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Evidence-based practice behind the scenes
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Evidence-based practice behind the scenes

How evidence in social work is used and produced

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II. Björk, A. (2014). Stabilizing a fluid intervention: The development of Motivational Interviewing, 1983-2013. *Addiction Research & Theory* 22: 313-324.

III. Björk, A. (2015). Evidence, fidelity, and organisational rationales: Multiple uses of Motivational Interviewing in a social services agency. *Evidence & Policy* (Online).

IV. Björk, A. *Reconsidering critical appraisal in social work: Choice, care and organization in real-time treatment decisions.* (Submitted).

Sammanfattning

Syftet med denna avhandling är att empiriskt undersöka vad Evidensbaserad praktik (EBP) och dess standardiserade rutiner blir när de omsätts i praktik i socialt arbete. EBP formulerades i början av 1990-talet inom medicinen och har sedan dess varit ett mycket omdiskuterat begrepp inom en rad olika professionella områden. Begreppet bygger på en idé om att professionell praktik bör baseras på systematisk och tillförlitlig kunskap om de insatser och instrument som används i detta arbete. Detta innebär en standardisering av både forskning och praktik, något som har varit mycket omtvistat inom socialt arbete. Inspirerad av arbeten inom teknik- och vetenskapsstudier (STS) analyserar denna avhandling det faktiska innehållet i standardiserade procedurer och deras användning i praktiskt socialt arbete.

Avhandlingen undersöker ett särskilt betydelsefullt fall för frågan om EBP inom socialt arbete, en missbruksenhet inom socialtjänsten som har arbetat systematiskt under flera år med att införa EBP. I avhandlingen ingår fyra artiklar som fokuserar på tre standardiserade procedurer som enheten använder för att realisera EBP: 1) det standardiserade bedömningsinstrumentet Addiction Severity Index (ASI), 2) den psykosociala interventionen Motiverande samtal (MI), och 3) beslutsmodellen Critical appraisal, vilken är den ursprungliga formuleringen av EBP såsom den formulerades inom medicinen. Etnografiska metoder användes för att studera hur enheten rent konkret använde sig av de standardiserade procedurerna i sitt vardagliga arbete. MI studerades också i forskningslitteraturen för att ta reda på hur det växte fram som en evidensbaserad intervention.

Utvecklingen av standarder inom EBP kan i grund och botten vara en rörig och paradoxal process. Vad det gäller framväxten av MI, till exempel, har dess flexibilitet och olika uttolkningar efterhand gjorts osynliga, vilket har skapat ett stabilt objekt som forskare och sedermera chefer och praktiker inom socialtjänsten betraktar som evidensbaserat.

Resultaten från de etnografiska studierna visar att EBP, såsom det ’görs’ i enhetens dagliga praktik, blir ett byråkratisk projekt där enhetscheferna har beslutat om och kontrollerar användningen av en uppsättning av standarder. Det innebär att vad som utgör relevant kunskap och evidens inom enheten inte är baserad på socialarbetarnas professionella omdöme, utan i slutändan avgörs av cheferna.

Snarare än att vara neutrala verktyg, introducerar de tre standarderna nya typer av logiker och i sin tur spänningar inom enheten, något som socialarbe-

tarna lämnas att hantera i sitt praktiska arbete med klienter. Huvudsakliga konflikter handlar om hur socialarbetarna kan organisera sitt klientarbete samt motstridiga organisatoriska rationaliteter. De tre standarderna används i olika utsträckning inom enheten, något som kan förstås genom att undersöka vad de försöker att standardisera och hur de omsätts i praktiken. Critical appraisal användes inte alls, vilket främst kan förstås mot bakgrund av dess utformning. Genom att bortse ifrån organisatoriska faktorer vad det gäller hur beslut om behandling fattas – något som är oundvikligt inom socialtjänsten – kunde inte beslutsmodellen anpassas till enhetens arbete. ASI och MIs öden såg annorlunda ut, främst på grund av deras organisatoriska anpassningsförmåga. ASI infördes i flera faser av enhetens arbete, vilket resulterade i en ömsesidig anpassning av instrumentet och enhetens arbete. MI blev både begränsad av men kunde också, i och med sin flexibilitet, anpassas till organisationen. ASI och MI kunde således i viss mån passa in i, men också transformera och bli transformerade av redan existerande arbetssätt inom enheten.

En viktig slutsats är att EBP och dess standardisering är, och förmodligen måste vara, en mycket mer dynamisk och mångfacetterad process än vad som tidigare uppmärksammats inom socialt arbete. Snarare än en deterministisk enkelriktad process finns det olika typer, grader, och en ömsesidig omvandling av standardiseringsprocesser. Detta är något som måste beaktas i forskning och praktiska försök att införa EBP. Med tanke på de organisatoriska faktorernas betydelse inom professionellt socialt arbete finns det ett behov av att komma bort från individualistiska föreställningar om EBP och att istället tänka över vad användning av evidens och kunskap kan innebära ur ett organisatoriskt perspektiv.

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Abbreviations

ANT	Actor-network theory
ASI	Addiction severity index
EBP	Evidence-based practice
EBM	Evidence-based medicine
MI	Motivational interviewing
NBHW	The Swedish national board of health and welfare
RCT	Randomized controlled trial
SOU	Swedish government official reports
SALAR	Swedish association of local authorities and regions
STS	Science and technology studies

Introduction

This dissertation is about evidence-based practice (EBP) in social work. It studies empirically how evidence in the form of interventions, instruments, and decision making models actually is used and produced in practice, beyond common claims, or as the title suggests – behind the scenes.

EBP is built on the idea that professional practice to a greater degree should be based on systematic and reliable knowledge of the interventions and instruments that are used. This implies a standardization of both research and practice that some scholars fear and some hope for. Previous studies of EBP in social work have therefore discussed, on theoretical grounds, whether this is a suitable model for social work practice. Instead of discussing these aspects rhetorically, it is my argument that it may be more useful to study how this kind of standardization actually turns out in practice. While studies in social work have examined the use of 'softer' kinds of knowledge such as expertise or the social meanings of evidence use, few have examined the actual *content* of using and producing formal kinds of evidence. This dissertation is inspired by science and technology studies (STS) that have examined evidence-based medicine (EBM) in healthcare with a similar empirically grounded approach. What motivates this dissertation, however, is that it looks at evidence use in a different professional and organizational context. Although the differences should not be exaggerated, social work differs from healthcare along some general lines, for example the character of the problems handled, the interventions used to handle these problems, professional status, and how professional work is organized. This means that the use and production of evidence is implicated in different kinds of processes, compared with medicine, which may affect how it is enacted in practice.

In order to examine these aspects in practice, I have closely studied a social services agency working with substance abusers that has worked extensively for several years with trying to implement EBP. This case therefore allows for a general discussion about the challenges and possibilities of working with EBP in social work that is grounded on an empirical analysis of its practical outcomes.

What is EBP?

Evidence-based practice is difficult to summarize. Indeed, what EBP *is* in practice is in fact the major topic of this dissertation. In its broadest sense, however, it is about incorporating research evidence into professional practice. The idea originates from the medical field, there called evidence-based medicine (EBM), where a group of scholars in the early 1990s proposed that the medical profession should make more use of recent developments in clinical research (Evidence Based Medicine Working Group, 1992).[1] They argued that methods such as the randomized controlled trial and meta-analysis can "increase the confidence one could have of knowledge about patient prognosis, the value of prognostic tests, and the efficacy in treatment" (ibid., p. 2421). Thus, the idea implies a de-emphasizing of clinical expertise and general theories of how medical and social problems arise in favor of more systematic knowledge of the effects of the interventions and tests used in professional practice.

In discussions about the idea, there is often a focus on interventions and that these should have a documented effect. But as the above quote shows, it also focuses on aspects of assessment and diagnosis. According to the original pronouncement, then, even the tests and instruments used in assessment and diagnosis should be informed by more systematic research.

This can be said to be the heart of EBP; and this is how the concept will be used in this dissertation. But as it has spread across professional, institutional, and national contexts, a wide range of conceptual siblings have seen the light of day: evidence-based social work, evidence-*informed* practice, knowledge-based practice, and evidence-based policy, to name a few. They all suggest different interpretations either of what should count as evidence in professional practice or how this should be promoted and organized.

In social work and healthcare, two major models of EBP can be discerned: the critical appraisal model and the guideline model (cf. Bergmark & Lundström, 2011b). These models differ with respect to the role of the professional. In the critical appraisal model, the professional has an active role in searching for and critically appraising research evidence. In making decisions about treatment for a client, this should be applied together with the client's preferences and the social worker's own expertise (Sackett et al., 2000; Shlonsky & Gibbs, 2004; Gambrill, 2006). This is usually described in a series of steps including:

1) Define an answerable practice question
2) Search for evidence to answer this question
3) Critically appraise the relevant evidence found

[1] See Bohlin (2011) for a more comprehensive account of the emergence of the evidence movement.

4) Integrate this with the professional's clinical expertise and the client's values and preferences in deciding on an appropriate intervention.
5) Evaluate the outcomes of this intervention.

In the guideline model, which has been proposed as a more realistic alternative to individual finding and incorporating evidence (Guyatt et al., 2000; Rosen et al., 2003), the professional has a less active role with regard to evidence use. Here, the professional relies on clinical practice guidelines developed by experts who systematically evaluate the research literature on a given topic, for example the effectiveness of psychosocial interventions, or the validity of standardized assessment instruments. The guidelines result in recommendations of interventions and instruments based on the strength of the evidence found. Thus, in the guideline model, the professional does not make an independent appraisal of the literature in every case, but uses more general recommendations from experts. While guidelines have become the preferred modus operandi of EBM in health care (Timmermans & Mauck, 2005), the critical appraisal model still holds a strong position among social work scholars (Gambrill, 2006; Thyer & Myers, 2011).

Three methods or techniques have been central to the development of EBP in healthcare and social work: the randomized controlled trial, the meta-analysis, and the aforementioned clinical practice guidelines (Bohlin & Sager, 2011). The randomized controlled trial (RCT) is often referred to as "the gold standard" for evaluating the effects of an intervention (Will & Moreira, 2010), where the effects of an intervention are tested against at least one control group, who are given either a different intervention or no intervention at all. The participants are randomly assigned to either group, meaning that the groups only differ with regard to which intervention they are given. Accordingly, potential difference in outcome between the groups can with some certainty be attributed to the intervention. In medicine, RCTs are often 'double blind', which means that neither the patient nor the staff knows what medication is being administered. This is a way to secure an unbiased procedure. In psychosocial interventions, however, where an intervention consists of social activities of different kinds, this is virtually impossible to achieve.

The second method is meta-analysis, a statistical technique for synthesizing results from different studies, often RCTs (Bohlin, 2012). As clinical trials often point in different directions, a meta-analysis is a convenient way of summarizing the evidence on a given topic. The third method is the clinical practice guideline, which can be seen as a method to make relatively abstract research findings practically relevant.

In social work, where 'psychosocial interventions' are the prototypical way of handling clients' problems, a fourth tool may be added, namely the treatment manual (Addis & Cardemil, 2006). Psychosocial interventions are characterized by a high degree of complexity – as distinct from many inter-

ventions in healthcare (cf. Lambert, 2006) – derived from the fact that they are dependent on how they are carried out by professionals and the psychosocial processes that are evoked. A treatment manual thus seeks to standardize important elements of how a psychosocial intervention is used: the basic approach, order and details of sessions, and potential exercises. Similar 'procedural standards' (Timmermans & Berg, 2003a) are present in healthcare but are more technical in their orientation. Standardizing psychosocial interventions into treatment manuals is a way of making them 'testable' in clinical trials, to be able to draw conclusions as to whether certain elements are efficacious. Manuals are also used in clinical trials to ensure that the intervention is used with 'treatment fidelity' – meaning close adherence to its theoretical description – and have become a common tool in social work and mental health practice where 'treatment fidelity' to evidence-based interventions is increasingly expected (Westen et al., 2004). Treatment manuals can thus be seen as a tool that seeks to stabilize the connection between complex 'evidence-based' psychosocial interventions and their actual use in professional practice.

EBP, standardization, and professionalism

No matter how it is defined, EBP can be described as a standardization project (Knaapen, 2014). The production of evidence is subjected to highly standardized methods such as RCT and meta-analysis; when evidence is transported to clinical practice, standardized procedures such as guidelines and treatment manuals are used; and in the case of critical appraisal, the decision process is supposed to follow a standard procedure entailing a series of steps. EBP can thus be said to be part of a larger societal movement that emphasizes standards and standardization (Brunsson & Jacobsson, 2000; Timmermans & Epstein, 2010).

The modern call for standards can be understood in terms of trust. While traditionally professional expertise has been trusted, Porter (1995) argues that when expert disciplines or professions are put under pressure, they are forced towards standardization. Whereas expertise is tied to personal and social features of a discipline, a standard is independent and impersonal. It means following the rule and implies a check on subjectivity. To an outside community this is easier to trust than personal expertise. Thus, educational background, practical experience and personal expertise are no longer sufficient as a basis for trust in professional work. It must further be legitimized by showing concrete results, numbers, that are not flawed by personal bias (RCTs and meta-analysis), and that assessment and decision making are held in check by standards of different kinds.

This implies a challenge for the professions, because while standards can increase accountability, they can also reduce the autonomy of the profession

(Timmermans & Berg, 2003). A profession is often defined as an occupation having control over the form and content of their work (Freidson, 2001). Thus, a standard developed outside the profession – a guideline, intervention manual, or assessment instrument – detailing what the professional should do, can infringe on the professional autonomy. In this case, professional judgment is opened up to third parties. In healthcare, EBM has primarily been a professional project, with the guidelines of different kinds mainly developed within the profession (Timmermans, 2005; Armstrong, 2007).

The social work profession, however, operates under somewhat different circumstances. Social workers' professionalism is to a large extent defined by the bureaucratic organizations in which they operate (cf. Lipsky, 1980). Evetts' (2009) concepts of 'organizational' and 'occupational' professionalism can be used to describe this difference between medicine and social work. Whereas medicine as an 'occupational profession' emphasizes collegial expertise and autonomy of judgment, social work as an 'organizational profession' is based on organizational control where professional autonomy is limited. In line with this logic, EBP has by and large moved to social work through bureaucratic structures. In Sweden, it is the central bureaucracy that has been the driving force, promoting the idea, initiating educational programs, and commissioning guidelines, among other things (Bergmark, Bergmark, & Lundström, 2012). The idea of EBP has then been picked up by managers in the social services, such as the agency studied in this dissertation. Rather than expressing a professional ambition as in healthcare, EBP in Swedish social work reflects an organizational or bureaucratic ambition, something which may shape how it is enacted in practice.

The evidence movement

EBP and its conceptual siblings have seen a remarkable spread across countries and professions during the last two decades. The efforts being done to make sure that evidence is produced and used in professional and policy work is often referred to as 'the evidence movement'; articulated through the launch and work of a wide range of organizations, governmental as well as non-governmental. The Cochrane Collaboration was one of the earliest organizations working to synthesize and make evidence available for professionals and other stakeholders within healthcare. Comprised of an international network of researchers, they take as their mission to conduct easily accessible systematic reviews of RCTs. Established in 1993, they are now the largest evidence-producing institution in terms of publication of systematic reviews. A similarly important organization for social work is the Campbell Collaboration, which was initiated in 2000 to produce and make available systematic reviews of the effects of social, behavioral and educational interventions. As with the Cochrane Collaboration, the work of the

Campbell Collaboration is based on a strict methodological program in which RCT's are viewed as the primary method to be included in systematic reviews.

