bergmark, Bergmark and Lundström (2011) want to emphasise the two main findings from these surveys. Firstly, Swedish social workers tend only in a small extent to take in what research shows; in relation to both reading articles in scientific journals and to read what is available on organisations' web-pages, for example Campbell Collaboration. This result is consistent with the result from surveys of social workers in several other countries, according to Bergmark, Bergmark and Lundström (2011). However, there have been some changes and during recent years social workers are beginning to show a larger interest for research (ibid.).

Secondly, social workers are in general positive towards evidence-based practice and have become more so with each survey; most social workers have an idea what evidence-based practice is. Even though social workers have a 'more positive attitude towards' evidence-based practice this is not necessarily 'an expression for that all have good cognisance of what an evidence-based program … de facto entails, and what changes of their own practice ... may lead to' *[author's translation]* (Bergmark, Bergmark and Lundström, 2011:151; Bergmark and Lundström, 2011a). There are also social workers with a more sceptical attitude towards evidence-based practice; they perceive that working methods with a scientific basis are less usable in social work because the meeting between people is what social work really is all about (ibid.). For example, one question in the questionnaire asks how acquainted they are with evidence-based practice and what value they place on evidence-based practice (Bergmark A and Lundström, 2011). Almost 78 per cent of the social workers answered that evidence-based practice entailed the use of 'methods and interventions with effects proven in scientific studies', and 37 per cent answered that it was about being 'updated on social work research' and for 25 per cent of them evidence-based practice means to follow 'scientifically based guidelines from e.g. the National Board of Health and Welfare' (ibid:327) *[author's translations]*. Evidence-based practice did not mean anything for just

over eight per cent of the social workers. Bergmark, Bergmark and Lundström (2011) conclude that Swedish social workers' attitudes appear nonetheless not to be an obstacle to introducing evidence-based practice.

Strategies to introduce evidence-based practice

Through the division of doctors as evidence users or evidence-based practitioners, as Upshur and Tracy (2004) did, a large group of doctors who do not critically appraise research on their own emerges. Instead, doctors gain knowledge from research, from more updated colleagues or through written summaries. Then the doctors are more evidence users and not evidence-practitioners. Through critical appraisal, as defined by Sackett et al., professionals' become evidence practitioners (Bergmark, Bergmark and Lundström, 2011). This also applies to other professionals, such as social workers or teachers. In one of the surveys, referred to above, regarding social workers approach to evidence-based practice, almost half of them answered that the most important source of knowledge in work is their own experience, and just over 20 per cent answered that colleagues were important (Bergmark and Lundström, 2002).

If critical appraisal and the professional as an evidence-practitioner is one way of understanding the introduction of evidence-based medicine (and evidence-based practice), the other way is to a larger extent to lean on guidelines, summaries of research and so on, that are formulated and transferred to the professionals' by other actors. The term Bergmark and Lundström (2011) and Bergmark, Bergmark and Lundström (2011) use for this is the guideline model. When professionals receive knowledge in this way they become to a greater extent evidence users rather than evidence practitioners, as described by Guyatt et al. (2000) and Upshur and Tracy (2004). The guideline model is launched by Rosen, Proctor and Staudt (2003) as a possible way for social workers to gain knowledge about interventions. It is explained that it is better if social work and researchers within social work create tools that social workers can use in their work:

> Rather than continue to place unrealistic expectations for use of research on practitioners, social work and its researchers should assume the responsibility and increase efforts to devise decision-making aids for practitioners to ensure that the best available empirically tested knowledge is used in practice. (Rosen, Proctor and Staudt, 2003:209).

There is a risk that expectations about evidence-based practice become too unrealistic for social workers to achieve. But, by developing guidelines social work was made easier; the guidelines become 'one important means to facilitate the utilization in practice of relatively complex, empirically based knowledge' (ibid:209).

The guideline model can be attributed to the concept of evidence-based practices (EBPs). By using EBPs the emphasis is placed on that it is about several interventions that have been assessed effective and are thus evidence-based, such as evidence-based practice was initially introduced in social work in Sweden (cf. Bergmark and Lundström, 2011). The EBPs approach implies an emphasis on the interventions' effectiveness (Gambrill, 2006, 2011). Gambrill (2011:34) writes that 'the effectiveness of certain intervention is decided on by some authority. The guidelines or treatment

manuals are ways to introduce these EBPs. Critical appraisal is a more general approach which involves a process where the professional critically appraises and evaluates knowledge and also weighs in the characteristics and preference from the individual user in an overall assessment. Gambrill (2006; 2011) emphasises that critical appraisal is transparent and therefore clarifies the uncertainty that exist, for example the decisions taken become visible. This differs from EBPs because guidelines, treatment manuals, summaries and so on, do not clarify what the scientific basis is. The knowledge in guidelines, for example, is already determined when the professionals use them. This lack of transparency may create uncertainty among practitioners (Bergmark and Lundström, 2011).

Bergmark, Bergmark and Lundström (2011) explain that Gambrill compares critical appraisal with EBPs and argues that a too narrow interpretation of evidence-based practice (as EBPs) entails a loss of the most important points with evidence-based social work, because the critical appraisal that is so central is not performed. Gambrill (2011:40) writes:

> Evidence-based practice is a clashing paradigm to the use of authority to forward claims (e.g. appeals to tradition, expertise, credentials and titles). And, basing decisions on criteria such as tradition and popularity saves time. Understanding alternative views, especially big new ideas, takes time. It is much easier to ignore the new view or simply describe what you think it is without checking. Another benefit is that you can keep on doing what you have always done.

As Gambrill (2011) points out, it requires a lot for professionals to change a way of working and to depart from the approach they have always had. The anti-authoritarian elements found in Sackett's model disappears (ibid.). What is lost is that social workers do not strengthen the basic competence and the dependence on authorities does not become weaker. Work will thus be performed as others say it should be performed in a given situation (Bergmark, Bergmark and Lundström, 2011 referring to Gambrill; see also Gambrill 2011; Mullen et al., 2005).

The use of guidelines and other types of summaries of research is one way to ensure that the profession is still using evidence-based practice. This approach can be seen as an answer to the model Sackett et al. created that is often considered difficult to realise. Knowledge from guidelines and summaries of research are therefore transferred to the professionals for them to use, instead of the professionals themselves seeking and assessing knowledge in research. This transfer is usually done via government agencies and researchers who indicate what treatments are appropriate to use within different areas. This means that the professionals do not themselves search for knowledge in research that is useful in their work. The procedure described here is associated with what is described as evidence users (Bergmark and Lundström, 2011). Work in accordance with the guideline model involves applying treatments or interventions that others have advocated, which is stated in the guidelines and in different summaries. Those advocating the guideline model claim that through this approach it is possible to established evidence-based practice (Bergmark, Bergmark and Lundström, 2011).

Howard and Jensen (1999), for instance, write that there is a need for new strategies in order to integrate research with the practical work and to make work more effective, where guidelines is one possible way to increase the empirical basis and effectiveness in social work. Furthermore, it is emphasised that guidelines helps social workers make decisions based on science which reduces uncertainty in social work. But in the same way as for critical appraisal there are studies that show that the practitioners do not use guidelines in their daily work. This could be because practitioners increasingly rely on authorities or that they can continue to do as they have always done without taking into account what is stated in the guidelines. It may also be that the guidelines are too general or too specific for practitioners to feel that they are useful in the daily work (Howard and Jensen, 1999; Bergmark, Bergmark and Lundström, 2011). The use of guidelines has been criticised for causing a 'deprofessionalisation' of the practitioners, who are 'reduced to performers of given procedures that have little or no room for adjustment to the individual client or patient' *[author's translation]* (Bergmark and Lundström, 2011:168). It has also been criticised for being introduced from a top-down perspective (ibid.).

There is, according to Bergmark, Bergmark and Lundström (2011), much that suggests that the guideline model is used in Sweden. One example is the guidelines that the National Board of Health and Welfare produce and disseminate to both social work and health care. The development of evidence-based practice in social work has been initiated by Swedish central bureaucracy with the National Board of Health and Welfare at the front. Over the last hundred years central government has had a significant part in shaping the normative structure for the profession (Bergmark and Lundström, 2011), even though municipalities are autonomous.

Accordingly, it was government agencies and not the profession that launched and disseminated evidence-based practice as a way to develop work within the social services (Bergmark and Lundström, 2011). The Ministry for Social Health and Social Affairs initiated the creation of the Centre for Evaluation of Social Services (CUS) in 1993, with the assignment to give social workers access to a scientifically based knowledge support (Socialstyrelsen, 2013a). The role model for CUS was the Swedish Council on Health Technology Assessment (SBU). The basis for evidence-based practice was therefore medical practice, and not social work practice or the education of social workers (Bergmark and Lundström, 2011). CUS and later the Institute for Evidence-based Social Work Practice (IMS), both located at the National Board of Health and Welfare, were two key organisations when evidence-based social work was introduced in the late 1990s.

Organising evidence-based practice

In this main section I focus on the need to organise the introduction of evidence-based practice at an organisational or management level. Then I continue to describe important actors in a Swedish context for introducing evidence-based practice and what responsibility these actors have. National actors of importance are, for example the National Board of Health and Welfare and the Swedish Association of Local Authori-

ties and Regions (SALAR), regional actors are primarily Research and Development Units, and the actor at the local level is the social services with the management and social workers. I also describe the regional Research and Development Unit and the five municipalities in this thesis more closely.

Introducing evidence-based practice within social work is however not that easy; the introduction is, using Gray, Plath and Webb's (2009:148) words, 'fragmented and variable'. There are obstacles in the introduction of evidence-based practice, both at macro and micro levels. Whether the introduction of evidence-based practice succeeds or not, the on-going process is 'best understood in strategic terms as involving obligatory points of passage, from which, for example, research passes into policy and then into practice' (ibid:162f). Obstacles in this process in countries like the United States and United Kingdom can be related to insufficient funding from governmental agencies, regarding the development of a structure or contribution to the emergence of a culture for evidence-based practice in social work (ibid.). Introducing evidence-based practice in Sweden can also be characterised by these 'points of passage' between for example the national and local level, or between the management and social workers in a social service. Although these are the main obstacles there are other factors contributing to the difficulties of introducing evidence-based practice, such as time and resource factors, 'technological solutions, professional culture, models of intervention and networked relations' (Gray, Plath and Webb, 2009:164).

There are two related concepts worth mentioning, used to describe this transferring of evidence-based practice mainly from the national level to regional or local level. Those concepts are knowledge management and evidence-based policy. Knowledge management is a concept used in Sweden by, for example, the National Board of Health and Welfare and SALAR (cf. Socialstyrelsen, 2011; Sveriges Kommuner och Landsting, 2012, 2012a). On a general level, knowledge management can help politicians and authorities get knowledge about which interventions are proven to have the best scientific evidence. This knowledge should inform their decisions (Sundell and Ogden, 2012). Research is one factor for politicians and authorities to take into consideration, other important factors are the severity of current problems and issues of cost efficiency (Socialstyrelsen, 2011; Sundell and Ogden, 2012).

Decisions at a policy level about which interventions are needed in the municipality or decisions about which interventions the municipality shall keep and which interventions are not effective are examples of knowledge management. When decisions and priorities are made in the municipality it is important in an evidence-based practice to relate the effects of the interventions to the cost for the municipality. Expensive interventions may be effective but it may entail that only a few individuals can receive them, or a cost effective intervention for the municipality may increase the costs of other organisations or activities, so called synergy effects (Socialstyrelsen, 2011; Sundell and Ogden, 2012). Evaluations, systematic reviews and guidelines are products useful in knowledge management (cf. Sundell and Ogden, 2012; Svanevie, 2013).

Other points of passage in the transference of evidence-based practice are in the local social services, between the management and social workers. Although evidence-based practice is very much about an approach and working process in the social workers

daily practice, there have to be conditions in the organisation that enables the use of evidence-based practice (Svanevie, 2013). There are different conditions that are important when evidence-based practice is introduced in the local social service. The responsibility for these conditions lies mainly on a managerial level and not at the level of social workers. *Firstly*, there is a need for available relevant research about the effects of different interventions (Oscarsson, 2009). There is not always, according to Bergmark, Bergmark and Lundström (2011), enough evidence of what works within social work, which is different from the situation within the medical field. *Secondly*, there must be both time and space for reflection, where professionals reflect over their cases (Oscarsson, 2009).

Thirdly, there has to be an array of interventions to choose from, otherwise the work performed is not evidence-based practice (ibid.). Limited resources can be about too few different treatments or interventions to offer, which is especially characteristic of smaller municipalities (Bergmark, Bergmark and Lundström, 2011). Neither users nor social workers will then have any real choices, and opportunities to work with evidence-based practice as a foundation. This is also different from health care which usually have more treatments to choose between (ibid.). *Fourthly*, local evaluation and follow-ups are essential so that the local municipality has knowledge about what works for different users (Oscarsson, 2009). To introduce evidence-based practice is also about organising the activities so that work becomes based on science and proven experience, as far as possible. Evaluations and follow-ups of the interventions are an essential part in this structure. Therefore organisations, the management, must, as Svanevie (2013:112f) stresses, 'have strategies for how the needs of knowledge which are identified by the professionals in the direct contact with the users shall be communicated and handled' *[author's translation]*.

Fifthly, the social workers have to systematically document what they do. With documentation, the social workers should be able to follow the work process and reflect over their work, and also that documentation makes it possible to spread knowledge to others, for example researchers, politicians or other social workers. And *the sixth* factor is the need for knowledge about evidence-based practice through different types of educations (ibid.). Another factor that Bergmark, Bergmark and Lundström (2011) describe as limiting for the introduction of evidence-based practice is when social workers are dealing with compulsory interventions or when there are different opinions in a family or between the social worker and the family (ibid.). This is a factor that lies more on the social workers responsibilities as professionals and is about a direct contact and relation to the users. However, the need for supervision to deal with difficult situations is an issue for the organisation.

Introducing evidence-based practice in the local organisation entails a responsibility for the management, for local politicians in the Social welfare committee and for the mangers, especially middle managers. There is no easy way to influence middle managers because they are 'limited by jurisdictional, institutional, functional and territorial fragmentation and differentiation of control and responsibility in social work' (Gray, Plath and Webb, 2009:164). In relation to politicians who plan goals for the social services, middle managers are the ones who have the responsibility for the practice and for different innovations, that evidence-based practice is one example of. Gray, Plath

and Webb (2009) describe this as a tension between the two actors which gives some explanation of why it is difficult to reach middle managers. One attempt to reach managers that the Institute for Evidence-based Social Work Practice (IMS) made was to publish a series of books which contained different aspects of evidence-based practice and of the introduction of evidence-based practice. One of those books was specifically written for managers, 'To lead evidence-based practice. A guide for managers in the social services' published in 2009 and revised in 2012. This book is a translated and edited version of the English book 'Leading Evidence-Informed Practice', which was originally published by the organisation Research in Practice (Svanevie, 2011).

Swedish organisations important for introducing evidence-based practice

In Sweden, evidence-based practice is transferred to the local social services to a great extent from organisations at the national level, and is described, by for example, Oscarsson (2009), and Bergmark and Lundström (2011), as a top-down approach. Although it is not a complete presentation of the organisations working with the introduction of evidence-based practice, the organisations described in this section are considered important. My intention is rather to provide an overview of how the introduction of evidence-based practice is organised in the Swedish context.

National level

The *government and the Ministry of Health and Social Affairs* provide the frames for initiatives regarding the development of evidence-based practice. In a report from the government (Regeringskansliet, 2014) 'A knowledge-based and innovative development for health and welfare', the Ministry of Health and Social Affairs describe what has been done regarding evidence-based practice. Agreements have been made since 2008 when the government and SALAR agreed to invest in knowledge development within substance abuse and addiction care. In the beginning the agreements were about specific areas and not the whole social services (Sveriges Kommuner och Landsting, *Bakgrund till satsningen*). In 2010 the government, together with the Swedish Association of Local Authorities and Regions (SALAR), decided to invest in a platform for the development of evidence-based practice covering the whole of social services. Yearly agreements between the government and the municipalities would give the frames for the initiatives (Regeringskansliet, 2014).

The Swedish Association of Local Authorities and Regions (SALAR) is an employer organisation for the Swedish municipalities and county councils and regions. Their assignment is to represent the municipalities and county councils 'governmental, professional and employer-related interests' (Sveriges Kommuner och Landsting, *About SALAR*). Some of their assignments are to give support and service to its members, have a dialogue with the government and other authorities, sign collective agreements, to keep abreast of changes taking place outside of local governments, and to 'strengthen local self-government and the development of regional and local democracy' (ibid.). Through the agreements SALAR has become an important actor for the introduction of

evidence-based practice, with the main task to 'support knowledge use in practice' (Alexanderson et al., 2012:165).

Another organisation that works at a national level to introduce evidence-based practice is *the National Board of Health and Welfare*. Organised under the Ministry of Health and Social Affairs, they are a government agency with a responsibility for, among others, health care and social services. Their primary focus is to 'ensure that people's need for health and social care is met throughout their lives' (Socialstyrelsen, *About us*). Alexanderson et al. (2012:165) describe the National Board of Health and Welfare as an important organisation that 'primarily promotes governing knowledge into practice by providing knowledge reviews, guidelines, handbooks, and so forth'. For example, the National Board of Health and Welfare have responsibility for a method guide, where there is current information about different methods for assessments and interventions, and where one can read what the scientific base is for each method. The methods are those that are used within Swedish social work, such as Motivational Interviewing and ASI (Socialstyrelsen, *Metodguide för socialt arbete)*.

In 1992 the National Board of Health and Welfare was given the assignment by the Ministry of Health and Social Affairs to investigate 'how the need for science-based evaluations of treatments and other interventions within the social services individual and family service can be met' *[author's translation]*. This led to the formation of The Centre for Evaluation of Social Services (CUS) in 1993 (Bergmark and Lundström, 2011:170). With reference to the Ministry of Health and Social Affairs Bergmark and Lundström (2011) describe two reasons for launching CUS. Social work should, like other areas of the welfare sector, strive for efficiency, and that the Swedish Council on Health Technology Assessment (SBU) within health care could be a role model for social services. There was thus from the beginning a strong link between social work and the medical field (Bergmark and Lundström, 2011). SBU was responsible for compiling results from research so that decisions can be based on those compilations. The National Board of Health and Welfare has a major responsibility for implementing those results, which is primarily done via clinical guidelines (Bohlin, 2011).

In 2004 CUS was incorporated into the Institute for Evidence-based Social Work Practice (IMS), which had more or less the same responsibility as CUS but with the difference that the responsibility was expanded and included the entire social services. The primary responsibility for CUS had been individual and family service (Socialstyrelsen, 2013a). A major reorganisation of the National Board of Health and Welfare was made a few years later and in 2009 IMS was incorporated into the ordinary organisation of the National Board of Health and Welfare. IMS did not become a separate department; its tasks were merely divided so that now there are parts in different departments (Bergmark and Lundström, 2011).

CUS was formed in 1992, with the SBU as a role model, and in 2009 IMS became a part of the National Board of Health and Welfare. The responsibility for evidence-based practice is now located in a department that works with both the social and the medical fields. The proximity to the medical field is thus evident.

Regional level

Since the government and SALAR began with the common agreements, especially since the agreement in relation to a platform for evidence-based practice was made in 2010, *Research and Development Units* have become an important actor in the development and introduction of evidence-based practice within social work (Svanevie, 2013). In an evidence-based practice both knowledge from research and experiences are needed, and it is in this point of intersection that Research and Development Units become a natural actor (FoU Välfärd, 2013). The responsibility ought to be a support near the practice, which, for example, includes being innovative, mediating and developing knowledge, and that they can also advantageously be a link between universities and practice (ibid.). Alexanderson et al (2012:165) also perceive that Research and Development Units are a necessary link to the local practice, as 'active parts in knowledge development in collaboration with practice'. In a frequently used Swedish Government Official Report (SOU 2008:18) the importance of Research and Development Units for introducing evidence-based practice, and as an essential link between actors at a national level and the municipalities at the local level, is emphasised (ibid.).

The government funded the development of Research and Development Units between 1997 and 2001 (Printz and Ljunggren, 2005; Kommittédirektiv 2007:91; SOU 2008:18). The funding from the government usually constituted of an economic foundation when the units started their activities and the principals financed those working at the units (Printz and Ljunggren, 2005). Initially they were focused mainly on individual and family service, but have developed to other areas within the social services, such as elderly care and care for disabled persons (Kommittédirektiv 2007:91; SOU 2008:18). Today there are Research and Development Units in almost all of Sweden's counties, but they are organised in different ways and have different directions in their activities (Riksdagen, 2009). The foundation is that the units 'contribute to a systematic method and knowledge development and make research more available for practitioners' (ibid:138). The government funding is being phased out completely, soon.

In a conversation with one of the leaders of the Research and Development Unit in North Bothnia, it was explained that the 14 municipalities in the county own and finance the Research and Development Unit that started in the year 2000 with financial support from the government. The working area is defined as the activities of social services; these activities are individual and family service, social psychiatry, elderly care and the care of disabled. The county council in North Bothnia has its own Research and Development Unit. In other counties there exist units organised between municipalities and the county council, and some pursue their activity in cooperation with a university as a part of the Research and Development Unit (Riksdagen, 2009).

In this thesis I have interviewed five persons working in or near the Research and Development Unit described above. All of them are called regional representatives because in this thesis they represent the regional level in the introduction of evidence-based practice in the social services. I consider the Research and Development Unit in North Bothnia as a key actor in the introduction of evidence-based practice because they are striving to become this link between the national and local level.

Local level

The local level is where the social work is managed by the management and ultimately performed by the social workers. North Bothnia County is a large area in the north of Sweden consisting of fourteen sparsely populated municipalities with around 260 000 inhabitants in total. Social services are organised in the local authority, led formally by local politicians in the Social welfare committee. The main part of the activities in social services is governed by Social Services Act (Bergmark and Lundström, 2008a).

Individual and family services are 'administrative determinations of professional fields' *[author's translation]* which makes it hard to compare different countries, where its counterpart is often missing (Bergmark and Lundström, 2008a:19). The concept social service is usually used to describe similar organisations to those in Sweden, although working tasks may differ. The five social services I have investigated are public social services, which contain no voluntary work. The same applies to individual and family services (in Sweden called individual and family care, not service), which do not have the same meaning and content in all countries. The area that most countries have within social service work is work with children and youth in need of support (ibid.), which is also the area I focus on in the thesis, although other areas are mentioned and referred to in the interviews.

Usually, in Sweden, social workers work within the public sector, such as within social services, healthcare or at schools, and are therefore dependent on the organisation to perform their work (Bergmark and Lundström, 2008b). Social workers are dependent on rules and regulations but they are also affected by norms and power relations within social services. The local politicians within the Social welfare committee govern the work, takes formal decisions about how to organise work and what the rules are, and they have influence over the practical work conducted by social workers. Social workers are thus 'dependent of their environment, of the (local) politicians that give them resources and power, by the state and the surrounding society that decides what kinds of social problems shall be eligible for an intervention' *[author's translation]* (ibid:36). This means that there are many aspects that social workers have to consider in their daily work (ibid.).

A typical division of the social services in the five municipalities in this thesis is that it is divided into individual and family services (those who work with children and families, substance abuse, financial support, and in some municipalities social based psychiatry), elderly care and disability care (that social based psychiatry is sometimes included in). Most of the social workers that work within individual and family services have a degree from the university (Bergmark and Lundström, 2008a). They are trained social workers when they graduate. When they work within social services and within individual and family service they have the title social welfare officer, or social welfare secretary.

In summary, when the term social workers is used in this thesis I mean employees within public social services working within individual and family services, mainly with children, youth and their families. The managers within social services are also governed by the Social welfare committee.

The five municipalities where I have interviewed social workers and managers are divided according to how the individual and family services are organised; into small municipalities (of which there are two), middle-sized municipalities (of which there are two), and large municipality (of which there is one). In the two *small municipalities* there are up to five social workers within each individual and family service. I have interviewed four of them. Their responsibility is to help children and families in need as well as people with substance abuse. Some of them also work with those in need of financial support. Work within each individual and family service is managed by one middle-manager and one senior manager is responsible for several activities or municipal social services in its entirety.

In the two *middle-sized municipalities* the individual and family service are divided in three work groups; children and families, substance and addiction care, and financial support. The seven social workers interviewed work with children and families. Work is led by one middle manager for the work group and one senior manager for the entire social service. In the *large municipality* the individual and family services are divided in areas mentioned above, but also sub-divided within the work with children and their families. For example, some of them only receive applications or notifications and assess if an investigation has to be conducted, and some of them only do the investigations, and some work with interventions in outpatient care. In this municipality there are two levels of middle managers and two levels of senior managers.

National initiatives to introduce evidence-based practice

In this fourth main section I will concentrate on what has happened in Sweden since evidence-based practice started spreading nationally. The section is about how national efforts, organisations and even persons have worked and strived for the development and introduction of evidence-based practice in Swedish social services, and also that the efforts have changed since it began the end of the 1990s.

In the year 1999 the National Board of Health and Welfare received the assignment of developing a Program for a national support for knowledge development within social services. The chief director Lars Pettersson and director general Kerstin Wigzell, both representing the National Board of Health and Welfare, published an article in Dagens Nyheter (Daily News) in 1999. The article attracted attention and prompted a debate concerning the advantages and disadvantages with evidence-based practice within social services in general and in individual and family services in particular. This article became the start of the national initiative regarding working with national support for knowledge development within social services (Börjeson, 2006).

Pettersson and Wigzell (1999) stated that the social services in too little extent knew which effects there were with the interventions that were given. According to Pettersson and Wigzell (1999) the background to the article was a survey done by National Board of Health and Welfare, where they asked senior managers in 140 of Sweden's municipalities about the benefit of interventions being given by individual and family services. The result of the survey is described as disheartening; about half of the senior

managers knew what use the interventions were and 15 per cent said they generally had good insight into the results of the interventions. Pettersson and Wigzell (1999) meant that these problems had to be addressed, and efforts from both national and local actors were needed. For example, national actors had to support the municipalities with funding and the local politicians responsible for the activities in the municipalities had to make it clearer what they want for their money, not only to focus on the budget. There were also, Pettersson and Wigzell (1999) pointed out, a need for managers in the municipalities with scientific training and a need for further research within social work.

After the article the social services knowledge development was debated for a few years, primarily in the trade union magazine for social workers called *Socionomen* (see Piuva, Börjeson and Lobos, 2011, for a review). In one issue the discussion considered what evidence-based practice means for patients, the practitioner and for science. At the same time as this debate was going on government investigations and development work focusing on evidence-based practice was being conducted. A few years later and still today there is a debate about the use of knowledge in social work, for example a debate about the usefulness of random controlled trials and meta-analysis in social work. According to Piuva, Börjeson and Lobos (2011:29) the debate can be understood as an 'expression of a power struggle between the academy and the government authority, something that must inevitably occur when the topic regards what can be accepted as knowledge and scientificity'.

National initiatives from the National Board of Health and Welfare, to develop evidence-based practice

The government decided to finance a Program of national support for knowledge development and contributed with 50 million Swedish crowns[6] between the years 2001 and 2003 (Socialstyrelsen, 2004). The aim was to 'create and strengthen the structures for systematic knowledge building and effective knowledge dissemination within different areas of education, research and practice' (Börjeson, 2005:64), in line with what Pettersson and Wigzell (1999) wrote in the article. The Program became thus an answer to the critique against social services for the lack of a knowledge base in the work (Börjeson, 2006). The Program consisted of eleven sub-projects (Socialstyrelsen, 2004), where two strategies were visible. The first was to take the responsibility to develop an evidence-based practice, which resulted in the creation of the Institute for Evidence based Social Work, IMS. And the other strategy was to create 'social services universities' where practitioners worked together with researchers (Börjeson, 2006) on equal terms.

One of the other sub-projects in the Program for a national support was an evaluation of the Research and Development Units that had developed since 1997, with national funding (Socialstyrelsen, 2004). In summary the result of the evaluation shows that the units are important actors that seem to be working well, they are often ambitious and work with relevant projects and educations. However, they also stated the difficulties in

[6] SEK 50 million, is about 5,1 million EUR today.

relation to that the universities still worked with research at an overall and theoretical level, and that this was far away from the work of the Research and Development Unit. The Research and Development Units did not contribute enough to a knowledge development in the long term. Another reservation was that they often lacked a long-term stability regarding the economy and the organisation (ibid.).

Institute for Evidence based Social Work

With Karin Tengvald as manager the Institute for Evidence-based Social Work Practice (IMS) became an important organisation in the development towards a more result oriented social service. The development of a result oriented and evidence-based practice was a new direction for Swedish social services. With this development followed a need for a more close cooperation between research, education and practice (Ogden, 2006). Knut Sundell took over as manager of IMS in 2007. Sundell et al. (2010) write in an article that the efforts to develop an evidence-based practice has largely been a policy-driven process in Sweden, often initiated by national actors such as the central government, the National Board of Health and Welfare, The Centre for Evaluation of Social Services (CUS) and later IMS. Other organisations important for this process are the Swedish Association of Local Authorities and Regions, and the Association of Sweden's Social Work Agency Directors.

Regarding the introduction of evidence-based practice, Sundell et al. (2010:720) note that 'this top-down pressure and support is necessary but not sufficient in the long run'. It is also described how IMS worked to gain legitimacy from politicians, managers, social workers and users. In regard to social workers Sundell et al. (2010:717) point out the importance of providing social workers with information about the unethical perspective of not using knowledge about which interventions that are effective or not, that is 'what works and what does not work', and add that 'the social work community seems to be receptive to the argument on the ethical aspects of interventions'.

From January 2010 IMS has been integrated in the Department of Knowledge-Based Policy and Guidance at the National Board of Health and Welfare. Sundell writes in a newsletter from IMS (IMS nytt, 2009) that a reason why IMS became a department at the National Board of Health and Welfare is because of the importance to integrate social services activities with health care as far as is possible. Instead of focusing on the organisation it was more important to start from an overall perspective on the individual. The work at the new department would focus on science and have ethics and evidence as its key concepts (ibid.).

BBIC

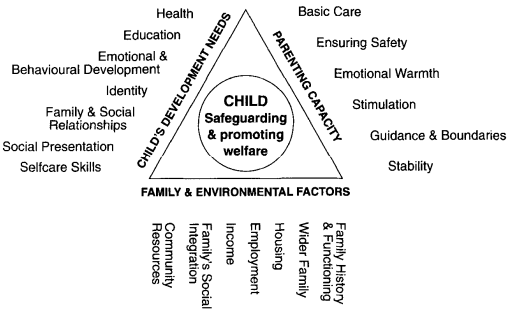
One development work that has gained a massive impact on the Swedish social services is the development and introduction of BBIC. Because the interviewees from the social services and the regional representatives talk a lot about BBIC I choose to give a presentation of how BBIC has developed and briefly what BBIC is.

BBIC is a shortening for Barns Behov I Centrum (Children's Needs In the Centre) and is described as 'a system for managing and documentation in investigation, planning and

follow-up' *[author's translation]* (Socialstyrelsen, 2013:17). The foundation of BBIC is the English 'Integrated Children's System' (ICS), which is developed through thorough research and development work. A series of forms have been produced within ICS, which follows a case from start to finish (ibid.).

In Sweden the development started when an instrument for follow-ups for placed children had been created by English researchers at the request of the Department of Health (Socialstyrelsen, 2013). The instrument was called Looking After Children System, LACS. The core in the development of LACS were seven areas of needs: 'health, education, emotional and behavioural development, identity, family and social relations, social behaviour, and the ability to fend for oneself' *[author's translation]* (ibid:14). The development of a new model for investigations led to the Framework for the Assessment of Children in Need and their Families. The seven areas of needs, developed in LACS, were linked to six aspects of parenting capacity to respond to the children's needs and environmental factors, and this is usually illustrated with a triangle (ibid.).

Figure 2: The assessment triangle (Sinclair, 2000:179)



Thereafter, the ICS system was developed by linking together LACS with the Framework for the Assessment of Children in Need. ICS as a system in work covers investigations, planning and follow-ups (Socialstyrelsen, 2013). ICS has spread to several other countries around the world, for example New Zealand and Canada. However, how ICS has been adopted, if it is the whole English system or certain parts of it, differs in each country. In Sweden and Denmark, for example, major changes have been made to the system in order to adapt it to the national context. What is common between ICS and BBIC is that it is a system for managing and documenting the work of social services with children; structured documents and the triangle, which is almost the same, are used (ibid.).

The development in Sweden began with a project conducted called the Dartington project, which was about LACS, between 1995 and 1997 (Socialstyrelsen, 2013). The background to this project was an assignment for The National Board of Health and Welfare, from the Swedish government, to develop the care of children placed in family homes. The care had been criticised in Sweden as well as in England. The

National Board of Health and Welfare decided to test some of the material used in LACS. Four municipalities tested the material, how it worked and how it could be adapted to Swedish circumstances. The social workers who tested the material thought it was good but time consuming, and some aspects were missing; such as children's health problems. After a request from the social workers the material was tested in investigations with children involved (ibid.).

The BBIC project was conducted between 1999 and 2005, also through the National Board of Health and Welfare (Socialstyrelsen, 2013). Seven municipalities in Sweden tested and adapted what would become BBIC to Swedish condition, in cooperation with researchers and the National Board of Health and Welfare. As with the development of ICS the objective was to create a whole system for investigations, planning and follow-ups. One intention with introducing BBIC was to structure and systemise the work in a better way than before (ibid.).

An ambition that the National Board of Health and Welfare had with introducing BBIC is that it should be integrated in the ordinary structure in each social service (Socialstyrelsen, 2013). For example, agreements are made between the municipalities and the National Board of Health and Welfare; the BBIC education shall be given in their own organisation through so called BBIC-educators. This idea with educators within the organisations was an inspiration from England. There are certain requirements on the municipalities working with BBIC, which include a requirement of a licence to use BBIC that is regulated by a contract between the National Board of Health and Welfare and the Social welfare committee. First the municipalities can apply for a temporary licence when testing and building the structure for BBIC, and then they apply for a permanent licence. The municipalities also have to have a person responsible for BBIC, who becomes the contact person with the National Board of Health and Welfare, and a BBIC-educator who informs and educates new employees. There are benefits of cooperating with other municipalities or within the county when, for example, educations are conducted (ibid.).

BBIC has spread to a majority of Swedish municipalities; 81 per cent of municipalities had a permanent licence in April 2014, which is an increase from 2010 when only 28 per cent had a permanent license (Socialstyrelsen, *Allt fler kommuner har BBIC-licens*).

Government Official Report investigate the need of evidence-based practice

The Program for a national support for knowledge development within social services was an important step towards evidence-based practice, the Governmental Official Report published in 2008 'Evidence-based practice in social services – the benefit of the user' is another (SOU 2008:18). The commission was led by Kerstin Wigzell and the result made an impact on how evidence-based practice has been introduced in Sweden since then.

The government decided to appoint a commission in 2007 because there was a belief that the interventions of social services were still not based on knowledge about the

result of the work to the extent desired, and that the quality and efficiency were too low (SOU 2008:18). Before the investigation started the Committee directive (Kommittédirektiv 2007:91), specified the reasons for it:

> The knowledge base for the interventions in the social services is undeveloped. Work is conducted on the basis of legislation, policies and routines for handling a case. It is unsatisfactory that the social work in such a limited extent builds on knowledge of the effect of different interventions, ways of working and methods and in an excessive degree rests on tradition and non-scientifically anchored perceptions *[author's translation]* (ibid:4).

Sundell, the head of IMS, wrote in a newsletter prior to the investigation that this orientation is important because social services have not in general introduced evidence-based practice, even if evidence-based practice as an idea is well known (IMS nytt, 2007).

The investigators addressed, in accordance with the directives, the issues that could lead to a strengthening of knowledge within the social services as a whole, and focused on structures for developing knowledge (SOU 2008:18). The long-term objective for the municipalities should be to develop an evidence-based practice. Evidence-based practice is defined in accordance with the broader approach to evidence-based practice, as 'a practice that is based on the users experiences, the professionals expertise and the best available scientific knowledge' *[author's translation]* (ibid:10). To reach an evidence-based practice there is a need for efforts both at the national and local level and it has to be done with a long-term perspective, where all actors are engaged (SOU 2008:18); ideas that are not entirely new.

Support at different levels are needed

The proposals submitted by the commission should be regarded as a step towards the long-term efforts needed to introduce evidence-based practice within social services. Crucial to the success of the proposals is that all parties at different levels are engaged and take responsibility; that is, politicians both at the state and municipal level, professionals, user organisations, education providers, and state agencies (SOU 2008:18).

At the *local level* it is primarily the responsibility of municipalities to see that their work is based on 'knowledge about quality, results and effects' *[author's translation]* (SOU 2008:18:100). Practitioners' conditions need to be improved, and there is a need for the municipalities to 'invest time, money and the education of staff, support an adaptation of the working organisation and ways of working, and have an active approach to the use of knowledge and knowledge building' *[author's translation]* (ibid:101). Although this responsibility is mainly that of municipalities, organisations at state level have to support the local development. However, this support must be given in other ways than it has previously been. Research and Development Units, at the *regional level*, were also mentioned in the investigation as an important support for the introduction of evidence-based practice (ibid.).

At the *state level* responsibility is about giving support to achieving the formulated objectives and to facilitate the municipalities. A national responsibility is to create sustainable structures that will endure, which can be integrated with the priorities that are made and with the objectives formulated at the local level (SOU 2008:18). The structure has to be designed to facilitate the use of new knowledge and it should facilitate evaluations and follow-ups. It is also proposed that the government should support research, higher education and research competence within social work so that it more closely conforms to the proposed alignment (ibid.).

The suggestions from the commission

Four proposals are submitted in the investigation (SOU 2008:18). *Firstly*, it is suggested that the state together with the principals design a common long-term strategy in order to develop a knowledge-based social services. For this purpose, the government and the Swedish Association of Local Authorities and Regions (SALAR) should enter common and annual agreements in relation to how to support the development. One important aspect in these agreements should be to provide support for building structures for the introduction of evidence-based practice which should be tailored to local circumstances. Organisational structures that can have a supporting function are, for example, the Research and Development Units and national centres. *Secondly*, it is suggested that the state should invest in national projects targeting specific development areas, such as developing new methods or ways of working (ibid.).

Thirdly, in the suggestions made in the investigation the importance of research about effects and quality in social services were expressed, which was also proposed for financial support (SOU 2008:18). There is also a suggestion of increasing intervention research, controlled and randomised studies, and the kind of research which includes the development of evidence-based practice. *Fourthly*, the commission believes that at the next evaluation of the social workers education the Swedish National Agency for Higher Education should value the educations, especially in relation to what promotes the development of evidence-based practice, and they emphasised the need of research competence within the profession (ibid.). Finally, it is noted that the restructuring of the efforts made and the distribution of funds are likely to result in better use of the money, better performance, higher quality and greater efficiency in social services (SOU 2008:18).

Swedish Association of Local Authorities and Regions as a key actor to introduce evidence-based practice

The proposals made by the commission in 'Evidence-based practice in social services – the benefit of the user' (SOU 2008:18) were about the need for the development of knowledge within the whole of social services with the aim to introduce evidence-based practice. For this purpose, joint agreements should be concluded between the government and the municipalities, represented by the Swedish Association of Local Authorities and Regions (SALAR) (ibid.).

The proposal with joint agreements is not an entirely new idea. SALAR and The National Board of Health and Welfare wrote a letter in 2007 to the Ministry of Health and Social Affairs about a change in how the state supported municipalities (cf. Sveriges Kommuner och Landsting, *Bakgrund till satsningen*), meaning that the support was too 'ad-hoc-like'. Instead, the support should be provided in a more strategic way in order to support the development of a knowledge-based social service, with a more long-term funding. The aim with the support should be stated in annual agreements. A similar letter from SALAR and The National Board of Health and Welfare had also been submitted in 2004 (SOU 2008:18). Corresponding agreements already exist within health care, signed by SALAR and the government. The content of the agreements is development work[7] in health care (ibid.).

Under the guidance of the Ministry of Health and Social Affairs the government and SALAR agreed in June 2010 how they should work to develop a 'Platform for evidence-based practice in social services' (Regeringen, 2010; Socialutskottets betänkande 2010/11:SoU10). It was agreed that in cooperation to set the direction for the initiatives taken. They also agreed that future agreements should be based on common priorities at a national level, and should be long-term efforts. The National Board of Health and Welfare received the assignment to develop a national web-based knowledge portal within the areas of elderly care and psychiatry (ibid.).

The overall aim with this agreement is to create conditions for the introduction of evidence-based practice in the work of social services by, for example, creating structures for implementation, to provide support to local authority managers and also to increase social workers' knowledge. The agreement is an attempt to take a holistic approach so that social services work with evidence-based practice, and that those areas that the national level perceives important are prioritised. One basic motive specified is that users get support and interventions that have been proven to be effective (Regeringen, 2010, 2010a).

Earlier agreement between the government and SALAR focused on a specific area within the social services, but the intention with Platform-agreements was to include the whole social services. A part of this work was to build regional support structures for the development of knowledge, covering all activities within social services. Examples of agreements, specified at certain issues, are the development work Knowledge to Practice, Program for a good care of the elderly and Performance-based government support for interventions to the elderly (Regeringen, 2010a, 2011).

In the beginning of 2011 a new agreement was concluded, with the title 'Agreement about the development of an evidence-based practice in social services' (Regeringen, 2011a). Developing evidence-based practice is linked to the work with increasing the quality in social services, regarding both the exercise of authority and the interventions given. From the state level it is important that the agreements have their ground in priorities made on both the national and local base. The government also point out that

[7] I use the concept development work when writing about the national initiatives and development projects conducted in the municipalities. This is in accordance with the concepts used by the Swedish Association of Local Authorities and Regions, which administer most development works.

development work is not only a responsibility for national actors; it is as much a responsibility for the municipalities that have to invest with time, money and the education of their staff. It is also important, according to the government, that development is conducted in a dialogue between the local, regional and national levels (ibid.).

A part of the 2011 agreement includes a regional support for knowledge development, which aims at creating regional support structures and to employ development managers within the areas of substance and addiction care, eHealth, elderly care and the social care for children and young people (Regeringen, 2011a). A part of the national support is their task to develop or introduce models and analysing tools within substance and addiction care, as well as in the area of children and young people, user participation, technical infrastructure and information structure (eHealth). In the agreement the importance of user participation, funding to research, and also educations and further educations for managers and management when introducing evidence-based practice is also emphasised (ibid.).

The agreements from 2012, 2013 and 2014 follow the same content, building on the former agreements, as the regional support for development of evidence-based practice. Some areas are new, as support to persons with disabilities in the agreement from 2012, and knowledge support to those working with children in the agreement from 2013 (Regeringskansliet och Sveriges Kommuner och Landsting, 2012, 2013, 2014). These agreements had not made an impact in the municipalities when the interviews for this thesis were conducted. Therefore, for this thesis, it is mainly the agreements until 2011 that are relevant understanding how the interviewees perceive their situation, and how the government and SALAR work to support and manage the introduction of evidence-based practice.

Evaluations of the agreements

The investments made through the agreements have been evaluated with three intermediate reports. The Swedish Agency for Public Management has been asked to submit three reports between 2011 and 2013 and a final report in 2013. This assignment entails to investigate if the agreements are a support that facilitate conditions for developing evidence-based practice and to use information technology within social services (Regeringen, 2011b).

In the first intermediate report from the Swedish Agency for Public Management (Statskontoret, 2011) it is described as positive that the agreements emphasise evidence-based practice. It is perceived essential, from a symbolic perspective, that the actors stress this as an important area to work with. It is also positive that the agreements have an overall perspective of social services as a whole, where all development areas are coordinated. There is however some room for improvements such as clearer accountabilities between the government and SALAR, and there are a few concrete objectives which can create unclear expectations for the municipalities. Regarding the creation of regional support structures, it is too soon to evaluate in the different counties (Statskontoret, 2011). Also in the intermediate report from 2012 it is stated that the regional support structures are not built yet and refers to SALAR that says that the

counties need more time than to the year 2013 (Statskontoret, 2012). However the evaluation indicates that it has been easier creating supporting structures where there already is a functioning cooperation between regional associations, county councils, universities or Research and Development Units (ibid.).

Regarding the governance and organising of these efforts, the Swedish Agency for Public Management (Statskontoret, 2012) note in the second report that there have been some difficulties with the documentation when the agreements have been developed, among others because of staff turnover. Furthermore, the mandate and assignment to those managing the development work is still somewhat unclear, which risks hampering the work (ibid.). In the last intermediate report (Statskontoret, 2013), the evaluators explain that there have been improvements, such as a clearer project management from SALAR where their work is more transparent, and the regional support structures are more established than what the earlier evaluations showed. One example given in the evaluation of what is lacking, that is coordination between SALAR's different initiatives. The contact/key persons from the municipalities participate in several initiatives, and this may take a lot of time and effort from the daily work. Another example given is that the authorities do not use the support structures. The linkage to health care needs to be improved, and there is a risk that there will be parallel structures in the counties (ibid.).

3

Methodological considerations and method

This chapter provides a description of methodological considerations that I have made in the thesis, and the approach and method I used. I present my choices about which cases to study, the theory and the methods of collecting the empirical material and my choices in terms of analysis. Then, I describe how I have selected and conducted the interviews and how the empirical material was processed and analysed. The chapter concludes with an account of reflections I have made about the quality in my research. Finally I reflect over my experiences and understanding of social work, and although the contents of this section are better suited to the methodology discussion I choose to place it at the end because it is also linked to the quality of my research.

The choices a researcher makes have an impact on the outcome of the research, and are relevant to how the empirical material is collected, processed and analysed (Clough and Nutbrown, 2002; Hartman, 2004; Sohlberg and Sohlberg, 2013). It is also important to account for the choices made in a transparent manner (Sohlberg and Sohlberg, 2013), not least to allow a critical assessment of the research. Validity and reliability are two key aspects in assessing quality in research, which in a general understanding indicates having a critical approach to the quality of the data collected (Jacobsen, 2002). Therefore, it is an advantage to consider the whole thesis work as a process of analysis, where analysis is always present and founded in the choices made early in the research process (Widerberg, 2002).

The analysis process is not only about what is done after the empirical material has been collected. Some form of analysis has at that stage already been made; it is about selecting methodology, methods, and theoretical perspectives and so on. All these choices might be limited by the research project, time and economic conditions that constitute a frame for the research (Widerberg, 2002.). Researchers often operate within a given research tradition, or a paradigm, which means that a complete ontology and epistemology are provided, and thus also a complete methodology (Sohlberg and Sohlberg, 2013). Even within a research tradition there are several different positions and schools, which are not always easy to use in research. It is common that researchers work without reflecting on fundamental ontological, epistemological and methodological issues. Instead, one accedes to what Thomas Kuhn termed as normal science.

Choices I made about the research

A methodology defines what to do when studying a chosen phenomenon, and refers, according to Silverman (2005:99), to 'the choices we make about cases to study, methods of data gathering, forms of data analysis etc., in planning and executing a research study'. Methodology is also about which underlying assumptions that different approaches are based on, and which types of explanations that are considered satisfactory (Andersen, 2012). As a theoretical base I have chosen new institutional organisational theory, because this theory is useful in understanding how ways of organising work are received in organisations, such as the social services. Useful concepts are for example isomorphism, legitimacy, decoupling. I have also chosen to use Berger and Luckmann's (1967) theory of social construction because they among other things write about how reality (in social work) is constructed in interaction with others. Routines and legitimacy are useful concepts which Berger and Luckmann (1967) use.

Cases to study

My interest to do research about evidence-based practice in social work was something that begun when I did the last interviews for my licentiate thesis, in 2009. The interviews as well as the licentiate thesis were about cooperation between and within social services and health care (Eliasson, 2010). Two of those interviewed, both middle managers, also answered a few questions about evidence-based practice, or evidence-based work as I called it at that time. Although it was not the first contact with evidence-based practice, my knowledge was quite limited when these interviews were conducted. The first contact with evidence-based practice was three-to-four years earlier when working as a coordinator for two smaller projects involving the development of methods within psychiatric services in four municipalities and health care. The projects were financed and managed by the Institute for Evidence-based social Work Practice, at the National Board of Health and Welfare.

The project manager from the Institute for Evidence-based social Work Practice explained the importance of using structured ways of working in social work, in order to determine what the users' needs are. The project manager also emphasised the importance that social work not only emanated from social workers experiences, as well as that the results could be measured. Developing methods and structured ways of working would also be beneficial for social services in cooperation with health care. However, it was not during these projects that I realised this was knowledge management and development towards evidence-based practice; for me it was simply a development of a method. Later, I realised that it was my first encounter with evidence-based practice in social work, and this was at a relatively early stage when evidence-based practice began to spread within Swedish social work, from the National Board of Health and Welfare and the Institute for Evidence-based social Work Practice. In the beginning of the introduction of evidence-based practice it was more about the development and use of methods than about evidence-based practice as an approach to work.

To return to the year 2009 and the interviews with the two middle managers from my previous research (which were performed for the licentiate thesis), I asked questions about advantages and disadvantages with evidence-based work. My intention was to find out the approach of these managers to evidence-based social work. Common in their answers were that it was much easier for them to describe the advantages with evidence-based work than it was the disadvantages; a perspective that interested me. I wondered why it was like that: Why was it difficult to describe disadvantages with evidence-based work? Why did they not reflect upon disadvantages or advantages? It was not, and is still not, that I believe evidence-based practice is a good or for that matter a bad idea for social workers, organisations or users. It is rather about that the managers did not seem to reflect about evidence-based work. And if there were aspects with the introduction of evidence-based work that may be less good, this may cause difficulties for the organisations. What the two managers said about evidence-based social work turned out to be no one-off experience; it was confirmed in the interviews conducted for this thesis.

Those two interviews became a starting point for me. Evidence-based practice is, like cooperation, concepts and phenomena associated with good values and they have received considerable attention in the national efforts made to develop social services. Both cooperation and evidence-based practice are often described as entailing higher quality and increased efficiency in social work and better support for the users. It is difficult being against something associated with these good values (cf. Axelsson and Bihari Axelsson, 2007; Bergmark and Lundström, 2008b; Vindegg, 2009).

Another factor contributing to the choice of subject is that the introduction of evidence-based practice is a highly topical subject for social services and for the regional Research and Development Unit in North Bothnia (Forsknings- och utvecklingsenheten Norrbotten), who funded my research. Their assignment is to provide support for social services in the county's 14 municipalities. Although I am funded by them, I have been quite free to choose what to write about, but the social services provided the framework. Their intentions were that my research would be conducted in some of the municipalities in North Bothnia. So, with a little influence from the Research and Development Unit, I decided that the focus should be evidence-based practice and social workers working mainly with children and families. Other adjacent areas, such as persons with substance abuse, were also included, when they were part of the social workers tasks. Substance abuse is usually organised within individual and family service, as the work with children and families. Another contributing factor in the choice of subject was that a similar study was planned with social workers working with children and youth in England, and that the material would become comparable. However, this planned study was never meant to be included in this thesis.

The thesis is not about the same subject as the licentiate thesis (cooperation and evidence-based practice), but is instead a deepening of the licentiate thesis. Evidence-based practice as a way of organising work, mediated from national actors to the local social services, has many similarities with the way that cooperation has been introduced; that is mediated from the national level. Therefore, new institutional organisational theory has been the theoretical cornerstone of both the licentiate thesis and this thesis.

Theory and method

New institutional theory has been present throughout the thesis, from the beginning when the problem and interview questions were formulated, when the material was compiled and analysed, and when the result was presented. New institutional theory explains that organisations strive to become similar to each other, which can explain the interest for evidence-based practice among the interviewees. Introducing evidence-based practice can also be understood as a way to achieve legitimacy. Indeed, organisations can also assert that they introduce evidence-based practice but in reality not all the initiatives have resulted in any major changes in practice. New institutional theory has at times been criticised for not considering the actors (see Greenwood et al., 2008, for a review).

As I wanted to understand how social services and social workers approach evidence-based practice (how they act), I have also chosen to use Berger and Luckmanns (1967) theory of social construction. Berger and Luckmann (1967:1) advocate 'that reality is socially constructed and that the sociology of knowledge must analyze the processes in which this occurs'. The two key concepts in their theory are therefore reality and knowledge. My thesis has primarily a perspective designed to reach an understanding, which can be achieved by studying the processes where the reality is being constructed.

Berger and Luckmann's (1967) sociology of knowledge can be transferred back to phenomenology, so also Alfred Schütz's work, which is based on Husserl's philosophy of the social world (Kvale and Brinkmann, 2009). For Berger and Luckmann (1967:3) 'a "sociology of knowledge" will have to deal not only with the empirical variety of "knowledge" in human societies, but also with the processes by which *any* body of "knowledge" comes to be socially established *as* "reality"'.

As I strive for an increased understanding of evidence-based practice in social work, I selected a qualitative approach with interviews. A qualitative approach aims to reach an understanding of an individual's life world or of a group of people (Widerberg, 2002; Hartman, 2004). Kvale and Brinkmann (2009:42) explain that qualitative research predominantly has had a general phenomenological approach:

> Generally, phenomenology in qualitative studies is a term that points to an interest in understanding social phenomena based on actors' own perspective and describe the world as it is experienced by them according to the assumption that the relative reality is what people perceive it to be. *[Author's translation]*

My intention was not only to examine how ways of organising is introduced in an organisation. The intention was to get as close as possible to social workers reality, and illustrate their experiences and knowledge as social workers. This also applies to the interviewed managers, regional representatives and doctors. I wanted to understand evidence-based practice from the interviewees' perspective, as they experience the world they live (and work) in, even though new institutional theory has been present throughout the thesis. The aim of qualitative interviews is to reach an understanding from the interviewee's own perspective (Kvale and Brinkmann, 2009).

Understanding and interpretation is often contrasted against explanation (Danermark et al., 2003; Sohlberg and Sohlberg, 2013). Explanations focuses on fixed, external causes, while understanding focuses on a 'more recognisable perspective in relation to people's intentions and aspirations' *[author's translation]* (Sohlberg and Sohlberg, 2013:168). This houses an ontological aspect, since a focus on understanding implies that there is another 'object of study' than in natural science. The historian and philosopher Wilhelm Dilthey (1833–1911) is considered a prominent figure for a research tradition that is oriented towards understanding, an 'understanding scientific' or 'human scientific' research tradition (ibid.). According to Boglind, Eliæson and Månson (1998) Dilthey contributed to the contemporary debate about differences regarding basic traits between natural science and human science. Dilthey considered that, where nature can be explained, human life can be understood (ibid.). Within sociology, Max Weber (1864–1920) has been an important person. Weber is known for being oriented towards understanding, focused on social acts (Boglind, Eliæson and Månson, 1998).

Gathering the empirical material

A qualitative method and interviews focus on the subjective, and give a nuanced description of many aspects where the relationship between the interviewee (the individual) and the context is interesting (Hartman, 2004; Kvale and Brinkmann, 2009). Interviews are opportunities to produce knowledge (Kvale and Brinkmann, 2009). The form of knowledge that interviews generate is associated with epistemology and questions about what knowledge is and how it is obtained. I perceive that there are two central features of knowledge created in the interview context, which are present in my interviews. The first aspect, also described by Kvale and Brinkmann (2009), is that the interview becomes a social context where knowledge is produced. Knowledge is produced in the social interaction when I as an interviewer ask the questions and the interviewee answers. In a postmodern epistemology knowledge exists in the relation between a person and the world, and in that context produces knowledge. The second aspect of how knowledge is created is that human life and human understanding is contextual. Therefore, the knowledge created in an interview cannot be automatically transferred into other contexts. I believe that knowledge is relational *and* contextual.

I had limited knowledge of evidence-based practice and wanted to be as open as possible for what I had not thought of or had no knowledge of. I soon found, in the initial interviews with social workers, that the social workers did not feel particularly familiar with evidence-based practice. Although I did not think they worked completely according to evidence-based practice I did not expect to get this response from the social workers. Instead, to gain insight in their work and how they related to evidence-based practice, I chose to let them talk about what methods they used and their ways of working. I regard this as an important event, and it is an example of how knowledge was created in the interview situation between the interviewer and the interviewee. This flexibility had not been possible with a quantitative method, based on 'a positivist philosophy that sees research as rule-based and scientific knowledge as quantitative' *[author's translation]* (Kvale and Brinkmann, 2009:76).

Another example where knowledge is created in the interview situation is the interviews with the doctors. The interviews had an open approach because I was uncertain

how to formulate the questions (which is described more closely in section *Conducting the interviews*). The interviews were semi-structured so I as an interviewer could have an open mind for the different perspectives that the doctors wanted to highlight regarding evidence-based medicine. However, all of the interviews had a structure, with predetermined themes and questions (Lofland and Lofland, 1995; Jacobsen, 2002).

Initially, my intention was to use several methods and a questionnaire was designed and sent out to some social workers and managers working in two social services. They were asked to fill in the questionnaire and give comments on how they perceived the questionnaire. Very likely, I had to work further with the questionnaire so the questions would be easier to answer, but their answers highlighted the same problems that became apparent in several of the interviewees, when they explained that they did not know what evidence-based practice really was. The questionnaire, however, was never meant to replace the interviews; instead it would have been used as a complement to the interviews. For example, a questionnaire could be used to investigate if what the interviewees said about evidence-based practice also existed in social services of other municipalities. Although there may be advantages of using different methods I chose to exclude the questionnaire because of these difficulties. The interviews were prioritised because a qualitative approach better suits my purpose and research questions. Which method to use for gathering the empirical material is always related to the purpose and research questions (Hartman, 2004).

Analysing the empirical material

A significant choice for the analysis is about whether research will be conducted with closeness to empirical data or to theory. These choice about being close to the empirical or the theoretical material are made early in the research. For example, data reduction starts, according to Miles and Huberman (1994), when a researcher makes decisions about a conceptual framework, research questions, cases to study and an approach to collecting the material. As a researcher I must relate to the material that is to be processed and analysed, which often involves complicated interpretations (Sohlberg and Sohlberg, 2013). Based on Alvesson and Sköldberg (2008), my analysis and interpretations is on-going from the beginning and it is an interaction, or spiral motion, between the whole and parts, or understanding and pre-understanding. The choice of interaction between the whole and parts, understanding and pre-understanding, are related to what is described as abduction (Mason, 1996; Alvesson and Sköldberg, 2000; Alvesson and Sköldberg, 2008).

Abduction includes other elements than induction and deduction, and can therefore not be seen as a mix between them (Alvesson and Sköldberg, 2008). One essential feature with an abductive approach is that it involves understanding. Empirical facts are the basis (as in induction), but an abductive approach also uses theoretical pre-conceptions (like in deduction). Alvesson and Sköldberg (2008:56) explain:

> During the research process an alternating between (former) theory and empiricism thus takes place, through which both are successively reinterpreted in light of each other. *[Author's translation]*

With an abductive approach the construction of the interviewees work practice becomes the focus, where evidence-based practice is central. My pre-understanding, which includes both theoretical and practical knowledge, formed the basis for the research and the interview questions designed early in the research process. A significant part of my pre-understanding was gained through my licentiate thesis and through the projects within social services and health care that I participated in or managed since 2003 (see further in section *My experience and understanding of social work*). I also needed theoretical knowledge to understand and interpret what the individuals said in the interviews. My understanding of the subject has deepened since I started with this thesis, both regarding the theoretical framework and of the empirical material. There has been an interaction between my understanding and my pre-understanding for what I studied (see Alvesson and Sköldberg, 2008).

The selection of interviewees

In this section I describe how I have planned and conducted the interviews, and how I have treated and analysed the empirical material. Initially, the intention was to interview social workers working with children and families in the three municipalities with most inhabitants in North Bothnia (with between 27 000 and 76 000 inhabitants). One reason was that the conditions for the interviews would be as similar as possible, for example in terms of how work is organised. However, two of the three largest municipalities in North Bothnia declined to participate in the interviews due to reorganisations programs that were underway. Therefore I asked social workers in three other municipalities that all agreed to participate, and one social worker from a fifth municipality who agreed to be my test person for the interview.

The empirical material consists of interviews with 33 persons (30 interviews), that were conducted during 2012 and in January of 2013. Four groups of professionals were interviewed; social workers, managers working in social services, regional representatives of the Research and Development Unit (the regional unit) and doctors employed by county council.

Social workers

A total of 18 social workers were interviewed in 16 interviews, which means that I did two group interviews consisting of two social workers in each group. Those interviewed worked within four municipalities, and one social worker (a pilot interview) came from a fifth municipality. Of the 18 interviews were 17 women and one a man. They all worked in individual and family service, primarily with children and families. Social workers in the smaller municipalities have other tasks as well, such as working with people with substance abuse and with financial support. The interviews were conducted during the first half of 2012. In one group interview the two social workers were joined by a middle manager half way through the interview, which I was informed about this before the interview. This middle manager mostly listened through the interview and was interviewed as a manager later. I have not presented any quotations from when this manager participated in the interview with the social workers, because she mostly listened and then talked about the same issues in her own interview.

With these interviews, I wanted to get an understanding of how social workers work with and relate to evidence-based practice. Social workers represent a local perspective for the understanding of evidence-based practice.

In order to test the formulated questions I did a pilot interview with one social worker from a medium sized municipality. The questions did not change much after the pilot interview, and the pilot interview was included in the empirical material with the other social workers. The difference between the pilot interview and the other interviews that I perceived was that this person had experience of working in the social services in a municipality and at the regional Research and Development Unit. It was this interview that made me aware of the importance of interviewing people from the regional unit.

To find people to interview I contacted managers in six municipalities. Four municipalities agreed to participate with interviewees. The social workers were free to choose to participate. In most cases I was given their e-mail addresses by their managers, so I could contact them and arrange a date and time for an interview. In one of the municipalities social workers arranged a two day schedule for the interviews. The sample of social workers can be described as a non-probability sample and is somewhere between a convenience sample (selecting those who are easiest to get in contact with), self-selection (those who want to participate) and arbitrary selection (those who the interviewer believes are representative) (Jacobsen, 2002). Such a selection procedure might create bias in the material and in the result, such as how social workers relate to evidence-based practice. One event where my sampling process facilitated was when I had arranged an early morning interview with one social worker that was forced to withdraw because of an unexpected urgent case. Although she did arrange a replacement for me to interview I was able to accept this person as an interviewee because of my sampling process.

Managers

I have also interviewed seven managers from three of the five municipalities, all working within social services. They were conducted in late 2012 and early 2013. I contacted the managers via e-mail or by telephone, four senior managers and seven middle managers. Of those eleven managers that I contacted seven answered my request and were interviewed. Four of them had a position as middle manager and three had a position as senior manager.

The sample was a non-probability sample and it was those who responded positively to my request that I interviewed, except one manager who was asked to participate by a colleague, also a manager. Middle managers had slightly different job titles, depending on which municipality they worked in, but all of them worked as managers close to the social workers. Senior managers had a more overall responsibility for several areas within social services; they were not only responsible for individual and family service but also for areas such as the care of elderly and disabled. My intention with these interviews was to let the managers talk about evidence-based practice from a local perspective, such as organisational aspects in relation to introducing evidence-based practice.

Regional representatives

Five interviews with regional representatives were conducted between May and June 2012, before the interviews with the managers. In one interview two regional representatives attended while the others were interviewed separately. Three of them worked primarily in the area of individual and family service and two of them worked with evidence-based practice in a broader perspective (building a structure for evidence-based practice). With these interviews I wanted to increase my understanding of how the regional unit works to support the introduction of evidence-based practice and what preconditions exist for social services to introduce evidence-based practice. In what I term as the regional unit both the Research and Development Unit in North Bothnia and Union of Municipalities of North Bothnia are included (Kommunförbundet Norrbotten). The Research and Development Unit is part of the Union of Municipalities of North Bothnia, and the development work conducted can be administered by any of the two.

All five regional representatives who were asked to participate in an interview agreed to be interviewed. The selection of interviewees was based on my knowledge about the regional unit and the development work carried out by them at that time. Thus, this is a convenience sample insofar that I chose those who would be representative for my research topic (Jacobsen, 2002). All those working with development work or evidence-based practice were not asked. There were more persons at the regional unit that could have contributed, but the possibility of maintaining confidentiality would then have be even smaller than it already was. On the other hand, it was important for this thesis that regional representatives were interviewed for an understanding of the introduction of evidence-based practice. When this thesis was written several aspects of development work had been completed, others have started and new people work at the regional unit.

The Research and Development Unit funded my thesis work and I therefore have good contact with several of the people interviewed. How this affected the interviews is difficult to determine with any certainty. An interview is associated with a power relation that is asymmetric (Kvale and Brinkmann, 2009). Probably, it had some impact on the result of the interviews, for example all five agreed to participate in the interview. Nonetheless, during the interviews I feel that they talked openly. There is always a balancing in an interview between the interviewer and the interviewee, and the relationship is determined by the trust that exists and develops between the two actors. However, I have my office at the university and not at the regional unit, which might create a certain distance to the interviewees because they are not my colleagues and I do not work with them every day.

Doctors

Three interviews conducted with the medical doctors, all men. They were performed at the turn of 2012-2013, last of all the interviews. The sample of doctors is characterised as a convenience sample (Jacobsen, 2002). I asked two doctors that it was possible for me to contact at short notice, doctors I had met in previous projects. One of those doctors suggested that I should interview a third doctor (snowball or chain sample)

because he had experience of introducing evidence-based medicine and could, therefore, be relevant for me to interview. During the analysis of these interviews I discovered that they described evidence-based medicine from different perspectives (national/international, regional and local perspective). I had not planned in advance that these different perspectives would be represented. At the same time, I am aware that what these doctors say about evidence-based medicine does not apply to doctors in general, and the results have not been interpreted that way.

I had not intended to interview doctors from the beginning, but when I had done almost all other interviews, I felt that their perspective would enrich my empirical material and my understanding of evidence-based practice within social services. The intention was not primarily to analyse how they work and perceive evidence-based medicine; three interviews are too few for such a purpose. Instead, the intention was to provide another perspective on the development and introduction of evidence-based practice in the social services. In that respect the interviews with the doctors were important, not least because evidence-based practice is often described as having originated in the medical field and in evidence-based medicine (Reynolds, 2000; Angel, 2003; Morago, 2006). The evidence movement within the medical field has a strong connection to the methodological positivism in which the criteria of generalisation that were developed for the specific research has spread and applies to research in general in the medical field (Kvale and Brinkmann, 2009). Evidence is often assumed to be based in research that is formalised and quantitative, even when these ideas have evolved to other areas beyond the medical, not least through the development of the evidence-based practice movement (ibid.) within social work.

With this background I have found it interesting to interview members of a profession that represents the natural science view on knowledge. I selected doctors from three different fields where primary care and psychiatry are more closely connected to social work than the specialist's work. On the one hand there are more difficulties in working according to evidence-based medicine within primary care and psychiatry than in specialist medicine. On the other hand, when the doctors talk about evidence-based medicine their stories conform, even though they represent these different medical fields.

Conducting the interviews

All interviews were semi-structured with fixed areas and questions in each area. Kvale and Brinkmann (2009) explain that a semi-structured life world interview is based on the interviewees' own interpretation of the meaning of the studied phenomena. I designed an interview guide to each group interviewed (Appendix II). For formulating the interview questions I combined new institutional organisational theory with the content in Lars Oscarsson's book from 2009 (published by The Swedish Association of Local Authorities and Regions). Oscarsson's book aims to introduce practitioners to evidence-based practice. For formulating the questions, I mainly used the following sections from the book: (a) Research as a source of knowledge, (b) The client as a source of knowledge, (c) The practitioner as a source of knowledge, and (d) To organise and introduce an evidence-based practice.

The order of the questions was changed between the different groups I interviewed (social workers, managers, regional representatives and doctors) and sometimes between the individuals interviewed. One reason why I used semi-structured interview guides is because I did not want to interrupt an individual that talked about something I was going to ask later in the interview, at the same time as I wanted to be sure not to miss any questions. According to Lofland and Lofland (1995:85), an interview guide should be flexible, and should not contain 'a tightly structured set of questions to be asked verbatim as written'. The interview guide should support the interviewer in remembering to ask all questions. Thus, it has less significance in what order the questions are answered (ibid.).

I felt it was important to have that flexibility, so when an individual began telling me about further educations I continued to ask the questions about that. The order the questions and which follow-up questions I asked, were most flexible in the interviews with the doctors and to some extent also with the managers. In their responses many different perspectives are therefore included, which on the one hand made the material more difficult to analyse, but, on the other hand, gave new perspectives unknown to me. During the interviews conducted toward the end of the process I was more confident and did not need the interview guide to remember the questions. The interviews with the doctors are more open in character, but all questions were asked some time during the interviews. I also informed the doctors that they could describe aspects of evidence-based medicine that I did not ask about. I perceive that this approach worked well.

There were no big differences in the answers, although the questions were not asked in the same order in the interviews. I chose to have a few questions in a particular place in the interviews. All interviews started with background questions and how their work was organised. Early questions in the interviews were about when they heard about evidence-based practice, or evidence-based medicine, for the first time, and how it was presented. These questions were in the beginning of the interview because I wanted to get the interviewees' perspective about evidence based practice/medicine, and that they were influenced as little as possible by me and my questions. Another question that I deliberately kept at a certain place in the interview was about the weighing together of different sources of knowledge in an evidence-based practice. Social workers were asked this question at the end of the interview because I did not wanted them to feel that I gave *the* definition of evidence-based practice.

Generally, I felt that the interviewees talked about evidence-based practice from their own perspective. I perceived that one social worker had read about evidence-based practice before the interview, and I have included this person's answers after careful consideration in each category of answers. My interest was what they told me, and that they answered from their perspective; everyone's perspective was important and there is no right or wrong way to answer (Lofland and Lofland, 1995). For example, if they did not know what evidence-based practice was or if they did not feel they had opportunities to work in accordance to evidence-based practice, I wanted them to feel free to tell me that. My understanding was that social workers found it difficult to explain what evidence-based practice was, but there was a positive attitude towards evidence-based practice. All interviews were concluded with me asking if they wanted to add or clarify

something that had been said, and whether I could get back to them if something needed to be explained further.

An information letter (Appendix I) was sent out via e-mail before the interviews, and the same information was given to the interviewees at the interview. The letter contained information about the study, how the result would be used, the duration of the interview, where the thesis would be published and that the interviewees were given the opportunity to read the interview when it had been transcribed. The information also included ethical principles applicable to this research (Vetenskapsrådet, no date[8]; Jacobsen, 2002; Silverman, 2005). These principles mean that it is voluntary to participate, and that participants can withdraw their participation whenever they want to. They also imply that all materials and information are to be treated as confidential, that personal information about specific individuals and other sensitive information about individuals will not be included in the result. Finally, in accordance with the ethical principles, the material has been kept locked in a cabinet and no unauthorised has had the opportunity to take part of the material.

Each interview lasted between one and two hours and was recorded digitally. Social workers were the first group I interviewed, and those interviews were also most extensive. These interviews were more extensive because I wanted to let the social workers talk about evidence-based practice from different perspectives and because they are in focus in this thesis. The interviews with the other groups were more limited; over time I was able to specify the questions and shorten the interview, and the interviews with the managers took about one and a half hours and with the doctors one hour. Jacobsen (2002) recommends that the interviews should be between one and one and a half hour. If they are too limited, they do not provide enough material, while they should not be too long, so that it is not possible to conduct the interview. Furthermore, all interviewees had the opportunity to choose where they wanted to be interviewed, which was also a part of the information they received. It was essential that we could sit undisturbed during the interview, which in most cases worked well. Three people from the regional unit chose to be interviewed at my office. All of the others chose their own work place because it was more convenient for them.

