

Lost in translation

Mental health professional's understanding of care pathways and its implications for policy construction and implementation.

Tine Nesbø Tørseth

Thesis for the degree of Philosophiae Doctor (PhD)
University of Bergen, Norway
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Scientific environment

While writing this thesis, I worked as a PhD candidate in the Department of Administration and Organization Theory, Faculty of Social Sciences, University of Bergen. I was also a member of the research group Law, Politics and Welfare (LPW) at the University of Bergen and have been affiliated with the research group Law, Democracy and Welfare at the Western Norway University of Applied Sciences. Additionally, the Mohn Centre for Innovation and Regional Development provided me with an overall scientific environment.

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Introduction

I remember watching a documentary on India as a child, and what struck me most was the constant whirlwind of life and death, suffering and joy, calm, and sanity coexisting side by side. The dead were carried in the streets next to new-borns; the old and sick died at home, and beggars were present in everyday life. It made me think of these existential phenomena that have been almost non-existent in my everyday life and how modern society has organised the above so that our daily life can be free of such burdens. At that time, I did not know that it was the organising of these elements that made them so invisible to me. However, my interest in the phenomena was present then and was probably why I chose to engage myself in the world of organising.

The modern way of living is all about organisation. We organise society, and some authors, like Michel Foucault and Nikolas Rose, claim that we even organise ourselves. When viewing things from an organisational lens, it is easy to see the constant organising and reorganising that occurs around us.

This PhD thesis is about the organisation of mental health services in Norway. It is about the organisation of services for the vulnerable among us – for the everyday person who has hit a mental obstacle they cannot surpass, those struggling with their mental health. It is for the professionals who have dedicated their work and career to helping and supporting these individuals.

This thesis is for them.

Abstract in English

This main aim of this thesis is to research the understanding of care pathways among professionals in the Norwegian mental health services, and how this understanding has influenced the construction and implementation of care pathways that are then utilised in outpatient clinics within the specialist health care services. A care pathway is a complex intervention for the mutual decision-making and organisation of care processes for a group of patients during a specific period. An explicit statement of the goals and key elements of care based on evidence, best practices, and patients' expectations and their characteristics recognises the CP approach.

In 2015, the Norwegian government decided to reorganise its mental health services into care pathways (CPs). Shortly after the above announcement by the state, mental health professionals reacted by publishing numerous articles and chronicles where they stated that the organisation of mental health care through the utilising of CPs has been a large failure and something that will jeopardise patient treatment. Despite these reactions, mental health services in numerous reports have shown several weaknesses related to the use of standardised diagnostic practices, treatment facilitation, a high degree of coercive measures and an imminent capacity issue with long waiting list and times. The emergence of CPs in 2016 was initiated by the Norwegian Directorate of Health, that made work groups with different professionals to produce different CPs, with the aim of producing 22 care pathways with a diagnostic outlook and evidence-based best practices. The CPs were put into effect on 1 January 2019.

Furthermore, this thesis delineates to two research areas related to care pathways. The first area will focus on research related to the construction of a care pathway designed to be utilised in outpatient clinics. The second area of engagement research revolves around the implementation of this care pathway at four different hospitals. The thesis thus seeks to get an overview and understanding of the care pathway from multiple levels, and will consist of three articles and the kappa.

The first article asks how mental health professionals' interpretation of a CP influences the construction of a CP for use in outpatient clinics. When understanding the concept

of a care pathway (CP), the two main actor groups – mental health professionals and politicians – are guided by the values associated with a specific logic. Compared to mental health services, actors in the political arena are guided by values of discretion and autonomy, as opposed to those in the political field, who value control and efficiency. During this discussion, a polarisation between patient and efficiency concerns then emerge. The pathway is formulated by the Norwegian Directorate of Health, with the input of health professionals, who have knowledge of the values of both types of logic – of which were part of the consideration process during a CP formulation – that operate in the political domain. The above factor explains how CPs have become a negotiation process between the two logics, where both actors are able to maintain their core values. The result is a logistic pathway aiming for more transparency and control but without affecting professionals' autonomy and discretion.

The purpose of the second article is to examine how mental health professionals make sense of CPs and, furthermore, how issues of trust affects the implementation process. Case studies are conducted in four community mental health centres (CMHCs) in different regions of Norway. Individual and focus group interviews are conducted to collect qualitative data. There are four distinct themes or reactions to CPs and their implementation that arose from these interviews: 1) ambiguity concerning the overall goals and content of the CPs; 2) an increased burden in terms of coding, registration, and administrative work that then causes stress among the health care professionals; 3) an IT system and medical records that do not match the coding in the CPs; and 4) an unrealistic distinction between assessment and treatment. The process where sense is made of the care pathway implementation by professionals encourages health professionals to reduce the importance that they associate with the CP system. Distrust of and resistance to the CP system overshadows some of the overall quality goals, a view that is shared by many mental health professionals.

The third article examines how mental health professionals involve themselves in the care pathways' overall goal regarding increased user participation (UP) and contributes to an understanding around the lack of research on the professional roles played by street-level bureaucrats (SLBs) in mental health care. The introduction of increased UP

and patient involvement in treatment facilitation is crucial for CP implementation. Throughout this article, we see how SLBs emphasise UP as part of their practice, influenced by professional institutional logics. When using the policy's measure on involving patients in treatment, certain implications arise. In addition to analysing the political trend of construing shared decision-making (SDM) in mental health care as a form of UP, this article questions its transferability.

The overall concern of this thesis is related to how mental health professionals' understanding of CPs influences their construction and implementation. The conclusion is that mental health professionals have an overall negative postponement of CPs, as they believe that the use of CPs would take away their discretion and autonomy and therefore lead to poorer patient treatment outcomes. However, these concerns are considered by the authorities responsible for the design, and construction of the CP, and the final approach to be implemented by the professionals is a logistic pathway that aims for more control around how their time is utilised. Furthermore, even though the pathway does not take away their discretion and autonomy, a belief of distrust towards those responsible for its designation produces a sense-making process that encourages professionals not to involve themselves in matters related to CPs. When examining how the overall goal concerning increased UP and the involvement of patients in treatment facilitation, two issues emerge. The first issue is that the notion of UP is interpreted as integrated into professional practice by providing correct patient treatment. Involving patients in matters of treatment facilitation is, at certain times, regarded as poor patient treatment. Additionally, the ideal of the medical professionals and the patients as two equal partners regarding treatment facilitation is not agreed on by these professionals, as they believe that there should be a professional reason to meet patients in terms of their treatment requests.

Furthermore, this thesis elaborates on the care pathway approach in cancer treatment, and discuss this as a case to be compared to the care pathways in mental health care.

Sammendrag på norsk

Denne avhandlingen har som siktemål å undersøke profesjonelle aktører innen psykisk helse sin forståelse av pakkeforløp, og hvordan denne forståelsen påvirket konstruksjonen samt implementering av pakkeforløp til bruk i poliklinisk behandling innen psykisk helse og rus. Et pakkeforløp er et standard pasientforløp som beskriver organisering av utredning og behandling, kommunikasjon/dialog med pasient og pårørende, samt ansvars plassering og konkrete forløpstider. I 2015 annonserte daværende statsminister Erna Solberg at pakkeforløp skulle iverksettes innen psykisk helse og rus. Kort tid etter annonseringen oppstod det en betent medidebatt. Kronikker og innlegg var primært fra profesjonelle som arbeider innenfor psykisk helsetjenester og som mente at denne formen for organisering ville sette korrekt pasientbehandling på spill. Til tross for disse reaksjonene, har psykisk helsefeltet i flere rapporter vist store svakheter i henhold til bruken av standardiserte verktøy, lange ventelister, høy ventetid samt for høy bruk av ulike tvangsmidler. Introduksjonen av pakkeforløp I 2016 var initiert av helsedirektoratet som involverte fagfeltet, brukere og pårørende gjennom ulike konferanser og arbeidsgrupper. Målet var å produsere 22 ulike forløp basert på diagnose og evidensbasert praksis. Pakkeforløpet ble implementert første 1. januar 2019. .

Avhandlingens avgrensning seg til to forskningsområder relatert til pakkeforløp. Første område ser nærmere på konstruksjonen av et pakkeforløp til bruk i poliklinisk behandling. Andre studie undersøker implementeringen av dette pakkeforløpet ved fire ulike sykehus. Avhandlingen ser dermed på pakkeforløp fra flere innfallsvinkler og nivå og består av tre artikler samt kappen.

Den første artikkelen omhandler konstruksjonen av pakkeforløpet og har som teoretisk innfallsvinkel hvordan de ulike aktørene i feltet sine meninger relatert til pakkeforløp delvis påvirkes av deres institusjonelle logikker. Som en konsekvens av dette oppstår en dynamikk hvor debatten omkring pakkeforløp og nytteverdi innen psykisk helse og rus sirkulerer som et slags polariseringsideal hvor effektivitet og korrekt pasientbehandling blir motpolar. Denne polariseringen har også et politisk, retorisk formål hvor målet

med den skriftlige debatten i forkant er å diskreditere ideen om pakkeforløps overførbarhet til det psykiske helsefeltet. Konstruksjonen ledes av Helsedirektoratet med god kjennskap til de ulike logikkene. Sluttresultat ender opp med å bli et forhandlet produkt hvor man har tatt bekymringene til helsepersonell på alvor gjennom å produsere et logistikkforløp som bringer med seg målepunkter, men uten å røre profesjonelt skjønn og autonomi som kjennetegner pasientbehandling.

Artikkel to undersøker implementeringen av pakkeforløpet innen poliklinisk behandling ved 4 ulike poliklinikker. Resultatet viser fire ulike, dog distinkte reaksjoner knyttet til implementeringen av pakkeforløpet. 1) ambivalens knyttet til overordnede mål og innhold i pakkeforløpet, 2.) økt administrativt arbeid knyttet til koder og registreringer av og i et forløp 3.) Et IT-system som ikke korresponderer med pakkeforløpets koder 4.) Et falskt skille mellom diagnostisering og behandling.

Artikkelen opererer med Sense Making teori for å vise hvordan aktørene finner ulike «hint» i omgivelsene som brukes aktivt for å unngå videre involvering i pakkeforløpet. Videre diskuterer artikkelen hvorledes mistillit mot myndighetene samt opplevd mistillit til dem som behandlere, farger implementeringen og delvis forklarer det svake implementeringsutfallet.

Den siste artikkelen undersøker hvordan det overordnende målet om økt brukermedvirkning (ikke) blir tatt i bruk. Videre analyseres operasjonaliseringen av fenomenet «brukermedvirkning» fra helseprofesjonelle i deres rolle som bakkebyråkrater. Denne analysen viser hvordan helseprofesjonelle tolker brukermedvirkning som innlemmet i profesjonell praksis gjennom å ha et overordnet blick på pasientene til enhver tid.

Andre del av artikkelen ser på hvilke utfordringer og barrierer som oppstår når man (som pakkeforløpet anbefaler), skal involvere pasienter i behandlingsvalg. Analysen her viser at to ulike «coping»-mekanismer oppstår for å håndtere målet om pasientinvolvering i behandlingsrommet. Mekanismene forstås som handlinger som tolkes av behandlerne som enten er til fordel for pasientene, eller dem selv og fungerer

som elementer som gjør at de kan mestre en arbeidshverdag med stor pågang av pasienter, men lite ressurser.

I spennet mellom idealet om brukermedvirkning slik det er formulert i pakkeforløpet og praksis oppstår et paradoks hvor ulike normative forståelser av individ/pasient kommer i skvis. Overordnet sett finner avhandlingen at det er stor diskrepans mellom ulike politiske ideal og ideer om pakkeforløp og dets overordnede mål om økt brukermedvirkning, og hvordan disse endres i møte med helseprofesjonene.

Denne avhandlingen presenterer implementering og utfalle av pakkeforløp i kreftbehandling, og bruker dette som et komparativt case for å bedre belyse og diskutere utvikling og implementering av pakkeforløp innen psykisk helsetjenester.

List of Publications

Tørseth, T.N. (2021). Organizing as negotiation: the construction of a pathway in Norwegian mental health services. *Int J Ment Health Syst* 15(26).

Tørseth, T.N. & Ådnanes, M. (2022). Trust in pathways? Professionals' sensemaking of care pathways in the Norwegian mental health services system. *BMC Health Serv Res* 22(33).

Tørseth, T. N. (2022). "Implementing user participation in the context of care pathways in Norwegian mental health services. A street-level bureaucrat perspective," is under revision in "*BMC health services research*".

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1. Introduction

1.1 Motivation for the dissertation and problem framing

Organization is an attempt to order the intrinsic flux of human action, to channel it towards certain ends, to give it a particular shape, through generalizing and institutionalizing particular meanings and rules (Tsoukas & Chia, 2002: 567).

The organisation of efficient public health care services has intrigued researchers for decades. An essential element is that these organisations lack mechanisms to alleviate the demand for such services (Arrow, 1963; Lipsky, 2010), and as a result, health care organisations are constantly demanding more resources than they can provide (Berlin et al., 2022; Brodtkin, 2011; Tummers, 2017). The increased demand for resources and efficient health care services in Western countries is often met with a solution involving a focus on reorganisation. Bearing this in mind, during recent decades, health care services in Western countries have been faced with pressure to optimise their organisation of the care and treatment on offer (Kreindler, 2010; World Health Organization (WHO), 2017). An occurring trend within this organisation in health care is the introduction and implementation of care pathways (Pinder et al., 2005; Schrivjers et al., 2012). A care pathway is a complex intervention for the mutual decision-making and organisation of care processes for a group of patients during a specific period (Schrivjers et al., 2012). Care pathways are based on evidence, best practice, and the patients' expectations and personal characteristics, and also involves the coordination of the roles and sequencing of activities across multidisciplinary care teams, patients, and their relatives, in addition to the documenting, monitoring, and evaluation of the inherent differences and outcomes (Schrivjers et al., 2012).

While somatic hospitals in Norway have implemented care pathways in several areas, the organisation of mental health care services has, for the most part, been left untouched. However, several reports have indicated that, in recent years, mental health

care has failed to provide efficient services (OECD, 2014; Office of the Auditor General of Norway, 2021; Norwegian Board of Health Supervision, 2010). These reports show that a high degree of variation exists in diagnostic practice and treatment facilitation. Moreover, long waiting lists and coordination issues further contribute to inefficient services. Coercive measures are also frequently used, resulting in a negative perception of mental health care institutions (Directorate of Health, 2019). Mental health care services offer treatment to vulnerable individuals, who are often experiencing difficult life circumstances and a high degree of stress. However, the long wait time between referral and treatment is a severe problem; in fact, in 2016, the wait time for adults to receive treatment was 46 days.^[1]

In 2016, a requirement to produce care pathways in mental health care was presented by the Ministry of Health to the Directorate of Health, who then established an external work group, aiming to finish a process and evaluation plan to be delivered to the Ministry of Health by 1 April of the same year. Within the document; “Project description, care pathway mental health and substance abuse”^[2], one finds a detailed description of the challenges faced in mental health care and how care pathways can provide a solution to this problem. Here, one also finds the plan to produce 12 different pathways based on a diagnostic outlook, in addition to a separation between the diagnostic practice and examination into one care pathway, and treatment facilitation into another care pathway. Shortly thereafter, work groups for each pathway were established. Each work group consisted of professionals in the field as well as patients and their affiliated organisations and unions. During this process, different conferences were arranged, where agents provided expertise and relevant actors were free to state their opinions. In addition to this, the care pathways were sent out for public hearings. Originally, these pathways were intended to be implemented in September 2018; however, delays meant that they would not be put into action until 1 January 2019.

Shortly after the announcement that the mental health care services would be launching the new care pathways in 2015, an intense debate followed. The care pathway concept caused anger among health professionals working in the field who claimed that

organising mental health care services based on care pathways would take away their discretion and autonomy, leading to poor patient treatment, a sentiment highlighted by one doctor as follows:

The government wants to organise mental health care in care pathways and sells it as equal treatment. The basic idea of what it means to help is at risk. Care pathways belong more to Toyota, and not humane health services.^[3]

Indeed, the reactions from mental health professionals after the announcement proved that there is a lot at stake for them, in terms of the reorganisation of their services into standardised pathways. The threat to their autonomy and discretion represented by the introduction of care pathways was interpreted by these actors as something that would jeopardise their patient treatment.

This PhD thesis seeks to understand mental health professionals' reactions and understandings of care pathways and how the new standardisation introduces implications in terms of policy construction and implementation. The overall research problem guiding this thesis is thus:

How did mental health professionals understand and relate to the concept of care pathways, and what were the implications during the construction and implementation of a care pathway for adults in outpatient clinics?

1.2 Delimitation and specification of the research problem

Researching how the construction and implementation of a care pathway has unfolded and, more importantly, the reason for such unfolding was carried out for this project by focusing on two areas of engagement. First, the process of constructing a care pathway to be utilised in an outpatient clinic is examined. The implementation and outcomes of various reforms and services in the mental health sector in Western societies have been a focus of research over the past few decades (Colquhoun et al., 2017; Ferlie et al.,

2001). Despite this fact, there has been little research on how care pathways are created, particularly on how they emerge as constructs of policy, profession, and practice (Allen, 2009; Tørseth, 2021). This thesis therefore first examines the process of policy development in the context of care pathways, including the exploration of the associated power battles and struggles, as well as “the muddling through” during the birth of the care pathways (Lindblom, 1959). (Lindblom, 1959).

Furthermore, Berg (1997) caution that discussions about the pros and cons of standardisation can become detached from the practice of daily work. Taking this warning into account requires an examination of care pathway implementation and the outcomes of this in an outpatient clinic, which thus takes us into this second area of this thesis’ focus. Barley and Kunda (2001) encouraged researchers to “bring work back in,” meaning that the field of research should examine daily work practices within organisations thus bringing work as an act back into focus. This organisational approach was performed in accordance with Abbott’s (1988) approach, which encouraged researchers to explore the activities of professionals. This view was shared by Bechky (2011: 1162), who called for an examination of organisations that focuses on actors’ practices and sense-making in their everyday work. Researching these issues is important for several reasons. For example, providing a thorough elaboration of mental health professionals’ work practices provides insights into how and why they organise their work, which could be helpful for future attempts to solve some of the issues that such services are struggling with today. Additionally, care pathways in mental health care, how they impact professionals, and professionals’ attitudes to these are underexplored areas of research (see Section 2.7), suggesting that this thesis can contribute to narrowing the gap in the literature.

Figure 1 shows the operationalisation of the overall research problem.

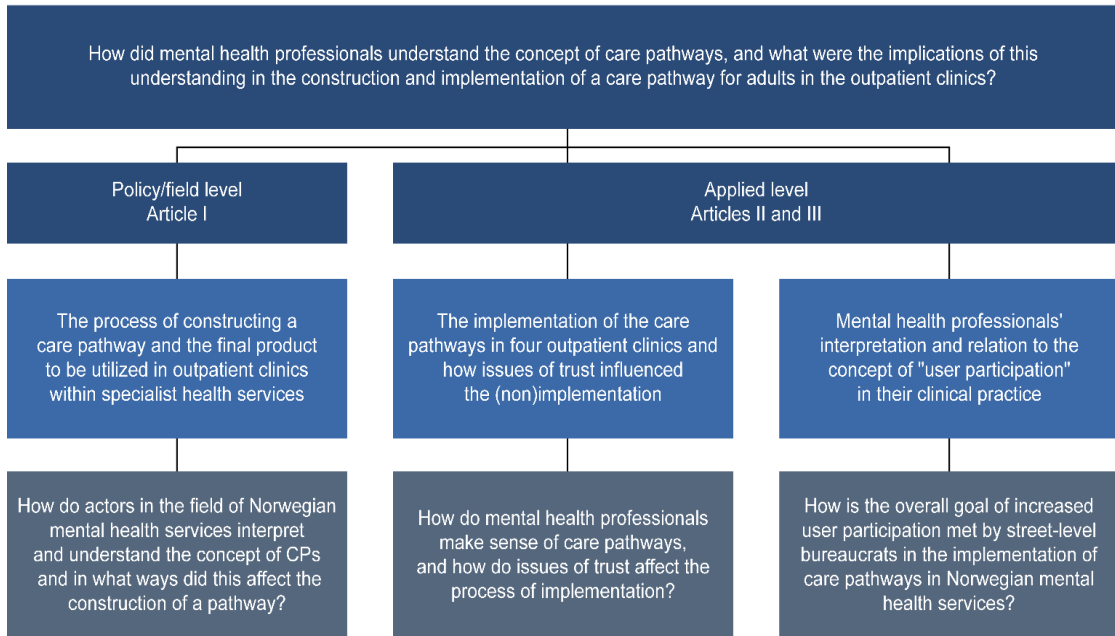


Figure 1 Operationalisation of research problem

1.3 Article-based thesis

The care pathways within mental health and substance abuse care in Norway are guided by five overall goals, to ensure: increased user participation and satisfaction; coherent and coordinated patient pathways; avoidance of unnecessary waiting times for providing a diagnosis, treatment and follow up; more equal services regardless of geographical location, and; improved focus on somatic health and lifestyle.

The result of a care pathway for adults in an outpatient mental health clinic explains the process from diagnosis through treatment and the finalisation of treatment. The care pathways introduced timeframes for assessment and treatment, allowing for a maximum of 6 weeks to finish the assessment and provide patients with a diagnosis, in addition to allowing for a maximum of 6 weeks from diagnosis to first evaluation. The different steps involve time frames that need to be coded, but they neither state which

diagnostic tools should be used nor whether the pathway explains preferred treatment strategies for different diagnoses. Finally, the general objectives are as follows: Within six weeks, a treatment plan (assessment) must be drawn up and implemented. The patient must receive a copy of the plan. An explanation of any rejection of treatment should be provided, and guidelines for priority setting, provide indications of when assessments for different conditions should begin, should be created. To achieve predictability in assessment and waiting times, 59 quality standards need to be addressed compared to current practice. As part of the new care pathways, there are several important stages, including examination or treatment in the hospital. Furthermore, increased user participation is an important goal and should be utilised in the first stage, where examination in a specialised hospital takes place. Here, the patient's goals and needs are prioritised, and in some cases, their next of kin are also invited to participate. In the next step, patients, professionals, and perhaps next of kin participate in the development of a treatment plan. By providing information to the patient, the treating personnel can outline an appropriate treatment plan for the patient. Identifying the health personnel who will coordinate the chosen pathway (treatment) is an important step in the coordination process. Patients and health care professionals are expected to actively use individual plans. A patient's right to participate in the treatment process also allows them to request different treatment personnel, different treatments, more frequent treatment meetings, and so on. The new care pathway also includes the patient's right to evaluate treatment in regular coordination meetings and has an overall focus on shared decision-making.

This thesis is based on the outlook of three research papers, each presenting a distinctive approach when looking at how professionals in mental health care relate to the concept of care pathways.

The article, "Organizing as negotiation: the construction of a pathway in Norwegian mental health services," was published in March 2021 in the *International Journal of Mental Health Systems*, the objective of which was to conduct a thorough study on the making of the care pathways, specifically those used for treating mental illness among

adults. The research question answered for this article is as follows: *How do actors in the field of Norwegian mental health services interpret and understand the concept of care pathways, and in what ways does this interpretation affect the construction of such pathways?* The article examines this process from the idea stage through to the creation of the final product, with an exploration of the public debate on care pathways considered through a discourse analysis, as well as through the use of qualitative interviews with those responsible for the designing of the care pathways.

The second article, “Trust in pathways? Professionals’ sensemaking of care pathways in the Norwegian mental health services system,” was published in *BMC Health Services Research* in January 2022. The research question examined was as follows: *How do mental health professionals make sense of care pathways, and how do issues of trust affect the process of implementation?* The above study examined mental health professionals’ descriptions of their work in four different outpatient clinics, how they made sense of the care pathway implementation and how issues of trust affected the outcome of its implementation.

The third article, “‘How shared is shared decision making?’ User participation in the context of care pathways in Norwegian mental health services” is under revision in *BMC Health Service Research*. The study investigates the implementation of the overall goal on increased user participation and shared decision making. The research question is as follows: *How was the goal of increased user participation met by street level bureaucrats in the implementation of care pathways and what were the implications for shared decision making?* First, the above article explores the ways in which treatment providers at an outpatient clinic interpret and relate to the concept of user participation in clinical practice. Second, the above work then discusses how this interpretation creates challenges when utilising the measure of involving patients in treatment facilitation.

My overall aim in this thesis is to demonstrate how the above three articles make a coherent whole and, together, make a substantial contribution to the knowledge on

mental health professionals' relation to care pathways during the construction and implementation of care pathways in Norwegian outpatient clinics.

1.4 Thesis structure

The thesis consists of five main chapters, followed by a discussion of the three articles. This first chapter covers the research questions and background for studying care pathway construction and implementation within Norwegian mental health services. The second chapter presents the context that enables an understanding of care pathways, involving the academic literature on different organising ideals as well as the organisation of mental health services in addition to international research on care pathways and care pathways in Norwegian cancer treatment. The third chapter presents three overall theories with which to explain the research question of this thesis and its operationalization for the research design. Chapter four elaborates on my methodical approach, including my overall scientific outlook, case selections and qualitative data collection. In the fifth chapter, the main findings of the above articles are summarised . Chapter six discusses the contributions of this thesis to the overall research problem by comparing the care pathway construction and implementation with those in cancer treatment in addition to a discussion on the case in light of macro level theories. Chapter seven serves as a conclusion, and includes directions for future research.

2 Study context

This chapter describes the context in which care pathways are utilised. The first part of this chapter explains, theoretically, different organising ideals in mental health care and how they relate to the concept of care pathways. Thereafter, a literature review on care pathways is presented to show how this thesis aims to fill the research gap. The second part of this chapter describes the empirical context relevant for the concept of care pathways in mental health care.

2.1 Professionalisation as an organising ideal

Recently, there has been a lack of consensus concerning the meaning, definition and operationalisation of the concept of professionalism. According to Gewirtz et al. (2009: 3) there is a “need to work with plural conceptions of professionalism”, which is also the aim of this thesis.

As Schön (1983: 21) elaborated, “professional activity consists of instrumental problem solving made rigorous by the application of scientific theory and technique”. Professionalism can be understood then as involving the application of general, scientific knowledge to individual cases in routinised or institutionalized ways (see Abbott, 1988; Elliott, 1972; Freidson, 1994, 2001).

Furthermore, professionalism involves control, particularly the more specific institutionalised or disciplinary control of professional practices by the professionals themselves (e.g., Abbott, 1988; Freidson, 2001). The act of working therefore becomes professional because it is institutionalised – workers become professionals when they engage in professions that constitute, define, and control professional work, and given these professional associations, professionals are entitled to control and regulate professional practices because they have been granted jurisdictional autonomy through the law and licensing (Abbott, 1988).

Professionalisation in health care is often referred to as discretion practised autonomously by an individual practitioner or professional group (Abbott, 1988). Professionals utilise the knowledge and skills they possess to assess situations, make decisions, act and intervene. Moreover, these types of professionals have been given the autonomy to regulate client and case treatment and structure, to strengthen their knowledge and skills, and to improve their levels of assessment and action. Professional actors do not follow their own selfish interests, as their profession is developed to solve problems and/or issues for the betterment of society. The ethics of such professionals are therefore based on client needs, and professional groups define performance standards and ethical codes for their members in accordance with thorough training (Mastekaasa, 2011; Scott, 1998; Sena, 2017). To guarantee autonomy and its appropriate use, protected professional associations have developed educational programmes, codes of conduct, and selection and supervision procedures.

The “power” of a profession includes the identification and safeguarding of the content and practices of its work (Abbott, 1988; Freidson, 2001; Sena, 2017). Professionalism is, therefore, considered a regulative activity. Workers themselves regulate their knowledge, skills, and expertise and how they are applied in specific situations. As Noordegraaf (2013: 783) summarised: “professionalism is a matter of ‘(self)controlled content,’ whereby professional self-control is executed inside professional domains, also to protect these domains against outside forces” (e.g., Abbott, 1988; Freidson, 2001).

2.1.2 Professionalisation within mental health care

Several occupational groups work in this sector. These different types of professionals have their own preferred ways of viewing the aetiology of mental illness and how to provide appropriate treatment. First, the dominant paradigm of the last half century has followed a medical perspective, where psychiatry has invested its hopes in neuroscience as a path to understanding mental disorders and the developing of more effective and curative medical treatments. Evidence based medicine rests within this

paradigm, and the preferred way of organising the disease is found as an ideal within somatic health care (Kirmayer and Crafa, 2014; Rose, 2018).

Second, there is a psychological outlook aiming to understand each individual case as unique and to provide treatment means to individualise the organisational facilities for each patient.

In Norway, in 1973, a monopoly on the term psychologists came about and has not since changed. In 1971, the first government proposition on the law regulating the professional title of “psychologist” was enacted, and in 2001, a law aiming to strengthen psychologist jurisdiction and responsibilities was established. Both laws state that psychologists are regarded as health personnel in Norway and that they also have the possibility to provide diagnostic practices. (Act relating to patients' rights § 1–3 and Act of 2 July 1999 No. 64 relating to Health Personnel § 3), which has implications for psychologists given that they are obligated, according to these laws, to provide not only help but also diagnostic practice as well as a diagnosis. Professional management regarding the demand of diagnostic practice is according to the International Classification of Diseases (ICD; WHO, 1993). However, Vaskinn and Egeland (2012) showed that only approximately 2/3 of specialist health services utilise manuals and structured tools when providing patients with a diagnosis, enhancing how their work practices are characterised by a high degree of discretion and autonomy and rejecting more standardised work practices. Additionally, psychologists are the dominant group of professionals working in mental health outpatient clinics (Norwegian Directorate of Health, 2019b).

Third, the user representative paradigm and the concept of “recovery” both view an individual as a human being with social needs and rights, which involves the provision of social support systems, jobs, and leisure activities being for the public; the professionals that adhere to and function in light of these ideals are often occupational health and/or social workers.

2.2 Organisation of health services based on managerial ideals

Organisation by and through professionalisation has been criticised in recent decades. First, since the 1970s, it has been argued that protected forms of professionalism are counterproductive. For example, Illich (1976) argued that instead of helping clients, clients became more dependent on help and professionals. In the 1980s, professionalism was criticised for its inefficient use of (public) resources; professional work had to be both rationalised and rationed (Kirkpatrick et al., 2005; Pollitt, 1993). This became part of a new approach to the governing and management of public services, referred to as *new public management* (NPM). NPM celebrates managerialism, which aims to make public administrators more responsive to citizens by adapting their management techniques to align with those in the private sector. To address the growing gap between resources (both economic and staff resources) and scientific research and treatment possibilities, it is believed essential to assume overall political leadership in the health sector (Skogaas, 2011). As a result of NPM reforms, several benefits have been attributed to the greater emphasis on public leadership, goal steering, and results (Pollitt and Bouckaert, 2011). NPM entails the devolution and decentralisation of decisions within public services and ensures citizens' freedom and choice by preventing the concentration of power within a single large-scale government agency (Simonet, 2014). NPM tools place increased emphasis on managerial autonomy, on explicit performance standards, such as performance targets and pay-for-performance mechanisms, and on the use of public-sector resources to ensure that agencies are judged based on their results rather than on their inputs. The assessments of output costs and benefits reflect a belief in objective knowledge (Dahlström et al., 2010; Simonet, 2014).

