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Standardized knowledge, the IBIC and knowledge-based social services

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ABSTRACT

This article discusses the contribution of standardized methods to knowledge-based social services. The point of departure for the study is the Swedish assessment method the *Individual's Needs in Focus* (IBIC). How does the IBIC, based on the terminology of the ICF, contribute to standardized documentation and to a focus on the needs of the individual? The study is based on 80 social service investigations, from four different Swedish municipalities, concerning daily living support interventions, as well as 13 interviews with case officers. Our analysis exposes major flaws in terms of clarity and uniformity. The client's needs may be seemingly randomly assigned to a particular life domain; environmental factors and personal factors have no specified content, and the assessment of the degree to which functioning is limited is subjective. As a standardized method, the IBIC fails in the fundamental requirement of providing a basis for comparison – the headings do not necessarily coincide with the content. From a social perspective, one can also question why, according to the IBIC, needs are centred to *functions*, supposedly improved by practice/learning. Overall, this also jeopardizes its value relative to goal fulfilment at both individual and aggregated levels. We argue that one reason why it is difficult to apply the IBIC is that its construction does not align with the premise of social work. The IBIC constructs an approach to knowledge that tends to place a high premium on the simple and well-defined, rather than the holistic and complex.

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Introduction

Since the turn of the millennium, National Board of Health and Welfare (NBHW) has been tasked with promoting evidence-based practice (EBP) within Swedish social services in several ways, such as national guidelines, method evaluations, targeted research funding and the introduction of standardized documentation methods (Brunnström 2021; Rexvid 2016). The argument in favour of standardized documentation methods is that they make the decisions less reliant on the discretion of individual case officers and thereby will counteract subjectivity and arbitrariness (Björk 2017; Tøssebro, Mjøen, and Bruteig 2022). Another argument is that standardized documentation will facilitate measurement of social service outcomes at both individual and aggregated level and thereby facilitating comparisons between municipalities (Björk 2017; Sletten and Björkquist 2021). Standardized documentation, carried out by caseworkers at the individual level, will provide information for the national register data. These data are seen as contributing to transparency and accountability at national and local level, and as providing opportunities for better quality

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outcomes for users (Tøssebro, Mjøen, and Bruteig 2022). The belief in standardized documentation is not only rooted in EBP, but also in the introduction of New Public Management, which shares the goal of improving quality in the public sector and facilitating comparability, uniformity and transparency (Carlstedt and Jacobsson 2017; Martinell Barfoed 2018).

While the implementation of standardized working methods has raised a great many hopes, it has also provoked criticism. The introduction of standardized documentation has been coupled with criticism of the implementation of EBP through a top-down model of governmental knowledge management (Jacobsson and Meeuwisse 2020). Questions have been asked about how social work professionals' discretion is affected by predetermined questions, headings and manuals (Jacobsson and Meeuwisse 2020; Munro 2011). Others question whether 'the client's voice' can make itself heard in standardized documentation (Eika 2016; Hall et al. 2010; Martinell Barfoed 2016, 2018). Ponnert and Svensson (2016) argue that the seemingly intense focus on the client is actually a focus on the client group and not necessarily the individual client. Critics claim that the fragmented classification makes it harder to take a holistic view and that the client as actor and subject is lost (Hall et al. 2010). Similarly, standardized documentation with predetermined headings and boxes has been criticized for its inability to capture the complexity and individuality of each client (Martinell Barfoed 2018; Skillmark and Oscarsson 2020). Munro and Hardie (2019) argue that: 'If social work is to provide a personal service, social workers need to be able to take account of unique features of the case [. . .]' (p. 423). Others have questioned whether the social aspects would disappear due to standardization, EBP and NPM (Hanssen et al. 2015).

Sweden has a tradition of structured documentation systems, such as Children's Needs in Focus (BBIC), inspired by the British Integrated Children System (ICS), as well as the Addiction Severity Index (ASI). Both of these systems enable gathering of structured data for analysis but have also been criticized for being underutilized both for local follow-up and within national research (Martinell Barfoed 2018). However, one area in which social services were perceived to be in need of improvement was the investigation process in relation to interventions.

