Efforts of mobilization in the care of drug abusers

- the role of standardized assessment instruments in collaborative work

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Introduction

Collaboration is charged with positive connotations and there is a general assumption in the literature that collaboration is a factor that increases the possibility of success when e.g. new programs in the public sector are implemented. The importance of collaboration is also taken for granted at work as well as across organizational borders – in fact everywhere and constantly. The most obvious benefit of collaborative work is the exchange of knowledge and experience. Other benefits are possibilities to influence decision-making and prospects of receiving rewards. The costs of collaboration are rarely pointed to. There is however, an increased interest in deciding whether organizational changes introduced to improve collaboration, in fact serves the interest of the citizens or not.

Research within different fields has contributed to the knowledge about collaborative work. To mention just a few, research has be carried out in the fields of collaborative management, cooperation, coordination, collective action, networking, and boundary work. However, to create a common understanding of what is known about how to improve collaboration and possible outcomes collaboration involves some difficulties that is related to the specific features of the various perspectives taken. For example, scholars who use network theory tend to focus on structural variables, and thereby disregarding critical components of collaboration such as "*1) an appreciation of the uniqueness and differential strengths and weaknesses of governments, non-profit organizations, businesses, and communities; (2) ongoing process dimensions, including leadership broadly defined; and (3) the dynamic nature of collaborative development*" (Bryson, Crosby & Stone, 2006: 52). These components have been devoted great interest from researchers looking at collaboration as collective action, although without offering a sufficiently rich theoretical base. These findings are however easily translated to practice and communicated with practitioners. Knowledge development within the field would thus have much to gain from relating observations of different perspectives to one another.

In the public sector, collaboration is now considered to be a necessary condition for managing duties. According to Vigoda (2002), the requests for collaboration can be seen as a reaction to traditional bureaucracy with its disinclined attitude to people's needs. Collaboration is seen as the solution to get around the problems originating from years of hierarchical control which have created *administrative boundaries* and complexities in public management (Huxham, 1996, 2000; Glouberman & Mintzberg, 2001a; Sullivan &

Skelcher, 2002; Kelner, et al., 2004; Shuval, 2006; Verhoef, Boon, & Mutasingwa, 2006; Blomgren Bingham & O'Leary, 2006). Collaborative public management can be defined as "the process of facilitating and operating in multi-organizational arrangements to solve problems that cannot be solved, or solved easily, by single organizations" (Agranoff and McGuire, 2003:4). Further, collaboration can be blocked by the way the public sector is governed by laws and decrees and by its nature of referring to specific professional fields - *occupational boundaries*. Nevertheless, the public sector has increasingly opened up for initiatives taken by local actors to solve problems, to search for bases for concerted action and to govern through networks. Such processes serve the purpose of facilitating interaction, resolve different positions and reach mutual agreements where citizens are important actors (Barnett, 2003). However, despite an increasing body of empirical research on collaborative management in the public sector, there is still much to learn about how collaborative work between agencies and organizations affects the implementation of new policies and procedures (McGuire, 2006). *"As a result, we do not yet have a higher-order theory to help public managers make informed choices about the participants, goals, likely outcomes, design, implementation, evaluation, or institutionalization of collaborative governance*" (Blomgren Bingham & O'Leary, 2006:161).

In the public health care, as in the public sector in general, different types of devices have been introduced to secure the intended outcomes of national policies and programs. For example, attempts have been made to secure minimum levels of treatments on a national level and to standardize denominators for investigation and counseling work. This paper uses the introduction of a *standardized assessment instrument* in the care of drug abusers, as a case study (for a complete description of the case study see Wikström & Lindberg, 2006). This instrument was introduced by the Swedish Ministry of Health and Social Affairs in order to improve care practices by developing a sustainable model for knowledge based and individualized care of drug abusers. The question discussed in this paper is how such an instrument does affect collaboration and practice. To answer the question, we propose in the first section that improving health care practices – or any practices – can be understood in terms of *establishing a community of practice*. The second and third sections of the paper are based on an empirical study of *The Role-Model Municipality Project*, which is part of the response of the Swedish of Health and Social Affairs to increased drug abuse. We particularly look into achievements of improved practices of the involved

parties, i.e. people employed by municipalities (social services), county councils (health care), and by Prison and probation service. Finally, in the concluding section, the empirical observations are related to existing knowledge about collaborative work in health care.