Although NPM is a well-known steering system within the wider health care system, criticism has been raised by the research in this field, claiming that governing the health care sector restrains professionalism and influences patient care in a negative manner and pushes forward a “cost-cutting” over an “effectiveness” agenda (see e.g., Foster and Wilding, 2000; Leicht et al., 2009; Simonet, 2015).

Norwegian mental health services are organized into two organisational levels—the specialist and municipal levels—with each receiving separate financing. Hospitals and specialised mental health services are run by nineteen health trusts, which are owned and instructed by four regional health authorities. Each health trust runs one or more general hospitals, including mental health clinics. Specialised psychiatric inpatient wards are included in the general hospitals and in buildings that housed former psychiatric hospitals. These consist of acute wards, specialised wards for psychosis, and high security wards. Addiction and substance abuse services consist of outpatient clinics as a part of the mental health services in health trusts and of primary health and social services run by municipalities. ^[4]

The introduction of different NPM reforms during the 1990s and 2000s resulted in comprehensive structural changes in Norwegian health care focusing on the efficiency and modernisation of the health care sector (Christensen and Lægreid, 2001; Christensen et al., 2008). The 2002 Hospital Reform reorganised specialist health services and introduced new management principles for hospitals (Parliamentary Report No. 5/2003). Part of this Hospital Reform reflected NPM approaches where centralisation, decentralisation and commercialisation were implemented into its formal structure (Christensen et al., 2008). Over the past 20 years, Norway's hospital payment models have been characterised by the use of activity-based financing (ABF) and an increase in institutional autonomy. ABF ties hospital income directly to the level of activity, introducing a financial incentive into what would otherwise have been a purely medical decision (Kjøstolsen et al., 2021). In 2017, an ABF model was introduced into mental health care too.

2.3 Organisation of health care services and their utilisation of standards and standardisation

During the 1990s, professionalisation was criticised for its use of knowledge in a monopolised and subjective manner (e.g. Noordegraaf, 2013). This critique pushed

forward a wave of standard practices like EBM and best-practice solutions so as to eliminate any variation in the service provision.

According to its definition, EBM emphasises, above all, that the best diagnostic or treatment procedure is determined by scientific evidence from clinical research, while clinical experience and intuition are helpful but not the main basis of decision-making. Doctors and patients can select the best possible solutions for each patient through the application of EBM (Lambert, 2006; Masic et al., 2008; Mykhalovskiy and Weir, 2004; Timmermans and Almeling, 2009). Organising through EBM means applying standards and standardisation as a tool (Timmermans and Almeling, 2009; Timmermans and Berg, 2003). Timmermans and Berg illustrated in their 2003 study that standardisation in health care, such as through practice guidelines and EBM, is synergistic with other elements involved in the “programme of technical rationality”. The outlook of the above authors is that routinisation promotes standardisation, which allows organisations to maximise the efficiency of their processes by utilising their accumulated knowledge (Wears, 2015). There is also an inextricable link between standardisation and the Industrial Revolution, Taylorism, and Lean Thinking. Its philosophical underpinnings are an understanding of the world as complicated but also understandable and linearly predictable, enabling standardisation to be used as an approach to issues or problems that need to be solved, of which scientific management is one such concept (Taylor, 1911). To maximise efficiency and profit, every component of a job can and should be scientifically studied, measured, timed, and standardised. Every task has a single best way of carrying it out, according to Taylor's system (1911). Indeed, various management philosophies and production methods have been identified, such as Lean (Kim et al., 2006; Womack and Jones, 2003). According to de Koning et al. (2006: 5), “Lean is an integrated system of principles, practices, tools, and techniques aimed at reducing waste, synchronising workflows, and managing variability in production flows”.

Both Taylorism and Lean Thinking provide an approach to the issues of professionalism when viewed as an inefficient steering system for resource allocation,

which was the main critique of professionalisation as an organising ideal (Brorström and Nilsson, 2008).

The increasing popularity of standardising work of all aspects in health care has, however, been met with criticism. Wear's (2015) article regarding standardisation and professional work in health care highlighted how such standardised routines conflict too strongly with the work models inscribed in frontline workers' actual jobs, which could explain some of their resistance to standardisation. The development of contextual judgements, explanations, and situated actions at the front line is much more about making sense of an uncertain and ambiguous jumble of unfolding phenomena than about rule-based decision-making – that is, practice rather than prescription (2015).

Another critique is that standardisation restructures work and changes relations, thus potentially creating additional negotiation opportunities and occasional conflict (Timmerman & Berg 2003). However, some authors have claimed that professionals resist standardisation more to reinforce their professional identities and occupational boundaries than as a careful consideration of its advantages and disadvantages (Dixon-Woods, 2010).

2.4 Ideas of care pathways: combining professionalisation, standardisation, and managerial ideas

There are no simple and harmonious organisational solutions to ambivalent ideas based on economic models, health care strategies and traditional care values. It would be far too simplistic to take the best of the two rationalities and then combine them (Skogaas, 2011). However simplified care pathways are portrayed, the approach to combining standardisation ideals with managerial ideas and professional practice is found in the organisation of care pathways, and this approach to the organisation of health care services is gaining momentum at a global level (Allen, 2009).

The first use of the term *care pathways* can be traced back to 1985 at the New England Medical Centre (De Bleser et al., 2006). Shortly after, the concept of care pathways – also defined as clinical pathways, critical pathways, care paths, integrated care pathways, case management plans, clinical care pathways or care maps – was born. The development and implementation of care pathways can also be distinguished as top-down or bottom-up. Top-down processes related to care pathway implementations are often associated with implementing general guidelines from evidence-based medicine, increasing risk control, or reducing variation. The bottom-up approach is more commonly motivated by increased interdependence in decision-making, patient logistics, and medical development with the goal of improving medical outcomes (Mæhle et al., 2021)

The trend of organising health care services into care pathways is surprising for several commentators (Pinder et al., 2005). The popularity of such services is even more remarkable because of their effectiveness and limited evidence base (Pinder et al., 2005). Allen, 2009 ask, what is the reason for the increasing popularity of such services within the health care sector? The idea that they align professional values, administrative interests and political concerns has been presented as a relatively successful, widely adopted innovation (Greenhalgh et al., 2004). However, this breadth of appeal conceals tensions between clinical and management agendas, thus creating challenges in the design of pathways and thus their implementation in practice (Greenhalgh et al., 2004). Furthermore, critics have pointed out the potential detrimental effects of protocolising care at the expense of professional discretion (e.g. Pinder et al., 2005). The conceptual criticism prevailing within this rationale is found in three areas. First, pathways are criticised for their embracing of a technical-rational approach that prioritises auditable aspects of care and allows for the managerial scrutiny of professional decisions. Second, pathways replace clinical judgement with rule-based “cookbook medicine,” which could impact how professionals are able to provide the dimension of care (Martin et al., 2017; Pinder et al., 2005). Third, despite the intended purpose of identifying and addressing “variances” – such as noncompliance – pathway documentation may lead clinicians to be reluctant to deviate

from prescribed practices (Allen, 2010; Martin et al., 2017). Additionally, pathways demonstrate the tension between managerial and professional logic in terms of health care delivery (Martin et al., 2015).

The conceptual critique shows how the care pathways challenges and sometimes opposes professional ideals when providing care for patients, such as discretion and autonomy. One consequence of the implementation of care pathways could therefore be that instead of bridging the divide between centralised and local control and clinical and organisational worlds, the failure to involve professionals in their use creates the appearance of transparency and standardisation while preserving medical staff autonomy (Allen, 2014). The summation of the ideas of care pathways and their targets leads to the dilemma explained by Pinder et al., (2005: 774):

Are care pathways to be regarded as Taylorist devices for standardising care and treating each individual patient in precisely the same way, or are they the means of affording individualistic treatment while simultaneously creating organisational efficiency by 'tailoring' the organisation to the patient (rather than the other way round)?

The above quote highlights how issues arise when the interpretation and meaning of care pathways are fragmented. The idea of care pathways as belonging to different governing regimes shows that to some, care pathways could be centred around patients, while to others, patients should be centred around the pathways. The two understandings have implications for how these pathways are interpreted and met by professionals. Overall, Noordegraaf (2011) claimed that public service analysts have focused too much on the organisational aspects and too little on the social and societal aspects of changing professional work. Furthermore, the author also went on to argue that it is common for analyses of professionalism to assume some core idea of professionalism, which is either adapted by the creation of organisational frameworks or defended by professionals who resist those frameworks, leading into how professionalism is not so much related to organisational environments but rather to

wider societal, institutional factors that affect professional work and settings more fundamentally (Noordegraaf, 2011: 793–795). Bearing the above aspects in mind, this thesis seeks to further understand mental health professional work as intertwined in its institutional and societal framework.

2.5 Introducing care pathways in Norway

In 2016, a report from the Directorate of Health on mental health services for adults showed an increase of 3.2% in the number of people receiving treatment within this sector compared to the previous year – this consisted of a total of 148,000 patients receiving treatment and an average waiting time of 46 days before the start of treatment (Directorate of Health, 2017). Furthermore, it is expected that 50% of the population will have a mental illness that will require treatment during their lifetime (Directorate of Health, 2019a). A report from the Directorate of Health (2018) showed major geographical differences affecting this sector. Undesirable variation in waiting time, treatment, examination and follow up ^[5] is widespread. Finally, patients with serious mental illness (SMI) tend to live 15 to 20 years less on average compared to the average individual (Directorate of Health, 2018a).

In addition to the above factors, the patient population is extremely varied, from patients in treatment for lighter types of depression to those with more severe mental illnesses (SMI), which then require constant care for longer, even years. Many of the patients suffer from comorbidities, and their health often changes over time (Directorate of Health, 2015–2019). All the above factors show that such services are in need of complex coordination by and between professionals, levels, organisations, and systems. However, the heterogeneity of professionals involved entails that treatment facilitation within these services is complex, implying different organisational challenges (Willumsen and Ødegård, 2014). However, it is also important to accept that the mental health care system is characterised by disagreements, uncertainties, and ambiguities.

The ideal of providing quality and efficiency in the utilisation of care pathways in Norway can be found in several policy documents – such as “From Piecemeal to Comprehensive – A Continuous Chain in the Health Service” (The Wisløff Committee, NOU, 2005: 3) which points out that well-coordinated patient pathways contribute to the improved quality of services, the effective use of resources and stimulating work environments. Within “And it is Going to Get Better!” (National Strategy for Quality Improvement in Health and Social Services 2005-2015), the idea of quality is portrayed in the form of streamlined services. The National Health Plan for 2007–2010 highlighted how patient pathways are regarded as a useful tool in the design of service provision in the system. On top of this, the coordination reform, entitled “Proper Treatment – At the Right Place and the Right Time,” pointed out that coordination remains a major problem and the reform aims to provide patients with the appropriate treatment at the appropriate place and time. Here, “well-designed patient progressions” will, to a greater extent, become a common reference point for all actors in health care services. Public policy documents thus use terms such as “patient pathways” or “cohesive treatment chains” to underpin such approaches and strategies that make for a more effective use of the resources within the system. In the *Mental Health Escalation Plan 1998–2008*, an increased focus on standardisation is highlighted. In addition, the 2014 *Patients’ Health Service* focuses on how health care services are centred around patient/users and user participation, requiring more standardised and streamlined approaches focusing on patients.

2.5.1 care pathways in cancer treatment

The article “Exploring the triggering process of a cancer care reform in three Scandinavian countries” by Mæhle et al. (2021) investigates the introduction of care pathways in cancer treatment. The dominant narrative of “unacceptable waiting times” was the overall motivation behind the new organization. Yet, originally, this narrative was linked to medical outcomes of waiting times in Denmark, where its focus was on patients' subjective demands for safety and predictability. When introducing the cancer reform in Sweden, Denmark and Norway, it was not clear in the political landscape that the core narrative should be centred around eliminating delays in diagnosis or

treatment. In fact, the overall narrative that did then emerge was about the cancer patients' experiences of not being taken seriously. In Norway the arguments related to waiting times were based on patient experiences and putting the patient's perspectives first.

The challenge of eradicating these unacceptable waiting times and finding the organisational solution to provide an answer to this issue was not clear from the start. Existing models had an impact on the decision to introduce Cancer care pathways because they could provide the desired outcome. The model created at Vejle Hospital was one such major source of inspiration for Demark, of which later the Danish reform interpreted as a success, and went on to function as model for Norway and Sweden (ibid). In Norway, the Directorate of Health held the position of strategy director for cancer care, where they appointed multidisciplinary groups covering each major type of cancer diagnosis. These groups recruited members from the specialised medical society. The first task of the multidisciplinary groups was to produce a unified nationwide action programme comprising guidelines for diagnostics and treatment (Mæhle and Smeland, 2021). These cancer-specific organisational structures also played a major part when orchestrating the implementation of the reform. Other project-like structures emerged on several levels during its implementation. The design for each diagnosis was organised like a project. Communication about the mission and CPP tools was accomplished through campaigns like conferences and meetings. Support groups, resource groups, and task forces were established at both the national and regional levels (ibid).

During the construction of the care pathways, three institutional logics were identified. First, a medical logic anchored in best medical practice. Second, an economic-administrative logic connected to effective production through optimal use of available resources. And third, a patient-related logic, which entails a subjective, emotional and personalised basis. Several institutional entrepreneurs were present for this stage. Some of the actors that held more decisive roles on the national level had connections to several distinct institutional fields and therefore filled the role of bridging such gaps between different actors (Mæhle et al. 2021).

Norway introduced care pathways for lung, colorectal, breast and prostate cancers in January 2015 and later added twenty-four new cancer diagnoses to the organisation of care pathways. One of the measures introduced to aid in the implementation of the care pathways was the national professional guidelines. Here, standardisation and evidence-based medicine (EBM) are considered necessary when it comes to maintaining equitable, high-quality provision of the service – a relevant criterion for the treatment of diseases. The care pathways declare these professional guidelines to be knowledge-based, and they are therefore prioritised over the internal guidelines, procedures and routines already developed in health care organisations (Olsen et al., 2021). Care pathways for cancer in Norwegian health care services operates through standardised patient treatment plans that outline what the patient can expect in terms of the organisation, responsibility for assessment, treatment and communication, in addition to time between the different action points. The care pathway is based on professional guidelines described in the “programme for action, cancer¹” document. The main aim behind the care pathways is described as: “... cancer patients should meet a well-organised, holistic and predictable course of treatment without unnecessary delays in assessment, diagnostic practice, treatment and rehabilitation” (ibid). Even though resistance from the professional community is common when it comes to top-down initiatives, positive reception of this reform was evident in the case of Norway, and professionals contributed in the implementation of the core measures (Mæhle and Smeland, 2021).

The planning and introduction of the care pathways was coordinated by the Directorate of Health, while the implementation was organised on the local level by the hospitals themselves. One strategic instrument used to avoid delays and to create predictability can be found in the form of the predefined action points. Each care pathway is separated into three parts with each phase to be accomplished within a set time limit. Phase one regulated time from the patient’s referral until the start of their assessment. Phase two is time from assessment until clinical decision, and phase three is time from clinical

¹ Directorate of health, action program for cancer, <https://www.helsedirektoratet.no/tema/krefit> (assessed 20.02.2023)

decision until the start of treatment. For example, for breast cancer, the maximum time frame from the suspicion of cancer to the first appointment at the hospital is 7 days, from the first appointment to the clinical decision is 7 days, and from clinical decision to the start of initial treatment is 10–13 days. Health personnel responsible for coding this information will enter specific, standardised codes, usually in the electronic patient record, indicating the start/completion time for each phase in the pathway. One of the overall goals laid down by the government was for 70% of the care pathways to be performed within the set time limit. Coding of action points enables to follow up on whether the overall goal has been met. The specialist health care services report monthly data to the Norwegian Patient Register (NPR) who are responsible for monitoring. The statistics are published officially, so anyone interested in this can follow the results of each hospital and their timelines in the care pathway for cancer. ²

2.5.2 introducing care pathways in mental health

In 2010, the first care pathways were introduced into Danish mental health care, with the model copied from the cancer trajectories using an outlook from a diagnostic perspective which involved evidence-based practice and strict time frames that must be followed. The transfer of policy from one country to another is often interpreted as a process of mimicking in the search for successful solutions to a problem. If one solution is a success in one country, it is adapted into a new context to act as a legitimate solution in the second country (Di Maggio & Powell, 1983).

This was the reasoning behind the idea of the care pathways being introduced into Norwegian health care. However, it is not a question of transfer but also of translation. In other words, the original organisational idea needs to be adapted to the new local environment (Boxenbaum, 2005). Translation theory (see e.g. Brown et al., 2002; Røvik, 2006) focuses on how ideas and various representations of practices travel in time and space, also, the theory conceive management ideas as immaterial accounts that are transformed as they spread. The power behind the travel does not stem from

² National recommendations and advice on care pathways <https://www.helsedirektoratet.no/produkter?tema=nasjonalt-forlop> assessed: (20.02.2023)

one source, but is created from the interpretations of the idea that triggers indifferent actors within a network (ibid).

The translation of care pathways into mental health care practices is the overall aim of this thesis. As outlined in the title of this thesis, the ongoing study seeks to pinpoint the driving forces behind the attempt to transfer such policy across borders, how this was “lost in translation”, and to explore its outcomes.

2.6 User participation in mental health care

In the academic literature, there is no consensus regarding an explicit definition on what constitutes user participation or patient involvement, and inconsistencies and ambiguities are prevalent (Solbjørg et al., 2011; Wiig et al., 2013). Despite this lack of a universal definition, there is however consensus that both the provider and patient are expected to be active participants in the process. An overall idea of this is that information exchange and cooperation meet the complex and unique needs of service users (Bettencourt et al., 2002). Furthermore, in the mental health field, the importance of utilising complementary competences between service users and service providers through respectful cooperation is emphasised. User participation was born as a concept in mental health, through the “Recovery-wave” of the 1980s and had an explicit focus on knowledge developed through a “lived life” and the psychiatric patient’s own thoughts and goals for improvement. The focus was on society, living conditions and social processes (see, e.g. Borg et al., 2012; Topor et al., 2009). This notion made way for recovery and “empowerment” where ideas collected mainly from user movement groups – like “normalisation” and “autonomy” – became some of the key terms in the politics of welfare state reform and brought about the deinstitutionalisation and downsizing of psychiatric hospitals (Fineide, 2012; Rose, 2018). Furthermore, in the 1990s, user participation truly became a key matter within mental health services, lending ideas from NPM, where patients were portrayed as consumers of a service (Barnes and Cotterell, 2012). User participation, in the form of legislation, was introduced in 1997, when the law on the prioritisation of patients (Regjeringen, 1997) became a strategic tool for how hospitals would be organised going forward. A few

years later, in 1999, the Act relating to Patients' Rights (LOVDATA, 2022c) was enacted, where services were required to involve their users. These policy documents are expected to involve users at both the individual and system levels. Following that, the "Escalation Plan for Mental Health Care" – a large-scale political reform from 1998 to 2008 (The Norwegian Government, 1998) – considered user participation as a fundamental part of this plan. At the same time, the district psychiatric centres (DPCs) and outpatient mental health teams grew to provide mental health care treatment where the individuals actually lived.

As part of its "Comprehensive Mental Health Action Plan 2013-2020" (WHO, 2013-2020), the WHO listed service user involvement and more responsive services as the key objectives. Furthermore, in its green paper "Improving the mental health of the population, towards a mental health strategy for the European Union 2005" (Green Paper, 2005³) the European Commission emphasised the need for mental health services to be oriented towards the involvement and participation of patients. Mental health services in Norway are regulated by the Mental Health Care Act. Specific legislation in mental health care services is found at three distinct levels. The individual level is regulated by the law on patient and user rights^[6], which regulates the rights to be informed and to participate, meaning that patients are expected to participate in the choice and formulation of the services available. At the systemic level, the services are regulated in the "Regulation on management and quality improvement within health and care services"^[7] and in specialist mental health services, with the Health Authorities and Health Trusts Act^[8] §35 stating that the board must ensure that the voices of user representatives are heard.

One trend that has gained momentum in recent years involves patients in treatment facilitation, theoretically understood as shared decision making (Slade, 2017).

Shared decision making is a collaborative process between mental health professionals and patients (Slade, 2017: 146) and involves health professionals working with patients to choose tests, treatments, and management based on clinical evidence and their informed preferences, including providing evidence-based information about options, outcomes, uncertainties, and decision-support counselling as well as a system with which to record and implement their informed preferences. Typically, clinicians are considered experts on diagnosis, aetiology, prognosis, treatment options, and outcome probabilities, while patients are considered experts on illness experiences, social circumstances, attitudes towards risk, values, and preferences (Coulter & Collins, 2011; Slade, 2017).

2.7 State-of-the-art research on care pathways, professional responses, and user participation.

The aim of a care pathway is to enhance the quality of care across the board by improving risk-adjusted patient outcomes, promoting patient safety, increasing patient satisfaction, and optimising the use of resources. Despite the wide utilisation of such pathways, several uncertainties are involved. First, the terminology, definition and developmental aspects are unclear (De Luc, 2000, 2001). Second, their efficiency remains unclear. Reviews on the effect of care pathways (Dy et al., 2005; Hindle & Yazbeck, 2004; Van Herck et al., 2004) describe a variety of outcomes. This chapter seeks to replicate the scientific literature on care pathways by focussing on four areas.

2.7.1 Studies on care pathways in mental health care

MacDonald et al.'s (2018) review study on pathways in mental health services for young people identified pathways into mental health care as an understudied area. Amaral et al. (2018) showed in their article that the provision and integration of services for adequate acute and long-term care in mental health services have yet to be achieved. A systematic review based on global tendencies and the efficacy of care

pathways in mental health care found considerable variations from country to country (Volpe et al., 2015). Indeed, Volpe et al. further highlighted that there is a considerable variation in care pathways outcomes based on different contexts.

Taking this into consideration then means to be aware of the context that care pathways operate within. Focusing on both areas of somatic health care by looking into care pathways in cancer treatment care, as well as the field of mental health care, can help highlight the different factors that could be enabling the difference in outcomes between these two contexts, which will be explored in the discussion in section 6 of this thesis.

2.7.2 How care pathways influence professionals' work

In their study on care pathways, Allen (2010) found that community nurses may be better able to recognise and manage mental health problems for war veterans and war widow(er)s if they use a structured pathway rather than solely relying on their judgement. The above study enhanced how the application of standardised tools for the evaluation of mental health issues was able to pick up on cases in which sole discretion would have potentially missed. Khandaker et al. (2013) then found that a care pathway model led to more focused interventions in community mental health in the UK, while Hunter and Segrott's (2009) review study, "Re-mapping client journeys and professional identities – a review of the literature on clinical pathways" showed limited evidence of the impact of such pathways on client care. However, the authors also found that nursing and other health professions may be greatly affected by care pathways too, as they can redraw professional identities and boundaries as well as transform how they document care. The study went on to state that "the impact of standardised pathways on professional ideologies which emphasise individualised care and clinical autonomy will require long-term programs of research" (Hunter & Segrott, 2009). Moreover, Sleeman et al. (2015) examined health professionals' views on a care pathway for palliative care, the results of which showed both negative and positive elements concerning the use of care pathways. Among the benefits, the study showed that care pathways served as clearer, more consistent, and comprehensive care

processes. This perceived clarity was interpreted by others, however, as potentially harming to the patients, as the overreliance on paperwork led to prescriptive, less thoughtful care and the removal of case-specific decision-making. As the results showed, the concern for how care pathways turn care into something instrumental coexists with the notion of how an explicitly described care process could be beneficial for patients. Additionally, Bjurling-Sjöberg et al. (2014) studied nurses' perspectives on a care pathway in aortic surgery and showed that despite being aware that a pathway can lead to unreflective standardisation, the nurses in the study identified a number of advantages for the use of a pathway to care for patients. Corroborating this, Martin et al. (2017) showed how a care pathway implemented in an emergency ward was not resisted by its members but rather, resulted in a complex intertwining between standardisation and clinical autonomy. Viney et al. (2022) examined how personalised medicine within a breast cancer pathway challenges the standardised pathway but also results in managing a threshold between EBM and experimental medicine. This study showed how the care pathways are stretched when they are combined with new and personalised technologies and how the involved actors still manage to meet the standardized structure of the care processes, thus opening up the possibility of discretionary use in the care pathways (Viney et al., 2022.).

The abovementioned studies showed how care pathways are often stretched and adapted by the actors involved and that the possibility for discretionary activities is possible, despite a standardised practice being in place. However, the studies presented are primarily from hospitals where evidence practice is utilised as a normal part of everyday work. A more thorough exploration of an area where evidence-based medicine is present in the Norwegian context is its cancer treatment services. The following section will thus highlight the research related to this specific area.

2.7.3 Professional work in Norwegian cancer pathways

An evaluation report on care pathways in Norwegian cancer services (Melby et al. 2021) evaluated how care pathways was experienced by professionals and patients. The evaluation showed how changes understood as a trend/development that had

already implemented were streamlining of processes, efficiency and different management practices made it hard for the professionals to identify which changes were brought about as a result of introducing the care pathway approach (ibid).

The implementation of CPPs was not accompanied by the allocation of funding, meaning that the hospitals could not increase capacity to meet the target treatment times. Melby & Håland's (2019) article "Speedy, predictable and secure cancer care? Introducing cancer patient pathways in Norway" showed how keeping to the waiting times has become a major concern. This study shows how most of the effort in hospitals has been directed towards reducing waiting times. It also documents how professionals reorganise their resources and prioritise cancer patients before other (elective) patients. However, predictability and security rest on the patients being informed about receiving care organised through a CPP and the authors found that in many instances this was not the case. Another study looking into these target times is Melby and Håland's (2021) article, "When time matters: a qualitative study on hospital staff strategies for meeting the target times in cancer patient pathways" which showed how Norwegian professionals developed strategies to comply with the new time allocation that the care pathway put forward. These strategies included internal reorganisations within hospitals, individual behavioural changes and the redistribution of services to providers outside the hospital.

Another concern related to the target times in the diagnostic and assessment phase of the care pathway is how physicians deal with time limits and rapidness when performing this work. Næss and Håland's 2021 study looked into this matter in the article "Between diagnostic precision and rapid decision-making: Using institutional ethnography to explore diagnostic work in the context of Cancer Patient Pathways in Norway", for which they examined how the CPP policy influenced physicians' experiences of diagnostic work and found that diverse social processes (interests) targeting cancer care management are proven to be increasingly difficult to balance, compelling medical professionals to negotiate between two types of guidelines: one demanding rapid decision-making (CPPs) and one demanding diagnostic precision

(clinical practice guidelines). Furthermore, in cases where guidelines present conflicting demands, physicians rely on their professional autonomy and discretion to prioritise clinical guidelines over CPP guidelines, thus justifying the breaching of CPP timeframes.

Codes and coding practices raise questions regarding what quality of care represents and how it could/should be measured in the care pathways. This is examined by Håland and Melby (2023) in their article “Coding for quality? Accountability work in standardised cancer patient pathways” which shows that many advocate for coding as important work. More specifically, they advocate for coding as more important for the patient than for some vague notion of *the system*. Thus, coding is made legitimate to health personnel when patient work as a core part of their professional identity. This also shows how organising for quality becomes a crucial part of professional work (Håland et al. 2023: 142).

2.7.4 User participation and shared decision making

Studies on measurable outcomes of a shared decision-making approach

Duncan et al.’s 2010 “Systematic Review study on Shared decision making interventions for people with mental health conditions” researched whether interventions to increase shared decision making affected patient satisfaction with treatment or care led to better health outcomes or to patients being less likely to be readmitted to hospital. The study showed that no effects were found on the clinical or health service outcomes. A Cochrane review on shared decision making within mental health care by Aoki (2020) assessed the effects of SDM interventions for people with mental health conditions, carers, or health care professionals, on outcomes including: clinical outcomes, participation/involvement in the decision-making process, recovery, satisfaction, knowledge, treatment/medication continuation, health service outcomes, and adverse outcomes. The conclusion is that there is uncertainty whether SDM interventions improve clinical outcomes, such as psychiatric symptoms, and re-

admission, compared with control due to very low-certainty evidence. Overall, they found that most evidence was of low or very low certainty, meaning there is generally a low level of certainty about the effects of SDM interventions based on the studies assembled thus far. The study also showed a lack of theoretical exploration of shared decision-making in the mental health field, and no concept analysis of shared decision-making for adults with mental health illness has been conducted. Due to the lack of a clear concept of shared decision-making, health professionals have found it difficult to understand the roles and needs of such people.

Studies on user participation in a care pathway approach

Studies on how a care pathway approach influence user participation is rare. The studies that do exist shows varied results. Archer et al.'s 2012 study on a collaborative care model studied the collaboration between a medical doctor, a case manager (with training in depression and anxiety), and a mental health specialist (such as a psychiatrist) to provide treatment in an outpatient clinic for depression and anxiety. The treatment is organised by a case manager who has regular contact with the patient and the result was associated with significant improvement in depression and anxiety outcomes compared with usual care. The author also went on to conclude that this model represents a useful addition to clinical pathways for adult patients with depression and anxiety. Bosch-Capblanch et al.'s 2007 study on how contracts – a verbal or written agreement that a patient makes with health care practitioners, or with carers, where participants commit to a set of behaviours related to the care of a patient – aim to improve the patients' adherence to treatment or health promotion in outpatient clinics. Kendrick et al.'s 2016 Cochrane study on "Routine use of patient reported outcome measures for improving treatment" assessed the effects of routine measurement and feedback of the results during the management of common mental health disorders and found no evidence of a difference in outcome in terms of symptoms, between the feedback and no-feedback groups.

Qualitative studies on shared decision-making in mental health care

In the article “Empowerment and pathologization: A case study in Norwegian mental health and substance abuse services” (Larsen & Sagvaag, 2018), factors that impacted patients’ ability to be heard when collaborating with staff to improve these services was explored. The results point to a constraining, diagnostic organisational culture that made user involvement challenging. Stigmatisation and pathologisation of risk and contextual constraints appeared to limit patient input in discussions about service development. In addition, staff and patients perceived empowerment as something patients were permitted by mental health professionals. This perception was both one-sided and limiting to any exploratory dialogue, as patient impact on service development was controlled by staff.

In the article “Unlocking service provider engagement in constrained co-production partnerships” (Larsen, Sagvaag, & Karlsen, 2020), critical conditions for co-production in an organisational setting constrained by organisational policy and professional codes of conduct was explored. The result showed that staff had difficulties managing communication and power relations with patients. Avoidance mechanisms were present (avoiding/changing the topic, back-stage opposition) that tilted the power relationship in the professionals’ favour even more, and they avoided discussing and resolving issues directly with patients, instead opting to approach their department head or other staff. This process continued until patient co-researchers risked involuntary discharge.

Steinacher et al. (2012) investigated the changes that came about as a result of the implementation of care pathways in the treatment of patients with schizophrenia and found that patients actually reported a lower degree of satisfaction with their treatment after the care pathways were introduced. These studies elaborate on issues that are also documented in Velligan et al.’s 2016 study on shared decision-making in mental health care, where barriers are potentially modifiable and can be addressed by changing attitudes. Furthermore, and even more importantly, according to the results, patient

participation is hindered by organisational barriers rather than patients choosing not to involve themselves in these matters (Velligan et al., 2016).