To fill this gap, a new standardized documentation system was introduced in Sweden. It started in the field of elderly care and was then transferred to other areas, including the field of disability. This documentation system was named the Individual's Needs in Focus (IBIC) to underline the individual's right to support based on their specific needs rather than on predetermined interventions. According to the NBHW (2021), the IBIC should focus not only on the need for support but also on the individual's own resources. The IBIC is also intended to improve the documentation of goal attainment. Research and comparisons will benefit from the fact that the IBIC is based on the International Classification of Functioning, Disability and Health (ICF) developed by the WHO, which is assumed to offer a structure and a standardized language for describing functioning and disability in relation to health based on a biopsychosocial model (National Board of Health and Welfare 2021). The National Board of Health and Welfare (2021) associates three improvements with the implementation of the IBIC:

- The use of a common language and approach to knowledge to understand and describe resources, needs and objectives in daily life.
- Appropriate, structured documentation based on uniform and unambiguous terminology.
- The ability to follow up a result and evaluate goal attainment for the individual, which can then be compiled at various levels and contribute to knowledge-based social services.

Despite the recommendation of the NBHW that all Swedish municipalities use the IBIC, this working method has rarely been evaluated. Those studies that have been carried out have largely dealt with the difficulties of implementing the IBIC (Åhlfeldt 2021; Health and Care Services Analysis 2021; Larsen 2020). Björk (2017) claims that, usually, problems arising from the disconnect between the documentation's intention and its practical application by social workers is explained in terms of implementation difficulties, rather than any difficulty experienced by the practitioners

in applying the method in their actual work situation. This is highly applicable to the IBIC. Standardized documentation is usually constructed in a research context and based on those variables that are most relevant from a strictly scientific viewpoint, and then tested on the basis of whether they are psychometrically sustainable. Less consideration is given to how well the standardized documentation works in social service practice, according to Björk (2017).

In this article, we do not examine the implementation of IBIC, but take a different approach by examining the empirical results of using IBIC in a practical context. The NBHW (2021) considers the IBIC documentation to be of crucial importance, and points out that structured, appropriate documentation using unambiguous, uniform terminology is the foundation for local and national monitoring and thus for knowledge-based social services. Consequently, we empirically examine whether the intentional outcomes set by the NBHW are fulfilled. This article thus contributes to a discussion of the value of standardized methods for knowledge-based social services, with a focus on the IBIC.

Aim

We address the question of whether the IBIC, based on the ICF terminology, creates the conditions for knowledge-based social services and for standardized documentation, and whether the IBIC helps place the needs of the individual in focus.

The article proceeds from the following research questions:

- How does IBIC contribute to standardized documentation?
- In what way does the IBIC contribute to knowledge-based social services, and what kind of knowledge is generated?
- How does the IBIC help identify and document the needs, including social needs, of the client?

How is the IBIC designed?

IBIC is based on ICF, which is a framework for describing and organizing information about functioning and disability. It provides a standard language and conceptual basis for defining and measuring health and disability. The ICF can be used to describe and document a person's resources, needs and goals in their daily life, regardless of age, situation and environment, according to the National Board of Health and Welfare (2021).

In Sweden, social services are based on a purchaser-provider system. The client applies for support from the social services and the case officer starts an investigation according to IBIC. The case officer describes the client's assessed functioning (current state) and the intended functioning (the goal of the intervention). This is achieved via a number of headings/chapters based on the ICF categorization system. Some of this deals with the individual's functioning within 11 available life domains, nine of which are taken directly from the ICF component Activities and Participation, while two have been added to reflect Swedish conditions (feeling of safety and personal support from a person who supports a relative). It also covers so-called related factors, which is a collective term for health conditions, body structures, body functions, environmental factors and personal factors. Related factors are intended to be used to document components that affect the individual in their daily life, such as the resources available to the client and facilitators or barriers existing in their environment (National Board of Health and Welfare 2021).

In addition to classifying the functioning, the case officer and the client should each make an estimate of the extent of the current limitations and which objectives are to be achieved. Assessing limitations and setting goals are important aspects of how IBIC contributes to follow-up opportunities.

A positive decision, where the client is granted support, is placed with the support provider that needs to establish an implementation plan together with the client describing how and when support will be provided. This implementation plan is based on the objectives set by the case officer.