During the interviews I did not keep notes because I wanted to focus entirely on the interview and the dialogue with the interviewees. However, it might have been an advantage to keep notes because it could provide a signal to an interviewee that I as an interviewer was interested in what the person said (Jacobsen, 2002). My experience was that the contact with the vast majority of the interviewees was good, and I felt that the topic interested them. In previous research when I conducted interviews, as in the licentiate thesis, I have made some notes at the same time, but have found it easier to create a relation to the interviewee when I did not take notes at the same time.

The interviews were transcribed verbatim. I transcribed 27 interviews and a project employee at the regional unit transcribed three of the interviews with managers. I listened to these three interviews afterwards with the transcription in front of me, so I could be sure that no errors or misunderstandings had occurred. After transcribing the

[8] Swedish Research Council. Ethical principles for human and social science research.

interviews, each interviewee was given the opportunity to read through their own interview. Some of them took that opportunity, but most did not want to read the interview. At the interview I informed them that I would e-mail them when the interviews were transcribed and ask if they wanted to read the interview, and so I did. They were also given the opportunity to comment if they felt that something had been misunderstood during the interview, or needed to be explained further. No one gave any comments afterwards. A few social workers worked no longer at the social services when their interviews had been transcribed, and therefore I could not reach them.

Processing and analysing the empirical material

This section describes the analysis process from the point that the interviews were conducted and transcribed. In reality, the analysis process has not been as linear as it is described here. My intention is rather to illustrate the way the analysis was performed. The stages of the analysis process I describe is the processing of the empirical material and the interpretation of it. There are various descriptions of how the actual analysis process is performed, see for instance Miles and Huberman (1994) for a review of qualitative data analysis. I have mainly used Miles and Huberman (1994), Jacobsen (2002) and Widerberg (2002) for this analysis.

When the empirical material is processed, the researcher can start from categories retrieved from the researcher's material (Ely et al., 1993). Some researchers base their analysis on categories they collect from literature (including theory) and from their own experiences of research. Others use analysis schedules that other researchers have developed that can be adapted to their own research. The idea with categories is that the researcher creates structure and meaning with the material, regardless of the starting point or type of analysis (ibid.). In accordance with an abductive approach, I have oscillated between generating data, empiricism, theory, and analysis (Mason, 1996). My pre-understanding of social work and theoretical knowledge were woven together with empirical data in the analysis, and enriched each other with time (Mason, 1996; Alvesson and Sköldberg, 2000; Alvesson and Sköldberg, 2008).

This part of the analysis process can, according to Jacobsen (2002), be described as a bottom-up process. This means to start with the extensive and often incalculable material, and gradually clear away some of the detailed information. Structure is created when the researcher moves from the specific to the more general, by categorising and finding correlations in the material. Although this may appear to be in contradiction to the intentions of qualitative research, it is not practical to retain all aspects found in the interview material (ibid.). This is a way to condensate data, which according to Gummesson (2005:312) means 'to make the same information more compact and manageable but not lose weight'. This implies that the rich contents are preserved while at the same time the material is condensed (Gummesson, 2004). Although I have reduced my empirical material considerably I have strived to condense it and retain many aspects from the interviews.

To describe this bottom-up process and creating structure, I will provide examples of how I have worked with the four interviewed groups. My experience was that it was

more difficult to analyse the doctors', regional representatives' and managers' interviews, than it was the social workers' interviews. This is because there were relatively few individuals interviewed. Although there were many similarities between the interview groups, it was sometimes difficult to find commonalities within each group. It was especially difficult to find what was common among the managers, because they answered the questions from very different perspectives. Still, most categories could be used for all groups, at least the groups representing social services.

Analysis of the individual interviews

Once the interviews had been transcribed and printed out, I read through them more than once and made notes in the margin of each interview, when something interesting emerged. I did not use any computer program, developed for analysing a qualitative material, like nVivo. Instead, the interviews were summarised and analysed in separate data documents. The notes made at significant quotes acted as categories which were used in the analysis. I compared the individual interviews with each other by looking for significant concepts and examples, how the interviewees approached evidence based practice, what was common but also what deviated. I did the same procedure for all interviewed groups (doctors, social workers, managers, and regional representatives). This provided a summary and analysis of each individual interview.

In this part of the analysis, my intention was to find patterns in the material, for example regarding context for some employees (as social workers or doctors) or organisations (social services or health care). This is one type, or form, of analysis described by Widerberg (2002). Another form of analysis mentioned is a thematic analysis. This involves comparing different organisations and positions, such as a comparison between social services and health care or evidence-based practice and evidence-based medicine (ibid.). The main purpose was not to compare health care with social services, even if I have done that and considered it relevant in certain parts in the thesis.

On the first page of each data document (one for every social worker) I wrote down categories with a short description of what they contained. These categories could be grouped into two main categories, one oriented to the organisational aspect and the other to the practical work. I illustrate how I worked, by giving examples of two categories that relate to each main category:

> ***POSITION (POS[9]):*** Position in the organisation, in relation to managers and local politicians.
>
> ***CHANGES (FÖR):*** How work has changed and what characterises social work
>
> ***DOCUMENTATION (DOK):*** Documentation in the social workers daily work.
>
> ***COLLEAGUES (KOLL):*** For example, how social workers use each other's knowledge and experiences in their work.

[9] The abbreviations are in Swedish.

The same categories were in the document. Here is an excerpt from one of the interviews in which the social worker answers how they use their colleagues at work:

> It is each other that we have as a support. Thus, we go in to each [other's offices] a lot and asks for concrete examples. Thus, what have, how have you written in your investigation or where did you read what you said, or how do you think about this? … It would be really tough being all on your own in this work. We use it a lot.[i] *(S01:448 KOLL)*

In brackets at the end of the quotation was a code which specified which social worker (S01), and on which row (488) the quote was in the transcribed interview. My intention was not to specify what individuals said in the interview but to keep track of where statements existed in the transcribed interviews. They were removed in the final analysis and presentation of the results.

Analysis of the interviews together

After each interview had been examined, I chose the categories that applied to more than one interviewee, and brought together the interviews. Sometimes, I also retained what only applied to one person, when it was important for the result (Ely et al., 1993). Although there were many similarities between each interviewee group, I analysed each group separately. I started with the doctors and then the social workers, the managers and finally the regional representatives. This was an analysis of each individual case (Jacobsen, 2002). At this stage the purpose was to understand each interviewee in their context. It is common to conduct an analysis of each case or situation, before moving on to an analysis which includes several units or interviews, a so called topic related analysis (Jacobsen, 2002). The focus moves from the particular to common themes or phenomena that apply to multiple units (ibid.).

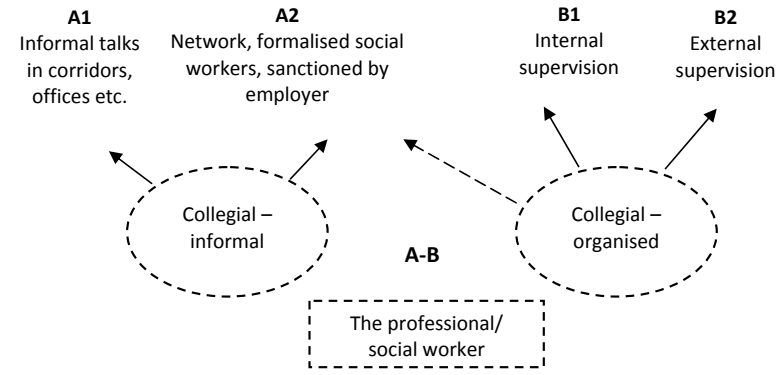
In the next stage of the analysis process I analysed the interviews together, but still with each group separately. Descriptions that could be traced to the same category were grouped together in a Word document, now as matrices. This is an example of how such a table could look (here translated from Swedish to English):

IP	**KOLL** **[Colleagues]**	**Comments**
S01	It is each other that we have as a support. Thus, we go in to each [other's offices] a lot and asks for concrete examples. Thus, what have, how have you written in your investigation or where did you read what you said, or how do you think about this? … It would be really tough being all on your own in this work. We use it a lot.[ii] *(S01:448 KOLL)*	*Colleagues*
S02	*How colleagues' experience is used:* We do this, or I do, probably quite a lot. I work in a group … [where] we have a few, very experienced and we have some, if I count myself, as newer in the field. And we … talk to each other, we have supervision once a week where we take up cases where you have concerns, questions, what can you do. And where we listen much to each other.[iii] (S02:538)	*Colleagues* *Supervision in cases* – forum for exchange of experiences

In the analysis I often used matrices like the one above, in order to structure the material. When it was necessary for my understanding, I designed models with boxes and

arrows, to clarify the relation between the interviewees' answers and my categories. These can be likened with mind mapping. When the relationships between what is studied are complex it may help to draw models; it makes relationships more transparent and easier to understand (Jacobsen, 2002). This model represented a first version of the map that was made regarding support from colleagues and managers:

Category: Collegial Support



The category *collegial support* included the subcategories *informal collegial support* and *formal, organised collegial support*. Each subcategory was divided into informal talks, network, internal and external supervision. The arrows in the model symbolises how phenomena were related (Jacobsen, 2002), for example how and who organised network meetings or supervision. Letter and number combinations A1-B2 were used to specify how the individuals answered, see the table below; they were used to divide the answers into the various subcategories.

Through this way of working I could visualise how many interviewees (S01-S16b) there were within each subcategory, and I could compare the answers with factors such as year of graduation or size of the municipality. I did such a comparison in some categories regarding the social workers, for instance a comparison between aspects of evidence-based practice and year of graduation. This is an example of such a table, linked to the model above about collegial support:

A-B	A1	A2	B1	B2	Other responses*
S04	S01	S05	S02	S04	S03
S09	S03	S14	S03	S06	S07
S12	S04	S15a	S04	S09	S16a
S13	S06	S16b	S08	S10	S11
S14	S10		S09	S11	
S15a	S11		S10	S13	
S16a	S13		S11	S14	
	S14		S16b		

⋆ *Other responses related to the category*

I used tables when I considered it a help in analysing the material, and mainly for analysing the material from social workers. Relatively few individuals were included in the other groups, and the need for tables in those groups was less. This procedure was used for the analysis of social workers' interviews, and to some extent for the managers and the regional representatives, but not for analysing the doctors' interviews. Neither tables nor models are presented in the results chapters; they were a support in my analysis and a good way to get an overview over the material. By comparing how respondents answered, and comparing a category with year of graduation, age and so on, was a way to critically examine the material (Jacobsen, 2002).

There may also be aspects that have not emerged earlier in the analysis, but which are of great importance. For example, one of the managers reflected over the introduction of evidence-based practice in such a way that none of the other managers did, or for that matter any of the other interviewees. This meant that the manager's opinions ended up in a separate subcategory, and I had to reflect over what impact this had on the result. The perspective as this manager had about evidence-based practice, and other changes in the social services, led to an important insight, although the manager was alone with this perspective.

According to Ely et al. (1993), this is about creating themes – looking for supporting facts in each category to determine how categories can be linked together, in order to create a broader understanding and meaning of the result. This is done within each group and between the groups. Themes can be based on the empirical or theoretical material (ibid.). For me, theory has formed a background and was therefore a part of my pre-understanding, but I had the intention of listening to the interviewees and not only search for what my theory can explain. Themes can be determined when they occurred many times and/or for most of the studied individuals, and when it proved to be of great importance for the analytical result, even though it only appeared one time. By using themes, the researcher can find patterns, differences and unique features, consistent with each other (ibid.).

This stage in the analysis is usually done at the end (Ely et al., 1993), and a legitimate question is when the analysis is completed. Ely et al. (1993) explain, with reference to Tesch that the analysis is to be regarded as completed when new facts no longer give rise to new insights. Ideally, this is when the material is, so to speak, saturated and when the interpretation and the processing of the material do not provide any new insights (ibid.). I feel that the empirical material and the analysis are saturated in relation to the interview questions that i have had; few new insights have come when the last interviews were analysed. This applies primarily the social workers but also the others who have been interviewed.

Reflections about quality in research

All scientific work needs to be examined to establish its credibility. There are requirements that the results should be possible for others, than the researcher, to critically examine, that the chosen method for data collection produce results that are reliable (reliability) and valid (validity) (Lantz, 2007). In this section, I will reflect over the

quality in the research, and give some examples of, what I perceive as important aspects in relation to the quality in research. A lot of what is described earlier in this chapter can also be attributed to the quality and reliability of the research.

Validity in research

The first criterion to assess quality in research that I choose to illuminate is *validity*, which according to Kvale (1989:78) 'involves checking the credibility of knowledge claims, of ascertaining the strengths of the empirical evidence and the plausibility of the interpretations'. Validity can be assessed both in terms of the quality of the data collected (internal validity) and whether the results can be transferred to other contexts (external validity) (Miles and Huberman, 1994; Jacobsen, 2002).

To discuss the quality of the data the researcher collects is about the *internal validity*, or credibility (Miles and Huberman, 1994). When it comes to interviews, the quality becomes assessed by the interviewer and the interviewee, where the compliance between them 'is determined by how well the interviewer managed to capture and mirror their source of information' *[author's translation]* (Lantz, 2007:101). How well this compliance is achieved is difficult to determine for an individual researcher. Therefore, it is more a feeling that I as an interviewer manage to reflect what the interviewee says and that the interviewed, to some extent, recognises their self in what I am describing. A somewhat appealing alternative is to go back to some interviewees (Jacobsen, 2002). I have not done any such structured feedback of results to the interviewees. But, I have talked with a few social workers on some occasions, where I have told them about my research and in those conversations I have acquired an understanding of what they think of my results. My experience from these conversations is that evidence-based practice is of interest to the interviewees, they talked positively about evidence-based practice, and I feel that the social workers recognised themselves in what I described. However, I may understand the introduction of evidence-based practice in a different way, because my theoretical background as a sociologist is partly another than a social workers theoretical background.

Another way to assess the internal validity is to reflect on whether the source the researcher uses provides the right information or if there are other sources providing different understandings (Jacobsen, 2002). I have interviewed social workers, managers and regional representatives from social services, and doctors from health care. These are relevant groups to interview because I have a perspective on evidence-based practice as an idea of a new way of organising work introduced largely from the top, with the medical field as a role model. A group, also essential for the understanding of this topic, is the local politicians in Social welfare committee, because they govern the social services and have a major responsibility for how the work is conducted and organised. The choice not to interview the politicians was due to my own pre-understanding that politicians in the Social welfare committee are generally not very familiar with evidence-based practice. With hindsight I recognise that it had been important to get their perspective. Even *if* the politicians did not have great knowledge about evidence-based practice, it would have been a significant result.

External validity or transferability is another criterion for assessing quality in research (Miles and Huberman, 1994). External validity involves, according to Jacobsen (2002:266), deepening concepts and phenomena, to 'get a grip on general *phenomena' [author's translations]*. That is, to generalise from a smaller sample of, for example, interviewees to a more theoretical level (Dey, 1996; Jacobsen, 2002). In quantitative research it is more common that findings are being generalised from a random sample to a larger population. I agree with Lantz (1993) when she writes that validity and reliability needs to be approached from another angle when a qualitative method is used. The external, theoretical, validity can be assessed by how well concepts and correlations are grounded in theory, where theory aims to deepen the understanding of the phenomenon's meaning (ibid.). Concepts and relationships from the analysis of the empirical material are anchored in theory, and as I have described earlier in this chapter constitute new institutional organisational theory, the theoretical foundation of the thesis. The knowledge has deepened in the interaction between theory and the empirical material. However, there are other possible explanations and theories to use, that can explain the result from other approaches, such as gender, class or profession theories.

An interesting reflection in relation to other possible ways to analyse the empirical material, is that social workers and the managers use metaphors in the interviews when describing evidence-based practice. When they describe changes in social services and their work they use expressions like this: 'we are no isolated island', 'it hangs in the air, the pendulum in Sweden oscillates a little back and forth', 'as the reindeer herd, that if one goes everyone goes, and abruptly change direction', and 'throw the baby out with the bathwater'[iv].

Metaphors can be regarded as 'conceptual frames that are applied to organizations in order to facilitate insight, generate new meaning and provide new perspectives of change' (Tietze, Cohen and Musson, 2008:43). Metaphors introduced to organisations by, for example, managers, consultants or researchers (ibid.), can help to explain and form understandings that we lack words for (Jacobsen, 1993). I have not done an analysis of the use of metaphors, which would be possible, but I did consider why social workers and managers used metaphors more often than the doctors when they talked about evidence-based practice or evidence-based medicine in the everyday work. It would be possible to analyse to what extent the use of metaphors about evidence-based practice is related to that it is a relatively new phenomenon compared to what evidence-based medicine is for doctors. Alternatively, it would also be possible to analyse how evidence-based practice is presented through the use of metaphors by the managers and actors from the national and regional level.

An aspect in my research that I want to highlight is how I selected the municipalities and what opportunities this entails regarding the non-response. Initially, I asked the three municipalities with most inhabitants in the county, and when two of them declined, I needed another sample of municipalities. Now I selected municipalities of different sizes, one municipality with around 20 000 inhabitants and two municipalities with under 10 000 inhabitants. The test interview person came from a municipality also with around 20 000 inhabitants. In the analysis, the selected municipalities was divided in large, medium sized and small municipalities, from the way they organise their work which is due to the number of inhabitants.

When compiling and analysing the interviews, I was very thorough in my examination of to what extent the result differed between the municipalities. Where it was relevant to understanding I separated the results into small, medium and large municipalities. However, there were no major differences regarding evidence-based practice in relation to the size of the municipality. There were nevertheless some organisational differences in terms of conditions for evidence-based practice, such as access to supervision and alternative interventions. Some differences also exist in the material between social workers with longer respective shorter experience in social services work. From this perspective, that social workers working in municipalities of varying sizes have been interviewed is advantageous.

I described earlier in this chapter how the selection of interviewees was made, but I want to point out that I had relatively little control over the sample process, which could result in a bias which affected the result. The sample made it difficult to analyse the non-response because I did not have knowledge about all social workers working in the municipalities, or from the other interviewed groups. Therefore, the non-response can not be analysed to the extent that the interviewed groups are representative of the whole group, for example in terms of gender, age, and work experiences and so on. I do not claim that the results apply to an entire population. There is also a risk that some social workers experiences were left out (Jacobsen, 2002). It might be those most supportive of evidence-based practice that chose to participate, and I risk having missed the less positive social workers. My experience after the interviews is that most social workers were positive to evidence-based practice and it is those who had longer professional experience that could describe changes and compare different ways of working.

Reliability in research

The next criterion to assess quality in research is *reliability*, or dependability (Miles and Huberman, 1994). Reliability is about how the study was conducted, how reliable and careful the research method was, in terms of the procedure itself (Andersen, 2012), and if it is possible to rely on the data included in the study (Jacobsen 2002). In this chapter, I describe choices I made, the reasoning behind the choices, and the accuracy I have endeavoured to maintain – so it would be possible for others to review my work. During the thesis work this has mainly been done in meetings with my supervisors and through participating in seminar sessions with other researchers, for example sociologists and social workers.

The issues examined are influenced by the study design, Jacobsen (2002) explains. I have been influenced during the writing of this thesis about evidence-based practice in social services by the interviews conducted with the managers in previous research and from the theoretical knowledge, especially from the licentiate thesis. This has affected the phenomenon studied, the way I planned and performed the thesis. Knowledge is created between interviewer and interviewee, in the interview situation. I carry with me this knowledge to the interviews conducted later. For example, I changed the interview questions a little between the groups interviewed, and sometimes even within the group. I also want to clarify two more aspects at the interview sessions that may have influenced the results. The first aspect was that I have met some of the interview-

ees during previous projects I have worked in. Although some of them knew me I believe that they spoke openly during the interviews, about both positive and negative experiences. Possibly, they felt they could not refuse to be interviewed, but I asked them only once, in most cases via e-mail. The second aspect is that I am not a social worker. Being a sociologist have had an impact on what questions I asked, the interviewees' responses, and how the material was analysed and interpreted. At the same time, it is important to emphasise that although the context is social work, my thesis is in sociology and human work science. Social work is where I collected my empirical material.

I would also like to highlight some difficulties involved in writing the thesis in English. There is a risk that the reliability of the research decreases in the sense that quotations may be translated incorrectly or with insufficient accuracy, and that my own language barriers hinder me from expressing myself sufficiently correct. I find it difficult to express myself in the same way in English as I do in Swedish, for instance express nuances in a text. Writing in English was not my intention in the beginning of the thesis work. This decision was made during the years since I began 2011. My licentiate thesis from 2010 is only available in Swedish. I chose to write this thesis in English because it then becomes accessible to more readers. To avoid the language becomes a too large barrier to the quality of the study, I have sought help with proof-reading mainly from a colleague and also from a company specialising in proof-reading. Nevertheless, the responsibility for the written text has been, and is still mine.

Even if the thesis is in English, I conducted the interviews in Swedish. This means that I translated all the quotations included in the thesis retrospectively. Translating the quotations was the most difficult part of writing this thesis because I had to maintain the spoken language and the meaning of what the interviewees said. The spoken Swedish language is not consistent with the spoken English language, and it is impossible to translate everything word for word. Nuances disappear, and expressions, proverbs and metaphors used in Swedish may not be used in English, or may have a different meaning. Similar experiences are described by, for example, Cervantes (2005) in her thesis. The most important is however that what the interviewees want to emphasise does not disappear due to the translation.

To facilitate the reading of the chosen quotations, I have reformulated them to written language, when it has not changed the meaning of what is said. This was done before they were translated. Words that are repeated and words that have no meaning for the understanding (for example, after all, so, as well, that is) have been removed. Like both Piippola (2003) and Cervantes (2005), I chose to present the quotations from the interviews in Swedish, in endnotes (Appendix III), so that readers have the possibility to understand and control the meaning of the translated quotations. Through this procedure the transparency is increased, and it becomes possible for Swedish-speaking persons to relatively easily control the extent to which the meaning of the quotation conforms in the Swedish and English versions. Despite the linguistic difficulties it was important to use quotations from the interviewees, and that all interviewees' voices should be heard. The intention is that the reader should understand the results of the thesis.

Quotations from the empirical material are an important part in qualitative studies, and are described as equivalent to tables in quantitative method (Jacobsen, 2002). When citations have been selected, I have sought that all interview persons should be cited, so the result do not solely consist of a few people's quotes. I have also chosen the quotations that best describe what I wanted to highlight. When there have been parts in the quotes that I thought were less relevant for understanding or which included names or other recognisable information, I have removed those sequences. Shorter sequences are replaced with three dots (...) and longer sequences are replaced with three dashes (---).

My experience and understanding of social work

Finally, I want to describe my own background and experiences in relation to social work in order to creating a better understanding of the content, quality and results of the thesis. This section is associated with the methodology discussed earlier in the chapter. However, I also believe that it is important to account for my experience and understanding of social work, when discussing the quality in my research. How the researcher understands people are always dependent on the researcher's background, which will shape the perceptions of those involved in the study (Hartman, 2004). This means that there is a fusion of the researcher's and the interviewee's life-world, a horizon fusion. We can never reach a complete understanding of other people because our own perceptions are present all the time (ibid.).

Since my master degree in sociology in 2003 I have worked in several projects within social services and health care, mainly within the area of individual and family service. Four of those projects were included as case studies in my licentiate thesis (Eliasson, 2010). Experiences gained through those projects have primarily been at an overall level, as a project manager or coordinator. There are, whether it has been about psychiatry, substance abuse or elderly care, many similarities between them, the projects were mainly national initiatives whose ideas were introduced in local practice. However, my own experience of practical social work is limited and I consider myself more as a sociologist than a social worker. Although I have some experience of social work, as an administrator within disability care, part time about one year before I started my PhD studies in 2007 and as an assistant nurse within elderly care for one year in the end of the 1980s. I am educated as assistant nurse at upper secondary school 27 years ago, but have only worked one year in that occupation.

The experience from educations, projects and practical social work have however shaped how I understand social work. Social work is not a completely unknown area, although my experiences are relatively superficial (and somewhat outdated). However, my knowledge and experiences are deeper when dealing with project work and project management, and with ideas travelling to practice, irrespective of whether the idea is about cooperation, evidence-based practice, other ways of working or something else. The challenges and opportunities are often relatively similar.

My background was an important part when the topic of this thesis was selected. Not least, my background and experiences from the projects was crucial when planning and conducting the study, and especially when the interview questions were formulated. Unlike my licentiate thesis, it was my conscious choice not to research on projects I

have been involved in. One very important reason was to avoid the difficulty of writing about my own projects and keeping a distance between what is studied and my own tacit knowledge of what I, for example, could have done differently in the projects. I found it easy to have self-criticism but difficult to explain this in a scientific manner because it was based on what I experienced and which often was not explicit. Instead, the arena for my thesis became evidence-based practice in work with children and families, an area which I perceive as important for the social services and social work in general and which I had not so much insight in; until now.

4

Theoretical perspectives

The theoretical framework of this thesis is about organisations; it is about changes that organisations are undergoing. The key concepts are institutions and legitimacy. The theoretical base is primarily new institutional, or neo institutional, theory, and Peter Berger and Thomas Luckmann (1967) which represent a theory based on a social constructivist perspective. The main features of Berger and Luckmann's (1967) theory was published in 'The Social Construction of Reality', and is one of the earlier contributions within institutional theory. Within new institutional theory two articles have largely formed the basis for the further development of institutional theory. These are John W. Meyer and Brian Rowan's article 'Institutionalized Organizations: Formal Structure as Myth and Ceremony' published in 1977, and Paul J. DiMaggio and Walter W. Powell's article 'The iron cage revisited: institutional isomorphism and collective rationality in organizational fields' from 1985.

I will start this chapter with a short discussion about different levels of analyses – micro, macro and meso – that are possible within sociology and with institutional and new institutional theory. Then, I give a general introduction to institutional theory with a section about organisations and people in organisations as actors. The next main section is about new institutional theory. This constitutes the core of the theoretical chapter, it explains elements important to understanding how organisations work and alter. Through new institutional theory I believe that analyses at all three levels are possible, although this is usually done at a macro or meso level. The last main section is based on Berger and Luckmann's (1967) insight into the social construction of everyday life, which is well suited to perform analyses at the micro level.

The links between different levels

Within new institutional theory organisations can be analysed to create understanding of key aspects of human interaction. Organisations can be considered as an 'intermediary link between … society's micro and macro levels' *[author's translation]*; an intermediation between people's actions and more structural processes (Ahrne and Hedström, 1999:5f). Human actions are coordinated and turned into social processes in organisations (ibid.). How social workers create legitimacy for their work through interaction can be explained through a theory about social construction (Berger and

Luckmann, 1967). The social services become in this respect the intermediary between the introduction of evidence-based practice, and social workers and managers who act in the organisation and create the work practice. When extensive changes are made, such as evidence-based practice entails, confusion and insecurity among social workers may exist and they may not know how to relate to the changes being experienced. The social services are striving to achieve legitimacy in relation to its surroundings, society in general and particularly the users, by introducing recommended changes regarding, for example, evidence-based practice.

This thesis moves between different levels, between micro and macro level and also at a meso level. Analyses at a macro level concentrates on large groups of people, organisations, social systems and societies, while analyses at a micro level is about individuals and their behaviour in everyday life situations (Giddens, 1998; Guneriussen, 1997; Engdahl and Larsson, 2011). An analysis on the meso level can be about how people's actions are coordinated (Engdahl and Larsson, 2011). Traditionally, the relation between the micro and macro levels has been regarded as an external relationship where there were few or no connections between the levels (Guneriussen, 1997). This has changed and today there is a combination between micro and macro levels in analyses, which for example can involve relationships between the management and the staff, and the organisation. The organisation as a whole constitutes thus the macro level, but when the relationship between the actors are analysed it is the micro level. Guneriussen (1997:301) explains the relation between micro and macro: 'the institutional frames also constitute a meaningful symbolic order that defines and gives meaning to the actions or action alternatives' *[author's translation]*.

The so called Scandinavian institutional theory developed in the early 1980s with inspiration foremost from the United States, and was building a lot on researchers such as Meyer, DiMaggio and Powell (Eriksson-Zetterquist, 2009). The interest within Scandinavian institutional theory was the practices in organised work and local translations, especially in public sector (Czarniawska, 2008). This lead to a lot of field studies. This was not the case in other orientations within institutional theory. Czarniawska (2008:772f) explains that 'the constructivist version of institution theory permitted the Scandinavians to continue their tradition of organization studies, consisting of fieldwork with a processual focus'. These field studies gave answers to the need for research of institutions at a micro level (ibid.).

Other researchers also point out the need to take micro-processes into account in an institutional analysis, in a greater extent than has been done (cf. Barley, 2008; Powell and Colyvas, 2008). For example, Powell and Colyvas (2008:295) emphasise the importance of analysing 'how efforts on the ground, so to speak, may prompt macro-level changes and responses'. Berger and Luckmann's theory was first published in 1966, and Erving Goffman's 'Interaction Ritual' and Harold Garfinkel's 'Studies in Ethnomethodology', which are theories that provided a micro foundation for the institutional theory were published in 1967. Those are still used in research (ibid.). Berger and Luckmann's work was also an influence when Meyer and Rowan wrote their article 'Institutionalized Organizations: Formal Structure as Myth and Ceremony' in 1977 (Johansson, 2006; Meyer 2008).

One attempt to explain how to combine different levels of analysis is made by Barley and Tolbert (1997:100), who argue that 'social behaviours constitute institutions diachronically, while institutions constrain action synchronically'. Barley and Tolbert (1997) emphasise that the analysis has a process perspective which must consider the history because it is important for understanding the creation of institutions. This means that an analysis focusing on the connections between actions and institutions needs to examine how the actors' actions change or maintain institutions, and how an institution controls and limits the actors' options to act over time (Johansson, 2006). According to Dent (2003), Barley and Tolbert (1997) provide an explanation as to how actors can act in an effective way at the same time as the organisation is loosely coupled. On the basis of a study conducted during the mid-1990s within health care in eight European countries Dent (2003:170) compared 'the implications of public management reforms for hospital doctors and nurses working within the public sector'. Dent (2003:170) stresses the importance of 'being aware of the particular histories of medicine, nursing and the state, and of how their relations have variously negotiated implicitly as well as explicitly' for understanding 'how organisational and managerial reforms might be responded to within particular societies'.

Blom (2006) uses new institutional theory and Berger and Luckmann's (1967) theory when analysing changes that the purchaser and provider model entailed for the work within individual and family service in a Swedish context. The advantage with this combination is that it links together different organisational levels; the micro, meso and macro levels. It is therefore possible to coherently explain how the launching and introduction of international ideas about organising work can be transferred to local models of organising work. The introduction can also, as Blom (2006) notes, alter the patterns for how the individual actors think and act, and also how it affects the users.

Other researchers that have taken the macro, meso and micro levels into account are Gray, Plath and Webb (2009:19), who explicate the different levels of formalisation in relation to evidence-based social work:

1. At the *macro level*, evidence-based policy drives organizational cultures within research and practice.
2. At the *mezzo level*, this drives professional, agency- and community-based practice.
3. At the *micro level*, the individual practitioner makes decisions.

Decisions taken at a micro level are not done separately from what goes on at the macro and meso level, instead it takes place in a 'complex web of relationships within a broad macro political landscape' (ibid:19). Gray, Plath and Webb (2009) use network theory to explain 'how this macro-level "mesh" gives the impression that evidence-based practice has a wide reach when, in reality, it has had little impact on the day-to-day practice of social work' (ibid:3). Social workers, the individual practitioner, and their work are to a great extent affected by what happens in their surroundings, for example which information is spreading within social services, macro policies, and governmental policies. Political opinions with an increasing focus on 'evidence-based practice, outcome-based interventions and "what works", are embedded in a climate of political opinion which surrounds the formation of social policy in advanced capitalist

societies and the systems of quality assurance and performance culture associated with the process' (ibid:20).

Organisations and people as actors of change

Even though organisations consist of people they should be considered as 'something more than just a temporary group of people' *[author's translation]* (Ahrne, 1999:13). The organisation has an independent existence, and exists independently of the individuals in it. Usually organisations exist longer than the people working and managing them. Individuals, members or employees, can therefore be replaced without the organisation disappearing. Yet at the same time organisations are dependent on individuals for their survival, on that employees actually go to their work (ibid.), or that employees have the knowledge required for the work.

Organisations are often regarded as actors, collective actors, since they can act, enter into contracts, use resources and own property (Scott, 2003). When described in terms of that organisations act, organisations do things, which actually mean that it is the people in organisations who act. People do what the organisation plans and requires to be performed. Because the acts of people are coordinated, it appears as if it is organisations who act. Even if it is the people in the organisation who act, these acts are not entirely their own. The people perform the acts on the behalf of the organisation (Ahrne, 1999). While human acts are organisational, it is people that perform these acts and they are based on their own thoughts and experience. Hereby there exists a tension between what organisations require and the people (ibid.).

This tension is salient in how Lipsky (2010|1980) describes street-level bureaucrats. Street-level bureaucrats are public service employees, for example social workers or teachers, who in their work interact with citizens or users, and their work is performed under certain conditions. Characteristic for street-level bureaucrats is their 'discretion in exercising authority' and that they are constrained in relation to the work structure in the organisation. This entails that street-level bureaucrats 'cannot do the job according to ideal conceptions of the practice' (ibid:xvii). The problems that arise for street-level bureaucrats are insufficient resources and contradictory expectations. Not everyone employed within social services can be characterised as street-level bureaucrats (ibid.), but those social workers within individual and family service that I interviewed in this thesis, work under these conditions. Social workers must, on the one hand, be flexible and be able to form the support they give from the users' individual needs and preferences, as well as, on the other hand, be aware of what resources there are available, not least the organisation's economy.

Ahrne (1999) describes this relationship and tension with the concept 'social hybrid', meaning that there are people who act in organisations but these acts are at the same time organisational. The organisational structure is shaped through the ideas of people and their ability to act; the humans carry the organisation's function and perform the tasks necessary (Scott, 2003). What effect the acts of people have depends on whether and to what extent they can be coordinated with the acts performed of other people in

the organisation (Ahrne, 1999). The humans constitute the social structure that is needed in order for organisations to exist. According to Scott (2003) theorists such as Pierre Bourdieu mean that actors can be considered both as a tool for continuity and change, where continuity means that the system is reproduced and change means that the organisation changes with new ideas and innovations.

Traditionally new institutional theory has not focused on individual organisations or actors, but on networks of organisations called organisational fields. The relationship organisations have to their surroundings means that they cannot solely be regarded as closed systems. Instead this relationship should be considered as an interaction between the organisation and the surrounding environment. Organisations are both open and closed systems, but how open or closed they are varies. With organisations as open Ahrne (1999) means that organisations can be influenced by the environment as well as have an influence on the environment. Organisations are to some extent also closed systems because there are boundaries between organisations and the surrounding world, boundaries that are guarded. One example is that not just anyone is admitted into an organisation via its personnel entrance. Furthermore, controls are made of the transactions that occur across organisational boundaries, such as the purchase or sale of goods and services (ibid.).

When organisations are regarded as open systems, it is important to consider cultural-cognitive elements in the construction of organisations (Scott, 2003). Organisations are dependent on ideas, conceptions, and models and so on, which are introduced and adapted to the organisation, with or without intentions. Organisations are according to Scott (2003:29) 'congeries of interdependent flows and activities linking shifting coalitions of participants embedded in wider material-resource and institutional environments'. What characterises organisations as open systems is the relationship to the surroundings, where actors can have multiple loyalties and identities. Furthermore, actors join and leave the organisations, or they can attend depending on what benefits are available and what agreements are reached. Therefore, no one can assume that the actors have common goals or that they always act with the organisation's best interests and survival in focus. Organisations are included in a system of interdependence between them, where they are dependent on one another's activities, where some are loosely coupled to one another and others are coupled more tightly. Organisational phenomena should therefore be regarded as part of a larger system of relations (Scott, 2003).

Institutions influence on organisations

An area that new institutional theory is interested in concerns the impact that institutions have on organisations, but also how institutions are created by organisations. Institution accounts for something else than organisation and is, according to Ahrne and Hedström (1999) social phenomenon of various types. While organisations are 'formal associations of certain identifiable individuals', institution constitutes a more cognitively oriented phenomenon which includes 'knowledge, conceptions, regulations (eg. legislation)' *[author's translation]* (ibid:7). There is, in social life, a continuous interaction

between organisations and institutions. Institutions affect the way people act as individuals and as members of the organisation but institutions alone cannot perform acts. For example, evidence-based medicine contains perceptions about what knowledge is desirable and how to use that knowledge. Doctors are influenced by evidence-based medicine and perform the work with evidence as a foundation. It is therefore doubtful whether it is at all possible to regard institutions as actors (ibid.).

Organisations are surrounded by formal and informal rules of what is acceptable ways to act, which can be supported through legislation. They can be taken for granted, or there may be general thoughts of what is acceptable. Such normative obligations can be conveyed to organisations as facts that actors must consider and take into account (Meyer and Rowan, 1977; Johansson 2002). Institutionalisation is a social process where actors create a common definition of the social reality. Evidence-based medicine becomes institutionalised when a joint definition is created among doctors working within health care, and this has an impact on the organisational structure. Among doctors there is a more common definition of work according to evidence-based medicine than is the case with evidence-based practice, within social services work. Institutionalised rules affect the structure of the organisation and the practical work, and may have effects other than the technical requirements placed on organisations (Meyer and Rowan, 1977).

Institutions consist of three elements or pillars which shape and support them, that together with 'associated activities and resources, provide stability and meaning to social life' (Scott, 2008:48). These elements are the regulative, the normative and the cultural-cognitive. Organisations consist, in practice, of a combination of these three elements and cannot easily be distinguished, other than analytically. The regulative element explains that institutions limit and control behaviour through laws and regulations, and by surveillance and sanctions. There are also other controlling forms of regulative elements, for example controlling forms that regulate institutions through licensing or through the allocation of power and benefits to some, but not other, actors (ibid.).

Central to the normative element are the values and norms which may apply appropriate ways to act in certain situations or from certain positions (Scott, 2008). This determines, to a great extent, how people should act and what ways of acting that are desirable for the organisation. Evidence-based medicine and evidence-based practice contains a lot of values and norms in relation to how to act in work. The way of working as BBIC[10] requires has normative as well as regulative elements. There are demands from the National Board of Health and Welfare of certain structure in order to receive the licence to use BBIC. While normative systems often limit social acts it can also enable people to act (ibid.). With the cognitive element, institutions can be considered 'as knowledge-systems that control social behaviour' *[author's translation]* (Blom, 2006:180; see also Johansson, 2002). Rules and routines are being followed by individuals because they are taken for granted, and the individual does not think that there might be another way to act (Johansson, 2002). The cognitive frameworks can control what

[10] The Swedish BBIC (Barns Behov I Centrum/ Children's Needs in the Centre) is 'a system for handling and documentation in investigation, planning and follow-up' *[author's translation]* (Socialstyrelsen, 2013:17).

information gets attention, how it is coded and interpreted (Scott, 2008), such as how evidence-based practice is perceived and performed in practice.

Organisations striving for legitimacy

There is often talk about organisations' need of increased efficiency, and efficiency has become a main reason for organisational change. Blom (2006) explains in a brief review of developments in individual and family service that politicians and management often mention increased efficiency as a reason for organisational change, along with motives for improved service for citizens and an increased democracy. The high level of confidence for the welfare sector in Sweden during the 1960s and 1970s has been questioned in more recent years. Blom gives the purchaser and provider model as an example of the response to this demand within individual and family service. The introduction of new management techniques and models within the public sector, as new public management and knowledge management are other examples where the inspiration comes from the private sector (Sahlin and Wedlin, 2008).

However, organisational changes can not solely be explained by efficiency motives, instead it can be understood as an attempt by organisations to achieve legitimacy (Meyer and Rowan, 1977; Stern, 1999; Blom, 2006). The ambition to gain legitimacy is more common within institutional fields (such as within education, health care or social work) than in fields where organisations are more technically oriented and where efficiency motives are more explicit (Meyer and Rowan, 1977; Stern, 1999). According to Stern (1999) a characteristic feature of institutional fields is the difficulty of measuring the product quality and quantity, and Stern (1999) refers to Meyer (1977) who writes about the educational sector, and Scott and Meyer (1991) who focus on the societal sector. Organisations are a part of a large system of relations where emerging control systems are difficult to use. One of Scott and Meyer's (1991:138) conclusion is that 'fiscal and fragmented decision making tends to rely on structural and process controls, that … are associated with loose coupling between administrative and production tasks'. The increased endeavour to control these sectors usually depends upon the perceived lack of control over what is produced and also over the results (ibid.).

Meyer and Rowan (1977) point out that earlier organisational theory focused on the pursuit of efficiency, and in these theories the formal structure of legitimacy was taken for granted. The formed structure was created to coordinate and control the work. But these rationalisation norms are not just some general values, they can take the form of more specific rules, understandings and contexts of meaning that are attached to the institutionalised social structure. For example, there are activities as decision makers, legislators and various professional groups, presuppose that they are performed in a certain way – according to certain criteria and within a specific organisational structure, believed to be the best (Meyer and Rowan, 1977). Traditional health care is one example where the organising is done from different responsibilities and tasks. Such activities are considered legitimate regardless of what, for example, evaluations show about the effects of the activity. These activities are referred to as rationalised myths, and can be seen as a strategy to deal with requirements for change (Meyer and Rowan 1977; Johansson 2002).

When institutional rules arise within a particular field, organisations will incorporate the rules as part of the formal structure. Thus, organisations strive to achieve structural agreement with the myths that are in the surrounding environment, and through this effort they become increasingly similar. This is important to organisations, because when more organisations adopt institutional rules, they become more similar (isomorphic), achieve legitimacy and can get the resources necessary to survive (Meyer and Rowan 1977; Johansson 2002). In Blom's (2006) example, mentioned earlier, about the introduction of purchaser and provider model within individual and family service, organisational change can be explained as a mimetic isomorphism. The municipality in question chose an organisational model from the private market, which was in vogue then. Through imitating this model, the municipality tried increasing its legitimacy and its economic efficiency (ibid.). The evidence-based practice movement within areas such as social work can also be regarded as a strategy for organisational change through which organisations within the public sector become more similar to each other and other organisations within the medical field, that use desirable ways of working.

In accordance with what Meyer and Rowan (1977) argue, organisational changes are more often based on rationalised myths than what is shown to be most effective in different evaluations (Stern, 1999). According to Blom (2006:186) it is also possible to consider the changes within individual and family service when introducing purchaser and provider model, as 'coercive isomorphism because there was social and cultural pressure' *[author's translation]* from other sectors within the municipality, that had introduced the model. Therefore, the changes that introducing purchaser and provider model entailed mirrored the rationalised myths of the efficiency in the market, rather than the actual activities within individual and family service (ibid.). Rationalised myths are cognitive institutions. Cognitive institutions have an impact on how organisations develop and how successful they will be.

The objective of organisational change is that the organisation becomes legitimate in relation to their surroundings (Stern, 1999), for example in the eyes of citizens or users. Organisations where legitimacy is high, which have become isomorphic and can demonstrate that they meet the requirements placed on them, are not contested by other organisations in the same way as they would have been if those requirements are not met (Holmblad Brunsson, 2002). Those who fulfil and adapt to external requirements receive greater confidence from the environment than those who do not. But organisations have not only to adapt to these myths, they must also maintain a facade that the myths in relation to the organisation's activity really work. This entails that organisations might face contradictory demands in the sense that they are expected to operate effectively whilst they also are expected to meet the demands that the surrounding environment impose on them (Meyer and Rowan, 1977; Holmblad Brunsson, 2002).

The use of rationalised myths can create problems or inconsistencies when they are in conflict with technical activities and demands for efficiency (Meyer and Rowan, 1977; Boxenbaum and Jonsson, 2008). Organisations use two strategies or techniques to address these contradictory demands, these are 'decoupling' and 'the logic of confidence and good faith' (Meyer and Rowan, 1977:356f). Decoupling is an internal strategy to handle changes through decoupling between what creates legitimacy in the organisation

and the technological activities (ibid.). The development within health care has been towards increased quality controls, where professional self-regulation has moved towards an increased managerial scrutiny (Dent, 2003). Decoupling is a strategy needed when health care shall be carried out in an effectively way, although there is an increased managerial scrutiny. Evidence-based medicine, with its demand on transparency, has been a part of this development in the United Kingdom (ibid.). Evidence-based medicine has a strong foothold in Swedish health care also.

Decoupling means to disconnect (to decouple) practical acts from the formal structure, so the organisation can maintain a standardised (uniform), legitimised formal structure while the acts or the activities performed in the organisation vary according to the practical considerations that are made (Stern, 1999; Johansson, 2002; Eriksson-Zetterquist, 2009). The work is performed as usual, which means that 'organizations abide only superficially by institutional pressure and adopt new structures without necessarily implementing the related practice' (Boxenbaum and Jonsson, 2008:81). According to Lindberg (2002) Meyer and Rowan's perspective on decoupling is that it is a process because the structure and the working activities are decoupled.

In the mid-1970s the idea with decoupled structure and action influenced the development of the concept loosely coupled, which implies that organisational elements can be loosely coupled (Boxenbaum and Jonsson, 2008). Weick (1976) is usually described as the person developing the concept loose coupling (Johansson, 2002; Czarniawska, 2008; Kraatz and Block, 2008; Palmer, Biggart and Dick, 2008). In following work, Orton and Weick (1990:204) interpret loose coupling as dialectic:

> Loose coupling suggests that any location in an organization (top, middle, or bottom) contains interdependent elements that vary in the number and strength of their interdependencies. The fact that these elements are linked and preserve some degree of determinacy is captured by the word coupled in the phrase loosely coupled. The fact that these elements are also subject to spontaneous changes and preserve some degree of independence and indeterminacy is captured by the modifying word loosely.

Loose coupling between different units have several advantages for the organisation. For example, loosely coupled system have the ability to vary when the environment changes, and adapting to these changes. This in contrast to cases with more tightly coupled systems (Johansson, 2002).

Evidence-based practice is presented as a myth, and will therefore be perceived positively by those working in the social services, and many organisations want to emphasise that their work is evidence-based. Nonetheless, there is variation in how evidence-based practice is actually introduced into the practical work. The same applies to cooperation, how cooperation is introduced and used in practice, which was the main topic in my licentiate thesis (Eliasson, 2010). There are similarities between introducing evidence-based practice and cooperation, both presented in a positive way, not least by those working in the organisations. At the same time there is a variety in how it becomes incorporated in organisations, and those working within social services or health care are aware of what makes the introduction more difficult.

A way for organisations to maintain decoupled activities is to avoid evaluations and follow-ups of working methods and results. By referring to previous studies that she has been involved in, Eriksson-Zetterquist (2009) explains that decoupling is a way to maintain legitimacy. The example concerns the implementation of equality plans. Among other things it is specified in the plan that within a period of two years a certain percentage (in this example 25 per cent) of managers in an organisation would be women, but this was not practically possible to achieve:

> By adopting the gender equality plan the organisation appeared as legitimate to the surroundings, when the company seemed like the others. It also appeared to be legitimate seen from the employees' perspective on contemporary organisations. --- If the equality plan would be too tightly coupled organisations would go under because there are no women to recruit into the organisation. Through decoupling the equality plan, however, the organisation will survive. *[Author's translation]* (Ibid:71).

These plans provide the organisation with legitimacy, but it would be too demanding to follow them exactly. That is why the plans become loosely coupled to the organisation's ordinary activities. Stern (1999) writes, with Meyer and Rowan's (1977) understanding of decoupling, that reforms, reorganisations, new management techniques and ways of working and so forth, will have a limited influence on the organisation's activities. There becomes a loose coupling between activities performed and the formal structures (Meyer and Rowan, 1977).

What organisations do is important, but what might be even more important is 'that they can talk about what they do in a trustworthy way' *[author's translation]* (Eriksson-Zetterquist, 2009:145), which can be done, for example, by marketing or internal education. With this, the second strategy, which concerns the logic of confidence and good faith, comes into focus. This strategy builds on the existence of trust among employees and among customers, users, patients and so on, who are outside the organisation, that the organisation is working as intended and that any problems are solved unnoticed. This assumption that everything is in order, and that employees and managers do what they are obliged to do, enable the organisation to carry out the daily work with decoupled structures while being able to maintain a confidence in the work they perform (Meyer and Rowan 1977; cf. Johansson 2002).

Being as others but at the same time unique

Organisations with similar assignments and where they agree that particular institutional activities are conducted are within an organisational field. What unites organisations in a field is the notion that they belong together and share common ideas (Johansson, 2002), not necessarily that there is an objective existence, or an interaction between them (Forssell, 1992). The Swedish public sector is an example of an organisational field where there are similar ideas and ideals (Sahlin-Andersson, 1996). Another example is provided by Forssell (1992), who examined the saving banks' transformation from the 1950s into a modern enterprise, where a market economy system became the central feature. The saving banks were incorporated into a new organisational field, first as a subdivision but the boundaries between the subdivisions gradually became blurred.

The changes, not unique for banks, meant that the definition of the organisations activity became another; 'the organisational fields took on another composition than before and other norms and rules' *[author's translation]* became important (ibid:180).

Organisational fields are changing, they may be expanded as new actors enter the field or they may cease entirely if the activity taking place there disappears, although this is not very common (Forssell, 1992). It is not certain that all actors in the field define the field in the same way, for example the extent of the field and how it is structured. This is because there is no objective definition of an organisational field (ibid.); it is an analytical structure whose boundaries are determined by those observing the field (Sahlin-Andersson, 1996). However, there need not be any major difficulties in determining the limits for an organisation that already knows 'what it is doing, what its relevant external environment looks like, and what rules and norms apply, and who might take all this for granted' *[author's translation]* (Forssell, 1992:176). This was the case with the saving banks (ibid.).

Since the field has no defined boundaries and is constantly changing, the field should be considered as a frame of reference or a reference system in which ideas about the organisation spread and the structure and identity is determined (Sahlin-Andersson, 1996). DiMaggio and Powell (1983) argue that organisational fields only exist insofar as they are institutionally defined. Institutionalisation is described as a process termed structuration. This process entails an agreement among organisations that they have something in common (Johansson, 2002). A field consist of a system of relations, which develop between actors when they define issues that are common for them (Sahlin-Andersson, 1996). Within a field, organisations have different positions, those with a dominant position create reference points and models that other organisations use to compare themselves with, and which they aim to reach. The acts of organisations are, among other things, determined by the meanings and the identities that develop within the field. Sahlin-Andersson (1996), in accordance with Pierre Bourdieu, believes that a development of coherent patterns of acts and meanings exists without that individual actors consciously work to create this pattern and those similarities.

Organisations within institutionalised fields tend to become increasingly similar over time, a uniformity which is called isomorphism. Three forces driving the process of institutional isomorphism that are often distinguished are coercive, mimetic and normative isomorphism (DiMaggio and Powell, 1983). Uniformity means that the work of organisations will be organised in much the same way, similar procedures will be established and they will present themselves outwardly in a similar way (Holmblad Brunsson, 2002). There are many actors that influence and create the institutions of society, for example the education system, research and management consultants, but the state is probably one of the most powerful creators (Stern, 1999, see also Meyer, 1977). Regarding evidence-based practice within social work, Bergmark, Bergmark and Lundström (2011) and Oscarsson (2009) regard the state, and not the profession, as is a very important actor for the introduction of evidence-based practice and for what evidence-based practice is considered to be.

Organisations are rewarded and become successful, when they are similar to other organisations in the field. The rewards of uniformity are for instance that transactions

will be easier to perform; it becomes easier to recruit and employ staff, and obtain contracts and receive funding. This enables organisations to become more effective and achieve legitimacy (DiMaggio and Powell 1983; Eriksson-Zetterquist 2009). One example is that the performance-based financial support that social services can take part of is linked to specific tasks determined by the state, and that have to be performed. The three driving forces mentioned above represent, as is the case of the organisational field, analytic constructions that cannot be easily distinguished. In practice they overlap and merge into one another (Stern, 1999). There is however one major difference between mimetic isomorphism and the coercive and normative forms of isomorphism. This difference being that with mimetic isomorphism the uniformity comes from within the organisation rather than from the outside as is the case with the other two forms (Blom, 2006).

Coercive isomorphism is a process where rules decide how an organisation's activities should be conducted, dictates that organisations *must* follow. This includes both formal and informal requirements that dominant organisations within a field place on weaker organisations. At the same time the weaker organisations are dependent on organisations that have a more dominant position (DiMaggio and Powell 1983: see also Johansson 2002). Blom (2006:181) explains that this form of isomorphism primarily involves 'political influence and a legitimacy problem towards the rest of the field' *[author's translation].* Political pressures and the decisions taken by parliament and government, by legislation (or regulations, ordinances or guidelines), are handed to organisations within a field. There may also be cultural expectations in a society that results in organisations that act in similar ways (Blom, 2006; Eriksson-Zetterquist, 2009).

Rules established at the state level are very important for the structural uniformity of organisations, as they apply to several or all organisations within a field (Stern, 1999). Stern (1999) refers to Nils Brunsson's work and writes that legislation affects the framework which organisations can act within and also affect the character of the economy and politics in the society. The state can also influence the direction of organisations activities by providing resources for organisations to covet (Johansson, 2002), for example in the form of project funding, stimulation funds or remuneration based on performance.

Normative isomorphism has its origin in professionalism and the tendency that organisations increasingly employ staff with professional educations. The specific training and knowledge acquired during education engenders the uniformity of particular professions, people learn how work should be conducted within a certain area (DiMaggio and Powell, 1983). People within the same profession, with the same education, tend to organise themselves in professional and trade associations that define and declare normative rules about professional and organisational behaviour (Powell and DiMaggio, 1983). For example, doctors gain legitimacy through their profession, and this also contribute to uniformity in doctors' work (Holmblad Brunsson, 2002). Networks created by professionals during the education help maintained this similarity. New ideas and new information are disseminated within these networks and are incorporated into the organisation in a relatively similar way (DiMaggio and Powell, 1983, see also

Johansson, 2002). This occurs both within and between organisations, and thus contributes to normative isomorphism (Blom, 2006).

Organisations that organise their activity in a manner consistent with the expectations that various professions and occupations have are considered attractive and legitimate. When the work is organised similarly, whichever organisation is concerned, it will also be easier for employees to change work (Holmblad Brunsson, 2002). BBIC, which has been introduced in most of the municipalities in Sweden, is one example of a national initiative that involves a normative isomorphism. Among other things, BBIC entails that work with investigations can be conducted across social services and between different social workers in a more uniform manner.

Mimetic isomorphism creates uniformity within a field when organisations imitate each other. The driving force here is uncertainty, since uncertainty encourages imitation and imitation can be a way for organisations to gain legitimacy and success (DiMaggio and Powell, 1983). This occurs when 'organisational technologies are unclear, when the goals are ambiguous' *[author's translation]* (Blom, 2006:182). It is natural for organisations within an organisational field to imitate organisations in the field which are perceived to be successful. Organisations can feel uncertain about the effect of the work activities they carry out, and in such cases it may be a comfort to continue working in a certain way – as everyone else does. In this way, the organisation can show others what activities they have (Holmblad Brunsson, 2002). Stern (1999:85) emphasises that: 'Successful organisations influence our perceptions; they become models or templates that spread both directly through consulting firms and industry associations and indirectly through redeployment of personnel' *[author's translation]*. Organisations save both time and resources, they adopt a practical solution without too high costs, and the mistakes made by others can be avoided (Eriksson-Zetterquist, 2009).

Stern (1999) gives two examples of mimetic isomorphism. One example relates to the growing interest in quality aspects of the work, including the ISO certification. The second example, also described by Blom (2006), is the purchaser- and provider model, which is an influence from the way work is organised in the private sector. This way of working changed large parts of the Swedish public sector from the late 1980s. It is presumed that these reforms would result in greater efficiency and lower costs. This is uniformity (an isomorphism) where an organisational field imitates models available in the surroundings. The importance of organisations using rationalised myths become obvious in the example with the purchaser- and provider model (ibid.), when it was presented as something desirable that organisations need and want. Sahlin-Andersson (1996) also explains that organisations in the public sector take after and compare themselves with private organisations which are usually regarded as more successful.

The translation process

One research area within new institutional theory is that ideas are travelling; they circulate and become edited (Sahlin and Wedlin, 2008). The concept of translation is used to understand how ideas are spread and received by actors in organisations. It is a

concept used by the sociologists Bruno Latour and Michel Callon (Johansson, 2002) that, according to Czarniawska and Joerges (1996:24), is useful because it:

> Comprises what exists and what is created; the relationship between humans and ideas, ideas and objects, and human and objects – all needed in order to understand what … we call "organizational change".

Research using the concept idea within new institutionalism, which can be models, practices, and new regulations as standards, guidelines or templates (Sahlin and Wedlin, 2008). Because the concept idea is used by researchers referred to in this and other sections of this thesis I have chosen to keep that concept when referring to them. This thesis is about the organising of evidence-based practice within social work, how this develops from evidence-based medicine, and how evidence-based practice is introduced within the work of social services. Therefore, I believe that a theoretical understanding for how ideas are circulating is useful.

Through the concept of translation, the spread of ideas about organising work can be understood as an on-going process. It is seldom that ideas spread without any change. Instead, they are picked up, translated and altered on the basis of the organisation's local conditions and circumstances (Sevón, 1996). Travelling is a metaphor used to illuminate that it is about an active process, where these ideas are carried from one place to another (Sahlin and Wedlin, 2008).

There is a tendency for organisations to become more similar to each other over time, which the three forms of homogenisation demonstrate. However, ideas do not spread automatically, by diffusion; instead they are changed by people in organisations (Sahlin-Andersson, 1996). In every organisation there are acting and thinking individuals and all changes in organisations depends on people (ibid.). Barley and Tolbert (1997) argue that the agent's perspective needs to be clearer when institutional processes are studied. Both the organisations and the individuals can consciously alter or reproduce institutions (ibid.). There are examples of reforms (and other changes in organisations) that are not introduced in the same way in all of the organisations that introduce them. Instead, they are changed and translated in different ways (Blomquist, 1996). When the introduction of reforms is understood as a translation it is possible to explain that there is an 'active and multifaceted character in the reform processes under study' *[author's translation]* (ibid:183). Thus, one can explain why reforms and new organisational models, such as evidence-based practice or cooperation, are not introduced in all organisations despite an intention to do so, and it explains why not all changes will be as successful as they were intended to be.

Using Anthony Giddens concepts of disembedding and reembedding, Czarniawska and Joerges (1996), and also Sahlin-Andersson (1996), explain how ideas travel as a process which follows a certain pattern. Giddens (1990) analyses the disembedding of social systems, which means that social relations are lifted from their local context of interaction and are structured anew in various contexts, independent of time and space (ibid.). The idea that is spread becomes decoupled from time and space (Czarniawska and Joerges, 1996). It is only in an objective form that the idea can leave the local context by 'entering translocal paths' and becomes thus disembedded, which means being de-

contextualised (ibid:23). For it to be possible to travel it has to become an object, for example a text or a picture. When ideas reach different places, they are adopted by local actors, and abstract features are adapted to local circumstances. This is a re-embedding that is taking place (ibid.). Reembedding explains, according to Giddens (1990), how disembedded social relations are reallocated to local contexts, but differs somewhat depending on local conditions. The spread of evidence-based medicine to evidencebased practice can be interpreted as a translation process where the original idea, as a decontextualised idea, has travelled to areas such as social work, education and the probation service. Evidence-based medicine becomes reembedded in the local context, as evidence-based practice. For example, when looking upon evidence-based practice from a distance it appears to be easily transferred to other areas than medicine, but when examining it more closely it becomes apparent that this is not the case (Bohlin and Sager, 2011).

The translation process, where ideas are transformed as they move between different actors, can be likened to a chain in which no link is more important than any of the other links and all links will in some way alter the original idea (Sevón, 1996). Therefore it is not possible to determine where the process starts or where it ends. Organisations usually imitate only certain features from other organisations, it is not a whole pattern that is imitated but parts, both their own experience and that of others are used. The ideas are modified to suit the specific conditions of the organisation. Within social work there are advocates of a wide perspective of evidence-based practice (cf. Oscarsson, 2009). There are difficulties to performing research conducted via random controlled trials and there is a lack of meta-analysis, which, according to evidence hierarchies, is regarded as the most reliable methods to conduct research. Random controlled trials are more often used within the medical field. Oscarsson (2009) explains that difficulties in relation to the complexity in social work entail a need for also using other sources of knowledge in practical social work. Those sources are the user and the practitioner, the professional. Oscarsson (2009) also advocates the use of studies with single-case design when random controlled trials are difficult to perform.

As described in the case with social work, the result of the imitation will differ somewhat between different organisations. What is introduced will not be the same as the original idea, nor is the result the same in all organisations. The results will vary between actors and change over time and space (Sevón, 1996). According to Giddens, the disembedded mechanisms interact 'with reembedded contexts of action, which may act either to support or to undermine them' (ibid:80). One consequence for this adapting to local conditions and contexts is that organisations not only strive to be like each other but they also strive to perceive themselves as special, as differentiate from other organisations. Through the process of translation organisational fields become both heterogeneous and homogenous (Sevón, 1996).

With this approach, people (the receivers) are placed in focus because ideas will not be disseminated without their active involvement: 'The receivers are not just transporters, but also transformers (and thus innovators) of ideas' *[author's translation]* (Johansson, 2006:30). As Trinder (2000a) points out with reference to the spread of evidence-based practice to other areas; the receiving of evidence-based practice become more similar the closer the area is to the original area of the acute, specialist medicine. The actors

have therefore a great impact on how the ideas spread in their own organisation and how they spread to other organisations. The driving force of imitation comes thus from the organisation, ideas are not something that are forced on organisations. Instead, which ideas are adopted, where the starting point is, how the situation is perceived and their own as well as others' identity are dependent on the actors, the people in an organisation (Sevón 1996; see also Eriksson-Zetterquist 2009).

The translation process is very similar to the process in which organisations construct an identity; comparison between themselves and other organisations are made and those parts of organisations they desire are imitated (Sevón, 1996). The identity is regarded as a social construction that occurs through a continuous process of negotiation between an organisation and other actors in the surrounding environment (Sevón 1996; Johansson 2006); it is in the interaction with other organisations in an organisational field that an organisational identity is developed and maintained (Svensson, Johnsson and Laanemets 2008). As already explained, one can consider organisational fields as a common frame of reference and, as the term frame of reference refers to, organisational fields can be understood as the social contexts in which organisations within certain boundaries create their identity. The identity will therefore change in relation to changes in organisational fields, as organisations go in and out of the organisational field. Boundaries will be moved, changed, disappear and arise (Johansson, 2006). When evidence-based practice is introduced social workers will probably alter their professional identities.

The continuation of the translation process in organisations

The process of imitation and of the creation of identity can be explained on the basis of the concept of the 'logic of appropriateness' (Sevón, 1996:52). What are appropriate acts are determined when the organisation compares itself with other organisations; such as when social work compares themselves with the medical field. Sevón (1996:53) describes a model for imitation, based on the main features of the logic of appropriateness. The model comprises three elements: '(1) matching of identifications and situations, (2) construction of desire to transform, and (3) institutionalized action.' Organisations, usually its management, begin to ask questions about who they are. To find out whom they are and who they are similar to, they compare themselves with other organisations that serve as role models. Often this involves a comparison with more successful organisations and with organisations that have a good reputation. In this comparison a desire for change emerges, when the organisation that they compare themselves with has something to pursue. To become more like other organisations, they look for suitable ways to act. By comparing itself with others, the organisation will identify itself and others, and also how it is possible to become as the organisation wants to be.

Sahlin-Andersson (1996) focuses on editing in the translation process, where editing explains how translation continues. Editing is the process in which ideas are introduced into new environments, where they are adapted, created and re-created in the local context (ibid; Sahlin and Wedlin, 2008). Editing begins when an idea has been imitated, when organisations have compared themselves with other organisations that are perceived, in any respect, to be the same, or that have traits that seem to make them successful. The process of change is problem-based, which means that a problem an

organisation has is defined when they compare themselves with other organisations. The defined problem is: 'the difference between a desired state and a present state' (ibid:71), that is, something that the organisation is missing but which it seeks. This also helps to create the organisation's identity. Since it is possible to edit ideas, spaces to act are created, and the actors can choose which parts shall be imitated and which parts shall be omitted (ibid.). However the process of translation and editing might be regarded as open-ended and creative. But Sahlin and Wedlin (2008:225) argue, with reference to earlier research, that 'processes of translation … rather characterized by social control, conformism and traditionalism – thus following rule-like patterns' which both restrict and direct this process. Ideas translated may also be influenced and changed by 'its supporting ideology', whereas new public management and other management ideas are typical examples (ibid:227).

What organisations imitate is in most cases the ideas, practices and working models that are considered successful and thereby worth pursuing. It can be about ideas which the public sector, social services and health care, regard as successful. These ideas are often retrieved from the private sector; they may be about economic governance, cost effectiveness, customer orientation, independent profit centres and the purchaser and provider model (cf. Blomquist 1996; Jacobsson 2002; Lind 2002). Fernler (2002) conducted an empirical study and interviewed people from three municipalities about the introduction of the purchaser and provider model, and what space the local conditions were given when introducing the model. The purchaser and provider model was introduced in the three municipalities in different ways. A criticism in one of the municipalities was that the municipal management did not consider the activities situation and needs before the introduction. This, it was argued, was because the municipality's 'leading politicians and officials had devoted an unusual amount of time to developing their model, which created a strong tethering around the model's ideology' *[author's translation]* (Fernler, 2002:116). This also made it difficult to change. In the other municipality, called 'fashion follower', the purchaser-provider model became to a large extent adapted to the local condition. This local adaption of the model was reinforced by a consultant that had been involved in the introduction. The third municipality had officially declined to introduce 'general models' *[author's translation]*, but introduced it eventually anyway (ibid:117).

The distance between how people who imitate assume that it is in the organisation that is being imitated and how it actually is in the imitated organisation creates a space for translation (Sahlin-Andersson, 1996). What is imitated, such as working models or practices, can therefore be interpreted and complemented in various ways by the imitating organisation. What often attract attention are successes. Failures are barely mentioned. This characterizes developments in the social services. Sahlin-Andersson (1996) explains that in her previous research she concluded; changes that are introduced in one place often serve as a role model and are easy to imitate and implement in any organisation. Moreover, it is far from always that the imitating organisation has its own experience of the organisations or practices they refer to and wish to imitate. What happens is that they imitate rationalisations instead, which is:

> [S]tories constructed by actors in the 'exemplary' organization, and their own translations of such stories. What spreads are not experiences or

> practices per se, but standardized models and presentations of such practices. (Ibid:78)

One example given is when a so-called science park was planned south of Stockholm. Those who planned the science park were referring to Silicon Valley as a successful example. The planners were not really imitating Silicon Valley, but they imitated the (success) story about Silicon Valley. The editing process involves the story about an idea or a model being told and retold differently each time in each situation, which means that the result is one of several forms of translation (ibid.).

In such stories, it is seldom that one deals with specific situations or spatial characteristic. What is created is a context free role model that can serve as examples for numerous organisations and situations, which also applies to evidence-based practice. Those who serve as editors of the ideas and models, the success stories, can be, for example, scientists, professionals, managers, consultants or people that work with planning in organisation. In the same example given about Silicon Valley it is evident that it was primarily consultants who formulated the stories about Silicon Valley, and that they emphasised some aspects of the story and left out others. These are described as 'stories that took the form of recipies [sic], with a set of necessary ingredients, that it was possible to copy elsewhere' (Sahlin-Andersson, 1996:83). The consultants related to the experience of others and to ideal models, and not to their own experience (ibid.).

Czarniawska and Joerges (1996) use the terms fashion and fashion followers, to explain why certain ideas will have an impact on the local level and undergo a translation process. This may explain why an idea will have an impact in several organisations at the same time. Røvik (1996) argues that there may be multiple fashions in an organisation, and the concept can explain that the different ideas, working methods and practices are becoming popular, embraced and after a while they will be replaced with others that the organisation finds more contemporary. A fashion has a greater attraction when dealing with a new idea, and when not so many organisations have embraced it, as is the case with evidence-based practice or BBIC. Taking on new ideas in an early stage creates success and is a way to get specific traits that distinguish one organisation from other organisations; they get their own identity. As the idea spreads, it will lose its attractiveness. When organisations embrace ideas at a late stage it is because the necessity to follow the fashion has shifted from a necessity to differentiate itself to a desire to be like others. At that stage it is all about imitation (Røvik, 1996).

Social construction of reality with focus on organisational change

In the following sections I have the intention to present three perspectives, all present in Berger and Luckmann's (1967) theory of social construction. These sections do not however provide a full description of the whole theory. The next section is about the importance of routines in work, in relation to social services work. In the section thereafter, attention is given to a need for legitimation of institutions, which according to Berger and Luckmann (1967) are used when an institutional order is transferred to

future generations. The last of these three sections deals with how knowledge and the spoken language are used in the reality of everyday life, and in my case within social services work. I want to point out that I have deliberately chosen to use several of Berger and Luckmann's concepts as they use them. Specific concepts are marked with quotation marks one time in the text, without reference to a page number, because they are used throughout in Berger and Luckmann's theory.

In 'The Social Construction of Reality' Berger and Luckmann (1967) describe how reality is constructed, and the processes through which social actions become institutionalised. The base in Berger and Luckmann's theory is that habits and routines ease people's lives, because it decreases the choices people have to make (Berger and Luckmann, 1967; see also Engdahl and Larsson, 2011). Berger and Luckmann (1967) write about how institutions arise, and use for this purpose the concepts 'habitualization' and 'typification'. These concepts are used to explain that actions are performed after a given pattern and that these actions are collected and classified to specific patterns for actions and for actors. Two other key terms are reality and knowledge. Reality is understood 'as a quality appertaining to phenomena that we recognize as having a being independent of our own volition ("we cannot wish them away")', and knowledge is understood 'as the certainty that phenomena are real and that they possess specific characteristics' (ibid:1). What is reality and what is knowledge for different people depends on the specific context. This means that what is taken for granted in different societies differs (ibid.).

Their theory is also useful, I believe, when analysing organisational changes within, in my case, the work of social services. If new institutional theory emphasises how ways of organising work, as evidence-based practice, spreads to organisations, the theory of social construction explains what takes place in the interaction between social workers when new ways of working are introduced. It is important to study the process of when knowledge is developed, transmitted and maintained in social situations. Studying how social work is conducted on a daily basis is essential to understanding how evidence-based practice is introduced at a local level.

The importance of routines in work

Berger and Luckmann (1967) use the concepts 'typification' and 'habitualization' to understand how institutions arise. Human actions are incorporated into patterns which mean that actions can be performed in ways that are experienced; the actions become habitual, making life easier for the individual. The number of alternative ways of acting decrease and the individual does not have to bear the burden of all the decisions that are possible to make. Since the possibility of choosing is reduced the individual gains 'psychological relief' (ibid:53) and can focus on other things. This creates a stable background and individuals can act without having to make too many decisions. Habitualization means that not every situation must be redefined every time that a situation arises. A better option is to use so-called 'predefinitions'. With these predefinitions as a starting point the individual can anticipate what action(s) to take, in the situations that arise (ibid.).

Typification is about 'sorting or classifying patterns for actions and actors' (Eriksson-Zetterquist, 2009:16). Actions are carried out according to a particular 'pattern of conduct' (Berger and Luckmann, 1967:55). The institutionalisation occurs when mutual typifications of habitual actions are emerging between people. An institution presupposes 'that actions of type X will be performed by actors of type X' (ibid:54). It is thus both individual actors and individual acts that are typified. Rather than that the individual must choose among all theoretically possible actions, institutions offer predefined patterns of actions which steer actions in a certain direction. An advantage of this is that it is possible to predict how others will act. The interaction becomes predictable, saving time and effort for the individuals (ibid.). From this point of view predefinitions are also a precondition for how to handle the constant stream of meeting people we do not know (Engdahl and Larsson, 2011). The predefinitions tell how we and others are expected to act, because the interaction follows this pattern (ibid.).