Shared decision-making in cancer care pathways

The action points and coding are all related to the overall aim behind the care pathways, namely that of reducing the waiting time. This element has been researched from the patient perspective in the article “Patient experiences of waiting times in standardized cancer patient pathways in Norway – a qualitative interview study” by Solbjør et al. (2021), where the researchers found that patients are comforted by knowing that they are being treated within a structured care pathway that ensures rapid diagnosis and a set start of treatment. However, the pathways needed improvement to: avoid delays, allow for adaptations to patient needs, and include more information for the patients in order to avoid stress.

The shared decision-making approach is researched by Andersen-Holekim et al. (2021) in the “Shared decision-making in standardized cancer patient pathways in Norway—Narratives of patient experiences” study. A range of experiences were reported by patients, including autonomous decision-making and nonparticipation. Overall, patients understood standardisation as evidence-based, and trusted the health care professionals to make decisions on their behalf. When facing preference-sensitive treatment choices, such as keeping or removing the breast in the breast cancer pathway, patients sought recommendations from health care professionals. However, the study also showed that when patients with individual preferences that deviated from the set care pathway at the hospitals, such preferences complicated the shared decision-making process and the patients experienced that they had to fight against the system to make their voice heard and for their preferences to be taken into consideration.

2.8 Identifying the research gaps

Even though the design of policy relating to the care pathways for cancer treatment in the Scandinavian countries has been researched (see e.g. Mæhle et al. 2021; Mæhle & Smeland, 2021; Melby et al., 2020), research into the process of care pathways actually being created for mental health care is lacking, and only one study on the construction of a pathway in mental health care has been identified: Allen's (2009) study on the development of a mental health pathway. Allen's study found that disagreements about the evidence base for clinical judgement resulted in a policy document negotiated by different actors, the result of which aims to make recommendations instead of a precise, prescriptive pathway. Another prospect of research into policymaking and care pathways is the contribution by Checkland et al. (2020) in their article "Road to Nowhere? A Critical Consideration of the Use of the Metaphor 'Care Pathway' in Health Services Planning, Organization and Delivery" which looks further into how the negatively loaded metaphors related to the notion of care pathways used by health professionals demonstrate how care pathways – in their role of not just describing the world but also framing it – determine what is seen/unseen, and the possible solutions.

Studies informing how care pathways are met by professionals have been identified within this chapter. However, as the studies show, mental health professionals' reactions and ways of relating to the concept – how an implementation of a care pathway approach influences their daily work – is missing. Additionally, two studies on increased user participation by way of a shared decision-making approach within mental health care shows the difficulties that the patients encounter (Larsen & Sagvaag, 2018, 2020) and further research into this matter is encouraged by Aoki et al. 2021.

Thus, based on the above, the aim of this PhD thesis is to narrow the gap in the literature concerning:

1. the construction of care pathways in mental health care,
2. a thorough elaboration on how mental health professionals interprets and make sense of care pathways within the frames of an institution and,
3. how the overall goal on increased user participation is met by mental health professionals.

3 Theoretical outlook

As addressed in chapter 2.8 on the state-of-the-art research on care pathways, professional responses, and user participation, there is a lack of research on this topic and how the care pathways are implemented in practice. The overall goal of this thesis is to therefore further understand these juxtapositions based on my empirical data. The theories following this chapter provide an explanation and conceptualisation of the overarching research question. Indeed, the theories presented can explain different aspects of this juxtaposition depending on the two areas of engagement of which the thesis focuses on, namely, the construction and implementation of a care pathway. The three theoretical outlooks to be presented are *institutional logic*, *street-level bureaucracy* and *sense-making theory*.

3.1 Institutional logic: A keystone when organising

Institutional logic prescribes what constitutes legitimate behaviour and provides an understanding and conception of what operational situations are about, what goals are appropriate, and what means are legitimate for achieving the goals in question (Fossestøl et al., 2015)

Institutions are durable social structures consisting of norms, routines, and practices (Scott et al., 2000), and while organisations and their actors are the players, institutions are the rules by which they play (North, 1990). Institutional theory is among the leading approaches within organisation theory over the last four decades and aims to explain organisational behaviour as something more than simply economic factors and rational reasoning (Johansen & Waldorff, 2015). However, despite its popularity in the field of organisational research, criticism concerning organisational behaviour has also been raised. The main issues centre around the theory's failure to incorporate agency into its explanations and its lack of explanations relating to organisational change and heterogeneity (Johansen & Waldorff, 2015).

The concept of institutional logic seeks to address these issues – the theory of which has gained momentum in organisational research in recent decades, and which represents an avenue of research within new institutionalism (Friedland & Alford, 1991).

The theory is utilised in empirical organisational analysis when issues related to change arise, like those concerning the implementation of new ideas into an established organisational structure and also claims to bridge the gap between the micro and macro levels of an institutional field (Thornton et al., 2012). Institutional studies have traditionally focused on continuity, although they are increasingly acknowledging the importance of change. On the other hand, entrepreneurship has focused on change even though it acknowledges that change is difficult. Hence, institutional entrepreneurship offers considerable promise for understanding how and why certain innovative organisational solutions, such as new practices or new organisational forms, arise and become well-established over time by juxtaposing institutional and entrepreneurial forces into one single concept (Garud et al., 2007). According to Battilana et al. (2009, 72):

Institutional entrepreneurs, whether organisations or individuals, are agents who initiate, and actively participate in the implementation of, changes that diverge from existing institutions, independent of whether the initial intent was to change the institutional environment and whether the changes were successfully implemented.

Institutional entrepreneurship offers considerable promise for understanding how and why certain new organisational solutions come into existence and become well-established over time (Breton et al. 2014).

The foundational work on institutional logic is viewed as “*organizing principles*”. Fundamental to this perspective is the belief that the interests, identities, values, and assumptions of individuals and organisations are embedded within prevailing institutional logic (Thornton et al., 2012). Within the literature, institutional logic as a “common cultural frame of reference” (Cornelissen & Werner, 2014) has been used to

refer to a background structure of shared reality that structures actors' perceptions (see Goffman, 1974: 21; Weick, 1995: 111), while institutional logic in the theoretical model is structured and rigid, the expression of which in empirical organisational contexts is fluid, overlapping and blurred (Røhnebæk, 2021).

A review by Johansen and Waldorff (2015) on the utilisation of institutional logic showed indifference in terms of the use of definitions and the analytical operationalisation of the concept. This thesis utilises the definition from Thornton and Ocasio (1999: 804), who defined institutional logic as “the socially constructed, historical patterns of material practices, assumptions, values, beliefs, and rules by which individuals produce and reproduce their material subsistence, organize time and space, and provide meaning to their social reality”. Bearing this definition in mind, institutional logic frames the understandings and actions that are recognised as functional and reasonable in the institutional landscape (Werner & Cornelissen, 2014). Decisions and outcomes are a result of the interplay between actors' agency and the institutional structure in which they operate (Friedland & Alford, 1991; Thornton & Ocasio, 1999).

3.1.1 Institutional logics in health care

The above section illustrates that actors are likely to be exposed to multiple types of institutional logic at any given time. There are several explanations at both the organisational and individual actor levels for the coexistence of professional and managerial logics in health care (Andersson & Liff, 2018; van den Broek et al., 2014). The struggle between professionalism and managerialism (Scott et al., 2000) has been explained as colonisation by Thorne (2002) and Bejerot et al. (2011) and as decoupling by Kitchener et al. (1999) and Addicott et al. (2007). Arman et al.'s (2014) study on the relationship between two types of institutional logic at three psychiatric care units for children showed a process of “hierarchization”. While managerial logic dominates, professional logic still coexists and is in competition, albeit in a subordinate position. In addition, the study shows that the dominant managerial logic is legitimised by the quantification of patient input. This use of quantification supports the meta-trend of

placing trust in numbers. Allen's (2014) study on the translation of a clinical governance concept, care pathways, into an infrastructural technology by utilising institutional logic shows how the concept of care pathways transforms in its encounter with health professionals' daily work practices. Kristiansen et al.'s (2015) study on nurses' understanding of contradicting logic in a nursing home showed how sense-making enables contradicting types of logic to coexist. Moreover, Holm-Petersen et al. (2021) showed how hijacking, is related to power differentials and identified the types of work that contributes to obscuring underlying conflicts between science and care logics in a hospital setting. Furthermore, Andersson and Liff (2018), from an institutional logic framework, described how managers co-opted elements of professional logic and how professionals co-opted elements of managerial logic in their attempts to support their own interests in outpatient units, specifically for child and adolescent psychiatric care in Sweden.

3.1.2 Institutional logic as an organising principle in mental health care

Freidson (1986: 152) argued that the "nature of professional work and the position of professional employees contribute to the classic conflict between managers and professionals. Managers are concerned with the preservation of the integrity of the organization under the general policy of the governing board, while professionals adhere to their specialized pursuit of a discipline or profession". Freidson added here that it is this diametric contrast between managers and professionals that creates such tension. In 2001, Freidson went on to present professionalism and managerialism as opposite types of logic in organising and controlling work, emphasising their antagonistic relation by showing that freedom of judgement and discretion in performing work are integral to professionalism, which directly contradicts the managerial notion that efficiency is gained by minimising discretion. This professional logic clearly separates itself from managerial logic influenced by the market and has emerged as a result of NPM reforms. In this, the emphasis is placed on efficiency through resource management and economic control. The division of labour and hierarchy are also stressed (Flynn, 2002; Pollitt, 1993). Theorising how different ideas belong to an ideology – like professionalisation or managerialisation as an institutional

logic – is therefore a fruitful approach when elaborating and examining phenomena such as the care pathways that entails both ideologies.

Understanding how these types of logic are interpreted by the actors within the system, in this regard, the medical professionals, involves looking into identity work. An important aspect of institutional logic is that it provides a sense of self and identity, given that mutual frames of reference form the choices of actors for mutual sense-making to motivate their action (Meyer & Höllerer, 2014). The role of institutional logic is to tie together the works undertaken by various professionals (Byrkjeflot, 1997). The principles of institutional logic therefore shape how identity is perceived (Thornton et al., 2012: 2). The literature on identity work in this area operates with two types of understandings, one being individual identity, which focuses on a person's perceived self, and the other being professional identity, focusing on the experience, values, attitudes, and beliefs associated with a particular profession. We can view the professions as institutional orders with specific clinical-professional logic. Professionals rely on discretion, trust, autonomy, and collegiality to complete their work, with each type of professional having their own unique approach to management. Planning daily activities and strategic work is rooted in the knowledge gained from education and training (Abbott, 1988; Freidson, 1994). Indeed, studying the phenomenon of professional identity is fundamental to understanding the changes that take place in an institution (Berg et al., 2017; Evetts, 2009, 2011), specifically when building on the perspective of institutional logic as a way forward when understanding change and its related processes.

3.1.3 Contributions to the institutional logics perspective

Greenwood and Hinings (1988) and Kraatz and Block (2008) showed the usefulness of identity work when studying organisational complexity (Thornton et al., 2012: 180). These authors pointed to the need for more research into the complexity of identity that occurs in an organisation, where different actors hold different professional identities – something particularly relevant in the field of mental health care.

More specifically and relevant to the concern of this PhD thesis is the fact that the concept of institutional logic has been applied when understanding implementation research in the health domain (Currie & Guah, 2007; Gutierrez & Friedman, 2005; Koç & Vurgun, 2012; Sahay et al., 2010). However, Blomgren and Waks (2015) and Bishop and Waring (2016) called for research on interpretation and sense-making in contexts where multiple types of logic occur. This call was accentuated by Johansen and Waldorff (2015), who called into question how actors use multiple sets of expectations to cope with an environment at the intersection of several institutional fields. The examination of the construction of the care pathways is one such preferred area of examination, where the logic held and used by different actors is separated from their organisational affiliation.

Even though the research utilising the perspective on institutional logic is broad, several scholars have pointed towards the need for a critique that specifically revolves around how these processes among institutional actors occur, stating that attention needs to be refocused on how institutional logic works on the ground (Johansen and Waldorff, 2015). This call is further accentuated by McPherson and Sauder (2013), van de Bovenkamp et al. (2017), and Felder et al. (2018), who claimed that attention needs to be paid to the micro processes of day-to-day organisational activity in professional contexts. Taking these precautions into account, I am utilising the theory on sense-making to explain these micro processes, in particular when examining the second area of engagement, namely that of the implementation of care pathways. Researching how such implementation and new policies are responded to by mental health professionals and the outcome of these processes is also understood through the utilisation of theory on street level bureaucracy, leading to the next part of this chapter.

3.2 Street-level bureaucracy

A distinctive contribution of street-level research is its commitment to investigating what I refer to as the 'inside story,' that is, what goes on in the often-hidden recesses of organisations that deliver public policy, what factors systematically shape those

practices and the consequences of street-level practices for policy and, more broadly, for politics. (Brodkin, 2015: 25)

Tackling social issues from a central level by producing policies is hardly a new idea (Durose, 2011; Hill & Hupe, 2003; Rowe, 2007). Pressman and Wildavsky (1973) famously presented this problem in their work: “Why were policies not delivering as intended?”. In this study, they encouraged scholars to open up the “black box” within which policy implementation exists. Lipsky’s theory of street-level bureaucracy was an attempt to do just that by bringing the organisational literature on discretion into the direct conversation concerning the policy literature on implementation (Brodkin 2015). A paradox that arises occurs when “policy as written” differs from “policy as executed” (Lipsky, 1980; 2010: vii). Lipsky (1980) initiated a new scholarly theme within policy research, where its success and failures were to be understood at the street level, that is, among those professionals working in the front lines of policy implementation. The above authors named these workers “street level bureaucrats” (Lipsky, 1980), explaining this as: “[T]he decisions of street level bureaucrats, the routines they establish, and the devices they invent to cope with uncertainties and work pressures effectively become the public policies they carry out” (Lipsky, 2010: xiii).

3.2.1 Mental health professionals as street level bureaucrats

After Lipsky’s introduction of the idea of street-level bureaucracy, studies on the subject have introduced a variety of conceptualisations, research approaches, and causal inferences (Hupe & Buffat, 2013). A working definition of street level bureaucrats by Hupe et al. (2015) states that street level bureaucrats work in contact with individual citizens while performing their duties as public servants and that they usually have specific tasks for which they have the appropriate education and training. In their role as street level bureaucrats, they possess inherent discretion, function as policy co-makers, and demonstrate a certain level of craftsmanship in completing their tasks. All of these characteristics are also found in work within mental health care. Even though Lipsky’s (1980: 3, 73–74, 138) study did not address the health field in any detail, health workers were included in his definition of street level bureaucrats. Discretion within this field is what Harrison and McDonald (2008) refer to as “clinical

freedom,” “clinical autonomy” or “professional autonomy”. Different standardisation tools and their introduction into mental health care could represent a constraint for professional discretion and potentially influence street level bureaucrats (Tørseth, 2021). Furthermore, health care policies create what Hupe and Hill (2007) called an “action imperative” – something that needs to be dealt with by street level bureaucrats.

3.2.2 Coping in a workday characterised by competing logic

Although street-level work is often highly scripted, it also requires improvisation and a responsive attitude towards each individual case. The term *street-level bureaucracy* even captures this paradox: “How to ensure all citizens’ rights are treated equally while being responsive to individual cases when necessary” (Rowe, 2007). Discretionary decision-making is based on adapting law and policy to the circumstances of a specific case. As part of the apparatus of public administration, management and performance measurements are carried out to ensure that discretion is aligned with law and policy compliance or to produce legal equity in which similar cases are treated equally (Maynard & Musheno, 2003). A key concept in understanding this paradox and the policy-making role of street level bureaucrats is discretion, which is the capability to make choices within the established boundaries (Lipsky, 1980, 2010). The paradox is understood as a parallel and seemingly contradictory trend towards both the standardisation and the customisation/individualisation of health care (Mannion & Exworthy, 2017). Standardisation and customisation have quickly become major fault lines within health care systems, creating a “*muddle and mess*” that requires street level bureaucrats to reconcile these new requirements of governance with professional autonomy (Maynard-Moody & Musheno, 2000). Wallace and Pease (2011) further introduced the concepts of shielding, adaptation, and resistance to understand the ways in which workers may deal individually with these possibly conflicting types of institutional logic. *Shielding* refers to avoiding tensions between different standards and requires workers to focus on aspects of service that (still) require professional inference, such as therapeutic work or coaching, while ignoring more business-like imperatives, such as managerial standards (van der Aa & van Berkel, 2015).

Another research prospect that has been addressed in recent years and is worth mentioning is how street level bureaucrats cope with increased workloads in an already tight work schedule (Berlin, 2022). To reduce their workload and manage the “public service gap” (Hupe & Buffat, 2013), staff must develop their own strategies (Berlin et al., 2022). Three coping mechanism has been theorised by Tummers et al. (2015) as the act of *moving towards a client* and can be viewed as coping in one’s work for the benefit of the client. In the latter two cases, the worker is coping for his or her own benefit. The term *moving away from clients* refers to street level bureaucrats when avoiding meaningful interactions with clients, while the term *moving against clients* refers to their confrontations with clients. New guidelines and managerial standards, like care pathways, often collide with the attempt to ensure room for discretionary activity. To cope and find a way through this “muddle and mess,” street level bureaucrats develop strategies and practices “– to reduce the stress and strain of their work” (Tummers et al., 2015). Routing is the most frequently mentioned method of coping *moving away from patient* (and for themselves), and is the process of dealing with clients in a standardised manner. Due to a high workload, workers have to compromise on quality in order to serve many people in a short time frame. Similarly, this coping mechanism uses rationing as a coping mechanism where public services are made harder to access. Street level bureaucrats also utilise rationing when work pressure is high, and they have substantial control over service availability (ibid.). Thus, discretion is as much about spaces created in the wake of the unintended consequences of others” (Evans, 2015).

An article by Berlin et al. (2021) highlights different strategies to reduce the pressure in Swedish mental health care outpatient clinics, such as trying to decrease the inflow of work by raising the requirements for acceptance for treatment. The staff therefore continually discussed the importance of discharging patients, even though they had not been fully treated. Patients who were unmotivated, caused disturbances, acted out and made threats were given lower priority. The staff worked individually and together to reduce the workload. In the collegial exchange, the focus was on the clinic’s total workload being limited and reduced, defending reducing behaviour, and working to get fewer patients refereed to their own team (ibid). For the professionals, focus was on

becoming more efficient, working faster, taking shorter breaks and working overtime (Tummers et al., 2015). When the workload increased, the focus became narrower and the workers' social commitment decreased (Evans & Harris, 2004).

3.2.3 Street-level bureaucracy and the theoretical contributions of this thesis

These discretionary spaces where logics and coping mechanisms collide are as Noordegraaf (2011) explained, not only reactions to “external” pressures on policy and management but also a possible strategy through which to reconfigure and develop professionalism. Lipsky (2010) observed that most street level bureaucrats see themselves as professionals. However, he did not elaborate on how professionalism affects street-level decision-making (van der Aa & van Berkel, 2015). This situation is described in different terms by Midgley et al. (2001: 93), who stated that “any explanation of behaviour also needs to consider motive”. A recent study by Cecchini and Harris (2022) addressed these issues and stated that almost no literature exists on street level bureaucrats' professional conduct in their encounters with new policies. To be more precise, there is a lack of studies that examine the effects of street level bureaucrats' discretion and professional practice when translating policy goals into working practices (Nørup & Jacobsen, 2022). This thesis elaborates on how mental health professionals utilise their professional conduct during decision-making when implementing the goal of user participation and further seeks to address this research gap.

Going forward then, researchers need to investigate the “how and why” of street-level implementation (Hupe, 2014). For example, how professionals playing the role of street-level bureaucrats make sense of and understand policy (Goldman & Foldy, 2015). In addition, how public organisations handle high workloads impacts the quality and accessibility of their services – as a result, it is important to develop theoretical knowledge on how professionals cope with high workloads in public health care

(Berlin et al., 2021). An attempt to answer this research gap has been carried out in this thesis in two ways. First, there are a lack of studies that examine the effects of street-level bureaucrats' discretion when the translation of policy goals into work practices is entrusted to street-level bureaucrats (Nørup et al., 2021). In addition to this matter, almost no literature on street-level bureaucracy and its role on professional conduct exists either (Cecchini & Harrits, 2022). This thesis seeks to elaborate on these elements, by examining how mental health professionals in their role as street-level bureaucrats use their professional conduct to understand the overall goal of care pathways on user participation. How their understanding creates barriers as a result of the goal of the care pathway to involve patients during treatment facilitation is also elaborated further. Pursuing these theoretical research objectives means to mend a lack of research into professional conduct and street-level bureaucrats. This call is accentuated by Cecchini and Harrits when they state: "The literature on street-level bureaucracy and frontline work is remarkably silent on how to understand the role of professional knowledge in frontline work" (Cecchini & Harrits, 2022).

This section shows that even though theory on street-level bureaucrats enables an explanation of how professional conduct within mental health care influences how it is implemented, an elaboration of how this sense-making actually occurs is still missing. The last part of this theory chapter seeks to bring this meaning back into the discussion (Meister et al., 2014).

3.3 Sense-making

In real-world practice, problems do not present themselves to the practitioners as givens. They must be constructed from the materials of problematic situations which are puzzling, troubling, and uncertain. In order to convert a problematic situation into a problem, a practitioner must do a certain kind of work. He must make sense of a situation that initially makes no sense (Weick, 1995: 9).

It is often the case that implementation and change distort conventional work methods, causing organisational actors to undergo cognitive restructuring to figure out how to accomplish their new tasks (Maitlis & Christianson, 2014). In understanding these change processes, where expectations and experiences are at odds, sense-making theory has made a major contribution (Brown et al., 2014). The sense-making perspective, as Brown et al. (2014: 2) noted, has been “a tremendously influential perspective” and “lies at the very core of all organization” (Maitlis & Christianson, 2014: 60).

There is no single agreed-upon definition of *sense-making*. However, there is an emerging consensus that sense-making refers to the processes through which people attempt to explain ambiguous, equivocal, or confusing events or issues in plausible ways through specific processes in which actors engage when trying to restore interrupted activities (Brown et al., 2014; Colville et al., 2012; Maitlis, 2005; Weick, 1995). The common thread among the various definitions of sense-making, however, is that it involves meaning creation and understanding (Klein et al., 2006).

The sense-making perspective was first elaborated in Weick’s (1995) seminal book, *Sensemaking in Organizations*. In Weick's view, sense-making refers to the process of creating order when the current state of the world is in contrast with the expected state. Weick has an overall focus on understanding the ways in which sense-making affects organisational roles, leadership, management, and projects from an individual perspective.

3.3.1 Sense-making during the implementation phase

Current research on sense-making has focused on three sets of interweaving processes: the perceiving cues (noticing), making interpretations, and engaging in action (Maitlis & Christianson, 2014). The above actions happen when an individual experiences an event that triggers a sense-making episode in the first place, a process through which actors attempt to make sense of an interrupted activity. In more specific terms, the

creation process involves bracketing, noticing, and extracting cues from our lived experience of the interrupted situation (Weick, 1995: 35). As Weick put it, “sensemaking is a process by which individuals select specific cues on which to base their decisions” (1995: 54). The cues were further identified as being linked to a series of ideas and actions. These links can help to “tie elements together cognitively” which makes the cues on which individual actors rely an important of the process, because if the extracted cues align with the decision-making processes of the organisation, then sense-making can be a tool for supporting the change process. In contrast, the implementation or change process may not be supported if the cues are inconsistent or if some important cues for the dominant change narrative are missed or ignored (Helms-Mill, 2003). However, a clarification is needed here. Even though it is the process of extracting cues that is explained as the reason behind successful or unsuccessful implementation, it is the process of the interpretation of such cues that further leads to action/inaction. Furthermore, analysing these cues in the wake of the care pathway implementation is vital when understanding why actors choose not to engage themselves more in the implementation process.

3.3.2 Identity work and sense-making

Identity construction is vital in sense-making, according to Helms-Mill (2003: 55). Indeed, Sandberg and Tsoukas (2015) argued that identity influences the ways in which sense is made and in which meanings are enacted, facilitating a process of identity construction, where “who we think we are (identity) as organizational actors shapes what we enact and how we interpret, which affects what outsiders think we are (image) and how they treat us, which stabilizes or destabilizes our identity” (Weick et al., 2005: 416). The connection between identity construction and sense-making is vital for understanding how one interprets cues (Coopey et al., 1997: 312). However, one caveat revolving around the interaction between identity and sense-making must be elaborated on and this limitation could be important for several reasons. First, although Weick (1995) described sense-making as being grounded in identity construction, little elaboration has been carried out concerning how this actually takes place (Weick, 1995, 2001). Second, the review article on sense-making by Sandberg and Tsoukas (2015)

showed that most of the reviewed studies focus more on how sense-making is involved in identity work (that is, how identity is constructed through sense-making) than on how identities influence sense-making (e.g. Kjærgaard et al., 2011; Korica & Molloy, 2010; Lutgen-Sandvik, 2008). Third, there is a lack of understanding of how the external context influences identity (Taylor & Van Every, 2000: 251; Weber & Glynn, 2006: 1639). In more general terms, related to the sense-making perspective, Weick did not adequately deal with how sense-making is affected by external factors (Holt & Cornelissen, 2013; Maitlis & Christianson, 2014; Maitlis & Sonenshein, 2010; Mills et al., 2010b; Weick et al., 2005), and this neglecting of the broader institutional context has even been acknowledged by Weick himself (e.g. Weick et al., 2005: 417).

Bearing these ideas in mind, several considerations need to be elaborated before moving forward from the sense-making perspective.

3.3.3 Critique of the sense-making perspective

First, according to Helms-Mill (2003), individuals are not in control of their own sense-making, separate from external forces and a power context, entailing that the symbiotic relation between sense-making and identity construction is not something that can be separated as taking place within the frame of the workplace or within the organisation in which the change takes place. Second, when understanding these external forces and how the institutional context influences individual actors, how identities influence sense-making should also be researched Helms-Mill (2003). Furthermore, there is a gap in the sense-making literature between understanding how individuals react and relate to change and how the context influences this understanding (see the reviews by Brown et al., 2014; Maitlis & Christianson, 2014; Maitlis & Sonenshein, 2010; Weick et al., 2005). The latter can be traced back to the fact that the sense-making literature focuses primarily on the outcomes, rather than the process, of sense-making. Further research into the process of how actors make sense, and their associated actions is thus needed (Schildt et al., 2019).

3.3.4 The Critical Sense-Making perspective

Taking these elements into account then, one way forward could be to further consider the Critical Sense-Making (CSM) perspective by Helms Mills and Albert J. Mills. A key element of CSM is the argument that an analysis of sense-making needs to be explored through, and in relationship to, the contextual factors of structure and power in which individual sense-making occurs (Carroll et al., 2008; Mills et al., 2010a; Mills & Mills, 2000). CSM highlights the influence that organisational rules have on organisational actors, meaning those who work within the structure of the organisation in question. Rules inform the ways in which individuals may act and with this, the possibility of appropriate interpretations of meaning being constrained by meta-rules and formative contexts – structures that limit what can be imagined and made sense of (Mills et al., 2010a). Moreover, Thurlow (2007: 193) revealed how agency can lie in the interplay between practices and discursive influences: “As local sensemaking happens within a broader context, the linkage between local action and discursive effects cannot be overlooked” (Thurlow, 2007: 169). Another important contribution to the CSM literature is that of O’Leary and Chia (2007: 393), who noted that sense-making (SM here) is largely ignorant regarding “how structurally such various kinds of organizing are rendered possible. The underlying epistemic context of sensemaking is missing in most SM studies and should be elaborated further” (O’Leary and Chia, 2007). Since sense-making is grounded in identity construction (O’Leary & Chia, 2007; Weick, 1995), an understanding of the actor’s episteme when elaborating on their identity construction can help explain how professional institutional logic influences their sense-making and, at the same time, connect the theories combining institutional logic with the sense-making perspective. However, even though the CSM perspective describes the process of sense-making as linear and streamlined, it is important to illuminate that the process often overlaps and is contradictory in real-life practice (Sandberg & Tsoukas, 2020).

3.4 Theory delimitation and operationalisation

How the different theories connect to each other has been explored and clarified throughout this theory chapter, and Figure 2 further illustrates these connections and how they relate to the care pathways.

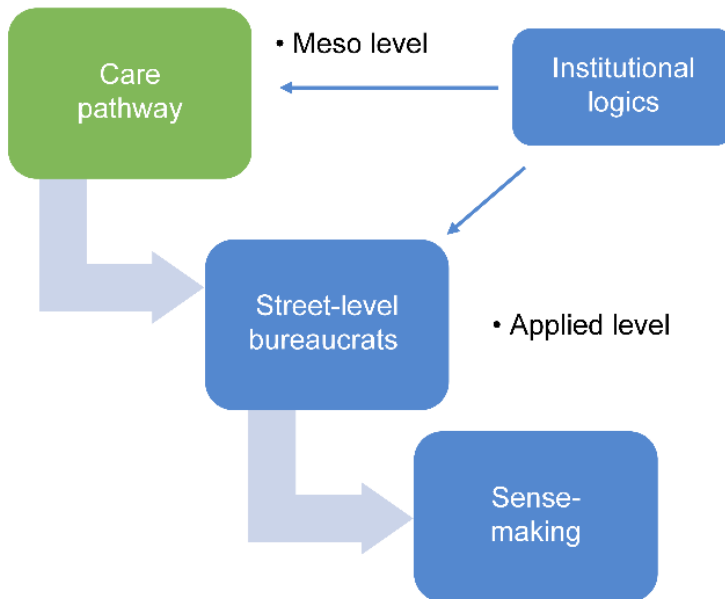


Figure 2: Theory operationalisation

This theoretical chapter provides insight into the framework that will be used when analysing the data collected. However, since additional theories have been applied in the articles, a more thorough description is presented in the following subchapters.

3.4.1 Article I

First, when elaborating on the construction process of a care pathways, the empirical material comes from two main sources: textual documents and qualitative in-depth interviews. The material is mainly preoccupied with researching the mechanisms behind the outcome of the care pathways and the process leading up to it. When

understanding the deliberative process in the construction of the care pathways, institutional logic proves to be vital. However, there is an important caveat here: this PhD thesis aims not to replicate if and how the institutional logic changes during the pathway implementation but rather to examine how the logic, at the time, functions as a frame of reference when interpreting and making sense of the care pathways.

However, to replicate institutional logic, a common frame of reference is needed. The literature thus far has shown that the institutional logic perspective can be utilised in many ways. Furthermore, as identifying a particular type of logic is delicate work, the original utilisation from Thornton et al. (2012), where an institutional logic consisting of values, belief, rules and material practices enables a more systematic replication of such logic, is utilised as an analytical strategy in the empirical material collected. Moreover, it is expected that institutional logic affects organisational decision-making too, by steering the attention of decision makers. Regarding this matter, the institutional logic lens can provide useful knowledge for understanding decision-making and agency in work groups (Friedland & Alford, 1991; Thornton & Ocasio, 2008).

3.4.2 Article II

Even though some claim that the institutional logic perspective bridges the macro and micro levels (Thornton et al., 2012), there are still weaknesses related to how this theory explains actor behaviour at the micro level. Thus, my aim in this second article is to develop an understanding of this micro-level perspective. To understand the implementation of the care pathways, a case study consisting of four outpatient clinics and qualitative interviews of treatment personnel is conducted. My main aim is to elaborate on the sense-making related to this process.