Understanding collaborative work as establishment of a community of practice

Collaborative work, in this paper, is seen as involving efforts of two or more organizations which use their respective resources to accomplishment a goal. This can occur through *intermittent coordination* or *temporary task forces*. The degree of adjustment of the organizations varies as well as the duration of the collaboration. A *permanent and regulatory coordination* is based on formal agreements of recourse exchange, which means that the risk taken by the parties can be reduced. The form of collaborative work that involves most personal contacts is commonly labeled *coalitions or networks* and the most far-reaching network is called *action network*. However, to capture the complexity of collaboration different perspectives have to be bridged. In this paper we introduce the notion of *community of practice* in an attempt to contribute to this well needed bridge-building.

A community of practice builds from mutual engagement from the members (Thompson, 2005; Sapsed & Salter, 2004; Bechky, 2003; Wenger, 2000, 1998; Brown & Duguid, 1991). One important definitional feature of a community of practice is the boundaries of the community (Wenger, 1998). The boundary setting is produced by negotiations of a meaning between the members, which establishes a common vocabulary. Wenger (1998) argues that this negotiation of standards and responsibilities results in relations of mutual accountability concerning accepted actions and repertoire. These relations of accountability will therefore include a system of standards that the community has agreed upon, in accordance to their definition of what is good and appropriate or bad and inappropriate. To produce accounts that demonstrate our responsibility there is a need to relate to requirements of information other people may have about what basis we have for our actions (Garfinkel, 1984). In this way, links and interrelationships to others are established through interaction (Silverman & Jones, 1976; Gibb, 1978). To consider ourselves as personnel or members of an organization, we need to be able to account for both our actions and our accomplishments (Czarniawska-Joerges, 1996).

Collaborative work has also been found to be dependent on the existence of *boundary objects* (Engeström, 1990; Bowker & Star, 1999). Other studies point out the production of *narratives* as a decisive factor (Gabriel, 2000). Still other studies highlight the direct antecedents of collaborative work, i.e. *linking mechanism*. Linking mechanisms are for instance a "legitimate convener, a shared problem definition that identifies interdependence and shared interests, and prior relationships that lead to trust" (Blomgren Bingham & O'Leary, 2006:162).

Boundary objects

Engeström (1990) has observed that tools, material arrangements or other objects can mediate activities. Engeström et al (2003) develop this discussion further in their study of how people from hospital and local primary care health centers establish ways of working across boundaries in order to provide care of chronically ill children. In their study, a new notion of collaborative medical work is developed, "negotiated knot working". The knot working was built around care agreement. A care agreement can be described as a boundary object (Star & Griesemer, 1989). A boundary object has different meanings in different social worlds, although the structure of the object is common enough to make it recognizable in more than one. Bowker and Star (1999:297) argue that boundary objects are "*those objects that both inhabit several communities of practice and satisfy the informational requirements of each of them.*" Boundary objects act as means of co-ordination and delimitation at the same time. The co-ordination refers to possibility of people gathering around and connecting to the object, meanwhile the delimitation refers to how the object itself defines why they do gather around it. In other words, a boundary object is a way of working in a specific setting, in which different professional occupations meet and collaborate across boundaries to solve heterogeneous problems (Star, 1989).