Outside of everyday life, working life is one area where typifications and habitualization occurs (Berger and Luckmann, 1967). Eriksson-Zetterquist (2009) explains that in working life, one does not need to consider which way of many ways one should start the working day. Instead one can simply do as one did the day before and the day before. According to Eriksson-Zetterquist (2009), this is an example of what Berger and Luckmann refer to as psychological relief. The situation is defined in advance; the action that is needed in the beginning of the workday is predictable and only a minimum of decisions time about how to act is needed. Instead, the time can be used to other tasks, which need the employee's time and attention (ibid.). The energy is thus available for decisions it may be necessary to make in special occasions.

Social work has undergone changes in recent decades, not least since evidence-based practice was launched as a concept in the first years of the 2000s. This involves breaking older habits and work practices which were largely founded on the knowledge and experience that each individual social worker has. Criticism directed at social work is that the knowledge base is not developed enough and that the foundation of social work is foremost experience in combination with legislation and the use of guidelines, and that there is too little knowledge about ways of working, working methods, and about the effects of interventions (cf. Socialstyrelsen, 2000; SOU 2008:18). This has resulted in agreements between the government and the municipalities, via the Swedish Association of Local Authorities and Regions, where evidence-based practice is a core theme. Although evidence-based practice does not represent a completely new way of working, it involves new tasks and a need to use other knowledge sources that are not part of the social workers habitual routines. Using research within social work is an area for improvement. The same applies to the increased importance that is linked to follow-up the activities and also to develop of systems for statistical data (SOU 2008:18).

When the actions become predictable, they can be carried out according to routines, which determine the life and actions of people (Berger and Luckmann, 1967). When common habits and routines are perceived to be self-evident they can be described as institutionalised (Engdahl and Larsson, 2011). Many actions can then be performed 'on a low level of attention' in the sense that the actions of one person do not pose a danger or threat to the other, as when work is performed as it usually has been performed (Berger and Luckmann, 1967:57). A background of routines is created, and these are

taken for granted, so to speak. This background of routines creates stability in actions and interaction as well as creates and enables a division of labour between people that interact. This provides opportunities for new innovations that may need to be performed at a higher level of attention, which should give opportunities to develop social work. However, the actions that become habitual and routinized must be relevant to people who interact (ibid.).

Reality in everyday life, as the social work is shaped, emerges for each individual (each social worker) as reality, which means that it is taken for granted, arises and is maintained through people's thoughts and actions (Berger and Luckmann, 1967). The language is central to the maintenance of everyday reality. The reality in everyday life is interpreted by individuals and also subjectively meaningful to individuals in a coherent world. Social work practice is formed by a continuous interaction where social work is very much perceived as real to social workers. The common world is not completely in line with how each individual perceive it. However, what is significant is that the individuals knows they are living together with others, in a shared world where there are 'ongoing correspondence' between how the world is perceived by the individuals, in this thesis the social workers and the other interviewed persons. This knowledge, which is shared with others in 'the normal, self-evident routines of everyday life' is termed commonsense knowledge (ibid:23). Commonsense knowledge is based on common sense and 'constitutes the fabric of meanings' (ibid:15), which means that individuals take everyday life for granted as their reality. This is important for the existence of a society (ibid).

Berger and Luckmann (1967) write that everyday life has habits and routines which facilitate the lives of the individuals. The number of choices people have to make is reduced when daily life is built on routines and habits. The decisions people have to make at work can, in this way, be saved for situations that arise and that is somehow crucial for individuals. Routines reduce the doubts that may exist about everyday life and as long as people live routinely every day without interruption, life is perceived to be without any problems (ibid.). Social workers', as well as the other interviewees, work is largely based on routines and habits, how the work is usually organised and conducted. The prevailing habits and routines will be broken when something new which changes the work is introduced, as evidence-based practice does. When evidence-based practice is introduced the habits and routines of social workers are disrupted. Instead of the work running according to the routines and habits used in their usual way of working without any problems, their commitment and energy will be used to shape a new way of working. What is characterising evidence-based practice is rather its link to evidence-based medicine and the similarity to positivism, in which certain methods give the most reliable and useful knowledge and explains how scientific knowledge can improve the practice (Grimen, 2009). It is not that social work did not develop before evidence-based practice was introduced.

Berger and Luckmann (1967) argue that when problems arise, individuals tend to integrate the sector of everyday life that is perceived as problematic in relation to what is perceived as problem free. What is problem free in relation to new ways of working, for example, depends on how work has been conducted before; to introduce evidence-based medicine in health care ought to run more smoothly than introducing evidence-

based practice within social work because there is more that is not coherent with the earlier way of working. According to the national documents I referred to earlier, social work cannot solely be based on social workers' own experience and knowledge (Socialstyrelsen, 2000; SOU 2008:18).

Commonsense knowledge is used to determine what can be integrated into the daily routines (Berger and Luckmann, 1967). And as long as the problems still belong to the everyday reality it is possible to incorporate the new knowledge into everyday life, and in doing so enrich everyday life reality. Therefore, it would be possible to introduce evidence-based practice in social work. The integration occurs through interaction between social workers and the surrounding society. The surrounding society is not only the municipality, it should also be considered in a national and international perspective (ibid.).

A need to legitimise

The subject of this section is the need to legitimise institutions, which according to Berger and Luckmann (1967) are used when an institutional order is conveyed to 'new generations'. Social interaction becomes institutionalised when ways of acting are transferred to others, and it is during this process that institutionalisation becomes complete. To understand an institution, one must also understand the historical process by which the institution was created; the institution is a product of a shared history. Hereby, objectivity arises as a feature, which means that the individual (usually a child) perceives institutions as having their own reality regardless of which 'individual that "happens to" embody them at that moment' (ibid:58). When the predefinitions are perceived to exist without that people reflect over them, for example when a way to act is perceived as obvious, then it has cognitive and normative legitimacy (Engdahl and Larsson, 2011). Generations that follow are socialised to accept the self-evident and natural character (ibid.).

The routines initially established between A and B, or parents with Berger and Luckmanns (1967) terms, have a tendency to live on, even if A and B have the option to alter or abolish them. However, when they are transferred to the next generation (the children) the routines are not as easy to change, not even for A and B. The world that the parents pass on to the children will not be as transparent, which means that children perceive their reality as inherited. The transfer to the next generation can only be done '*as* an objective world' (ibid:59).

Eriksson-Zetterquist (2009) gives an example from working life where new employees may have more difficulty to know how to act when meeting suppliers than those with more experience. This is probably not a problem for the more experienced employees who know how to act (ibid.). Although the objectivity of the institutional world may seem solid and appear to be real, this objectivity has been created by human beings. It is a dialectical relationship between the human and the social world, where there is an on-going interaction that creates a product that has repercussions for the people involved in creating it (Berger and Luckmann, 1967). The pattern for how to keep in contact with the supplier may easily be altered between more experienced employees

and suppliers (Eriksson-Zetterquist, 2009). For the newly employed it seems that the work has to be conducted in a specific way, which indicates that the institution has become more stable and less transparent (ibid.).

Legitimation is not necessary during the first step of 'institutionalization', when the institution is perceived as obvious for all and therefore does not require additional support (Berger and Luckmann, 1967). However, when the social world is transferred down through generations it becomes more and more solid, and must therefore become legitimised. New generation do not perceive the institutions as self-evident and knowledge of the original institutional history becomes hearsay and increasingly inaccessible. Sanctions are used to socialise new generations into the institutional order, which Berger and Luckmann (1967:62) explain like this:

> The institutions must and do claim authority over the individual, independently of the subjective meanings he may attach to any particular situation. The priority of the institutional definitions of situations must be consistently maintained over individual temptations at redefinition. … The more conduct is institutionalized, the more predictable and thus the more controlled it becomes. If socialization into the institutions has been effective, outright coercive measures can be applied economically and selectively.

The more conducts are taken for granted 'on the level of meaning', the fewer alternatives there will be for 'institutional programs', and the conduct will become more predictable and controlled (ibid:62). A person is controlled through the institutions coercive force and through control mechanisms which follow with institutions (Eriksson-Zetterquist, 2009). Legitimation has the function of making the primary 'objectivation' that becomes institutionalised (as described above) 'objectively available and subjectively plausible', or reasonable (Berger and Luckmann, 1967:92).

Legitimation means to explain and justify the institutional order. It has both normative and cognitive elements. Legitimation, Berger and Luckmann (1967:93) argue, '"explains" the institutional order by ascribing cognitive validity to its objectivated meanings'. The legitimation of institutions is a question of both knowledge and values, knowledge explains what things to do and values explain why things are as they are. Through knowledge the individual acquires an explanation about what is right and wrong action within a structure which is based on tradition, for example a kinship structure. Values justify an act and explain why an individual 'should' act in a certain way (ibid.). When routines for evidence-based medicine developed, the values and knowledge are more self-evident to the doctors than when the same values and knowledge transferred to other fields, such as evidence-based practice. Then it becomes less self-evident.

Over time there will be deviations from the way of acting that institutionalisation carries (Berger and Luckmann, 1967). This is because the meanings of actions decrease during transference. It is easier to deviate from what you have not been involved in shaping, that which has merely been transferred to you. Legitimation also involves preventing chaos, which Berger and Luckmann (1967:103) explain like this:

> The legitimation of the institutional order is also faced with the ongoing necessity of keeping chaos at bay. *All* social reality is precarious. *All* societies are constructions in the face of chaos.

One example of what happens when chaos occurs in a society is provided by Berger and Luckmann (1967:104). When President Kennedy was assassinated in 1963 it became clear why such events were at once followed by 'the most solemn reaffirmations of the continuing reality of the sheltering symbols'.

Four levels of legitimation

Berger and Luckmann (1967:94) distinguish between four different 'levels of legitimation', on a theoretical level. There are difficulties to distinguish these four levels of legitimation empirically, as they overlap one another. Separating them is only possible analytically. In this thesis, the third level of legitimation is most relevant.

The *first level* of legitimation is termed 'incipient legitimation' (Berger and Luckmann, 1967:94). Legitimation at this level provides the foundation or base for other theories. Knowledge is obvious and explanations are acquired by individuals through language and its vocabulary; they are 'so to speak, built into the vocabulary' (ibid:94). One must achieve this level of 'self-evident "knowledge"' to be incorporated with tradition. The example is provided about a child and how language legitimates a conduct; the child has learned the word cousin and will thereby accept and associate an appropriate way of behaving in relation to a cousin. This alone will legitimise the conduct toward the cousin. Legitimation on the *second level* consists of 'theoretical proposition' in a relatively undeveloped, or primitive, 'rudimentary' form. Here the individual acquires a basic knowledge. Different pragmatic 'explanatory schemes' linked to concrete actions which usually consist of '[p]roverbs, moral maxims and wise sayings … legends and folk tales' (Berger and Luckmann, 1967:94).

In the *third level* of legitimation Berger and Luckmann (1967) include more explicit theoretical approaches through which a 'body of knowledge' is differentiated, widened and deepened. The degree of legitimation increases with a deeper body of knowledge. Legitimation at this level provides a relatively extensive frame of knowledge in relation to the institutionalised conduct (in different sectors). The transfer of theories is done by specialised personnel, experts, because it involves complex and differentiated theories. This means that legitimation goes beyond pragmatic application and becomes to a greater extent a 'pure theory'. This provides legitimacy a certain degree of independence in relation to the legitimated institutions, and independent institutional processes may be created (ibid). Explanations are given a higher status through specialised personnel, experts, who uses theories and research and so on as legitimation.

Legitimating on a *fourth level* is at a cosmic level called 'symbolic universes' (Berger and Luckmann, 1967). This level provides explanations that give the whole society meaning. It is the most comprehensive of the four levels of legitimating. Through this level of legitimating 'the reflecting integration of discrete institutional processes reaches its ultimate fulfilment' (ibid:96). The symbolic universe becomes responsible for integrating independent institutional processes, which also implies that society is given a meaning. For instance, a political order gains legitimacy 'by reference to a cosmic order

of power and justice, and political roles are legitimated as representations of these cosmic principles' (ibid:103).

One should be aware that the institutional order is constantly threatened by realities that are meaningless; meaningless seen from the perspective of an institutional order. All legitimating and symbolic universes are thus human products, they have their origin in 'concrete individuals, and have no empirical status apart from these lives' (Berger and Luckmann, 1967:128).

Language and knowledge

This section contains how knowledge and the spoken language are used in the reality of everyday life, and within work. The relation between human and social reality is dialectic. Although humans create social reality it is perceived as an objective reality that affects the humans. To explain this dialectic interaction between human and social reality Berger and Luckmann (1967) use the terms externalisation, objectification and internalising. Blom (2006) gives a summary explanation of what Berger and Luckmann mean with these three terms. Externalisation means 'that the human's internalised social world is located outside the individual, through their actions' *[author's translation]* (ibid:184). Objectification entails a process where the externalised products from the human activity get an objective character. Internalisation is about that the objectified social world becomes incorporated in the individual's consciousness. In the internalisation different schemes are created for how humans should interpret and act in a situation (ibid.).

The language becomes important in this process (Berger and Luckmann, 1967). Everyday life is shared with other people, and the most significant experience of the others occurs when we meet them in so called 'face-to-face situations' (ibid.). Although Berger and Luckmann (1967) foremost associate this with the spoken language, Blom (2006:183) argues that these situations also comprise 'non-verbal aspects of social actions', like 'gestures, sound and symbols' *[author's translation]*.

In the study of the introduction of the purchaser and provider model, as has been referred to earlier in this chapter, Blom (2006) draw the conclusion that language was central in the process of institutionalisation and was influenced by this new model for organising work. Those working within individual and family service had to use another vocabulary which originated from the area of economy. Blom (2006:192) gives examples of words that were not used before the purchaser and provider model was introduced in the early 1990s, such as 'production, profit unit, purchaser, agreements, customers and profit' *[author's translation]*. The language is very important in the process of institutionalisation and Blom (2006:192) mean, in accordance with Berger and Luckmann, that 'the language forces people in to social patterns and gives therefore guidance how we shall interpret, feel and act in the social world'. The language creates changes at the same time as the changes are reflected in the language (ibid.) *[author's translation]*. The same changes, in what regards the language, should apply for social work and evidence-based practice.

Routines are essential for the institutionalisation, and every institutional order exists in typifications of people's actions (Blom, 2006). Typifications and 'typificatory schemes' used in the reality of everyday life, are important for an individual's interaction with others; they tell how an individual perceives and treats those people he or she meets in those face-to-face situations (Berger and Luckmann, 1967). The typificatory schemes, used by each individual, become joint in the meetings with others, through 'negotiations' that take place. These negotiations are most often arranged in advance. For example when a buyer and seller bargains about the price of a good, the interaction follows a specific pattern. The further away from face-to-face situations an individual is, the more anonymous these typifications become. The degree of anonymity also depends on how important a person is to the individual. One example given is about the newspaper vendor on the street corner which a person walked by every morning on the way to work, and that is still anonymous to that person (ibid.).

The reality of everyday life becomes possible only if expressions of feelings and thoughts are objectified, meaning it 'manifests itself in products of human activity that are available both to their producers and to other men as a common world' (Berger and Luckmann, 1967:34). This enables subjective processes to be experienced outside the direct face-to-face situations. It is only through these objectifications as reality of everyday life becomes possible. The language is central to maintain the reality of everyday life; it can more easily be freed from interaction face-to-face (ibid.). For example, you can talk about things that you have not experienced yourself or things that are not physically near. The language has according to Berger and Luckmann (1967:37) the ability to 'communicate meanings that are not direct expressions of subjectivity "here and now"'. Language becomes an 'objective repository' (ibid:37) of meaning and experience which can then be passed on to the next generation. Therefore, the language reaches beyond 'here and now' and can bridge and integrate different zones into a meaningful whole. These 'zones of meaning', or 'semantic fields' are built up by language and is thus linguistically limited. Such semantic fields can be formed in a profession, which Berger and Luckmann (1967:41) clarify:

> The sum of linguistic objectifiations pertaining to my occupation constitutes another semantic field, which meaningfully orders all the routine events I encounter in my daily work. Within the semantic fields thus built up it is possible for both biographical and historical experience to be objectified, retained and accumulated. The accumulation, of course, is selective, with the semantic fields determining what will be retained and what "forgotten" of the total experience of both the individual and the society.

A stock of knowledge is built up, through this accumulation of routine events, in semantic fields, which in turn can be transferred to coming generations. The knowledge is available to the individuals who know that they share this knowledge, or at least part of this knowledge, with others. In this way, an individual's interaction with others in the everyday life is 'constantly affected by our common participation in the available social stock of knowledge' (ibid:41). The social stock of knowledge also specifies knowledge about an individual's situation, and the borders, so that the individual can determine where other individuals are and how those can be properly handled (ibid.). The origin of the institutionalised order is typifications of performed actions

(Blom, 2006). Typifying is about naming or labelling the actions. We share a stock of linguistic typifications. Blom (2006:183f) explains that:

> Typifications of various forms of actions require that they have an objective meaning, which in turn require a linguistics objectification. That is, a vocabulary which can "catch" these forms of actions in linguistic categories. The language converts unordered experiences to a coherent order through putting words on the experiences. Thereby, one can summarise them in general categories for one self and others. *[Author's translation]*

A prominent place in the social stock of knowledge has, what Berger and Luckmann (1967) call 'recipe knowledge'. This knowledge is a practical knowledge applicable in routine actions. As long as there is no need for further knowledge, one only uses the necessary pragmatic knowledge. For example, an individual knows how to use a phone and what to do if it fails. However, the individual probably has not, and does not need knowledge on how phones are made. The same applies to the relation between humans. Large parts of the social stock of knowledge tell or give recipes on how individuals manages routine problems. As long as the problems that arise can be solved with this cookbook knowledge there is seldom any interest in or need for more knowledge than this pragmatic knowledge (ibid.).

The social stock of knowledge divides reality into different sectors based on how familiar we are with them (Berger and Luckmann, 1967). How detailed and complex information that the social stock of knowledge gives depends on whether it is about sectors of everyday life that are often used, or if it is more remote sectors. Those sectors that lie close to the individual include more complex and detailed information than sectors that are more distant. For example, knowledge that an individual has about his or her own work is more comprehensive and specific than the knowledge the individual has about other professions, where knowledge becomes more incomplete (ibid.).

The social stock of knowledge contributes with 'typificatory schemes' for all sorts of acts and experiences that are needed for an individual to be able to handle everyday life's most important routines (Berger and Luckmann, 1967). Knowledge of daily life structured by what is perceived relevant is termed 'relevance structures'. There are many typifications in everyday life and its routines, for what applies in different situations, and they tell us what a person should do when encountering different situations. Knowledge is valid until a problem arises that cannot be solved using existing knowledge. What is relevant knowledge depends on the individual's pragmatic interests and position in society at large. For example, if a person does not own any shares, there is hardly any relevance to that person whether the shares fall in value or not. Relevance structures overlap other relevance structures and it is important to have knowledge about the relevance structures of others (ibid.).

Furthermore, Berger and Luckmann (1967) point out that individuals encounter knowledge socially distributed in the everyday life, which means that the knowledge owned by an individual varies. The knowledge owned by an individual is not shared with all other people, sometimes maybe not with anyone else. Professional knowledge is probably shared with colleagues but maybe not be with the family, for example. This develops a need among individuals for knowledge and advice from experts, professional

advice, for example, is needed about how a disease should be treated and who the individual might turn to. In this sense individuals have an overall knowledge of how the social stock of knowledge is arranged (ibid.).

5

Doctors about evidence-based medicine

This chapter provides a description of doctors' work in relation to evidence-based medicine. With these interviews I want to examine how doctors' perceive that evidence-based medicine was introduced within the medical profession, how they use and relate to evidence-based medicine in the daily work, what problems and benefits there are with work according to evidence-based medicine, and in what way the county council supports this work. Evidence-based medicine has been a part of doctors' work for a longer time than evidence-based practice has been a part of social workers work. The aim of understanding how a professional group, such as the doctors, relates to evidence-based medicine is to provide a context for how evidence-based practice is introduced and used within social work. The interviews are conducted and primarily analysed through the lens of new institutional organisational theory, where organisations strive to become more similar through different normative, coercive and mimetic processes (DiMaggio and Powell, 1983). With these processes organisations strive for legitimacy (Meyer and Rowan, 1977; Stern, 1999; Blom, 2006).

The doctors, who are men, have been practicing for at least 20 years and are specialised in general medicine, psychiatry and internal medicine. They thus represent three different disciplines, or fields, where primary care and psychiatry are more closely connected to social work than the specialist's work. One of them explains that compared with health care, social services work is 'if one can use the expression, software'[v] but that primary care, where he works:

> … is the part of the health care system that is closest to social services in the fact that it is complex and psychosocial and so on. So it is there that I can sometimes feel that I belong, that sometimes the social services understand my concerns better than the specialist [at the hospital].[vi]

This means that he and the psychiatrist work within areas that are more closely related to social services than specialist healthcare is, in the sense that primary care and psychiatry often meet individuals with complex needs and several diagnoses, which may make it difficult to work evidence-based. The interviewees give examples of this. One doctor represents specialist health care. This part of health care is often described as being the easiest to adapt and work according to evidence-based medicine, because it is easier to study and evidence-base more demarcated areas than within those areas where the other doctors work (cf. Trinder, 2000a). Although representing different medical fields,

the doctors stories conform when they, for example, talk about how they use and approach evidence-based medicine.

They all work both as doctors and meet patients, and with other tasks within the county council. One of them has been a physician executive for a clinic for ten years. Another of them is a chief physician with partial patient responsibility and he also works in the county council with medical practices within the county. The third doctor is a senior physician of a specialist department in the county council, and is also working part of the time at a university, with the development of an academic environment for medical training and research. The doctors stress the importance of keeping the clinical work alive, even when they have other duties.

The psychiatrist represents a local level and describes evidence-based medicine in relation to the practical work in the local context where he works. In this clinic they focus on motivation and enhancing individual's social skills and situation, and cooperation with municipal social services is a part of the clinic's responsibility. The doctor from primary care describes evidence-based medicine from a local perspective in primary care, but explains the work done at the regional level in the county council in relation to knowledge management within health care. He points out that knowledge management is a concept used extensively today within county councils in Sweden. The specialist doctor has been engaged in the development of evidence-based medicine nationally, in national projects, and he has to some extent also worked in organisations at the national level in conjunction with the development of evidence-based practice in social work. He has therefore a national perspective on evidence-based medicine and evidence-based practice in social work.

When these three doctors describe evidence-based medicine they do it thus from different vantage points. They represent different fields within the health care system, and also different levels of the work in relation to evidence-based medicine, which are the national, regional and local level. These different levels will provide a foundation in the following sections in this chapter. While there are these differences in the doctors' responsibilities and work, there are also many similarities in their answers, for example how they approach evidence-based medicine.

Development of evidence-based medicine

Evidence-based medicine began to spread in the medical field in the mid-1990s. According to the doctor with national experience of introducing evidence-based medicine, it had a secure foothold in Sweden a decade later:

> It was launched internationally in the 1980s, slowly at first, systematic reviews and Cochrane. The term was coined by Gordon Guyatt and the group around him who began a series of articles in JAMA, sometime at the beginning of the 90s, under the working name Evidence-Based Medicine Working Group, who, I would say, was really the essence of what was then spread, primarily by SBU[11]. Through sending people out, having lectures and seminars, and involving very central decision-makers in Swe-

[11] Swedish Council on Health Technology Assessment

> dish health care in discussing the issue of evidence-based medicine. And it was there, when I got published in the medical journal, that the time was ripe to try to get it out even wider, and the articles in the medical journal slotted in very nicely into the development phase.[vii]

This is also when the other two doctors first come in contact with the concept of evidence-based medicine. The doctor from primary care first heard about it in the newly founded Swedish Council on Health Technology Assessment (SBU). He explains that 'the modern concept of evidence-based medicine came during, if I remember correctly, the end of the 1980s and beginning of the 1990s'[viii] and that the county council selected representatives to establish national guidelines. The psychiatrist's understanding is that the evidence concept began to emerge about ten years ago; which is early 2000. This is around the time the doctor with national experience points out as when its popularity began to grow within Swedish health care.

The launch of evidence-based medicine amid doctors was a few years before the launch of evidence-based practice within social services (cf. Trinder, 2000a; Svanevie, 2011). But even though evidence-based medicine and practice were launched in both areas within a few years, the natural science view on knowledge has been a part of doctors' work for a long time: 'One might say that [evidence-based medicine] has been around forever, but the actual concept seems to have emerged more recently.'[ix] Earlier the work of doctors was more about science and proven experience:

> Evidence-based has of course existed as a less used expression, but then one spoke more about science and proven experience, and that you as a doctor should act accordingly. So, and I see it as the primitive version of it, before evidence-based medicine we used that expression, and it is in the doctors oath and everything.[x]

One of the doctors also gives examples of how it was when he was studying to be a doctor, that back then one did not call it evidence. Science was nonetheless an important part of the education, one discussed 'what confidence interval there is and … how safe it is to use it'[xi] and 'above all natural science but even humanities'[xii] were a part of the basic education. Other concepts such as effectivity were also used and 'at the beginning a lot of attention was given to statistics and research method'[xiii].

Today evidence is more widely used, or 'at least it spread more and one participates in meetings and share, increase the level of knowledge'[xiv]. The work practice has been changed by evidence-based practice:

> Before it was proven experience that mattered: generally. And local traditions were very important. [Here] there was a long tradition [of psychiatric care]. One knew roughly what one should do, and, for the better and worse naturally. There were of course a few things that were good with [the mental hospitals] as well.[xv]

Even if the medical profession is founded on natural science there has been a shift from the founding of the past on proven experience toward a founding more on evidence. One example is given by the psychiatrist when he describes a treatment – lobotomy – that is no longer used:

> A rather good example of this, how it can become, was a method of treatment that we shy away from these days, and that was lobotomy. That was quite commonly used, and even in Sweden, but we do not talk about it that much. It was really a craze that started and one seemed to see progress at some patient groups, but no good follow-ups were done. One did not see, for example, that there were many that died, until later. And that was bad evidence on the treatment, but there are tens and thousands that have been lobotomised. So that is a typical example.[xvi]

Another example, given by the primary care doctor, is the use of Neurosedyn (Thalidomide) in the early 1960s, which gave severe birth defects and deformed children.

The development of evidence-based medicine has nonetheless not been without disputes. In the debate that existed when SBU was established in 1987, as the first national organisations in the world for Health Technology Assessments (HTA), and evidence-based medicine was launched, there was

> a view that now everything can become science, now everything shall be according to EBM [evidence-based medicine], and that which there is no evidence for, that we shall not get involved in. And, then there was the other pole that said, yes, but that is so little, most of what we do is not EBM.[xvii]

This debate was founded in '… some kind of naïve belief that what is not evidence-based, that we should not do. But, I perceive it has been more, very strict organ specialists that have patients with one illness'[xviii]. Also the doctor with national experience recognises that how evidence-based medicine is portrayed has changed. This quotation begins with the controversy that existed back then, when evidence-based medicine was introduced, between those that were for and those that were against evidence-based medicine. Those who were against evidence-based medicine argued that it was in favour of the specialists:

> From the beginning it was mostly about statistics and research methods, and was widely understood as an exercise for researchers such as epidemiologists and others a long way from clinical everyday work and without contact with the clinical everyday work. There were often discussion about, here you can sit in your academic ivory tower and say that we shall do this or that, or that we shall not do anything, because there is no evidence. But we out here must act.[xix]

He continues to describe that this was largely an international debate that was going on, yet without the same strength in Sweden as in many other countries:

> And there were quite a few hot conflicts raging during the 90s in journals, primarily the British Journal and Lancet and JAMA, which were maybe some of the central journals. And it was very much an Anglo-Saxon discussion, and to some extent even then in Sweden, but in a little lower tone. … It was never so filled with conflicts, maybe typical Swedish. One did not go out in the same way as those that represented EBM, with the same, I shall say, a little square approach that one had done abroad. Today it is more that everyone thinks that, well but it is of course clear that we shall take our decisions on the basis of available knowledge; it is completely obvious of course. No one would question it today. But there

> were many questions back then about, but my clinical experience does that not count for anything, I have treated five patients and I *know* how it is. And we said, yes but oh my god there are studies that treat a thousand patients that show definitely the exact opposite to your limited experience.[xx]

Both these doctors express that these positions have equalised and today one has reached something of a consensus about what evidence-based medicine is and how it ought to be used. One of them explains that 'the conflicts have, like, successively solved themselves'[xxi] and the other explains it like this:

> And today I think it has landed in a sensible discussion where we, through national guidelines and SBU reports[12] and such, examines the evidence and draw it out and then one tries to get an arranged introduction and a discussion about priorities throughout the county council. So that, today I think that in Sweden there is a reasonably sound and rational view of what evidence-based medicine is. And one sees it as a necessary compliment, but as also about having routines for how one shall receive it in a county council, how one shall cope with it in relation to what we do today and other evidence areas, and areas that there is little evidence for but where we still must in any case act.[xxii]

This is apparent in the description given by them all of what, and how, they do in their daily work as doctors. Even though there continues to exist critique of evidence-based medicine in relation to doctors' discretion, and to which extent doctor's experience has meaning, there is no longer a big discussions about whether doctors work ought to be based in evidence-based medicine or not:

> Clearly today nobody would, what shall we say, publicly go into polemics with the statement that health care shall be carried out on the best scientific ground. Then in private they can have opinions about that it can be managed too hard, for example. That nobody gives consideration to their own experience and such. That, we still meet.[xxiii]

The understanding of evidence-based medicine is that it should be a base of the work or to be used in most cases but that there will always be exceptions. Today it is more accepted to work according to evidence-based medicine but at the same time there will always be cases that demand compromises:

> It has become more accepted, that *at large*, we should treat high blood pressure like this, but of course there will always be exceptions that I, on the basis of that I know my patient very well, local conditions and such, mean that I will be able to deviate. But I cannot deviate all the time. I cannot simply go against for all patients. Then I must be able to argue very well for my cause. And there is a difference, I think.[xxiv]

When doctors deviate from the available research they must be able to motivate the choice for doing so; it requires critical reflection by doctors in relation to why they do or do not act in a certain way.

[12] Reports from Swedish Council on Health Technology Assessment.

When these doctors speak about what they do in relation to clinical work today, they all describe their work in the same way. Evidence-based medicine is a starting point but there are exceptions that prevent them from always following precisely what the research says, or there is no research to turn to, especially within the area of primary care and to some extent within psychiatry. Nonetheless, they do not considered this way of working as problematic. For example, one of the doctors explains that evidence-based medicine is not questioned today, not the concept or its application but that the dispersion of evidence-based practice in the organisation is a more current issue:

> The thing that can possibly be debated is how can full penetrating force be achieved? How can it be quicker from when there is evidence for something, to that the district doctor in [a small rural municipality] knows about it?[xxv]

This is about the dispersion and introduction of evidence-based medicine at an organisational level and not how doctors' apply evidence-based medicine in practice. This is described more closely in the section *A system and structure for evidence-based medicine*.

National launch of evidence-based medicine

The Swedish Council of Health Technology Assessment (SBU) is a state organisation that was created in the year 1987 as a tool to manage health care. They work with Health Technology Assessments (HTA). In general, SBU's early work with evidence-based medicine was described as a top-down process, but leading experts in the country within selected areas were consulted at a later stage. Those consulted became ambassadors for introducing evidence-based medicine. Their task was to produce documents about evidence-based medicine that could be circulated within Swedish health care. The experts engaged by the SBU were successful doctors, clinicians *and* researchers that still worked in part with clinical activities. This is described as an effective way to reach out with the message about evidence-based medicine, to doctors. Here one doctor explains about the need to be able to govern health care that the national actors have:

> SBU started at the end of the 1980s, following patterns from the USA, really the first outside the USA that began with evaluation of medical methods, from the Government authorities. … [T]here was dissatisfaction, one realised that we could not govern health care, in so far that doctors did as they wanted, the dentists, the nurses did as they wanted, certainly social services too, and what they had heard at the latest lecture, what an influential person [said]. There were a lot of eminence-based activities. And to be able to come, get a tool, said the Government authorities then, that we need to have an authority that has as a job to look carefully at, what we really do know about the best way to treat. And then one selected national diseases, a lot, especially in the beginning. It was back ache, it was high blood-pressure, it was stroke and other such things.[xxvi]

The doctors mean that SBU, with the published SBU reports, is an important organisation for the introduction of evidence-based medicine. The doctors also describe the importance of organisations such as the Swedish Association of Local Authorities and Regions (SALAR) and Cochrane Collaboration, for evidence-based medicine, as well

as the National Board of Health and Welfare's national guidelines. In addition there is 'a mass of research and a mass of reports and so, which do not carry the weight needed to become a national guideline or a SBU report but which is evidence-based, that is important to keep track of'[xxvii]. The SBU were the first organisation created in Sweden to work with evidence-based medicine and the National Board of Health and Welfare's guidelines provide a concrete contribution to evidence-based medicine. As one doctor explains, SBU paved the way for evidence-based medicine but the designing of national guidelines that are evidence-based was 'definitely the next stage'[xxviii], as they also weighed in health economics and priorities and could in this way also provide recommendations for clinicians'.

The difference between the guidelines from the National Board of Health and Welfare's and SBU's work with HTA is that:

> The SBU reports stop at saying, this we *know*, that this or that works or does not work. But from there, to saying what we shall do is a much longer process, as EBM had not understood when one started giving priorities. Considerations in relation to health economics are really, much more difficult than evaluating ordinary science and effects. So it was a big step forward. … In a way, the guidelines became the end product, the most palpable right now.[xxix]

Assessments and priorities that organisations make, for example which treatments a doctor shall give patients, helps doctors' work according to evidence-based medicine. It is not always the most expensive treatment that is the best way from the perspective of health economics. The Dental and Pharmaceutical Benefits Agency's (TLV) working methods are also founded in evidence-based medicine. TLV is a relatively important organisation because it approves and sets the price of the pharmaceuticals, and that they are allowed to be sold. Therefore, TLV is, as one doctor puts it, 'an extremely powerful factor in Swedish health care, not just an economic power factor'[xxx]. The same doctor also explains that the SALAR does some work centrally with evidence-based medicine but they 'try to work with it a little clumsily but they have no real organisation for knowledge issues, in that way'[xxxi].

The doctor with the national experience of the introduction of evidence-based medicine explains that SBU have had an important responsibility, 'from the beginning it was a top-down process, definitely, from the Government authorities. The Government authorities wanted to find a way of controlling health care … knowledge management of health care'[xxxii]. Knowledge management emerged as a concept towards the end of the 1990s and began to appear in documents from, amid others, the Ministry of Health and Social Affairs. There was, as described above, a need for a different approach than the top-down perspective to be successful in introducing evidence-based medicine within the medical profession. Doctors that worked with SBU emphasised the need for another approach:

> We said that this is well and good, but we also know that doctors will never accept anything that is only launched as a top-down decree. So we suggest that if one should do something about this, one has to start in parallel at the other end. One must start reaching out to Swedish doctors from the bottom.[xxxiii]

SBU started, as a part of this work, a series with evidence-based medicine, and educated doctors to pharmaceutical committees and those called SBU-informers – doctors that then educated other doctors in their own county council. These were prominent doctors, usually working both as a clinician and a researcher. The intention was that the doctors should feel that 'this is a question owned professionally, just with reference to that we want of course, to conduct our work on the best possible grounds'[xxxiv]. Although doctors 'are in many ways individuals'[xxxv] they wanted the work with patients to be based on the best knowledge.

To give credence to SBU's work, they gave doctors that represent the medical profession a mission to bring evidence-based medicine to the health care system. Using them as good examples to promote the idea of evidence-based medicine and to transfer professional norms is described as a successful strategy. Through this approach it did not appear as a control by the authority:

> And I believe that the argument, when doctors' meet doctors' peer-to-peer, so to speak, has been a strong driving force that successively won. The result of this is that EBM has been accepted from the bottom in Sweden in a different way than in many other countries. In many other countries attempts have been made to push it down from the top. And that has become like a steering from authority, they restrict our professional freedom and so on, and that has not been so successful.[xxxvi]

The best experts in the country were taught about evidence-based medicine. They were given the task from SBU to prepare a document, a SBU report, that would meet 'all the demands for rigor and transparency'[xxxvii] and it should be possible to follow how they reasoned. There was a purpose with hiring these doctors at SBU, although it was unspoken:

> There was like an under text that was never really expressed, but through going over, doing these yellow reports within a host of activity areas, one had the support of all the prominent opinion-leaders there really were … and made them ambassadors. And … it was a very successful strategy.[xxxviii]

In order for evidence-based medicine to be successfully introduced into the medical profession it was important that evidence-based medicine was introduced and promoted by doctors themselves. Prominent doctors were selected to be intermediaries in introducing evidence-based medicine.

The work on national guidelines is described as an important part in the development within health care, and they are used in knowledge management. The process of development is often financed through project funding or performance based compensation, in health care as well as within other areas of the public sector. The three doctors describe different parts of knowledge management, depending on their position in the county council. The doctor that works in a clinic, where patients stay for a relatively long period of time, often carries out development work in project form or work that is performance based. One example of performance based funding is through SALAR, who sets the conditions on the payment:

> We get money out of the state and SALAR, if we do what they think we should do. So then, we really only have to have activity and report and then you get a penny for it.[xxxix]

One of the projects they work with is about increasing individual participation, where participation is an area they shall follow through measurements. Measurement often consists of quantitative data which can be achieved by going through individual plans, for example how often the individual has participated in health care planning, which is to be noted in the individuals' medical record. This is nonetheless a quantitative way to examine participation, but there is also a qualitative aspect with participation that is about 'in which way has the patient been participating at health care planning, have they only been given the paper, did they tear the paper up'[xl]. But, then it becomes more difficult to measure, statistically.

Another method used by the state to manage health care is through quality registers. The same doctor that speaks about the project work above shows how information from a quality register is presented and explains how this information can be used:

> Here it is full with graphs and bars and we follow twenty or so factors, amongst other things weight and we follow which crime has led to the care, we look at the length of care. … And we are very close to the national average, but we do not have long-time-care here. So such things are good to know. So with this as a base one can find a lot.[xli]

As a part of following-up and evaluating the work, they can choose from a list of eight objectives and examine them. It can be a way for the clinic to improve their quality. Another way to examining and monitor activities is the legislated demand that audits be carried out. An example in one doctor's area is given. The audits shall be made by a doctor from another clinic, not the own clinic. This doctor has participated in a group endeavouring to establish how such an audit is made. It can be described as an assessment of other colleagues, a peer review (cf. Vedung, 2009). The audits also provide an opportunity to exchange good examples with one another, and get inspired by others.

A system and structure for evidence-based medicine

One of the doctors is involved in what the county council call arranged introduction. I consider that he is working at a regional level with introducing evidence-based medicine, because this is done within the whole county council. This arranged introduction is, according to this doctor, about knowledge management of health care. Knowledge management is the concept used today within the county council:

> It has become a kind of mantra; there is talk of *knowledge management*. It is the word for the day. And it is of course really, knowledge management is about using evidence-based medicine when it is available.[xlii]

An arranged introduction involves a central commitment in the county council; expert groups are formed to implement new knowledge in relation to, for example, a treatment or a national guideline. This organisation is being created at regional level:

> This [arranged introduction] is one way [that we], like many other county councils, build up an organisation. Where national guidelines are frequently issued for the big usual common national diseases … a group within the county, an expert group, is the one that receives them. We … have for diabetes, and we have for asthma, musculoskeletal disease, life-styles etcetera, … various expert groups. So for diabetes there are people from primary care, doctors, diabetes nurse, medicine doctors, nurse from the municipality, and [they] keep track of the processing agreement which is evidence-based, what one shall do. And it is then easily searchable for doctors … [internally via the Internet].[xliii]

It is also about prioritising and identifying blockages to the introduction. Expert groups also have the task of overseeing suggestions and decide how these suggestions stand in relation to how they work today, and what needs to be done to enable the introduction of the proposals, and who has the responsibility, in that case. The expert group for diabetes, for example, meets around six times each year and members have regular contact with one another, primarily through e-mail. This work with an arranged introduction is something that currently occurs in several of Sweden's county councils.

> This is nationally, this discussion about how to relate from the small to the greater knowledge and with arranged introduction.[xliv]

Some of the expert groups have existed for a long time, others are new. It is easier in the groups that have existed for some time because there is already an established structure for arranged introduction. This is the case in the area of diabetes, for example:

> It has been easy in areas like diabetes where a county group has existed for a long time … where both primary care and [specialist care] are represented, and work with different care program issues. Then there is a forum that directly addresses this. And in other areas there is nothing like that, and then it becomes very difficult to find ways of reaching out with it.[xlv]

A part in the arranged introduction for the county council is also to create a central resource for the analysis and evaluation that can work with statistics within the current system. These people are not a part of the expert groups but complement them. The objective is that what the county council is investing in also must be possible to evaluate and follow up. Here, this is explained in connection with the organisational solutions that facilitate the introduction of evidence-based medicine:

> In the corridor for knowledge management, if there is such in everyday life here in the house, there must be both these resources that receive, in a concerted and arranged way, and consider who is doing what and how do we prioritise this here. But also … that there are resources for analysis and evaluation that can, yes okay now we say that we shall do this but how do we ensure that this happens.[xlvi]

Expert groups will then have the responsibility to make suggestions in relation to which parameters for following-up are most important to measure quality and safety. And it may for example be something that is in open comparisons from the National Diabetes Register. The resource for analysis and evaluation are responsible for knowledge about feasible parameters that is possible to get from the systems available within the county

council, without requiring a lot of extra work. When the expert groups propose parameters, that the resource of analysis and evaluation establish are possible to use, then the expert groups suggest that these parameters should be used in evaluations. Then the parameters have to be approved at a central level by the county council.

For the work with the national guidelines there is a routine portal on the county council's internal website, where the main points of the guideline are presented. Those doctors that wish to read more about the guidelines must read at the National Board of Health and Welfare's website, where more information about the guidelines is available:

> If you want to search the background and also the list of sources, then you have to work more. But this should be more consensuses, short and tersely. … It is for practical, quick work, not for background and research, then you must go into the national guidelines.[xlvii]

It is important that information posted on the county councils internal web is kept updated and current, as the information constantly changes. An arranged introduction also includes revising and updating the documents established by the expert groups:

> So there, on all documents it shall be written what its validity is, who is responsible for it. So it is about constantly building this knowledge bank bigger and bigger, and not just by bringing in new but also constant reviewing, see if it matches, who is responsible for keeping it updated. And here we see, this has become a lot better. … Today they are dated, responsibilities are attached, they are monitored … for if we have the type of documents that is swished around then it speaks rather against knowledge management. Then people stop trusting what they find.[xlviii]

If the information is not current and kept up to date on these internal web pages, doctors use proven experience instead, search online or call a colleague instead and ask what or how to do.

There are different computer systems, besides the internal web, which are used for knowledge management in the county council. One example of a data system is VIS (Health care information system[13]), and SIL (Swedish pharmaceutical information database[14]) will soon be introduced. This is exemplified when a doctor describes how the county council can control and change the dosage of antibiotics in a relatively simple way without any extensive educations for all doctors, by adding a directive in the computer system:

> If we know that we shall treat with four-dose instead of two-dose now, then we do not, in the computerised world, need to have any education, we just make sure to pre-prescribe all prescriptions. So when I write prescriptions it says "according to new evidence sinusitis shall have antibiotic four times a day. Ok", question mark, yes, and then, one sets' it in. And then no training or anything is need, but just make sure you add it into the system.[xlix]

[13] Vårdens InformationsSytem
[14] Svensk Informationsdatabas för Läkemedel

However, it is not mandatory for the doctor to prescribe a medicine recommended by the data system: 'So far, the [doctor] has the right to prescribe freely, but the doctor wants to do the right thing'[l]. If there is a valid reason to deviate from a recommendation it is possible for the doctor to do so. But it is still a control.

Depending on what the change is about, it can therefore be a need for anything from making changes in the computer system, targeted information to educations of large groups of doctors. This, however, requires an organisation for knowledge management that can cope with the situations that arise:

> Then you have to have an organisation, a knowledge management, in the county council who sits and says, okay now we have these five new national guidelines, they say we should change that. Which one do we take first, well what is the most important, where do we have the greatest patient benefit, we start there. And, we are not there so we have got that really good structure for the arranged introduction, but we are very far on the way.[li]

As described earlier, the National Board of Health and Welfare's guideline work constitutes the next step from SBU's work. The guidelines are also taking into account health economics, as a way to providing recommendations in the clinical work.

The introduction and implementation of national guidelines would be much more difficult without the arranged introduction and the use of modern technology. One of the other doctors shares his experience:

> Because it is not just sending out a SBU report or national guidelines to the organisations, it was long ago one stopped believing that change happened just because one distributed various tools. And these implementation problems are gigantic. … [B]ecause it is one thing to reach people with knowledge, it is another thing to, I mean how does one bring about changes, do they stand in conflict with prevailing perceptions about what good care is, for example how to break or change and deal with such barriers. Organisation, it is not just a matter of "shall we prescribe medicine A or B". It may be about if we shall organise it differently around patients and that takes a *very long* time.[lii]

In order to bring about change requires having organisations which support changes and take decisions and determine what changes shall be made and, for example, what needs to be reorganised in order to achieve those changes. In this section, the doctors described the importance of that knowledge management organised at an organisational level, here at a regional county level. The next section comprises evidence-based medicine at a practical, local, level.

Evidence-based medicine in practice

Two of the doctors describe evidence-based medicine as if the work is founded on science and evidence, which is the base that the medical profession rests on. But doctors must supplement this with proven experience because there is little evidence in some areas and because they must always take aspects of the local context into consideration.

They must take the individual patient they encounter, who can have multiple diseases or other issues that make it difficult to work according to evidence-based medicine, into account. Defining evidence-based medicine from the perspective of working as a doctor, one of them describes evidence-based medicine like this:

> As a doctor, as health care staff, one shall work according to science and proven experience, and the science is the evidence-based. That is, do things that there is evidence for that this is good, and stop doing things where there is evidence that it is bad. But if one would only work according to EBM, evidence-based medicine, one would not survive long in the daily work, but lots of things are proven experience and practice, which one may supplement with EBM. So, EBM is an important part but it is not all that governs what one shall and should do in health care.[liii]

Describing the relationship between research and science, and proven experience somewhat more in-depth a second doctor defines evidence-based medicine similarly:

> The actual word evidence, with it means that one has proof actually that a treatment is good or bad. And this is based on research that has been done. The concept of evidence is not enough, because good research has not been done in many areas. Therefore, we must add "and proven experience". But the whole thing, the end product, shall become, anyway a care that is good, that has so few side effects as possible, and as many benefits as possible. And that it shall not be, so to speak, invented anew each time. We should have a base, we must be able to fall back on something, experiences made.[liv]

This places a responsibility on the individual doctor, to keep themselves updated about what knowledge and evidence that is available. The same doctor continues to describe this:

> [T]here it is about keeping abreast, to not only listen to others but to read for yourself. It is a very important part of this, the job, is to read. But we have too little time to do that. There are also those who have dedicated themselves to researching after evidence. There is an institute in England, named Cochrane, that has looked at many treatments; are they evidence-based or not? And what they usually find is that very few studies have been done on the subject. And then we are left with fragile evidence, and therefore we must have this proven experience, alongside. But for large diagnostic groups, major problem areas, there is good research done. And that is what evidence is.[lv]

In the description above, the doctors' own responsibility for keeping themselves updated with the latest available research is emphasised, which is necessary to be able to work with evidence-based medicine. The third doctor describes evidence-based medicine from a different perspective, explaining that evidence-based medicine coexists both on an organisational and on a practical level, and like the doctor above also weaves in the critical aspect with evidence-based medicine, in accordance with Sackett et al.'s (1996) definition:

> Evidence-based medicine is, we can say, an approach to knowledge and science. A structured and critical approach to the knowledge presented on the best way to diagnose and treat patients, and created ... a framework for

> how one can relate to the difficult problems we have in health care. To say, how shall we treat this patient, how we shall treat this one, how we shall choose new, expensive treatments instead of old cheap treatments and weigh them together in a way so that it is very transparent which foundation one has. And then, it is a form of practice in turn, which deals with the individual practitioner. So that it is like two levels really, a definitive meta-level about how the health care as a structure and systems shall work and relate to, and one that is more concerned with, how you as a regular doctor in your practice, when you meet patients and manage your knowledge needs.[lvi]

What is described in this section about national and regional governance is part of what is referred to here as the meta-level. How doctors relate to and work with evidence-based medicine is evidence-based medicine at a local level. One example of how evidence, science and (proven) experience are used in everyday work is given by the psychiatrist when he describes how an assessment can be made based on a real life situation:

> This last patient we got had a mania. Now, this person is difficult to treat and goes well beyond all evidence, research. But we must have a base there, has lithium been tried? Yes, it has been done. Has Clozapine been tested? Yes, it has been done. It was a disaster with both of them. Yes, and now we sit here in the situation of having to find something else. And then I do searches, what can one do in this diagnosis?[lvii]

Often different search engines on the Internet, which are very helpful for finding knowledge, are used. The doctor from primary care explains that evidence is not always accessible, that there are areas in medicine that are not researched, because it is difficult to do research in certain areas. Therefore, there are situations when using the evidence is difficult, for example:

> Primary care and psychiatry, two major, heavy corner stones, are areas where there is quite little EBM, relatively speaking. Where there are SBU reports and EBM is maybe within abuse, addiction, schizophrenia, depression, but very much mental ill-health, a great deal of primary care is not EBM.[lviii]

Here the doctor indicates that not everything in health care is founded on evidence-based medicine. When people have several illnesses it is more difficult to use evidence and, unlike when dealing with people with one illness, it is also more difficult to do research:

> It is easy to do research on patients who have diabetes, and it is easy to do research on patients who have heart failure, and easy to do research on patients who become demented. But how shall one do research on one of the most common hassle-patients at primary care; 79-year-old's with diabetes and heart failure and dementia and osteoporosis and pain that comes along. And one has to take all these things into account, and one has to say, yes but there is evidence that diabetes should be treated so, there is evidence that heart failure should be treated so. So within each illness there is evidence, but it is of little help here. And then, because the patient does not care for this, because now she has so much pain or is sad that the dog has died. And, this is the main problem today. And how does

> one research that, what to do in that complex situation. … And a lot of primary care is like that, patients come with a bag of mixed troubles.[lix]

Doctors, as well as social workers, need to be sensitive to the problems that those they encounter have and that there may be several diseases and problems which are interrelated. This means that doctors need to deviate from the evidence, within certain areas and in certain contexts. While some areas are well studied, the limitations of evidence-based medicine lay mainly in that there is not knowledge in all areas. A practical example of this is given in the quotation above. According to the doctor within specialist health care, the lack of evidence in some areas means greater restrictions than what the organisation constitutes:

> Really, the substantial limitation is the lack of knowledge *in general*. ... That there is no knowledge. You see, some areas are extremely well studied; other issues are very poorly studied, even though they are very relevant. ... That is probably the real limitation. There is no restriction from, if we say, management or in everyday life.[lx]

He continues to explain that evidence-based medicine is not something doctors consciously relate to in every meeting with a patient, instead it exists as the basis in work:

> For the regular doctor this is not something that we is actually doing with each patient. But it is something we have in one's further education, and when you sit down perhaps pondering over some patients, afterwards, or you may need to dive deeper.[lxi]

Also one of the other doctors explains that they do not search for knowledge in the daily practice and for every patient they meet. Much knowledge also comes from personal experience and in combination with the circumstances of each individual:

> If one is to generalise it to an individual, it is a bit difficult. ... You always have to have this opportunity to, well, feel what is reasonable and right for the individual. And there it is, we cannot just write in and have an automatic note, yes depression, and then there are a whole row then, now we shall do this and this and this and this and this. It will take time if we shall follow such a logarithm. … And that is were proven experience comes in. A skilled, experienced doctor … can see, fairly quickly, here we can skip this and that.[lxii]

Doctors build up reliable experience over time. This means that they know how to act, what the problems are and how it can be solved or treated. Here is one example of how doctors work with evidence-based medicine in everyday life. Today evidence-based knowledge has become the basis for work and is accepted by doctors. In the daily work, the doctors do not read national guidelines or SBU reports, because it would not be possible. Evidence-based medicine is though

> … a background that is there, but that one still quite often may say that, yes but okay, can I really apply this straight off for this patient, … or is there something to be said for or against an alternative way to do, not do something or actually do something not normally recommended by the

> guidelines. And for most doctors this process is not very explicit or verbalised.[lxiii]

This doctor continues to explain that doctors' usually do not reflect over how they work every time they meet a patient, because:

> The core is still that the usual conditions recur and there it is possible to work according to some form of protocol. But then, sometimes it gets "hot" and there are conflicts, not least within the group of colleagues, but why are you doing that, I always do this, but why do you do it, yes, but I have indeed read the studies of Pettersson and Svensson and it says, but this does not agree with the national guidelines.[lxiv]

The reflections that the doctors do are concerned with being able to justify departing from a certain way to treat a disease. Reflections are thus not only about considering what knowledge is needed. Sometimes there are occasions when colleagues discuss different ways of treating diseases. However, they recognise most diseases and the treatments that are needed, and then there is no need for further reflection.

The use of experiences

All the doctors explain that experience and knowledge exchange with other physicians is an important part of the work, especially when it comes to treatment for patients. There are forums for sharing experiences among doctors, which often involves very specific cases:

> Where I worked for twenty-five years we had doctors meetings for twenty minutes each day, right after lunch, and then it was very much about patient cases; I had a patient who sought for this and that, had pain when she twisted the arm like this and there was no skeleton injury, but how do we usually do? And then, yes, but my experience, and if one has been working there a long time, it tends to be that they have stretched the muscle and ... it usually passes within a few days, so call and say that.[lxv]

This exchange of experience between colleagues and when they consult with each other is part of being an experienced doctor and building their own proven experience:

> So, I would say, this transfer of the doctor's role is very much about learning all of this, collecting the proven experience from colleagues and then create their own proven experience, which means that the longer you have been working, the less often you are surprised and have no clue as to what to do. Even if it still happens and one then says, now I have to speak with someone or I do not know what I shall do.[lxvi]

Here is an example of knowledge which can be gained in part through reading literature but it is also experience learned knowledge that the doctors convey to other doctors. This is important because knowledge is taught through other doctors' experiences, but their knowledge is not only based on experience; it is a weighing together of different knowledge. One doctor explains that 'one learns it from each other, and it is in the books'[lxvii] which means that knowledge is taught 'both from literature and from doctor to doctor it is very much proven experience that is taught further'[lxviii].

It is not easy to determine the source of knowledge in specific cases, as it is often a weighing together of knowledge, which is gathered in proven experience. According to one of the doctors different patient cases are discussed by doctors during exchanges of experience. These conversations can be about new ways of working, usually based on evidence-based medicine. But 'one does not put it into words anymore, because [evidence-based medicine] has become "business as usual", in that way'[lxix]. Evidence-based medicine has become the accepted way to work and doctors do not always reflect on that they work according to evidence-based medicine:

> I believe that we look at it as if EBM has been established as normal science, simply as the normal approach. So that it is not that one can come and think whatever without somebody saying; yes but what evidence do you have for that, really.[lxx]

However, it is not merely about experience that is being discussed in the workgroup, but evidence and research are at the heart of the issues discussed. Not everything is stated in the guidelines and then they must look for other knowledge, for example at 'Best Evidence or Critical Practice to find the best, so to speak, EBM source, or somebody goes and searches for an article or lecture notes'[lxxi]. Such knowledge prompts discussions concerning reliability and what is an 'adequate base'[lxxii]. Even the exchange of experience between doctors is described as important. The psychiatrist gives examples of experience exchange in a wider perspective. Doctors from different clinics in the north of Sweden meet regularly and keep in contact with one another, not to mention that he usually participates in a congress in Sweden where doctors within his area meet.

The use of external knowledge

To gain new knowledge one of the doctors usually reads the newsletters the SBU regularly sends out. In these one can read a summary of studies that have been done and one of the doctors feels that this information is useful in his work. He also explains that Cochrane is often cited in articles but he himself does not usually read what is on the Cochrane homepage. Another form of help is the Internet and search engines, 'often one gets by with Google, one quickly finds the quality one needs to have, so it is not just an "I think-forum"'[lxxiii]. The doctor from primary care feels that the Internet is used increasingly more but the worry with using the Internet is 'to be able to trust it'[lxxiv]. This is what the county council is attempting to achieve, through placing material that doctors need on their internal web. He describes this from his current position within the county council:

> It is largely about … trying to have order on the rules and routines so that one shall not need to go out on the net and search after how one treats diabetics with kidney failure, then we know that one can find it. … Because when one uses the net, one maybe need not Google it but finds the right, what should I say, respectable sources. Sources know to be reliable, for to know that one is doing the right thing and that it is not some quack … that has a homepage where he thinks … how one ought to deal with sprained fingers.[lxxv]

The specialist doctor gets knowledge by reading large international journals. He has a subscription for the table of contents that comes once each week via e-mail. And that he feels this to be a very good way to follow new literature and research:

> It is a very good way to follow the literature and scan over so that one, yes but this article looks interesting; one just clicks and looks closer at it. And that I believe many use today, that work for the specialised. … This comes from different, all journals, let us say JAMA or Lancet or some other like these. Once each week the table of contents arrives as a mail just like that. And just click here and one has a short summary where one can see if it is relevant for my work. … And it is by far the easiest way I use. Many others travel to conferences and congresses and such like but I am more like, it is a lot of hassle at those, one gains a lot through keeping an eye on it, in this way.[lxxvi]

There are also international portals on the Internet with systematic overviews 'that reports precisely what they base their recommendations on'[lxxvii], for example, Best Evidence and Clinical Practice. These are used by the specialist doctor who describes Best Evidence and Clinical Practice:

> Best Evidence and Clinical Practice, it is the British medical Journal that has been very much at the centre of the whole EBM-movement, they have a site that the county council subscribes to, where they really have tried to focus on diagnosis. Let us say if someone comes and says I think I have gout in my big toe, oh, one begins to think about it, how was it now, what is the best way to diagnose and treat. Then one can look it up in which ever text book you like but they are rarely evidence-based. But if one goes into Clinical Practice or Best Evidence, which are really two different portals that reach the same thing, may one see that ok, to do a diagnosis this has the best characteristics whilst this other method performs worse and costs more and you should therefore choose this here and that there. It is one of the best, hands-on, everyday instruments we have in fact.[lxxviii]

Because they are international studies in these, one must nevertheless always consider the local, national, context. It is 'not always possible to translate directly, there are a different ways to deal with issues that mean that one must filter it in some way through a national filter'[lxxix].

6

Regional representatives supporting evidence-based practice

In this chapter the results from the interviews with the regional representatives are presented. My intention is to examine how a regional unit perceives evidence-based practice, how the regional representatives work to support the county's municipalities in introducing evidence-based practice and how they act as an intermediary between the national level and the local level. The chapter also explores the challenges and opportunities the introduction of evidence-based practice creates and what the regional representatives perceive needs to be done during the introduction of evidence-based practice. To understand what the regional representatives say I have used literature mainly about the development of evidence-based practice in Sweden in combination with new institutional organisational theory. New institutional theory is used to form an understanding of how ways of working and organising social work spread from the national to the local level and how legitimacy is an important factor for organisations. In the spread of evidence-based practice, for example through governmental steering of important areas to development for the social services, or ways of organising development work with contact persons and network meeting, different types of isomorphism are made visible.

The objective of the regional Research and Development Unit[15], which is owned by the county's 14 municipalities, is to give support to municipal social services. Most of the regional representatives that have been interviewed were employed at the Research and Development Unit and some at the Union of Municipalities of North Bothnia[16]; two co-located organisations. The interviewees' responsibility for development work and support to the social services is the same regardless where they are employed and where the development work is administrated. To ease the reading of this thesis and to avoid misunderstanding these organisations are referred to as *the regional unit* and unless it is important to point out what position the person has in an organisation the interviewees are referred to as *regional representatives*. In accordance with my theoretical base I use these terms because they illustrate the regional responsibility of the Research and Development Unit as the mediator of evidence-based practice to the municipalities.

Since the interviews were conducted during the year 2012 this chapter presents the development work that took place at that time. In 2014, when this thesis is written, the

[15] FoU Norrbotten.
[16] Kommunförbundet Norrbotten.

situation is somewhat different. Some development work has been completed and some of the people that were interviewed are no longer employees at the regional unit. However, it is my opinion that the responsibility of the Research and Development Unit towards the county's municipalities has increased during the last year. The Research and Development Unit has more permanent employees than when the interviews were conducted and *innovation* (R&DI) has been added to the name. In addition, today's Research and Development Innovation Unit is also responsible for the education-sector and to some extent for the overall municipal sector. The basis for its activities is evidence-based practice regardless of the area.

All of the regional representatives that were interviewed are women with responsibilities either as a leader of a part of the Research and Development Unit or as project managers that are referred to as development managers according the title used by the Swedish Association of Local Authorities and Regions (SALAR). The same applies to development work, which is the concept used by SALAR and in this thesis instead of the concept development project. Four of the regional representatives are social workers and one has a vocational university degree in the field of health care. Three of the social workers received their training during the 1970s and the fourth in the late 1980s. The three that were educated during the 1970s have worked at the regional unit longer, between six and eleven years, than the other that began working at the regional unit around 2010-2011.

The social workers have previously worked within individual and family service as social welfare officers, and three of them have also held management positions, middle or senior managers, within social services. The one which had vocational education has worked both within county council and in municipalities since 2003, mainly as a manager. Together they also have a wide experience of other work, including in youth detention, probation care, occupational health services, and trade union duties. One of them has been involved in the pilot project through the National Board of Health and Welfare to develop the system BBIC[17], which took place at the end of 1990s in a municipality of North Bothnia County.

Four of the regional representatives are working with various development projects and one has a more overall responsibility for a part of the regional unit. At least they were at the time of the interviews. One of the state's investment programs has a clear intention to introduce evidence-based practice within social services, which is the EBP-initiative[18]. Overall, the EBP-initiative involves building regional support structures and creating networks with contact persons in the county for the introduction of an evidence-based practice. Education is a part in the EBP-initiative.

[17] The Swedish BBIC (Barns Behov I Centrum/ Children's Needs in the Centre) is built among others on the English Integrated Children's System, ICS (Socialstyrelsen, 2013). I choose, in order to avoid confusion, to use the Swedish abbreviation in the text, because Sweden has adapted the original English version to Swedish conditions and created a system based on 'national practice, organisation and legislation' *[author's translation]* (ibid:20). BBIC is described as 'a system for handling and documentation in investigation, planning and follow-up' *[author's translation]* (ibid:17).

[18] I term this specific initiative for the *EBP-initiative*, to distinguish this initiative from other initiatives (in specific areas), where evidence-based practice is a part.

Another area of development is Knowledge to Practice, which is a government initiative within substance abuse and addiction care in both social services and health care. Even in Knowledge to Practice regional networks are used with contact persons and educations. Development work within work with children and family is about introducing BBIC in the municipalities, for example. And the regional unit has some responsibility for network meetings. In addition, there are other development work administrated and managed by the regional unit, the initiative within elderly care (dementia, palliative care, care prevention, medicine, coherent health and care) within addiction care (Frequent Users is a follow-up of persons with heavy substance abuse or addiction and support to parents with an addiction), and within the area of support to disabled people. Most of these development works are financed by SALAR.

The regional unit as intermediary for change

The task of the Research and Development Unit is to provide support for the municipalities in the county, 'in their follow-up work'[lxxx] and in different further educations for the social services staff. This implies that the national initiatives lie well in line with the Research and Development Unit tasks, especially the EBP-initiative. In the national initiatives initiated to develop social services, the regional unit becomes an important actor; they become an intermediary between the national level and the local level (se figure 3, below). Ideally, this is a work that goes both ways, but so far it has largely been initiatives from governmental agencies that promote evidence-based practice. Through agreements with the government, the Swedish Association of Local Authorities and Regions (SALAR) has become an important actor for the development towards evidence-based practice. SALAR has the contract to manage the state money, allocate and grant funds to the municipalities, often via the regional unit.

Figure 3 illustrates how SALAR regards the process of knowledge development, where there is a knowledge management (guidance and support) from national actors to the local practice. The arrow on the right hand side of the figure, which I have added, indicates where the regional unit and the development works are placed; it has a central position, where it says 'Dialogue'.

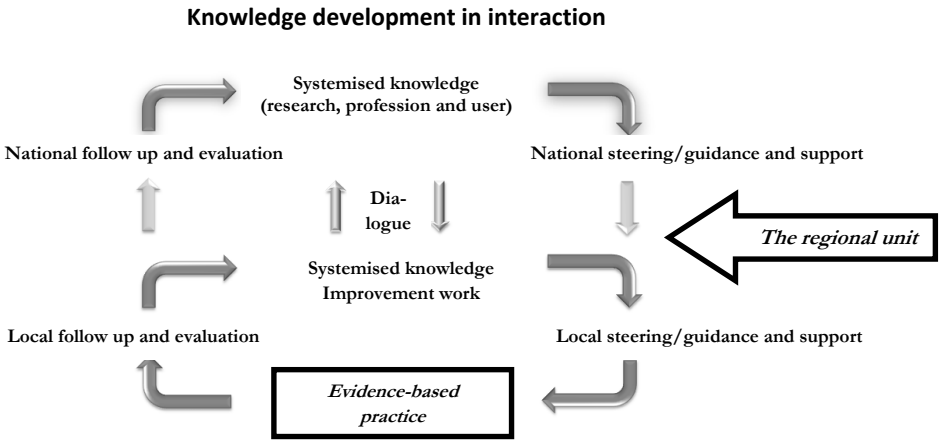


Figure 3: Knowledge development – an interaction between different levels (Sveriges Kommuner och Landsting, 2012:22). [Author's translation]

The regional representatives consider the regional unit as a suitable actor to maintain a support structure and that it is possible for the regional unit to function as a link between the national and local level. The process of knowledge development is conducted in the opposite direction; the intention is that the local practice will contribute with knowledge through local evaluations and follow-ups. The task of the development managers that have been interviewed is to, in line with the expectations the national actors have, mediate and translate initiatives into practical work within the county's municipalities. Even if the regional unit is not, as one of the regional representatives points out, 'responsible for the initiatives, it is clear that we are becoming little blowtorches in our roles'[lxxxi]. One of the regional representatives gives an example of the expectations she feels that SALAR has of her as a development manager and her development work:

> The expectations are that [I] shall be the one that drives the development work and that one makes sure that one gets all the municipalities involved in the work and that one takes the local needs in the municipalities into account. That it is, at county level, the coordinators' responsibility. That one does not think big but relate to the local needs, in the municipalities.[lxxxii]

The expectations are perceived to be conveying the national initiatives intentions and get all the municipalities to participate in the development work. At the same time they must create conditions adapted to local variations. The regional representatives require knowledge about which needs there are in the municipalities and speak about the necessity to take into account the conditions each municipality has.

That the regional unit has the task of driving development work for the whole county means increased resources for the regional unit, but also means that those resources are

used in a different way than if every municipality perform their own development work. The activities at the regional unit have been expanded through governmental financing, with more people employed in different development work which 'vitalises the activities'[lxxxiii]. The increased financing also develops the regional unit, more people work with the development of social services, and one of the regional representatives believes that the governmental funding is used in a better way:

> It becomes much more structured, and that all municipalities can benefit from this money in another way. Small municipalities would not have the opportunity to apply for all project funds, as they do not have the resources to write applications and employ people for follow-ups and reports. There is so much administration for them.[lxxxiv]

By conducting development work in this way, the social services receive support in the development of their activities, especially the smaller ones. The administrative work of applying for funding from the government administration is in principal the same irrespective of the size of the social service. Small municipalities have more difficulties to do this than larger municipalities, because large municipalities often have specialised employees working with developmental issues.

Governance for development

The regional representatives feel that this way of conducting development work and the government's way of financing it functions well as resources are used in a better way. However, two of the regional representatives want to point out that this involves control from the national level over what the municipalities shall invest in. One of them reflects about this in relation to the money that SALAR paid to the regional units after coming to an agreement with the government:

> This involves a certain amount of steering or [a] rather pretty decent steering of what the money shall go to. It is not that the municipalities can say we want to do this, we want to do that. Because the state has said, that this money shall be used for *this*. And it is clear that it becomes a steering, because money is always welcome.[lxxxv]

The other of the two regional representatives that are reflecting about this has worked at the regional unit for a long time. She feels that this control has varied over time, but that it has increased during the latest years to be a relatively strict control today:

> [Today] it is very much pointing with the whole hand from above. Even if they then say from SALAR, which has stepped in as an actor in this by managing the state funds, that the municipalities are naturally independent, autonomous, and make their own decisions, one is very much governed, not only by the ideas about what one shall work [with], but one defines exactly within which neglected areas the initiatives shall be in, through putting money there. And one has performance-based compensation to the municipalities, that is ... to be allowed to be involved and receive a share of the money one shall do certain things, achieve certain demands and there are different levels and percentages as well, and one shall register in different registers. And then it has been the latest years, open comparisons come pouring in all the time. ... [It] has changed. It has

> become very, very clear over the last five years, six, maybe seven. Because they steer with money, they steer with money.[lxxxvi]

The state controls the development within the municipalities through this funding (see chapter 2). With directed money the state can control which areas they feel are in need of development. Through, for example, performance-based compensation the state can steer the development despite the fact that the municipalities are self-governing. With open comparison the municipalities receive a result that they can use to measure their own activities and compare themselves with themselves, with other municipalities, and with the country as a whole. And if they do not succeed particularly well within specific areas these areas are marked in red in the presented results. The table below is an excerpt from the open comparison regarding children and young people. I have chosen four variables that cover knowledge-based social services that give the reader an understanding of how this looks. Every row represents one municipality.

Table 1: Excerpt from open comparison regarding social services for children and young people (Socialstyrelsen, Öppna jämförelser Barn och Unga[19])

	Family homes competence	***Systematic assessment***		
	Concerted plan for family homes competence development	The use of standardised assessment instrument:		
		Acting out behaviour	Addiction and abuse	Parenting skills
Municipality I	No	No	Yes	No
Municipality II	Partly	No	Yes	No

Open comparison is a form of control because the areas (variables) are determined nationally and municipalities are working to improve these areas. This may cause that the municipalities work exclusively with the most acute areas, with those areas that are marked in red, which is described by one regional representative:

> One measures and if one has many red fields then I believe that it triggers rather a lot of stress, worry and such, and one runs with these balls and perhaps misses the continued development of that which is yellow and green in these comparisons.[lxxxvii]

She also feels that after using comparison for two or three years many of these areas are not yet 'fully developed so that what one really measures and asks for may not have yet been established but they are controlling these red fields tremendously'[lxxxviii]. The areas of development that the government invests money in is admittedly control, but some regional representatives also feel that these areas are those that the municipalities experience as relevant. Otherwise the municipalities would not have received money, and she says that the government and SALAR 'have tried as much as they can to investigate which problems there are in society'[lxxxix]. She is convinced that SALAR, through their network groups, has listen to its members, the municipalities and county councils. In this way the areas of development are relevant to the municipalities.

[19] The table is translated and edited by the author of this thesis. The intention is to show how the result is presented to the municipalities.