In social work, the evidence movement has been differently institutionalized in different countries. In the US, there has been an emphasis on non-governmental organizations promoting EBP and evidence production (Bergmark, Bergmark & Lundström, 2011). In the UK, work to synthesize and make evidence available has been a dynamic effort between independent researchers and the central bureaucracy (Hansen & Rieper, 2009; 2011). In Norway and Sweden, it has mainly been a central bureaucratic project (ibid). As may have been noted, most of the efforts of the evidence movement can be subsumed in a guideline model of EBP. However, the organizations differ with regard to what kind of knowledge is emphasized and produced. Whereas Cochrane and Campbell stand for a strict methodology, the Social Care Institute of Excellence (SCIE) in the UK takes a much more pragmatic stance (Pawson et al., 2003).

Sweden has a long tradition of central bureaucratic efforts to make sure that social services interventions are effective (Bergmark, Bergmark & Lundström, 2011). Already in 1993, before EBP was launched in Swedish social work, a unit within the NBHW was initiated with the aim of synthesizing evaluations of interventions in the field of social work. When EBP came into popular use during the late 1990s, this unit became the central promoter of the idea in Sweden. However, their interpretation of what EBP stands for has remained somewhat unclear. Although officially advocating a critical appraisal model (cf. Sundell et al., 2006), their work has focused on promoting the use of 'evidence-based' interventions and standardized assessment instruments in social work practice (Sundell et al., 2008). The social services agency studied in this dissertation collaborated with this unit for two years in trying to implement EBP.

The unit gradually developed a strict methodological program for EBP, arguing strongly for RCTs as fundamental in assessing the effects of social work interventions (Soydan, 2010). This work has been criticized by social work scholars for its rather forceful and inconsistent attempts to promote EBP in Sweden (Bergmark, Bergmark & Lundström, 2012).

In 2008 a government report (SOU 2008:18) was published that suggested that the development of EBP should be an overarching goal in the Swedish social services. The report argues for a critical appraisal model, but suggests that standardized assessment is also needed, both as a way to strengthen assessments and as a way to facilitate local evaluation of social services interventions. Following this, work with EBP has gradually shifted from the NBHW to the Swedish Association of Local Authorities and Regions (SALAR). Beginning in 2011, SALAR and the Swedish government annually signs agreements about the commitment to EBP in the social services. Here, EBP is defined as a critical appraisal model. The agreement

obligates SALAR to initiate different projects to support the development of EBP. Between 2011 and 2014, a total sum of SEK 682 million was allocated to the agreement (Statskontoret, 2014).

One of the most comprehensive projects within the substance abuse area is 'knowledge to practice', which was a nation-wide campaign aimed at implementing the NBHW guidelines on substance abuse treatment (Socialstyrelsen, 2007). The campaign also included a basic course that covered a wide range of topics around substance abuse. Although the agreement between SALAR and the government describes EBP as critical appraisal, this project deals with a different definition that is more in line with the guideline model (Karlsson & Bergmark, 2012). This illustrates that the Swedish public discourse about EBP in social work still is somewhat confused and leans towards a guideline model, at least regarding the concrete attempts to orchestrate the idea.

This dissertation

The overall aim of this dissertation is to study empirically what EBP becomes when put into practice. That is, instead of being content with theoretical discussions about what EBP is or should be, this dissertation asks what it means and implies in actual practice. As such, it does not depart from a fixed idea about EBP, but takes an empirical stance both on what is and on the potential benefits and drawbacks of the idea.

To study these questions, ethnographic fieldwork was conducted in a social services agency that has worked extensively with implementing EBP for several years. Having adopted the public discourse on EBP and collaborated with the NBHW, they can be seen as a critical case of the central bureaucracy's attempts to establish EBP in the Swedish social services. The dissertation consists of four papers that all analyze various aspects of EBP in practice.

I. How the standardized assessment instrument ASI is incorporated in the agency's daily practice.
II. How the psychosocial intervention Motivational Interviewing (MI), commonly regarded as 'evidence-based', and its efficacy has been constructed in the substance abuse research literature.
III. How MI is incorporated in the agency's daily practice.
IV. How treatment decisions are made in the agency's daily practice compared with the critical appraisal model.

Papers I, III and IV focus on the agency's use of different aspects of EBP that are commonly discussed within the evidence movement. Studying these aspects in practice, the papers reveal critical processes and assumptions in-

volved in the implementation of EBP that have been neglected or hidden ‘behind the scenes’. Since MI is such an important aspect of the agency’s enactment of EBP, its development within the substance abuse research literature was comprehensively examined in paper II. Although it concerns research practice, it points in a similar manner to the work that is done to produce an ‘evidence-based’ intervention; work that often becomes invisible once the label has been generally accepted. Paper II thus also studies evidence behind the taken-for-granted ‘scenes’.

Approaches to EBP and standardization in previous research

In this chapter, I briefly summarize how EBP has been approached in previous research. As it is closely connected with aspects of standardization – manualized interventions, standardized assessment and decision making, etc. – the chapter will also touch upon these aspects. There are three bodies of literature that will be related to: the social work literature, the addiction research literature, and science and technology (STS) research on EBM and its standards as applied in healthcare. In the social work and substance abuse research literatures, the reception of EBP has turned out radically different. In social work there has been an explicit and extensive discussion around the pros and cons of EBP as well as how it should be implemented. In addiction research, few have explicitly discussed the concept of EBP. Instead, it is possible to see what might be called an unspoken adoption of the tenets of EBP in empirical studies: clinical trials, studies on the dissemination of empirically-based interventions, quantitative evaluation of implementation strategies, and development of systematic reviews and guidelines. In the STS literature, which is reviewed here because this dissertation draws on typical STS theories and methods, EBM has been approached in a more empirical fashion.

Positions in social work

In social work research, EBP has been received with both hope and fear. The literature about EBP is vast and messy, and there are numerous positions that have been taken. This review is not exhaustive but tries to sketch some general features of these positions.

Two major traditions of EBP proponents can be discerned (cf. Bergmark & Lundström, 2012). One tradition, comprised mostly of American scholars, argues actively for the critical appraisal model of EBP (Gambrill, 1999; 2006; 2010; Gibbs & Gambrill, 2002, Shlonsky & Gibbs, 2004; Thyer & Myers, 2011). Here, EBP is described as a decision making process in line with Haynes et al. (2002) that uses professional judgment in integrating information about the client, client preferences and research evidence. This has also been called the ‘enlightened practitioner’ model and is built around the

individual social worker. One of the leading proponents of this interpretation, Eileen Gambrill argues that:

> The key implications of this view of EBP are the following: (a) Move away from authority-based decision making in which appeals are made to tradition, consensus, popularity, and status; (b) honor ethical obligations to clients such as informed consent; (c) make practices and policies and their outcomes transparent (Gambrill, 2006 p. 341).

However, some scholars point to the difficulties of achieving this in practice and argue instead for the development of guidelines that can aid the social workers' decision making (Rosen et al, 2003; Rosen & Proctor, 2003). Such guidelines, developed by researchers or government agencies, can provide 'evidence-based' recommendations on what interventions to choose for which clients. However, this has met with criticism from critical appraisal proponents arguing that this is yet another way of relying on authority and that it omits attention to client values and their individual circumstances (Gambrill, 2006). In a similar line, Shlonsky & Gibbs (2004) argue that EBP is not about imposing standards from above, but a bottom-up process that begins and ends with the client. Further, Thyer & Myers (2011) argue that lists of empirically supported treatments are in fact antithetical to the original and "correct" interpretation of EBP.

Another tradition of EBP proponents consists of scholars with a less programmatic approach, but nevertheless with an explicit aim to promote use of evidence in practice. This is mainly a British tradition and many of the scholars are tied to the Social Care Institute for Excellence (SCIE), an independent agency working to share knowledge about 'what works' in social work and care. Within this tradition there is a broader attention to the use of evidence, and critical appraisal is merely one out of several models considered (Nutley et al., 2009). Compared with the American tradition which focuses on the decision process as a whole – and not just the incorporation of evidence – this tradition has concentrated on promoting the use of evidence and knowledge in social work. Important discussions have evolved around what kinds of knowledge are necessary for social work practitioners. There is generally an appreciation of broader types of knowledge than are traditionally acknowledged in EBP. Although research evidence is seen as an important type of knowledge, it is contended that social work practice needs different types of knowledge, including qualitative research, organizational knowledge, practitioner knowledge, and service user knowledge (Pawson et al., 2003; Coren & Fisher, 2006; Marsh & Fisher, 2008; Trevithick, 2008).

EBP has also met with criticism from a variety of perspectives. Some scholars have dismissed it altogether, whereas others have criticized aspects of it or how the question has been talked about or handled by public authorities. One of the most forceful critiques against EBP has been formulated by

Stephen Webb (2001), who argues against both a positivistic view of knowledge and a rationalistic conception of decision making in EBP. He contends that the view of knowledge inherent in EBP "underplay[s] the values and anticipations of social workers at the level of ideas, [and] ignores the processes of deliberation and choice involved in their decision-making" (Webb, 2001, p. 67). Regarding the stepwise decision process in EBP, he argues that:

> Evidence-based practice entraps professional practice within an instrumental framework which regiments, systematizes and manages social work within a technocratic framework of routinized operations. While this dominant form might be applicable for certain branches of medicine, its translation across to social problems and issues is far from being straightforward (Webb, 2001, p. 71).

Similar lines of critique, although more modest, have been called to attention by other scholars. For example, van de Luitgaarden (2009) criticizes EBP for resting on a decision making model that does not fit with the actual decision tasks existent in social work practice, and proposes a 'recognition primed decision making model' arguably more suitable for the complex decision tasks of social work. Although not refuting more formal kinds of evidence, other scholars have argued for a broader view of knowledge in assessing the merits of interventions and in making decisions (Månsson, 2003; Gray & McDonald, 2006). On a similar note, Nevo & Slonim-Nevo (2011) have questioned the word 'based' in Evidence-*based* practice. They argue that decisions cannot be 'based' on evidence as the word suggests a singular basis on which social work practice should rest. They instead suggest Evidence-*informed* practice (EIP), which they argue deemphasizes formal evidence as merely one out of several influences to consider.

Scholars in social work and addiction research have also questioned some traditional assumptions of EBP in face of many clinical trials that do not suggest any important differences in outcome between 'bona fide' psychosocial interventions (Bergmark & Lundström, 2011; Manuel et al., 2011). The interpretation of these results with regards to EBP has been a debated topic in psychotherapy research for two decades (Wampold, 2001; Westen et al., 2004) and has only recently been highlighted in social work (Bergmark & Lundström, 2011; Mullen et al., 2011; Sundell, 2012; Mullen et al., 2012).

Empirical studies of EBP

Although discussions about EBP have been central within the social work field, few studies have engaged in empirical investigations of the concept. As in the social science literature about EBM, discussions have tended to be "grand, organized as abstract critique of EBM rather than as empirical re-

search of particular cases of its development or use" (Mykhalovskiy & Weir, 2004). As we saw above, there are also notable proponents in social work, but the discussion is nevertheless pitched at high levels of abstraction. However, empirical studies about EBP – in different meanings – have started to appear. These studies can be categorized into a promoting tradition with an explicit goal to improve the implementation of EBP and studies that are more independent with regards to the goals of EBP.

The promoting tradition in social work and addiction research is in many ways connected with the field of implementation science, which has arisen in the wake of the evidence movement's call for increased use of evidence in professional practice. Implementation science embraces the tenets of EBP and seeks to establish a scientific approach to its implementation within a wide range of professional fields. This often means using experimental quantitative methodology to find factors that support or hinder implementation. Studying the implementation of psychosocial interventions, the ultimate goal is to achieve 'treatment fidelity', which means adherence to a theoretical description of an intervention, often specified in a treatment manual. One of the most frequently cited implementation studies in social work is Dean Fixsen and colleagues' review of 743 implementation studies within a wide range of fields,[2] among other things the social services (Fixsen et al., 2005; 2009). They arrive at seven 'core components' that they view as essential for supporting high-fidelity implementation. These include staff selection, pre-service and in-service training, ongoing coaching and consultation, staff performance assessment, decision support data systems, facilitative administration, and systems intervention. In social work and addiction research, this approach to implementation has mainly been used to study the implementation or diffusion of interventions and the effectiveness of various training strategies (Stern et al., 2008; Bond et al., 2009; Garner, 2009; Madson et al., 2009; Manuel et al., 2011; Schwalbe et al., 2014). There are, however, studies in social work that have examined the implementation of EBP as a process, using a similar approach (Gray et al., 2012). Although this tradition relies heavily on quantitative methodology, there are qualitative studies that have studied implementation of EBP with a similar approach. These have typically focused on attitudes towards or knowledge of 'evidence-based' interventions or the EBP process, and perceived barriers to implementation (Barratt, 2003; Aarons & Palinkas, 2007; Manuel et al., 2009; Lundgren, 2011).

In this tradition, a great variety of variables have been shown to contribute to the implementation outcome, and there is no single variable that can explain all the variance. Depending on theoretical orientation, variables can be operationalized differently, which further contributes to the plethora of

[2] Other fields include agriculture, business, child welfare, engineering, health, juvenile justice, manufacturing, medicine, mental health, and nursing.

variables that have been suggested as important. Variables that are often mentioned include staff attitudes, training in the approaches that are implemented, monitoring of implementation results, and organizational resources. And regarding implementation of the critical appraisal model of EBP, lack of evidence is often mentioned as a barrier (Mullen et al., 2008; Gray et al., 2012). Thus, there is an attention to virtually all variables except the things that are supposed to be implemented, namely EBP and its various interventions.

In more independent empirical studies, which are marginal compared with the promoting tradition, attention is also directed toward EBP and standardized procedures as such; but here, EBP is not taken for granted as something 'good' that shall be implemented no matter the cost. This research is theoretically more diverse than the promoting tradition and there are different levels of analysis.

On an overriding level are studies that have mapped the adoption of EBP among social workers, their attitudes to it as well as their reported activities related to the concept. Surveys in Sweden, the United Kingdom, United States, and Australia suggest that a majority of the social workers support the basic idea of EBP, but that they rarely search for or apply research findings in practice (Bergmark & Lundström, 2002; Bergmark & Lundström, 2011; Morago, 2010; Pope, Rollins, Chaumba & Riesler, 2011; Gray, Joy, Plath & Webb, 2015). A common finding regarding social workers' attitudes toward EBP is that it can represent a variety of different meanings (Scurlock-Evans & Upton, 2015; Avby et al., 2014). Gray and colleagues have investigated the spread of what they call the 'EBP network' by studying institutional efforts to establish EBP in different countries (Gray et al., 2009). They note a remarkable spread, but that EBP as a concept is modified as it is handled in different national and institutional contexts.

Regarding more practical aspects of EBP, studies have now emerged that examine evidence production as well as the use of EBP in practice. Studies examining activities of evidence production have pointed out inconsistencies regarding the standardization aspects within EBP. It has been shown that there is little agreement between clinical guidelines' and evidence-producing organizations' claims about the evidence base of psychosocial interventions (Bergmark et al., 2014; Karlsson et al., 2014). Further, Karlsson & Bergmark (2015) show that Cochrane and Campbell reviews on psychosocial interventions underappreciate the use of control-group types, something that gives a confused picture of treatment efficacy.