However, although on paper this appears to be a clear and structured system, in practice it presents several challenges: the case officer's chances of assessing the degree of difficulty experienced by the client; the erasure of the concept of *need* in favour of *functioning*; the apparent rarity of the provision of an analysis of facilitators and barriers in the client's life; the seemingly random distribution of background data under different headings; and the way in which a complex life situation is broken down into small individual tasks. These challenges are the focus of this study.

Method

This is a qualitative study based on a document review and interviews. The common denominator for the documents and informants is that all relate to daily living support interventions. Daily living support is the most common intervention for people with psychiatric disabilities (National Board of Health and Welfare 2019, 2022) and refers to practical and social interventions in the individual's everyday life. Currently, 53% of Swedish municipalities use the IBIC for investigations and 38% use it for following up the results of interventions (in the unit of social psychiatry) (National Board of Health and Welfare 2022).

The documentation covers investigations, decisions, orders and implementation plans for granted support. We have reviewed 20 cases in each of four different municipalities, amounting to a total of 80 cases. We have also interviewed 13 case officers who work in accordance with the IBIC in these municipalities. The documents form the most important material for the study, while the interviews serve as a supplement.

The participating municipalities have been selected from the area of Greater Stockholm and represent a variety of sizes and socioeconomic structures. Three of the municipalities had worked with the IBIC for three to four years, and one municipality for approximately one year. The selection of documents was carried out by the case officers based on the representation of both women and men who had applied for daily living support during 2020/2021. Except for sex and age, the material was de-identified by the authority in question. The 80 investigations relate to 48 women and 32 men between the ages of 20 and 83 (the majority under 65 years of age) with psychiatric disabilities.

The investigations were reviewed on the basis of the concepts and key arguments provided by the NBHW as reasons for introducing standardized documentation in accordance with the IBIC: a common professional language with unambiguous and uniform terminology that facilitates equivalence, local and national monitoring and increased participation on the part of the client. A further overarching purpose of the IBIC is to strengthen evidence-based practice and a common approach to knowledge (National Board of Health and Welfare 2021). All of these starting points have served as guidance for a critical review of the documentation according to the IBIC.

In this article, we have primarily concentrated on those parts of an investigation corresponding to headings established in the ICF: 'Life domains', 'Personal factors' and 'Environmental factors', as well as 'Assessment' and 'Decision'. The headings 'Body function', 'Body structure' and 'Health conditions' have been disregarded. They are related to the biomedical approach within the ICF, which will be reviewed in a future study.

The purpose of the interviews was to capture how case officers, using the IBIC, perceive and reflect on the method. The interview approach was qualitative, using open-ended questions to understand the perspectives of respondents and to offer them opportunities to express their own understanding in their own words (Kvale and Brinkmann 2009). Both researchers took part in all interviews. The interviews were conducted digitally and lasted approximately one hour. All interviews were recorded and transcribed verbatim.

Analysis

Investigations and interviews were obtained from one municipality at a time. The investigations were first reviewed by the researchers separately, after which the emerging thematic structures were compared. The first analysis allowed the identification of relevant themes that offered guidance for the next 20 documents, and so on until all of the documents had been analysed under constant comparison between individual and joint analyses (Charmaz 2006). In the next phase, each investigation was summarized based on the research questions and identified themes. These then formed the basis for an initial sorting of the contents of the standardized documentation. Constant reference to original documents during the analysis, as well as the combination of individual and collective reviewing, should serve to strengthen the validity of the analysis. The same procedure of iterative comparisons was used to analyse the interviews (Charmaz 2006).

A certain amount of quantitative content analysis has also been conducted, such as counting how many lines have been dedicated to the heading 'Personal factors' and how many life domains figure in each investigation (see Krippendorff 2018; Silverman 2001). Personal factors constitute that part of an investigation in which the specific *person* is expected to emerge with their own experiences and background. Given the *raison d'être* of the IBIC (the Individual's Needs in Focus) and the holistic view that is supposed to characterize social work (Swedish Social Services Act 2001), it is particularly interesting to study how much space is devoted to 'the individual traits that make the person unique' (National Board of Health and Welfare 2021, 23, our translation). The number of life domains in an investigation is assumed to provide an indication of how broadly needs are viewed in the investigation (Health and Care Services Analysis 2022).

Ethics

The study was approved by the Swedish Ethical Review Authority (ref. no. 2021-04935). All informants were apprised of the purpose of the study, and told that participation was voluntary and that they could end their involvement at any time. Verbal consent was recorded in conjunction with the interview.