A supporting regional structure

As part of the EBP-initiative and other development work via SALAR, regional support structures where one or two employees in every municipality functions as contact persons for the regional unit shall be created, to facilitate working with evidence-based practice. The intention is to support the municipalities in the development work being done. One development manager explains the municipality's need of support in the EBP-initiative:

> One needs a support function, absolutely, someone that [municipalities] can juggle with, and also this with sharing one another's knowledge, to get an experience exchange, that is, how others do. And this we have tried working with through the network that has been created in the county.[xc]

At the same time as the form of the initiatives is decided by SALAR, the municipalities have a right to determine how and in what way the initiatives will be done. The strategy that SALAR uses, which includes building a local and regional structure and further educations, is used in several initiatives from SALAR other than the EBP-initiative. Here one of the regional representatives explains the regional unit's task as mediator of the EBP-initiative and the support function that they provide to the municipalities:

> I see that R&D [The Research and Development Unit] is very important as support to the municipalities in this initiative. Not only be this megaphone, the state's megaphone out to the municipalities and speak about *what* they shall do, but supporting municipalities to, in their own activities, find the areas where they maybe see deficiencies. Perhaps one needs to follow-up in a better way, one needs to take advantage of all the knowledge that actually is in the social services and evaluate, put what one knows into words. And, maybe take a critical approach towards some parts in this initiative, to be able to find areas for improvement in their own activities. That I think is our obvious role, in this initiative.[xci]

In the statement above attention is drawn to the importance of the regional unit functioning as a support for the municipalities so *they* can introduce evidence-based practice in relation to their specific local conditions. This involves a challenge for the regional unit because the initiatives must be locally adapted, and that 'one has to be aware that all [municipalities] are not going in the same speed'[xcii]. Participation in development work has meant a greater workload for the municipalities and that they have difficulties in participating. One of the development managers often hears comments such as 'but we do not have the time to participate in everything'[xciii]. Another explains that the municipalities experience the EBP-initiative as one work task of all tasks in a social service that must be done at the same time and it becomes a burden for those that choose to participate in yet another development work. This problem is more obvious in smaller municipalities where they have few employees and those become involved in several development works, described by one of the leaders for the Research and Development Unit:

> If we take the largest municipality, 70-75 000 inhabitants, and the smallest, 3 000, it is obvious that all initiatives may end up in the lap of one,

> two, three people in Arjeplog[20]. It is not like that, that they can distribute so that they have one responsible for … every area, it rather ends with the same person. … And that is tough.[xciv]

This problem becomes visible when one of the development mangers describes the difficulties finding contact persons that can participate in the networks created. In order to fulfil the assignment as a development manager, they need to be attentive and flexible to the municipalities' different contexts and conditions:

> We must create networks, we have to get all municipalities involved in some way, we must have an understanding that there are different preconditions to participation. And we cannot demand equally from all municipalities, that they shall in terms of staff or, invest as much in this network work and maybe not in the implementation work either. That it may come in different rates. We must have that understanding.[xcv]

She emphasises the importance of taking the municipalities different conditions and contexts into account. One of the regional representatives explains, in much the same way, that these differences can depend on high personnel turnover or that managers leave and new arrive.

There are limitations in the function of development managers in relation to what they can do. While trying to adapt the development work to the conditions of each municipality, they cannot do the actual work in the municipalities. One development manager points out that each and every municipality is responsible for introducing evidence-based practice. Another of the regional representatives observes that the high level of strains on municipalities has sometimes caused them to not always express any expectations on the regional level, such as what and how the regional unit can do to support them:

> At the same time as the municipalities are under such *enormous* strain, you know the practice must function regardless of these pointing fingers from the state, and sometimes I have a feeling that the municipalities are not really capable of making demands on us. They have so insanely much with their daily tasks in some ways. So that they would maybe prefer that we took care of it, but that cannot be done. It just cannot be done.[xcvi]

Sometimes the municipalities desire that the regional unit shall perform the development work, which is not practically possible and the intention with the municipalities' development work is also lost. For the development managers it is a difficult balancing act, between the governmental initiatives and local practice. In a comparison with how knowledge management works within health care (see previous chapter), the difference is that the county council is responsible for health care in the whole county, but the regional unit is not responsible for any municipality, and must rely on their willingness to participate. Instead the municipalities own the regional unit.

The regional representatives share the understanding that the regional unit's function is important for the municipalities general development work and more specifically for the introduction of evidence-based practice. One of them explains the need for a

[20] Arjeplog is the county's smallest municipality with just under 3 000 inhabitants.

regional unit that in the future is an engine in the development work but this must be prioritised nationally:

> I believe that they … from the national level, that they keep the flame burning somehow, and from the county level that there is an organisation steering for issues of development. That, I believe … is very important. And that one works toward different kinds of networks. But it should not be allowed to be too many [networks, so it becomes a burden]. … But the engine must in any case be at county level.[xcvii]

One difficulty in maintaining evidence-based practice in a long-term perspective is related to the municipalities' resources and priorities:

> It is always about resources. … It demands resources, it demands time, it demands that you allow for example follow-up in the municipalities, that you allow staff to be released and disengaged, for example. User involvement might demand that you fund and pay users that participate. You may have to pay personnel that educate users, that meet users, and that is an … adjustment. … It need not ultimately become more expensive, but almost certainly in a period of change because then you have a tendency to do the same thing you have been doing, plus the new, before you phase out the old.[xcviii]

The perception that several regional representatives have, is that the municipalities understand evidence-based practice as 'something we introduce'[xcix] in the municipalities, as something new and not as something that partly already exists, and as each municipality can work further with. Economic gains for the social services increase their interest further and result in changes in the direction towards evidence-based practice. The regional unit has therefore, according to the regional representatives, an important responsibility during following years, but also that there is a continued government funding of evidence-based practice.

Regional representatives about evidence-based practice

All of the regional representatives that are educated social workers first heard about evidence-based practice somewhere between the end of 1990s and the beginning of 2000s. The person that has a vocational education within health care has had evidence-based practice as an element in her education. Two of the regional representatives refer to the article published in Dagens Nyheter (Daily News) at the end of 1990s written by Lars Pettersson and Kerstin Wigzell (1999) and the discussion about evidence-based practice in the social services that followed. One of them describes this:

> The concept evidence-based practice, it turned up some time, can it have been just before the start of the new millennium. … It was at the end of the nineteen nineties, a debate article was written. It was, among others, the then general director of The National Board of Health and Welfare, Kerstin Wigzell, who wrote a debate article about how little one in social services really knows about what the effects invested money has for the users. And there was an outcry, especially out amid those professionals that thought that this was an attack on the profession.[c]

She continues to explain that the debate the article triggered was about the importance of a knowledge-based social service, and that Pettersson and Wigzell (1999) prompted the state into conducting an inquiry:

> This brought with it that a discussion started and Kerstin Wigzell managed to get a government commission to The National Board of Health and Welfare, to look at … how one provides a knowledge-based social service, as it was called. And the investigation started at the end of the 1990s and … it was then that this with the evidence concept began to be used. … The discussions turned insanely heated because there was a polarisation between a numbers of researchers. Where one side spoke about the academic research as the only base and in terms of social work they said, there is no research because there were not these …. RTC-studies. Thus one cannot do a compilation of knowledge about what is researched in social work. While the others said that, yes but you know, it is not possible to reason like that, and one had a completely different attitude. Since then these two opposite poles have somehow merged, I can think. And we got this concept evidence-based practice, defined as these three legs one can say.[ci]

There were different understandings about how to describe evidence-based practice and 'there was hard antagonisms'[cii] from the beginning of 2000s and for some years forward. Evidence-based practice eventually became an acknowledge concept and the ways of conceptualising and defining evidence-based practice have become less controversial over the years. Today it is more a question of using several knowledge sources and not only evidence-based methods, which it was in the beginning.

The other regional representative that heard of evidence-based practice at the end of the 1990s also perceives that it was more about specific work methods than about practice but that it has developed:

> Then it was perhaps not evidence-based *practice* but evidenced-based *method* that one talked about. What is effective, how shall, a little engineer-like; which methods shall we use to get a good result. Since then it has developed so that I think that … maybe five years ago or something like that, when they began getting closer to some kind of definition of evidence-based practice with social services, not evidence-based methods.[ciii]

In the quotation above she explains that the definition and understanding of evidence-based practice in the beginning was 'engineer-like' and it was very much about methods and models, something that came to change with time. The same regional representative continues to describe this development from an international perspective:

> It was many such discussions, in Sweden and England. … For, it was one from England that we had here at the beginning of the 2000s. … "Evidence Informed Practice", was the idea she wanted to have, and there was an awful lot of opposition from the Kerstin Wigzell camp and from the state. She meant then from the English perspective that one can inform oneself about what there is, the research [as] there is, but one cannot say that it is based only it ... I believe that the discussion contributed to a sort of re-formulation of evidence-based practice. So, that one gets other sources of knowledge in than just evidence-based methods. For it has

> been established, there is not so many methods what we, if we do this then the children will be fine, or. But it is, one must listen to them, the clients, and listen also to what experience the personnel have of different things. So that in some way it becomes a little softer and … packaged in such a way so that it could be adapted to the reality.[civ]

What this regional representative says is consistent with how evidence-based practice is described in literature (cf. Sackett et al., 2000; Haynes et al., 2002; Oscarsson, 2009; Socialstyrelsen, 2011). Lars Oscarsson's contribution is emphasised by one leader of the Research and Development Unit:

> With Oscarsson's definition, there are in all cases conditions, I think, to start talking about evidence-based practice. But still, it persists that evidence-based practice are tools and it is methods and it is models to be implemented. … But it is an approach where one shall be open to all these three sources of knowledge and develop it. [Lars Oscarsson's book from 2009 rests] largely … on what Kerstin Wigzell then wrote about a knowledge-based social service for the good of the users, Kerstin Wigzell and Martin Börjeson, which is an SOU-report [Swedish Government Official Report][cv].

One of the other regional representatives, who worked as a senior manager in a municipality when evidence-based practice started to be introduced, does not remember that she was especially engaged in the introduction of evidence-based practice. Instead she remembers that it was described more at an abstract and theoretical level than as a practical understanding. Therefore, she did not prioritise the introduction of evidence-based practice.

Today, evidence-based practice is understood as an approach to work, but two of the development managers are uncertain about whether this is the general understanding that employees in the social services have:

> I believe that today, although one might be influenced by that one sits and works with just this initiative. But I feel that it is less about evidence-based methods and that it is more about an approach, and that is of course *good*, I think. Actually, more the original reasoning.[cvi]

> I believe that one sees how it fits together more now, I mean the whole thing, that it is not just about methods or it is not just about national guidelines or what it is. It is about the whole thing. … It is more an approach. I believe it has swung over time to that understanding. … If we go and ask [the personnel in the organisations] … they might not say that at all.[cvii]

The one who has worked as a senior manager, reflects if this altered perception of evidence-based practice is something that has also changed in general among social workers, or if it is because they, as development managers, have 'focused more on it and talked more about it'[cviii]. The knowledge about this more concrete understanding of evidence-based practice is something that has 'spread somehow from the top right down to local level'[cix], which also placed the responsibility at the local level.

Evidence-based practice at different levels

It is apparent in the sections above that the regional representatives perceive evidence-based practice as an approach that includes not only the use of certain specific work methods or ways of working but the entire practice. To do that social workers are required to use several sources of knowledge in the daily work. One development manager working with the EBP-initiative describes evidence-based practice from this perspective:

> Really it means that one supports oneself on all three legs. And that you work systematically and systemised with these issues. That you create structures in the municipalities that support these processes, at all levels I think. Because you cannot think that it is only at the individual level, because it is not supported if it is not done at the activity level or structural level. Therefore, you have to build it in at all levels as a basic approach I think.[cx]

The quotation above illustrates three sources of knowledge in evidence-based practice that according to Oscarsson (2009) are research, the client and the practitioner as sources of knowledge in social work. In addition, the quotation highlights that there is an organisational, or structural, perspective besides the individual perspective of evidence-based practice. Evidence-based practice is an approach that must exist as a foundation within the social services, where the organisations must create the structural prerequisites so that evidence-based practice can be introduced in practice. Another of the development managers agrees and continues to shed light on the organisational aspect of evidence-based practice:

> It is very important to build it into the structures of the organisation. That they have a system for monitoring knowledge, that they have a system for how we preserve experience-based knowledge within our organisation. ... And that one constantly spreads this within the organisation, so that it is a living work practice that *managers and management* actively support and demand results from. Yes, a living workshop of some kind. But that *necessitates* that one builds it into the structure, it is not enough that the lone social worker or occupational therapist does this, all the way. Thus, it is enough to some extent because it affects some users but it must be built into the structures.[cxi]

There are more of the regional representatives that reflect on evidence-based practice from different perspectives. Examples of follow-ups and evaluations are given, where follow-ups at the level of the individual (the social worker and user) are carried out, in accordance with the legislated demands that exist. However, no evaluations that examine the effects of an intervention are conducted in the municipalities, for example the placement of children. Ideally, the result from these evaluations should be presented at an aggregated level, after being compiled and reflected over by social services. This is an example given by one of the regional representatives where she begins by describing evidence-based practice from a practical perspective:

> In some way it is about several levels. Partly if one says, in the meeting with the client or the family, to be updated according to research about families with substance abuse for example. … And to … weigh in your own knowledge about those things, I think; how was it, what experience

> do I have of this here? It is a kind of, weigh it into decision making on an individual level or family level.[cxii]

Thereafter she continues to explain that a structural, organisational perspective is also included in evidence-based practice:

> Then, it also involves having systematics in the follow-up of how it goes for the children, the young persons in my case, so that they see, that we are doing things differently now, we offer different things and they go through different programs or interventions. … How has it been for them during this time but also how it is for them afterwards? And … what meaning has what we did on some aggregated level? This with local follow-ups of the activities, I think it is a prerequisite to … carrying out evidence-based practice, to lift it up. So that it is on several levels.[cxiii]

In what this and other regional representatives convey, it appears that evidence-based practice can be considered from different levels, similar to the way the doctors talk about in regard to health care. At the organisational level, evidence-based practice can be understood as how social workers work with and relate to evidence-based practice in their daily activities, but also as structures within the organisation that support evidence-based practice in the everyday activities. There is also a level which is primarily concerned with how evidence-based practice is supported and promoted at the national level. A third level consists of the regional work that the Research and Development Unit conducts. All levels are necessary so that it functions as an evidence-based practice.

One of the leaders for the Research and Development Unit is one of few who lift the understanding of evidence-based practice to a national level by speaking of the importance of a critical stance to what is coming from the national level. She describes this by highlighting a form of therapy for anxiety and depression that was used earlier but which is not recommended in the national guidelines. Now, the National Board of Health and Welfare, which is responsible for the guidelines, is beginning to change opinions after gaining new knowledge. She explains why it is important to have a critical approach:

> That, on one side relates oneself to the governance there is. National guidelines for interventions for, what was it, anxiety and depression, came a few years ago, [it is] not old. This lifted up cognitive behavioural therapy [CBT] as the one and only therapy, or the only form of therapy. And now this spring I hear that one of those responsible for the national guidelines, on The National Board of Health and Welfare, is saying that psychodynamic psychotherapy has also been found to work. And large parts of health care and the therapeutic world have already tried to turn the ship, invested in a whole lot of education in cognitive behavioural therapy, supported with money from the state. … Then one must take a critical stance. And of course there were critics, but they drowned somewhat in the hallelujah chorus around CBT. … So it is very important I think, a critical approach.[cxiv]

There are however not many persons interviewed from the municipalities that express the need for this kind of critical reflection. One of the regional representatives talks about the resistance to evidence-based practice that she feels exist, but that it is probably

more about resistance to changes than to the introduction of evidence-based practice itself. This resistance can be expressed as that the municipalities listen to and are interested in the development work the national level proposed, but they do not take the additional initiatives themselves to reflect upon that which is suggested:

> They listen, they do not grab on and think that yes but I shall investigate that there a little more, now I want to ponder, now I want, this here, they keeps a low profile. That is the way they think, that perhaps it all blow over, or I do not know.[cxv]

These two regional representatives, quoted above, speak in similar way about the need for reflection in the municipalities about the initiatives that they have opportunities to participate in. The other of the two feels that it is probably also good that there is a resistance in the municipalities:

> It is of course healthy too, that they do not just say that, yes we should, evidence-based knowledge, *this* we shall do. But that they have a cautious attitude. However, this can mean that they also think that, yes but, this they can carry on with, we do as usually.[cxvi]

One disadvantage can also be that if the municipalities do not reflect if they have a need to participate in a specific development work, and then rejects it without reflection.

Organisations as receivers of evidence-based practice

There is no doubt among the regional representatives that the management in an organisation, managers and local politicians, are important for the results of development works. For example one of them emphasises the importance of investing in and developing managers' competence, and that this ought to involve 'how I as a manager can work to develop and implement it in the work'[cxvii]. That is, knowledge about what is important for managers to know in order to be able to support and make possible the work of change, like the introduction of evidence-based practice.

One challenge with development work, in relation to management, is how one brings about a proliferation in the organisation so that it reaches everyone involved. If one is to reach all employees within all the activities in social services in the county's municipalities, which is a long-term goal with the EBP-initiative, it means thousands of employees. The municipalities should, according to one of the regional representatives, consider how to solve such issues themselves, as in this example regards taking in new knowledge:

> This is one of those things … that they must consider and find ways for in the organisations. That is, how do we fix this, the width? For … every single individual cannot be expected to keep up with the width. And how can we then solve this? That in any case gets a summary of everything that is happening. How do we find a system for that, in the practices? … It is very easy to lay it on every single social worker or nurse or whatever it is but … it is not realistic.[cxviii]

The outcome when the management do not take in the importance of working with these issues on a structural, organisational level is that the responsibility is placed on the individual social worker. Therefore, the municipalities need priorities within social service:

> There must be some kind of common approach in a social service that … before one decides that now we work according to this guideline or according to this routine that is based on this or this or this. So that … all the considerations are not the individuals' either, some must take place at a different level where they establish a program or a plan of action or something and then it must be based, yes. So, all [decisions] are not individuals' consideration.[cxix]

One development manager, who is involved in the EBP-initiative, feels that managers do not take the responsibility they should for following up and evaluating the work. They do not ask, for example, about the results of the work at an organisational level:

> I do not believe that the management have become so much better at doing follow-ups. … Because they have not been so engaged. It is the personnel that are working. And it demands the management becomes more controlling and works more with follow-ups. And follow-ups, they have not started with. And there, work is still needed.[cxx]

Instead it is the personnel that do most of the work with evidence-based practice. The local politicians in the Social welfare committee has a general responsibility to prioritise what is important in the work, for example, to ask for results from follow-ups and evaluations of the work. It is also the politicians' responsibility to create discussions about priorities and to make plans for the organisation's activities. The same regional representative as quoted above continues to explain:

> But it is *them* [the politicians] that must place the demand on that they follow-up, it is *them* that shall ask senior managers questions; how is it going with this, and how much is the cost of that and that, and what is the treatment that we use, and why do we choose that and what basis do we have for choosing this way or that there shall be so and so much money for this activity?[cxxi]

Her experience is that it does not work this way in so many municipalities, possibly only in the larger municipalities where they have full-time employed politicians. Questions of this type are not often raised whatsoever by politicians. Two of the regional representatives express that the politicians have knowledge about evidence-based practice but that it is 'quite superficial knowledge'[cxxii]. It is politicians and managers that are responsible for introducing evidence-based practice:

> Unless this lays in the manager's lap, unless politicians begin to put questions to the organisation, yes but then it is worthless. Then it is worthless. It must be that there *are* the heads of social services in the county that feel that it is we who own the question, it is our responsibility. And politicians must know that, we need to have these requirements on the officials. We must know: What do we get for our money? What does it provide for our citizens, is it the absolute best available knowledge we have?[cxxiii]

As long as senior managers and politicians do not take responsibility for introducing evidence-based practice it becomes a difficult assignment for middle managers and not least for social workers. The regional unit has organised seminars and further educations for managers and politicians to support them in the process of introducing evidence-based practice. The regional representatives have at the same time an understanding of the situations each municipality has. Several of the regional representatives express that the municipalities do not cope with all changes conducted at the same time. They also describe that introducing evidence-based practice is one of several development works that compete with the everyday tasks they have to do in the social services.

When many tasks compete it is easy to give development work a lower priority than those tasks which *must* be performed. One development manager experience is that it is often allowed to be a personal choice for the managers to engage in development work. This example concerns the extent to which managers have chosen to participate in further educations and seminars organised via the EBP-initiative:

> In some municipalities, it has been more or less compulsory for managers to participate in the educations that there has been. While in others, it has been very sporadic and up to each manager, do I want to do this or not, have I time, have I space? No, it cannot be done, or yes but this might be fun. So it has been very, very different. So, if we talk [about activities] where knowledge really needs to be … then I think it is very flawed.[cxxiv]

Introducing evidence-based practice involves changes and requires a lot of work in the social services. That it is an individual responsibility for the managers witness several regional representatives of, for some manager evidence-based practice is 'closer and warmer to the heart while for others evidence-based practice feels very strange'[cxxv]. It has not been easy to reach all managers with the educations, the same difficulties exist in reaching all personnel; it is not easy when dealing with large numbers of managers if one includes the entire social services and all management levels. Managers and local politicians are, however, essential for the introduction of evidence-based practice. Especially middle managers, who are described as particular important 'to give legitimacy to the work'[cxxvi] because the personnel 'have a lot of other things … must does[cxxvii] that takes most of their time. When other tasks compete with development work and organisational conditions do not support social workers, then it becomes 'those who have a little more interest and think this is more important than anything else'[cxxviii] that get involved.

None of the regional representatives have an understanding that the social workers work all the time with evidence-based practice in mind. One of the development managers, for example, talks from her experience:

> There are very few today that in some way consciously do this here weighing up; that now I shall act based on these sources of knowledge.[cxxix]

Evidence-based practice exists partially in the work process at the individual, social workers, level. There are 'glimpses, but absolutely not in the total'[cxxx]. There are a few that reflect upon how they use different knowledge sources in the daily work and that think about the work as evidence-based. In another example, it is explained that few

social workers search after the latest research, instead they rely on different methods that they are educated in:

> I believe that there are still rather few that go out on the net and searches for the latest research, just in this here area or that area. Instead I believe that where you have been trained, in those working methods that are proven, and *those* I believe one uses.

Social workers' also use national guidelines, such as for the care of those suffering from substance abuse and addiction, as a reference book. The guidelines and their summaries provide support in the work. Otherwise it is not so easy to find knowledge, for example on the Internet. It is described as a challenge and a very time consuming work. At the same time it is an important part of evidence-based practice.

Likely, it is those people that have attended the educations about evidence-based practice, organised for example by the EBP-initiative, that have a greater understanding for evidence-based practice and how different knowledge sources can be used in the daily work. One regional representative with experience mostly from individual and family service perceives that a great deal of the social work is done according to evidence-based practice 'although one might not call it that now we are working evidence-based'[cxxxi]. From one development manager's experience and the work with the EBP-initiative, it is not very obvious that the dispersion of knowledge about evidence-based practice is working well in most personnel groups. Instead she means that the work is often based in the social workers own experience and the knowledge they have:

> [This] has a lot to do with which individual I am and which journey I have done, yes the knowledge journey or whatever one should say. So I act based on the knowledge *I* have. And then it depends on, what knowledge I have encountered and what experiences I have had.[cxxxii]

When the work to a great extent rests on social workers experience, the knowledge becomes the social workers own knowledge.

As local politicians described as quite absent, and because it largely seems to be up to each manager to what extent they are working with the introduction of evidence-based practice, it becomes the social workers themselves that have to form the work according to evidence-based practice.

Challenges with evidence-based practice

In this concluding section I want to highlight some benefits and challenges in introducing evidence-based practice described by the regional representatives as important. These benefits and challenges emerge to a large extent when they talk about the advantages and disadvantages with evidence-based practice. The regional representatives describe, for example, the need to develop the work with evaluations at a local level, user participation and making social workers knowledge visible, as challenging areas for the development of evidence-based practice.

The regional representatives have no difficulty in explaining in which ways they understand that evidence-based practice benefits the work in social services. On the contrary, they perceive few disadvantages with evidence-based practice:

> I do not know disadvantages. There are not so many disadvantages.[cxxxiii]

> I see mostly only advantages.[cxxxiv]

> Yes advantages are easy to say, but what are the disadvantages with it.[cxxxv]

When the regional representatives actually do explain which disadvantages there are or what makes the work with evidence-based practice challenging, it is not about *that* there are disadvantages with evidence-based practice. Instead it is about *if* staff in social services does not work with evidence-based practice as it is meant, *then* it may engender some difficulties or disadvantages. One of the regional representatives points out that: 'Once you have reached a functioning evidence-based practice I do not know if there can be any disadvantages.'[cxxxvi] Another of them explains in a similar way:

> If one … use it [for] to weigh these here different legs against each other it is difficult to say that there can be disadvantages. Because that means that if I think that something, this time, weighs more, then I shall choose that. … And that is really an advantage, that you weigh different perspectives. … Then it is clear that we may have missed something, that we can find out in five years, yes but that, we did not think about that then.[cxxxvii]

In this quotation it is explained that social workers must compare and determine which knowledge and perspective that is important in a specific situation, in the meeting with the user. If the social services do not reach that far in developing evidence-based practice, then some risks may occur, according to the regional representatives. One of those risks is that social work becomes *instrumental*:

> It is not enough that I mechanically follow, ask all the questions, I must also be engaged. I cannot forget that I am still important as a person and how I meet the client and which approach I have. So that, one cannot lose sight of the big picture. That can be the risk.[cxxxviii]

Largely, the regional representatives understand the disadvantages with evidence-based practice as how it may become if evidence-based practice is not introduced as it is meant, and if it is oriented too much towards methods, models, cheque-lists and so forth, then there would not be an evidence-based practice in social work. It is the connection between the methods and models that the regional representatives stress the importance of when they describe how evidence-based practice was understood from the beginning, when it was introduced in Sweden.

Disadvantages that make evidence-based practice a challenge to introduce from a practical perspective are that it takes a lot of *time and resources* for the social workers. Here is one example given that it takes time for the social workers to adjust, to think anew and alter their way of working:

> It is clear, that for the individual working in the social service, there might become disadvantages, perhaps it takes time and becomes more

> documentation, perhaps more time goes into collecting knowledge. But I think that the advantages weigh up. But yes some individuals might experience that it is heavier and more difficult or take a longer time or.[cxxxix]

It is not just the individual social workers that must alter the way they think about work, it is also a need for changes within the organisations, as implied above. One regional representative stresses the importance of a reorganisation to be able to introduce evidence-based practice. This involves 'new contents in the organising, new follow-up instruments'[cxl], which are not always so easy to achieve in the municipalities, she says.

Another challenge is how the social workers *tacit knowledge* becomes the whole group's or the profession's knowledge. Tacit knowledge can, through evidence-based practice, be made explicit. Social workers' knowledge has not been made visible before and is not possible to find in documentation, either:

> It is not enough to reflect, one must articulate and document in some way. That I am absolutely convinced of. What was it that made it go well, and what was it that made it go wrong? And, one must, in the collegial group, lift up, compare experiences.[cxli]

Social workers need, in addition to documenting their tacit knowledge, to reflect over their work and the result of the work. According to one of the regional representatives, tacit knowledge can unify, they 'define together'[cxlii] and express and talk about, which means that tacit knowledge translated into words. One way for social workers to talk about their experiences and knowledge is through network meetings or similar forums as social workers organises themselves or those organised by the regional unit, often within the frame of national development work. Some of the regional representatives talk about the importance of networks and cooperation between municipalities in general:

> I believe that it is very important because … this contact net, that they said that, oh how good it is to meet like this, one always learn something from some other municipality. That it is an exchange of experience and it has great meaning because in the daily work one is so pressed and stressed so that one does not take the time to stop and analyse and consider and plan and find out. But when one meets like that and talk about their activities and one will gladly lift up that which works [in their municipality]. It provides opportunities for others to learn and there were many times that it happened that, oh well but can I take contact with you later and talk about this and how you have done and if we can, like do the same and adapt in some way at our work.[cxliii]

Partly, this explains that network meetings give the social workers opportunities to exchange experiences, partly that they can give and receive advice about how to conduct the work. Network meetings give social workers opportunity to reflect, because they seldom have the opportunity to reflect in their daily work.

Two other challenges with evidence-based practice mentioned by several regional representatives are a need to increase user participation and to start doing evaluations of the

local practice. Improvements for the *user* are one of the main reasons for introducing evidence-based practice, and are also one of the greatest challenges ahead:

> The very idea with the whole activity is that [users] shall have it better. To [investigate] how it is for them and what they themselves think about it, it must be the most important for the development of the activities. … So therefore I think that it has its significance, that it is about quality development, to do better things for [the users]. That is the objective with it.[cxliv]

Another of the regional representatives explains that an increased participation for the user is a way to improve quality in work:

> But as far as it is possible it can become more similar and that increases the security, the trust for what we are doing. … For the individual the expectation is that they can participate more in the decision and that perhaps decisions are more correct, with more successful interventions.[cxlv]

It is important that work is based on 'the best available knowledge and experience'[cxlvi] because the social services support vulnerable persons. Social workers must therefore work in such a way that the user can 'trust' the social workers and 'feel secure'. Evidence-based practice can contribute to this.

Evaluations of the local practice as a challenge are described by several of the regional representatives. Doing local evaluations are an area of development in the work with introducing evidence-based practice:

> I think that this [local evidence] really needs to be emphasised, what is it we see at the local level and evaluate different issues within in my case the social services for children at the local or regional level. So that one does not just, because research is always available in *some context*, this … [does not] apply equally in the whole of Sweden. ... Similarities do exist but one must still [read] the research in a selective way, maybe. But, to emphasise the local, to raise the local evaluation I believe is very important because one shall also get a, this we know in North Bothnia or in Luleå or Boden[21] and strengthen it. This creates a strong feeling of self-esteem that one knows something about one's activities. And not only, can also reflect upon new knowledge that comes from somewhere else.[cxlvii]

By evaluating, and follow up municipalities own activities, based on local conditions, a surplus value for social workers is created, and it becomes easier to take in knowledge from other places. Evaluations compiled at an aggregate level also give advantages for the organisation; it strengthens the quality of the social services:

> [Evaluations] lift … the question at a little higher level, that it is important that we do something about the quality. Other things have of course surfaced as well, I mean the concept of quality and the need of following up activity so that you know what you do and what the outcome is. [This] exists in another paragraph also, the quality paragraph.[cxlviii]

[21] Luleå and Boden are two of the three largest municipalities in the county.

When organisations evaluate the activities, the responsibility for evidence-based practice becomes the management's responsibility. There is, as pointed out above, a quality paragraph in the Social Services Act. The pursuit after a high quality in social work is nothing new that came with evidence-based practice; on the contrary it has been raised in many contexts in society (cf. SOU 2010:65). One of the other regional representatives mentions a general organisational level for the use of evidence-based practice, giving the organisation a 'security in that here we work from an evidence-based practice and where we know that we satisfy the demands and duties we have on our activities'[cxlix]. In that are included demands on quality, and is a question of legitimacy.

Finally, the regional representatives emphasise that social workers will grow in their profession when evidence-based practice is introduced. This is not a challenge but a result of introducing evidence-based practice. Two of the regional representatives exemplify this:

> As a social worker [I can] soon stand up straight and hold my head up high for … to be a social worker is not something that really belongs to conversations at dinner one might say. It is a difficult occupation and an important occupation that is easily belittled. … So in this way I believe that it is really good. And above all it is that, if we dare stand up straight … then it will provide a security even for those we are supposed to give support and services to, interventions. … I believe it is very important. Or it *is* important. It is disadvantaged groups, vulnerable groups we come in contact with. We must be able to stand up for what we do and know that it is the best available knowledge we use.[cl]

> It is this feeling of that what I do is professional. It is not something that I invent, or think, or something like that, it is a professional work that I perform. And, one does not see the clients as some mass either, it is the individual that I meet and my approach is of great importance in this job. And I have different kinds of tools in my toolbox that I can use when I meet these different people. So that it is, yes it is … professionalism, I think, considerable.[cli]

Through introducing evidence-based practice social workers' competence increase, and a legitimised activity and a security as a professional social worker is created.

7

Managers about evidence-based practice

This chapter is divided into three main sections, where each section has its theoretical foundation in new institutional organisational theory, and the associated theoretical concepts. The *first main section* introduces the reader to how managers perceive evidence-based practice. Since evidence-based practice is launched mainly with a top down perspective it becomes important to understand how managers relate to evidence-based practice. The *second main section* aims to explain that managers are a coordinating link between different stakeholders, namely the government, the organisation's management and the social work practice. And, the *third main section* is about the managers' perception of how they support social workers in their work, and how external knowledge and users' knowledge is used in social services work. I present how managers receive what is introduced from national actors regarding, for instance, evidence-based practice, as well as how they relate to those initiatives and to the requirements that the organisations management place on them. This provides, for instance, the possibility to analyse what they say through the concepts of legitimacy, decoupling and isomorphism.

Seven managers are interviewed about their work as managers in relation to evidence-based practice and other development work[22]. Four of these are middle managers and three have a higher management position in the municipal social services. Although the managers have different job titles they are divided into middle and senior managers based on their responsibility in the organisation for development work, including evidence-based practice. The four middle managers are responsible for development work and to support the social workers in their practice. Two of the four middle managers also have a responsibility for personnel. The three senior managers have an overall responsibility for several areas of the social services as well as over development work. Working with children and families is one of these responsibility areas. There are some differences between what middle managers and senior managers choose to highlight, based on their experience and position in the organisation. Such as their understanding of the daily work social workers perform. This creates a deeper understanding of the tasks that managers perform and the conditions they work under.

[22] I use the concept development work when writing about the national initiatives and development projects conducted in the municipalities. This is in accordance with the concepts used by the Swedish Association of Local Authorities and Regions, which administer most development works.

Five managers are women and two men, of which one is a middle manager and one a senior manager. Men working within the social services are an under-represented group. For example, a total of 19,2 per cent are men, of all those working in social and curative occupations (regardless of position) in Sweden. In North Bothnia County, the corresponding share is 16.5 per cent (Sveriges Kommuner och Landsting, *Kommunal personal. Tabell 7*). To ensure that these men are not recognised, I choose not to distinguish them in the text.

Three of the middle managers are educated social workers. Two of those three have between 15-25 years working experiences within social services and have worked as middle managers about four and ten years. The fourth middle manager has worked as a social worker and middle manager for about 20 years, but is not an educated social worker. She has another university degree, which during the years has been complemented with courses in social work. Of the senior managers, two are trained social workers. Both have more than 25 years' experience, mainly in the municipal social services. The third senior manager has a different university degree acquired about 25 years ago. She has experience of working as a manager within the public and private sectors. All senior managers have worked as managers for a long period of time. The one with the shortest experience has worked twelve years as manager.

A positive perception of evidence-based practice

Evidence-based practice emerged, according to one senior manager with long working experience, when evidence-based practice was introduced in the late 1990s. The understanding of evidence-based practice has gradually been modified, developed from a quite narrow understanding of evidence-based practice to a more nuanced broader meaning today:

> When it was taken up it was very much this with research, and therefore I think the expansion that has happened with evidence-based practice ... tell me, who does not agree with that. That it is very wise to, like, have several legs when you look at what we do and what the result is.[cliii]

It is hard to be opposed to evidence-based practice with the understanding that exists today, with the understanding of evidence-based practice as weighing together several sources of knowledge (*several legs*) to a daily practice. Evidence-based practice is perceived positively by most managers, and considered to be of good value to social work, which is exemplified by three managers:

> But I think it is good.[cliii]

> I think in general that it is only positive.[cliv]

> Hamper, I have real difficulty in seeing what it could be. … It [facilitates] that we know we get better written products from us … and that clients receive, of course, what they are in need of. So I find it hard to see anything negative about it. I see only positive things with it.[clv]

Few of them describe evidence-based practice being negative or as hampering social work in some way. But there has not always been consistency in the understanding of how evidence-based practice should be conceived, which was debated a lot when Lars Pettersson and Kerstin Wigzell first brought up the need for knowledge-based social services toward the end of 1990s. The development of evidence-based practice that has occurred since then is described further by the same manager:

> When it did not become so defensive, then one has, of course, seen that it is important to find methods and ways of working that ensure better results. … There are limited resources and that means that we shall direct them to what one then finds to be effective. Then, there is this concern that we rarely have any control groups as … health care has.[clvi]

As evidence-based practice is understood today, most of the managers think that it will be a part of social work in the future. One of them says that the ambition is that it 'will be a natural part of our work'[clvii]. Managers perceive that there is an interest in evidence-based practice among social workers, here explained by one manager:

> But *today* I would like to say that there is a lot, I can only speak for individual and family service, that there is a strong interest.[clviii]

Although almost all managers feel that evidence-based practice is something that will be introduced and survive, there is one senior manager who has a slightly different view. She emphasises that there is currently a very strong focus on evidence-based practice, but that it 'will probably be toned down as so many other issues'[clix]. One middle manager believes that evidence-based practice will exist but is not sure how evidence-based practice can be maintained in smaller municipalities, as the one she works in:

> In a small municipality, maybe not the same way. I do not really know. I think, in a larger [municipality] … there is a considerable group of similar cases. Here it is, if I say custody investigations, they are so infrequent and child care investigations ... four at most. … If it continues that way. And strange it would be if there would be much more if the population does not increase. If one does not work with our cases in the municipalities [in this part of the county], for example. And then one could … get a sufficient basis.[clx]

The conditions in smaller municipalities are not the same as in larger municipalities. As described above the amount of cases are too few in the smallest municipalities to do evaluations of their own work.

Benefits for practice

Regardless of this difficulty in smaller municipalities, the manager has nevertheless a positive perception of evidence-based practice. Evidence-based practice entails an increasing participation and influence for users, especially for children. The managers highlight the importance of user involvement since it is almost impossible to force someone to a voluntary intervention if they do not want the support. When the user wants support from social services and wants to change their life situation 'then their thoughts are worth gold'[clxi]. Almost all managers perceive that evidence-based practice also has positive effects for social work, such as that the work becomes less arbitrary,

more uniform, entails security for the social worker as well as opportunities for local evaluations and follow-ups. Several managers relate to BBIC[23] when describing the benefits with evidence-based practice, for example improved the practical work through a uniform way of gathering information about the user in a case:

> BBIC … is just a system for how we shall gather information, how we will ensure that the basic principles that BBIC is based on is included into social work around children and youth. And that we do not guess things, as one might have done before when it was a little more arbitrary. We had no uniform way to gather information and investigate and follow-up our interventions. This could be done in many different ways from one municipality to another, even within the municipality. … Depending on the case officer who did the job, it could differ very much.[clxii]

As it has not been introduced in the municipalities yet, several of the interviewees from social services, both managers and social workers, have difficulties talking about evidence-based practice. Instead, they talk about the work in general. This means that large parts of the interviews were about BBIC and other ways of working.

Furthermore, BBIC contributes to more complete investigations and to that all users are asked the same questions. One senior manager explains that investigations according to BBIC also give politicians a more complete picture of the child's situation. And one middle manager says that investigations become more thoroughly and legally secure, and more uniform. Uniformity creates greater security for social workers because they *know* that they do not miss investigating any important areas:

> It was the idea, that everyone shall be the same. That is good, that every [investigation] is equal and one does not need to be insecure, then [as social worker]. … Before, it could be that, of course, have I now everything that is required for this?[clxiii]

Social workers uncertainty is linked to a concern that everything of importance in the individual case has been taken into consideration and been investigated. This uneasiness reduces when social worker use BBIC.

Benefits for the organisation

So far, the benefits with evidence-based practice and BBIC as the managers' talk about have mainly been about social workers' practical work. These benefits dominate when managers consider the benefits with evidence-based practice and BBIC. But there are some benefits mentioned in regard to the organisation; such as quality aspects. For example, evidence-based practice increases the quality in the interventions given and entails a more effective work. One of the managers explains that:

[23] The Swedish BBIC (Barns Behov I Centrum/ Children's Needs in the Centre) is built among others on the English Integrated Children's System, ICS (Socialstyrelsen, 2013). I choose, in order to avoid confusion, to use the Swedish abbreviation in the text, because Sweden has adapted the original English version to Swedish conditions and created a system based on 'national practice, organisation and legislation' *[author's translation]* (ibid:20). BBIC is described as 'a system for handling and documentation in investigation, planning and follow-up' *[author's translation]* (ibid:17).

> It shall be effective, what we give our clients, it shall give them something too. … [Evidence-based practice enables] us to have better … control on what we do … why we do. … It is about trying to maintain some kind of quality in what we do. So, just that the concept came, that this is important to consider in social work, yes but that has brought, I think, that we have better control. We are more careful to do the right things, so to speak.[clxiv]

Quality aspects have been emphasised through the introduction of the concept evidence-based practice. Effectiveness is a term often mentioned by the managers along with good quality. There is a need in social work, to know that they 'give the right intervention to the right person and that it gives the right effect'[clxv]. According to this middle manager there are growing demands for good quality and effectiveness in the social services, which is an on-going development where the employees carrying out social work are at the same time becoming fewer and fewer. She says that they have to 'start streamlining, because we will not get more money just because I say that a new legislation has come'[clxvi], for example. High quality is assumed to involve more efficient social services. Expectations as the managers perceive on the work are that it should be performed with a high quality even when resources are declining. Searching for external knowledge may, according to one of the middle managers, provide security in social work, and can be used to find support in decisions made by the social workers, so the interventions become effective.

To translate evidence-based practice from theory to practice

These two senior managers do not see that there is any major difficulty in understanding what evidence-based practice is, and they do not believe that evidence-based practice represents an entirely new way of working:

> I think most people still know what evidence-based practice is. But it may be me that thinks that.[clxvii]

> Evidence-based practice for us who have an academic background, as for me, it is not a … difficult question. I mean, we talk about this all the time, about this to ensure the science in it, so to speak.[clxviii]

Another middle manager agrees; she explains that she does not feel that it is a new way of working, using evidence, and says that they have always used evidence in the work. A lot of what is done in the daily work is evidence-based practice.

One of the middle managers argues that social workers admittedly work a lot according to evidence-based practice, but that the very concept of evidence-based practice appears to confuse social workers and create resistance among them. She reflects over whether it could be called something else in order to facilitate the introduction of evidence-based practice:

> I think I am starting to call it in any other way. I can imagine that sometimes it is the word in itself that scares people. Thus, they already do this without thinking about what they do. You use knowledge, especially those who have worked a little longer. You use your knowledge; how was it to meet this? You know, for example, about certain diseased or

> anything, psychiatric. Then comes, click, I did go on this course. … So in a way you use it but without knowing. That is the bit that I think is missing. Except the users own opinions.[clxix]

She explains that different knowledge sources are used in the daily work, but the social workers do not reflect on that they do this weighing together.

On the contrary, another middle manager from a small municipality with few employed social workers says that she and two of her colleagues, both with substantial working experience as social workers, perceive evidence-based practice as something new to be introduced, and that it has been presented as it will change social work:

> I am completely sure that [two of the older colleagues] feel exactly so. … It feels big, difficult to grasp. … The concrete is missing. It is too abstract, it feels like.[clxx]

On the other hand, she is more uncertain if her younger colleague feels the same way. The same manager also experiences that it is difficult to translate the theoretical knowledge about evidence-based practice that she gained from the seminars she participated in, to the practical work within individual and family service. The seminars about evidence-based practice were organised through the EBP-initiative, and she perceives them as directed towards social work in general. Translating this general knowledge to individual and family service is difficult and raises many questions; 'how shall we work'[clxxi] at individual and family service, and 'how do we evidence-base this?'[clxxii] Therefore, this manager feels that evidence-based practice has not been introduced within individual and family service in her municipality:

> It hangs in the air. … No one really knows what to *do* with it. One talks in their own way about evidence-based. … Especially for [individual and family services] part, I would like to have, what do we do: concrete? [We are] groping. And I think it makes it feel uncertain and when it feels uncertain, then there will be reluctance.[clxxiii]

The same manager explains that the people organising the further educations and seminars about evidence-based practice have chosen educators that talk about evidence-based practice in a way that is not concrete enough for them in this area of social services. One social worker, who has work experience in individual and family services and at the regional unit, feels that there is a gap between how the regional unit and local social services talk about and understand evidence-based practice. These understandings of evidence-based practice differ, and social services have not reached the point that they perceive evidence-based practice as a combination of different sources of knowledge.

The middle manager quoted above began working in social services in the late 1980s and she explains that social work has changed since then. Back then, they used their own experience in work to a great extent, and they did not talk about using evidence in work as they do today:

> There was no one who was talking in terms of evidence-based or that there must be something proper and important, but it was more like that taking chances, yes … but it has been shown that it is not possible if you

> do this and that. It is not doable, for example, if you send someone against their will to a treatment or if you send a youth to the LVU[24], it does not give the results that you desire. We had it only as experience, but we had no statistic on it.[clxxiv]

Earlier, social workers worked from what this manager describes as 'everyday evidence-based'[clxxv], which means that social workers primarily used their own knowledge and experience in work. Professional knowledge is part of evidence-based practice and is included in weighing together different knowledge sources to a whole.

This transition is, according to the manager, more difficult for social workers who have worked long in the profession, and that have traditionally used their own knowledge and experience a lot. One of the other middle managers speaks in a similar way about differences in what kind of knowledge social workers have depending on when they were educated:

> We have a professional group who were educated in the 70s, when social work education was very practical, the education itself. And those who have been studying now … got their education very … research-oriented, thus theoretical. And sometimes the two things collide. Those who have been social workers from the 70s they have *very* much practical knowledge that those coming directly from school today do not have. They get practice only after completing their studies, regardless of the practice time. But on the other hand many of the older snort ... why should one read the research, and so on. So I think that is the biggest gain, to merge these forces. Yes, and then be able to talk *about* it. It is no less knowledge in my eyes than those who know that, yes but SOU[25] 2012 says so and so. But they have to merge.[clxxvi]

She continues to explain that the practical, proven experience and knowledge that social workers have is weighed together with other knowledge sources, such as theoretical knowledge in evidence-based practice. An example of this is that the knowledge base that social workers have, regardless of when they were educated, is complementary and needed in social work. Similarly, another middle manager explains that the mix of knowledge that newly graduated social workers and social workers with longer experience have is an asset in social work today:

> It is an asset in a workgroup that there are some who have worked a very long time and some are relatively recently graduated. That they add [knowledge to] each other … for those who have been educated recently, they have a completely different knowledge base than we old ones. So, we give to each other automatically … and then we get to hear what is now going on at educational institutions. … It is a good mix in this.[clxxvii]

Different knowledge enriches the social work and also evidence-based practice. Theoretical knowledge for instance, 'adds new knowledge to the practical side that we have ... great use of'[clxxviii] in today's social work.

[24] LVU stands for compulsory care according to The Care of Young Persons (Special Provision) Act.
[25] Swedish Government Official Report.

At the same time as some mangers do not perceive evidence-based practice as an entirely new way of working, it is evident here that there are those who feel that it is difficult to translate evidence-based practice from theoretical to practical knowledge. This difficulty may depend on when the social workers were educated and if they have learned a more experience-based or theory-based social work, that the two managers reflect over.

Managers as a coordinating link

Managers' responsibility for development of social services includes evidence-based practice, BBIC and other development work going on. Managers are a coordinating link between the activity of social services (social workers daily work), senior managers, politicians as well as the government agencies, and have to consider the requirements of these stakeholders. This is described by the managers when they talk about their work. One senior manager puts it like this:

> One becomes a link somewhere between the politics and our activities [social services]. And what has been ... the focus, it has been working environment, it has been economy. Though actually the contrary, economy in the first place, for it is out of control. We have an aging population, greater need of care and caring. So those are the challenges, what I try to work with, that is to get my managers [below me] to feel like doing more for less.[clxxix]

She provides an over-all description of her position and responsibilities within the organisation and what has been prioritised. It is obvious that economic requirements from management largely control managers' work. The senior manager quoted above also claims that the managers lower down in the organisation should always have the budget in mind. One middle manager agrees with this and describes the economic requirements within individual and family service in her municipality:

> A middle manager shall be, develop work, see new possibilities how one shall do, of course more efficient and cost effective, and above all keep the *budget* [in balance]. It is important too. And that, I can think, that it is a little difficult to balance this, what you see for need of interventions. But we must at all times have the budget in the back of the head.[clxxx]

What the managers above, and other managers, talk about are the requirements that exist in the organisation to keep the economy in balance and that economy usually takes precedence before other tasks.

The managers are also responsible for development work, often including the introduction and maintenance of evidence-based practice. Development work often derives from national requirements of what is needed in social services. Evidence-based practice is such a development area. One senior manager says that they 'have a huge role in this, because we visualises it and we keep it alive all the time'[clxxxi]. She also thinks 'it is really important that we are involved and monitor'[clxxxii]. Managers' responsibility should be emphasised and documented in such as plans of action. One reason is that the

organisation should not be dependent on a driving spirit. Instead the responsibility should be a part of the organisation's structure.

Two other senior managers explain that the responsibility for the introduction of evidence-based practice lies mainly with the middle managers, the officials:

> Until now, I feel that [the responsibility] has been on officials to introduce this. … As has come with ideas and both developed and [drafted proposals], and received decisions about it.[clxxxiii]

> Within the area, they have all responsibility [for development work]. I want them [the middle managers] to come to me and say; now we have seen this. What do you think about this?[clxxxiv]

The middle managers are, according to the first of the two managers quoted above, 'key people'[clxxxv], and they 'must be the carriers of the change'[clxxxvi]; they are responsible for changes in the practice. The other manager quoted above explains that her responsibility is to ensure that the middle managers develop work.

Although there is an interest for evidence-based practice among social workers and managers it is not enough for introducing evidence-based practice. There is also a need for a structure for the introduction in the whole organisation, created at an organisational level by the management. With managements' commitment to evidence-based practice the possibilities for social workers' to work with evidence-based practice increase. One senior manager points out that it is not enough trying to change the practice; they also need a structure through which they can clarify responsibilities for the development work done in the municipality. In her example it is shown that they, in this municipality, missed including the middle managers when BBIC was introduced:

> That it not only becomes the [BBIC] investigation, but also that there is a structure on another level. And there we can see, not least, what we did wrong [with the introduction of BBIC]. We, yes it was forgotten a little bit the first-line managers who are so incredibly central for development work.[clxxxvii]

Her experience is that first-line managers, namely middle managers, are key people in development work because they are the link between the practical work and the management, including the local politicians. Today they have the intention to involve middle managers when they faces changes, and they have a management group that meets regularly to discuss other development issues and priorities:

> What do we need to focus on, what are the questions, what are the areas of development that we need to continue working on. That it is not only the investigation itself, but that there is also a structure at another level.[clxxxviii]

This group becomes a forum to keep the chosen areas for development alive and being prioritised. There are additional examples from other municipalities where management groups exist, having the overall responsibility for such things as development issues, competence issues and further educations. One senior manager explains the aim with

such a management group in her municipality, where those participating are responsible for development issues documented in plans of actions:

> We have created plans of actions for what we want to achieve. And that is … to follow up and to have it with them all the time, that it is a living document. … We revise them regularly, also … and I expect that my managers then in turn do the same with the activities. We do the overall, what are the management group's assignments, purpose, thought, what *we* want to accomplish.[clxxxix]

It is the middle managers that introduce ideas about work to the social workers, which according to the manager above is listed in the plans of actions drawn up.

Two middle managers talk in a similar way about how the aims in scorecards can be linked to the need of education, for example. The original thoughts about which educations, or other development work, social services need often come from the social workers and the middle managers. In the first quotation the general priorities of educations are described, and in the second quotation a more concrete example is given of when the method Motivational Interviewing (MI) was introduced:

> Someone is curious here about, whether we as managers or some social worker who has read about some website or has got it sent to us that, well it might be worth trying, testing. … If we make the assessment in the management group also, but we let these, a few people go and see what it is. … It is [in the management group] … we decide which educations and how we will plan for the year.[cxc]

> We decided that we should have a basis with MI among case officers. It comes naturally from the top that we could take it into the scorecard. ... We take this, of course from scorecards, and remodel it as an activity and we also decided at the management level that this is something that we think is important that everyone has as their basis.[cxci]

There are forums in the municipalities and with it a kind of structure where managers can affect development issues, such as the introduction of evidence-based practice and other matters relating to education and competence development. The examples given by the managers above are not specifically about evidence-based practice. Instead they comprise development work in general. How these ventures are organised and who participates in the management groups varies between municipalities, as does the extent to which the work is based on goals and scorecards. In one municipality where they do not work with goals and scorecards a senior manager explains that essentially they work in the same way, but they do not use those terms.

As mentioned above, there is a structure for development issues in most municipalities, forums where managers can meet and talk about the daily practice, education and development work. Similar network meetings, but at a more overall level, where senior managers meet other managers who are in the same position as them, are arranged nationally. According to one senior manager those meetings are mostly concerned with gaining knowledge about what is happening in the country; she calls it 'reconnaissance on the world around'[cxcii], which she says is an important tasks for managers. This is a term I have heard used in social services when, for example, those working with devel-

opment issues describe their tasks. Primarily, it means to be familiar with what are happening, trends and current development areas, nationally. Although according to another senior manage, evidence-based practice is not something that is discussed at those meetings. Instead, they discuss changes within the social services on a more general level, they take note of what others have done and get ideas about how to organise social work. These network meetings are essential, explains the senior manager, because they provide opportunities to exchange experiences with other managers.

This section has provided an introduction of managers as coordinating links between the requirements and needs of different stakeholders. In order to further understand the managers' approach to evidence-based practice the following sections focus on the position of managers in relation to government efforts and the organisation's management (manager and politicians).

Government control of social services

According to the managers there is governmental control in social work. They are expected to perform certain tasks and participate in different development initiatives. Often, these initiatives mean participation in further educations, courses or seminars, different networks and sometimes being the social services' contact person for development work. It also means building structures in the organisation in support of participation in initiatives such as the introduction of evidence-based practice and BBIC. One manager speaks of this control:

> We get requirements on us, to implement things and then maybe project funds will be created. And sometimes it is incentive grants but other times it is performance based compensation, and then we have to show some results to get part of the money. Open comparisons have … been such. These registers, Palliative and Senioralert are such and … Support to relatives has been one, where there has been money. And now we shall fend for our self. … It has been a flurry.[cxciii]

The control may involve a requirement to provide information to quality registers in order to have the opportunity to use the information available in these systems and get access to financial funding that comes with those commitments. There are also changes in legislation including the strengthening of the Social Services Act on the ability of social services to 'follow up a child after an investigation *without* consent from the parents'[cxciv]. Changes in legislation, like the one above, govern the development of social services in the direction of an evidence-based practice, with the goal of improving it for the users'.

When many parallel development works are conducted, it creates a large workload for the social services, especially if it is a small individual and family service, and the few social workers employed there have to participate in all of them. One middle manager describes the difficulty when a national coordination between them is missing:

> That when several started, and then we have small municipalities. … For, exactly the same time, it was about violence against women, at the same

> time it is about domestic violence, and then it is about children who witness violence. … And all these were so important.[cxcv]

She does not feel that the on-going development initiatives are coordinated suitably. It is about a need for structure in the organisations where the initiatives come from. Some managers' speak about the importance of sustainability; that initiatives are introduced in a way so that the social services feel they have the endurance to make all the changes required. The importance of sustainability is referred to the introduction of evidence-based practice and BBIC, and is described by a senior manager:

> I think that I see, when it regards … [BBIC], if we had not been persistent we had probably have gone back to the old way of being. And this evidence-based practice, it is not enough with a year or a few years; here it will take a *long* time before one has turned the ship.[cxcvi]

Development work that is not long-term risks becoming more of a project than an organisational development and is at risk of not surviving in the social services. The same manager as above has the experience that when they started to introduce BBIC 'there was a big difference in whether you did things like projects or with the focus of organisational development'[cxcvii]. She also feels that national initiatives that the Swedish Association of Local Authorities and Regions (SALAR) are responsible for are not enough long-term, even if their ambition is to work on a more long-term basis than in earlier years:

> [I think] that one is a little too, they invest such large funds in such a short time instead of lubricating the organisation for some more years. Because when we get the money, then we are not ready to start so we have almost lost the first year. It takes longer because we do not know, will we get this money, which means we are a bit dormant and then there is a risk that we shall do far too much in this short time. It becomes very much project instead of a development of the activities.[cxcviii]

The risk is that when there is uncertainty as to whether government funds will be allocated to the municipality they await approval, which implies that they are not prepared to start up the development work at once when they do get money. An example of this is the EBP-initiative, where there was a high ambition from the national level to introduce evidence-based practice through regional support structures. Although being a large municipality, she continues, they were not prepared to widely introduce evidence-based practice when the EBP-initiative started:

> [SALAR] wanted to spread it on a fairly *broad* basis, and we were not there. So we have probably gone a little out of step when it comes to that part. … There I think it is more about, when one shall support something like this, it is about endurance.[cxcix]

Another senior manager speaks in a similar way, explaining that project funding often causes extensive work for a limited time, which tends to mean a lot more paperwork than real changes in practice. She also lacks long-term thinking in the state funding of development works. One example of the initiatives with performance-based funding as is given to the social services during a start-up period when they submit data into quality registers is provided here:

> And the register is I suppose a good thing. This palliative register and Senior Alert, and that we analyse and look at the deviations and so on but, sometimes I can feel that … they are chasing us in the municipality. … It is a lot more so [today]. And sometimes one does not keep up as a middle manager and especially not as case officer with what is available, because it goes at a cracking pace. And there may be someone who sits in their room and creates a document, and it does not become this process, I say as a social worker, as it should be, but one is forcing out something that looks good. And then there will be no good.[cc]

These are requirements coming from the National Board of Health and Welfare involve work creating documents which in the end risk being unused in the municipality. The data gathered is only sent to a register, and then the municipality has fulfilled their assignment which is a kind of lowest level of effort. The same manager mentions value guarantees, which involves the municipalities creating documents about an agreed value basis for work. This is part of the development work and is what municipalities get money for. But it is not 'certain that we use them or look at them' afterwards. There is a risk that when the funds for development cease, so do the work conducted in the municipality. There are almost no structural conditions to continue working with these efforts in an everyday practice.

The management sets the frame for the work

Another stakeholder that managers need to take into account is the higher management of the organisation, comprised of local politicians in the Social welfare committee and senior managers. This section is about how middle and senior managers experience the relation to the management; it is not about how for example politicians work or how they perceive evidence-based practice. The intention is to give the managers perspective of their preconditions to work with introducing evidence-based practice.

Within the organisation the local politicians have an overall responsibility for activities within social services. At the same time as managers are key people for developments in the organisation and know what the needs in the practice are, there is an organisational control that entails that managers must adapt to the requirements of the organisation. As described earlier in this section, this may involve adapting the practical work to the budget or after the organisation's general objective. There are examples where the municipality's financial situation controls what they can do and which development work they can perform. For example, one middle manager believes that there are limited resources and that the economy 'controls pretty much what we do'[cci], for example which further educations to invest in. Another middle manager explains that the financial situation in her municipality means that the personnel are not allowed to participate in any further education, with one exception – further education in a working method that politicians decided that social workers must use.

Few managers feel that they get assignments from the local politicians in the Social welfare committee, except the financial framework they have to follow. Nor do the managers experience that the politicians are particularly familiar with evidence-based practice or any other development work. One senior manager illustrates this with the

introduction of evidence-based practice and the development within individual and family service:

> I experience, that from the politics, we may not, or, we very rarely get assignments or ideas about what to apply, or such. It may have been some [of the politicians] that have been on some course sometime. It is us, as officials, who get to bring things up.[cii]

Another of the senior managers believes that politicians are 'pretty ignorant, but that they think a lot'[cciii]. At the same time she understands that they cannot have detailed knowledge of every area within the social services. One middle manager also agrees that politicians do not have much knowledge about evidence-based practice but she 'does not know if they need it'[cciv] either, although it makes their job a bit easier when politicians have some knowledge about work within individual and family service. Here one manager explains why she thinks it is positive when the politicians are familiar with their work:

> Then they ask, then they are interested and ask. But if they do not participate in educations … or gatherings or so, then they are not interested either.[ccv]

She has a long experience of social work in different municipalities and has met politician during the years that have shown interest for their activity as well as those who have not shown the same interest and engagement. Individual and family service constitutes a relatively small area within the social services. Another manager shares the experience that individual and family services is a smaller area, with a smaller budget than other areas such as elderly care, which affect politicians' interest for this, area.

However, some national initiatives intend to involve local politicians in the Social welfare committee by making them a part of the structure required for, for example, the introduction of evidence-based practice and BBIC. One senior manager believes that national actors 'have been eager to spread ... the responsibility'[ccvi], so development work shall 'permeate the organisation'[ccvii]. Nonetheless, she does not feel that the politicians have all the knowledge about the development work undertaken. Therefore, it is in large part the responsibility of managers, and especially middle managers, to introduce, for example, evidence-based practice.

Knowledge about effects and quality

One aspect with evidence-based practice, which involves both managers and local politicians very much, is the possibility to base social work on knowledge about the effects and quality of the interventions given. Knowledge from such local evaluations could be used to plan for future activities and can help management make relevant priorities. However, it is very rarely that these kinds of evaluations are conducted in any of the municipalities and, or, perceived as one of the most important development areas. Here one manager highlights the importance of evaluations at an organisational level:

> We need to document and follow up much much more than what we do. At times it is like that, that an intervention is closed without any reason. Maybe the users do not want it, or whatever it is. … Then, one puts it in

> the file instead of maybe stop and, what was it that made it become like this, that one finished the intervention in advance, maybe. That would be interesting, to make an evaluation, how did this happen, could we have done something different?[ccviii]

In this context it becomes important for social services to reflect over results, to 'stop and analyse and think about things, why do we do this, and is it this we shall keep on doing?'[ccix] This reflection is necessary if evaluations shall contribute to a development of the work, and the reflections have to be made along with a political discussion of the effects of interventions and the organisations design and structure.

Most local politicians do not give directions about work and they do not ask for results of the work either, according to several managers. One middle manager gives an example that the politicians rarely ask for evaluations or after results of their interventions:

> Follow-up and evaluation, then it is … not another evaluation of this, so to speak, annual statistics on quantity of cases, how many children are placed, and. But not any [evaluation of results].[ccx]

Evaluations undertaken and reported to the politicians are mainly compilations of statistics. Some managers explain that they have evaluated their organisation for upcoming organisational changes or working with targets or are introducing a quality management system that can be used for future evaluations. These types of evaluations of the activities are described by three middle managers:

> Because we precisely analysed all our processes, it has been a way to evaluate one part since we have looked at the process of investigations and ... various types of interventions. ... Yes, all these processes we have looked at.[ccxi]

> It is goal-oriented and … the Social welfare committee makes decisions what goals they shall have for the coming year and what we shall work with more specifically … And … that we do.[ccxii]

> We must build [a] … quality management system, for quality. All municipalities must [introduce it] … in social services. And it shall also be data-based so that one has a process of thinking when an application comes, what happens within different areas, and how one quality assures everything ... from A to B, until the people disappear from the process.[ccxiii]

The examples given above of what is evaluated in the social services are admittedly evaluations of the activity, but it is more about evaluating the working process than to evaluate the results of how the interventions work for the users. This is two different types of evaluations; in one is the processes measured and in the other it is outcomes and effects. Representatives for evidence-based practice usually advocate the latter.

Blom and Morén (2011) discuss the quality concept, and from the description these managers provided in this section they measure the quality of services that social services provide and the aspects related to structural quality, performance quality and process quality. Managers rarely indicate that it is the users' quality of life or well-being that is measured in the municipalities (see Blom and Morén, 2011). The quality concepts Blom and Morén (2011) have retrieved from a Government Official Report

(SOU 2005:110). In that report it is explained that structural quality is about measuring the quality of the resources and the frames of work, for example economy and resource allocation, or the competence of personnel (SOU 2005:110).

According to Vedung (2009) many evaluations within the public sector have an economic perspective. Usually these evaluations aim to increase social services efficiency, in short to use existing money in a better and more effective way. Many of the ways of measuring quality mentioned above have an economic perspective. Performance quality is about outcomes and objectives, and can measure the extent to which they have achieved what they intended to achieve (SOU 2005:110). In this section, and throughout this chapter, the managers acknowledge that their work is based on organisational objectives. They use scorecards as a way to measure to what extent the organisation can reach their objectives. The evaluation of process quality can be about the performance of the services, the content in the services, or the working climate (ibid.). This can be about methods or ways of working, for example when managers talk about introducing the system for quality management.

An issue of priority

If the need to gain local knowledge about the effects of the social services' work is one aspect with the introduction of evidence-based practice, another aspect is related to a need to set priorities within the organisation. Local evaluations require priorities about which interventions are needed, for example, and what competence the personnel should have. In the end it is about using resources in the best way possible based on the needs of both organisations and users.

Managers have more than just evidence-based practice to relate to in their work. There are other on-going development works and other tasks they are responsible for that go on simultaneously. This requires a structure and a priority within the organisation. When managers describe what they do it is clear that evidence-based practice is *one* of many tasks they have to relate to and perform. Examples of other tasks appears in the interviews, such as increased documentation, responsibility for the work environment, national supervisions, completing data in national registers and open comparisons, implementing national guidelines, introducing quality management system, and other development work more or less linked to the national EBP-initiative.

On a structural level in the organisation there is a need to reflect over the efforts being made in development work, what they mean and not least if each social service has the potential to incorporate the initiative into daily practice. In the end this entails local politicians making formal priorities that the organisations must follow. This includes evidence-based practice and everything else that has to be conducted within the frame of social services. This middle manager gives an example of when other assignments concur with the introduction of evidence-based practice:

> There has been something every year that has been very relevant. [The regional unit] and the state, the National Board of Health and Welfare, have always had some area. … It is abuse and addiction, common guidelines, then it has … started this evidence-based, and then we have domestic violence, as is *very* current. … We have had supervision from the

> National Board of Health and Welfare, so that we have to work together. And that is why evidence-based is *entirely* on ice. … And because we have had some turnover of staff, I have not had time to even think evidence-based.[ccxiv]

In this municipality there are reasons why evidence-based practice is not prioritised; turnover of staff, changes of contact persons to the EBP-initiative, supervision and a lot of other development work are among others mentioned. These become obstacles for introducing evidence-based practice that can be derived from organisational conditions rather than from the willingness and interest of social workers and managers to use evidence-based practice. One middle manager also explains that there are many on-going development works that compete for their time and some of them are perceived as parallel tracks even though they are conducted separately from each other. She continues, and says that:

> Reality in small municipalities does not quite fit [with] the demands from the outside world. It requires us to know everything and "fine", but we have to take it in, sort of, one at a time.[ccxv]

This becomes a problem for smaller municipalities that do not have as many employees and that cannot participate without the daily work suffering. This is a drain on resources and creates confusion, and could engender reluctance to participation in development work. Although this problem is likely to be larger in smaller municipalities it also occurs in larger ones. One senior manager representing a large municipality feels that the ambition of the state with the EBP-initiative was too high and that it should have started on a smaller scale:

> There, we were not really in the scale. But we said, much, much narrower, because … even a large municipality needs to start small. Otherwise we will *just* be confused, I think. Then it is a risk that we pick up a lot of balls that are not really thought through. I do not mean that it should take forever.[ccxvi]

What she indicates is implied by other managers as well; that is, the importance of considering what the municipalities choose to introduce and the importance of being aware of which priorities have been made in the municipality. It is not only national initiatives that require priority, these initiatives also compete with what goes on in the daily work within social services that must be performed in parallel. One example is given where a priority is made; when national supervision is conducted it gets the highest priority whilst other assignments are put aside because resources are not enough for everything. Another example given by one senior manager is in relation to that they have not prioritised the introduction of evidence-based practice because of their large budget deficit, which is prioritised instead. This manager explains that the politicians have signed an agreement with the National Board of Health and Welfare in regard to the use of BBIC. She continues and explains it is basically all that they have done:

> There had to be a political decision that we shall work with [BBIC]. And, I have done that. I have done exactly what I should do. But they [the politicians] do not ask for it and I do not talk about it and, so it is not a big question. We have a budget deficit. … It is more important to negoti-

> ate away an agreement about leasing cars that costs half a million [Swedish crones] more than it did before.[ccxvii]

What this manager is saying is that the politicians agreed to introduce BBIC but that a budget deficit was more important for the politicians and senior manager to solve. The politicians do not talk about BBIC or evidence-based practice and the manager does not talk about them either, with the politicians. Therefore, it has not become a prioritised issue. She continues, saying that if the politicians should be asked to describe evidence-based practice, they probably would not know what to answer.

This senior manager, as is quoted above, is one of the few persons that strongly question how evidence-based practice is launched from the national level. Most social services do not reflect on what is introduced into the work or how it should be received and managed in the organisation. This is not unique for evidence-based practice; it is present in this manager's general perception of how national initiatives are introduced within the public sector. Moreover, the same manager explains, it is customary that social services accept offers to participate in national efforts because the initiative brings money to the municipality. These initiatives, or projects, begin without any or little reflection over what the initiatives will entail. Social services follow what is advocated by national actors which this manager claims results in that 'we jump from tussock to tussock, we do not complete'[ccxviii] what has been started. She continues:

> I do not want to belittle [evidence-based practice], but then, last year when they started this, when it became a project, then it became for me, oh well, now it is … *this* track. But where is reflection over how we shall actually take care of it once we have documented all this, how shall we deal with it?[ccxix]

A reflection and discussion about what a national initiative means for the social services and what happens when the national funding ceases and shall be incorporated into the daily work without financial support from the state should be there from the beginning. This also applies for introducing evidence-based practice.

One of the other senior managers wishes for more long-term perspectives in the national initiatives taken, and explains that many efforts and projects have not been properly thought through:

> [SALAR and the National Board of Health and Welfare] needs even more to hold a line for these parts, I think, because they also have a tendency to propose certain methods and then one is ready to throw it out pretty fast. And then it will be like, the Swedish municipalities, as the reindeer herd, that if one goes everyone goes, and abruptly change direction. … Endurance is not always so clear, because it is perhaps the case that there are certain things one has to change, while others one shall be a bit more careful before one throws it out.[ccxx]

The manager says that social services usually follow the national trends, without reflecting over what actually is introduced. National actors, such as SALAR and the National Board of Health and Welfare, change direction relatively quickly in their efforts and methods that were considered good may be rather rapidly be replaced. She continues to explain that a local adaptation is needed because all methods do not fit all

individuals and it is not good to dismiss methods too hastily. But for many it can be the best method. She mentions the twelve-step program and the national guidelines for the care of those suffering from substance abuse and addiction. In those guidelines cognitive behaviour theory (CBT) has been advocated and many other methods were rejected, but there is a development towards a broader approach today. There is, therefore, a need for continuity as well as a need for the organisation to see the gains with evidence-based practice, 'that it really is thought through before introducing things, I think it is more likely to be consistent'[ccxxi].

Evidence-based practice in social workers daily work

A central part of evidence-based practice is the social workers responsibility to weigh together the gathered knowledge, such as external knowledge and knowledge from the users and the professional. One middle manager explains how a social worker can use several sources of knowledge included in evidence-based practice:

> It is not just us sitting here in our "chambers" and doing an investigation on our own, we have our own education and then, based on the research that others conduct, who are specialists in this area. One must seek the support of [colleagues], because of course we do not have the same knowledge. Then we have experience also, that you weigh in. … But it is precisely in the assessment in a case that it [occurs most].[ccxxii]

Although several knowledge sources are used, the experience-based knowledge has a large part in social work.