There are but few studies that have looked at the use of EBP and associated standardized procedures in practice. Only one study in social work has looked at the use of EBP as a decision process (Plath, 2012). Drawing from interviews with managers, specialists and front-line staff in a human service organization committed to EBP, Plath finds that although the decision model is relevant within the organization, some modifications may be warranted.

Plath discusses a need to call attention to the organizational contingencies of individual decision making and that a cyclic, as opposed to a linear, approach to EBP might be a fruitful way forward. Qualitative studies on the use of evidence in practice have tended to focus on 'softer' kinds of knowledge such as 'expertise' or 'practice-based knowledge' (Avby, 2015; Smith, 2014a; Smith, 2014b). When more standardized procedures have been studied – such as use of the ASI – there is often a focus on the social *meanings* of using a standardized instrument, such as its ability to increase the legitimacy of the agencies using it (Abrahamson & Tryggvesson, 2009; Martinell Barfoed & Jacobsson, 2012). Thus, analysis of actual use of the instrument is marginal. In cases where more standardized procedures indeed have been explored in practice, a general conclusion is that these fail to understand how social work practice actually functions (Broadhurst et al., 2010; Gillingham, 2011; Ponnert & Svensson, 2011; Smith, 2014a; Martinell Barfoed, 2014). While some studies discuss this in relation to the specific intervention or tool studied (Broadhurst et al., 2010), some raise more general doubt toward standardization in social work practice (Gillingham, 2011; Ponnert & Svensson, 2011; Martinell Barfoed, 2014).

EBMs actual evidence base and actual use of evidence and standards in healthcare

In the STS literature, there is a more explicit empirical focus on the evidence base of EBM and how its standards are actually used in practice. That is, rather than equating EBM with its formal rules, empirical attention is turned to how actors in fact relate to these rules in the production and use of evidence and standards (Knaapen, 2014). Research on the actual evidence base of EBM has shown that the generation and classification of evidence is not a 'natural' process in which it has a clear-cut definition, but that there is diversity in how evidence is produced and justified. Studies on the conduct of randomized controlled trials have shown how deviation from research protocols is common, but is 'cleaned up' and made to disappear through various practices (Helgesson, 2010; Will & Moreira, 2010). Studies on the construction of guidelines and evidence-based policies have shown how different principles, apart from 'high quality' evidence, are used to justify the inclusion of studies, and that the very definition of evidence varies between the actors involved in such projects (Moreira, 2005; Knaapen, 2013; Fernler, 2015; Sager & Eriksson, 2015). Consequently, it has been argued that EBM does not reflect a simple regime change that favors 'numbers' over expertise (Cambrosio et al., 2006).

In a similar manner, studies concerned with the actual use of EBM standards have shown that they often are adjusted and complemented with other

kinds of input as they are applied in practice. Ethnographic studies have shown that whereas a standard is supposed to be applicable universally, they often are reinterpreted, transformed, or 'tinkered' with in line with situated judgments and knowledge of the local setting in which the standard is supposed to be implemented (Hogle, 1995; Mol, 2008; Mol, Moser & Pols, 2010; Timmermans & Epstein, 2010; Sager, 2011). Based on several cases studying the practical use of standards, Timmermans & Berg (2003a) argue that such reinterpretations need not reflect professional resistance, but that it is a central feature of how standards are made to work in a local context. They have also highlighted the *mutual* adjustments that take place when using standards in practice. It is not only practitioners that reinterpret standards; the standards can also lead to reinterpretation of the roles of the practitioners, their skills and work tasks, etc. (see also Berg, 1997). Thus, rather than replacing professional expertise, which some have feared regarding EBM, there is in practice a dynamic interaction between standards and professional expertise.

'Relating to the literature'

In sum, a lot has been written about EBP in the social work and STS literature, and to a less extent in addiction research. In social work, a great number of studies have been devoted to arguments for and against different conceptions of EBP. Most empirical research in both social work and addiction research has focused on trying to find out how best to implement EBP in different meanings. Here, EBP and interventions are regarded as something self-evidently 'good' that ought to be implemented in order to improve social work or addiction treatment practice. There are also empirical studies that do not share this normative stance but direct attention to the concept of EBP and its standardized procedures. Many studies have focused on attitudes towards EBP but only a few have studied actual practice.

This dissertation contributes to an independent empirical approach to the study of EBP, and more specifically to understanding the concrete practice of working with EBP. But contrary to most previous social work studies that either have an uncritical view or sweepingly dismiss EBP and standardized procedures in social work, this dissertation challenges a simplistic and one-sided attention to standardization. In line with STS research on EBM, it sees the fit or non-fit of standardized procedures in social work as a question open to empirical examination. It is only by looking closely at the interaction between these that it is possible to see how they can or cannot feed into each other. How this is conceived of theoretically is detailed in the next section.

Theoretical perspective

As suggested earlier, the focus on practice is a central point of departure in this dissertation. Although charged with different meanings, the concept of EBP points at something to be realized in practice; evidence shall be produced and social services agencies shall use this evidence according to certain standards. The theoretical concepts used in this dissertation are derived from the field of science and technology studies (STS), which builds on a view of science and technology as active processes or practices (Sismondo, 2010, p. 10).

The interventions, instruments, and decision-making models that are studied in this dissertation are referred to generically as standardized procedures or standards. Within the STS framework, these standards can, depending on the context, be seen both as scientific and as technological objects. In the sense that the term evidence suggests scientific activities of evaluating the effects of an intervention, it can be seen as a scientific object. But in the sense that interventions as well as instruments in social work often are highly standardized activities that are supposed to produce certain outcomes, they can also be seen as technological objects. Defining the exact boundaries between science and technology, however, is arduous – the above distinction serves mainly as a rationale for how both the science and technology sides of STS can be relevant for the study of EBP in social work.

A focus on practice: construction and enactment

The field of STS began in the 1970s with the argument that it is possible to empirically study the *content* of scientific knowledge (Bloor, 1991 [1976]). While earlier studies in the sociology of science had focused on organizational and institutional aspects *surrounding* science (cf. Merton, 1957), this argument suggested that it was possible to study empirically how knowledge, or whatever people take to be knowledge, is brought about. Later developments in STS have moved away from merely studying the outputs of science – knowledge, that is – to studying science as *practice*, meaning what scientists actually do (Pickering, 1992). Beginning in studies of science, similar approaches to technology have developed underway (Pinch & Bijker, 1984; Bijker & Law, 1992). More recently, this approach has also

been applied to the study of standards under the heading 'sociology of standards' (Timmermans & Epstein, 2010; Knaapen, 2014).

Focusing on practices of scientific and technological work, STS can thus provide theoretical concepts that help me analyze the practical construction and use of standardized procedures in social work practice. But before describing the particular concepts, I will begin by describing how I relate to the concept of practice, which I see as the theoretical foundation of the dissertation.

Treating science, technology, and standards as *practice* means that they are seen as active open-ended processes. Thus, practice is interesting in its own right, as opposed to traditional approaches where the primary concern has been the end products of science, technology, and development of standards (Pickering, 1992; Timmermans & Epstein, 2010). This can be illustrated using an example of how the implementation of EBP and its standardized procedures are usually approached in social work (and in many other fields for that matter). Often departing from diffusion theory (Rogers, 2010), standardized procedures – regarded as innovations – are treated as fixed or given entities that are diffused or communicated between people. Different strategies are studied to make an innovation spread and to make people use it, but the innovation itself is mainly unproblematized. In contrast, focusing on innovations in practice implies trying to understand what standards and EBP *become* when used in practice and what conditions contribute to the ways in which it is used. In a comparison with the 'model of diffusion', Latour (1987) calls this approach 'the model of translation', which points to the circumstance that technologies or standards are dependent on how they are handled or used. That is, people do not just use standards in a neutral way, but also do something to them; translate them to their particular interests or contexts.

This view of practice highlights that no element within it is 'given', but emerges in interaction with other elements in practice. There are different ways of describing this emergence. Traditionally in STS, this has been seen as social construction (Berger & Luckmann, 1966). That is, facts and technologies are essentially *human* products. However, the sole focus on *social* constructions has been criticized for not leaving a role for the material world in scientific and technological work (Sismondo, 2010). This has been a controversial issue in STS, where different traditions have fought over how to understand the role of material objects, or nonhumans. In the Actor-network theory (ANT) tradition, a 'symmetrical approach' has been proposed in which humans and nonhumans should be granted the same status in the analysis of science and technology (Callon, 1986; Callon & Latour, 1992). This approach has been fiercely criticized by proponents of the sociology of scientific knowledge (SSK) tradition, which argues that humans and nonhumans are crucially different (Collins & Yearley, 1992). Even if not everyone agrees with the 'symmetrical approach', many STS scholars have skipped

the word social and instead use *construction* in order to denote the heterogeneity of the objects of science and technology. But not only scientists and engineers construct objects of different kinds, the objects of science and technology are involved in shaping society as well (Bijker & Law, 1992). This is often referred to as *co-construction* or *co-production* (Oudshoorn & Pinch, 2003).

But to talk of actors constructing a phenomenon can be somewhat clumsy. As Mol (2002) notes, doctors do not *construct* or *make* a disease when working with patients. Neither does the social services agency I am studying construct the notion of EBP, but nevertheless they use it and do something to it in practice. Mol's solution is to use the word *enactment* for studying how objects come into being in practices. In practice, objects and subjects of different kinds are *enacted*.[3]

In this dissertation I make use of both the notion of construction and of enactment to describe how EBP and its standardized procedures are handled in practice. The dissertation as a whole is about the enactment of EBP. This means that I am interested in the various ways in which EBP is done, without judging it against different theoretical definitions. That is, if I find that the agency violates some theoretical definitions of EBP, I will not dismiss their interpretation but try to understand what aspects of practice contribute to this particular enactment. The notion of construction is used mainly to denote how "evidence-based" interventions come into being by the work of researchers developing and evaluating it. Neither the term "evidence-based" nor the identity of the intervention is given, but is constructed within research practices. Here, I do not use the term social construction, since the researchers do not only draw from social resources, but use tools such as RCTs and meta-analyses. Although not viewing nonhumans as full-blown actors, I take them to be important for understanding the unfolding of many kinds of events. The term co-construction is used to denote the negotiations or mutual adjustments that take place when the standards are put to use by the social workers at the agency.

[3] This view of objects and subjects carries epistemological and ontological consequences. Mol (2002) argues that this way of approaching objects is a move away from epistemology. "Objects…are not taken here as entities waiting out there to be represented but neither are they the constructions shaped by the subject-knowers." Instead, the reality of an object is to be found in the practices in which it is handled. This is to say that ontology is an empirical matter, and that ontology is not necessarily singular, since objects can be handled differently in different practices. In STS, this has been talked about as an 'ontological turn', which has led to a debate about whether it is a turn, and what is ontological about it (Sismondo, 2015). I do not emphasize the ontological aspects of enactment in this dissertation; it is rather a concept that has helped me to stay empirically sensitive to the way standardized procedures are used in different practices.

Evidence-based interventions in the making

Studying the emergence of an evidence-based intervention, MI (paper II), I have made use of an analytical approach in STS that focuses on how knowledge or facts are brought about. It starts out with a fact that is collectively agreed upon; in this case that MI is an evidence-based intervention. But instead of treating this as a necessary or self-evident fact, this approach is interested in understanding how and why this has occurred. This kind of historical analysis requires a *symmetrical approach* toward the different statements about MI's efficacy that have existed throughout its development (Bloor, 1991). That is, all statements require explanation, not only those that are now considered false or irrational. In other words, the different statements are not interpreted through the lens of what is now believed to be true. This is a way of highlighting that what we now consider true does not naturally follow from reality – it could be otherwise.

To account for both the ambiguous and the well-ordered aspects of MI's development, I have used the concepts of *fluid technology* (de Laet & Mol, 2000) and *stabilization* (Pinch & Bijker, 1984; Latour & Woolgar, 1986). Traditionally, technological objects are viewed as stable entities with clear-cut boundaries. The notion of a *fluid technology,* however, points to the constructedness of an object as it is used in practice. De Laet & Mol find that the Zimbabwe bush pump is fluid in several ways. For example, its component parts are not necessarily fixed but are easily changed and can even be replaced by whatever is to hand (branches, old tires, etc.) without losing its ability to pump water. This fluidity is an important aspect for its wide dissemination. But fluidity is not merely a case of interpretative flexibility in which people socially construct the meaning of the pump. Rather, the fluidity is built into the pump itself. Similar aspects can be identified in MI as well. It was created as a fluid intervention, which its developers have been keen to preserve.

But it is also possible to see that some kind of stability in MI has been created. This has been analyzed using the concept of *stabilization.* Latour & Woolgar (1986) use the term stabilization to describe how statements regarding the properties of scientific objects are transformed into more and more certainty (although it could just as well move in the other direction, signifying a de-stabilization). In this view, a statement referring to a taken-for-granted fact contains no modalities that explicitly mention possible uncertainties underlying it. This is something that everybody knows. But in less stable stages, a modality may be added. For example, the statement: "X has been shown to be effective in studies A and B," contains a modality that mentions *where* X has been shown to be effective. This can be compared with the statement "X is effective," which treats it as common knowledge. In creating such statements in research articles, researchers try to persuade their audiences by using the resources available: research designs (in this case

often RCT's and meta-analyses), number of observations, tables, diagrams, etc.

MI's stabilization has been tracked in a similar fashion by focusing on statements about its efficacy in studies evaluating its effects. Given the fluidity of MI, it can be different things and be talked about using different words. The question then becomes how researchers relate to the object of their study: is it MI or something inspired by MI that displays these effects? Therefore, the stabilization of MI's efficacy can be said to contain two components: 1) the object of concern, and 2) the various degrees of efficacy that this object is assigned. The statement "MI is efficacious" thus reflects a more stable statement than "adaptations of MI are efficacious."

An interrelated stabilization process concerns the developers' strategies to promote that MI is used with fidelity in clinical as well as research practices. I call this identity stabilization. This concept is inspired by STS studies on technologies which draw attention to how technologies are shaped over time and how they are involved in shaping society (Pinch & Bijker, 1984; Bijker & Law, 1992).

Interventions, instruments, and decisions in practice

In studying the agency's use of 'evidence-based' interventions, standardized assessment instruments, and their efforts to make treatment decisions in line with critical appraisal (paper I, III, and IV), I have used what Timmermans & Berg (2003b) call a *technology-in-practice* approach. This implies a critique against both technological determinism and social essentialism in the study of technology, or in this case, standardized procedures. A technological determinist account sees standards as determining social events. This thinking underlies critics of EBP fearing that it risks reducing professionals to mindless cooks, only acting in line with instruments and treatment manuals (see Knaapen, 2014). On the other hand, social essentialists study the social meanings of standards without actually incorporating the specific *content* of the standard into the analysis. For example, use of evidence-based interventions and instruments is often studied as a strategy to increase the legitimacy of social services agencies. In this case the standards are reduced to being mere symbols. While these approaches both pay one-sided attention to standards, the technology-in-practice approach asserts a dual focus on the standard and the practices in which it is used, and the dynamic relationship between these. Hereby it is possible to analyze how standards are transformed as they are used as well as how they are involved in transforming ideas, social hierarchies, and ordering of activities.

Incorporating divergent scripts and logics

Standards are not neutral tools, but contain a set of explicit and implicit assumptions about the practice into which they are to be inserted (Timmermans & Epstein, 2010). As these assumptions rarely are entirely fulfilled in practice, they cannot be combined in a simple manner. A standard does not "simply slip into its predestinated space within a practice" (Berg, 1997, p. 79). Thus, making a standard and a pre-existing practice work together requires active efforts, negotiations, and prioritizations. Studying the agency's use of the ASI, MI and critical appraisal, I have used the concepts of *script* and *logics* to account for the underlying tensions that are brought to the fore.