Without an object that is possible to refer to by the involved parties from different organization, collaborative work cannot be established. However, it is not sufficient to have a common object for the efforts of the involved parties. The object has to be *plastic* enough to be adjusted to local needs and limitations and at the same time robust enough to secure an identity that is understood in similar ways in different contexts. Standardization may therefore be seen as a possible solution to problems of establishing collaboration involving different competences among care-providers (Bowker and Star, 2000). According to the

literature, standardized assessment instruments can function as boundary objects that facilitate such collaboration. Whether or not a standardized assessment instrument will facilitate collaboration, is dependent on its ability of becoming naturalized within the communities of practices involved. If not, it will become a *monster*, threatening to obstruct the possibility of collaboration – and in the worse case obstruct existing and well functioning communities of practices. Furthermore, the role of standardized assessment instruments in providing the marginal care-providers with influence over the treatment practice is crucial.

Boundary experiences

Managing organizational boundaries is important since it works as a threshold for uncertainty exposure from the environment by excluding threats and including possibilities. It is also important because boundaries work to bind structures by producing and reproducing internal unity. In order to create a sense of belonging to a community, common experiences are important. "Field trips, bus tours, project, joint problem solving, and community activities" (Feldman, Khademian, Ingram, & Schneider, 2006:94) are examples of activities that can facilitate for people and organizations to cross boundaries. Such experiences can be spontaneous, but can also be planned for. Belonging to an organization means one has acquired a specific "*understanding of the organizational realties and an interpretation of these in relation to environmental realities*" (Llewellyn, 1994:20). Whether the understanding of "organizational realities" etc. has to be shared or not – or to what degree it has to be shared in order to be called a community, is a question of dispute. However, this disagreement may be dissolved by the ideas behind collective action (reference), were practices are assumed to be the accomplishments of competent members of collectives. Competent members act together, and are concerned about coordinating and aligning their actions to one another: "[…] *when people participate in a particular practice their actions express understanding rules, teleologies, and affectivities that number among those organizing the practice. This means that what makes sense to them to do is determined – at least in part – by these phenomena.*" (Schatzki, 2001:54).

Becoming competent within a field involves learning to practice conceptual knowledge in problem solving related to real-life situations, i.e. *understanding the vocabulary* belonging to the field and *being able to enact it*. Ability to communicate in an understandable way is

crucial for an individual that wishes to be perceived as trustworthy to other people. Such an individual will have greater possibilities to influence and change prevalent practices. "*It is part of the nature of a shared practice that learning what it is and enacting it is inseparable. This is one reason why shared practices change."* (Barnes, 2001:25).

Boundary organizations

Inter-organizational collaboration raises issues concerning control and governance. Politicians, belonging to rightwing as well as leftwing parties, have advocated an introduction of market solutions to the problem of public sector efficiency, not solved by hierarchical control. The rhetoric behind is based on the assumption that competition will lead to increased efficiency. However, increased competition may as well harm trust-relations and hinder lasting improvements (Entwistle & Martin, 2005). Collaboration has been up for discussion from time to time for over three decades as a way to overcome fragmentation and transcend the dualism of "market versus hierarchy" (Lewis & Surender, 2004, p. 71). Collaboration and collective action is dependent on three basic things: reciprocity, trust, and reputation. *"As collaborative partners interact and build reputations for trustworthy behavior over time, they may find themselves moving away from the more contingent 'I will if you will' reciprocity to longer term commitments based on institutionalized 'psychological contracts'*." (Thomson & Perry, 2006: 28). This takes place when personal relationships supplement formal organizational relationships, psychological contracts replace legal contracts and informal understanding and commitment complement formal organizational agreements. Trust is thus what is needed for inter-organizational relationships to be sustained over time. Trust plays a prominent role in collaborative work since a common belief of a group is that another group will 1) make "*good-faith efforts to behave in accordance with any commitments both explicit and implicit*," 2) "*be honest in whatever negotiations preceded such commitments*," and 3) "*not take excessive advantage of another even when the opportunity is available*" (Cummings & Bromiley, 1996). Although there is a general agreement about the time need to build up trust together with a continuous personal interaction, less is known about how to facilitate the trust building process between parties. The management of trust is thus problematic (Entwistle & Martin, 2005), especially when time restrictions to establish such relations are present, or to put it into other words, "*create trust where you can; find alternatives where you can't*" (Moyanihan, 2005).