Results

Our results consist of two parts. The first part deals with what hides behind the standardized headings and the second with how needs are identified and documented. Finally, these two parts are brought together in a discussion of the IBIC as a source of knowledge within social work.

One critical question when reviewing and analysing the 80 investigations is the extent to which the IBIC documentation contributes to uniformity and unambiguousness and thus comparability. Below, we analyse three areas within the IBIC documentation system: Life domains, Personal factors and Environmental factors.

Life domains

One key element of the IBIC documentation system is life domains. It is in one or more of these that the individual's level of limitation (functioning) is identified (National Board of Health and Welfare 2021). The life domains consist of 11 headings/chapters, each of which has subheadings for both text and codes. Sometimes these subheadings are used and sometimes not. No codes were used in the investigations studied here.

The table below shows the IBIC life domains occurring in the investigations.

The most common life domain in terms of the daily living support intervention is undoubtedly 'General tasks and demands', which occurs in 82% of all investigations. This is followed by 'Domestic life' (34%), 'Education, work, occupation and economy' (25%) and 'Interpersonal

interactions and relationships' (24%). In the last of these categories, which highlights a specifically social aspect of the individual's functioning, the majority of occurrences belong to the subcategory 'Formal relationships' – i.e. contacts with public authorities and healthcare providers. Only a handful of life domains occur frequently. A remarkable 40% of investigations include only a single life domain – in most cases, 'General tasks and demands' – and 29% of cases only two. Thus, almost 70% of investigations constitute what the Health and Care Services Analysis (2022) calls 'narrow' investigations.

Table 1 indicates that it is possible to keep statistics and follow up which life domains are actualized in an investigation (cf. Health and Care Services Analysis 2022) and thus in which life domains an individual's 'needs' manifest as 'functioning' and the social services provide their interventions. However, on reviewing the life domains that occur in the investigations, it is immediately apparent that it is difficult to distinguish one life domain from another, which is an observation that was confirmed in the interviews with case officers. It turns out that there is a disconnect between the expected uniformity and the actual documentation due to a constant confusion of life domains: the same type of need may be investigated within quite different life domains.

Four frequently occurring difficulties experienced by individuals in the reviewed investigations were related to 'home maintenance', 'leaving the house', 'administrative and financial tasks' (paying bills, completing forms, etc.) and 'contact with public authorities'. The review shows that each of these is likely to turn up in any life domain.

- Limitations related to home maintenance appear frequently in two life domains: *General tasks and demands* and *Domestic life*. Sometimes, the same limitation is described in both life domains in the same investigation, sometimes in only one.
- Difficulty in leaving the house may be described under six different life domains: *General tasks and demands*, *Interpersonal interactions and relationships*, *Mobility*, *Community, social and civic life*, *Education, work, etc.* and *Sense of security*.
- Administrative and financial tasks, such as opening post, paying bills, filling in forms, etc., may be entered under five disparate life domains: *General tasks and demands*, *Learning and applying knowledge*, *Domestic life*, *Interpersonal interactions and relationships* and *Education, work, etc.*
- Problems with contacting public authorities/healthcare providers appear under five different life domains: *General tasks and demands*, *Education, work, etc.*, *Communication*, *Learning and applying knowledge* and *Interpersonal interactions and relationships*.

Interviews with case officers confirm that it is far from certain which life domains should be investigated.

Table 1. Life domains and their occurrence in the 80 investigations.

Life domains		% of 80
General tasks and demands	66	82%
Domestic life	27	34%
Education, work, occupation and economy	20	25%
Interpersonal interactions and relationships	19	24%
Community, social and civic life	13	16%
Self-care	10	12%
Mobility	6	8%
Learning and applying knowledge	5	6%
Sense of security	5	6%
Communication	4	5%
Support from a carer or close friend or relative	0	0%

Well, I think mostly it goes like this: ‘Well, these are the life domains we have got, and we’ll squeeze in whatever we need under them’. I think so. There are probably some you use more often than others. Then, I think we’re actually very unsure about what goes where. So, we take what we think fits in the moment, and we get better and better at that. (B1)

Other ways of dealing with the classification system can take the form of multiple needs being investigated under a single life domain (approx. 20%). In this way, the case officer can avoid splitting up and attempting to regulate a complex situation in detail.