Studying the use of MI, I have employed the concepts *script* and *description* (Akrich, 1992). Treating a standard like a film script facilitates an analysis that stresses its active role in the practice where it is inserted. Hereby the standard is not just a passive object waiting to be used, but is actively delegating roles to the user and envisions specific use contexts. In the case of psychosocial interventions it is easy to see this aspect in treatment manuals that specifies what should be said and done, and in what order. However, an intervention also implicitly creates scenarios for how users and contexts should be arranged. An intervention presupposes a certain kind of social worker, working in a certain kind of agency, with certain economic margins, etc. If the conditions *inscribed* in the intervention are not fulfilled in the 'real' practice setting (which they rarely are), the script and the various elements of practice will have to be adjusted to each other (Berg, 1997). This implies an adjustment of the script, a *de-scription*, as well as an adjustment of the user and the user-context.

A similar approach is used to analyze the agency's use of the standardized instrument ASI and the efforts to make treatment decisions in line with critical appraisal. Similar to the concept of script, the ASI and critical appraisal contain both explicit and implicit scenarios for how activities within the agency are and should be arranged. But in contrast to script, which primarily concerns the role of specific objects, the ASI and critical appraisal entail much broader scenarios that have to do with the overall modes of ordering practice. To account for this, and how they relate to the agency's preexisting practices, I have used the concept of logic (Mol, 2008). By logic I am referring to overall principles stating what kinds of activities are appropriate or relevant in a specific situation. A notion that captures similar principles of action is 'modes of ordering' (Law, 1994).

The ASI entails what I call a 'laboratory logic.' This logic is oriented towards producing quantitative knowledge about clients and requires careful coordination of activities at the agency. The ASI contains a number of preset questions that are put to clients during assessment and follow up. Thus, it seeks to coordinate *what* questions the social workers are asking as well as *when* they are asked. Done successfully, this enables quantification and in

turn statistical analyses of outcome and comparison of different client groups, etc.

Critical appraisal is based on the 'logic of choice' (Mol, 2008) containing a set of assumptions, both about how treatment decisions are made in social work practice and how they can be improved. This is in line with a rational choice model, much discussed in studies of organizational decision making (cf. Lindblom, 1959; March, 1988). Talking about decision making in individual terms, critical appraisal assumes that social workers are autonomous actors who make rational choices isolated from organizational arrangements. Moreover, it tends to view treatment decisions as 'one-off' events in which all the relevant facts and goals or values are collected and thereafter acted upon.

These logics are contrasted with the 'logic of care', developed as an alternative by Annemarie Mol (2008) to understand care processes in diabetes care. The logic of care can be described as an ideal mode of ordering the social workers' activities within the agency. Compared with the laboratory and choice logics, it suggests a more uncertain and less ordered practice. But this relative disorder is guided by a logic of its own. Rather than preset rules, activities within this logic are ordered so as to improve clients' daily lives and be attentive to clients' changing needs and unanticipated events that may occur during these processes.

Comparing the 'new' or alternative logics with the logic of care makes it possible to focus on two aspects of social work practice that are often conceived differently. The laboratory logic emphasizes quantification in social workers' assessment and follow-up of clients, as opposed to the logic of care, which emphasizes a need to adjust such activities to the client's unique situation. The logic of choice concerns the issue of how 'good' treatment decisions are made, when and by whom. In contrast to the logic of choice, the logic of care suggests that treatment decision-making is a more uncertain and iterative process involving a continuous attuning to the daily lives of clients and the various effects that treatment may have. Using an 'evidence-based' intervention is never a guarantee for success in practice, it may have unanticipated consequences that must be continuously attended to. In the logic of care, evidence, instruments, and aspects of the clients' daily lives are adjusted to each other or 'tinkered' with in order to improve the clients' overall situation (Timmermans & Berg, 2003; Mol, 2008; Mol, Moser & Pols, 2010).

But the logic of care is not the only logic that is relevant in social services treatment decisions. In the critical appraisal study (paper IV), the logic of care is complemented with what I call an 'organizational logic' in order to fully grasp the multiple considerations that must be made to make treatment decisions. Similar to the logic of care, studies in organizational decision making have shown that decisions in practice are uncertain and iterative (cf. Lindblom, 1959; March, 1988). But whereas the logic of care concerns the

relation between the social worker and different aspects of the clients' daily life, the organizational logic is useful for analyzing the organizational aspects of treatment decisions that are apparent in a bureaucratic setting such as the social services (Lipsky, 1980). Attention to clients' changing needs and preferences is thus merely one out of several organizational rationales that must be considered within a social services agency in order to make a treatment decision. But opposed to the logic of choice, which assumes that these rationales are external and stable over time, they have been shown to be rather ambiguous and internal to the decision process itself (Lindblom, 1959; March, 1988).

Both the logic of care and the organizational logic are close to the notion of practice used in this dissertation, which emphasizes that no element within practice is 'given' – e.g. clients' needs and preferences, and organizational rationales – but that they are defined in interaction with other elements of practice. But the logic of care tends to make uncertainty or complexity into a virtue, something that makes issues of standardization and better use of evidence impossible to pursue. My notion of practice highlights that such things do not exist naturally, but rather require active effort (cf. Latour, 1987; Berg, 1997). Quantification and situations of choice are not naturally occurring phenomena, but are *constructed* in practice. How this is done is a matter of continuous negotiation and prioritization.

* * *

Taken together, the theoretical concepts that are used in this dissertation are tools that help me analyze how EBP and its standardized procedures are actually used and produced 'behind the scenes'. The concept of stabilization points to the work that is done to produce a statement claiming an intervention to be 'evidence-based', something which often becomes invisible once the statement has been accepted, and. It thus opens up a space for studying evidence behind the taken-for-granted 'scenes'. The concepts of script and logics facilitate an analysis of what the ASI, MI and critical appraisal actually mean and imply in practice by helping to highlight critical processes and assumptions involved in the implementation of EBP in social work that are otherwise neglected or hidden 'behind the scenes'.

Methods

This dissertation makes use of ethnographic methods as the major data collection approach. Although much has been written about EBP in social work, few studies have explored how this is dealt with in the actual practices of social work settings. Quantitative studies typically measure the adherence to EBP models or specific interventions, and qualitative studies often focus on attitudes or what social workers say they do in relation to EBP. In line with Goffman (1989), this dissertation does not give much weight to what people say *only*, but tries to compare this with what they actually do in their everyday work, in their everyday contexts. This is the advantage of using ethnographic methods such as participant observation, interviews, and document analysis – it makes us come closer to phenomena as they actually occur in practice. As EBP points to something that shall be accomplished in practice, it is important that its practical effects, anticipated or not, are investigated as they happen in concrete social work settings.

Case selection

In order to use ethnographic methods, one needs one or several cases to study. In this dissertation I have studied one case, a social services agency that was selected because of some of its unique characteristics, described below.

In any kind of research, cases are used to say something of a whole class. In ethnographic research, the ability to make generalizations is limited in many respects. In fact, the methodological tradition is more interested in situated than universal knowledge (Abbott, 2004). But there are forms of sampling that can increase the generalizability of case studies. The case described in this dissertation was selected as a 'critical case' (Flyvbjerg, 2001). This means that it has strategic importance with regard to the general problem that I study in this dissertation, namely EBP.

First, the social services agency I have chosen has worked with EBP for several years, and they have done so in line with the public EBP discourse set by the NBHW and SALAR. They have even collaborated with and received extensive support from the NBHW in order to implement EBP, and were later highlighted as a 'good example' in their newsletters. Second, being a relatively large agency (by Swedish standards) they also have structural

preconditions in terms of budget, specialized social workers, and a variety of treatments that are required in order to implement EBP. Third, the agency handles substance abuse problems, which is a relatively evidence-dense research field compared with other branches of social work. This means that there actually is evidence to be used, which is hardly the case in other areas (Mullen et al., 2008).

These three aspects make this into a ’critical case‘ for the Swedish work with EBP in the social services. This does not mean, however, that the case is representative of Swedish social services’ work with EBP; but it may reveal important aspects of the challenges and possibilities of working according to EBP within the social services. If this agency cannot implement EBP as constructed by Swedish authorities, it is unlikely that any other social services agency in Sweden would succeed.

Getting initial access

Once I had formulated my research plan, it was more or less obvious that I should contact the agency described above. However, it was not self-evident that they would be interested in having me as an ethnographer snooping around in their corridors and offices. The reason for this doubt was that professors at my department had been critical of the NBHW’s work with EBP and that this agency, through the collaboration described above, was in some sense allied with them. I might have been regarded as an adversary only interested in criticizing their work. Nevertheless, I sent an e-mail to the intake and investigation unit manager of the agency, describing my plans, and asked whether they would be interested in participating. Fortunately, the answer that came the following day was positive.

After this initial consent, I met up with the manager to discuss practical details about my forthcoming fieldwork: how the work is structured, how to present myself and the project to the working group, and generally, how to proceed. We decided that I should present my project during their weekly workplace meeting, ideal since attended by all the social workers in the concerned units of the agency. During the meeting with the manager, it also became clear that I should seek permission from the individual and family services’ manager (a higher level) in order to be allowed to partake of sensitive classified information about the clients. This included writing a short description of the project signed by my supervisor.

This application was also approved, and after signing papers about confidentiality concerning client information, I was finally permitted initial access to the agency. I call this ‘initial access’ since access in ethnography is not only a matter of mere physical presence but something that must be negotiated continuously with numerous informants in the field (Hammersley & Atkinson, 2007). This access was also ‘initial’ in the sense that it did not

include all units of the agency. The treatment unit was accessed 18 months later when I knew that it would be relevant to study their work. However, this initial access meant that I had access to the physical space of the intake and investigation units, having been granted an access card that allowed me to come and go as I pleased, as well as access to their computers and intranet.

The field

> The field is produced (not discovered) through the social transactions engaged in by the ethnographer. The boundaries are not "given." They are the outcome of what the ethnographer may encompass in his or her gaze; what he or she may negotiate with hosts and informants; and what the ethnographer omits and overlooks as much as what the ethnographer *writes*. (Atkinson, 1992, p. 9)

I understand my "field" essentially as a field of practices (Czarniawska, 2007). A field need not be a singular or even a physical location, but places in which practices relevant for the agency's enactment of EBP occur. Although a description of a field is always to some extent a rationalization based on the ethnographer's goals, concepts and research aims, I will attempt to give a description of the field that at least helps the reader to understand some basic structures of the social services agency and the 'extended field' that is the focus of this dissertation. A description in all its complexity would preempt the remains of this dissertation, especially since the agency has undergone some changes during my fieldwork.

Geographically, the social services agency is located at the center of a large Swedish city. This particular area, once a working class district, is a gathering point for substance abusers and homeless persons, some psychiatrically ill, and often these problems come in various combinations. The last twenty years or so have seen a rapid gentrification with an influx of wealthier residents, making the district into an attractive part the city – and making the agency's clientele somewhat diverse.

The social services agency in which I did ethnographic field work is scattered across physical locations and organizational divisions; but coheres in the sense that it is part of what the informants speak of as a "chain of care" providing psychosocial as well as other practical support to people with substance abuse problems. The organizational complexity of the field has made it difficult to name it in a meaningful manner. I have, somewhat simplified, used the term social services agency to denote the chain of care in its entirety, because I see it as an example of a social services agency, even though it is not organizationally coherent as such. The parts of the chain of care are referred to as units. All unit parts of the chain of care belong organizational-

ly to the city's Individual and Family Services, which is, as already mentioned, large by Swedish standards.

All employees of the organization, including social workers and managers, are qualified social workers with at least a Bachelor degree. The social workers in the treatment unit are more educated in general, however, some with further psychotherapeutic training.

The agency consists of four main units: 1) Intake, 2) Investigation and treatment planning, 3) Psychosocial treatment, and 4) Reinforced aftercare.[4] There are five social workers at the intake unit. Here, the clients enter the agency, either by own volition or after being reported by family, friends, or other authorities, and undergo initial assessments to investigate whether they are entitled to services from the municipality. This work is regulated in the Social Services Act, which stipulates who are entitled to social services. However, sometimes clients with severe problems are not willing to voluntarily participate in treatment, which means that decisions about compulsory treatment according to the Care of Abusers (Special Provisions) Act may be considered. If the client is entitled and desires support from the agency, this is normally followed by a standardized assessment interview, in this case the ASI. Clients typically meet the intake social workers three or four times before being remitted to the investigators. Previously located in the same unit as the investigators, they now belong organizationally to a common intake unit within the Individual and Family Services which receives cases from all branches of the social services: social support, social psychiatry, and child protection. This means that they have their own unit manager.

The investigators are located in the same building, an ordinary office building with postmodern architecture, but on a different floor. The ten social workers there have long-term responsibility for the clients as long as they are involved in any support from the organization. Their work involves further investigation, planning for psychosocial treatment and various other kinds of support (housing, home support, employment support, etc.). The long-term responsibility means that they have to handle all the problems that can arise during the entire chain of care – relapses, evictions from homes, suspensions of treatments, etc., and make new treatment plans. Sometimes they too must consider remitting to compulsory treatment. The treatment and support that the investigators first and foremost consider are different outpatient treatments within the agency's own treatment unit, but even various external residential treatment centers and housing alternatives contracted by the municipality. There is a policy written by the unit manager that names these external services and suggests which types of clients are suitable for which service, and the investigators are expected to follow this as closely as possible. The investigators are also responsible for following up on their

[4] The following several paragraphs contains quotes from a paper in the dissertation (Björk, 2015).

clients, which they are obligated to do using the follow-up form of the ASI. Once a pure substance abuse unit together with intake, they are now organizationally joined with social psychiatry; but the substance abuse investigators nevertheless have their own manager.

The treatment unit is located in a different building a couple of blocks away from the intake and investigation unit. Being a cooperation between health care, psychiatry and the social services, the unit houses different kinds of professionals. Apart from the eight psychosocial treatment staff, who are employed by the social services, there are also two nurses and a part-time psychiatrist. In my fieldwork I have concentrated on the psychosocial treatment staff as they are seen as an important part of the chain of care. And when I refer to the treatment unit it is the psychosocial treatment staff I have in mind, who. They are essentially divided into three groups depending on their psychosocial orientation: cognitive behavioral therapy (CBT) in group or individually, twelve-step facilitation (TSF) in group, and individually tailored counseling and support with a wide range of theoretical influences such as MI, community reinforcement approach (CRA), solution focused therapy, etc. CBT and TSF are standardized treatment programs that follow a manual and are by far the most common interventions in the unit.

Reinforced aftercare belongs organizationally to the treatment unit and also shares the building. It is the task of two social workers to help the clients think about and plan for their everyday life during – but most importantly after – the psychosocial treatment is completed and the client is to begin a life without drugs and alcohol. Although it is the final step in the chain of care, reinforced aftercare is involved in the case directly after intake and they meet clients on a regular basis until three months after the psychosocial treatment has ended.

The extended field

Above I have only described the physical field. There are, however, practices in other places relevant for the agency's work with EBP. One example is the NBHW and SALAR's broad campaign for EBP in the Swedish social services, which the agency draws from as the main idea guiding their work of implementing EBP. Another example is the NBHW guidelines for substance abuse treatment, which is – at least formally – an important source of evidence in the agency's treatment decisions. Yet another example, which I have plunged into in extra empirical detail, is the agency's use of MI. All of these examples are part of 'the field' as they are fundamental for the agency's work with EBP. These have been accessed mainly through written texts: public documents and research articles.