In this third main section I present what the managers have chosen to raise when talking about their relation to the social worker and their daily practice. Firstly, a description of how managers feel that they support social workers in their daily work. Which are mainly about supervisions and collegial support, and that social workers get opportunities to exchange knowledge and experiences from other social workers through participating in network meetings and the like. Then I go on to a section where the social workers' use of external knowledge is in focus, which managers describe as one area of development that is needed before evidence-based practice can be said to be introduced. The final section concerns another development area, which briefly describes the need to get users' knowledge through local evaluation in order to develop evidence-based practice.

Building on proven experiences

A responsibility that managers have towards the staff is to supervise them in their practical work, usually in specific cases. This is an internal supervision and is the middle managers responsibility. To be supervisor is, according to this middle manager, about supporting the social workers in their development, to build their base of knowledge, experience and understanding of what it means to be a social worker, or case officer. Here a middle manager describes the idea with supervision:

> It is one of our major tasks; it is to supervise … the social workers, to lead this supervision in the group, which is about to mirror and angle from

> different perspectives and ways. And sometimes … you do not go as deeply into a case, one does a scanning of it to see where they are, and how it looks like and what we should think about; is there something we have to change? And go through the assessment that the case officer is doing and has done. And, are there any doubts and whys, and difficulties that may arise, can we do it in a different way?[ccxxiii]

Other social workers experiences, especially supervisors' experience, are important at these supervisions. One of the other managers says that supervision 'builds very much on experience'[ccxxiv] and that they as managers and supervisors are 'of course the main characters in the meeting, that lead … [and] maybe also interpret and come with viewpoints, thoughts and ideas'[ccxxv] in order to 'start the case officers thinking'[ccxxvi] or reflection. The middle managers that are also supervisors stress the importance of that a supervisor has some years of experience of social work so that the supervisor can contribute with own experience and knowledge about social work. These meetings are especially important for social workers with no or little working experience of social work. They tend to be more uncertain and insecure in their work. This is explained by one manager like this:

> The one that is experienced is more secure in their role. We know the consequences of all the decisions. Maybe that is difficult to see for a new social worker. And it is tough to work as a social worker within the area of children and youth, because it is decisions which … affect a family situation very much, apprehension of children and placements and questioning the parental ability. Yes, it is very tough, I think.[ccxxvii]

Supervision is a way to 'strengthen that we do not miss anything'[ccxxviii], says one middle manager, and is also a way to raise the quality in social work. Social workers also have supervision from external supervisors, where they discuss issues not directly linked to specific cases. Instead, they discuss problems from a broader perspective, for example how to act in a meeting with users. For municipalities that have supervision, the supervisors and more experienced social workers become the ones that convey experience based knowledge to the more newly educated social workers. Supervision gives not only opportunities to use their own experience and knowledge but also to bring in knowledge from outside.

Social workers and managers try to help other social workers with knowledge that can be used in the investigations. In their workgroup and during supervision collegial learning and support are very important. Social workers also exchange knowledge when participating in different networks. There are various constellations of network meetings, for example a network for BBIC-educators, days organised within the social services (involving among other things questions about methods and how social workers work), and networks for personnel in different areas within individual and family service. Some managers also mention that social workers have joint meetings with social workers from neighbouring municipalities. One manager describes why these network meetings between neighbouring municipalities are important:

> It is really good to go on network meetings and hear how others are doing. And I urge my colleagues to do so. Because you get a huge amount out of it, meet colleagues and inspire. Be inspired and inspire.[ccxxix]

It is largely about taking advantage of and to share good examples and experiences, or as this manager above says, be 'inspired and inspire'. She gives an example, from elderly care, of how good ideas are spread when the personnel visit other municipalities' elderly care or in other ways hear about how others work:

> Then maybe you look and get influences. … Right now there is a great interest around this with diet, meal times and such things among the elderly. There exists, if it is down in Gothenburg, they have made good results about this, to meet up with the elderly, that it is not we who decide maybe the time, it is more adapted after those who live there.[ccxxx]

Study visits give opportunities to get ideas for their own work, for example how to perform and organise the work; they provide new thoughts on how to develop the work, and can also lead to that they reflect over their own work and can establish what actually works well, which one might not have thought of before. One middle manager explains that new ideas often occur when they visit other municipalities and practices, and that ideas from good examples are brought back to their own workplace.

Most managers highlighted the importance of using social workers knowledge and experience, and to consider the local prerequisites, in order to conduct a flexible and structured work. Supervision and networks are forums where professional knowledge and proven experience are formed. The next section is about the use of external knowledge. Although it cannot be understood as being separate from social workers own experience and knowledge I aim to illuminate the difference between how these knowledge sources are used and how they are prioritised.

The use of external knowledge

With external knowledge I mean knowledge that social workers and managers need to search for outside of the organisation and their workplace. External knowledge contains of scientific research (research), but in external knowledge also includes evaluations, reports from among others the National Board of Health and Welfare or Research and Development Units, other information and knowledge from educations, seminars, the Internet, and so on. Scientific research is a central part in evidence-based practice, which means that I and the managers occasionally distinguish between external knowledge and research (although research is part of the external knowledge). In other words, the term external knowledge used when managers talk about knowledge in general, and the term research is used when managers talk specifically about research. This is one of three areas that managers feel needs to be developed in the introducing of evidence-based practice, especially to search for and use research.

The challenges of using research in social work is to a large extent about access to research in social work, and to find research suitable for social work. The managers explain that social workers have access to research and the other forms of external knowledge. Everyone has access to JP Socialnet, for example, which is a service mainly for those working with Social Law within social services, health care or other authorities and private organisation (JP Socialnet). The managers also mention the Internet and Google as useful sources of knowledge gathering as well as the websites of organisations and associations, for example the Swedish Association of Local Authorities and Regions

(SALAR), The National Board of Health and Welfare, and trade associations are available sources of external knowledge. At the same time as one senior manager explains that social workers do need to search for and use research in their work she also says that there is not enough research in social work, yet.

One senior manager states that social service on the one hand needs to become better at searching for and using research in the work and on the other hand to a lesser extent base the work on social workers knowledge and experience. Several managers talk in this context about the difficulty for social workers to have time to search for external knowledge, especially research during working hours. They have, according to one middle manager: 'their work cut out with their activities, as middle manager for example, or case officers … they have their work cut out'.[ccxxxi] Another manager agrees with this and claims that social workers are not able to find external knowledge when time is limited and largely devoted to investigations in individual cases:

> The social worker sits in their "chamber" documenting and writes in records and investigations, all the time. So the small space there is to compile investigations and write analyses and where we are trying … We help each other as well, during supervision, that, do you have any tips on anything new that has come in this, which I can [use].[ccxxxii]

Pointed out above is the lack of time to search for external knowledge in their work. To improve evidence-based practice social workers must become more interested in searching and using external knowledge, especially research. And, the organisation must facilitate this. On the one hand there must be working routines that give social workers space to search for external knowledge. On the other hand, 'an equally important part, is to get people to become interested to develop, not only do their work tasks but develop the work, because that is how it is'[ccxxxiii] in today's social work. This same manager perceives that the most difficult aspect with the introduction of evidence-based practice is to 'motivate people to actively search for information, to make suggestions'[ccxxxiv] about their work.

Knowledge that is collected externally is often used in an investigation when social workers make their documentation before taking decisions, specifically when writing the analysis. There they can, according to another middle manager, refer to 'various reports and studies that have been done'[ccxxxv]. Social workers use external knowledge as a support. They use external knowledge, and especially research, primarily in investigations concerning child protection, and not in their daily work. The external knowledge is particularly important when they document in the investigation. A middle manager explains that research is used in specific cases and not in their everyday work:

> For instance, if you say incest cases, then we can check what research shows about the child and so. But sure, it is an area where we should focus more, and develop. That there becomes like … a more casual way of working, that one always weaves it together.[ccxxxvi]

This manager experiences that social workers feel more secure when decisions are made if research is used in the investigation:

> It feels safer for one self, it is not only your own musings as it has often been, that you have used yourself as a tool for this. But now it becomes that you can lean on research and you can use, a little bit in the investigation too, that research says this and that in similar cases. … One feels safer that now you have done a correct investigation. … Research is … included in the investigation.[ccxxxvii]

Another middle manager gives a concrete example from her work of how research can be used to give greater security and also credibility to the social workers:

> If I say, now you shall go through all contact persons, check who really needs and who might be attending outpatient care. And then I have, the latest research shows that there is no greater benefits with contact persons. I am more credible. … It is not my judgement, instead it really is something that someone else has come up with.[ccxxxviii]

Outpatient care is considered a more economical advantageous solution to individual interventions. External knowledge can be used to support social workers in their decisions and they will gain a greater credibility towards the users. This entails security for the social worker when decisions are made based on knowledge and not only from social worker's own values.

When social workers start to take in new knowledge, for example through research and accumulate it with their own knowledge, it becomes 'more everyday work'[ccxxxix], says one middle manager, and adds: 'the more you get used to checking various things the easier it gets'[ccxl]. Other middle managers also experience that evidence-based practice will improve and simplify the work in a long run, here described by one of them:

> [Evidence-based practice] hampers in that way before it becomes a natural feature, then it takes more time. It eases in the end when we have started to learn, when it becomes natural that I shall check research, then you do not have to do that in some single case, start searching feverishly what [research] says. ... You build up a knowledge bank at all times so that it in the end it becomes … easier because assessments, decisions and interventions become better if you have built up this bank of knowledge.[ccxli]

The efforts needed of a social worker decrease when building this knowledge bank and in the future when routines and habits (Berger and Luckmann, 1967) have established, it will not be, according to the managers, as time consuming for the social workers as it is perceived today.

Gaining users' knowledge through local evaluations

The managers emphasise the need to take the knowledge and experience of users into account and to take advantage of the knowledge that evaluations and follow-ups contribute to as two other development areas. These areas are interrelated in the sense that evidence-based practice stresses the importance of taking the users knowledge and wishes into account. Here is an example of how managers describe these development areas:

> I think what actually is missing is knowledge from the users. … We do follow-ups, then we follow up how it is at the treatment centre, whether

> it corresponds to our expectations, and so on. But not this to get direct information from the users … Because, as said, we have no treatment centres here [in this municipality]; it also applies to children. So we have to rely very much on their [the treatment centres] websites, which do not always correspond to what is reality.[ccxlii]

One way of getting knowledge from users is through local evaluations, compiled and analysed by the social services at an aggregate level. But one of the managers says, in compliance with other managers, regional representatives and social workers that it usually 'stays with the one doing follow-ups individually but not evaluations'[ccxliii]. Follow-ups on an individual level (what happens to an individual user) are made as required by the law but compilations of the result of different interventions, for example, are not.

In the end this is about that users receiving better support which is tailored to their needs. These areas for development involves compiling and analysing evaluations at an aggregate level, which are used by the social services in order to organise work in a way that gives the users a better support:

> We need to develop it, not just at an individual level but also at an aggregate level. Thus what we see not only for this and this and this, but [for], this group, for example. If you look at abuse, we can see now that we care for those who are aged 20–30 years. And there you would be able to work much more to evaluate, of course the individual, as we do, but are there any pattern in this, to take it as an example.[ccxliv]

One of the other managers gives a concrete example on what the manager above asks for. She explains that a few years ago they investigated why a certain age group of young persons are frequent visitors at their social service, and how they in the workgroup could avoid the same problems in the future. This they investigated and reflected over in the workgroup, but the manager did not term it as an evaluation at an aggregated level. At the same time, the manager emphasises that these types of investigations need a certain amount of cases to analyse. In this small municipality there are few cases every year where the users have similar problems and life situations. For example, the cases regarding abuse and addiction are very 'diverse and sprawling, there is no consistency in the cases'[ccxlv], so it is difficult to compile. In the development towards evidence-based practice the priorities of the organisation are also included, where needs and requests should specify what interventions the social services provides.

8

Social workers and evidence-based practice

In this chapter the main focus is what the interviewed social workers say about their daily work within municipal social services. Primarily how they relate to evidence-based practice and BBIC[26] and in what way they create their daily work practice with evidence-based practice and BBIC as a foundation. The concepts habits and routines, used by Berger and Luckmann (1967), are important for creating this understanding. I also use new institutional theory for to understand how evidence-based practice is received in the social services.

The chapter starts with a short introduction of the social workers, for example their education, year of graduation, work experience and age. Then, the chapter is divided in three main sections. *The first main section* explores how the social workers relate to evidence-based practice, which is, in general, a very positive perception of evidence-based practice as important in social work. Yet, at the same time there is an uncertainty about what evidence-based practice actually means and how to work with evidence-based practice in the daily work. Because evidence-based practice is somewhat unclear several social workers choose to talk about BBIC instead of evidence-based practice. BBIC is also described as part of evidence-based practice.

The second main section is about how social workers use and weigh together different knowledge sources in the daily practice, all described as part of evidence-based practice. Those sources of knowledge are external; it is mainly knowledge that social workers search for or receive that is used in their work, knowledge from colleagues and from users. An intention with this section is to understand how social workers at the local practice level work with evidence-based practice. *The third main section* explores aspects in relation to the expectations and support from the management group, middle and senior managers and local politicians in the Social welfare committee, as it is described by the social workers. As are the other main sections, this section is concerned with evidence-based practice at a local level, but is about how work is organised in order to

[26] The Swedish BBIC (Barns Behov I Centrum/ Children's Needs in the Centre) is built among others on the English Integrated Children's System, ICS (Socialstyrelsen, 2013). I choose, in order to avoid confusion, to use the Swedish abbreviation in the text, because Sweden has adapted the original English version to Swedish conditions and created a system based on 'national practice, organisation and legislation' *[author's translation]* (ibid:20). BBIC is described as 'a system for handling and documentation in investigation, planning and follow-up' *[author's translation]* (ibid:17).

introduce evidence-based practice. However, it is still from the social workers perspective.

A presentation of the social workers

The 18 social workers in this study work in five municipalities in the county. Seven of them work in what I call a large municipality, seven persons work in two medium-sized municipalities and four persons work in two smaller municipalities[27]. Of the 18 interviewees there is one male social worker interviewed, and two persons that do not have a social worker degree. Those two persons have other educations within or near the area of social work and work with children and families and evidence-based practice. To ensure that these individuals are not recognised I choose not to distinguish them in the text.

Most of the interviewed social workers (39 per cent) are between 30-39 years of age. National statistics, from 2013, shows that almost 29 per cent of social workers are between 30-39 years of age (Sveriges Kommuner och Landsting, *Kommunal personal. Tabell 6*). Although this difference in per cent is quite large difference, it is the largest age category in both national statistic and among the interviewed social workers. In general the age distribution of the interviewed social workers follows that of the country. Eleven social workers have a maximum of ten years' experience within individual and family service. Eight of these eleven social workers have up to five years' experience, and the two that have the longest experience has worked within individual and family service for 30 years. Five of the 18 social workers graduated between 1970 and 1990, six between 2000 and 2007, and seven between 2008 and 2011.

Most social workers have worked within individual and family service since their education, often with different types of cases (children and families, addiction treatment, or economic assistance). Several of them have also worked in different municipalities. Only one has longer experience from another area in social services. This person graduated some 25 years ago and has worked in the social services since then and within individual and family service for about one year. In general, there is coherence between the interviewees' graduation and what they have been working with since then. Some began their professional career in other areas, for example as case officer in elderly care, but moved quite quickly to individual and family service.

Social workers perception of evidence-based practice

This first main section focuses on how social workers explain and understand their work when it is based on evidence-based practice and BBIC. Evidence-based practice, and especially BBIC, brings many positive aspects to practical social work. The subsequent three sections portrays the ambiguity that social workers feel towards evidence-

[27] The selected municipalities is divided in large, medium sized and small municipalities, from the way they organise their work which is due to the number of inhabitants (see the section *Validity in research*, in chapter 3).

based practice; that evidence-based practice is an important part of social work at the same time as they find it difficult to explain what evidence-based practice actually means in their daily work practice.

BBIC constitutes a large part of social workers daily work, which is the reason why they often relate to BBIC when describing their work. However, according to most social workers evidence-based practice is not an explicit part of everyday work and evidence-based practice is somewhat unclear. BBIC has been introduced, or is well on track, in these five municipalities, while the introduction of evidence-based practice has not reached as far. Several social workers perceive BBIC as part of evidence-based practice in the sense that it is a proven way of working, containing research and as is developed after conditions in Sweden.

Evidence-based practice is important

Evidence-based practice is a concept that comprises positive values and all social workers perceive evidence-based practice as important for the work of social services. Social workers mention a few reasons why they feel that evidence-based practice is important. These aspects correspond well with the developments taking place in society which have an impact on social work; the work has to be effective for the user and the organisation, the social services need to know what they are doing and should therefore base the work on research in relation to the effect of given interventions (cf. Oscarsson, 2009; Sundell et al.; 2010; Regeringen, 2010, 2010a). This social worker, who has seven years of work experience, talks about how developments in society are changing their work:

> [One shall] listen more to the client, one shall take their views and motivate them too. … But if you look at society in general, it has, and then maybe it has generally been the same within social services, that I believe that requirements nevertheless have increased in recent years that one must have a quality and … then it means that those working in the organisation … shall *have* good knowledge and one shall keep abreast of what is doable and favourable.[ccxlvi]

She says that demands for increased effectiveness in social services have also led to requirements that social workers must have knowledge about which ways of working that are effective for the users.

It is important for evidence-based practice that different sources of knowledge (from the social workers, users and research) are weighed together (cf. Oscarsson, 2009). Social workers' experience is perceived to be insufficient in social work. Neither the interviewed social workers nor those advocating evidence-based practice at national level think that experience alone is enough in social work (cf. Pettersson and Wigzell, 1999; SOU 2008:18). Social workers cannot only rely on experience. Instead they need to base their work in knowledge from these different sources. Several of these aspects become apparent in the dialogue between two social workers in one of the group interviews:

> It shall be measurable, so that one really, as far as possible, can see that an intervention has effect. For, many interventions are very restrictive and then you have to be able to offer an alternative that is better. I think that is important.
>
> *Yes … And it becomes a quality assurance as well, I think. That one, now it becomes not always correct, maybe, even though you have results to start from. Because it is so individually driven [that is, a support given from the individual's perspective], but you still have something to work from. … And I think that would be a help to us in the end … a support for us.*
>
> Yes, and it will also become, I think, a matter of credibility, actually [towards citizens].[ccxlvii]

In this dialogue it is indicated that evidence-based practice is about quality in work and to be able to evaluate the work, and it is also about the legitimacy of social services for citizens and users. This is part of the development that is occurring in society and the criticism levelled against social services for not sufficiently basing their work on knowledge and research (cf. Pettersson and Wigzell, 1999; SOU 2008:18). Two social workers explain that their work altered, based on changes in society, and that they in their jobs have to be aware of how society develops. One of them perceives that they are a part of the society, and that they cannot become 'an isolated entity or island, but [that] we ... follow the developments in society and not live our life on the side'[ccxlviii]. She also says that social services have endured criticism for some time that 'there they sit behind their closed doors'[ccxlix]. Another social worker describes the importance of making decisions that are well substantiated, and the need to know what they do so the user will get better support:

> I think it is so important what we do, it affects people and hopefully we can of course, the idea is that it will be better for them. And if we have evidence-based methods, we have a basis for the decisions we make, it ought to imply that there is a greater chance that things go well for them, than if we take chances. … Although one base's on experience, things can then, things change a lot in the society as well. It is difficult to just rely on [experience]. So I think … it is so important for the people, that it becomes right.[ccl]

Part of the development within society and social services, and evidence-based practice, is that work should also consider the users' needs and preferences. The introduction of BBIC is a major national initiative which is on-going in Sweden and in several other countries. BBIC is described as a way of working to clarify and make the best use of, especially, children's perspectives of investigations.

Social workers perceive that BBIC provides a foundation in work which social workers can lean against when conducting an investigation and making decisions. Several of them talk about the complexity in work, and that BBIC and evidence-based practice make the work clearer. Two social workers talk about their need to work with what is effective:

> We are working with such things that you cannot take [on], and then it is easy that we get a little fuzzy job. Because, I mean … it is not possible to measure emotions, and how someone likes it. And then I think it is really

> good that we have a base and know, yes this works. So I think it is *really important* that we have it.[cli]

> It is hard *enough*, our job. So what little support we can get, around what works best, is *good*. That we not only, somehow sit and waffle together on our own but that it actually, it is this which has been proven to give a good effect, this we shall work with.[clii]

What emerges here is that evidence-based practice and BBIC provides a basis for the daily work. This enables social workers to appear as if they are not working solely from their own thinking and feelings. They do not seem to be unclear or ineffective either. Several of the social workers perceive that knowledge about what is effective creates security and legitimacy in the daily work. One social worker explains:

> The more you can follow up and see what has been working, what can we say, the more safe I become as case officer, also to suggest interventions and not just come up with proposals to somehow have an intervention, without really knowing that it works.[cliii]

Many of the social workers express that their work is facilitated when using established methods and models in work, because these have been developed and are proven by research before they are introduced in the social services. When working with methods or models, work, according to social workers, becomes more unified regardless of the individual social worker or the specific social service. The investigations and decisions taken will become less arbitrary. One social worker expresses, as many other social workers do, that work 'has felt very arbitrary before'[cliv] and that 'it feels incredibly reassuring that we have BBIC to work from'[clv] nowadays.

Social workers perceive that evidence-based practice is important in their work, and there are those who reflect over changes in society which have led to the need to introduce evidence-based practice. Evidence-based practice makes their work less arbitrary and less based on the social workers own values and they become more secure in their work. The users also benefit when evidence-based practice and BBIC are introduced in the daily work.

What evidence-based practice is about

Evidence-based practice involves that social workers use knowledge from different sources in their daily practice. These knowledge sources include research and external knowledge, users' knowledge and the knowledge of the professions. Two social workers describe evidence-based practice and the use of knowledge like this:

> It is based on the needs I assess that the family has. … Somewhere, I base myself on the theories that exist about child development, I do that. … Then, it is … thus based on the child's needs, as I see it and certain wishes from the family as well. You attempt to find a balance. Yes, there must be a balance between them.[clvi]

> It means that I as far as possible plan for, grant interventions as I assess should be able to achieve these … goals that we have, and why I base myself, why I believe this intervention works for these problems. And

> that one … still is trying and … when you do not know then it is really good to try to find what the research says, what are the facts about this one shall do. I mean, if I shall do an [investigation] of right of access or if I shall grant an intervention, then I try to see if I can, if I do not know or my colleagues know, than I try to search for it, to the extent possible.[cclvii]

The social workers explain that the daily work in accordance with evidence-based practice is a combination of different knowledge sources. The first of the two social workers also explains that it is not easy to determine which knowledge she has collected and why she leans against this particular knowledge. There is no question that weighing together knowledge is the individual social workers' responsibility, and they use their own experience a lot for this. However, external knowledge often appears to be a supplement in the work, when the daily work is described, as in the second of the two quotations above. For example, social workers search external knowledge when they do not know how to proceed in a certain case they are working with.

Many social workers perceive that evidence-based practice involves working with different methods, models and other structured ways of working, and not least working with support of BBIC. Others say that evidence-based practice involves working with research as a basis, and some social workers explain that methods contain research and that they therefore uses research in their work. Two social workers describe how they perceive the links between evidence-based practice, and methods and models:

> If I think that I, with evidence-based, work according to BBIC and I do these HOME-interviews[28], it is still that I somehow have some kind of. Yes there is someone who has been researching, that this is *good*, to keep on like this, that one does it in this way, I think.[cclviii]

> I do not know how … evidence-based [the Staircase-model[29]] is, but when we have been on the Staircase-education, we could say that research shows that it has worked, and that one has tried and that it has worked. And then it is a lot easier for me to talk to dads for example, who are sceptical to, yes they may not want to even admit that they beat their women or that the children would have been harmed by it, and so. It becomes like a support.[cclix]

For these social workers such ways of working are a part of evidence-based practice. Social workers often relate evidence-based practice to the use of methods and models, and therefore they perceive that they use research in their work. Research is built into the methods and models used, 'it has been proven that it works … that it is research based, in some way'[cclx]. Several social workers give BBIC as an example where researchers have been involved in the development, here is one example:

> Everything is developed with the help of researchers in these different areas, for it to be a system covering all areas they have looked at the legal, developmental, psychological, social aspects.[cclxi]

[28] HOME (The Home Observation and Measurement of the Environment) is a method for doing assessments in the work with parents and children up to ten years (Socialstyrelsen, *Metodguide för socialt arbete, HOME*).

[29] Staircase model (Trappanmodellen) can be used for crisis talks with children, when they have experienced violence in their family. (Socialstyrelsen, *Metodguide för socialt arbete, Trappanmodellen*).

The importance of research in social work seems to have been raised by the introduction of BBIC. One social worker says that BBIC has largely contributed to that they use research in a more conscious way. Research and external knowledge that they search for is used to clarify something specific which the social workers want to illuminate when doing their investigations, analysis and assessments.

Using methods and models is also perceived as useful in contact with the users. One social worker refers to evidence-based practice, and considers it important that research is an integral part of the work together with what has been proved useful in practice for the users:

> It shall not be my own thoughts and thinking, my own values. It shall be something that one sees in research and in practice have importance for individual persons … much like with medication and so. It shall be tested that the medication has an effect on these particular problems, or how one should put it.[cclxii]

The social worker makes a comparison with health care and explains how they can work with evidence-based practice. She believes that they partially work that way today; they use proven methods and research. But, what is missing is to evaluate the interventions given by the social services locally.

In relation to evidence-based practice there are social workers who identify it as their responsibility to search for research and external knowledge. Here two social workers, in one of the group interviews, explain that they try to keep abreast with new research and knowledge, as it is important to maintain confidence in the work they do:

> I think we are trying to work seriously and keep up with. … I have always felt like this, we are a small municipality … and it is important to keep up. We … shall not be some, how shall I say? We must not appear as if we here are completely gone. So it feels like we have all the time, over the years, tried to pick with us [new knowledge]. And sometimes I think that we are more responsive than other [larger] municipalities because they have an organisation that can provide this. Here, we must try to pick up on what is new and going on, and.
>
> *Everyone wants to do good work and we think it is exciting with new angles and such. And it also means that one is prone in a different way to search new information and think about, oh well now we usually do this but how could we do this better? Then, there is not always sufficient time. … There is an effort, anyway.*[cclxiii]

These social workers have long experience within the profession and have over the years built up a personal experience that may cause them to feel a need to bring new knowledge in their work. Those who are more recently graduated are busier creating their own experience. Other social workers also say it is their own responsibility to bring in other sources of knowledge, which is exemplified here by one social worker:

> It is this, not to dig in … its own little track here and think that, yes but I think like this. You still must twist and turn on things and see what is the knowledge about this problem or what has occurred, or. Yes, and … praxis, what we usually do. But it may not apply to this particular family or this child or this youth, that here things are different. … It is not that

> simple. … There are no templates but you have to somehow take in knowledge from different sources.[cclxiv]

The social worker quoted above is one among few who says that evidence-based practice is 'a combination of research, my knowledge and the client's preferences and situation'[cclxv], an understanding of evidence-based practice as weighing together different knowledge sources, where the social workers have the responsibility to coordinate these parts.

In this section the perception of evidence-based practice that social workers have is in focus, and some sources of knowledge are briefly described. Research and external knowledge constitute a large part in evidence-based practice; it is important to know the effects of the work, and the social workers are responsible for identifying and using relevant knowledge. Social workers talk about using methods and ways of working as part of evidence-based practice. The user will benefit when the social services introduces BBIC and evidence-based practice according to the social workers

Uncertainty about evidence-based practice

At the same time as all social workers state the importance with evidence-based practice in social services and that it provides good value, there are some social workers who experience that it is difficult to actually know what evidence-based practice means in practice. Over half of the social workers experience difficulty in explaining what evidence-based practice is, which is exemplified here:

> Oh God, what a difficult question. … I do not think that I in the everyday work talk as much like that, evidence based.[cclxvi]

> But God, excuse me such difficult questions. … It is a bit troublesome I feel to answer when I am so new.[cclxvii]

The second of these two feels that she cannot give an answer because she recently graduated, but it is the newly graduated who first heard about evidence-based practice during their education. Another social worker who has difficulty explaining what evidence-based practice is, says that she does not know what it means to work with evidence-based practice:

> I just do not know what it *means*, evidence-based.[cclxviii]

Nor is she sure if she works that way:

> Yes, but *do* I do that? I do not know if I do it.[cclxix]

One social worker reflects a bit more about the vagueness and the positive values there are with evidence-based practice:

> Yes, I think [evidence-based practice] is important, but … it does not feel like we know, really what it is or, the connection is not given there. … It is easy to say that it is *important* but what, *what* is it? … But I think it is important that one, like, wants to do as well as possible … for the chil-

> dren, that is. But yes, I do not know. I find it … difficult to get it together, the gap I think.[cclxx]

This difficulty with translating theory to practice is dispersed among all social workers, but is especially pronounced among those who heard about evidence-based practice during their education (approximately between the years 2005 and 2007). One of them describes:

> It does not become quite concrete [during the education] how it works in practice, in that it is the theory one then reads and you can talk a little about how it could be performed in practice. But it is still not to the extent that one benefits from it … in that way now once you are out in practice. I had no idea that it might be like this.[cclxxi]

It is when social workers start working, after their education, that they gain practical knowledge about evidence-based practice. Another social worker mention in a similar way that it has been difficult to translate what she has heard at further educations about evidence-based practice, via the EBP-initiative:

> I have been on several [meetings about evidence-based practice], but it is one thing to get the information ... how it shall be done. But what it means in practice is a completely different thing.[cclxxii]

This is also confirmed by one social worker who has some experience of working at the regional unit, and she perceives that there is a gap between understanding and transference of evidence-based practice from the national to the local level, via the regional level:

> I think it is like a gap between … when talking evidence-based and when you are doing the job [at individual and family service], that it has not reached together properly or you do not have the time to get it together, or we do not talk that way in reality. So it is like different worlds. … If I think [on the regional level], one talks about evidence-based and then I can hear my [local] managers say they have been [at the regional unit] or had contact with them, then. And then one thinks, oh how and what should we do with it now on home ground, and so? But then I hear my colleagues and they are then more in reality, and *there* it has not quite reached together, I think. They are working on and, oh well, but what evidence? So, there is not, and you do not have the time even to tie it together, and you do not have the time to reason, I feel. There is the gap, sort of.[cclxxiii]

For several of the social workers it is therefore somewhat difficult to take the step from thinking that evidence-based practice is important, to understand how they are going to do it in practice. BBIC is more concrete for the social workers to work with and to grasp. Although social workers have difficulties explaining what evidence-based practice is, it is presented by them as something desirable.

Several social workers say that they do not know what evidence-based practice really means. Some have heard what evidence-based practice is but do not know what to do with it in their daily work. Through describing the uncertainty that exists among social

workers about evidence-based practice the problem with translating theoretical knowledge to practice becomes obvious.

Social workers and their use of different knowledge sources

This second main section has the intention to provide an understanding of how social workers work in their daily practice with different sources of knowledge, which are usually described as part of an evidence-based practice. My intention with this section is to understand how social workers work with the different knowledge sources at the local practice level. Firstly there is a section about how social workers retrieve external knowledge and how they use it in the daily work. Secondly there is a section about knowledge from colleagues, what it is and how it is used in the organisation. Managers and social workers experiences constitute an important part of this collegial support. This main section ends with how users' knowledge are used and not used in the daily practice and in the social services.

Before moving on to describe how social workers relate to the different sources of knowledge, I want to point out that it is not really possible to distinguish the different sources; they are interrelated and intertwined in social workers daily practice. This is highlighted by some social workers, here is one example where a social worker describes that knowledge from education and knowledge from the Internet cannot be separated in the daily work:

> It is hard to say that you take knowledge from the Internet. Often, it is things one has learned … through education. Then you check some things online. There are websites for different educations and, the National Board of Health and Welfare has much about BBIC … that you can read.[cclxxiv]

However, my aim with this division is to give an increased understanding of how these social workers relate to and work with evidence-based practice.

External knowledge

With external knowledge I mean knowledge that social workers receive from outside the organisation and their workplace. External knowledge comprises different knowledge sources and includes knowledge that social workers search for or receive, and that they use in their work. It is knowledge that comes from research, reports, surveys, literature (such as social work theories and other theories used), and information from authorities, organisations and private organisations[30]. External knowledge also includes knowledge from educations, courses and lectures, such as further education in

[30] Examples of authorities, interest organisations and private organisations that the social workers use: National Board of Health and Welfare, the National Agency for Education, Student Health (Elevhälsa), Swedish Council on Health Technology Assessment (SBU), Research and Development Units, Save the Children Foundation, and Children's Welfare Foundation Sweden (Stiftelsen Allmänna Barnahus). Another website used is JP Socialnet, which is a service mainly for those working with Social Law within social services, health care or other authorities and private organisations (JP Socialnet).

different methods, models, and ways of working. It comprises primarily further educations included in the national initiatives Knowledge to Practice's educational package, which include working methods as Motivational Interviewing[31], AUDIT[32], ADAD[33], and ASI[34]. BBIC is consistently the further education that social workers have received or as new employees shall get.

Otherwise, it is to a great extent up to the social workers to search for the information and knowledge that they need in their work, which is mainly done by reading literature or searching on the Internet. When they search on the Internet, they usually use Google, or read on the National Board of Health and Welfare homepage or JP Socialnet. Only a few social workers read journals from their union, such as the journal Socionomen for educated social workers. Socionomen publishes special issues with different themes. These special issues are mentioned by a couple of social workers as a source of knowledge. No one mentioned national and international research journals, or the Campbell Collaboration or the Cochrane Collaboration as sources where they get knowledge.

Almost none of the social workers have received a further education that focuses on evidence-based practice. One single social worker mentions specifically the EBP-initiative. She says that 'I have been to a few, but that is just me'[cclxxv], and continues to explain that the education was carried out within the national EBP-initiative and was organised through the regional unit. The education was for all social services in the county and she was the only person who participated from her workgroup. None of the other social workers mentioned that they participated in educations within the EBP-initiative. Some are however unsure whether they have taken part in any further education about evidence-based practice or not, and some say that they have participated in education about evidence-based practice and then referred to BBIC or other methods and models.

Colleagues and managers also contribute with external knowledge. Some social workers mention that colleagues advise each other about external knowledge; some of them have not themselves a great interest in searching via the Internet or find it difficult to search. There is often a colleague within the working group that appears to be better at and more interested in searching knowledge on the Internet and then sharing it with the other social workers:

> [My colleague] is absolutely superb at finding, like online or getting tips and ideas, and then she prints it out to all of us. Yes, and then we read it.[cclxxvi]

[31] Motivational Interviewing (MI) is used in counselling and therapy to facilitate motivation and behavioural change (Socialstyrelsen, *Metodguide för socialt arbete, MI*).
[32] AUDIT (Alcohol Use Disorders Identification Test) is an instrument used to identify a hazardous and harmful use of alcohol (Socialstyrelsen, *Metodguide för socialt arbete, AUDIT*).
[33] ADAD (Adolescent Drug Abuse Diagnosis) is an instrument for assessment of young persons with addiction and social problems. (Socialstyrelsen, *Metodguide för socialt arbete, ADAD*).
[34] ASI (Addiction Severity Index) is a method used foremost within abuse and addiction treatment. It measures alcohol and drug related problems (Socialstyrelsen, *Metodguide för socialt arbete, ASI*).

The main part of the social workers also have supervision with colleagues and managers which are an opportunity to gain knowledge for their work, knowledge as to a large extent build on former experience, but also on other kinds of knowledge. One social worker explains that at supervisions they can 'try to talk, to raise the question and then together trying, is there anyone who knows if there is any evidence behind this issue'[cclxxvii]. Supervision as a source for knowledge is a subject later in this chapter, when describing colleagues as a source for knowledge.

Reflections on gathering knowledge

Besides describing how they search and gather knowledge there are several social workers who also reflect over the knowledge that is found and used. As Internet and Google are used a lot to search for knowledge, there are social workers talking about the importance of reflecting over what they find on the Internet:

> One must be very careful with how one searches' on the Internet and what kind of information you get. For, what is the source? … It is really about being careful what source you use.[cclxxviii]

To reflect in a critical way about the knowledge sources used is also important in an evidence-based practice. The social worker above says that she uses the Internet a lot but does not feel that it is difficult to determine what reliable knowledge is, while others find it more difficult. This social worker stresses that it is not always easy to know what they find on the Internet but she also says that there are some websites considered more reliable:

> That you just are out and Google for something and it comes up thesis and so, but you still do not really know what there is. So, the National Board of Health and Welfare is there also, and their bank of knowledge, feels like it is a bit more reliable. ... There we can sit and read.[cclxxix]

Those social workers quoted here emphasise the importance of being critical towards the sources of knowledge available on the Internet. One way for them to know that they have found useful and reliable knowledge is to go to websites that they perceive as reliable. The National Board of Health and Welfare's website is one of those websites that most social workers consider reliable and informative.

Some social workers also perceive that it can be difficult to determine what current and good research is. One example is given where a social worker describes an occasion when they searched for research about sexual abuse on children. They did not find a lot and they 'found much that was old'. She highlights the difficulty to know what reliable research is:

> And what I also think … this with research, it changes over time. So … you do not know what it is today and what it was before, so it is difficult. … Is this the last thing one has said in the research, and like this?[*cdxxx*]

Difficulties to search for research and to assess what is found are described by several social workers. When knowledge is not readily available, the search for external knowledge risks being given low priority, especially when work is stressful. One social

worker says, if 'only one copes, copes searching long enough'[cclxxxi] they can find something reliable. It may be because it is difficult to find knowledge and assess the quality, and that it is time consuming. A general feeling is that they do not have time during their workday to search for knowledge.

The use of external knowledge

Although it is not possible to identify precisely where social workers' knowledge derives from, it is obvious that they, in general, use their own and colleagues experience and knowledge a lot. What emerges in several social workers answers is that searching for external knowledge takes place a little bit to the side of their daily work. It constitutes a complement to their work which risks being not prioritised in stressful situations. One of the social workers differs from the others in the way she describe her own knowledge base:

> I have always research with me, so it is, absolutely. It provides the foundation for everything. … If I do not have that with me … then I may think that, but it seems to, it works fine.[cclxxxii]

This social worker perceives that research is the basis of her work and she says that in the daily work she often refers to theory and research. At the same time she expresses a difficulty in determining which different knowledge she uses.

From what social workers say, they mainly use external knowledge as a complement to their own knowledge, and mostly external knowledge constitutes a deepening of what they already have knowledge about. One social worker gives an example of this:

> Then you compare the knowledge you have had before and if you should change it in any way, whether to deepen something, do it in any other way, add something, subtract something.[cclxxxiii]

She explains how new knowledge enriches what was known before. They often have to deepen their knowledge when working with a particular case or problem, as in the example about sexual abuse on children.

How external knowledge is used depends largely on whether it is a case where social workers and user agree to an investigation or not. The more their perceptions and assessments of the situation differs, the more important it is, the social worker explains, that external knowledge is used throughout the investigation. It is partly about having external knowledge as a foundation for decisions, 'it gives a little more to stand on … for confirmation', and partly about being able to provide an explanation and motivation to the user, so users 'know why we decide this, why we think what we think[cclxxxiv].

There are several social workers who believe, like the one above, that external knowledge is useful because it provides an extra weight, a foundation for the investigation and the decisions taken. Two social workers describe how they use external knowledge in their daily work:

> Much literature [that I use] is what we have. So that you have something to stand on in the investigations. For you cannot come with your own

> values and opinions, what is considered, what to say [is] normal or not. … We say we have a youth that has a risk-behaviour, consumes drugs or … does criminal acts. … Well, then we have a book that I use, that this researcher has developed, [about] various risk factors with these behaviours and, that one then weaves into the investigation itself. So that we do not come with your own opinions.[cclxxxv]

> Mostly, it is in investigations [that knowledge is used], thus, in the actual writing. Then you can, sure, it may be in some cases, you may need to take it with the parents. … Sometimes one has to try to motivate and explain at different levels. This has been shown, research has shown this and that. To try to get them more involved. But mostly it is in the writing. That is it for me anyway.[cclxxxvi]

The social workers say that it is important to use external knowledge and literature so that their own values about what is appropriate or not does not control the investigation and the decisions made. External knowledge is then woven together with the knowledge and experience that the social worker has. Some other social workers explain that external knowledge may increase their own understanding of a problem and can confirm their own knowledge.

When it is more important to use research in an investigation is, for example, when cases shall be decided on by someone else, as by the Social welfare committee. Or, when it regards a child care investigation and especially when compulsory care is needed, according to The Care of Young Persons (Special Privion) Act (SFS 1990:52). One social worker gives an example from a case, where she felt a need to have more evidence from research when others take the formal decisions:

> It is in these kinds of situations, that when you are going to do a LVU[35]. Then we have, I know I do it. … When it was about attachment, and then I tried to find out how I would describe and what … research says about such attachment damages. But, I searched and we discussed a lot and *I* felt somewhere that, no this is so difficult to express and say, because the court is very used to, has the child been beaten or is the mother drinking or, you must have evidence. How should one prove attachment? How should we describe attachment? … But it did not go, in court. And there, I felt very much that I would want to have much more of such arguments. That is, there I would have, in any case, been able to refer to it.[cclxxxvii]

She continues to describe that evidence-based practice is not that present in the daily work when she and the users want the same thing. Then it is more a dialogue:

> It is when it becomes like a real-life situation, but otherwise we work on, and … when the parents agree … then you talk more and … agree on, and … one has no need, I think, to say that this is evidence-based. … It is when you shall explain the purpose and to defend oneself [that] one needs it more.[cclxxxviii]

It is apparent in the examples above that social workers do not search for external knowledge in every case. Instead, they search knowledge when they perceive they

[35] LVU is an abbreviation for: The Care of Young Persons (Special Provision) Act (SFS 1990:52).

really need it. In some cases other actors, such as the Social welfare committee or the administrative court, makes decisions on the basis of social workers investigations. External knowledge is used in such cases to explain and confirm what problems they assess exist.

External knowledge can in some situations be used as an explanation and as a motivation for user, to create an understanding of what social workers perceive that users' need. Then external knowledge can reduce the arbitrariness that, according to the social workers, exists in social work. Here is one example of how knowledge is used to explain and motivate what they do:

> We always communicate and then we have to … get it clear that this is not just something that I think. It is not that I "throw myself in", it is not good that you drink. But, this we know, there will be harmful effects, it is not something that I think. … It is something that is researched that has shown how children actually feel. Thus, you have to get the individual to understand that there is more behind, it is not just me, something I say.[cclxxxix]

By using external knowledge, social workers create more credibility towards the users and it can reduce the feeling that their work is arbitrary, as is expressed in the interviews. This may also increase the legitimacy in work towards the users and citizens. The benefits of BBIC and evidence-based practice are described as being about increased safety and security for social workers, that uniformity in the work increases and that it becomes less arbitrary.

Collegial knowledge

All social workers emphasise the importance of using knowledge from colleagues. This support entails an exchange of experience and knowledge and may be used when someone is uncertain as to how to work with an investigation, for example. As described by the social workers, a part of the collegial support is when they advise each other about literature and other information they have read. This support is described as very valuable and used daily, which this social worker talks about:

> I think *no one* makes an assessment without consultation … if it is not very simple things, like if you are granted income support beyond the norm because of social reasons, or something like that. But if it is about more difficult, it may be decisions that affect a family very much. Such decisions, I think, that no one makes without having a good assessment with them, along with [nearest managers] and colleagues as well. So that, it will not be like shooting from the hip in such decisions.[ccxc]

It is important to use each other's knowledge and experience so the work not only emanates from the individual social workers own thoughts about what a social worker does, how work is performed and what decision are made:

> We discuss a lot, cases, with each other. And ball ideas back and forth. We do so in most cases … otherwise may … my own thoughts and ideas and values affect my way of thinking. So I think it is really important to discuss.[ccxci]

Such opportunities to exchange knowledge and experience are a way to transfer knowledge between colleagues, and a way to develop professionally as a social worker:

> And then I like to discuss a little bit. … Have I missed something, is there anything else I should think about or could it be like this, and … because that is what makes us develop, too. And I mean there are so many angles of approach in all our cases, and everyone sees different things, because we all have our experience with us, both privately and at work.[ccxcii]

Social workers build a bank of knowledge and experience through this transfer of knowledge, which can be compared to what the doctors say about proven experience. Collegial support is especially important for newly educated social workers, which is expressed by some of the social workers. One social worker, who works in a municipality where all are relatively new at work, feels that she has had a need to ask colleagues about her work, and continues to say:

> It would have been easier to come to a place where there is a group with more experience. I think so. Thus, now it feels like, we are a few new ones that started at the same time and … [we] are pondering together.[ccxciii]

There are other working groups where there are few but more experienced social workers, and they also use each other a lot in the daily work because work is to a great extent built on an exchange of knowledge and experience. One of them says that 'there is no right answer, we need to discuss these assessments and then we use each other's knowledge'[ccxciv]. The different knowledge and experience that social workers have is described as an advantage because they work with people with very different and complex life situations.

The forums for using knowledge from colleagues, as social workers describe it, is about a more informal collegial support, along with support that is organised by the employer, which the social workers usually call internal and external supervision. Network meetings and working together is also described as forums for knowledge exchange between colleagues.

Informal use of collegial knowledge

With *informal* use of collegial knowledge I mean that the knowledge exchange that exists is not organised or controlled by specific individuals, for example the manager. These forums are however not organised without being sanctioned by the employer. For example, network meetings are often organised alternately by the social workers themselves and the content is to a great extent to exchange experience. Most network meetings organised by the regional unit are also held on behalf of the social workers in the municipalities, and it is optional to participate.

The use of collegial knowledge in an informal way is significant in practical situations, such as in an investigation. Here is an example given of how this support works in social workers' daily practice:

> It is each other that we have as a support. Thus, we go in to each [other's offices] a lot and asks for concrete examples. Thus, what have, how have

> you written in your investigation or where did you read what you said, or how do you think about this? … It would be really tough being all on your own in this work. We use it a lot.[ccxcv]

The collegial support is experienced by social workers as very important. In large part, the work is performed as a one-man job, except in some cases when they have to be two social workers. Without these informal forums for exchanging knowledge and experience, work would be harder to cope with, and colleagues are an important part of this:

> It would not be possible to work without them, I can feel. Because there … would not be such good assessments if I alone would meet a family and would sit alone in my room and think, what shall I do now? And we have nevertheless different things with us in our baggage, and knowledge. Although we have the same educational background, it is so that we is very dependent on each other. We are a support for each other, too.[ccxcvi]

According to this social worker it would be harder to do a good job, and the quality in the investigations would be lower if it were performed without colleagues to bounce ideas with.

Network meetings for social workers outside their workgroup, organised by the social workers or the regional unit, are another forum where colleagues exchange knowledge and experience. These are sanctioned by the employer. This form of forum for collegial support has not been mentioned by all social workers, but is experienced as important by those who did mention them. One social worker from a small municipality describes the importance of meeting social workers from other social services, with an example regarding BBIC:

> We felt this need for network meetings, in that we are [a few people who work here]. We do not know where we are going, how shall it look like? … And it has been really great. And I became glad when I was in [the neighbour municipality], because then it was them who had been working a lot with BBIC and were just as insecure as I was. So it felt, but it is not only me.[ccxcvii]

Especially important are network meetings for those working either in small municipalities with few employees, or for those working in the county in more specialised areas with few employees, such as working with unaccompanied children. It is also explained that there are networks in the county to maintain BBIC and MI (Motivational Interviewing).

In general, the network meetings are organised twice a year, sometimes initiated by the regional unit and sometimes by themselves. The content is mainly to exchange experience and knowledge with each other, to get good ideas on what they can do in the daily practice, and how to develop social services. These meetings give, according to this social worker, opportunities to exchange experience, 'because there you can bounce thoughts, and it always comes up, oh you are doing that well, yes but we are doing this'[ccxcviii].

Supervisions as an organised collegial support

Supervision for social workers is a forum for exchanging knowledge and experience between colleagues in a workgroup. This supervision is formalised and organised differently in the municipalities, depending on what the needs are. The organised collegial support is mainly about the internal supervision that managers administer and leads. It is also about external supervision which is a forum where social workers meet a supervisor who is employed as a consultant with this assignment. However, not all municipalities have formal supervision and in one municipality they have neither internal nor external supervision. The reason, given by those social workers, is that they work in a workgroup with a few but experienced social workers, and that they therefore do not need this kind of supervision. A social worker from one of these municipalities explains:

> We have had social workers who have worked here for thirty years that have an enormous experience. … It has not been so much personnel turnover so there has been a huge amount of knowledge and experience here.[ccxcix]

The social workers in the other municipality, where they do not have any supervision at all, are also very experienced in their work. Instead of organised supervision they have a solid support that is available in the experienced social workers. A social worker from a municipality where there are several social workers with short working experience explains this in a similar way, but from their perspective:

> It is needed and because we are so many new here it is a little different. No experienced colleagues that have many years of [experience] and know a lot.[ccc]

Most of the interviewees have access to both internal and external supervision and some have also access to various forms of support for the use of methods and ways of working, such as BBIC. And those who have access to supervision experience it as a great support in the work.

Internal supervision is conducted about once a week and participants are usually those working in the same workgroup. One social worker describes these occasions like this:

> We take up when we are stuck in the cases or if we are thinking about interventions; have I thought about the right intervention? And … it is not just [the manager] who speaks, the whole workgroup may, if someone asks something so can the whole group give their views; what are *you* thinking and what are *you* thinking and what are *you* thinking? So, that we get to hear.[ccci]

The internal supervision is often led by the social workers nearest manager, but all colleagues in the workgroup are participating in the supervision. Together they provide knowledge to specific cases or other matters in need of discussion on these occasions. Although various sources of knowledge are used during supervision, the most common is to use the experience and the knowledge supervisors and colleagues have from previous cases. It seems more uncommon to explicitly discuss research or other external knowledge at those supervisions, which is also consistent with what the managers say.

External supervision is available in some municipalities and is conducted about once every two or three weeks. External supervision means that a consultant leads a discussion within a workgroup. The issues usually discussed have a broader perspective on social work than in internal supervision, and is not about specific cases. It is rather, one social worker says, 'a little bit more … based on us as humans and not just social workers'[ccciii]. She continues and explains that they can discuss how to handle situations 'that take a lot of energy'[ccciii] from them, as with 'angry parents or cooperation partners'[ccciv].

Knowledge from users

To consider and use the knowledge from users in social work is emphasised as an essential part in evidence-based practice and is often portrayed as one of the areas where social services needs to improve (see for example how the regional representatives describe the need to develop user participation). Social workers use knowledge from users mainly in individual cases and investigations. BBIC is described by social workers as a benefit to the users; the children are especially highlighted in an investigation. None of the social workers mentioned that user participation involves compiling knowledge from users at a group-level, for example to meet with user organisations when planning their work or doing local evaluations.

Individual user's knowledge is taken into account

In order to make users participate on an individual level, the social worker is dependent on the user's willingness to participate, as most of social services interventions are non-compulsory. When it comes to compulsory treatment user participation becomes more difficult:

> It is different depending on whether it is a volunteer intervention or if it is an intervention with compulsion. There, it is harder to get a client involved because they by definition do not agree with us on what we [suggest].[cccv]

How a user comes in contact with social services has therefore great importance for their participation and influence. Even if the social workers try to involve users it can be difficult when they distrust social services. No matter how they come in contact with social services and regardless of what they feel about the contact, social workers must create a relationship with the user, so the investigation can be done with the individual's participation and influence. Social workers find it difficult when users do not want to participate or receive support that is granted. One social worker says:

> Sometimes I assess that a family is in need of support via our outpatient care, that they would need support in their parenting. But the parents do not want any support, and then I cannot do much but to close the case without intervention, but write *that* there is a concern and that we think they had needed it, but. But it is a voluntary intervention so it is not something that can be forced on them.[cccvi]

These situations reveal the importance of a good relationship between the social worker and the user. It is a balancing for social workers when they perceive that there is a need

for support while users do not have the same perception of the situation. Social workers are required to determine whether to open an investigation or not, when a notification has been handed in to the social services. At the same time as they have this obligation they are also dependent on a good contact and relationship with the user.

User participation and influence is according to social workers about informing users, listening to them and letting them be heard. One of them says:

> I always try encouraging them, that they themselves also always shall ask the questions that they have and if they feel that … there is something they do not understand or anything that they feel that, but why are we doing this. Yes, but that they take it up with me, just so I can explain or that they get their voices heard. I think that is important, that they may have their say.[cccvii]

BBIC and the different documents belonging to BBIC are perceived facilitate users' participation and influence. It is easier for the social workers to involve parents and children and to explain to them in a way they can understand. BBIC also facilitates for users to express themselves, to be heard and listened to.

While social workers talk about the importance of user involvement and influence, they also emphasises that it is social workers who take decisions about interventions and that they cannot always do as users want and think is best. They are, according to this social worker, 'exercising authority'[cccviii] which they can never ignore, 'however much one wants to … have user participation'[cccix].

Social workers also talk about the legal responsibility of following-up the support given at an individual level by the social services. There is, in the Social Services Act, a statutory responsibility that social workers have to do follow-ups during an intervention. The follow-ups shall be done at least every six months with each individual user, and according to the social workers, the managers and the regional representatives this is done. One social worker explains:

> If there is an intervention then you have to follow-up. … You follow-up and see and, is this the right … intervention. And then it might happen that, yes, it has been that … [the user] may not need it for a while.[cccx]

As a help to follow-up, they use different plans (for example care plan, work plan) which are drawn up for each individual. These form the basis for follow-ups on the individual level and are used to determine how the intervention works for the individual, if it can be ended (the goals and aim have been achieved) or if the intervention needs to be changed somehow to work better for the individual. However, social workers have no legal responsibility to follow-up on an individual after an intervention has ended or, if the individual is not granted an intervention 'it is nothing we follow-up then'[cccxi], says one social worker and continues by explaining that instead the users have to 'come back if they feel that the situation has changed'[cccxii].

When social workers talk about their work with the users, they talk primarily about how they work with the users today, and they explain that it is important to create an as good relation to them as possible. An important aspect of evidence-based practice is

to use the knowledge that individual users have, which will increase user participation and involvement. It is also a legislative requirement to follow-up the support given. These follow-ups are not compiled at a group- or organisational level in any of these five municipalities, as the following section deals with.

Users' collective knowledge is not used

Users' knowledge is important, in the way evidence-based practice is presented, not only at the individual level but also at an organisational level (Oscarsson, 2009; Freij, 2012; Svanevie, 2013). Reasons given are that users shall be satisfied with the support they receive, and that the support has positive effects for both users and the social services. Finding ways for user participation and influence is often described at the organisational level as a development area. Regular evaluations are not made in any of these five municipalities. Most social workers claim that evaluations are not done by the organisation and no follow-ups have been compiled on an aggregated level. For example, one social worker explains that 'it is voluntary interventions so there is nothing that we can do'[cccxiii].

However, there are social workers who feel that evaluations would benefit their work, and that it is something that they have discussed doing:

> We talked about it quite many times because it felt that we needed to do that, for each time you end a placement or an open intervention ... or a contact person, contact family, you would have needed doing some follow-up around, or documenting; how, what was it that was successful, what was it that made it function and that one reached the goal? But it is like there was neither … time nor a plan for how it would be. ... We have too much else to do. ... But it would have been good because it would benefit us in the job and benefit the clients.[cccxiv]

In the quotation above it is mentioned that her and her colleagues have discussed doing this sort of evaluation, and they perceive the need and usefulness of evaluating work, for the organisation as well as for the users. At the same time she says there is no time for conducting the evaluations in the competition with the daily work.

Social workers working on the behalf of the organisation

In this, the third main section, the social workers perception of the management groups' expectations and their support of the introduction and use of evidence-based practice and BBIC is presented. This is about evidence-based practice at the local level, but in contrast to the former main section, this section concerns how work with introducing evidence-based practice is organised in the social services, still from the social workers perspective, and not from the managers and politicians' perspective. The social workers talk a lot about BBIC in this main section because that is what has been introduced in the social services. Evidence-based practice has not however been introduced, at least according to the social workers. I do not have an intention to include all different organisational conditions. One example is about legislation, which is almost not taken into account because the social workers do not mention it.

In this main section there are three subsections, where the first section is about what expectations and support the social workers experience from the organisation, regarding working with evidence-based practice and the more concrete BBIC. Thereafter, I focus on social workers' experience of organisational resources, for example social workers' experience of the lack of time. The question of resources is also discussed; as a part of evidence-based practice social workers should search for and use the knowledge needed in each case. Finally, the last two subsections involve two interrelated aspects of evidence-based practice. The first aspect deals with local evaluations of the organisation's efforts, where the results are compiled and analysed at an overall level, so it can provide a basis for further planning and priority for the social services. The next aspect, also important in an evidence-based practice, is about whether the range of interventions available in the municipalities corresponds to users' needs and preferences.

Expectations from the management

This section is about the expectations from the management about introducing evidence-based practice, as social workers experience it. The management is the social workers managers, both middle and senior managers, and the local politicians in the Social welfare committee. Social workers are talking mainly about BBIC and evidence-based practice. To introduce BBIC and evidence-based practice is easier if there are clear directives from the management, where the management expresses that this is what we want the social workers to work with.

Most social workers are aware that there are written agreements about BBIC because a political decision and an agreement with the National Board of Health and Welfare were needed to get a licence to use BBIC:

> It is decided that we are going to use BBIC … the Social welfare committee has decided that.[cccxv]

In contrast there are few social workers that know if there is some document or policy that states that evidence-based practice should be used in the social services:

> Yes only BBIC … but I do not know in regards to others.[cccxvi]

> No, I have no idea.[cccxvii]

There are also few social workers that experiencing expectations on them from the management group, managers and local politicians in the Social welfare committee, about evidence-based practice. Three social workers say:

> I do not actually know if we have. Yes clearly MI [Motivational Interviewing] and BBIC we shall work after. But then it is not. I do not know. It is not really ... so very high demands.[cccxviii]

> From politicians we do not feel any [expectation].[cccxix]

> It is nothing that I have heard anything about.[cccxx]

Some social workers feel that there are expectations that they should work according to evidence-based practice. In the way that expectations about evidence-based practice are described, the management seems not to express such expectations. Rather it seems more like an ambition. One social worker says for example that 'it is implied that we shall endeavour to work evidence based'[cccxxi] which is not a clear directive expressed by the management. There is however increasing demands from the management that investigations should be done with BBIC, and BBIC is often related to as a part of evidence-based practice.

Expectations mainly about BBIC

Most of the social workers that experience expectations from the management talk about BBIC. The social services have allocated financial resources to introduce BBIC and there are therefore expectations that social workers use BBIC in their daily work, and to use it correctly. One social worker, where they have worked for several years with BBIC, perceives that the politicians in the Social welfare committee have higher demands nowadays and have started to ask more about the investigations they take part of:

> It becomes more and more that, I mean if I shall write a proposal for a decision to ... [politicians] about a placement [of a child], it has to be founded partly in the needs, thus doing a proper … description, what risks this might have for the child. And then also motivate why I am thinking that this person … shall get this kind of help. … But certainly higher requirements on that have started to be set … it shall be well motivated and founded.[ccxxii]

Through applying for a license the local social services has committed themselves to conducting investigations involving children and youth with BBIC. This commitment does not apply evidence-based practice; the social services has neither committed to using evidence-based practice against national actors nor expressed expectations on social workers that they shall use evidence-based practice.

Low expectations about evidence-based practice and BBIC

Some social workers perceive the expectations from the management as realistic and some that they are too low. When the management have low demands it is because they have too little knowledge of evidence-based practice or BBIC, according to one of the social workers:

> The managers do not know as much about BBIC as my colleague and I, because we are educators. … And the managers do not know either, the politicians absolutely do not know; they do not even really know how the investigation should be or how it should benefit the child best.[ccxxiii]

This social worker is a BBIC educator in her municipality, which means that she has gained more knowledge about BBIC than many other social workers, managers and politicians.

Some of the social workers are not facing high demands from the management group, about evidence-based practice, but wish that expectations on them would be higher. Here are two examples about perceived expectations from the local politicians:

> There are no expectations. We would probably like to have more expectations on us, that they had a desire to actually pursue it. There is almost no thought about what we should do actually. Except keeping the costs down.[cccxxiv]

> I do not think that they feel they set too high demands on us, from above, from a political point of view. No I do not think that. I might think that they could become clearer about what they want. … They also need to be more informed, they do not work with this on a daily basis, but they also must read more and learn more, so it is. To be able to be clear. They have to have a unified attitude.[cccxxv]

Both these social workers feel that the expectation about evidence-based practice is too low from the management. The first social worker mentions that the management conveys that it is important to keep in mind the finance, and experience of the other social worker is that management, and local politicians in particular, lack knowledge and it is therefore not clear how they want the work to be performed.

One social worker underlines that the demands which are raised about evidence-based practice from national level are realistic but that there is a lack of resources at the local level, in the social services, to work with evidence-based practice:

> Then we have to have the conditions to be *able to* use it, it takes time to acquire new knowledge and if we have cases up to our necks, it clashes. You do not have time to learn what you need to do, to be able to perform your job. So then it comes down to resources. Thus, if it shall be a reasonability, that we get better at this, then we also need resources accordingly.[cccxxvi]

At the same time as this social worker expresses that the expectations, from national actors, are 'totally the right expectations'[cccxxvii] about evidence-based practice, the resources that are needed are not taken into account. There are not enough resources in the organisations that match national requirements on the introduction of evidence-based practice.

In one municipality, social workers claim that there are no expectations on them from the management because they have not yet decided if they are to participate in introducing evidence-based practice. She and her colleagues from the same workgroup feel it is like a 'vacuum' and continue to explain the reason why it is like that:

> The core activity should be prioritised and everything else in addition, it has to be if ... this *shall*, from, for example, The National Board of Health and Welfare. And, this about evidence based practice, yes, sure, but concretely then? And ... we are few here, if anyone should go away on something or there is information about something then, it is always in relation to all the other activities.[cccxxviii]

The social workers from this municipality have a desire to introduce evidence-based practice but there is no support from the management. The introduction of evidence-based practice has started to develop in most local social services in North Bothnia and in Sweden, primarily through the national EBP-initiative. This municipality is the only one of those participating in this research that is discussing the possibility to actually introduce evidence-based practice in the organisation with existing resources. This reflection is not just about one believing in evidence-based practice, it is also about to what extent there are enough resources to cope with the daily work parallel with introducing evidence-based practice and other activities and requirements that are coming to the organisation, for instance changes in legislation or national supervision. Those social workers, who experience that the management group has not taken any decisions about whether to introduce evidence-based practice, are supported by the manager's description of the situation in this particular municipality.

Support from the management

In order to introduce evidence-based practice or BBIC in practice it is, according to the social workers, important that managers and politicians have knowledge and competence, and that they support the process that the introduction involves for the social workers. Overall, about half of the social workers experience support from their nearest managers regarding the introduction of evidence-based practice alternatively BBIC. This is illustrated in two quotations, where the first is about BBIC and the second about evidence-based practice:

> Yes I think there is … an incredible knowledge that [my nearest manager] has [about BBIC]. … And is there anything she is hesitant about then she knows what roads we shall take to find the right [solutions].[cccxxix]

> I think they need more. ... I am thinking in general that it is so. --- I have no idea of how [my nearest manager] is thinking or what she knows.[cccxxx]

Below is an example of one social worker's experience that the manager is supporting the introduction of evidence-based practice:

> She is very, exceptional on the track, my nearest manager. She is ... checking, reading, informing about that, I have read a good book. And now we should start with this [meetings] and work active with certain books. So she is very interested and incredibly knowable person.[cccxxxi]

In the social workers description of the nearest managers' support, many of them emphasise that they have competent managers that are interested and want the work to develop. The same social worker as above expresses also that the support given by the managers are linked to the person:

> It is also so linked to the person, who you have as your nearest manager. And it is dangerous because it is so much about that in social work, so incredibly connected to the person.[cccxxxii]

Thus, to what extent social workers have support depends on the person who is manager, and it is up to each manager if they want or are interested in supporting

evidence-based practice. Other social workers also experience that there are differences between managers. One of these perceives that the differences may depend on the individual manager's interest and experience:

> It differs between [managers], the collected ability is probably rather high. Although then, maybe on an individual level, it is someone who has a lower [competence], I think you can say. ... Then there is someone that [has higher competence], depending on the interest and experience they have.[cccxxxiii]

The social workers have difficulties to determine the senior managers and politicians' knowledge and competence in relation to evidence-based practice.

However, there are also social workers experiencing that their nearest manager does not show any particular interest in introducing evidence-based practice. One of those who does not experience any support from the management group to work with evidence-based practice explains that they do not talk about evidence-based practice and therefore she does not know what happen in this issue on a higher level in the organisation:

> I do not think we have so much discussion about this. So, it is hard to know. I think they are positive but I do not know how much they work with this.[cccxxxiv]

Evidence-based practice is not something this social worker experience that they talk about in the management group. Another social worker, who also has experience of development work[36] on a regional level, does not perceive that there is much talk about evidence-based practice in the local social services where she works. She gives an example:

> When it is about evidence based, I do not think that one, one does not express it anyway in that way. ... One does not talk about it in that way. But if you are thinking about BBIC I feel that there has been expectations that I should work with it [as BBIC educator] ... But otherwise, it is never that you are saying that; yes but now we are, like from outside. Thus, one does not use these concepts.[cccxxxv]

What this social worker is experiencing can be explained from a local perspective. In the social services they have introduced certain methods and BBIC, and the concept and understanding of evidence-based practice has not quite yet had an impact in the organisation. This can depend on when it started to be highlighted by the national actors, then it was more about introducing methods and ways of working rather than a whole approach to work practice, including how to organise work. This can also depend on that it is an abstract concept that is not that simple to translate to practice, either for managers, politicians or for social workers. This is explained in different ways by social workers, managers and regional representatives. The methods then become

[36] The concept development work is used when referring to national initiatives and development projects conducted in the municipalities. This is in accordance with the concepts used by the Swedish Association of Local Authorities and Regions, which administer most development works.

something concrete to work with, especially for those that are newly educated and those social services where the employee turnover is high.

Time and resources

One organisational condition, which most social workers refer to, as an aspect that complicates the introduction of evidence-based practice and BBIC, is lack of resources, time and staff. Social workers experience that it takes longer in the beginning, before they learn how to work, and they also experience that this extra time does not exist because at the same time as they are learning something new they also have to do the ordinary daily work, with as many cases and investigations as usual. This for instance is expressed when the social workers are talking about getting new knowledge in work (which is a part of evidence-based practice), and the introduction of evidence-based practice in general and BBIC more specifically.

Just under half of the social workers describe that the organisational conditions needed for searching and taking in new knowledge do not exist in their daily work. In evidence-based practice taking in external knowledge is an important part of the work. In general, the social workers do not find that this part of evidence-based practice is prioritised by the organisation. Only one social worker expressed that she has the time to take in new knowledge and that she does not use her spare time to read things that are useful for her work. 'I have plenty of time'[cccxxxvi], she says. Otherwise, there are many examples of social workers who perceive that there is not enough time to read and search for new knowledge, during working hours. One social worker experiences that they lack time to search for research, except in really specific cases when they had 'to *take* that time'[cccxxxvii].

As many social workers describe, they have to collect knowledge and read in their spare time, if they at all shall find time to read. What is explained by the social worker below is that this becomes really hard when you have small children at home, and she states that:

> But God knows when one, should one lie home in the evenings and read?[cccxxxviii]

And another social worker talks about this in a similar way and explains a bit more:

> But this is stuff you have to read at home, in your spare time. --- Then you always have your books here, where you look and find. But to read further, that is an activity in your spare time.[cccxxxix]

In the beginning when new methods are brought into the work it is more time consuming than when they become familiar with using the method. One social worker says that with the same resources as before they are expected to do this extra work with learning new methods, 'and it is clear that there will be a strain'[cccxl] in their everyday work. Some social workers say that they usually have to prioritise at work, and searching for knowledge often gets a low priority. So it is a combination of time and priority, as one social worker formulates it, 'it is … about the lack of time and that you do not prioritise it'[cccxli].

However, one social worker explains that this does not depend on that they are not interested in searching for new knowledge, 'everyone here wants to be skilled and all here see a need to want to learn more in different areas'[cccxlii], but there is not enough time. Except for lack of time for social workers and managers, one social worker feels that there is no structure in the organisation in relation to how they are supposed to spread knowledge to the whole workgroup when for example someone has been on a further education.

Based on the examples that social workers provide it appears that the responsibility to be updated in terms of knowledge, finding time to search knowledge and reading is the individual social worker's. They experience that there are not enough resources and that it tends to be accepted by the management to give this part a low priority when their working time is needed for the daily work with investigations and meeting users. However, it is not only the organisations that give knowledge acquisition low priority. Social workers also have responsibility to complete all investigations, and support all who seek help, and they make an effort to do so. In relation to these individuals, who need support, knowledge acquisition becomes secondary, as something they can do if and where they have time. The same applies for evaluations. A few exceptions mentioned where social workers get the time to search knowledge and read, and that is in specific cases about a certain problem and where someone else takes the final decision (the Social welfare committee or the administrative court).

For the individual social worker it is not easy to sit down, prioritise and take the time to read and reflect over work:

> It has to go so fast that I do not have the time to think or I do not give [myself] permission to take that time and reflect, simply. But, would I … if I encounter a problem, that I would take my literature and allow myself to read and search and reflect, yes but yes, I did right, no I did wrong, maybe I would have thought like this, or. Often, you cannot even take the question to the [work] group, because I do not know how I am going to think or discuss or reason. So we maybe could get some more time from the start, from the beginning, maybe.[cccxliii]

Time to introduce and learn evidence-based practice, BBIC or other ways of working is an organisational issue. For social workers it is easy to prioritise away evidence-based practice because almost no one in the management asks about it and that the daily work tasks take precedence over introducing evidence-based practice. If evidence-based practice becomes unseen, no one has to do anything about it. And as municipalities are autonomous, it is the social service's decision about if they give social workers those prerequisites. In the same way as regarding the situation for knowledge gathering (which gets a low priority when competing for social workers' time), BBIC competes with the daily tasks, at least it will until BBIC becomes a familiar part in the daily practice. Social workers perceive that evidence-based practice and BBIC will increase the quality and efficiency in the future work.

Planning ahead

An important aspect in the introduction of evidence-based practice is in what way the organisation plans ahead for the activities. As described by the doctors, evidence-based medicine is also about priorities in relation to what is effective and to the organisations economy. Conducting evaluations is usually described as a core activity. This section considers the management groups' knowledge about the work practice and this is associated with the range of interventions available in the municipality. Theses aspects are interrelated and part of evidence-based practice.

Evaluations of the effects of interventions are important for the management, in order to know how the work shall be organised and what priorities they have to make. These priorities should be based on the users' needs, but it should also be based on the social services economy. This is primarily about evidence-based practice on an organisational level and not about evidence-based practice at the individual level.

The information that is requested by the management about any kind of evaluation is, according to these social workers, mainly statistical data about the number of cases and placements. The management do not, for example, ask for information about how the interventions work. Both social workers explain:

> No, no more than just the number of cases and number of placements. … Nothing from that perspective, what works, what does not?[cccxliv]

The required statistical information is used by management to follow-up the activities, but with this information social services cannot know the outcome of the interventions that have been made, and they cannot make plans for the future on the basis of what works for the users. Similar to what the managers describe, it is largely about evaluating the process in the organisation and not the result of the work. A social worker states that evaluations compiled at a group or activity level are not demanded by politicians or managers and they do not ask how the interventions work:

> But they can ask how many placements we have had and how many placements we think we will have. ... There is often a financial character to this question.[cccxlv]

Placements in treatment homes or other placements are among the most expensive interventions social services have and it is also one of the data sets requested by the management. These costs can quite quickly become a huge sum and it is difficult for social services to plan for this in advance.