If you get down to the minute details of cleaning or all of the domestic chores, there are just so many different things [to deal with]. So then you take as much as possible and put it under one life domain, so you don’t have to go into too much depth. I don’t think that makes things clear for the client, or for the assignment; somehow it becomes too detailed. (A1)

Nor is it uncommon (38% of investigations) for case officers to repeat the same text in several life domains.

There are so many [life domains], I never thought that I was missing anything exactly. It’s more a matter of where you place the information, in which life domain. [...] it might also be somewhat connected as well, so you almost want to write the same thing in two different places. (B2)

The varying investigative methods of case officers need not be a problem in itself; rather, the problem is the high expectations of uniformity. It is difficult to escape the question of how well-suited the ICF’s detailed classification system is to the multifaceted nature of social work in general and daily living support interventions in particular. The fact that the life domain ‘General tasks and demands’ occurs in over 80% of investigations may well be a result of the category’s generality. The otherwise detailed classification system seems to evoke a fragmented picture of the client’s situation that is hard to interpret.

Generally speaking, the review of life domains demonstrates a striking lack of both uniformity and unambiguousness regarding the headings under which different items of information should be sorted. Choosing a life domain appears to be a constant matter of interpretation for the individual case officer (cf. Hedlund 2014). Added to this is the fact that there is a good deal of mixing up of information between life domains and related factors.

Personal factors and environmental factors

The documentation structure includes factors related to the individual and their environment. These factors are intended to help explain an individual’s behaviour based on their background, experiences, lifestyle, etc. Personal factors are not part of the ICF categorization system and lack special headings and are therefore not available for follow-up of the individual, or rather follow-up of the functioning. Nonetheless, this type of individualized, person-centred information is likely to play a decisive role for the possibility of placing the *individual’s* needs in focus.

Whether personal factors are given weight and space in the investigations – under the specific heading Personal factors – varies significantly from one investigation to the next (and to a certain extent, from one municipality to the next). In 13 of the investigations, there is no information whatsoever under the heading Personal factors. The number of lines written under the heading varies from 0 to 37. One municipality stands out, with an average of only 1.4 lines (between 0 and 5 lines in all investigations), while the others average between 8 and 12 lines. However, the fact that information about the client’s experience and background varies greatly between investigations and municipalities – and that it is often so sparse – does not necessarily mean that such information is lacking in the investigation. It may have been included under other headings.

Environmental factors are intended to capture the individual’s environment and how this impacts their *functioning* within identified life domains. The documentation should state the factors that are either *facilitators* of or *barriers* to the person’s functioning in relevant life domains.

Environmental factors encompass the physical, social and attitudinal environment and consist of five chapters: 1. Products and technology; 2. Natural environment and human-made changes to environment; 3. Support and relationships; 4. Attitudes; and 5. Services, systems and policies (National Board of Health and Welfare 2021). Sometimes these chapter headings are used in the investigations, sometimes only ‘environmental factors’. When the headings are used, the most common are Products and technology and Services, systems and policies.

The conclusion of the review of environmental factors is that it is seldom possible to grasp whether these are linked to relevant life domains and whether they are barriers to or facilitators of the client’s functioning. Instead, they are presented as a kind of fragmentary ‘background’.

The division between environmental and personal factors turns out to be problematic from a uniformity and unambiguousness perspective. Eight of ten commonly occurring themes may figure as either environmental or personal factors. This relates to information about housing, social network, work/occupation/studies, contact with public authorities/healthcare, livelihood/finances, interests, addiction and civil status. Only two themes are clearly identified: medication as an environmental factor and age as a personal factor.

The results demonstrate major deficiencies in terms of equivalence in case management concerning the IBC chapters Life domains, Personal factors and Environmental factors.

Assessing need

As noted above, the individual’s ‘functioning’ becomes central in the investigation. The transformation of the investigation from the individual’s needs to a focus on functioning is remarkable. The concept of ‘functioning’ is entirely absent from Swedish social services legislation and social work. On the one hand, it implies that the focus is on the individual’s functioning (not on the individual) and, on the other, it redefines the individual’s ‘needs and resources’ in terms of ‘functioning’ (National Board of Health and Welfare 2021, 66). This is to be done by integrating all of the collected information and analysing how various related factors affect the individual, either as obstructing or facilitating environmental or personal factors (National Board of Health and Welfare 2021). (Impairments in body function and body structure are also considered but these are not analysed in this article.) The final assessment of functioning and what the intervention is expected to achieve is based on a qualifier scale of no, mild, moderate, severe and complete limitation. One important element of case management is to determine ‘assessed (current) functioning’ and ‘intended (target) functioning’. Through these two assessments – the current situation and the target – the objective of the intervention emerges.