Using MI is one of the agency's main ways of implementing EBP, and one of the activities that has had most impact on their work. The rationale behind its use is because it commonly is regarded as evidence-based. I therefore found it especially important to 'follow' MI as it was articulated in the

substance abuse research literature and tried to track the practices resulting in it being talked about as evidence-based (Czarniawska, 2007; Latour, 2005).

In the field

Fieldwork was begun in April 2011 and finished in December 2012. I did not spend the entire period in the field, but did three 'rounds': April-July 2011, November-December 2011, and May-November 2012. This was motivated by the somewhat varied focus of the three ethnographic papers in the dissertation, which will be described in more detail below. During the fieldwork rounds I was in the field on average three days per week. In sum I spend approximately 400 hours in the field, doing participant observation and interviews.

I began my fieldwork with a broad interest in what social workers and managers actually do in relation to EBP. Given the theoretical focus on enactment and the constructedness of ideas, evidence and technologies, I did not have an a priori conception of what EBP meant, but was interested in how the agency defined it and how they went about doing it. It should be noted, however, that my conceptual framework differs from EBP with regard to epistemological stance. While EBP is rooted in a positivist tradition where scientific knowledge or evidence is seen as stable and objectively 'given', my conceptual glasses, grounded in a constructionist tradition, are inclined to see evidence as locally constructed and contingent. My contention is, and I hope this is shown in the four papers of the dissertation, that this has not prevented me from seeing stability as well. This is not least displayed in previous STS studies which have been able to account for stability in scientific, public, and medical work (e.g. Latour, 1987; Porter, 1992; Timmermans & Berg, 2003a).

The first round of fieldwork, spent in the Intake and Investigation Unit, was therefore a way to familiarize myself with the agency's work and to work out ideas for the papers that would comprise the core of the dissertation. (I had already decided in my research plan that I would write four separate articles.) I discovered pretty quickly that their use of ASI and MI were central in their efforts to implement EBP, so by the end of this round I had decided that I should study at least these two aspects. At that time, I was also intrigued by their decision-making practices and how research evidence did not seem to fit into this work. I therefore thought that some kind of study of treatment decision-making would be relevant. These three ideas eventually became the three ethnographic articles of this dissertation (Papers I, III, and IV). I shall refer to them as the ASI study, the MI study and the treatment decision-making study.

While the first round of fieldwork can be described as a pilot study, broadly intended to explore the agency's work in general and their effort to implement EBP specifically, the second and third rounds were designed according to the more specific aims of studying the use of ASI and MI, and treatment decision-making.

Different modes and focus of participant observation

In the field, I used different ethnographic methods such as participant observation, interviews, and analysis of documents and objects. My focus on practice and enactment led me to use participant observation as my major method of investigation. This method allowed the greatest opportunity for me to discover what the social workers and managers in the agency were doing and why. My participant observation has focused on the social workers' work with clients; the concrete actions by which they go about trying to help clients, as well as the surrounding factors that shape how this can or cannot be done. It is this I refer to when I talk about practice or practices. My focus on practice is inspired by Annemarie Mol's notion of *praxiography*, which "allows and requires one to take objects and events of all kinds into consideration when trying to understand the world" (Mol, 2002, p. 158). Whereas ethnography translates into 'writing about people', the notion of praxiography can be translated as 'writing about events', implying a decentering of human actors. All events described in this dissertation contain people, but they also contain many other factors or 'nonhumans' that nevertheless exert agency and that are crucial for understanding the unfolding of each event, e.g. the ASI, MI, guidelines, and local documents. This will be discussed in more detail later.

The participant observation has ranged from pure observation to almost pure participation. I did not, however, take employment as a social worker in the agency, nor did I perform any work as a full member of the agency. Even though all social workers knew (as did the clients) that I was there in the role of researcher, I was often treated as a member, or at least a semi-member, like, say, a trainee. For example one of the managers said, only half-jokingly, to one of the social workers that I was about to become an employee in the agency. I guess this had to do with our shared educational background as I also am a qualified social worker, albeit with no working experience as such. This was definitely something which helped me to establish trust and rapport with the informants, described in the ethnographic literature as absolutely necessary for accessing 'backstage' information otherwise hidden from non-members (Emerson, 2001, p. 126-127). It should be noted that I did not encounter any overt suspicion from any informant regarding my affiliation with the department that had criticized the NBHWs and SALARs work with EBP.

More specifically, participant observation has centered on different units and activities depending on the focus of each substudy. This is simply because the topics of the substudies were not relevant for all units and activities of the agency. The first round was spent in the intake and investigation units, mostly because it was these units that had most experience of implementing EBP. The second round, which focused on the agency's work with ASI, was also spent in these units, simply because it was these units that were responsible for using the ASI. During the third round, which centered on treatment decision-making and the use of MI, all units were investigated. This was motivated by a policy of the agency saying that all social workers are supposed to use MI in their client work. For the treatment decision study, however, there was special attention paid to the investigation unit since they are responsible for making treatment decisions. It should be noted that in analyzing the data, all previously gathered data were included in the analysis – not only those gathered specifically for the study in hand.

As a discrete way of getting acquainted with the informants (and they with me), I began attending meetings with social workers and managers only. In these meetings I mostly had an observational role, trying to write down what they discussed, and occasionally asked questions when there was something I did not understand. Attending these meetings, I established closer relationships with the informants and eventually I thought it appropriate to ask them whether they would let me follow or *shadow* them during an ordinary workday.

Shadowing

Shadowing is a participant observation technique that is suitable for studying moving informants and scattered fields (Czarniawska, 2007). Since the social workers are certainly moving targets, rushing around in the corridors, fetching faxes, checking their physical mail boxes, chatting with colleagues and managers, having meetings with clients, making house calls, and attending meetings outside the office building, shadowing is indeed a good way of capturing these activities. I found shadowing to be a useful approach to learning about the social workers' activities in a 'naturalistic' manner. Since I followed the informants wherever they went (except when doing private errands), the shadowing technique prevented a biased sampling of activities or places in the agency. For example, it would not be self-evident to study the social workers as they sat in their offices in front of their computers. They often expressed that this could not be interesting for me as a researcher. But although seemingly arid, this is a place in which many important activities occur in the social workers' daily work. It was here I realized that they have to employ certain strategies in order get time over for documentation, e.g. administrating the ASI, writing investigations, and administrating cases in the electronic client report. Shadowing also provided an opportunity to talk more extensively with the informants about their work: how they

think about their work, about the agency, and their work situation, as well as stories about specific cases. Although I stated pretty clearly at the beginning or before a day of shadowing that I did not want to interfere with their ordinary doings, they were more than keen to talk about their work whenever there was time (and sometimes when I felt there was none).

I did not employ any specific sampling procedures regarding the social workers that I shadowed, but tried to be sensitive to whether they actually were interested in having me following them around. Some informants were clearly not interested and were avoided accordingly. Taken together, I shadowed all but a few social workers at the intake, investigation, and reinforced aftercare units. Only three social workers were shadowed at the treatment unit, mainly because they were the focus of one paper. I did not shadow any of the managers. This was because of my major interest in studying how EBP eventually was used in daily client work. The managers' work is of course an important determinant of this, but because of concerns of time and efficacy their work was accessed otherwise, mainly through interviews and observation of meetings at which they were present.

Attending meetings

Shadowing was in a sense the foundation of my participant observation. In order to maximize the data collection with regard to the specific topics of the substudies, however, I selected specific meetings that I attended extra frequently. This selection was made based on my first round of fieldwork where I had identified meetings for each substudy that proved especially fruitful to investigate.

The units of the agency had several permanent meetings that were held on a weekly basis, sometimes more than once a week. Mostly, the units had separate meetings, but there were also joint meetings in which two or more units were gathered. I attended all kinds of permanent meetings in all units, except supervisions in which an external supervisor helps social workers (in group) to reflect upon their work, both emotionally and professionally (see Bradley & Höjer, 2009). Since this supervision is not focused on direct work with clients and since it can contain sensitive personal matters, it was not considered ethically motivated to study these meetings.

The most common permanent meeting, which was found in all units, was the client conference. Although this took different shapes in the units, the common denominator was that a group of social workers met together with a manager to discuss cases. In these meetings the discussions could be oriented towards making a specific decision – whether compulsory care should be initiated, what sort of outpatient treatment is suitable for the client, how treatment of a non-compliant client should be proceeded with – or it could be a way for the social workers to get advice and guidance from colleagues in difficult cases. No client conference was solely directed towards making decisions. For the ASI study, the intake unit's client conference was attended

with special interest. Since the intake social workers were obligated to do an ASI interview before remitting clients to the investigators, an important topic at these meetings was when and how ASI could be done, or whether it could at all be done. For the treatment decision-making study, the investigator's client conference was also especially interesting, given that they are responsible for treatment planning and thus making treatment decisions. However, since I found treatment decision-making to be such a hard-found phenomenon, I did not make any direct delimitations regarding this study.

Another permanent meeting was the intake and investigation units' case referral meeting. Here, the intake social workers presented new cases for the investigators that were then divided up between them. I saw this meeting as an extension of the intake unit's client conference, and the picture of the clients' conditions was often deepened as the investigators asked for further details about the clients. This was a valuable meeting for study both of the ASI and of treatment decision-making.

The next permanent meeting in the agency's chain of care is the 'trialogue', in which three units – the intake and investigation units and reinforced aftercare – meet with the client to discuss his or her future treatment and support. This meeting is intended to facilitate a smooth transition from intake to investigation and reinforced aftercare. During this meeting the intake social worker gives feedback from the recently conducted ASI interview, making sure that nothing has been misunderstood. The meeting is concluded with the client making appointments with the investigator and reinforced aftercare, respectively. This meeting was valuable for all studies for different reasons. Since ASI feedback was an important part of the meeting, it was relevant for the ASI study. Since future treatment and support were explicitly discussed at the meeting it was valuable for the treatment decision-making study. And further, since it was a meeting with a client and the social workers were supposed to use MI in all direct work with clients, it was valuable for the MI study as well.

There were also permanent meetings that did not focus directly on specific cases. The intake and investigation units' weekly 'EBP meeting', held once every second week, is one example. This meeting was introduced as the agency started working systematically with implementing EBP and can be seen as an implementation strategy, to sustain their work and keep up to date with the various activities related to EBP, e.g. the ASI, MI, and the critical appraisal model. However, this meeting was being phased out as I began fieldwork and I did not have the opportunity of attending more than three sessions, but this meeting was particularly interesting for the ASI study, as it was a permanent item on the agenda. Under this item the manager and the social workers discussed different, often technical, aspects of the ASI, such as how they made specific ratings and how they reported certain questions in the formula (to make sure they did it alike).

MI workshops were another kind of permanent meeting that did not address specific cases. At these meetings, groups of five to seven social workers met once every second week to discuss their own MI practices and MI texts from a book that the agency had purchased for this purpose. This can also be seen as a strategy to enhance the social workers use of MI. Evidently valuable for the MI study, this was a way for me to learn about the social workers' thoughts about MI and the strategies by which the managers were trying to implement it.

A final type of meeting that I attended was different kinds of encounters with clients: intake meetings, treatment planning meetings, treatment sessions, reinforced aftercare meetings, and visits at treatment and housing facilities. Observations of client meetings were the major data source for the MI study. The reason for this was that the social workers were supposed to use MI in all meetings with clients. Accordingly, this was the only way in which I could directly observe their use of MI. For this study I worked actively to schedule client meetings with the social workers, running between their offices trying to fill out the time in the field with as many meetings as possible. It was hard work but with pretty much downtime anyway, especially since clients had a tendency not to turn up for appointments. At this stage, the social workers had got used to me and did not seem to be threatened by my presence. Regarding the clients' consent, it was typically asked by the social workers as they were meeting up with them. The social workers briefly described the purpose of my participation and asked whether the client was willing to have me there. I kept in the background in order not to make the clients feel imposed upon to accept.

So how did I go about observing these meetings and how did I relate to them? Compared with the relatively low-intensive shadowing, observing meetings was characterized by a whole different intensity. While I had a chance to catch my breath from time to time during shadowing, observing meetings required me to be alert the whole time – everything went fast and everything could be important, was my impression. The intensity was especially apparent in client conferences; cases were described fast and often in an implicit manner since clients were often known from previous contacts, and an abundance of names on different treatment and housing facilities, at first completely unknown to me, were constantly being discussed. Although I saw myself as a semi-member, it was difficult to make sense of it all at first. I tried to ask questions during meetings whenever it was possible, but there were often some unanswered questions left. Sometimes I could pick up answers directly afterwards, otherwise, if there was some information I thought to be important, I would try to catch the social worker of concern later on. Initially I tried to capture every case that was discussed during a meeting, but gradually I learnt that it was better to focus on every third case. This way I could develop more substantial and detailed descriptions of the

cases. However, I would abandon this principle if there was particularly interesting cases of significance for any of the substudies I was planning.

Observing client meetings was equally intensive. For the MI study it was important to capture a lot of dialogue since MI to a large extent concerns what the practitioner says and how he or she reacts to clients' utterances. And this was a real challenge. In order to cope with this task I took quite extensive notes during the meetings (mostly dialogue). And in four cases I used an audio recorder (had I only thought of this earlier!). This was used after I had made sure all informants approved. After a client meeting there was often time for a debriefing with the social worker, giving me the opportunity to ask about lingering questions. This was also a situation in which the social worker often asked for feedback regarding the meeting in general or their use of ASI or MI in particular. I felt somewhat uneasy about this and explained that I am not an expert on how things are *supposed* to be done. After this caveat, feeling a bit indebted for being allowed to attend their meetings, I would give at least some reflections on the meeting. And this was often very much appreciated.

Some aspects of the meetings described above can be characterized as concrete client work. But in cases where the meetings concerned *talk* about direct client work, including MI, ASI and treatment decision-making, this was approached in a "realist mode" (Mol, 2002 p. 15). This means that I viewed their talk, not as discourse – that is, *how* it is talked about or what perspectives they imply – but as something revealing information about their concrete work with clients. The validity of such accounts should not be dismissed simply because they are subjective, nor can they be accepted at face value (Hammersley & Atkinson, 2007), but need to be scrutinized against the background of other sources of information, e.g. participant observation.

Writing fieldnotes

My ambition was to write full fieldnotes on the same day as the observations took place. This is a common ethnographic standard, due to the fact that small but important details are easily forgotten after some time has passed (Emerson, Fretz & Shaw, 2011). However, after long days in the field I did not always have the time or the energy to write up everything at once, but was forced to take up writing the next day. I did not record everything in the field, but focused on events that seemed important for the overarching questions for the dissertation and each sub study. The time it took to write and the amount of fieldnote text thus varied greatly depending on what I had observed. A sixty-minute meeting could take several hours to write up, whereas a whole long day of shadowing could take about as long a time.

In order to remember important details and dialogues in the field, I often took notes during ongoing observation, mostly during meetings, which were, as I have already mentioned, quite intense. Sometimes when I witnessed a significant comment or scene without having access to paper and pen I

would make a headnote and try to write it down as soon as possible. During meetings with social workers and managers only, my overt note taking was not an issue. During client meetings, however, I tried to be discrete, although not hiding it altogether. This was sometimes commented upon, both by clients and by social workers, but it was not something that I felt affected vital aspects of the meeting. In cases where an audio recorder were used, I did not transcribe the whole recording but used it as support for writing conventional fieldnotes, using only significant passages of dialogue. Only dialogue recorded verbatim has been used as quotes in the full fieldnotes. In other cases, turns of dialogue have been summarized or quoted indirectly.