The sense-making theory utilised in this thesis has several prerequisites. First, the context influences the individual's sense-making. Second, an individual's sense-making is grounded in identity work. Both these conditions fit well with Mills and Mills's (2000) CSM perspective. Regarding the first prerequisite on the utilisation of theory, namely, the need to include the context, a theoretical understanding of how trust

or, to be more precise, distrust influence the implementation of the care pathways is vital. There is a call for more research on trust in organisations, particularly institution-based trust (Schilke et al., 2017). In the prominent theories of trust production, institutions are central (Bachmann & Inkpen, 2011; Fuglsang & Jagd, 2013), but most of the discussion has focused on a limited set of institutions, such as normatively sanctioned roles and interactions (Ocasio et al., 2017). Bringing the trust perspective by Möllering (2006) into my empirical material shows how three elements – familiarity, calculated interest, and compatible norms and values – render trust and explains how trust depends less on the individual and more on those social norms and values in which actions are embedded. Möllering’s perspective on trust shows how the context influences the micro level. Bridging the elements of social context (trust) and sense-making can thus be seen as answering Sandberg and Tsoukas’s call for research combining the perspectives of trust and sense-making in their review article of 147 articles applying the sense-making perspective; however, the above authors found only one such article.

The correlation between how an institutional context influences how trust emerges from and within social structures also influences the actors’ sense-making processes. The connection of theory on trust and how these issues influence the micro level provides insights into how the social context influences individuals in an organisation (e.g., Brown et al., 2014; Maitlis & Christianson, 2014).

3.4.3 Article III

Finally, the third article examines how the overall goal of user participation is utilised in an outpatient clinic. The data stems from ten in-depth interviews with mental health professionals, and several theoretical conceptualisations are put forward.

To begin, an overall theoretical outlook street-level bureaucracy. The theoretical discussion thus far has shown how such theory invites us to see more of the “inside story” (Brodkin, 2015), as encouraged by Hupe (2019). There is also then the appeal

from Cecchini and Harrits (2022) to investigate street-level bureaucrats and their role in professional conduct. An important element is how mental health professionals cope with the ever increasing workload appearing in these services. Further research into how these coping mechanisms express themselves in the encounter between street-level bureaucrats and clients has been called for (e.g. Tummers et al. 2015, Berlin et al., 2021):

This article helps refine the existing framework for studying street level bureaucracy work by proposing the notion of professional logic and captures the role of professional and pragmatic knowledge, which has often been overlooked in existing research (Cecchini & Harrits, 2022) by examining which role the professional and pragmatic knowledge plays when they cope with everyday work (Tummers et al., 2015), and the additional work burden that the care pathways goal on increased user participation brings about. More specifically, understanding how street level-bureaucrats make sense of user participation, how they integrate the notion, and which potential dilemmas occur during the shared decision-making approach can allow for this professional and pragmatic knowledge to be put forward (Tummers et al., 2015, Berlin et al., 2021).

Within the context of mental health care, there are understudied obstacles when it comes to introducing user participation (Larsen & Sagvaag, 2018). Thus, it is necessary to examine how user participation is incorporated and potentially changed after its initial introduction (Carr, 2007). These calls for further research are answered in this article by examining how mental health professionals involve users in treatment facilitation, which, when considered under a theoretical lens, can be understood as the concept of *shared decision making* (Slade, 2017: 146).

This theory chapter has thus far shown the theoretical outlook in terms of the empirical material. However, a more thorough examination of these data is necessary and is presented in the next part of this thesis.

4 Methodology

The purpose of this chapter is to illustrate the relationship between the theoretical and empirical research levels covered in this thesis. This chapter begins by presenting the scientific outlook of critical realism. Second, the research design is discussed. Following that, this chapter proceeds to consider the data, which – due to the research design's separation into two different areas of engagement – is discussed by taking this into account. Finally, a critical assessment of the data concludes the chapter.

4.1 Critical realism

Choosing a research strategy means stating the philosophical assumptions and methodological basis of the research (Binder & Edwards, 2010). There is a lack of research demonstrating the potential of applying critical realism in qualitative empirical management and organisation studies (Frederiksen & Kringelum, 2021), and thus, my aim is to show how this potential can unfold.

Critical realism is a somewhat novel approach suggesting a somewhat shared ontology and epistemology for the natural and social sciences (Sayer, 2000). This perspective takes an ontological position, stating that social structures and material dimensions are real and exist independently of our perceptions of them (Fleetwood, 2005). Within this perspective, the researcher seeks knowledge about reality or research phenomena (Bhaskar, 2013). The overall purpose of critical realist research is to determine which causal mechanisms have been triggered in a situation, and the effect they are having” (Stutchbury, 2022: 115) Therefore, the critical realism outlook is a fruitful approach when one examines the causal mechanisms behind care pathway policy construction and implementations. .

Furthermore, critical realism presupposes a three-layer stratification (Bhaskar, 2013) where a distinction is drawn among the “real”, the “actual”, and the “empirical”. First, *the real* is whatever exists and the realm of objects, as well as their structures and

powers. As a result, actors are constrained and enabled to take certain actions in a certain setting (agency) by independent structures (or social forms) (Tao, 2016), and research in this paradigm involves understanding the relationship between structure and agency (Bhaskar, 2013). In order to investigate structure and agency one needs access to the social structures (discursive, institutional and embodied) (Fairclough, 2001, 2005; Scott, 2010) as well as access to the past experiences, values, beliefs, interests and agendas of the participants, and their professional identities (Stutchbury, 2022). Given the motive of this PhD thesis, the care pathways have, as Lawson (1997: 21) put it, “potential, capacities, or abilities to act in certain ways and/or to facilitate various activities and developments”. This potential has been elaborated on in the introductory chapter, where the potential accompanying a care pathway is based on how the actors interpret the pathway and if or how they choose to engage themselves in this matter during the implementation phase. The *real* stratum is composed of the mechanisms and structures that generate and explain events (Vincent & O’Mahoney, 2018). The main commitment of the research on critical realism can therefore be considered as that of understanding the *real* level (Bhaskar, 2013; Vincent & O’Mahoney, 2018). My commitment in this thesis has been to look for the mechanisms and structures that explain the juxtaposition between professionals and care pathways by providing a theoretical outlook to explain these events in detail.

Where the *real* refers to the structures and powers of objects, the *actual* then refers to: what happens when the potential is activated; the effects and consequences, such as the outcome when the care pathways are implemented; the effect this has on work in outpatient clinics; and the consequences of the implementation for those professionals involved and for the patients receiving treatment.

The *empirical* is the domain of experience, meaning how the actors (health care professionals) relate to the care pathways. Regarding the perspective of critical realism, the empirical level is one area of examination or, to be more precise, my empirical material. The empirical level explains, influences and transforms the actual, meaning in this context, how a care pathway looks in an organisation (Sayer, 2000). The critical

realism approach acknowledges that empirical observations are mediated through concepts but that these concepts are dependent on the structural properties of real objects (Sayer, 2000). Translating this notion into the framework of this thesis means that the construction and implementation of the care pathways is dependent on the actors engaging in it, leading me to another important aspect of the critical realism perspective, namely, that the primary objective of social scientific research is not to predict or to interpret but rather to *explain* a phenomenon – in other words, to develop empirically supported theories and hypotheses about how, why and under what conditions particular phenomena occur (Fletcher, 2017: 185), meaning the result of the two areas of engagement – and in this context, the construction and implementation of care pathways.

Indeed, as Volkoff and Strong (2013) pointed out, “those subscribing to critical realism as an appropriate philosophical underpinning for understanding organizations and how they operate have identified the central task of organizational theorists as uncovering generative mechanisms” (2013: 821). Thus, the aim of the research on critical realism is to produce explanations (theories) about the essences (properties), which takes any potential generalisations from the empirical to the theoretical (Danermark, 2002: 77), transforming the primary purpose of this research into a theorising of explanations in a phenomenon (construction and implementation of care pathways) that have been observed (Haigh et al., 2019).

Understanding the organisational effects/outcomes associated with the introduction of new structures – here understood as the care pathways – means understanding the generative mechanisms associated with those structures, that is, the real level (Morgan, 2015). One way to uncover these processes is by observing the underlying mechanisms that can produce such events (Danermark, 2002; Sayer, 2000; Volkoff & Strong, 2013). This approach entails that the utilisation of critical realism is aimed at more than simply uncovering the real level, namely, to search for a theoretical framing (Morgan, 2015). To provide a theoretical explanation of the real level, the possibility of expanding the real level as an object of enquiry, where theory development occurs, also arises. As

already noted, a research gap exists in terms of the juxtaposition between mental health professionals and care pathways. Utilising critical realism enables the further understanding of this connection, and in utilising theories to explore new phenomena, this also further contributes to theory development in the scientific community.

4.2 Research design

Research design can be defined as the overall plan connecting the research questions, theoretical framework, data, and findings in a study (Yin, 2018: 26).

Yin (2009) emphasised the importance of associating theoretical propositions with research questions, which provides the researcher with guidance on what to study and where to look for relevant evidence. Several critical research scholars have shown how case studies, as a research approach, fit well with the methodological aims of exploring phenomena in context and in real life situations, in order to seek explanations (Ackroyd & Karlsson, 2014; Edwards et al., 2014). Regarding the research question guiding this thesis, a case study will be utilised in the research design and analysed in the forthcoming chapter.

4.3 Case study research

Case studies are defined as singular combinations of diverse arrays of methodological approaches with one or more temporally and spatially defined objects that researchers construct and target as a focus of their study (Sandelowski, 2011: 153). Utilizing a case study design, defining the case, the context and the type of case study is an important part of the research process (Baxter and Jack, 2008). This approach enables me to study the phenomena of the juxtaposition between mental health care professionals and care pathways at two different analytical levels. Defining sampling units clearly is essential when it comes to avoiding messy and empirically shallow research (Gobo, 2015). The sampling units chosen are based on the two levels of investigation, a more detailed explanation of which is presented below.

4.3.1 Policy/field level

Examining the construction of the care pathway was done by looking into this policy/field level, where the discussion regarding the care pathways took place, and choosing two different sampling units.

The first sampling unit was chosen as the field of mental health care. My empirical outlook was then the public debate centred around care pathways so as to focus on and understand the relation between care pathways and mental health professionals. When studying phenomena like the care pathway, case studies allow for an integrated approach to the phenomenon of interest by enabling the researcher to explore the phenomenon in context and uncover contextual conditions that are believed to be important (George & Bennett, 2005: 19). The contextual framing provided by a discourse analysis shows how these contextual conditions influence the construction of the care pathways. When the idea first was launched, my hypothesis was that the care pathways would bring about a professional debate centred around the best way to organise the services and which treatment facilities to provide, which is common in the field of mental health care (Torgalsbøen, 2009). I wanted to take a closer look at the existing power battles and how they could potentially come to an agreement. However, an important factor within the case study approach is how such studies build upon an adaptive research design, which could be modified as the researcher(s) gains more insights into the cases, the phenomenon of interest, and the data collected (Yin, 2018: 63). This adaptive approach led me to focus on how the idea of the care pathways was portrayed in the public debate, and I needed to include how the care pathways were portrayed at the policy level where the construction took place, leading me to the second sampling unit.

The second study area within this level was the work that occurred in the “work group” responsible for the construction of one care pathway aimed at providing treatment for patients in outpatient clinics in Norwegian specialist health care hospitals. The first sampling unit showed a major gap between the ideas around the introduction of a care

pathway approach from political actors and those of the professionals at the hospitals. Since work groups were initiated by the Norwegian Directorate of Health, the idea of this sampling unit was to gain insights into the construction process. I wanted to determine how they came to an agreement on delicate matters since the debate thus far has shown irreconcilable differences concerning the notion of care pathways. There were several work groups based on different diagnoses. However, I chose to involve myself with the work group aimed at producing a pathway for several diseases. My choice of this work group was based on the data at the policy level where the discussion was circulated around care pathways as a general idea in the field of mental health care. Since this work group was preoccupied with providing a pathway for several diseases, I believed that tensions and disagreement would be more visible and present because the pathway represented several diagnoses, entailing more ideas regarding how to provide diagnostic practice and treatment, which would lead to discussions and possibly show the power battles present in the field.

4.3.2 Applied level

When researching the second area of engagement, namely, care pathways implementation, the empirical investigation was conducted at an outpatient clinic. The reason for choosing an outpatient clinic instead of, for example, a clinic for psychotic illnesses, was based on the sampling unit in my first area of engagement. Since I had already engaged myself in a pathway to be utilised in an outpatient clinic, I had already been familiarised with the work in this area. Additionally, providing coinciding sampling units would enable a replication of how ideas at the policy level influence the micro level, where work practices take place in more coherent and systematic ways.

An outpatient clinic that provides specialist mental health services offers treatments for numerous illnesses. As is common when receiving treatment, the patient typically meets the treatment provider every week, or every other week. The average time for treatment is approximately ten consultations for common diseases such as depression and anxiety and longer for more serious personality disorders or complex post-traumatic stress disorders.

However, gaining access to this sampling unit was difficult. At first, my plan was to be present in the clinic throughout an ethnographic study and a collaboration with one of the hospitals in Western Norway. To be allowed access, approval from the Regional Committees for Medical and Health Research Ethics (REK) was needed. As the application was turned down, I needed to shift my focus from an ethnographic and observational study to a study with qualitative interviews with mental health professionals, an approach that did not need approval from the REK.

4.3.4 Recruitment strategy

Gaining access to interviews with treatment personnel in an outpatient clinic was difficult. I was first invited to interview treatment personnel by the head of the outpatient clinic in the hospital at which I initially was planning to do an ethnographic study. I was present in a team meeting where I introduced myself and my research project as well as an informal request to contact me. I was also able to follow the head for two days, which provided me with insights into her daily work practices, and was able to ask any type of questions. However, even though these days gave me insights into daily work in an outpatient clinic, gaining access to the psychologist and psychiatrist who worked there proved impossible. After several e-mails with zero response, I realised that I needed to approach somewhere else.

Luckily, at the time I was researching other outpatient clinics, I received a tip about a hospital director who was establishing a collaboration with a contact person in my network. I contacted this person who invited me to participate in an event aimed at improving collaboration between different stakeholders within mental health care initiated by this hospital director. At the end of the event, I introduced myself to the director, and I was invited to collect data in this hospital's outpatient clinic. Shortly after this first encounter, I started my data collection. Even though the director provided me with four informants, I also needed to carry out some networking in the hospital on my own. The director encouraged me to meet the treatment personnel in the outpatient clinic in their common lunchroom so that I could establish a relationship with the psychologist working there. On the first day on which I took this approach, I was met with both curiosity and hostility. The need to defend their work practices and time

allocations toward me was present from the beginning. I was, by some, viewed as the enemy from the Directorate of Health, and I had to spend a lot of time demonstrating my neutrality by validating and creating a safe environment in which they could share with me their thoughts and experiences in an open and uncritical way. In addition to this, I had to be pushier and more active in recruiting informants, and my final strategy was to approach individuals and ask what time would be best for them to be interviewed. However, sickness and absence in the form of prioritising more important matters was common, and a few attempts at interviews failed. Even so, I managed to perform 14 interviews, 11 of which were from those working in the outpatient clinic. Furthermore, when analysing the material from the outpatient clinic, a report analysing the implementation of care pathways from SINTEF research centre, containing rich quantitative and qualitative material, was published. In the report, data from several outpatient clinics were analysed. While collecting these data, an interview guide almost identical to mine guided these interviews. I saw this as an opportunity to analyse richer data material and contacted the project leader with a formal request regarding the sharing of data as a collaborative project. The research manager considered my request in a positive light, and we agreed to share data and to co-write the second article together. A notification of change in the SINTEF project was sent to the Norwegian Centre for Research Data (NSD), enabling my inclusion as a research fellow. To enable the sharing of data, all the informants had to agree in writing that one more researcher could have access to this material. The project leader in SINTEF performed follow-up data collection in addition to the first round of interviews in some of the outpatient clinics, where she obtained consent to do so. I was then able to access material from three additional sampling units. The next section provides an elaboration on the qualitative material collected from my own study into the process of the construction and implementation of care pathways.

4.4 Qualitative methods

Qualitative methods – ranging from participant observation over interviews to discourse analysis – have become key methods of social research since the 1980s (Kvale & Brinkmann, 2015). Qualitative methods use different strategies when collecting data; however, as a common practice, they are based on theories of human experience and hermeneutics (Malterud, 2003). Within this outlook, the relations in their natural context can be studied, and in the process, these relations can be interpreted and understood as phenomena and the associated sense-making (Thagaard, 2003). The word *qualitative* represents a focus on units' qualities, which cannot be quantified through statistics (Thagaard, 2003).

4.4.1 Qualitative interview

In their qualitative research work, Kvale and Brinkmann (2009), recommended a semi-structured qualitative interview as a method through which to gain knowledge on actors' experience of different phenomena. This thesis is partly based on qualitative, semi-structured interviews, partly based on the following definition given by Kvale and Brinkmann:

A semi-structured life-world interview attempts to understand themes from the subjects' own perspectives. This interview form seeks to obtain descriptions of the interviewees' lived world with respect to interpretation of the meaning of the described phenomena (2015: 15).

The researchers further highlighted how the interview process is also a part of the analysis process. By this, they mean that during interviews, one often finds different subjects or themes that need to be elaborated more closely. A semi-structured interview guide enabled such elaboration throughout all data collection sessions.

4.4.2 Policy/field level

Within the policy/field level, my main motivation was to gain insight into the process of constructing care pathways. The Norwegian Directorate of Health had posted information online concerning the different work groups and the members affiliated with them. I used Google to search for the contact information regarding the different members to whom I sent out a formal request to participate in my research project. Utilising Creswell and Creswell's (2018) criterion of optimal variation, I strategically selected interviewees representing actors from different professions, as well as patients and users. When possible, two representatives of similar backgrounds were interviewed as a means of control for variations in personal opinions (Eisner, 1991). The interviews were conducted between August and October 2018, took place either over Skype or face-to-face, and lasted between 40 and 60 minutes. The interviews were guided by an interview guide circulating around three themes. First, informants were asked about their own views on care pathways, what they thought initially, and the results. Second, they were asked about the process of how care pathways are constructed, such as any disagreements and power imbalances. Third, they were asked to describe the greatest challenges within mental health care and the extent to which care pathways lessened these challenges. Transcriptions and recordings in Norwegian of all interviews were made.

Additionally, I needed informants from another level at the Directorate of Health who worked on more strategic matters regarding the care pathways to answer the questions that the members of the work group could not. These themes revolved around how they had come to decisions regarding the construction of the template to be utilised within the work groups as well as other strategic matters, such as the name itself, "care pathways".

4.4.3 Applied level

Research on the implementation process was the second part of my study. The data were collected in an outpatient clinic in Western Norway. All the data were collected between June and November. Interviews were guided by an interview guide. This guide

was separated into four main themes for exploration, with an overall aim of understanding the sense-making experienced by treatment providers during the implementation of the care pathways. These themes were: first, their ideas and opinions about the care pathways; second, the introduction and implementation process; third, general work practices and daily tasks; and fourth, the effect of the outcome of the care pathways on their daily work, as well as other aspects within their organisation.

4.4.4 Textual resources

Documents can provide important insights into the study of different phenomena (Bowen, 2009). The documents gathered in this PhD project aim at different goals depending on which area of engagement the textual resource seeks to understand. Elaborating on the construction of the care pathways means utilising written resources as a part of the primary data collection, while textual resources are used as secondary data during the implementation part of this study.

4.4.5 Primary data

Textual resources were utilised as primary data at the field/policy level, where my main goal was to replicate the actors in the field of mental health care ideas and interpretation of the care pathways. Text and documents can function as containers for discourses and arenas in which actors can circulate opinions or claims (Callon, 1998; Laclau & Mouffe, 2001). When replicating an understanding of the process of the construction of care pathways, it was important to understand what the actors in the field thought about the idea of the care pathways and its appropriateness as a solution to some of the issues within the field of mental health care. Shortly after the decision was made to introduce what, at the time, were referred to as care pathways into the field of mental health care, an intense media debate followed. The debate informed me that these ideas would face resistance from actors in the field. Because the construction of the care pathways was partly based on the opinions of these actors, a thorough elaboration of the field through a discourse analytical approach, where I was able to replicate the main actors and their opinions by following the line of this debate, was required. At the time I started looking into this debate, a doctor in the field had made a

web page where he had collected various chronicles and articles in a structured manner. This web page ^[9] allowed me to collect numerous articles and opinion pieces. Furthermore, since the doctor responsible for the web page was an active opponent of care pathways, I had to be aware of the fact that he could have been biased with his preconception when selecting what to post. In addition, I used Google to frequently update myself on new posts that were published online. The number of chronicles, opinion pieces and articles that were analysed is shown in Table I, data collection overview.

4.4.6 Secondary data

An overview of the secondary data is presented in Table I, data collection overview. The document material includes policy documents related to the care pathways as well as two reports from SINTEF (Ådnanes et al., 2020, 2021) analysing these care pathways. The policy documents were utilised to gain more information regarding care pathways, while the reports from SINTEF were utilised mainly to validate my findings and to provide me with more thorough information regarding care pathways implementation and outcomes at the national level. These reports were based on rich qualitative and quantitative data material and were preoccupied mainly with measuring how the overall goals were met by different hospitals. An overview of the data material can be found in the table below.

Table I. Data collection overview.

Study	Empirical entity/unit of analysis	Method of data collection
Paper 1	Primary data 1: Actors in the field of mental health care	Primary data 1: 52 articles and opinion pieces (Aug. 2015–Nov. 2017)

		Primary data 2:
	Primary data 2: Actors affiliated with the construction of the care pathway, treatment for adults, general pathway.	11 semi-structured interviews of members affiliated with the construction (2018)
		Secondary data: 8 policy documents (2015–2019) and 30 public hearing responses (2018)
Paper 2	4 Norwegian outpatient clinics	Primary data: 12 semi-structured individual interviews
		3 group interviews: group 1 (11), group 2 (5), and group 3 (9)
		Secondary data: 3 policy documents related to the care pathway (2019–2020)
Paper 3	1 Norwegian outpatient clinic	Primary data: Semi-structured interviews with 1 psychiatrist, 9 psychologists and 1 mental health nurse working in the clinic.
		Secondary data: 1 policy document on care pathways (2019), 2 reports evaluating the care pathways (2020–2021)
Thesis		Data from all three papers:
		Interviews
		Semi-structured individual interviews, N=24
		Semi-structured group interviews, N=3 groups, 25 informants
		<u>Total informants, N=49</u>
		Textual resources
		Articles & opinion pieces, N=52
		Policy documents, N=8
		Public hearings, N=30
		Evaluating reports, N=2
		<u>Total textual documents, N=92</u>

4.5 Data analysis

Coding is the “process of analysing qualitative text data by taking them apart to see what they yield before putting them back together in a meaningful way” (Creswell, 2015: 156). However, before redescribing the data, one needs to replicate the empirical data so that it has analytical meaning, so as to systematise the data collected (Braun & Clarke, 2006). According to Richards (2015), the data need to be coded at least three times: once with descriptive coding (done during the transcription of the interview), once with topic codes, and finally once with analytical coding, with the higher order codes carrying the meaning forward. To perform what Richards (2015) labelled as *topic coding*, the utilisation of a thematic analytical strategy, where one identifies and analyses themes, is fruitful here (Braun & Clarke, 2006). This level of coding uses descriptive, low-inference codes, which are very useful for summarising segments of data and serve as a basis for higher-order coding. As a result, the topic coding phase tends to focus on pattern codes (Elliott, 2018). Using pattern codes, one can reduce the amount of material to a smaller number of meaningful units or categories (Elliott, 2018; Punch, 2014). According to Creswell (2013), categories are broad units of information composed of several codes that form a common theme. Furthermore, Richards (2015) described analytical coding as identifying and welcoming themes, ideas, information, and perspectives that had previously gone unnoticed or that emerged as relevant and important for analysis. Because critical realist-inspired projects are theory driven (Danermark, 2002; Morgan 2015), conducting case studies should be based on the outlook of theoretical discussions or empirical insights into the context (Edwards et al., 2014; George & Bennett, 2005). Thus, the analytical process involves redescribing the findings as causal mechanisms or processes between related elements that serve to explain them (Morgan, 2015), which involves redescribing the observed (interviews and documents) in terms of theory. The utilisation of an analytical coding process in this thesis therefore means employing theories to explain my findings.

4.5.1 Article I

Article one focus on, and analyse textual resources. An in-depth, methodical analysis of a specific phenomenon can be conducted with a discursive approach. A discourse concept describes how language is structured differently when we interact within different social domains (Fairclough, 2001). Such a concept encompasses several interdisciplinary approaches that can be used to explore a wide range of social domains in several types of studies [85].

Indeed, Fairclough et al. (2011) argued that a version of critical discourse analysis based on a critical realism social ontology is of potentially great value to organisation studies. The analytical part of the discourse analysis for this thesis was conducted in three steps. First, I needed to identify the main actors in the field of mental health care. I used NVivo to categorise this material into three main groups: mental health professionals, patients and politicians. Second, I analysed all written material and separated them into two broad categories based on the overall ethos of the text as being positive or negative towards care pathways. A structuring of the material enabled a realisation that the user/patient perspective was mostly negative towards care pathways, which aligned with most of the mental health professionals, while politicians had focused on the positive aspects of this reorganisation. Third, I combined the discourse analytical approach with the theoretical outlook on institutional logic as outlined by Thornton et al. (2012). This approach states that the institutional logic perspective consists of values, belief, rules, assumptions and material practices. The institutional logic perspective was utilised as an outlook for the pattern coding of the material by utilising the elements as overall categories. I reread the texts and looked for how these categories were present in the written material. For this, I first had to look for patterns regarding how the actors portrayed treatment in mental health services preferred treatment to be organised. Secondly, I had to reciprocate how the care pathway related to this belief. And thirdly, I needed to analyse these patterns related to the ideas of care pathways by utilising the outlook of institutional logics from the framework provided by Thornton et al. (2012).

After this coding process was completed, I realised that the perspectives of the professionals and patient/user groups related to the care pathway were so similar that I chose to merge the two outlooks into one institutional logic.

4.5.2 Field/policy level

The second source to be analysed was from the interview in the work group. Here, I employed a strategy of systematic text condensation in which the main themes from the interview were used as broad categories to be reread and coded. These categories were also recoded when the main themes related to the process became visible. These themes were: 1. *opinions on care pathways and mental health services*; 2. *influence, agency and decision-making*; and 3. *power struggles and disagreements*. These themes were then utilised as categories, and quotes from each group were chosen as examples to describe the process in the first article.

4.5.3 Article II

The data from this level are centred around the process of the implementation of the care pathways in an outpatient clinic. In the descriptive/thematic part of the coding, systematic text condensation was utilised in NVivo. As a result, codes were created based on the data.

Article one had an overall focus on expectations regarding care pathways or, more precisely, experiences with the implementation process and the impact of these pathways on everyday work practices. A descriptive theme was formed by clustering codes, for example, *time spent on coding work processes*. Related descriptive themes were then grouped together to form analytical categories, for example, *care pathways lead to more administrative work*. The introductory coding process resulted in four categories: 1) *lack of clarity regarding the overall goals and content of the care pathways*; 2) *the increased burden of coding, registration and administrative work, which professionals experienced as a stressor*; 3) *an IT and medical record system that did not correspond to the coding of the care pathways and*; 4) *an unrealistic distinction between assessment and treatment*. Furthermore, after the thematic coding was performed, an area to be observant of was how issues of trust or distrust were an

ongoing theme in the material. Based on this finding, my second coding iteration – analytical coding – was theoretically informed by employing theories on trust to highlight certain parts of the empirical material and to shed light on the causal relation between the empirical world and theories, namely, to understand the underlying mechanisms influencing mental health professionals during the care pathways implementation process.

4.5.4 Article III

This article seeks to understand how mental health professionals relate to user participation and how they involve themselves in matters related to patient involvement in treatment facilitation. NVivo helped me categorize the notion of user participation into descriptive codes. These codes were based on how the care pathways relate to the initial idea behind them, such as more patient involvement in treatment, feedback tools, individual plans, as well as information regarding care pathways.

The data were analysed in line with the second article by employing systematic text condensation coding strategy (Malterud, 2012). Based on these data, codes were created focusing on two main themes: user participation and patient treatment. During this phase, patterns were searched, and codes, code groups, themes, and concepts were developed. In my empirical material, I found 81 empirically close codes using the keywords *user participation*, *involvement* and *treatment*. *User participation* was discussed in one group, while shared *decision-making* was discussed in the other group.

As part of the *shared decision-making* coding group, my material was pattern coded into three main categories. In a code group called *negative aspects of patient involvement in treatment*, empirically close codes were collected, including examples such as “Normally, I do not consider involving patients in treatment because I do not see the benefits” and “Patients are here to get treated, not to have many choices”.

A reclassification and refinement of the code groups produced two main categories: (1) *User participation and its integration in professional practice*, (2) *Mental health*

professionals rejecting the idea of shared decision-making and (3) Patient involvement and professional practice.

To understand how professionals interpret and relate to the concept in general, I employed an analytical coding strategy based on the coping family of moving towards or away from patients (Tummers et al., 2015) as an outline, which provided me with which themes and keywords to look for in the empirical material. Furthermore, since user participation was a theme that occurred in the text without the informant always explicitly using this word, it was important to perform several thorough re-readings of the material to capture these hidden parts of the text. As Graneheim and Lundman (2004) explained, “qualitative content analytical approaches focus on analysing both the explicit or manifest content of a text as well as interpretations of the ‘latent content’ of texts—that which can be interpreted or interpolated from the text but is not explicitly stated in it” (Graneheim & Lundman, 2003: 108; Guba & Lincoln, 1994).

4.6 Ethical considerations

Clegg (2002) stated the following:

There is an ethical dimension to organization studies [...]the organization analyst has a responsibility towards the subjects of that science. When we investigate organizations, we also address the impact of major structures of society on the lives of ordinary people (2002: xxvi).

This responsibility was mine to take. First, I had an ethical responsibility towards my informant, to whom I guaranteed full anonymity throughout the whole process. Recommendations on how to take this into account were provided by the NSD, all of which were followed during the project.

This study is based on two data collections, both of which were approved by the NSD (reference IDs: 280027 and 419206). The NSD issues nationally valid judgements for

studies within the Norwegian context. Written informed consent was obtained from all participants. Furthermore, all research methods were performed in accordance with the relevant guidelines and regulations.

Second, an organisation researcher has a responsibility to the subjects of that science, which I interpret as a responsibility to replicate the word of enquiry in the most truthful way, meaning the critical evaluation of my own work and methods, which is presented in the concluding section of this chapter.

4.7 Critical considerations

Validity in research is concerned with the accuracy and truthfulness of scientific findings. A valid study should prove that what exists is accurate, and the measure should measure what it is supposed to measure (Cypress, 2017). The validity of qualitative research results depends on the investigator's careful recording and verification of the data throughout the research process. With this in mind, several considerations should be taken into account when determining validity.

4.7.1 Article 1

An important issue related to the discourse analytical approach is that a discourse is linked by a particular expert community, not simply by common goals and languages but rather by what the experts want and know how to impose on their audience, to elicit the response they want (Smirnova, 2011). I was aware that most of the text had a political agenda, namely, to argue for or against the implementation of care pathways. Consequently, some issues were highlighted in the text that perhaps otherwise would have been left out. Being aware of this means being aware of the differences that exist, for example, between mental health professionals and patients, which are extensive and more complicated than has been shown by the current debate. The logics replicated in

this part of the analysis are relevant to the care pathways approach but are not representative or transferable to more general mental health care practices.