The case officer therefore carries out one assessment, but the client and possibly other professionals – such as a support worker or nurse – might also assess the extent of the limitations. In a small number of cases in our material, the client and the case officer reached different assessments of the problems; however, the grounds on which the case officer eventually reached a decision are not clear. The NBHW considers this assessment process to be very important for the client’s engagement in the investigation process. It is assumed that such engagement will increase through their assessment of their limitations.

However, this assessment process is seen by the case officers as difficult to use. One challenge is understanding and agreeing on what the various grades of limitation mean. What differentiates a ‘severe limitation’ in the domestic life domain in terms of ‘independently planning, shopping for and preparing a meal’ from a ‘moderate limitation’? Here, the manual’s grading of a limitation of 50–95% as a severe limitation and one of 25–49% as a moderate limitation is no help. One case officer noted:

Yes, well, it’s not easy, it would almost need... at least that we think alike in the group. That we have some consensus and agree on what is ‘severe’ and ‘moderate’. Especially in the areas we need to assess. That’s something I feel I could do with a little more consensus on. (C2)

This uncertainty leads more case officers to opt for ‘moderate limitation’: ‘I don’t know, but it’s usually moderate by default or however you want to put it’ (D2). The assessment is made more difficult by the fact that psychiatric disabilities may vary over time. Something that is feasible one day may be impossible the next (Andersson 2009).

The uncertainty felt by case officers concerning this assessment process means that they seldom ask clients to assess their own problems. Only one of the four municipalities in this study involves clients in using the qualifier scales. The others see this as an area for development: ‘As long as we don’t feel secure with it ourselves, it feels like it would be extremely difficult to help clients apply the right rating as well’ (C2).

Despite this uncertainty, all investigations resulted in an assessment of current and intended functioning. These assessments are the basis for individual follow-up of the interventions in terms of goal attainment. Hence they play a central role in both investigation and follow-up.

Decisions regarding needs

Thus, the investigation describes the client’s functioning within various life domains. From many pages of text describing a complex and challenging daily life emerges a decision expressed as grades of functioning in one or more life domains. A number of case officers describe this as succeeding in ‘pinpointing the need’.

When an individual has many or complex needs, the manual encourages case officers to select a smaller number of goals to work towards, preferably based on the client’s wishes (National Board of Health and Welfare 2021). These goals then govern the assignment for the support worker. Some case officers argue that the requirement to formulate goals provides support workers with clearer assignments, as well as making it easier to finalize the intervention.

What I can say is that assignments will be clearer, definitely. [...] That’s what the IBIC improves, to measure it – have you achieved the goal of the assignment, or should you continue with the same assignment? ‘OK, now we’ve achieved this, is there something else we should be working on?’ Because, sometimes, it can be too much to take on everything at once; you have to take certain parts and then, when you’re finished with that, continue with the next. So, yes, I think it does make measurement and intervention easier. (A1)

The case officer continues: ‘This is good, as I said, measurement, and that’s what we want these days – to measure interventions, whether they have an effect and so on, the impact goals. That’s what it’s all about. When you think about it, I don’t know if this is really about the client’s needs’. (A1)

The final sentence of this quote questions whether goals and assessments really capture the client’s needs. It is apparent that clients are seldom routinely involved in how goals are formulated and followed up: ‘I think that perhaps we don’t work with following up goals, and the client’s participation in following up goals, as much as I think the IBIC is actually intended to do’. (C1)

And further: I think this is the next step for us, to begin involving the client a little more in scale assessments and in the goals as well, asking in general about goals and then formulate them and put them in writing. But we haven’t sat down together at that point. Of course, that’s the whole point of the IBIC, to sit down together, as I understand it anyway. (B2)

Given that the idea of the IBIC is that it should promote client participation, the lack of participation in goal formulation and assessment becomes deeply problematic. It is, after all, regarding these elements that emphasis has been placed on the importance of increased client participation in the investigation procedure. Formulating the goal of an intervention without the client’s presence is one way of dealing with this part of the investigation; another is to hold a meeting with the client to discuss goals, after which the case officer formulates them.