One reason why evaluations compiled at an aggregate level, is that the management can use them in planning for future activities, so that activities match the users' needs. For the social worker, this entails that they investigate a family's needs and they reach a conclusion about how these needs should be met through weighing together different knowledge sources, and offer support based on that knowledge. For the users it means a support that is more likely to be effective for them. When the activity is not organised in this way it may end up with that the social workers base their decisions about inter-

ventions on which interventions are already available in the municipality. This social worker gives an example of this, from the use of BBIC:

> With BBIC I think that you should not think about what interventions there are, instead you shall do, make the necessary interventions. But it is easy to end up in that track that ... parents and children get the interventions we already have, like that.[cccxlvi]

At the same time as this social worker tells that they cannot base their work entirely on users' needs, because the range of interventions is not wide enough, she also feels that the support given to the users somehow works for them:

> In one way or the other it works though you are not always satisfied, and often it is like that, that it does not become good and then you do not know if it is because we have the wrong intervention or if, yes what is what in this. We have to take many rounds, several times.[cccxlvii]

The complexity in social work is shown here above. When the social workers suggest and give an intervention it is seldom that the intervention works to the extent that the family does not have any needs anymore. Instead the result is dependent on the interventions, on the individual circumstances, on what happens in the family and in the surroundings. Social work is often described as complex and difficult to study and evaluate because of these contextual aspects. In smaller municipalities the difficulty to evaluate arises because the amount of cases is too few, for example, in one municipality they have no more than four or five placements of children each year. Their conditions and life situations can vary a lot, and the results of an evaluation then risks being unreliable.

Which variety of interventions there are available in different municipalities depends largely on their size and economic opportunities to organise a broad and specialised activity, with an array of interventions. It is mostly in the smaller municipalities that social workers perceive that there are fewer interventions. One social worker from a small municipality says:

> It is a bit hard I think in a smaller municipality. We do not have so many interventions to offer. ... So it feels, open interventions according to SoL[37] can be hard to accomplish in a small local authority.[cccxlviii]

In the smaller municipalities social workers experience that there is not a wide range of interventions to choose between, especially outpatient care according to Social Services Act, but they try to shape workable interventions somehow:

> We twist and turn inside out on ourselves. We do, really, but in some cases we feel that it would have required other interventions.[cccxlix]

> Somehow you must be energetic in the case you have, and then you get to look at what is available. It is a small municipality, it is not specialised and [there are not] that many options, either.[cccl]

[37] Social Services Act (SFS 2001:453).

Social workers in medium sized and large municipalities also experience that there is not enough interventions, or that the treatment given is dependent on a specific employee. One social worker from a medium sized municipality explains that the confidence of the users can disappear if there are no interventions to offer them once they are motivated. Sometimes they may have spent a lot of time motivating a user to receive support and when the user is motivated then the person that gives the support is ill or on leave.

9

Discussion

In this thesis I describe and analyse different processes of the introduction of evidence-based practice. One aspect is what these processes have contributed to in terms of organising ways of working and management within social services, the other is what this means for social work. My research questions are: How is evidence-based practice introduced into social work and what changes are evidence-based practice expected to entail for social work? What organisations are involved in introducing evidence-based practice? How do professionals at different levels relate to evidence-based practice? In what way do the doctors perceive and relate to evidence-based medicine in their daily work? Is it possible to introduce evidence-based practice in social work in a similar way as in the area of medicine? In what way is social work shaped (and constructed) as it is increasingly based on evidence-based practice?

I answer my research questions for this thesis through analysing how social work approaches the introduction of evidence-based practice in social services, from different perspectives. From a macro perspective, the analysis consists of groups of people, organisations, social systems and the society (Guneriussen, 1997; Giddens, 1998; Engdahl and Larsson, 2011). My intention by analysing evidence-based practice with a macro perspective is to provide a framework for how evidence-based practice is presented and introduced in the social services, since the development is significant for how social workers relate to evidence-based practice. The development of evidence-based medicine within health care is an important source for understanding the development of evidence-based practice in other fields, not least within social services, that is the primary empirical base in this thesis.

From a micro perspective the analysis is about individuals and their behaviour in everyday life situations is in focus (Guneriussen, 1997; Giddens, 1998; Engdahl and Larsson, 2011). The introduction of evidence-based practice cannot be understood without investigating how actors involved (social workers, managers, regional representatives and doctors) act and create work whilst performing their daily tasks. The organisational structure is shaped by people, they perform the tasks necessary (Scott, 2003). Meso level focuses on how people's actions are coordinated; for example how the social services coordinate employee's actions into a whole, where today evidence-based practice is an important factor. An institutional frame such as evidence-based practice will, according to Guneriussen (1997:301), create a 'meaningful symbolic order that defines and gives meaning to the actions or action alternatives' *[author's translation]*.

A full understanding of the introduction of evidence-based practice is difficult to achieve, but to illuminate aspects of the development of both evidence-based medicine and evidence-based practice can provide a relatively holistic understanding of evidence-based practice. For example, the perspectives of local politicians, or nurses, or persons from governmental organisations could contribute to a more holistic result. However, by highlighting parts of the process that the introduction of evidence-based practice entails it is possible to provide an understanding. I believe that the method I use to achieve my purpose and answer my research questions has worked well. As discussed in the method chapter (chapter 3), the intention was not to present the truth for all doctors. Three interviewed doctors are too few for that purpose. Instead, what the doctors say in the interviews about their work is analysed as a reference in order to understand those working with evidence-based practice in the social work area. I chose doctors from three different areas and their answers are consistent with each other and with the theory. Furthermore, doctors working in different medical areas are unanimous in their stories. In addition, what the regional representatives talk about can be related to what the managers and the social workers say in the interviews. The documentation about evidence-based practice and evidence-based medicine by organisations are complemented by what is said in the interviews. The same applies to understanding how evidence-based medicine has evolved and spread to social work.

Understanding the introduction of evidence-based practice in daily work is difficult without considering the developments that have taken place in medicine. By combining new institutional theory with Berger and Luckmann's (1967) understanding about social construction, I can move between a macro, meso and micro perspective to understand the introduction of evidence-based practice – what is presented, introduced and received. The historical understanding is important (cf. Barley and Tolbert, 1997); the history is relevant to what is happening today in areas such as social services and medicine. For example, how the social welfare sector is organised, which management techniques are introduced in public organisations as new public management or the purchaser and provider model that Bloms (2006) explored. With this approach I consider the introduction of evidence-based practice as a process.

New institutional theory is a well-founded theory to explain how different ways of organising activities spread between and within organisations, as usually is located within the same organisational field (cf. Johansson, 2002). Organisations in a field strive to become more like each other, through various isomorphic processes (DiMaggio and Powell, 1983). These isomorphic processes will result in increasing opportunities for organisation's to achieve legitimacy. The Swedish welfare sector is, as in many other countries, exposed to increasing demands for a better use of tax revenue, and requirements for an increased efficiency and influence of users and citizens (Holmberg, 2003; Berg, Chandler and Barry, forthcoming). Neo-liberalism is well in line with the development in the welfare sector with increasing private rights for individuals, and free market and trade (Harvey, 2005). Legitimacy is often the real cause of changes even though it is expressed that organisational change is done to increase efficiency (Meyer and Rowan, 1977; Stern, 1999; Blom, 2006).

An analysis on the micro level describes how social workers create their reality and how routines and habits become institutionalised. In order to analyse how social workers

shape their daily work an analysis from a micro perspective is needed. Organisations change continuously and it is especially important to study what is going on inside organisations (Tsoukas and Chia, 2002). Berger and Luckmann (1967) perceive that the reality of everyday life is socially constructed. Work is an important part of everyday life where the habits and routines have been created to simplify work. The language constitutes a large part of the routines and habits that become institutionalised (ibid.). Therefore, an analysis at a micro level is about how those interviewed relate to and facing evidence-based practice in the daily work.

Evidence-based practice from different perspectives

The introduction of evidence-based practice should be understood as a process, and can be described as an idea that travels, that has been picked up by national actors, translated and edited by them and by the regional units responsible for development work. And, finally become re-embedded and adapted at the local level by the social services. In this thesis it is too early to claim that evidence-based practice has been re-embedded, but it is on the way and social workers, especially, are interested using evidence-based practice.

The actors involved in the introduction of evidence-based practice, which has been illuminated through this thesis, are firstly national actors such as the government, the National Board of Health and Welfare and the Swedish Association of Local Authorities and Regions (SALAR). Secondly, the regional unit is important for carrying out the national initiatives which strive for the development of evidence-based practice. Thirdly, the local social services are also important and can be analysed from a work practice level and from an organisational, meso level.

National actors and evidence-based practice

From a national perspective there are several organisations that are important for the introduction of evidence-based practice. The government sets the frames, and the National Board of Health and Welfare and SALAR are two organisations with a mission to support the introduction of evidence-based practice (Alexanderson et al., 2012). The National Board of Health and Welfare primarily govern 'knowledge into practice by providing knowledge reviews, guidelines, handbooks, and so forth' (ibid:165). There has been a change from when evidence-based practice started to be introduced, when the National Board of Health and Welfare administered a large part of the development projects. When the interviews were conducted SALAR had a major responsibility for the development work conducted within the social services (cf. Regeringskansliet och Sveriges Kommuner och Landsting, 2012, 2013, 2014), and their primarily task is to support the social services to use knowledge (Alexanderson et al., 2012).

The organisations at the national level transmit the idea of evidence-based practice to municipalities. This is mainly done through project or development work (as is the term used) within specific areas, with economic support to the municipalities. What areas are important to focus on are specified by the government and SALAR, via the annual agreements. Some of the regional representatives with longer working experi-

ence perceive this as control or steering by the state, which has increased over the years. Although the regional representatives say that there is a dialogue between the government and the municipalities about what areas that need supporting. One way in which the government controls what municipalities do, and how this is done, is to provide performance based compensations for development work in particular areas. Scott and Meyer (1991) argue that the increased endeavour to control these sectors usually depends upon the perceived lack of control over what is produced and also over the results. Decisions in organisations with loose coupling 'tends to rely on structural and process controls, that … are associated with loose coupling between administrative and production tasks' (ibid:138).

Bergmark and Lundström (2011) explain that the introduction of evidence-based practice was largely initiated by the Swedish central bureaucracy, who formed normative structures surrounding social work. There is on the one hand a contradiction between the municipalities' autonomy and independence and on the other hand the efforts of government to control the work towards particular objectives. The result is often, according to Meyer and Rowan (1977) that the municipalities decouple or loosely couple their practice from what the idea of change conveys to the municipalities. National actors grant funds in arrears when municipalities have performed the specific work tasks being acquired by national actors, for example filling in data in open comparison. For example, one manager says that they get requirements to implement things and then maybe project funds will be created. And sometimes it is incentive grants, but other times it is performance based compensation, and then we have to show some results to get part of the money'. These required tasks are being performed by the municipalities, to take part of the money and to reach legitimacy for their work.

The national strategy for controlling social services is a form of regulative control (cf. Guyatt et al., 2000; Upshur and Tracy, 2004), evident in areas such as substance abuse and addiction treatment where the National Board of Health and Welfare produce national guidelines. These guidelines are based on evidence, and this particular guideline within addiction treatment is common to the municipalities and county councils. Guidelines are a way to get professionals to use evidence in their work (Guyatt et al., 2000; Rosen, Proctor and Staudt, 2003), and is one strategy used in Sweden to introduce evidence-based practice according to Bergmark and Lundström (2011) and Bergmark, Bergmark and Lundström (2011). This particular guideline has been criticised for having a too narrow view on evidence, and for promoting certain methods and discarding others. This is described by some interviewees, one regional representative says: 'And of course there were critics, but they drowned somewhat in the hallelujah chorus around CBT. … So it is very important I think, a critical approach' to what is presented from national organisations. There is one manager who clearly expresses the need for social services to reflect over what is introduced in their activity; she did not perceive that evidence-based practice was not useful but that there must be preconditions for social services to take care of whatever is introduced, regardless if it is evidence-based practice, BBIC or something else. She puts it like this: 'But where is reflection over how we shall actually take care of it once we have documented all this, how shall we deal with it?'

When SALAR became an actor in the field, they became responsible for supporting the municipalities introducing evidence-based practice. This has been done through regulative control and with an intention to transfer normative elements about evidence-based practice. One strategy with the national initiatives is to build support structures for evidence-based practice, which includes further-education in methods and practices of work, and evidence-based practice. The development works Knowledge to Practice, and the EBP-initiative have these requirements with an intention to strive for long-term efforts. A need for a more long-termed support was illuminated in different investigations and missives (cf. SOU 2008:18; Regeringen, 2010; Socialutskottets betänkande 2010/11:SoU10), and has the ambition to be realised from the national level in the agreements between the government and SALAR (cf. Regeringskansliet och Sveriges Kommuner och Landsting, 2012, 2013, 2014).

A regional perspective of the introduction of evidence-based

The regional unit, the Research and Development Unit is responsible for several development projects, which in different ways include evidence-based practice. The regional representatives describe their assignment as a mediator between the national level and the 14 municipalities in the county in relation to the investments made in different development work. As intermediaries, the regional representatives have the main responsibility for the development work and for realising the requirements of national actors towards the municipalities, at the same time as they perceive a need to adapt these initiatives to local circumstances. They have a great understanding for the difficulties the municipalities meet in their everyday activities. One example of this is given by one regional representative who confirms that they 'must have an understanding that there are different preconditions to participation' and that they 'cannot demand equally from all municipalities that they shall in terms of staff or, invest as much in this network work and maybe not in the implementation work either'.

In documentation from SALAR (cf. Regeringskansliet och Sveriges Kommuner och Landsting, 2012, 2013, 2014) it is explained that there must be a working chain between knowledge development, knowledge dissemination and the use of knowledge (see figure 3, in section *The regional unit as intermediary for change*). With figure 3 SALAR illustrates the interaction between the national, regional and local levels in terms of knowledge development within social services. In order to develop a good quality in social services, all these parts are needed. The regional unit and the EBP-initiative can be placed in the middle of figure 3, with their aim of developing a support structure for evidence-based practice. The regional representatives consider the regional unit to be a suitable actor to maintain a support structure and that it is possible for them to function as a link between the national and local level, as is described by one regional representative who says that their responsibility is '[n]ot only to be this megaphone, the state's megaphone out to the municipalities and speak about what they shall do, but supporting municipalities to, in their own activities, find the areas where they maybe see deficiencies'. In this quotation the importance of adapting development work to local circumstances and their responsibility as mediators is emphasised.

Several of the regional representatives discuss the importance of adapting development work to local circumstances, and perceive a need for understanding that social service is

comprised of many tasks as well as that it is not always easy for social services, especially for smaller social services, to manage all the development work being conducted. As such, the regional unit mediates the state's intentions and becomes a support for local social services in the introduction of evidence-based practice and other development works. To act this way makes the regional representatives an important part of the translation process, where evidence-based practice becomes edited (Sahlin and Wedlin, 2008), re-embedded locally and adapted to local circumstances (Czarniawska and Joerges, 1996).

The regional unit is working at a level that resembles county council level within health care, in the sense that it is their responsibility to work with all municipalities in the county. One important difference is that the municipalities are autonomous; they cannot be controlled in the same way as health care units are controlled by the county council. One doctor provides some examples of how they work at a regional level with what they call an 'arranged introduction for knowledge management'. One example is concerned with how they control drug prescriptions with the help of technological solutions, another relates to how different expert groups are created to implement the national guidelines that The National Board of Health and Welfare develop.

These examples are a part of the arranged introduction which needs to be complemented with prioritisation from the organisation. One doctor describes the arranged introduction and that there is also a need for 'a discussion about priorities throughout the county council'. The municipalities included in this thesis do not have this supporting structure. Working with an arranged introduction of evidence-based medicine entails what Guyatt et al. (2000) describe; that doctors are evidence-users more than evidence-practitioners. Guyatt et al. (2000:955) understand that there are difficulties with doctors being evidence-based practitioners all the time and with this strategy the doctors are still 'up to date practitioners who deliver evidence based care'. The arranged introduction is used by the county council to provide doctors with knowledge and evidence about how to conduct their work, not least via national guidelines.

The introduction of evidence-based practice from a local perspective

Introducing evidence-based practice can be analysed from a local perspective, a level where social workers should work according to evidence-based practice. Evidence-based practice is usually described as a decision making process for the practical social work (see figure 1, section *Evidence-based practice from a wider perspective*) where the individual social worker is expected to weigh together different sources of knowledge.

The introduction of evidence-based practice also consists of a structural aspect at the local level, which is pointed out by for example Gray, Plath and Webb (2009). How an organisation creates structures for the introduction of evidence-based practice, or other organisational changes is important for the result of the introduction of evidence-based practice in each social service. Managers at all levels of the organisations, but especially middle managers, have a major responsibility for the change and development of social service's work. This is one result which was evident in my licentiate thesis; where middle managers did not have to participate it became a personal choice to support the project, with various effects (Eliasson, 2010). Social workers interviewed in this thesis

also explain that the support for evidence-based practice largely depends on who is their manager. One of them says: 'It is also so linked to the person, who you have as your nearest manager. And it is dangerous because it is so much about that in social work, so incredibly connected to the person'.

When managers describe their work, evidence-based practice is identified as one part of their responsibility. Not one of them expresses a belief that evidence-based practice is the foundation of social work that all other development work should be based on. Even though the ultimate and formal responsibility for social services is held by local politicians in the Social welfare committee, neither the managers or social workers feel that local politicians have enough knowledge of evidence-based practice. A few managers say that politicians do not have knowledge about evidence-based practice but are not sure if they need specific knowledge about evidence-based practice anyway. In general managers experience that they 'very rarely get assignments or ideas about what to apply', and then it is difficult to give evidence-based practice priority. Instead, another manager says, it is the economy that 'controls pretty much what we do'. Politicians may have greater knowledge of BBIC than of evidence-based practice, and examples are given in the interviews that politicians ask if investigations concerning children are done with the help of BBIC, but they do not otherwise, in general, give directions that evidence-based practice should be a fundamental part of the work within individual and family services.

Since the managers and social workers do not feel that politicians are committed to their responsibility of introducing evidence-based practice, the responsibility becomes the managers. But the managers tend to view evidence-based practice as one of the many tasks they are responsible for and it thus becomes social workers that are responsible for shaping the work and deciding, consciously or unconsciously, the extent to which evidence-based practice is actually used in practice. In many ways it appears as though social workers are still grappling with evidence-based practice because evidence-based practice has not become edited and re-embedded in the local practice. New habits and routines are competing with the routines used in the current situation (Berger and Luckmann, 1967).

For example, both social workers and managers find it difficult to explain the disadvantages of evidence-based practice. They tend not to reflect upon possible disadvantages. Not all social workers understand how to use evidence-based practice in their daily work, 'I just do not know what it means, evidence-based', says one social worker. And others describe the difficulties of translating the theoretical knowledge of evidence-based practice, mainly from educations and further-educations, to the work practice. Many social workers and managers also feel that there are no real opportunities in the organisation to conduct follow-ups, evaluations or to search for research. One middle manager states that social workers 'do not have the time even to tie it together, and they do not have the time to reason'. Social workers point in particular to the lack of time to search for external knowledge, especially research. And to read is, according to several of them, 'an activity in your spare time'. Instead they collect knowledge from other social workers, and work is largely comprised of the personal knowledge and experiences of colleagues and managers. External knowledge is mainly acquired

through their education and further education, such as courses, seminars, and lectures, and through reading on the Internet.

Changes that create legitimacy often have a limited influence on what takes place in an organisation (Meyer and Rowan, 1977). Organisations have a need to strive to be regarded as legitimate and to be accepted; they need to show that they live up to prevailing norms of rationality, progress, renewal and so on. Through decoupling practical action and conduct from the formal structure, the organisation can continue to maintain a legitimate formal structure for the work and evidence-based practice, whilst their actions and activities vary based on which practical considerations are made within the organisation (ibid.). Therefore, when new work practices are introduced they do not always have an impact on the practical work. In this way, an organisation can conduct activities without being bothered too much by the various 'legitimacy-generating reforms' (Stern, 1999:82).

The evidence-based practice myth

This section will focus more on evidence-based practice as a rationalised myth, decoupled or loosely coupled activities and isomorphic processes. Through an evidence-based practice myth, a notion of evidence-based practice is conveyed. In Sweden, the main source of this myth is how national organisations have presented evidence-based practice (cf. Meyer and Rowan 1977; Johansson 2002). The approach to evidence-based practice has changed since it was first introduced (Gambrill, 2003). Often there is reference to organisations such as the Cochrane Collaboration and Campbell Collaboration when evidence-based practice is described, internationally and nationally (see chapter 2).

These international organisations work to a large extent to a narrow understanding of how evidence should be used. In a rigorous use of evidence random controlled trials (RCT) is considered to be the best method to get reliable results (cf. Gray, Plath and Webb, 2009). RCT-studies are used whenever possible and only when there are no RCT-studies or there are not possibilities to do RCT-studies can other methods be chosen. Further down in the hierarchy, there are methods that are not considered to be as reliable. A broader understanding of the use of evidence and knowledge has evolved to better suit areas such as social work because there are relatively few RCT-studies done within this field, and it is more difficult and more complicated to obtain the best evidence (cf. Grimen, 2009; Oscarsson, 2009; Bergmark, Bergmark and Lundström, 2011). Within health care it is easier to conduct RCT-studies and there are therefore more studies available (Bergmark, Bergmark and Lundström, 2011).

The definition of evidence-based medicine by Sackett et al. (1996) is often used as a definition of evidence-based practice. After the definition of evidence-based medicine was launched it has been extended by Sackett et al. (2000). Evidence-based practice is presented as containing three main knowledge sources; the best scientific evidence, users' preferences and actions, and the professionals' knowledge and clinical expertise (Sackett et al., 1996, 2000; Haynes et al., 2002; Mullen et al., 2005; Bergmark, Bergmark and Lundström, 2011). The professional doctor or social worker is responsible for

how these knowledge sources are used and weighed together. All of them must be taken into account in the work. This model of evidence-based practice is widely used, also in Sweden. In the initiatives that are carried out that the regional representatives describe it is mainly this extended understanding of evidence-based practice that is communicated from national organisations through the regional unit to the local practices. This perception of evidence-based practice is obvious for example in the agreement between the government and the SALAR.

These knowledge sources also correspond to the norms around evidence-based practice, which prescribe what appropriate behaviour is, in certain situations (Giddens, 1998). If social work is performed according to evidence-based practice, the work will become less arbitrary, create security and uniformity and become more effective. These are aspects that are mentioned by those interviewed from the social work field as being the advantages with evidence-based practice. Using BBIC makes the investigations more similar and investigations are done the same way in every municipality and they become more similar between social workers. Through following the norms an imitation where social workers and the social services become more similar to each other occurs. And when they use much the same model for how to work social work also becomes more similar to health care. Although there are differences in how evidence-based practice and evidence-based medicine have been introduced and used in social services and the health care.

The development of evidence-based practice was done with evidence-based medicine as a role model. Evidence-based medicine developed in the beginning of the 1990s, a few years earlier than evidence-based practice. Sackett and colleagues become important for the development in the mid-90s when they worked to improve the education of doctors (Reynolds, 2000). The idea was that the doctor would critically assess research that they could use in clinical work; it was thought that this would reduce doctors' dependence on authority figures (cf. McColl et al., 1998; Upshur and Tracy, 2004; Bergmark, Bergmark and Lundström, 2011). There was also criticism of that doctors, to a great extent, acted arbitrarily and did not use treatments where there was evidence indicating that the treatments were effective. An example that one doctor talked about is lobotomy, which was used without there actually being evidence of that it was good. Lobotomy is an example that has historically produced as a scientifically based treatment with good effect, and which medicine since then has distanced itself from (Ekeland, 2009).

Evidence-based medicine developed internationally in large parts in England and the United States. From there, evidence-based medicine has travelled to other countries and other areas (cf. Reynolds, 2000; Trinder, 2000a; Angel, 2003; Morago, 2006). With Giddens (1990) terms disembedding and re-embedding, Czarniawska and Joerges (1996), for example, explain how ideas travel and that this is done after a specific pattern. Social relations are lifted from their local context of interaction (the medicine) and structured anew in other contexts, such as social work (Giddens, 1990). Re-embedding takes place when new actors adopt and adapt what has been spread to local circumstances (Czarniawska and Joerges, 1996). This explains how evidence-based medicine has spread to other contexts outside the medical field, but also from where it was shaped. This also explains why the results of introducing evidence-based practice

will differ depending on the local circumstances and context. What is introduced is often the story, or the myth, around the idea rather than the reality (Sahlin-Andersson, 1996). According to Berger and Luckmann (1967) the language is important in the process of institutionalisation. Introducing evidence-based practice is done, as described through forming a myth or a success story, and in this process the language is central. Blom (2006:192) gives an example of the importance of the language and argues that 'the language forces people in to social patterns and gives therefore guidance about how we shall interpret, feel and act in the social world'.

However in reality it is not easy to adapt evidence-based practice to the organisation's specific conditions (Sevon, 1996). In 1999 Pettersson and Wigzell wrote a debated article published in Dagens Nyheter (Daily News) where they criticised social work for being based too much on experience, and the same argument was raised later, for example in the SOU report from 2008. In Sweden and in other countries, the broader understanding of evidence-based practice is often advocated rather than the narrow understanding with the evidence hierarchy. Some countries use the term evidence-informed practice instead of evidence-based practice. It has however been an adaptation to the local context of social work. Evidence-based practice is a way to think about change and can be regarded as a rationalised myth as it contains many positive values. As Blom (2006) points out in the example with the purchaser and provider model, changes mirror the rationalised myths about the efficiency of the market. The rationalised myths changed when a wider perception of evidence-based practice emerged, and the presentation of evidence-based practice become more appealing to social workers and social services when it better suites their work.

Evidence-based medicine is spread to evidence-based practice through a mimetic process

Evidence-based practice derived from evidence-based medicine, which was a role model and spread to evidence-based practice within social work. This spread has occurred both nationally and internationally between the medical and social fields (see chapter 2). Organisations have a tendency to organise their work in similar ways as other organisations sharing an organisational field. Isomorphism involves organisations within a particular field adopting similar procedures and presenting themselves in the same way (Holmblad Brunsson, 2002) which is evident in the case of evidence-based practice.

There are strong reasons to characterise the spread between the medical area and social work area, as a mimetic process (Hansen and Rieper, 2009a, 2011), not least through the organisations formed to disseminate evidence-based medicine as evidence-based practice, and also by the people who have been active in this development. For example, the Campbell Collaboration and the Cochrane Collaboration was built on the same principles and the latter is the role model. The spread to the Swedish social services occur through a mimetic isomorphism; organisations at the national level associated with social work imitate similar organisations within the medical field (Blom, 2006). For example, the Swedish Council on Health Technology Assessment (SBU) was formed with the Centre for Evaluation of Social Services (CUS) as a model.

Evidence-based medicine spreads down as a professional project

As is described in the interviews with the doctors, evidence-based medicine has to a great extent been spread by the profession, although national actors have been active and supported the introduction of evidence-based medicine. National actors, as SBU and the National Board of Health and Welfare, have supported the introduction through financial support and providing evidence, through SBU-reports and national guidelines. The introduction of evidence-based medicine has not been without debate in relation to whether and to what extent evidence-based medicine could be used in health care. There was in the beginning, according to one doctor,

> a view that now everything can become science, now everything shall be according to EBM [evidence-based medicine], and that which there is no evidence for, that we shall not get involved in. And, then there was the other pole that said, yes, but that is so little, most of what we do is not EBM.

Today the doctors perceive that evidence-based practice has become an accepted way to work. Normative isomorphism usually occurs in professionalization, where similar education and knowledge creates uniformity (DiMaggio and Powell, 1983). Evidence-based medicine is a process of normative isomorphism where normative rules about the work are established within the profession (ibid.).

Evidence-based practice has been introduced within social services with a top down perspective (Bergmark and Lundström, 2011) but the situation within the medical field is somewhat different. One of the interviewed doctors with experience of work from a national level explains from a Swedish perspective how evidence-based practice has been launched within the social services and medicine. He perceives that the state initiated evidence-based practice from a top down perspective within social services, where advocates of evidence-based practice were organisations, such as the National Board of Health and Welfare and The Institute for Evidence-based Social Work Practice (IMS), are inked to the government. The profession, the social workers, is not a driving force for introducing evidence-based practice in social work in the same way that doctors were in introducing evidence-based medicine.

Within the medical field, evidence-based medicine has been introduced with help of the profession, where doctors' became engaged at SBU as ambassadors of sorts, for the launching of evidence-based medicine. The doctor as is engaged at national level describes how they told SBU that 'doctors will never accept anything that is only launched as a top-down decree'. This led to an initiative where doctors met other doctors and talked about evidence-based medicine. To get legitimacy for evidencebased medicine they used prominent researchers and clinicians who advocated introducing evidence-based medicine; the issue was 'owned professionally' by the doctors.

Evidence-based practice is loosely coupled to practice

When evidence-based practice reached Sweden at the end of 1990s, it was promoted by Lars Pettersson and Kerstin Wigzell (1999) when they wrote about the need for a different way to work in social work. The work should not be built on the social

workers' own experience to the extent to which it had been, and they noted that knowledge of the effects of interventions was poor. And that there was need for more research in social work which focused on identifying which efforts were effective. This became a start for many of the development projects and development work done since then with the aim of developing a knowledge-based social service and evidence-based practice (see chapter 2).

As described above, evidence-based practice was not spread by the professionals in the same extent as with evidence-based medicine. Social workers were not involved in the launching of evidence-based practice as doctors were. Many social workers say that they do not know what evidence-based practice really is, and in the way they describe evidence-based practice it is clear that when evidence-based practice is introduced it is a relatively new way of working. One of the social workers describe it as difficult to know what evidence-based practice is, even though she perceives it as important: 'Yes, I think [evidence-based practice] is important, but … it does not feel like we know, really what it is or, the connection is not given there.' The myth of evidence-based practice has had an impact but evidence-based practice has not been re-embedded.

The way evidence-based practice has been presented is that it includes many good values (cf. Pettersson and Wigzell, 1999; Trinder, 2000a; Pease, 2009; Vindegg, 2009), and social workers do not question those values. The social workers interviewed indicate that they perceive evidence-based practice as a good way of working. Their experience of evidence-based practice is that it provides security, uniformity and improves the results of their work. Many social workers agree with the one quoted here who explains that the work 'felt very arbitrary before' but that 'it feels incredibly reassuring that we have BBIC to work from' nowadays. They often refer to BBIC or other work practices when talking about evidence-based practice in the interviews. BBIC is to a great extent equated with or is a part of evidence-based practice, according to social workers and managers. When using BBIC they perceive they also use evidence-based practice and research because it is built into BBIC.

National actors convey norms for how social work should be conducted through projects and development work and evidence-based practice is considered as central and as pervading all efforts made from the national level. Few of those interviewed from the social services and from the regional unit reflect on whether there are disadvantages with evidence-based practice. When they do mention disadvantages it is mostly about what happens if evidence-based practice is not introduced properly. Then work risks being too instrumental and social workers too tied to the strict use of models and methods. Challenges for the introduction are that social workers do not have enough time, resources are lacking, they perceive in general that the management do not have enough knowledge about evidence-based practice, and that the management do not have enough expectations about evidence-based practice.

The development work initiated and funded by the state is to a certain extent controlled in some areas, where the pervading ambition is to introduce evidence-based practice in the social services. An increasing number of national initiatives control with performance-based funding for well-executed tasks that are within the scope of evidence-based practice and within other forms of control such as new public manage-

ment. Introducing evidence-based practice makes the social work within social services more similar. Norms about how to perform the work within social services are transmitted through a normative isomorphism. Evidence-based practice is mainly an initiative from national organisations that invest money in different areas for development. Besides being a process to transfer norms it is also therefore coercive isomorphism. As one regional representative says about the state, 'they steer with money'.

When national actors transmit norms for how social work should be conducted with evidence-based practice it is done from a longer distance between the social workers daily work and what evidence-based practice is described to be than there is between evidence-based medicine and the doctors' daily work. Especially since social workers have not been as engaged as doctors have been in the introduction. Those interviewed from social services was generally positive to the introduction of evidence-based practice and felt that it would improve work. However, they have some difficulty in describing what evidence-based practice is. This entails that social workers have adopted the linguistic presentation of evidence-based practice, but that evidence-based practice is not an obvious part of the daily routines. The regional representatives have more knowledge about what evidence-based practice is than social workers and managers have. They relate to evidence-based practice in the wider perspective and perceive the usefulness of transmitting evidence-based practice to the social services. At the same time, several of the regional representatives reflect on the governance from national organisations, how it works and that governance has increased today.

Evidence-based practice is presented in ways that appeal to social workers. However, the rationalised myth of evidence-based practice is different from the social workers everyday practice to a greater extent than is the case with the doctors and the regional representatives. The managers have a relatively clear understanding of what evidence-based practice generally means in the daily work of social workers. In contrast, managers present the introduction of evidence-based practice as one of the tasks to be done, in competition to the budget, open comparison, quality registers, and national supervision and so on. Managers do not talk about evidence-based practice as changing the entire way that social workers work. There are also only a few managers who believe that evidence-based practice is requested by senior management and local politicians. One manager says that they 'very rarely get assignments or ideas about what to apply' from the local politicians. Instead, the management is more interested in the economy and statistical data about the activity. When the rationalised myth is decoupled or loosely coupled from the local practice, then the ordinary activity is conducted as if no changes have occurred. The organisation is able to maintain a façade that they work according to evidence-based practice, for example (Meyer and Rowan, 1977; Holmblad Brunsson, 2002).

The myth of evidence-based practice seems to be loosely coupled to the everyday practice for managers. It is loosely coupled rather than decoupled. The two sides of practice and myth may create controversy, and the management chooses to conduct its activities as usual because there are legislative and financial requirements that *must* also be met; the foundation of evidence-based practice is not legislative and financial. That does not mean they are not interested, but evidence-based practice is about changing a way of working and a way to organise activities that break the habitual ways of work-

ing, their already established routines and habits. Difference between managers and social workers is that social workers to a greater extent than managers try to adapt to evidence-based practice, perhaps due to that the myth of evidence-based practice is oriented towards the broad interpretation of evidence-based practice, and not towards the structural aspect of evidence-based practice. The broad interpretation of evidence-based practice makes it more attractive and possible to use for social services; the myth complies with the practice to a greater extent than the more narrow approach to evidence-based practice, and evidence.

Organisations within the public sector strive for efficiency and social services are no exception. Social work receives legitimacy in the eyes of citizens, users and so on when they succeed to introduce evidence-based practice or when they do what they have to do and present this in a trustworthy way (cf. Meyer and Rowan 1977; Johansson 2002; Eriksson-Zetterquist, 2009). The most reflective and somewhat sceptical manager interviewed said that she informed the Social welfare committee about BBIC, and did what she had to do to get the licence, and gain legitimacy, but because of a strained budget neither she nor the politicians speak of BBIC or evidence-based practice. Working with the budget deficit was more important. In this case, evidence-based practice and BBIC is being performed on the lowest level to get legitimacy from national actors and users.

Different conditions

There are differences between the medical field and the field of social work. Evidence-based medicine reflects more closely the doctors' education and profession than evidence-based practice reflects social workers education and profession. One of the most obvious differences that illustrate the contradiction between the myth and the practice regards what the interviewed social workers and doctors say about how they use research or evidence in their work. The social workers are less certain when they describe how they work and use external knowledge, including research and evidence. External knowledge is a source of knowledge that is consulted in the relation to complex investigations, when social workers are required to justify a decision in front of local politicians and other decision makers, or when social workers have to motivate or explain to the users. External knowledge adds weight to their judgment and decisions. Social workers describe in the interviews, in several ways, the importance of a collegial support, supervision and use of internal and experience based knowledge. External knowledge is considered as a complement for the social workers in investigations, so they 'have something to stand on' so they do not use their 'own values and opinions'.

Doctors also use what they call proven experience a lot, for example within areas where there is not so much evidence, when, for example, they meet patients with several diagnosis and problems. But proven experience is described as the complement in doctors' work. One doctor explains that evidence is not enough in their work; they must therefore 'add proven experience'. The doctors also seem to be more comfortable with evidence-based medicine than social workers with evidence-based practice. Evidence-based medicine had been introduced a few years earlier than evidence-based practice, but from what the interviewees say it does not differ that much when the concepts were introduced in each area. However the doctors explain that although

evidence-based medicine is a relatively new concept they talked earlier 'more about science and proven experience', and natural science has long since been a part of the medical education. For social workers evidence-based practice is a relatively new concept which is not related to an earlier way of working. Several of them also have difficulties translating theoretical knowledge of evidence-based practice to their daily work. This also applies to some of the managers.

These differences entail that the myth of evidence-based practice is more loosely coupled to social work than evidence-based medicine is to the doctors' work. From a far distance evidence-based practice appears to be easily transferred from the medical area to other areas, but when looking at it more closely it is not that easy to transfer (Bohlin and Sager, 2011) without altering and adapting it to local circumstances. Furthermore, evidence-based medicine has spread to the doctors more as a professional project with professional norms than what is the case with evidence-based practice and social work, where to a greater extent there has been an initiative from national actors.

Social workers shape evidence-based practice

When evidence-based practice travelling from one context to another, it becomes packaged and presented in a certain way, as a myth (Meyer and Rowan, 1977; Stern 1999) or a success story (Sahlin-Andersson, 1996) which will influence how people act and think in the organisations. Evidence-based practice is a cognitive phenomenon, an institution that consists of knowledge, beliefs and of regulations (cf. Ahrne and Hedström, 1999). When the myth becomes re-embedded in a new context it will meet new individuals that have to confront their ordinary way of working with what is being introduced, in this case evidence-based practice. This section comprises an analysis from a micro perspective, when evidence-based practice is in a stage to be re-embedded in social work (Giddens, 1990, 1998; Czarniawska and Joerges, 1996) or internalised (Berger and Luckmann, 1967). The main focus is therefore social workers daily practice.

Social work has traditionally been described as being based on individual social workers knowledge and experience and that this is not enough in today's social work. This approach is especially obvious in what is presented by national actors. This means that when new work practices are introduced the traditional ways of working will be changed and long established routines will be broken (Berger and Luckmann, 1967). Evidence-based practice is an example of this. When knowledge and experiences are transferred between social workers a learning process is created. Newly educated social workers will learn from those with longer experience, who have created routines and habits in work that are transferred to new generations of social workers (ibid.). Social work emerges for the individual social workers as reality, and this transference of knowledge from colleagues is a way to create legitimacy for social work. The reality is taken for granted and is shaped and maintained through people's thoughts and acts (Berger and Luckmann, 1967), for example in supervision. Those interpretations are not the same for all individuals, but what is important is that there is a correspondence between how work is perceived among the individuals, that is, what social work is. When everyday work has been created in interaction with others it is taken for granted. The choices people have to make are reduced when daily life is perceived as a whole

and when it is built on routines and habits. Recipe knowledge, practical knowledge used in routine actions, has a prominent place. With routines, decisions can be saved for situations which arise that are crucial for the individual. Language is important, and with semantic fields the routines a person encounters in the work can be meaningfully ordered (ibid.).

Several social workers and managers emphasise the importance of supervision in the work group. An example of this is taken from the interviews is about the need for forums where collegial knowledge and support can be used and supervision within the work group. The language becomes important in these supervisions. A primary intention is to develop the knowledge and experience that social workers have in order to improve the quality of the investigations and the interventions. Social work values and norms are created largely in forums such as supervision, network meetings and so on. The knowledge and support from colleagues is shared between them, and are perceived to be very important for most of the social workers; 'It would be really tough being all on your own in this work' says one social worker. And a manager explains that the supervision 'builds very much on experience'. Both social workers and managers say that supervision is especially important for newly educated social workers. This can be compared to how doctors work. They also use each other a lot in the daily work and newly educated doctors use more experienced doctors in order to learn to be a doctor. One doctor explains that 'this transfer of the doctor's role is very much about learning all of this, collecting the proven experience from colleagues and then create their own proven experience'.

Although evidence-based practice is perceived as something to strive for, the interviews contain several examples of that social work is shaped primarily through colleagues' knowledge and experience. There are however attempts from social workers to use external knowledge, but one challenge is that the organisation is structured for the use of collegial knowledge more than it is for searching and using external knowledge and, especially, research. Only one social worker mentions that she has the time to read during her work day, all the others say that they do not have, or do not take the time to read on a daily basis. Instead, several social workers feel that this is something they must do at their spare time. Primarily, they search for external knowledge in specific cases when they need knowledge in an investigation. As long as problems that arise can be solved by the cook book knowledge there is no need for further knowledge (Berger and Luckmann, 1967). Although Berger and Luckmann (1967) write about the use of cook book knowledge in everyday life their reasoning is transferable to work situations. This is different from the situation within the medical field as is described in the former section. The doctors I interviewed also use each other a lot, but external knowledge is expressed to have a more natural place in their daily work and in their routines. For example, one doctor says that 'one does not put it into words anymore, because [evidence-based medicine] has become "business as usual"'. Evidence-based medicine is more internalised for the doctors than what evidence-based practice is for social workers.

It seems that evidence-based practice is an idea which is filled with desirable aspects for social workers, but it is described as implying a lot of changes in their way of working. Using colleagues' knowledge and external knowledge is the most obvious example

presented in the interviews. Evidence-based practice entails changes for the practical social work and also for the organisation, changes that will disturb routines and habits in social work. At least until they are internalised in the consciousness of social workers and social services. However, it is not easy to break and create new routines and ways of working. The following description is given by a social worker when she describes the importance of collegial support, she says 'in the daily work one is so pressed and stressed so that one does not take the time to stop and analyse and consider and plan and find out'. Another social worker says that searching for external knowledge risks being given a low priority, especially in stressful work situations, she says if 'only one copes, copes with searching long enough' they can find something reliable. These are examples of social workers work situation, and that the routines and the recipe knowledge is a help for them to cope with their daily work.

Working tasks such as searching for research or starting to do evaluations takes a lot of energy for the social workers and are described by some social workers as stressful, because they compete with the daily work that also must be performed. No extra resources are available, according to the social workers, which confirms to what most managers say. This appears especially disruptive when the ordinary work is to be conducted in parallel with development work, including the EBP-initiative. Then the introduction of evidence-based practice becomes especially challenging because social workers on the one hand have to do their investigations and meet the users, and on the other hand create new routines and habits which include evidence-based practice. Evidence-based practice has not really had opportunities to be internalised (Berger and Luckmann, 1967) or be re-embedded in the local context (Giddens, 1990; Czarniawska and Joerges, 1996).

Introducing evidence-based practice with evidence-based medicine as a role model may entail even larger changes in social work than in the medical field. In this respect, the introduction of evidence-based practice to social work implies that social worker's habits and routines must be incorporated into the new habits and routines being created by the introduction of evidence-based practice. In the transition phase social workers time and energy will be devoted to the change rather than that the work goes on without interruption. At the same time the daily work with users has to be performed as usual.

Integrating old and new habits and routines

What I want to emphasise in this section is that social work before evidence-based practice started to be introduced in general was to a larger extent based on collegial knowledge and experience. Social workers used external knowledge in work before evidence-based practice was introduced, but the use of external knowledge has been highlighted as an important area for improvement and are as such a part of the presented myth. This is also a challenge evident in the result from the interviews. Evidence-based practice did not, according to most social workers, constitute a large part of the social work education, not even among those social workers that graduated one to two years before the interviews were conducted, around 2010. In this more collegial knowledge based work social workers use their routines, habits and recipe knowledge to solve the problems that arise (Berger and Luckmann, 1967). This way of

working does not need to be legitimised internally in the same way as when evidence-based practice is introduced with a top down perspective, because this is a common reality for social workers.

National actors have, in parallel with ordinary social work, translated evidence-based practice with inspiration from the international development and with the development in medicine as a role model (see chapter 2). The ideas of evidence-based practice held by national actors are transmitted to the local practice, usually via the regional level; at least it is in relation to development work being conducted at the time for the interviews. According to Sevón (1996) this can be described as a chain with several links, all important for the introduction of evidence-based practice in the local social service. The original idea altered when passing through these links and will not be the same in local social services as it was when it was presented at the national level (ibid.). Berger and Luckmann (1967) argue that what is being transferred to others will be less transparent and more solid, something that is apparent with the introduction of evidence-based practice and the transference from national actors to local social services. When evidence-based practice as a way to organise work is transferred to each social service there is a need for legitimisation (ibid.).

For social services this means that two ways of working collide and it is largely up to social workers to integrate them to a whole, into a common way to work with new routines and habits. Introducing new ways of working creates challenges and takes time, time and conditions that social workers and their managers do not perceive exist. Social services work with evidence-based practice is therefore loosely coupled to their daily ordinary work, but it is an on-going development, and there is a large interest in evidence-based practice. Introducing evidence-based practice is a way to gain legitimacy from outside, from citizens and users, and it is a way to get necessary resources (Meyer and Rowan, 1977; Johansson, 2002), for example funding for development work from the government.

Concluding thoughts

In this chapter I have analysed different processes of the introduction of evidence-based practice. These processes are interrelated and contributed to an understanding of evidence-based practice as complex and contains different meanings and interpretations depending on who approaches evidence-based practice. Evidence-based practice is only in the beginning of its introduction, and in this thesis it becomes clear that this is definitely not a linear introduction. Instead evidence-based practice is presented as complex, and it will probably be a long-term before evidence-based practice has become a natural part of social workers daily work. However, evidence-based practice is not going to be introduced on its own. The people in the organisations are important because they receive the idea as it travels (Johansson, 2002), which means that it is the people working in the organisations that have to approach evidence-based practice. The management are especially important to rethinking social work, and also the regional representatives as mediators of the idea of evidence-based practice. The result is not the same when doctors approach evidence-based medicine as it is when social workers approach evidence-based practice, because of their different preconditions.

In the result of this thesis it is clear that social work is approaching evidence-based practice, although there are several challenges ahead, such as poor conditions in the organisation, lacking resources and requirements from the management. There is a great interest to introduce evidence-based practice among those interviewed from the social services and the regional unit, and several of them describe the importance of keeping abreast of changes in society which will have an impact on social work. Some of the social workers with longer working experience perceive that there has been changes in society which affect their work, one of them believes that 'requirements have nevertheless increased in recent years, that one must have a quality and … then it means that those working in the organisation… shall *have* good knowledge and one shall keep abreast of what is doable and favourable'. There are also examples of how social workers and managers perform the work without reflecting over what evidence-based practice is in what they do, for example how they work with the users or reflecting about a group of users problems and so on.

Therefore, I want to highlight the importance of considering and understanding that introducing evidence-based practice is not only development work for social workers, it is the whole organisation that has to adapt to evidence-based practice. Reflection over what is introduced and how to make conditions for the social workers is one aspect of introducing evidence-based practice which can be improved. My position after interviewing the social workers is that there is a strong interest and belief in evidence-based practice and that much of what social workers do is well on the way to being evidence-based practice. There is however a need in social services to reflect over what is already done and what evidence-based practice social work is.

One last but important aspect that I have barely mentioned in this thesis is the link between evidence-based practice and social work education. Alexanderson et al. (2012) describe the universities as one of the four key actors for conveying knowledge to social work. I mention in the thesis that when evidence-based practice is introduced in social services the distance to the education and work practice is longer for social workers than it is for doctors. Therefore, I want in my concluding thoughts to highlight the importance of that the university education received by social workers will include the aim to introduce evidence-based practice. The growing interest for evidence-based practice will affect the education of social workers because the requirements of what knowledge and skills social workers need to be able to perform social work. In my interview material there are some social workers with as much as 30 years' experience within individual and family service and others that finished their education one to two years before the interviews were conducted. Although there are some differences between them most social workers, regardless of when they graduated, experience that evidence-based practice did not constitute a large part of their education, and those who heard about evidence-based practice during their education experience difficultly in translating that theoretical knowledge into practice when they start working.

References

Ahrne, Göran. (1999). Organisationer och människor. In: Ahrne, Göran. & Hedström, Peter. (eds.). *Organisationer och samhälle. Analytiska perspektiv.* Lund: Studentlitteratur.

Ahrne, Göran. & Hedström, Peter. (1999). (eds.). *Organisationer och samhälle. Analytiska perspektiv.* Lund: Studentlitteratur.

Alexanderson, Karin., Beijer, Elisabeth., Hyvönen, Ulf., Karlsson, Per-Åke. & Marklund, Kristin. (2012). Let's Come Together: A Macro-Oriented Model for Organizing the Support of EBP. In: Dill, Katharine. & Shera, Wes. (eds.). *Implementing Evidence-Informed Practice. International Perspectives.* Toronto, Ontario: Canadian Sholars' Press Inc.

Alvesson, Mats. & Sköldberg, Kaj. (2000). *Reflexive Methodology. New Vistas for Qualitative Research.* London: SAGE Publications Inc.

Alvesson, Mats. & Sköldberg, Kaj. (2008). *Tolkning och reflektion. Vetenskapsfilosofi och kvalitativ metod.* Lund: Studentlitteratur. Second edition.

Andersen, Ib. (2012). *Den uppenbara verkligheten. Om kunskapsproduktion i samhällsvetenskaperna.* Lund: Studentlitteratur.

Angel, Bjørn. Øystein. (2003). Evidensbaserte programmer – kunskapsformer og menneskesyn i sosialt arbeid. *Nordisk sosialt arbeid* (2): pp. 66-73.

Axelsson, Runo. & Bihari Axelsson, Susanna. (2007). Samverkan och folkhälsa – begrepp, teorier och praktisk tillämpning. In: Axelsson, Runo. & Bihari Axelsson, Susanna. (eds.). *Folkhälsa i samverkan mellan professioner, organisationer och samhällssektorer.* Studentlitteratur, Lund.

Barley, Stephen R. (2008). Coalface Institutionalism. In: Greenwood, Royston., Oliver, Christine., Sahlin, Kerstin. & Suddaby, Roy. (eds.) *The SAGE Handbook of Organizational Institutionalism.* London: SAGE Publications Ltd.

Barley, Stephen R. & Tolbert, Pamela S. (1997). Institutionalization and Structuration: Studying the Links between Action and Institution. *Organization Studies.* 18(1): pp. 93-117.

Berg, Elisabeth., Chandler, John. & Barry, Jim. (forthcoming). The Uncertain Rise of Evidence Based Practice in Social Work in Sweden and England, in Contexts Framed by New Public Management and Neo-liberalism. *Forthcoming in Soziale Welt.*

Berger, Peter L. & Luckmann, Thomas. (1967). *The Social Construction of Reality. A Treatise in the Sociology of Knowledge.* New York: Anchor Books. Original edition published in 1966, by Doubleday.

Bergmark, Anders., Bergmark, Åke & Lundström, Tommy. (2011). *Evidensbaserat socialt arbete – teori, kritik, praktik.* Stockholm: Natur & Kultur.

Bergmark, Anders. & Lundström, Tommy. (2008). *Evidensfrågan och socialtjänsten. Om socialarbetares inställning till en vetenskapligt grundad praktik. Socionomens forskningssupplement,* 3:5-14.

Bergmark, Anders. & Lundström, Tommy. (2011). Evidensbaserad praktik i svenskt socialt arbete. Om ett programs mottagande, förändring och möjligheter i en ny omgivning. In: Bohlin, Ingemar. & Sager, Morten. (eds.). *Evidensens många ansikten. Evidensbaserad praktik i praktiken.* Lund: Arkiv förlag.

Bergmark, Anders. & Lundström, Tommy. (2011a). Guided or independent? Social workers, central bureaucracy and evidence-based practice. *European Journal of Social Work.* 14(3): pp. 323-357.

Bergmark, Åke. & Lundström, Tommy. (2002). Education, practice and research. Knowledge and attitudes to knowledge of Swedish social workers. *Social Work Education,* Vol. 21, no. 3, pp. 359-373.

Bergmark, Åke. & Lundström, Tommy. (2007). Att studera rörliga mål. Om villkoren för evidens och kunskapsproduktion i socialt arbete. *Socionomens forskningssupplement,* 19:4-16.

Bergmark, Åke. & Lundström, Tommy. (2008a). Det socialtjänstbaserade sociala arbetets organisering. In: Bergmark, Åke., Lundström, Tommy., Minas, Renate. & Wiklund, Stefan. (eds.). *Socialtjänsten i blickfånget. Organisation, resurser och insatser. Exempel från arbete med barn och ungdom, försörjningsstöd, missbruk.* Bokförlaget Natur och Kultur, Stockholm.

Bergmark, Åke. & Lundström, Tommy. (2008b). Socialtjänstens individ- och familjeomsorg. Om det sociala arbetet och dess förutsättningar. In: Bergmark, Åke., Lundström, Tommy., Minas, Renate. & Wiklund, Stefan. (eds.). *Socialtjänsten i blickfånget. Organisation, resurser och insatser. Exempel från arbete med barn och ungdom, försörjningsstöd, missbruk.* Bokförlaget Natur och Kultur, Stockholm.

Bhatti Yosef, Hansen Hanne Foss & Rieper Olaf. (2006). *Evidensbevægelsens udvikling, organisering og arbejdsform. En kartlægningsrapport.* København: Akf forlaget.
Bilson, Andy. (2005). Introduction. In: Bilson, Andy (ed.). *Evidence-based practice in social work.* London: Whiting and Birch Ltd.
Blom, Björn. (2006). Marknadsorientering av socialtjänsten – orsaker, motiv och effekter. In: Grape, Ove., Blom, Björn. & Johansson, Roine. (eds.). *Organisation och omvärld – nyinstitutionell analys av människobehandlande organisationer.* Lund: Studentlitteratur.
Blom, Björn. & Morén, Stefan. (2011). Kvalitetsbegreppet. In: Blom, Björn., Morén, Stefan. & Nygren, Lennart. (eds.). *Utvärdering i socialt arbete. Utgångspunkter, modeller och användning.*
Blomquist, Christine. (1996). *I marknadens namn. Mångtydiga reformer i svenska kommuner.* Stockholm: Nerenius & Santérus Förlag AB.
Bodin, Maria. (2012). Ordlista. In: Sundell, Knut. (ed.). *Att göra effektutvärderingar.* Stockholm: Gothia Förlag.
Boglind, Anders., Eliæson Sven. & Månson, Per. (1998). *Kapital, rationalitet och social sammanhållning. En introduktion till klassisk samhällsteori.* Stockholm: Rabén Prisma.
Bohlin, Ingemar. (2011). Evidensbaserat beslutsfattande i ett vetenskapsbaserat samhälle. Om evidensrörelsens ursprung, utbredning och gränser. In: Bohlin, Ingemar & Sager, Morten (eds.). *Evidensens många ansikten. Evidensbaserad praktik i praktiken.* Lund: Arkiv förlag.
Bohlin, Ingemar. & Sager, Morten. (2011). Inledning. Evidensbaserad praktik i praktiken. In: Bohlin, Ingemar. & Sager, Morten. (eds.). *Evidensens många ansikten. Evidensbaserad praktik i praktiken.* Lund: Arkiv förlag.
Boruch, Robert., Soydan, Haluk., de Moya, Dorothy. & the Campbell Collaboration Steering Committee. (2004). The Campbell Collaboration. *Brief Treatment and Crisis Intervention.* 4(3): pp. 277-287.
Boxenbaum, Eva. & Jonsson, Stefan. (2008). Isomorphism, Diffusion and Decoupling. In: Greenwood, Royston., Oliver, Christine., Sahlin, Kerstin. & Suddaby, Roy. (eds.) *The SAGE Handbook of Organizational Institutionalism.* London: SAGE Publications Ltd.
Börjeson, Bengt. (2006). Maktens arrogans och ignorans. In: Ljunggren, Synnöve. (ed.). *Mellan Scylla och Charybdis. En skrift till Karin Tengvald.* Stockholm: Socialstyrelsen.
Börjeson, Martin. (2005). Försök att systematiskt koppla socialtjänst, högre utbildning och forskning i Sverige. In: Ljunggren, Synnöve. (ed.). *Empiri, Evidens, Empati. Nordiska röster om kunskapsutveckling i socialt arbete.* Köpenhamn: Nordiska ministerrådet och Nopus.
Campbell, Donald T. (1969). Reforms as Experiments. *American Psychologist.* 24(4): pp. 409-429.
Cervantes, Sara. (2005). *Attitudes towards starting small business. Youth and local authorities in a changing labour market?* Luleå University of Technology, Dissertation 2005:47.
Chaffin, Mark. & Friedrich, Bill. (2004). Evidence-based treatments in child abuse and neglect. *Children and Youth Services Review.* 26(11): pp. 1097–1113.
Chalmers, Iain. (2001). Comparing like with like: some historical milestones in the evolution of methods to create unbiased comparison groups in therapeutic experiments. *International Journal of Epidemiology.* 30(5): pp. 1156-1164.
Chalmers, Iain. (2003). Fisher and Bradford Hill: theory and pragmatism? *International Journal of Epidemiology.* 32(6): pp. 922-924.
Chalmers, Iain. (2003a). Trying to Do Moore Good than Harm in Policy Practice: The Role of Rigorous, Transparent, Up-to-Date Evaluations. *Annals of American Political and Social Sciences.* 589: pp. 22-40.
Clough, Peter. & Nutbrown, Cathy. (2002). *A Student's Guide to Methodology. Justifying Enquiry.* London: SAGE Publications Company.
Cochrane, Archie A.L. (1972). *Effectiveness and Efficiency. Random Reflections on Health Services.* Cambridge, UK: University Press.
Czarniawska, Barbara. (2005). *En teori om organisering.* Lund: Studentlitteratur.
Czarniawska, Barbara. (2008). How to Misuse Institutions and Get Away with It: Some Reflections on Institutional Theory(ies). In: Greenwood, Royston., Oliver, Christine., Sahlin, Kerstin. & Suddaby, Roy. (eds.) *The SAGE Handbook of Organizational Institutionalism.* London: SAGE Publications Ltd.
Czarniawska, Barbara. & Joerges, Bernward. (1996). Travels of Ideas. In: Czarniawska, Barbara. & Sevón, Guje. (eds.). *Translating Organizational Change.* Walter de Gruyter, Berlin.

Danermark, Berth., Ekström, Mats., Jakobsen, Liselotte. & Karlsson, Jan Ch. (2003). *Att förklara samhället*. Lund: Studentlitteratur. Second edition.
Davies, Philip. (2004). Systematic reviews and the Campbell Collaboration. In: Thomas, Gary. & Pring, Richard. (eds.). *Evidence-Based Practice in Education*. New York: Open University Press.
Dey, Ian. (1993). *Qualitative Data Analyisis. A User-Friendly Guide for Social Scientists*. London and New York: Routledge.
Dill, Katharine. & Shera, Wes. (2012). Introduction.. In: Dill, Katharine. & Shera, Wes. (eds.). *Implementing Evidence-Informed Practice. International Perspectives*. Toronto, Ontario: Canadian Sholars' Press Inc.
Dill, Katharine. & Shera, Wes. (2012a). Pushing the Envelope: Future Directions for Evidence-Informed Practice. In: Dill, Katharine. & Shera, Wes. (eds.). *Implementing Evidence-Informed Practice. International Perspectives*. Toronto, Ontario: Canadian Sholars' Press Inc.
DiMaggio, Paul J. & Powell, Walter W. (1983). The Iron Cage Revisited: Institutional Isomorphism and Collective Rationality in Organizational fields. *American Sociological Review*, 48(2): pp. 147-160.
Ekeland, Tor-Johan. (2009). Hva er evidensen for evidensbasert praksis? In: Grimen, Harald. & Terum, Lars Inge. (eds.). *Evidensbasert profesjonsutøvelse*. Oslo: Abstrakt forlag AS.
Eliasson, Benitha. (2010). *Konsten med samverkan. Från idéer till praktik*. Licentiatuppsats, Luleå univerisy of technology.
Ely, Margot et al. (1993). *Kvalitativ forskningsmetodik i praktiken – cirklar inom cirklar*. Lund: Studentlitteratur. Original title: Doing Qualitative Research: Circles in Circles. Original edition published in 1991 by The Falmer Press, New York.
Engdahl, Oskar. & Larsson, Bengt. (2011). *Sociologiska perspektiv. Grundläggande begrepp och teorier*. Lund: Studentlitteratur.
Epstein, Irwin. (2009). Promoting Harmony Where There Is Commonly Conflict: Evidence-Informed Practice as an Integrative Strategy. *Social Work in Health Care*, 48(3): pp.216–231.
Eriksson, Robert. (2006). En färd mot en bättre kunskapsgrund för det sociala arbetet. In: Ljunggren, Synnöve. (ed.). *Mellan Scylla och Charybdis. En skrift till Karin Tengvald*. Stockholm: Socialstyrelsen.
Eriksson-Zetterquist, Ulla. (2009). *Institutionell teori – idéer, moden, förändring*. Malmö: Liber AB.
Esping-Andersen, Gøsta. (1990). *The Three Worlds of Welfare Capitalism*. Cambridge, UK: Polity Press.
Esping-Andersen, Gøsta (2002). Towards the Good Society, Once Again? In: Esping-Andersen, Gøsta, with Gallie, Duncan., Hemerjick. and Myles, John. *Why we need a New Welfare State*. New York: Oxford University Press Inc.
Fernler, Karin. (2002). Generella modeller och lokala lösningar. In: Jacobsson, Bengt. (ed.). *Organisationsexperiment i kommuner och landsting*. Stockholm: Santérus Förlag.
Forssell, Anders. (1992). *Moderna tider i Sparbanken. Om organisatorisk omvandling i ett institutionellt perspektiv*. Stockholm: Nerenius & Santérus Förlag AB.
FoU Välfärd (2013). *FoU-miljöers roll för en evidensbaserad socialtjänst*.
Freij, Birgitta. (2012). *Evidens i praktiken – grundbok i evidensbaserat socialt arbete*. Stockholm: Gothia Förlag.
Gambrill, Eileen. (2003). Evidence-Based Practice: Sea Change or the Emperor's New Clothes? *Journal of Social Work Education*. 39(1): pp. 3-23.
Gambrill, Eileen. (2006). Evidence-Based Practice and Policy: Choices Ahead. *Research on Social Work Practice*. 16(3): pp.338-357.
Gambrill, Eileen. (2007). Book reviews: Norcross, J.C., Beutler, L.E. & Levant, R.F. (eds.) (2005). Evidence-based practices in mental health: debate and dialogue on the fundamental questions. Washington, DC: American Psychological Association, *Research on Social Work Practice*. 17(3): pp.428-434.
Gambrill, Eileen. (2011). Evidence-based practice and the ethics of discretion. *Journal of Social Work*. 11(1): pp. 26-48.
Giddens, Anthony. (1990). The Consequences of Modernity. Cambridge: Polity Press.
Giddens, Anthony. (1998). *Sociologi*. Lund: Studentlitteratur. Original titile: Sociolgy. Original edition published in 1989.
Gray, Mel., Plath, Debbie. & Webb, Stephen A. (2009). *Evidence-based Social Work. A critical Stance*. London, New York: Routledge.

Gray, Muir J.A. (2000). Evidence-Based Public Health. In: Trinder Liz with Reynolds Shirley (eds.). *Evidence-Based Practice. A Critical Appraisal*. Oxford: Blackwell Science Ltd.

Greenwood, Royston., Oliver, Christine., Sahlin, Kerstin. & Suddaby, Roy. (2008). Introduction. In: Greenwood, Royston., Oliver, Christine., Sahlin, Kerstin. & Suddaby, Roy. (eds.) *The SAGE Handbook of Organizational Institutionalism*. London: SAGE Publications Ltd.

Grimen, Harald. (2009). Debatten om evidensbasering – noen utfordringar. In: Grimen, Harald. & Terum, Lars Inge. (eds.). *Evidensbasert profesjonsutøvelse*. Oslo: Abstrakt forlag AS.

Gummesson, Evert. (2004). Fallstudiebaserad forskning. In: Gustavsson, Bengt. (ed.). *Kunskapande metoder inom samhällsvetenskapen*. Lund: Studentlitteratur.

Gummesson, Evert. (2005). Qualitative research in marketing. Road-map for a wilderness of complexity and unpredictability. *European Journal of Marketing*. 39(3-4): pp. 309-327.

Guneriussen, Willy. (1997). *Aktör, handling och struktur. Grundproblem i samhällsvetenskapen*. Lund: Studentlitteratur.

Guyatt, Gordon H., Meade, Maureen O., Jaeschke, Roman Z., Cook, Deborah J. & Haynes, R. Brian. (2000). Practitioners of Evidence Based Care: Not All Clinicians Need to Appraise Evidence from Scratch but All Need Some Skills. *British Medical Journal*. 320(7240): pp. 954-955.

Hansen, Hanne Foss. & Rieper, Olaf. (2009). Evidensbevægelsens rødder, formål og organisering. In: Grimen, Harald. & Terum, Lars Inge. (eds.). *Evidensbasert profesjonsutøvelse*. Oslo: Abstrakt Forlag AS.

Hansen, Hanne Foss. & Rieper, Olaf. (2009a). The Evidence Movement: The Development and Consequences of Methodologies in Review Practices. *Evaluation*. 15(2): pp. 141-163.

Hansen, Hanne Foss. & Rieper, Olaf. (2011). Evidenspolitik – fallet Danmark. In: Bohlin, Ingemar. & Sager, Morten. (eds.). *Evidensens många ansikten. Evidensbaserad praktik i praktiken*. Lund: Arkiv förlag.

Harlow, Elizabeth., Barry, Jim., Berg, Elisabeth. & Chandler, John. (2013). Neoliberlism, Managerialism and the Reconfiguring of Social Work in Sweden and the United Kingdom. *Organisation*. 20(4): pp. 534-550.

Hartman, Jan. (2004). *Vetenskapligt tänkande. Från kunskapsteori till metodteori*. Lund: Studentlitteratur.

Harvey, David (2005) *A Brief History of Neoliberalism*. New York: Oxford University Press.

Haynes, Brian., Devereaux, P J. & Guyatt, Gordon H. (2002). Physicians' and patients' choices in evidence based practice. Evidence does not make decisions, people do. *British Medical Journal*. 324(7350): pp.1350-1351.

Holmberg, Ingalill. (2003). Varför finns ledarskapet i offentlig sektor? In: Holmberg, Ingalill & Henning, Roger. (eds.). *Offentligt ledarskap – om förändring, förnyelse och nya ledarideal*. Lund: Studentlitteratur.

Holmblad Brunsson, Karin. (2002). *Organisationer*. Lund: Studentlitteratur.

Hood, C., Scott, C., James, O., Jones, G. & Travers, T. (1999). *Regulation Inside Government: Waste-Watchers, Quality-Police and Sleaze-Busters*. Oxford: Oxford University Press.

Howard, Matthew Owen. & Jenson, Jeffery M. (1999). Clinical Practice Guidelines: Should Social Work Develop Them? *Research on Social Work Practice*. 9(3): pp. 283-301.

IMS nytt (2007). *Nyhetsbrev från Institutet för utveckling av metoder i socialt arbete. Nr. 3*.

IMS nytt (2009). *Nyhetsbrev från Institutet för utveckling av metoder i socialt arbete. Nr. 2*.

Jacobsen, Dag Ingvar. (2002). *Vad, hur och varför. Om metodval i företagsekonomi och andra samhällsvetenskapliga ämnen*. Lund: Studentlitteratur.

Jacobsen, Jan Krag. (1993). *Intervju. Konsten att lyssna och fråga*. Lund: Studentlitteratur.

Jacobsson, Bengt. (2002). Reformer och organisatorisk identitet. In: Jacobsson, Bengt. (ed.). *Organisationsexperiment i kommuner och landsting*. Stockholm: Santérus Förlag.

Jergeby, Ulla. & Sundell, Knut. (2008). Evidensbaserat socialt arbete. In: Jergeby, Ulla. (ed.). *Evidensbaserad praktik i socialt arbete*. Stockholm: IMS and Gothia Förlag.

Johansson, Håkan. (2008). *Socialpolitiska klassiker*. Malmö: Liber AB.

Johansson, Håkan. (2010). Aktiva medborgare i den svenska välfärdsstaten. In: Hjort, Torbjörn., Lalander, Philip. & Nilsson, Roddy. (eds.). *Den ifrågasatte medborgaren – om utsatta gruppers relation till välfärdssystemen*. Linnéuniversitetet.

Johansson, Roine. (2002). *Nyinstitutionalismen inom organisationsanalysen. En skolbildnings uppkomst, spridning och utveckling*. Studentlitteratur, Lund.

Johansson, Roine. (2006). Nyinstitutionell organisationsteori – från sociologi i USA till socialt arbete i Sverige. In: Grape, Ove., Blom, Björn. & Johansson, Roine. (eds.). *Organisation och omvärld – nyinstitutionell analys av människobehandlande organisationer.* Lund: Studentlitteratur.

Jonsðottir, Sigriður. (2005). Vidensudvikling inden for social service i Island. In: Ljunggren, Synnöve. (ed.). *Empiri, Evidens, Empati. Nordiska röster om kunskapsutveckling i socialt arbete.* Köpenhamn: Nordiska ministerrådet och Nopus.

Kommittédirektiv 2007:91. *Nya former för stöd till kunskapsutvecklingen inom socialtjänsten.* Beslut vid regeringssammanträde den 20 juni 2007.

Kraatz, Matthew S. & Block, Emily S. (2008). Organizational Implications of Institutional Pluralism. In: Greenwood, Royston., Oliver, Christine., Sahlin, Kerstin. & Suddaby, Roy. (eds.) *The SAGE Handbook of Organizational Institutionalism.* London: SAGE Publications Ltd.

Kvale, Steinar. (1989). To Validate Is to Question. In: Kvale, Steinar. (ed.). *Issues of Validity in Qualitative Research.* Lund: Studentlitteratur.

Kvale, Steinar. & Brinkmann, Svend. (2009). *Den kvalitativa forskningsintervjun.* Lund: Studentlitteratur.

Lantz, Annika. (1993). *Intervjumetodik. Den professionellt genomförda intervjun.* Lund: Studentlitteratur.

Lantz, Annika. (2007). *Intervjumetodik.* Lund: Studentlitteratur.

Lind, Jan-Inge. (2002). Kommuner som marknadsskapare. In: Jacobsson, Bengt. (ed.). *Organisationsexperiment i kommuner och landsting.* Stockholm: Santérus Förlag.

Lindberg, Kajsa. (2002). *Kopplandets kraft. Om organisering mellan organisationer.* Göteborg: Bokförlaget BAS.

Lipsky, Michael. (2010|1980). *Street-Level Bureaucracy. Dilemmas of the Indivudals in Public Services.* New York: Russell Sage Foundation. Original edition published in 1980

Ljunggren, Synnöve. (ed.). *Mellan Scylla och Charybdis. En skrift till Karin Tengvald.* Stockholm: Socialstyrelsen.

Lofland, John. & Lofland, Lyn H. (1995). *Analyzing Social Settings. A Guide to Qualitative Observation and Analysis.* Belmont California: Wadsworth Publishing Company.

Löfstrand, Ingrid. (2008). *Professionellt föräldraskap. Samhälleliga förutsättningar för familjehem för tonåringar.* Licentiate thesis, Luleå univerisy of technology.

Mason, Jennifer. (1996). *Qualitative Researching.* London: SAGE Publications Ltd.

McColl, Alistar., Smith, Helene., White Peter. & Field, Jenny. (1998). General practitioners' perception of the route to evidence based medicine: a questionnaire survey. *British Medical Journal.* 316(7128): pp. 361-365.

Meyer, John W. (1977). The Effects of Education as an Institution. *American Journal of Sociology.* 83(1): pp. 55-77.

Meyer, John W. & Rowan, Brian. (1977). Institutionalized Organizations: Formal Structure as Myth and Ceremony. *The American Journal of Sociology.* 83(2): pp. 340-363.