The Role-Model Municipality Project

The motivation for choosing the present case is the assumption that improved care of drug abusers is dependent on collaboration and a stronger care-chain between authorities and care provider organizations with different principals. In order to achieve this, great expectations were attached to the idea of introducing the standardized instrument at different organizational levels and by various educational programs aimed at learning to use the information obtained by the instrument.

Intentions of the project

The Swedish Ministry of Health and Social Affairs launched the *Role-Model Municipality Project* (*RMMP*) in 2004. The aim was to stimulate the development of a sustainable model for knowledge based and individualized care of drug abusers. 1.800.000 EUR was invested in the change program. The project was a countermeasure to severe consequences of drug abuse that has been, increasing steadily since the 1990s (see Diagram 1). Also, during the period in question, there had been cuts in the budget for drug treatments.

A National Drug Policy Coordinator was commissioned by the Swedish government to implement and follow up a National Action Plan and to coordinate measures against drug use at a national level. In order to fulfill this mission, the Swedish National Drug Policy Coordinator set up an office called *Mobilization against narcotics/drugs* (MOB). The Swedish Government provided MOB directly with its funding, and it was thus not part of the budget of Ministry of Health and Social Affairs. One reason why MOB was established, instead of giving the assignment to a board or authority under the administration of the Ministry, was that issues concerning drug abuse did not fit in to one area of responsibility. Another reason was to give drug policy issues an increased political priority. As a consequence, the National Drug Policy Coordinator was accountable to the Swedish Government instead of the Health Ministry.

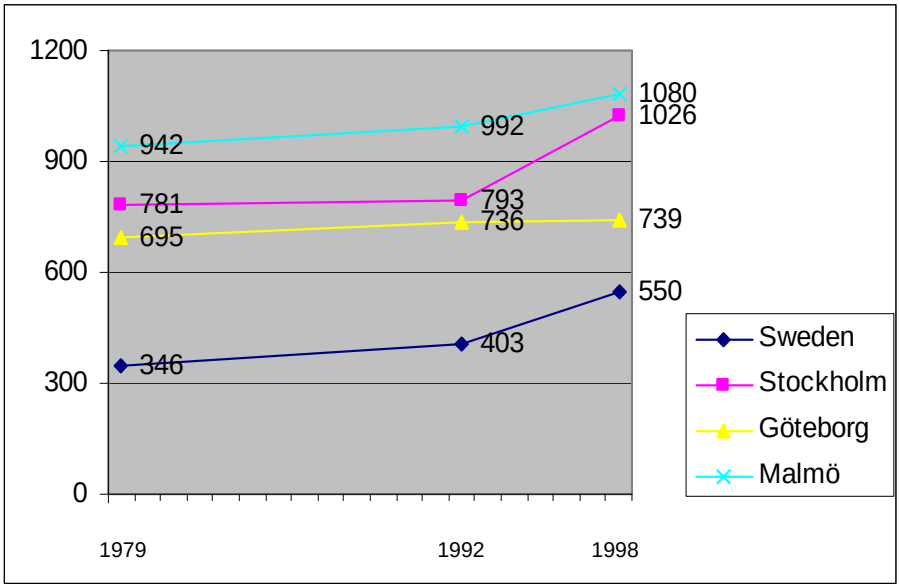

Diagram 1. Number of heavy drug-abusers per 100.000 inhabitants of age 15-54 i Sweden, 1979, 1992 and 1998.

The National Action Plan described the current status of the drug treatment at the time. The report showed a great variety in the choice of treatments, which was in accordance with local traditions and routines. In the action plan several references were made to reports showing how treatment chains for drug addicts were not working as intended. The report also showed a lack of strategies and guiding principles for the work concerning the Swedish drug treatment. To improve the situation, one of the main aims of MOB was, to *"…contribute to building up functional collaboration between preventive work and early measures, care and treatment and combating crime, ensuring that measures against drugs are followed up and evaluated and that good examples are spread"* (National Action Plan, 2006, pp. 3-4).