Interviews

In addition to collecting data by participant observation, I also made use of two kinds of interviews. First, I was able to conduct many casual and informal interviews with social workers and managers. This was an important complement to purely observing what they did. Through these interviews (if they can be seen as an interview, talk may be a more appropriate wording) I learnt about their views on their work and their various rationales for doing what they did. Often these informal interviews were a natural part of shadowing or when I asked after a meeting about some detail, or when an informant wanted to explain something to me. In other cases I had thought about specific questions and sought out an informant who was able to answer them.

The other type of interview I used was a more formal semi-structured interview in which I had prepared themes of questions. These interviews were audio recorded and fully transcribed. They were typically conducted at the end of every round of fieldwork, when I had got a fairly good impression of the general conclusions of my substudies. Thus, the interviews served both as a way of testing or validating my findings and of gaining new insights that were hard to reach through participant observation only. My ambition was to conduct all formal interviews with two or more informants at the same time. This was made in part with Goffman's advice in mind to seek out multi person situations:

> "Two person situations are not good since people can lie to you while they're with you. But with three people there, then they have to maintain their ties across two other persons (other than yourself), and there's a limit to how they can do that. So that if you're in a multi-person situation, you've got a better chance of seeing things the way they ordinarily are." (Goffman, 1989, p. 132)

Although this quote is about participant observation, similar mechanisms are certainly in play during formal interviews. Group interviews also allow the informants to expand or oppose each other's statements, making visible dif-

ferences as well as commonalities between the informants' understandings of, in this case, work practices. Time was also a parameter for relying on group interviews.

In sum, 8 formal interviews were conducted. Two of them were conducted with one informant only, the rest were held in groups of two or more, amounting to a total of 20 informants. Three interviews (n = 9) were conducted with the ASI study in mind, four interviews (n = 9) for the MI study, and one interview (n = 2) was conducted for the treatment decision-making study. The selection of interview subjects was not based on any well thought-through criteria. First of all, I only conducted formal interviews when I found it necessary for my analysis, if I lacked certain relevant perspectives, etc. Since I was able to conduct many informal interviews during fieldwork, formal interviews were not always motivated. Managers of the concerned units were interviewed for each substudy. This was because I found that they played a crucial role in introducing and driving the implementation of the various aspects of EBP, but also because I did not center on their work during fieldwork. The social workers I interviewed were recruited publicly at different group meetings. This meant I had no control of exactly which social workers I would eventually interview, apart from their unit affiliation.

Given the praxiographic approach, I viewed the interviews with the social workers as giving information about their direct work with clients. Accordingly, the interviews have focused on what they do – that is, how the ASI and MI are used in client work – and what factors affect what they can do, as well as their motives for specific actions. Asking people what they ordinarily do, and why, is a difficult business and we all easily fall into rationalizations. In order to avoid or at least mitigate these processes, I therefore tried to focus on concrete events, using my own experiences and observations in the field. Asking about concrete events, as opposed to asking how they ordinarily do and why, etc., also makes it easier for informants to talk about their work (Smith, 2014, p.52).

Interviews with managers have mainly served as background information for understanding specific demands posed on the social workers: the managers' motives for introducing EBP, the ASI and MI, and how they have organized implementation work. These interviews have also reflected upon the results of the implementation work, providing the managers' views of why things evolved as they did. Also in these interviews I tried to be as concrete as possible, asking about the different agency projects. I found it useful to bring to interviews and talk around different documents that I had identified as important for governing their work, for instance an implementation plan for the ASI project, a housing policy document, or a figure in a research article (Haynes, Devereaux & Guyatt, 2002). This can be seen as a kind of 'elicitation' (cf. Harper, 2002) and added to the concreteness of the discus-

sions, and sometimes even reminded the managers of things they had done but forgotten.

Studying documents

Apart from studying people, I also studied documents. Documents were identified throughout fieldwork, either by asking for documents that I supposed would exist or by informants mentioning them as important for their work. I also browsed around the agency's intranet in order to find documents that might reveal some important information about the agency. The documents that were analyzed can be divided into three categories. First, there are documents produced within the agency that describe the agency's work, or as is often the case, more visionary accounts of how managers would *want* things to be. Such documents include power point presentations for new employees, implementation plans, agency operational plans, and annual agency reports. These documents were especially important in the early stages of my fieldwork in order to get acquainted with the agency. Second, there are documents that function explicitly as rules for how things should be done at the agency. I denote this as policy documents or guidelines, which include their housing policy, delegation of decisions, and internal treatment guidelines as well as the NBHW clinical guidelines. Another document that may qualify as a policy or guideline is their investigation template, which was designed for the purpose of including the parts of EBP, as described by Haynes, Devereaux & Guyatt (2002), into the written investigations. Being factors that the social workers very concretely relate to in their daily client work, these kinds of documents have been invaluable for understanding the conditions of their practices. Third, there are also documents that can be seen as the output of agency activities. Within this category, I have not made use of written investigations or the social workers' notes in the electronic client report. The reasons for this are twofold. First, I am interested in real-time practice, and written investigations are not very well suited to studying such processes. Second, this potential source of information was simply too comprehensive for me to use in a meaningful way, especially since I had heaps of other data to analyze. One type of output document that I did use, however, was different kinds of documents concerning their use of the ASI, including excel documents monitoring its use as well as various texts in which the ASI data were analyzed. These documents were crucial for understanding how the ASI was used at an aggregate level as well as understanding the agency's production of outcome measurement.

Since the praxiographic approach requires one to take not just people but all kinds of objects into consideration in order to understand events, I have tried not to be attentive to the role that objects may play in practice. Although the role of 'nonhumans' has been acknowledged and debated in STS for a couple of decades, what it actually means methodologically has re-

mained underdeveloped (Sayes, 2014). The term nonhuman is used to denote entities that are not entirely human, but nevertheless make a difference to events or practices. That is, not only people can exert agency; documents, guidelines, psychosocial interventions, assessment instruments, etc., also have the capability of influencing the course of events. This is not to say that they are full-blown actors with intentionality, but rather that they may have a role to play. Contrary to many scholars belonging to the Actor-network theory (ANT) tradition, I do not go so far as to depict nonhumans as actors or actants (Sayes, 2014; Latour, 2005).

In my fieldwork I came across several nonhumans that were important for understanding the social worker's dealing with clients. For example, the investigation template mentioned above actually forces the social workers to write investigations under fixed headings such as: "what does the research say?" Since this is the template they are supposed to use when writing up investigations, the social workers are forced in every investigation to write something about relevant research, which almost exclusively means the NBHW practice guidelines. Thus, the template in itself affects the course of action. In traditional social science, the template would be seen merely as a proxy for the manager who constructed it. But in transferring the managerial imperative into a template, it is given a much wider impact – it does something with the manager's message. Without the template the manager would have to rely on the social worker's listening to her demands about incorporating the national guidelines in the investigations, or she would have to remind them constantly. But with a template readily present as a file in every social worker's computer, this work has been delegated. This is but one example of how I have approached the agency role of nonhumans.

A nonhuman that received extra attention was MI. I found that it played a crucial role in the agency's work, but the more I read about it in research articles, the more I wondered what MI actually was. And how can something that nobody really knows what it is, how can that be considered 'evidence-based'? This was the basic question I pursued when I expanded the ethnographic approach to following MI in research articles, books, unpublished manuscripts, and websites between 1983 and 2013. In following how it was created, tested, talked about, used and developed, I thus analyzed the construction of an 'evidence-based' psychosocial intervention (or nonhuman) that has had a huge impact, not only in this agency, but in clinical practice settings all over the world.

Analyzing data

In this dissertation, as in many other ethnographic projects, analysis was not a separate stage of the research process. Rather, both the formulation of the topics of the substudies and the specific analyses were done in and through

data collection. As mentioned above, the topics of the substudies were identified during the first round of fieldwork and were gradually specified as fieldwork went on. The same goes for the analysis that emerged through the course of the data collection. The emerging analysis, in turn, affected how and where I collected data. For example, the interviews I conducted were an integral part of the analysis in that they tested or in best cases deepened or threw new light on my previous analyses. This is an example of the iterative nature of ethnographic analysis (Hammerlsey & Atkinson, 2007, p.159).

The basic analytic strategy in all the substudies of this dissertation consists of contrasting an ideal standard (or taken-for-granted fact) with actual practice. In the ASI, MI and treatment decision-making studies, the ASI, MI, and critical appraisal represent ideals that are supposed to be used in practice. In the historical MI study, I question the taken-for-granted view that MI is evidence-based, and look instead at the practices underlying this statement. This strategy is ultimately descriptive and involves trying to understand the differences between ideal and practice as well as which factors contribute to the different outcomes.

The analysis concerning the three ethnographic studies was developed by way of rough thematic coding using NVivo 9. Even though data collection was specifically directed towards the different substudies, all data that had been collected so far was included in the final analyses. I typically began coding data with regard to the relevant activities I sought to study, e.g. practices or talk concerning MI, EBP, and ASI, thus collecting all items in one place and making it easier to continue the analysis. In some cases I have also coded the material depending on the situation: client meetings, client conferences, unit, etc. Later, I would continue making finer codes, for instance situations that compromised treatment decision-making, or the use of the ASI and MI. Since the meaning of the codes would sometimes change as the data collection and analysis proceeded, the entire material was reread and coded several times. After this was 'completed', I would normally begin writing, which can be seen as a continuation of the analysis since I had to describe and make explicit the sometimes abstract analysis. Often during writing I found loopholes in the analysis which forced me to look through the data and the codes once again.

Regarding the historical MI study, no structured coding was conducted. Instead, the data were analyzed with regard to some general questions that were asked of each text: What is MI? What activities (interventions and techniques) count as MI? How has its identity been controlled and protected? As with the ethnographic studies, the data were reread several times and analysis continued throughout the writing of the article.

Finally, a note on the use of theory in the analysis is also warranted. Although my choice of conceptual framework has been influential in suggesting directions as to what to focus on (practice, that is), analysis has not departed from any "definitive concepts" (Blumer, 1954). Rather, I tried to

bracket theory in the data collection and early process of analysis in order not to become overly governed by specific concepts. In later stages of analysis, however, data and theory (to the extent that they can be separated) were in constant interplay. Some findings made me take interest in specific concepts, which in turn (sometimes) helped me deepen my data collection and further analysis. What specific concepts I finally ended up using was ultimately based on how well they illustrated and allowed me to discuss my findings.

Ethical reflections

Just as in all social research, ethnographic research requires thorough ethical consideration. Since participant observations included people in vulnerable positions, e.g. client needing help from the social services, it was not self-evident to study such situations. However, such ethical considerations must be done with regard to the potential benefits of the research. Studying direct client work may also be a way of highlighting the clients' conditions within the social services, which we know very little of, and may ultimately be a way towards improving client work (Mol, 2006). It was therefore considered ethically motivated to observe situations involving clients.

Before doing participant observation and interviews, informed consent was always strived after. I tried to be as open as possible about my role as a researcher. Regarding the social workers' consent, this was not always explicitly asked. Attending new meetings with social workers I had not previously met, I always asked permission before I went about observing. However, as fieldwork proceeded and everyone in the agency knew about me and my research, I did not continue to ask for consent. I tried, however, to be perceptive of signs of when informants did not want me around. In some situations, I did not have an opportunity to present myself and ask consent. For example, at one so-called network meeting involving several professionals and a client, I described my research and asked the participants' consent before the meeting started. But when the meeting was already underway and new professionals arrived late, it seemed quite inappropriate to break off proceedings further to present myself and ask consent.

Regarding the clients, I explicitly asked consent in each situation. I was careful to make sure clients did not see me as an inevitable part of the investigation or treatment. As already mentioned, this was done by letting the social workers ask the clients about my attendance in peace and quiet ahead of time while I kept in the background. The social workers had different attitudes toward my presence at client meetings. Some thought it was obvious I should be there, while some were more cautious, considering the clients' exposed situation. And this surely affected how they asked the clients. I tried to explain, however, that the clients' consent should not be taken lightly

and that the social worker should ask in a way that allowed the client to decline. Sometimes, in special circumstances, the social workers would decline beforehand, e.g. with mentally unstable clients or when something dramatic had occurred in the client's life situation. The clients themselves only declined in a couple of cases.

Information about the informants as well as the agency has been handled in a way that, to the largest possible extent, allows the participants confidentiality. The anonymity of places and names has been protected so that no participants in the project can be identified. A precondition for accessing the agency was that I sign a contract concerning respect for client confidentiality. In describing my research in research publications, lectures and presentations, I have not described the informants in any such detail that would make it possible to identify specific persons.

Summary of papers

This dissertation consists of four papers that in different ways address the enactment of EBP in social work practice. The papers focus on the social services agency's use of three kinds of standardized procedures that reflect their main efforts to develop EBP. These standards are: the standardized assessment instrument, the Addiction Severity Index (ASI); the psychosocial intervention Motivational Interviewing (MI), and critical appraisal. As the agency's use of MI is motivated by the widespread claim that it is evidence-based, MI has also been followed beyond the boundaries of the agency as its efficacy has been discussed within the addiction research field.

Paper I: Working with different logics: A case study on the use of the Addiction Severity Index in addiction treatment practice

Use of standardized assessment instruments has become an important part in discussions of EBP and fills the need in EBP for systematic and transparent assessment as well as facilitating outcome measurement. The ASI has been thoroughly psychometrically tested and it is one of the most widely used standardized instruments in Sweden and internationally. The agency studied in this dissertation is determined to use the assessment and follow-up interview systematically, both as a part of the clinical work and as a way of achieving aggregated outcome measurement.

Aims

While earlier studies have examined psychometric properties, attitudes towards standardized instruments, and how to use them in outcome measurement, this paper explores how the ASI is integrated into the agency's daily work. Hereby it is possible to scrutinize the applicability of the popular idea of standardized instruments in social work practice.

Methods

The empirical data are based on ethnographic fieldwork at the agency and consist of four kinds of materials: participant observation of daily work, interviews with professionals and managers, analysis of internal documents, and analysis of quantitative ASI-data.

Findings

The main challenge of introducing the ASI into the agency's routine work can be described using the concept of logic. Incorporating the ASI to a full extent is not just about using a sheet of paper to investigate clients' problems, but rather implies a thorough change in how activities are ordered at the agency – a change in logics, as it were. Whereas traditionally client work is based on "the logic of care", the ASI introduces a "laboratory logic" which to a larger extent focuses on coordinating activities and information within the agency. It is only through careful coordination that valid outcome measurement can be achieved. This poses demands on the agency managers who have to create and enforce appropriate ASI routines. This has been done by adding routines, but also by transforming the organization of the agency. The professionals, in turn, struggle to follow the laboratory logic in their client work. In order to make the ASI fit into the daily work, the ASI and the client work are mutually adjusted to each other. But sometimes this adjustment is pushed too far. Especially the follow-up interview seems to be difficult to integrate with the professionals' work, as this does not fill a clear need in their work with clients. It is described as too detailed and a follow-up for "the sake of it". When it comes to producing outcome measurement, it is the administration of the follow-up interview that accounts for the most difficulties. It is not administered systematically and it is uncertain what kinds of interventions – if any – the clients have actually received, rendering the meaning of the outcome measurement somewhat uncertain. That is, different information sources have not been coordinated sufficiently in line with the laboratory logic.