Meyer, Renate E. (2008). New Sociology of Knowledge: Historical Legacy and Contributions to Current Debates in Institutional Research. In: Greenwood, Royston., Oliver, Christine., Sahlin, Kerstin. & Suddaby, Roy. (eds.) *The SAGE Handbook of Organizational Institutionalism.* London: SAGE Publications Ltd.

Miles, Mattew B. & Huberman, A Michael. (1994). *Qualitative Data Analysis. An Expanded Sourcebook.* California, Thousand Oaks: SAGE Publications Inc. Second edition.

Morago, Pedro. (2006). Evidence-based practice: from medicine to social work. *European Journal of Social Work.* 9(4): pp. 461-477.

Mullen, Edward J. (2006). Karin Tengvald's Contributions to International Social Work Research. In: Ljunggren Synnöve. (ed.). *Mellan Scylla och Charybdis. En skrift till Karin Tengvald.* Stockholm: Socialstyrelsen.

Mullen, Edward J., Shlonsky, Aron., Bledsoe, Sarah E. & Bellamy, Jennifer L. (2005). From concept to implementation: challenges facing evidence-based social work. *Evidence & Policy.* 1(1): pp. 61-84.

Nevo, Isaac. & Slonim-Nevo, Vered. (2011). The Myth of Evidence-Based Practice: Towards Evidence-Informed Practice. *British Journal of Social Work.* 41(6): pp. 1176–1197.

Oakley, Ann. (1998). Experimentation and social interventions: a forgotten but important history. *British Medical Journal.* 317(7167): pp. 1239-1242.

Oakley, Ann. (2000). A Historical Perspective on the Use of Randomized Trials in Social Science Settings. *Crime & Delinquency.* 46(3): pp. 315-329.

Ogden, Terje. (2006). Evidensbaserte praksis i arbeidet med alvorlige atferdsproblemer blant barn og unge. In: Ljunggren, Synnöve. (ed.). *Mellan Scylla och Charybdis. En skrift till Karin Tengvald.* Stockholm: Socialstyrelsen.

Olofsson, Jonas. (2009). *Socialpolitik. Varför, hur och till vilken nytta?* Stockholm: SNS Förlag. Second edition.

Orton, Douglas J. & Weick, Karl E. (1990). Loosely Coupled Systems: A Reconceptualization. *The Academy of Management Review*. 15(2): pp. 203-223.

Oscarsson, Lars. (2009). *Evidensbaserad praktik inom socialtjänsten. En introduktion för praktiker, chefer, politiker och studenter.* Stockholm: Sveriges Kommuner och Landsting, SKL Kommentus.

Palmer, Donald., Biggart, Nicole. & Dick, Brian. (2008). Is the New Institutionalism a Theory? In: Greenwood, Royston., Oliver, Christine., Sahlin, Kerstin. & Suddaby, Roy. (eds.) *The SAGE Handbook of Organizational Institutionalism*. London: SAGE Publications Ltd.

Pease, Bob. (2009). From Evidence-Based Practice to Critical Knowledge in Post-Positivist Social Work. In: Allan, June., Briskman, Linda. & Pease, Bob. (eds.). *Critical Social Work*. Sydney: Allen & Unwin.

Peile, Ed. (2004). Reflections from medical practice: balancing evidence-*based* practice with practice-based evidence. In: Thomas, Gary. & Pring, Richard. (eds.). *Evidence-Based Practice in Education.* New York: Open University Press.

Petrosino, Anthony., Boruch, Robert F., Rounding, Cath., McDonald, Steve. & Chalmers, Iain. (2000). The Campbell Collaboration Trials Register C2-SPECTR, *Evaluation and Research in Education*. 14(3-4): pp. 206-219.

Petrosino, Anthony., Boruch, Robert F., Soydan, Haluk., Duggan, Lorna. & Sanchez-Meca, Julio. (2001). Meeting the Challenges of Evidence-Based Policy: The Campbell Collaboration. *The Annals of the American Academy of Political and Social Science*. 578(1): 14-34.

Pettersson, Lars. & Wigzell, Kerstin. (1999). 'Hjälp till svaga bara chansning. Ny undersökning från Socialstyrelsen: Varannan socialchef vet inte om socialtjänsten gör någon nytta. *Dagens Nyheter, 6 October, 1999.*

Piippola, Saila. (2003). *Gränsvandrare positionerar sig på arbetsmarknaden. Handlingsutrymmen för arbetssökande inom ett begränsat geografiskt område.* Luleå University of Technology, Dissertation 2003:22.

Piuva, Katarina, Börjeson, Martin. & Lobos, Cecilia. (2011). Introduktion om utvärdering och om evidensbaserat social arbete. In: Piuva, Katarina, Börjeson, Martin. & Lobos, Cecilia. (eds.). *Utvärdering i praktiken. Om att värdera social arbete för människor med psykiska funktionshinder.* Lund: Studentlitteratur.

Pollitt, Christopher. & Bouckaert, Geert. (2004). *Public Management Reform. A Comparative Analysis*. Oxford: Oxford University Press.

Powell, Walter W. & Colyvas, Jeannette A. (2008). Microfoundations of Institutional Theory. In: Greenwood, Royston., Oliver, Christine., Sahlin, Kerstin. & Suddaby, Roy. (eds.) *The SAGE Handbook of Organizational Institutionalism*. London: SAGE Publications Ltd.

Printz, Anders. & Ljunggren, Synnöve (2005). Inledning. In: Ljunggren, Synnöve. (ed.). *Empiri, Evidens, Empati. Nordiska röster om kunskapsutveckling i socialt arbete.* Köpenhamn: Nordiska ministerrådet och Nopus.

Regeringen (2010). Protokoll vid regeringssammanträde 2010-06-17. S2009/4028/ST (delvis).

Regeringen (2010a). Protokoll vid regeringssammanträde 2010-06-17. Bilaga till S2009/4028/ST (delvis)

Regeringen (2011). Protokoll vid regeringssammanträde 2011-01-27. S2011/986/FST (delvis)

Regeringen (2011a). Protokoll vid regeringssammanträde 2011-01-27. Bilaga till S2011/986/FST (delvis)

Regeringen (2011b). Regeringsbeslut 2011-05-19. S2011/986/FST (delvis)

Regeringskansliet (2014). Kunskapsbaserad och innovativ utveckling för hälsa och välfärd. Ett urval av regeringens vidtagna åtgärder. S2014.020. Utgiven av Socialdepartementet.

Regeringskansliet och Sveriges Kommuner och Landsting (2012). *Stöd till en evidensbaserad praktik för god kvalitet inom socialtjänsten. Överenskommelse för år 2012 mellan staten och Sveriges Kommuner och Landsting.*

Regeringskansliet och Sveriges Kommuner och Landsting (2013). *Stöd till en evidensbaserad praktik för god kvalitet inom socialtjänsten. Överenskommelse för år 2013 mellan staten och Sveriges Kommuner och Landsting.*

Regeringskansliet och Sveriges Kommuner och Landsting (2014). *Stöd till en evidensbaserad praktik för god kvalitet inom socialtjänsten. Överenskommelse för år 2014 mellan staten och Sveriges Kommuner och Landsting.*

Reynolds Shirley (2000). The Anatomy of Evidence-Based Practice: Principles and Methods. In: Trinder Liz & Reynolds Shirley (eds.). *Evidence-Based Practice. A Critical Appraisal.* Oxford: Blackwell Science Ltd.

Rieper, Olaf. & Hansen, Hanne Foss. (2007). *Metodedebatten om evidens.* København: AKF Forlaget.

Riksdagen (2009). *Forskning som berör socialtjänstlagen och kompletterande regelverk.* Rapport från riksdagen 2009/10:RFR3. Stockholm: Riksdagstryckeriet.

Rosen, Aaron., Proctor, Enola K. & Staudt Marlys. (2003). Targets of Change and Interventions in Social Work: An Empirically Based Prototype for Developing Practice Guidelines. *Research on Social Work Practice.* 13(2): pp. 208-233.

Røvik, Kjell Arne. (1996). Deinstitutionalization and the Logic of Fashion. In: Czarniawska, Barbara. & Sevón, Guje. (eds.). *Translating Organizational Change.* Walter de Gruyter, Berlin.

Sackett, David L., Rosenberg, William, M.C., Gray, J.A. Muir., Haynes, R. Brian. & Richardson, Scott. (1996). Evidence Based Medicine: What It Is And What It Isn't: It's About Integrating Individual Clinical Expertise and The Best External Evidence. *British Medical Journal.* 312(7023): pp.71-72.

Sackett, David L., Straus, Sharon E., Richardson, Scott., Rosenberg, William. & Haynes, Brian R. (2000). *Evidence-Based Medicine: How to Practice and Teach EBM.* New York: Churchill Livingstone. Second edition.

Sahlin, Kerstin. & Wedlin, Linda. (2008). Circulating Ideas: Imitation, Translation and Editing. In: Greenwood, Royston., Oliver, Christine., Sahlin, Kerstin. & Suddaby, Roy. (eds.) *The SAGE Handbook of Organizational Institutionalism.* London: SAGE Publications Ltd.

Sahlin-Andersson, Kerstin. (1996). Imitating by Editing Success: The Construction of Organizational Fields. In: Czarniawska, B. & Sevón, G. (eds.). *Translating Organizational Change.* Walter de Gruyter, Berlin.

Scocozza, Lone. (2000). The Randomised Trial. A critique from the philosophy of science. In: Gannik Dorte Effersøe & Launsø Laila. (eds.). *Disease, Knowledge, and Society.* Frederiksberg C: Samfundslitteratur.

Scott, W. Richard. (2003). *Organizations. Rational, Natural and Open Systems.* Upper Saddle River, New Jersey: Pearson Education, Inc. Fifth edition.

Scott, W. Richard. (2008). *Institutions and Organizations. Ideas and Interests.* Thousand Oaks California: Sage Publications, Inc. Third edition.

Scott, W. Richard. & Meyer, John W. (1991). The Organization of Societal Sectors: Propositions and Early Evidence. In: Powell, Walter W. & DiMAggio Paul J. (eds.). *The New Institutionalism in Organizational Analysis.* Chicago: The University of Chicago Press.

Sevón, Guje. (1996). Organizational Imitation in Identity Transformation. In: Czarniawska, Barbara. & Sevón, Guje. (eds.). *Translating Organizational Change.* Walter de Gruyter, Berlin.

SFS 1990:52 The Care of Young Persons (Special Provision) Act (Lag med särskilda bestämmelser om vård av unga).

SFS 1991:900 Local Government Act (Kommunallag).

SFS 2001:453 Social Services Act (Socialtjänstlag).

SFS 2008:962 The Act on System of Choice in the Public Sector. (Lag om valfrihetssystem)

SFS 2010:800 Education Act (Skollag).

Shadish Jr, William R., Cook, Thomas D. & Leviton, Laura C. (1991). *Foundations of Program Evaluation. Theories of Practice.* California: SAGE Publications, Inc.

Sherman, Lawrence W. (2003). Misleading Evidence and Evidence-Led Policy: Making Social Science more Experimental. *The Annals of the American Academy of Political and Social Science.* 589(1):6-19.

Shlonsky, Aron. & Ballan, Michelle. (2012). Evidence-Informed Practice in Child Protection. In: Dill, Katharine. & Shera, Wes. (eds.). *Implementing Evidence-Informed Practice. International Perspectives.* Toronto, Ontario: Canadian Sholars' Press Inc.

Shlonsky, Aron. & McLuckie, Alan. (2008). Betydelsen av professionell expertis i evidensbaserad praktik. In: Jergeby, Ulla. (ed.). *Evidensbaserad prakik i socialt arbete.* Stockholm: IMS and Gothia Förlag.

Shlonsky, Aron. & Stern, Susan B. (2007). Reflections on the Teaching of Evidence-Based Practice. *Research on Social Work Practice*. 17(5): pp. 603-611.
Silverman, David. (2005). *Doing Qualitative Research. A Practical Handbook*. London: SAGE Publications Ltd. Second edition.
Sinclair, Ruth. (2000). Framework for The Assessment of Children in Need. *Child Care in Practice*. 6(2): pp. 174-181.
Socialstyrelsen (2000). *Nationellt stöd för kunskapsutveckling inom socialtjänsten*.
Socialstyrelsen (2004). *För en kunskapsbaserad socialtjänst. Redovisning av ett regeringsuppdrag åren 2001-2003. Slutrapport*.
Socialstyrelsen (2011). *Om evidensbaserad praktik*.
Socialstyrelsen (2013). *Barns behov i centrum. Grundbok BBIC*.
Socialstyrelsen (2013a). *Mot bättre vetande. Centrum för utvärdering av socialt arbete (CUS) och Institutet för utveckling av metoder i socialt arbete (IMS) 1992 till 2009*.
Socialutskottets betänkande 2010/11:SoU10. *Socialtjänstfrågor. Motionsyrkanden*.
Sohlberg, Peter. & Sohlberg, Britt-Marie. (2013). *Kunskapens former. Vetenskapsteori och forskningsmetod*. Stockholm: Liber AB.
SOU 2005:110. *Jämförelsevis – Styrning och uppföljning med nyckeltal i kommuner och landsting*. Finansdepartementet.
SOU 2008:18. *Evidensbaserad praktik inom socialtjänsten – till nytta för brukaren*. Betänkande av Utredningen för en kunskapsbaserad socialtjänst.
SOU 2010:65. *Kompetens och ansvar*. Betänkande från Behörighetsutredningen.
Schartau, Mai-Brith. (2003). Ledarskap i välfärdspluralism. In: Holmberg, Ingalill & Henning, Roger. (eds.). *Offentligt ledarskap – om förändring, förnyelse och nya ledarideal*. Lund: Studentlitteratur.
Statskontoret (2011). *Evidensbaserad praktik inom socialtjänsten. Uppföljning av överenskommelsen mellan regeringen och SKL. Delrapport 1*. Rapport 2011:30.
Statskontoret (2012). *Evidensbaserad praktik inom socialtjänsten. Uppföljning av överenskommelsen mellan regeringen och SKL. Delrapport 2*. Rapport 2012:34.
Statskontoret (2013). *Evidensbaserad praktik inom socialtjänsten. Uppföljning av överenskommelsen mellan regeringen och SKL. Delrapport 3*. Rapport 2013:17.
Stern, Charlotta. (1999). Nyinstitutionell organisationsteori. In: Ahrne, Göran. & Hedström, Peter. (ed.). *Organisationer och samhälle. Analytiska perspektiv*. Lund: Studentlitteratur.
Sundell, Knut. & Ogden, Terje. (2012). Introduktion. In: Sundell, Knut. (ed.). *Att göra effektutvärderingar*. Stockholm: Gothia Förlag.
Sundell, Knut., Soydan, Haluk., Tengvald, Karin. & Anttila Sten. (2010). From Opinion-Based to Evidence-Based Social Work: The Swedish Case. *Research on Social Work Practice*. 20(6): pp. 714-722. First published online December 2009.
Sundhedsstyrelsen. (2003). *Årsberetning 2003. Center for Evaluering og Medicinsk Teknologivurdering*. URL: http://www.cemtv.dk
Svanevie, Kajsa. (2011). *Evidensbaserat social arbete: Från idé till praktik*. Akademisk avhandling, Umeå Universitet, Institutionen för socialt arbete.
Svanevie, Kajsa. (2013). *Socialt arbete som evidensbaserad praktik*. Lund: Studentlitteratur.
Svenaeus, Fredrik. (2010). *Evidensbaseringsrörelsen och det goda omdömet – en kritisk betraktelse*. Ikaros tidskrift om människan och vetenskapen. *Populärvetenskaplig essä*.
Svensson, Kerstin., Johnsson, Eva. & Laanemets, Leili. (2008). *Handlingsutrymme. Utmaningar i socialt arbete*. Stockholm: Bokförlaget Natur och Kultur.
Svensson, Lennart G. & Karlsson, Anette. (2008). Profesjoner, kontroll og ansvar. In: Molander, Anders. & Terum, Lars Inge. (eds.). *Profesjonsstudier*. Oslo: Universitetforlaget.
Sveriges Kommuner och Landsting (2011). *Offentligt och privat driven verksamhet. Vilka legala skillnader finns?* Stockholm: Sveriges Kommuner och Landsting.
Sveriges Kommuner och Landsting (2012). *Evidensbaserad praktik i socialtjänst och hälso- och sjukvård*. Positionspapper.
Sveriges Kommuner och Landsting (2012a). *Vägval för socialtjänsten. Underlag för omvärldsanalys*.
Tengvald, Karin. (2008). Den evidensbaserade praktiken i sitt sammanhang. In: Jergeby, Ulla. (ed.). *Evidensbaserad praktik i socialt arbete*. Stockholm: IMS and Gothia Förlag.
Thröler, Ulrich. (2000). *To Improve the Evidence of Medicine. The 18th century British origins of a critical approach*. Edinburgh: The Royal College of Physicians of Edinburgh. Electronic edition 2012.

Thyer, Bruce A. (2006). What Is Evidence-Based Practice? In: Roberts, Albert R. & Yeager, Kenneth R. (eds.). *Foundations of Evidence-Based Social Work Practice*. Oxford: Oxford University Press.

Tietze, Susanne., Cohen, Laurie. & Musson, Gill. (2008). *Understanding Organizations through Language*. London: SAGE Publications Ltd.

Trinder, Liz. (2000). A critical Appraisal of Evidence-Based Practice. In: Trinder Liz & Reynolds Shirley (eds.). *Evidence-Based Practice. A Critical Appraisal*. Oxford: Blackwell Science Ltd.

Trinder, Liz. (2000a). Introduction: the Context of Evidence-Based Practice. In: Trinder, Liz. & Reynolds, Shirley. (eds.). *Evidence-Based Practice. A Critical Appraisal*. Oxford: Blackwell Science Ltd.

Tsoukas, Haridimos. & Chia, Roberg. (2002). On Organizational Becoming: Rethinking Organizational Change. *Organization Science*. 13(5): pp. 567-582.

Upshur, Ross E.G. & Tracy, C. Shawn. (2004). Legitimacy, Authority, and Hierarchy: Critical Challenges for Evidence-Based Medicine. *Brief Treatment and Crisis Intervention*. 4(3): pp.197-204.

Vandvik, Per Olav. (2009). Evidensbasert medisin uvurderlig verktøy for klinikere. In: Grimen, Harald. & Terum, Lars Inge. (eds.). *Evidensbasert profesjonsutøvelse*. Oslo: Abstrakt Forlag AS.

Vedung, Evert. (2009). *Utvärdering i politik och förvaltning*. Lund: Studentlitteratur. Third edition.

Vetenskapsrådet. (No date) Forskningsetiska principer inom humanistisk-samhällsvetenskaplig forskning. Utgivare: Vetenskapsrådet. *Ethical principles for human and social science research*.

Vindegg, Jorunn. (2009). Evidensbasert sosialt arbeid. In: Grimen, Harald. & Terum, Lars Inge. (eds.). *Evidensbasert profesjonsutøvelse*. Oslo: Abstrakt Forlag AS.

Weick, Karl E. (1976). Educational Organizations as Loosely Coupled Systems. *Administrative Science Quarterly*. 21(1): pp. 1-19.

Welbourne, Penelope. (2011). Twenty-first century social work: the influence of political context on public service provision in social work education and service delivery. *European Journal of Social Work*. 14(3): pp. 403-420.

Widerberg, Karin. (2002). *Kvalitativ forskning i praktiken*. Lund: Studentlitteratur.

Documents and information from organisations websites

Centre for Reviews and Dissemination
Available at: http://www.york.ac.uk/inst/crd/ [12th August 2014]

EPPI-Centre The Evidence for Policy and Practice Information and Co-ordinating Centre
Available at: http://eppi.ioe.ac.uk/cms/ [12th August 2014]

HTAi, *Mission*. Health Techonology Assessment international
Available at: http://www.htai.org/index.php?id=427 [23rd May 2012]

JP Socialnet.
Available at: http://www.jpinfonet.se/Tjanster/Informationstjanster/JP-Socialnet/ [24th July 2012]

Social Care Institute for Excellence, *About SCIE*
Available at: http://www.scie.org.uk/about/index.asp [12th August 2014]

Socialstyrelsen, *About us*
Available at: http://www.socialstyrelsen.se/english/aboutus [15th August 2014]

Socialstyrelsen, *Allt fler kommuner har BBIC-licens*
Available at: http://www.socialstyrelsen.se/nyheter/2014april/alltflerkommunerharbbic-licens [16th August 2014]

Socialstyrelsen, *Metodguide för socialt arbete*
Available at: http://www.socialstyrelsen.se/evidensbaseradpraktik/metodguide [17th August 2014)

Socialstyrelsen, *Metodguide för socialt arbete, ADAD*
Available at:
http://www.socialstyrelsen.se/evidensbaseradpraktik/sokimetodguidenforsocialtarbete/adad [31st July 2014]

Socialstyrelsen, *Metodguide för socialt arbete, ASI*
Available at: http://www.socialstyrelsen.se/evidensbaseradpraktik/sokimetodguidenforsocialtarbete/asi [31st July 2014]

Socialstyrelsen, *Metodguide för socialt arbete, AUDIT*
Available at:
http://www.socialstyrelsen.se/evidensbaseradpraktik/sokimetodguidenforsocialtarbete/audit [31st July 2014]

Socialstyrelsen, *Metodguide för socialt arbete, HOME*
Available at:
http://www.socialstyrelsen.se/evidensbaseradpraktik/sokimetodguidenforsocialtarbete/home Available at: http://www.socialstyrelsen.se/english/aboutus [31st July 2014]

Socialstyrelsen, *Metodguide för socialt arbete, MI*
Available at:
http://www.socialstyrelsen.se/evidensbaseradpraktik/sokimetodguidenforsocialtarbete/motiverande-samtal [31st July 2014]

Socialstyrelsen, *Metodguide för socialt arbete, Trappanmodellen*
Available at:
http://www.socialstyrelsen.se/evidensbaseradpraktik/sokimetodguidenforsocialtarbete/trappanmodellen [31st July 2014]

Socialstyrelsen, *Öppna jämförelser Barn och Unga*
Available at: http://www.socialstyrelsen.se/oppnajamforelser/barnochunga [18th July 2014]

Sveriges Kommuner och Landsting, *About SALAR*
Available at: http://english.skl.se/about_salar [15th August 2014]

Sveriges Kommuner och Landsting, *Bakgrund till satsningen*
Available at: http://www.skl.se/vi_arbetar_med/socialomsorgochstod/evidensbaserad-praktik-inom-socialtjansten/bakgrund-till-satsningen [16th August 2014]

Sveriges Kommuner och Landsting, *Kommunal personal. Tabell 6.*
Available at: http://www.skl.se/vi_arbetar_med/statistik/statistik-personal/kommunal-personal-2013 [23rd July 2012]

Sveriges Kommuner och Landsting, *Kommunal personal. Tabell 7.*
Available at: http://www.skl.se/vi_arbetar_med/statistik/statistik-personal/kommunal-personal-2013 [28th July 2012]

Swedish Medical Association (Sveriges Läkarförbund)
Available at: https://www.slf.se/Info-in-English/ [21st June 2014]

Swedish Medical Association (Sveriges Läkarförbund), *Läkarförbundets etiska regler.*
Available at: https://www.slf.se/Forbundet/Etikochansvar/Etik/Lakarforbundets-etiska-regler/ [21st June 2014]

Swedish Psychological Association (Sveriges Psykologförbund)
Available at: http://www.psykologforbundet.se/Om-forbundet/English/ [21st June 2014]

Swedish Psychological Association (Sveriges Psykologförbund), *Yrkesetiska principer för psykologer i Norden.*
Available at: http://www.psykologforbundet.se/Profession-Yrkesfragor/Yrkesetiska-principer-for-psykologer-i-Norden/ [21st June 2014]

The Union for Professionals (Akademikerförbundet SSR)
Available at: https://www.akademssr.se/in-english [21st June 2014]

The Union for Professionals (Akademikerförbundet SSR), *Etik*
Available at: https://www.akademssr.se/etik [21st June 2014]

Appendix I: Information letter

Luleå December 2012

Information about participating in an interview about evidence-based practice within social services

My name is Benitha Eliasson and I am a PhD student at Luleå University of Technology financed by Union of Municipalities of North Bothnia County, R & D unit. In my thesis work I will interview people who work in social services in North Bothnia. The intention is also to interview social workers in one or two municipalities in England.

The purpose of the study is to create an understanding of how social workers in social services in Sweden and England perceive evidence-based practice and how social workers work with an evidence-based practice.

The interviews I conducted will be treated according to the ethical principles that exist for research. This means that your participation is voluntary, that all the information you provide will remain confidential and you may withdraw your participation at any time. There will not be any information about you as an individual and no way to connect the result that I compile with you. Furthermore, the information you provide will be treated and kept in such a way so that unauthorised people can not view them.

To participate in an interview, I recommended that you set aside [X number] hours, so you or I feel no time pressure. The interview can be conducted at your workplace or at my office at the university, whichever is easiest for you. Most important is that we can sit undisturbed during the interview. The interview will be recorded and then printed in verbatim (except for personal information such as names and other sensitive data, which are made anonymous). You will have the opportunity to read through the interview, when it has been transcribed.

The result will be presented in my doctoral thesis, published on Luleå University's website. If you have any questions about the study or your participation in it then please contact me via e-mail: Benita.Eliasson@ltu.se, or by phone: 0920-49 14 89.

Best regards,
Benitha Eliasson

Department of Human Work Science

Luleå tekniska universitet/Luleå University of Technology
POSTADRESS/POSTAL ADDRESS: SE-97187 Luleå, Sweden
BESÖKSADRESS/VISITING ADDRESS: Universitetsområdet, Porsön, Luleå
TELEFON/PHONE: +46 (0)920 49 10 00 TELEFAX/FAX: +46 (0)920 49 13 99

HEMSIDA/WEBSITE: www.ltu.se

Appendix II: Interview guides

Social workers

Background questions

Education (what, where and when)?
Professional experience?
Time in the profession as a social worker working with children and youth/families?
Job title
Male or female?
How the work is organised (units/departments, number of employees)?

1. Describe your work and your work tasks.
2. What characterises your work (the work in social services) today? Are there any differences from when you were a new employee, compared to today?
   E.g. what knowledge/competence, approaches and resources needed?
3. When did you hear of evidence-based practice in social work? How was evidence-based practice presented then?
4. Describe what it means for you to work evidence-based.
5. Do you and your colleagues work in this way? What is consistent/inconsistent with that way of working?
6. What methods and models (or structured ways of working, forms and the like) do you/your colleagues use at work today?
7. Do you and your colleagues work in that way? What is good and what is bad with that way of working?
   - Does some of it qualify as evidence-based? Which?
   - For what reason(s) have you chosen these methods/models?
8. Are there any methods or models that have disappeared or are not used today? Which and why are they not used?
9. When does your work (e.g. in a case) usually include evidence-based practice or evidence-based methods/models? Which?
10. Describe what and how you document your work and in what way(s) the documentation is used?
11. What is the basis for the decisions you make and the support you grant in your work?
    Is the starting point e.g. that decisions about a certain intervention are determined by the interventions available in this municipality, or are decisions based on clients' needs and preferences, available research, colleagues and your own experiences of what is appropriate, or what a evidence-based method shows?
12. What is your responsibility for a case when the investigation is completed and/or after the intervention has finished *(towards the client, management, local politicians)*?
13. Do you follow-up and evaluation each case on an individual or a group level? Give some examples of how you do this.
14. How is the result of follow-ups and evaluations compiled on individual and group level, and what do you use the results for?
15. How do you work to involve and make a client participate in a case? When is this done?
16. In what way(s) are you dependent on others to carry out your tasks?
17. In what way(s) do you use your colleagues' knowledge and experiences in your work?

Evidence-based practice

18. Do you feel that it is (un)important that the work in social services is evidence-based? For what reason do you (not) feel this way?
    Eg. for the client, more effective work and budget requirements, competition from other care givers.
19. What advantages and disadvantages are there with working with evidence-based practice?
20. Have you and your colleagues discussed anything about the advantages and disadvantages with evidence-based practice in social services (or about methods and models)? What were the discussions about?
21. How does an evidence-based practice facilitate and complicate your work *(in terms of time, enough interventions, clear directives from managers etc.)*?
22. Are there any obstacles or resistance to the introduction of evidence-based practice at your workplace? What are the reasons? Give some examples.
23. What does your closest manager (and other managers and local politicians) do in order to introduce (support the introduction of) evidence-based practice or evidence-based methods/models? How did you experience it; what worked well and what did not work as well?
24. When you work evidence-based:
    - What ethical considerations are important to make?
    - What opportunities and constraints do you feel exist in relation to the client and to management (managers/politicians)?
25. What is the importance of cooperation when working evidence-based? Does cooperation facilitate or hamper evidence-based practice – in relation to the client, as well as other departments or organisations?
    For example, does cooperation further clarify the needs (and demands) when the work is conducted according to evidence-based practice, for instance through the use of guidelines. This applies to cooperation with other organisations/departments and to cooperation with the client.

Knowledge and evidence-based practice

26. How do you get knowledge about evidence-based practice, working methods and models?
    E.g. conferences, lectures, websites/Internet (for example Social net, Socialvetenskap, Campbell Collaboration), journals from unions, short or long research reports (abstracts), colleagues, books, internal or external courses/workshops/seminars, scientific journals, governments agencies websites.
27. Have you/your colleagues participated in any education, lecture etc., in relation to working evidence-based? What was the aim with those activities?
28. Have any of those activities been web-based or via the web? If so, what advantages and disadvantages do you feel there is with gaining knowledge in this way?
29. How do you use the knowledge and information about evidence-based practice available online in the daily work, for example through knowledge bases and government agencies websites?
30. Do you feel that the knowledge and information available online (see the examples in question 27) is useful in the daily work? What is useful and what can be improved?
31. Do you usually search for research that describes how an intervention works in relation to your clients? Where do you search – *or* – do you know where to search?
32. While working with a case; how do you use the knowledge you gain through research, your colleagues' knowledge, education and so on? Give some examples of how this can be done.
33. Describe when and for what you use computers and other technology in your work?
    E.g. the documentation that law provides for, legal security, but also documentation that aims to conduct follow-ups and evaluations of the work – if the range of interventions meets the needs of clients.

34. How do you perceive the technology that you use in your work (not only to retrieve information/knowledge but, for example, also in a case)? Is technology a tool or a hindrance, a facilitator or is it stressful?
35. Does your closest manager (and the other managers and local politicians) have sufficient knowledge and competence about what evidence-based practice means? Give examples. Is there anything that you feel would facilitate the introduction of evidence-based practice?
36. Do you feel that your knowledge/competence is consistent with the tasks you are responsible for performing? Describe what knowledge/competence you think you lack, and what is not demanded by managers and local politicians?

Concluding questions about evidence-based practice

37. What expectations have been placed on you (and your colleagues) regarding evidence-based practice, by management in your municipality and by the state, such as the National Board of Health and Welfare and the government?
38. How are these expectations being met? Are they realistic?
39. What has the development of an evidence-based practice in the social services meant for you and your colleagues (which consequences)?
40. What has the introduction of evidence-based practice added to the work you and your colleagues do?
41. What do you do in your workplace to maintain an evidence-based practice, which working methods and models do you use?
42. Do you think it is possible to maintain an evidence-based practice in your work in the longer term (5-10 years)? What challenges will it entail?
43. How do you feel about that it is the weighing together of your experiences, current research and clients' needs and desires (which are described as the three sources in an evidence-based practice)? Are there any of them that you use more than any other? Which and why?

Do you have anything you want to add?

May I come back to you if there are any questions that I need to have explained further?

Middle managers and group/team leaders

Background questions

1. What is your:
   Education (what, where and when)?
   Professional experience?
   Time in the profession?
   Job title
2. Describe (briefly) your responsibility in the social services and what it means to work as [TITLE]?
3. What characterises your work (the work in social services) today? Are there any differences from when you were a new employee, compared to today (trends)?
4. Since you started working within social services, what changes have occurred in society, relevant for social services?
5. What social problems are common in this municipality (types of cases)?

Evidence-based practice

6. Today a common description is that evidence-based practice includes three sources: research, the professionals' experience and the users' preferences and needs. In what way do you feel that these three sources are weighed together at your workplace (by the social workers)? Are there any of them that are used more or less than any other?
   - In what way is research and knowledge from research used in social workers daily work? Is it important that research is used in the work? Of what reasons? How does using research affect the work?
   - In what way do social workers use support from colleagues (including support from managers) in their daily work? What impact does the support of colleagues have?
   - In what way is the success of the work followed and evaluated? For what reason do you (not) follow up/evaluate the work? If yes: How are the follow ups/evaluations conducted and how are they used?
7. When did you hear of evidence-based practice in social work? How was evidence-based practice presented then? How has it altered since the time when you first heard about evidence-based practice?
8. Have any other similar concepts been used *(knowledge-based social services, evidence informed practice, etc.)*? Which and how were they described? How would you describe the differences between these terms?
9. Evidence-based practice is heavily influenced by the medical field. Is this visible in any way? Do you feel that evidence-based practice has been adapted to the conditions that exist in the social services?
10. Which written/expressed directives, policies, guidelines, etc., are there regarding evidence-based practice (or methods, models, ways of working)? Are there some unspoken directives? If so, which? What is included in these directives? (Conditions for licence, BBIC responsible and BBIC educator).
11. What responsibility do local politicians, managers and staff have to initiate, introduce and maintain evidence-based practice? What is your responsibility?
12. Describe (give examples of) how it works when you decide to introduce a particular method, model, knowledge, education, and so on? Where do you get the information about what is a good investment? Who decides this?

13. Describe if there is cooperation between municipalities within Individual and family service? *E.g. opportunities to share experiences, or about certain methods, models, ways of working or purchases of services.*
14. What has the development towards an evidence-based practice meant (brought) for the work in your workplace?

Knowledge and evidence

15. Where do you find knowledge about evidence-based practice? Have you participated in any course, education or lecture? Which and what were they about?
16. Do local politicians, your closest manager and the staff have sufficient knowledge and competence to be able to work according to evidence-based practice? What is missing?
17. In what way can you (in social services) contribute to increase knowledge about the work within social services, and its effect?

Conditions for evidence-based practice

18. In what way facilitates and complicates evidence-based practice your work (eg. time, resources, efforts, (un)clear directives from managers)?
19. The national board of Health and Welfare, SALAR and R&D unit (in Norrbotten) are examples of actors actively working with introducing evidence-based practice. What support are they in the introduction of evidence-based practice? What is missing in their support?
20. What organisational and technological solutions are important for the social services, so they can work with evidence-based practice as a foundation? Is there something missing *(e.g. enough interventions, time, and economic conditions)*?
21. What do you do in your workplace to maintain an evidence-based practice, which working methods and models do you use?
22. Do you think it is possible to maintain an evidence-based practice in your work in the longer term (5-10 years)? What challenges will it entail?

Do you have anything you want to add?

May I come back to you if there are any questions that I need to have explained further?

Managers in a high position within social services

Background questions

1. What is your:
   Education (what, where and when)?
   Professional experience?
   Time in the profession?
   Job title
2. Describe (briefly) your responsibility in the social services and what it means to work as [TITLE]?
3. What characterises your work (the work in social services) today? Are there any differences from when you were a new employee, compared to today (trends)?
4. Since you started working within social services, what changes have occurred in society, relevant for social services?
5. What social problems are common in this municipality (types of cases)?

Evidence-based practice

6. Today a common description is that evidence-based practice includes three sources: research, the professionals' experience and the users' preferences and needs. In what way do you feel that these three sources are weighed together at your workplace (by the social workers)? Are there any of them that are used more or less than any other?
7. When did you hear of evidence-based practice in social work? How was evidence-based practice presented then? How has it altered since the time when you first heard about evidence-based practice?
8. Have any other similar concepts been used *(knowledge-based social services, evidence informed practice, etc.)*? Which and how were they described? How would you describe the differences between these terms?
9. Evidence-based practice is heavily influenced by the medical field. Is this visible in any way? Do you feel that evidence-based practice has been adapted to the conditions that exist in the social services?
10. Which written/expressed directives, policies, guidelines, etc., are there regarding evidence-based practice (or methods, models, ways of working)? Are there some unspoken directives? If so, which? What is included in these directives? (Conditions for licence, BBIC responsible and BBIC educator).
11. What responsibility do local politicians, managers and staff have to initiate, introduce and maintain evidence-based practice? What is your responsibility?
12. What has the development towards an evidence-based practice meant (brought) for the work in your workplace?

Knowledge and evidence

13. Where do you find knowledge about evidence-based practice? Have you participated in any course, education or lecture? Which and what were they about?
14. In what way can you (in social services) contribute to increase knowledge about the work within social services, and its effect?
15. In what way is the success of the work followed and evaluated? For what reason do you (not) follow up/evaluate the work? If yes: How are the follow ups/evaluations conducted and how are they used?

Conditions for evidence-based practice

16. The national board of Health and Welfare, SALAR and R&D unit (in Norrbotten) are examples of actors actively working with introducing evidence-based practice. What support are they in the introduction of evidence-based practice? What is missing in their support?
17. What organisational and technological solutions are important for the social services, so they can work with evidence-based practice as a foundation? Is there something missing *(e.g. enough interventions, time, and economic conditions)*?
18. What do you do in your workplace to maintain an evidence-based practice, which working methods and models do you use?
19. Do you think it is possible to maintain an evidence-based practice in your work in the longer term (5-10 years)? What challenges will it entail?

Do you have anything you want to add?

May I come back to you if there are any questions that I need to have explained further?

Regional representatives

The work at the regional unit

1. How long have you worked at the regional unit?
2. What have you worked with during your time at the regional unit?
3. What did you do before you started at the regional unit?
4. What is your education?
5. What expectations are there on the regional unit regarding the introduction of evidence-based practice (from the state and from the municipalities)? Are the expectations realistic? Have the expectations been fulfilled?
6. What responsibility has the regional unit in the process of introducing evidence-based practice?
7. What has the introduction of evidence-based practice led to – for the regional unit and for the social services?

Developing and introduction of evidence-based practice

8. In what way can you (in social services) contribute to increase knowledge about the work within social services, and its effect?
9. Describe the developments in social work from when you started until today with evidence-based practice in focus?
    - What characterises your work (the work in social services) today? Are there any differences from when you were a new employee, compared to today?
      For example knowledge, competence, approach, resources?
    - What changes in society relevant for the development of social work have occurred?
10. When did you hear of evidence-based practice in social work?
    - How was evidence-based practice presented then?
    - In what way has the idea of evidence-based practice evolved?
11. Do you have knowledge of any method/model that is evidence-based? Which one and what is the method/model about?
12. How and when do you feel that evidence-based practice is used in the municipalities?
13. What has the development towards an evidence-based practice meant (brought) for the work in your workplace?
14. How could you (in your project and from the regional unit) work to facilitate the introduction of evidence-based practice?

Their project

15. Describe your project (work) and your tasks:
    Employment rate?
    Financier of the project?
    Objectives of the project?
    Results of the project (impact)?
    Responses from project participants (and others)
    Difficulties?
    Changes in the project?
    Local variation, between different municipalities?
16. Describe, if there is any, the cooperation between municipalities regarding the introduction of evidence-based practice.
    - How do you work to facilitate cooperation between municipalities?

- How important is cooperation between different municipalities for the introduction of evidence-based practice?
- What does cooperation like this leads to?

About evidence-based practice

17. Do you feel that it is (un)important that the work in social services is evidence-based? For what reason do you (not) feel this way?
    Eg. for the client, more effective work and budget requirements, competition from other care givers.
18. Describe what it means for you to work evidence-based.
    - Do those working in the municipalities work in this way?
    - What is consistent/inconsistent with that way of working?
19. What advantages and disadvantages are there with working with evidence-based practice?
    - Are there any discussions at national, regional or local levels about the advantages and disadvantages?
    - What were the discussions about?
20. In what way facilitates and complicates evidence-based practice your work (eg. time, resources, efforts, (un)clear directives from managers)?
21. Are there any obstacles to the introduction of evidence-based practice? Which, what level, what they are due to.
22. Is there support to introduce evidence-based practice and to work evidence-based in social services – from the managers and politicians, from the regional unit as well as from the national level?
23. What do you feel is missing for the work in the municipalities to be evidence-based (e.g. follow-ups, evaluations, time to search for research)?
24. Do you perceive that social workers, managers and local politicians have the knowledge and competence needed to work with evidence-based practice? Is there any knowledge or competence missing?

Evidence-based practice; weigh together three sources

25. In what way do you feel that these three sources are weighed together by the social workers in their daily work?
26. Are there any of them that are used more or less than any other? What characterises a good balance between the three sources?
    - What is missing for it to be a good balance between the sources *(for example, searching research, do follow-ups, is there enough interventions)*?
    - Have those who work in social services more difficult to work with any of the three sources? Which one and for what reason *(e.g. lacking prerequisites, time knowledge)*?
27. In your project, do you work more with any of the three sources? Describe.

Concluding questions

28. What is needed in the municipalities to maintain an evidence-based practice (methods/models) in the longer term (5-10 years)?
29. What challenges will it entail?

Do you have anything you want to add?

May I come back to you if there are any questions that I need to have explained further?

Doctors

1. What is your professional experience (education, experiences, position, time in the profession etc.)?
2. Describe (briefly) your responsibility in health care and what it means to work as [TITLE]?
3. Describe what evidence-based medicine is. When did you come in contact with evidence-based medicine? How was evidence-based medicine presented then?
   - How has it altered since the time when you first heard about evidence-based medicine?
   - Have any other similar concepts been used within the medical field? Which and how were they described (differences)?
4. How is the debate about evidence-based medicine within health care (are there positions for and against, which and from whom)?
5. What does evidence-based practice add to your (doctors) work? (entail/imply)
6. Give examples of how work according to evidence-based medicine is performed.
   - In what way do doctors cooperate with other doctors in their daily work?
   - How is research (results of research) used in the daily work of doctors?
   - Describe how you work to involve and make patients' participate in their own health care/treatment?
   - Describe in what way follow-ups/evaluations of the work are done.
7. Which written/expressed directives, policies, guidelines, etc., are there regarding evidence-based medicine? Are there some unspoken directives? If so, which? Who are included by these directives?
8. What is your responsibility in relation to the initiation, introduction and maintenance of evidence-based medicine?
9. Where do you find knowledge about evidence-based medicine? Have you participated in any course, education or lecture? Which and what were they about?
10. What happens when new knowledge (eg. about a treatment) is gained and implemented? Who decides which knowledge is worth investing in? Which organisations/actors are important for that? For what reason are they important?
11. In what way facilitates and complicates evidence-based medicine a doctors (your) work?
12. What organisational and technological solutions are important for health care, so they can work with evidence-based medicine as a foundation? Is there something that can be improved *(eg. enough interventions, time, and economic conditions)*?
13. What do you do to maintain evidence-based medicine within health care (here)? Are there any difficulties?
14. How do you perceive that the social services work today? What can be improved in cooperation between health care and social services?

Do you have anything you want to add?

May I come back to you if there are any questions that I need to have explained further?

Appendix III: Quotations in Swedish

Chapter 4

[i] Det är varandra som vi har som stöd. Alltså jättemycket så att vi springer in hos varandra [på kontoren] och frågar efter konkreta exempel. Alltså, vad har, hur har du skrivit i din utredning eller var läste du det där som du sa, eller hur tänker du om det här? … Det skulle vara jättetufft att vara helt själv i det här jobbet. Vi använder det jättemycket.
[ii] Det är varandra som vi har som stöd. Alltså jättemycket så att vi springer in hos varandra [på kontoren] och frågar efter konkreta exempel. Alltså, vad har, hur har du skrivit i din utredning eller var läste du det där som du sa, eller hur tänker du om det här? … Det skulle vara jättetufft att vara helt själv i det här jobbet. Vi använder det jättemycket.
[iii] Det gör vi, eller jag, nog ganska mycket. Jag arbetar i en grupp, … [där] har vi några, väldigt erfarna och så har vi några, om jag räknar mig som en nyare inom området. Och vi … pratar med varandra, vi har handledning en gång i veckan där vi tar upp ärenden där man har funderingar, frågor vad skall man göra. Och där lyssnar vi mycket på varandra.
[iv] 'vi är ingen isolerad ö', 'det hänger i luften', 'pendeln i Sverige svänger lite hit och dit', 'som renflocken att far en så far alla och tvärt byter liksom riktning', och 'kasta ut barnet med badvattnet'.

Chapter 5

[v] om man får använda det uttrycket, mjukvara
[vi] … är den del av hälso- och sjukvården som står socialtjänsten närmast i just detta att det är komplext och psykosocialt och så vidare. Så där kan jag ibland känna en samhörighet, att ibland förstår socialtjänsten mina bekymmer bättre än specialisten [på sjukhuset].
[vii] [Det hade] lanserats internationellt sedan slutet av 80-talet, lite långsamt, systematisk översikt och Cochrane. Och begreppet hade börjat lanseras av Gordon Guyatt och gruppen kring honom som började en artikelserie i JAMA, ungefär -90 någon gång, under sitt arbetsnamn Evidence Based Medicine Working Group som blev egentligen kärnan för det som spred sig sedan, i första hand fortfarande genom SBU, vill jag nog påstå. Genom att de gång på gång skickade ut folk och hade föreläsningar och seminarier, och involverade väldigt centrala beslutsfattare inom svensk sjukvård i diskussionen kring det här med evidensbaserad medicin. Och det var väl där, när jag kom till Läkartidningen, så var tiden mogen att försöka föra ut det ännu bredare, och då föll de här artiklarna i Läkartidningen väldigt väl in i den utvecklingsfasen.
[viii] det moderna begreppet evidensbaserad medicin kom under, om jag kommer ihåg rätt, slutet av 80- och början av 90-talet
[ix] det moderna begreppet evidensbaserad medicin kom under, om jag kommer ihåg rätt, slutet av 80- och början av 90-talet.
[x] Evidensbaserat har ju funnits som ett mindre vedertaget uttryck men då pratade man mer om vetenskap och beprövad erfarenhet, att du som doktor skall agera enligt det. Så, och jag ser det som den primitiva varianten av det, före evidensbaserad medicin så använde vi det uttrycket, och det står i läkareden och allting.
[xi] vad fanns det för konfidensintervall och … hur säkert var det att använda det
[xii] framförallt naturvetenskap men även humaniora
[xiii] början handlade ganska mycket om statistik och forskningsmetodik
[xiv] åtminstone så sprids det mer och man deltar på träffar och då delar man med sig, höjer kunskapsnivån.
[xv] Tidigare så var det beprövad erfarenhet som gällde: I högre grad. Och sedan då lokala traditioner var väldigt viktigt. [Här] fanns det en väldigt lång tradition [av psykiatri]. Man visste ungefär hur man skulle göra, och på gott och ont naturligtvis. Det fanns ju en del saker som var bra med [mentalsjukhuset] också.
[xvi] Ett ganska bra exempel på detta hur det kan bli, det var en behandlingsmetod som vi numera ryggar för och det var lobotomi. Den var ganska vanligt förekommande, och även i Sverige, men vi talar inte

så mycket om det. Det var egentligen en fluga som startade och man tyckte sig se framgång hos vissa patientgrupper, men det gjordes inga bra uppföljningar. Man såg inte till exempel att det var många som dog, förrän senare. Och det var en dålig evidens på den behandlingen, men det är ju tiotusentals som blivit lobotomerade. Så det är ett typiskt exempel.

[xvii] en syn att nu kan allting bli vetenskap, nu skall allt vara enligt EBM och det som inte det finns evidens för det skall vi inte pyssla med. Och så fanns det då den andra polen som sa, ja, men det är så lite, det mesta vi gör är inte EBM.

[xviii] … någon slags naiv tro att det som inte är evidensbaserat det skall vi inte göra. Men det, jag uppfattar att det har varit mer, väldigt strikta organspecialister som kanske har en-sjukdomspatienter.

[xix] Från början handlade det ganska mycket om statistik och forskningsmetodik, och uppfattades ganska mycket som en exercis för forskare som var typ epidemiologer och annat långt borta ifrån en klinisk vardag och utan kontakt med den kliniska vardagen. Det var ofta diskussion om att här kan ni sitta i era akademiska elfenbenstorn och säga att vi skall göra si eller så eller att vi inte skall göra någonting för att det finns ingen evidens. Men vi här ute måste ju agera.

[xx] Och det var ganska mycket heta konflikter som rasade under 90-talet i tidningar, som i första hand British Journal och Lancet och JAMA, som var väl kanske några av kärntidskrifterna. Och det var väldigt mycket en anglosaxisk diskussion, och i viss mån även då i Sverige men i ett lite lägre tonläge. … Det var aldrig så konfliktmässigt, kanske typiskt svenskt. Man gick inte ut på samma sätt ifrån de som företrädde EBM, med samma jag skall säga lite fyrkantiga förhållningssätt som man hade gjort utomlands. Idag är det mer att alla tycker att, ja men det är väl klart att vi skall fatta våra beslut på basen av tillgängliga kunskaper, det är väl alldeles självklart. Det skulle ingen någonsin ifrågasätta idag. Men då var det mycket frågan om, men min kliniska erfarenhet, skall den inte räknas som någonting till, jag har ju behandlat fem patienter och jag *vet* hur det är. Och vi sa, ja men herre gud det finns studier som behandlar tusen patienter som visar på definitivt motsatt dina begränsade erfarenheter.

[xxi] konflikterna har liksom löst upp sig successivt

[xxii] Och idag tycker jag det hamnat och landat i en vettig diskussion där vi, nationella riktlinjer och SBU-rapporter och så, då granskar man evidensen och tar fram det och så sedan försöker man få ett ordnat införande och en prioriteringsdiskussion ute i landstinget. Så att, idag tycker jag att det i Sverige är en ganska sund och rationell syn på vad evidensbaserad medicin är för något. Och man ser det som ett nödvändigt komplement, men som också det handlar om att ha rutiner för hur man skall ta emot det i ett landsting, hur man skall handskas med det gentemot det vi gör idag och andra evidensområden och områden som det inte finns så mycket evidens för men där vi ändå måste agera.

[xxiii] Alltså ingen idag skulle, vad skall vi säga, offentligt gå i polemik med påståendet att sjukvården skall bedrivas på bästa vetenskapliga grund. Sedan kan de ha synpunkter privat på att de kan bli för hårt uppstyrda, till exempel. Att ingen tar hänsyn till deras egna erfarenheter och annat. Det möter vi fortfarande.

[xxiv] Det har blivit mer accepterat att i *stort* bör det vara så här vi behandlar för blodtryck, men självfallet det kommer att finnas undantag som jag, på basen av att jag känner min patient väldigt väl, lokala förutsättningar och annat, gör att jag kommer att kunna avvika. Men jag kan inte avvika i allt. Jag kan inte gå rakt emot för samtliga patienter. Då måste jag kunna argumentera ohyggligt väl för min sak. Och det är en skillnad, tror jag.

[xxv] Det som möjligen debatteras är, hur skall det få full genomslagskraft? Hur skall det gå fortare från att det finns evidens för något till distriktsläkaren i [en lite kommun] vet om det?

[xxvi] SBU startade i slutet av 80-talet efter mönster från USA, egentligen det första utanför USA som började med utvärdering av medicinska metoder, utifrån statsmakterna. … [D]et fanns ett missnöje, man insåg att vi kunde inte styra sjukvården, i den mån doktorerna gjorde som de ville, tandläkarna, sköterskorna gjorde som de ville, säkert socialtjänsten också, och vad de hade hört på den senaste föreläsningen, vad en inflytelserik person [sade]. Det fanns mycket eminensbaserad verksamhet. Och för att kunna komma, få ett verktyg sade statsmakterna då att vi behöver ha en myndighet som har det här som ett jobb att titta nogsamt på, vad vet vi egentligen om bästa sättet att behandla. Och då valde man folksjukdomar, väldigt mycket, speciellt i början. Det var ont i ryggen, det var högt blodtryck, det var stroke och lite annat sådant.

[xxvii] en massa forskning och massa rapporter och så, som inte får den tyngden att det kanske blir en nationell riktlinje eller en SBU-rapport men som också är evidensbelagt, som är viktig att ha koll på.

[xxviii] definitivt nästa steg

[xxix] SBU-rapporter stannar vid att säga, det här *vet* vi, att det ena eller andra fungerar eller inte fungerar. Men därifrån till att säga, vad skall vi *göra*, är en mycket längre process som inte EBM hade förstått när man började, att göra prioriteringar. Hälsoekonomiska avvägningar är egentligen mycket svårare än att utvärdera vanlig vetenskap och effekter. Så det var ett stort steg framåt. … Riktlinjerna blir liksom den slutprodukten just nu som är mest påtaglig.

[xxx] en extrem maktfaktor i svensk sjukvård, inte minst en ekonomisk maktfaktor.

[xxxi] försöker jobba med det lite valhänt men de har ingen riktig organisation för kunskapsfrågor, på det sättet.

[xxxii] från början var det en top-down process, definitivt, från statsmakten. Statsmakten ville hitta ett sätt att styra sjukvården … kunskapsstyrningen av sjukvården.

[xxxiii] Vi sa det att det här är gott och väl, men vi vet också att doktorer kommer aldrig att köpa någonting som bara lanseras som ett top-down påbud. Så vi föreslår att skall man göra någonting åt det här så måste man parallellt börja i precis andra änden. Man måste börja nå ut till svenska läkarkåren nedifrån.

[xxxiv] det är en fråga som ägs professionellt, just med hänvisning att vi vill ju förstås bedriva vårt jobb på den bästa tänkbara grunden.

[xxxv] är individualister på många sätt.

[xxxvi] Och jag tror att det argumentet, när läkare möter läkare peer to peer, så att säga, har varit en stark drivkraft som successivt vunnit. Och det har gjort att svensk EBM har accepterats nedifrån på ett annat sätt än vad det gjorts i många andra länder. I många andra länder har man försökt putta ned det uppifrån. Och det har blivit liksom en myndighetsstyrning, de inskränker vår professionella frihet och så vidare, och det har inte varit lika lyckosamt.

[xxxvii] alla kraven på stringens och transparens

[xxxviii] Det fanns som en undertext som inte riktigt var utsagt, men genom att gå över, göra de här gula rapporterna inom en mängd olika verksamhetsområden så hade man [stöd] av att alla tyngre opinionleaders som fanns egentligen, haft dem och gjort dem till ambassadörer. Och … det var en väldigt framgångsrik strategi.

[xxxix] Vi får pengar utav stat och SKL om vi gör det de tycker vi skall göra. Så då skall vi egentligen bara - ha verksamheten och rapportera och så får ni en slant för det.

[xl] På vilket sätt har patienten varit med i vårdplan, har de bara fått pappret, har de rivit sönder pappret.

[xli] Här finns fullt med grafer och staplar och vi följer ett tjugotal faktorer, bland annat vikten, och vi följer också vilket brott som har föranlett vården, vi tittar på vårdens längd. … Och vi ligger alltså väldigt nära rikssnittet, men vi har inte långtidsvård här. Alltså sådant är ju bra att veta. Så med den här som bas kan man hitta på mycket.

[xlii] det har blivit ett sådant där mantra, det pratas om *kunskapsstyrning*. Det är som ordet för dagen. Och det är ju egentligen, kunskapsstyrning handlar ju om att använda evidensbaserad medicin när det finns.

[xliii] Det [ordnade införandet] är ett sätt [som vi], likt många andra landsting, bygger upp en organisation där vi för de stora vanliga folksjukdomarna, där det kommer med jämna mellanrum nationella riktlinjer, … [har] en länsgrupp, en expertgrupp som är den som tar emot. Vi … har för diabetes, och vi har för astma, rörelseorganens sjukdomar, levnadsvanor med mera, … olika expertgrupper. Så för diabetes sitter det folk från primärvården, det sitter läkare, diabetessköterska, medicindoktor, kommunsköterska och håller ordning på en handläggningsöverenskommelse som är evidensbaserad, vad skall man göra för någonting. Och den är då lätt sökbar för doktorer [internt via webben].

[xliv] Det här är nationellt, den här diskussionen om hur förhålla sig från den lilla till den stora kunskapen och med ordnat införande

[xlv] Det har varit lätt inom områden som diabetes där det sedan länge har funnits en länsgrupp … där både primärvård och [specialistvård] är representerade och jobbat i väldigt många år, med olika vårdprogramsfrågor. Då finns det ett forum som direkt kan ta till sig det där. Och i andra ämnen så finns det inte något motsvarande och då blir det väldigt svårt att hitta vägar att nå ut med det.

[xlvi] I korridoren för kunskapsstyrning, om det nu finns en sådan i vardagen här i huset, så skall det finnas dels de här resurserna som tar emot, ha ett samlat och ordnat mottagande och tanke på vem som gör vad och hur prioriterar vi det här. Men också … att det finns då resurser för analys och utvärdering som kan, ja okej nu säger vi att det här skall vi göra men hur ser vi till att det blir så.

[xlvii] Vill man söka bakgrunden och källistor också, då får man jobba mer. Utan det här skall vara mer konsensus, kort och kärnfullt. … För det praktiska snabba arbetet, det är inte, bakgrunden och forskningen, då får du gå in i de nationella riktlinjerna.

[xlviii] Så där, på alla dokument, skall det stå vad det har för giltighet, vem som är ansvarig för det. Så det handlar om att hela tiden bygga den här kunskapsbanken större och större och inte bara genom att föra in nytt utan också se över, få se stämmer den, vem ansvarar för att hålla den uppdaterad. Och här ser vi, det här har blivit jättemycket bättre. … Idag dateras de, sätts ansvar, sätts bevakning på … för har vi den typen av dokument som skvalpar runt då talar det snarare emot kunskapsstyrning, då slutar folk lita på vad de hittar.

[xlix] Om vi vet nu att nu skall vi behandla med fyr-dos istället för två-dos då kommer vi i den datoriserade världen inte att behöva ha någon utbildningsinsats, utan vi bara ser till att vi för-förskriver alla recept. Så när jag skriver recept så står det 'enligt ny evidens så skall bihåleinflammation ha antibiotika fyra gånger per dag. Ok', frågetecken, ja, och så sätter man in det. Och då behövs det inga utbildningsinsatser eller någonting utan det är bara att se till att man lägger in det i systemet.

[l] Än så länge har [läkare] den fria förskrivningsrätten men doktorn vill ju göra rätt.

[li] Då gäller det att ha en organisation, en kunskapsstyrning, i landstinget som sitter och säger, okej nu har vi de här fem nya nationella riktlinjerna, de säger vi skall ändra på det. Vilken tar vi först, ja vad är viktigast, var har vi störst patientnytta, vi börjar där. Och där är vi inte så vi har den där jättegoda strukturen för det ordnade införandet men vi är väldigt långt på väg.

[lii] För att det är inte bara att skicka ut en SBU-rapport eller nationella riktlinjer i verksamheten, det var längesedan man slutade tro att förändring skedde för att man bara distribuerade olika redskap. Och de här implementeringsproblemen de är gigantiska. … [F]ör det är en sak att nå folk med kunskap, det är en annan sak att, jag menar hur genomför man förändringar, står de i strid med rådande uppfattningar om vad som är god vård, till exempel hur bryter man eller förändrar och hanterar sådana barriärer. Organisation, det är inte bara fråga om, 'skall vi skriva ut läkemedel A eller B'. Det kan handla om att vi skall organisera det annorlunda kring patienter och det tar *jättemycket* tid.

[liii] Att som doktor, som sjukvårdspersonal, skall man jobba enligt vetenskap och beprövad erfarenhet och vetenskapen det är det evidensbaserade. Det vill säga göra saker som det finns evidens för att det är bra och sluta göra saker där det finns evidens för att det är dåligt. Men skulle man bara jobba enlig EBM, evidensbaserad medicin, så skulle man inte klara sig länge i det dagliga jobbet utan massor av saker är ju beprövad erfarenhet och praxis, som man får komplettera EBM med. Så att EBM är en viktig del men inte allt som styr vad man skall och bör göra i sjukvården.

[liv] Själva ordet evidens, med det avses att man har belägg egentligen för att en behandling är bra eller dålig. Och det baserar sig på forskning som är gjord. Begreppet evidens räcker inte hela vägen, för att det är inte gjord bra forskning på många områden. Därför måste vi koppla in "och beprövad erfarenhet". Men det hela, slutprodukten, skall bli, i alla fall en vård som är bra, som har så lite biverkningar som möjligt och så mycket fördelar som möjligt. Och att den inte skall vara, om man säger, påhittad på nytt varje gång. Vi skall ha en bas, vi måste kunna falla tillbaka på någonting, erfarenheter som är gjorda.

[lv] [D]är gäller det alltså att hålla sig a jour, att inte bara lyssna på andras utan själv läsa. Det är en väldigt viktig del det här, av jobbet, är att läsa. Men vi har för lite tid till det. Det finns också de som har ägnat sig åt att forska om evidens. Det finns ett institut i England, som heter Cochrane, som har tittat på många behandlingar; är de evidensbaserade eller ej? Och det man oftast hittar det är att det är ganska lite studier gjorda på det ämnet. Och då står vi där med en bräcklig evidens, och därför måste vi ha det här beprövad erfarenhet utmed. Men för stora diagnosgrupper, stora problemområden där finns det bra forskning gjord. Och det är det som är evidens.

[lvi] Evidensbaserad medicin är, kan vi säga, ett förhållningssätt till kunskap och vetenskap. Ett strukturerat och kritiskt förhållningssätt till den kunskap som presenteras om bästa sättet att diagnostisera och behandla patienter, och skapade … ett ramverk för hur man kan förhålla sig till de svåra problemen man har i sjukvården. Att säga, hur skall vi behandla den här patienten, hur skall vi behandla den här, hur skall vi välja nya, dyra behandlingar mot gamla billiga behandlingar och väga ihop dem på ett sätt så att det är väldigt transparent vilket underlag man har. Och sedan är det en form av praktik i sin tur som behandlar den enskilda yrkesutövaren. Så att det är som två nivåer egentligen, en definitiv metanivå kring hur sjukvården som struktur och system skall jobba och förhålla sig och en som handlar mer om, hur gör du som vanlig doktor i din praktik, när du möter patienter och hanterar dina kunskapsbehov.

[lvii] Den senaste patienten vi fick har en mani. Nu är den personen svårvårdad och går liksom utanpå all evidens, forskning. Men vi måste som ha en bas där, har man provat Litium? Ja, det har man gjort. Har

man provat Clozapine? Ja det har man gjort. Det var katastrof bägge två. Ja och då sitter vi nu i det läget att vi måste hitta något annat. Och då gör jag sökningar, vad kan man göra vid den här diagnosen?

[lviii] Primärvård och psykiatri, två viktiga tunga hörnstenar, det är ju områden där det finns rätt lite EBM, relativt sett. Där det finns SBU-rapporter och EBM det är inom kanske missbruk, beroende, schizofreni, depression men väldig mycket psykiskt dåligt mående, väldigt mycket primärvård är inte EBM.

[lix] Det är lätt att forska om patienter som har diabetes och det är lätt att forska på patienter som har hjärtsvikt och lätt att forska på patienter som blir dementa. Men hur skall man lägga upp en forskning på en av de vanligaste krångel-patienterna på en vårdcentral; 79-åringen med diabetes och hjärtsvikt och demens och osteoporos och smärta, som kommer. Och så måste man ta hänsyn till alla de här sakerna och då skall man säga, ja men det finns evidens för att diabetes behandlar vi så, det finns evidens för att hjärtsvikt behandlar vi så. Så inom varje delsjukdom finns det evidens, men jag är ju inte hjälpt där. Och då, därför att bekymret är att patienten struntar i det för att nu har hon så ont eller är så ledsen för att hunden har dött. Och det är det viktigaste problemet idag. Och hur beforskar du det, vad du gör i den komplexa situationen. … Och väldigt mycket av primärvård är så, det är en kompott av bekymmer som patienten kommer med.

[lx] Alltså den rejäla begränsningen är bristen på kunskap *generellt*. … Att det inte finns kunskap. Alltså vissa områden är extremt välstuderade, andra frågor är väldigt dåligt studerade, fastän de är väldigt relevanta. … Det är nog egentligen begränsningen. Det finns ingen begränsning från, om vi säger, ledningen eller i vardagen.

[lxi] För den vanliga doktorn så är detta inte någonting som man egentligen håller på att syssla med för varje patient. Utan det är någonting man har i sin fortbildning och när man sätter sig ner kanske och funderar över enstaka patienter, efteråt, eller så kan man behöva djupdyka.

[lxii] Om man skall generalisera det till en individ, det är lite svårt. … Man måste alltid ha den här möjligheten till, ja känna vad som är rimligt och rätt för den individen. Och där går det, vi kan liksom inte skriva in och ha en automatisk anteckning, ja depression, och så kommer det då en hel rad med då, nu skall vi göra det och det och det och det och det. Det kommer att ta tid om vi skall följa en sådan logaritm. … Och där kommer då den beprövade erfarenheten in. En van, erfaren doktor … kan se, ganska snabbt alltså, här kan vi hoppa över det och det.

[lxiii] … en bakgrund som ligger där men som man då ganska ofta ändå får säga att, ja men okej, kan jag verkligen applicera det här rakt av för den här patienten eller finns det någonting som talar för eller emot ett alternativt sätt att göra, att inte göra någonting eller faktiskt göra någonting som inte normalt sett rekommenderas av riktlinjerna. Och den här processen är för de flest doktorer inte vidare explicit eller verbaliserad.

[lxiv] Kärnan är ändå att de vanliga tillstånden återkommer och där går det ändå att köra någorlunda enligt någon form av protokoll. Men så, då bränner det till liksom ibland och det blir konflikter, inte minst inom gruppen av kollegor, men varför gör du så där, jag gör alltid så här, men varför gör du det, ja men jag har minsann läst studierna av Pettersson och Svensson och den säger, men det stämmer inte allts med nationella riktlinjerna.

[lxv] Där jag jobbade i tjugofem år så hade vi läkarträff tjugo minuter varje dag, direkt efter lunch, och då var det jättemycket just patientärenden; jag hade en patient som sökte för det och det, hade fått ont när hon vred på armen så och det var ingen skelettskada, men hur brukar? Och då, ja men min erfarenhet, och så har man jobbat där länge, det brukar vara så att de har sträckt den muskeln och … det brukar gå över på några dagar, så ring och säg att.

[lxvi] Alltså, så skulle jag säga att, den här överföringen av läkarrollen handlar väldigt mycket om att lära sig allt detta, att samla in den beprövade erfarenheten från kollegorna och sedan skapa sig en egen beprövad erfarenhet, vilket gör att man, ju längre man har jobbat desto mindre ofta blir man ställd och har inte en aning om vad man skall göra. Även om det händer fortfarande och att man då får säga att här måste jag höra med någon eller jag vet inte vad jag skall göra.

[lxvii] lär man det av varandra och det står i böckerna

[lxviii] både litteraturmässigt och från doktor till doktor så är det mycket beprövad erfarenhet som lärs vidare

[lxix] Även om man inte sätter namn på det längre för det har blivit 'business as usual', på det sättet.

[lxx] Jag tror att vi ser det som att EBM har blivit etablerat som normalvetenskap, normalförhållningssätt rakt av. Så att det är inte som att man kan komma och tycka vad som helst utan att någon säger; ja men vad har du för evidens för det egentligen?

[lxxi] Best Evidence eller Critical Practice för att hitta den bästa, så att säga, EBM-källan, eller så går någon och letar någon artikel eller föreläsningsanteckning
[lxxii] adekvat underlag
[lxxiii] oftast klarar man sig bra med Google, man hittar snabbt den kvalitet som man behöver ha, så det inte bara är ett tyckar-forum
[lxxiv] att kunna ha tillit till det
[lxxv] Det handlar rätt mycket om att … försöka ha ordning på regler och rutiner så att man skall inte behöva gå ut på nätet och söka efter hur man handlägger diabetiker med njursvikt utan då vet vi att då hittar man det. …. För när man använder nätet, man kanske inte behöver googla på det utan hittar de rätta, alltså vad skall jag säga, säkerställda källor. Källgranskade källor för att veta att man gör rätt saker och att det inte är någon kvacksalvare … som har en hemsida där han tycker … hur man skall handlägga stukade fingrar.
[lxxvi] Det är ett väldigt bra sätt att följa litteraturen och så skannar man över och så ser man, ja men den här artikeln ser intressant ut och så bara klickar man upp lite och tittar lite mer på den. Och det tror jag många idag använder, som jobbar med det specialiserade. … Den kommer ifrån olika, alla tidskrifter, låt oss säga JAMA eller Lancet eller någon sådan där. En gång i veckan kommer det en innehållsförteckning som ett mail helt enkelt. Och så klickar man upp och så får man en kort sammanfattning och så kan man se om det är av relevans för min verksamhet. … Och det är väl det enklaste sättet jag använder. Många andra åker mer på konferenser och kongresser och sådant men jag är nog mer, det är ganska mycket grus på dem, man kommer väldigt långt genom att hålla ett öga, på det här sättet.
[lxxvii] om redovisar precis vad de bygger sina rekommendationer på
[lxxviii] Best Evidence och Clinical Practice, det är British Medical Journal som har varit väldigt central i hela EBM-rörelsen, de har en site som landstinget prenumererar på, där de verkligen har försökt att göra diagnosinriktat, det vill säga kommer det någon och säger att, jag tror att jag har gikt i stortån, jaha man börjar fundera hur var det nu, vad är bästa sättet att diagnostisera och behandla. Då kan man slå upp vilken lärobok som helst men de är sällan evidensbaserade. Men går man in på Clinical Practice eller Best Evidence, det är egentligen två olika portaler som når samma sak, så får man se att, okej, för att diagnostisera så har det här den bästa karaktäristika medan den här andra metoden presterar sämre och kostar mer och därför bör du välja den här och den här. Det är nog en av de bästa, handfasta, vardagliga instrumenten vi har faktiskt.
[lxxix] inte alltid att översätta rakt av, det finns lite olika sätt att hantera frågor som gör att man ändå måste filtrera det på något sätt genom ett nationellt filter.

Chapter 6

[lxxx] i deras uppföljningsarbete.
[lxxxi] står för satsningarna är det klart att vi blir lite blåslampa i våra roller
[lxxxii] Förväntningarna är att [jag] skall vara den som driver utvecklingsarbetet och att man ser till att man får alla kommuner med sig i arbetet och att man beaktar de lokala behoven i kommunerna. Att det är, på länsnivå, samordnarens ansvar. Att man inte tänker i stort utan man hämtar de lokala behoven, i kommunerna.
[lxxxiii] vitaliserar verksamheten
[lxxxiv] Det blir mycket mer strukturerat plus att alla kommuner får nytta av de pengarna på ett annat sätt. För att små kommuner skulle inte ha möjlighet att söka alla projektmedel, för de har inte resurserna att skriva ansökningar och anställa folk och följa upp och redovisa. Det är så mycket administration för dem.
[lxxxv] Det innebär en viss styrning eller [en] ganska ordentlig styrning vad pengarna skall gå till. Det är inte bara så att kommunerna kan säga vi vill göra si, och vi vill göra så. Utan staten har sagt, de här pengarna skall gå till det *här*. Och det är klart att det blir en styrning, för pengar är alltid välkomna.
[lxxxvi] [Idag] är det väldigt mycket peka med hela handen uppifrån. Även om man då säger från SKL, som har klivit in som en aktör i det här genom att hantera de här statliga pengarna, att kommunerna är naturligtvis självständiga, autonoma och fattar egna beslut, så styrs man väldigt mycket, inte bara av idéer om vad man skall jobba [med], men man definierar precis inom vilka eftersatta områden, satsningarna skall ligga, genom att sätta pengarna där. Och man har prestationsbaserade ersättningar till kommunerna, det vill säga … för att få vara med och dela pengarna skall man göra vissa saker, uppfylla vissa

krav och man har nivåer och procentsatser och allt, och man skall registrera i olika register. Och sedan har det nu de senaste åren, så duggar öppna jämförelser tätt. … [Det] har förändrats. Det har blivit väldigt, väldigt tydligt de senaste fem åren, sex, sju kanske. Därför att man styr med pengar, man styr med pengar.