The work of MOB was organized around responsibility areas, e.g. preventive work, care and treatment and measures of control. It employs 15 people, most of them responsible for a specific area in which they initiate projects and ventures at regional and local levels. One of the initiatives of MOB in the responsibility area of care and treatment was the above mentioned change program, *RMMP*. Based on previous efforts to improve care of drug abusers, four municipalities representing different regions in Sweden were selected for

RMMP. Their initial task was to investigate available resources and the needs at hand. Thereafter they initiated projects to establish collaboration with care-providers working with other principals in establishing care-chains, and to facilitate this, a standardized assessment instrument was introduced. MOB strongly directed how the projects where organized, e.g. by supplying a model for the project plan. Both municipalities and county councils signed a mutual agreement to use ASI and to collaborate based on their initial investigation of common resources and needs. The agreement was a condition for being included in the change program.

Based on project plans proposed by the four municipalities, decisions about the funding of each project were made by the Swedish Ministry of Health and Social Affairs.
The selected projects received specific budgets, varying from 400.000 EUR to 600.000 EUR. The financial support covered a year and a half, and included salaries for project managers together with large-scale investment in educating the staff from the participating organizations, e.g. people from the Police Department, the National Prison and Probation Administration and voluntary organizations. The social services in respective municipality became the principal for the various projects and responsible for the budget.

The investigation of resources and needs attempted to describe what actions were required to be taken by the municipalities together with what possibly could be achieved. The action plan was supposed to include, beside a plan for activities to be performed, a description of the structure that guided the work. All activities should be based on the use of the standardized assessment instrument.

The standardized assessment instrument

To become involved in the change project the use of a standardized assessment instrument was required. This constituted an attempt to standardize both the treatment procedures and the working routines in drug abusers care. The instrument was intended to secure minimum levels of treatments and to ensure functions at lowest common denominator for investigation and counseling work. Hereby, the instrument was expected to facilitate collaboration between involved parties, representing different organizations and professions. The conditional support from MOB emphasized these efforts.

The four municipalities all agreed on using a standardized assessment instrument called Addiction Severity Index, (ASI), in their treatment of drug abusers. ASI is based on a structured interview, containing questions of relevance to the clients' addiction problems. Since its introduction in 1979, ASI has become one of the world's most widely used instruments in drug abuse treatments and research. ASI is an assessment instrument designed to be administrated as a structured interview with clients who require treatments for their drug abuse. Information about seven areas of a client's life is collected through the instrument: medical, employment/support, drug and alcohol use, legal, family history, family/social relationships, and psychiatric problems. Using a ten point scale from 0 to 9, the interviewers' severity ratings indicate the degree of the problems of the client in each of the seven problem areas. The rating is based both on historical and current information. Composite scores are based entirely on current information and are indicators of the present status of the client; they are thus useful for treatment outcome studies, since successive composite scores can be used to summarize changes in the status of the client. In the project, all involved care providers and authorities were supposed to use this information.

Research setting and methods

The research reported here involves the four municipalities that participated in *RMMP*. The four municipalities represented different sizes of municipalities and different regions of Sweden. The first municipality is located in a suburb of the capital of Sweden, Stockholm and the rate of unemployment and heavy drug problems is high. The project participants had a long experience of working with drug treatments and had used standardized assessment methods for a long period. In this municipality established units were in place where social service and primary care worked together. The second municipality is one of the ten biggest municipalities in Sweden. Drug abusers care had for a while had high priority of the political agenda in the municipality. The change program thus received a great support from both politicians and managers in the participating organizations. The politicians and managers where part of an already established network where issues like collaboration and care chains could be discussed. Within this municipality, some of the care providers already had the experience of using standardized assessment methods. The third municipality is a middle-sized municipality in mid-Sweden. In this municipality, there was limited tradition of contacts between people from the municipality and the county

council. The fourth site was formed as collaboration between three smaller municipalities in northern Sweden. The reason behind this was that these smaller municipalities had too few drug abusers to justify a change program on its own. Also, only a small number of employees worked with drug abusers in each of the three municipalities. This also meant that the change project came to cover a large geographical area. For example, a social worker from one of the municipalities had to drive 30.000 kilometers to meet a participant in one of the other municipalities. The participating parties were novices in using standardized assessment methods. These four projects were examples of municipalities with different conditions, regarding both demographic aspects and experiences of using standardizing instruments.