Conclusions

Integrating standardized instruments and managing the two logics described above require a thorough transformation of existing modes of social work practice, something which has not received much attention in previous discussions about standardized instruments. At the same time as standardized instruments must be administered systematically, professionals must also be able to adapt to the clients' specific and changing needs; and this balance is not straightforward. In current discussions, there seems to be an overemphasis on the laboratory logic, which makes it difficult to integrate standardized

instruments in practice without compromising client work. A middle way might be to reduce the amount of questions (or to use fewer) in the ASI and similar instruments. With fewer questions it should be easier to incorporate the two logics at the same time.

Paper II: Stabilizing a fluid intervention: The development of Motivational Interviewing, 1983-2013

In EBP, use of evidence-based interventions is a must. But how does an intervention become collectively acknowledged as 'evidence-based'? This paper looks at how MI, one of the most cherished interventions in social work and the substance abuse treatment fields, came to be regarded as an evidence-based intervention.

Aims

The aim of the paper is to understand the processes through which MI grew into a widely used intervention regarded as stable and effective. In a more general sense, the aim is to look behind taken-for-granted statements about MI; to find out what it *is* and how its efficacy has been constructed in the addiction treatment field.

Methods

MI's development has been traced as articulated in research articles, books, unpublished manuscripts, and websites between 1983 and 2013. This material has been complemented with mail correspondence with some of MI's developers. This material has been analyzed paying special attention to how researchers and developers have used the word 'MI', what has been done in its name, and what activities count as MI.

Findings

MI was introduced in 1983 as an intervention structured around a set of principles, allowing considerable flexibility in practical use. It is therefore suggested that MI can be regarded as a fluid intervention. This fluidity has been promoted in different ways by its developers throughout MI's emergence. Although MI's fluidity has been a positive aspect regarding its massive dissemination, it has also presented difficulties for its subsequent stabilization.
As MI has been differently operationalized in clinical trials it was not obvious at first to talk about the efficacy of MI as a single object of concern. There were several ways to interpret MI's efficacy. However, along the way,

the statement about MI's efficacy has become increasingly stabilized. While early systematic reviews and meta-analyses talked about the efficacy of a composite object, such as 'adaptations of MI', the most recent meta-analyses have chosen an interpretation in which it is allowed to talk about the efficacy of 'MI', thus hiding the heterogeneity within the primary studies.

MI's fluidity has also been troublesome for its developers who have seen their intervention become misused (in their terms). This has sparked efforts to stabilize MI's identity – promote its fidelity – by giving it more articulated definitions and by creating systems to disseminate it and control its use. Compared with other psychosocial interventions the stabilization of MI is characterized by a high degree of fluidity, as these control systems are not centralized and mandatory but open and voluntary.

Conclusions

The development of MI can be characterized as the stabilization of a fluid intervention. It is argued that the combination of fluidity and stability is an important part of MI's success. The fluidity makes it easy for professionals to use it in various settings, and it has been made stable enough to be regarded as an evidence-based intervention. A closer look at its development, however, reveals that a different interpretation of its efficacy is possible. This illustrates that what is commonly regarded as 'evidence-based' does not naturally follow from use of standardized methods such as RCTs and meta-analysis, but is always embedded in interpretative processes.

Paper III: Evidence, fidelity, and organisational rationales. Multiple uses of Motivational Interviewing in a social services agency

Using evidence-based interventions with strict treatment fidelity is a common approach through which treatment agencies seek to enact EBP. As MI has spread and come to be regarded as 'evidence-based', it has also reached the agency studied in this dissertation. This paper explores the agency's efforts at trying to use MI in in their daily work with clients.

Aims

The aim of the paper is to understand the practicalities of using an intervention within a specific context. Hereby, a one-sided attention to treatment fidelity is also problematized.

Methods

The methodological approach focused on participant observation of actual use of MI in different kinds of interactions with clients at the agency. As a complement I also performed interviews with managers and different professional groups, and attended MI workshops in which the professionals discussed their MI use. In order to understand and conceptualize variations in MI use, observed MI practices were then compared with central texts describing how it should be performed.

Findings

Although the agency, in line with recent implementation research, had taken several measures to achieve strict fidelity to MI, it is used differently depending on the specific requirements of the professionals' different work tasks. The professionals adjust to MI in important ways, but they also adjust MI to gain a better fit with their agency-designated roles. In terms of treatment fidelity, this is hardly a positive thing. Different and partial uses of an intervention suggest implementation deficits and that these practices, in a strict sense, are not 'evidence-based'. However, treating strict treatment fidelity as merely one rationale among others, it is possible to see that non-fidelity can be constructive. Rather than reluctance or incompetence among the professionals, which is a common explanation of implementation deficit in previous research, the professionals' multiple uses can be interpreted as necessary adjustments in order to make MI fit into their specific work tasks.

Conclusions

These findings highlight the importance of fit between intervention and context when trying to achieve treatment fidelity in professional practices. Whereas previous studies tend to assume that interventions can be implemented with fidelity across diverse contexts, this study points to the necessity of adjusting interventions to the practice context. Although treatment fidelity is one important aspect, it is argued that there may be other rationales to take into account when implementing evidence-based interventions in professional practices.

Paper IV: Reconsidering critical appraisal in social work: Choice, care and organization in real-time treatment decisions

Critical appraisal is the original model of EBP and by many scholars in the social work field viewed as the 'true' model that social work agencies should strive after. But many studies have found difficulties with implementing the model. This paper argues that this can be understood by comparing the logic inscribed in critical appraisal with the logics that guide real-time treatment decisions.

Aims

The aim of the paper is to gain an ethnographic understanding of how treatment decisions are made in real-time social work practice and to contrast this with the critical appraisal model. Hereby it is possible better to understand the difficulties that social services agencies meet when trying to work according to critical appraisal and to suggest further directions as to how evidence can be integrated into practice.

Findings

At the agency, several measures have been taken by the managers to implement critical appraisal. New employees are introduced to EBP, books have been bought and promoted among the social workers, and an investigation template has been developed that follows the steps of critical appraisal. However, during my fieldwork, not a single case was observed in which these steps were followed. Rather than reluctance from the social workers, I see this as a reflection of critical appraisal building on a poor understanding of how treatment decisions are actually made in social work practice.

Studied as they occur in real-time practice, treatment decisions within the agency are guided by organizational and care logics – as opposed to the 'logic of choice' inscribed in critical appraisal – that differ in three respects: regarding decision process, decision maker, and decision factors. Whereas the logic of choice assumes that decisions are clearly defined in time, the organizational and care logics highlight that decision processes are uncertain and iterative. Real-time treatment decisions emerge over time as unexpected events in the clients' daily lives occur and as different organizational rationales are weighed together. Regarding the decision maker, the logic of choice views treatment decisions as an individual activity performed by an autonomous social worker. In contrast, the organizational and care logics emphasize that treatment decisions are made within an organizational context that shapes what treatment decisions can be made. The social workers are cir-

cumscribed by various organizational rules that prevent them from making certain decisions on their own. Moreover, how treatment alternatives are organized also shapes treatment decisions, something which can be seen both as a constraint and as a resource for the social workers' ability to make treatment decisions. Thus, treatment decisions within a social services agency are 'organizational' rather than individual. Regarding decision factors, the logic of choice assumes that they are external to the decision process and stable over time. In contrast, the organizational and care logics illustrate that decision factors in practice are rather malleable and internal to the decision process. Clients' preferences and needs are transformed along the way, and evidence and clients' needs are interpreted in relation to various organizational rationales, most notably financial considerations.

Taken together, decision making *in practice* is guided by organizational and care logics in which decisions emerge over time in interaction with factors relating to the clients and the organization. Since this kind of decision process is derived from the clients' often unstable motivation and daily lives, it cannot in a simple way be organized into the stepwise procedure that critical appraisal suggests.

Conclusions

These results point to important differences between how treatment decision-making is conceived by critical appraisal and how it actually is done in practice. In order to improve or evidence-base treatment decisions, however, we need to build on a more realistic conception of treatment decision-making. Instead of trying to make treatment decision processes more rational, we should consider how to handle these iterative and ambiguous processes in a more conscious and reflective manner. Moreover, since decision making is an organizational rather than an individual activity, we should consider how organizations can support evidence-based decision making. Otherwise, EBP is in danger of becoming nothing more than shallow rhetoric.

Discussion

This dissertation has looked at evidence-based practice (EBP) in social work behind the scenes, as it is enacted in practice. It asked a basic question: What does EBP mean and imply in practice? The question was posed in relation to previous research in social work that in a rather theoretical and abstract way has debated whether EBP and the standardization it is associated with is good or bad. This dissertation is based on the argument that it may be more useful to engage in empirical examination of what EBP actually might mean in practice. To do so, I have done ethnographic fieldwork in a social services agency that has worked extensively to implement the idea in their daily work. I have closely studied their work with EBP and the interventions, instruments, and decision models that are involved in this ambition.

The agency's enactment of EBP has centered on incorporating three kinds of standardized procedures into daily practice: the standardized assessment instrument, the Addiction severity index (ASI); the psychosocial intervention Motivational interviewing (MI), and the evidence-based decision model critical appraisal. These efforts are also the subject of three of the four papers that constitute this dissertation (papers I, III and IV). The fourth paper (II) is about how MI evolved into an 'evidence-based' intervention within substance abuse research, a development essential for the agency's motives to use the intervention.

As an ethnographic study, this dissertation has obvious limitations with regards to the generalization of the results. However, this agency was selected as a 'critical case' (Flyvbjerg, 2001), which means that it has strategic importance with regards to EBP. Since they have worked extensively over a long period of time with developing EBP, difficulties in implementing the idea are not likely to be a result of poor efforts. Therefore, it allows a more general discussion of the possibilities, limitations and preconditions for EBP as a concept in social work practice that is grounded in an empirical analysis of its practical outcomes.

EBP transformed into a bureaucratic project

A central finding is that EBP at the agency is a bureaucratic rather than a professional project. It is the managers who have decided to implement a set of standardized procedures that the social workers are expected to use in

daily work with clients. Here, EBP is not a matter of independently appraising research evidence, but rather a way to incorporate and control the use of specific standardized procedures. Even though the managers have decided to implement critical appraisal, the social workers are not expected to search for and appraise research evidence on their own. Instead, they are obliged to use the NBHW guidelines to support their treatment decisions.

This stands in contrast to how evidence-based medicine (EBM) has evolved in healthcare. EBM was formulated within the medical profession and efforts to develop the idea in practice have also been conducted mainly within the profession. Although concerns have been expressed as to whether the standardization in EBM implies a threat against professional autonomy, it can also be argued that it may increase the medical profession's accountability or 'collective autonomy' (Timmermans, 2005; Armstrong, 2007). Thus, EBM can be seen as a strategy to strengthen professional judgment by incorporating different kinds of evidence-based standards.

But when the idea was disseminated to Sweden and the social work profession, it faced new conditions that have shaped how it is enacted. Previous studies have showed how the evidence movement in Swedish social work has become a central bureaucratic project (Bergmark, Bergmark & Lundström, 2012). My findings show that, when enacted in the social services' actual practice, a bureaucratic interpretation of EBP is continued. Rather than a strategy to strengthen professional judgment, EBP is incorporated into a bureaucratic rationale based on organizational control of social worker activities (Lipsky, 1980; Evetts, 2009). Here, EBP is transformed into a set of bureaucratic rules which the social workers are supposed to follow, e.g. implementing and controlling the use of a set of standardized procedures. When it comes to the agency's use of critical appraisal, which has been advocated in social work because it contains an independent and thus more professional assessment of research evidence (Shlonsky & Gibbs, 2004; Gambrill, 2006; Thyer & Myers, 2011), no room has been given to the social workers to actually search out and appraise research evidence. Evidence use is limited to the NBHW guidelines and their own follow-up data, where the social workers have restricted capacity to use their own professional judgment.

However, this should not only be seen as an effect of bureaucratic control stifling social worker efforts to make independent professional assessments of research evidence. Working within an 'organized profession', Swedish social workers may not be particularly interested in the kinds of 'occupational professionalism' that characterizes the medical profession (cf. Evetts, 2009). For example, a national survey of Swedish social workers' orientation to EBP show that a rule-oriented stance that calls for clear directives regarding evidence use is common (Bergmark & Lundström, 2011). As we shall see in the next section, however, this does not mean that the bureaucratic rule-based EBP envisioned by the managers is smoothly implemented in the

social workers' daily work with clients. This can be explained by the fact that these rules introduce into practice new and conflicting logics. Thus, even though EBP has been transformed into a bureaucratic project, it challenges pre-existing bureaucratic structures such as organizational roles, the agency's budget, the decision-making order within the agency, and the social workers' attention to the clients' unique situation.

Considering different standardizations in EBP

Other central findings, which all the papers address, concern the dynamic between standardized ways of acting and more local and contextual considerations. In papers I and III, I showed how the ASI and MI were mutually adjusted in relation to the agency's pre-existing practices. The ASI and MI contain logics and scripts that are difficult to combine in their entirety with the already existing logics of practice. In order to make them function within the agency, both aspects of the standardized procedures and the agency's practices were transformed, resulting in the construction of completely new practices containing elements of both pre-existing practice and the standardized procedures. The efforts to incorporate the ASI mainly concerned conflicts about the underlying logics guiding the assessment and follow up of clients. In contrast, the use of MI mainly invoked organizational rationales. The specific roles that MI delegates to its users could not be easily enacted within the social workers' various organizational roles, something which sparked adjustments of both MI and the organizational roles.

As in the papers above, paper IV showed that critical appraisal entails a specific logic for how treatment decisions are made in practice. But in contrast to these papers, paper IV showed that the logic inscribed in critical appraisal describes treatment in a way that makes it extremely difficult to follow in practice. Whereas critical appraisal seeks to standardize the process by which individual social workers make treatment decisions, the results show that managing clients with unstable motivation and sometimes chaotic daily lives requires highly client-attuned and organizationally appropriate responses, which cannot be standardized in a meaningful manner. Thus, standardizing treatment decision-making at an individual level does not seem reasonable given how unpredictable and iterative individual treatment trajectories are in practice.

Paper II deals with the relation between standardization and contextual considerations or interpretations in the development of MI in two ways. First, it was shown that the claim about MI's efficacy was not the mere result of following standardized methods such as the RCT or meta-analysis. The 'closure' of the claim about MI's efficacy is rather the result of social and interpretative processes. Second, MI's development has been characterized by a dynamic between standardization and openness to adaptation (which I

refer to as stabilization and fluidity in the paper). This kind of 'loose' standard allows for use across various contexts, something that is clearly illustrated in paper III, and which is also one important explanation of MI's widespread use.

Kinds, degrees, and mutual transformation of standardization processes

These findings add to previous studies of EBP in social work by showing how standardizing aspects of EBP actually turn out in practice. As such it challenges several assumptions, hopes and fears concerning EBP and standardization that have been expressed in the social work literature. This can be summarized in three points, that 1) there are different *kinds* of standards and standardization processes, 2) there are different *degrees* of standardization, and 3) there is a *mutual* transformation of standardized procedures and pre-existing practices.