[lxxxvii] Man mäter och har man mycket röda fält då tror jag att man triggar igång ganska mycket stress, oro och så, och så springer man på de bollarna och kanske missar att fortsätta utveckla det som är gult och göra det grönt i de här jämförelserna.

[lxxxviii] Många av de här öppna jämförelserna har kommit kanske en, två eller tre … år i rad, och är naturligtvis inte färdigutvecklade så att riktigt vad man mäter och frågar efter kanske inte har satt sig, men de blir oerhört styrande därför de här röda fälten.

[lxxxix] de har ju så gott det går, att undersöka vilka problem som finns i samhället.

[xc] Man behöver en stödfunktion, helt klart, någon [kommunerna] kan bolla med och också det här att ta del av andras kunskaper, att få en erfarenhetsspridning, alltså hur gör andra. Och, det har vi försökt jobba med då också genom nätverket som är bildat i länet.

[xci] Jag ser att FoU [som är en del i den regionala enheten] är väldigt viktigt som stöd till kommunerna i den här satsningen. Inte bara vara den här megafonen, statens megafon ut till kommunerna och tala om *vad* de skall göra, utan stötta kommunerna att faktiskt i sin egen verksamhet hitta de här områdena där de ser att det kanske brister. Man kanske behöver följa upp på ett bättre sätt, man behöver ta tillvara all den kunskap som faktiskt finns i socialtjänsten och värdera, sätta ord på vad man kan. Och, att kanske förhålla sig kritisk till vissa delar i den här satsningen, för att själva hitta förbättringsområdena i den egna verksamheten. Det tycker jag är vår självklara roll, i den här satsningen.

[xcii] man får liksom vara medveten om att alla [kommuner] går inte i samma takt.

[xciii] men vi hinner inte delta i allting.

[xciv] Om vi tar den största kommunen 70-75 000 invånare och den minsta tre tusen, det är självklart att alla satsningar kanske hamnar i knät på en, två, tre personer i lilla Arjeplog. Det är inte så där att man kan fördela det så att man har en ansvarig för … var sitt område, utan det hamnar hos en och samma person. ... Och det är tufft.

[xcv] Man måste skapa nätverk, man måste få alla kommuner med på något sätt, man måste ha förståelse för att det är olika förutsättningar att delta. Och man kan inte kräva lika mycket från alla kommuner, att de skall personalmässigt eller, satsa lika mycket i det här nätverksarbetet och kanske implementeringsarbetet heller. Att det får komma i olika takt. Man måste ha den förståelsen.

[xcvi] Samtidigt som kommunerna är så *oerhört* belastade, alltså praktiken måste fungera alldeles oavsett de här statliga pekfingrarna, och ibland har jag en känsla av att kommunerna inte riktigt mäktar med att ställa krav på oss. De har så vansinnigt nog med sin vardag på något sätt. Så att helst kanske de skulle vilja att vi tog hand om det, men det går inte. Det går ju inte.

[xcvii] Jag tror att man … från nationell nivå, att man håller lågan levande på något sätt, och att från länsnivå att det finns en organisation som driver utvecklingsfrågor. Det, tror jag … är jätteviktigt. Och att man jobbar gentemot olika slags nätverk. Men man får inte bli för många [nätverk så att det blir en börda] … Men motorn måste vara ändå på länsnivå.

[xcviii] Det handlar alltid om resurser … Det kräver resurser, det kräver tid, det kräver att man tillåter till exempel uppföljning i kommunerna, att man tillåter personal att frigöras och frikopplas, till exempel. Brukarmedverkan kräver kanske att man bekostar och betalar brukare som deltar. Man kanske måste betala personal som utbildar brukare, som möter brukare och det är en … omställning. … Det behöver inte i förlängningen bli en fördyring, men alldeles säkert i en omställningsperiod för då har man en förmåga att göra samma sak man har gjort, plus det nya, innan man fasar ut det gamla. …

[xcix] någonting vi inför

[c] Begreppet evidensbaserad praktik, det dök upp någon gång, kan det har varit strax före millennieskiftet … Det var i slutet av nittiotalet, så skrevs en debattartikel. Det var, bland annat dåvarande generaldirektören på Socialstyrelsen Kerstin Wigzell, som skrev en debattartikel hur lite man i socialtjänsten egentligen vet om vad satsade pengar ger för effekter för brukarna. Och det blev ett ramaskri, inte minst ute bland de professionella som tyckte att det här var påhopp på professionen.

[ci] Det här förde med sig att det kom igång en diskussion och Kerstin Wigzell lyckades få ett regeringsuppdrag till Socialstyrelsen, att titta på … hur man kan åstadkomma en kunskapsbaserad socialtjänst, som det hette. Och utredningen sattes igång där i slutet på 90-talet … och det var nog då det här med evidensbegreppet började användas. … Diskussionerna [gick] vansinnigt höga därför att, det blev alltså

en polarisering mellan ett antal forskare. Där den ena pratade om den akademiska forskningen som den enda basen och när det gäller socialt arbete så sa man, det finns ingen forskning, därför att det fanns inte de här … RCT-studierna. Alltså kan man inte göra kunskapssammanställningar på vad som är forskat i socialt arbete. Medan de andra sa att, ja men ni vet, det går inte att resonera så där, och man hade en helt annan inställning. Sedan har de här två motpolerna på något sätt jämkats ihop, kan jag tycka. Och vi fick det här begreppet evidensbaserad praktik, definierat som de här tre benen kan man väl säga.

[cii] det var hårda motsättningar

[ciii] Då var det kanske inte evidensbaserad *praktik* utan evidensbaserade *metoder* som man pratade om. Vad är verksamt, hur skall, lite ingenjörsaktigt; vad skall vi sätta in för metoder som ger bra resultat. Sedan har den här utvecklats så att jag tycker att … kanske fem år sedan eller något sådant där, när man började närma sig en slags definition av evidensbaserad praktik inom socialtjänsten, inte evidensbaserade metoder. Men det var … i slutet 1900, alltså sekelskiftet där någon gång tror jag.

[civ] Det var mycket sådana diskussioner, i Sverige och England. … För, det var en ifrån England som vi hade här i början av 2000-talet. … 'Evidence Informed Practice', ville hon ha som idé och det var väldigt mycket motstånd från lägret av Kerstin Wigzell och från statens håll då. För hon menade då från engelska perspektivet att man kan *informera* sig om vad som finns, forskningen [som] finns, men man kan inte säga att det är baserad bara på det ... Jag tror att den diskussionen bidrog till en slags omformulering av evidensbaserad praktik. Så att man får in de andra kunskapskällorna än bara evidensbaserade metoder. För det har man konstaterat det finns inte så mycket metoder vad vi, om vi gör det så får barnen det bra, eller. Utan det är, man måste lyssna på dem själva, klienterna själva och lyssna på vad också personalen har för erfarenheter av olika saker. Så att på något sätt blir det lite uppmjukat och … paketerat på något sätt så att det gick att anpassa till verkligheten.

[cv] Med Oscarssons definition, finns det i alla fall förutsättningar, tycker jag, att börja prata om evidensbaserad praktik. Men fortfarande lever det kvar mycket det här att evidensbaserad praktik det är verktyg och det är metoder och det är modeller som skall implementeras ... Utan det är ett förhållningssätt där man skall vara öppen för alla de här tre kunskapskällorna och utveckla det. [Lars Oscarssons bok från 2009 bygger] väldigt mycket … på det som Kerstin Wigzell sedan skrev om en kunskapsbaserad socialtjänst till nytta för brukaren, Kerstin Wigzell och Martin Börjesson, det är en SOU-rapport.

[cvi] Jag tror att idag, fast kanske man är färgad utav att man sitter och jobbar med just den satsningen. Men jag känner att det handlar mindre om evidensbaserade metoder och att det mer handlar om ett förhållningssätt, och det är ju *bra*, tycker jag. Egentligen mer den ursprungliga tankegången.

[cvii] Jag tror att man ser hur det hänger ihop mer nu, alltså helheten, att det handlar inte bara om metoder eller det handlar inte bara om nationella riktlinjer eller vad det nu är. Det handlar om helheten. … Det är ett förhållningssätt mera. Jag tror det har svängt över till den förståelsen. … Om vi går ut och frågar [personal i verksamheterna] … så kanske de inte alls säger det.

[cviii] fokuserat mer på det och pratat mer om det

[cix] fört uppifrån på något sätt ned ända på lokal nivå

[cx] Det innebär egentligen att man stödjer sig på alla tre benen. Och att man arbetar systematiskt och systematiserat med de här frågorna. Att man bygger *in* strukturen i kommunerna som stödjer de processerna, på alla nivåer tänker jag. För att man kan inte tänka att det bara är på individnivå för att det stöds inte om det inte sker på verksamhetsnivå eller strukturell nivå. Utan man måste bygga in det på alla nivåer och ha det som ett grundförhållningssätt, tänker jag.

[cxi] Det är jätteviktigt att bygga in det i organisationsstrukturerna. Att man har ett system för kunskapsbevakning, att man har ett system för hur tar [de] tillvara erfarenhetsbaserad kunskap inom vår organisation ... Och att man hela tiden sprider det här inom organisationen, alltså att det är ett levande arbetssätt som *chefer och ledning* aktivt stödjer och frågar efter resultat från. Ja en levande verkstad på något sätt. Men det *förutsätter* att man bygger in det i strukturerna, det räcker inte att den enskilde socionomen eller arbetsterapeuten gör det här fullt ut. Alltså det räcker till viss del för att det berör ju några brukare men det måste byggas in i strukturerna.

[cxii] På något sätt handlar det om flera nivåer. Dels om man säger, i mötet med klienten eller familjen, att vara uppdaterad om forskning om familjer med missbruk till exempel. … Och att … väga in sina egna kunskaper om de sakerna tänker jag; hur var det, vad har jag för erfarenhet av sådant här? Det är ett slags, väga in det i beslutsfattande på en individuell nivå eller familjenivå.

[cxiii] Sedan innebär det också att ha någon systematik i uppföljning av hur det går för barnen, ungdomarna i mitt fall här då så att de, se nu gör vi olika saker, vi erbjuder olika saker och de genomgår olika

program eller insatser. … Hur har de det under tiden men också hur det blir för dem efteråt? Och … vilken betydelse har det vi gjorde på någon aggregerad nivå? Det här med lokal uppföljning av verksamheterna, det tycker jag det är en förutsättning för att ... bedriva evidensbaserad praktik, att lyfta upp det. Så det är på flera nivåer.

[cxiv] Att å ena sidan förhålla sig till den styrning som pågår. Nationella riktlinjer för insatser vid, vad var det, ångest och depression, kom för några år sedan, [den är] inte gammal. Den lyfte fram kognitiv beteendeterapi [KBT] som det enda och allena saliggörande terapin, eller den enda, terapiformen. Och nu i vår–vinter här så hör jag att en av de ansvariga bakom riktlinjerna, på Socialstyrelsen, säger att det har visat sig att den psykodynamiska psykoterapin fungerar också. Och då har stora delar av hälso- och sjukvården och den terapeutiska världen redan försökt vända skutan, satsat på jättemycket utbildning i kognitiv beteendeterapi, med statliga stödpengar. … Då skall man förhålla sig kritiskt. Och visst fanns det kritiker, men de drunknade i lite grand halleluja-kören kring KBT. … Så det är jätteviktigt tycker jag, kritisk hållning.

[cxv] Att man lyssnar, man hugger inte tag och tänker att, ja men det där skall jag undersöka lite mer om, nu vill jag fundera, nu vill jag, det här att man ligger lite lågt. Det är så man tänker, att det kanske blåser över eller jag vet inte.

[cxvi] Det är ju sunt också att man inte bara säger att, ja det borde vi, evidensbaserad kunskap *det* skall vi göra. Utan att man har en liten avvaktande hållning. Men det kan innebära också att man tänker att, ja men, det där får de väl hålla på med, vi gör som vi brukar.

[cxvii] hur *jag* som arbetsledare kan jobba för att utveckla och implementera det i verksamheten

[cxviii] Det är en av de där sakerna … som man måste tänka över och hitta sätt för i organisationen. Alltså, hur fixar vi det, bredden? För … varje enskild individ kan inte förväntas hänga med på bredden. Och hur kan vi då lösa det? Att ändå få summering av allt som händer. Hur hittar man system för det, i verksamheterna? … Det är väldigt enkelt att lägga det på varje enskild socionom eller sjuksköterska eller vad det är men … det är inte realistiskt.

[cxix] Det måste vara något slags gemensamt angreppssätt i en socialförvaltning att … innan man fastslår att nu jobbar vi enligt den riktlinjen eller enligt den rutinen som grundar sig på det eller det eller det. Så att … alla överväganden är inte heller individens, utan en del måste ske på en annan nivå där man fastslår ett program eller en handlingsplan eller någonting och då måste det grunda, ja. Så, alla är inte individens övervägande.

[cxx] Jag tror inte att arbetsledningen har blivit något mycket bättre att följa upp … För de har inte varit så engagerade. Utan det är personalen som jobbar. Och det kräver att arbetsledningen blir mer styrande och jobbar mer med uppföljning. Och uppföljning har man inte kommit igång med. Och där behövs fortfarande arbete.

[cxxi] Men det är *de* [politikerna] som måste ställa kraven på att man följer upp, det är *de* som skall ställa frågorna till verksamhetscheferna; hur går det med det här, och hur mycket har vi kostnader för det och det, och vad är det för behandlingar vi använder, och varför väljer vi dem och vad har vi för underlag för att välja på det här sättet eller att det skall si och så mycket pengar för den här verksamheten?

[cxxii] ganska ytliga kunskaper

[cxxiii] Om inte det här ligger i chefernas knä, om inte politikerna börjar ställa frågor till verksamheten, ja man då är det värdelöst. Då är det värdelöst. Det måste vara så att det *är* socialcheferna ute i länet som måste känna att, det är vi som äger frågan, det är vårt ansvar. Och politikerna måste veta att, vi måste ställa de här kraven på tjänstemännen. Vi måste få veta: Vad får vi för pengarna? Vad ger det våra medborgare? Är det den absolut bästa tillgängliga kunskapen vi har?

[cxxiv] I en del kommuner har det varit mer eller mindre obligatorium för chefer att gå de här utbildningarna som har varit. Medan andra, har det varit väldigt sporadiskt och upp till varje chef, vill jag gå det här eller inte, har jag tid, har jag utrymme, nej det går inte, eller ja men det här kanske kan vara kul. Så att det har sett väldigt, väldigt olika ut. Så att om vi pratar [om verksamheten] där kunskapen verkligen måste finnas … så tror jag att det är väldigt bristfälligt.

[cxxv] närmare och varmare om hjärtat medan andra känner sig väldig främmande

[cxxvi] att ge legitimitet åt arbetet

[cxxvii] har väldigt mycket andra saker, … måsten

[cxxviii] blir det de som har lite mer intresse och tycker att det här är viktigare än något annat" som engagerar sig

[cxxix] Det är väldigt få som i någon slags medvetenhet gör de här övervägningarna idag att; nu agerar jag utifrån de här kunskapskällorna.
[cxxx] glimtvis, men absolut inte i totalen
[cxxxi] fast man kanske inte *kallar* det att nu jobbar vi evidensbaserat
[cxxxii] [Detta] har mycket att göra med vilken individ jag är och vilken resa jag har gjort, ja kunskapsresan eller vad man skall säga. Så jag agerar utifrån de kunskaper *jag* har. Och då beror det på, vad har jag stött på för kunskaper och vilka erfarenheter har jag gjort.
[cxxxiii] Nackdelar vet jag inte. Det är väl inte så himla många nackdelar.
[cxxxiv] Jag ser mest bara fördelar.
[cxxxv] Ja fördelar är lätt att säga men vad finns det för nackdelar med det.
[cxxxvi] Har man väl nått en fungerande evidensbaserad praktik så vet jag inte om det kan vara några nackdelar.
[cxxxvii] Om man … använder det [för] att väga de här olika benen mot varandra så är det svårt att säga att det kan vara en nackdel. För det innebär att om jag tycker att något, den här gången, väger tyngre, så skall jag välja det. … Och det är också fördelen, att man väger olika perspektiv. ... Sedan är det klart att vi kanske har missat något, det kan vi komma på om fem år, ja men det där tänkte vi inte på då.
[cxxxviii] Det räcker inte att jag mekaniskt följer, ställer alla frågor, utan jag måste vara också engagerad. Att, man får inte glömma bort att jag är fortfarande viktig som person och hur jag bemöter klienten och vilket förhållningssätt jag har. Så att, man får inte tappa bort helheten. Det kan vara risken.
[cxxxix] Det är klart att för den enskilde som arbetar i verksamheten kanske det blir nackdelar, det kanske tar tid och det blir mer dokumentation, det kanske går åt mer tid till kunskapsinhämtning. Men jag tänker att fördelarna väger upp. Men visst kan vissa av de enskilda kanske uppleva att det är tyngre eller svårare eller tar längre tid eller.
[cxl] nytt innehåll i organiseringen, nya uppföljningsinstrument
[cxli] Det räcker inte med att reflektera utan man måste på något sätt artikulera och dokumentera. Det är jag alldeles övertygad om. Vad var det som gjorde att det gick bra, och vad var det som gjorde att det gick fel? Och det måste man i kollegiegruppen kunna lyfta, jämföra erfarenheter.
[cxlii] definierar tillsammans.
[cxliii] Jag tror att det är jätteviktig för att … det här kontaktnätet också, de sa att, oh vad bra det är att träffas så här, man lär sig alltid någonting från någon annan kommun. Att det är utbyte av erfarenheter och det har stor betydelse för att i vardagen är man så pressad och stressad så man unnar sig inte tid att stanna av och analysera och fundera och planera och ta reda på. Men när man träffas så där och man berättar om sin verksamhet och man vill gärna lyfta upp det som fungerar [i deras kommun]. Det ger tillfälle för de andra att lära sig och det var många gånger som det hände att, jaha men kan jag ta kontakt med dig sedan och så får vi prata om det här och hur ni har gjort och om vi kan liksom ta efter och anpassa på något sätt hos oss.
[cxliv] Själva idén med hela verksamheten är att [brukarna] skall få det bättre. Att [undersöka] hur de får det och vad de själva tycker om det, det måste vara det viktigaste för utvecklingen av verksamheten. … Så därför tänker jag att det ändå har sin betydelse att det är kvalitetsutveckling det handlar om, att som göra bättre grejer för [brukarna]. Det är syftet med det.
[cxlv] Men så långt det är möjligt så kan det bli mer likartat och det ökar tryggheten, förtroendet för det vi håller på med. … För individen är förhoppningen att den får vara mer delaktig i beslutet och att det blir kanske mer riktiga beslut, med mer lyckade åtgärder.
[cxlvi] bästa tillgängliga kunskapen och erfarenheten.
[cxlvii] Jag tycker att den [lokala evidensen] verkligen behövs lyftas fram, vad är det vi ser på lokal nivå och utvärdera olika frågor inom i mitt fall den sociala barnavården på lokal eller regional nivå så att man inte bara, för forskning finns ju alltid i *någon kontext*, det … gäller [inte] i hela Sverige likadant ... Det finns likheter men man måste ändå [läsa] forskningen på ett selektivt sätt kanske. Men att lyfta fram den lokala, att höja den lokala utvärderingen tror jag är väldigt viktigt för att man skall också få en, det här vet vi i Norrbotten eller i Luleå eller Boden och stärka den. Det blir också en stärkt självkänsla att man vet någonting om sin verksamhet. Och inte bara, också kan reflektera över ny kunskap som kommer annorstädes ifrån.
[cxlviii] [Utvärderingar] lyfter upp … frågan på en lite högre nivå att det är viktigt att vi gör någonting åt kvaliteten. Det har kommit med andra saker också, jag menar kvalitetsbegreppet och behovet av att

följa verksamheten så man vet vad man gör och vad det blir för utfall. [Det] finns i en annan paragraf också, kvalitetparagrafen.

[cxlix] trygghet i att, här jobbar vi utifrån en evidensbaserad praktik och där vi vet att vi tillgodoser de krav och ålägganden vi har på vår verksamhet.

[cl] Som socionom [kan jag] snart räta på ryggen och sträcka upp huvudet för … att vara socionom är inte någonting som riktigt hör till middagskonversationen om man säger så. Det är ett svårt yrke och ett viktigt yrke som lätt förringas. … Så att på det sättet tror jag att det är jättebra. Och framför allt är det att, om vi vågar sträcka på ryggen … då kommer det ge en trygghet även för dem vi är satta att ge stöd och service, insatser. … Jag tror det är jätteviktigt. Eller det *är* viktigt. Det är utsatta grupper, sårbara grupper, vi kommer i kontakt med. Vi måste kunna stå upp för det vi gör och veta att det är bästa tillgängliga kunskap vi använder.

[cli] Det är den här känslan av att det är professionellt det som jag gör. Det är inte bara någonting som jag hittar på eller tycker, eller någonting sådant, utan att det är ett professionellt arbete som jag utför. Och, man ser inte klienterna heller som någon massa utan det är individen som jag möter och mitt förhållningssätt har stor betydelse i det jobbet. Och jag har olika slags verktyg i min verktygslåda som jag kan använda när jag träffar de här olika människorna. Så att det är, ja det är … professionalism, tycker jag, mycket.

Chapter 7

[clii] När det togs upp så var det väldigt mycket det här med forskning och därför tycker jag att den här nyanseringen som har blivit med evidensbaserad praktik … säg vem som inte ställer sig bakom det. Att det är väldigt klokt att liksom ha flera ben när man tittar på vad vi gör och vad det blir för resultat.

[cliii] Men jag tycker att det är bra.

[cliv] Jag tycker nog överlag att det är bara positivt.

[clv] Försvåra har jag jättesvårt att se vad det skulle kunna vara. … [Underlättar] det är att vi vet att vi får bättre skriftliga produkter ut från oss … och att klienterna får, naturligtvis, det de behöver ha. Så att jag har svårt att se något negativt med det. Jag ser bara positiva saker med det.

[clvi] När det inte blev så försvarsinställt så har man naturligtvis sett att det är viktigt att man hittar metoder och sätt att arbeta som ger ett bättre resultat. … Det finns begränsat med resurser och det betyder att vi också skall lägga dem på det som man då finner är verkningsfullt. Sedan är det ju det här bekymret att vi sällan har några kontrollgrupper som … sjukvården har.

[clvii] Kommer att vara en naturlig del i vårt arbete.

[clviii] Men *idag* skulle jag vilja säga att det finns mycket, jag kan bara uttala mig för individ- och familjeomsorg, att det finns ett starkt intresse.

[clix] kommer att tonas ned som så många andra frågor

[clx] I en liten kommun kanske inte på samma sätt. Jag vet inte riktigt det. Jag tänker att i en större [kommun] … finns det större skara av samma typ av ärenden. … Här är det … om jag säger vårdnadsutredningar, de är så sällan förekommande och barnskyddsärenden … fyra på sin höjd. … Om det fortsätter så. Och konstigt vore det om det skulle bli mycket mer om inte befolkningen ökar. Om inte att man jobbar med våra ärenden i alla kommuner [i den här länsdelen], exempelvis. Och då skulle man kunna … få underlag.

[clxi] då är deras tankar guld värt

[clxii] BBIC … är bara ett system för hur vi skall samla information, hur vi skall tillförsäkra att de här grundprinciperna som BBIC bygger på, att det finns med i det sociala arbetet kring barn och ungdomar. Och att vi inte gissar saker, som man kanske gjorde förr, när det var lite mer godtyckligt. Vi hade inget enhetligt sätt att samla information och utreda och följa upp våra insatser. Utan det kunde ske på väldigt många olika sätt från kommun till kommun, också inom kommunen. … Beroende på vilken handläggare som gjorde jobbet så kunde det skilja väldigt mycket.

[clxiii] Det var tanken att alla skall vara lika. Det är bra, just att alla [utredningar] är lika och då behöver man inte vara osäker [som socialarbetare]. Förr kunde det vara naturligtvis så att, har jag nu tagit upp allt som krävs för det här?

[clxiv] Det handlar någonstans om att försöka ha en god kvalitet i socialt arbete, att det får inte bli godtyckligt hur vi handlägger och förfar hos oss. … Det skall vara verksamt de vi ger våra klienter, det skall ju *ge* dem någonting. … [Evidensbaserad praktik medför] att vi bättre ... har koll på vad vi gör … varför vi

gör. … Det handlar om att försöka upprätthålla någon slags kvalitet i det vi gör. Så bara det att begreppen kom, att det här är viktigt att tänka på i socialt arbete, ja men det har medfört tycker jag att man har bättre koll. Man är mer noga med att göra rätt saker, så att säga.

[clxv] ger rätt insats till rätt person och att den ger rätt effekt

[clxvi] börja effektivisera, för vi kommer inte att få mer pengar bara för att jag säger att det har kommit en ny lag.

[clxvii] Jag tror att de flesta vet ändå vad evidensbaserad praktik är. Men det kan vara jag som tror det bara.

[clxviii] Evidensbaserad praktik för oss som har en akademisk bakgrund, som för mig, är det ingen … svår fråga. Jag menar det här pratar vi jämt om, det här med att säkerställa vetenskapen i det så att säga.

[clxix] Jag tror jag börjar kalla det på något annat sätt. Kan tänka mig att vissa gånger är det själva ordet som skrämmer folk. Alltså de gör det redan utan att tänka vad de gör. Du använder kunskap, särskilt de som har jobbat lite längre. Du använder din kunskap; hur var det att bemöta just det? Du vet till exempel vissa sjukdomar eller någonting, psykiska. Sedan kommer, klick, jag gick ju den här kursen … Så på sätt och vis använder du det men utan att veta. Det är biten som jag tror fattas. Förutom brukarnas egna åsikter …

[clxx] Jag är alldeles säker på att [två av de äldre kollegorna] känner det precis så. … Det känns stort, svårt att greppa. … Det här konkreta fattas. Det är för abstrakt känns det som.

[clxxi] På vilket sätt skall vi jobba på IFO?

[clxxii] Hur får vi evidensbasering på det här?

[clxxiii] Det hänger som i luften. … Ingen vet egentligen vad man *gör* med det. Man pratar på sitt eget sätt om evidensbaserat. … Särskilt nu för [individ- och familjeomsorgens] del … skulle jag vilja ha, … vad gör vi konkret? [Vi] famlar. Och jag tror att det gör att det känns osäkert och när det känns osäkert då blir det ovilja.

[clxxiv] Det var ingen som pratade i termer av evidensbaserat eller att det skall vara något riktigt och viktigt utan det var mer som att höfta till att, ja … men det har visat sig att det inte går om man gör si och så. Det håller exempelvis inte om man skickar mot sin vilja någon till behandlingshem eller någon ungdom som man skickar till LVU, … det ger inte det resultatet som man önskar. Det hade man bara som erfarenhet men man hade inte någon statistik på det.

[clxxv] vardagsevidensbaserat

[clxxvi] Vi har en yrkesgrupp som har utbildat sig på 70-talet, då var socionomutbildningen väldigt praktiskt lagd, alltså själva utbildningen. Och de som har studerat nu … fick utbildningen väldigt … forskningsinriktad, alltså teoretisk. Och vissa gånger krockar de två sakerna. De som har varit socionomer från 70-talet, de har *väldigt* mycket praktisk kunskap som de som kommer direkt från skolan idag inte har. De får praktik först efter avslutade studier oavsett nu praktiktiderna. Men å andra sidan fnyser många av de äldre … varför skall man läsa forskning, och så vidare. Så det tror jag är den största vinsten, att slå ihop de här krafterna. Ja, och sedan kunna prata *om* det. Det är inte mindre kunskap i mina ögon än den som vet att, ja men SOU 2012 säger si och så. Men de måste gå ihop.

[clxxvii] Det är en tillgång i en arbetsgrupp att man är en del som har arbetat väldigt länge och en del är relativt sett nyutbildade. Att man tillför [kunskap till] varandra … för de som har gått utbildningen nyligen, de har en helt annan kunskapsbas än vi gamla. Så att, man tillför varandra automatiskt … och så får vi höra vad som pågår nu på utbildningsinstitutioner. … Det är en bra mix i det.

[clxxviii] tillför ny kunskap till den praktiska sidan som man har … stor nytta av.

[clxxix] Man blir en länk någonstans mellan politiken och vår verksamhet [socialtjänsten]. Och det som har varit … i fokus, det har varit arbetsmiljö, det har varit ekonomi. Fast egentligen tvärtom, ekonomin i första hand för där skenar det iväg. Vi har en åldrande befolkning, större behov av omvårdnad, omsorg. Så det är de utmaningarna, att det jag försöker jobba med det är att få mina chefer [under mig] att känna för att göra mer för mindre.

[clxxx] En enhetschef skall vara, utvecklar arbetet, ser nya möjligheter hur man skall göra, naturligtvis effektivare och kostnadseffektivt, och framför allt hålla *budgeten* [i balans]. Det är det viktiga också då. Och det kan jag tycka att det är lite svårt balansera det här, vad ser man behovet av insatser. Men man måste ändå hela tiden ha budgeten i bakhuvudet. Och att det ändå är rättssäkert, och så här.

[clxxxi] har en jättestor roll i det, för att vi synliggör det och vi håller det vid liv hela tiden.

[clxxxii] det är jätteviktigt att vi är med och bevakar.

[clxxxiii] Fram till nu tycker jag ändå att [ansvaret] har legat mycket på tjänstemännen att införa detta. … Som har kommit med idéer och både tagit fram och [formulerat förslag], och fått beslut omkring det.

[clxxxiv] Inom området har man allt ansvar [för utvecklingsarbete]. Jag vill att man [mellancheferna] kommer till mig och säga, nu har vi sett det här. Vad tror du om detta?
[clxxxv] nyckelpersoner
[clxxxvi] måste bli bärare av förändringen
[clxxxvii] Att det inte bara blir själva [BBIC-]utredningen, utan det finns också en struktur på annan nivå. Och där ser man, inte minst vilka fel vi gjorde [med införandet av BBIC]. Vi, ja det glömdes bort lite grand första linjens arbetsledare som är så *otroligt* centrala för utvecklingsarbete.
[clxxxviii] Vad är det vi behöver fokusera på, vad finns det för frågetecken, vad finns det för utvecklingsområden som vi behöver jobba vidare med. … Att det inte bara blir själva utredningen utan det finns också struktur på en annan nivå.
[clxxxix] Vi har skapat handlingsplaner vad vi vill åstadkomma. Och det är … att följa upp det och ha med det hela tiden, att det är levande dokument. … Vi reviderar dem regelbundet också. … Och jag förväntar mig att mina chefer sedan i sin tur gör det ute i verksamheterna. Vi gör övergripande, vad är ledningsgruppens uppdrag, syfte, tanke, vad vill *vi* åstadkomma.
[cxc] Någon blir nyfiken här på, antingen vi som chefer eller någon socialsekreterare som har läst på någon hemsida eller har fått det tillskickat att, ja det där är någonting som kanske vore värt att pröva, testa. … Om vi gör den bedömningen i ledningsgruppen också att, men vi låter de här, ett par stycken gå och ser vad det är. … Det är [i ledningsgruppen] … vi beslutar om vilka utbildningar och hur vi skall lägga upp för året.
[cxci] Vi valde att vi skall ha en MI-grund bland handläggarna. Det kommer naturligtvis uppifrån att vi kunde plocka in det i styrkortet. … Det plockar vi ner, naturligtvis från styrkort och gjorde om som en aktivitet och bestämde också på ledningsnivå att det här är någonting som vi tycker är viktigt att alla har som grund.
[cxcii] omvärldsspaning
[cxciii] Vi får krav på oss att genomföra saker och ting och då kanske det tillskapas projektmedel. Och ibland är det stimulansbidrag men andra gånger är det prestationsersättningar och då måste vi uppvisa ett visst resultat för att få ta del utav de pengarna. Öppna jämförelser har varit … sådan. Men de här registren, Palliativ och Senioralert är sådana och … Anhörigstöd har varit en sådan där det har kommit pengar. Och nu skall vi klara oss själva. … Det har varit en uppsjö.
[cxciv] följa upp barn efter avslutad utredning *utan* samtycke från föräldrarna
[cxcv] När det startas flera olika, och sedan har man små kommuner. … För, precis samtidigt, det var kvinnofrid, samtidigt började våld i nära relationer och sedan är det barn som bevittnar våld. ... Och alla de här var så viktiga.
[cxcvi] Det tycker jag att jag ser, när det gäller Barns Behov I Centrum [BBIC], hade vi inte varit uthålliga hade vi nog gått tillbaka till det gamla sättet att vara. Och det här med evidensbaserad praktik, det räcker inte något år eller några år; här handlar det om *lång* tid innan man har vänt om fartyget.
[cxcvii] det var stor skillnad på om man gjorde saker och ting som projekt eller med inriktning verksamhetsutveckling
[cxcviii] [Jag tycker] att man är lite för, man satsar så stora medel på så kort tid istället för att smörja organisationen lite fler år. För när vi får pengar, då är vi inte startklara så vi har nästan förlorat första året. … Det tar längre tid för att vi vet inte, kommer vi att få de här pengarna, alltså ligger vi lite vilande och då finns det risk för att vi skall göra alldeles för mycket under den här korta tiden. Det blir väldigt mycket projekt istället för verksamhetsutveckling.
[cxcix] [SKL] ville sprida det på en ganska *bred* bas och där var inte vi. Så att vi har nog gått lite i otakt när det gäller den delen. … Där tror jag mer det handlar om, när man skall stödja något sådant här så handlar det om uthållighet.
[cc] Och registret är väl bra. Det där palliativa registret och Senioralert och att vi analyserar och tittar på avvikelser och så vidare men, ibland kan jag känna att … man jagar oss i kommunen. … Det är mycket mer så [idag]. Och ibland hänger man inte med som enhetschef och framför allt inte som handläggare om vad som finns, för det går i ett rasande tempo. Och det kanske är någon som sitter på sin kammare och skapar ett dokument och det blir inte den här processen, säger jag som socialarbetare, som det skall vara, utan man krystar fram någonting som ser bra ut. Och då blir det inte bra.
[cci] styr ganska mycket ändå vad vi gör
[ccii] Jag upplever att från politiken kanske vi inte, eller vi får väldigt sällan uppdrag eller uppslag om vad vi skall tillämpa eller så. Det kan ha varit någon [av politikerna] som har varit på någon kurs någon

gång. Utan det är vi tjänstemän som får ta upp det och det bästa är om det kommer från verksamheten direkt själv.

[cciii] ganska okunniga men att de tycker mycket

[cciv] vet inte om de behöver ha det

[ccv] Då frågar de, då är de intresserade och frågar. Men går de inte på utbildningar … eller sammankomster eller så där, då är de inte intresserade heller.

[ccvi] har varit måna om att sprida … ansvaret.

[ccvii] genomsyra organisationen

[ccviii] Vi behöver dokumentera och följa upp mycket, mycket mer än vad vi gör. Emellanåt så är det sådär att det avslutas en insats av någon anledning. Brukare kanske inte vill ha det eller vad det nu är … Då lägger man det i skrivbordet istället för att kanske stanna upp, vad var det som gjorde att det blev så här, att man avslutade insatsen kanske i förtid. Det kan vara intressant, att göra en utvärdering, hur blev det så här, kunde man ha gjort annorlunda?

[ccix] stanna upp och analysera och fundera över saker och ting, och varför gör vi det här och är det det här vi skall hålla på med?

[ccx] Uppföljning och utvärdering, då är det … inte någon annan utvärdering mer än den här så att säga årliga statistiken om ärendemängd, hur många barn är placerade och. Men inte någon [utvärdering om resultat].

[ccxi] Genom att vi precis har genomlyst alla våra processer, så det har varit ett sätt att utvärdera en del eftersom vi har tittat på utredningsprocesser och … olika typer av insatser … Ja, alla de här processerna har vi tittat på.

[ccxii] Det är målstyrt och … nämnden fattar beslut om vilka mål de skall ha för det kommande året och vad man skall arbeta mer specifikt ... Och … det gör vi.

[ccxiii] Vi skall bygga upp [ett] … kvalitetsförsäkrat ledningssystem, för kvalitet. Alla kommuner skall [införa det] … inom socialtjänsten. Och det skall vara även databaserat så att man har ett process-tänk när ansökan kommer in, vad händer i olika områden och hur kvalitetssäkrar man allt … från A till B tills människorna försvinner från processen.

[ccxiv] Det har varje år varit någonting som har varit väldigt aktuellt, [den regionala enheten] och staten, Socialstyrelsen, har alltid haft något område. … Det är missbruk och beroende, gemensamma riktlinjer, sedan har det … börjats den här evidensbaserad, och sedan nu har vi våld i nära relationer som är *väldigt* på tapeten. … Vi har haft tillsyn från Socialstyrelsen så det *måste* vi jobba med. … Och det är därför evidensbaserad ligger *helt* på is. … Och på grund av att vi har haft lite omsättning på personal så har jag inte hunnit ens tänka mig evidensbaserad.

[ccxv] Verkligheten i små kommuner stämmer inte riktigt [med] kraven från omvärlden. Det krävs att vi skall kunna allt och 'fine', men vi måste ta det i, typ en åt gången.

[ccxvi] Där var vi inte riktigt, i den bredden. Utan vi sa, mycket, mycket smalare för … även en stor kommun behöver börja i det lilla. Annars blir vi *bara* förvirrade tror jag. Då är det risk för att vi plockar ned en massa bollar som sedan inte riktigt är genomtänkta. Jag menar inte att det skall ta hur lång tid som helst …

[ccxvii] Det skulle till ett politiskt beslut att vi skulle jobba med [BBIC]. Och det har jag löst. Jag har gjort precis det jag skall göra. Men de [politikerna] frågar inte efter det och jag pratar inte om det och, så det är ingen stor fråga. Vi har ett budgetunderskott … Det är viktigare att förhandla bort ett bilavtal som kostar oss en halv miljon [kronor] mer än vad det gjorde tidigare.

[ccxviii] vi hoppar från tuva till tuva, vi färdigställer inte

[ccxix] Jag vill inte förringa [evidensbaserad praktik], men då här förra året när man drev igång det här, när det blev ett projekt, så blev det för mig, jaha nu är det … *det* spåret. Men var är reflektionen över; hur skall vi faktiskt ta hand om det när vi väl har dokumenterat alltihopa detta, hur skall vi handskas med det?

[ccxx] [SKL och Socialstyrelsen] … behöver ännu mer hålla en linje för de här delarna tycker jag, för de har också en tendens att föreslå vissa metoder och sedan är man beredd att kasta ut det ganska fort. Och då blir det som, de svenska kommunerna, som ren-flocken att far en så far alla och tvärt byter liksom riktning. Och det satsas pengar på det och så blir det inte. Uthålligheten är inte alltid så tydlig, för det är kanske så att det är vissa saker man måste byta ut, medan andra skall man vara lite mer försiktig innan man kastar ut.

[ccxxi] att det verkligen är genomtänkt innan man inför saker och ting, så tror jag det har större förutsättningar att bli bestående

[ccxxii] Det är inte bara vi som sitter här på kammaren och totar ihop en utredning utifrån våra egna, vi har vår egen utbildning och sedan utifrån den forskning som andra bedriver som är specialister på området. Man måste söka stöd hos [kollegor], för naturligtvis har vi inte samma kunskap. Sedan har vi erfarenheten också, som man väger in. … Men det är just i bedömningarna i ärendet som det [förekommer mest].

[ccxxiii] Det är en av våra stora arbetsuppgifter; det är att handleda naturligtvis socialsekreterarna, att hålla i den här grupphandledningen som är att man speglar och vinklar utifrån olika perspektiv och sätt. Och ibland … går man inte så djupt ner i ärendet, man mer skannar av och tittar vart ligger man någonstans och hur ser det ut och vad bör vi tänka på, är det någonting man måste förändra, och går igenom de bedömningar som handläggaren gör och har gjort. Och, finns det tveksamheter och varför, och svårigheter som kan uppstå, kan man göra på ett annat sätt?

[ccxxiv] bygger väldigt mycket på erfarenhet

[ccxxv] huvudpersoner naturligtvis i det här mötet … [och] också som kanske tolkar och kommer med synpunkter, tankar och idéer

[ccxxvi] för att få igång tänket hos handläggarna

[ccxxvii] Den som är erfaren, då är man mer säker i sin roll. Man vet konsekvenserna av utav alla beslut. Det är kanske svårt att se det för en ny socialsekreterare. Och det är tufft att jobba som socialsekreterare inom barn och ungdom för att det är beslut som … påverkar en familjesituation väldigt kraftigt, omhänderta barn och placerar och ifrågasätter föräldraförmågan. Ja, det är väldigt tufft tycker jag.

[ccxxviii] stärka upp så att vi inte missar någonting

[ccxxix] Det är jättebra att åka på nätverksträffar och höra hur andra gör. Och det uppmanar jag mina medarbetare att göra. För man får enormt mycket utav att träffa kollegor och inspirera. Inspireras och inspirera.

[ccxxx] Då kanske man tittar och hämtar influenser. … Just nu så finns det ett stort intresse omkring det här med kost, mattider och sådana här saker bland äldre. Det finns, om det är nere i Göteborg, de har gjort bra resultat omkring det här, att möta upp de äldre, att det inte är vi som bestämmer kanske klockslagen utan det är mer anpassat efter dem som bor där.

[ccxxxi] de har fullt upp med verksamheten, som enhetschef till exempel eller som handläggare, … de har fullt upp.

[ccxxxii] Socialsekreteraren sitter på kammaren och dokumenterar och skriver i journaler och utredningar hela tiden. Så det lilla utrymme som finns att sammanställa utredningar och skriva analys och där försöker vi. … Vi hjälper varandra också, där under handledningen, att har du några tips om något nytt som har kommit inom det här, som jag kan [använda].

[ccxxxiii] lika viktig del, är att få folk att bli intresserade av att *utveckla*, inte bara göra sina arbetsuppgifter utan utveckla verksamheten, för att det är det som det gäller

[ccxxxiv] motivera folk att aktivt leta efter information, att komma med förslag.

[ccxxxv] olika rapporter och studier som har skett

[ccxxxvi] Exempelvis, om man säger incestärenden, då kollar man vad forskningen säger om barnet och så här. Men visst, är det ett område som man bör fokusera mer och utveckla. Att det blir som … mer vardagligt arbetssätt, att man alltid väver ihop.

[ccxxxvii] Det känns säkrare för en själv, då är det inte bara egna funderingar som det många gånger har varit, att du har använt dig själv som redskap för det här. Men nu blir det att man kan luta sig mot forskningen och man kan använda lite grand i utredningen också att forskningen säger så och så i liknande fall. … Man känner sig säkrare att nu har man gjort en korrekt utredning. … Forskningen är med … i utredningen.

[ccxxxviii] Om jag säger, nu skall ni gå igenom alla kontaktpersoner, kolla vem som verkligen behöver och vem som kan gå öppenvård. Och då har jag, den senaste forskningen visar att det är ingen större nytta med kontaktpersoner. Jag är mer trovärdig. … Det är inte mitt tyckande, utan det är verkligen någonting som någon annan har kommit fram till.

[ccxxxix] mer vardagsarbete

[ccxl] Ju mer man vänjer sig att kolla upp olika saker desto lättare blir det.

[ccxli] [Evidensbaserad praktik] försvårar på så sätt innan det blir ett naturligt inslag, så tar det mer tid. Det lättar i slutändan när vi har börjat lära oss det, när det blir naturligt att jag skall kolla forskning då behö-

ver du inte göra det i något enstaka ärende, börja leta efter febrilt att vad säger [forskningen]. … Du bygger upp kunskapsbanken hela tiden så att i slutändan blir det … lättare, för det blir snabbare, bättre bedömningar, beslut och insatser, om du har byggt upp den här kunskapsbanken.
[ccxdii] Jag tycker faktiskt att det som fattas är kunskap från brukare. … Vi gör uppföljningar, sedan följer vi upp hur det är i behandlingshemmet, om det motsvarar våra förväntningar och så vidare. Men inte det här att få direkt information från brukare. … För att, som sagt, vi har inga behandlingshem [i den här kommunen], gäller även barn. Så vi måste lita väldigt mycket på deras [behandlingshemmens] egna hemsidor vilket inte alltid motsvarar det som är verklighet.
[ccxdiii] stannar med att man gör bara uppföljningar individuellt men inte utvärdering
[ccxdiv] Vi behöver utveckla det, inte bara göra det på enskild nivå utan även på aggregerad nivå. Alltså vad ser vi inte bara för den och den och den, utan [även för] den här gruppen, till exempel. Om man tittar på missbruk så kan vi se nu att vi vårdar de som är i åldern 20-30 år. Och där skulle man kunna jobba mycket mer med att utvärdera, naturligtvis den enskilde, vilket vi gör, men finns det något mönster i det här, för att ta det som ett exempel.
[ccxdv] så olika och spretiga, det finns inte någon enhetlighet i ärendena

Chapter 8

[ccxdvi] [Man skall] lyssna mer på klienten, man skall ta in deras synpunkter och motivera dem också. … Men om man tittar på samhället i stort så har det ju, och då kanske det generellt har varit likadant i socialtjänsten att jag tror att kraven ändå har ökat senaste åren på att man skall ha en kvalitet och … då innebär det att de som jobbar i verksamheten ... skall *ha* bra kunskaper och att man skall hålla sig a jour med det som är gångbart och som är gynnsamt.
[ccxdvii] Det skall kunna vara mätbart, så att man verkligen, så långt möjligt, kan se att en insats har effekt. För många insatser är väldigt ingripande [i människors liv] och då måste man kunna erbjuda ett alternativ som är bättre. Det anser jag är viktigt. *Ja … Och det blir en kvalitetssäkring också, tänker jag. Att man, nu blir det inte alltid rätt kanske ändå, fastän man har resultat att gå på. För det är så individstyrt [det vill säga, ett stöd som ges från individens perspektiv], men du har ändå någonting att utgå ifrån. … Och jag tror att det skulle vara en hjälp för oss i slutändan, … ett stöd för oss.* … Ja, och det blir också, tänker jag, en trovärdighetsfråga, faktiskt [gentemot medborgarna].
[ccxdviii] isolerad enhet eller ö, utan [att] vi så att säga följer samhällsutvecklingen och inte lever vårt eget liv på sidan om
[ccxdix] där sitter de inom sina stängda dörrar.
[ccl] Jag tycker det är så pass viktigt det vi gör, det påverkar människor och förhoppningsvis så kan vi ju, tanken är att det skall bli bättre för dem. Och har man evidensbaserade metoder, man har någon grund för de besluten vi fattar, det borde ju tyda på att det är större chans att det går bra för dem, än om vi chanser. … Även om det är erfarenhet man grundar på, kan saker, alltså det förändras mycket i samhället också. Det är svårt att bara gå på det [erfarenheten]. Så jag tycker … det är så pass viktigt för de personerna att det blir rätt.
[ccli] Vi jobbar med sådant som man inte kan ta [på], och då är det lätt att vi får lite flummigt jobb. För jag menar … det går inte att mäta känslor, och hur någon tycker om det. Och då tror jag det är jättebra att vi har någon grund och vet, ja det här fungerar. Så jag tror det är *jätteviktigt* att vi har det.
[cclii] Det är *nog* svårt, vårt jobb. Så det lilla stöd vi då kan få kring vad som fungerar bäst, det är *bra*. Att vi inte bara, på något sätt, sitter och svamlar ihop vårt eget utan att det faktiskt, det är det här som visat sig ge en god verkan att det, det skall vi jobba med.
[ccliii] Ju mer man kan följa upp och se vad har varit verksamt, vad *kan* vi säga, desto tryggare blir jag som handläggare, också att föreslå insatser och inte bara komma med förslag för att på något sätt ha en insats utan att egentligen veta att den hjälper.
[ccliv] har känts väldigt godtyckligt tidigare
[cclv] det känns otroligt betryggande att vi har BBIC att utgå ifrån
[cclvi] Det är utifrån de behov som jag bedömer att familjen har. … Någonstans grundar jag mig på de teorier som finns om barns utveckling, det gör jag. … Sedan, det är … alltså utifrån barnets behov, som jag ser det, och visst önskemål från familjen också. Man försöker hitta en balans. Ja, det skall vara en balans däremellan.

[cclvii] Det innebär att jag i möjligaste mån planerar för, sätter in insatser som jag bedömer skall kunna uppnå de här … målen som man har och att varför jag liksom grundar mig, varför tror jag att den här insatsen fungerar för de här problemen. Och att man … ändå försöker och … när man inte vet då är det jättebra att försöka hitta vad säger forskningen, vad finns det för fakta om det här när man skall göra. Jag menar om jag skall göra ett umgänge eller om jag skall sätta in en insats då försöker jag se om jag kan, om inte jag vet eller mina kollegor vet, att jag försöker söka efter det i möjligaste mån.

[cclviii] Om jag tänker att jag med evidensbaserat arbetar enligt BBIC och jag gör de här Home-intervjuerna, det är ändå att jag på något sätt har någon form av. Ja det är någon som har forskat fram att det här är *bra*, att hålla på så här, att man gör det på det här sättet tänker jag.

[cclix] Jag vet inte hur … evidensbaserat [Trappanmodellen] är, men när vi har gått Trappan-utbildningen så har vi kunnat säga att forskningen visar att det har liksom fungerat och att man har prövat och att det har fungerat. Och då är det jättemycket lättare för mig att prata med pappor till exempel som är skeptiska till att, ja de vill kanske inte ens tillstå att de har slagit sina kvinnor eller att barnen skulle ha farit illa av det och så. Det blir som ett stöd.

[cclx] Att det har visat sig att det fungerar, tänker jag, att det är forskningsgrundat på något vis.

[cclxi] Allting är utarbetat med hjälp av forskare på de här olika områdena för att det skall vara ett heltäckande system, man har tittat på det juridiska, utvecklingsmässiga, psykologiska, sociala aspekter.

[cclxii] Det skall inte vara mitt eget tyckande och tänkande, mina egna värderingar. Det skall vara någonting som man ser i forskning och i praktiken har betydelse för enskilda människor … ungefär som med medicinering och så. Det skall vara testat att medicinerna har effekt på just de här problemen, eller hur man nu skall säga.

[cclxiii] Jag tycker vi försöker jobba seriöst och hänga med. … Jag har alltid känt så här, vi är en liten kommun … och det är viktigt att vi håller oss framme. … Vi skall inte bli några, hur skall jag säga? Vi får inte framstå som att vi här är vi helt borta. Så att det känns som att vi har hela tiden under åren, försökt plocka med oss [ny kunskap]. Och ibland tänker jag att vi är mer lyhörda än andra [större] kommuner därför att de har en organisation som kan ge det här. Här måste vi själva försöka plocka upp vad som är nytt och på gång och. *Alla vill göra ett bra arbete och vi tycker det är spännande med nya infallsvinklar och så. Och det gör också att man är benägen på ett annat sätt att söka ny information och fundera kring, jaha nu brukar vi göra så här men hur skulle vi kunna göra det här bättre? Sedan räcker tiden inte alltid till … Det finns en strävan i alla fall.*

[cclxiv] Det är väl det här att inte grotta ned sig i … sitt eget lilla spår här och tänka att, ja men så här tänker jag. Utan man måste ändå vrida och vända på saker och se vad finns det för kunskaper kring det här problemet eller det som har uppstått, eller. Ja och … praxis, vad brukar vi göra. Men det kanske inte stämmer in just på den här familjen eller det här barnet eller den här ungdomen, att här ser det annorlunda ut. … Det är inte så enkelt. … Det finns inga mallar men man måste på något vis ta in kunskaper från olika håll.

[cclxv] en kombination av forskning, min kunskap och klienternas kunskaper och önskemål och situationer

[cclxvi] Och Gud vilken svår fråga. … Jag tycker inte att jag i vardagen pratar så mycket så, evidensbaserat.

[cclxvii] Men Gud, ursäkta så svåra frågor. … Det är lite bökigt känner jag att svara när jag är så pass ny.

[cclxviii] Jag vet bara inte vad det *betyder*, evidensbaserat.

[cclxix] Ja men *gör* jag det? Jag vet inte om jag gör det.

[cclxx] Ja, [evidensbaserad praktik] tycker jag är viktigt, men … så känns det inte som att vi vet riktigt vad det är eller, kopplingen är inte given där. … Det är lätt att säga att det är *viktigt* men vad, *vad* är det? … Men jag tänker att det är viktigt att man liksom vill göra så bra som möjligt … för barnen alltså. Men ja, jag vet inte. Jag tycker det … är svårt att få ihop det där glappet tror jag.

[cclxxi] Det blir inte riktigt konkret [under utbildningen] hur det fungerar i praktiken i och med att det är teorin man då läser och man kan prata lite hur det skulle kunna utföras i praktiken. Men det är ändå inte i den omfattningen så man har nytta av det … på det sättet nu när man väl *är* ute i praktiken. Man hade ingen aning om att det kanske skulle vara så här.

[cclxxii] Jag har varit på flera [träffar om evidensbaserad praktik] men det är en sak att få informationen … hur det skall gå till. Men vad det innebär i praktiken är ju en helt annan sak.

[cclxxiii] Jag tycker att det är som en glipa mellan … när man pratar evidensbaserat och när man sedan är i jobbet [på individ- och familjeomsorgen] att det har inte nått ihop riktigt eller man har inte tid att sätta ihop det, eller vi pratar inte på det sättet i verkligheten. Alltså att det är som olika världar. … Om jag tänker [på regional nivå] så pratar man liksom evidensbaserat och så kan jag höra mina [lokala] chefer

säga att de har varit [till den regionala enheten] eller haft kontakt med då. Och så tänker man, oj hur och vad skall vi göra av det nu på hemmaplan och så? Men sedan hör jag mina kollegor och då är de liksom mer i verkligheten och *där* har det inte nått ihop riktigt, tycker jag. Utan de jobbar på och, jaha men vad då evidens? Alltså det finns inte och man hinner inte ens knyta ihop det och man hinner inte resonera, upplever jag. Där är glipan liksom.

[cclxxiv] Det är svårt att säga att man tar kunskap från Internet. Ofta är det saker man har lärt sig … genom utbildningen. Sedan kollar man upp vissa saker på nätet. Det finns hemsidor för olika utbildningar, och Socialstyrelsen har mycket kring BBIC … som man kan läsa.

[cclxxv] Ja jag har varit på några stycken, men det är ju bara jag.

[cclxxvi] [Min kollega] är helt suverän på att hitta liksom på nätet eller få tips och idéer, och så drar hon ut det till oss alla. Ja, och då läser man det.

[cclxxvii] försöka prata, väcka frågan och sedan ändå tillsammans försöka, är det någon annan som vet om det finns någon evidens bakom den här frågan

[cclxxviii] Man måste vara väldigt försiktig med hur man söker på Internet och vilken typ av information man får. För, vilken är källan? … Det gäller verkligen att vara noga med vilken källa man använder.

[cclxxix] Att man bara är ute och googlar på någonting och så kommer det upp avhandlingar och så, men man vet ändå inte riktigt vad det är som finns. Så att Socialstyrelsen är ju också, deras bank av kunskap känns som att den är lite mer tillförlitlig. … Där kan vi sitta och läsa.

[cclxxx] Och det jag tänker också … det här med forskning, den ändras ju över tid. Så … man vet inte vad som är idag och vad som var förr, så det är svårt. … Är det här det sista man har sagt i forskningen, och så här?

[cclxxxi] bara man orkar, orkar leta nog länge.

[cclxxxii] Jag har alltid med mig forskning, så är det ju, absolut. Det ger grunden till allting. … Om jag inte har med mig det … då kan jag tycka kanske att, men nog verkar det alltså, det fungerar bra.

[cclxxxiii] Då jämför man med den kunskapen man har haft tidigare och om man skall lägga om den på något sätt, om man skall fördjupa någonting, göra det på något annat sätt, lägga till någonting, dra ifrån någonting.

[cclxxxiv] vet varför vi beslutar det här, varför vi tycker som vi tycker.

[cclxxxv] Mycket litteratur [som jag använder] är det man har. Så att man har någonting att stå på i utredningarna. För man kan inte komma med sina egna värderingar och åsikter vad som anses, vad man skall säga, [är] normalt eller inte. … Vi säger vi har en ungdom som har ett riskbeteende, konsumerar droger eller … gör kriminella handlingar. … Ja då har vi en bok som jag använder mig av, som den här forskaren då har tagit fram olika riskfaktorer med de här beteendena och, så att *det* väver man in då i själva utredningen. Så att man inte kommer med egna åsikter.

[cclxxxvi] Mest blir det i utredningar [som kunskap används], alltså i själva skrivandet. Sedan kan man, visst kan det bli så i en del ärenden, kan man få ta med föräldrar. … Ibland får man försöka motivera och förklara på olika nivåer. … Det här har visat sig, och, forskning har visat si och så. För att försöka få med dem mer. Men mest är det i skrivandet. Det är det, för mig i alla fall.

[cclxxxvii] Det är sådana här gånger som när man skall göra ett LVU. Då har vi, jag vet att jag gör det. … När det gällde anknytning och då försökte jag hitta hur jag skulle beskriva och vad … säger forskningen om sådana anknytningsskador. Men, jag letade och vi resonerade jättemycket och *jag* kände någonstans att, nej det här är så svårt att uttrycka och säga för att rätten är mycket van vid att har barnet blivit slaget eller dricker mamman eller, man skall ju ha bevis. Hur skall man bevisa anknytning? Hur skall man beskriva anknytning? … Men det gick inte i rätten. Och där kände jag jättemycket att jag hade velat ha mycket mera sådana där argument. Alltså att där hade jag kunnat på något sätt hänvisa till.

[cclxxxviii] Det är när det blir så där skarpt läge men annars går man liksom på, och … när föräldrarna är med … då pratar man ju som mer och … kommer överens och … man har inte något behov, tror jag, heller av att säga att det här är evidensbaserat. … Det är när man skall förklara syfte och försvara sig [som] man behöver det mer.

[cclxxxix] Man kommunicerar alltid och då måste man … få klart att det här är inte bara någonting som jag tycker. Det är inte så att jag bara slänger mig med att, det är inte bra att du dricker. Men, det här vet vi att det blir skadliga effekter, det är inte någonting som jag tycker. … Det är någonting som är forskat kring som har visat på att barn faktiskt mår. Alltså, man måste få den enskilde att förstå att det ligger mer bakom, det är inte bara jag, någonting som jag säger.

[ccxc] Jag tror att *ingen* gör en bedömning utan att samråda. … Om det inte är väldigt enkla saker, typ att du beviljas försörjningsstöd utöver normen på grund av sociala skäl, eller något sådant. Men handlar det om mer svåra, det kan vara beslut som påverkar en familj väldigt mycket. Sådana beslut, tror jag, det gör ingen utan att man har en bra bedömning med sig, tillsammans med [närmaste chef] och med kollegor också. Så att, det blir inte så där på en höft i sådana beslut.
[ccxci] Vi diskuterar mycket ärenden med varandra. Och bollar fram och tillbaka idéer. Det gör vi i de flesta ärenden, … annars kan … mina egna tankar och funderingar och värderingar påverka mitt sätt att tänka. Så jag tycker att det är jätteviktigt att man diskuterar.
[ccxcii] Och sedan tycker jag om lite grand att diskutera. … Har jag missat någonting, är det något annat jag skall tänka på eller skulle det kunna se ut så här, och. … för det är det som gör att man utvecklas också. Och jag menar det finns så många infallsvinklar i alla våra ärenden och alla ser olika saker för alla har vi med oss olika erfarenheter, både privat och i jobbet.
[ccxciii] Det hade varit lättare att komma till ett ställe var det är en grupp med mer erfarna. Det tror jag. Alltså nu känns det som, vi har varit några nya som kom samtidigt och … [vi] funderar ihop.
[ccxciv] Det finns inget facit, vi måste diskutera de här bedömningarna och då använder vi varandras kunskaper.
[ccxcv] Det är varandra som vi har som stöd. Alltså jättemycket så att vi springer in hos varandra [på kontoren] och frågar efter konkreta exempel. Alltså, vad har, hur har du skrivit i din utredning eller var läste du det där som du sa, eller hur tänker du om det här? … Det skulle vara jättetufft att vara helt själv i det här jobbet. Vi använder det jättemycket.
[ccxcvi] Det skulle inte gå att jobba utan dem, kan jag känna. Därför att … det skulle inte bli så bra bedömningar om jag ensam skulle möta en familj och ensam skulle sitta på mitt rum och tänka, hur skall jag göra nu. Och vi har ändå olika saker med oss i bagaget och kunskaper. Även om vi har samma utbildningsbakgrund så är det så att man är jätteberoende av varandra. Man är ett stöd för varandra också.
[ccxcvii] Vi kände just det här behovet av nätverksträffar, i och med att vi bara är [ett fåtal som arbetar här]. Vi vet inte var vi är på väg, hur skall det se ut? … Och det har varit jättebra. Och jag blev glad när jag var i [grannkommunen] för då var det ju de som hade jobbat jättemycket med BBIC och var lika osäkra som jag var. Det kändes, men det är inte bara jag.
[ccxcviii] för att där kan man bolla och det kommer fram, jaha men gör ni så, ja men vi gör så.
[ccxcix] Vi har haft socialsekreterare som har jobbat här i trettio år som har väldig erfarenhet. … Det har inte varit så mycket ruljangs på personalen här, så att det har funnits jättemycket kunskap och erfarenhet här.
[ccc] Det behövs och eftersom vi är så många nya så är det lite annorlunda. Ingen erfaren kollega som har många år och vet och kan mycket.
[ccci] Vi tar upp när vi har kört fast i ärenden eller om vi funderar kring det här med insatser; har jag tänkt på rätt insats. Och … det är inte bara [chefen] som pratar utan hela gruppen får, om någon frågar någonting så kan hela gruppen ge synpunkter; vad tänker du och vad tänker du och vad tänker du? Så att man får höra.
[cccii] lite grand mer … utifrån oss som människor och inte bara socialarbete
[ccciii] som tar mycket energi
[ccciv] arga föräldrar eller samarbetspartner
[cccv] Sedan är det olika beroende på om det är en frivillig insats eller om det är en insats med tvång. Där är det svårare att få med en klient eftersom de per definition inte håller med oss om vad vi [föreslår].
[cccvi] Ibland kan jag bedöma att en familj är i behov av stöd via vår öppenvård, att de skulle behöva ha stöd i föräldrarollen. Men föräldrarna vill inte ha något stöd och då kan jag inte göra så mycket utan då avslutar man utan insats, men skriver *att* det finns en oro och att man tycker att de hade behövt men att. Men det är en frivillig insats så att det är som ingenting man kan tvinga på dem.
[cccvii] Jag försöker alltid uppmuntra dem till att de själva också alltid skall ställa frågor som de har och det här att om de känner att … det är någonting som de inte förstår eller någonting som de känner att, men varför gör vi det här. Ja men att de lyfter det med mig just bara så att jag kan förklara eller att då få göra sin röst hörd. Det tycker jag är viktigt, att de får komma till tals
[cccviii] myndighetsutövande
[cccix] Hur mycket man än vill … ha brukarmedverkan.
[cccx] Blir det en insats så måste man följa upp. … Man följer upp och ser och, är det här rätt … insats. Och det kan sedan hända att, ja nu har det varit ett tag då … att [brukaren] kanske inte behöver det.

[cccxi] är det inget vi följer upp sedan
[cccxii] återkomma själva om de känner att situationen har förändrats.
[cccxiii] Det är frivilliga insatser så det är ingenting som vi gör.
[cccxiv] Vi pratade om det ganska många gånger för det kändes som att vi skulle behöva göra, för varje gång man avslutar en placering eller en öppen insats med öppenvård eller kontaktperson, kontaktfamilj så skulle man ha behövt göra någon uppföljning kring, eller dokumentera; hur, vad var det som var lyckat, vad var det som gjorde att det fungerade och att man ändå nådde målen? Men det var som att varken … tid eller plan fanns för hur det skulle se ut. … Vi har för mycket annat att göra. … Men det hade varit bra därför att det skulle gynna oss i jobbet och gynna klienterna.
[cccxv] Det är ju bestämt att vi skall använda BBIC, … nämnden har beslutat det.
[cccxvi] Ja just BBIC … men jag vet inte alls vad gäller andra.
[cccxvii] Nej ingen aning
[cccxviii] Jag vet egentligen inte om vi har. Ja klart MI och BBIC skall vi ju jobba efter. Men sedan är det väl inte. Jag vet inte, det är väl inte egentligen … så jättehöga krav *så*.
[cccxix] Från politiker känner vi ju inga [förväntningar].
[cccxx] Det är ingenting som jag har hört någonting om.
[cccxxi] det förmedlas att vi skall sträva efter att jobba evidensbaserat
[cccxxii] Det blir mer och mer att, jag menar skall man skriva ett förslag till beslut till … [politikerna] om en placering så skall det vara grundat dels i behoven, alltså man gör en riktig … beskrivning, vilka risker kan det här få för det här barnet. Och sedan också motivera varför tänker jag just att personen i fråga skall få den här slags hjälpen. ... Men visst börjar det ställas högre krav på att … det skall vara välmotiverat och grundat.
[cccxxiii] Cheferna vet inte så mycket om BBIC som jag och min kollega vet, för vi är utbildare. ... Och cheferna vet heller inte, politikerna vet absolut inte, de vet inte ens riktigt hur utredningarna skall se ut eller hur de skulle kunna gagna barnet bäst.
[cccxxiv] Det ställs inga förväntningar. Vi skulle nog vilja ha mer förväntningar på oss, att man hade en önskan om att faktiskt driva det. Men det finns lite liten tanke med vad vi skall göra egentligen. Förutom att hålla kostnaderna nere.
[cccxxv] Jag tror inte de tycker att de ställer några överkrav på oss, liksom uppifrån, från ett politiskt håll. Nej det tycker jag inte. Jag kanske tycker att de skulle kunna få vara mer tydliga med vad de vill. … De måste också vara mer insatta, de jobbar inte med det här daglig dags, men de måste också läsa mer och lära sig mer, så är det. För att kunna vara tydliga. Man måste som ha en enad hållning.
[cccxxvi] Då måste vi ha förutsättningar att *kunna* använda det, för att det tar tid att ta till sig ny kunskap och sitter vi liksom med ärenden hit upp då, det krockar. Du hinner inte lära dig det du behöver för att kunna utföra ditt arbete. Så att då måste det till resurser. Alltså skall det vara ett rimligt, att vi blir bättre på det här, då behöver vi också resurserna därefter.
[cccxxvii] helt *rätt* förväntningar
[cccxxviii] Kärnverksamheten skall prioriteras och allt annat utöver, det får bli om … det här *skall*, till exempel från Socialstyrelsen. Och det här med evidensbaserad praktik, ja, jo visst, men rent praktiskt då? Och … vi är få här, om någon skall åka iväg på någonting eller det är information om något då, det är alltid i relation till i övrigt.
[cccxxix] Ja jag tycker det finns … en otrolig kunskap hos den [närmsta chefen] jag har [om BBIC]. Och är det någonting hon är tveksam inför då vet hon vilka vägar vi skall gå för att hitta rätt [lösningar].
[cccxxx] Jag tror att de behöver mer. … Jag tänker generellt att det är så. --- Jag har ingen aning om hur [närmsta chefen] tänker eller vad hon vet.
[cccxxxi] Hon är väldigt, otroligt på banan, min närmsta chef. Hon … kollar, läser i, informerar om att, jag har läst en så bra bok. Och nu skall vi börja med de här [träffarna] och jobba aktivt med vissa böcker. Så att hon är väldigt intresserad och otroligt kunnig person.
[cccxxxii] Det är också så otroligt personbundet vem man har som närmsta chef. Och det är lite farligt för det är så mycket det i socialt arbete, så otroligt personbundet.
[cccxxxiii] Det skiljer mellan [cheferna], så att den samlade förmågan är nog ganska hög. Sedan så, kanske på individnivå, så är det någon som har lägre, tror jag man kan säga. … Sedan är det någon som [har högre kompetens], beroende på intresse och erfarenheter man har.
[cccxxxiv] Jag tycker inte vi har så mycket diskussioner om det. Så det är svårt att veta. Jag tror de är positiva men jag vet inte hur mycket man jobbar för det.

[cccxxxv] När det gäller evidensbaserat så tycker jag inte att man, man uttrycker det i alla fall inte på det sättet. … Man pratar inte om det på det sättet. Men om man tänker BBIC känner jag att det har funnits en förväntan att jag skall driva det [som BBIC-utbildare]. … Men annars, är det aldrig så att man säger att, ja men nu är vi, liksom utifrån. Alltså, man använder inte de begreppen.
[cccxxxvi] Jag har bra med tid
[cccxxxvii] tvungna att *ta* oss den tiden.
[cccxxxviii] Men det vete tusan när man, skall man liksom ligga hemma på kvällarna och läsa?
[cccxxxix] Men det är sådant man får läsa hemma, alltså på fritiden. --- Sedan har man ju sina böcker här som man då slår och hittar i. Men just läsa vidare, det är en fritidssyssla.
[cccxl] och det är klart att det blir en påfrestning
[cccxli] Det handlar … om den här tidsbristen och att man inte prioriterar det.
[cccxlii] alla här vill bli duktiga och alla här ser behov av att man vill lära sig mer inom olika områden
[cccxliii] Det måste gå så fort så att jag hinner inte tänka till eller jag ger inte [mig själv] tillåtelse att ta den tiden att reflektera, helt enkelt. Utan skulle jag … om jag stöter på ett problem att jag skulle ta min litteratur och tillåta mig att läsa och titta och reflektera, ja men ja, jag gjorde ju rätt, nej jag gjorde fel, jag kanske skulle ha tänkt så här, eller. För ofta så kanske man inte ens kan ta med frågan i [arbets-] gruppen för jag vet inte hur jag skall tänka eller diskutera eller resonera. Så man kanske skulle få lite mer tid från start, från början, kanske.
[cccxliv] Nej inte mer än bara antal ärenden och antal placeringar. … Ingenting ur liksom det perspektivet, vad fungerar, vad fungerar inte?
[cccxlv] Men de kan fråga hur många placeringar vi haft och hur många placeringar vi tror att vi kommer att ha. … Det är oftast ekonomisk karaktär på de frågorna.
[cccxlvi] Med BBIC tänker jag att man skall inte tänka på vilka insatser som finns utan man skall göra, tillverka de insatser som behövs. Men nog är det lätt att man hamnar i de spåren att … föräldrar och barn får de insatser man redan har, sådär.
[cccxlvii] På något sätt fungerar det fast man inte är nöjd alltid, och ofta är det så att det inte blir bra och då vet man inte om det är för att man har fel insats eller om, ja vad är vad i det här. Man får ta många svängar, flera gånger.
[cccxlviii] Det är lite svårt kan jag väl tycka i en liten kommun. Vi har inte så mycket insatser att komma med. … Så att det känns, öppna insatser enligt SoL kan vara svårt att tillgodose i en liten kommun.
[cccxlix] Vi vänder och vrider ut och in på oss själva. Det gör vi verkligen men i vissa fall så känner man att det skulle ha behövts andra insatser, helt klart.
[cccl] På något sätt skall man vara handlingskraftig i det ärende du har, och sedan får man titta då vad som finns att tillgå. … Det är en liten kommun, det är inte specialiserat och [det finns inte] hur stora valmöjligheter som helst, heller.