Goals have been the greatest problem, I think. [...] But you may still have had a goal that led you to apply for the intervention. Then, of course, you can have a chat about that and what the goal might be. Then, absolutely, we sometimes put words in the mouths of people: ‘Might this be a goal?’ That definitely happens. (B1)

The difficulty of picking the right goals has also been highlighted in terms of the chances case officers have of obtaining relevant information after one or two conversations, often in an office environment. When the support workers meet the individuals in their own homes, other difficulties might present themselves. This then demands a new administrative process in which the case officer reaches a new decision that must be documented.

I think that, overall, we get it right, support to go to the shops, and so on. But then we might not quite have time to grasp that, 'Of course, the problem is that there are so many people in the store'. That might emerge later and then you should probably revise the goal. (B1)

Discussion

Based on the reviewed empirical material, we question the standardized documentation of IBIC and its alleged benefits in the form of clarity, uniformity, increased participation and the concept of placing the individual's needs in focus. Our empirical review demonstrates major flaws in these areas and therefore the idea of using these data for quality improvements seems unrealistic.

The IBIC is built on a fundamental trust in the administrative structure surrounding the work with clients – the *social* work (exemplified here by daily living support). The IBIC documentation system (itself based on the ICF) is ascribed a high degree of validity and reliability and thus given an extended area of use – from local follow-ups to developing knowledge nationally, all based on a common language.

A further complication is the fact that many different needs are brought together under a single life domain, or that the same need is entered under several life domains. This illustrates the problem with using the IBIC documentation to follow up interventions: headings do not necessarily conform to the content.

Clarity and uniformity are also lacking in assessments of the degree of limitation of functioning. This is done through documentation of 'assessed (current) functioning' and 'intended (target) functioning'. Given the uncertainty expressed by case officers concerning how the assessment should be carried out, this opportunity to compare also falls by the wayside. Case officers have difficulty in applying qualifier scales in a consistent manner. The client faces an even greater challenge, both in understanding how the scales work and in recognizing themselves in the descriptions of their limitations as ranging between 'none' and 'complete'. Qualifying scales illustrate Munro and Hardie's (2019) contention that, despite the chimera of an objective scale, the case officer's subjective opinion will still be given space and those in positions of power will still be given importance. Lyneborg and Damgaard (2019) describe a risk that '[...] social workers are increasingly required to know citizens not as individuals, but as units with specific and predefined measurable attributes which can then be compared and computed' (p. 207).

The IBIC seeks to get away from intervention-based social services in favour of addressing the needs of the individual. It is questionable whether the IBIC actually addresses 'needs' when 'functioning' is the dominant concept in investigations. The apparent explanation for this is that the IBIC is rooted in the ICF, which describes 'functioning and disability in relation to health'. The weak link between health and social work is left without comment. Social work is not primarily defined as healthcare but rather as a discipline that 'promotes social change and development, social cohesion, and the empowerment and liberation of people' (www.ifsw.org).

When it comes to the IBIC, it appears that it is the ICF that, despite its tried and tested status, does not work satisfactorily in social work. Despite the faith in the ICF as a common language and biopsychosocial point of departure, it seems that uniformity is not easy to achieve in practice. The investigations studied here show that much of the universality that the ICF strives for is lost, as analyses of factors that are barriers to or facilitators of the client's functioning are rarely performed.

The criticisms levelled above are based on detailed studies of IBIC investigations. Let us suppose that the documentation had instead reflected the desirable uniformity and clarity. This would

undoubtedly have mitigated the criticism – at least in terms of the internal documentation logic of the investigations. However, there remains the initial criticism of standardized methods regarding aspects such as the focus on goal fulfilment (Kamstra, van der Putten, and Vlaskamp 2017; Larsson 2021), the impact on discretion (Jacobsson and Meeuwisse 2020; Munro 2011) and the lack of complexity and a holistic view (Munro and Hardie 2019; Skillmark and Oscarsson 2020). In accordance with Lyneborg and Damgaard (2019, 207), these challenges raise question about transferring ‘... new epistemologies, or new ways of “knowing” ...’ from health care to social services.