First, my conclusions challenge an inability in social work research to acknowledge the diversity of EBP or standardized procedures. My findings show that there are different *kinds* of standards that also possess different potentials of fitting into social work practice. Critical appraisal, MI, and the ASI seek to standardize social work practice in different ways, in different detail and on different levels. And their varying uses in practice that has been showed in papers I, III, and IV can to some extent be explained with *how* and *what* they seek to standardize. The non-use of critical appraisal can be explained by the fact that the standardization of treatment decision-making is aimed at an individual as opposed to an organizational level. The difficulty of using the ASI is mostly due to the level of detail sought to standardize, whereas the relative ease of using MI can be explained by the fact that it does not seek to standardize social workers' activities in a detailed manner. Implementation studies tend to imply that failure to implement EBP reflect poor implementation work or social worker resistance (Fixsen et al., 2005). Yet, in all but a few implementation studies, the aspect of relevance or fit has been acknowledged as a factor that affects the implementation result (Stern et al., 2008; Bond et al., 2009). In studies critical of EBP and its standardization, the concept is treated rather sweepingly as if it referred to a singular and coherent object (Webb, 2011; Petersén & Olsson, 2014). Moreover, as pointed out above, studies revealing difficulties in using standardized procedures in practice often conclude that standardization is not suitable to social work (Gillingham, 2011; Ponnert & Svensson, 2011; Martinell Barfoed, 2014). As my findings suggest, however, critique of EBP and standardization cannot be directed towards the phenomena in their entirety, but needs to acknowledge its specificities and *kinds*, something which only a few have done in previous research (Broadhurst et al., 2010). Appreciating

that there are different kinds of standards may contribute to a more realistic and practically relevant understanding of EBP and standardization.

Second, my conclusions emphasize that there are different *degrees* of standardization. The standardizing aspects of EBP have been discussed with both hopes and fears in social work research. No matter which specific orientation is advocated, proponents of EBP see the standardization of social work practice and research as a way to reduce bias of different kinds, for example 'opinion' and 'authority' (Gambrill, 1999; Rosen, Proctor & Staudt, 2003; Shlonsky & Gibbs, 2004; Sundell et al., 2009). Opponents, on the other hand, who raise concerns over the standardization of social work practice mean that it underplays the importance of values in social work practice (Webb, 2001). Moreover, in discussions about how EBP should be practiced, critical appraisal advocates argue that reliance on guidelines fails to acknowledge the client's preferences and the social worker's expertise (Gambrill, 2006; Thyer & Myers, 2011). All these positions tend to exaggerate the regulatory effects of standardization in research and practice. Standardization can come in different degrees and does not completely erase local or contextual considerations. Rather, these kinds of input may be necessary for the standard to function at all in local practices. Thus, use of guidelines or standardized interventions may standardize some aspects of practice, but does not exclude attention to values or expertise. Regarding the standardization of research through the use of RCT and meta-analysis methodology, my findings show similarly that it does not exclude more informal input.

A third assumption that my conclusions challenge is the 'either-or' positions that have been taken in social work studies about the use or implementation of standardized procedures. Rather than either-or, use of standards is often implicated in mutual transformations of both the standards and preexisting practices. In one social work tradition, which is interested in furthering the implementation of EBP, attention is directed only towards social work agencies' adaptation to a standard (Fixsen et al., 2005; Gray et al., 2012; 2013). In many cases, this is discussed in terms of 'treatment fidelity', which means that an intervention is used correctly according to a theoretical definition of the intervention (Stern et al., 2008; Bond et al., 2009). The idea underlying this approach is simple: using an intervention with fidelity, which has been proven efficacious in clinical trial, would produce the same outcomes in daily professional practice. But as my findings show, this one-sided view is problematic. Achieving strict fidelity to a standard in an agency that is already inhabited by other logics and ideas comes at a cost; some vital elements of practice must be transformed, and this is not always regarded as worth the effort by managers and social workers. This may shed some new light on the difficulties of implementing EBP that have been shown within this tradition (Aarons & Palinkas, 2007; Gray et al., 2012). It is therefore possible to question how realistic, or if possible, how desirable it is to achieve strict fidelity in the daily work of social service agencies. Moreover,

as is shown in paper II, what an intervention actually *is* in clinical trials and systematic reviews can differ. This calls to attention what it actually is that professionals should be faithful to.

The above discussion concerned the problems of focusing solely on *adaptation* to a standard. In social work studies that have examined use of standardized procedures in practice, there is a tendency to view standardization of practice as problematic. If negative consequences are shown or if standardized procedures prove difficult to implement, a common conclusion is that such tools do not have a place in social work practice (Ponnert & Svensson, 2011, Martinell Barfoed, 2014) or may even be harmful (Gillingham, 2011). These conclusions reflect a static view of standard use in practice. My findings show that using standardized procedures in practice is a much more dynamic process in which a standard and pre-existing practice is mutually transformed. Rather than something that is fixed and ready-made, there are many potential uses and interpretations of a single standard. My findings suggest that standardization is about finding a balance between the requirements of the standard and what aspects of practice should be preserved. In some cases as in critical appraisal, the standard may pose unrealistic demands on the practice setting, which renders it near impossible to use. But arguing that standardization is not feasible in social work practice, as if it was something fixed, simply does not make sense from this perspective.

A conclusion that is often made within this tradition, and that my findings support, however, is that standardized tools need to be based on a better understanding of social work practice (Broadhurst et al., 2010; Smith, 2014b). Many standardized procedures are built on a rationalistic conception of professional practice (e.g. the ASI and critical appraisal, but not MI), which disregard or ignore organizational and care logics in this kind of work. By attending to such circumstances, a more practically suitable standardization could be achieved.

The conclusions discussed above add to many similar findings within a large body of research in the field of science and technology studies (STS) and the sociology of standards examining EBM in healthcare. Reviewing these bodies of literature, Knaapen suggests that "EBM and its tools are less 'standard' and uniform than its formal rules and writings suggest" (Knaapen, 2014, p. 832). That is, the kinds of adjustments or reinterpretation of standards *in practice* that have been revealed in this dissertation are not unique for social work practice. Use of standardized procedures in medical practice has routinely been shown to be complemented with informal input such as tacit knowledge, expertise or skills (Timmermans & Berg, 2003a). Greenhalgh et al. (2008) suggest that tacit knowledge is a precondition for making standardized procedures work in professional practice. Standards are also often 'made' to work through 'tinkering' or adjustment to the pre-existing logics or rationales embedded in practice (Timmermans & Berg, 2003a; Timmermans & Epstein, 2010; Mol et al., 2010). Thus, use of standardized proce-

dures does not in itself mean a dehumanization of practice, but depends ultimately on how the standard is used and 'produced' in practice.

How these kinds of standardizing processes actually turn out is in no way self-evident, a finding that has caused scholars in the field to call for a closer empirical analysis of the specific and often unanticipated consequences of different kinds of standards in practice. As Timmermans & Epstein comment, "the specificity of the actual standard matters" (2010, p. 83). A common finding, however, is that loose standards may be easier to use under different and varying circumstances (ibid.; Hogle, 1995), which is in line with my findings showing how MI as a much more fluid standard compared with the ASI was easier to use across varying contexts.

Compared with many STS works on EBM, however, this dissertation points to the importance of organizational factors in enacting EBP. While previous studies have focused on the dynamic between standards and medical professionals' skills, expertise, and judgment (Timmermans & Berg, 2003a; Greenhalgh et al., 2008; Mol, 2008), my findings show how EBP and its standards are also negotiated with bureaucratic and organizational factors. Although my findings point to similar standardization processes as in healthcare, the organizational circumstances appear to be more salient in social work. As discussed above, this may reflect the different professional and organizational circumstances that medical work and social work operate within. Whereas medical professionals have a tradition of protecting their expertise and professional judgment, social workers are much more tied to the organizations where they work. Therefore, making standards work in a social services agency does not only require expertise and professional judgment, but also attention to the organizational aspects of client work. Only a few studies in STS have explicitly examined such aspects of EBM. Organizational aspects have been shown to be important in developing evidence-based policies in healthcare (Fernler, 2011; 2015). Regarding medical practice, it has been shown how organizational or managerial concerns become crucial when considering particularly expensive 'evidence-based' treatments (Sager, 2011). However, it seems that organizational aspects are more pronounced throughout in social workers' client work, not only when it comes to financial considerations. Social work may hereby serve as an example from which lessons can be learned also within healthcare regarding how organizational aspects such as laws, rules and budget can impinge on evidence use. This is not to say that social work and healthcare function in the same way, but rather that similar aspects are present also in healthcare.

Implications

The conclusions of this dissertation point to the many practical challenges that can arise when trying to implement EBP. It is my argument that this

should not be taken as an argument for rejecting the idea as a whole. Instead, we should consider paying more specific attention to the challenges and possibilities in present formulations of EBP. So far, I have deconstructed EBP and standardization into smaller pieces, seeing practical problems in some aspects while seeing possibilities in others. How can the pieces be put together to provide recommendations for future directions that are more attuned to the realities of social work practice? This final section is devoted to outlining some future directions based on the findings of this dissertation.

Many attempts to improve social work and professional practice in general are based on the idea of standardization. Standardized procedures are good when they achieve something, for example facilitating local follow up (as in ASI) or making sure that treatment effects can be measured in a reliable manner (as in RCTs). But standardization is not necessarily good in itself (Timmermans & Berg, 2003a). A question that policy makers, managers, and social workers therefore must ask before they venture into the arduous work of implementing a standardized procedure is: *When is standardization good?* There is no definitive answer to this question; it is something that must be done by carefully analyzing current practices and comparing them with what a standardized procedure has to offer.

I have shown that top-down strategies of implementing standardized procedures do not determine social workers' activities, that standards in practice are tinkered with or complemented with local knowledge or expertise. While top-down strategies may be warranted and indeed may increase use of evidence, it can nevertheless be argued that bottom-up strategies are also needed. Merely complementing a standard with skills and expertise can be seen as a defensive input from social workers. It is my argument that social workers possess a great deal of knowledge that deserves to be used to a much larger extent than is the case today. *It is the responsibility and possibility of both social workers and managers to create constructive standardization processes.* The findings in this dissertation have shown how social workers' situational judgments together with organizational circumstances are instrumental in determining the outcomes of standardization efforts. As long as social work is stuck in the either-or positions outlined above, the constructive contribution of standards *and* social workers' expertise will not come about.

The findings of this dissertation may also shed some light on the practicability of the common 'solutions' of EBP as currently defined. Talk of the critical appraisal model, the guideline model, or standardized assessment (as I have done so far), tends to suggest that they are substantives that can be implemented to a full extent. Instead, we should see evidence-use in practice as a more general striving that may encompass strategies on different levels. The 'solutions' that have been examined and discussed in this dissertation may to some extent have a place in social work practice. However, they

should not be seen as 'ready-made' solutions, but rather as strategies that can be adapted to local contexts.

Critical appraisal is the original model of EBP as it was first expressed in medicine, and it is a model that many actors in the evidence movement regard as an ideal. In healthcare, however, the idea has to a large extent been abandoned because of lack of time and skills to critically appraise evidence (Knaapen, 2014; Guyatt et al., 2000; Gabbay & le May, 2004). My findings show the idea to be extremely difficult to implement in its entirety. Given how decisions are made in practice, the idea is unrealistic on an individual and case-by-case basis. Even if the procedures were followed by the social workers at some point of a treatment decision, it is likely that the decision will have to be reconsidered later on. Further, a social worker's decision is always constrained by financial restrictions and other organizational arrangements, which means that the result of a critical appraisal cannot always be realized within the organizational confines of the agency. While this problematizes the individual stepwise procedure of critical appraisal, there are other aspects of the idea that may fit into the realities of social work practice. My findings do not suggest that social workers searching out and critically appraising evidence on their own is impossible, *it merely questions whether critical appraisal should be done on a case-by-case basis*. A more realistic alternative would be to give at least one social worker or manager in a social work agency the task of critically appraising research evidence in relation to the clients' problems. This does not have to be done in every case, but perhaps rather in particularly difficult or unusual cases where universal guidelines fall short.

The practical problems of realizing critical appraisal casts serious doubt on the appropriateness of the Swedish government's and SALAR's agreement on EBP which has made the idea into the overarching goal of the Swedish social services. An alternative approach may be to acknowledge a more general ambition to promote the use of research evidence in social work practice – an approach that would also better reflect the concrete activities to implement EBP that have been undertaken by this agreement.

Another popular solution to enact EBP is use of guidelines. This solution has been criticized for circumscribing social workers expertise and for failing to acknowledge clients' specific problems. However, since critical appraisal has been showed to be difficult to apply in practice, there seems to be a need for guidelines that can provide at least a general direction regarding effective treatment strategies. But *use of guidelines does not have to imply that social workers should rely on them as the only source of influence in a treatment decision.* As my findings suggest, use of such standards do not exclude other kinds of influences.

A solution related to guidelines is use of evidence-based interventions. Achieving strict treatment fidelity is often proposed as the best way to move an intervention showed to be efficacious in a research setting into profes-

sional practice. But as discussed above, strict fidelity often competes with important elements of pre-existing practice, and some interventions fit better than others. Deciding about incorporating evidence-based interventions, social services agencies would benefit from a systematic contextual analysis on how an intervention may fit in and what it may contribute, given how client work is organized. Cartwright & Hardie (2012) provide some practical advice concerning how this could be done. They discuss 'support factors' as important for understanding how an intervention (or 'policy', in their terms) might work in a new setting. Achieving strict fidelity is a waste of effort if there are insufficient support factors necessary for an intervention to make the contribution that is hoped for in the new setting. For a psychosocial intervention to be effective, support factors may include trained social workers, reasonable case load, or motivated clients. Such factors are generally not studied explicitly in RCTs, which means that we cannot know for certain what factors are actually necessary. Consideration of 'support factors' means that *use of evidence-based interventions alone is not sufficient but needs to be complemented with a systematic contextual analysis.*

Another common 'solution' in EBP is use of standardized assessment instruments. This has been proposed as a way of strengthening social worker assessments and to facilitate local follow-up. My findings suggest that the level of detail that is sought in many current standardized instruments, including the ASI, may be too fine-grained. This is an important reason as to why they are not used to a larger extent. *Efforts to develop standardized assessment should consider dramatically reducing the amount of questions.* Hereby, it would be easier to incorporate the questions into regular assessment work, which does not always benefit from highly specific standardized questions.

Finally, we should also consider looking beyond present popular solutions in EBP. The solutions that have been discussed so far are placed at an individual level that seeks a relatively detailed standardization of social worker activities. Since my findings point to the importance of organization, *there is a need to think about what evidence use might mean from an organizational perspective* (cf. Nutley, Davies & Walter (2007). As treatment trajectories on an individual level have been showed to be rather messy and unpredictable, there is a need to think about how these processes can be handled organizationally. Zuiderent-Jerak (2007) proposes that situated standardization of treatment trajectories on an aggregated or organizational level might be a feasible strategy. This kind of standardization is not about top-down implementation, but an outcome of a collaborative organizational effort. Knowledge that many clients relapse and are suspended from housing and treatment programs may thus be a starting point for thinking about how treatment can be organized in a more efficient manner. Treatment trajectories can be organized in a way that increases retention. For example, waiting time for treatment might be reduced. Moreover, there may be standardized

ways of dealing with different kinds of disruptions in the treatment trajectory based on research evidence or experiences within the organization.

Lastly, as social workers' treatment decisions are constrained by the organizational context, improving decision making at an individual level is not sufficient. Social workers' ability to make evidence-based decisions may be enhanced by organizationally creating decision alternatives. This may include organizing evidence-based programs within the agency, as has been done in the agency studied in this dissertation. It may also include a specific attention to research evidence and treatment effects when social services agencies procure external treatment programs. This could of course mean increased costs for social service agencies, but without real evidence-based decision alternatives, talk of EBP becomes no more than shallow rhetoric.

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