The researchers' fieldwork began in winter 2004/2005. To obtain a rich field material various techniques for collecting data were used, e.g. interviews, observations and studying documents. Interviews and observations were conducted repeatedly over the three-year period, 2005-2007. Interviews were conducted with the project managers in the municipalities and with people who took part in the collaboration between care-provider representatives. Representatives from the two authorities, the Swedish Ministry of Health and Social Affairs & the National board of Health and Welfare, were also interviewed .

The research interviews consisted of four parts. In part one the respondents were asked about their background, position and education. Part two asked about the work environment related to actions taken to develop the care of drug abusers. In Part three questions about everyday activities were raised. Finally, part four of the interviews asked about the respondents views on possible ways to improve the activities.

Several meetings have been observed. An example of a meeting the researchers observed is a meeting where the representatives from the Swedish Ministry of Health and Social Affairs presented the government initiative to the project managers. Other examples are meetings at which representatives from the National board of Health and Welfare presented the assessment instruments to participants of an educational program. A great deal of the research material consists of documents produced by the Swedish Ministry of Health and Social Affairs, the National board of Health and Welfare and the participating municipalities. The research material was thus textual, consisting of interview notes, other observations (field-notes) and documents.

Achievements of the municipalities

Educational program

Together the four municipalities carried out an extensive educational program in the use of ASI. This educational program was in fact the main activity of the project. Most of the money the municipalities received was thus used for educational activities. The use of IT was regarded as a means to standardize ways of working and to measure activities,. It was also seen as a platform for collaboration and improvements of care-chains. The ASI-methods are multi-perspective and take time-aspects into consideration. This implies that the idea of a care-chain is built into the methods. The introductory and follow-up interviews with the clients– as well as the treatment alternatives that are identified by judging the situation of the individual client – are thus important steps to form the base for a care-chain. The idea is that if all personnel use standardized assessment instruments, e.g. ASI, in a consequent manner over time, possibilities to get the same treatment irrespective of where it is given increases.

Besides enhancing individual competence of the people involved in the projects, the educational programs were seen as crucial for the organization of activities and performance of the tasks at hand. Importantly, it was also seen as an unique opportunity for the involved parties to meet and develop a common language and understanding. Accordingly, the educational program gathered participants from different care providers and principals to facilitate exchanges of experiences.

> "Joint training sessions [in ASI] is one way to make people from different organizations come together, to develop a mutual language and conceptions." (Representative for Mobilization against narcotics/drugs, Swedish Ministry of Health and Social Affairs)

The following statements are extracted from observations of an educational occasion, and illustrate how ASI was introduced to the participants in one of the municipalities:

Educator A: - We are here to give some sort of management education.

Educator B: - I am conducting research on the Addict Severity Index at the department of psychology at XX University.

Educator A: - The ASI is a broad mapping interview and covers how the client experiences his or her situation. It's a semi-structured interview and It's a collection of facts, clients description of his or her experience of his or her situation. It's the client's description of the help needed.

Both experts and academics were engaged to educate practitioners, politicians and administrators in the use of the ASI, which was a deliberately chosen strategy to establish trust and secure the implementation of ASI. However, all participants were not convinced as following questions from the participants illustrate:

Participant X: - Are there any politicians that hesitate about the implementation or use of the assessment instruments? It is appealing with evidenced based methods but it presupposes that we as well as the politicians understand the system.

Educator B: - In xx Municipality they… (the educator gives an example)

Participant Y: -…what type of changes or developments? Improved investigations, knowledge about outputs at a group level?

Educator A: - Documentation will create feedback to decisions.