Concerning setting goals and goal fulfilment, one can question why, in investigations and decisions made according to the IBIC, needs are concentrated on the client’s functioning – what the individual is capable and incapable of *doing*. This is particularly important to discuss in a social context where a social perspective should be applied (Hanssen et al. 2015). This focus on functioning means that the individual and their needs are defined through their behaviour (cf. Blom and Morén 2012; Sundgren 2005). Sundgren (2011) believes that this shows ‘a form of accumulation of supposed knowledge about human subjects by listing external characteristics’ (p. 23, our translation) and that this does not grant access to the specific person or their life. It appears deeply problematic to reduce social work to measurable ‘doing goals’.

By finding specific goals from a complex life situation, the caseworker translates the individual’s needs into the administrative process and the predefined areas of life (cf. Tøndel 2012). The construction of goals and the ambition to fulfil the goals in the investigations presents a person with impaired functioning who can be trained/taught. After training, the goals are supposed to be ticked off. The constant attention to training or practicing in order to achieve goals is sometimes in contradiction with the understanding that support is linked to the social worker’s company and the relationship within a context (Andersson 2009).

The focus on doing goals also have implication for discretion, given the tangible risk that neither the formulated goal nor the follow-up will capture the actual support being given. A previous study of the administrative process that the IBIC also represents exposes this bias in the administrative process. The result is a discrepancy between daily living support ‘on paper’ and daily living support in practice (Andersson and Gustafsson 2017). There is clearly a risk that the IBIC will repeat this bias by equating an administrative system with the social work that actually takes place.

We have already commented on the difficulties case officers and clients face in assessing functioning on a scale. This uncertainty also jeopardizes the value of changes in terms of goal fulfilment at both individual and aggregated levels. As Morén and Blom (2003) have noted, another problem with this type of documented goal fulfilment is that it only tells us *whether or not* a change has taken place. Knowledge about *why* and *how* the intervention contributed to the result – something that would seem to be necessary for genuine knowledge development – is missing. As Morén and Blom (2003) argue: ‘When it comes to results in social services, as a rule they are judged in relation to set goals or other formulated intentions. Once again, the evaluation of what can be considered a satisfactory outcome is based on the norms of the socio-administrative system’ (p. 34, our translation).

The IBIC entails an approach to knowledge that tends to put a premium on the simple and well-defined, rather than on the holistic and complex. Sletten (2021) also emphasizes the challenge presented by the fact that knowledge is seen as residing in the predefined and structured, rather than in the situation itself. One-dimensional knowledge is valued above knowledge that is multi-dimensional (Sletten 2021). We argue that one important reason for this lack of capturing complexity within IBIC is that the epistemological claims on which the IBIC is based do not align with the basis for or practice of social work. The basic categorization, the structure and the instrumental language based on the ICF are not applicable to the practice of social work. Social work does not rest on a foundation of biopsychosocial knowledge. Social work is rooted in a social perspective that complements other perspectives, and should therefore be documented from a social perspective. Otherwise, we also risk individualizing social problems, as complex relationships and contexts

cannot be captured within this system (cf. Hanssen et al. 2015). Although other perspectives are also important, an open and critical discussion is needed concerning when and how these complement the social perspective (see also Healy 2016).

The purpose of standardization, according to NBHW, is to achieve consistency regardless of who uses the instrument (2012). However, as we have been arguing, standardized methods have their inherent problems that seem inevitable to avoid. Perhaps it is time to leave the paradigm of standardization behind and look elsewhere to improve knowledge within the social services.

An investigation can be structured without being standardized, while a standardized investigation is structured as well. A possible 'way out' could be to think of these concepts as a continuum where structured (eg. headings is placed to the left and standardized (eg. common language) to the right. IBIC would then end up on the far right, hopelessly stuck in a dead end of false premises and expectations. Thus: Structured documentation allows everyone to follow an overall pattern but are expected to do it differently while in standardized documentation everyone is expected to do the same but do it differently.

Of course, moving towards a knowledge-based social service with access to relevant data is worth striving for. The key is to fill the documentation with relevant data that actually provides social services with useful information for development and follow-up (cf Eika 2016; Lyneborg and Damgaard 2019).

This study reveals crucial flaws in the IBIC's ability to produce knowledge. The arguments for introducing the IBIC appear to fall like ninepins, and, with them, so does the sought-after knowledge development within social services.

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