The data explaining work in the work groups was from qualitative interview data from the respondents, conducted months after the work had been done which could then have had an impact on the results given that the informants were asked to reflect on a process that they were no longer involved in.

4.7.2 Article II

Firstly, the implementation process was examined at the very start of the introduction of the care pathways and at a time where the hospitals were receiving conflicting messages from the Directorate of Health. This issue was categorised as one of the main findings within this article. However, I also needed to be aware that an examination of some issues – such as how the care pathways transform work practices – could potentially result in a different answer if the process had been examined at a later time.

Secondly, my own data of one outpatient clinic to examine a case of national implementation would probably have been too small for valid generalisations. However, this issue was solved when I received data from three added outpatient clinics. I knew these data were collected independently of my own study, so a careful review of the interview guide used and themes researched was carried out before the data were viewed under the same theoretical lens.

One important matter that could have been highlighted was the difference between the different professional groups who work in outpatient clinics. However, the analysis of the data did not look into this.

4.7.3 Article III

This study examined how user participation was interpreted by mental health professionals and how they involved themselves in shared decision making on

treatment facilitation in one outpatient clinic. Several considerations need further elaboration.

First, user participation was examined in connection with the implementation of care pathways, which could have resulted in a bias in the answers given from my informants about their own notion of the concept. Second, only one outpatient clinic formed my empirical material. Third, I elaborated on user participation without examining it from the user perspective. An examination into user experiences with the concept, particularly treatment facilitation, would have enabled a richer and fuller exploration. However, even though the aforementioned weaknesses do exist, some of these issues were neutralised by using the SINTEF report II, where user participation in the care pathways was examined as secondary data.

In the following chapter, I present an outline of the three research articles of which this thesis is based on, including their main findings and contributions. In the last part of the thesis, I relate these findings to my research questions.

5 Findings

This section presents the main findings from the three articles. The first article relates to the construction of the care pathways, the second article examines the implementation of the care pathways in the four outpatient clinics, and the third article discusses how the overall goal of increased user participation from the care pathways was met by mental health professionals in one outpatient clinic. The chapter finishes with a critical assessment of the articles.

5.1 Birth and awakening of a care pathway in mental health services

The objective of this paper is an examination of the formulation of the “mental illness in adults” pathway in Norwegian mental health services. The main goal behind this article is to explain how the idea of a pathway containing a diagnostic outlook with strict time frames, was changed in the construction process, and transformed into a logistic pathway without the outlook of diagnosis, however with overall goals formulated as recommendations.

The starting point of this paper is a study of the main actors’ hegemonic ideas around the care pathways in mental health care viewed in a discourse analytical framework utilising Thornton et al.’s (2012) definition on institutional logic. Here, values, belief, assumptions, rules and material practice are all part of a logic. The data show that three main actors are engaging engaged in the public debate on care pathways and their suitability in the field of mental health care: 1. professionals, 2. patients and user organisations and 3. politicians responsible for health care policy.

The discourse analysis in combination with the institutional logic perspective can shed light on the social worlds and how they interpret the notion of care pathways, which is vital in the understanding of the work and decision-making process in the work group responsible for the way in which it was designed. This part of the paper deals with written material from the public debate and sheds light on how the three main group of

actors believe the services should be organised as to be more efficient, and how an organisation into standardised care pathways would potentially influence this.

The analytical framework entails an outlook into which values, beliefs and rules the actors attach to the care pathway, and how the material practices would potentially look in these services. The theory chapter on institutional logic has shown that within this literature one finds a managerial logic as a contrast to a professional logic when understanding work practices within the health care sector. Furthermore, these logics are often utilised when explaining how work practices look in the actors' everyday working arena. In this sense both logics are influenced by a political agenda which in turn impacts how they portray the care pathway.

Utilising “political logic” as a term, specifically when using this to understand the ideas connected to a care pathway, shows how politicians use the term in alignment with a political agenda, by highlighting the ideal end results they believe a care pathway approach would be able to produce. Additionally, this perceived result rests on some basic assumptions, or core values regarding the organising of public services. By utilising the institutional logics approach, it becomes possible to identify the actors' values, specifically to understand how they believe work should be organised in mental health care services, with the care pathway approach as a useful example. The identification of the two logics – the political logic and a professional logic – illuminates the core values that each logic rest upon. In this regard, identifying these beliefs and values from the different actors and their affiliated institutional logics highlight which part of the care pathway they are agreeing or disagreeing over, and why. The debate showed how the value of correct treatment in the mental health services was portrayed differently depending on who was presenting it. Where values in the political landscape regarded efficiency – that is, in terms of fast recovery – the values related to efficient treatment from the actors operating in the field, namely professionals and users meant to have an individual outlook and to adapt treatment to patients. The idea of standardising treatment as an outlook as it was portrayed in the care pathway and the consequences that would potentially unfold were therefore understood differently. The

consequence of the above is a polarised debate between whether the actor is more concerned about the patients or efficiency.

One important matter from this article concerns the *individualisation* approach which further informs us on how the logics function as an arena to highlight the different actors' values in the discussion on how to organise mental health services. Whilst the professional logic highlights how an individual approach served by a high degree of discretion and autonomy is a core value and organising principle that collides with a standardised approach, patient and user groups highlight how their idea of an individualised approach, namely user participation, is at risk if the standard solution provided by the care pathway approach is implemented into these services. Their individualisation logic in the discourse separates themselves from the professional logic by highlighting how increased user participation functions as their preferred organising principle. The idea of increased user participation is indeed shared by the politicians, however, they do not discuss or elaborate further on how these two contradictory organising ideals would look like in practice –they simply state that both are important. However, even though the ideas from user participation forming this logic is different from the professional logic, they share the same values of having an individualised outlook to treatment only made possible by professionals utilising discretion and autonomy. This results in the patients' and users' voice in the debate aligning with the ones of the professionals, who in turn become their representatives in the debate, where their main idea rests in discrediting the idea of a standardised, clinical pathway.

The institutional logic approach highlights how values form strong bonds between the actors with the same beliefs, and how values are non-negotiable when it comes to the construction of care pathways. The approach also helps illustrate how these values are important to a heterogeneous group of professionals, and how users *join forces* with professionals whom they normally oppose on these matters. When this happens, disagreements in a heterogeneous field are overlooked in their quest to discredit the utility value of care pathways as an overall organising strategy.

The Norwegian Directorate of Health is responsible for the construction of the care pathways and they involved actors operating in different domains within the field of mental health care. The involvement of different stakeholders during a care pathway construction rests on the idea that deliberate decision-making produces better and more efficient solutions (Sørensen & Torfing, 2015). When examining this process, my motivation is two-fold: first, to research how care pathways are constructed (Allen, 2009), and second, to answer the call of Johansson and Waldorff (2015) for research on what happens when institutional logic meets at the intersection two or more fields, or when actors must muddle through the decision-making process.

The second part of this paper investigates how one of the care pathways is constructed by interviewing members of the Norwegian Directorate of Health and of the work group responsible for its design. The structuring of the initial construction phase had clear project-like features: Process managers, project leaders, resource groups and task forces were among the instruments borrowed from the project management toolkit. They arranged large meetings to address marketing and mobilisation and for the purpose of dialogue. The motivation behind these events was to potentially influence the normative engagement of the involved organisations and added to the process a type of organisational behaviour resembling social movements in a time where learning from social movements was encouraged as a promising tool in executing change within major health care systems (Bate et al., 2004).

However, this was not the case. The actors involved transform the idea of a clinical pathway with an outlook into diagnosis and evidence-based medicine, and turned it into a logistic trajectory – a care pathway aiming to achieve five overall goals, by focusing on user participation, coordinated patient flow, avoidance of unnecessary waiting times, improvement of equal access to services regardless of geographic location, and increased emphasis on physical health and lifestyle. The overall goals are not operationalised, and merely function as recommendations. Additionally, no

concrete, or standardised measures in terms of diagnostic, assessment and treatment were defined.

Attention towards the values of actors involved in this process is paid when looking at the perspective of both the politicians and professionals' institutional logic. The political idea of standardisation as a solution to these issues faces a great deal of resistance when actors are involved in production. Negotiation is led by the Directorate of Health who are thoroughly aware of the value-driven institutional logic at stake, and thus construct a care pathway around these *unnegotiable issues*, when then creates a logistic pathway without touching professional discretion while still managing to focus on efficiency by creating a timeline and codes to be monitored. However, the negotiated product is characterised by an aim to serve the actors affiliated with institutional logic and how they think mental health services should be organised. When taking these actors into account, the Directorate of Health's main aim is for the implementation of care pathways to be successful. The examination of the implementation and outcome of the care pathways will be explained in the two forthcoming chapters.

The contribution of this paper is, first, to answer Johansson and Waldorff's (2015) call for studies to utilise institutional logic in different fields to learn more about the "informal organization, the chaos and the 'muddling through' ... in the decision-making processes, and actors' tiring negotiations and power struggles". The above paper showed the muddling through in the awakening of a care pathways and how the process is guided by a delicate negotiation between professional and political logic.

Secondly, the paper gives an empirical contribution into understanding how new policies are constructed, and its implications for the actors involved. The analysis shows the downside by involving actors in deliberative decisions through "social like movements" (Bate et al., 2004). This article illuminates what happens when the agents involved are preoccupied with integrated values when interpreting the ideas behind care pathways. The debate focused on either discrediting the idea of the care pathway

or arguing in favour of it. This is shown in the article by illuminating how the debate became a polarisation between the two main actors as either caring for patients or caring for efficiency. The goal of the pathway was to improve on important matters that do not function optimally in the field of mental health care, however, this discussion was, for the most part, left out in the debate, as well as in the construction of the care pathway.

5.2 Implementation of care pathways and how trust influences mental health professionals' sense-making in the outpatient clinics

The starting point of this paper is a qualitative study on the implementation of the care pathways in four different outpatient clinics in Norway. The overall data reveal four overall reactions to the new organisational structure, that there is: 1. a lack of clarity regarding the overall goals and content of the care pathways; 2. an increased burden of coding, registration and administrative work; 3. an IT and medical record system that did not correspond to the coding and; 4. an unrealistic distinction between assessment and treatment.

This study draws on critical sense-making theory (Mills & Mills, 2010) to understand how mental health professionals interpret and act towards care pathways in combination with Möllering's (2006) theory on trust. These theoretical understandings put forward an analytical framework that recognises how actors' sense-making during implementation is influenced by trust, or the lack of it, when individuals: act on cues, are influenced by trust, and enact new environments.

Møllering (2006) sees trust as less dependent on the individual trustee and more dependent on social norms and values in which actions are embedded. The elements of familiarity, calculated interest, and compatible norms and values render trust or distrust. By familiarity, Møllering (2006) refers to the general premise that prior interaction results in "familiarity" and, in turn, builds trust between organisations. In

this study, trust and calculated interest are expressed as mistrust from mental health professionals and as a need to defend their work practices and the amount of time spent on different procedures, as well as an overall sense that mental health professionals need to be controlled. The above situation is based on the belief that the care pathways system is not designed to improve services but rather to allow for professionals and users to gain more control over them.

Regarding trust and compatible norms and values, mental health clinic work is found to be characterised by several aspects, including unpredictability, difficulties in planning treatment, and a high degree of discretion and autonomy, since each patient requires individualised care. These elements are based on strong, professional values that underpin treatment and care. The elements of autonomy and individuality clash with some of the goals of the pathway system, such as efficiency, equality, and standardisation. To be more precise, familiarity renders distrust because of actors' prior interactions and what the care pathways represents for professionals in the field.

The values belonging to the originators of the care pathways (health authorities) are clearly not compatible with those responsible for its implementation, namely, mental health professionals. The analytical proposition considering the empirical data from the outpatient clinics shows two cues that guide mental health professionals' overall sense-making. The sense-making perspective used when answering this research question is based on three elements that are activated when street-level bureaucrats are faced with the implementation of care pathways :

1. Perceiving the cues: *await further action and we are already doing the necessary work.*
2. Interpretation: "this is to be in control over services, not over improvement. This does not benefit patients" (distrust); and
3. Action: A. avoid and reduce its importance and B. fool the system.

Mental health professionals need to make sense of the care pathways to reduce its importance in their everyday work.

The contribution of this article is firstly, a theoretical one by referring to Sandberg and Tsoukas' (2015) literature review on sense-making, who found only one article applying sense-making theory in combination with trust and thus called for further research combining the two perspectives. The present study adds to this theoretical contribution. Studying implementation processes while paying attention to how individuals make sense of their environments and acknowledging the societal context is a focus provided by the critical sense-making perspective of Aromaa et al. (2019) and is a fruitful way forward when combining the two perspectives. CSM positions this context as a link between context and individual action. The application of Möllering's (2006) theory on trust serves as the context in which sense-making occurs, thus acting as the analytical framework from which the implementation is understood.

Secondly, my empirical contribution is related to how the implementation of the care pathway was met in outpatient clinics, and how mental health professionals responded to this new policy by rejecting it. One of the conclusions from the previous article was the belief from the Directorate of Health that by involving actors in the field of mental health care during the construction of the pathway, the policy would be implemented successfully. However, as this article shows, this was not the case. The professionals rejected the implementation, despite agreeing on the overall goals that the pathway was aiming for. The empirical contribution is therefore twofold, because it shows that despite involving the "street-level" in the construction phase of the policy, one is not guaranteed a successful result. This will be elaborated in more detail in chapter six.

5.3 Attempt to implement increased user participation and shared decision-making in the care pathway context

The third article examines the implementation of the overall goal of increased user participation as part of care pathways in Norwegian mental health services by researching the role played by mental health professionals as street-level bureaucrats

when making sense of user participation during the care pathways implementation process (see e.g., Caswell et al., 2017; Van Berkel 2019).

This article focuses on how mental health professionals, in their role as street-level bureaucrats, utilise user participation as an important part of their professional work practice by being tuned into their patients and by providing a safe alliance. Furthermore, the article attempts to reconstruct an understanding of how mental health professionals in their role as street-level bureaucrats relate to user participation as portrayed in the care pathway, by employing the coping mechanisms of moving either towards or away from patients (ibid).

An important measure related to user participation in the context of care pathways is the goal of involving patients in the facilitation of treatment. The idea of involving patients is found in theory related to *shared decision making*, a mechanism for decreasing the informational and power asymmetry between doctors and patients by increasing patients' information, sense of autonomy and/or control over treatment decisions that affect their well-being (Hamann et al., 2003: 404). However, during the attempt to introduce care pathways and this goal, several obstacles occurred in relation to user participation in treatment facilitation. An understanding of these barriers, or obstacles, can be established by employing theory on how street-level bureaucrats cope with the goal of involving users in treatment whilst addressing already high work demands within a tight schedule (Tummers et al., 2015, Berlin et al., 2021).

The article identifies two strategies that occur when the topic of involving users in treatment is addressed. The first is to leave the patient with no real choice by advocating for the treatment they are trained in. The second is rejecting wishes for treatment as professional evaluations that serve to evaluate if they believe the outcome of treatment will be benefitted by changing treatment approach.

When these results are analysed in relation to the backdrop of theory on coping as a matter of actions that move the professionals towards, or, against patients, two

approaches are identified. The first coping mechanisms identified are when mental health professionals interpret user participation as integrated in professional practice thus moving them towards patients. In this regard, they can focus on their core task, of providing patient treatment whilst providing *user participation*. The second coping mechanism identified is when they choose not to involve the patient further in treatment choice, theorised as shared decision-making. Coping regarding this matter is interpreted as something they do for the benefit of themselves, thus moving them away from patients.

Coping is justified by utilising two mechanisms identified in the theory on *moving away from patients*. The first is performed by “*routinizing*” treatment by offering the treatment they are specialised in, and by standardising this approach by “advocating for the method they know”, independent of the individual patient. The second mechanism is by “*rationing*” additional treatment, or request of treatment, with a professional evaluation. The consequence is that potential additional work burdens are eliminated.

Additionally, involving patients in treatment is viewed as something that does not serve the effectiveness of different interventions and furthermore, something in which they choose not to involve themselves with. Thus, the idea of shared decision-making as an important part of providing more efficient outcomes is not shared by the mental health professionals. Instead, the notion of user participation is to provide correct patient treatment by being tuned in to patients and creating a safe and therapeutic alliance.

This article seeks to add a theoretical contribution into three different areas of engagement. A call for research on the effect of professionals acting as street-level bureaucrats on professional conduct (Cecchini & Harrits, 2022; Nørup et al., 2021) is answered, first by arguing that mental health professionals become street-level bureaucrats in their daily work practices, characterised by a high degree of discretion in their daily encounter with patients, and second by arguing the possibility of granting benefits theorised as *shared decision making*. Lipsky’s (1965) main argument on street-

level bureaucrats was that they are responsible for the success or failure of new policies due to the role that these discretionary activities play in patients' lives. This article highlights how professional conduct guides street-level bureaucrats by justifying coping mechanisms that either move them towards themselves or patients in the quest for increased user participation that the care pathway desires.

The gatekeeping of treatment offers, is guided by the role played by professionals. Therefore, professional evaluations guide their conduct and decision-making, as opposed to the ethical dimension of giving autonomy and choice to patients, which then answers the call by Cecchini and Harrits on the research into professionals in street-level work (*ibid*) and Berlin et al.'s 2021 call for research to understand how health professionals cope with high workloads.

This article also responds to a call for theoretical contributions concerning issues and obstacles when introducing user participation (Larsen & Sagvaag, 2018), as well as giving a theoretical contribution into research concerning shared decision-making in routine mental health services (Slade, 2017).

To summarise, my empirical contribution is, firstly, that I aim to enhance the understanding of the decision-making processes of mental health professionals in Norwegian mental health services. This is important regarding the ongoing debate on how to organise these services better, and more efficiently. Secondly, my empirical contribution highlights important matters when policies are formulated as "should matters", meaning less binding expectation with a loose coupling into service production. My overall data shows how these "should formulations" are ignored. And third, my empirical contribution shows the barriers that exist when question on how to increase user participation within this sector arise.

5.4 Critical assessment of the articles

There are many empirical studies on the adoption and implementation of new policies and management ideas, and several attempts to theorise such processes. Employing some alternative theoretical ideas within my empirical material helps highlight the different outlooks that could have been employed in the process of introducing care pathways into the Norwegian health care system, and provide a richer and more nuanced discussion of the overall research question. This elaboration requires an introduction into this alternative theoretical outlook.

An explanation on how ideas change during translation when they move from one context to the other (Boxenbaum, 2005) is found within the outlook of translation theory. Translation theory sheds light on how knowledge transfer between source and recipient organisations takes place, how outcomes of knowledge-transfer processes depend on “translation performances”, as in how actors apply various translation rules when de-contextualising practices in source units and contextualising representations of practices in recipient units (Røvik, 2016: 292). Translation is therefore political, when referring to the pursuit of interests, acts of persuasion, power dynamics and strategic manoeuvres, a geometric meaning that mobilizes human and non-human resources “in different directions”. Translation also has a semiotic meaning, in regard to the transformation of meaning that occurs during the movement of the object in question (Wæraas & Nielsen, 2016). Latour’s research on translation focuses on how power is enabled, accepted, and diffused. According to Latour’s model of translation, power is enabled if others accept it; however, they change the order of the person who holds power into something completely different to reach their own objectives (Latour, 1986: 268).

Another vast area of the literature on this topic theorises and investigates organisations’ absorptive capacity (AC) when understanding differences in outcomes of the adoption of new ideas and their implementation processes (see e.g. Cohen et al., 1990; Lane et al., 2006). Absorptive capacity is about the ability of an organisation to recognise the value of new external information, assimilate it and apply it for business purposes

(Cohen & Levinthal, 1990). Furthermore, Zahra and George (2002) reconceptualise AC and develop a model which concentrates on its internal processes. This model focus on how knowledge enhances competitive advantage and is therefore a more fruitful outlook when understanding how new ideas assimilate into organisations within public sector. (Esterby & Smith et al., 2009). Finally, knowledge is linked to power, and how the decision to share, request or transfer knowledge is a political act (Marshall & Brady, 2001). The power dimension is elaborated on by Jones (2006) who demonstrated how recruited managers in their roles as institutional entrepreneurs imported new ideas from outside of the organisation. Meaning then that it was the agency of these individuals that enabled the integration of the implementation of something new within the system.

Another theoretical outlook focus on “best practice” theories, some of which argue for top-down implementation or bottom-up strategies as decisive for outcomes (Fixsen et al., 2009; Sabatier et al., 1986; Long et al., 2004).

5.4.1. Article I, “Organizing as negotiation”

The article elaborates on the construction of a care pathway to be implemented in Norwegian specialist mental health services’ outpatient clinics in 2019. The article utilises theory by combining the institutional logic perspective (Thornton et al., 2012), with a discourse analysis (Fairclough, 2007) to illustrate this process. The article also explains the rationale of how the idea of having 22 diagnosis-based pathways was transformed into nine logistic pathways aimed at five overall goals, formulated as recommendations and not operationalised further.

Firstly, and importantly, the article does not discuss the overall political landscape or macro tendency of applying standardisation and its following mechanisms into the health care sector. Giving more space to the political landscape could have highlighted why the choice of utilising care pathways in the mental health care sector was proposed and could potentially have opened up for a discussion on how organising ideals from

this macro level influence mental health care services and the rationale behind this approach (Timmermans & Berg 2003; Wears, 2015).

Secondly, the article does not discuss how ideas change during translation when they move from one context to the other (Boxenbaum, 2005). Utilising translation theory (e.g. Røviks, 2016) could have shed light on how knowledge transfer between source and recipient organisations takes place. This theory could have provided useful perspectives on the process of translating practices and ideas for achieving various organisational ends.

And thirdly, utilising theory on the role that institutional entrepreneurs play in the construction of policy (Mæhle et al., 2021) could have highlighted whether there were certain actors who influenced the construction of these in a specific direction. Even so, this article address important knowledge regarding how policy construction occurs, and the rationale behind the final result by focusing on the meso and micro levels, while utilising an institutional logic approach.

5.4.2 Article II: “Trust in pathways? Professionals’ sense-making of care pathways in the Norwegian mental health services”

The outlook of this article is the implementation of the care pathways at four outpatient clinics in the Norwegian mental health sector in 2019. The article explains how the implementation was met with an overall idea that the rationale behind the care pathway was not to improve the services, but rather, to have more in control over the professionals working in the system, rendering an experience of distrust towards its designers and authorities. The theory on sense-making showed how they made sense of the implementation by rejecting it, and in minimising its impact on their daily work lives.

Several empirical studies on the adoption and implementation of new policies and management ideas exist, in addition to attempts to theorise such processes. One vast

literature stream theorises and investigates organisations' absorptive capacity when understanding differences in outcomes of adoption of new ideas and the implementation processes (see e.g. Cohen et al., 1990; Lane et al., 2006). Another theoretical outlook focuses on *best practice* theories, some of which argue for top-down implementation or bottom up strategies as being decisive in regard to their outcomes (Fixsen et al., 2009; Sabatier et al., 1986; Long et al., 2004). And finally, several management theories on how to influence workers and implement overall strategic goals are found within this stream of management theories. One influential theory defines the concept of "*transformational leadership*" which refers to a leadership approach that aims to enact change in both individuals and social systems. A variety of mechanisms are employed by the use of *transformational leadership* to enhance workers' motivation, morale, and performance (see e.g. Sashkin, 2004; Bass, 2006).

Neither of the abovementioned theories have been applied to my empirical material. The article in question does not discuss the difference between the different outpatient clinics or between the professional groups working there either. Further exploration into these differences could potentially have explained several elements related to the theories that will be presented in this section.

First, discussing the difference between the clinics would have been able to illuminate how the management/leadership dimension could have neutralised the experience of distrust from the professionals and focused more on the benefits that the care pathway brought about, such as the overall goals of which the professionals agreed upon. Moreover, employing theory on transformational leadership (Sashkin, 2004; Bass, 2006) would highlight whether a specific management or leadership existed in the outpatient clinics that then influenced how the professionals portrayed the care pathways by focussing on its overall goals.

Secondly, a discussion between different professionals working within these services could have shown how different professions interpret the care pathway system and if this in turn affected the way it was implemented. Within an outpatient clinic, there exists a medical hierarchy with different professionals having a preferred way of how

to view and treat mental illness. A discussion on the affiliation of their different institutional logics to standardisation and evidence-based practice would have brought in another dimension whereby doctors trained in medical treatment and evidence based medicine may contrast to how a music therapist views treatment. This discussion could have benefitted by a theoretical outlook into an organisation's "absorptive capacity" (Cohen et al., 1990; Lane et al., 2006), by illuminating how different professionals relate to, and absorb the idea of the care pathway which in turn influences the outcome for the patient.

Third, and finally, explorations between top-down, or bottom-up implementations (Fixsen et al., 2009; Sabatier et al., 1986; Long et al., 2004) could have illuminated which factors involved in the implementation could potentially have been improved upon in order to provide a more successful outcome.

Even though these alternative empirical and theoretical outlooks exist, this article focus on the micro level by concentrating on the actors' overall sense-making in four outpatient clinics, thus providing an important insight into the "street-level" of policy implementations and the reason behind the unsuccessful outcome of the care pathways in mental health care outpatient clinics in Norway.

5.4.3 Article III "How shared is shared decision-making?" User participation in the context of care pathways in Norwegian mental health services

The overall goal of this article is to understand the failure to implement increased user participation in treatment as proposed by the care pathways. The article elaborates on how treatment providers in an outpatient clinic interpret user participation as something already integrated in patient treatment. Involving patients in treatment choice and facilitation is one of the pathway's main objectives, and the article further discusses this element through the lens of street-level bureaucracy theory and coping mechanisms to show how the professionals have strategies when it comes to not involving the patient any further than they deem necessary, understood as a coping mechanism for

the benefit of themselves rather than for the patient, in order to deal with high workloads and tight deadlines.

While user participation can be studied at different levels (Alm Andreassen, 2004), the analysis here is limited to the micro level, focusing on how professionals understand and integrate the notion. However, focusing on the political rhetoric about user participation at a macro level as the phenomenon appears in national documents and in the care pathway itself could have opened up a larger discussion in relating user participation to the historical context, such as by referring to the initial idea of patients' needs for basic human rights in a mental health system characterised by inhumanity and coercive measures (Borg et al., 2012; Topor et al., 2009), and transformed into a notion of the ideal of an involved and democratic citizen being an equal partner in medical decision-making (Sørensen & Torfing, 2015). Another prospect worth mentioning in this regard, is how the user participation approach, originally coming from the ground by patientes, changes during the attempt to implement it in a top-down approach.

User participation and previous studies on this topic are not compared nor discussed in this article. A discussion of how my study relates to other studies would have had the potential to discuss user participation and how the notion of it changes with context, thus showing the richness of the concept.

Another critical consideration that needs to be take into account is that several goals related to increased user participation was formulated in the care pathway, such as information concerning CP, information regarding different treatments, participation in treatment plans, influence on treatment through shared decision making approaches and through regular evaluations, and the use of feedback tools. However, the article related to user participation only discusses the aspect on involvement in treatment. The evaluation report also showed a low degree of involvement in all of these matters except for that of the feedback tools which was used more frequently after implementation. Why mental health professionals chose to involve themselves in this

particular matter, whilst ignoring the others would have been able to strengthen the decision-making approach.

The inclusion of these alternative theoretical and empirical outlooks could have shown user participation from a broader perspective. However, the aim of this article is to show how user participation takes place in the interaction between the patient and professionals and how different contexts influence the professionals in their role as street-level bureaucrats.

6 Discussion

Politically imposed changes in health care involve highly complex processes that introduce and require behavioural changes at the clinician level in hospitals. This makes this domain particularly interesting to study (Mæhle et al., 2021). The articles address different aspects of the birth, awakening, implementation and outcome of the care pathways within mental health care, and serve as a basis when answering the overall research question:

How do mental health professionals understand the concept of care pathways, and what are the implications during the construction and implementation of care pathways for adults in outpatient clinics?

In order to more fully understand the concept of care pathways and how context influences the professionals' understanding of the phenomenon, a discussion on how the design and implementation of the care pathways within cancer treatment took place will provide a richer elaboration into this discussion. Additionally, the critical assessment of the articles showed several areas that could have provided a fuller explanation of my empirical material. These areas will be discussed in the final part of this thesis.

6.1 Construction of care pathways by involving mental health professionals.

Top-down processes associated with the implementation of care pathways aim to: introduce general guidelines from evidence-based medicine, increase risk control, or reduce variation in care. In contrast to this, increasing interdependence in decision-making, patient logistics, and medical development are common motivators when considering a bottom-up approach. (Mæhle & Smeland, 2021). When the idea of a care

pathway for mental health care was first launched, the initial design followed a top-down approach, however, the eventual design of the care pathways came, as it should, from the bottom up. This creates a hybrid version where the final result is influenced by both levels and thus requires a more thorough outlook into the context that the construction of the care pathways construction took place in.

Ideas change during translation when they move from one context to the another (Boxenbaum, 2005). Røvik's 2016 theory on translation explains how outcomes of knowledge-transfer processes depend on "translation performances", that is, how actors apply various translation rules when de-contextualising practices in source units and contextualising representations of practices in recipient units (292).

The institutional logic approach illuminates how the translation of care pathways are contextualised by the recipients' interpreting of the care pathway approach from a professional perspective. During the introduction of the care pathways, several conferences were organised. The overall aim of these conferences from the political side was to guide the field into a certain direction where the ongoing issues such as capacity issues and long waiting lists should be eliminated by utilising the care pathways approach. This idea of organising the construction of the care pathways by involving actors from "the street-level" (Sørensen & Torfing, 2015; Brodtkin, 2012) had previously been a success during the construction of a care pathway in cancer treatment and the goal was to reproduce this arena as a place to influence the actors on its suitability. However, according to Yaseen and Perry, "when linking a certain discourse with a certain expert community, it is not simply a question of a particular group of experts having a common set of goals and language; it is what the experts want and know how to impose on the audience" (2019: 266). Indeed, power is essential in a discourse analytical approach, meaning that the dominant group uses language with a hidden agenda and interests, to convince the other party that what they are saying is common sense (Fairclough et al., 2011).

The idea of standardisation follows a governing paradigm occupied with control and transferability, which is portrayed as a major issue among health professionals and

other actors in mental health care. Agreement on treatment facilitation within the field of mental health care is a rather uncharacteristic trait during discussions held within a heterogeneous professional group. However, during the discussion on the applicability of care pathways in the field, a rare agreement on the treatment facilitation occurred. Across the board, the professionals believed that the individualised perspective (when treating mental illness in an outpatient clinic) does not fit with the ideas stemming from a diagnosis-specific outlook, and that the pathways used in cancer treatment are not transferable to this field. Additionally, users, patients and user organisations, when arguing for their rights to be heard, are normally situated within the system where health professionals work, and their opponent is normally professionals who work in this system. The quest of discrediting the idea of a care pathway seemed more important than engaging in discussions of the type that normally characterises the field. Conclusively, moving the pathway away from a diagnosis-specific outlook is a vital quest in the conference's leading up to the formation of work groups. Understanding this joint commitment to devalue the care pathway approach in this field is from Latour 1986, understanding of power during translation of ideas (Røvik, 2016), which is enabled if others accept it; however, they change the order of the person who holds power into something completely different to reach their own objectives (ibid). This was the attempt of the actors from "the street-level" during the construction of the care pathways. Prolonged the construction of the care pathway shows a downside towards the trend on producing services within the "co productive" perspective (Sørensen & Torfing 2015), because the co productive arena became a power field where the actors did not concentrate on building better services, but instead concentrated on opposing the ideals that the care pathways brought about.