Participant Z: - Does it have effects on the costs of the treatments? Will the costs of treatments increase when we are able to see the need of the clients?

Educator B: - ASI secures quality but it is not evidence based. Evidence is achieved by the results of the treatments.

The educators introduced ASI by telling stories and giving examples of implementation and use of ASI in other municipalities. This was done in order to encourage discussion and make the participants comfortable to ask questions. The educators thereafter presented ASI as a semi-structured survey-interview where facts about the clients, their perception of their situation and their need for help are documented. One of them declares that the ASI is standardized: “It doesn’t matter who the person is who conducts the interview”. The ASI does have a value for the clients as well, since they are informed about the nature of the data that is collected. They also recognize their own words and phrases in the texts. The educator concludes: “This is black on white. The interviews are done systematically, implying that decisions are taken on safer grounds.” Later on, she tries to engender the feeling of a unquestionable claim of truth, reflected by the expression “black on white”: “As a client you may become shaken when you get it black on white.” And again later on: “It is nice to have it black on white.” In the afternoon, the researcher involved in the education uses the same rhetorical device when he presents a diagram that shows estimations of the need for help based on ASI. He concludes: “We have it black on white that it works.”

The agenda for the afternoon session had the politicians as the target group. The educator explains how ASI may facilitate the achievement of their political assignment. They explain how the data from ASI-interviews can be aggregated into reports, specifically useful to politicians. It is also emphasized how the judgments of the social secretary will become more uniform with the assistance of ASI.

The participants appreciated the education and described it as an activity that immediately increased their competence. They considered that the change project had increased their attention to the need of improvement in respect to drug abusers care. Furthermore, the participants claimed that the education and the focus on standardized assessment instruments had a normative effect on their ways of working. Finally, by offering a possibility to measure the effects of the treatment practice, ASI increased their professional legitimacy. An explanation to the positive response towards the education may be the participants’ perceived need of education, combined with previous lack of money for educational efforts.

Use of the Addiction Severity Index (ASI)

It is important to point out that at the time of the study ASI had recently been taken into use at all four municipalities. This means that the effects on the treatment practices are not included in this study and need to be investigated later on.

ASI exists in different versions and is adjusted to each specific setting. However, the interview guide is not delimited to the activity areas of the involved organization only. On the opposite, the questions include and refer to activities of other organizations. Personnel at the social service may accordingly ask the client questions of interest to the county council, the police, the Prison and Probation Service and voluntary organizations. The content of the ASI is thereby expected to increase the contacts that take place between the involved parties and to support employees' communication regarding their clients and their treatment. It is evident from the research interviews that the ASI had been used for the interviews with the clients, although the data had not been registered in the IT-system. In addition, some of the persons in charge found it difficult to ask some of the questions that were included, e.g. people at the social services could find it difficult to ask questions related to the Prison and Probation Service. Such questions were frequently excluded or it was referred to other organization as an attempt to explain the reason for asking them. Another user problem was the feeling of offence attached to the request of using a form for the interview. Some of the informants stated that their professional identity was questioned.

The informants stated that ASI is an instrument that gives a complete description of the problems of the client – both in the social and medical sphere. It is a mean to avoid getting stuck arguing about definitions, for example whether a diagnosis for abuse or for addiction are applicable. Rather, it focuses on finding appropriate solutions to the actual problems of client. Irrespective of what type of organization they represent, care providers agree; by using the ASI, their knowledge will develop and more and more aspects will be taken into account.

Introduction of Care-Chains

The role-model municipalities agreed on collaboration within the treatment and on establishing care-chains. This was primarily achieved by describing the units and organizations which were involved in the treatment. Several groups were appointed,

consisting of participants from these units and organizations, to facilitate collaboration across boundaries. The study shows that a number of arrangements were initiated by the participants, however the concrete actions taken differs among the four municipalities.