Where institutional entrepreneurs within the construction of the care pathways in cancer treatment functioned as bridge builders between different levels of the system, and sought to push the construction of the pathways in their own preferred direction, no such entrepreneurs advocating for the care pathways were identified in this process. The gap between the political field and the street-level therefore only increased when

the idea of care pathways was launched, which can be seen in the debate that prolonged the new organisation of the services in mental health care explained further by Dobson (2015) in Checkland et al.'s 2020 article, when he claimed that "the use of linguistics by enactors of policies becomes a reflection of their social worlds". To further explain this social world and the attempt of the policy transfer into practice, theory on institutional logic (Thornton et al., 2012) is vital as it has the ability to shed light on the different actors' social worlds. One objective of the institutional logic approach is to show how decision-making processes are grounded in certain logics, giving identity to different groups and directions on how professionals interpret the care pathways.

Reports from when the idea of the care pathways was published show major weaknesses in the organisation of the targeted services. In terms of mental health care, this includes major capacity problems, differences in terms of treatment provisions, unequal services and low user participation and was highlighted by the authorities as issues they believe the care pathway would address. These issues were also present when the idea of care pathways in cancer treatment was introduced. Professionals in somatic care however, such as cancer treatment, are trained in a diagnosis specific outlook and evidence-based medicine, which in turn shows how the context of somatic medicine is already centred around values aligned with the care pathway approach. On the other hand, professionals in the field of mental health care do not exhibit their work practices to be centred around evidence-based guidelines, but rather around individual patients. So even though these issues are recognised by professionals working in the field of mental health care, the solution as to how to approach them, they believed, should be different from that used in somatic medicine.

When the work in the work groups commenced,, the Directorate of Health had already decided on the templates that were to be employed by the groups. Several conditions are noteworthy here. The template was produced by the Directorate of Health and is not concrete in terms of which diagnostic tool or specific treatment procedures are to be discussed. The idea of logistics is an overall aim of the template, excluding those discussions that normally take place in the field. The above is understood by employing

knowledge on institutional logic and how values function as the core of identity work. The Directorate of Health therefore circulates the discussion around these values by producing a negotiated product where the discussion is to take place.

An explanation of the transformation from a care pathway to a logistic pathway is taken from Fairclough et al.'s elaboration on an important issue that can be identified through critical discourse analysis: "What makes organizations resilient in the face of change, resistant to change, or open to change?" (2011: 935).

The above quote highlights the resistance that the care pathways would potentially meet in hospitals. Understanding Fairclough et al. (2011) means to understand health authorities' fear that the care pathways will face too much resistance *on the ground*. However, the negotiated product does not provide the opportunity for these organisations for change, which the authorities had probably hoped and which is further explored in the next section.

6.2 Mental health care professionals resisting the implementation of a care pathway in outpatient clinics

Researching the second area of engagement, namely, the implementation of care pathways, uses a framework for viewing organisations as sense-making systems and is rooted in and developed from Weick (1995, 2001). Theory on sense-making proves to be important when examining the use of care pathways in an outpatient clinic as it shows how factors that influence mental health professionals during the implementation process further influence the eventual outcomes. Viewing professionals in these services as street-level bureaucrats is an analytical framework that enables contextualisation of the actors' work by making it more transparent (Lipsky, 1990). This part of the thesis studies the processes experienced by mental health professionals and, whilst doing so, considers the previous work of Abbott (1988) and Barley and Kunda (2011). Additionally, the overall understanding behind intended

goal achievement needs to be considered by looking at how the actors relate to different aims, and equally as important, the infrastructure surrounding them (Brodkin, 2012). The above shows how the context that the care pathway implementation takes place is of vital importance for its outcome.

Translation theory (Røvik, 2016) highlights how outcomes of transfer processes depend on “translation performances”, meaning the translation rules during de-contextualising practices and contextualising representations of practices in recipient units. These translation performances are elaborated on by using Möllering’s (2006) theory on how trust or distrust can be found in the institutional context influencing actors translation performances. Möllering relates less trust to the individual and more to the social norms and values influencing the actors by utilising the concept of familiarity, calculated interest, and compatible norms and values. This context again renders trust or distrust and influences the implementation. Utilising theory on trust shows how these translation rules impacted by trust influence how professionals in mental health care contextualise the representation of the care pathway in their own units.

When applying theory on trust into the care pathway implementation for cancer treatment, an important matter distinguishes these issues from the area of mental health services. Whilst professionals operating in cancer treatment services believe that the coding and time frames in the care pathway benefits the patients, they do not experience distrust (Melby et al., 2021). Rather, they believe that the calculated interest from the top level is to improve these services to benefit patients, which makes their norms and values compatible.

Furthermore, the evaluation report shows how professionals experience the streamlining of processes, the improving of efficiency, and the implementation of different management practices as elements they were familiar with, making it difficult for professionals to identify which changes were a result of the care pathway approach (Melby et al., 2020). The above shows how this sector is familiar with established

strategies similar to the care pathway approach which in turn influences the “familiarity” approach, which then creates trust (Møllering, 2005).

Bringing Møllering’s understanding of trust in its interaction with institutional logic into my empirical material reveals two findings. First, institutional logics influence professionals during the implementation of care pathways by providing them with a frame of reference with which they can interpret the meaning of, and behind, care pathways. Second, the construction of care pathways has ripple effects on the implementation process because of this familiarity and prior interaction with the notion of care pathways.

The institutional logic perspective also explains that actors interpret different phenomenon from a professional identity. Discussing this matter means having an outlook into an organisation’s absorptive capacity when understanding differences in outcomes of adoption of new ideas and the implementation processes (see e.g. Cohen et al. 1990; Lane et al., 2006). First of all, absorptive capacity is linked to power, and the decision to share, request, or transfer knowledge is often a political act (Marshall & Brady, 2001) as was seen during the top down initiative to implement care pathways. Absorptive capacity is about the ability of an organization to recognize the value of new external information, assimilate it and apply it for business purposes” (Cohen & Levinthal, 1990). The absorptive capacity of health care organisations related to care pathways therefore lies in the actor’s ability to recognise the value of the new information, mainly how it influences patient treatment and outcomes, which in turn impacts the assimilation into these services. Zahra and George’s 2002 model on absorptive capacity focuses on the internal processes by studying how new ideas assimilate into organisations within the public sector, where knowledge enhances competitive advantage. Focus is placed on internal processes, such as activation triggers and mechanisms relating to social integration. Activation triggers may include external changes such as the care pathway introduction (Esterby & Smith et al., 2009), and social integration mechanisms (ibid). Social integration is here understood as the abilities of the social actors to integrate new ideas and

implementation into their everyday work routines. The care pathways both require professionals to increase their time spent on administrative tasks and to use a more standardised diagnostic process. During the implementation of care pathways in cancer treatment, Håland et al. (2023) researched how the increased administrative work and coding of patient work is viewed by health personnel as a core part of their professional identity and shows how organising for quality has become an important part of professional work. The coding and administrative work in the cancer pathways is thus experienced as part of their professional conduct, and not something that is experienced as an increased administrative burden from the outside. The above explains how the actors recognise the value of the care pathway approach, and that they have assimilated into their professional conduct. However, as the data shows, this was not the case during the implementation of the care pathways into mental health services. The actors did not recognise the value of the care pathway approach, and therefore the attempt by the authorities to assimilate this approach into the services was rejected by way of different sense-making strategies.

Finally, institutional entrepreneurs played a vital role by bridging different levels of the system and thus influencing the street-level where the implementation took place within the cancer pathway. The theory on *transformational leadership* explains a leadership approach that causes change in both individuals and social systems. Understanding the role these entrepreneurs played from ideas found in theory on transformational leadership explain how medical doctors in their role as entrepreneurs during the care pathway implementation in cancer treatment managed to influence other doctors on the positive aspect of this reorganisation. However, no such entrepreneurs were identified during the implementation in mental health care.

6.3 User Participation in the care pathways

Increased user participation is an overall goal found within care pathways for both cancer and mental health care

As discussed previously, user participation as a concept was born in the field of mental health care, where the focus of integrating the “whole” person, and to be viewed as something more than a patient was advocated for. Beating a system known for inhumanity and coercive measures was its initial purpose (Borg 2012). However, the ideal has transformed into an idea of a democratic citizen to be an equal partner in service development and medical decision making (Sørensen & Torfing 2015, Slate 2017).

The strategy when producing the care pathways in cancer treatment was to integrate user participation in the pathway system by highlighting how delays and waiting time is negatively influencing patients and prognosis of the disease. This narrative shows how user participation became a political size used strategically in this approach by highlighting how care pathways are constructed for “the best of the patients”. Furthermore, involving patients in treatment facilitation was also advocated by the health authorities during the care pathway approach, thus showing how user participation is a political size when viewing patients as democratic citizens that should be involved in decisions about themselves (Sørensen & Torfing, 2015). However, user participation in the care pathway for mental health care was constructed differently. First and foremost, the narrative on the care pathway as being for “the best of patients” was not agreed upon by either patients or professionals. Whilst professionals highlighted how a standardized approach would render impossible an individual outlook provided by discretion and autonomy, user and patient organization focused on how standardization would be a buffer against issues they was arguing for, namely increased involvement and influence in treatment facilitation and to combat a paternalistic system. This lack of a mutual agreed definition on the concept makes it complicated to operationalize because actors relate to it differently. The above gives

valid argumentation to Pilgrim 2008, who consider user participation to be a polyvalent concept, meaning that there is superficial agreement and an apparent consensus among disparate stakeholders regarding this concept, but this ostensible agreement conceals incompatible assumptions and expectations. This could possibly explain why the end product focus more on user participation as a separate size to aim for, instead of an overall integration in the narrative. However, constructing user participation as overall goals to aim for the top level still focus on patients as users of services, and the democratic ideals related to this. Also, by taking users and professionals voice into consideration when constructing the pathways the top level also shows willingness to involve actors in service production (Sørensen & Torfing 2015).

However, as my data reveals, leaving it up to the professionals to integrate the notion has consequences for the patients and users of the services. Street level bureaucracy theory claims that coping with the “public service gap” is an important strategy in a workday that does not provide enough resources even more importantly, during times of new implementations that disturb their initial workflow (Weick 2001). Further elaboration on how professionals in their role as street level bureaucrats cope is found in the coping family of moving towards, away from or against patients. Coping here is understood as organizing their work to benefit the users of the services (moving towards), or to benefit themselves by ignoring further involvement with work of a specific kind (moving away from or against) as to protect themselves from stress and increased burdens (Berlin et al 2021). The data shows how mental health professionals integrates user participation in treatment by having an individualized approach to patients and by organizing their work by focusing on the alliance between the patient and professional. Interpreting user participation in these terms allows them to continue their work practices without further involvement with the care pathway. However, coding and increased administrative work is seen as work not benefitting the patients. This view is contested as to how professionals in the care pathways for cancer view these practices. They believe that the coding is for the benefit of the patient, and furthermore, interprets this work as belonging to their professional conduct Håland et Melby (2023). The important part of the care pathways, namely the coding and time

frames becomes two different sizes depending on whether the professionals operate in the domain of mental health care or the somatic medicine.

Additionally, within care pathways for cancer treatment, prioritising patients by level of urgency or thorough assessment practice always comes before making the time frames in the care pathway (Næss & Håland, 2021). Understanding these practices means that professionals in cancer treatment move towards patients and against the system of the care pathways if they find it necessary. These concerns were not reflected on by the mental health professionals in my empirical data. However, the research by Larsen and Sagvaag (2018, 2020) shows how mental health professionals in Norwegian mental health services actually move away from, and against patients when matters on patient involvement occurs, to cope with requests and wishes from the patients. This is done primarily by relating to collegial coping mechanisms, as is the conclusion from Berlin et al.'s (2021) research into how street-level bureaucrats cope with additional, high workloads in Swedish mental health care services.

Another important measure related to user participation in the care pathways is the idea of involving the patient in the facilitation of treatment. Slade (2017) defines this notion as a collaborative process between mental health professionals and patients and involves the health professionals working with patients to choose tests, treatments, and management based on clinical evidence and their informed preferences. This type of involvement is of little concern in the care pathways for cancer because this notion does not involve increased overall survival rates, which is their primary concern. However, the care pathway approach states that informing and involving patients *is* of importance in this field. Research into these matters also shows that when patients do get involved in choices relating to their treatment, they most likely leave it up to the professional to decide, and many patients experience this involvement as a stressor. On the contrary, when they do have request that oppose the streamlining of the process that is the care pathway, patients experience their wishes not to be granted easily, and instead they have to spend resources to fight against “the system” (Andersen-Holekim et al., 2021). Understanding user participation here is that of viewing patient choice as

integrated into the flow chart of the care pathway and user participation that require a pause in this streamlining of the treatment process is experienced as difficult. Understanding this process of streamlining and what occurs when patient request wishes that does not support this is also found in the shared decision-making approach in one outpatient clinic is examined in the third article that forms this PhD thesis. First of all, as previously discussed, mental health professionals believe that they integrate user participation when they offer an individualised approach to treatment facilitation. Secondly, when the question of patient involvement does occur, different strategies for not involving them further are employed. Both strategies are theoretically understood as coping mechanisms of either coping for the benefit of the patient (by providing correct patient treatment), or by not involving themselves in matters of increased work – that would come about as a result of granting wishes from patients – as a coping that moves them away from patients (and for the benefit of themselves). The occurring matters thus revolve around the professional maintaining professional jurisdiction and the autonomy to decide, and plan treatment without the interference of the patient, as the studies by Larsen and Sagvaag (2018, 2020) also show.

Even though streamlining and standardising are issues that the professionals within mental health care strongly oppose in the public debate, the third article that this PhD thesis explores shows how professionals within mental health care actually standardise and streamline the treatment process themselves and the issues that do occur when request that somehow interferes with this process. This aligns with the research into shared decision-making within cancer treatment too.

7.0 Conclusion

Arguably, the study of “the black box” (Brodkin, 2011; Hupe, 2014) is the study of what occurs in time between when a decision is made in an office, and how it is met at the street-level, that is, within the actual services. Opening this box has been the main motivation behind this thesis. With the title “lost in translation,” this thesis investigates how mental health professionals understand care pathways. The title indicates that the idea has in some ways gotten lost in translation during its construction. Indeed, as this thesis has demonstrated, the care pathways system has been rejected or lost in translation within clinical practice in the sample outpatient clinics. Even though these explanations seem rather simple at first, those of the associated phenomena are more complicated. Suddaby (2010: 15) asked the following:

If the central puzzle of institutional theory is to understand why and how organizations adopt processes and structures for their meaning rather than their productive value, then why has ‘meaning’ disappeared from institutional theory?

This thesis seeks to bring meaning back into the question, and shows the complexity involved when constructing and implementing new policies: the sense-making, the influence of the institutional context and the coping mechanisms used by the professionals during their workday that are demanding and negate their ability to ensure the availability and use of enough resources.

My ambition for this thesis was not to determine whether the implementation of care pathways is the right solution for issues within mental health care nor to take sides in the debate on how to organise the mental health services. Rather, my ambition was to observe what was happening from the outside. As seen from the critical realism perspective, by researching the actual level (the care pathways) at the empirical level, the domain of experience, meaning how actors (health professionals) relate to the care

pathways, I was able to view these levels in light of theory, and have hopefully provided insight into what is going on on the real level, namely, the structures and powers of this system (Suddaby, 2010: 15).

The contributions of this work are twofold, involving an empirical character and a theoretical character. The identification of how we can understand the construction of care pathways in the Norwegian mental health services is important for three reasons. Regarding its empirical character, this work gives thorough insights into the domain of mental health care in Norway. By researching this “black box,” I open up an understanding of how the actors on the frontline (mental health professionals in outpatient clinics) operate and deal with issues, particularly how they react to top-down ideas. This insight can hopefully be considered when and if further policies are to be constructed and implemented in this field.

Second, I have researched what arises when the ideas circulating in the macro field, such as standardisation, as a solution to issues relating to aspects like resources, end up guiding policy construction. The uncovering of these ideas and how they look in real life is crucial for future policymakers when coming up with new and hopefully better ideas for how to organise the health care services. The idea of translating best practices from other parts of the health care sector (as in this instance, cancer treatment) proved to be more difficult than was intended. This thesis reminds us that being context-sensitive to standardisation when attempting to copy them in other sectors is vital.

Third, the meaning, agency, and sense-making of mental health professionals within this process has been researched at several levels. First, the ideas from these professionals were brought forward during the construction of the care pathways. The idea had been to involve several different actors so as to produce a care pathway upon which they could agree and that would be aimed at the best and most efficient solution. However, this ideal was challenged by actors who were guided by institutional logic and whose main motivation was to discredit the idea of implementing care pathways in the first place. The final product became a negotiated solution based on guiding

values in their affiliated institutional logic. Furthermore, the concept of user participation, represented in this thesis as shared decision-making, highlights important measures that should be considered when trying to increase user participation in this field. There is a lack of consensus on what the term truly means, and agency could be considered given to the patients, instead of leaving this evaluation up to the professionals.

Theoretical contributions have been elaborated on throughout this thesis, including how the different approaches relate to and complement each other. The theoretical part seeks an explanation of the “real” level. The theories chosen have enabled me to elaborate on the complexity that the care pathways circulate in and how and why things have turned out as they have. The backdrop of the theory on standardisation allowed me to explain the macro level and why care pathways were chosen as an overall strategy through which to resolve some of the issues in the field of mental health care. An outlook into theory on institutional logic when explaining the forthcoming work, showed how the actors were guided by values belonging to their professional identity, which also guided their view towards care pathways. An intense media debate followed, in which the main motivation of professionals in the field was to discredit the idea of care pathways, which they believed was not to improve the services but rather to be more in control over the professionals’ work practices. This factor influenced the outcome of the pathway, which was originally based on a standardised product with an outlook towards diagnosis and EBM, transformed into a logistic pathway where the main actors were able to retain the core of their professional identity and how they believed work should be organised within an outpatient clinic.

When the implementation of the care pathways was examined within four outpatient clinics, the process was met with scepticism from the street-level bureaucrats responsible for its use. Distrust towards health authorities was analysed utilising theory on trust, where trust was seen as less dependent on street-level bureaucrats but was instead found within the institutional environment. Thus, trust was portrayed as *familiarity*, where the ongoing media debate guided their beliefs, which were still

preoccupied with the notion of control and a sense of distrust towards them as a unified group of professionals, and as a *calculated interest* that they did not perform their work as accepted. Furthermore, the *values and norms* analysed in the construction of the care pathways did not correlate. The trust perspective in this matter bridges the correlation between the construction and implementation by utilising institutional logic as the crossing point. By utilising this perspective on trust in combination with a CSM perspective, I was able to identify two cues that guided street-level bureaucrats and gave them reason not to involve themselves any further in the care pathways.

The theory of street-level bureaucracy explains how the street-level bureaucrats, in this case, mental health professionals, are responsible for how policy looks in practice and, as a result, become policy designers themselves. This theory also shows how coping could be portrayed as a matter of work practices that they believe move them either towards or away from patients. The data analysed show that street level bureaucrats do not see how care pathways benefit patients and that street-level bureaucrats consider engaging in this work as *moving them away* from patients. This finding could also explain why the professionals did not engage themselves more in the care pathways. The belief was strengthened by the additional administrative tasks – work that they believed did not benefit patients.

Finally, this thesis elaborated on the concept of user participation. The idea of increased user participation and research into the matter was particularly interesting as this was something that the different actors could all agree on from the outside; however, reports showed poor involvement when such actors were transferred to outpatient clinics. This part of the thesis also rested on the idea of street-level bureaucracy and their coping mechanisms. Moreover, shared decision making showed how the ideal of co-productive practices was challenged when politics met practice.

In this chapter introduction Suddaby 2010, said, *if organizations adopt processes and structures for their meaning rather than their productive value, then why has 'meaning' disappeared?* Policy construction and implementation is, as this thesis has shown, a

delicate matter that involves several actors who attach meaning to the phenomenon of care pathway differently, which in turns influence how they perceive new ideas and policies, as well as the outcome from the street level. This thesis has shown how the construction and implementation of care pathways in cancer treatment was portrayed a success, mainly because the care pathway approach aligned with how they prefer treatment to be organized as to benefit outcome for patients. Furthermore, to answer Suddabys question, the care pathway approach gave good meaning to professionals operating at the street level.

Even though mental health professionals strongly oppose standardization as an organizing ideal, the data reveals that they do standardize their own work in terms of treatment facilitation and work task. This becomes explicitly apparent when matters that interfere with their daily streamlining of work are often rejected. However, the care pathway did not give meaning to the professionals because they believed this meaning was attached to how the Government wanted to be more in control of the services, and not something that would benefit patients.

Taking this into account means to take this *meaning* back into organizational analysis, which I believe this thesis has showed.

7.1 Directions for future research

Regarding directions for future research, two areas of engagement have been identified.

First, when it comes to the perspective of institutional logic, I have not elaborated on if and how care pathways can change such a logic. Institutional complexity is, according to Fossetøl et al. (2015) for the most part handled by three general response strategies. First, the dominant logic can become the focus by repressing other types of focus (Greenwood & Hinings, 2006; Pache & Santos, 2010). Second, the organisation

could balance multiple types of institutional logic, and this navigation or balancing might be accomplished by separating the various types of logic and transforming into a “hybrid organization”, as termed by Pache and Santos (2013) and Jay (2013). Third, the ability of organisations to integrate different types of logic and produce hybridisation as a result can be realised. Mental health professionals have the opportunity to influence prioritisations, work practices and policies. If the logic changes, so will the prioritisations and their day-to-day work. Thus, care pathway implementation encourages more standardised work practices, and if this situation changes, then the institutional logic involved would be a fruitful way forward. Analysing how institutional complexity is handled in outpatient clinics has not been a part of my research but could be a productive area of further research into how care pathways can potentially change institutional logic.

Second, how street-level bureaucrats cope with increasing demands and workloads is particularly relevant within the field of mental health care. The constantly increasing number of patients being referred to clinics and the long waiting list reveals an imminent resource issue. This is one of several issues mentioned in the interviews with professionals in this study. How these issues influence work practices and prioritisation by street-level bureaucrats is one possible area of research. Moreover, how mental health professionals cope with this steadily increasing amount of work and constant reorganisations reveals how these workers often draw on the coping mechanism of “moving towards clients,” revealing a strong tendency among them to help their patients, even under stressful conditions. As Tummers et al. (2015) concluded, an agenda for future studies could involve looking for new theoretical, methodological, and empirical opportunities through which to advance the understanding of such.

8.0 References

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Notes

- [¹] Waiting time and patient rights; Karstensen and Håndlykken (2017).

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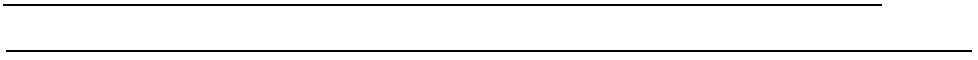
[5] National plan for implementation of care pathways Nasjonal plan for implementering av pakkeforløp for psykisk helse og rus 2018–2020 (IS-2734) (01.08.2022)

[6] Law on patient and users' rights (LOVDATA, 2022b).

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RESEARCH

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Organizing as negotiation: the construction of a pathway in Norwegian mental health services

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Abstract

Background: In 2015, a decision was made to implement clinical pathways in Norwegian mental health services. The idea was to construct pathways similar to those used in cancer treatment. These pathways are based on diagnosis and evidence-based medicine and have strict timeframes for the different procedures. The purpose of this article is to provide a thorough examination of the formulation of the pathway “mental illness, adults” in Norwegian mental health services. In recent decades, much research has examined the implementations and outcomes of different mental health sector reforms and services in Western societies. However, there has been a lack of research on the process and creation of these reforms and/or services, particularly how they emerge as constructs in the contexts of policy, profession and practice.

Methods: A qualitative single case study design was employed. A text and document analysis was performed in which 52 articles and opinion pieces, 30 public hearing responses and 8 political documents and texts were analysed to identify the main actors in the discourse of mental health services and to enable a replication of their affiliated institutional logics and their views concerning the clinical pathway. Additionally, ten qualitative interviews were performed with members of the work group responsible for designating the pathway “mental illness, adults”.

Results: This article shows how the two main actor groups, “Mental health professionals” and “Politicians”, are guided by values associated with a specific logic when understanding the concept of a clinical pathway (CP). The findings show that actors within the political field believe in control and efficiency, in contrast to actors in mental health services, who are guided by values of discretion and autonomy. This leads to a debate on the concept of CPs and mental health services. The discussion becomes polarized between concern for patients and concern for efficiency. The making of the pathway is led by the Directorate of Health, with health professionals operating in the political domain and who have knowledge of the values of both logics, which were taken into consideration when formulating the pathways, and explains how the pathway became a complex negotiation process between the two logics and where actors on both sides were able to retain their core values. Ultimately, the number of pathways was reduced from 22 to 9. The final “Pathway for mental illness, adults” was a general pathway involving several groups of patients. The pathway explains the process from diagnosis through treatment and finalizing treatment. The different steps involve time frames that need to be coded, requiring more rigid administrative work for compliance, but without stating specific diagnostic tools or preferred treatment strategies.

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Conclusions: This article shows that there is also a downside of having sense making guided by strong values associated with a specific institutional logic when constructing new, and hopefully better, mental health care services. This article demonstrates how retaining values sometimes becomes more crucial than engaging in constructive debates about how to solve issues of importance within the field of mental health care.

Keywords: Clinical pathway, Mental health services, Standardization, Autonomy, Discretion, Health profession, Institutional logics

Background

Most Western countries are struggling with the rising cost of health care services. There is a common view that better organizing these services is the answer to the issues of lack of resources and increased demands [1]. This context reinforces an ideology of increased monitoring and transparency, where management is given more power to ensure that hospitals are better controlled and more predictable [2–4]. These elements all lead to standards and standardization being proposed as solutions [5, 6]. Organizing health care services through standardized clinical pathways (CPs) occurs in several areas of Norwegian health care, with the implementation of CPs within cancer treatment as the largest national introduction of standardized service production [7]. The European Pathway Association (EPA) defines the standardization of care processes into CPs as “a methodology for the mutual decision making and organization of care for a well-defined group of patients during a well-defined period” [8]. The method defines goals and decision making on which measures to include in the treatment. The measures should reflect evidence, best practice solutions, and the involvement of the patient [9, 10].

More than once, politicians have been accused of not prioritizing mental health, leading to waiting lists as well as an eminent capacity and resource problem.¹ Furthermore, over recent decades, Norwegian mental health services have met with much criticism from professionals and patients within the field [11]. This has led to a debate regarding the organization of mental health care. Often polarized viewpoints circulate around terms of efficiency and/or care, user participation and/or medicalization [12, 13]. This battle regarding the organization of health care services is often presented in the literature as disputing logics that influence health care practices in different ways. These logics contain a particular set of behaviours, rules and norms and function as guiding principles for the actors inhabiting them [14–18]. In January 2016, the Ministry of Health and Care Services officially assigned the production of several CPs in mental health services to the Directorate of Health [19] CPs in somatic medicine

were imported from Danish health care, raising a desire to copy pathways in mental health services from Denmark as well. The CPs in Danish mental health services had an outlook on diagnosis with strict time frames and different standardized manuals to follow, thus influencing discretion and autonomy of individual professionals [7].

The analysis provided in this article builds on the different views of the main groups of actors and interpretations of CPs within the field of mental health services. Understanding the logics and its affiliated values is vital when analysing the process that led to the final product [20]. Elaborating this issue further leads me to the following research question.

How do actors in the field of Norwegian mental health services interpret and understand the concept of CPs, and in what ways did this affect the construction of a pathway? This article starts by elaborating the main actors in the field of mental health services before discussing the current elements of what constitutes a preferred way of organizing health care services today. Professionalization and its discretionary activities contrast with scientific bureaucratic medicine. In enabling an explanation of the different actors’ understanding of CPs, I present theory on institutional logics to show how different values associated with a logic influence the actors’ sense making and interpretation of a CP. In the methodological section, I show how a case study in combination with discourse analysis enables me to categorize my textual analysis into two main institutional logics. The analytical part explains how the pathway became a complex negotiation process between the two logics and where actors on both sides were able to retain their core values. Finally, this paper concludes that deliberative policy making has a pitfall when the agents responsible for the construction is guided by values belonging to different institutional logics, because withholding these causes polarization of the debate, potentially influencing the final product negatively.

This paper’s contribution, is twofold. By examining the development of a new policy, I offer a supplementary approach for those studying health organization and implementation [21]. As Dobson [22] highlights, the unconscious use of linguistics by the enactors of policies becomes a reflection of their social worlds. By elaborating

¹ The Norwegian Directorate of health, official statistics, mental health care.

this concept, I wish to demonstrate that the different values of different actors influence the implementation of policy development. Furthermore, I extend the literature on CPs by researching issues other than their use in an individual care setting as well as broadening an understanding of institutional logics' empirical expression. Johansson and Waldorf [23] point to the lack of studies on how actors use multiple sets of expectations to cope with an environment at the intersection of several institutional fields. Conclusively, they encourage researchers utilizing institutional logics to "know much more about the informal organization, the chaos and the 'muddling through' [24], in decision-making processes, and the actors' tiring negotiations and power struggles". This article aims to answer these calls.

The field of mental health services in Norway

Mental health services as a field encompasses many actors, and the field encounters ongoing criticism from different perspectives [11, 25–31], Norwegian mental health services is no exception. As the field of mental health services with its actors does not anticipate shared meaning [25–31], this paper utilizes a more practical definition by DiMaggio and Powell [32] that suggests that a field is "*those organizations that, in the aggregate, constitute a recognized area of institutional life: key suppliers, resource and product consumers, regulatory agencies, and other organizations that produce services or products*". Furthermore, they concede that the struggles to write the rules and control the resources are all a part of the construction of an organizational field [33]. Finally, fields become centres of debate in which competing interests negotiate issue interpretation [34].

In Norway, mental health services are a part of the welfare state that aims to provide care and help to inhabitants in need of it. The key terms in the welfare reforms of 1980 were "normalization" and "autonomy", leading to a deinstitutionalization of mental health services, meaning that people suffering from mental disorders received health services where they lived. These ideas were collected mainly from user movement groups reflecting ideologies of recovery [9]. The concept of recovery is debated, but overall recovery can be viewed as a phenomenon including social processes and everyday practices in mental health care. The focus is on society, living conditions and social processes. Home, work and activity as well as education, money, friends and community all play a role in the recovery process [35, 36].

These tendencies brought forward "The escalation plan for mental health care", a large-scale political reform from 1998 to 2008 built upon White paper no. 25, "Openness and wholeness: a report on mental

health care and services". The reform and its overall goals were described in government proposition no. 63 (1997–1998) [37], and the reform aimed at quantitative and qualitative improvement of the services and was built upon values emphasizing independence, autonomy and the ability to master one's own life. Furthermore, sectors and service providers were encouraged to establish networks across sectors and administration levels.

This focus on recovery was further emphasized in the establishment of drug-free services based on requirements from "The Joint Action for Drug-Free Services," I 2011, which is an association of the organizations National Association for Relatives in Mental Health (LPP), Aurora Support Association, Mental Health, White Eagle, and We Shall Overcome (WSO) [38]. In 2015, a letter from the Minister of Health was sent to each regional health enterprise demanding the establishment of drug-free mental health care services by 1 June, 2016 [39] thus providing patients with an increased ability to influence their own treatment. The aim was to further empower patients in the field and reduce the use of coercive measures.

Despite the focus on recovery and users, Ekland [40], in his review on Norwegian mental health services, shows that despite the action plan [37] in which the government tried to involve the user perspective [37, 40], there exists a hegemonic position within mental health services that leans towards medicalization and a bio-medical model as well as increased psychologization, with the cause of the problem being placed within the individual instead of examining structural issues like social support [30, 40].

Furthermore, numerous reports have found weaknesses regarding challenges in the organization and execution of treatment within Norwegian mental health care [41–44]. A common conclusion from these studies is a lack of equal services, standardization and quality of different service providers in different parts of Norway.

The field of mental health services examined in this paper circulates around three different groups of actors: 1. politicians deciding and executing mental health policy, 2. health professionals and patients operating in the field, and 3. user and interest groups aiming to improve different psychiatric services. Moreover, within the field, we find both organizations and individuals who inhibit the prospect of expressing logics, values and perspectives that potentially influence patients and organizations as well as the field in general. Furthermore, different health professions base their logics on what psychiatric illnesses are and how to treat them from many angles, ranging from dedication among

doctors believing in the use of medication to improve an unbalanced brain to social workers believing in peer support and care, representing the other side of the spectrum.

Professionalization in mental health care: discretion and autonomy as core values

Professionalization in health care is often referred to as discretion practised autonomously by an individual practitioner or professional group [45]. Professional actors do not follow their own selfish interest, as their profession is developed to solve problems and/or issues for the better of society. Therefore, their ethics is based on the needs of the client [46], and professional groups define performance standards as well as ethical codes for their members in accordance with thorough training [47–49]. The “power” of a profession includes the identification and safeguarding of the content and practices of its work [45, 49]. Furthermore, Freidson [50] concludes that autonomy and discretion are more important than professional knowledge and expertise because upholding autonomy is the only way a profession can secure control and protect its standards, autonomy and discretion [45].

Further, he [50] argues that professionalism is an ideal type of organization of work (or what he terms “a third logic”), where health professionals act as mediators presiding over the interests of the state by serving the needs of the public and demands of patients [51]. The arguments above all rest on the idea that professional knowledge should be valued in such a manner that health professionals have the freedom to execute their work without further external restrictions [51].

Although health professionals within the field of mental health services believe in their own discretionary evaluations and behaviour, few studies have proven their abilities. A pioneer in this field was Meehl, who in 1954 wrote the book *Clinical versus statistical prediction*, in which he compared clinicians’ discretionary activities and simplified mathematical formulas. His conclusions clearly indicated that experts’ evaluations were poorer than even the simplest mathematical model. The same conclusions were enhanced in 1998 by Garbs in “*Studying the clinician*.” Here, he performed a thorough examination of research on the connection between the experience and quality of clinical discretion within the field of behavioural analysis, psychological diagnosis and evaluation of personality and psychopathology. Since then, hundreds of studies have been performed that compare professionals’ discretion and statistical, linear models and reliable outcomes; however, the correlations are weak and/or non-existent on the discretionary side [52, 53]. This lack of linear significance has been explored by many researchers, including

Hoghart [54], Kahneman [55], and Kirkeboen [53]. A common understanding of the phenomenon is the lack of evidence-based frameworks for understanding individual behaviour as well as different biases in cognitive interpretations of the world [53].

However, despite the evidence against relying too heavily on discretion, health professionals within this field believe in their professional abilities to make correct evaluations and judgements. There could be many reasons for this, such as threats against one’s professional self, economic reasons and common myths about professionals’ discretionary abilities [53]. Furthermore, this article shows that one such explanation is withholding values belonging to an agent’s professional identity.

Scientific bureaucratic medicine

Scientific bureaucratic medicine is a term from Harrison and Ahmad’s [56] research on care pathways and its following guidelines. It is called “scientific” in the sense that it draws on the accumulated evidence of large-scale research and “bureaucratic” in the sense that it translates the output of such research into a particular species of bureaucratic rule for application in medical care organizations [56]. The concept could be understood scientifically in light of evidence-based medicine (EBM) and bureaucratically in light of new public management (NPM).

EBM is grounded in best practice solutions, guidelines, protocols, and checklists for standardizing procedures in the belief that it is the best way to reduce unwanted variation in diagnosis and treatment [57, 58]. In the Norwegian context, EBM was introduced in 1995 and institutionalized in 2004 through the establishment of the Norwegian Knowledge Centre for Health Services [59].

EBM has found an ally in NPM, a concept motivated by increased efficiency as the desired outcome and inspiring public reforms across the Western world [2]. The focal point is adopting market-based models aiming at a broad focus on performance measurements and control measures within the public sector, to be monitored at the political level [2]. Within health care, NPM has been an international trend during the last three decades [60–63], and the implementation of performance-based financing in Norwegian somatic hospitals in 1997 and within mental health services in 2017 were two of several NPM ideas within health care [5, 60–64]. However, despite the influence of NPM and EBM in public health care, there are huge differences in understandings and opinions of these concepts, placing them as conflicts between core opposing values such as care and quality treatment versus financial objectives [64, 65] and, furthermore, between professional and political work [66, 67].

Table 1 Data sources

	Articles and opinion pieces (Aug. 2015–Nov. 2017)	Public hearing responses to clinical pathway	Political documents and texts	Interviews affiliated with “the work group”
The government	8		5	
Health professionals	33	15		Psychiatrists: 2 Psychologists: 2 Psychiatric nurses: 2
User groups & special interest organizations	11	15		2
Directorate of Health			3	3

Institutional logics

The foundational work on institutional logics is viewed as “organizing principles” [68]. Fundamental to this perspective is the belief that the interests, identities, values, and assumptions of individuals and organizations are embedded within prevailing institutional logics [69]. Thornton and Ocasio [70] define institutional logics as.

“the socially constructed, historical patterns of material practices, assumptions, values, beliefs, and rules by which individuals produce and reproduce their material subsistence, organize time and space, and provide meaning to their social reality”.

Despite the fact that an institutional logic consists of several elements that the actors utilize when making sense of the world, there is an understanding that this sense making consisting of assumptions, beliefs, rules and material practices is based on values. This makes.

“...value central to an institutional logic: a presumed product of its prescribed practices, the foundation stone of its ontology, the source of legitimacy of its rules, a basis of individual identification, a ground for agency, and the foundation upon which its powers are constituted” [71].

Institutional logics influence actors’ sense making when they identify with the collective identities of an organization and/or profession [69, 72, 73]. Within professional fields, professional logics offer the identities through which professionals make sense of who they are “Professional role identity is enabled and constrained by the institutional environment and provides interpretations that professionals adopt” [74]. The relationship between institutional logics and identity is recursive—each shapes the other, institutional logics give identity to those who share them, and those who share identity mutually reinforce their shared logics. Identity provides the link between the field-level meaning, institutional orders, and the sense making of individual human actors [68, 69, 75–77]. In and between different situations encountered

by actors, they activate a variety of social identities based on different institutional logics [78]. Johanssen and Waldorff [23] examine how research within this domain of institutional logics has had a tendency in the empirical expression of logics to lack a common ground for operationalization, see e.g. [79, 80]. Studying how actors in the field of mental health services engage in a negotiation process can provide empirical insight into how an operationalization based on Thornton and Ocasio’s [70] initial definition expresses itself.

Methods

Data sources

To understand the making of a pathway in its context and how the different actors make sense of the phenomenon, a methodological outlook through a case study is fruitful [81].

Text and documents

First, the written material in the public realm of CPs in mental health services is analysed. This process involves examining chronicles, political speeches, documents and hearing responses as well as the pathway. A more specific overview of the texts and documents can be found in Table 1, Data sources. This part of the analysis focuses mainly on identifying institutional logics.

Qualitative interview

The interview data come from ten in-depth interviews with members of the work group designated by the Directorate of Health to compose the “pathway for mental illness, adults”.

Selection and recruitment

The informants were found via the Directorate of Health web page. The interviewees were strategically selected based on Creswell & Creswell 2018s criterion of optimal

Table 2 Clinical pathway and institutional logics

Characteristic	Mental health professional/ patient logic	Political logic
Material Practice	EBM & standardization interfering with discretion, making it hard to provide correct patient treatment	CP secures correct and best practice execution of services
Assumption	CP is unsuitable for Mental health care services because each patient needs individual care	CP is the solution to capacity problems, unwanted variation, and inefficient treatment
Values	CP collides with discretion and autonomy	CP secures control, efficiency and quality
Beliefs	CP is only concerned with efficiency and cost reduction, making patient care and recovery harder	CP will improve the services
Rules	CP opposes professional values: Humanity (patients), care (services), knowledge and autonomy	CP requires rules and standards to be monitored and controlled

variation [82] so that actors from different professions as well as the perspectives of patients and user groups were included. To control for variations in personal opinions [83], interviews were carried out with two representatives from equal backgrounds where possible.

The execution of the interviews

The interviews were collected between August and October 2018, took place either over Skype or face to face, and lasted between 40 and 60 min. The informants were asked about their own ideas of a CP, what they thought about it initially and the result. In addition, I asked them about the process of making the pathways, such as differences of opinions and whether there were any power imbalances in the group. Furthermore, they were asked to provide a brief account of what they considered the greatest challenges within mental health care and to what extent the CPs improved these elements. All the interviews were taped and transcribed.

Ethical issues

Furthermore, approval for the project was provided by the Norwegian Centre for Research Data (NSD). The gathering of data followed the ethical guidelines of the NSD, including obtaining written informed consent for my interviews and explaining the purpose of the study. The documents were sent by e-mail before each interview.

Analytical strategy

Discourse analysis

A discursive approach is a choice when one wants to perform an in-depth, methodical analysis of a specific phenomenon. The term discourse covers the basic idea that language is structured in different patterns when we interact within different social domains [84, 85]. Discourse analysis is not just one approach but also a

series of interdisciplinary approaches that can be used to explore many different social domains in many different types of studies [85]. When linking a certain discourse with a certain expert community, it is not simply a question of a particular group of experts having a common set of goals and language; it is what the experts want and know how to impose on the audience [86].

Identification of the institutional logics

To understand a field's belief system and practices is a complex process, I follow the examples of Reay and Hinings [17] and Scott et al. [14] by examining indicators that identify the different actors' logics, meaning to look for similarities in the expression within the already established elements. These are material practices, assumptions, values and beliefs based on Thornton and Ocasio's [70] definition of institutional logics and how they unfold in the context of the the idea of a CP.

The operationalization of the logics consists of elements that enable a structured coding of the written material. NVivo (qualitative data analysis software) enabled me to categorize my material in a structured manner. Later, I reread the material and looked for patterns that enabled replication. In this part of the analysis, I was able to identify three main actors. However, it was clear that the overall and generalized values, assumptions and beliefs about a CP were shared by health professionals working within mental health care as well as user groups. Therefore, during the analytical part, the user/patient perspective is merged into one, enabling a comprehensible reproduction of the textual analysis. A complete overview of this analysis is shown in Table 2. "*Clinical pathway and institutional logics*".

Results

This part of the paper seeks to provide a thorough examination of the making of the pathway in Norwegian mental health services. The Directorate of Health established

an external work group in 2016, aiming to finishing a process and evaluation plan to be delivered to the Ministry of Health and Care Services by 1 April the same year. Shortly after, work groups for each pathway were established. Each work group consisted of professionals in the field as well as patients and their affiliated organizations and unions. During the process, different conferences were arranged where agents provided expertise and relevant actors were free to state their opinion. In addition, the pathways were sent out for public hearings [19]. Originally, the pathways were intended to be implemented in September 2018; however, delays brought them to life on 1 January 2019 [19, 87]. After the prime minister, Solberg, announced the reorganization of mental health care services into CPs in 2015 [88], a tense media debate regarding mental health treatment and service organization occurred. This media debate is followed in the first part of the analysis, where the main goal is to identify each group's institutional logics and the values affiliated with them. The second part of the analysis examines the process as well as the final result.

The media debate

Shortly after the prime minister announced the plan to implement CPs in Norwegian mental health services in 2015 [88], a tense media debate arose [19, 87, 89].

The debate focused for the most part on the negative effects standardization potentially has on individual care and treatment. A common view was an expectation that the pathways would be copied from Danish health care and somatic cancer treatment, leaving out much of the discretion and autonomy of each individual provider, elements that were characteristic of treatment facilities when the idea was launched. The criticism from health professionals was met by politicians with a promise to listen to both professionals and patients but without changing their ideas about implementation. The debate, however, shed light on the different groups' institutional logics, and a more detailed analysis follows.

The political logic: the CP as the solution to issues in mental health services

Recent years have revealed issues of capacity within mental health care, and in accordance with NPM- and EBM-inspired beliefs within the political logic, increased control and standardized measures could be solutions to some of these issues. The wish to implement CP in mental health services was hailed as an approach that could improve these services and the issues they face when Prime Minister Solberg first elaborated the idea in 2015 [90]:

“We will make a radical grip to make diagnosing

and treatment of mentally ill patients faster, better and more predictable. We will introduce clinical pathways into mental health services.”

There is a firm belief that this way of organizing health care services leads to more efficient services. Standardization is the preferred strategy for achieving at this goal. This is further explained by Minister of Health Høie [91] when he states:

“The methodology behind clinical pathways is about standardizing the patient's services with two main objectives: to reduce unnecessary waiting time and to secure that everyone gets the best possible treatment.”

Furthermore, CPs combine EBM with NPM, making the concept belong to the idea of scientific bureaucratic medicine. This form of medical logic is based on and promotes the values found within political logics, namely, efficiency, quality, and control.

Political logics values of efficiency, quality and control

These values function as cornerstones in several issues regarding governing public health care, and in relation to mental health services, where these issues have been frequently discussed, there is an almost taken-for-granted assumption that control and standardization, namely, through CPs, are the solutions. This comment from Prime Minister Solberg [92] emphasizes this assumption:

“Clinical pathways in mental health services would lead to less discrimination by implementing standards for the content in the examination of and treatment strategies for the patient as well as more predictability for the patient with timeframes for the different steps.”

Control, efficiency, and quality guide arguments on how and why CPs are the best way to organize mental health services. The way to control the services is by outsourcing responsibility that can be monitored and thereby controlled by the political level. This will hopefully lead to better quality and efficiency, as is stated explicitly by Minister of Health, Høie [93]:

“Clinical pathways will not only provide patients with more predictability but will also give practitioners in the different parts of the services more predictability. They will clarify what responsibility the different practitioners have during examination and treatment.”

There is a conspicuous absence of a softer language associated with work in this field. Compassion, trust, and

care are all important in regard to understanding work within a mental health institution and are often utilized through discretion or autonomy. However, these elements are more difficult to quantify and standardize and are thus much left out of the discussion on CP at the political level. Conclusively, the different beliefs, assumptions and material practices found in this institutional logic come from the core values of efficiency, quality and control as the drivers of the CP.

Health professional logic and the conflict between standardization and individual care

The overall assumption within this logic is that CPs are unsuitable because each patient needs individual care, making standardized practices unsuitable for patients within the field of mental health. Individuality is closely linked to discretion and what psychiatrist Aare and Mehdi [94] pinpoint in their chronicle *The house of cards that collapses in mental health services*:

"It's about time to fight for the patient's right for individuality and professionals calling to be professional"

This individuality is further emphasized in the overall debate as something that characterizes patient treatment within the field, and there is consensus that individuality, and not equality, is something that characterizes good patient treatment. The way the CP unfolds from the outlook of health professionals is portrayed as something generally negative and what Doctors Vogt and Pahle [95] state in their chronicle: *"Equality on assembly line"*:

"The government wants to standardize mental health care in clinical pathways and sells it as equal treatment. The basic idea of what it means to help is at risk. Clinical pathways belong more to Toyota than humane mental health services..."

The rationale behind CPs is believed to be the same as that behind NPM, efficiency and cost reduction. This brings forward an assumption of concern with either efficiency and cost reduction (political level) or patient and care (health professional level), leading the debate into polarization. The polarization originates from professional beliefs in discretion and autonomy as the ideal way to practise mental health care.

Values: the CP interferes with discretion and autonomy

The number-one guiding value in a health professional logic is discretion, closely followed by autonomy. An overall understanding of the public debate made visible that withholding these values in the making of the pathway was of vital importance. The consequences of losing

their discretion are addressed by psychiatrist Aare and Mehdi [94];

"The values that form the basis for the patient's health service are not compatible with clinical pathways. In the worst case, they are making new rules on how patients and practitioners should organize themselves. Rules that take away their freedom and creativity"

The fear of losing their freedom in terms of executing treatment and providing care is in accordance with Freidson [50], who elaborates how health professionals secure control and determine their standards by protecting autonomy and discretion [50].

"What are the core values behind clinical pathways? Control! Control over professionals, and a system one experiences as uncontrollable, cost reduction and efficiency, efficiency, efficiency!"

The above quotation from the two doctors Pahle and Vogt [95] further enhances the protection of boundaries by discrediting the opponent's values as being unconcerned with patients. The polarization of the debate is, namely, done by agents of the health professional logic, and the arguments are centred around how a focus on efficiency means being concerned not about patients but about cost reduction. Health professionals view standardization as incompatible with individual adaptation and flexibility, a major part of their work practice.

When standardization meets individualization, the user perspective meets political values

Anne Grethe Teien, a former patient, responds to the post from Tove Gundersen in *"Dagsavisen"* [96]. She warns that CPs based on different standardized package solutions make user participation more difficult as the patient only gets to choose from the treatment involved in the CP. She fears that CPs will move mental health services in the opposite direction because of the standardized approach. *"It would be nice, after all the talk about the importance of user involvement, if knowledge from experience, help on the premises of the patient, etc., finally started to show up in real life"*

Keeping an individualized perspective while at the same time standardizing elements meet some challenges, as is expressed in the above quotation. However, the rhetoric that this is indeed possible exist in the political domain and is further expressed by Prime Minister Erna Solberg in a speech at a meeting at the National Center for Experience-based Competence in 2015 [97]. In her speech, she talks about an increased focus on user-driven

mental health services and medication-free services for patients to choose from. She states:

“We have to stop asking the patients: what is wrong with you? We have to start asking the patient: What is important to you? Listening to the patients also means listening to those who want medical-free services.”

Despite the promise that the CP will take the patient’s wishes seriously, she also, in the same speech, claims:

“Clinical pathways will ensure that the services provided are based on the best evidence-based practice for the disease.... This involves clear deadlines for the different steps in the treatment....This will give more equal treatment despite geography and different institutions.”

The ideas of standardization and individualization clearly collide between the different groups of actors’ logics, and interpretations of what they mean and how they materialize as practices within mental health care. The final result was transformed into something quite different than the pathway around which the public discussion circulated. Understanding this process means examining the work of those designating the pathway “Mental illness, adults”. However, this process is influenced by the values and institutional logics of the different groups, as is shown when analysing the work process leading up to the final product. A complete overview of each group’s institutional logic and their relations to CPs is found in Table 2.

It is obvious when looking at the table that the two actors relate to pathways differently and that their sense making is guided by already established values, assumptions and rules to be found within their professional identity. How each logic has influenced the final product and the making of the pathway is elaborated in the next, and final, part of the analysis.

Organizing as negotiation: the directorate of health as a mediator

The conferences

Thornton and Ocasio [70] remind us that actors in the field are strongly guided by values in their way of viewing their world and in their organizing of time and space. When taking this into consideration, the process of making a pathway means creating an arena to which the different groups bring their own institutional values and ideas. Furthermore, the work groups could be viewed as an informal negotiation arena in which the logics of professionals and politicians meet. The actors’ acceptance of these logics creates leverage in the informal “negotiation.” When pursuing an understanding of the making of the

pathway, the issue of identification is of vital importance. In social situations encountered by the actors in the field, they activate a wide variety of social identities from different institutional logics [78]. Actors who work in the Directorate of Health are operating in the field between health professionals executing their daily work and politicians deciding on different health care policies and strategies. Identification is therefore based on different institutional logics. Furthermore, this gives them unique knowledge of both institutional logics. This sense making enables them to know which elements are negotiable and which are not.

“When we first got the assignment from the ministry, we thought, Well, if clinical pathway is an answer to a question, then what is that question?”

The following quotation from a health professional working in the Directorate of Health shows the start of a “muddling through” [24], the process where negotiation occurs and where the different logics, values, and assumptions clash, affecting the making of and final result of the pathway. Furthermore, it shows how the Government wanted to transfer the idea from somatic health in a new area without thorough knowledge of the mental health care field. Shortly after the Directorate of Health was given the assignment by the ministry, conferences with different professionals working within mental health services were arranged. The agenda and motivation behind the meetings were to provide a space where ideas concerning organization of mental health services, and pathways were to be discussed. Based on mental health services’ heterogeneity, these conferences often led to heavy discussions and disagreements on how to provide the right kind of treatment. However, this did not happen at the conferences where the content of the pathways, and organization of mental health services were to be discussed. This is what one user group representative recruited to the work group had to say about the themes that were discussed at the conference:

“People at the conferences were completely agreeing. That was something I found interesting because normally there are big disagreements. The participants all repeated the same message: ‘We cannot have diagnosis-specific treatment as they have in Denmark....’ Before it was decided what kind of pathway we should make, we found out that we had to bend the order from the department. The order from the department said that the pathways would be organized around diagnosis. We bent it by putting several diagnoses into the same pathway.”

The above quotation indicates how guiding health professional values such as discretion and autonomy are

within this professional logic. *It is expected that institutional logics affect organizational decision making by steering the attention of decision makers* [98]. This attention was steered towards a common goal where the focus centred around protecting professionals' values and boundaries. The conference could have been an arena in which the different actors actively involved themselves in discussions regarding the issues mental health care services face today, and different solutions applicable. However, as the informant stated above, this did not happen. The protection of values is aligned with Friedland's [71] research into how values are the foundation of the ontology and something that guides overall sense making [71]. An explanation for the phenomenon could be that withholding values of discretion and autonomy is more important because the clinical pathway is experienced as a threat to their work. This made the discussion around the CP circulate around the themes of CPs and their inappropriateness in mental health services.

The work group

The work group also appeared to function without much of the disagreement that normally occurs when different actors in a heterogeneous field come together. This is explained by a psychiatrist in the work group:

"The work group functioned really well. Everyone was heard, and there were no big conflicts. Not that we just sat and played along, but there were no big contentious issues. There was not anything to be discussed that the members were really disagreeing on."

Another health professional in the work group said:

"Everyone was heard; everyone was listened to. Nothing like what is happening in meetings in (mental health services red.) real life"

This shows the unfolding of the subtle negotiation process, and a possible interpretation is that the Directorate of Health had already made sure to rule out disagreements by organizing the pathways in such a manner that discretion and autonomy were withheld, showing that part of the negotiations where the importance of retaining each logic's values was handled by the directorate. Considering this matter, a psychiatrist in the work group answered as follows when asked how much the members of the work group were able to influence the making of the pathway:

"We had received a template that was a bit like the cancer pathways. Like what titles to fill in, and we were made clear from our first meeting that this was only logistics, and this was repeated through the process. And I think many were surprised about that."

We started out thinking that we were there to recommend what diagnostic tools to use, but we were wrong. We were not allowed to recommend anything concrete."

Despite accommodating health professionals' values, it was well known to the members of the work group that this was part of a negotiation process and that not all of their needs would be accommodated by the Directorate of Health.

"The government wanted something in return. I understood that immediately. And then they need something to evaluate; there must be some codes involved. And we must remember the coding, and that is the challenge. I really do not understand how we are going to make it work"

The coding and the extra work related to it was an overall concern as well as a cause of general discontent among most of the professionals in the work group, and the above quotation from a psychologist indicates in stating that "they wanted something in return" that this was a negotiation between the two logics. Furthermore, it shows that the needs of the political logic for rationalization and control are well known to the professional logic. In addition, the need for control of health professionals' work is expressed as a burden for the actors involved, and the frustration over this is clearly expressed in the above quotation. Pursuing this from the perspectives of different values, the quotation also indicates the polarized view on the values behind a CP. Control for a political logic means efficiency and better services for patients. Control for the health professionals' logic means losing time that could be spent on patient treatment and instead using it on administrative tasks. However, the codes involved do not directly interfere with discretion, meaning that individuality and flexibility in terms of treatment are not lost, so their core values are still intact.

One of the main issues regarding CPs, from early on and to date, is the term and the issues associated with the idea of a CP. A CP is a way of organizing services within somatic medicine, and cancer treatment is one of them. Moreover, the elements of standardized work practices and EBM provoke actors in the professional logic, as they collide with the core values of discretion and autonomy. However, for the political logic, the name CP indicates success, as it has been proven to reduce waiting time and unwanted variation and is more or less portrayed as an achievement [99]. The name "clinical pathway" legitimizes political will and action in the field of health care services. The name is also misleading because the clinical aspect of the pathway was lost early in its making. Some

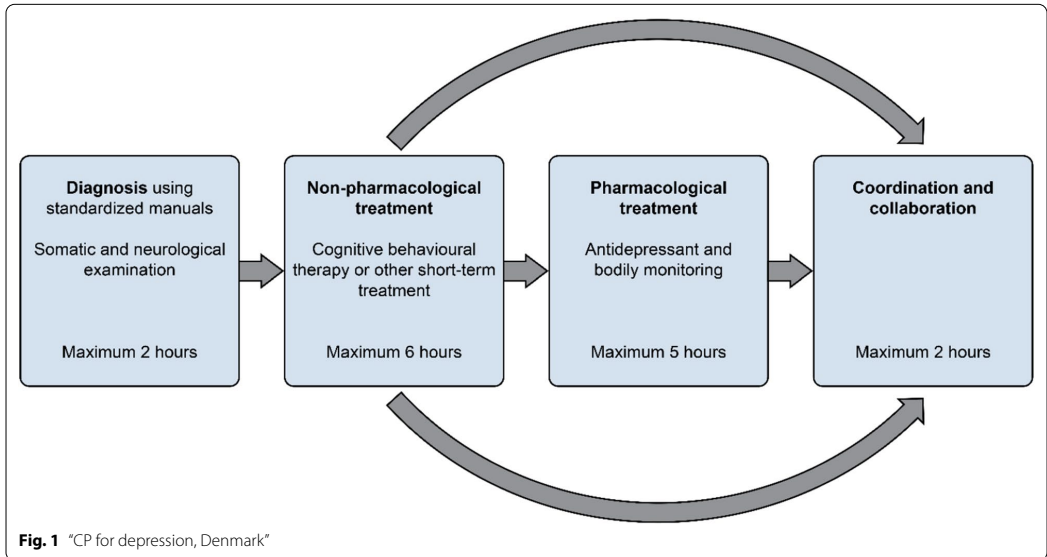


Fig. 1 “CP for depression, Denmark”

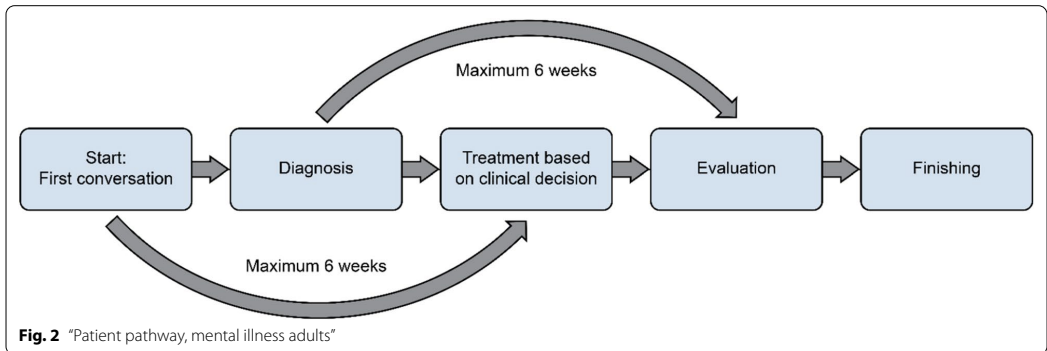


Fig. 2 “Patient pathway, mental illness adults”

of the critique from actors in the field of mental health services could possibly have been avoided by naming the pathways differently and leaving out the negative connotations that these actors associate with the name. However misleading the name was, it was not for sale:

“It was not our call to decide the name of the clinical pathways. It was given. So... there has been quite a lot of resistance to it. We addressed this with the ministry. The ministry is familiar with these issues, and they have been for some time. They kept the name ‘clinical pathway’; it was not our call to make”.

The quotation from a health professional within the Directorate of Health also indicates the possibility that the department knew “how to choose their battles”. The name was not something to fight for, as this did not interfere with the issues in the conflict regarding CP suitability in mental health services. The name, however, caused much unwanted noise, as its connotations caused the professionals to feel threatened long after their autonomy and discretion were safe.

The final product: from CP to logistic pathway

At the time of implementation, the number of pathways had been reduced from 22 to 9. As the idea of having

diagnosis-specific CPs based on EBM with standardized practices copied from the Danish model, such as Fig. 1 “CP for depression, Denmark” illustrates, the outcome had moved far off the original intention.

The final result of the “Pathway for mental illness, adults” is utilized to treat depression, and became a general pathway involving several groups of patients. Within this pathway, all patients belonging to the same service area are generalized, making the pathway a description of the services. The pathway explains the process from diagnosis through treatment and finalizing treatment. The different steps involve time frames that need to be coded, but without stating which diagnostic tools should be used, nor does the pathway explain preferred treatment strategies for the different diagnoses. Figure 2 “Patient pathway, mental illness adults” illustrates the general pathway for treatment for adults.

Finally, the pathway is guided by five overall goals: 1. increased user participation and satisfaction; 2. coherent and coordinated patient pathways; 3. avoidance of unnecessary waiting time for diagnostication, treatment and follow-up; 4. more equal services despite geographical location; and 5. improved focus on somatic health and lifestyle. The overall goals were meant to be guidelines for the implementation strategies. Furthermore, the pathways change professional work practices by imposing a more rigid system of documentation and coding of the different steps, involving a more bureaucratic system. This documentation makes the time spent by health professionals per patient in their daily work more transparent, and enables it to be monitored by the political level, but without touching professional discretion and autonomy. The pathway in the matter of the previous discussion therefore ends up being a product negotiated from the values presented in the institutional logics.

Discussion

The analytical discussion also shows the downside of having sense making guided by strong values associated with a specific institutional logic. It seems to be an almost taken-for-granted way of viewing how a certain health care service should be organized without questioning whether this is, in fact, the best solution. Those at the political level assumed that transferring successful ideas from other hospitalization services could be easily done, but without having a thorough knowledge of the field. They did not adopt a context-sensitive focus on understanding the nature of the problems and how they might be solved, which is considered a condition for appropriate problem solving [100, 101]. Therefore, a thorough understanding of the field and the mission is essential for every decision maker’s competence. In the case of mental health services, this involves understanding empathy for

patients and health professionals’ work, respect for professional knowledge, responsibility for limited economic resources and social trust [100].