In the municipality of Botkyrka, two groups were working with care-chain, one with getting clients back to work and to a place to live in, and the other with visiting work. Both were focusing the sequences in the care-chain where the contacts between organizations, mainly within the social service, did not function satisfactorily. The group *Collaboration Age18-24* (*Samverkan 18-24 år)* sought to improve collaboration, e.g. by investigating how clients were moved between different organizational units, i.e. mapping the actual care-chain.

A similar approach was adopted within the municipality of Pite älvdal, where several networks were established to come to grips with specific problem areas in need of solutions. One of these networks was focusing on the care-chain and the representatives from different organizations took part in discussing improvement of their contacts. To get to know each other facilitated contacts in situations where it was needed for the treatment of clients. Another example of network was the one established for work against drug-abuse among women.

In the municipality of Karlstad, a process organization for the Department of alcohol and narcotics was worked out. This could be seen as a first step towards a new organization based on an internal care-chain between units within the social services, where collaborative work had been a current issue since 2002. A group of people, *the process improvement group,* was responsible for the development.

Lastly something should be said about the municipality of Örebro, where care-chains were found to be useful for the design of complete solutions to the problems of the clients. Some activities were jointly organized by the municipality and the county council, e.g. in pooled locations. Furthermore, other groups representing different organizations and principals had been established such as the PULS-group (a political management group involving e.g. civil services, county councils and treatment of offenders) and the ASI-group.

To conclude, the study shows that ASI is available for the care-providers and preferably

used in their interaction with management. To a certain degree, the instrument is also used by politicians. The resources received have been used for education in how to apply the instrument and for education in different treatment methods. It is therefore asserted that the efforts made hitherto demonstrate stronger ambition to develop the managerial practice than to develop the treatment practice. This may be in line with the intentions of the project, since the local municipalities selected for the project already had started up a development that included ASI. The effects on the care-chain and the treatment practice remain to be studied.

Concluding remarks

RMMP could be interpreted as a case of standardization and our intention with this paper was to describe and discuss what type of standardization has taken place and its effects, besides trying to explain the outcome of the project so far.

The introduction of ASI can be seen as a very powerful way to make the treatment of drug-abusers uniform through-out Sweden. The responsibility for diagnosing and treating clients has been decentralized to the municipalities and county councils. However, by the introduction of ASI, the Swedish Ministry of Health and Social Affairs signals constraints in this responsibility. To decide whether ASI is used or not, is simple. The client records may confirm whether the social secretaries and other persons in charge do use the ASI-form when interviewing the clients.

The focus on the concept of care-chain can also be seen as a standardizing device, since it implies that the personnel has to be aware of the responsibility for the client at the time for handing over the client to the next link in the chain. This is valid for both the delivering as well as the receiving party. Compared to deciding whether ASI is used or not, finding out if a care-chain has been established or not, is more complicated. At the end it is the clients' experiences of their treatment and their life-situation that tell something about the functioning of the care-chain.

Although it is too early to evaluate the project in terms of effects on the treatment, it may still be possible to answer the question if any community of practice has been established – meaning that the parties meeting the clients collaborate to improve the care. It may also be

possible to discuss the role of standardization, i.e. the introduction of the ASI-form and the concept of care-chain, in this context. Have they contributed or impeded the establishment of a community of practice? What are the explanations to the outcomes of the project?

The explanation to the fact that ASI not yet is used as intended, may be that enough resources have not been invested and that the personnel find it difficult to use it or that they find it not useful. In terms of the theory about communities of practice, explanations can be found in the fact that ASI – the intended boundary object – has turned out become a *monster* partly because of the format of educational program. As it was, the participants could not use their own experiences to discuss ASI. The role of ASI in the establishment of a boundary organization, i.e. care chains, has accordingly been marginal. ASI has been used managerially in the discussion with the politicians, rather than professionally in the treatment.

Looking ahead, some alternative scenarios for the use of ASI can be suggested. A possible future is that it will be forgotten within a few years. Another possibility is that it will be used extensively for managerial purposes. However, we cannot see any indication of ASI as having an important role in the improvement of the care for drug abusers.

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