Furthermore, although health professionals guided by their values, namely, discretion and autonomy, have a thorough knowledge of the field and its weaknesses, it seems that retaining these values is sometimes more important than actively involving themselves in the debate regarding the negative aspects and issues of the current organization of mental health services. According to Argyris [101], in Falkenstrøm et al. [102], how a certain problem is defined and solved may be the cause of the problem. Therefore, it is necessary to question the underlying assumptions and principles and seek a broader, more dynamic, and critical understanding of the problem. This way of learning and viewing things differently implies a change in the mental model that forms the basis for decision making [101]. Nevertheless, a review of theory on institutional logics shows that a change in a mental model means opposing values forming strong identities, and in the quest for a new perspective and understanding, one could possibly end up losing one’s professional identity.

Conclusively, CPs are understood in a polarized terminology by health professionals, where being concerned with efficiency means not caring for patients, and the public discussion regarding mental health care became a battlefield where their main motivation was to discredit the idea of the CP and its suitability in mental health services instead of engaging in what could possibly have become a more constructive discussion.

Conclusions

This article provides a thorough examination of the making of a new health reform in Norwegian mental health services: the idea of a CP in Norwegian mental health services from 2015. This article sheds light on some of the issues that occur in the making of new health reforms. In the health care field, different actors interpret the ideas of the CP differently, bringing the values and assumptions associated with their institutional logics to this understanding. In the ensuing alternation, a negotiation process occurs where the guiding values decide what elements that are up for negotiation. Within the professional logic, the values of autonomy and discretion are not for sale, and this is accepted by the political logic because they can retain their values of control and efficiency. The Norwegian Directorate of Health led the way in the process. Actors who work there have a health professional background but work within the political field, giving them access to both logics. This knowledge of the

values made the process a rather seamless negotiation, as both logics were able to retain the core of their identity.

Abbreviations

CP: Clinical pathway; EBM: Evidence based medicine; NPM: New public management.

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Notes

Official statistic on mental health capacity and utilization. <https://www.helse.direktoratet.no/statistikk/samdata-spesialisthelsetjenesten/psykisk-helsevern#produktivitetipsykiskhelsevern>.

Authors' contributions

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Declarations

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Norwegian centre for research data approved the data collection in ref no 280027 and provided me with guide lines to follow regarding written consent. All ethical guidelines were met.

Consent for publication

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Competing interests

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Trust in pathways? Professionals' sensemaking of care pathways in the Norwegian mental health services system

Tine Nesbø Tørseth^{1,2*} and Marian Ådnanes³

Abstract

Background: In January 2019, care pathways within specialist mental health and substance abuse treatment services were officially launched in Norway. The care pathway introduced timeframes for assessment and treatment, allowing a maximum of 6 weeks to finish assessment and provide the patient with a diagnosis, in addition to allowing a maximum of 6 weeks from diagnosis to the first evaluation. The different action points required coding. The system was based on goals to improve services by focusing on user participation, coordinated patient flow, avoidance of unnecessary waiting time, improvement of equal access to services regardless of geographic location, and increased emphasis on physical health and lifestyle.

The purpose of our study was to examine how mental health professionals made sense of care pathways and furthermore, how issues of trust affected the process of implementation.

Methods: Our multiple case study included four outpatient clinics for adults in four community mental health centres (CMHCs) in different parts of Norway. Qualitative data were collected through in-depth individual and focus group interviews and analysed using systematic text condensation. The informants were treatment personnel and leaders in four different outpatient clinics for adults.

Results: The results indicated four distinct themes or reactions to the care pathway and its implementation: 1) lack of clarity regarding the overall goals and content of the care pathway; 2) the increased burden of coding, registration and administrative work, which professionals experienced as a stressor; 3) an IT and medical record system that did not correspond to the coding of the care pathway; and 4) an unrealistic distinction between assessment and treatment. These themes/reactions increased the health professionals' distrust towards the care pathway, and a process of *sensemaking* encouraged them to reduce the importance of the care pathway system and its implementation.

Conclusion: Theories of trust help in understanding how mental health professionals interpret care pathway implementation. Distrust and resistance towards the care pathways overshadow some of the overall quality goals of the care pathway, a view that was indeed shared by mental health professionals.

Keywords: Care pathway, Sensemaking, Trust, Mental health; implementation

Background

In recent years, care pathways in health care have been developed at an increasing rate, and managers are expected to promote these pathways and their implementation in clinical work. However, research on care pathway implementation has shown that clinicians often

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have mixed or negative attitudes regarding the standardization of health care utilizing pathways [1, 2].

Mental health care is seen as a difficult service to manage in terms of implementing change and new innovations because of the strong professional values and identities by professionals working in this field [3, 4]. Furthermore, new guidelines such as care pathways often require new IT systems within hospitals; this need is portrayed as notoriously problematic because these systems interfere with health professionals' usual workflows and because the anticipated benefits take time to materialize [5, 6].

The process of implementing care pathways for mental health services in Norway started in autumn 2018 with national and regional conferences to introduce the new system. A national plan for its implementation from 2018 to 2020 [7] was sent out to the regional health authorities. Organization of health care services through standardized care pathways (CPs) has occurred in several areas of Norwegian health care, with the implementation of CPs for cancer treatment as the largest national introduction of standardized service production [8]. The European Pathway Association (EPA) defines the standardization of care processes into CPs as "a methodology for the mutual decision making and organization of care for a well-defined group of patients during a well-defined period" [9]. The method defines goals and decision making, as well as the measures to include in the treatment. The measures should reflect evidence, best practice solutions, and the involvement of the patient [10, 11]. Schrijvers et al. (2012) [12] show how several definitions of care pathways have been used (e.g., "patient pathway", "integrated care pathway", and "clinical pathway"). Furthermore, the authors [12] recommend using the name and concept of "care pathways" from the EPA, and this convention is applied throughout this article.

In January 2019, the new guidelines within specialist mental health and substance abuse treatment services were officially launched in Norway, with treatment organized according to structured care pathways. The care pathway introduced timeframes for assessment, treatment and evaluation that did not exist previously. A maximum of six weeks is now allowed for patient assessment and diagnosis. The first follow-up evaluation is then required to take place within a maximum of six weeks after a patient's assessment/diagnosis. The care pathway is guided by five strategic goals. These were increased user participation, increased collaboration and coordination, avoidance of unnecessary waiting time, improvement of equal access to services regardless of geographic location, and increased emphasis on physical health and lifestyle. To determine whether the time frames are followed and the overall goals achieved, several new

"pathway codes" were introduced and are registered by the therapist or administrative staff. This registration allows the Directorate of Health to monitor development within the services.

Despite having clear strategic goals, the Directorate of Health was reticent about the execution of care pathways, leaving the interpretation and accomplishment to each hospital or unit within specialist mental health care.¹ Furthermore, there was already much resistance towards the new care pathway from health professionals working in mental health services [13].

The process through which organizational actors attempt to explain, interpret and relate to new innovations or implementations has become a critically important topic in the study of organizations and is often theorized as sensemaking [14]. The ability of organizational actors to make sense of events or issues has been linked to change and its outcomes [15–17]. Trust is seen as fundamental for good-quality health care, new implementations, and outcomes in many national and local health care contexts [18–20].

To understand how trust emerges and influences care pathway implementation, we suggest that combining sensemaking theory with trust theory is a fruitful approach when analysing the complex implementation process. Sandberg and Tsoukas [21], in their review of 147 articles using sensemaking theory, report that only one article applied sensemaking in combination with trust theory and that there was a need for further research combining the two theories. In our study, we studied how health professionals who work in outpatient clinics made sense of care pathway implementation and how issues of trust affected this sensemaking.

How do mental health professionals make sense of care pathways, and how do issues of trust affect the process of implementation?

Theoretical outlook

Understanding change: making sense of implementations

Sensemaking theory has been utilized in several studies examining change [22, 23] and implementation processes within the health care system [24–26].

A central element in much sensemaking research is an overall focus on the individual and the need to understand complex and confusing circumstances and turn them into comprehensible situations that enable purposeful action [10, 21, 22, 27, 28]. Sensemaking directs both cognitive and social mechanisms for coping with

¹ The Norwegian Directorate of Health, National plan for implementation of care pathways 2018–2020

new or unexpected events, and it explains actors' behaviour in practice [10, 24]. The experience of equivocality leads individuals to extract and interpret environmental cues through three sets of interweaving processes: perceiving cues (noticing), making interpretations and engaging in action [22, 23].

Sensemaking helps to resolve incongruity in ways that enable activity [22]. Moreover, individuals utilize sensemaking as a strategy when interpreting new innovations or change projects [21–23, 29, 30]. In recent years, repeated calls have been made to include materiality and relational practice in theory [21, 28, 31, 32]. The critical sensemaking perspective explains how sensemaking already exists in subjects, objects, values and practices when individuals understand and interpret the world from a specific role or identity. This approach comprehends sensemaking as a holistic practice where the context and environment are integral [21, 22, 31, 32].

Trust within mental health care

Trust plays an important role in relationships among the state, health care practitioners, and patients [33–36], and the meaning and enactment of trust is influenced by top-down policy-makers [37]. Gulati and Nickerson [38] define trust as the expectation that another organization can be relied on to fulfil its obligations, to behave in a predictable manner and to act and negotiate fairly even when the possibility of opportunism is present [38–40].

In Szulanski's [41, 42] model on knowledge transfer and implementations in health care, the motivation of the source and credibility are important factors determining success or failure [41]. Furthermore, the same trust needs to exist among governmental agencies realizing national guidelines, health care services and the professionals involved [41]. For consideration of how trust affects these relationships, an assessment of the interests of the source, or trustor, is important [43]. This is in line with Sandström et al.'s [2] research on the implementation of guidelines within mental health care, in which the authors conclude that *regardless of from whom guidelines are released, they are unlikely to be utilized or implemented in the care of patients if those further down in the hierarchy do not trust the source* [1].

When elaborating the role of trust within health care systems, one must be observant of institutions, the number of relationships that must be managed to deliver outcomes, and the importance of developing shared meanings to sustain delivery [43, 44].

Sensemaking and trust in mental health care: bridging the gap

Fuglsang and Jagd [45] examine how sensemaking may serve as a bridge between institutional contexts and

interpersonal trust processes. The critical sensemaking perspective, introduced by Mills et al. [46] and elaborated further by Aaroma et al. [47], provides a framework for understanding how individuals make sense of their environments at a local level while acknowledging the societal context. By examining contexts, the critical sensemaking framework creates space for a discussion of how different policy implementations, such as care pathways, in which individuals operate affect the cues they extract and how they make sense of different events. Critical sensemaking positions the context as a link between dominant social values and individual action [46, 47].

Conceptualizing how trust influences sensemaking may be a useful way forward. Möllering [48] mentions three elements when explaining why trust depends less on the individual trustee and more on the social norms and values in which actions are embedded. The elements of familiarity, calculated interest, and compatible norms and values render trust [48]. Thus, enabling an understanding of trust means becoming familiar with these structures. One approach is to look towards these structures within the field of mental health care that exist during the time of care pathway implementation. The field of mental health care in Norway is heterogeneous, and different actors bring their own logic on how treatment should be organized and how the care pathway seeks to address these issues [13]. Scientific–bureaucratic medicine is a term from Harrison and Ahmad's [49] research on care pathways and their guidelines and shows how doctors and psychiatrists relying on medication and evidence-based medicine could have a more positive outlook regarding care pathways than, for example, psychologists firmly believing in a trusted alliance between patients and professionals that is hard to standardize [13]. Despite these differences, a trend that has developed over the last decades is viewing different governance and policy arrangements, such as new public management and other standardized tools aimed at developing structures, policies and processes [50, 51], as mistrust of health professionals and a threat to professional value discretion and autonomy [9, 52, 53].

New policies therefore affect organization as much as they influence trust by impacting the identities, skills, and prioritizations performed by the professionals and managers [16, 54, 55].

In sensemaking, "individuals, drawing on identity resources, act on cues, influenced by trust, and enact new, sensible environments as they do so" [22]. This enables a context that affects which cues are extracted as well as the interpretation of the extracted cues [56].

Analysing the outcome of care pathway implementation therefore means conceptualizing the theories

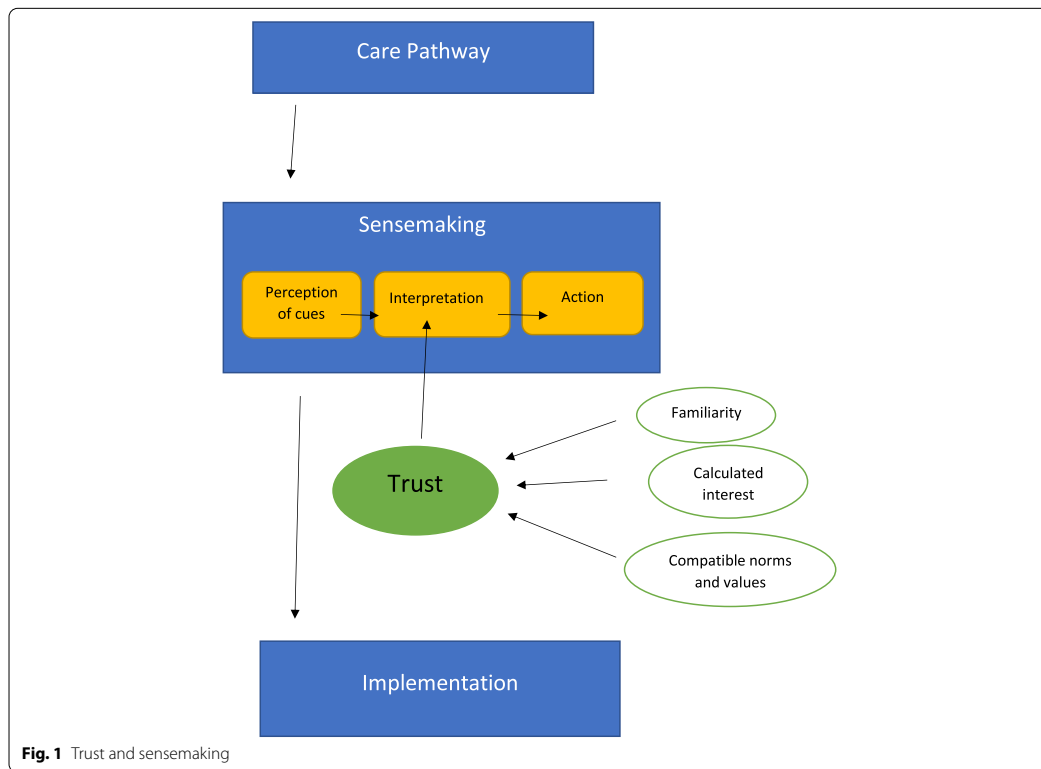


Fig. 1 Trust and sensemaking

presented in a more comprehensible framework. Such a framework is shown in Fig. 1, sensemaking and trust.

Methodology

We used a multicase study design and qualitative techniques to understand the response of health professionals to care pathway implementation [57]. In this study, in-depth individual and focus group interviews with health professionals working in four different outpatient clinics for adults were performed. Qualitative interviews are a well-established and effective method of data collection and are particularly suitable for obtaining information on informants’ experiences and perceptions [49]. Focus groups provide a wide variety of data regarding the concept being studied [58] and can help people explore and clarify their perspectives to a greater extent than is possible in individual interviews [59].

Study setting and sample

In Norway, mental health services are public and organized in tandem with general health services at the municipal level and specialist level. Hospitals and specialized

mental health services are run by 19 health trusts owned and instructed by four regional health authorities on behalf of the state as owners [60]. The specialized mental health services system currently comprises 66 community mental health centres (CMHCs) consisting of outpatient clinics, mobile teams and inpatient wards [60].

Our study included four outpatient clinics for adults in four CMHCs. The informants were treatment personnel and leaders of teams, units or departments.

The CMHCs were invited to the study via a formal request sent to the leader. The invitations were distributed to leaders at lower levels and to treatment personnel. An overview of the participants is given in Table 1.

Data collection

The interviews were conducted between May and November 2019 and took place face to face by one or two researchers visiting the clinic. Individual interviews lasted between 40 and 60 min, and focus group interviews lasted approximately 90 min.

A partially structured interview guide was used. The informants were asked about their attitudes towards and

Table 1 Data collection

	Outpatient clinic no. I	Outpatient clinic no. II	Outpatient clinic no. III	Outpatient clinic no. IV
Individual interviews with treatment personnel and leaders	Psychiatrists: 1 Psychologists: 9		Leader (nurse): 1	Leader (nurse): 1
Group interviews with treatment personnel, some of whom were leaders of teams or units	Not performed	Psychiatrists: 1 Psychologists: 4 Nurses: 3 Others: 3	Psychologists: 5	Psychiatrist: 1 Psychologists: 4 Nurse: 1 Others: 3

experiences with the pathway system and the implementation process as well as how the system influenced their everyday work.

All interviews were audio-recorded and transcribed.

Data analysis

The interview transcripts were first read in their entirety and were later imported into NVivo qualitative software. The data were analysed utilizing systematic text condensation [61], where codes were created based on the data and were concentrated on the main themes from the interview, namely, positive and negative expectations regarding care pathways, negative and positive experiences with the implementation process, and experiences concerning the pathways' influence on the informant's everyday work practices. Codes were subsequently clustered to form descriptive themes, for example, "increased time spent on coding work processes." Furthermore, the descriptive themes that were related were clustered together to form analytical themes, for example, "care pathways lead to increased administrative work." All included themes were grounded in the text throughout the analysis.

Results

"There is something problematic about the fact that we are asked to do a whole lot of extra things, including more coding, more questions, more evaluation and stuff, without anything being added. We need to learn a whole new way of organizing our work, new systems, new codes, in addition to everything else we are working on. I don't understand how we are going to make it work..." (psychologist)

The results indicated four distinct themes or reactions towards the care pathway system. These themes were lack of clarity regarding the overall goals and content of the care pathway; new codes, registration, and deadlines in the care pathway; an IT and journal system that did not correspond to the care pathway; and last, interference of the care pathway with discretion and autonomy, creating some professional dilemmas.

Lack of clarity. "Care pathways, what are they?"

"We didn't really know what the care pathway was, and we spent some time figuring out what it was, but when we asked our leader, we were told to await..." (psychologist)

The implementation strategy and start date were postponed and changed several times during the care pathway's birth and infancy. This had ripple effects on the rollout within the different clinics and, as one psychologist stated,

"There has been so much talk about the visions and goals behind the care pathway, why it is so important. But what does it look like in the clinic? No one really knows, it seems..."

This uncertainty was handled by the leaders by telling their staff to await further action, as one clinical leader said, "The pathway, well, I don't like it at all, I must say. We already have too much to do. However, I try not to show this to the staff, so when they ask me about it, I just tell them to await things."

However, awaiting the next step created unrest within the clinic but at the same time allowed everyday work to continue.

The care pathway's overall goal of improved quality within the mental health services e.g., increased user participation and better coordination, were relatively open for interpretation in terms of their attainment. The leaders of the outpatient clinics were responsible for implementing the care pathway. Despite the efforts made by some of the leaders to involve the staff in the overall goals, the most common strategy for the professionals was to ignore further involvement with the overall goals, because as many stated, "This is something we are already doing and have been doing for many years."

Codes, registration, and deadlines in the care pathway

"... None of these codes are anchored on how mental health work actually takes place. Treatment is difficult to plan, because the effect of treatment is unpre-

dictable.” (psychologist)

Many professionals thought that the workflow presented in the pathway system and the codes involved did not correspond to a real-world timeline for mental health patients. Moreover, statistics based on the codes registered – for example, when deadlines are not met – could be traced to the therapist’s work, without attention to all kinds of reasons behind the codes, e.g., patient no-show, holidays, rotation in inpatient wards, or access to a specialist to make a clinical decision. All these elements caused stress by imposing a rigid time system without taking into consideration that breaks often occur and are more generic than the pathway system accounts for. A psychologist expressed the following opinion that was shared by many of our informants:

“The deadlines between action points are way too short. I often see that I have negative time breaks that do not count as legitimate time breaks [in the coding system], so I’m punished for that.”

The timeline and following deadlines therefore did not reflect work as it unfolds within an outpatient clinic. The consequences of this limitation were an overall feeling of frustration towards the system and the opinion that the idea behind the pathway was for the government to be more in control of work within an outpatient clinic.

“All this coding and administration, everything that is involved with the care pathway is just based on an idea that the government does not trust us or understand what we are doing. They want to control us.”

An IT and journal system that does not correspond to the care pathway

“All these new deadlines are supposed to be coded, however through an IT system that does not correspond with the new coding. So, everything needs to be written down and remembered. I mean, what’s the point?” (psychologist)

Registration of the action points, such as providing a diagnosis or evaluations within the care pathway, became a problem for several reasons. The lack of anchoring for real-time usage was vital; however, this was not the only issue. Another problem was that the different electronic journal systems used in the clinics did not correspond completely to the new codes. The practical implications were that deadlines were followed manually one way or another by the therapist, for example, by keeping an account for each patient. The frustration this caused was immense.

For practitioners with many patients, this meant a large amount of extra work, as this psychologist explains:

“I have 25 patients at any time, and the computer system does not tell you about the deadlines, so we need to write it down in a paper book that we are told not to use, and in addition I need to remember it, so I get quite stressed about it...”

In addition to extra work, this manual “book-keeping” – which could be done using an Excel sheet or the therapist’s Filofax – also caused stress due to privacy concerns. A more comprehensive and overarching problem that required sensemaking was that the ideal workflow for a care pathway interfered with professional values of discretion and autonomy. This will be further elaborated in-depth in the final section.

Care pathway interference with discretion and autonomy: when standardization creates professional dilemmas

“The relation between patient and provider is the most important factor when it comes to healing. This means creating a space of trust where the patient decides what to share and when to share it. Some of the questions (from the care pathway) could actually make patients more sick by retraumatizing them...” (psychologist)

The pathway involves a distinction between the assessment period and the treatment period, with a deadline of six weeks to finish the assessment and give the patient a diagnosis. Many professional dilemmas related to this timeline were presented by health professionals. First and foremost, many providers had a negative reaction to the care pathway system’s emphasis on the use of formal schemes and standardized questions, for example, in the first meeting with the patient. It was a concern that this approach could negatively impact the relationship between the patient and the treatment provider. This relationship between the patient and provider is of particular importance in mental health care. Many professionals expressed a concern that the care pathway invaded this relation and had the potential to negatively influence patient treatment, as the psychologist quoted above explained.

Second, in addition to the deadline of six weeks to finish the assessment and the standardized manuals utilized, the care pathway operates with a separation between diagnostic practice and treatment that does not correspond to real-world work practice, as this psychologist explains:

“Important information for the diagnosis is sometimes not given before many months have passed,

and the patient feels safe enough and trusts me with this kind of information. So, this distinction between diagnosis and treatment is not anchored in reality."

Third, having the autonomy to organize treatment is of vital importance for mental health professionals. However, the care pathway has the potential to influence this autonomy by dictating that the first encounters are centred around assessment and diagnostic practice. This approach could influence professionals' experience of autonomy, as a psychologist explained:

"If a patient has trouble with sleep, the care pathway states that I must wait at least four consultations before I can do something about it, because the assessment and diagnostic practice must happen first, even if the patient is obviously depressed and has major sleep issues."

Finally, the above shows that the care pathway influences the core values of mental health professionals, namely, autonomy when planning for treatment and discretion when providing treatment.

Discussion

This study sought to elaborate on the sensemaking that health professionals experienced during the first ten months of care pathway implementation in four outpatient clinics in the Norwegian specialist mental health services system. In Møllering's theory on trust, three elements were found to influence trust and distrust: calculated interest, familiarity, and compatible norms and values.

The analysis shows how sensemaking circulated around two cues within outpatient clinics. One cue was to await further action, and the other was to recognize that the health professionals were already doing the necessary work. Both cues led to actions of avoiding and reducing the importance of the implementation.

Care pathways and trust

Sutcliffe [62] states that sensemaking occurs as follows: *when enacting order into the ongoing circumstances from which they extract cues, people act their way into knowing* [62].

Regarding the issues related to care pathways, the fundamental question is why the care pathway needs to be made sense of when the pathway is designed to improve the issues that are faced in mental health services. The analysis thus far has shown that ignoring the pathway is more important than actively engaging in it. Therefore, in regard to Sutcliffe and the act of knowing, an examination of the pathway's relation to trust will help us understand why sensemaking occurs.

Elaborating Møllering's [48] theory on trust shows how the issue of trust also depends on social norms and values, thus offering an explanation of how the pathway system was interpreted, understood, and made sense of in matters of trust and distrust. Furthermore, Møllering's three elements of calculated interest, familiarity and compatible norms and values are of particular importance and will be further elaborated.

Trust and calculated interest

The pathway system is based on ideas of standardization [63, 64] and new public management [65], where increased control and efficiency are some of the guiding goals [1, 9, 65]. Thus, health professionals interpret care pathways as health authorities' interest in having more control over the activities and development of these services.

This mistrust was expressed by the health professionals in our study as the need to defend their work practices and the amount of time spent on different procedures, as well as an overall idea of the need for control of mental health professionals. The interest is therefore calculated as a belief that the intent behind the care pathway system was not first and foremost to improve the services but rather to attain more control of the services.

Trust and familiarity

Familiarity is understood as the general premise that prior interaction creates "familiarity" and in turn enables organizations to develop confidence in each other's trustworthiness [38]. The relationship between health authorities and mental health services is characterized by a general reciprocal scepticism towards each other's intentions, something that makes implementing policy within this sector difficult [1, 9]. The context of increased control and management over the services within this field is based on several legislative changes during the last decades [66, 67], where the government is aiming for more transparency. The way the care pathway system evolved was characterized by mixed messages and a lack of a clear and coherent strategy, as seen by health professionals. This poor delivery of the new services further increased their aversion and led to distrust towards the care pathway and its developers. However, the issues of trust also had ripple effects on the professionals' work practices, a phenomenon that needs to be understood more thoroughly.

Trust and compatible norms and values

Work in a mental health clinic is characterized by several elements, such as unpredictability, difficulties in planning treatment and a high degree of discretion and autonomy, because each patient needs individual care

[68]. All these elements are based on strong, professional values on which treatment and care rest. First, the elements of autonomy and individuality collide with some of the intentions of the pathway system, such as efficiency, equality and standardization [68, 69]. This incongruity makes the implementation of these measures difficult, as Sutcliffe [62] explains, when the actors involved understand, judge and interpret the care pathways from a professional identity. Therefore, the elements of the pathway system that do not correspond to an individual's professional identity are interpreted accordingly. In addition, as Calnan and Rowe [70] describe, new policies affect the organization as much as they influence trust when influencing the identities, skills, and prioritizations performed by professionals and managers [70]. Because the care pathway did not take their work practices into consideration and was grounded on other values, the skills and prioritizations performed by the professionals discredited the care pathway and led to further distrust.

All these issues explain how the pathway system required overall sensemaking in an attempt to disregard its importance within the outpatient clinic.

Making sense of the care pathway

Making sense of the care pathway by avoiding it and reducing its importance

First and foremost, *sensemaking is an explicit response to chaos, which generates "an undifferentiated flux of fleeting sense impressions"* [71]. This chaos creates the need to make sense of something, and while doing so, restore the order that allows everyday work to continue. Professionals working within mental health care often deal with high workloads, a large amount of responsibility and work that is mentally demanding [72]. The care pathway system was developed in an attempt to be the solution to some of these issues. The important question therefore becomes why mental health professionals experience the pathway as a stressor. Their elaborations of how sense is made when they experience issues that cause frustration and stress [72] show how individuals look for cues to cope with the experience [56].

As the data clearly show, care pathway implementation caused frustration for the participating health providers. The results identified two main cues within these services. The first cue was *to await further action*. The second cue was to recognize that *we are already doing the necessary work*. Both cues led to an overall sensemaking conclusion that indicated that the professionals should ignore the content of the care pathway because *"plausible explanations shape sensible situations: they normalize the breach, restore expectations, and enable projects to continue"* [10]. In this way, health professionals could continue their everyday work.

Making sense of threats to professional values by fooling the system

An important concern among professionals in our study was that the care pathway generates issues that influence professional autonomy by dictating when professionals should provide assessment and diagnostic practice and when the treatment phase should start. More precisely, the distinction between assessment and treatment in the care pathway system, as well as the rigid manuals, have the potential to influence health professionals' autonomy and discretion and potentially negatively influence treatment [73, 74]. Interruption of the subsequent relationship between a health professional and a patient is understood as something that potentially threatens professional mental health work [1, 9, 74]. In addition, as Sutcliffe [62] states, *"identity and identification provide clear frames of reference from which judgements and interpretations fan out"* [62].

Under these circumstances, health professionals make sense of the pathway system so that the threat to their professional identity is eliminated. The approach in an outpatient clinic is understood as the use of different decoupling mechanisms aiming to maintain professional autonomy in daily practice and meetings with new patients, e.g., continuing assessment when the patient is in the treatment phase or avoiding questions that could potentially negatively influence patient treatment. Therefore, the same actions that preserve discretion and autonomy discredit the system upon which the care pathway is built. Therefore, the resulting cue is to ignore parts of the care pathway, in line with the conclusion of the previous analysis.

Conclusions

Despite the issues facing current mental health services and the attempt to solve some of them through the care pathway, the introduction of this system was met with much resistance. The issues of distrust from professionals working within mental health specialist services towards politicians and policy-makers responsible for different arrangements to be implemented in health care, such as standardization and evidence-based medicine, were further reinforced by the introduction of the care pathway system. Health professionals agreed with the overall goals of the care pathway system, such as greater user participation and better coordination. However, their emphases, worries and perspectives were first and foremost on what they perceived to be controversial and challenging about the system – the measures, coding and increased administrative work and what they perceived as a reduction in the time dedicated to patient assessment and treatment. We sought to determine how mental health professionals made

sense of the pathways and how issues of trust affected their implementation. Our findings and analysis show that issues of trust or, more precisely, issues of distrust, affect how mental health professionals make sense of the care pathway by reducing its importance within the organization. These issues of trust have further implications, because it seems that the measures that affect distrust and resistance towards the pathway overshadow the care pathway's overall goals, such as greater user participation and better coordination. This sentiment was indeed shared by mental health professionals. Changing professional practice within mental health care, where professionals are guided by strong professional values, has been shown to be complicated. Our study confirms this observation. Furthermore, trust between authorities and mental health care professionals in Norway probably needs to be restored for better success with top-down policy implementation.

Abbreviations

CP: Care pathway; NPM: New public management.

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Authors' contributions

Both authors discussed the results and contributed to the final manuscript. TNT conceived and designed the theoretical background model, the results section and analytic section. MÅ contributed to data collection, analysis and wrote the methodology section.

Authors' information

The main author, TNT, is currently a PhD candidate at the University of Bergen and The Mohn Centre for Innovation and Regional Development. Her research project focuses on the construction/implementation/outcome of care pathways within the Norwegian mental health services system.

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Availability of data and materials

The datasets generated and/or analysed during the current study are not publicly available due to regulations provided by the NSD-Norwegian Centre for Research Data. Data are available only upon request to the corresponding author; however, additional written consent to share the data from each participant needs to be sampled. For more information, see the National Competence Centre for Data Protection and Data Management in Norway.

Declarations

Ethics approval and consent to participate

This study is based on two data collections, both approved by the NSD-Norwegian Centre for Research Data (reference IDs: 280027 and 419206). NSD issues nationally valid judgements for studies within the Norwegian context. Written informed consent was obtained from all participants. All research methods were performed in accordance with the relevant guidelines and regulations.

Consent for publication

Not applicable.

Competing interests

None.

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